Public Board Meeting

Thu 01 June 2023, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Russell Hardy

Apologies were received from Alan Dawson

13:00 - 13:00
0 min

2. Declarations of Interest

Russell Hardy

13:00 - 13:00
0 min

3. Minutes of the Meeting held on the 6th April 2023

Decision *Russell Hardy*

3. PUBLIC BOARD MINUTES -APRIL 2023 LF, KO, FM.pdf (18 pages)

13:00 - 13:00
0 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

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

13:00 - 13:00
0 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Glen Burley*

5.1 1st June 2023 - WVT CEO Report.pdf (8 pages)
5.1a Appendix A - AoG Recent Activity Summary_.pdf (2 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 01 April 23.pdf (31 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/David Mowbray*

5.2.2. Activity Performance

Discussion *Andrew 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. Draft Annual Report and Annual Governance Statement 2022/23

Decision *Katie Osmond/Erica Hermon*

- 6.1 20230524 - Draft Annual Report for Board.pdf (2 pages)
- 6.1a Draft AR Version 13.pdf (89 pages)

6.2. Draft Quality Account 2022/23

Decision *Lucy Flanagan*

- 6.2 Quality Account Frontsheet.pdf (2 pages)
- 6.2a QA2022-23 v3.pdf (91 pages)

6.3. Quality Committee Terms of Reference and Workplan

Decision *Lucy Flanagan*

- 6.3 Quality Committee - ToR April 2023 FINAL.pdf (7 pages)

6.4. Board Assurance Framework

Decision *Erica Hermon*

- 6.4 - Covering BAF Report for Board.pdf (2 pages)
- 6.4a BAF 2023.pdf (2 pages)

6.5. Modern Slavery Act Statement

Decision *Erica Hermon*

- 7.3 Board Modern Slavery Statement Report.pdf (2 pages)

6.6. Foundation Group Strategy Committee Terms of Reference

Decision *Russell Hardy*

- 6.6 FGSC Terms of Reference.pdf (3 pages)

13:00 - 13:00
0 min

7. Items for Noting and Information

7.1. Digital Programme Update

Discussion *Katie Osmond*

- 7.1 WVT Digital Programme.pdf (7 pages)

7.2. Policy Panel Update

Discussion *Erica Hermon*

- 7.2 Board Policy Review Panel Update.pdf (2 pages)

7.3. Committee Summary Reports:

7.3.1. Audit Committee 16 March 2023

Discussion *NICOLA TWIGG*

- 7.3 AC Front Sheet.pdf (1 pages)
- 7.3.1 Audit Summary Mar 23.pdf (2 pages)

7.3.2. Integrated Care Executive 14 February 2023 and 3 April 2023

Discussion *Frances Martin*

- 7.4.2 ICE Update for WVT Board.pdf (3 pages)

7.3.3. Quality Committee 30 March 2023 and 27 April 2023

Discussion *Ian James/Nicola Twigg*

- 7.3.3 QC Board Summary Report - March 23 Public.pdf (3 pages)
- 7.3.3.a QC Board Summary Report - April 23 Public.pdf (4 pages)

7.4. Committee Minutes:

7.4.1. Audit Committee 8 December 2022

Information *NICOLA TWIGG*

- 7.4.1 Audit Committee minutes - December.pdf (14 pages)

7.4.2. Foundation Group Board (and Action Log) 3 May 2023

Information *Russell Hardy*

- 7.4.2 Draft Public FGB Minutes (WVT) - 3 May 2023.pdf (11 pages)
- 7.4.2a . FGB Public Actions Update Report - 3 May 2023.pdf (1 pages)

7.4.3. Quality Committee 23 February 2023 and 30 March 2023

Information *Ian James*

- 7.4.3 QC minutes - FEBRUARY.pdf (21 pages)
- 7.4.3a QC minutes - March.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 17.01.23.pdf (3 pages)

13:00 - 13:00
0 min

11. Date of Next Meeting

The next meeting will be held on 6th July 2023 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 6 April 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
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Jon Barnes	JB	Chief Transformation and Delivery Officer
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Val Jones	VJ	Executive Assistant (For the minutes)
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)
Andrew Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director (ANED)

	The Employee of the Month award was presented to Emma Bell, Paediatrics. The Chair read out the reason why Emma had been nominated for this award. The Team of the Month award was presented to the Ross Community Hospital – Peregrine and Merlin Wards. The Chair read out the reasons why the team had been nominated for this award. The Chairman welcomed Jo Rouse, Associate Non-Executive Director to the meeting.	
Minute		**Action**
BOD01/04.23	**Apologies for Absence** There were no apologies received.	
BOD02/04.23	**Quorum** The meeting was quorate.	
BOD03/04.23	**Declarations of Interest** There were no new declarations received.	

BOD04/04.23 **Minutes of the meeting held 2 March 2023**

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The Chief Strategy and Planning Officer clarified re Elective Surgical Hub – Full Business Case - DRAFT paragraph (l) – The Trust do not refer patients to the Wye Clinic, this is a separate private enterprise.

Resolved – that with the agreed clarification, the minutes of the meeting held on 2 March 2023 be confirmed as an accurate record and signed by the Chairman.

BOD05/04.23 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD06/04.23 **Chief Executive's Report**

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

(a) Integration Frontrunner Programme – This is a national programme the Foundation Group is linked into which South Warwickshire NHS Foundation Trust (SWFT) are involved in. The Foundation Group are also involved in the Provider Collaborative Innovator work and through this the Lead Provider arrangements for SWFT are being accelerated. Progress in Herefordshire in relation to this was discussed in the Board Workshop held this morning. This programme is a consolidation of simplification but also an increase in the capacity of pathways flowing out of hospital, particularly into a Home First model. This will provide further evidence of the quality and financial benefit of having that approach. The CEO will report back to the Foundation Groups on progress.

(b) National NHS Staff Survey – This is on the agenda. This is a very positive set of results, particularly in the context of what has been occurring across the NHS over the last year. We were 7th out of 21 Trusts in the Midlands. We will always aim to improve, and are looking at a series of actions to address some of the issues that have come forward from individual members of staff. We will also look through the individual comments from staff made in the survey, which will also influence the actions that we take.

(c) NHSE Headcount Reduction – There is a combining of different bodies at a national level which will result in a headcount reduction. Some of this will also be delivered through the transfer of staff into the new arrangements in the NHS, including our Lead Provider model. We recognise that we do not have all of the skills to do everything that we will be called upon to do in the future, and so the CEO will be working closely with our Integrated Care Systems colleagues to ensure that we retain these skills within the NHS.

(d) Junior Doctors Strikes – The CEO recognised the considerable efforts of everyone during this time to ensure that services ran smoothly. There were only a small number of cancellations compared to other organisations. The CEO also noted the large period of industrial action between the 11th and 15th April, immediately following the Easter Bank Holiday which will result in a long period of reduced medical workforce. The workforce includes some very senior clinicians who are fundamental to the delivery of safe services across the organisation. The CEO and the Chief Medical Officer (CMO) met with the Consultant Body last night and passed on their thanks for everything they did during the last strikes and their plans for support during the next. This will also involve other senior clinicians and all the managerial effort that goes into making sure that we reorganise services to keep them safe. One of the CEO's concerns was the loss of "headroom" to consider some of the more strategic matters that we face.

(e) More from our Great Teams – Update from the Surgical Division – There are a number of areas highlighted, the most significant of which is the Da Vinci robot. We procured this in partnership with SWFT. This is an amazing piece of kit which allows us to deliver more minimally invasive surgery in an effective way. This is a technology that will evolve and develop in the future and will help us to recruit and retain more excellent surgeons to join our team. The report also includes an update on the Elective Surgical Hub and the surgical bed reconfiguration. Finally, regarding our 78WW performance, we had a large number of patients who could have potentially breached as we recover from Covid. It is very positive to see the organisation's performance with only four patients actually breaching. The CEO saw a chart this week that showed the amount of elective activity that has been carried out across Midlands Trust, and the data shows that Wye Valley performance is the highest out of the Trusts in terms of our comparative value of activity to the baseline year for 2019/20. In fact, the top four positions were occupied by the three Trusts in the Foundation Group.

(f) The Chairman noted that the last two points really bear testament to the phenomenal efforts of the Executive Directors and the Leadership Team, the Clinical Teams and everyone on the front line in terms of the work regarding and the growth of elective work since 2019.

(g) Ms Quantock (NED) queried regarding the new surgical robot, if we have a sense of how patients are feeling about this. We need to ensure that we alleviate any concerns with perhaps some education needed. The CEO advised that patients will be consented when we use the robot but also agreed that we need some wider communication so that people understand exactly how the robot works, ie the robot allows the magnification of surgery in effect by a skilled surgeon. This is around technology assisting the skilled surgeon and we will have a communication campaign to allay any fears. Ideally, this would involve our first patient undergoing surgery with the use of the robot (with permission) being a focus about the technology that we have introduced.

(h) Mr Cottom (NED) questioned whether we have an idea how we compared nationally with regards our 78WW achievement or is it too early, ie are some of our waiting times better than the national norm. The CEO noted that we need to be looking at improvement and the pace of this as the main focus. The Midlands Region has the biggest waiting list in the country and therefore the biggest challenge. We have historically had some of the longest waiting times which has necessitated dependency on the independent sector. It is positive to be in this position now as we look at our capacity to be able to say that along with our Elective Surgical Hub, we will be able to deliver our own activity internally very soon. There should be some more comparative data in the future that the CEO can share. The Chairman highlighted that as a Trust, we have benefited from very substantial capital investment provider from the Centre, which we are very grateful for. This has allowed us to revolutionise our theatre and surgical capacity.

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

BOD07/04.23 **Integrated Performance Report**

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

a) It is a positive report this month. It is also important to note that it is well over a month now since we have had any patients who have been boarded on our wards overnight. This was of concern during January and February, and we have heard some of the impact of that on our staff and patients at our Board Workshop this morning. We do still have to board some patients during the day to ensure that we keep flow going, but this is relatively small numbers. The latest Bed Report shows that we have some empty beds, which means that there will be no patients in the Emergency Department (ED) by tomorrow morning. This is very good progress, but not a position we will expect to be in following the next Bank Holiday weekend and the Junior Doctors strikes. This bed base had meant that we have had to ring fence all of those elective beds to enable our 78WW to be reduced down to just four patients. The plan is to get to the very highest levels of productivity through the Elective Surgical Hub, which the clinical teams have signed up to.

b) Our people metrics have continued to improve. We are aware that we have further to go but the Managing Director was particularly pleased by the recruitment and retention of our Health Care Support Workers. We made a strategic move around changing career pathways and pay for that group of staff, which is starting to pay off. We are undertaking a similar review of our Band 5 nursing workforce in terms of recruitment and retention. We should have some proposals to share by the end of the month of how that will look.

c) Urgent Care Pathway – We are in the middle of the pack for this, but we can do much better. There are two things to this – firstly our Urgent Care blueprint which is our blueprint for Herefordshire as a System and how we manage Urgent Care both into general practice and into our Community response and then into the hospital. We have an agreed set of principles which is being worked up into a case for change. We will not deliver this all at once as it is a big programme of change. It is over three phases over a number of years. The first phase we will be working on quickly. The second part is the way that our ED currently works. We made a lot of changes in ED to manage Covid safely through the department which has meant that we have been left with a very large ED, with that footprint not working now as effectively as it could. A piece of work was started around how we can redesign our ED so that we can deliver better performance for our patients. There is probably a financial saving to this also.

d) Mr James (NED) noted that as a Board we rightly focus on our challenges, but wanted to pay tribute to the Executive team regarding the good set of trends that we are seeing at the moment. There are a large number of people supporting the Directors and Mr James (NED) hoped that we are passing these messages down to these staff.

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

BOD08/04.23 **Quality (including Mortality)**

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

(a) We continue to see a very good response rate from our Family and Friends text messaging service. Our responses are now at the national average level. More importantly, we are receiving positive responses from patients, their families and friends. Further work is needed to do with feedback and responses back to clinical teams to enable them to focus on the improvements needed.

(b) On 23rd March, the National Place Audit results were published. These are the patient led assessment of the care environment. A full report will be presented to the Quality Committee in April. The headlines show a very good set of results for the Trust. We were above the national average for 19 out of the 32 domains across all four of our hospital sites. When we compare our performance from the last inspection in 2019 to 2022, we have made improvements in every element with the exception of two. These relate to food at one of our Community Hospital sites.

(c) In preparation for the next milestone of the National Patient Safety Strategy, we successfully transitioned from one Incident Reporting System to a new System last week. This occurred seamlessly and reporting levels have remained the same. The next milestone is in September when Incident Reporting nationally changes significantly.

(d) The CQUINS are included in the report. These are the five quality improvements that form part of our standard contract. We are very proud of the malnutrition screening and the pressure ulcer risk assessment screening CQUINS that were applicable to the Community Hospitals. There has been quarter on quarter improvements. We are also a front runner for our assessment, diagnosis and treatment of lower leg wounds for which we are part of a national programme.

(e) We undertook a baseline audit of the malnutrition screening tool for the Acute Hospital site. This was partly because the CQUIN did not apply to the County Hospital and we are aware that further work is required. We agreed in Quarter 3 we would undertake a baseline audit – the results from the 258 patients are included in the report. They show that improvements are required and are not dissimilar to the results that we saw for the Community Hospitals when we introduced the CQUIN at the beginning of last year. Our plan is to move that forward and to adopt all of the principles to the County Hospital site for both malnutrition screening and pressure ulcer screening. We will also be introducing our Clinical Practice weeks where we will take training and education to frontline teams rather than moving them into a classroom. The focus for May will be malnutrition screening and pressure ulcer screening and management.

(f) The Quality Priorities agreed through the Quality Committee this month are also included in the report. These were agreed following extensive consultation and engagement with frontline teams and looking at local intelligence to determine what our priorities should be.

(g) The Staffing Report covers February's data which is why fill rates are in excess of 100% in many areas due to the operational pressures that we were experiencing.

(h) The SHMI continues to fall. There is an anomaly with the HSMR which is significantly higher than the SHMI. The CMO is now confident that this is due to our palliative care coding. We score poorly with the level of coding for palliative care. If we took palliative care coding out of the HSMR score, we would be scoring under 90 as a Trust. The Mortality Project Manager has started some work around this.

(i) The individual outlier groups also are showing reductions in mortality. The crude mortality rate (which is the most responsive rate for mortality) also remains low.

(j) Due to the continuous flow model that we were had to introduce during winter, the CMO has been looking carefully at mortality rates and has not seen any increase overall in mortality during that period. This remains under close review.

(k) We had a good audit on our Stroke Mortality which was a concern about six months ago. There were no care concerns found and we are scoring the highest in the West Midlands for the Stroke SSNAP audit data.

(l) The Chairman queried how the CNO was feeling around the safety of our Maternity Services. The CNO felt confident that we continue on our improvement journey. Until recently, the Associate Director of Midwifery had not had a Clinical Director to support her in taking us forward with our improvement journey. Since last month the new Clinical Director for Maternity has been in post. This has proven to be a very positive addition to the leadership team. We have also appointed a Consultant Midwife who joins us next month as part of our investment in leadership. We also have very few vacancies within the maternity service.

(m) The Chairman questioned in terms of the challenge of recruiting midwifes, is the CNO assured that the Board is supporting the Midwifery Team on doing everything practically that we can. The CNO confirmed that they were. We have recently agreed to recruit to turnover so that we do not have any gaps in our service. This would then cover maternity leave, sick leave etc.

(n) The CMO advised that our extended perinatal mortality rates and still birth rates remain one of the lowest in the country and we are on target to reduce our rates by 50% by 2025. The CMO also reiterated the comments made by the CNO, noting that we can always improve and there is always something to learn from the tragic deaths that we see among babies.

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

BOD09/04.23 **Activity Performance**

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

(a) Junior Doctors Strike – The COO added his thanks to the operational, clinical and all of the support teams for the delivery achieved in March. Planning has been well underway for the Doctors Strike next week. This will effectively be a 10 day weekend for us but the COO is confident that we have robust plans in place. Again, all our teams have stepped up to provide reduced, but safe levels of cover across our inpatient wards, maintaining our emergency theatres and protecting as much elective activity as possible. This is expected to be lower than previously due to high levels of annual leave. We are looking at around a 25% reduction on our elective activity compared to Easter periods pre Covid but we have done very well at protecting as much cancer work as we can along with our long waiting patients. We have also been reducing our seven day length of stay patients and our super stranded patients (patients waiting over 21 days) and we have seen a reduction in the number of these patients over this week. There has been some very focused work regarding this with our Complex Discharge Team and our System Partners to try to reduce numbers to as low as we practically can ahead of the strikes.

(b) Last week we saw our busiest week of ED attendances that we have ever seen across the Trust. However, the latest Emergency Care Improvement Support Team Provider Indicator tables for February shows that Wye Valley had one of the best percentages of patients seen within an hour in ED and we are also in the top quartile of English Trusts for ambulance handovers within 30 minutes.

(c) There is still much work to be done around our Valuing Patients Time Programme and Agenda in terms of improving our 4 hour performance which is not where we want it to be ahead of the winter plan. Ahead of winter this year, we have a robust plan in place, particularly around expanding our virtual ward, Same Day Emergency Care and developing our ward based flow in quality dashboards to support teams in progressing timely discharges. We are also reviewing our acute floor pathways and floor plan to ensure that we can streamline decision making and patient pathway navigation. As part of the Foundation Group, we already have site visits arranged with George Eliot to do some peer reviews on some of our plans as they have such a high 4 hour performance.

(d) Cancer – Our 23 day faster diagnosis standard slightly reduced due to the post-Christmas and winter challenges, but we have seen a slight improvement in February to 68% and we are seeing early signs in March of this continued improvement. We have robust plans to maintain and deliver this standard by the end of this new financial year.

(e) Cancer – Patients waiting over 63 days reduced to around 115 patients before Christmas, which has remained static over the winter period. We are confident that we can deliver a 40% reduction on that figure during this year to get below 70 patients and hit our 62 day performance target.

(f) SSNAP Data – During the period October to December, the Trust achieved a Grade B with the best performing score for routine admissions across the West and East Midlands. This is a fantastic achievement for our Stroke team. Our diagnostic performance standard saw 78% of patients being seen in less than 6 weeks. We still have a long way to go to achieve our 99% target but this is the best performance that we have seen since before Covid.

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

BOD10/04.23 **Workforce**

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

(a) A lot of work continues in terms of enhancing the health and wellbeing support for our staff. Over the last 2 months we have started to see a reduction in sickness absence and the Chief People Officer is confident that this will continue. There are also some positive improvements with our KPIs around staff.

(b) Our refreshed Leadership Development Programme commenced in May and this will also include a new session on kind, compassionate and inclusive leadership. This is something that we want to roll out across the entire organisation. We remain committed to supporting a diverse and fair workplace and are working with the Muslim network promoting the holy month of Ramadan as part of our EDI Programme within the Trust.

(c) Our partnership with Job Centre Plus has been recognised as trailblazing and an innovative approach in terms of trying to find employment opportunities for local people.

(d) Mr James (NED) noted that vacancy levels are reducing but our turnover rates are increasing and are very high. This would appear to imply that retention is where our real challenges lie. How can we ensure that we bring the same focus to the retention part of the equation? The Chief People Officer advised that discussion was held at the Finance and Performance Executive meetings around increasing our efforts. We have local Recruitment and Retention Working Groups across all Divisions and they have some key objectives to obtain. There are some red/amber actions to be completed so we clearly need to put more focus on this over the next few months. If we can turn these to green, we will definitely start seeing more reductions in terms of staff turnover.

(e) Mr Myers (ANED) noted the reasons for staff leaving and there are some large numbers involved, and queried whether we should be having any special initiatives to deal with this eg career progression, and physical environment. Mr Myers is the Chair of the Charity Trustee and noted that there are funds available which could possibly be used to help with this. The Chief People Officer advised that one of the key actions we are undertaking (detailed in the report), is over a 3 month period we are going to be undertaking a lot of engagement sessions across the whole organisation. The idea is to work with teams and local managers to try to come up with some ideas to try to resolve some of these local issues.

(f) The CEO noted regarding the retention issue, that we have changed our strategy to ensure that we are a very flexible employer along with enabling staff to work beyond retirement if they so wish. We need to think about getting some role models to demonstrate how we can apply this in clinical settings as well as non-clinical settings. Secondly, it is around how we develop individuals to meet their maximum potential and offer things such as research opportunities that keep people interested in their role. Adding a training and development research element to add richness to roles alongside that flexibility will make quite a difference to our retention.

(g) Mrs Twigg (NED) noted that we are only getting 1 in 4 people to complete the Exit Survey. This is very valuable information that could give us a better picture if we were able to increase this percentage. She also queried if there was a better way of showing why staff are leaving the Trust as the data was not always "user friendly" to read and digest. The Chief People Officer agreed to review how this information is presented in future reports. He also advised that there is a Wye Valley Recruitment and Retention Working Group who will be delving down into more detail on this data. **GE**

<u>Resolved</u> – that:

(A) The Workforce Report be received and noted.

(B) The Chief People Officer will review how the data on staff leaving the Trust can be presented in a "user friendly" way in future reports. **GE**

BOD11/04.23 **Finance Performance**

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

(a) The report in the pack relates to Month 11 and from this year to date perspective, we have a deficit of £6.2m that kept us on track to deliver the planned year deficit of £6.6m. The team are currently closing on that position, and we anticipate that it will be in line with the £6.6m plan.

(b) Herefordshire and Worcestershire also remain on track to deliver the System planned deficit of £14.8m.

(c) Agency spend has remained high. We are starting to see a positive trend of reduction in spend and this is obviously a significant area of focus in next year's operational plan.

(d) CPIP – We are forecasting just under £9m savings in the current financial year of delivery. A greater proportion of this is non-current and this does have an impact into next year's plan as well.

(e) Productivity – We have discussed the increased performance from 2019/20 activity levels but we need to remember the marginal cost of delivering the extra activity. We are not yet seeing our cost per weighted activity unit as a broad measure of productivity reducing as quickly as we would like. We will continue to track this and focus on encouraging colleagues to deliver that activity at the lowest possible marginal cost. This will be a key focus moving into next year.

(f) Capital – We spent just over £5m at the end of February and are expecting a sizeable increase in this by the end of the year linked to some of the late additional capital funding that we received.

(g) Cash – There are no concerns at present and we did see the expected improvement in the Prompt Payment performance as we moved into February but there is still further work to ensure that we consistently hit this standard and support our small suppliers with their cash flow.

(h) The Chairman wanted to publicly record the Board of Directors' thanks for how the CFO is Chairing the Finance and Performance Executive meetings.

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

ITEMS FOR APPROVAL

BOD12/04.23 **Operational Planning: Financial Plan 2023/24**

The CFO presented the Operational Planning: Financial Plan 2023/24, which was taken as read, and the following key points were noted:

(a) The paper sets out the financial plan for 2023/24. This was due to be final by this point in the year, but given the national situation and the challenge that all organisations and Systems are experiencing, we are anticipating a further review and most likely a resubmission.

(b) Clearly due to the importance of us being able to maintain the financial and budgetary ownership throughout the organisation, we need to set and issue budget at a delegated level across the Trust from 1st April. Therefore we have used the numbers in this plan to allow us to issue those budgets to Departments, Directorates and Specialties so that they can take ownership and continue to drive the financial agenda.

(c) The plan reflects the deficit of just under £40m. This does not meet the requirement to deliver a balanced plan which was part of the national planning requirement, nor does the System position as a whole which reflects a net deficit. That is part of the reason for the ongoing process with NHS England in the background across both Herefordshire and Worcestershire and a number of Systems nationally.

(d) The paper sets out a triangulated view. It gives a view of activity, workforce and the money, because clearly the Financial Plan does not work in isolation of everything else.

(e) From an activity perspective, we are assuming a high productivity achievement through our core substantive capacity. We will only use additional capacity where if offers value for money and supports us in achieving the level of elective activity we need to achieve to earn Elective Recovery Funding on top.

(f) Overall, the activity plan delivers just over 107% of our 2019/20 activity excluding follow ups and does allow us to meet those key operational performance requirements that were part of the planning guidance.

(g) The table in the paper shows that we not yet going far enough regarding delivering the reduction in follow up activity and maximising the use of things like patient initiated follow up. Divisions are actively working on plans, so there does remain a significant productivity opportunity.

(h) The Workforce Plan in terms of the approved funded establishment is included. This is aligned to our Activity Plan and our Financial Plan. Clearly reviewing our workforce growth over the last few years through Covid and coming out of that, this is a key area that we are looking at and how we can become more efficient and productive.

(i) The plan is just under £40m deficit before any potential redistribution of funds across the ICB or any further mitigations that we identify as a System to bring that position more in line with the national expectation.

(j) From a cost improvement efficiency perspective, the total ask now within this plan is £15.8m reduced spend or around 4.6%. Around 4% of that represents our core assumptions that we committed to and does go further than the level assumed nationally and it needs to because of our lower recurrent delivery in the current financial year. The remaining £2m is where we have accepted an additional stretch target on the basis that we knew that we needed to strive to have greater ambition and to go further given our deficit position. At this point in time this is currently unidentified and does require further mitigation through the year.

(k) We are impacted by around about £6m of excess inflation over and above the level that is funded in the tariff and we continue to work with NHS England to explore any potential mitigation for this. This is primarily around our PFI contract and energy pricing.

(l) The paper sets out a number of risks to the Financial Plan. Primarily this is around our ability to deliver the Activity Plan through maximising productivity and our ability to secure recurrent cost improvement.

(m) A summary of the Capital Programme is included. Our availability of capital funding does remain challenging and that plan represents our most sensible prioritisation at this point and we will conclude the detail of that through our capital planning and prioritisation process internally.

(n) Whilst our cash balance currently remains healthy, clearly with a planned deficit of this scale, it is likely that we will require cash as we go through the year if we are unable to mitigate the deficit further from where we are today. We understand there is still a process to access that cash support, but clearly we have not had to test that over the last couple of years so it does remain a relative risk.

(o) The CFO is asking the Board to note the progress since the update last month and to ratify this plan as having been approved and noted that it was submitted under delegated authority due to timing, noting therefore that it may be subject to further changes, with updates to future Board meetings.

(p) Mr Cottom (NED) felt that the plan was very clear, which is needed as it is an important governance marker as it triangulates the internal targets for money, workforce and activity.

(q) Mrs Martin (NED) echoed the clarity and found it helpful laying out about which things we spend less on and do the same work and can do more and earn more money and which are directly within our control and which are external.

(r) Mrs Twigg (NED) felt that the inflationary information appeared light compared to some of the sensitivity analysis that for the next 12 months. Also, the £2m stretch target is nowhere near inconsequential and an area that we need to keep a close eye on.

(s) The Chairman felt that we have a massive opportunity to drive hard into the waiting lists that we have in terms of elective recovery and to start to really push to achieve the maximum of Payment By Results which is dependent on a number of areas such as the Junior Doctors strikes stopping.

<u>Resolved</u> – that the Operational Planning: Financial Plan 2023/24 be received and approved and delegated authority given to the Chief Finance Officer, Chairman, Chief Executive and the Managing Director to sign off the final version.

BOD13/04.23 **Standing Orders and Standing Financial Instructions**

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

(a) This document has been presented to the Audit Committee for review. There are no material changes but it has been reviewed against the model format and any changes that have been made are largely to strengthen the conflict of interest and general behaviours element of the document.

Resolved – that the Standing Orders and Standing Financial Instructions be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD14/04.23 **Fit and Proper Persons Report**

The ADCG presented the Fit and Proper Persons Report advising that there were no areas of concern to raise.

Resolved – that the Fit and Proper Persons Report be received and noted.

BOD15/04.23 **Staff Survey Results**

The Chief People Officer presented the Staff Survey Results and the following key points were noted:

(a) These are very positive results for the Trust when you consider the backdrop of what we have experienced over the last 2 -3 years including Covid and the cost of living crisis along with the staffing issues across the NHS.

(b) We are still above average in all 9 key areas of the survey. This is testament to the hard work of all of the leaders across the board along with the work with our Health and Wellbeing Programme and the wider range of Human Resource interventions that we have in place.

(c) There are also some areas of development identified. Within some of our staff groups we will be undertaking staff engagement sessions. It is important to engage the entire workforce to try to come up with a plan, which is agreed locally to address some of the areas of development highlighted in the survey.

(d) The feedback from staff on support they receive from their immediate line manager is very positive.

(e) The survey results reflect the national position in terms of morale and staff engagement. The staff engagement sessions that we will be conducting will help us to build on these results.

(f) The Chairman highlighted the very tough year that it has been for the NHS and Wye Valley and our frontline teams and he wanted to put on record again the Board of Directors thanks to our frontline teams for their perseverance and resilience and the commitment to the citizens of Herefordshire.

(g) Mr James (NED) noted the overall positive results with improvement required in some areas. He particularly wanted to focus on the questions around care of the patient, which is obviously a top priority for us, and how we can bring some emphasis to this. Given the challenges that we have gone through, there is some tendency to focus on numbers, flow and processes and we can lose sight of focusing on care of the patient themselves. We need to ensure that we keep this as a consistent message in everything that we do within the Trust. The CEO agreed that this is a good set of results for Wye Valley, but when compared to the rest of the Foundation Group, Wye Valley did better overall than George Eliot, but on that particular area and whether you would recommend Wye Valley for care, we score lower. This is clearly something we need to work on with our teams to ensure that they feel as we do as a Board, that this is our number one priority with a top level action on this area.

(h) Ms Quantock (NED) highlighted the number of incidents of violence towards staff, although not high numbers, any incident is one too many, and queried whether we could have a further update on this at the Board meetings. The Chairman reiterated that it is totally unacceptable for a member of the public to physically or verbally abuse or cause upset to any member of our staff who are trying to help them or their family. They may feel frustrated but there is never an excuse to threaten or use actual physical or verbal aggression. The Chairman asked the Chief People Officer to discuss with his colleagues in the Foundation Group, a campaign internally and externally (as bullying occurs internally as well), with two simple phrases becoming a mantra of our values – "be kind" and "be polite". These are both relevant to members of the public coming into the Trust and the way that we conduct ourselves from the Board down to all members of staff. The Chief People Officer advised that improvements have been made including the use of body cams, training and more security in the Trust. We continue to work with teams and Departments on what further action we can take. An update on the actions taken so far will be provided to the next Board of Directors meeting. The Chairman noted that every security guard we have to employ is money that could be spent on employing more nursing staff. He was very appreciative of all our staff who have to deal with this unacceptable behaviour. **GE** **GE**

(i) The Chairman asked for an update at a Board Workshop prior to the next Staff Survey on some of the cultural improvements that are being made. **GE**

Resolved – that:

(A) The Staff Survey Results be received and noted.

(B) The Chief People Officer will discuss with his colleagues in the Foundation Group, a campaign internally and externally, with two simple phrases becoming a mantra of our values – "be kind" and "be polite". **GE**

(C) An update on actions taken to improve security in the Trust regarding violence and aggression, will be provided to a future Board of Directors meeting. **GE**

	(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**
	COMMITTEE SUMMARY REPORTS	
BOD16/04.23	**Quality Committee Summary Report 23 February 2023** Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report 23 February 2023 and the following key points were noted: (a) We have discussed and agreed the Quality Priorities and CQUINS for this year. (b) The Committee have received three reports from the Infection Prevention team and we have now pulled together our Infection Prevention and Control planning into one plan. We are working closely in partnership with our Regional colleagues. The Regional Lead presented a session at our last Quality Committee meeting which was very useful. (c) In response to the question raised by the Chairman earlier in the meeting around maternity safety, Mr James (Chair of the Quality Committee and NED) advised that the Committee put a lot of focus on maternity in our meetings. (d) Multidisciplinary work within our teams is improving with a Lead Clinician now in post leading on this area. The CNO advised that she recently attended a Nursing and Midwifery Council session for our international nurse recruits and discussed this with the NMC Lead who led the session. The NMC and GMC have worked together to develop MDT working sessions that they deliver to organisations, specifically for maternity. The CNO has therefore put the Nurse and Midwifery Council Lead in touch with our maternity services to provide a MDT session at the Trust. (e) The Chairman wanted to confirm that the Infection Prevention team have good links with the Consultant in SWFT who deals with Infection Prevention. The CNO confirmed that the Trust meet regularly with our Foundation Group colleagues to discuss best practice, challenges etc. **Resolved – that the Quality Committee Summary Report 23 February 2023 be received and noted.**	
	COMMITTEE MINUTES	
BOD17/04.23	**Quality Committee – 26 January 2023** **Resolved - that the Quality Committee minutes 26 January 2023 be received and noted.**	
BOD18/04.23	**Any Other Business** There was no further business to discuss.	

BOD19/04.23	**Questions from Members of the Public** **Q1. "**Will Wye Valley Trust Home Care Support be available to Wye Valley Trust patients who live in Powys?" **A1.** The Managing Director was not sure if this was referring to the report on the work that is going on in Warwickshire, which of course we are watching and learning from and so will not be available in Powys. Equally, we are responsible for the Community Services in Herefordshire and work very closely with the Council on how we integrate those services. We are not responsible for the Community Services in Powys but we do link in with them closely. They have some Inreach staff who are located within our hospitals and work with us on discharge. They are also part of weekly calls that we have with all partners around discharge flows. The Powys Health Board are responsible for the Community Services in Powys and we only have a partnership relationship with them. **Q2.** "In the National Press it is suggested that verbal and physical assaults on NHS staff are increasing. Does Wye Valley publish figures of verbal and physical assaults upon its staff?" **A2.** The Chief Strategy and Planning Officer confirmed that we publish these figures in the Health and Safety Strategy. **Q3. "**What is the present situation at Wye Valley with regards to such assaults and are numbers increasing, and if so, by how much?" **A3.** The CEO felt that this was a good set of questions raised and there is potentially a low reporting culture in the Staff Survey results. We obviously want to encourage reporting of any such incidents. This is an area that we have discussed as a Board in the past, particularly related to ED and the investment in additional security. The Chairman suggested that a response to this question is included in the minutes to enable the figures to be reviewed. Response from the Chief Strategy and Planning Officer - *Violence and aggression incidents at WVT increased from 285 incidents in 2021/22 to 374 incidents in 2022/23, a 24% increase. The significant increase is likely to be partially the result of increased awareness and reporting of violence and aggression as much as an actual increase in incidents but it still will not cover every incident that takes place. Violence and aggression incidents are categorised as follows:* • *Inappropriate behaviour* • *Physical violence* • *Verbal harassment* • *Racial harassment* • *Sexual harassment*	**AD**

The Trust had previously run a task and finish group with partners to address violence and aggression at WVT called Operation Nightingale. This has now transitioned into a regular Security forum which meets quarterly and addresses all issues related to security.

One of the more significant developments recently at the Trust is the commencement of a Security Service at the County Hospital. Based in the Emergency Department 24/7, the service started in May 2023 and replaces the enhanced portering service that dealt with security incidents previously. The new service is also provided by Sodexo through the PFI contract and will be a fully managed service, provided by accredited security staff

Q4. "I expect the Wye Valley has a no tolerance approach to such assaults. How many cases have led to cautions or prosecutions?"

A4. The Chairman suggested that a response to this question is included in the minutes to enable the figures to be reviewed. **AD**

Response from the Chief Strategy and Planning Officer - *The Trust does indeed take a zero tolerance approach to violence and aggression. Most people that are treated through the Trust's policy receive a warning, either from the Trust or the police and a number are prosecuted. The Trust is aware of a handful of prosecutions or cautions in the last 12 months but the Trust will not always know whether further action is being taken, Further information has been requested from West Mercia Police.*

Q5. "The second graph, page 227, relates to harassment, bullying or abuse at work. In this case, 49% were reported by the Wye Valley Trust involving a colleague implying that 51% were not reported?"

A5. The Chairman suggested that a response to this question is included in the minutes to enable the figures to be reviewed. **GE**

Response from the Chief People Officer - *The Wye Valley Trust score of 49% is above the NHS average of 47.4% for this question. The best score for NHS organisations is 57.0% as a high score is seen as an indicator of an open culture where staff have a voice. It is worth noting that the Wye Valley Trust score relates to the 452 responses received and we are working actively with our staff networks and Freedom To Speak Up Champions to address any bullying, harassment or abuse at work in a timely and robust manner in accordance with Wye Valley Trust policies.*

Q6. "In another national survey recently reported in the press relating to medical equipment including X-ray machines, CT scanners and radiotherapy machines, it was found that many were outdated and in need of replacement. The survey also expressed concern over the maintenance cost of older machines. What is the situation at Wye Valley Trust?"

A6. The Chief Strategy and Planning Officer confirmed that the Trust have a managed equipment service with Phillips that replaces our equipment on a rolling basis and so there is no equipment of that kind at the Trust.

	The CEO noted that this is a very good arrangement for the Trust to have in place, which is not in place for the other members of the Foundation Group. This does mean that Wye Valley is in a situation where our equipment is refreshed at an appropriate stage rather than going on beyond its life cycle.
BOD20/04.23	**Date of next meeting** The next meeting was due to be held on 1 June 2023 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, THURSDAY 1 JUNE 2023

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD10/04.23 Workforce Report 6 April 2023	(B) The Chief People Officer will review how the data on staff leaving the Trust can be presented in a "user friendly" way in future reports.	GE	The WVT Recruitment & Retention Group is reviewing the exit interview process and a new process will be in place by September.
BOD15/04.23 Staff Survey Results 6 April 2023	(B) The Chief People Officer will discuss with his colleagues in the Foundation Group, a campaign internally and externally, with two simple phrases becoming a mantra of our values – "be kind" and "be polite".	GE	A comprehensive WVT staff engagement campaign (Intouch) was launched on 15/05/23 and this will run until July. The campaign focuses on 4 key areas (care of patients, flexible employer, health & wellbeing and creating a compassionate & respectful culture). We will be using the "be kind" and "be polite" phrases in discussions with staff on creating a compassionate and respectful culture. The Intouch campaign programme has been shared with Group HR colleagues.
ACTIONS IN PROGRESS			
BOD10/03.23 Workforce 2 March 2023	(C) A summary report of the analysis of the impact of menopause on our workforce will be included in the April Workforce Report.	GE	This is still work in progress as adjustments are being made to ESR and more guidance developed for line managers to ensure this is being captured appropriately. To be reported by July 2023.
BOD15/04.23 Staff Survey Results 6 April 2023	(C) An update on actions taken to improve security in the Trust regarding violence and aggression, will be provided to a future Board of Directors meeting.	AD	A written update will be provided to the next Board meeting. (A response regarding violence and aggression has also been provided to the public question in the meeting minutes).
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	The actions and cultural improvements made following the Intouch staff engagement campaign will be shared with the Board prior to the next staff survey.

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
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:	Appendix A: AoG Recent Activity Summary

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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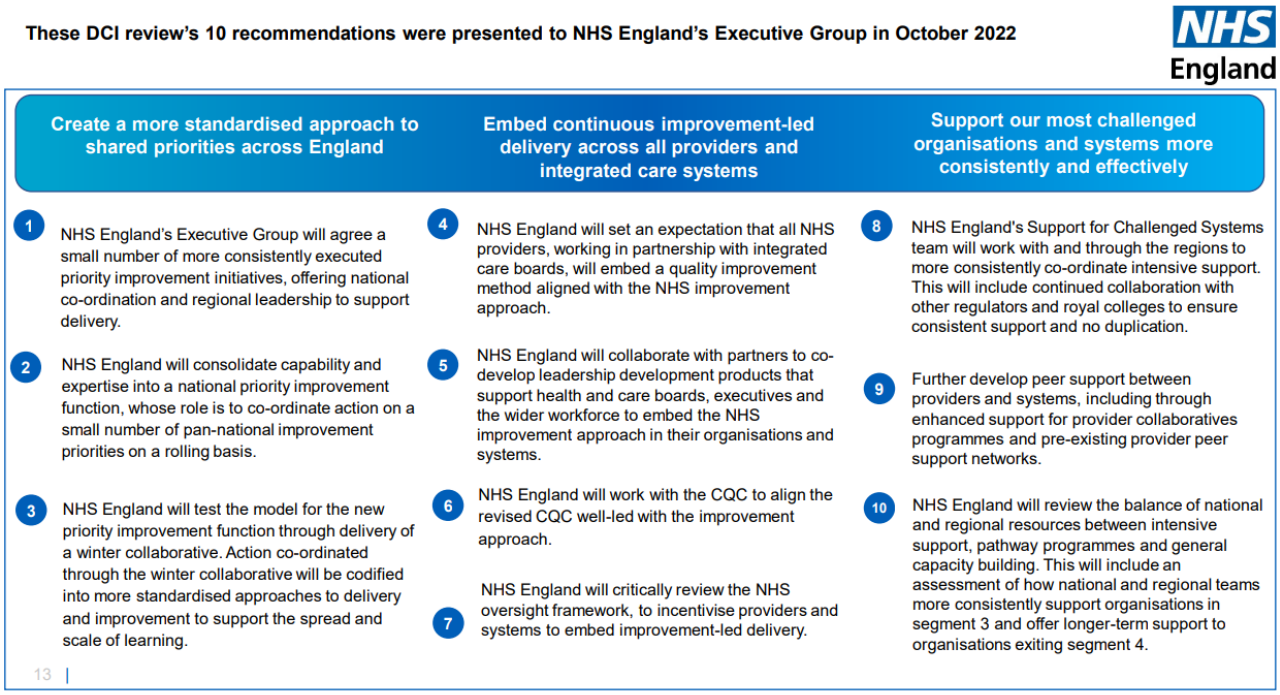
1) A NATIONAL APPROACH TO IMPROVEMENT

At the recent national CEOs meeting, Amanda Pritchard launched 'Impact', a national approach to improvement. This follows on from last year's review of the subject which was led by Julian Hartley, then CEO of Leeds Teaching Hospitals NHS FT. Julian is now CEO of NHS Providers and we were fortunate to hear of this work at our last Group Boards Workshop. The table below sets out the recommendations from last year's review which have been accepted by NHS England (NHSE) and captured in the resulting Impact programme. Leeds was one of the pilot sites funded by NHSE to trial the Virginia Mason Institute (VMI) improvement methodology. The University of Warwick Business School carried out a formal evaluation of the programme which also helped to shape the Impact plan. One of the key findings was that the VMI approach delivered quite variable results in the NHS Trusts which piloted it. They concluded that the underlying culture of the organisation was probably more important than the improvement methodology itself. Julian's review also looked at a number of other improvement methodologies used across the NHS including our own approach QSIR (Quality, Service Improvement and Redesign). The conclusion of the review was that many of the improvement methodologies are broadly the same under the surface and many originate from the Japanese Lean methodology. The national Impact plan therefore does not stipulate which approach should be used but that all Trusts and the systems in which they operate should adopt a methodology.

The approach also encourages the Care Quality Commission (CQC) and other regulators to embrace assessments of service improvement in their inspections. This hopefully will further reinforce the concept of continuous improvement as opposed to holding a view that standard operating procedures should be adopted and stuck to. As part of the national programme, all NHSE staff will be trained in improvement skills. This has prompted me to review our own approach. Whilst we have trained many staff and Place partners, our current approach is to support those who volunteer for training. I would like to explore how we could provide more training to more staff as part of core training.



These DCI review's 10 recommendations were presented to NHS England's Executive Group in October 2022

NHS England

Create a more standardised approach to shared priorities across England	Embed continuous improvement-led delivery across all providers and integrated care systems	Support our most challenged organisations and systems more consistently and effectively
1 NHS England's Executive Group will agree a small number of more consistently executed priority improvement initiatives, offering national co-ordination and regional leadership to support delivery.	4 NHS England will set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach.	8 NHS England's Support for Challenged Systems team will work with and through the regions to more consistently co-ordinate intensive support. This will include continued collaboration with other regulators and royal colleges to ensure consistent support and no duplication.
2 NHS England will consolidate capability and expertise into a national priority improvement function, whose role is to co-ordinate action on a small number of pan-national improvement priorities on a rolling basis.	5 NHS England will collaborate with partners to co-develop leadership development products that support health and care boards, executives and the wider workforce to embed the NHS improvement approach in their organisations and systems.	9 Further develop peer support between providers and systems, including through enhanced support for provider collaboratives programmes and pre-existing provider peer support networks.
3 NHS England will test the model for the new priority improvement function through delivery of a winter collaborative. Action co-ordinated through the winter collaborative will be codified into more standardised approaches to delivery and improvement to support the spread and scale of learning.	6 NHS England will work with the CQC to align the revised CQC well-led with the improvement approach. 7 NHS England will critically review the NHS oversight framework, to incentivise providers and systems to embed improvement-led delivery.	10 NHS England will review the balance of national and regional resources between intensive support, pathway programmes and general capacity building. This will include an assessment of how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

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2) VIRTUAL GROUP IMPROVEMENT CONFERENCE

Without knowing it, our virtual Group Improvement Conference which took place between 15th and 19th May 2023 was perfectly timed to coincide with the above. The event was organised by the respective Trust improvement leads coordinated by Lindsey McLean from Wye Valley NHS Trust. The event was a great success and provided the opportunity for further sharing of improvement projects between the Trusts as well as some excellent input from external speakers. Over the course of the 5 days the sessions covered

19 topics involving 60+ speakers. They also ran 8 QISR virtual training sessions in the afternoons and the average attendance across all sessions was 45 delegates from across the Group and beyond.

True to form, the improvement teams carried out daily Plan, Do, Study, Act (PDSA) cycles to seek to improve the event. The key outcome of this was a plan to hold a similar event next year due to its overall success. I would like to formally thank the organising team for their great work.

3) GROUP NURSING AND MIDWIFERY CARE EXCELLENCE CONFERENCE

This conference took place on 9th May 2023 at a Conference Centre in Bromsgrove. Sponsored by the Chief Nursing Officers from across the Group, the event provided an opportunity to share quality improvements and approaches between Group members as well as hearing from external speakers. Compared to booking into external courses, such events represent very good value especially when they are of such high quality. When I first produced the concept of the Group a few years ago, I dreamed of holding events like this, and the Improvement Conference, so it was personally very gratifying to take part in both.

4) GOING FURTHER TO REDUCE OUTPATIENT WAITING TIMES

Despite many challenges over the last twelve months the NHS has had a very positive impact to virtually eliminate 78 and 104 week waits. We know that we now have to deliver on 65 week waits being zero by March 2024 but the question is can we go further faster and demonstrate an accelerated reduction in our waiting times. Due to our significant local contribution to the national improvement, the Group has been invited to join a pilot programme which will push further and faster across both the admitted and non-admitted pathways. The programme will focus on the following objectives:

Whilst 80% of the current national waiting list is around outpatient activity it is crucial; we continue to drive improved efficiency and productivity around the admitted pathway. As part of this we need to ensure we maximise Day Case rates at 85% of the standard 'basket of procedures' as well as continue to improved theatre productivity. The programme sets an ambition for this to be regularly at least 85% of the 'capped theatre utilisation' measure. We need to maximise the use of the right procedure right place programme and take procedures out of the theatre environment into procedure rooms where guidance shows it is safe to do so. Finally, we need to make sure our length of stay for inpatient procedures is at the top decile so we maximise the utilisation of our elective beds, for those with elective Hubs coming on stream productivity and additionality will be critical.

We also agreed collectively that we would work together to push to deliver a 25% reduction in outpatient follow-ups broadly across 14 specialties by March 2024 and hasten our reduction of waiting times to a maximum of 52 weeks. To deliver on this ask, clearly Clinical leadership and an allied approach between organisations is essential, identifying strengths and areas of challenge between you within the specialties and associated pathways to share learning and support one another in this space.

We discussed the importance of supporting clinical leadership within each of your organisations and specialties to win clinical hearts and minds, and I would be grateful if you could identify your key leaders who we will support through our network of GIRFT Clinical Leads. Additionally, we will support via the GIRFT Academy and GIRFT Implementation, who will develop and share outputs from this work for the rest of the NHS to follow.

5) NATIONAL URGENT AND EMERGENCY CARE RECOVERY PLAN

The National UEC plan was launched in January and referenced in my Board papers at the time. There are several components to the plan including some immediate increases in capacity. The most important elements however focus on the consistent implementation of best practice models. By implementing best practice solutions to in and out of hospital flow we will provide better outcomes to patients and better value. I have been asked by NHSE to assist with the overall delivery of the plan focussing on the 'In Hospital Processes' element. This is positive recognition of the great work that has been undertaken by all three Trusts in the group in areas like Same Day Emergency Care, Frailty Assessment and overall flow improvements. To undertake this work, I have been appointed to the non-remunerated role of National Delivery Advisor. The time commitments are not too onerous and will involve workstream meetings and attendance at the national oversight Board, most of which will be virtual.

6) ASSOCIATION OF GROUPS (AoG)

For the past few years we have been members of the national NHS Association of Groups. Through this we pay a small membership fee which provides access to learning and development from other Groups elsewhere in the NHS. These groups have been selected to cover all regions and include a wide variety of Group models. At their recent CEOs meeting the AoG provided a helpful review of their activities over the past year which I have included at Appendix A. You will see from this that the AoG have also formed a Senior Operational Leaders Network (SOLNET) which has been part funded by member Trusts and NHSE. I am in the process of ensuring that we have suitable take up with half a dozen of senior leaders from across the Group

7) NHS PROVIDER LICENCE

As reported to the Board in December 2022, NHS England commenced a consultation exercise on the NHS Provider Licence. The consultation has now concluded and the new NHS Provider Licence came into effect from April 2023. It forms part of the oversight arrangements for the NHS and sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

All NHS foundation trusts and NHS trusts are now required to hold a licence. The NHS Provider Licence was first introduced for NHS foundation trusts in 2013 and has now been extended to NHS trusts with effect from April 2023. It was also introduced for independent providers in 2014 and a separate licence for NHS controlled providers was introduced in 2018.

The licence has now been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS Provider Licence and the NHS Controlled Provider Licence.

The modified licence no longer includes a requirement for NHS foundation trusts and NHS trusts to self-certify against the licence conditions and corporate governance statements. This is due to the range of other reporting mechanisms that would continue, such as the Annual Report, Annual Governance Statement and through any Care Quality Commission (CQC) well-led review. These will require Boards to continue to assess their compliance with corporate governance standards, and evidence of this compliance will continue to be considered as part of well-led assessments. Therefore the removal of the reporting requirements would streamline requirements and reduce burden. However the Trust feels that the self-certifications were useful in focusing the Board's attention to governance processes and compliance issues so self-certifications will continue to be undertaken and reported through to the Audit Committee and then assurance provided to the Board.

8) MORE FROM OUT GREAT TEAMS – UPDATE FROM THE CLINICAL SUPPORT DIVISION – MAY 2023

Outpatients
The Outpatient team are continuing to support specialities with the restoration of Outpatient activity e.g. evenings and weekend clinics and increasing Minor Operations sessions. The team are continuing work with the clinical teams to maximise room utilisation and minimise short notice cancellations, however with the pressures of strikes and rota changes this is still an ongoing challenge. This is being supported by the Outpatient Transformation Project Workstream which is developing well.

The Referral Management Centre have gone live with re-introducing some specialties to eRS, however the roll out is challenging due to short notice and being unable to book out. They are continuing to implement Advice and Guidance specialty-by-specialty with ICS colleagues, with some positive figures for both Urology and Rheumatology.

The Referral to Treatment Team are continuing to support the operational teams to manage long waiting patients, ensuring pathways are validated, tracked and recorded accurately and dealing with procedural queries to ensure effective management of the patient pathways.

Cancer Services
The Cancer Services team continue to support the Trust Cancer teams in the reduction of the cancer backlog and to improve performance against the cancer targets. Previous deep dives and action plans have taken place in relation to 28 day performance, this target has shown an increase to 71% across the Trust in March. There are still concerns with patients waiting above 63 days, so a deep dive has been arranged for May where this will be the focus. The main issues identified are diagnostic capacity, histology reporting and clinical admin delays. All Cancer specialties have pathway navigator roles appointed to which are funded by the Cancer Alliance.

In March this year the Cancer Services management team held an evening for all staff across the directorate to attend to discuss the achievements and challenges they had faced throughout the year. They identified what they considered to be the priorities for each of the Cancer Service teams over the next 12 months. The evening provided positive feedback from all staff and a 6 month review of the actions will be organised.

It had been identified last year that there was no clear brain tumour pathway for GP's to access after their requested diagnostic scan that showed suspicious lesions. The Trust has developed a temporary solution where GP's can refer these patients to SDEC for a next day review, which is working well. Senior contracts manager is supporting in developing a permanent solution where GP's can have access to refer directly to tertiary trusts.

There had been some delays with patient stratified follow up (PSFU) due to remote monitoring being implemented on MAXIMS. Positive steps have now been made and a trial will be piloted from the 15th May for three months with a sample of patients on Cancer pathways within the Breast, Colorectal and Prostate specialties.

The Haematology service remained open to referrals and safe with Locum recruitment, unfortunately we were unable to recruit to the substantive Consultant advert but are re-advertising again this month. All patients have been repatriated apart from Powys which should be completed over the next six weeks. In May the first task and finish group has been organised to discuss the actions from the HEE STAR workshop which will be led by Will Taylor, ICB Chief Medical Officer, to continue working towards a collaborative service with Worcester.

Diagnostic Services
The Radiology team have continued to deliver capacity significantly higher than that of 2019, which has enabled backlogs and waiting times to be significantly reduced with waiting lists circa 95% within 6 weeks. There has been positive development in terms of 28 day pathway delivery; with now a fourth Radiologist, following recent training, able to independently report CTC scans.

Progress on digital diagnostic transformation has continued, most notably with a successful case for national funding to support roll out i-refer Clinical Decisions Support tool, which will integrate with Order Comms to help achieve right test first time, supporting productivity, reducing demand and lost time for patients waiting.

The development of the Interventional Radiology service continues, following successful business case the first appointments for Radiology nursing have been made in March.

The national CDC team approved the Hereford City CDC business case in April – the project team are busy continuing work with designers and architects on the site options and readying for an internal business case for July board.

Pharmacy
Pharmacist recruitment continues to be the department's biggest challenge but during April two new Pharmacists have been recruited to start during the summer. One was as a direct result of the recently implemented recruitment and retention premium for Pharmacists. We are also looking forward to our own trainee Pharmacist registering in September and joining our Pharmacist team. Supporting our Pharmacist recruitment we are increasing our cohort of trainee Pharmacists from three to four in August and we have also increased our trainee Pharmacy Technician roles to 12.

Both the Pharmacist and Pharmacy Technician trainees include several cross sector placements with our colleagues in Community (High Street), Mental Health and GP Practice Pharmacy sector.

We continue to have one of the best skill mixes of Pharmacist, Pharmacy Technician and Pharmacy Assistants in the Midlands including the first Band 5 Pharmacy Assistant in the country as Deputy Dispensary Manager. We are far from recruiting to all the vacancies within the department but the skill mix and development opportunities within our department are attracting new recruits.

A knock-on-effect of the shortage of Pharmacists has been the impact on the aseptic production service within Pharmacy. This service prepares and clinically checks, amongst other medicines, the chemotherapy for our Oncology and Haematology patients. To safe guard the continuation of this vital service, this area has been prioritised and we have also worked with Gloucester Royal Hospitals to outsource some of our clinical screening activity and innovatively employed a remote working agency staff member to maintain the service while we recruit and await the return of our Lead Pharmacist from long term sickness.

Pathology

Wye Valley Trust was the first Trust to go clinically and technically live with Digital Pathology. We are continuing to pursue implementing digital reporting with our network colleagues and are hoping to utilise the Breast pathway to demonstrate the significant benefits of this new way of working. This is supported by the regionally funded Macropath system, allowing images of specimen dissection to be linked to the digital slide, supporting full remote off-site reporting.

We have recently purchased point of care equipment to support Care in the Community. This new service will be fully supported by the laboratory, ensuring quality standards for the service are met. It is expected this will allow robust and timely treatment of patients in the community and reduce hospital admissions.

The directorate continues to benefit from networking developments, with some £2K being awarded to support training in the department. We are also working with HEE to develop the role of clinical scientists in Haematology to support the Consultant workforce in this difficult to recruit to area. This development is being used as a pilot project for training key members of staff in workforce planning.

We have been working with our network partners to develop an ambitious plan to align the LIMS procurement project with the business case for the development of South Midlands Pathology. The final business case is currently planned for December 2023 and it is hoped that this move will address the potential revenue gap identified in the outline business case.

We have secured remote Consultant support for Blood Transfusion and Haematology, kindly provided by our colleagues in CWPS. This is working well and allowed us to maintain our UKAS accreditation status. We hope to secure a similar model of working to support our Immunology service with the resignation of the current Clinical Lead. Initial approaches to the lead at UHCW have been positive.

We continue, like many other parts of the NHS, to struggle with Consultant numbers in Histopathology and are looking at joint posts with our foundation partners and digitally enabled working.

9) Going the Extra Mile Awards – December 2022/January 2023

Employee of the Month December 2022 – Lindsey McLean

‘Transformation Tuesday has been a remarkable development in the life of WVNHST. The progress which it demonstrates and the team spirit which it engenders have been and continue to be exceptional.

It has been clear throughout that this initiative has been hugely influenced by Lindsey. Her enthusiasm is always infectious, her drive and passion are quite exceptional. The detailed organisation demonstrates not only attention to detail but also the respect in which she is held by those around her. The evolution of the concept into other aspects of the activities of the group has been significant as was witnessed in the recent Safety in Sync where her contribution warranted individual mention.

She has demonstrated total professionalism and not insignificant talent by going the extra mile.

Whilst this submission is based on Lindsey as an individual, I have no real knowledge of the team work behind her and would defer to the judges as to whether this should be recognition of Lindsey or her team'

Employee of the Month January 2023 – Claire Seal

'Following the Covid pandemic, we had a very significant backlog of Echo's within our Heart & Lung (Cardiac Physiology) department and the waiting list was in excess >2000 patients, with a 30+ week wait for this diagnostic, despite undertaking scans in-house at full-capacity.

Whilst we have had external support in the form of both outsourcing and insourcing, none of this would have been feasible without the hard work, dedication and excellence shown by Claire. Claire has taken on the Acting role of our Head of Echo for an interim period until we are able to recruit into this role permanently and has been outstanding in her support of the service.

Claire has gone above and beyond in supporting the deployment of our insourcing teams, attending work on her day's off to ensure that the staff supplied by the insourcing company are confident in their use of our systems. She is fully orientated with regards to, the department and to support any teething problems that usually happen at the start of such a wide scale implementation. She has supported with logistics, troubleshooting, departmental SOP's for the insourcing company and further clinical aspects and considerations needed to ensure that insourcing was both successful and safe all of which is both time consuming and in-depth. She has also been pivotal in supporting the integration of the use of EPR for Echo requests alongside the additional workload that insourcing has brought, supervising complex investigations and where necessary putting some of these investigations to MDT's. In addition to this, Claire has done a significant amount of quality assurance for all of the additional scans completed; she goes above and beyond on a daily basis.

Claire combines this with her own demanding workload of both inpatient and outpatient echos, alongside the additional demands and pressures of supporting two new B6 Cardiac Physiologists with supervision, education and training to allow them to meet BSE accreditation within the next 12-18 months.

Despite her significant workload, Claire is always cheerful, supportive and responsive as needed to the demands of the service.

The echo waitlist is now at around an impressive 8 weeks, with trajectory to be around 6 weeks by the end of the financial year (excluding patient choice); without Claire's support of both the insourcing and her general excellent and responsive leadership of the Echo team this would not have been possible.

All of the Cardiology clinical team and the Directorate Management team feel that Claire should be recognised for all of the dedication and handwork that she has put in to achieving the impression position that our Echocardiographs wait list is now in.'

Team of the Month December 2022 - Arrow Ward

I would like to nominate the Arrow ward team for going above and beyond every day, particularly supporting patients at the end of their life. This is evidenced by a series of cards they have recently received:

"Thank you for nursing me back from the brink"

"I would like to add my thanks for giving my husband such wonderful care! You are all stars shining in the small world of Side room 6 for nearly 6 weeks"

"Thank you so very much for the exemplary care you showed in looking after our late mother. So many different teams and individuals treated mum with great care and respect. Your ward staff and visiting staff are a tribute to the highest standards we could see in looking after mum."

"Thank you so much for the wonderful, amazing care you all gave to our beautiful mum. When we visited her on the ward, many times we saw staff having a laugh and a joke with her. It was lovely seeing her laugh while she was in hospital. Sadly, she passed away on the ward, she wasn't alone as I was allowed to stay the night. This was a great comfort to us. The nurse at the time was so wonderful, so caring and hugged me so hard as I cried. We are so grateful of the care of mum and us, you are amazing human beings."

“To the wonderful and totally amazing staff on Arrow Ward, can’t really express how valuable and appreciated you all are”

Glen Burley
Chief Executive Officer

Association of Groups (AoG) Activity Summary 2022/2023

Ongoing NHSE Meetings

- AoG met six times throughout the year with NHSE colleagues such as Chief Delivery Officer Mark Cubbon, Chief Operating Offficer David Sloman, Director of Provider Development Miranda Carter and the wider Provider Collaborative Policy team. Discussions covered provider policy guidance, delegation of improvement, workforce transformation and specialised commissioning

8th September - AoG Leads Call: Developing an ICS Strategy

- Throughout September AoG Leads' calls focused on 'Developing an ICS Strategy'. Colleagues shared their experiences of ICS strategy development, and the extent to which provider collaboratives were asserting themselves within their systems.

8th September - SOLNET event at Northern Care Alliance (NCA)

- SOLNET hosted an event focusing on 'Operational Performance Management' at NCA on 8th September. This event included an overview of the Messenger Review and its impact, and a showcase by NCA colleagues of their implementation of a High Performance Management System (HPMS), and the inclusive talent development approach and process..

20th October- AoG Leads Call- Specialised Commissioning

- On 20th October, the AoG Leads call focused on Specialised Commissioning. South London Specialised Services delegation programme materials were shared by Jackie Parrott (GSTT), which colleagues discussed. The group also discussed the risks, and possible mitigation strategies should responsibility for spec comm be delegated to ICS's.

Ongoing SOLNET Events

- Throughout the year, SOLNET have held monthly virtual events, aswell as two face to face events. These have covered a range of themes aligning mental health services, to navigating the ICS landscape, and included a variety of external speakers, aswell as bringing together colleagues from across AoG organisations.

17th November- Health & Social Care Integration Conference

- The AoG held a virtual conference around Health and Social Care Integration on the 17th November. This included talks from a variety speakers including DHSC representatives, Northumbria Healthcare NHS FT Chief Executive Sir Jim Mackey, Rochdale Care Organisation Chief Officer Steve Taylor andinnovative tech solutions were presented by The Tribe project.

22nd November - Joint AoG & SOLNET Event: Navigating the ICS Landscape

- This joint face-to-face event was facilitated to discuss 'navigating the ICS landscape'. It brought together speakers from within the AoG network to discuss their leadership journeys and own experiences of resilience.

14th February - Launch of the Chief People Officer Forum

- The AoG people call on the 14th February welcomed discussions from colleagues around the current challenges felt in relation to 'our People' across organisations. Several themes being highlighted including sustainable supply and critical gaps, productivity and value, opportunities through integrated care, ideas on leadership development and talent management.

28th February- SWFT Frailty Ambulance Sharing Session

- This event marked the first best practice/challenges sharing series. South Warwickshire Foundation Trust CEO Glen Burley, and Consultant Jyothi Nippani shared learning from a Plan-Do-Act-Study cycle seeking to convey frail patients by Ambulance direct to a frailty ward, with the support of a phoneline to provide Ambulance colleagues with medical input at the earliest possible stage.

13th April - Joint AoG & SOLNET Waiting Well

- The most recent joint virtual event around Waiting Well included a presentation from AoG Lead Jackie Parrott highlighting patient perspectives on Waiting Well following a patient engagement programme, innovative AI solutions to predict and understand DNA behaviours from Deep Medical founder Benyamin Deldar, and digital options for patient self-management and two way communication from Midlands and Lancashire Commisioning Support Unit.

Integrated Performance Report

April 2023

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

Our urgent care pathways performance measured by the four hour target not as good as I would like it to be. There is a focussed piece of work that is engaging all our specialty teams and the ED team to review and redesign our urgent care pathway. This coincides with the Covid restrictions and measures that have been fully lifted and so more flexibility it possible.

Our performance on type one activity was 14/37 in the Midlands region in the latest benchmarking and the April figures are at the national average, but we are ambitious to improve this rapidly to at the least national expectation of 76%.

At the next Board meeting our plan for winter will be presented to the Board that will include the anticipated impact of the front door redesign, virtual ward, urgent community response and other system initiatives to improve flow and reduce demand.

Despite all of the pressures on our urgent care pathways it is encouraging to see a further fall in our SHMI. It has been briefed in previous reports we have adopted an approach of reverse boarding on wards during the day and occasionally at night, to ensure there is a balance of risk across our urgent care pathway and not all risk is held in ED and impacting on ambulance turnarounds. Whilst the SHMI suggests that this has not has a detrimental effect on mortality outcomes we are undertaken a review of the policy that all staff can contribute to to understand the impact of patients and staff experience and broader quality.

It is very welcome that cleaning standards by our Sodexo partners have improved and now seem to be reliably at the required standard. It has been an area of volatile and unreliable performance in the past and I would like to thank Sodexo for their attention to the improved standards we have seen.

The reduction in nurse agency has been a significant contribution to our month one financial position which is a little ahead of our plan. This figure does flatter us as the phasing of productivity and efficiency improvement needs us to deliver much more in the second half of the year. We have not yet fully identified our cost improvements and still have a lot of productivity gains to make to deliver the financial positon that we have committed to as part of the wider integrated care system plan.

We are behind our activity plan, although in value terms it is much nearer to plan as we continue to work through the more complex long waiting patients. The announcement of a further junior doctor strike in mid-June is unwelcome both in terms of activity losses and the impact on patients and the level of management attention required to manage the risk of the action that would be better focussed on improvement.

We await the results of the consultant BMA ballot and the RCN re-ballot of their members for further industrial action.

It is really pleasing to see another positive set of HR metrics with vacancies, turnover and sickness absence all continuing the downward trend. I am particularly pleased by the impact the new deal for our heath care support workers that we agreed last autumn with turnover now below 20% and vacancies at 25 down from 82wte with a further 15 recruited to the vacancies.

Lastly I am concerned about our cancer performance, albeit out 28 day referral to diagnosis performance is improving our percentage of

Our Quality & Safety – Executive Narrative

David Mowbray

Chief Medical Officer

Lucy Flanagan

Chief Nursing Officer

Quality

The Trust developed an action plan to address the 'must and should do' recommendations from the CQC inspection report published in March 2023, in response to an inspection in November 2022. The majority of actions are completed with the exception of the following which are subject to ongoing improvement work

- Embedding the Mental Capacity Act and Deprivation of Liberty Safeguards into practice—this is a quality priority for 23/24 and an update on progress was presented to the Quality Committee last week
- Compliance with VTE assessment—this is a quality priority for 23/24. Changes to the electronic prescribing system (EPMA) in the next month will make assessment a mandatory element of prescribing prophylaxis
- Utilising the functionality of the EPMA system to support medicines audits—since the CQC inspection we have introduced routine audits of missed medication doses and this is presented through the Medicines Safety Committee report to Patient Safety Committee. In addition we are focussing on missed critical medications as part of the medicines quality priority for 23/24

Infection prevention and control—Covid 19

The NHS have stood down the incident response level to the Covid 19 pandemic. Part of the arrangements have included a revised approach to routine screening for Covid. National guidance was issued in April by UKHSA and NHSE colleagues. This guidance has been adopted by the Trust. On May 5th, due to very few cases of Covid 19 we were able to allow all clinical staff to stop wearing facemasks when providing general patient care, this is the first time we have been able to do this since the pandemic was declared. On May 23rd we had no patients with active Covid in our bed base.

Mixed Sex Breaches

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
121	203	81	240	517	233	150	173

We continue to be an extreme outlier for mixed sex breaches since pandemic restrictions were introduced. These are occurring in the following areas. AMU (37), CCU (9), Frome (9), ITU (2), Redbrook (16) and Wye (100)

Whilst it would not be unusual to see breaches occurring in CCU, ITU and Wye, given they all have high care areas where step down may be difficult, the numbers for Wye do seem very high. A review into the reasons for this is being explored.

Other than in high care areas mixed sex breaches should only be considered if the trust is under extreme pressure and ambulance off loads are proving problematic. Mixed sex breaches are discussed at every operational bed meeting. Fortunately we have not received any complaints or concerns from patients in this regard.

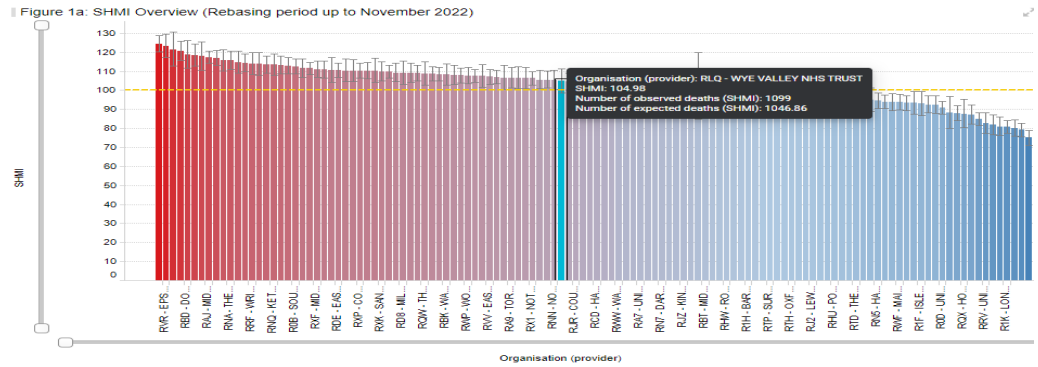
Quality and Safety – Mortality

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

12 month rolling SHMI (*HES based)* March 2022 to February 2023



What the chart tells us:

- **SHMI** (*HES Based*) from February 2022 to January 2023 shows Wye Valley NHS Trust at **104.9**, which is 2.3 reduction. This latest 12 month period has now removed a previous spike from January 2022. There has also been a significant reduction of 5.67 for the 'out of hospital' deaths. In comparison to the other hospitals in the Foundation Group, SWFT's latest SHMI is 107, and GEH are at 111, for the same time period.
- The latest reported **HSMR** *(in-hospital deaths only)*, for the period of February 2022 to January 2023, is **109.2.** A small reduction of 1.34 has been reported, but still remains at a higher than expected level, and equates to 87th out of 122 reporting Trusts. There are planned discussions to investigate this measure further.
- In-hospital **crude mortality rate** for April 2023 is at **1.71%** for all admissions, and continues to reduce following a period of high numbers of deaths over the winter.
- A significant reduction in the latest mortality rates for fracture neck of femur patients, with the SHMI falling to **111.97**, which equates to a 17 point drop. This has now returned to within expected levels of mortality for this group. A full review of the initial actions, in response to the rising rates, is currently being followed up on.
- Pneumonia and Stroke continue to report lower than expected rates, **97.75** and **84.14** respectively, and contribute a significant portion to our overall Trust mortality rates.

Key Actions:

Here are some of the key actions this month:

- Commencing in June 2023, there will be a regular monthly Emergency Department focussed mortality meeting, at which there will be a review of any cases that raised concerns by our Medical Examiner service or bereaved families.
- With the robust review of all our deaths on Acute Medical Unit, there is a plan to develop a simple quarterly report to summarise learning and key areas for improvement. This will start to form part of this report, but also feed into divisional governance structures.
- During March there were 113 in-hospital and ED deaths, of these the Medical Examiners reviewed 111 cases (98%), which subsequently highlighted 10 cases where further in-depth review was required.
- The planned review on the impact of introducing Boarding will now form part of a wider review with the Trust Divisions.
- Initial discussions have been held with the local Public Health team in order to combine our mortality datasets, the aim is to enhance our surveillance across Herefordshire, both in and out of hospital. This will help the system identify any areas of concern.

Quality and Safety – PLACE audit results

We are driving this measure because:

Patient Led Assessment of the Care Environment provides invaluable feedback from service users across a range of issues including cleanliness, estate and infrastructure, food and facilities. In previous inspections Wye Valley Trust performance has fallen below the national average.

Data

Wye Valley NHS Trust 2022/23 PLACE results

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

What do the charts tell us

The chart provides the scores for each hospital site, across all domains and compares the scores to the national average.. Where scores were lower than the national average for privacy, dignity and wellbeing (our lowest scores), in the main this related to:

- Lack of privacy curtains in bathrooms (community sites)
- Provision of multi faith prayer rooms
- Provision of minor procedure rooms
- Bed area curtain lengths
- Inclusion of disabled groups in estates reviews of access

As can be seen from the list some of these are not easily resolved and others can be rectified more easily.

Key Actions:

The Trust received the full results of the latest PLACE inspection in April 2023. Next steps include:

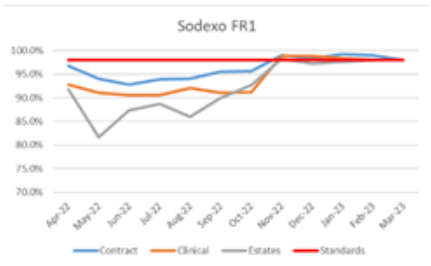
- Development of bespoke action plans for all 4 hospital sites.
- Establishment of a PLACE working group to oversee the action plans reporting into the cleanliness committee.
- Introduction of PLACE 'lite' from May 2023 to ensure there is a regular review of patient facing areas.
- Any area not included in the November inspections will be reviewed as part of the PLACE Lite review process

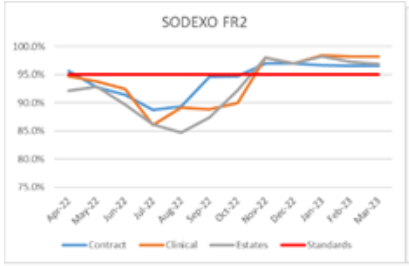
Quality and Safety –

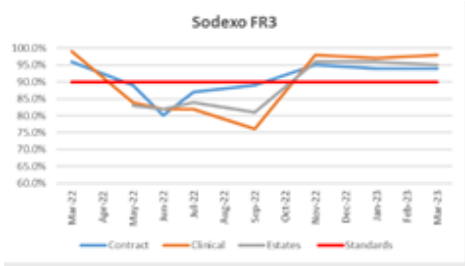
We are driving this measure because:

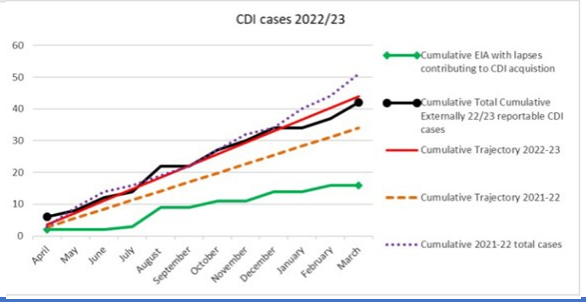
We have been an extreme outlier for our clostridioide (CDif) infection rates and receiving support from NHSE colleagues; additionally the Trust is driving the following Quality Priority: "Reduce our infection rates by delivering improvement in our cleanliness and hygiene regimes"

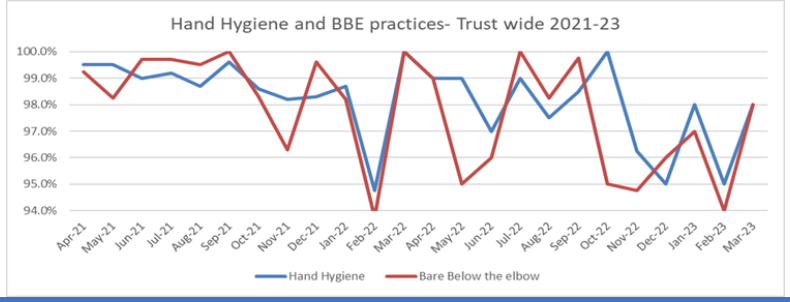
Data











What do the charts tell us

- The top 4 charts illustrate our performance over time for those areas serviced by the Sodexo contract. The FR 1-4 denotes higher risk clinical areas (1) and lower risk areas (4), with the standards demanding a higher target score for higher risk areas. The performance has improved significantly and consistently since November in all clinical areas
- The CDI chart plots our performance against trajectory for CDif cases. The year ended with 2 cases below trajectory and with a low number of lapses in care contributing to the case
- The hand hygiene and bare below the elbow chart shows trustwide performance against all staff groups. Whilst performance has dipped over the winter period compliance is still high and common themes where compliance wasn't fully achieved have related to temporary staff not following our local policies and the wearing of wrist attire including

Key Actions:

- The Trust continues to work closely with NHSE colleagues in developing our improvement plan, this has recently been reviewed by them and the ICS who are satisfied that progress is being made in all areas
- The infection prevention committee received an assessment of the trusts compliance against the health protection agency and department of health guidance on managing Cdif infection rates; overall we are compliant with the majority of recommendations and where we are not plans are in place. The findings will be added to the overall improvement plan and monitored quarterly through IPC Committee
- The Infection prevention team, senior nurses and Quality Committee members have all received a bespoke training session from NHSE in relation to the hygiene code
- The infection prevention Board Assurance Framework (BAF) has recently been reviewed and presented to Infection prevention committee; this shows good compliance overall. The BAF has recently been updated nationally (April), a further review will be undertaken during this quarter and presented to Quality Committee and Board

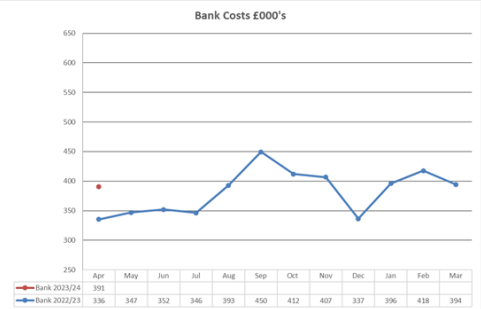
Quality and Safety – Staffing

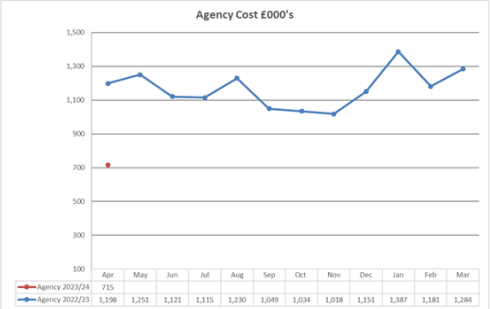
Fill Rate and CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	94%	78%	77%	90%	9.7
Maternity Ward	98%	93%	98%	89%	7.1
Children's Ward	120%	103%	99%	91%	13.5
Lugg Ward	95%	89%	101%	99%	5.6
Wye Ward	116%	83%	109%	93%	7.3
Cardiac Care Unit	100%	92%	100%	100%	12.6
Leominster Community Hospital	137%	92%	132%	136%	6.7
Bromyard Community Hospital	109%	115%	102%	129%	8.1
Ross Community Hospital	100%	111%	148%	109%	6.3
Teme Ward	74%	55%	85%	42%	10.2
Redbrook Ward	97%	105%	100%	108%	6.9
Special Baby Care Unit	92%	-	88%	-	8.0
Intensive Care Unit	107%	-	93%	-	27.4
Gilwern Ward	147%	145%	102%	115%	7.6
Acute Medical Unit	121%	90%	93%	113%	8.4
Ashgrove Ward	112%	99%	105%	140%	8.1
Dinmore Ward	131%	80%	101%	105%	7.0
Garway Ward	114%	104%	100%	128%	9.1
Frome Ward	111%	104%	99%	116%	7.5
Arrow Ward	140%	77%	139%	90%	8.1
Women's Health	100%	90%	98%	-	9.3

Analysis of Fill Rate Data

- Children's ward – Additional staff - one registered nurse from the ward attends ED daily; this is not in the established budget.
- Wye Ward – Increase in patient acuity and boarding patients.
- Community Hospital – Due to high dependency patients.
- Frailty Wards – Due to high patient acuity and dependency and boarding patients.
- Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV).
- Gilwern Ward – Change of specialty and require staffing levels greater than establishment.
- Low fill rates on Teme ward represent reduced staffing levels due to reduced bed occupancy on the ward





The Trust used less agency and bank staff during April (circa 100 wte less). This represents a significant reduction in spend as can be seen from the charts above.

This has been achieved through:

- Additional beds at community hospitals closing
- Less pressure in ED with a requirement to staff less escalation areas than in winter months
- A focus on reducing reliance on agency health care support workers
- Senior oversight in relation to expensive agency use
- Senior oversight to reduce reliance on registered mental health nurses
- Reduced health care support worker vacancy levels

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

April was a challenging month to start off 2023/24 with the pressure of an eleven day weekend, which included the Easter Bank Holiday weekend a four day period of Junior Doctors industrial action and a further weekend.

Whilst our operational and clinical teams faced this challenge “head on” the impact of our ability to maintain business as usual was stretched and as a result we had to postpone a number of elective patients over this period which had an impact of our elective activity plans and our ability to treat our patients already waiting a year and a half for surgery.

As I write this update we are planning for the next scheduled period of industrial action in mid-June.

Since the start of Covid our Acute Floor team have been working across an extended floor plan in order to support Infection Prevention Control measure and ensure capacity to manage patient flow. Whilst this was an operational requirement over the last two years it is clear that this way of working is now hindering our ability to manage quality, safety, performance and finance of our acute floor. Therefore, as part of the plan to review new and different ways of working, we have reduced the routine use of an expanded Emergency Department [ED] floor space whilst we Plan-Do-Study-Act developing, testing and implementing new changes.

Therefore, during May the Medical Division held an ED Summit. Over 70 colleagues from across the Trust ,and wider, were involved in reviewing our ED. The feedback was an extremely positive afternoon where it was felt that the wider team began the move from it being considered as the Acute and Emergency Directorate’s ED to a far more collective ‘our’ ED – this is critical to any improvements.

Other Urgent and Emergency actions in progress:

- Our Operational Ward based dashboards have been developed and rolled out to Divisions

- George Eliot Hospital [GEH] Peer visit. Really productive visit with GEH ED team to discuss ways of working and staffing models. Further review / analysis on-going

- Frailty held an away day at the end of April. At this meeting the Frailty pathway was discussed in depth and unanimous agreement was reached. The team want to look at how our Frailty Same Day Emergency Care [FSDEC] provision can be co-located with the Acute team on the Acute floor, this formed part of the ED Summit, and a revised job plan now has a Geriatrician allocated to support the front door team across five days of the week.

- Frailty and Acute Medicine Virtual ward [VW] We’re really pleased to have this up and running and have already increase the amount of planned capacity available ahead of time in order to support flow and patient experience. Our VW Advanced Clinical Practitioners are working across the Frailty wards, ED, SDEC and our Acute Medical Unit to maximum capacity across 7 days of the week.

The other significant concern is the challenges faced by our cancer pathways.

Although we have started to see an improvement in our 28 Faster Diagnosis Standards [FDS] and managed to maintain the level pf patients breaching the 62 day start of treatment standard to around 110 patients per month, pre Covid this was around 80, this has been as high as almost 200 patients during 2022/23.

The main issues facing the Trust are delays due to Diagnostics, particularly the ability to turnaround timely reporting patients imaging, Endoscopy, Histology and some of the capacity issues related to workforce in key specialities.

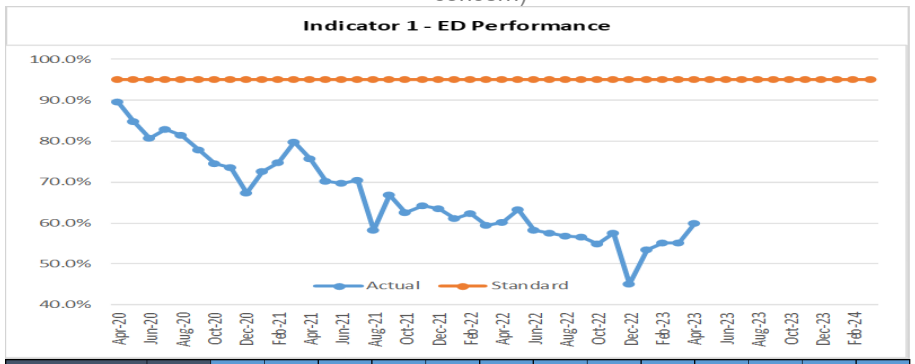
Within this months update I have included some of the action the Divisional teams are taking to stabilise and improve the position.

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

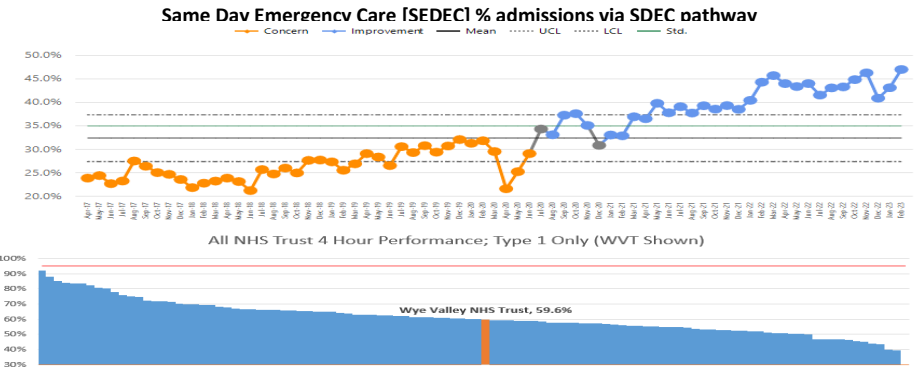
We are driving this measure because:

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



KPI	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
ED Performance	Actual	60.1%	63.3%	58.2%	57.5%	56.8%	56.6%	55.0%	57.4%	45.1%	53.5%	55.1%	55.2%	59.9%
	Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Performance and Actions

- 5,635 patients attended ED in April which was fewer than March. The range of attendances varied from 168 to 223 with 189 being the average daily attendances
- 1,708 ambulances conveyed to the Trust in month which was fewer than last month The range in month was 43 to 72. This includes 5% from Worcestershire [81], 4.5% from Shropshire [75] and 12% from Powys [203]
- Ambulance handover delays over 1hr were 8% of all conveyances [136] 75% of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 778 of all admissions via a Same Day pathway within no overnight admissions.

Actions to Address:

- Internal Acute Floor [ED /SDEC / AMU] action plan in place to improve ED Clinical Quality Indicators [CQIs]
- Hospital@Home bridging team expansion to support discharge of patients waiting discharge packages of care at home

Valuing Patients Time Agenda, Key areas of focus:

- Improve Discharge processes through system wide visibility of discharge capacity and barriers, improving patients being discharges before lunch and at weekends . Utilisation of Criteria to Reside being embedded to progress daily oversight of discharge delays for those patients that are clinically ready to proceed to discharge.
- Ward based patient dashboard to support clinical teams and support patient flow along with clearly documented patient centred 'the way we do things here…' for each ward and department.
- Frailty and Acute Medicine Virtual Ward was operational at the end of April.

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 te acute floor and our inpatient areas.
- System patient flow constraints due to workforce and capacity.

What the charts tells us:

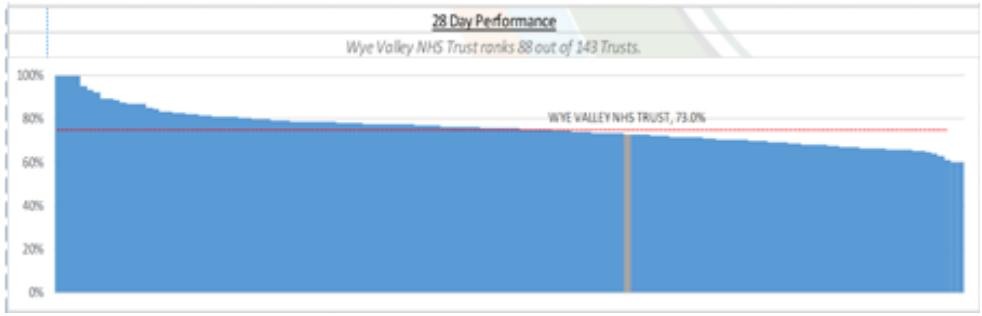
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
WVT Type 1 ED performance is 58 / 109 English Trusts

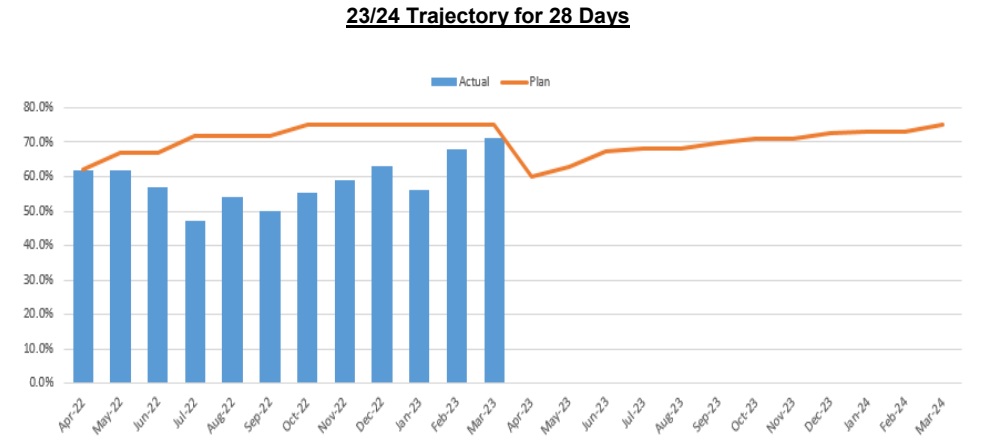
Operational Performance – Cancer Performance—28 Days Fast Diagnosis Standard [March 23]

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 25% increase compared with 2019/20, an additional 2264 patients, which is also 8% above our planning assumptions for 2022/23.
- Referrals remain high in key cancer site specialities, in particular Upper Gastrointestinal [UGI], Lower Gastrointestinal [LGI], Gynaecology, Urology and Lung.
- Implementation of the newly designed Faecal Immunochemical Test [FIT] pathway in in June should see a decrease in referral numbers for LGI.

28 Days

- Eight pathways failed to meet the target in March Breast, Gynaecology Haematology, LGI, Lung, Sarcoma, UGI and Urology.
- There has been an increase in the FDS performance in March to 71%, this is a 15% increase compared to performance in January.
- Early data suggest that the FDS has decreased slightly in April due to diagnostic and histo-pathology capacity.

Main Specialties impacting on performance reduction:

- Upper and Lower GI: Workforce challenges and Endoscopy remain the biggest challenges,. Computerized Tomography Colonoscopies [CTCs] are now being booked within 16 days but reporting is a further 15 days. Diagnostics update provides more detail. All endoscopy procedures are being booked between 2-3 weeks but a 6 month Locum has been funded to reduce the waiting time for patients on a cancer pathway.
- Urology have experienced challenges with delays with their histopathology being reported with their template biopsies as they are being sent away to report. An Service Level Agreement meeting is being organised with the company to review performance. .

Risks:

- Cancer referrals continuing to remain above 19/20 levels

What the charts tell us:

- 28 Day faster diagnosis = Performance against this target was 71.3% and remained below the target of 75%.

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

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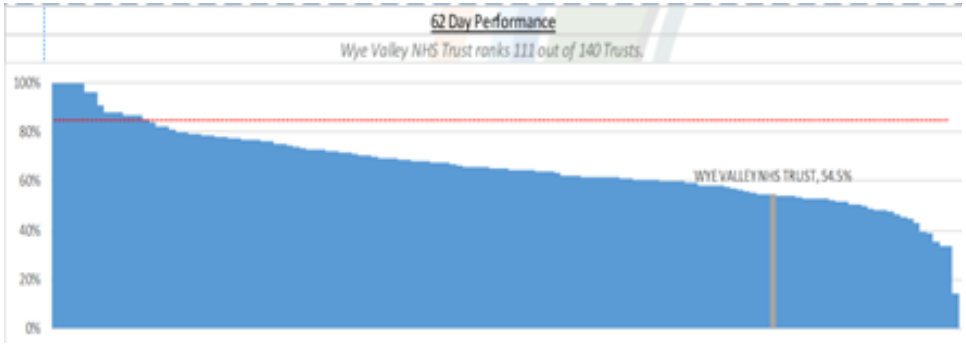
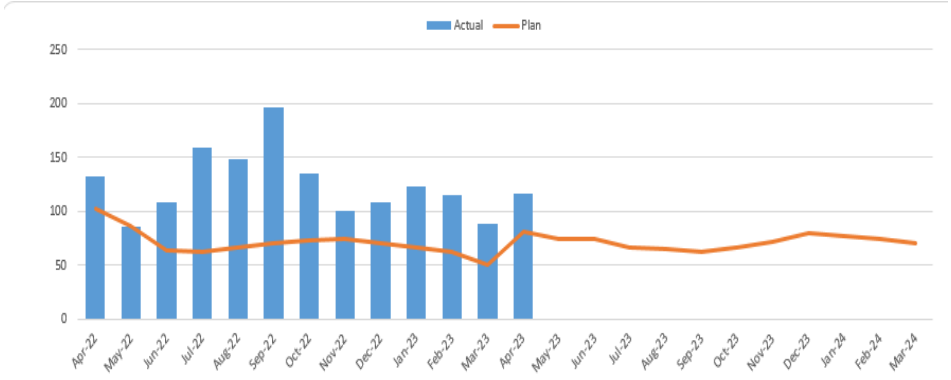


23/24Trajectory for Patients waiting over 63 days for Start of Treatment



Performance and Actions

62 Days:

- The trust position for 62 days in March was 55% with 35 patient breaches.
- The current positions in the number of patients waiting over 63 days for treatment or removal from a cancer pathway is 113 which is above the trajectory put forward to the ICB. The pressures have been the same related to the FDS performance, also theatre capacity and consultant vacancies / absence.

High Level Cancer Actions

- A deep dive took place in May in relation to 62 days and new actions have been set for specialties to take forward over the next few months to improve the position.
- Issues with Diagnostic reporting across key modalities. Ongoing discussions with current out of hours reporting provider to increase in hours report whilst workforce challenges remain and reviewing the processes for prioritising caner reporting
- Following up on Foundation Group learning for key cancer pathways
- Improvements around clinical processes in particularly mandatory requesting blood for key diagnostic pathways, one stop clinics for head and neck , improvement pre-operative pathway for Breast and Colorectal cancer patients, ring-fencing post Multidisciplinary [MDT] apportionments across all specialties
- Histopathology. Looking at further network and digital solutions including South Warwickshire NHSFT to advertise for skin support within job plans
- Endoscopy has improved from booking cancer patients within 3 weeks during March to 1 week towards the end of May and is working to maintain this and increase capacity.

Risks:

- Histopathology / Radiology vacancies—further workforce challeneges ongoing
- Endoscopy Capacity due to workforce shortfalls [See Diagnostics update]
- Impact of further Industrial Action

What the charts tells us:

- 62 day Treatment standard = The Trust performance was 55 % against a target of 85%.

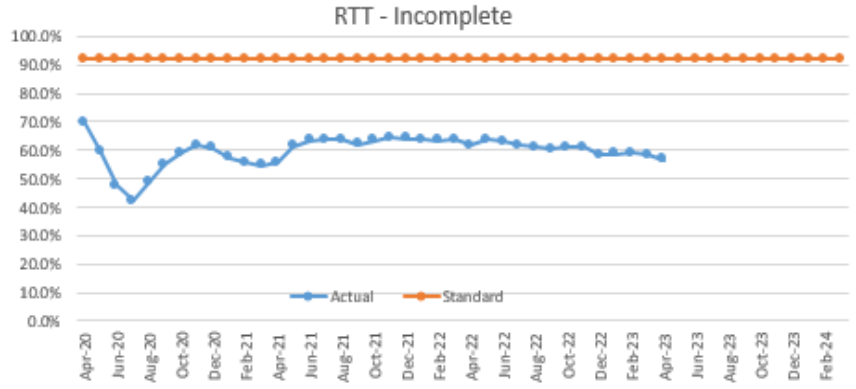
Operational Performance – Referral to Treatment Performance / Activity / Productivity

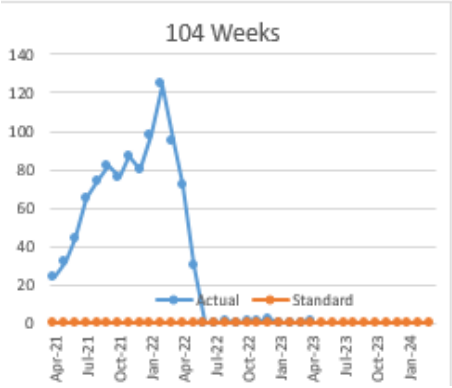
We are driving this measure because:

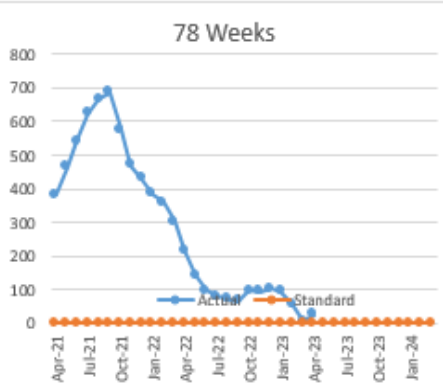
Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments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

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

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

Activity Summary:

- During April New Outpatients [OP] activity was 94% of 2019/20 activity and below plan for the year.
- Overall total elective activity was 80% of 2012920 activity and 15% below plan for the year.. Overnight electives were on plan, but both day case activity and Endoscopy were behind plan. Driven by a combination of workforce issues and industrial action impact .
- Value-based Weighted Activity [VWA] across over night elective, day case, outpatient procedures activity for acute specific Treatment Function Codes [TFCs]. During April we were one of four Trusts delivering above 100% for 3 out of 4 weeks.

Actions to address :

- Weekly Patient Tracking List [PTL] meeting to review with each speciality the 78 week risk for the rest of Quarter 1 and into Quarter 2
- Activity plans agreed for 2023/24 and revised monthly Divisional Check and Challenge in place to work in conjunction with Productivity Programme Board.

Productivity:

- Mean Operating Times have been compiled for each surgeon in each specialty. Teams are currently interrogating data with a view to using these timings to compile future lists. This should allow for more accurate bookings and thus an improvement of list utilisation.
- Pre-Operative Mini-Screening in June. The Mini-Screening process outlines that patients who have a Decision To Treat (DTT) for surgery in outpatient clinic, will receive all Pre-Op Assessment tests and observations and complete a Pre-Op Assessment Health Questionnaire before leaving the outpatient department.

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:

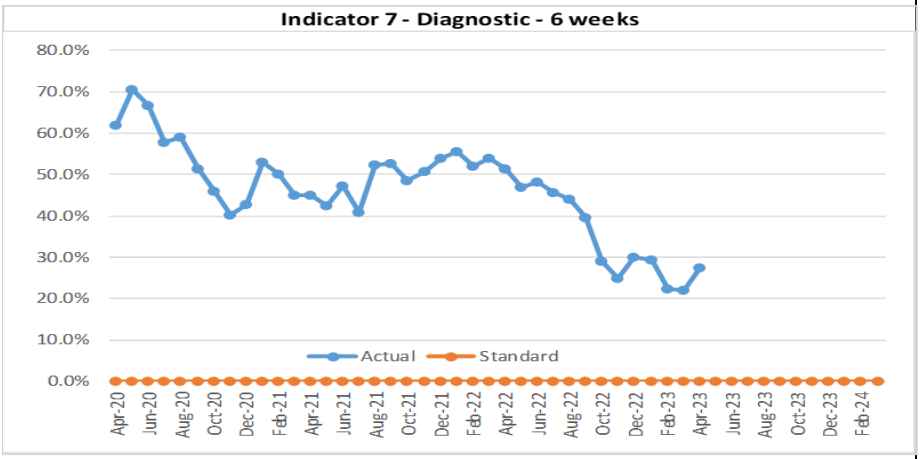
- Performance against English RTT standards in April was 56.7% - 1.6% decrease since last month.
- Performance against the Welsh RTT standards in April was 64.7% - 2.6a since last month.
- Referral to Treatment Number of Patients over 104 weeks = 1 / over 78 weeks = 19 English on Incomplete Pathways Waiting List

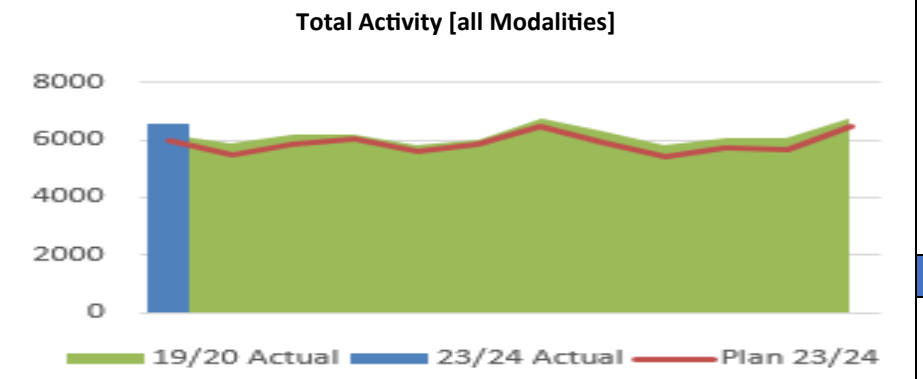
We are driving this measure because:

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 154% 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 138% of 2019/20 activity last month. Colonography CT [CTC] bookings at 14 days (providing bloods and prescriptions available—continuous review of these processes to improve).
- Non-Obstetric Ultrasound achieved 70% of 2019/20 activity last month 3 Whole Time Equivalent [WTE] on-going vacancy). Two new scanners now in place to deliver brand new community services in Ross and Bromyard Sonographer interviews took place mid May—1.8 WTE offered and bands 7 and 6 and a further 1 WTE band 7 interview booked for 8th June. These appointments should reduce demands on consultant workloads and improve performance.

Echocardiography [Echos]:

- Delivered 138% activity above 2019/20 levels in April with the waiting list around 12/13 weeks for routine Echos. However Insourcing has now restarted and we anticipate that we will have no patients breaching >13 weeks by June. We have also successfully recruited into one of our B7 Cardiac physiology (Echo) role and employment checks are currently underway.

Endoscopy

- Significant challenges in month with the loss of two General Surgery consultants, and three Gastroenterologist being absence for sometime [two have now returned], and reduced capacity at Ross Community Hospital due to decontamination washer replacement. This put pressure on the ability of the team to delivers its planned activity and backfill lists.
- Additional template sessions are scheduled through funding from the Cancer Alliance to recruit an Endoscopy Locum to carry out 3 lists per week Our Upper GI Non-Medical Endoscopist is looking to increase their job plan to include an additional Trans-Nasal Endoscopy session each week, along with increased non-medical waiting list clinical validation .

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.

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

Extensive planning ensured the Trust responded appropriately to industrial action organised by health trade unions over the past few months and we continue to work 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 are balloting consultants for industrial action and have announced that junior doctors will be going on strike for 72 hours in June. The RCN are now balloting their members on a national basis for potential strike action in July. Planning for the junior doctor strike action in June continues through the WVT industrial action group. In planning for industrial action we are maintaining good relationships with our union representatives and senior clinicians.

The majority of the Agenda for Change unions have accepted the pay offer and this will be implemented in June. The offer is made up of two one-off non consolidated awards worth 2% & a backlog bonus worth between £1,250 & £1,600 for 2022/23. A consolidated pay award of 5% for 2023/24. The entry level pay in the NHS has been increased to £11.45 an hour (£23,383 per year).

Our comprehensive *intouch* WVT wide staff engagement programme which includes suggestion boxes, a new staff engagement email, online surveys and divisional engagement workshops for staff was launched on 15/05/23. The campaign will run until July to ensure all employees have a say on 4 key questions (*being a more flexible employer, creating a more compassionate & respectful culture, improving the quality of care, improving health & wellbeing).* Employees will be informed about divisional and WVT wide actions following the engagement campaign.

We have seen a reduction of absence over the past 6 months and the % of absence has reduced from a high of 7.1% in December to 4.8% in April 2023. This reflects a significant reduction in covid cases and winter ailments as well as more rigorous efforts in managing staff absence. Targeted work in areas with high absence, further policy enhancements, developing our line managers and detailed absence reports at F&PE meetings have contributed to a reduction in absence. HR teams continue to sensitively support the management of long and short term sickness absence cases and we are working actively with line managers and OH on the management of absence to ensure this downward trend continues over the summer months.

Through our concerted efforts in recruitment & retention we have seen a reduction in staff turnover for qualified nurses & midwives from 15.24% (Nov 22) to 12.80% (Apr 23). We have also seen a reduction in staff turnover for band 2 hcsw staff from 28.3% (Jul 22) to 17.49% (Apr 23). The focused work in eliminating undue delays in the recruitment process continues and most employment checks are now completed within 10 days. Active work continues to fill our clinical posts and we welcomed 110 new international nurses in 2022/23.We now have over 25 WVT ambassadors supporting recruitment events for different staff groups and we continue to work closely with DWP and have several joint recruitment events throughout the summer months. The international nurse recruitment programme and the healthcare support worker programme have been nominated for the WVT Team Staff recognition award at the AGM in recognition of HR efforts over the past year.

The first HR roadshows for staff took place from 24-28 April across all sites supported by Halo, Talk Communities and DWP. This provided staff with information on wellbeing, career opportunities and the variety of benefits available at WVT. Services offered by the newly launched Staff Pension Support Service (PSS) was also promoted during the roadshows as a retention tool for staff who wish to retire and return.

Our commitment to equality, diversity, inclusion and staff wellbeing continues and we promoted the NHS EDI week in April and supported the national mental health awareness week focusing on support available for staff suffering with anxiety.

Compassionate leadership is at the heart of our WVT leadership development programme for 2023/24 as strengthening our positive leadership culture will drive better outcomes for our patients and lead to a better experience for those who work at the Trust.

Work has commenced across the Group on meeting our workforce strategic aim of Being a Flexible employer.

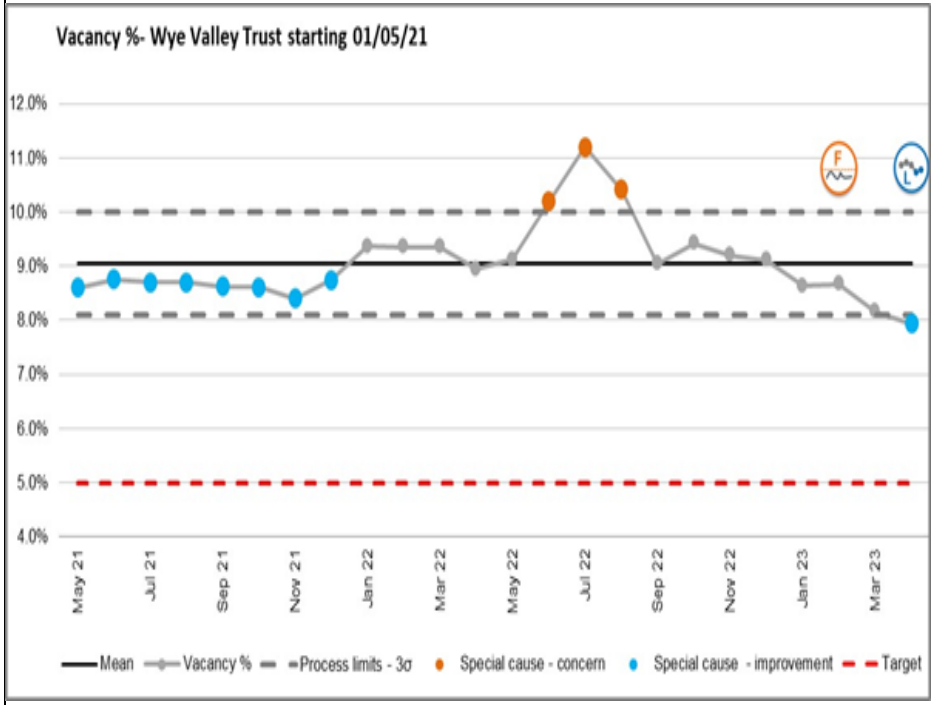
Our Workforce – Vacancy

We are driving this measure because:

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

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-
8.9%	9.1%	10.2%	11.2%	10.4%	9.0%	9.4%	9.2%	9.1%	8.6%	8.7%	8.7%	7.9%

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

HCSW – at the beginning of 2022 our HCSW vacancy gap was 80 WTE and we now have a vacancy gap of 26.39.WTE Since the introduction of the WVT pay & career framework in November we have been successful in recruiting & retaining staff and by the end of the year we are likely to have <10 vacancies.

N&M - 110 international nurses joined WVT in 2022/23 and no international nurse left the trust last year. We have 95.55 wte vacancies and we are now recruiting to the new business case for our international nurses for 2023/24 where the target is to have up to 120 more international nurses by end of March 2024. In April we welcomed 9 nurses and we have 10 due to arrive in May.

AHP - as part of the ICS AHP programme 1 podiatrist will be joining the Trust from South Africa by July.

M&D - we are working with a number of agencies in order to recruit international drs for WVT. Fortnightly meetings with CMD, Medical Staffing Manager & Strategic Medical HR Lead to review progress with vacancies and cases of concern Overseas recruitment of medics to continue throughout 2023/24. We currently have 63.42wte vacancies.

Pharmacy - with significant recruitment & retention challenges we have introduced a short term recruitment & retention premia and this is already having a positive impact in retaining staff.

To meet our strategic aim to *Be a Flexible employer*, we are advertising all jobs as open to flexible working, extending relocation packages in hard to fill areas, highlighting opportunities for personal and career development. We are extending our recruitment events and we will be promoting 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. 25 WVT Ambassadors are now supporting recruitment events for the Trust.

Risks: Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us:

The rolling 12 month position remains fairly consistent across the period between October 2021 and May 2022, although deteriorated in June and July 2022 but has improved in the months following to previous levels in early 2021.

Our Workforce – Sickness

We are driving this measure because:

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

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
7.4%	5.5%	6.5%	6.7%	5.3%	5.4%	6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	4.8%

Assurance	Variation	Data Quality Mark
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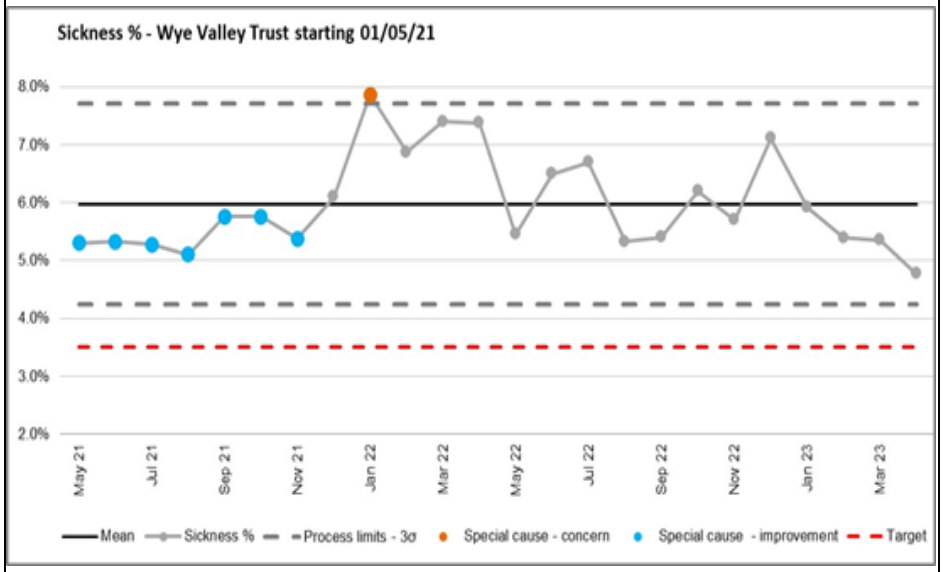


Performance and Actions

During this month, overall sickness at Trust level has decreased to 4.8%, which is the lowest % since April 22 compared to a rolling 12 month average sickness of 5.8%. This in part can be attributed to a reduction in covid absence and more focused HR support and coaching of line managers. The main reasons for absence are colds/flu, gastrointestinal issues, mental health issues, msk and migraines .

At F&PE meetings, divisions are required to present comprehensive data on sickness absence which includes heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT. By focusing on absence reports by departments we are ensuring that all line managers are dealing with absence effectively and appropriately.

We are piloting a part time staff physiotherapist and a mental health wellbeing nurse in OH using funding from NHS Charities. HR teams continue to sensitively support the management of long and short term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team based wellbeing support for staff. The wide range of health & wellbeing initiatives (Hereford & Worcestershire mental health hub, 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 monthly 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.

What the chart tells us:

The rolling 12 month position shows a fluctuating picture between May 2021 and December 2022, this is mainly due to the Covid related absences, as well as other winter pressures such as Flu. However there has been a reduction in the last 4 months to pre pandemic levels.

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.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
12.9%	13.6%	14.0%	14.5%	13.7%	13.6%	14.2%	14.4%	14.2%	13.6%	13.5%	12.8%	12.6%

Assurance

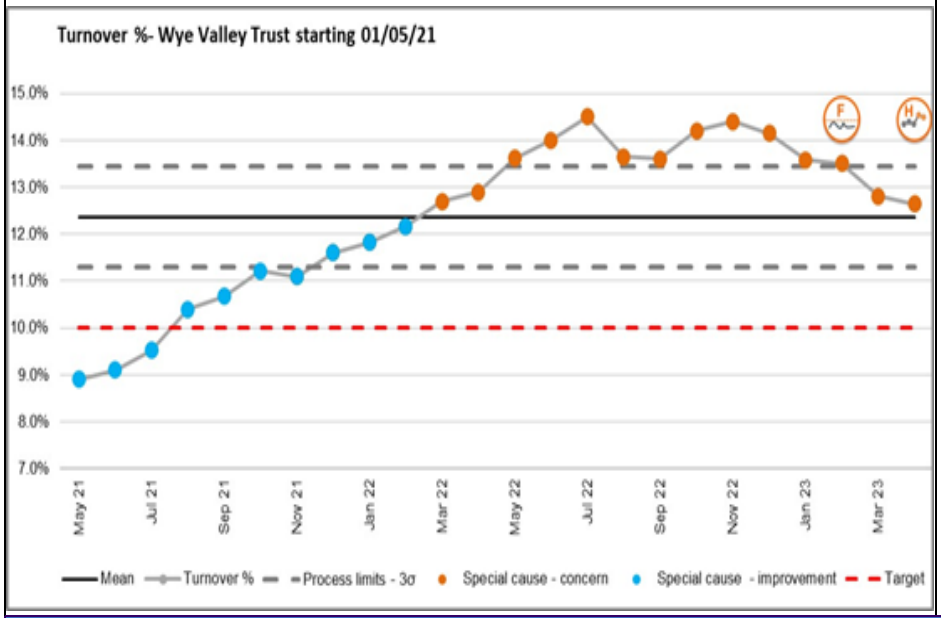
The system is expected to consistently Fail the target

Variation

Special cause variation – Cause for concern (where high is a concern)

Data Quality Mark

Reasonable Assurance



Performance and Actions

The overall rolling 12 month turnover at Trust level is now at 12.6% for April 2022 which is the lowest for the past year. The average for the previous 12 month's turnover is 13.7%

The turnover rate for clinical support workers at band 2 level has reduced from 28.3% (Jul 22) to 17.49% (Apr 23) The introduction of the WVT pay & career progression framework is having a positive impact on the recruitment & retention of staff at this level.

We are seeing a reduction in turnover rates for qualified nurses & midwives at band 5 level and this has reduced from 15.24% (Nov 22) to 12.80% (Apr 23). However, this remains a national area of concern and we still have 95.55 wte vacancies at WVT.

The plan to train and develop more WVT support staff into nurse associates and qualified nursing roles over the coming years is progressing and a review of the band 6 staffing establishment is being conducted to ascertain the feasibility of employing more band 6 nursing staff & band 4 associates in order to aid retention. At the end of the last financial year we employed 110 new international nurses at the Trust. We are expanding our international recruitment programme over the next year and we continue to work closely with the University of Worcester in sourcing qualified nurses.

All divisions have local recruitment & retention working groups in place to analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. HRBPs report on local actions to the WVT recruitment & retention working group which meets on a monthly basis. The group oversees 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. We are reviewing all cases where the reason for leaving is cited as lack of flexible working.

The ICS workforce planning officer is supporting workforce projects and NHS requests on workforce and finance establishment data for WVT.

Risks:

Growing staff turnover

What the chart tells us:

The rolling 12 month position shows a steady increase across the period between May 2021 and July 2022, then presenting a fluctuating pattern for the last few months, returning to decreasing trend for the last 5 months.

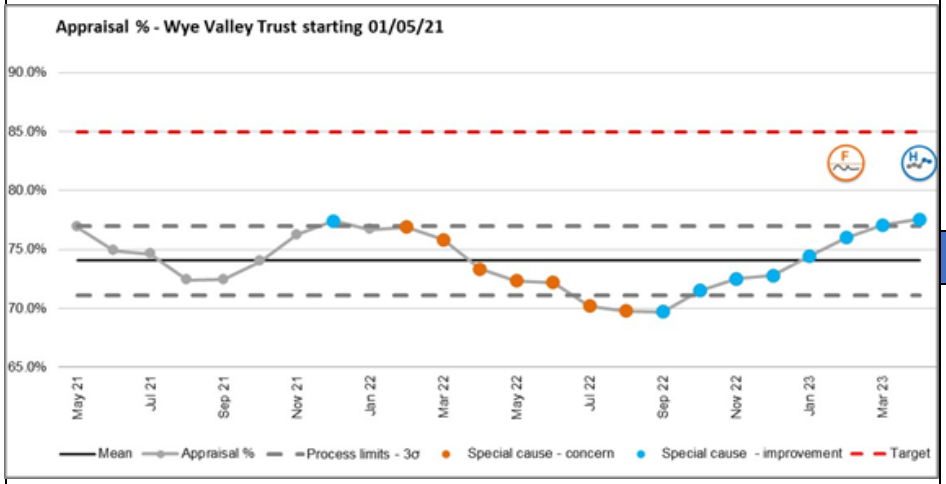
Our Workforce – Appraisal

We are driving this measure because:

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

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
73.3%	72.3%	72.2%	70.2%	69.8%	69.7%	71.5%	72.5%	72.8%	74.5%	76.0%	77.1%	77.5%

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



Performance and Actions

Operational pressures continue to have a significant impact on WVT and NHS wide management capacity to complete performance appraisals. The modified and streamlined appraisal form is being used by line managers in holding well-being appraisal conversations with staff. This will continue to be reviewed at F&PE meetings in 2022/23.

Divisional leaders have been asked to ensure recovery plans are in place for outstanding performance appraisals to be completed over the next 3 months.

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 was primarily due to the challenge of maintaining standards during the Covid Pandemic, however it is slowly increasing over the past few months.

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.

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

Assurance

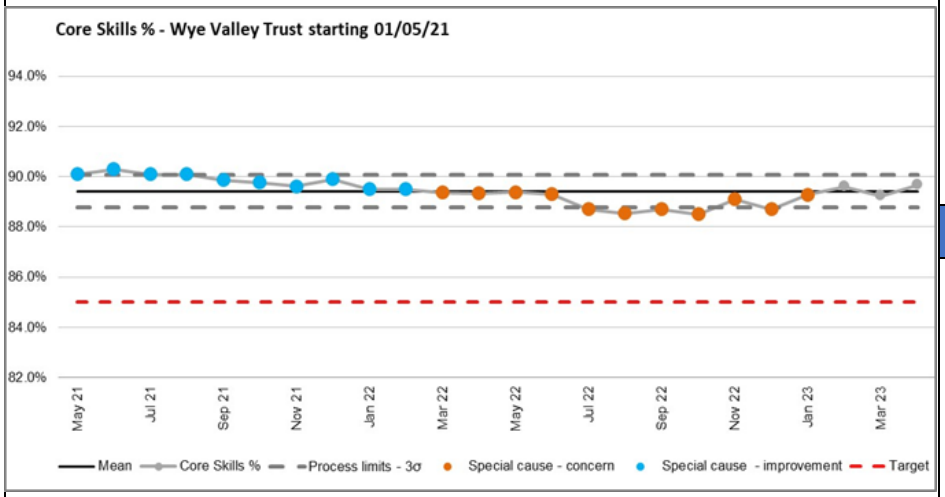
The system is expected to consistently Fail the target

Variation

Special cause variation – Cause for concern (where high is a concern)

Data Quality Mark

Reasonable Assurance



Performance and Actions

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

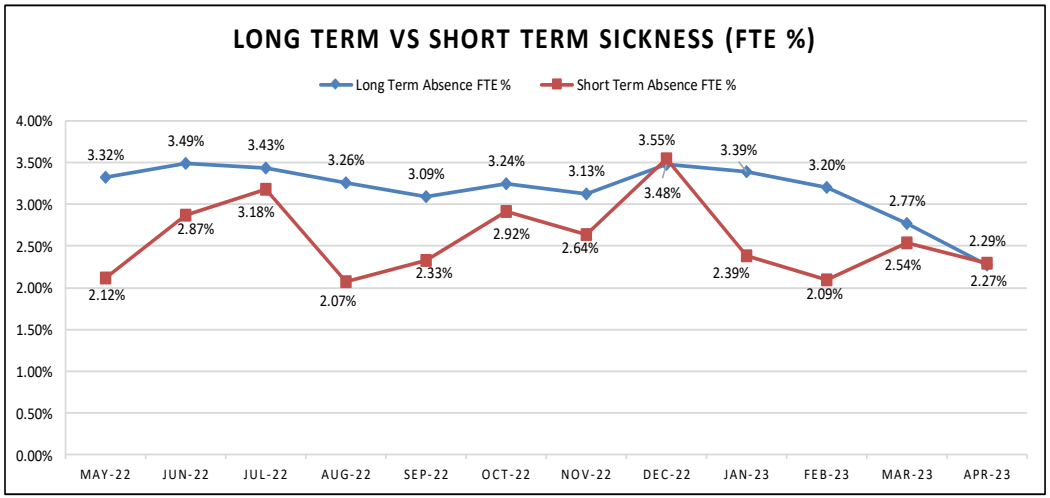
Risks:

What the chart tells us:

The rolling 12 month position remains fairly consistent for the Trust.

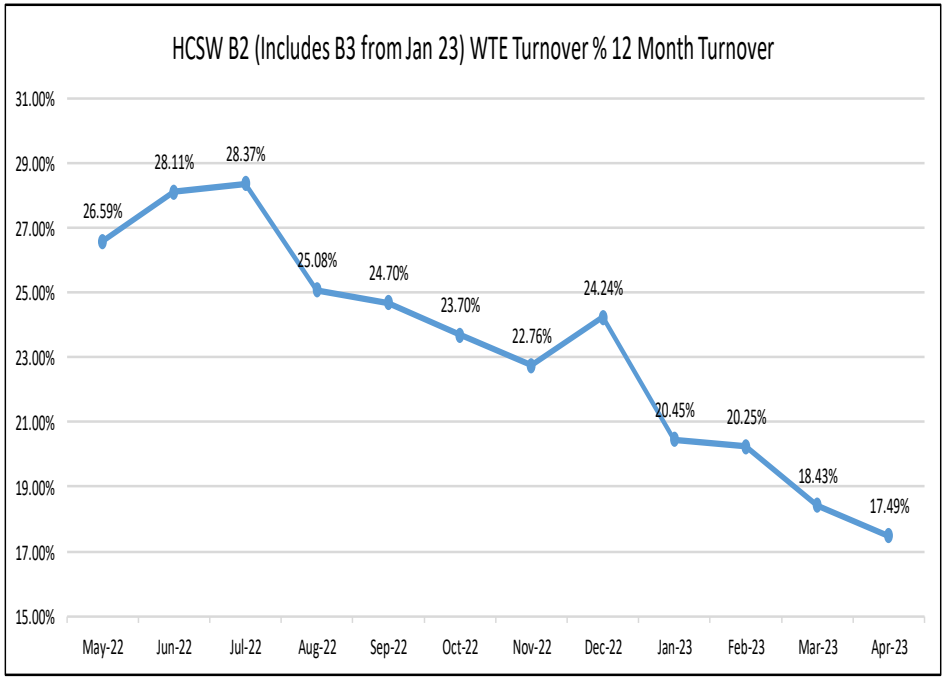
WVT charts on sickness absence & staff turnover for band 2 HCSW and Nurses & Midwives

More rigorous management / HR actions is leading to a reduction in absence

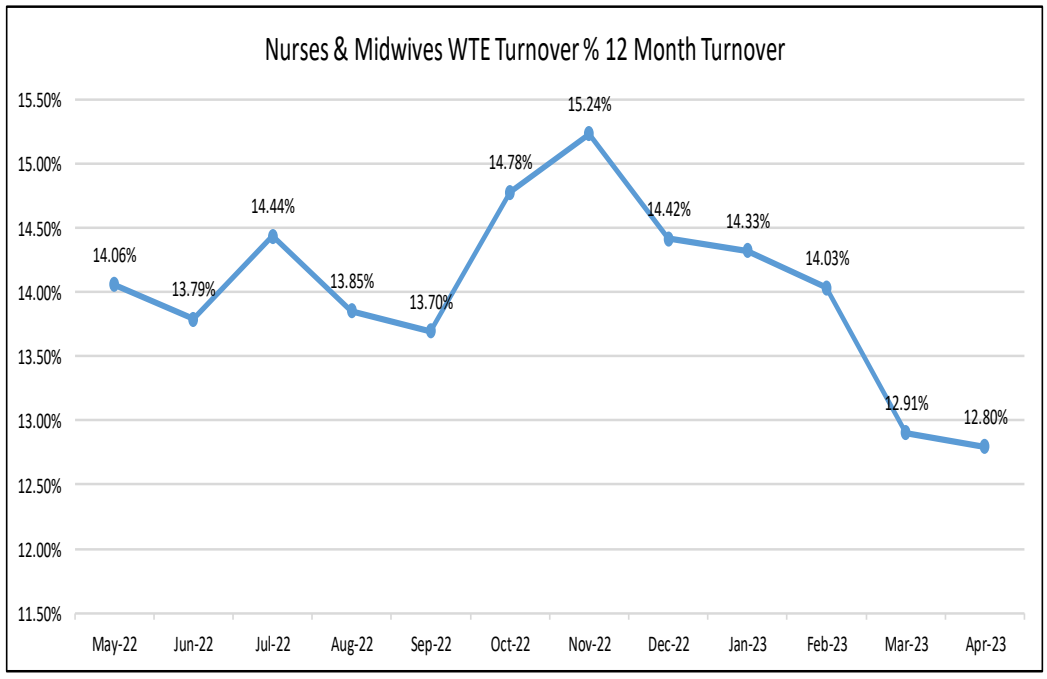


Main reasons for absence – Top 5	%
Cold, Cough, Flu – Influenza (6.77% of 22.31% is Covid related)	22.31
Gastrointestinal problems	16.32
Anxiety/stress/depression/other psychiatric ill-nesses	11.35
Other musculoskeletal problems	5.67
Headache/migraine	5.36

The chart below shows a reduction in turnover for band 2 HCSW



The chart below shows a reduction in turnover for nurses & midwives



Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Financial Plan 2023/24

The Board approved the 2023/24 draft financial plan at its April meeting, at which point potential additional mitigation for the deficit plan was being pursued. On 4th May, the final plan was submitted to NHSE under delegated authority. The final plan reflects an in year I&E deficit of £22.3m as shown in the table to the right. Changes from the draft financial plan relate to income associated with diagnostics activity, and a redistribution of funds within the Integrated Care Board (ICB). 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.

Statement of comprehensive income	Plan £'ms
Income	331.7
Operating Expenses	(324.2)
Operating Surplus / (deficit)	**7.4**
Net Finance Costs	(10.1)
Surplus / (deficit) for the period/year	**(2.7)**
Remove capital donations/grants I&E impact	(19.6)
Adjusted financial performance surplus / (deficit)	**(22.3)**

Income & Expenditure Performance

The financial position at the end of month 1 (April) was a deficit of £2.2m. Although pleasing that this is marginally ahead the plan, the completeness of month 1 reporting is typically impacted by the year end close and the plan contains a number of financial risks which require mitigation. Focused activity to reduce reliance on premium cost agency workforce has resulted in a significant reduction in the nursing agency run rate this month. Medical agency has stabilised. Delivery of our efficiency requirements and productivity improvement are key to securing delivery of the plan. The wider Herefordshire and Worcestershire Integrated Care System (ICS) has a planned deficit for 2023/24. Across the system we have seen pay pressures in month 1, reflective of the level of challenge within the plans and capacity requirements.

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. A prioritisation process is taking place to agree the final programme.

Cash

The cash position at the beginning of the year was better than planned, due in part to the early receipt of IES funding, though this worsened during the month. Despite this the Trust achieved its BPPC target of 95% as measured by invoice value and volume. The overall cash position is subject to ongoing management given our deficit plan and the need to access national revenue support during the year. Practical measures such as aligning payables to reflect cash utilisation and working with commissioners to optimise timing of cash flows are explored to ensure requests for revenue cash support are only made where necessary. Applications for revenue support for quarter 2 are due to be made by 14th June.

The Board are asked to endorse the request for revenue cash support to ensure minimum daily balances to meet obligations can be maintained.

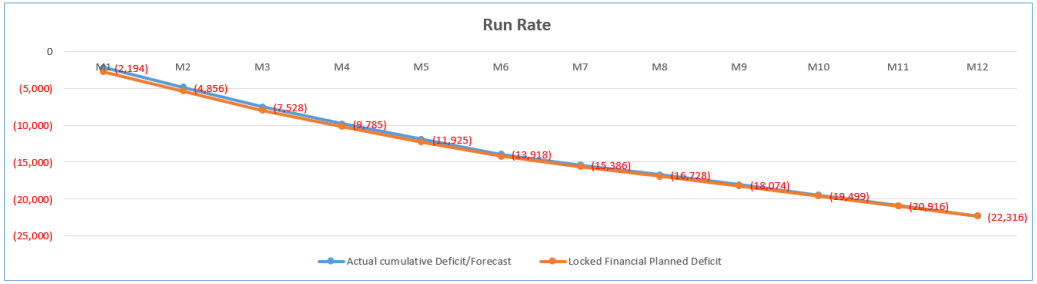
Our Finance – Year to Date Income and Expenditure

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 1 - 30th April 2023 - 2023/24

	2022-23 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Contract Income	270,413	22,168	21,998	(171)	(171)
Excluded Drugs	21,850	1,902	2,101	198	198
Non Contracted Activity (NCA's)	1,635	137	136	(0)	(0)
Other Income for Patient Care	9,038	770	774	3	3
Donations For Non Current Assets	20,500	838	1,317	479	479
Other Non Patient Income	7,110	593	551	(42)	(42)
COVID Funding	1,475	45	40	(5)	(5)
NHSE - central (22/23 pay award)	0	0	0	0	0
Total Operating Income	**332,021**	**26,453**	**26,916**	**464**	**464**
Pay Expenditure	200,854	17,054	16,527	527	527
Non Pay Expenditure	86,752	7,506	7,504	2	2
Excluded Drugs	23,546	1,960	1,910	50	50
Total Operating Expenditure	**311,152**	**26,520**	**25,941**	**579**	**579**
EBITDA	**20,869**	**(67)**	**975**	**1,042**	**1,042**
Depreciation	13,704	1,142	1,172	(30)	(30)
Interest Receivable	574	116	116	0	0
Interest Payable on Loans	266	22	28	(6)	(6)
Interest Payable on PFI	6,288	524	524	0	0
Dividends on PDC	3,868	322	322	0	0
Operating Surplus/ (Deficit)	**(2,682)**	**(1,963)**	**(955)**	**1,007**	**1,007**
Donated Assets Adjustment	**19,634**	**765**	**1,239**	**474**	**474**
Adj. financial performance retained Surplus/ (Deficit)	**(22,316)**	**(2,728)**	**(2,194)**	**533**	**533**



Performance and Actions

The indicative position at the end of month 1 (April) was a deficit of £2.194m. This was marginally ahead the current plan with an overall favourable variance of £533k year to date.

- Pay is underspending overall with some slippage on recruitment linked to capacity and unfilled vacancies. This net position also includes our high agency values — 8.1% of total pay costs in April although this has reduced since M12, particularly within nursing agency which saw a stepped reduction in usage in April. Medical bank usage at premium rates further increases this to 12.1% of overall pay. This is driven by volume and price (including off framework supply when unavoidable).
- The plan includes a significant level of additional capacity provided to achieve the operational plan, particularly recovering elective activity.
- We continue to experience cost pressures in staffing and non pay cost linked to urgent care pathways and volumes and acuity of patients.
- The Trust has set an annual cost improvement (efficiency) target of £15.7m (of which £2.5m is a further stretch target). In month 1 we delivered £0.4m of efficiency.

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

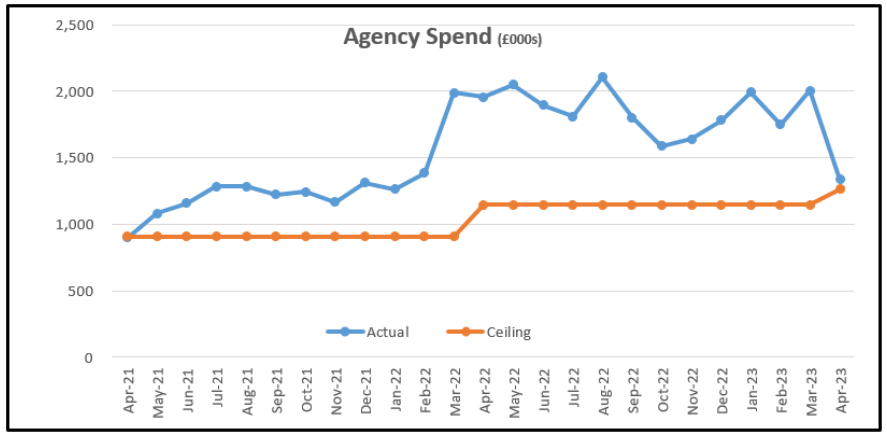
What the chart tells us:

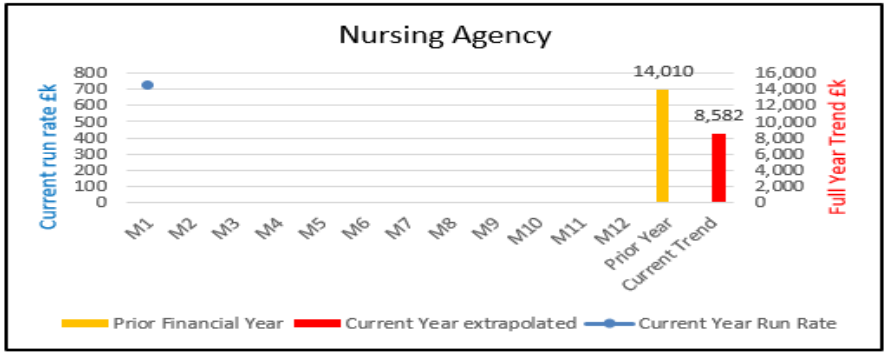
Based on month 1, the Trust is currently on target to deliver a deficit of no more than £22.3m though significant risk remains at this point in the year.

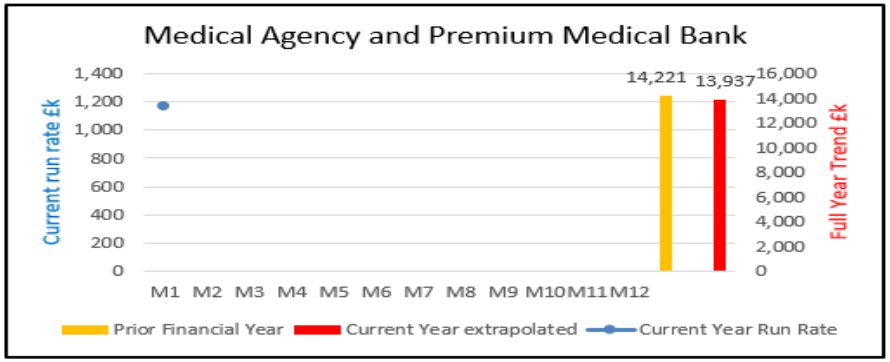
Our Finance – Agency Spend

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 represented 8.1% 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 there is a marked reduction in month particularly on Nurse Agency usage. All agency spend year to date (and excluding premium cost medical bank) has been M1 £1.3m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** expenditure, driven by usage significantly decreased in month. Increased control actions through NARP, together with the new Master Vend contract rate changes have shown improvement in the prior few months. The Trust spent £14.0m on nurse agency in the prior year (22-23) and if the month 1 improvement can be sustained, the extrapolated current year position would be £8.6m 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. The Trust spent £14.2m in the prior year (22-23) and whilst it is too early to extrapolate, the current run rate would not deliver the target spend for the year. Increased central controls have been introduced to further influence down the rates currently being paid and where appropriate, volumes used.

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

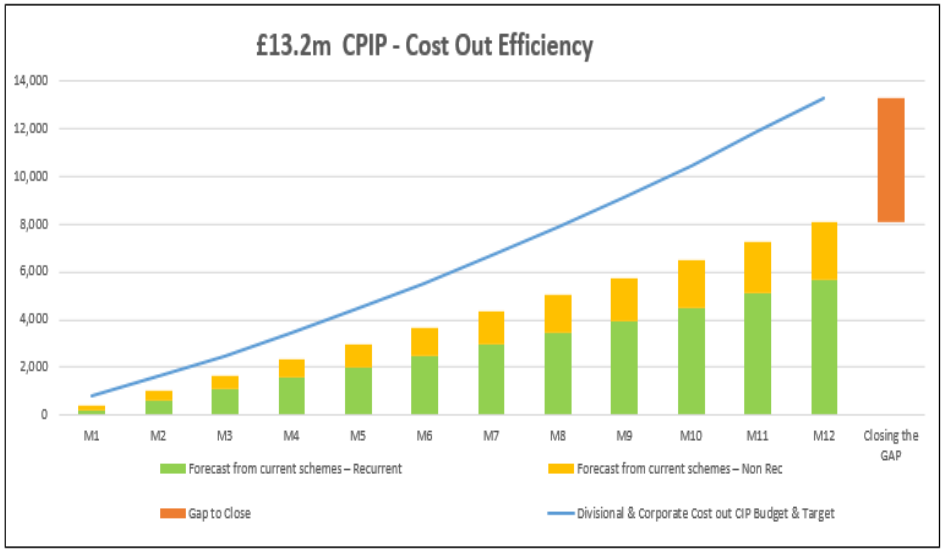
What the chart tells us:

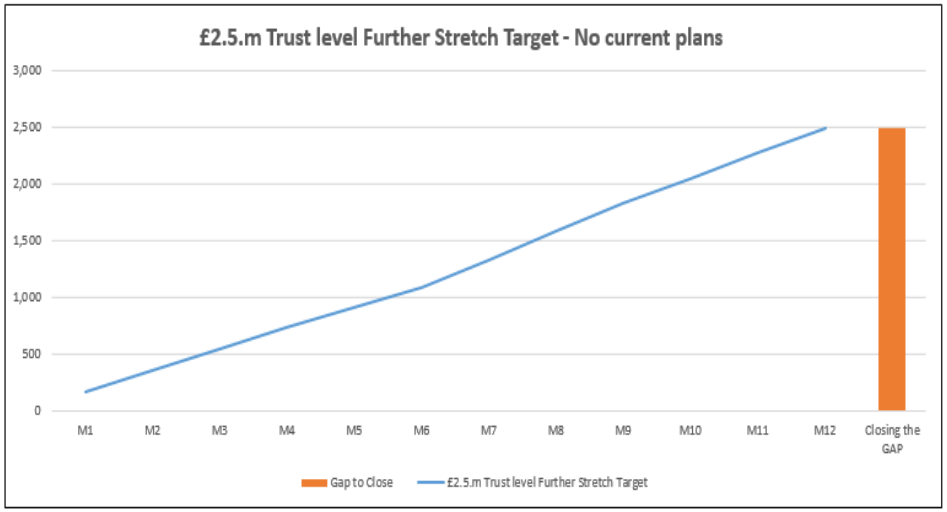
Agency use is at unsustainable levels and poses a significant risk to achievement of the financial plan.

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 that at month 1 there is still a shortfall in identified schemes. Increased scrutiny and oversight is in place including weekly progress tracking and escalation through TMB and F&PE meetings.

Although this drives an adverse variance from plan in month 1, where only £0.4m of the target £0.8m was delivered, the full effect of this was non recurrently mitigated.

Focus continues through the F&PE meetings, and a refreshed monthly CPIP meeting to maximise delivery in year, and development of recurrent schemes to support 2023/24 delivery. Reduction in Agency expenditure combined with increased productivity and gains from digital working, all combine to provide significant opportunities for the efficiency challenge all Trusts face.

Risks:

- Cost Improvement (CPIP) underachieves or only achieves non recurrent delivery. Mitigation - Refreshed monthly CPIP meeting, increased focus and management time. Progress will be closely monitored and routinely reported to the Board.

What the chart tells us:

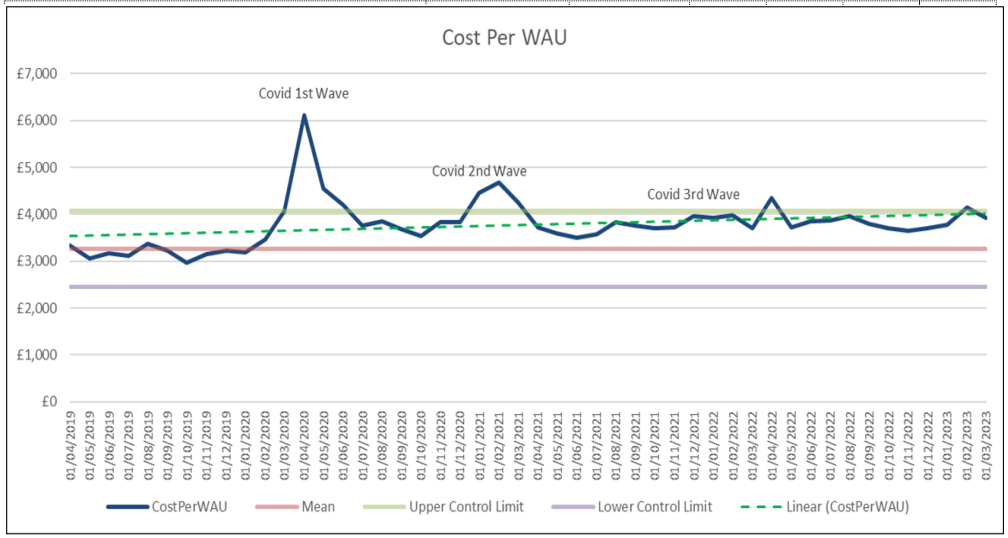
Focus is on converting opportunities into deliverable schemes, particularly recurrent schemes to mitigate the financial risk of underachievement against this programme and into 2024/25.

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.

Quality of care, access and outcomes	Responsible Director	Standard	Jan-23	Feb-23	Mar-23	Apr-23
Outpatient Activity - New attendances (% v 2019/20)	Chief Operating Officer	**2019/20**	101%	99%	116%	105%
Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	81%	93%	95%	89%
Total Outpatient Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	105%	102%	114%	107%
Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	95%	105%	100%	102%
Total Elective Activity (% v 2019/20)	Chief Operating Officer	**2019/20**	92%	99%	104%	85%
Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	80%	91%	88%	82%



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 operational plan requires us to deliver 106% 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 month 1 KPIs show that elective activity in volume terms is behind both 19/20 and our plan. On a value basis (as tracked regionally), performance against 19/20 has been stronger than indicated by volumes alone, suggesting a richer case mix.

Current performance gives us a degree of risk associated with the inclusion of ERF income in our financial position: Month 1 includes £0.6m of ERF. There remains a risk of clawback at the end of Quarter 1 if we do not achieve the planned levels.

Cost per Weighted Activity Unit (calculated and reported one month in arrears) remains above the target level. 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 106% of case mix weighted activity resulting in clawback of up to system ERF (£7.7m allocation). 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	63	14	49
Equipment Total	1,593	80	158	(78)
Estates Total	1,630	82	61	21
Total Core Operating (ICS) Capital	**4,473**	**225**	**233**	**(8)**
TIF PDC Total	12,602	630	349	281
CDC Total	10,296	60	36	24
Frontline Digitalisation PDC Total	3,300	165	28	137
Total National Programme Funding Bids	**26,198**	**855**	**414**	**441**
Donated Assets	20,600	1,030	1,317	(287)
Grand Total	**51,271**	**2,110**	**1,964**	**146**

Cash Balance

Month	Performance	Target	Direction	Rating
Feb	21.7	15.0		
Mar	35.0	15.0		
Apr	24.0	15.0		

The cash balance at the end of April reduced compared to 31 March position. The cash balance remains above plan for the month due to the opening balance having been higher. The cash position includes £4.4m of cash receipted for the IES where spend has yet to take place and income was deferred in to 2023/24. The trade payables position has improved in Month 1 through the utilisaton of cash

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
Feb	92.6%	95.0%		
Mar	93.4%	95.0%		
Apr	97.9%	95.0%		

April's reaults indicate that on a volume basis, the Trust paid 97.9% of invoices withn 30 days which is the best result ever achieved. The performance as measured in terms of invoice value was 95.5% which also achived the target.

Performance and Actions

Capital: The overall capital expenditure at Month 1 is £1,964k which represents just under 4% of total budget spent. There was a high level of equipment expenditure at the end of 2022/23 and the first months of the new year normally sees a slow down in capital spend.

The Donated Assets line included £20,100k of budget for the Integrated Energy centre phase 2 project. This will be rolled out over the year and is fully funded via a Salix grant.

The TIF PDC relates to funding given to undertake the Elective Surgical Hub.

Cash: The Trust continues to hold cash balances which exceed the plan. The cash position worsened in April due mainly to a reduction in accounts payable. Cash support will be required during the year in line with the deficit plan. The Trust delivered its BPPC target by value and by invoice volume for the first time.

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. Submit requests for revenue cash support in line with national process.

What the chart tells us:

Capital expenditure is broadly in line with plan, and cash balances remain healthy though there is risk associated with constrained capital funding and the planned deficit.

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.

April 2023	2022/23	2023/24			
	Accounts £000s	M01 Plan £000s	M01 YTD £000s	Variance £000s	YTD Change £000s
NON-CURRENT ASSETS:					
Property, Plant and Equipment	130,131	124,663	132,596	(7,933)	2,465
Intangible Assets	13,834	16,090	13,367	2,723	(467)
Trade and Other Receivables	573	817	573	244	0
TOTAL Non Current Assets	**144,538**	**141,570**	**146,536**	**(4,966)**	**1,998**
CURRENT ASSETS:					
Inventories	5,316	4,780	5,253	(473)	(63)
Trade and Other Receivables	22,732	13,709	25,080	(11,371)	2,348
Cash and Cash Equivalents	34,969	23,068	24,038	(970)	(10,931)
TOTAL Current Assets	**63,017**	**41,557**	**54,371**	**(12,814)**	**(8,646)**
TOTAL ASSETS	**207,555**	**183,127**	**200,907**	**(17,780)**	**(6,648)**
CURRENT LIABILITIES					
Trade and other payables	(49,759)	(25,162)	(43,486)	18,324	6,273
Borrowings - Loans, PFI and Finance Leases	(5,779)	(5,814)	(4,339)	(1,475)	1,440
Provisions	(55)	(46)	0	(46)	55
Total Current Liabilities	**(55,593)**	**(31,022)**	**(47,825)**	**16,803**	**7,768**
NET CURRENT ASSETS/(LIABILITIES)	**7,424**	**10,535**	**6,546**	**3,989**	**(878)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**151,962**	**152,105**	**153,082**	**(977)**	**1,120**
NON-CURRENT LIABILITIES:					
Borrowings - Loans, PFI and Finance Leases	(31,138)	(31,515)	(32,074)	559	(936)
Provisions	(1,686)	(1,579)	(1,732)	153	(46)
Total Non-Current Liabilities	**(32,824)**	**(33,094)**	**(33,806)**	**712**	**(982)**
ASSETS LESS LIABILITIES	**119,138**	**119,011**	**119,276**	**(265)**	**138**
TAXPAYERS EQUITY					
Public dividend capital	270,216	272,112	270,216	1,896	0
Revaluation reserve	28,672	30,874	29,880	994	1,208
Income and expenditure reserve	(179,750)	(183,975)	(180,820)	(3,155)	(1,070)
TOTAL	**119,138**	**119,011**	**119,276**	**(265)**	**138**

Performance and Actions

General

The table identifies the statement of financial position as at 30 April 2023 against the plan.

Non-Current Assets

Non-Current assets increased £2.47m in PPE compared to last month.

Current Assets

Accounts Receivable increased by £2.3m compared to the previous month. Cash held decreased by £10.9m.

Current Liabilities

Current liabilities decreased by £7.8m compared to last month. Trade payables reduced by £6.3m and provisions have been re-balanced between current and non-current liabilities.

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 for the year to date. The forecast includes an increase in the revaluation reserve in line with the increase in asset values.

Risks:

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

What the chart tells us:

There has been little movement to date in the SOFP compared to the year end position.

Wye Valley NHS Trust

Trust Key Performance Indicators (KPIs) - 2023/24

Performance Against Target (Status)	Activity Performance Only
Meeting Target	Over 5% above Target
Not Meeting Target	5% above to 2% below Target
	More than 2% below Target to 5% below Target
	Over 5% below Target

Type	Item	Description
Pass/Fail	F	The system is expected to consistently Fail the target
Pass/Fail	P	The system is expected to consistently Pass the target
Pass/Fail	?	The system may achieve or fail the target subject to random variation
Trend Variation	H	Special cause variation - cause for concern (indicator where HIGH is a concern)
Trend Variation	L	Special cause variation - cause for concern (indicator where LOW is a concern)
Trend Variation	~	Common cause variation
Trend Variation	H	Special cause variation - Improvement (indicator where HIGH is GOOD)
Trend Variation	L	Special cause variation - Improvement (indicator where LOW is GOOD)

Example

Data Quality Assurance Questions		Overall KPI Rating Key
S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?	No Assurance
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?	Limited Assurance
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?	Reasonable Assurance
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?	Substantial Assurance

Quality of care, access and outcomes		Responsible Director	Standard	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Latest Month Numerator	Latest Month Denominator	Year to Date v Standard	Trend - Apr 2019 to date	Latest Available Monthly Position: VVT Latest month v benchmark	Latest Available Monthly Position: National or Regional		Pass/Fail	Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	75%	55.5%	58.8%	63.2%	56.3%	68.1%	71.3%		730	1108	58.8%			74.2%		?	~	
	2 Week Wait all cancers	Chief Operating Officer	93%	90.2%	94.2%	91.4%	89.5%	88.8%	88.0%		968	1100	91.1%			83.9%	March	?	L	
	Urgent referrals for breast symptoms	Chief Operating Officer	93%	72.0%	89.5%	82.8%	77.3%	39.3%	63.6%		21	33	79.5%			77.6%		?	~	
	Cancer 31 day diagnosis to treatment	Chief Operating Officer	96%	93.6%	90.1%	86.2%	81.7%	89.6%	91.1%		92	101	88.0%			91.9%		?	~	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Chief Operating Officer		4	5	10	14	13	12				91					?	H	
	Cancer 62 days urgent referral to treatment	Chief Operating Officer	85%	79.8%	60.2%	67.7%	61.5%	60.7%	54.5%		42	77	65.2%			63.5%		?	L	
	Cancer 62-Day National Screening Programme	Chief Operating Officer	90%	0.0%	83.3%	71.4%	33.3%	0.0%	0.0%		0	0	66.7%			71.6%	March	?	~	
	Cancer consultant upgrade (62 days decision to upgrade)	Chief Operating Officer	85%	57.1%	60.0%	71.4%	58.5%	74.2%	71.0%		11	16	65.2%			76.8%		?	L	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	Plan	135	100	108	123	115	89	117								?	~	
Primary care and community services	Community Service Contacts - Total	Chief Operating Officer	v 2022/23	106%	104%	105.7%	113.1%	102.7%	100.4%	93.0%	25620	27559	93%					?	~	
	Urgent Response > 1st Assessment completed on same day (facilitated discharge & other)	Chief Operating Officer	80%	100%	100%	98.6%	99.2%	100.0%	98.2%	96.7%	118	122	96.7%					P	~	
	Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	70%	90.0%	91.1%	80.0%	90.2%	91.7%	83.3%	91.4%	53	58	91.4%			86%	Mar	?	~	
	% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	89.7%	90.5%	88.4%	89.2%	89.2%	89.2%	90.3%	2120	2349	90.3%			91.8%	Mar to Feb	?	~	
Urgent and emergency care	A&E Activity	Chief Operating Officer	Plan	107%	102%	108.0%	95.8%	96.8%	107.7%	98.9%	5635	5699	99%					?	H	
	Ambulance handover within 15 minutes	Chief Operating Officer	95%	42.1%	42.5%								42.6%			26%	Nov	F	~	
	Ambulance handover within 30 minutes	Chief Operating Officer	98%			58.7%	77.0%	81.0%	82.9%	75.1%	1137	1513				79%	March			
	Ambulance handover over 60 minutes	Chief Operating Officer	0%	7.3%	6.1%	25.0%	9.2%	6.6%	5.2%	9.0%	136	1513	8.8%			7%		?	H	
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	Plan	102%	111%	110%	115%	113%	117%	119%	2178	1834	119%					?	H	
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	>40%	39.5%	40.8%	37.1%	36.5%	40.4%	37.2%	37.8%	757	2001	37.8%			35%	Mar to Feb	?	H	
	A&E - % of patients seen within 4 hours	Chief Operating Officer	76%	55.0%	57.4%	45.1%	54.7%	55.1%	55.2%	59.9%	3378	5635	59.9%			60.9%	Apr	?	L	
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		16.6%	13.8%	24.6%	19.3%	18.4%	16.2%	9.7%	545	5635	17.5%			6%	March to February	F	~	
	A&E - Time to treatment (median)	Chief Operating Officer		01:36	01:34	02:44	01:28	01:36	01:38	01:47						01:52			H	
	A&E max wait time 4hrs from arrival to departure	Chief Operating Officer		In development - to be reported next month																
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	<15 minutes	00:42	00:46	01:06	00:42	00:41	00:44	00:41						00:25	Mar to Feb	F	H	
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	0	322	238	346	288	308	263	107			3413					F	~	
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	3%	8.4%	7.7%	7.2%	7.4%	7.2%	8.3%	7.1%	107	5303	7.1%			8%	Mar to Feb	F	L	

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	92%	61.1%	61.2%	58.4%	58.6%	59.0%	58.3%	56.7%	12632	22269				58.6%	Mar		
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	95%	70.0%	69.4%	68.0%	66.7%	67.5%	67.3%	64.7%	2741	4234							
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		24525	24698	24997	24974	25301	25957	26503									
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	1336	1326	1463	1446	1391	1453	1552						359798			
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	428	404	495	490	439	365	417						91126	March		
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	98	94	104	94	58	6	27						10737			
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	1	1	2	0	0	0	1						559			
	GP Referrals	Chief Operating Officer	2019/20	113%	118%	103%	100%	111%	168%	92%	2759	3003	92%						
	Outpatient Activity - New attendances (% v 2019/20)	Chief Operating Officer	2019/20	99%	105%	96%	101%	99%	116%	105%	4277	4085	105%						
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	Plan	92%	92%	103%	81%	93%	95%	89%	4277	4822	89%						
	Total Outpatient Activity (% v 2019/20)	Chief Operating Officer	2019/20	103%	105%	97%	105%	102%	114%	107%	14270	13396	107%						
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	Plan	105%	98%	109%	95%	105%	100%	102%	14270	13348	102%						
	Total Elective Activity (% v 2019/20)	Chief Operating Officer	2019/20	90%	96%	85%	92%	99%	104%	85%	1998	2341	85%						
	Total Elective Activity (volume v plan)	Chief Operating Officer	Plan	84%	86%	89%	80%	91%	88%	82%	1998	2430	82%						
	BADS Daycase rates	Chief Operating Officer	Actual	79%	82%						638	781	82.4%			82%	Mar to Feb		
	Elective - Theatre Productivity (% Booked sessions used)	Chief Operating Officer	95%	97.3%							286	294	95.6%						
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	85%	New measure calculation from April 2023 inline with GIRFT methodology						74.4%			74.4%			75%	April		
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	85%							84.8%			84.8%			80%			
	Cancelled Operations on day of Surgery for non clinical reasons	Chief Operating Officer	10 per month	26	46	32	16	16	16	9			9			18975	Jan to Mar		
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	Plan	146%	139%	138%	141%	138%	108%	138%	2786	2022	138%						
	Diagnostic Activity - Endoscopy	Chief Operating Officer	Plan	124%	121%	100%	122%	131%	123%	50%	493	383	50%						
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	Plan	129%	143%	139%	132%	142%	117%	166%	1461	881	166%						
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	<5%	29.2%	24.9%	30.0%	29.4%	22.2%	22.0%	27.6%	1329	6044				25.0%	Mar		
Maternity	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	90%	94.0%	94.9%	97.3%	89.3%	96.3%	98.6%	96.7%	123	127	96.7%						
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Chief Medical Officer	<15%	20.9%	18.5%	15.8%	14.5%	15.2%	16.2%	14.0%	14	100	14.0%						
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Chief Medical Officer	<34%	61.9%	62.5%	63.4%	63.3%	60.9%	60.0%	58.8%	107	182	58.8%						
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Chief Medical Officer	<60%	86.9%	87.3%	87.2%	87.0%	88.4%	86.6%	87.3%	96	110	87.3%						
	Maternity Activity (Deliveries)	Chief Nursing Officer	v 2022/23	109%	97%	95%	70%	99%	117%	111%	125	113	111%						
	Midwife to birth ratio	Chief Nursing Officer	1:26		1:29	1:33	1:24	1:24	1:31										
	Maternity - Breast Feeding at 6 - 8 weeks (Community Midwives & Health Visitors) - Latest Quarter (Q1)	Chief Nursing Officer		In development - to be reported next month							0	0							
Outpatient transformation	DNA Rate (Acute Clinics)	Chief Operating Officer	<4%	6.2%	6.0%	6.8%	6.3%	6.5%	5.8%	6.0%	1343	21206	6.0%			7.8%	Mar to Feb		
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	90%	82.9%	81.6%	79.2%	78.1%	79.3%	78.4%	80.6%	11230	14016	80.6%						
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Chief Operating Officer	v 2019/20	105%	105%	97%	107%	103%	114%	107%	3393	3111	107%						
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	Plan	111%	100%	112%	102%	110%	102%	110%	3393	3126	110%						
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	25%	23%	23%	25%	26%	25%	23%	25%	3540	14270	24.8%			20%	Mar to Feb		

Preventative long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer		10.6%	6.7%	10.5%	9.9%	12.4%	7.3%	12.0%	15	125								
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	<92%	92%	91%	92%	97%	103%	97%	95%	273	287	95%			94%	Apr			
	Bed occupancy - Community Wards	Chief Operating Officer	<92%	94%	97%	96%	97%	96%	95%	94%	71	76	94%							
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	0	203	81	240	517	233	150	173			173			4475	Mar			
	Patient ward moves emergency admissions (acute)	Chief Operating Officer		10.3%	10.2%	9.9%	10.9%	8.6%	7.3%	9.1%	94	1260	9.1%							
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	4.5	4.7	4.3	4.4	4.9	4.1	4.5	4.1	7565	1830	4.1			4.5	Mar to Feb			
	ALoS - General & Acute Elective Inpatients	Chief Operating Officer	2.5	2.2	2.4	2.3	2.6	2.1	1.8	2.2	555	254	2.2			2.9				
	Medically fit for discharge - Acute	Chief Operating Officer	5%					22.7%	22.0%	19.5%	8184	1593				23.1%	Dec			
	Medically fit for discharge - Community	Chief Operating Officer	10%					57.9%	61.1%	60.4%	2341	1413								
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	5%	8.9%	9.1%	10.0%	7.1%				232	4103	9.1%			7.9%	Mar to Feb			
	HSMR - Rolling 12 months	Chief Medical Officer	<100	108.3	107.7	110.5	109.2				703	644				100	Mar to Feb			
	Mortality SHMI - Rolling 12 months	Chief Medical Officer	<100	102.9	103.5	103.8					1145	1105				100	Jan to Dec			
	Never Events	Chief Nursing Officer	0	0	0	0	0	0	1	0			0							
	MRSA Bacteraemia	Chief Nursing Officer	0	0	0	0	0	0	0	0			0							
	MSSA Bacteraemia	Chief Nursing Officer		0	1	1	0	0	0	1			1							
	Number of external reportable >AD+1 clostridium difficule cases	Chief Nursing Officer	44	5	3	4	0	3	5	5			5							
	Number of falls with moderate harm and above	Chief Nursing Officer	2022/23 (30)	3	1	1	1	3	5	3			3							
	Pressure sores (Confirmed avoidable Grade 3,4)	Chief Nursing Officer	0	2	8	2	3	11	6	3			3							
	Serious Incidents	Chief Nursing Officer	Actual	9	14	9	10	30	16	6			6							
	VTE Risk Assessments	Chief Medical Officer	95%	90.4%	92.3%	90.7%	89.7%	90.6%	90.4%	87.7%	3276	3737	87.7%							
	WHO Checklist	Chief Medical Officer	100%			99.5%			99.5%											
	% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	60%	58.3%	47.7%	79.1%	71.7%	60.7%	48.8%	68.8%	33	48	68.8%							
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	90%	100.0%	75.0%	62.5%	80.0%	33.3%	75.0%	57.1%	3	4	68.2%							
	Stroke Indicator 80% patients = 90% stroke ward	Chief Medical Officer	80%	70.2%	73.6%	71.0%	76.9%	82.9%	88.1%	78.1%	25	32	80.3%							
	Cleaning Standards: Acute (Very High Risk)	Chief Nursing Officer	98%	In development - to be reported next month							0	0								
	Cleaning Standards: Community (Very High Risk)	Chief Nursing Officer	98%	In development - to be reported next month							0	0								
	Number of complaints	Chief Nursing Officer	2022/23 (253)	22	19	18	19	18	25	24			24							
	Number of complaints referred to Ombudsman	Chief Nursing Officer	0	0	0	0	0	0	0				0							
	Complaints resolved within policy timeframe	Chief Nursing Officer	90%	45.5%	58.3%	34.8%	50.0%	20.0%	64.7%		11	17	42.5%							
	Friends and Family Test - Response Rate (Community)	Chief Nursing Officer	30%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%		2	5123	0.0%							
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Chief Nursing Officer	95%	Nil Return	Nil Return	Nil Return	Nil Return	Nil Return	0.0%							80%	February			
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Chief Nursing Officer	95%	100.0%	67.0%	80.0%	100.0%	82.2%	89.9%	90.0%	161	173	90.0%			94%				
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Chief Nursing Officer	95%	100.0%	67.0%	0.0%	100.0%	100.0%	100.0%		2	2	87.9%			95%				
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Chief Nursing Officer	95%	100%	100%	100%	100%	0.0%	100.0%				90.4%			92%				
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	25%	Nil Return	Nil Return	Nil Return	Nil Return	Nil Return	0.0%											
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	30%	0.1%	2.0%	0.9%	1.0%	20.2%	21.0%	19.0%	179	918	19.0%							
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	30%	18.8%	23.0%	3.3%	4.0%	0.0%			2	0	13.1%							

People		Responsible Director	Standard	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/ Fail	Trend Variation	DQ Mark
											Numerator	Denominator			WYT Latest month v benchmark	National or Regional				
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	6.4%	9.6%	10.2%	11.1%	12.0%	10.5%	6.9%	8.1%			8%							
	Appraisals	Chief People Officer	85%	71.5%	72.4%	72.8%	74.4%	76.0%	77.1%	77.5%	2290	2953	78%			76%	2021/22			
	Mandatory Training	Chief People Officer	85%	88.5%	89.1%	88.7%	89.3%	89.6%	89.2%	89.7%	3270	3646	90%			88%				
	Overall Sickness	Chief People Officer	3.5%	6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	4.8%	4754	39706	5%			6%	Oct			
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	10%	14.2%	14.4%	14.1%	13.6%	13.5%	12.8%	12.6%	411	3261	13%							
	Vacancy Rate	Chief People Officer	5%	9.4%	9.2%	9.1%	8.6%	8.7%	8.2%	7.9%	288	3623	8%							

Finance and Use of Resources		Responsible Director	Standard	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/ Fail	Trend Variation	DQ Mark
											Numerator	Denominator			WYT Latest month v benchmark	National or Regional				
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	≥0	-£372	-£623	-£383	-£519	-£517	-£355				-£6,514							
	I&E - Margin (%)	Chief Finance Officer	≥0%	-1.4%	-2.5%	-1.5%	-1.9%	-1.9%	-0.8%		-£355	£26,556	-2.2%							
	I&E - Variance from plan (£k)	Chief Finance Officer	≥0	£83	-£33	-£39	£36	£13	£201				£94							
	I&E - Variance from Plan (%)	Chief Finance Officer	≥0%	-18.1%	5.6%	5.6%	-6.5%	-2.5%	-36.2%		£201	-£530	1.8%							
	CPIP - Variance from plan (£k)	Chief Finance Officer	≥0	-£164	£125	-£344	-£717	-£666	-£869				-£3,020							
	Agency - expenditure (£k)	Chief Finance Officer	N/A	£1,578	£1,634	£1,874	£1,880	£1,744	£2,017				£22,385							
	Agency - expenditure as % of total pay	Chief Finance Officer	N/A	9.4%	10.1%	11.5%	11.4%	10.5%	9.0%		£2,017	£16,679	11%							
	Agency - expenditure as % of cap	Chief Finance Officer	≤100%																	
	Productivity - Cost per WAU (£k)	Chief Finance Officer	N/A																	
	Capital - Variance to plan (£k)	Chief Finance Officer	≥0	-£53	-£17	£377	£414	£14	-£107				£591							
	Cash - Balance at end of month (£m)	Chief Finance Officer	As Per Plan	£20	£21	£22	£18	£22	£35				£21.7							
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	≥95%	86.4%	75.8%	77.0%	89.1%	77.4%	85.5%		£10,480	£12,257	83.8%							
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	≥95%	92.6%	93.0%	93.9%	86.5%	92.6%	93.4%		£5,257	£5,629	89.4%							

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Draft Annual Report and Annual Governance Statement 2022/23
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	
Author:	Erica Hermon on
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The purpose of the report is for the Board of Directors to approve the draft Annual Report and Annual Governance Statement 2022/23 prior to submission to the Department of Health and Social Care.

2. Recommendation(s)

For the Board of Directors to note the Annual Report and Annual Governance Statement for 2022/23, and to delegate its responsibility for the final approval of the reports and accounts to the meeting of the Audit Committee on 15 June 2023.

3. Executive Director Opinion[1]

The Annual Report and Annual Governance Statement 2022/23 has been developed to ensure compliance with the requirements and timescales as set out by NHS Improvement and the Department of Health and Social Care and to provide assurance about the stewardship of Wye Valley NHS Trust.

All NHS bodies are required to produce an Annual Report and Accounts in compliance with the Manual for Accounts issued by the Department of Health and Social Care.

The report is subject to external audit and the auditors carry out their review before completing their opinion and report. Comments received from External Auditors, Deloitte LLP will be included in both the Annual Report and Annual Governance Statements.

The Board is asked to delegate its responsibility for the final approval of the reports and accounts to the meeting of the Audit Committee on 15 June 2023. Subject to Audit Committee approval and without any major changes being made to this version of the document, the Trust Board can be assured that its publication complies with Department of Health requirements.

Auditors submit original copy of annual governance statement to the Department of Health as part of the annual report and accounts submission process. NHS trusts should also submit a final copy of the signed annual governance statement to NHS Improvement.

[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***

2022/2023

ANNUAL REPORT AND ACCOUNTS

Right care, right place, right time....every time

Contents

Introduction from the Chief Executive

While contemplating how to sum up the last 12 months, it would be fair to say it's been a roller-coaster of a year.

We began the last financial year in April 2022 at National incident level 4 due to the pandemic and we remained at this level until June.

Throughout the year we had to constantly adjust to changes to testing regimes, visiting arrangements, Infection Prevention Control measures and social distancing rules and regulations.

The legacy of the pandemic then hit us in the winter when we faced the most challenging winter the NHS has ever faced, partly because of an increase in respiratory patients following two winters of supressed transmission due to lockdown.

And if that wasn't enough, we then had to contend with the fall-out from a wave of industrial action and the new set of challenges this brought.

This may read like a tale of woe, but despite the unprecedented pressures we have experienced, I'm delighted to be able to welcome you to a very positive annual report for 2022/23. I am exceptionally proud of the achievements we've made over the past year in delivering healthcare services to our patients, despite these mountainous challenges.

Before I get into the detail, first and foremost I would like to take the opportunity to formally thank every one of our staff members. Their dedicated and tireless efforts have been instrumental in ensuring we continued to provide high-quality safe care to our patients during these difficult times. Despite the many obstacles we faced, our staff rose to the occasion, putting the needs of our patients first, doing whatever it took to keep our services running. Their unwavering commitment to the people we serve has been reflected in the various accomplishments our Trust has achieved over the past year, and I would like to take a moment to highlight some of these.

Key areas of activity that we focused on included improving patient flow, developing our approach to integrated care and improving productivity.

Crucially, many of our own objectives tied in with those of the Herefordshire and Worcestershire Integrated Care Board which came into being last year and marked a significant shift in the mindset for the delivery of health and care services across the two counties.

Areas of focus under the Integrated Care Board umbrella included the reduction of long waits for elective care, the return of cancer waiting times to pre-pandemic levels, reducing ambulance handover times and developing plans to address workforce challenges.

In September 2022 we were already facing severe pressure with demand for services having reached winter levels – we knew we had to do something different if we were to continue providing safe services for our patients through the winter period.

By October, after many conversations and discussions, we introduced proactive "reverse boarding" – the process of moving patients from beds in ward to non-ward areas.

This created extra capacity on our wards to accept patients from the Emergency Department (ED) who needed admitting, which allowed a quicker through-put of patients in ED, and resulted in shorter ambulance handover times.

This came at a cost though, and throughout the winter months and well into spring, we continued using reverse boarding which, while easing the pressure in ED, spread the pressure across wards and increased the demand which ward staff had to absorb and manage.

Thanks to their tenacity, reverse boarding has been key to making our track record of ambulance handover times one of the best in the region – during one period, our handovers were 25 minutes shorter than handovers at neighbouring Trusts.

This particularly came into its own during the periods of strike action and meant we were, in some instances, able to offer mutual aid to other struggling neighbouring Trusts and receive some patients via ambulance who would have otherwise faced long delays in other hospitals.

Once again, it was a great example of team WVT stepping up when required.

In December, the Care Quality Commission announced its findings following an unannounced inspection carried out two months earlier, in October 2022.

It was good news for our patients as the inspectors upgraded the “inadequate” ratings to “requires improvement” in the safety, well led and overall domains for surgery.

Of course, while the results were pleasing, there is still a lot of work to do, it was a clear indication of our determination to become an NHS Trust which is rated “Good” overall in the coming years.

Our Foundation Group continues to go from strength to strength.

In October we refreshed the group’s strategy with a focus on prevention – “helping you to help yourself” – and last year we began quarterly board meeting, when the boards of all three Trusts in the group meet to benchmark and share best practice.

And jumping back to May last year, the Foundation Group links meant some Wye Valley NHS Trust patients were seen more quickly – as South Warwickshire University NHS Foundation Trust’s orthopaedic surgery waiting lists were among the lowest in England, some Wye Valley NHS Trust patients who were happy to travel to Warwick were treated there.

I’m very pleased to say that in December we were able to report particularly impressive performance in cancer care.

Our 28 day performance improved in all three cancer specialities with particular success in dermatology where new processes meant that in this month, 90 per cent of patients were informed of the outcome of their investigations within 28 days (target 75 per cent) and we reported a significant improvement in our 62 day Upper GI performance.

During the last year, the Trust has continued to prioritise the integration of technology and digital innovations into our services.

We have rapidly adopted digital technologies, such as virtual consultations and online portals, which enable patients to access the care they need, more quickly and safely.

I believe this is just the beginning, and we will continue to work towards enhancing our digital capabilities as we go forward.

With fuel rocketing in price, and the climate emergency we are all facing, I'm pleased to announce that this winter we have been able to switch over to new fossil-fuel free green heating in some of our buildings on the County Hospital site.

This puts the Trust at the forefront of national requirements for Trusts to reduce their carbon footprints and means the Trust is one of the greenest Trusts in the UK.

The new ground source heat pump, which is fed by 47, 200m deep boreholes on the County Hospital site, is able to keep two of the buildings warm without the use of fossil fuels for the first time.

And the good news is that plans to convert the whole of the hospital site into a fossil-free fuel zone are progressing following a successful bid for a further £21 million of government money.

This will allow the Trust to install more ground source heat pumps on the site – a move which is expected to further reduce the amount of carbon produced to heat the hospital by around 97 per cent – equivalent to saving 3,715 tonnes of carbon a year from going into the atmosphere.

With one eye looking over our shoulder at the space vacated after the last of the two hutted wards were demolished, and one eye looking to the future, we now have the shell of our new elective hub rising on the site adjacent to the new corridor which links the main building with our new ward block.

The previous tented corridor to give access to the new ward block – fondly nicknamed as the polytunnel by staff – was finally taken down in March and the new corridor brought into use.

The new £23 million elective hub is expected to open its doors to patients early next year, and is one of 50 which are being built across the country to help tackle the backlogs caused by COVID-19 and will offer patients quicker access to day case procedures.

It will help the Trust speed up elective surgeries and reduce waiting lists. Types of procedures will include day case surgeries such as Ear, Nose and Throat, cataracts and minor operations.
The two-storey centre will house assessment rooms, pre-op waiting rooms, two specialist operating theatres, a dedicated cataract suite for eye operations, recovery bays and associated facilities including a reception and staff offices.

We have also recently been informed that our case for a £16.5 million community diagnostic centre has been approved so work is underway to put together a robust business case to support such a facility which has the potential to bring so many benefits to our patients.

Overall, it's been a year that has had its highs and its lows, but what really sticks out in my mind is the tenacity and determination of Team WVT to deliver despite the odds.

I'd also like to pay tribute to our many patients who have heeded the pleas which have gone out, particularly during the winter months, to choose wisely and use alternatives to ED where possible. This has been key and allowed us to concentrate on the many really sick people we've had to care for and treat in our Emergency Department.

Looking ahead, there is no doubt that we will continue to face challenges in the coming year. But I am confident that we have the right team, the right values, and the right vision to navigate these challenges successfully.

In conclusion, I would like to thank all our staff, volunteers, partners and stakeholders for their invaluable contributions to the achievements of the Trust this year. It is because of your hard work and efforts that we have been able to maintain our commitment to excellence in healthcare throughout the pandemic.

I hope you find our annual report informative and useful, and that it demonstrates our continued dedication and commitment to delivering outstanding healthcare services to the people of Herefordshire and beyond.

Glen Burley, Chief Executive

Introduction from the Chair

It is my great pleasure to welcome you to Wye Valley NHS Trust's Annual Report and Accounts for the year financial year 2022/23.

As the Chairman of this Trust, I am proud to lead a team of dedicated professionals who work tirelessly to deliver high-quality healthcare services to our local and regional communities.

Over the past year, our Trust has faced numerous challenges, including the ongoing COVID-19 pandemic, the busiest winter period the NHS has experienced and more recently, the industrial action which is affecting the health and care world.

Despite these obstacles, our staff have remained steadfast in their commitment to providing excellent patient care.

A key achievement over the past year has been the development of our workforce, with particular focus on staff wellbeing and engagement. We have implemented new training and development programmes, as well as support mechanisms to help our staff manage the challenges of working in a high-pressure environment.

In the face of the toughest winter yet, our staff members have proved their resilience once again and last year's NHS staff survey confirmed that, despite the onerous challenges faced, colleagues remain upbeat and positive about working for the Trust.

The results confirmed that we remain above the national average in all nine key themes based on the People Promise Elements, with particularly strong and improving feedback about managers.

Staff reported feeling valued and supported, with a high level of confidence in the quality of care they are able to provide.

However, there is much work to as the Trust's results mirrored national figures with a slight downward trend overall.

A key focus remains supporting our staff and we will bolster our health and wellbeing offer to ensure we support and do all we can to care for our best asset – those who work tirelessly day after day to provide the quality of care they would want for their friends or relatives.

The national shortage of nursing staff is well documented in the media so it's with great pride that I can reference another staff success story – this time regarding our growing cohort of overseas nurses.

In 2022/23 we recruited a total of 90 overseas nurses, and thanks to the welcoming environment and huge support from our HR team, I can report a zero per cent turnover. The previous year we recruited 58 overseas nurses and had a turnover of nearly ten per cent.

Our overseas nurses are a crucial cohort of our nursing staff and I'm also pleased to announce that we have secured funding to bring across a further 80 overseas nurses in the coming 12 months.

One of our key priorities over the past year has been to improve access to healthcare services for patients across our community. We have invested in new technology and equipment to improve our diagnostic capabilities, and we have implemented new ways of working to ensure that patients can receive care closer to home.

We have also established new partnerships with community health providers, enabling us to deliver more integrated and personalised care to our patients.

I'd like to pay tribute to colleagues on the newly formed Herefordshire and Worcestershire Integrated Care Board for their spirit of co-operation and enthusiasm which is allowing us to deliver care more effectively and efficiently while ensuring that our patients continued to receive safe care and the best possible outcomes, while maintaining a strong focus on sustainability.

The Foundation Group to which this Trust belongs is maturing and much work has taken place to help shape and define the Trust's future through five "Big Moves".

As we focus on these Big Moves, they will enable the Trust to create healthier lives for the public we serve, create an organisation people want to work for, and help us look after our environment:

- Be a very flexible employer
- Support the domiciliary care marketplace
- Lead the NHS in carbon reduction
- Embed prevention in every service
- Home First supported by technology and collaboration

Each of these Big Moves stand up as challenge in their own right. Bringing them together is a powerful tool for change, particularly as they have been adopted across the three Trusts in our Foundation Group.

These last 12 months have seen a number of firsts for the Trust and the county.

Last year we used a special cocoon which bathes babies with jaundice in special light for the first time. The cocoon can be used at home and allows parents with premature babies to care for their new-borns in the comfort of their own home.

Supported by our neonatal nursing team, it means babies who develop jaundice during the first couple of weeks can receive a period of phototherapy at home – a much better and preferred arrangement by parents.

And work behind the scenes which patients won't see, saw the Trust being the first in the West Midlands to go live with advanced digital pathology technology.

This is helping to transform services and improve the speed of cancer diagnosis for patients.

This is the biggest change in pathology technology for a century and was launched as part of a multi-million pound NHS initiative to modernise digital pathology in the UK.

The project has seen pathologists at Hereford County Hospital transition from solely using microscopes and glass slides to having instant access to high resolution digital images of patients'

tissue, for more than 20,000 specimens reported a year, speeding up the process for diagnostic results.

It's also pleasing to note that three of our young cancer patients were featured on the BBC's "Operation Ouch" programme, which is hosted by Dr Chris and Dr Xand.

It's a programme created to help children understand medical conditions and what types of treatment they can expect if they are ever faced with a similar diagnosis.

The three young patients who were being supported by the Trusts Children's Nursing Team, had the opportunity to ask the doctors about their medical condition.

So, as we look to the future, we remain committed to delivering excellent patient care, improving patient outcomes, and ensuring that our services are sustainable and resilient in these challenging times.

We will continue to work with our partners to identify new and more efficient ways of working, and to deliver innovative and integrated healthcare solutions for our patients.

I would like to take this opportunity to thank our patients, communities, and partners for their ongoing support and encouragement.

Without their support, it would not be possible for us to continue providing the vital healthcare services that we do and we look forward to continuing to work closely with them as we move into the next 12 months.

In closing, I would like to express my gratitude to our staff, whose courage, dedication, and hard work have made this year's achievements possible. I am immensely proud of the work that they have done, and I am confident that they will continue to deliver outstanding care to our patients in the years to come.

And finally, I'd like to thank our volunteers who make a difference to the experience of our patients every day. Anyone visiting the hospital will not fail to be impressed by this helpful and knowledgeable team.

Thank you.

Russell Hardy, Chairman, Wye Valley NHS Trust

Overview

This section provides background information about Wye Valley NHS Trust, sets out progress made by the Trust during 2022/23 and highlights challenges faced.

About Wye Valley NHS Trust

Wye Valley NHS Trust is the provider of healthcare services at Hereford County Hospital, which is based in the city of Hereford, along with a number of community services for Herefordshire and its borders. The Trust provides healthcare services at community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard.

The Trust has a workforce of around 3,900 providing a range of specialist and generalists functions. The Trust has strong clinical network connections with trusts in Birmingham, Worcester, Gloucester and Cardiff.

The Trust provides community care and hospital care to a population of approximately 195,000 people in Herefordshire and 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 over half (53 per cent) living in areas defined as 'rural', with the majority of these (42 per cent of the total) in the most rural 'village and dispersed' areas. Just under a third of the population live in Hereford city. The key principle of the Trust is to improve the health and wellbeing of the people it serves in Herefordshire and the surrounding areas.

We are the only secondary care provider for an area where the average age of the population is older than the national average. This demographic is driving health and social care needs that are often more complex than in areas where the average age of patients is lower.

The Trust combines the opportunity to work with state-of-the-art equipment within a highly trained multi-disciplinary team environment, whilst enjoying the unique benefits of city living with a country lifestyle in Herefordshire and the surrounding areas.

All dates referred to in this report are for the year April 1, 2022 – March 31, 2023, unless otherwise specified.

Established in 2011

Wye Valley NHS Trust was established on April 1, 2011. This followed extensive stakeholder engagement with our colleagues in health, social care and the third sector. It was England's first integrated provider of acute, community and adult social care services bringing together Hereford Hospitals NHS Trust, NHS Herefordshire's Provider Services (excluding Mental Health) and Herefordshire Council's Adult Social Care services (under a Section 75 arrangement). The Section 75 arrangement with Herefordshire Council ended in September 2013 and the Trust no longer provides adult social care.

Foundation Group

In 2017 a 'Foundation Group' was created in partnership with South Warwickshire University NHS Foundation Trust and Wye Valley NHS Trust. In 2018 George Eliot Hospitals NHS Trust joined the Group.

All three organisations face similar challenges and have a common strategic vision for how these can be solved. The Foundation Group model retains the identity of each individual Trust whilst strengthening the opportunities available to secure a sustainable future for local health services.

There are numerous benefits for local communities across Warwickshire and Herefordshire including the provision of a wider platform to share best practice and improving whole system patient pathways.

Vision, values and objectives

Vision

"To improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas".

Mission

"To provide a quality of care we would want for ourselves, our families and friends". Which means:-

Values

The Trust's values are so important to the way they work every day:

- Compassion – they will support patients and ensure that they are cared for with compassion
- Accountability - they will act with integrity, assuming responsibility for their actions and decisions
- Respect – they will treat every individual in a non-judgemental manner, ensuring privacy, fairness and confidentiality
- Excellence – they will challenge their selves to do better and strive for excellence.

Structure of the Trust

During 2022/23, the Trust's Board consisted of eleven voting Directors comprising the Chair and five non- executive directors (appointed by NHSE), together with five executive directors. In addition to this there were also three non-voting Executive directors, one non-voting Associate Non-Executive Director and the Company secretary in attendance.

The Trust has four main clinical divisions and a number of corporate functions. The operational management of the Trust ensures that there is good clinical and managerial leadership of our services.

Medical Division	Surgical Division
• Emergency Department (ED) • Rheumatology (Osteoporosis) • Dermatology and Plastics • Stroke; Wye ward • Frailty; Dinmore, Ashgrove and Garway wards • Discharge lounge/Medical DCU • Diabetes and Endocrine • Nephrology • Respiratory; Arrow ward • Cardiology, Path lab, and CCU • Heart and Lung • Gilwern ward • Gastroenterology; Lugg ward • Neurology and Neurophysiology • Acute Medical Unit • Same Day Emergency Care (SDEC)	• Paediatrics - In Patients and Out Patients • Children's ward • Obstetrics and gynaecology • Midwifery (Acute and Community) • Delivery suite and Maternity ward • Special Care Baby Unit • Health Visiting, School Nursing • Orthopaedics • Redbrook ward • Teme ward • General Surgery and Colorectal • Frome ward • Breast • Urology • Ear, Nose and Throat (ENT) • Maxillofacial, Orthodontics and Oral surgery • Vascular • Ophthalmology • Theatres • Endoscopy • Day case • Pre-Op • Anaesthetics • Intensive Therapy Unit (ITU) • Critical Care • Dentistry • Podiatric Surgery
Clinical Support Division	**Integrated Care Division**
• Referral Management Centre • Outpatients • RTT Performance • Radiology • Pathology • Histopathology • Microbiology • Phlebotomy • Audiology • Oncology - MacMillan Renton Unit • Breast Lymphoedema team and Gynaecology oncology • Clinical Haematology • Palliative Care • Pharmacy	• Community nursing teams • Community Hospitals • Community Integrated response hub • Integrated discharge team • Hospital@home • Home first • Bladder and bowel health • Occupational Therapy • Dietetics • Speech and Language Therapy • HABIT/Podiatry • Health psychology • Lymphoedema • Neurology • Musculoskeletal physiotherapy • Community Stroke service • Physiotherapy and Falls Prevention • Tissue Viability • Lower Limb service

Summary information on progress within each of these divisions 2022/23 is provided later in this report.

Trust objectives 2022/23

The Trust's objectives for 2022/23 were:

Quality improvement

- Reduce the time that patients wait for planned care, diagnostics and cancer care
- Develop a new integrated model for urgent care in Herefordshire reducing the time to treatment and time spent in hospital
- Improve our patients' experience of care by improving clinical communication
- Improve patient safety through implementing change as we learn from incidents and complaints across our system

Workforce and leadership

- Improve recruitment, retention and local employment opportunities by taking an integrated approach to support worker development across health and care
- Continue to improve our support for staff health and wellbeing and act on staff feedback
- Further develop partnership working through the One Herefordshire Partnership and Integrated Care Executive to deliver better value to our population
- Develop our managers' skills and system leadership capability

Sustainability

- Increase elective productivity by making every referral count, empowering patients and reducing waste
- Create sufficient COVID-19 safe operating capacity by delivering plans for a surgical hub
- Stop adding paper to medical records in all care settings
- Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain

Integration

- Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meet needs on the day
- Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level
- Improve quality and value for money of services by increasing the range of contracts that are managed by the One Herefordshire Partnership
- Join up care for our population through shared electronic records and develop a patient portal to transform patient experience

Wye Valley NHS Trust at a glance

Acute hospital

The number of patients attending the Emergency Department (ED) increased by 1.5 per cent in 2022/23 when compared to 2021/22. This increase is recognised nationally as an indirect effect of the pandemic.

The volumes of 'elective' patients treated both as 'day case patients' and as 'inpatients' increased during the year from 2021/22 by 2.3 per cent and 5.1 per cent respectively.

This was a direct result of “ring fencing” our elective beds from emergency non-elective patients and a reduction in the Infection Prevention Control issues guidance, as the NHS eased COVID-19 restrictions. As a majority of the long waiting patients required overnight elective admissions, due to complexity and comorbidities, we eradicated the waits for those patients waiting over two years during the year and therefore our elective increase was higher than our day case patients.

Activity	2018/19	2019/20	2020/21	2021/22	2022/23	Increase/decrease 2022/23 on 2021/22	Difference 2022/23 to 2021/22
Elective spells	4,169	3,834	1,740	2,889	3,035	146	5.1%
Day case spells	28,650	29,170	18,812	27,776	28,407	631	2.3%
Total emergency spells	24,078	27,719	21,945	25,104	26,612	1,508	6.0%
General and Acute emergency spells	18,680	20,965	18,055	20,356	20,635	279	1.4%
New outpatient attendances	73,326	72,560	46,109	68,263	72,544	4,281	6.3%
Follow-up outpatient attendances	163,784	174,948	142,235	165,597	177,210	11,613	7.0%
ED attendances	60,560	63,991	54,690	68,553	69,552	999	1.5%

Community activities

Activity	2018/19	2019/20	2020/21	2021/22	2022/23	Increase/decrease 2022/23 on 2021/22	Difference 2022/23 to 2021/22
Day case spells	1,039	2,803	669	1658	2168	510	30.8%
Community bed days	27,308	26,414	17,526	25,049	26,312	1,263	5.0%
New outpatient attendances	15,296	15,528	5,087	6,397	7,006	609	9.5%
Follow-up outpatient attendances	61,515	61,519	25,659	29,720	29,566	-154	-0.5%

Community activities were in a similar position to the main acute site in that day case and the use of community beds increased during 2022/23 versus 2021/22, but were still short of the pre pandemic levels.

Patient figures for 2022/23

118k
Patients using our services

32k
Patients seen in the community

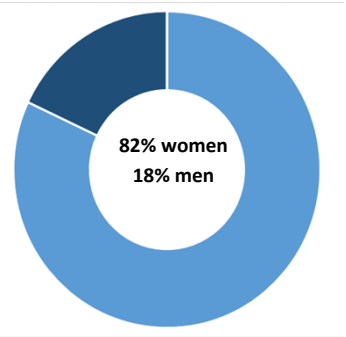
100k
Patients seen in Herefordshire

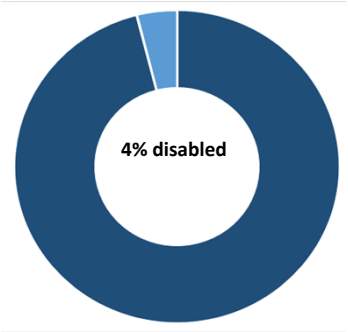
11k
Patients seen in Powys

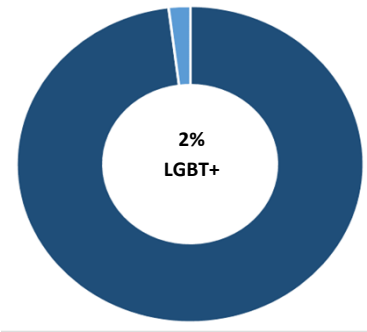
Please note figures are based on the number of individual patients seen and not number of appointments, i.e. one patient may have had three visits to the Emergency Department, five outpatient appointment and two admissions but these figures are counting the patient once and not the number of visits.

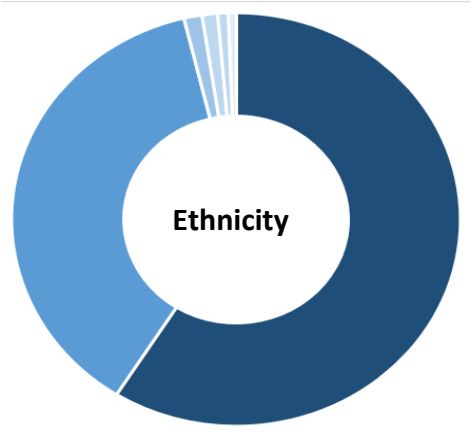
Staff figures for 2022/23

A further breakdown is provided later in this report.









Performance against key indicators

Further details on performance are set out in the Performance Analysis section of this report. Key issues and risks that could affect the Trust in delivering its objectives are noted in the Board Assurance Framework (insert page number), and detailed information on how the Trust reviews and manages key issues and risks can be found in the Annual Governance Statement.

Care Quality Commission report

Wye Valley NHS Trust is registered with the Care Quality Commission (CQC) who monitors, inspects and regulates all health services to ensure they meet fundamental standards of quality and safety.

In October 2022 there was a focused inspection of medical and surgical services. This inspection was focussed on revisiting issues found at a previous inspection in 2020, which meant the CQC had issued a Section 29a notice. This happens when there are issues of concern that require immediate action. A re-inspection would normally happen earlier however this was prohibited by the pandemic.

The focussed inspection rated Surgical services as 'requires improvement', an improvement from 2020 when the service was rated 'inadequate'. In both the 'Safe' and 'Well led' domains, the CQC

rated surgical services as 'requires improvement'. However due to the current CQC processes, and as this was not a comprehensive inspection of all services, the overall rating cannot formally be changed.

Our overall CQC ratings are shown in the chart below:

The Trust has a positive relationship with the CQC inspectors and meets regularly with them to provide assurance on key quality and safety concerns.

Operational performance and key targets

NHS England and NHS Improvement's Single Oversight Framework (SOF) is used for overseeing providers and identifying potential support needs. The SOF looks at five themes:

> Quality of care
> Finance and use of resources
> Operational performance
> Strategic change
> Leadership and improvement capability (well led)

Providers are segmented from 1 to 4, where '1' reflects providers with maximum autonomy and '4' reflects providers receiving the most support (special measures).

The Trust remains in segment 3 of the SOF.

Emergency department

ED standard	2019/20	2020/21	2021/22	2022/23
Total time in ED: four hours or less	76.3%	78.0%	65.6%	56.3%

The Trust did not achieve the national standard of 95 per cent of patients being seen, admitted or discharged within four hours from time of arrival in the ED. The challenges relating to system wide patient flow was the main driver for reduced ED performance during 2022/23, combined with significant winter pressures across our Urgent and Emergency [UEC] Pathways. In addition the impact of the "twindemic" (COVID-19 and seasonal influenza) along with Strep A, caused a delay in discharges.

Referral to Treatment (RTT)/52 weeks

In England, under the NHS Constitution patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable

steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

The table below shows our out turn for 2022/23. Despite the reduction in the percentage of English patients definitively treated starting in 18 weeks for 2022/23, the Trust did significantly reduce the number of long waiting patients. The Trust ensured that all patients waiting longer than 104 weeks for treatment had been managed by the end of June 2021 and significantly reduced the number of patients waiting over 78 weeks to less than ten by the end of March 2023. The position for the Welsh patients waiting under 26 weeks for start of treatment did improve to 67.3 per cent.

This has been achieved through our operational and clinical teams working hard to deliver as much clinical capacity to recover this position during the year. This included "ring-fencing" our elective capacity and increasing value weighted activity; this measures productivity across over-night elective, day case and outpatient procedure activity for acute specific Treatment Function Codes (TFCs). We are consistently over 100 per cent activity when compared against the corresponding months in 2019/20.

RTT incomplete performance

NB: English commissioned performance is 92 per cent of patients waiting under 18 weeks for treatment, Welsh commissioned performance is 95 per cent of patients waiting under 26 weeks for treatment.

	Mar-20	Mar-21	Mar-22	Mar-23
English (18 weeks)	77.8%	54.8%	63.6%	58.3%
Welsh (26 weeks)	83.1%	65.9%	66.2%	67.3%

Cancer care

The Trust's cancer performance standards were challenged over 2022/23 with significant increases, over 15 per cent, in cancer referrals compared with pre-pandemic levels. This combined with the pressure on diagnostics support to deliver this increase in capacity saw a deterioration across our cancer performance indicators. There is significant focus over the next twelve months in achieving our fast diagnosis standard by April 2024.

Key performance indicators	Key target	Actual 2019/20	Actual 2020/21	Actual 2021/22	Actual 2022/23
Cancer two week waits	93%	94.6%	97.2%	92.9%	91.1%
Two week waits (breast symptomatic)	93%	94.5%	98.5%	74.2%	79.5%
Cancer 31 days	96%	93.0%	90.6%	84.8%	88.0%
Cancer 31 days Subsequent treatments	98%	91.7%	90.4%	77.8%	69.0%
Cancer 62 days	85%	78.0%	76.3%	71.5%	65.2%
Cancer 62 days screening	90%	92.3%	66.7%	76.0%	66.7%
Cancer 62 days upgrades (no national target set)	85%	88.4%	82.2%	74.1%	65.2%
28 Day Faster Diagnosis			70.1%	64.4%	58.8%

Finance and use of resources

The Trust ended the financial year with an operating deficit of £4.99m (subject to audit) and a financial performance deficit of £6.51m (subject to audit) reported to NHS England. This was in line with the planned performance. Performance under the theme of finance and use of resources is assessed within the NHS Oversight Framework which considers performance across a range of domains and provides a segmentation from '1' to '4', where '1' reflects the strongest performance. For the most recent performance (quarter 3 2022/23) the Trust was rated in segment 3 of the NHS Oversight Framework.

Patient Safety Learning

In 2022/23, the Trust in conjunction with primary care colleagues, launched the Safety in Sync forum, a place based quality forum to come together with organisations across the healthcare system to discuss quality and safety issues and improvement projects. The aim of the forum is to breakdown organisational barriers and discuss issues that impact patient care to improve the healthcare system across Herefordshire. The forum discusses a wide range of topics and the aim of discussions in the forum is to connect colleagues from different organisations to work together and accelerate the opportunity to improve our collective services. Topics have included:

- System management of gestational diabetes
- Improvement of referral pathways for a number of conditions
- Antibiotic prescribing for various conditions
- The role of the medical examiner in Herefordshire
- The role of the Community Incident Response hub

During 2022/23 the Trust has been preparing for the implementation of the National Patient Safety strategy in line with the national implementation date of September 2023. This has included;

- Detailed analysis of our patient safety intelligence to understand our system based safety issues
- Implementing a new incident and risk management system
- Engaging with system partners to share learning and develop new pathways for responding to incidents, providing consistency with our Integrated Care System
- Piloting new incident analysis tools to focus on improvement

The focus in 2023/24 will be on continuing to improve our safety culture through implementation of the National Patient Safety Strategy through development of our Patient Safety Incident Response plan and underpinning processes to improve the management of patient safety incidents in line with the new principles. We will continue to develop our new incident and risk management programme to meet the new national reporting requiring for patient safety incidents.

Improvements to the Trust's estate and facilities

During 2022/23, the Trust:

- Completed £450k of backlog maintenance to address the condition and fabric of various buildings across Herefordshire.
- Completed the demolition of the hutted wards and enabling works for the next project planned to utilise the space created continued shortly afterwards.
- Completed the new corridor link to the frailty wards.
- Continued to roll out access control and backup power facilities, improving security and resilience.
- Completed Phase 1 of the Integrated Energy Centre seeing large sections of the non-PFI estate at the County Hospital now virtually free from fossil fuels.

The Trust was successful in getting outline business case approval for the Elective Surgical Hub and received significant enabling funds to take the scheme forward whilst awaiting final approvals. The Trust also succeeded in getting approval for over £20m for the second phase of the Integrated Energy Centre.

The focus in 2023/24 will be on delivering schemes which were supported over the last year which will start in earnest. Developments which are likely to feature highly in planning for preferred options and funding to be considered includes; community diagnostic centre, Endoscopy, breast screening, Macmillan Renton Unit and Ophthalmology. A new education centre has a preferred option now agreed and fundraising for this scheme is expected to intensify.

Capital developments

The Trust spent £12.8m on capital investments during 2022/23. The most significant elements within the capital programme were:

- £3.5m on the fees and commencement of construction of the Elective Surgical Hub.
- £3.5m spent on the digital programme including; Electronic Patient Record, Electronic Prescribing and Medicines Administration, GP Order Communications and E-Rostering.
- £2.2m on clinical equipment. This includes; replacement of Endoscopy equipment, Ophthalmology equipment and various smaller lifecycle replacements.
- £1.3m on surgical robot and associated equipment- to support cancer treatment.
- £1.2m on the construction relating to the new wards, primarily on a new link corridor.
- £1m on other estates schemes including backlog maintenance, community diagnostic centre development and associated costs.

Quality Priorities 2022/23

In the past year, we've continued to grow our culture of quality improvement, guided by the Trust's quality priorities:

SAFE
PRIORITY AIM

To reduce Clostridioide infection rates and deliver our cleanliness strategy
Improve Venous thromboembolism risk assessment
Reduce the incidence of avoidable hospital and caseload acquired pressure damage
Improve management of the deteriorating patient
EXPERIENCE
PRIORITY AIM
Using local and national intelligence to improve patient experience
EFFECTIVE
PRIORITY AIM
Ensure the Trust meets best practice requirements for nutrition
Embed the Mental Capacity Act and Deprivation of Liberty Safeguarding policies and process in practice
Ensuring patients receive timely critical medications

Transformation Developments

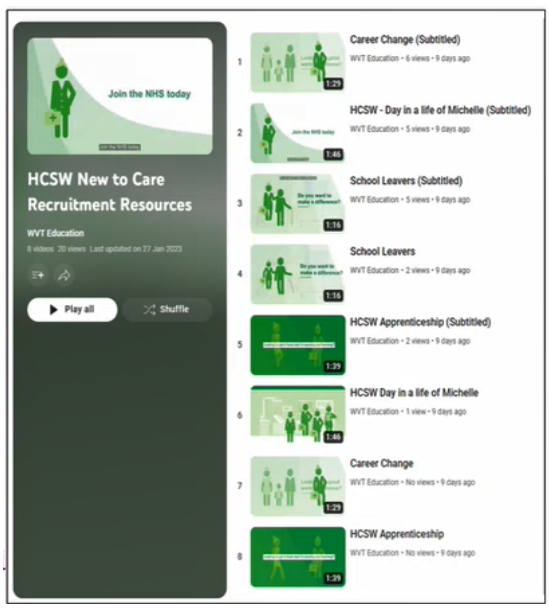
ED Sensory Development

Following a neurodiversity audit of the ED department at the County Hospital, the Trust worked alongside the Herefordshire Autism Partnership to introduce the following to enhance the experience for our patients:

- Sensory Boxes
- Reduced Signage
- Matt laminated posters
- New lighting
- Calming images

Healthcare Support Workers – New to Care Project

The Trust successful submitted a bid through NHSE to create some animated videos to encourage people to come and work within Health and Care. The videos covered the day in the life of and the career and training opportunities within the sectors.



Review of the Trust's clinical services

Medical Division

Our medical division provides a wide range of direct patient care services including: Frailty services , Dermatology, Stroke services, Diabetes and Endocrinology, Nephrology, Respiratory, Gastroenterology, Neurology, Cardiology, Emergency Department, Same day emergency care, Acute Medical Unit.

Key developments and achievements from 2022/23

- The opening of our new purpose built Frailty block in 2021/22 has enabled us to improve care to all of our frail elderly patients.
- Our Dermatology services have settled into their new skin centre and this has enabled them to improve their patients' pathways including consistently hitting cancer diagnosis targets.
- Our Stroke services are working with the ICS to develop pathways. They are at the top of the regional league table for thrombolysis.
- Diabetes multidisciplinary teams have expanded and are currently being offered to a number of localities across the five primary care networks (further expansion is ongoing).
- This year we have been successful in securing a nephrology consultant which has improved services for both inpatients and outpatients.
- Our respiratory team have successfully rolled out the replacement of non invasive ventilation machines.
- The cardiology team have worked to reduce the number of patients waiting for ECHO appointments from more than 2000 in April 2022 to just over 100 in March 2023.
- Gastroenterology have implemented a new my IBD (inflammatory bowel disease) app which gives patients more autonomy in managing their own condition.

Our focus in early 2023/24 will be to: undertake some transformation work in our Emergency Department to improve the speed and flow through the department; and, launch our new virtual ward which will allow some patients to be managed in their own home under the care of senior nursing and consultant staff.

Surgical Division

Our surgical division provides a wide range of direct patient care services including: General Surgery, Urology, Colorectal Surgery, Breast Surgery, Trauma and Orthopaedics, Ophthalmology, Ear Noise and Throat services, Oral and Maxillofacial services, Theatres, Intensive Care Unit, Endoscopy, Podiatric Surgery, Dentistry, Paediatrics, Special Care Baby Unit, Maternity, Obstetrics and Gynaecology, Community Paediatric services and Public Health Nursing services.

Key developments and achievements from 2022/23

- We have made steady progress in reducing waiting times throughout the year and have been working closely with our partner organisation, South Warwickshire University NHS Foundation

Trust (SWFT), on reducing our long waiting times in orthopaedics. Our patients have been very positive about their experience at SWFT.

- The division has introduced a new Clinical Nurse Specialist (CNS) post in vascular services and also a new Advanced Clinical Practitioner post in orthopaedics. There have been difficulties recruiting Operating Department Practitioners (ODPs) in theatres, however, four ODP trainees commenced training in January 2023.
- The Urology team have continued to improve their service in the Urology centre sharing good practice with Worcester, SWFT and George Elliot NHS Trust through site visits. They have developed a Holmium laser enucleation of the prostate (HOLEP) service; an alternative treatment to Trans-urethral Radical Prostatectomy which reduces length of stay and improves patient outcomes.
- Two CNSs are being trained in Local Anaesthetic Trans-perineal Prostate Biopsy (LATPB) which is being funded by the Cancer Alliance. Diathermy lists are also taking place in the Urology Diagnostic Centre, reducing reliance on theatres for these treatments.
- One of the division's CNS presented our GiRFT (Getting it Right First Time) improvements at the BAUN (British Association of Urology Nurses) Conference in Edinburgh. They were also invited to the European Association of Urological Nurses in Prague and is now part of European Special Interest Group (Prostate) sharing best practice.
- The new lower urinary tract symptoms clinic is a new radical retro pubic prostatectomy clinic now in place at the Trust. Wye Valley NHS Trust is the first trust in the region to provide this service (Holistic pre-prostatectomy needs clinic, supported by the Bladder & Bowel team, pelvic health physio, cancer specialist physio and Urology Cancer Nurse Specialist).
- The division has developed a web-based reporting system to monitor theatre performance and produce a trend analysis. We commenced a productivity improvement project in our theatres in 2022 engaging clinical teams to identify ways in which to become more efficient and productive, this work will be continuing in 2023/24.
- Our Podiatric surgery team have been working closely with the Diabetic foot service over the last year and a peer review of this service extolled the benefits of both services working closely together.
- Supported by the appointment of a colposcopy failsafe officer, Colposcopy performance has continued to deliver against all key performance indicators with excellent results from a patient survey.
- Additional hysteroscopy and colposcopy clinics have been running at the weekends.
- Positive progress has been made with smoking cessation in pregnant women. Following a regional insight visit we were pleased to celebrate our compliance with Saving Babies Lives, a care bundle which is designed to tackle stillbirth and early neonatal death.

Integrated Care Division

Our Integrated Care Division provides services in both the acute and community settings, with particular elements of integrated working with our partners across the system.

Key developments and achievements from 2022/23

- Implementation of a new divisional structure which includes management responsibilities links with Primary Care Networks, in an effort to progress with enhancing our "Team of Teams" within community services
- Significant quality improvements at our community hospital sites
- Increased recruitment to our Urgent Community Response (UCR) team to meet the needs of people who require expert input, but who can receive this at home rather than be conveyed and admitted to hospital
- Consistently achieved the two hour UCR national target
- Extended our UCR to 12 hour per day, seven days per week
- Employed trainee Advanced Clinical Practitioners to align with our "grow your own" workforce across UCR and Community Hospitals
- Supported our Local Authority Reablement team to provide rapid discharge from hospital
- Led on and delivered Criteria to Reside improvement programme, with compliance and data quality seeing huge improvements trust wide
- Reduced long waits within our Acute and Countywide services in line with the recovery programme
- Achieved a commitment to invest in our children's therapy services to recruit additional therapists to provide earlier input for children requiring support
- Supported the international nurse recruitment programme and have welcomed six new recruits to work at our community hospitals
- Led on the development of wound management across Herefordshire with particular focus on lower leg services.

Clinical Support Division

Our clinical support division provides a wide range of services which support the Trust and wider healthcare providers in Herefordshire to deliver frontline clinical services including: Pharmacy, Radiology and Pathology.

The division also delivers direct patient care in Cancer Services including Clinical Haematology, Oncology and Palliative Care, Audiology and general outpatients departments. We also support a number of trust wide corporate functions including the Referral Management Centre, Referral to Treatment Validation and Patient Access Policy oversight, General Office, Mortuary and Bereavement Services, patient communications (letter, digital and text messaging), oversight of Cancer standards and performance, multidisciplinary teams and patient tracking.

Key developments and achievements from 2022/23

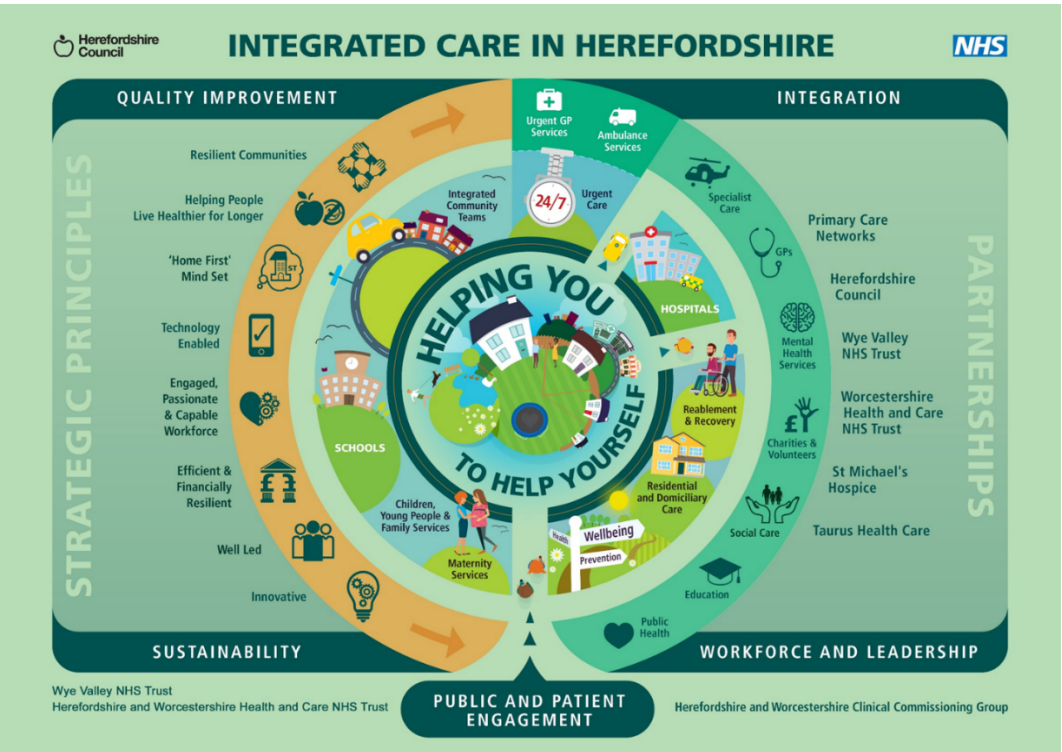
- Wye Valley NHS Trust became the first trust in the West Midlands to go live with digital reporting of histopathology slides which is a key enabler in becoming part of a wider pathology network bringing the benefits of faster diagnosis and access to expert opinion.
- The Radiology team reduced the six week+ backlog over the year. Of particular note is the reduction in over six week waits for CT scans which has reduced from 400 in April 2022 to six in February 2023. The non-obstetric ultrasound backlog has also reduced significantly over the

year from 700 to 46. Overall 91 per cent of patients are being scanned within six weeks against a target of 85 per cent for March 2024, the Trust is therefore ahead of this target.

- An interventional radiology suite has been opened enabling work to be taken out of theatres.
- Radiology consultant recruitment has seen great success with only one vacancy at present.
- In Cancer Services we have seen the opening of a new dedicated MDT facility which enables specialists in Radiology and Histopathology to dial in virtually. There have been improvements in cancer pathway tracking with the introduction of specialty based cancer navigators who are having a positive impact on the faster diagnosis target for patients. A Cancer of Unknown Primary service has been established to ensure that there is a robust pathway in place for these patients.
- At the start of the year the Trust had to close the Haematology service to new referrals due to unexpected consultant staffing difficulties. The Trust worked with Worcester, Shrewsbury and Telford Trusts and Powys Health Board to provide a service for our patients. We have recently been able to repatriate these patients and provide a full service due to resolving the previous staffing issues.
- In Outpatients there is now a six day service and also two evening sessions per week. A minor outpatient procedures service is fully recruited to for Trauma and Orthopaedics and Trans Nasal Endoscopy, enabling work to be taken out of main theatres to release capacity for more major surgery.

Integrated care and partnership working

Our Integrated Care Strategy starts with building on the strengths of individuals and their communities to improve their health – 'helping you to help yourself'.



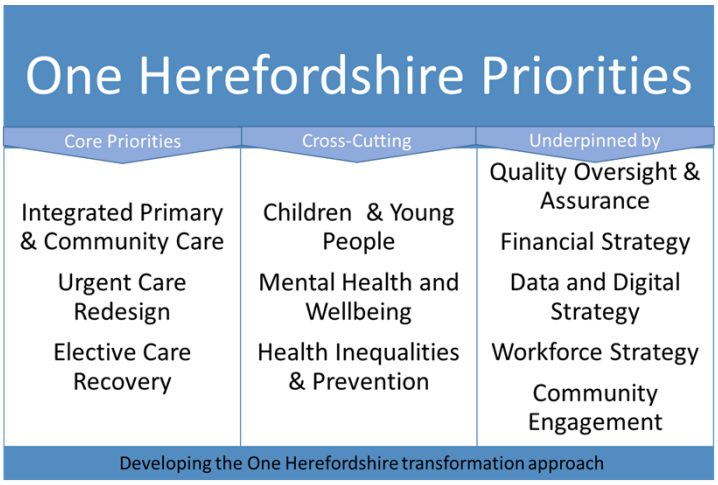
Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

Integrated Care Systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

One Herefordshire Partnership

System leaders are now focused on coordinating actions at the local level, using the One Herefordshire Partnership (OHP) to establish place-based approaches that incorporate the crucial role of the developing primary care networks (PCNs). The OHP is the primary interface with the Herefordshire and Worcestershire ICS, with a primary purpose of strategic planning, approval and engagement, and is chaired by one of the four core members drawn from general practice, Wye Valley NHS Trust, Herefordshire Council or Herefordshire and Worcestershire Health and Care Trust.

This place level of working offers the right scale and scope for tackling population health challenges – from health inequalities to the wider determinants of health – and for maximising opportunities across all public services through integration, service changes and aligned resources. Close working arrangements across all partners who have a role in improving population health and well-being are crucial to delivering this.



We aim to ensure that the experience of patients, service users, their families and carers is the foundation of how we develop and deliver our services. Our approach focuses on recovery, partnership working and embedding coproduction into day-to-day practice.

Key developments and achievements from 2022/23

- Virtual GP and Community Integrated Response Hub partnership delivering two hour response – supporting circa 500 patients a month and preventing 160 ambulance conveyances over the three months of Winter
- Community teams delivering improvements at network level, alongside partners, to reduce health inequalities, improve discharge arrangements and improve patient care
- Co-designing with partners an integrated urgent care pathway that is fit for the future
- Enhancing care in care homes across Herefordshire

- Improving heart failure and diabetes pathways, optimising patient care
- Working collectively to manage hospital referrals effectively and manage waiting lists
- Continuing to deliver mental health transformation in Herefordshire
- Developing a shared plan to tackle health inequalities
- Learning collectively from mistakes and celebrating successes
- Taking a joint approach to support worker recruitment

Health Inequalities Strategy

The Trust has worked with One Herefordshire partners to develop a Health Inequalities Strategy in 2022/23, described below. The Strategy has been agreed by the Health and Wellbeing Board and progress will be fed back annually.

Vision:	Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.		
The Challenge	Requires inequalities in health outcomes between different groups of people to be reduced. This necessitates a mix of short, medium and long term action including upon the wider determinants.		
We will focus on:	Reducing health inequalities across the population, particularly within:		
	Rurally dispersed	**Travelling community**	**Unregistered individuals**
To do this we will:	Work in partnership to develop local solutions, using national frameworks and best practice, which encourage and empower people of all ages and abilities to reduce inequalities and improve health and wellbeing; focusing on;		
1.	**Engaging healthcare professionals to improve digital and health literacy**		
2.	**Empower and support workforces to understand and deliver equitable services that reduce inequalities and address workforce inequality and training needs**		
3.	**Reaching communities to work in partnership to reduce inequalities**		

This plan on a page outlines how Herefordshire's partners will work to reduce health inequalities over the next five years, incorporating the national Core20Plus5 approach. At the Trust, teams are working within primary care networks to deliver a number of smaller, targeted, local schemes that reduce inequalities. The Trust is also analysing waiting lists, reviewing whether there are hidden inequalities within the lists, based on deprivation and ethnicity.

Trust charity

The Trust charity uses donations to fund special projects, support patients, service users, carers and staff, and improve the environment on our wards and other areas.

The Charity comprises of a number of separate ear-marked funds under the umbrella of Wye Valley NHS Trust charitable funds. The funds totalled £2,103k at the end of December 2022. During 2022/23 to date the Charity received donations and legacies of £1,169k and incurred expenditure of £173k.

Workforce and Organisational Development Strategy

The workforce and organisational development strategy identifies the workforce priorities to support the delivery of the Trust's strategic objectives and endorses our commitment to recruiting, developing and retaining a workforce that is engaged and motivated in providing high-quality healthcare to our patients.

The key themes in our workforce strategy 2022 – 2026 are:

- Workforce transformation – to have a more efficient and productive workforce
- Growing our workforce – grow and maintain a sustainable and flexible workforce
- Recruitment and retention – attract, retain and develop a high quality workforce

These themes are underpinned by enablers which are: Health and wellbeing, equality, diversity and inclusion, leadership and management development, education and training, staff engagement, HR policies and procedures.

There has been a focus on maintaining our Occupational Health service during a time of staff shortages in the year and we have had great success in recruitment to gaps and process/service improvements. We have also been successful in recruiting a staff mental wellbeing nurse and a staff physiotherapist, focusing on the key reasons for staff absence or illness, and will be ready to pilot these additional support roles from June.

We are also more than a year in to our partnership with Halo Leisure, providing weekly clinics for staff covering personal wellbeing coaching, goal setting and boditrax health evaluations.

Education

We are proud that the Education Directorate has been in place for 2 years we will continue in 23/24 with the same vision of promoting truly multi-professional education supported by one integrated team, making education accessible to all staff, from our most junior students to our most experienced leaders. We support a wide range of programmes for formal academic training as well as career development opportunities including management and leadership programmes and work collaboratively with key partners and stakeholders regionally to ensure WVT employees have access to a range of providers and a diverse portfolio of courses.

The Directorate's long-term goal is to create a new Education Centre for everyone to share, combining state of the art simulation and clinical skills rooms with a modern library and information hub and large bespoke lecture theatre. Our vision is to make the Trust a destination for students and staff for high-quality education, a lasting positive experience and to support the recruitment and retention of our staff. The proposed development is to expand and enhance the education we deliver by building a dedicated education and training facility on the County Hospital site.

Key developments and achievements from 2022/23

- £419,000 accessed for Continuing Professional Development funding (through Health Education England)
- £38,681 Workforce Development Funding
- Working with the Foundation Group and Herefordshire and Worcestershire ICS in supporting the development and delivery of a number of leadership programmes such as Mary Seacole, Insights, Coaching and Mentoring, leadership support circles.
- Launch of new virtual student induction programmes in March 2023 following a successful bid to Health Education England for funds to improve student / trainee placements. The online courses aim to standardise induction for all student / trainee groups and includes:
- The new WVT Education & Training Prospectus was launched in April 2022 which details all offerings and areas of the Education Directorate.
- Launch of virtual sessions via MS Teams for annual mandatory training subjects (Fire Safety, Information Governance & Infection Prevention & Control) providing an alternative to e-Learning and enables Q&As with subject matter experts within the organisation.
- Launch of a new Basic Life Support (BLS-Adults) refresher training pathway with the use of self-directed learning. The pathway also includes a knowledge check which is completed via the national Resuscitation Level 2 eLearning course on ESR. This has enabled the team to increase their educational offering which includes training acute illness management course and support for staff in the clinical area during clinical practice weeks.
- Successful implementation of Wye Valley NHS Trust Leadership and Management Development Programme delivering this to circa 90 candidates.
- Clinical Education Fellow programme - We have continued to expanded the fellow programme and develop innovative non-medical education fellow posts, which rotate to different specialties every year. The medical education fellow posts cover a wide range of specialties.
- The Practice Education Team have successfully recruited an Allied Health Professionals (AHP) to focus on the training and support of AHPs students across the Trust.
- Launch of a new collaborative network of NHS libraries (HeLM) across the Midlands with a shared Library Management System enabling access
- Launch of new online platform to make resource and evidence discovery easier
- Improved IT and Study facilities within the library

Students and training at WVT

- **Physician Associate Students.** We host approximately 20 physician associate students at any one time on placement from Worcester University.
- **Medical Students.** We host approximately 45 medical students at any one time on placement from Aston and Birmingham Universities and for the first time facilitated a successful Objective Structures Clinical Examination [OSCE] for 5th Year Medical Students from Birmingham in May 2022.
- **Doctors in Training.** There are approximately 110 doctors on training placements throughout the Trust. We support an expanding foundation training programme. In August 2022:

  - 23/26 FY1 doctors successfully achieved completion of their FY1 Training year.
  - 14/16 FY2 doctors successfully achieved completion of their Foundation Training Programme.
  - We also support an increased range of higher specialist training programmes across most clinical areas of the trust with an expanding GP training programme across the county of Herefordshire

- **SAS group development.** The SAS Bursary scheme has been successfully implemented and provided SAS doctors with an opportunity to apply for funding to support self-development. 11 SAS doctors accessed the bursary.
- **Support for Certificate of Eligibility for Specialist Registration (CESR).** CESR was piloted, this supported 9 doctors to work toward consultant status.
- **Preceptorship.** Preceptorship has grown significantly over the last 12 months. We have increased our number of intakes from two per year to four per year. We currently have around 140 staff members undertaking the programme. The Trusts new preceptorship policy has been published which was designed to align to the National Preceptorship Framework for Nurses (NHS England, 2022). Aligning with the framework will also enable us to apply for the National Preceptorship Interim quality mark that is being awarded by NHS England to all Trusts that can demonstrate compliance to the framework.

Recruitment and retention

During 2022/23, we focused on recruitment to increase workforce capacity to ensure we continued with our response to the pandemic and recruit to the new posts identified as part of the NHS Long Term Plan. As a result, we have seen a 2 per cent increase in the number of staff employed by the Trust (an additional 82 staff) compared to the same time last year.

Nursing recruitment interventions

In the last 12 months the Trust has recruited 110 nurses from various countries across the world with six placed into the community hospitals. In addition four paediatric nurses in children's services have been recruited. The majority of the international nurses work in acute medical and surgical teams. There is a national shortage of registered nurses in the UK, recruitment and retention of the overseas nurses is essential to maintain a quality service for our patients.

The Trust has a good reputation for the strong pastoral care providing and the on boarding process. Once international staff arrive our pastoral officers support them throughout their transition stage and we see that they settle into Herefordshire. Once they have passed their OSCE exams they then bring their families over and we support their spouses/partners as well.
It is a great team effort to recruit and retain the nurses, and everyone is committed to the programme to ensure the nurses are well supported. We can also see how they progress to senior nursing posts in the Trust, enhancing their careers.

Maternity services have recruited four midwives from overseas, who will be taking their maternity OSCE exams in June to become fully NMC registered midwives.

The Health Care Support Worker Programme

The healthcare support worker (HCSW) programme was launched in September 2019 to support NHS trusts to increase their HCSW recruitment, minimise vacancies, avoid reliance on temporary staff and so provide greater continuity of care for patients, and to support more people to progress into nursing and midwifery roles in the future. At the Trust we have been successful in reducing our HCSW vacancy gap from 80 wte in 2021 to 34.86 wte at the end of March 2023. At the end of March 2023, following successful recruitment and job offers issued (if accepted) this figure should reduce to below ten vacancies within the first quarter of 2023/24.

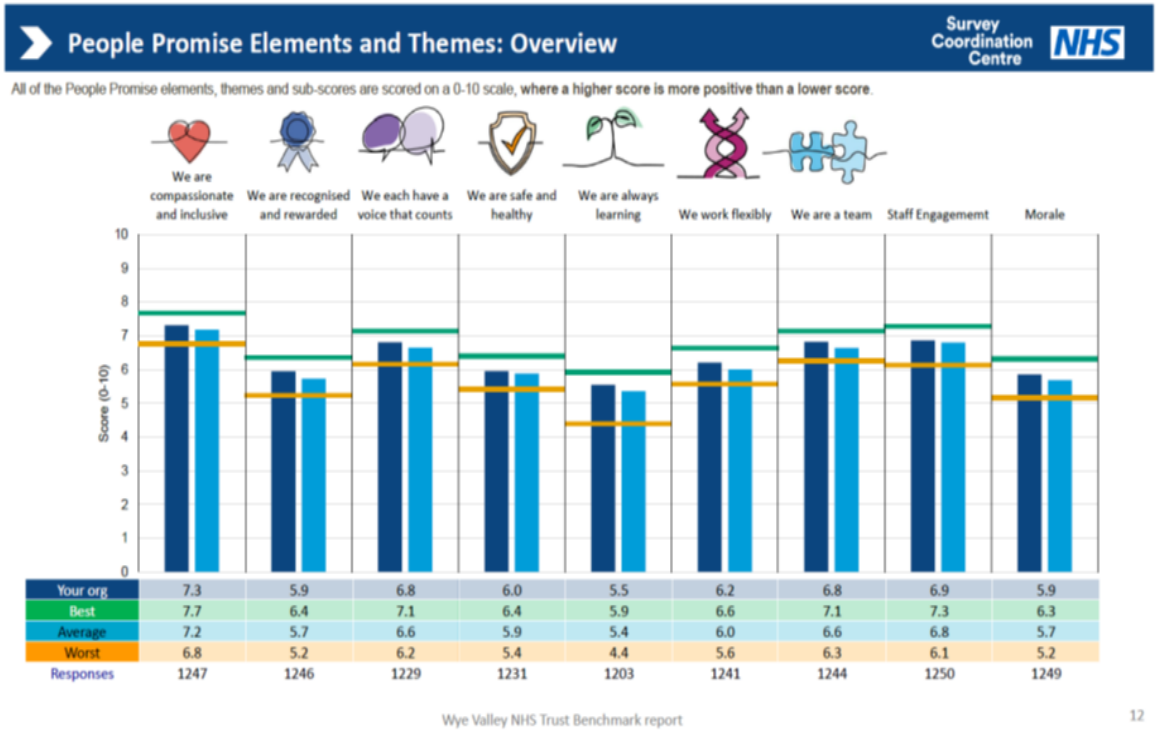
As part of the HCSW programme the Trust also joined forces with Hoople care and together we work in partnership to attract, recruit and retain HCSWs across the county forming **'Together Healthcare'** this has proved to be a great success and we continue to maintain this local partnership working for the local community across Herefordshire.

People practices

There has been focus on reviewing the Trust HR policies and procedures and changing the approach to working with stakeholder groups. Practices have been reviewed by responding to user feedback including providing of improved guidance and access via the Trust staff intranet pages.

Staff survey

A summary of the 2022 results for the Trust shows good progress with **above average scores in all nine areas of the survey** (compassionate and inclusive, recognised and rewarded, voice that counts, safe and healthy, always learning, work flexibly, we are a team, staff engagement, morale). This is attributable to a number of leadership, workforce and organisation design initiatives that have been implemented at the Trust over the past few years.



The table above provides a high level summary of the nine key areas of the survey.

The scores for the Trust in the table below are close to the average NHS scores and the overall staff survey scores are largely positive with no area rated as being amongst the worst NHS organisations.

In terms of violence and aggression, which was a major area of concern in previous surveys, actions implemented by Trust since September 2021 continue to have a positive impact.

That said, widespread dissatisfaction with levels of pay has led to ongoing industrial action across the NHS in 2022/23 with many staff being dissatisfied with their pay considering the cost of living crisis. Additionally, information from the 2022 staff survey still indicates that Black, Asian and Minority Ethnic staff are still reporting a poorer experience compared to white colleagues in terms of harassment, bullying or abuse and equal opportunities. Data from NHS Employers indicates that unfortunately this is still the case across many organisations in the NHS.

Over the past two years, the Trust has made good progress in establishing the Black, Asian and Minority Ethnic (BAME) network, the LGBT+ network and the Disability network for Trust employees. These staff networks are maturing and over time will be able to drive forward and support strategic equality and diversity issues affecting staff at the Trust.

The staff survey also indicates that staff with a long term condition or illness, are still reporting a less favourable experience in terms of harassment, bullying or abuse at work. This is also the case in many NHS organisations and the Wye Valley NHS Trust Disability network will be instrumental in supporting initiatives for disabled staff over the next year. The Trust managing attendance policy is being reviewed and provisions will be made in introducing a revised disability health passport to offer more support for disabled staff.

PEOPLE PROMISE ELEMENTS /THEMES - 2022	WVT	Average	Best	Worst
1. We are compassionate and inclusive				
Q23a – Care of patients / service users is my organisation's top priority	**70.9%**	**73.5%**	**86.6%**	**58.0%**
Q23b – My organisation acts on concerns raised by patients / service users	**68.3%**	**68.3%**	**80.6%**	**51.5%**
Q23d – If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**57.1%**	**61.9%**	**86.4%**	**39.2%**
Q21 – I would recommend my organisation as a place to work	**59.5%**	**56.5%**	**75.2%**	**41.0%**
2. We are recognised and rewarded				
Q4a – The recognition I get for good work	**53.4%**	**51.2%**	**61.3%**	**43.2%**
Q4b – The extent to which my organisation values my work	**42.6%**	**41.1%**	**53.5%**	**29.5%**
Q4c – My level of pay	**28.9%**	**25.1%**	**32.8%**	**18.5%**
Q9e – My immediate manager values my work	**73.5%**	**70.2%**	**78.4%**	**62.8%**
3. We have a voice that counts – downward trend NHS wide but above average scores for WVT in all areas				
4. We are safe & healthy				
Q3a – I am able to meet all the conflicting demands on my time at work	**42.7%**	**42.9%**	**53.2%**	**32.2%**
Q5a – I have unrealistic time pressures	**20.3%**	**22.3%**	**29.7%**	**18.0%**
Q11a – My organisation takes positive action on health & wellbeing	**58.4%**	**55.6%**	**71.4%**	**42.8%**
Q11c – During the last 12 months have you felt unwell as a result of work related stress?	**45.2%**	**45.1%**	**36.7%**	**51.5%**
Q13a – In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public	**11.9%**	**15.0%**	**7.7%**	**22.8%**
5. We are always learning – above average scores for WVT in key questions posed				
6. We work flexibly – above average scores for WVT in all questions posed but NHS wide concerns remain				
7. We are a team – above average scores for WVT in key areas and good feedback for support from immediate managers				
8. Engagement – dip for WVT and NHS wide since 2021				
9. Morale – dip for WVT and NHS wide since 2021				

Awards and recognition

Hereford Times Health and Social Care Awards 2022

The team behind the Trust's Healthcare Support Worker project lifted the prestigious tittle of Health Care Team of the Year at the Hereford times Health and Social Care awards. In addition Aziz Khan, who heads up the Gilwern Unit at the County Hospital was a finalist in the Excellence in Nursing category and our Meet and Greet volunteer team, was shortlisted as a finalist in the Volunteer of the Year category. Also Gemma Boland, healthcare assistant, was shortlisted in the Care Hero Award category.

HSJ Awards

There was a high commendation for the Herefordshire & Worcestershire COVID-19 vaccination programme. The multi-partner vaccination programme was an example of how partners came together to ensure that people across the two counties could access and receive their COVID-19 vaccination.

University of Worcester Mentor Awards – recognising exceptional student support in practice

The Trust's finalists across categories were: Lucy Knight-Summers (Midwife), MSK Physiotherapy outpatients, Ross Community Hospital, Alison O'Neil and Roberta Rayner (Paediatric OT).
Lucy Knight-Summers won the award for Outstanding Mentor of Midwifery Students.

Freedom to Speak Up Guardian and Champions

Our Freedom To Speak Up (FTSU) Guardian's role is to promote a positive culture of speaking up, in order to improve the experience and wellbeing of colleagues at work. Each speaking up event gives the Trust opportunity to learn and develop including cases that improve patient experience and safety.

In 2022/23 the hours ring fenced for the Guardian role were doubled for the appointment of a new Guardian. Hours were also allocated for the outgoing Guardian to support the new appointee.
The Guardian is supported by FTSU champions. At the end of the March 2023 there were 27 champions ensuring representation of all divisions. This is an overall increase of six for the year, with a number also leaving the Trust. This team, alongside the Guardian, promote the FTSU and Civility Saves Lives ethos, providing an alternative route for staff to speak up when they feel they cannot do this via the management route. This team includes six foundation year (FY) doctors. They have been a great asset supporting their FY colleagues. Our champions have helped to informally resolve conflicts or concerns within teams by supporting staff on an individual level and supporting speak up events throughout the year. They signpost staff to the Guardian for concerns to be escalated or simply for the Guardian to provide advice or give the individuals the confidence to return to their managers and raise their concern within their department. The Guardian also continues to have the support of a senior Consultant for cases involving medical staff when requested.

The Trust would expect compliance for the mandatory Speaking Up eLearning to be above 85 per cent compliant. At end March 2023, compliance reached 88.02 per cent. The Guardian also trained over 400 staff in Civility Saves Lives with support from the education team.

Local reporting shows that for the past four years concerns raised and advice sought from the Trust FTSU Guardian has been 70 plus cases in total, per year.

	2018/19	2019/20	2020/21	2021/22	2022/23
Number of cases	24	73	70	74	72

Equality, Diversity and Inclusion (ED&I)

In February 2023, the Trust Management Board received the ED&I reports with the 2022/23 data for the Workforce Racial Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Equality Delivery System 2022 and agreed the action plans for the year ahead.

- 14 per cent of the workforce is represented by the BAME community, making it more diverse compared to the local population in overall terms and shows the Trust's success in attracting candidates nationally and internationally.
- The WRES and WDES data has shown some improvements in areas such as access to training, and recruitment practices and employee relations. This has been positively supported through recruitment and training of a number of cultural ambassadors across the organisation and ICS.
- Each staff network, (BAME, disability and LGBT+), is sponsored by an Executive Director and Non-executive Director.
- The Trust has a calendar of events that is agreed with the staff networks to recognise and celebrate EDI throughout the year.
- The Chief People Officer is the Senior Responsible Officer and Chair of the ICS EDI workstream and of the ICS BAME network.

Armed Forces awareness

The Trust is proud to be a Veteran Aware hospital and have a silver award under the Armed Forces Covenant, this means:
We strive to be an exemplar of the best care for veterans and their families

- We encourage all staff and patients to let us know if they have ever served in the UK armed forces so that we can best support their needs
- We are committed to learning from our patients and their families in order to improve quality of care.
- We actively ensure that our staff are aware of our positive polices towards defence people issues.

VETERAN AWARE

Modern slavery

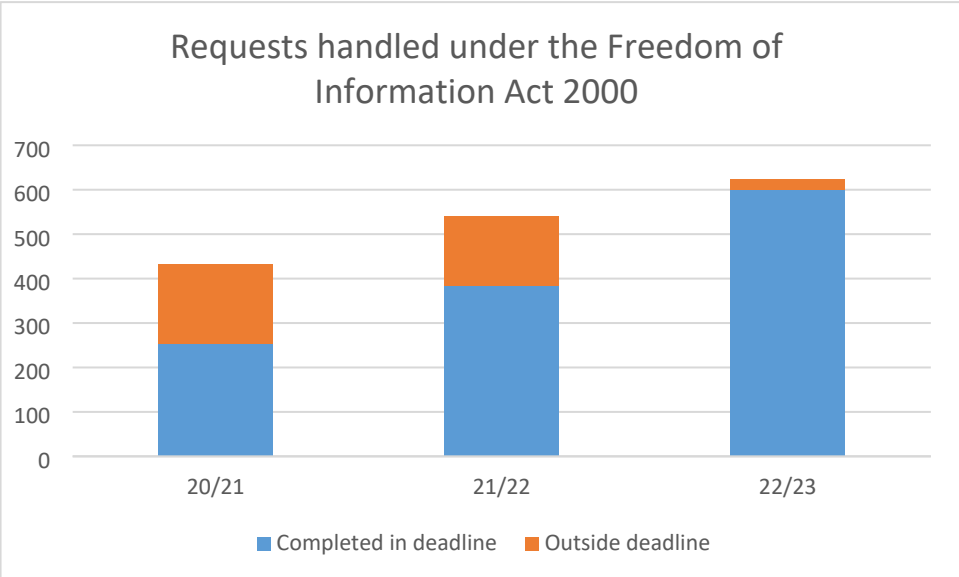
The Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015, and we expect our staff and suppliers to comply with the legislation and report concerns where they have them.

The Trust updates relevant Trust policies on a regular basis to highlight obligations where any issues of modern slavery or human trafficking might arise, particularly in our procedures for safeguarding adults and children, tendering for goods and services, and recruitment and retention.

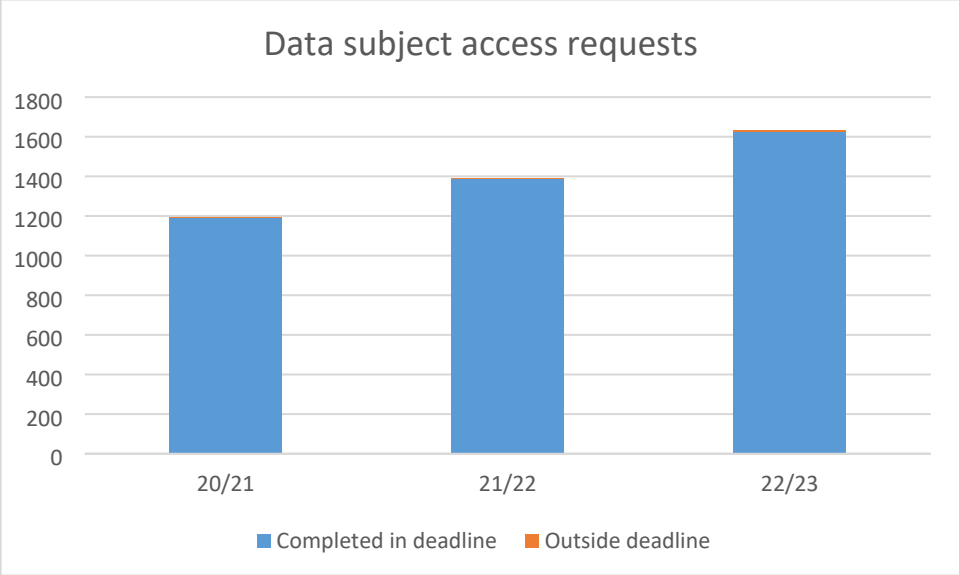
All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices and to report any concerns they may have.

Freedom of Information Requests

Over the year 2022/23, the Trust's information governance team has achieved a high standard of compliance with responding to requests for information within the statutory deadlines for both Freedom of Information (FOI) requests and Subject access requests. The volumes of requests have increased over the past three years, however the compliance with timescales have also considerably improved. The chart below shows compliance with deadlines for responding to requests made under the Freedom of Information Act 2000.



The chart below shows compliance with deadlines for responding to data subject access requests, where people can ask for copies of their personal information.



Performance analysis

The year 2022/23 has been focusing on recovery following the pandemic and we performed well against the majority of our targets and continue to remain in segment three of the system oversight framework (SOF).

Full details of our operational performance review for 2022/23 are published in the monthly board papers available on the Trust website.

National standards performance 2022/23

The table below shows performance against regulatory compliance: NHSE Single Oversight Framework for Quality, access and outcomes.

Quality of care, access and outcomes	Responsible Director	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Latest Month		Year to Date v Standard	Trend - Apr 2019 to date
															Numerator	Denominator		
28 day referral to diagnosis confirmation to patients	Chief Operating Officer	75%	62.0%	61.9%	56.9%	47.2%	54.0%	50.1%	55.5%	58.8%	63.2%	56.3%	68.1%		549	806	57.4%	
Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	Plan	133	86	109	159	148	197	135	100	108	123	115	89				
Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	70%	80.0%	87.0%	78.1%	69.4%	72.7%	81.1%	90.0%	91.1%	80.0%	90.2%	91.7%	83.3%	75	90	84.1%	
% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	88.2%	89.1%	89.7%	91.3%	89.9%	89.2%	89.7%	90.5%	88.4%	89.2%	89.2%	89.2%	2253	2527	89.5%	
Ambulance handover within 30 minutes	Chief Operating Officer	98%									58.7%	77.0%	81.0%	82.9%	1366	1648		
A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		15.9%	14.0%	15.8%	18.1%	18.7%	19.8%	16.6%	13.8%	24.6%	19.3%	18.4%		961	5234	17.5%	
Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	1223	1102	1050	1179	1229	1228	1336	1326	1463	1446	1391	1453				
Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	216	143	99	81	72	68	98	94	104	94	58	6				
Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	72	30	0	0	1	0	1	1	2	0	0	0.0%				
Total Elective Activity (% v 2019/20)	Chief Operating Officer	2019/20	91%	97%	91%	85%	89%	88%	90%	96%	85%	92%	99%	104%	3220	3099	92%	
Diagnostic Activity - Computerised Tomography	Chief Operating Officer	Plan	115%	126%	126%	139%	135%	138%	146%	139%	138%	141%	138%	108%	2508	2330	132%	
Diagnostic Activity - Endoscopy	Chief Operating Officer	Plan	103%	115%	101%	96%	99%	100%	124%	121%	100%	122%	131%	123%	853	695	111%	
Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	Plan	122%	87%	93%	96%	103%	123%	129%	143%	139%	132%	142%	117%	1282	1100	117%	
Outpatient Activity - Follow Up attendances (% v 2019/20)	Chief Operating Officer	v 2019/20	107.7%	110.7%	104.3%	104.3%	110%	103%	105%	105%	97%	107%	103%	114%	13870	12213	106%	
Mortality SHMI - Rolling 12 months	Chief Medical Officer	<100	109.4	108.8	108.6	106.7	104.8	103.8	102.9	103.5					1115	1075		
MRSA Bacteraemia	Chief Nursing Officer	0	0	0	0	0	0	0	0	0	0	0	0	0			0	
Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	44	6	2	4	2	8	0	5	3	4	0	3	5			42	
Overall Sickness	Chief People Officer	3.5%	7.4%	5.5%	6.5%	6.7%	5.3%	5.4%	6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	177	3314	6%	
Agency - expenditure as % of total pay	Chief Finance Officer	N/A	12.9%	12.9%	12.2%	10.7%	13.3%	10.3%	9.4%	10.1%	11.5%	11.4%	10.5%		£1,744	£16,679	11%	

The table below summarises a subset of the waiting times and access standards monitored by the Trust Board.

Wye Valley NHS Trust
Trust Key Performance Indicators (KPIs) - 2022/23

Quality of care, access and outcomes	Responsible Director	Standard	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Latest Month		Year to Date v Standard	Trend - Apr 2019 to date
											Numerator	Denominator		
28 day referral to diagnosis confirmation to patients	Chief Operating Officer	**75%**	54.0%	50.1%	55.5%	58.8%	63.2%	56.3%	68.1%		549	806	**57.4%**	
Cancer: number of urgent suspected cancer patients waiting over 62 days	Chief Operating Officer	**Plan**	148	197	135	100	108	123	115	89				
Urgent Response > 1st Assessment completed on same day (facilitated discharge & other)	Chief Operating Officer	**80%**	100%	99%	100%	100%	98.6%	99.2%	100.0%	98.2%	112	114	**99.5%**	
Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	**70%**	72.7%	81.1%	90.0%	91.1%	80.0%	90.2%	91.7%	83.3%	75	90	**84.1%**	
Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	**>40%**	37.4%	38.4%	39.5%	40.8%	37.1%	36.5%	40.4%	37.2%	785	2109	**38.3%**	
A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		18.7%	19.8%	16.6%	13.8%	24.6%	19.3%	18.4%		961	5234	17.5%	
Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	**<15 minutes**	00:47	00:45	00:42	00:46	01:06	00:42	00:41	00:44				
Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	**92%**	61.1%	60.3%	61.1%	61.2%	58.4%	58.6%	59.0%	58.3%	12690	21776		
Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	**95%**	68.7%	68.5%	70.0%	69.4%	68.0%	66.7%	67.5%	67.3%	2814	4181		
Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		23368	23813	24525	24698	24997	24974	25301	25957				
Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	1229	1228	1336	1326	1463	1446	1391	1453				
Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	72	68	98	94	104	94	58	6				
Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	1	0	1	1	2	0	0	0.0%				
Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<1%**	44.1%	39.5%	29.2%	24.9%	30.0%	29.4%	22.2%	22.0%	1329	6044		
Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	96.6%	91.3%	94.0%	94.9%	97.3%	89.3%	96.3%	98.6%	139	141	**94.2%**	
% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	**60%**	63.4%	64.8%	58.3%	47.7%	79.1%	71.7%	60.7%	48.8%	20	42	**58.0%**	

Performance indicators are reviewed annually and a suite of selected KPIs are scrutinised by the Board and sub-committees on a monthly basis. This is supported by a monthly deep dive of clinical services by the finance and performance executive. The structure enables the Board and sub-committees to focus on key areas of service quality, effectiveness and safety. The Trust is also part of the NHS benchmarking reference group and continues to participate and utilise external benchmarking reports to understand variation and inform our improvement agenda.

Patient experience

Our patient experience team provide a trust wide service that reviews incoming comments and concerns as well as reaching out into the communities we serve to gain a better understanding of the whole patient experience. In addition, the team use intelligence from national patient experience surveys to support services to improve the services they provide for our patients.

Learning from patient and carer experiences

The Trust has expanded the ways in which we gather patient feedback to have more regular and up to date intelligence in relation to the services we provide. We have developed local surveys across all our services; acute and community inpatients, district nursing and outpatients. In addition, the Trust has implemented a text messaging service to gather responses to the Friends and Family Test (FFT). Both the text messaging service and local surveys have greatly increased responses from our patients and provided a more detailed picture of the experience of our patients in our care.

The Trust has re-established its Patient Experience committee, seeking to expand the membership across all staff disciplines to create a more collaborative approach to improving patient experience. In particular, this is important when tackling issues with clinical communication.

Patient Advice and Liaison Service (PALS)

Patients, families or carer's contact PALS when receiving inpatient care, outpatient care or after care or treatment. They may also contact PALS in relation to delays or lack of communication about their future care and treatment. PALS provide an impartial and confidential service aiming to help resolve issues by addressing them as quickly as possible.

PALS will liaise with services across the Trust and other agencies aiming to support the individual to navigate the complexities of the healthcare system and avoid them having to contact multiple agencies to seek the information or resolution they need.

PALS also collate compliments about our services to share with colleagues.

During the year, the team received 4420 contacts summarised in the table below.

Type	2022/23	% change last year
Concerns	912	-4.30%
Compliments	2535	35.85%
Comment & Enquiry	973	110.15%
Total all	**4420**	**34.67%**

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is one of the mechanisms for the Trust to seek feedback from patients, their friends and family and act on it. We encourage take up with staff highlighting on ward rounds, including the link to the on-line survey in discharge letters and with postcards and collection boxes available in most of our reception areas.

In September 2022, the Trust introduced Friends and Family Test with the use of text messaging. Since its introduction, 5,368 responses have been received representing a 22 per cent response rate, this is in line with the national response rate. Using alternative data collection methods prior to this only generated a 6 per cent response rate.

92.25 per cent of patients rated their experience positively and patients offer constructive qualitative feedback in addition to the recommendation score. The information is accessible to users through a dashboard with patients also able to leave their comments. This enables managers to have live data for their areas on patient feedback.

We will continue to roll this project out to all services during 2023/24.

Complaints

During the year, the Trust received 253 complaints. This is a decrease of 25 per cent from the previous year.

Quality: patient experience	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Number of new complaints received in month (trust wide)	13	30	29	21	21	18	22	19	18	19	18	25
Number of complaints not responded to within agreed timeframe (open)	7	14	20	16	19	17	13	6	17	6	12	6
Number of complaints that were open, at the close of each month and had exceeded 30 days	55	60	50	50	51	50	50	44	45	41	47	47

Increasing operational pressures and the increasing complexity of complaints received has meant the Trust has not responded to all complaints in the agreed timeframe. This is routinely monitored and the Patient Experience committee is committed to supporting operational colleagues to review processes and improve this position for patients, families and carers.

Sustainability report

The Trust's Sustainable Development Management Plan (SDMP) is the blueprint for co-ordinating our response to the challenges of sustainability and is aligned with the UN's 17 Sustainable Development Goals (SDG) (2015/30), an ambitious collection of global aims intended to encourage countries to end all forms of poverty, fight inequalities and climate change, whilst ensuring that no one is left behind. This is also set against the backdrop of the NHS Green Plan aiming to achieve net zero carbon emissions by 2040.

The Trust delivered the final elements of the first phase of the Integrated Energy Centre, reducing carbon emissions by over 500 tonnes and saving money. A successful bid for phase two was placed in the year, securing over £20m for a scheme that will completely decarbonise 95 per cent of the County Hospital site by 2025.

Other elements of the SDMP delivered within the year were:

- Trial of recycling initiatives at the County Hospital site and a reduction in single use plastics
- Updated Travel Plan with a series of recommendations to encourage more sustainable and active travel
- Enrolled with NHS Forest and created/improved some green spaces across the Trust
- Recycled mobility aids following a public campaign

Emergency Preparedness, Resilience and Response

Each year the Trust is subject to an Emergency Preparedness, Resilience and Response (EPRR) assurance process carried out by NHS England and NHS Improvement to assess performance in relation to EPRR core standards. The Trust was found to be compliant in 43 out of 64 areas of the core standards, however non-compliant overall due to gaps created by new documentation requirements and the absence of exercising and testing of plans. A plan has been developed in consultation with stakeholders and progress will be monitored by the Emergency Planning Committee, Trust Management Board and Board.

Information Governance (IG)

The NHS Information Governance Framework (NIGF) sets the processes and procedures by which the NHS handles information about patients and employees. This applies to both personal confidential data and special category data (sensitive). The NIGF is supported by the data security and protection toolkit and the annual submission process provides assurances to the Trust, partner organisations and data subjects (patients and staff) that personal information is dealt with legally, securely, efficiently and effectively.

The Information Governance Committee (IGC), of which the Data Protection Officer (DPO) is an attending member, meets on a regular basis to assess risks to security and integrity of information, and management of confidential information. The Committee monitors the completion of the data protection security toolkit submission and information risks, also ensuring the Trust has an effective framework with up to date policies, processes and management arrangements in place.

The Trust submitted a 'standards not met' toolkit on the June 30, 2022, alongside an improvement plan. This put the Trust in the position of "approaching standards". This demonstrated that the Trust has appropriate technical and organisational measures in place to keep personal, confidential data and special category data secure, but did not evidence one element relating to the percentage of IG training compliance. An updated toolkit for 2023/24 will be submitted on June 30, 2023.

The Trust carries out an annual assessment of its position against the Data Security and Protection Standards published by the Department of Health and Social Care, and submitted a "Baseline Assessment" on February 28, 2023. An external audit will be carried out in March 2023 enabling any action plan to be completed prior to final submission in June 2023.

The Trust's DPO and the IG team monitor data security incidents on a daily basis and these are reported and reviewed monthly at the IGC with the Senior Information Risk Officer (SIRO). Any themes to incidents are identified and action is taken to anticipate and address any issues.

Proactive monthly monitoring of compliance to IG training is reported at IGC and the Trusts Finance and Performance Executive. The Trust also has robust processes for incident reporting and the investigation of serious incidents.

IG work programme

Our IG work programme is based on the National Data Guardian's (NDG) data security standards, which are listed below.

- **Personal confidential data.**

  The Trust ensures that personal, confidential data is handled, stored and transmitted securely, whether in electronic or paper form. We also ensure confidential data is only shared for lawful and appropriate purposes. We achieve this by drafting clear IG policies and making sure the policies are communicated to staff.

- **Staff responsibilities**

  The Trust's employment contracts have data security clauses, to ensure staff understand their responsibilities under the NDG's data security standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches. This is included in our induction for new starters.

- **Training**

  The Trust regularly reviews and updates its IG training programme which includes data protection and security training is received by; board members, staff with specialist roles, and clinical and corporate staff. The staff training is now provided using several different mediums e.g. Face to face – Teams, Presentations and associated tests, also via Trust induction for all new staff, this incorporates the requirements of the GDPR and the Data Protection Act 2018.

- **Access**

  The Clinical Systems Group and Hoople maintain a list of all staff and their roles. This is to ensure that staff only access the Trust's clinical systems if they have a legitimate need. Confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. Access is logged and regular audits are conducted to ensure that access to personal confidential data on IT systems is justified.

- **Process reviews**

  Incidents are logged and recorded on the Trust's incident management system. Incident reviews are used to identify and improve processes that have been linked to breaches or near misses. Following a data security incident, a root cause analysis is conducted. Processes that have allowed breaches or near misses to occur are identified and reviewed, with the aim of improving security and removing the need for workarounds. Learning from incidents is included in training to ensure wider staff learning.

- **Responding to incidents**

  Preventing cyber-attacks on critical infrastructure is a priority for the Hoople IT shared service, working alongside the Trust's IG team. Issues and concerns are raised through monthly information security review meetings.

Continuity planning

The Trust has recently invested in a multi-year programme to update the security and resilience of its IT hosting arrangements. This included their continuity and recovery plans in the event of a significant failure or cyber-security incident. A regular testing programme is in place with annual assurance provided to the Trust's Audit Committee. The Trust also participates in cyber and business continuity exercises conducted by the West Mercia Local Resilience Forum.

Unsupported systems

The Trust has a robust system to prevent unsupported operating systems, software or internet browsers being used within the IT estate. All software and hardware is monitored and any that are approaching the end of manufacturer support are upgraded, removed or uninstalled. A very small number of exceptions are managed securely.

IT protection

The Trust's systems are protected from cyber threats using a layered security model based on a proven cyber security framework. The Trust was re-accredited by external auditors as Cyber Essential Plus compliant on June 22, 2022. Annual IT penetration tests are conducted, which are scoped with Hoople, Trust senior management and the IG team. These tests include vulnerability scans and checks of password strength.

Accountable suppliers

The Trust has a robust system in place via its Procurement Shared Service to ensure that all supplier contracts contain appropriate confidentiality and Data Protection clauses. Contracts make it clear who is responsible and accountable for the security of confidential data. Data Protection Impact Assessments are conducted for all new or substantially changed systems. These include checks for recognised cyber-security certification and/or NHS data security and protection toolkit compliance.

Incidents and reporting

IG incidents are graded using the NHS Digital Breach Assessment grid, which is in line with the requirements of the GDPR and the Data Protection Act 2018. We ensure that data breaches are reported within 72 hours of being discovered. Incidents are graded according to their impact on the individual or groups of individuals affected, with 1 being the least serious and 25 the most serious. Incidents graded 6 or above are reportable to the ICO via the data security and protection toolkit incident reporting tool.

During the financial year 2022/23, there was one data breach reported via the DPST - there were no others that met the threshold. This incident met the threshold for reporting to the Information Commissioner's Office, but on their consideration no further action was required. However all IG incidents raised on the incident reporting system are subject to an investigation to ensure actions are taken to address any breaches and to put measures in place to ensure that similar issues do not reoccur.

Glen Burley
Chief Executive
Date:

Corporate governance report

Directors' report

Board of directors

Our Board of Directors has overall responsibility for setting the corporate and clinical strategy of the Trust, as well as overseeing performance, including finance.

The Board meets in public 12 times per year to discuss performance across the Trust, current and future challenges, and corporate and clinical strategy; four of these meetings are joint meetings with foundation group partners. When discussing issues of a confidential nature, the Board resolves to meet in private in accordance with the Public Bodies (Admissions to Meetings) Act 1960 s1 (2).

With effect from August 2022, quarterly Foundation Group Boards meetings were introduced which enabled the Boards of the South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust and Wye Valley NHS Trust to meet at the same time to share best practice and learnings from across the Foundation Group. The inaugural Foundation Group Boards meeting was held in August 2022 which was a private meeting and then the meeting in November 2022 included a public session. The meetings are held in May, August, November and February and Governors and members of the public are invited to join the virtual public sessions which are also recorded and published on each trusts website.

Details of public Board meetings and public Board papers are available on the Trust website: https://www.wyevalley.nhs.uk/about-us/the-trust-board.aspx

The Trust's standing orders and standing financial instructions were reviewed in October 2022 by the Trust Board.

Changes on the Trust Board

There were the following changes to the Trust Board during 2022/23:

- Rev Christobel Hargraves and Richard Humphries ended their terms of office as Non-executive Directors on September 30, 2022
- Frank Myers ended his term of office as a Non-executive Director and became an Associate Non-executive Director on September 30, 2022
- Grace Quantock, Frances Martin and Ian James, previously Associate Non-executive Directors, started their terms of office as Non-executive Directors on October 1, 2022

Board members

The composition of the Board is balanced with five voting Non Executives and five voting Executive Directors. The full list of members of the Trust Board who served throughout 2022/23, is as follows:

Chairman

Russell Hardy

Non-executive directors

Ian James (from October 1, 2022 – formerly Associate Non-executive Director)
Frances Martin (from October 1, 2022 – formerly Associate Non-executive Director)
Andrew Cottom
Nicola Twigg
Grace Quantock (from October 1, 2022 – formerly Associate Non-executive Director)
Richard Humphries (until September 30, 2022)
Rev Christobel Hargraves (until September 30, 2022)

Associate non-executive directors

Frank Myers (from September 30, 2022 – formerly Non-executive Director)

Executive directors

Glen Burley Chief Executive Officer
Jane Ives Managing Director
David Mowbray Chief Medical Officer
Lucy Flanagan Chief Nursing Officer
Geoffrey Etule Chief People Officer
Katie Osmond Chief Finance Officer
Alan Dawson Chief Strategy Officer
Jon Barnes Chief Transformation and Delivery Officer

Corporate governance framework

Sub-committees of the Trust Board

The Trust Board has the following sub- committees:

- Quality committee
- Audit committee
- Remuneration committee
- Executive risk management committee
- Trust management board
- Charity committee

Sub-committee membership

The table below details Board members' positions at 31 March 2023 on the Subcommittees of the Trust Board. Profiles of Trust Board members are available at https://www.wyevalley.nhs.uk/about-us/the-trust-board/board-members.aspx

Non-executive board members	Committee membership (* Chair)
Russell Hardy, Chair	Remuneration Committee* Charity Trustee
Ian James, Non-executive Director (Associate Non-Executive Director until October 1, 2022)	Quality Committee* (from September 30, 2022) Remuneration Committee Charity Trustee Audit Committee**
Frances Martin, Non-executive Director (Associate Non-Executive Director until October 1, 2022)	Remuneration Committee Charity Trustee Quality Committee
Nicola Twigg, Non-executive Director	Audit Committee* Remuneration Committee Charity Trustee Quality Committee
Grace Quantock, Non-executive Director (Associate Non-Executive Director until October 1, 2022)	Remuneration Committee Charity Trustee Quality Committee
Andrew Cottom, Non-executive Director	Audit Committee Remuneration Committee Charity Trustee
Frank Myers, Associate Non-executive Director (Non-executive Director until September 30, 2022)	Charity Trustee* Remuneration Committee Audit Committee
Rev Christobel Hargraves, Non-executive Director (until September 30, 2022)	Remuneration Committee Charity Trustee Quality Committee*
Richard Humphries, Non-executive Director (until September 30, 2022)	Remuneration Committee Charity Trustee Quality Committee

Executive directors	Committee membership (* Chair)
Glen Burley	Remuneration Committee** Charity Trustee Audit Committee ** for sign off of accounts
Jane Ives	Trust Management Board* Remuneration Committee** Charity Trustee

David Mowbray	Trust Management Board Charity Trustee Quality Committee
Lucy Flanagan	Trust Management Board Charity Trustee Quality Committee
Geoffrey Etule	Trust Management Board Charity Trustee Remuneration Committee**
Katie Osmond	Trust Management Board Charity Trustee Audit Committee
Alan Dawson	Trust Management Board Charity Trustee
Jon Barnes	Trust Management Board Charity Trustee

*Chair
** Attendance as required/by exception but are not committee members.

Register of interests

A register of relevant and material Board member interests is maintained and published on the Trust's website. Board and committee meeting agendas routinely include an opportunity for members to declare any interests in agenda items. Any such interests are recorded in the minutes of the meeting, as well as in a separate register maintained by the Trust Secretary. There have been no occasions during the year where a member has needed to withdraw from the discussion or decisions taken at any Board or committee meeting.

You can find the register of interests of executive and non-executive directors at:
https://www.wyevalley.nhs.uk/about-us/the-trust-board.aspx

Summary of Board activities 2022/23

The Board receives regular reports from all executive directors at each Board meeting on subjects across the Integrated Performance domains including monthly operational performance, finance, workforce and quality reports.

In 2022/23 the Board also received a number of reports and updates including:

- Financial Budget Plan
- Digital Programme
- Kirkup Self-Assessment
- NHSI Inspection
- Staff Survey
- Restoration of Services

- One Herefordshire Plan
- Elective Recovery Update
- Draft Accounts
- Quality Account
- Patient Experience Report
- Ockenden Update
- Workforce and Organisational Development Strategy
- Clinical Systems - Business As Usual
- Staffing Report
- Policy Panel Update
- Standing Orders and Standing Financial Instructions
- Health, Safety and Wellbeing Report
- Winter Plan
- Safeguarding Annual Report
- Virtual Wards Business Case
- Integrated Energy Scheme Grant
- CQC Report
- Clinical Negligence Scheme for Trusts (CNST) Self-Assessment
- Trust Strategy
- Trust Objectives
- International Nurse Business Case
- Elective Surgical Hub Business Case
- Use of Trust Seal

Board workshops/development sessions are held before each Board meeting. Topics considered in 2022/23 included:

- A regular front line team experience or patient story.
- Model Hospital and Productivity (PACE)
- PFI contract management and end of contract planning
- Out of Hospital Urgent Care Redesign
- Healthcare Support Worker Recruitment and Retention
- Sickness Absence
- Board Evaluation
- Better Care Fund
- Mental Health Act Board Training
- Productivity Transformation Programmes
- Local Authority Children's Services
- Herefordshire Big Economic Plan
- Risk Appetite
- MAXIMS – Inpatient and Outpatient Noting Overview

Committee programmes during 2022/23

All sub-Committees have an agreed programme of work for the year, which is cross-referenced to the BAF. Issues highlighted by sub-Committees of the Board during the year include the following:

Quality committee

In addition to its core responsibilities, the Quality committee focused on the following areas as part of its programme of work during 2022/23:

- Integrated Performance Report - Quality and Safety
- Research and Development Report
- Medicines Safety Report
- Colposcopy Report
- Mortality Report
- Safeguarding Reports
- Divisional Reports
- Staffing Report
- Infection Prevention Control Report
- Pressure Ulcer Report
- Ockenden Self-Assessment
- Perinatal Quality Surveillance Model
- Venous thromboembolism (VTE)
- Quality Account
- Quality Indicators
- Clinical Effectiveness and Audit Summary Report
- Patient Safety Committee Summary Report
- MCA/DOLS Report
- Nutrition Quality Report
- CQC Inpatient Survey
- Policy Panel Update
- Cleanliness Report
- Clinical Negligence Scheme for Trusts Update
- National Cleaning Standards
- National Cancer Patient Experience Survey
- CQC Inspection 2022
- Deep Dive Perinatal Mortality
- NHS Audit Inpatient Survey 2021
- Serious Incident Deep Dives
- Thrombosis Committee Summary Report
- Insight Visit October 2022
- Quality Priorities
- CQC Maternity Survey 2022
- The Commissioning for Quality and Innovation (CQUIN) framework programme 2023/24

Audit committee

In addition to its core responsibilities, the Audit committee focused on the following areas as part of its programme of work during 2022/23:

- Review of Annual Report and Accounts
- Annual governance statement
- Internal audit plan 2022/23 and progress reports:
    - Effective recruitment
    - Financial sustainability
    - Consultant job plans
    - Cost improvement programme
    - Risk and board assurance framework
    - Strategic workforce planning
    - Cleanliness review
    - Discharge management
    - Audit of audits
    - Data security protection toolkit
- Counter fraud
- Tender waivers
- Losses and compensation
- Value for money
- Standing orders and standing financial instructions

Remuneration committee

The Remuneration Committee met on four occasions in 2022/23 to discuss executive remuneration, Executive Directors' performance, pay award for very senior managers and Executive Director appointments.

Trust management board (TMB)

In addition to its core responsibilities, the TMB focused on the following areas as part of its programme of work during 2022/23:

- Freedom to Speak up Guardian quarterly Update
- Guardian of Safe Working – quarterly Update
- Education Quarterly Update
- Finance and CPIP Monthly Updates
- Digital Programme Monthly Updates
- Improvement Board Monthly Update
- Job Planning and E-Rostering Quarterly Update
- All Business Case for Clinical innovation and Operational Development approved via Trust

- Management Board e.g. Surgical Robot
- Capital Programme projects updated as required

Charitable funds committee

In addition to its core responsibilities, the charitable funds committee considered a number of bids, including for the Education Centre

Board performance and development

Board workshops during 2023/24 will support the Trust's organisational strategy and the well-led CQC framework domains around:

- Patient Safety Strategy
- Cybersecurity update
- Workforce update
- Armed Forces Covenant
- Research Updated and Academic Programme Proposals
- Digital Strategy including Paperless and Benefits Realisation

The Board is compliant with the Code of Conduct and Code of Accountability for NHS Boards.

Glen Burley
Chief Executive
Date:

Annual governance statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Wye Valley NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Wye Valley NHS Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust system for managing risk is premised on managers knowing what the predictable risks are, ranking them in order of importance and taking action to control them. The range of risk types includes but is not limited to health and safety, fraud, fire safety, information governance, infection control, security and workforce. Issues in one area could impact on another.

The outcome of risk profiling will be that the right risks have been identified and prioritised for action, and minor risks won't have been given too much importance to inform decisions about what risk controls measures are needed.

Risk management process

The Trust's risk management process ensures that risks are identified, assessed, controlled, monitored and when necessary, escalated.

The Trust has adopted the NHS standardised approach for calculating the level of risk by multiplying the Likelihood (probability or frequency) and Impact (severity) using a 5 x 5 risk matrix. The remedial action required and timeline for completion are recorded in the table below.

Risk rating score	Risk grade	Remedial action and timeline for completion
15 – 25	Extreme risk (red)	Immediate action must be taken to control the risk. Significant resources may be needed. Temporary suspension may be necessary until interim measures are in place. May require escalation for oversight at a higher managerial level.
8 – 12	High risk (amber)	Best efforts must be taken or planned to reduce risks to acceptable levels. May require resources but cost should not outweigh benefits.
4 – 6	Moderate risk (yellow)	Existing controls should be confirmed. Further action to reduce the risk further may be taken but should not impose additional cost or burden to resources.
1 – 3	Low risk (green)	No further action or additional control required. Risk can be accepted.

Not all risks can be dealt with in the same way. For example, in the case of a health and safety risk, our aim is to reduce the risk to be 'as low as reasonably practicable' (ALARP) by weighing the risk against the sacrifice needed to further reduce it. The process is not about balancing the costs and benefits of measures, but implementing control measures, except where they would involve grossly disproportionate sacrifice, whether in the financial cost, time or trouble.

In most situations, deciding whether the risks are ALARP will involve a comparison between the control measures already in place or proposed and the measures you would normally expect to see in such circumstances where there is already both relevant and recognised good practice. However, ALARP doesn't represent 'zero risk'. Health and safety risk arising from an activity can never be eliminated entirely unless the activity is stopped; sometimes harm will occur even when the risk is reduced ALARP.

There are clear responsibilities for risk identified across the Trust. Day to day management of risk is undertaken by operational management who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors, relevant committees and governance groups for risks where there are difficulties in implementing mitigations. The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly all managers. This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way.

Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: these are cornerstones of building safer, effective, and efficient care for the future.

Leadership of risk management and escalation

Trust Board

The Trust Board is responsible and accountable for owning the risk and control framework, and for ensuring that any risks that could affect the achievement of the Trust's strategic objectives are adequately controlled through the Board Assurance Framework (BAF). The Board also reviews the effectiveness of internal controls and monitors the work of the Committees with delegated responsibility for risk management.

Board members are responsible for:

- Approving the Risk Management and BAF strategy
- Ensuring risk information is available to them to support the decision making process
- Participating in the identification and evaluation of risks appropriate to the decisions they are making

Audit Committee

The Audit Committee, through assurance processes including Internal and External Audit, provides an independent objective opinion to the Board on whether the risk management arrangements in place are effective.

Quality Committee

The Quality Committee provides the Board with an independent and objective review of all aspects of quality and safety relating to the provision of care and services.

Executive Risk Committee

The Executive Risk Committee is chaired by the Trust's Managing director and attended by the executive team in addition to Divisional Directors. The Executive Risk Committee has met on a monthly basis and, on exception during hi-intensity peaks bi-monthly, to review the following risks:

- Medical, Surgical, Integrated Care, Clinical Support and Corporate Divisions' risks rated 15 (extreme) and above
- New risks opened during the previous month rated 15 (extreme) and above
- The BAF before presentation to the Board of Directors on a quarterly basis
- A deep dive by rotation of all divisional risks rated 12 (high) and above

Corporate Division Risk Committee

The Corporate Division Risk Committee is chaired by the Associate Director of Corporate Governance and reviews the following:

- Corporate risks rated 12 (high) and above from each of the Corporate Departments
- A deep dive by rotation of all of each functions' risks
- New risks

It has met on a monthly basis and, on exception during high-intensity peaks bi-monthly, and is attended by representatives from the following corporate functions:

- Health and safety
- Information and IT

- Information governance
- Human resources
- Finance
- Emergency planning
- Estates
- Education

Health, Safety and Wellbeing Committee

The Health, Safety and Wellbeing Committee is chaired by the Associate Director of corporate governance. The committee ensures the Trust discharges its health, safety and wellbeing duties, by setting strategy, monitoring health, safety and wellbeing performance, reviewing audit findings, and agreeing plans. The committee reports to the Executive Risk Committee.

Data Security

Risks to data security are managed through the Trust's Information Governance Committee which is chaired by the Chief Finance Officer. The risk register for Information Governance is reviewed by this committee each month and any risks to data security are added to the Corporate Division risk register.

Training

Staff receive appropriate training and support to equip themselves to manage risk in a way appropriate to their authority and duties, primarily through:

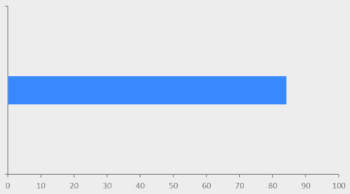
- Awareness of risk assessments which have to be carried out in their place of work and to compliance with control measures introduced by these risk assessments;
- Compliance with all legislation relevant to their role, including information governance requirements set locally by the Trust;
- Following all Trust policies and procedures;
- Reporting all adverse incidents and near misses via the Trust incident reporting system (Datix);
- Awareness of the Trust's Risk Management Strategy and their own patient safety and risk management processes; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Board recognises that to deliver their strategic objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

Risk appetite and tolerance

Risk appetite is defined as the 'amount of risk to which the Trust is prepared to accept, tolerate, or be exposed to at any point in time', that is, limiting exposure to an acceptable level for the expected gains by identifying the amount of risk that can be tolerated. The Trust's risk appetite was last considered at a Board Workshop in December 2022. The scale broadly identifies a preference and direction of travel rather than an absolute position.

People and workforce

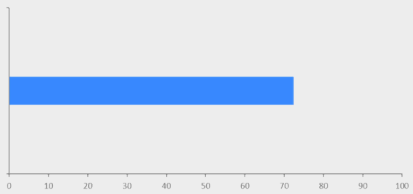


Strong preference towards a cautious model of workforce development

AVERAGE NUMBER 84

Strong preference towards innovate approaches with a willingness to take risks

"Left shift" V "right default" in the allocation of funding in the short and medium term

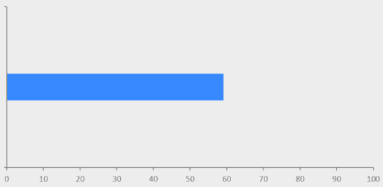


Strong preference towards funding costs where they are actually incurred

AVERAGE NUMBER 72

Strong preference towards investing in left shift options

Tackling health inequalities using a different funding mechanism

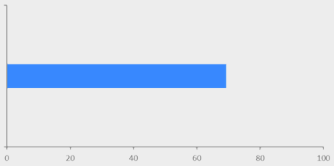


Strong preference towards retaining a "per head" financial allocation model

AVERAGE NUMBER 59

Strong preference towards developing more of a "population needs" financial model

Balancing innovation/quality outcomes and change with deliverability given current challenges

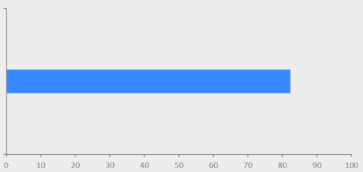


Strong preference towards being cautious in how we shape our transformation programmes

AVERAGE NUMBER 69

Strong preference towards implementing more stretching transformation programmes

Value for money and the "back office"

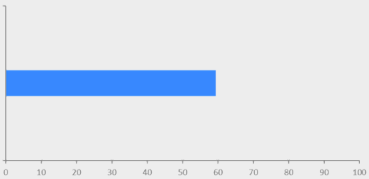


Strong preference towards avoiding disruption to enable staff to focus on existing priorities

AVERAGE NUMBER 82

Strong preference towards exploring all options for back office integration.

PHM, prevention and early intervention

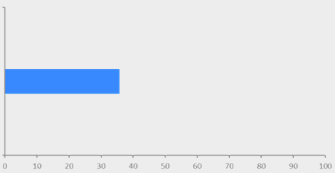


Strong preference against ringfencing funding for prevention and using growth to cover other costs

AVERAGE NUMBER 59

Strong preference towards ringfencing specific funding to support prevention initiatives

Achieving the right pace for financial recovery

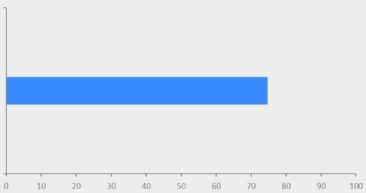


Strong preference towards having a cautious financial recovery plan that will result in a longer glide path

AVERAGE NUMBER 36

Strong preference towards an ambitious financial recovery plan that will require more short term service changes

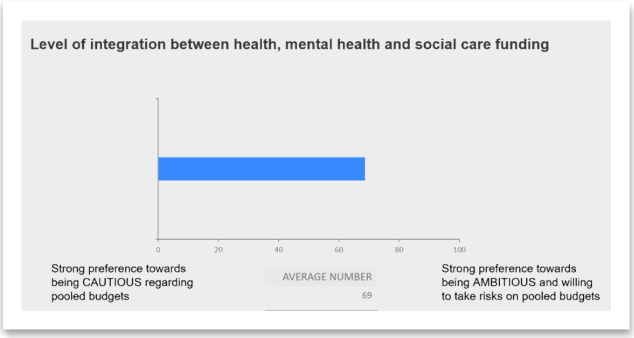
Local reputation management and managing external perceptions



Strong preference towards protecting our reputation and minimizing negative external perceptions

AVERAGE NUMBER 75

Strong preference towards taking the right decision even if there is a reputational consequence



BAF risks

Title	Description	Supplementary Information
BAF 2022/23 Ability of PLACE Partners to Record Incidents	PLACE partners do not have sufficiently mature or embedded processes to identify system risks, concerns and issues and thereby there will be missed opportunities to both identify and learn.	Strategic Objective: Quality Improvement: Improve patient safety through implementing change as we learn from incidents and complaints across our system
BAF 2022/23 Ability of system to manage flow across the urgent and emergency care pathway	Due to increasing urgent and emergency care demand, there is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.	Strategic objective: Quality Improvement: Develop a new integrated model for urgent care in Herefordshire improving access times and reducing demand for hospital care
BAF 2022/23 Accessible Information Standard	There is a risk of both patient harm and/or legal action due to non-compliance with the accessible information standard (AIS) which could result in patients with sensory impairment (not limited to blind, deaf, LD, Ddeaf, autism effecting communication etc) being unable to access information relating to their care and allowing them to access services.	Strategic Objective: Quality Improvement: Improve the experience of patients receiving care by improving our clinical communication
BAF 2022/23 Availability of Capital Funds to meet Trust's Strategic Objectives	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivering of key estates and investment being made on Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to an ability to procure essential equipment resulting in adverse impacts on healthcare delivery.	

BAF 2022/23 Clinical and support staff recruitment and retention	There is a risk to achieving the Trust's strategic objectives due to staff shortages and being unable to recruit to clinical and support staff vacancies, resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	Strategic Objective: Workforce and Leadership: Improve recruitment, retention and employment opportunities by taking an integrated approach to support worker development across health and care
BAF 2022/23 Delivery of the Digital Strategy	There is a risk of a delay to the delivery and in turn the future capital funding of the Digital Strategy due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.	Strategic Objective: Sustainability: Stop adding paper to medical records in all care settings
BAF 2022/23 Maturity of Integrated Care Executive	Due to the immaturity of the Integrated Care Executive (ICE) there is a risk that the necessary oversight required of ICE, in order to allow contracts to be devolved to the One Herefordshire Partnership, does not provide sufficient system assurance.	Strategic Objective: Integration: Improve quality and value for money of services by making a step change increase in the range of contracts that are devolved to the One Herefordshire Partnership
BAF 2022/23 Maturity of Primary Care Networks	There is a risk that Primary Care Networks are unable to achieve their objectives in support of the One Herefordshire Partnership in reducing inequalities and improving sufficiently the health and wellbeing of Herefordshire's residents given their immaturity.	Strategic Objective: Integration: Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level
BAF 2022/23 Recruitment to Health and Social Care Teams to Support Patients at Home	Recruitment to ICS health and social care teams (including Homefirst and Community Interface) is insufficient to support more people at home	Strategic Objective: Integration: Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meets demand on the day
BAF 2022/23 Risks to operational capacity plans and delivery	There is a risk that factors (not limited to COVID 19 outbreaks, staff shortages (and ability to recruit and retain staff including agency), ability to secure and maintain outsourcing and insourcing options, and ability to manage the urgent care pathway to mitigate impact on elective care) will severely impact on the delivery of revised operational capacity plans that deliver safe elective, emergency and critical care. All, individually or collectively, could significantly decrease the level of available capacity.	Strategic Objective: Quality Improvement: Reduce waiting times for diagnostics, elective and cancer care

BAF 2022/23 The COVID-19 pandemic has resulted in increased waiting times for planned care patients	The COVID-19 pandemic has resulted in large numbers of planned care patients waiting much longer for assessment and treatment. There is a risk that the delay in assessment and/or treatment will lead to patients coming to harm during this time that would have been avoided had treatment been more timely	Strategic Objective(s): Quality Improvement: Reduce waiting times for diagnostics, elective and cancer care.
BAF RISK 2022/23 Capital investment and approvals to support Sustainability Strategy	There is a risk that as an anchor institution the capital investment and approval required to achieve the NHS Greener Plan is not the available creating an inability to meet and non-compliance with national targets.	Strategic objective: Sustainability: Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain

Board of Directors

The Trust Board of Directors has overall responsibility for setting the corporate and clinical strategy of the Trust, as well as overseeing performance.

The Board has met in public 12 times, including as part of the Foundation Group Boards meetings in August and November 2022 and February 2023, to discuss performance across the Trust, current and future challenges, and corporate and clinical strategy. When discussing issues of a confidential nature, the Trust Board resolves to meet in private in accordance with the Public Bodies (Admissions to Meetings) Act 1960 s1 (2).

Sub-committees of the Trust Board

The Trust Board has the following sub- committees:

- Quality committee
- Audit committee
- Remuneration committee
- Trust management Board
- Charitable funds committee

The role of the Board's sub-committees

Quality Committee

The Quality Committee focuses on ensuring structures and processes are in place for governing the quality of clinical services and ensuring services are safe. The Committee's primary role is to provide assurance on clinical quality and safety, including clinical effectiveness, patient safety and patient experience.

Audit Committee

The Audit Committee is a standing Committee of the Board. The role of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk

management and internal control, across the whole of the Trust's activities, both clinical and non-clinical, to support the achievement of our objectives.

Remuneration Committee

The Remuneration Committee is a standing sub-Committee of the Board and is responsible for monitoring and evaluating the performance of Executive Directors and overseeing their contractual arrangements, as well as ensuring that they remain compliant with 'Fit and Proper Person' requirements. The duties of the Committee also include ensuring that staff are recruited in a fair, open and transparent way.

Trust management board

The Trust management board oversees the effective operational management of the Trust, including the achievement of statutory duties, standards, targets, and other obligations, and the delivery of safe, effective, high quality patient care. It informs and advises the Board in setting and delivering our strategic direction and priorities. It also promotes effective two-way communication between levels of senior management in the Trust and is the formal route to support me effectively discharging my duties and responsibilities as our Accountable Officer. The Trust Management Board is not attended by Non-executive Directors.

Charitable Funds Committee

The Charitable Funds Committee has been established by the Board to make and monitor arrangements for the control and management of the Trust's charitable Funds. Key duties of the Committee are to apply the charitable Funds in accordance with the charity's governing documents; to make decisions involving the sound investment of charitable Funds in a way that both preserves their capital value and produces a return consistent with prudent investment; and to ensure the charity's compliance with legal and regulatory requirements.

Board and sub-committee attendance

Attendance of Board and sub-committee meetings by executive and non-executive Board members during 2022/23 is shown below:

Name of Board or sub-committee	Number of meetings held	Attendance 2022/23
Quality committee	12	82.4%
Audit committee	4	80.4%
Remuneration committee	4	92.5%
Charitable funds committee	4	76.5%

To note that following the introduction of quarterly Foundation Group Boards meetings from August 2022, the Board of Wye Valley NHS Trust meets as part of the Foundation Group Boards meetings in May, August, November and February of each year and does not hold separate Trust Board meetings during those months.

Clinical governance and risk

We have structures, systems and processes in place to provide clinical governance assurance and deliver our key quality priorities. Assurance is provided to the Trust Board on quality governance through the Trust's Quality Committee. The Quality Committee is chaired by a Non-Executive Director. The Quality Committee has the following committees and groups reporting into it all of which have responsibility for an element of quality governance:

- Patient Safety Committee
- Overarching Safeguarding
- Infection Prevention and Control Committee
- Patient Experience Committee
- Clinical Effectiveness and Audit Committee
- Serious Investigation Panel

The Chief nursing officer is the executive lead for quality governance and is supported in this role by an associate director of nursing and a quality and safety team.

Clinical governance arrangements are reviewed regularly, with robust arrangements in place for performance reviews relating to clinical governance. For example, key quality and clinical performance targets are included when divisions give 'deep dive' presentations at monthly finance and performance executive meetings.

Clinical governance meetings also take place at divisional level.

Integrated performance report

There are regular discussions about the latest integrated performance report (IPR) at the Trust Board.

The IPR and patient safety dashboard include:

- Operational Performance
- Quality & Safety
- Well Led
- Financial Performance

Risk register

Clinical risks identified as having significant effect on the delivery of safe care across Trust services are included in the Board risk register. Executive ownership of this rests with the Managing Director and internal current assurance and actions to remove any gaps in assurance are described.

Workforce planning

The Trust's workforce planning activity is an essential part of the business planning process.

On an operational level there is strong alignment to business and budget planning. An excellent illustration of the integrated planning is the business case to introduce virtual wards which support patients who would otherwise be in hospital to receive the acute care, monitoring and support they need in the place they call home.

Core to the organisational strategy of the Trust is working with partners to provide integrated care to deliver better health outcomes for our population and best value. Wye Valley NHS Trust continue to ensure our services are as joined up as possible within the Herefordshire and Worcestershire Integrated Care System.

Our robust approach to workforce planning ensures the Trust complies with NHS England developing workforce safeguards recommendations. The electronic staff record (ESR) and financial systems are used to give a baseline for workforce planning. This is then adjusted in accordance with evidence-based forecasting of activity levels, service changes, service developments and contract commissioning.

With regard to giving assurance about safe staffing, the acuity process is performed manually by collecting data from individual services. This ensures safe staffing adheres to set levels and is signed off by the Chief Nursing Officer or Chief Medical Officer.

Our governance structure has been designed to ensure that key work streams feed into the Education and Workforce Committee, which in turn provides assurance to the Trust Management Board.

Register of interests

A register of relevant and material Board member interests is maintained and published on the Trust's website. Board and Committee meeting agendas routinely include an opportunity for members to declare any interests in agenda items. Any such interests are recorded in the minutes of the meeting. There have been no occasions during the year where a member has had to withdraw from the discussion or decision taken at any Board or Committee meeting.

An up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, is published on our website, as required by the Managing Conflicts of Interest in the NHS guidance.

CQC registration requirements

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, diversity and human rights legislation

Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with.

Climate change

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme.
The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

We recognise the importance of accurate data: it's a fundamental requirement for the effective, safe treatment of our service users and the efficient operation of our business. Frequent reporting at relevant meetings and to Committees outlines performance in relation to explicit quality expectations and provides assurance of adherence to internal and external data quality metrics. The use of: benchmark data; nationally sourced and verified data quality metrics within internal assurance processes; and quality reporting systems strengthens local assurance of nationally acceptable levels of data quality.

We've got dedicated data quality leads and informatics staff to regularly investigate and quality assure performance and waiting time data. Their work is supported by operational business intelligence reporting tools that all staff can access, with the ability to drill down to team and client level where appropriate. Performance management meetings are held for each service line including deep dive reviews by the executive team. Regular internal and external audits provide additional assurance of the quality and accuracy of data to the Board.

Annual quality account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The quality committee has received an update on the Trust's Annual Quality Account for 2022/23 and received assurance that this presented a balanced view and that there were appropriate controls in place to ensure the accuracy of data.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have relied on assurance provided by the following sources:

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit.

- The internal auditors have undertaken several reviews and have provided a substantial or reasonable assurance opinion with no significant internal control issues. These reviews have covered the following:

  - Discharge Planning
  - Key Financial Controls
  - [insert]

- The Trust's internal auditors have also issued the following partial assurance reports in the following areas:
  - Consultant Job Plans
  - Cost and Productivity Improvement Programme
  - [insert]

- No reports have been issued in 2022/23 with 'minimal assurance' opinion.

- Executive directors in the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The BAF itself provides me with evidence that the effectiveness of controls to manage risks to the organisation achieving its principal objectives have been reviewed.

- Registration with the CQC – the Trust currently has {?} regulatory notices.

- The Trust has had regular performance oversight meetings with NHS England and this provides me with independent external assurance regarding the Trust's performance and the effectiveness of the Trust's system of internal control.

I have been advised on the effectiveness of the system of internal control by the following Committees within the Trust:

- Audit committee
- Quality committee
- Finance and performance executive
- Trust management board

Conclusion

There have been no significant internal control issues identified in the Trust during 2022/23. The Board will continue to review progress and ensure that a process of continuous improvement is in place in the Trust in 2023/24, including:

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 per cent 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

Any issues will be reflected within the risk register and their management monitored through the BAF. The Trust will also continue to ensure the timely implementation of any internal and external audit recommendations.

The system of internal control has been in place at the Trust for the year ended 31 March 2023 and up to the date of approval of the Annual Report and Accounts.

I believe that this Annual Governance Statement contains full and sufficient information for its purpose and includes all of the key elements that are required of this document.

Glen Burley
Chief Executive
Date:

Remuneration and staff report

All executive directors at the Trust were confirmed as being paid in line with the 'established' pay ranges listed for small acute NHS trusts and foundation trusts. The salaries of all executive directors were increased in line with the recommendations of the NHSI in their guidance on the annual cost of living increases, backdated to April, 1 2022.

Methods used to assess the performance of Executive directors

Executive directors all have objectives set for the financial year by the Managing director. A review of performance of achievement of objectives is undertaken mid-way through the year and at the end of the year.

Remuneration of chairman and non-executive directors

The Secretary of State for Health sets and reviews the level of remuneration payable to the Chairman and Non-Executive Directors (excluding NHS Foundation Trusts who set their own rates). Current rates are £13,000 for Non-Executive Directors and £18,000 for the Chairman of the Trust. The Chairman also carries out the role of Chairman of South Warwickshire University NHS Foundation Trust and George Eliot Hospital NHS Trust for which he is separately remunerated. The Chairman and the Non-Executive Directors do not receive a pension provision.

Between 1 April 2022 and 31 March 2023, there were four meetings of the Remuneration Committee.

Directors salaries and allowances table

Name	Title	Duration	Salary (bands of £5,000)	All taxable benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	All taxable benefits (nearest £100)	Annual performance related bonus (bands of £5,000)	Long term performance related bonus (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
			£000	*£*	*£000*	*£000*	*£000*	*£000*	*£000*	*£*	*£000*	*£000*	*£000*	*£000*
H Oddy	Director of Finance	To May-21							15-20					15-20
K Osmond	Chief Finance Officer		120-125				117.5-120	240-245	95-100				5-7.5	105-110
L Flanagan	Chief Nursing Officer		105-110				30-32.5	140-145	105-110				25-27.5	130-135
J Barnes	Chief Transformation and Delivery Officer		115-120				0	115-120	115-120				22-25.0	140-145
A Parker	Chief Operating Officer		100-105				152.5-155	255-260	5-10					5-10
G Burley	Chief Executive (Note 1)		45-50	1,600				45-50	45-50	1,600				45-50
J Ives	Managing Director		125-130	4,800				130-135	135-140	5,200			10-12.5	150-155
D Mowbray	Chief Medical Officer		185-190				42.5-45	225-230	180-185				40-42.5	220-225
G Etule	Chief People Officer		100-105				25-27.5	130-135	100-105	1,400			22.5-25	125-130
A Dawson	Chief Strategy and Planning Officer		100-105				50-52.5	155-160						
R Hardy	Chairman		20-25					20-25	15-20					15-20
A Cottom	Non Executive Director		10-15					10-15	10-15					10-15
R Humphries	Non Executive Director	To Sep-22	5-10					5-10	10-15					10-15
C Hargraves	Non Executive Director	To Sep-22	5-10					5-10	10-15	1,100				10-15
N Twigg	Non Executive Director		10-15					10-15	0-5					0-5
F Martin	Non Executive Director	TBC	10-15					10-15						
G Quantock	Non Executive Director	TBC	10-15					10-15						
I James	Non Executive Director	TBC	10-15					10-15						

Note 1. Glen Burley is seconded from South Warwickshire University NHS Foundation Trust on a shared appointment with SWFT and George Eliot NHS Trust for a proportion of his time and the remuneration identified reflects this. G Burley's secondment covers both 2022/23 and 2021/22 and his full salary was within the range £235k to £240k (2021/22 £235-240k).

D Mowbray's remuneration includes £131k payable for his role as a Consultant Surgeon for the Trust.

Pensions Benefits 2022/23

Name	Title	Real increase in pension at 60 (£2,500 bands) £000	Real increase in lump sum at 60 (£2,500 bands) £000	Accrued pension at 60 as at 31-03-23. (£5,000 bands) £000	Accrued lump sum as at 31-03-23. (£5,000 bands) £000	Cash equivalent transfer value as at 01-04-23 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value as at 31-03-22 £000	Employer's contribution to stakeholder pension £000	Notes
K Osmond	Chief Finance Officer	5-7.5	10-12.5	35-40	60-65	518	83	405		
J Barnes	Chief Transformation and Delivery Officer	0-2.5	(2.5)-(5)	55-60	120-125	1,222	12	1,157		
A Parker	Chief Operating Officer	7.5-10	15-17.5	35-40	75-80	659	130	499		
L Flanagan	Chief Nursing Officer	0-2.5	0-2.5	40-45	75-80	790	34	719		
D Mowbray	Medical Director	2.5-5	0-2.5	50-55	100-105	1,097	52	997		
G Etule	Chief People Officer	0-2.5	0-2.5	20-25	40-45	355	17	314		
A Dawson	Chief Strategy and Planning Officer	2.5-5	2.5-5	40-45	75-80	726	50	642		

Note G Burley and J Ives did not pay in to the NHS Pension Scheme in 2022/23.

Pay Ratio Commentary

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation to the median 25th and 75th percentile remuneration values. These are disclosed in the table below for 2022/23 and the prior year. The table also discloses the remuneration for the highest paid director and remuneration of the median, 75th and 25th percentile employees. The increase in each value compared to the prior year is also disclosed. The values includes the impact of the paid element of the 2022/23 pay award. The table shows a significant increase in all measures except the highest paid Director. This reflects two elements, a pay award that benefitted lower banded staff in relative terms plus the impact of accounting for bank and agency staff within the measure.

	Pay Ratio		
	25th percentile	Median	75th percentile
2022/23	7.7	5.7	4.2
2021/22	9.0	6.7	4.6

The purpose of the ratios is to demonstrate the range of remuneration within the Trust by expressing the remuneration of the highest paid director as a multiple of the remuneration of the median, 25th and 75th percentiles.

The ratios declined compared to the previous year which reflects a small increase in the remuneration of the highest paid director compared to larger increases in the median, 25th and 75th percentile salaries.

The overall increase in average remuneration per FTE between 2022/23 and the prior year was 8.28 per cent.

	Total Remuneration			Ratio of highest paid director	
	2022/23	2021/22	% Change	2022/23	2021/22
Highest Paid Director	£185,000	£182,500	1.4%		
Minimum	£9,405	£8,408	11.9%		
Median	£32,526	£27,332	19.0%	5.7	6.7
75th percentile	£43,738	£40,079	9.1%	4.2	4.6
25th percentile	£23,949	£20,330	17.8%	7.8	9.0

Salaries paid by the Trust on a full time equivalent basis, varied between £8k and £415k per annum. In 2022/23, x employees received remuneration in excess of the highest paid director based on payment received in the year (2021/22, 16). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Sickness Absence Figures for Wye Valley NHS Trust 2022/23

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2022	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
3,191	46,087	1,164,582	74,763	14.4

The staff turnover percentage for the **2022/23 financial year was 12.8 per cent**. Turnover statistics are reported to NHS England and NHS Improvement. Figures refers to staff on permanent contracts only and includes all voluntary and involuntary reasons for leaving the Trust

Staff costs (subject to audit)

Costs	Permanent	Other	Total
	£000	£000	£000
Salaries and wages	131,757		131,757
Social security costs	15,184		15,184
Apprenticeship levy	693		693
Employer's contributions to NHS pension scheme	23,030		23,030
Temporary staff		39,260	39,260
Total staff costs	170,664	39,260	209,924
Of which			
Costs capitalised as part of assets	1,235	916	2,151
Total staff costs charged to revenue	**169,429**	**38,344**	**207,773**
Average number of employees (WTE basis)			
Medical and dental	212	203	336
Administration and estates	767	57	790
Healthcare assistants and other support staff	663	101	661
Nursing, midwifery and health visiting staff	898	152	901
Nursing, midwifery and health visiting learners	2	2	4
Scientific, therapeutic and technical staff	360	31	375
Healthcare science staff	75	4	75
Total average numbers	**2,977**	**550**	**3,142**
Of which:			
Number of employees (WTE) engaged on capital projects	8	13	21

Workforce profile

	2022/23 Total Number	2021/22 Total Number
Medical and Dental	389	364
Estates and Ancillary	113	109
Administration and Clerical	883	858
Nursing and Midwifery registered	1105	1103
Healthcare Scientists	86	91
Allied Health Professionals	313	300
Additional Clinical Services	850	811
Students	3	4
Add Prof Scientific and Technical	147	167
Total average numbers		
Of which:		
Number of employees (WTE) engaged on capital projects		

Gender Split for General Staff

	2022/23 Total Number
Female	3188
Male	701
Total	**3889**

Gender Split for Trust Board

	2022/23 Total Number
Female	7
Male	8
Total	**15**

Nb. This data does not include Glen Burley (Chief executive) and Russell Hardy (Chairman) and includes Erica Hermon (Company Secretary).

Workforce by Disability

	2022/23 Total Number
No	3294
Not Declared	313
Prefer Not To Answer	4
Unspecified	120
Yes	158
Total	**3889**

Workforce by Ethnicity

	2022/23 Total Number	Total %
White - British	2944	76.94
White - Irish	15	0.39
White - Any other White background	135	3.43
Mixed - White & Black Caribbean	9	0.25
Mixed - White & Black African	16	0.39
Mixed - White & Asian	17	0.52
Mixed - Any other mixed background	2	0.05
Asian or Asian British - Indian	343	8.29
Asian or Asian British - Pakistani	35	0.84
Asian or Asian British - Bangladeshi	21	0.49
Asian or Asian British - Any other Asian background	90	2.07
Black or Black British - Caribbean	6	0.17
Black or Black British - African	77	1.70
Black or Black British- Any other Black background	9	0.22
Chinese	11	0.30
Any Other Ethnic Group	94	2.22
Not Stated	65	1.70
Total	**3889**	**100**

Workforce by Sexual Orientation

	2022/23 Total Number	Total %
Bisexual	40	1.03
Gay or Lesbian	40	1.03
Heterosexual or Straight	3259	83.80
Other sexual orientation not listed	16	0.41
Undecided	4	0.10
Not stated	530	13.63
Total	**3889**	**100**

Exit packages

The Trust reported no exit packages in 2022/23 or 2021/22.

Compensation for loss of office (subject to audit)

There has been no payment or compensation paid for early retirement or loss of office or payments made to past directors in 2021/22 or 2020/21.

Off Payroll Engagements

Off payroll engagements relate to individuals employed by the Trust but not remunerated via the organisations payroll function. Typically, this would relate to self-employed individuals or those contracted via agencies. The Department of Health requires NHS bodies to report any off-payroll engagements as at 31 March 2023, for more than £245 per day*

Number of existing engagements as of 31 March 2023:	Number
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between 1 and 2 years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 years or more at the time of reporting	

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2022 and 31 March 2023, for more than £245 per day:

No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	Number
Of which:	
No. not subject to off-payroll legislation	
No. subject to off-payroll legislation and determined as in-scope of IR35	
No. subject to off-payroll legislation and determined as out of scope of IR35	
No. of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	

The [insert number] engagements reported above all relate to individuals contracted to work for the Trust via employment agencies and therefore the Trust have not been required to introduce contractual clauses.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	

Expenditure on consultancy

The Trust spent £50k on consultancy during 2022/23 compared to £35k in the previous year. This equates to just 0.015 per cent of the Trust's turnover in 2022/23.

Financial performance

Statutory basis

The Trust has fulfilled its responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Manual for Accounts and the International Financial Reporting Standards which give a true and fair view in accordance therewith.

Financial Breakeven

In 2022/23, the Trust delivered an unadjusted deficit of £4,988k. Once adjustments for the reversal of impairments and donations are accounted for this equates to an adjusted deficit of £6,514k. The table below indicates the overall value of the deficit once factors relating to the change in value of tangible assets and other technical adjustments are accounted for.

Trust Break even Duty

	2022/23	2021/22
	£000	£000
I&E: Retained (Deficit)/Surplus	**-4,988**	-3,570
Impairment of Assets/(Reversal of previous impairments)	**-2,584**	9,431
Remove capital donations / grants I&E impact	**935**	-4368
Remove net impact of DHSC centrally procured inventories	**123**	43
Adjusted Retained Surplus	**-6,514**	1,536

The Trust break even duty is calculated based on the retained Surplus/(Deficit) for the year adjusted for asset impairments and revaluations and the impact of donated assets and capital grants received. There was also a small impact relating to centrally held and issued inventory linked to COVID-19. The adjusted retained deficit was -£6.5m. The outturn was a marginal improvement on the Trust's financial plan.

Cost productivity improvement programme (CPIPs)

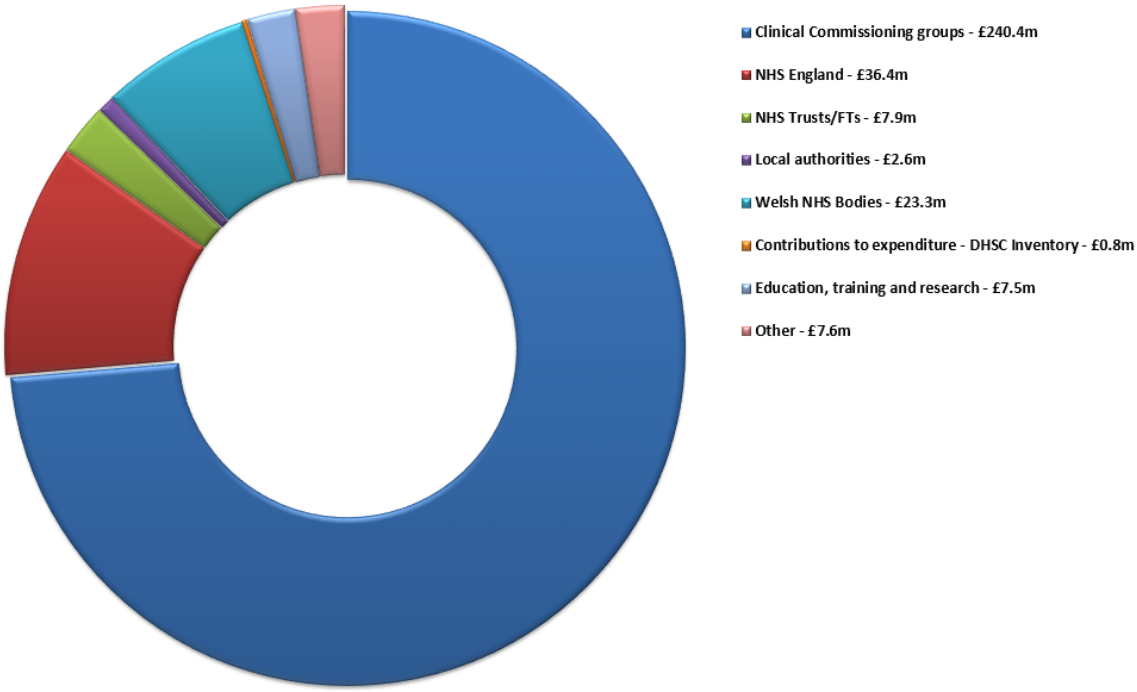
The Trust delivered £8.8m of savings from a broad range of best value for money, pay and non-pay saving initiatives. This was against a plan of £11.8m. £3.5m of the savings were delivered recurrently with a resulting benefit in future years.

Resources – Income and Expenditure

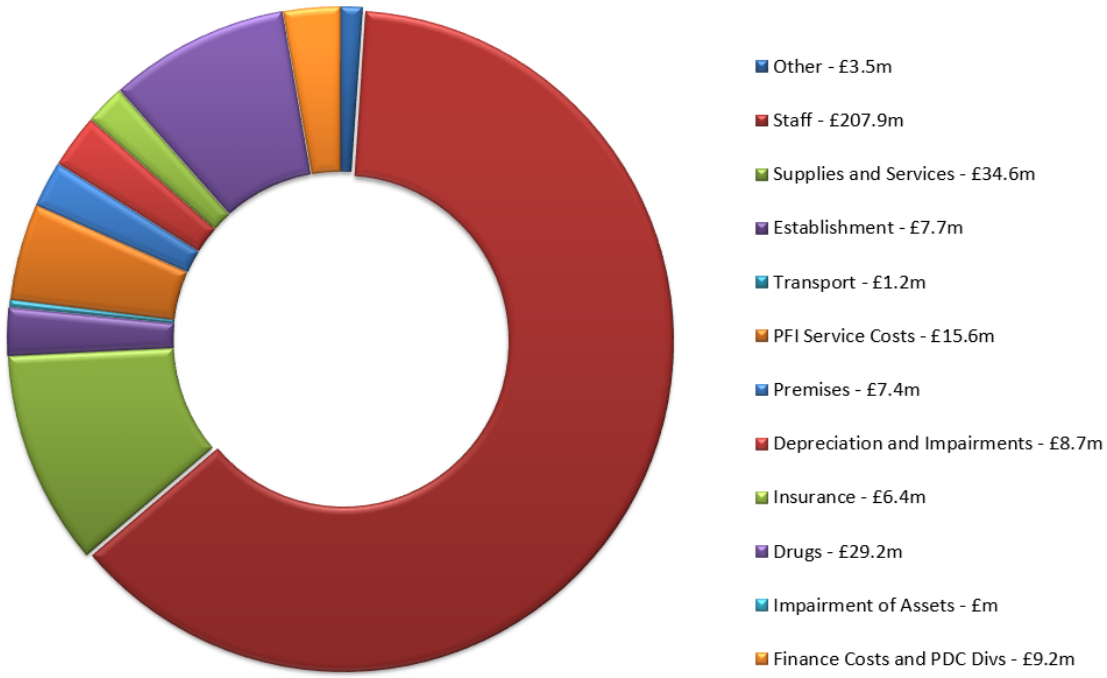
The Trust generated income of £304m during 2022/23. The first pie chart identifies income received from different sources for health related activity. The largest share of income is derived from Clinical Commissioning Groups (CCG) and successor ICB's. The primary source of income was from NHS Herefordshire and Worcestershire CCG/ICB.

The second pie chart identifies annual expenditure incurred in the year. Salaries and wages paid to permanent and temporary staff, including those employed through agencies, totalled £208m. Total expenditure on goods and services amounted to £114.3m and finance costs plus PDC dividends totalled £9.2m.

2022/23 Income Sources (£m)



2022/23 Annual Expenditure (£m)



Resources - How the Trust spends its capital

The Trust spent £12.8m on capital investments during 2022/23. The most significant elements within the capital programme were:

2022/23 Capital Expenditure	2022/23 £k
Clinical Equipment	2,165
Ward Replacement Scheme	1,218
Other Estates schemes	1,049
Digital (incl. Electronic Patient Record/Prescribing)	3,536
Surgical Robot Scheme	1,330
Elective Surgical Hub	3,507
Total Capital Expenditure	**12,805**

Pension Liabilities

Within the annual accounts, ongoing employer pension contribution costs are included within employee costs (see Notes 8 and 9 to the annual accounts for more detail).

Past and present employees are covered by the provisions of the NHS pensions scheme. Details of the benefits payable under these provisions can be found on the NHS pensions website at www.nhsbsa.nhs.uk/nhs-pensions

Better payment practice code

The trade creditor payment policy of the NHS is to comply with both the Confederation of British Industry (CBI) prompt payment code and the government accounting rules. The Government accounting rules stipulate that, unless otherwise stated, all invoices should be paid within 30 days of receipt of goods or services.

The Trust is measured against a 95 per cent compliance rate target in terms of both value and number of invoices.

	2022/23	2022/23	2021/22	2021/22
	Number	£000s	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	59,842	139,135	54,342	127,579
Total Non-NHS Trade Invoices Paid Within Target	53,931	116,608	48,756	106,388
Percentage of NHS Trade Invoices Paid Within Target	90.1%	83.8%	89.7%	83.4%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,353	12,213	1,224	11,512
Total NHS Trade Invoices Paid Within Target	1,023	10,489	941	10,231
Percentage of NHS Trade Invoices Paid Within Target	75.6%	85.9%	76.9%	88.9%
Total bills paid in the year	61,195	151,348	49,544	133,327
Total bills paid within target	54,954	127,097	42,728	119,722
Percentage of bills paid within target	89.8%	84.0%	86.2%	89.8%

It can be seen in the table above that in invoice volume terms the Trust delivered an improvement in its performance against the Better Payment Practice Code during 2022/23. This was aided by changes to processes. Further improvements continue to be made in efforts to achieve the 95 per cent target.

Counter fraud and corruption

The Trust has in place effective arrangements to ensure a strong counter fraud and corruption culture exists across the organisation and to enable any concerns to be raised and appropriately investigated. These arrangements are underpinned by a dedicated local counter fraud specialist and a programme of counter fraud education and promotion. The fitness for purpose of these arrangements is overseen by the Audit Committee which has confirmed them as being effective and proportionate to the assessed risk of fraud.

The Trust employs RSM Risk Assurance Services LLP to provide a service. This service undertakes investigations in addition to doing proactive work in relation to fraud in the NHS. There were 6 referrals received during the year and 1 which was carried over from 2021/22. Of the 7 referrals investigated 5 had no fraud proven and there was 2 referral(s) where fraud was proven.

Going Concern

International Accounting Standard 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity. During 2022/23 the Trust's operations were fulfilled within the context of an annual financial plan. In 2022/23 the Trust delivered an adjusted deficit of -£6.5m. In its initial 2022/23 plan produced in April 2022 the Trust forecasts a

deficit of -£6.6m. In the 2023/24 plan the Trust forecasts an adjusted deficit of £22.3m. This has been agreed in conjunction with Hereford and Worcester ICB.

The Directors have carefully considered the principle of going concern. The Trust has agreed contracts with its local commissioners for 2023/24. Services continue to be commissioned in the same manner as in prior years and there are no discontinued operations. The Trust's strategic partnership with the Foundation Group also continues to provide executive leadership and support to the Trust. The Board has thus concluded that the Trust remains a going concern and the going concern basis has been adopted for the preparation of the accounts. Further details on going concern can be found within the disclosure within the financial statements.

Statement of disclosure for auditors

Our Board of Directors considers that the annual report and accounts, taken as a whole, is fair, balanced and understandable, and that it provides the information necessary for patients, regulators and stakeholders to assess our performance, business model and strategy. The directors' responsibility for preparing the annual report and accounts is outlined in the Accountability Report and Annual Governance Statement.

The Board of Directors has prepared this Annual Report to provide a fair, balanced and understandable analysis of the Trust. This includes the strategy moving forward as well as a review of last year's progress.

Part D – Annual Accounts

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director

Independent Auditor’s Report to the Board of Directors of Wye Valley NHS Trust

Foreword to the accounts

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Annual Quality Account 22/23
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
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

The Trust Quality Account is published annually to report on progress against our quality priorities and the wider quality and safety agenda and sets out the priorities for the coming year.

2. Recommendation(s)

The Board is asked to approve the Quality Account for publication by 30th June subject to the actions outlined in the Executive opinion below. Quality Committee have received and reviewed the draft account and supported onward submission to Board.

3. Executive Director Opinion[1]

The Quality Account has been prepared in line with national guidance; the account is no longer subject to an audit opinion or usual validation checks. In my opinion, the account contains all of the elements that are mandated by NHS England. The Board is asked to approve the account with the understanding that the following will be undertaken prior to publication at the end of June;

- External stakeholders comments (not yet received), will be added prior to publication (any comments made by external parties that are material to the content of the account will be reported back to Board by exception).
- The account will be undergo a final proof read and quality check prior to publication.

[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

Quality Account 2022-23

Contents

Introduction to Quality Accounts

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Quality Account for Wye Valley NHS Trust (the Trust) reflects on the achievements made in the past year against the goals set. It also looks forward to the year ahead and defines what the priorities for quality improvements will be and how the Trust expects to achieve and monitor them.

How will the Quality Account be published?

In line with legal requirements, all NHS healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30th June 2023. The Trust also make the Quality Account available on the Trust website.

About the Trust

The Trust are an acute and community service provider, with a wide range of services to people of all ages living in Herefordshire and some of the population of mid- Powys. To do this, the Trust employs over 4000 staff who operate from the County Hospital, many community sites and in people's homes.

The Trust deliver joined up services, helping people to remain independent at home for as long as possible by providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, the Trust offer a wide range of services to keep you and your family well.

The Trust work as a member of a Foundation Group that includes South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust and Worcestershire Acute Hospitals NHS Trust (associate member).

Having been rated as 'Requires Improvement' by the Care Quality Commission the journey to 'Good' is continuing and the Quality Account illustrates what the Trust are doing to achieve this.

Wye Valley NHS Trust Mission and Values

Our Mission:

To provide a quality of care we would want for ourselves, our family and friends.

Our Values:

Compassion - We will support patients and ensure that they are cared for with compassion.

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

Introduction from the Chief Executive- DRAFT WORDS TO BE APPROVED

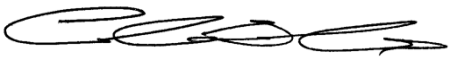
The last year has been a positive year for Wye Valley NHS Trust with much to celebrate with improvement in our services as we continue to recover from the COVID-19 pandemic. I am proud to see so many good news stories in the Quality Account for 2022-23.

During the year, the Trust moved into its Integrated Care System across Herefordshire and Worcestershire. This saw the opportunity to develop forums to focus on improvement in quality and safety. The introduction of Safety in Sync has proved to be a great success in bringing together colleagues across Herefordshire to work together on tackling service issues that span across our organisational boundaries, putting the patient at the heart of our improvement efforts.

A visit from the Care Quality Commission in October 2022 saw improvements in our surgical and medical services being recognised by our inspectorate. The Trust saw the ratings in the 'Safe' and 'Well led' domains move from Inadequate to Requires Improvement for the surgical core services, reflecting the hard work and dedication of our staff in improving the services they provide.

The Trust continues to have a focus on improving waiting times and ensuring patients are seen in a timely manner, in the right place at the right time. This includes a continued focus on recruitment and making Wye Valley NHS Trust a desirable place to work. Our recruitment of international nurses is testament to this and we are delighted to see more overseas nurses joining the Wye Valley team.

I welcome the Quality Priorities we have set for 2023-24 and recognise the need for improvement in these domains.



Glen Burley, Chief Executive

Celebrating Change - Shared Learning

To support the One Herefordshire Partnership priority for Quality Improvement and Learning, the Trust has seen the introduction of two exciting initiatives to facilitate the sharing of learning across organisations within Herefordshire and Worcestershire.

Transformation Tuesday and Safety in Sync have grown from strength to strength over the past twelve months and will continue to flourish into the future.

NHS Wye Valley NHS Trust

Herefordshire General Practice – Taurus Healthcare

Safety in Sync

Herefordshire (PLACE) Shared Learning Forum for Quality

Who is the forum aimed at?

Herefordshire and Worcestershire colleagues including colleagues from;

- WVT
- General Practice
- Taurus Healthcare
- ICB
- Herefordshire and Worcestershire Care Trust
- Herefordshire Council

Format

This forum is held once per month and usually contains two topics per meeting. The speakers will present the issue/project/improvement idea leading to a system wide discussion to how we can work together to create improvements. This format supports and aids discussion and involvement from as many participants as possible.

A one page summary newsletter is circulated after each meeting.

One of the priorities of the One Herefordshire Partnership is Quality Improvement and Learning. As a result of this, we have developed a PLACE based quality forum as part of the ICS Governance structure named Safety in Sync.

What is the purpose of this forum?

- To facilitate sharing of learning across organisations with a positive blame free culture.
- Find solutions (improvements)/ generate learning from quality and safety issues that span across the healthcare system.
- Create relationships between colleagues to improve quality of patient care.

The topics presented allow us to share/ celebrate changes demonstrating improvement, collaboratively identify opportunities for improvement, seeking solutions to issues affecting patients across our system and discussing significant issues for a particular sector that requires wider support to solve, always with the intention to be inclusive.

So far...

10 meetings

22 topics

45 Average No. of attendees

New specialist groups

Recruitment

Sharing technology

Educational support

New processes

Improvement projects

Digital systems


ALL WELCOME
Hosted by
NHS
Wye Valley
NHS Trust
TRANSFORMATION TUESDAY
A bi-weekly virtual meeting to collaborate, motivate and celebrate improvement across Herefordshire
In 2022...
91 topics discussed over 23 sessions
Idea
Average participants 63, with the largest attendance being 109
Attended by 12 different organisations across health, care and wellbeing

CELEBRATING EXTERNAL RECOGNITION

Covid Vaccination team highly commended at HSJ Awards 2022

The Covid Vaccination Programme delivered across Herefordshire and Worcestershire has been highly commended at the HSJ Awards 2022 for the Covid Vaccination Programme Award.

The inspiring multi-partner vaccination programme, which was launched in December 2020, with the roll-out of the Covid Vaccine nationally, was an example of how partners came together to ensure that people across the two counties could access and receive their Covid vaccination. This ensured one of the highest vaccination rates in the country.

Simon Trickett, Chief Executive for NHS Herefordshire and Worcestershire comments; "This recognition from the esteemed judges at the HSJ Awards in the Covid Vaccination Programme Award category means a huge amount to everyone involved in this project – what an honour! The impact of being awarded Highly Commended at the 2022 HSJ Awards will really drive our system of health and care partners to build on this success and encourage us and our colleagues to keep exploring ways of improving outcomes and implementing new innovations to help enhance our future partnership working.

The HSJ Awards is the largest annual benchmarking and recognition programme for the health sector. Over the last 42 years the awards have been celebrating healthcare excellence through huge political, technological and financial challenges within the sector. Through a rigorous, fair and transparent two-step judging process (including a Live presentation) the Awards produce a roll call of the best organisations, teams and people in the NHS and the wider health sector.

The winners and those highly commended were announced across 25 categories during the HSJ Awards ceremony held at Evolution London on November 17

Sue elected onto the BASL British Liver Nurse Committee

Huge achievement for WVT made by Sue Eldred recently as she has been successfully elected through a national vote onto the BASL British Liver Nurse Committee which will give her the chance to actively participate in National Initiatives, and Guideline and National Policy Development. She has also been accepted onto the Haemochromatosis Specialist Interest Group who work on producing revised National Clinical Guidelines. We are very proud of Sue for representing WVT and helping raise the profile for WVT Gastroenterology/Hepatology. Well Done Sue!

Queen's Nurses

Last week, two of our nurses headed to London for the Queens Nursing Institute Annual Awards ceremony.

Del Thomas, Lead Multiple Sclerosis CNS and Community Neuro CNS Team Manager was given the prestigious title of Queen's Nurse by community nursing charity The Queen's Nursing Institute (QNI).

The title is not an award for past service but indicates a commitment to high standards of patient care, learning and leadership. Nurses who hold the title benefit from developmental workshops, bursaries, networking opportunities, and a shared professional identity.

Many congratulations to Del.

Rachael Hebbert, Associate Chief Nursing Officer, who is also a Queen's Nurse, received an award for successful completion of the QNI Executive Nurse Leadership programme. Funded by the National Garden Scheme, this programme focusses on community and primary care nursing systems leadership with an emphasis on leading compassionately throughout the pandemic and supporting the wellbeing of the workforce going forward.

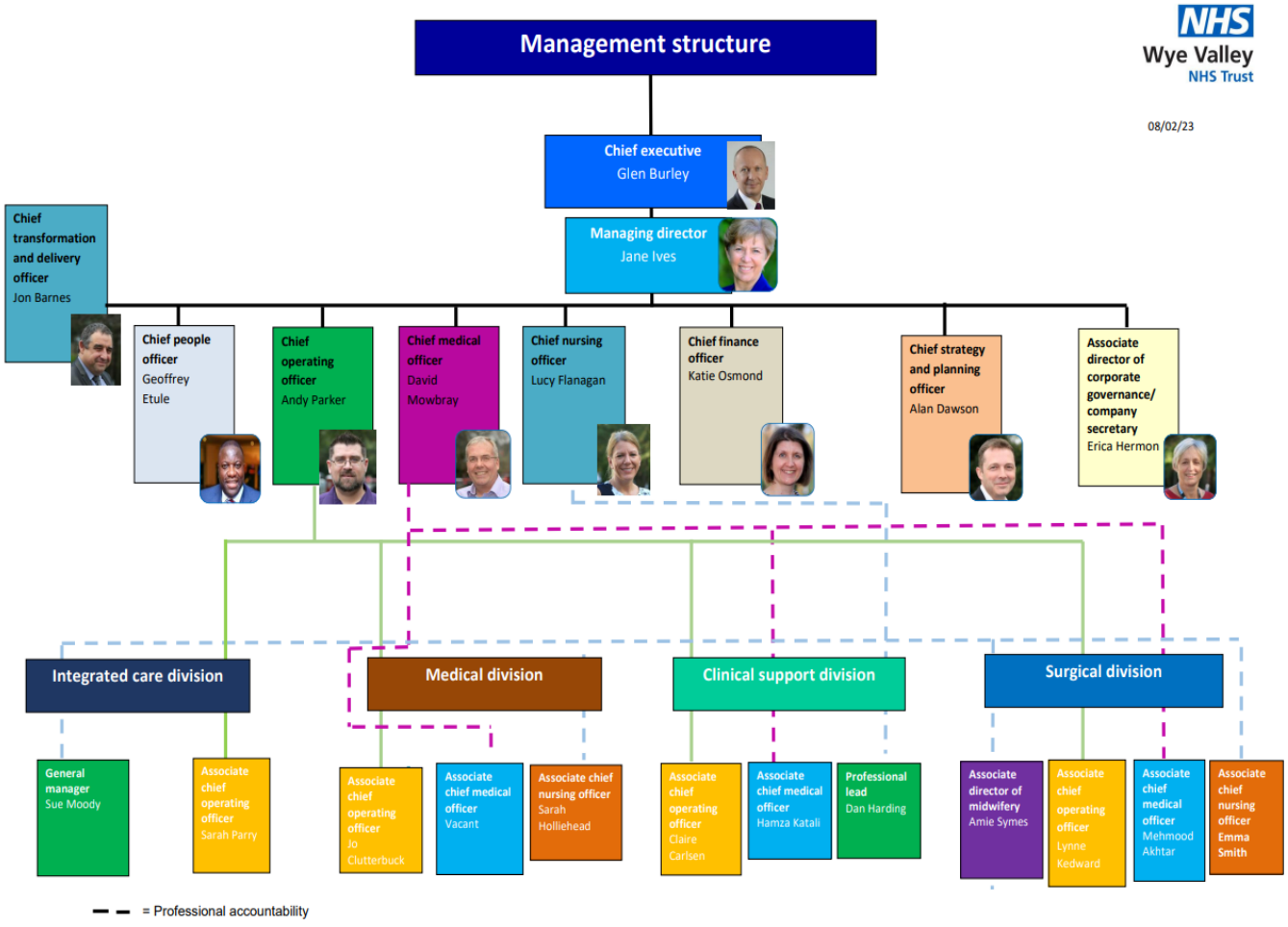
Many congratulations to Rachael for completion of this programme.

Core Areas of Assurance

Organisational Change

Wye Valley NHS Trust is part of a Foundation Group that also includes South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust. Each Trust retains its own Trust Board with the common link being a shared Chief Executive Officer and Trust Chairman. Worcestershire Acute Hospitals NHS Trust joined the Foundation Group as an associate member more recently, retaining their full board membership.

The Foundation Group enables the Trust to strengthen opportunities available to help secure a sustainable future for all three organisations and allows each Trust to maintain its own governance while benefitting from scale and learning across the wider group.



Statement of Assurance

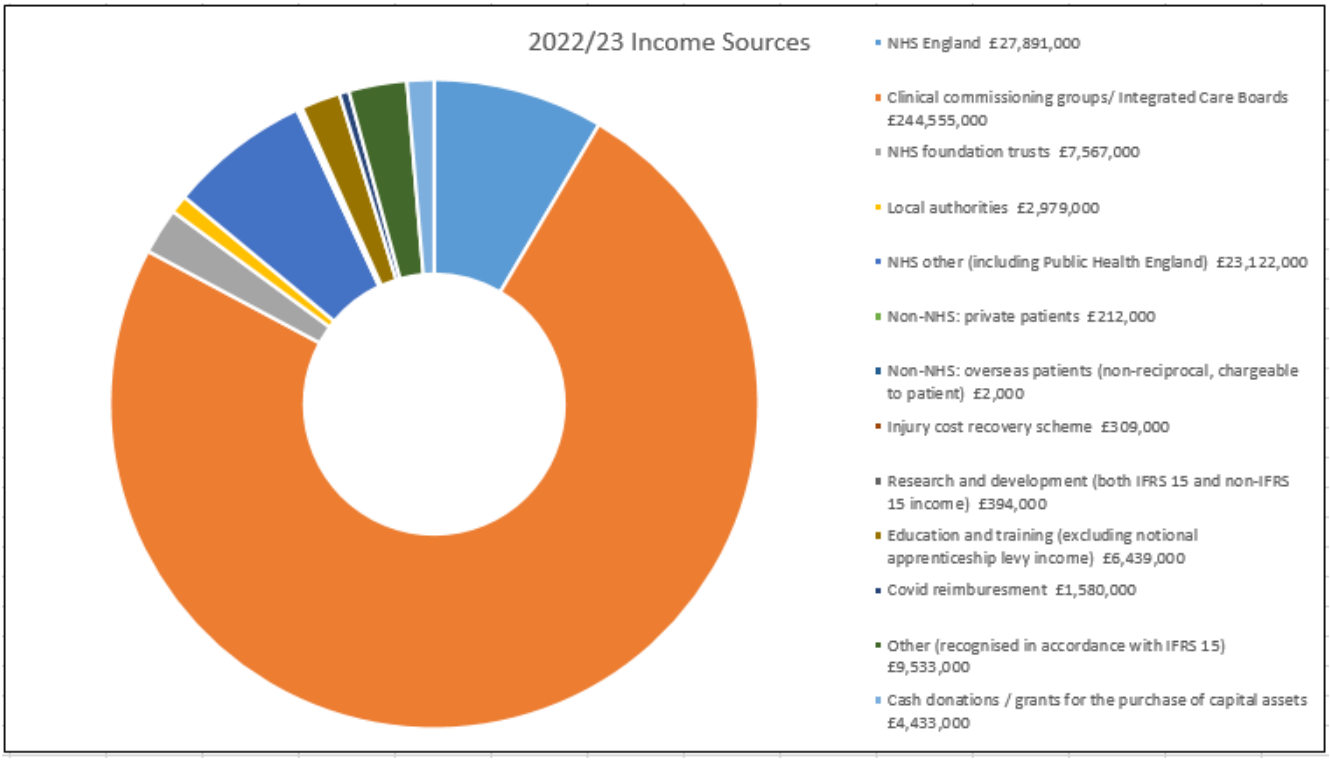
Review of services and income:

The Trust provided and/or subcontracted 58 acute and community services for the population of Herefordshire, bordering English counties, and mid- Powys (details on these services is provided in Appendix 4). The Trust has reviewed all the data available on the quality of care in all of these services.

More detail on the income of the Trust can be found in the Annual Report 2022-23.

The income generated by Wye Valley NHS Trust for services reviewed in 2022-23 represents 100% of the total income generated from the provision of relevant health services.

A breakdown of income received from each body for 2022-23 is illustrated below.



Care Quality Commission (CQC) Overview of Progress

In October 2022, the Trust welcomed a team of inspectors from the Care Quality Commission who undertook an unannounced focused inspection of the trusts surgical and medical core services at the County hospital.

During the inspection, inspectors visited all wards in medicine and surgery including older people's care, plus theatres and day case unit.

The focus of the inspectors was on the safety domain in medicine and surgery and the well led (how the division is being managed) domains in surgery.

The good news for patients is that the inspectors found improvements have taken place and they have upgraded the "inadequate" ratings to "requires improvement" in the safety, well-led and overall domains for surgery.

In its report, the team of inspectors noted that the service had enough staff to keep patients safe; staff had received training and understood how to protect patients from abuse. The hospital was also commended on the way it controlled infection risk well.

Jane Ives, WVT Managing Director
"It's not an end in itself, and there is still work to do, but it confirms our ambitions to be an NHS Trust which is rated "Good" overall in the coming years".

"We are an ambitious Trust and this report signals another positive step on our journey to provide the kind of quality service for local people that we want to provide for our family and friends"

The inspection team were pleased to note that staff felt respected, supported and valued and were focussed on the needs of patients receiving care.

In its report, the inspectors listed less than ten 'must do' requirements, some of which were easy to fix and have been addressed already, and for the remainder the Trust already has detailed improvement plans in place.

The County hospital's overall rating remains requires improvement. For the full breakdown of service ratings see Appendix 1.

The Trust is currently registered with the Care Quality Commission without any compliance conditions and is licensed to provide services.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Mar 2020	Requires improvement ➔➔ Mar 2020	Good ➔➔ Mar 2020	Requires improvement ➔➔ Mar 2020	Requires improvement ➔➔ Mar 2020	Requires improvement ➔➔ Mar 2020

National Audit and National Confidential Enquiries (NCEPOD)

During 2022-23, there were 48 national clinical audits that Wye Valley NHS Trust were eligible to participate in based on the services provided.

We participated in 45 (94%) of National Clinical Audits

Data submission ranged between 25-100% of eligible cases for individual audits

Clinical teams present reports and improvement action plans to their Specialty Audit Meetings

There were 3 eligible audits that the Trust did not participate in during 2022-23:

1. National Ophthalmology Audit Database
2. National Cardiac Arrest Audit
3. Inflammatory Bowel Disease (IBD) Registry

The Trust participated in 45 (94%) of national clinical audits and 100% of National Confidential Enquiries. Detailed in Appendix 2.

National Data opt-out

The national data opt-out is a service that allows patients to exclude their confidential patient information being used for research and planning.

Before the Trust submits data to the relevant national audits, a process is followed to identify and remove patients who have opted out. In some cases this means that the number of patients who are included in the audit is reduced, and in the event of low patient numbers, this can have an impact on the results of the audit, which will be considered when reviewing outcomes and putting in place actions.

Learning from Audit

In 2022-23 the Trust Clinical Audit Programme included a total of 268 projects (national & local combined). The programme is monitored by the Trust's divisional and directorate governance groups on a monthly basis with oversight through the Clinical Effectiveness & Audit Committee. Within Wye Valley NHS Trust the results from national and local clinical audits are reviewed by the clinical teams involved in the audit at specialty level. If the review indicates that improvements are required, action plans are devised and monitored within the divisions.

Highlights from Various Published National Audit Reports during 2022/23

There were 35 national clinical audits that published an annual report in 2022-23 and 7 reports for the National Confidential Enquiry programme. These have been sent for review by the relevant specialty and, where appropriate, action plans have been developed.

A number of these reports are highlighted, including areas of good practice and what the Trust intends to do where standards are not met.

Your baby's care

Measuring standards and improving neonatal care

NNAP
National Neonatal Audit programme

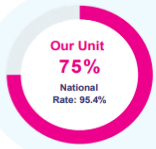
Wye Valley Trust takes part in the National Neonatal Audit Programme (NNAP), which monitors aspects of the care that has been provided to babies on neonatal units in England and Wales. The information below shows how the 2021 results for this hospital compared with national rates, as indicated in the NNAP Summary report on 2021 data.

How our unit did across 12 NNAP measures:

Antenatal steroids
Nationally, 92.1% of mothers of babies born at less than 34 weeks' gestation were given antenatal steroids.

Neonatal nurse staffing
Nationally, 73.9% of shifts were staffed according to recommended levels.

Antenatal magnesium sulphate
Nationally, 86.9% of mothers of babies born at less than 30 weeks' gestation were given antenatal magnesium sulphate.



On time screening of retinopathy of prematurity
Nationally, 95.4% of eligible babies were screened on time for retinopathy of prematurity (ROP).

Deferred cord clamping
Nationally, 43% of babies born at less than 32 weeks' gestation had their cord clamped at or after one minute from birth.

Bronchopulmonary dysplasia (BPD)
Nationally, 38.8% of babies born at less than 32 weeks' gestation developed bronchopulmonary dysplasia (BPD) or died between 2019-2021.

Temperature on admission
Nationally, 73.2% of babies born at less than 32 weeks' gestation were admitted with a temperature within the recommended range of 36.5-37.5°C.

Early breastmilk feeding
Nationally, 80.5% of babies born at less than 32 weeks' gestation received their mother's milk at 14 days of age.

Parental consultation within 24 hours of admission
Nationally, 96.3% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

Breastmilk feeding at discharge
Nationally, 60.6% of babies born at less than 32 weeks' gestation received their mother's milk at discharge home.

Parental presence at consultant ward rounds
Nationally, a parent was present on the consultant ward round at least once during the admission for 85.8% of admissions. The proportion of ward rounds with at least one parent present was 44.1%.

Medical follow up at two years
Nationally, 72.6% of babies born at less than 30 weeks' gestation had a documented medical follow up at the right time.

Areas reflecting good practice:

- The Trust has continued to perform well with above average rates in the audit measures of administration of steroids, magnesium sulphate and admission temperatures for babies. The Trust have also this year been one of the top performing trusts for delayed cord clamping in these babies. This suggests that the local work around these measures is embedded in practice and the Trust continues to monitor this and review all cases where this is not achieved.
- The Trust have regained the high rates of breast milk at discharge following the dip in 2020 and are focusing on further improvement by working towards the neonatal baby friendly initiative and Maternal and Neonatal Safety Programme work on early breast milk expression.
- All of these measures have been shown to improve outcomes for preterm babies. Along with the local level work the Trust also utilise the neonatal network and the Local Maternity and Neonatal Systems (LMNS) to look at cases when babies are not able to be transferred prior to delivery.

Areas requiring improvement:

- On time screening of retinopathy in premature babies.
- Documentation of parental consultation within 24 hours of their babies' admission.
- The 2-year developmental follow up of babies born less than 30 weeks gestation.

Local actions to be taken:

- Retinopathy of prematurity screening results do not show any significant concerns however there is a need to stay mindful that as a small unit there are a limited number of staff who can deliver this screening and that any absence of these staff could impact the provision of the service.
- The documentation of parent's discussions - As a neonatal unit the Trust would like to pursue the use of the Badgernet platform as Electronic Patient Record EPR for the neonatal unit. This would improve the consistency of documentation as when the record is accessed, staff would be able to see a notification to remind them of the need to document any update with parents.
- The 2 year developmental follow up - A formal business case to be developed once the resources required to deliver this service have been identified.

Report based on Procedures from April 2020 to March 2021

The aim of the National Audit of Cardiac Rhythm Management (NACRM) is to examine and improve service delivery for and outcomes of patients undergoing therapeutic electrophysiology procedures (ablations) or electronic device implantation to manage cardiac rhythm disturbances.

Areas reflecting good practice:

- Lower than expected complication rates.
- Short waiting times for simple and complex implants.
- Regular weekly multi-disciplinary team meeting for device issues and timely planning of implants.
- Early adoption of advanced implant techniques: mentoring of implanters from neighbouring Trusts in these techniques.

Areas requiring improvement:

- The Cardiology 'getting it right first time' (GIRFT) strategy document requires expansion of the service to allow at least 5 day working for implants, discussions are ongoing as to how this might be achieved.
- Improvement in validity of data upload to NICOR, and correlation with local audit.

Local actions to be taken:

- Ensuring timely and accurate data upload to NICOR in accordance with regulations.
- Recruitment of admin support for Cardiology audit to assist with data entry.
- Availability of Cath lab for emergency pacemaker implants 5 days a week.

Key Results demonstrated from a local audit report

Operatives Notes in General surgery are we doing well?

Operation notes are essential to ensure continuity of care between the operating team and other colleagues. It also provides a medico legal record of a patient's care and hence quality of operation notes is crucial. The aim of the audit was to review current quality of documentation and to achieve a standardisation of operative notes of surgery performed at the Trust.

Areas reflecting good practice:

- All operation notes audited included the type of procedure and specified the procedure side as required; including type of anaesthetic used.
- All operation notes audited have a section with a post-operative plan for the patient.
- Most operation notes (98-100%) included incision details, findings, and detailed surgical steps, as well as skin closure.

Areas requiring improvement:

- The General Medical Council (GMC) number was not documented in any operation notes.
- Names and grade were legible in only 72% of the 50 operation notes analysed.
- Factors such as estimated blood loss and requirement of prophylaxis antibiotics were documented in less than 40% of the operation notes.

Local actions to be taken:

- To achieve a good level of documentation, the introduction of an operation note template on the new clinical noting system would help to ensure clear and concise communication between the operating team and the ward team looking after the patient post-operatively.

  It would also electronically generate name and grade of the clinician creating the operation note and improve the consistency of documentation.

Trust Research Participation Overview

The Trust has continued to offer opportunities for patients to participate in national clinical research studies to improve health, treatment, care and diagnoses. In total, 620 patients at the Trust were recruited into 23 studies on the National Institute Health Research (NIHR) Portfolio approved by the Health Research Authority. This included 76 patients who were recruited into interventional studies, and 30 recruited into a commercial study. Many more patients also had contacts as part of their follow up in ongoing studies.

This research included interventional and observational studies into reproductive health and midwifery, anaesthesia, stroke, critical care, cancer, hepatology, dermatology and musculo-skeletal disorders.

Safety Alerts

Safety alerts are issued when there is a specific issue that without immediate actions being taken could result in serious harm or death.

In 2022-23, the Trust continued to receive the patient safety alerts through the Central Alerting System (CAS) and Medicines & Healthcare products Regulatory Agency (MHRA). These were managed appropriately through the established process, which includes checking for relevancy, and recording completed actions.

All historic alerts have been actioned and completed.

The Trust are in the process of implementing a new risk management system which will provide the functionality to triangulate safety alerts with internal intelligence such as incidents and risks. This will allow for a broader view of safety across the Trust and strengthen assurance in our management of safety alerts.

Field Safety Notices (FSNs) are important communications about the safety of a medical device that is sent to customers by a device manufacturer or their representative.

The management of FSNs has been reviewed and the number of open notices has reduced from 25% of the total number down to 3% of the total number in 2022-23.

As part of the improvement in the process the trust has added to the external web page an email address to make it easier for manufacturers to send the notices in.

Best Practice Guidance

NICE
National Institute for Health and Care Excellence

In year, 2022-23 the Trust has developed a new standard operating procedure for the implementation of NICE guidance (PR.S.21), developed by the Trust through a co-production group from staff across the Trust and members of the public.

Some of the key elements that have been adopted and implemented into practice are:

1. The use of the Risk Register to track and monitor the completion of baseline assessments.
2. All baseline assessments for guidance referenced NG and CG are completed

with the guidance lead and member of the Compliance Team:

- Ensures consistency and completeness.
- Assists the leads by offering admin support.
- Has seen an increase in responses received.

3. For all guidance where any recommendations are identified as non-compliant the guidance lead and compliance team complete a risk assessment, adding to the risk management system and creating an action plan:
   - Enables a centralised process for monitoring NICE actions and identifying which recommendations the Trust are working towards with timeframes for achievement.
   - Allows greater oversight and scrutiny of any risks related to not meeting NICE recommendations. With the possibility of identifying new risks for inclusion in business planning.

4. New process for the management of Technology Appraisal Guidance (TAG) following consultation with the Specialist Medicines and Clinical Policy Adviser at Herefordshire and Worcestershire ICB and Trust colleagues:
   - Removes the overlap of work being carried out in regards to medication TAGs.
   - Simplifies the Trust process by only sending out TAG guidance to leads once the medication is confirmed as being added to the Herefordshire and Worcestershire Formulary and funding pathway is in place for the implementation of the intervention.
   - Allows the clinician the ability to directly contact the pharmacy team for inclusion of the medication, knowing all processes are in place for pathway production.

For 2023-24, a process is in development to revisit past NICE guidance every 5 years. This will provide ongoing assurance that the Trust is still compliant with the released NICE guidance. Also, allowing opportunity to audit and review processes in place and providing specialties the opportunity to revisit previous recommendations that may have been accepted as not able to be implemented, with the potential to provide new opportunity to evidence business cases and improvement projects.

Information Governance

Information Governance is how an organisation handles patient and staff information which may be of a sensitive nature. This includes ensuring all information, especially personal, is held legally, securely and confidentially.

The Data Security Protection Toolkit (DSPT) was introduced in 2018-19 and replaces the Information Governance Toolkit (IGT).

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

The Trust's end of year position is shown in the table below.

Progress Dashboard and Reports			
Mandatory Reporting – **101/113 mandatory evidence items provided.**		Baseline submission (end of Feb) Current position - Approaching Standards Final submission due – 30/06/23	
Assertions 15/36		Confirmed	
Approaching Standards**: January 2023** **Staff % pass rate for the data security and protection mandatory test**	Current – (Feb 23) 86%	Target 95%	Action to address: *Trust action plan remains in place to deliver 95% by June 23.*

Clinical Coding and Error Rate

Clinical coding is the translation of medical terminology (written by the clinicians) that describes a patient's complaint, problem, diagnosis, treatment or other reason for seeking medical attention into standard codes that can then be easily tabulated, aggregated and sorted for statistical and financial analysis, in an efficient and meaningful manner.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip operation) so that indicators of quality can be produced to help improvement processes.

The Trust has a constant focus on data quality and the need to meet the organisation's reporting requirements against the National Data Security and Protection Toolkit.

Data Quality Standard 1. The Trust uses a variety of systems and processes to ensure poor data quality does not undermine the information being reported. Data quality (DQ) checks are performed on all main reporting domains (including quality, finance, operational performance, and workforce). The Trust makes use of internal and external benchmarks to highlight areas potentially requiring improvement to data quality.

As part of a Foundation Group-wide Information Group review, specifically around the longer term Information strategy, there is a theme around data quality, which will become a focus over the next 12 months. The Trust has started to implement a Data Quality Kite Mark across a small number of indicators within the main Board Key Performance Indicators (KPIs) and a plan is in place to have this across all indicators by the end of the year. This Kite Mark aims to give assurance, and highlight, the quality of the data which supports each indicator.

The following illustrates the percentage coding accuracy at Wye Valley NHS Trust in 2022-23 of which all mandated standards were met as set by NHS Digital.

	WVT results	Mandatory	Advisory
Primary diagnosis	90%	90%	95%
Secondary diagnosis	92%	80%	90%
Primary procedure	93%	90%	95%
Secondary procedure	89%	80%	90%

The Trust is committed to ensuring staff are aware of their responsibility for data quality and the accurate recording of data on Trust electronic systems and paper held records. The Trust have included this responsibility in all job descriptions and regular audits are undertaken. We work closely with our partner IMS Maxims who are supporting with electronic patient record development. The Trust's commitment to data quality is demonstrated by implementing the following principles:

- All staff should be fully trained in the use and recording of data on electronic systems – access should not be given until training has taken place.
- All managers are responsible for data quality within their services.
- Staff are aware of the reporting mechanisms for data quality issues and complaints.
- The Trust has a dedicated team for each electronic system, for managing data quality issues, system management, system configuration in line with national standards and advising staff on managing data quality issues.
- Regular reports are sent out for managers to ensure missing data and errors are actioned and regular meetings are held to discuss and report actions of the same.
- Summary data quality dashboard produced weekly and discussed at weekly Trust wide patient tracking list (PTL) meeting.
- Additional steps added to commissioning data sets processing to identify incorrectly recorded data and passed to the Electronic Patient Record Support Team to correct for the IMS MAXIMS system.

The Patient's NHS number

A patient's NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients.

The Trust submitted records during 2021-22 to the Secondary Uses Service (SUS), for inclusion in the Hospital Episodes Statistics (HES), which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number for the period April 2022 to March 2023, is detailed below.

NHS Number 22-23				
	Has NHS	No Number	Total	%
IP	72605	105	72710	99.9%
OP	319537	171	319708	99.9%
AE	68877	679	69556	99.0%

The Patient's Registered GP Practice Code

Accurate recording of the patient's GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

The Trust submitted records during 2022-3 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records which included the patient's valid General Medical Practice Code reached 100% in both Inpatient and Outpatients.

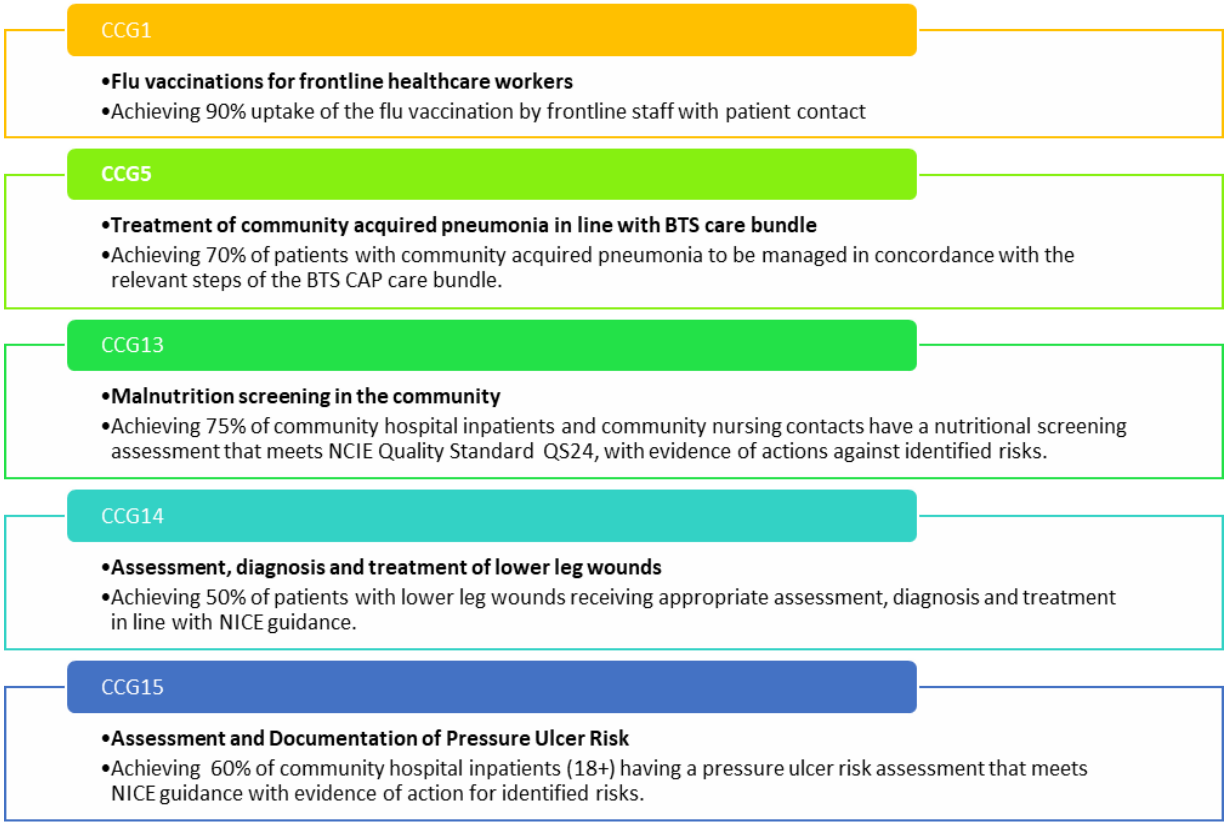
GP Code 22/23				
	GP code	No Number	Total	%
IP	72692	18	72710	100.0%
OP	319690	18	319708	100.0%
AE	67786	1770	69556	97.5%

Commissioning for Quality and Innovations (CQUIN) 2022-23

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care including transformational change.

Each year a number of CQUIN schemes are identified across areas of care. This is linked to targets which may have a financial reward for achievement. With a proportion of the Trust's income provided by meeting these set CQUIN targets. These are nationally reported throughout the financial year.

For 2022-23 the Trust, in agreement with Commissioners have selected five priority CQUIN projects that link directly to the Trust objectives or quality priorities and are as follows:



Wye Valley Trust have submitted the following results throughout the year for the 2022-23 CQUIN programme.

No	Area	CQUIN	Compliance Measure	Q1	% Q1	Q2	% Q2	Q3	% Q3	Q4	% Q4
CCG1	Trust wide	Flu vaccinations for frontline healthcare workers	70% - 90%	N/A	N/A	N/A	N/A	🔴	42.5%	🔴	47.6%
CCG5	Medical	Treatment of community acquired pneumonia in line with BTS care	45% - 70%	🔴	5%	🔴	14%	🔴	37%	🟡	48%
CCG13	Integrated Care	Malnutrition screening in the community (Community Hospitals)	50% - 70%	🔴	39%	🟢	85%	🟢	91%	🟢	94%
CCG14	Integrated Care	Assessment, diagnosis and treatment of lower leg wounds	25% - 50%	🔴	0%	🟡	38%	🟢	71%	🟢	71%
CCG15	Integrated Care	Assessment and documentation of pressure ulcer risk (Community Hospitals)	40% - 60%	🟡	52%	🟢	87%	🟢	87%	🟢	88%
PSS5	Medical	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines	74% - 98%	N/A	No Cases for inclusion	N/A	No Cases for inclusion	🟢	100%	N/A	No Cases for inclusion

Looking forward, the agreed selected indicators for 2023/24 will be as follows, with planning already commenced:

CQUIN05

- **Identification and response to frailty in emergency departments**
- Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

CQUIN06

- **Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service**
- Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.

CQUIN07

- **Recording of and response to NEWS2 score for unplanned critical care admissions**
- Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.

CCG12

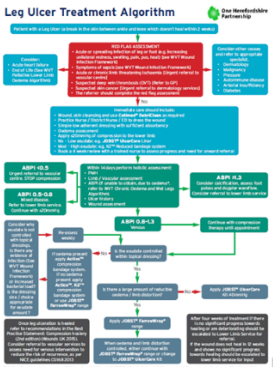
- **Assessment and documentation of pressure ulcer risk**
- Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

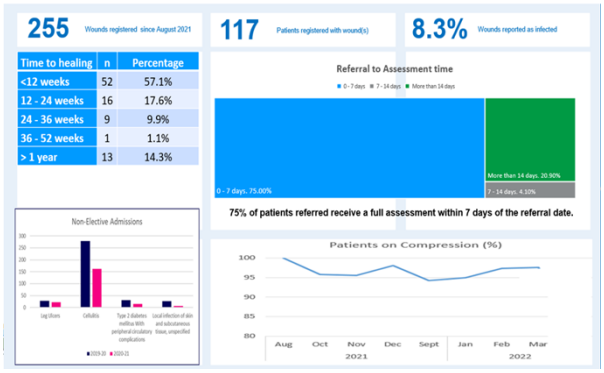
CCG14

- **Malnutrition screening for community hospital inpatients**
- Achieving 90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks

CELEBRATING IMPROVEMENT
Lower Limb Service – Wye Valley NHS Trust

The Wye Valley NHS Trust Lower Limb Service became a National Wound Care Strategy Programme First Tranche Implementation Site for Lower Limb Recommendation in 2020. They shared the view that improvements in data capture and information available to clinicians could support clinical decision-making and enable quality improvements. The WVT Lower Limb team wanted to investigate if digital technology in addition to robust clinical pathways and clear referral processes would enable them to improve healing rates, prevent unplanned admission and improve data capture and reporting.





The Lower Limb Service is now part of the Integrated Neighbourhood service and works closely with primary care providing education to practice nurses and running satellite clinics within GP practices and community hospitals. There is now a consistent approach to the assessment and management of patients with lower limb conditions in line with national recommendations.

At Wye Valley NHS Trust, we are leading the way nationally with the implementation of a Wound Management Digital System (WMDS) and with the innovative Leg Café model at Kington medical centre. This encompasses gold standard clinical care with the very important social elements involved for people who often become socially isolated with their leg ulcers.

Mrs A, is an 89-year-old female with a leg ulcer to the left leg. The ulcer had been present for around 12 months prior to her coming to the Lower Limb clinic. On presentation at the clinic Mrs A was fully assessed, a Doppler done, and the necessary compression applied. She did struggle with concordance to her compression treatment because she felt that it was not achieving any benefits or results. She was not confident that her wound was improving.

The nurse began to use eKare WMDS to digitally document wound assessments, image and measure her wound. It allowed them to easily look back at photographs and treatment plans and adjust accordingly. We were able to share the relevant information with Mrs A.

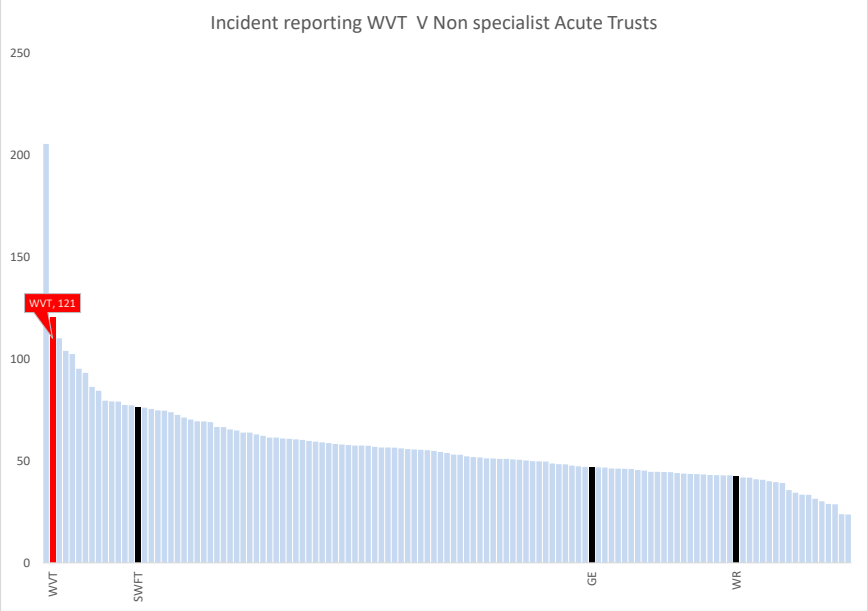
For the first time, Mrs A was able to see a clear picture of the progress of her wound from the photos and the healing trajectory graphs. She was able to see that her ulcer was healing! This really improved her understanding, through pictures, of how compression does help to heal the ulcer. The ulcer healed within 6 months of presentation to the lower limb team and she is now able to self-care applying her own cream and daily wrap.

Quality of Services - Key Areas

Clinical Incident Reporting

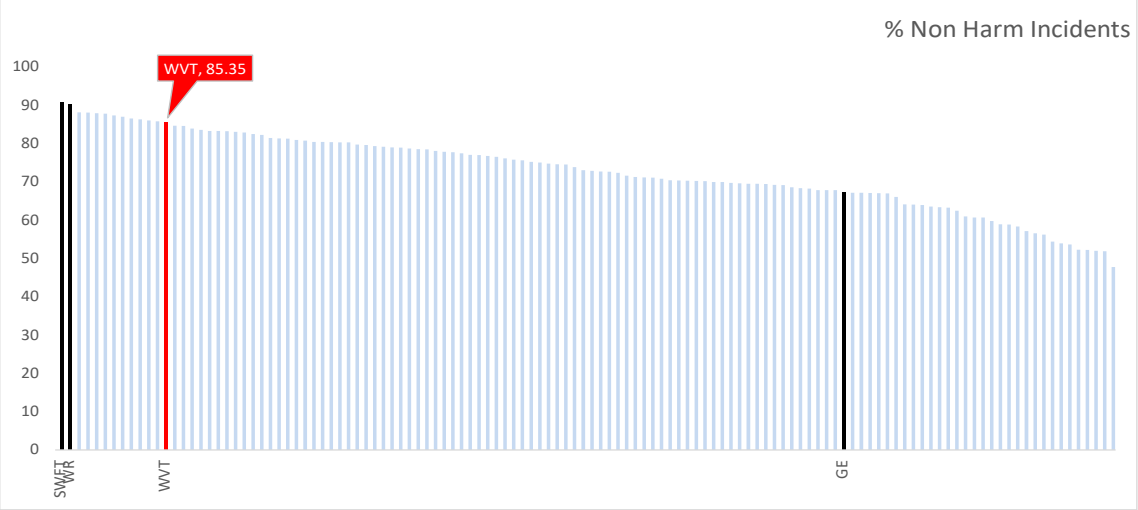
The Trust promotes a culture of safety where staff are encouraged to report actual or near miss incidents. The chart below is taken from the National Reporting Learning System (NRLS) and demonstrates a high level of reporting. The Trust is ranked second against all English Trusts for incidents reported per 1000 bed days, with an improvement seen in rate of reporting from the previous year.

Source NLRS October 2022(Incidents April 2021-March 2022)
Wye Valley NHS Trust is represented by the red bar in the table above. The black bars are the Trusts in the foundation group South Warwickshire Foundation Trust (SWFT) & George Elliot Trust (GE), also shown is Worcester Royal (WR)



Of those incidents reported the level of harm is low, as demonstrated by the next chart, which shows the percentage of no harm incidents 85.4%, compared to the previous year of 83.7%. The Trust is in the top 25% of English trusts for the proportion of incidents that do not cause harm.

Source NLRS October 2022(Incidents April 2021-March 2022)
Wye Valley NHS Trust is represented by the red bar in the table above. The black bars are the Trusts in the foundation group South Warwickshire Foundation Trust (SWFT) & George Elliot Trust (GE), also shown is Worcester Royal (WR)



The charts below provides a breakdown of the level of harm of incidents reported nationally to the NRLS. Diagram one, has the latest available information relating to incidents April 2021 to March 2022, of all the incidents reported that are attributable to the Trust 1% were reported as moderate harm or greater, this compares favourably in comparison to the national average for England of 2% (Diagram two).

Diagram 1

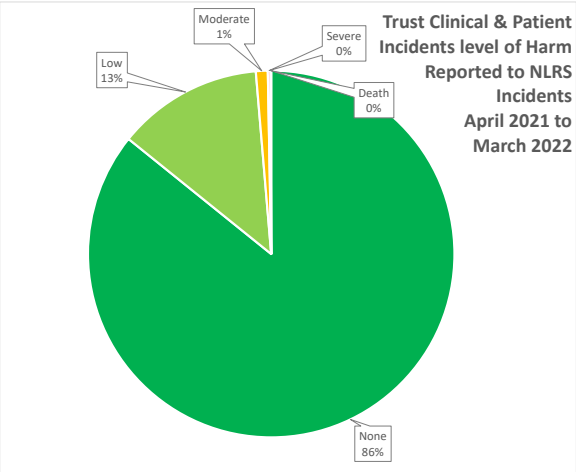
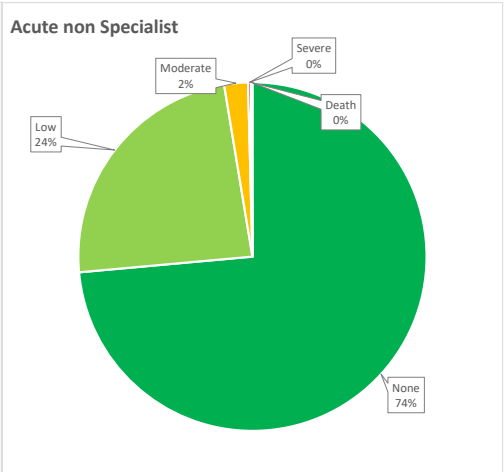
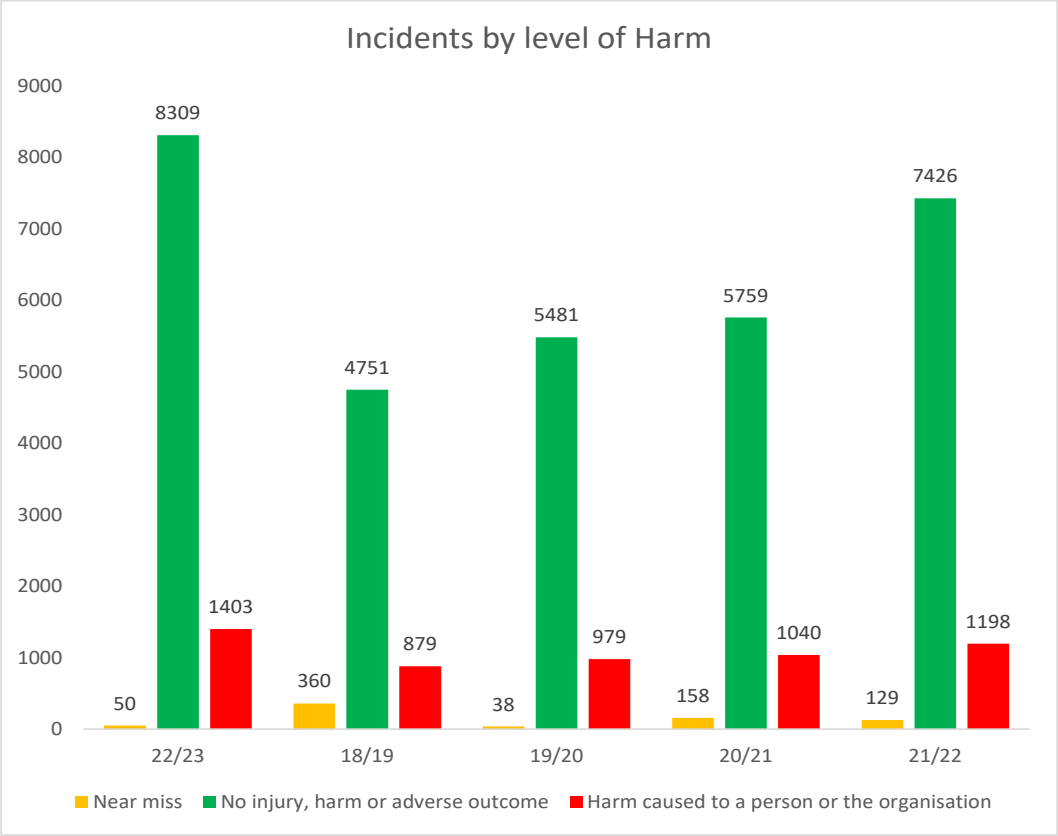


Diagram 2



The chart below shows all incidents reported by the Trust on the incident reporting system. The number of patient and clinical incidents reported increased during 2022-23 by 11.5%. This shows no harm incidents account for 86% of incidents. This increase in reporting is reflective of the increase in activity within the Trust whilst still managing with the impact of the COVID-19 pandemic.



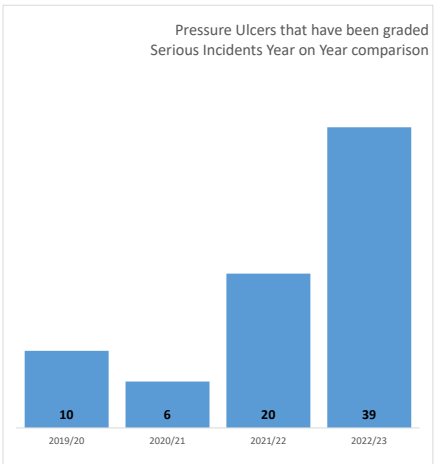
The top five categories of all incidents reported in 2022-23 on the incident reporting system are shown in the next table. The top five remain the same as the previous year.

Category	2021-22	2022-23	% change
Tissue Viability Incident	1926	2384	24%
Infrastructure (inc staff, facilities, environment)	1281	1257	1.87%
Falls	1010	1129	11.8%
Meds Total	931	978	5%
Admission, access, appointments, transfer, discharge	766	900	17.5%

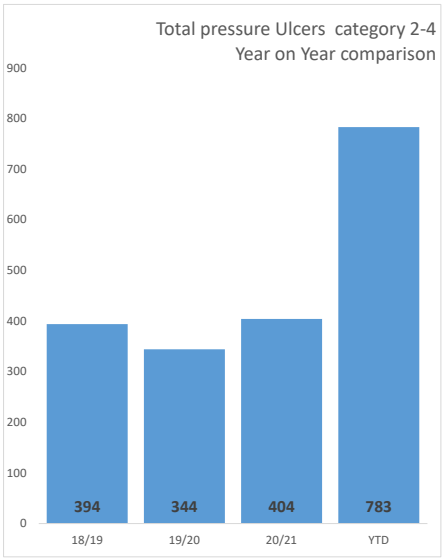
Reducing Harm to Patients

Pressure area care management

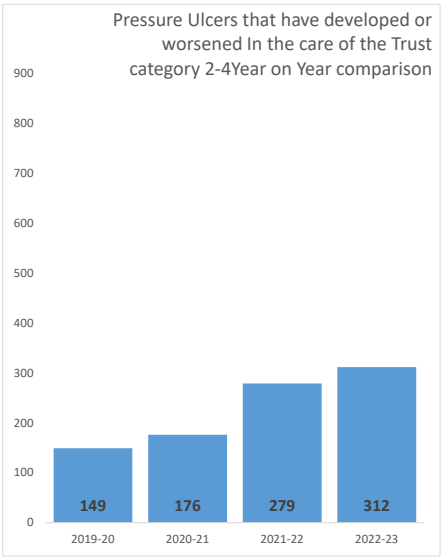
The number of Serious Incidents requiring investigation have increased from the previous year.



There was a 94% increase in pressure ulcers, graded 2-4 in 2022-23.



There was a 12% increase in the number of pressure ulcers that were acquired or advanced in our care



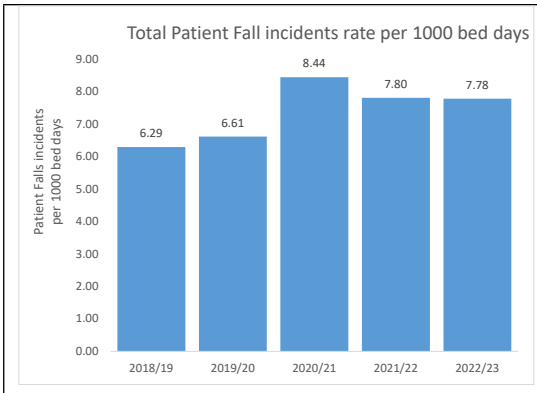
- The Pressure Ulcer Panel reviews all Category 3, Category 4 and unstageable pressure ulcers and deep tissue injuries (DTI) on a weekly basis and evaluate the information to determine if further investigation is warranted.

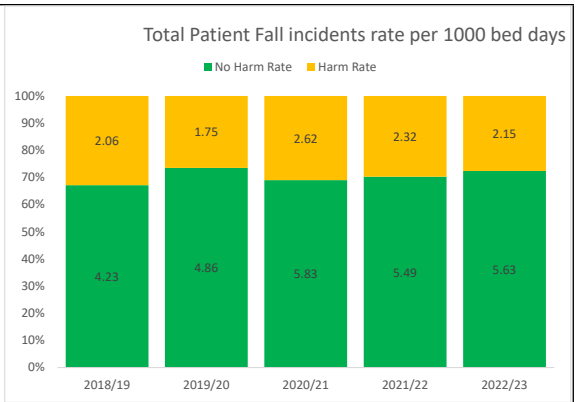
- Pressure ulcer incidence has increased nationally during the pandemic (data source Model Hospital). The Trust has seen an increase in the numbers recorded through patient clinical coding of attributable pressure damage with the impact of COVID-19 on capacity and availability of staff. The Trust has implemented a quality improvement to support the ongoing quality priority to reduce pressure ulcers.

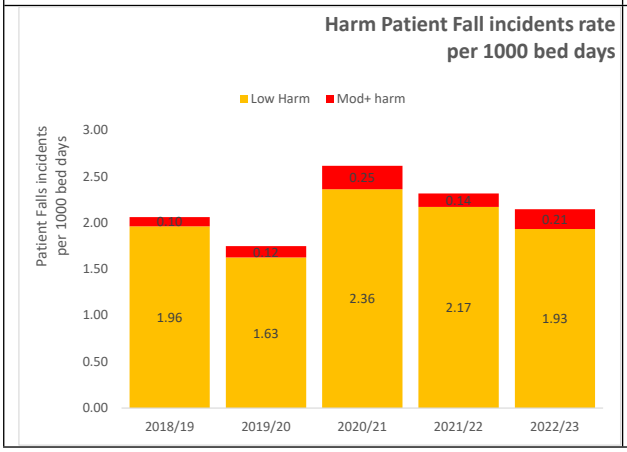
Reduce patient falls

In 2022-23 the Trust saw the following changes in comparison to 2021-22:

The number of falls is measured in relation to the workload of the Trust, the number of patients occupying beds, known as bed days. The charts below show the number of falls in this context.







- The total falls rate per 1000 bed days is very slightly lower than last year.
- Falls resulting in harm is also slightly lower.
- Low harm falls has shown a reduction of 11%.
- Greater harm falls rate has increased by 13%.

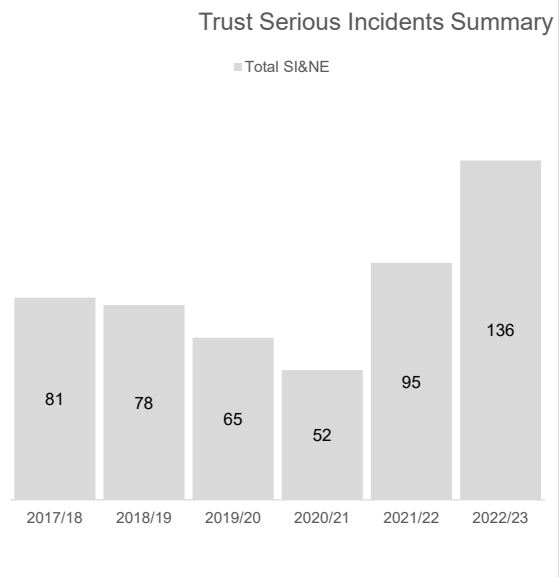
Serious Incidents

A Serious Incident (SI) is defined in the NHS Serious Incident Framework (2015) as an incident that has resulted in:

- The unexpected or avoidable death of one or more people
- The unexpected or avoidable injury to one or more people that has resulted in serious harm
- The unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user; or serious harm.
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/intervention to safeguard against abuse occurring; or where abuse occurred during the provision of care.

During 2022-23, the Trust has seen an increase in serious incidents to 136 with two never events (shown in the chart, opposite). This is a 43% increase, from the 95 incidents and one never event in the previous year.

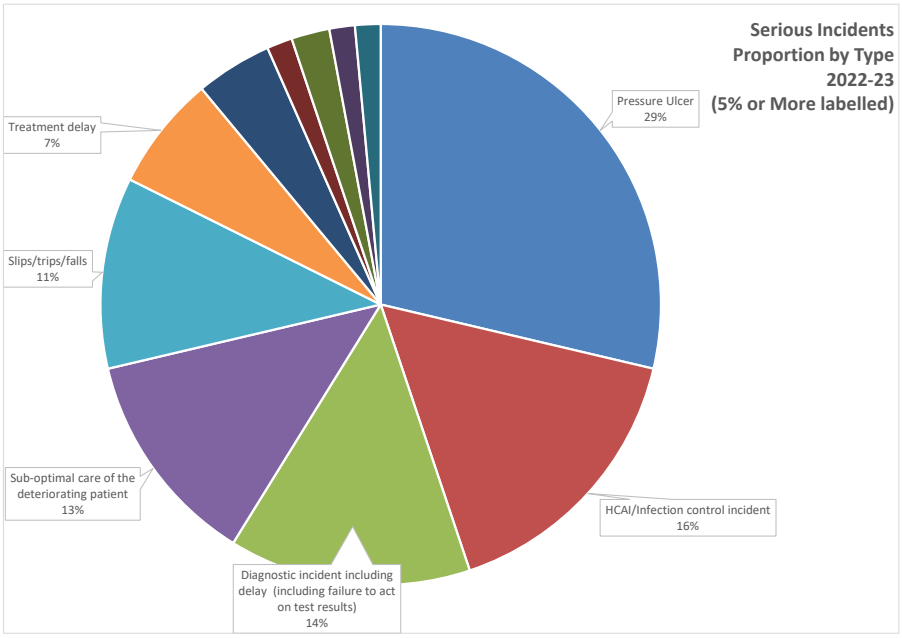
A summary of the cases and some changes to reporting are detailed below, but this increase is also attributed to a more robust discussion of individual cases at the weekly executive-led Serious Incident Panel and collaborative working with the Integrated Care System (ICS) Quality team to ensure the appropriate investigations are undertaken.



Top reported incidents

-Pressure Care (ulcers) 29%
-Healthcare associated infections 16%
-Delayed diagnosis 14%
-Sub optimal care of a deteriorating patient 13%

The chart below shows a breakdown of serious incidents by type for 2022-23.



During 2022-23 the guidance associated with managing the COVID-19 pandemic was continuing to have an impact on serious incidents reporting due to the continued need to report Covid 19 deaths as serious incidents where COVID-19 was acquired in a healthcare setting and died within 28 days of the diagnosis. Until mid-year COVID-19 outbreaks were also reportable as a serious incident. These cases accounted for 26 incidents of the 136 total serious incidents for the year.

In addition, there has been an increase in activity across the Trust with reduced staffing capacity due to the effects of the COVID-19 on sickness levels.

There has been an increase in maternity/obstetric related incidents and this relates to changes focussed on learning and review of processes within the speciality leading to better reporting of incidents that occur. Diagnostic incidents and delays remain at similar level to the previous year.

A reduction in serious incidents relating to falls is consistent with the Trust's clinical focus in these areas.

Management of Serious Incidents

In 2022-23, the serious incident panel has continued to meet on a weekly basis to review patient safety incidents that have been reported as moderate or above harm. The introduction of new ways of focusing on learning have commenced within the Trust, with the principles of the Patient Safety Incident Response Framework (PSIRF). Developing the approach to maintain effective systems and processes for responding to patient safety incidents.

The following developments have been implemented:

- Cluster reviews of incidents that present with similar themes.
- Focussing on learning and robust actions.
- A balanced approach to the level of investigation required.
- Engaging patients and their relatives in the reviews and investigations.

The Trust continues to triangulate with complaints, claims, mortality reviews, safety alerts and quality improvement to ensure thorough reviews are completed.

During 2022-23, the Trust reported two Never Events both related to ophthalmology procedures.

These incident have been investigated fully under the current Serious Incident Framework (2015) using the Root Cause Analysis methodology. The outcomes of these investigations are monitored through the Patient Safety Committee.

Duty of Candour

It is the legal duty of all health and social care providers to be open and transparent with people using services. To ensure the Trust do this for every patient every time, our incident reporting system has a prompt which directs the handler of the incident to record relevant information to fulfil duty of candour.

Duty of candour is then monitored through monthly divisional and corporate reports up to the Trust Board.

The Trust endeavours to put the patient at the heart of our processes and provide a transparent decision making process for how we investigate incidents and complaints. In addition to ensuring we apologise to patients when something has gone wrong or harm caused, the Trust continues to provide an opportunity to patients and their families to be involved in the investigation whether that is by sending a list of questions or face-to-face meetings.

In 2022, the Trust aligned the patient safety and complaints team under the same leadership. A primary reason for this was to create stronger links in intelligence in relation to patient harm. Patients could be reporting incidents when raising a complaint. The aligned teams can therefore better make a decision how best to investigate individual cases and ensure collaboration occurs where a complaint has been received relating to a known incident. This is to provide one single point of contact for the patient and families and ensure they feel included in the investigations if they choose to do so.

SAFEGUARDING

Adult Safeguarding

Adult Safeguarding means protecting a person's right to live in safety and free from abuse and neglect and is everybody's business. This remains a high priority for the Trust and we continue to work with partner agencies across Herefordshire and beyond to ensure best practice.

The Trust ensure the principles of empowerment, prevention, proportionality, protection; partnership working and accountability have been applied preserving the individual's wellbeing at its core. The outcomes being that people are:

- Safe and able to protect themselves from abuse and neglect.
- Treated fairly and with dignity and respect.
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

Making Safeguarding Personal (MSP) continues to remain a high priority and the Trust have ensured the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests process in everyday practice. The Trust has an adult safeguarding performance dashboard, which is monitored and discussed at the Trust's Overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Quality Committee, with a report produced for the Trust Board annually.

The Trust has maintained their commitment to be an active member of the Herefordshire Safeguarding Adult Board and associated sub-groups, contributing to multi-agency audit,

Safeguarding Adult Reviews and

The Trust has equally maintained their commitment to work collaboratively with out of county Safeguarding Boards.

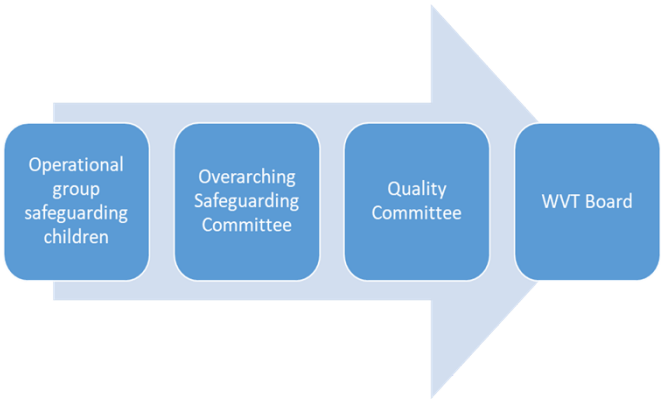
Children Safeguarding

A child and/or young person is defined as anyone who has not yet reached their 18th birthday.

Safeguarding children and young people is central to the quality of care provided to patients by the Trust. The Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2018. All NHS trusts are required to have effective arrangements in place to safeguard vulnerable children and to assure themselves, regulators and their commissioners that these are working. All health providers must be registered with the Care Quality Commission (CQC) and are expected to be compliant with the fundamental standards of quality and safety. The Chief Nursing Officer is the Trust's Executive Lead for Safeguarding Children and the Associate Chief Nursing Officer oversees the management of and the work undertaken by the safeguarding children team. The Trust has maintained a robust focus on Safeguarding Children through the governance arrangements depicted below.

- Provide oversight and assurance

Domestic Homicide Reviews.



The work of the safeguarding team is multi-faceted and relies heavily on partnership working, both internally and externally. The Trust strive to deliver a seamless integrated service to safeguard children from abuse and neglect. The Child Safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

The core functions of the team are to:

- Provide clinical leadership in respect of safeguarding to support high quality safeguarding practice.
- Offer support for practice development through:
  - Providing a robust training and development strategy utilising education forums, light bite sessions as well as formal training.
  - Supervision.
  - Coaching.
  - Share learning from safeguarding practice reviews.
  - Support and advise on case management, including attendance at complex meetings.

regarding how the Trust is meeting

its obligations in respect of Safeguarding Children.

- To provide oversight and development of policy and procedures.
- To provide challenge and scrutiny of safeguarding practice internally and externally.
- To support staff to provide high quality statements for court, the police and if attendance at court is required.
- To undertake internal management reviews and contribute to multi-agency practice learning / serious case reviews.
- Support the business of the multi-agency partnership.

The Trust has an established safeguarding children quality framework, which includes a safeguarding children performance dashboard and an annual audit plan. The Trust's Overarching Safeguarding Committee monitors this framework. A report summarising activity and priorities is produced for the Trust Board annually. Learning from single and multi-agency audits, child safeguarding practice reviews and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

Ensuring staff receive the required safeguarding children training continues to be a priority and compliance rates for Levels 1, 2, 3, 4 and Board level, are shown in the table below.

Training	At 28th Feb 2023	Target
% staff trained at level 1	88%	85%
% staff trained at level 2	88%	85%
% staff trained at level 3	82%	85%
% Staff trained to level 4	100%	85%
% Board Level	87%	85%

The Trust continues to support the business of the Herefordshire Safeguarding Children Partnership in a number of ways for example; by aligning safeguarding children priorities to those of the partnership; contributing to the work of the various subgroups and task and finish groups and by providing trainers for various learning and educational events. Additionally, the Trust provides the health practitioner within the multi-agency safeguarding hub (MASH) which is often the first point of contact for professionals, family members or the public when they have concerns about a child's welfare or safety.

National Safety Standards for Invasive Procedures and Local Safety Standards for Invasive Procedures (NatSSiPs and LocSSiPs)

Over the past twelve months, the Trust has continued to embed LocSSIPs into practice with the:

- Introduction of a centralised Trust register for LocSSIPs.
- Following a review of existing documentation, the introduction of an updated. LocSSIP standard operating procedure template and new 'how to guide'.
- Commenced uploading LocSSIP templates onto 'Maxims' to enable electronic completion of documentation, in line with the shift to a paperless system.

National Safety Standards for Invasive Procedure 2 (NatSSIPs). Published January 2023

For 2023-24, the Trust will focus on implementation and embedding the recently published guidance 'NatSSIPs 2' by the Centre for Perioperative Care (CPOC).

This publication has seen NatSSIPs guidance evolve, containing less emphasis on tick boxes or rare 'Never Events', to now including cautions, priorities and a clear concept of proportionate checks based on risk with the focus being on implementation.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records for:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases
- certain 'dangerous occurrences' (near miss – incidents with a high potential to cause death or serious injury)

The reporting requirements relating to cases of or deaths from, COVID-19 under RIDDOR apply only to occupational exposure, that is, because of a person's work.

The Trust has a legal duty to report all RIDDOR reportable incidents in a timely manner. Work related accidents which lead to a member of staff unable to work, or are unable to perform their normal duties for a period of more than seven days need to be reported within 15 days of the incident. More serious incidents including deaths, fractures, breaks need to be reported within 48hrs.

During 2022-23, there were a total of 13 RIDDOR reportable incidents, an increase of 4 compared to 2021-22. Of the 13 incidents, there was 1 staff and 12 patient incidents.

All patient incidents were due to falls, 10 of which were unwitnessed. The list below provides an outline of some of the injuries sustained from these incidents:

- 6 fractured neck of femurs.
- Fractured left pubic rami.
- Fractured humerous.
- Displaced orbital fracture.
- Multiple rib fracture.
- 2 fractured neck of greater tronchanter.

The staff incident was a slip on level ground, when rainwater had egressed during a heavy storm into the corridor. The staff member slipped on the wet floor and sustained a wrist fracture.

Patient Related Outcome Measures (PROMS)

What do we do?

Participation in the national patient Reported Outcomes (PROMs) programme is mandatory for Trusts in England where the relevant operative procedures are undertaken. The procedures included within the programme are: Hip replacements and knee replacements.

Patients are asked to complete a questionnaire pre-operatively and then at 6 months post-surgery. The questionnaires include general quality of life measures and some condition specific measures. Comparison is then made of scores pre- and post-surgery to gauge the level of health gain following the operation. Results are usually publicly available through the NHS & Social Care Information Centre website.

How are we doing?

Reporting has currently been paused due to a national issue and NHS digital has not yet given a date when publications will resume but the Trust continues to submit data to the programme.

Statement from NHS Digital relating to report availability

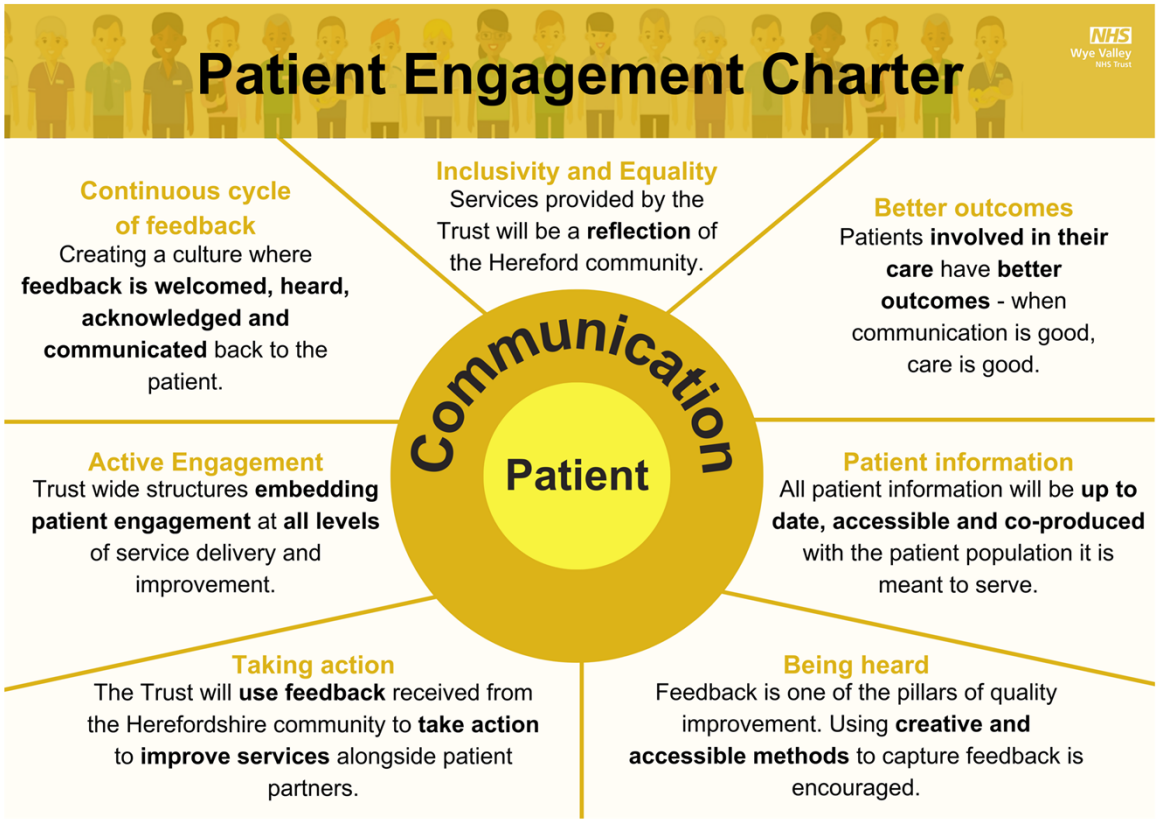
"In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known".

Improving Patient Engagement

The Trust receives feedback on its services through a number of different sources. This includes direct engagement and survey results as well as friends and family test (FFT), compliments, concerns and complaints data.

The patient engagement charter, co-produced with the trust wide patient Engagement group, was presented to and approved by the Trust Board as part of a wider patient experience workshop in July 2022. At this workshop a new framework for patient engagement was also presented that defined levels of engagement as well as the recruitment processes and training required at each level.



Within the Trust our engagement representatives supported the reinstated PLACE (patient led assessment of the care environment) audit. This saw service users joining staff to carry out the audit across both Acute and Community sites. Once published these results will be shared with those who participated. Service users also joined the Chief Nursing Officer at a workshop to develop user-friendly posters to share the cleanliness star ratings with service users.

Service users also continue to support review of patient information resources as part of our virtual reader panel, to ensure patient information is understandable and accessible to end users.

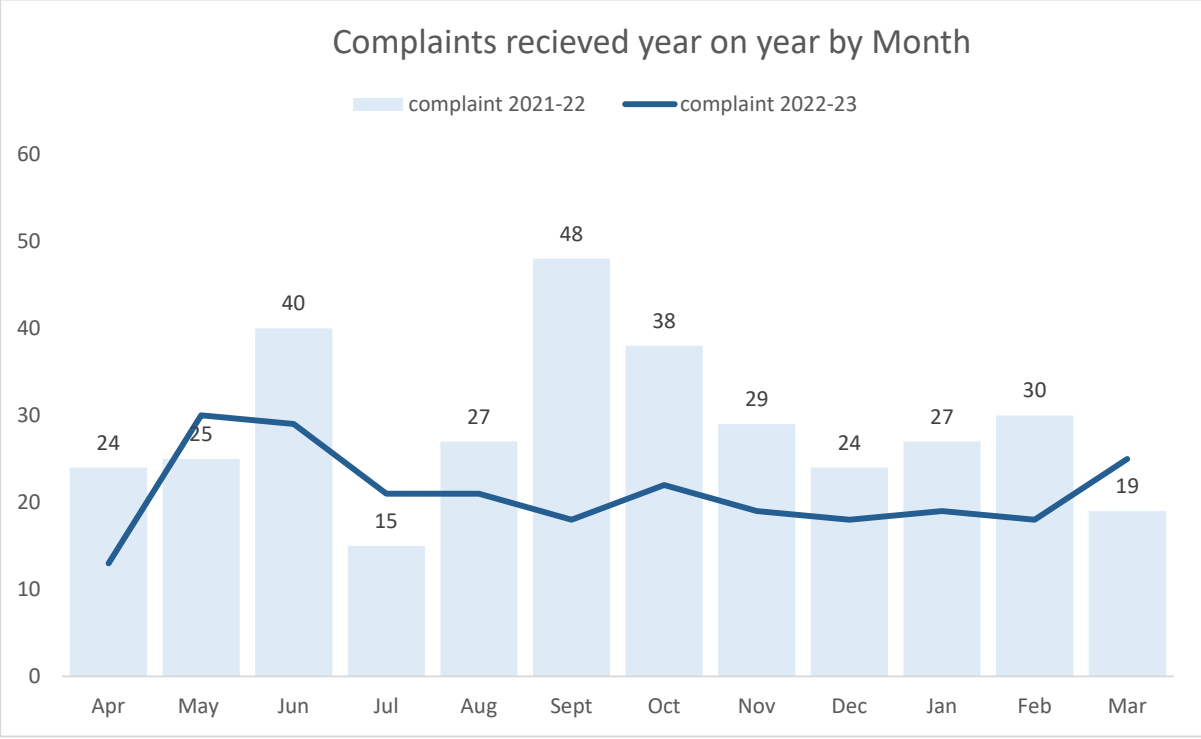
In addition, the Trust continues to work with both healthcare and voluntary sector partners, through the Maternity Partnership Voices Forum (MVPF), Herefordshire Community Partnership and as part of the wider ICS Herefordshire Engagement Network to share learning and support the embedding patient engagement in all areas of service development.

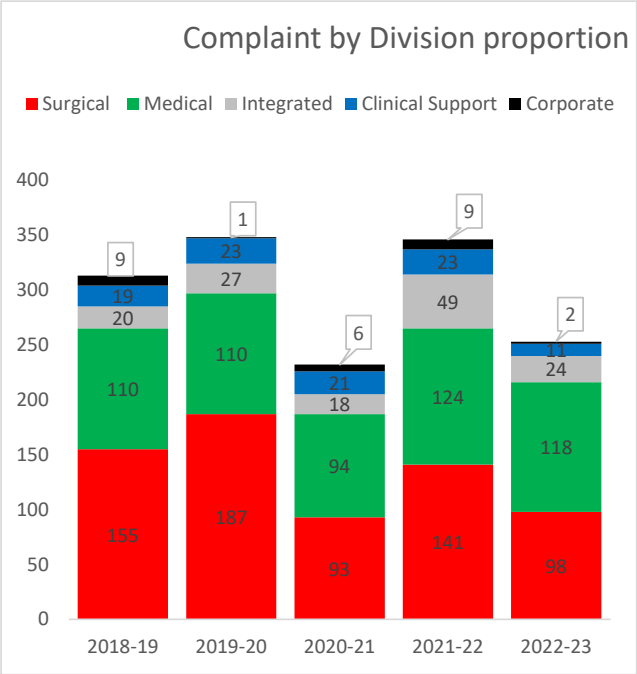
Complaints

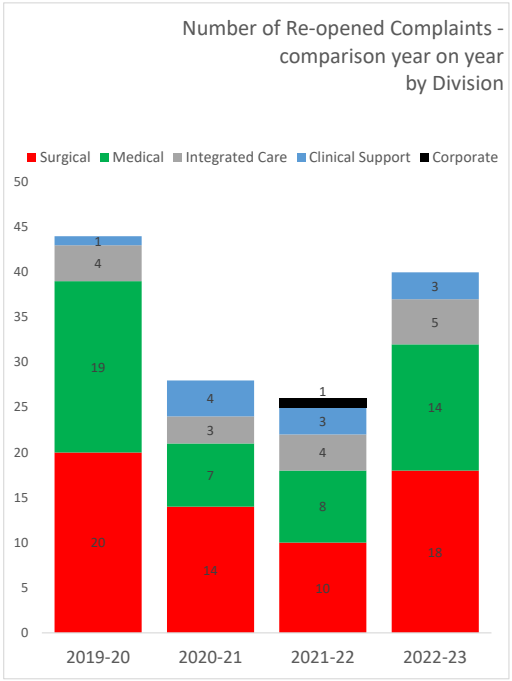
During 2022-23 the procedure for logging complaints has been reviewed and there is now a robust triage process to analyse complaints in more depth, identify themes and triangulate with multiple sources of patient safety information, which improves our understanding of safety, and our patient safety culture as well as patient experience.

The overall number of complaints received during 2022-23 saw a 27% reduction (or 93 complaints less) when compared to the previous year. The medical division received the highest proportion of complaints, with a significant reduction in complaints relating to surgical services this year.

Whilst an overall reduction in complaints has been noted, there has been an increase of complaints that have been reopened, from 21 in 2021-22 to 41 in 2022-23 (95%). In addition, the number of complaints being investigated by the Parliamentary and Health Service Ombudsman (PHSO) in 2022-23 was 2, compared to 0 in the previous year.







Complaint categories

In 2022-23 73% of complaints received related to reported issues with the following categories by complainants:

- Communications.
- Clinical treatment.
- Patient Care.

1. Communication:

There may be more than one communication issue within a complaint e.g. communication with patient or carer, between departments or with the GP. Overall, from late 2020 the number of communication issues identified within a complaint has increased, whilst the number of complaints has decreased which may reflect the more detailed complaint examination process.

2. Clinical Treatment:

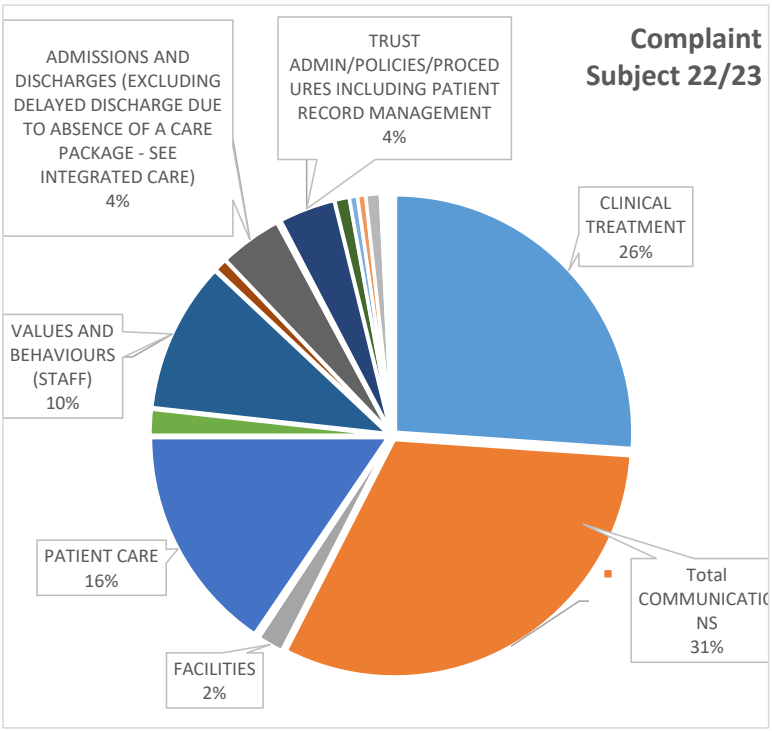
A review of complaints in terms of subcategory shows delay in treatment or diagnosis accounts for 63% of complaints and concerns within a Clinical Treatment category.

Triangulating this data with patient safety incidents shows us that Clinical assessment (including scans, tests, assessment and treatment) accounts for 7% of total incidents, almost 800 incidents and 8% of harmful incidents.

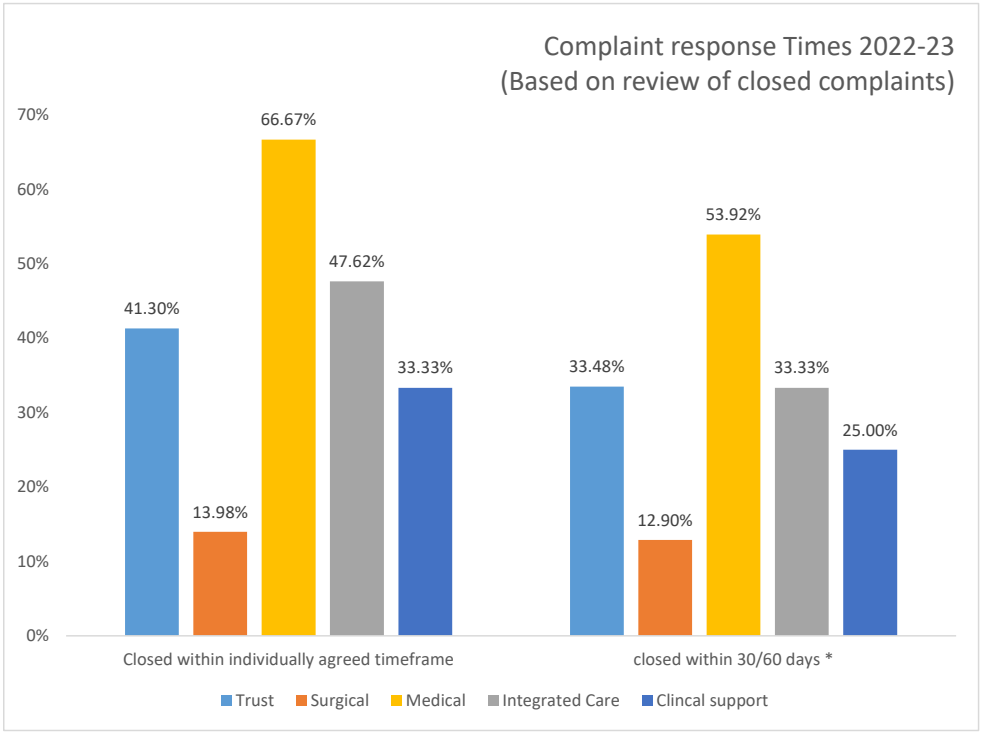
3. Patient Care:

There are 36 sub-subjects within the patient care category. A review of the complaints received within the patient care category shows the most frequent are falls, issues with access to or assistance with food and hydration and care needs not being adequately met.

There is now a standing session in the corporate induction programme regarding complaints management and the support that the complaints team can offer colleagues and there are plans to also incorporate a session on incident and complaint management and governance into the revised medical induction programme.



Complaint response times:



Due to the increase in operational pressures experienced by the Trust at the beginning of 2023, complaint response times were increased from 30 days to 60 days for the months of January and February.

Over all, the number of complaint responses that are completed within the agreed 30-day timeframe is low at only 33%. This increases when a response timeframe has been agreed that differs from the 30 days but remains poor at 41%.

Despite having the highest proportion of complaints, the Medical Division has the best compliance with complaint timeframes with the Surgical Division having the lowest compliance. Work is underway to further understand the barriers to timely responses and to learn from better performing divisions.

Given that trust wide compliance requires improvement overall, work is also underway in partnership with the ICB to refine processes for complex or multi-organisation complaints. This will also be presented at Safety in Sync to discuss responsiveness to complainants and ways of improving PLACE level responses.

The changes proposed in the National Patient Safety Strategy will also influence the Trusts processes for management of complaints over the coming year. The strategy implementation work was one of the drivers for the Trusts decision to move to an alternative digital risk management system from April 2023. The new provider 'InPhase' will have additional functionality within its platform to effectively triangulate data from all modules. Being able to analyse emerging themes and trends will enable effective oversight and early action to support safety improvement work.

In late March 2023 the Trust transitioned from our previous risk management system; Datix to InPhase Oversight.

Inpatient and National Surveys

Two national survey reports were released by the CQC in 2022/23 for the following areas:-

Inpatient Survey

A total of 1250 patients who had an overnight stay in an acute bed in the hospital during November were given the opportunity to participate in the survey. A total of 571 responses were received, representing a 48% response rate. The results of the survey were issued by the CQC in October 2022.

1. When compared to results from all Trusts nationally, WVT performed 'about the same' as other Trusts in 43 areas.
2. There were four questions where we performed lower than average. These were:-
   - Being given food that met your dietary requirements.
   - Rating of the hospital food
   - Information with respect to your condition or treatment .
   - Giving views on quality of care.

The Trust is actively working with our PFI partners and food providers to regularly monitor and audit our food services, to include engaging and working with patients and obtaining regular patient feedback.

In response to our patients being given the opportunity to comment on the quality of their care, the Trust has invested in the use of text messaging to obtain feedback and this is being rolled out to all areas. In addition, the Trust has implemented a rolling programme of local surveys to capture more real time feedback and drive improvement of our services for patients in our care.

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National Surveys 2022/23

There were three national surveys, commissioned by Care Quality Commission (CQC) and carried out during 2022/23; the annual inpatient survey, maternity survey and Adult and Emergency Care Survey.
The results of these will be received later in 2023.

Maternity Survey

A total of 244 mothers who gave birth during January and February 2022 were given the opportunity to participate in the survey. A total of 117 responses were received, representing a 49% response rate. The results of the survey were issued by the CQC in November 2022.

1. When compared to results from all Trusts nationally, WVT performed. 'about the same' as other Trusts in 47 of the 50 questions asked.
2. The Trust performed worse than expected in the following two questions:
   - At the start of your labour did you feel you were given appropriate advice and support when you contacted a midwife?
   - Were you told who you could contact if you needed advice about any changes to your mental health?
3. The Trust performed better than other Trusts in the following question:
   - On the day you left hospital, was your discharged delayed for any reason?

The results have been shared with the maternity team for review and to develop improvement plans

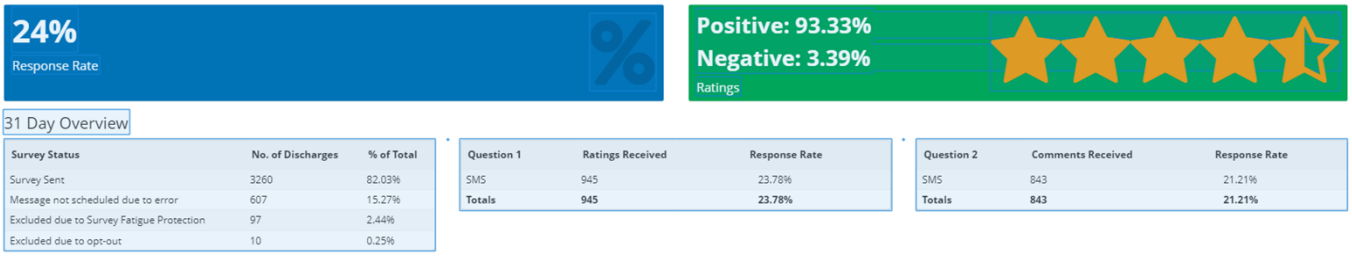
Friends and Family Test (FFT) – National Data Collection

In July 2022, the Trust introduced a new system for receiving feedback from patients for the Friends and Family test. The Trust now sends a text message to patients to receive their feedback. The service has now been rolled out to outpatient, inpatient and day case services.

Since its introduction, a total of 3576 ratings have been received. This represents a 22% response rate from our patients and service users. Over 92% of ratings were positive. Whilst Trusts are no longer monitored on response rate we know that the more feedback we receive the more opportunity we have to improve patient experience. Prior to using the text messaging service the Trust response rate was between 1% and 6%.

The plan for 2023/24 is to continue the roll out to all areas (Emergency Department, Maternity and Community Services).

The benefits of the new system include live data dashboards. Staff have real time access to feedback specific to the service they provide which allows for meaningful, focused improvement initiatives. The next year will focus on staff training ensuring that the dashboards are being used for this purpose. The Patient Experience Committee will oversee how the feedback is being used to improve service provision for patients.



Survey Status	No. of Discharges	% of Total
Survey Sent	3260	82.03%
Message not scheduled due to error	607	15.27%
Excluded due to Survey Fatigue Protection	97	2.44%
Excluded due to opt-out	10	0.25%

Question 1	Ratings Received	Response Rate
SMS	945	23.78%
Totals	**945**	**23.78%**

Question 2	Comments Received	Response Rate
SMS	843	21.21%
Totals	**843**	**21.21%**

Freedom to Speak Up (FTSU)

The requirement for Trusts to have a FTSU Guardian, as a mandated post in NHS Trusts continues as an outcome of the public enquiry in 2016 chaired by Sir Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust.

There are now over 900 FTSU Guardians in over 500 NHS primary and secondary care, independent sector organisations and national bodies. FTSU guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017. In 2022-23 WVT had over 70 cases with each providing an opportunity to learn and improve to benefit the wellbeing of our colleagues and the care we provide to our service users. Research and data shows that an open culture in a Trust provides the safety needed for staff to speak up in the confidence that their voice will be heard.

After a year in post Dr Jayne Chidgey-Clark, the second National Guardian for the NHS, said:

"The Freedom to Speak Up movement has been a catalyst for positive change but there is still much more to be done"

FTSU and Civility Saves Lives

The Guardian alongside the team of FTSU Champions at the Trust continue to work together striving to meet the National Guardian's call to *'do as much as possible to push for positive change'*.

The Guardian leads on this by promoting FTSU, Civility Saves Lives (CSL) and the need for teams to create a space of physiological safety. This has all been promoted across the Trust in a number of ways both virtually and increasingly face to face:

- Mandated eLearning for Speaking Up for all WVT staff. This is one of the KPIs for measuring staff awareness of how to raise concerns and what they can expect.
- Delivering CSL sessions to almost 400 staff both Trust wide and bespoke to teams.

National Speaking Up Month

In the National Speaking up Month, October 2022, a presentation was made to a Board Workshop including a gap analysis and full review of Speaking Up at WVT. The work for this and the discussion within the session framed the FTSU action plan for 2022 and 2023.
In addition, the FTSU team contributed to Staff Wellbeing week and attended the Foundation Group FTSU conference hosted by SWFT as well as promoting FTSU via the Trust's Safety Bites Bulletin within Trust Talk (the global weekly newsletter for staff).

FTSU Quality Indicators

- Delivering awareness of FTSU and CSL at every Corporate Induction as well as other bespoke training. This includes timetabled sessions with foundation doctors, doctors in training, preceptorship nurses.

FTSU quality indicators include the Trust's National FTSU Index score. The score is currently calculated using four questions from the NHS National Survey.

Year of the Staff Survey	WVT Score	National/ Sector Score	Position Nationally
2021 Model Hospital /Staff Survey report	6.7	6.4 [2]	Quartile 3 Mid to High
2022 Model Hospital/Staff Survey report	6.5	Awaiting publication	Awaiting publication

Six data points are included in the quarterly returns to the NGO by the FTSU Guardians that include Worker Safety (new in 2021-22) and Inappropriate Attitudes and Behaviours added for 2022 -23.

Totals for year 2022-23

(Note numbers will not match number of cases as some have more than one data point associated with the case and some have none)

Anonymous Reports	6		Suffered a Detriment	2
Bullying and Harassment	5		Worker Safety/Wellbeing	23
Patient Safety / experience	16		Inappropriate Attitudes and Behaviours	22

Staff Friends and Family Test

The Staff Friends and Family Test is no longer run separately, with the questions now included in the national quarterly pulse survey and annual staff survey.

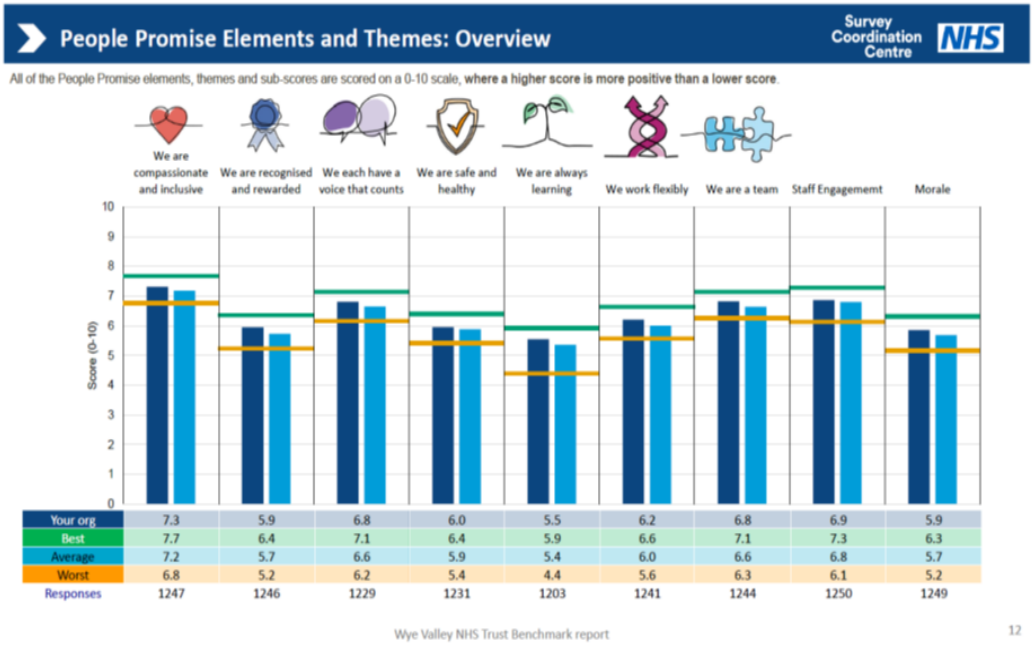
NHS Staff Survey 2022

The 2022 NHS Staff Survey ran from September to November 2022 and 35% or our staff (1,255) participated in the survey. From the 2021 survey, onwards the questions in the NHS Staff Survey are aligned to the People Promise i.e. key elements that would most improve the working experience for staff.

WVT has above average results in all 9 areas which are:

- Compassionate and Inclusive.
- Recognised and Rewarded.
- Voice that Counts.
- Safe and Healthy.
- Always Learning.
- Work Flexibly.
- We are a Team.
- Staff Engagement.
- Morale.

The following chart details the Trust's performance against the seven People Promise elements, benchmarking WVT results against the best and the worst performers within the benchmark group of Combined Acute and Community Trusts.



The two themes of Staff Engagement and Morale are directly comparable over a number of years dating back to 2018 and both have remained at similar levels and higher than the average benchmark throughout.

Whilst the Trust have achieved above average scores across the nine areas, we know that there continues to be more to do to make improvements and a refreshed action plan has been produced for the year ahead both at organisational level and with bespoke plans at Divisional and Directorate levels. The Staff Survey Working Group will continue to monitor progress against the plan and ensure sharing and regular communication of good practice.

Health & Wellbeing

This last year has continued to present a challenging time and despite this our staff have continued to go above and beyond in providing care for our patients and support for our colleagues.

Health and Wellbeing of our staff remains a high priority, and the Trust continue to have in place support and interventions accessible to all staff which include the Mental Health & Wellbeing Hub, Employee Assistance programme, access to NHS apps and support lines, face to face counselling and clinical psychology. In addition, we are now delivering regular Schwartz Rounds to support emotional and psychological wellbeing of staff and Halo Leisure instructors have expanded their presence and wellbeing programme across our Community Hospital sites.

As part of our wellbeing programme, the Trust signed up to the Menopause Workplace Pledge to demonstrate our commitment to creating a supportive environment for all employees affected by the menopause at work.

The WVT Health & Wellbeing group and the Menopause Working group with Occupational Health, Human Resources and Halo leisure representatives will continue working on actions to provide more support to staff over the coming year.

Appraisals and Mandatory Training

The table below shows the Trust's performance against statutory and mandatory training and appraisal as at end of January 2023.

	Target	Actual January 2023
Statutory and Mandatory Training	85%	89.3%
Appraisals	85%	74.5%

Recruitment and Retention

Recruitment and Retention has been a key focus as part of the Trust's organisational strategic objectives, we have made good progress throughout the year in particular in reducing our vacancy levels of Healthcare Support Workers, and have recruited to target our international nurses.

The Trust has forged a strong collaborative working approach with DWP and other partners on our local recruitment strategy as well as joint events with partners across the ICS.

We are extremely proud to have won the Hereford Times Health & Social Care Awards 2022.

Workforce and Organisational Development (OD) Strategy

Our Workforce & OD Strategy identifies the Trust's 5-year workforce priorities through to 2026 and is designed to support the delivery of the Trust's vision, mission and strategic objectives. It sets out our strategic workforce priorities and the approach we will take to deliver them.

The key enablers within the strategy to support its delivery are themed as:

- Health, Wellbeing and Staff Engagement
- Equality, Diversity and Inclusion
- Leadership and Management Development
- HR Policies and Procedures
- Education and Development

In addition to this, for the year ahead one of our Workforce strategic objectives is 'To be a very flexible employer' which will link strongly to the Trust's ability to attract, recruit and retain.

NHS Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps.

Our Medical and Surgical Divisions maintain detailed rotas identifying gaps. Detailed improvement plans are in place to address gaps, actions within these plans include Divisions

undertaking a targeted piece of work on our Junior Doctor requirements to ensure that the Trust has sufficient baseline numbers to cover all the specialties with agreed numbers of staff. In addition, a review of the rotas had how they work together will be undertaken to ensure cover is sustained. Pre-emptive recruitment is undertaken for predicted gaps with robust processes being in place to manage short notice gaps.

Table A – 1st rotation 03/08/2022 – 06/12/2022
Deanery Doctors

Grade	Entitled To	Filled	Gap
Medicine FY1	17	13	4
Medicine FY2/IMT	3	3	0
GPST	3	2.6	0.4
ED FY2	3	2.8	0.2
ED GPST	3	2.6	0.4

Table B – 2nd rotation 07/12/2022-04/04/2023
Deanery Doctors

Grade	Entitled To	Filled	Gap
Medicine FY1	17	13	4
Medicine FY2/IMT	3	3	0
GPST	3	2	1
ED FY2	3	2.8	0.2
ED GPST	3	1	2

Celebrating Change

Over the past 12 months, our community hospitals have undertaken extensive quality improvement work that they wish to shout about!

NHS Wye Valley NHS Trust

Integrated Services Directorate

Safe

- Introduction of Community Hospital Tri to cover Clinical and operational requirements
- Weekly CD Audits at 100%
- Weekly senior nurse ward assurance checklist
- Monthly Matrons ward assurance checklist
- Improvement in compliance seen in Documentation audits
- Lessons learnt from individual CHs DATIX implemented across all 3 sites

Effective

- Daily clinical oversite of staffing across all three Community Hospital sites
- CQUIN audit improved above 90%
- Bi Monthly Sisters meetings bringing CH together instead of individual sites
- Development of CH Quality Board and development of robust governance and assurance reporting processes
- Reduction in overdue incidents overall – improvement plan in place to target remaining incidents.

Caring

- Positive feedback in PLACE Audits with improving trajectories seen in all areas
- Civility Saves Lives Sessions completed in each CH site
- Staff engagement events completed in each site
- Reintroduced weekly Chaplaincy visits to the wards.
- Both ICD Matrons qualified as Professional Nurse Advocates and provide regular Restorative Clinical Supervision to support staff resilience

Responsive

- MDT Daily Board Rounds implemented within all CHs to identify and action any medical, clinical and therapy requirements for each patient
- Criteria to reside and Length of stay collected and monitored daily.
- Successful recruitment events across all CHs resulting in reduction in agency spend and continuity of care for patients
- Recruitment of the first 10 OSCE nurses across the 3 sites. Further 6 OSCE nurse recruitment agreed for 2023

Well Led

- Appraisals over 85% in all 3 sites
- Monthly ward meetings implemented to ensure key information is shared with all members of the team
- Daily focus of risk assessments including MUST Monday, Training Tuesdays, Waterlow Wednesday, Thirsty Thursday, Falls Friday to
- Excellent feedback from student Community pathway
- Increase in compliments from Patients and families
- Increase of Band 6 Junior sisters roles to provide leadership across all sites

Quality Priorities:

Review of the Previous Twelve Months

Quality Priorities for 2022-23

The Trust identified ten quality priorities for 2022-23 which are detailed below. This section explains the progress made for each priority over the previous 12 months.

Safe	Effective	Experience
1. Reduce the incidence of pressure ulcers acquired/ deteriorating in our care and improve lower limb wound healing rates. 2. Focus on Mortality Outlier Groups 3. To reduce Clostridioides Difficile infection rates. 4. Improve patient safety through implementing change as we learn from incidents and complaints across our system.	5. Ensure the Trust meets best practice requirements for nutrition. 6. Improved compliance with VTE assessment and prevention in line with best practice.	7. Demonstrate overall improvement and improve our scores on all aspects of the inpatient survey and experience of community service users (district nursing). 8. Improving the discharge experience from all services (acute and community based) for our patients and their families/carers. 9. Patients will have an up to date shred RESPECT form accessible via EMIS.

Quality Priorities - Safe

Safe	Reduce the incidence of pressure ulcers acquired/deteriorating in our care and improve lower limb wound healing rates	Focus on Mortality Outlier Groups
	To reduce clostridioides difficile infection rates	Improve patient safety through implementing change as we learn from incidents and complaints across our system

1. Reduce the incidence of pressure ulcers acquired/deteriorating in our care and improve lower limb wound healing rates.

The Trust has seen a sharp increase in pressure ulcers acquired or worsened in our care, mirroring both the regional and national trend particularly during the pandemic. The causes of this are wide ranging and work is already underway to understand in more detail the root causes of this increase.

The Trust has a Lower Limb Wound lead, with great improvements already made in this area by participation in a national improvement programme, further detail is provided in the good news story on page 27 of this document.

The Trust continues to strive for excellence in this area and in addition to the national improvement; the Trust has included the CQUINs for improving pressure ulcer care and the assessment and documentation of pressure ulcer risk, in our annual programme of quality improvement initiatives.

Assessment, diagnosis and treatment of lower leg wound scores CQUIN for patients treated in the community nursing service (CCG14)

The CQUIN criteria includes patients treated in the community nursing service with a wound on their lower leg and the requirement for lower limb nurses to refer through to Vascular services. Effective leg wound management is fundamental to the provision of high quality care. This CQUIN was selected as the improvement work undertaken supports this quality priority.

Whilst the lower limb nurses continue to refer patients that need to see a vascular consultant in the same way, they have also introduced referring all other lower leg wound patients to the Vascular clinical nurse specialist (CNS). These patients are being successfully treated with compression therapy by the lower limb nurses, in addition by providing instruction of the treatment initiated allowing the CNS to assess and take any further action if required. This, along with an improved data capture and the process now embedded in eKare has made significant improvement to the CQUIN performance throughout Quarters 1-3.

Assessment and documentation of pressure ulcer risk in Community Hospitals (CCG15)

The assessment and documentation of pressure ulcer risk, also known as 'Waterlow' is a screening tool to identify adults at risk of pressure damage and support the development of an individualised care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. Effective pressure ulcer risk screening and care planning is fundamental to the provision of high quality care. This CQUIN was selected in order to identify correct application of the assessment tool and documentation.

Results for 2022-23 have shown a clear sustained improvement made following the successful implementation of an improvement plan following the initial Q1 results with the Trust exceeding the CQUIN targets quarter on quarter.

To build on the success achieved in 2022-23, reducing pressure damage will continue as a Quality Priority for the Trust into 2023-24.

2. Focus on Mortality Outlier Groups

Introduction

Following the recent pandemic, Wye Valley NHS Trust showed a concerning period of sustained and slowly increasing mortality rates, and by the end of 2021 (*Jan-Dec*) we were reporting in the bottom ten for mortality rates in England – *see Chart 1*.

Consequently, there was a renewed focus around the mortality programme, with deep dives into key areas of the data and our mortality outlier groups, developing a clear action plan to address areas of concern. The Trust have since managed to consecutively report a reduction in the mortality for the past 11 months. The latest position, as highlighted in *Chart 2,* shows Wye Valley at 105.16 which equates to 76th out of 122 NHS Trusts.

Chart 1: A bar chart to show WVT's position for the 12 month rolling period from January 2021 to December 2021 – SHMI – HES Based - ***115.64.***

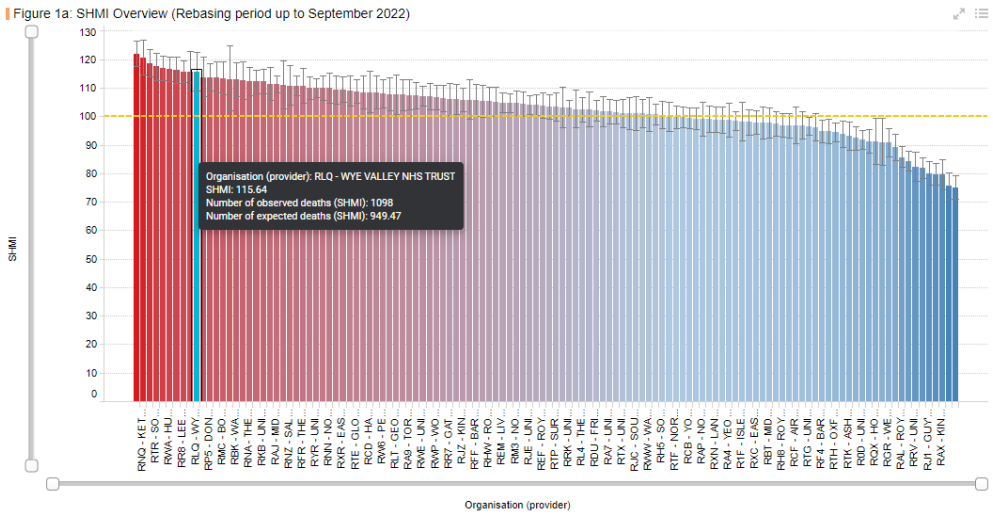
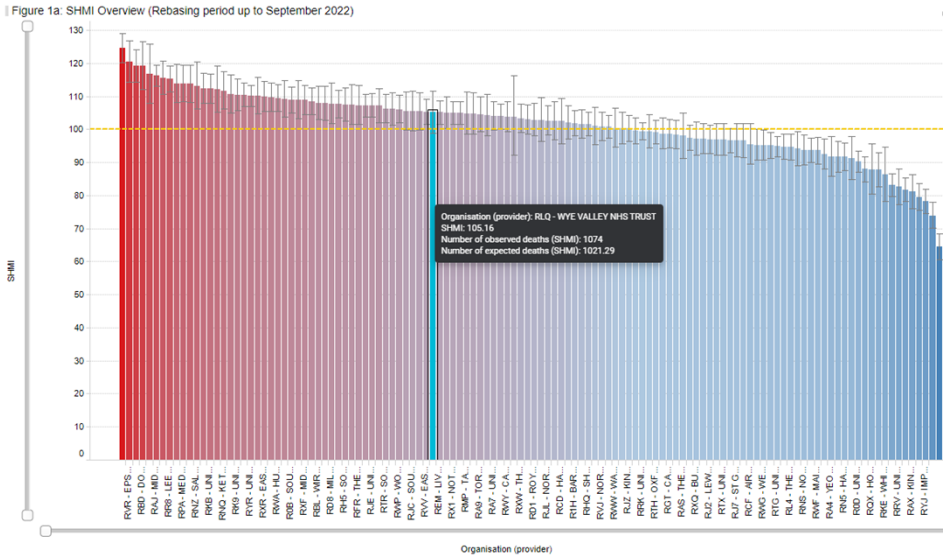


Chart 2: A bar chart to show WVT's position for the latest 12 month rolling period from December 2021 to November 2022 – SHMI – HES Based – ***105.16*** ***(-10.48)***



Mortality Outlier Updates

The progress with our key mortality outlier groups has been overall a positive reduction in areas of excess deaths. In 2021, for the five key mortality outlier groups alone, there were 45 excess deaths in total. In comparison with the latest data, which covers the majority of 2022, reports only 10 excess deaths.

12 month rolling SHMI

	Jan 2021 to Dec 2021 *(Excess Deaths)*		***Dec 2021 to Nov 2022*** *(Excess Deaths)*	
Overall SHMI:	**115.64**		**105.16**	
Pneumonia	118.52	+23	96.60	-5
Heart Failure	109.58	+5	113.10	+7
Sepsis	116.93	+11	112.30	+9
#NOF	93.23	-2	132.20	+8
Stroke	115.38	+8	90.50	-9

+45 deaths → **+10 deaths**

The two biggest groups of deaths, which contribute towards the overall Trust mortality, are Pneumonia and Stroke. Over the past 12 months, these two areas alone have managed to reduce their deaths by 45, which has had the biggest impact on the overall SHMI at Wye Valley NHS Trust NHS Trust.

The majority of our groups have undertaken thematic audits of the deaths, working with our clinical leads and clinical coding department, using a structured judgement review approach to extract learning and build in local improvement plans.

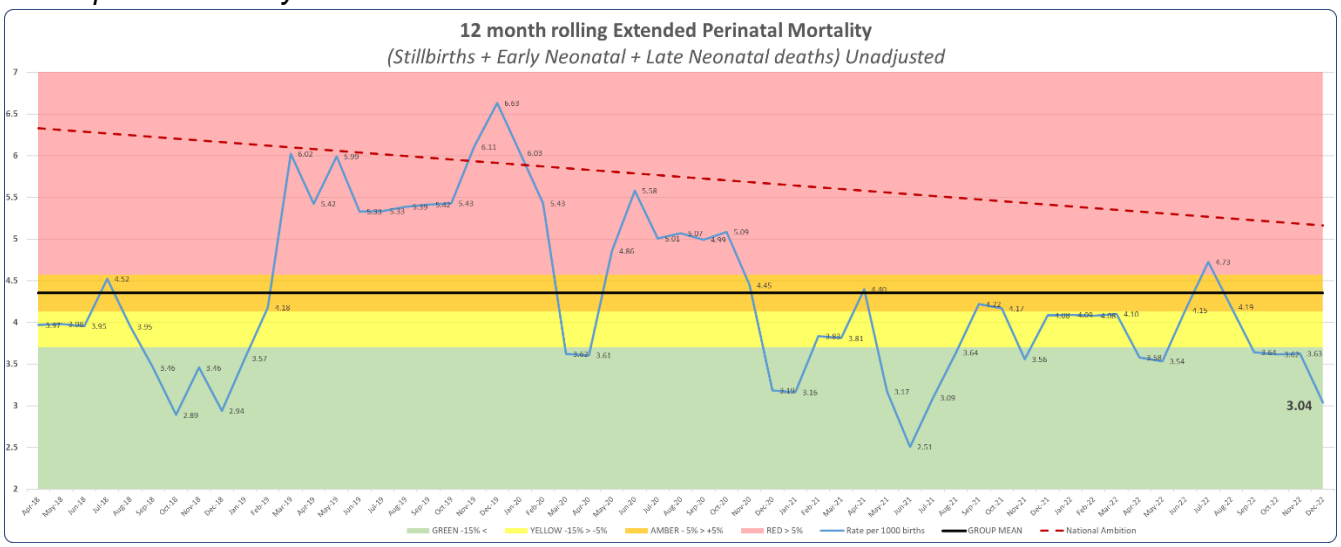
In addition to reviewing our clinical work, we have established a working group to fully understand the data quality for mortality. One of the key aims of the group is to develop a simple dashboard for monitoring our data quality and clinical coding, allowing us to identify any areas for further investigation.

Perinatal Mortality

Over the past few years, the Trust has developed robust local systems to monitor our latest mortality rates for Neonates. Through these systems, which replicate the national measures, the Trust are able to track rates in a real time fashion as opposed to the two-year delay from national reports. Using our surveillance, any 'spikes' or increases in deaths at a point in time can be to be investigated promptly, identifying any areas of concern and addressing them.

The latest 12 month period, January 2022 to December 2022, is amongst one of the lowest ever reported extended perinatal rates at the Trust, and continues to report well below the expected level of mortality for a trust our size – *see Chart 3.* At 3.04 deaths per 1000 live births, this remains firmly on track to achieving the national ambition of a 50% reduction in neonatal mortality. In addition, the latest period reports 1.82 stillbirths per 1000 live births, which is amongst some of the lowest rates in country.

Chart 3: A SPC chart showing the rolling 12 month extended perinatal rate at WVT: Latest 12 month period: January 2022 to December 2022.



Medical Examiner Service

In 2022-23 the Trust have managed to recruit a full complement of Medical Examiners, including hospital and community doctors, to provide the expertise required to scrutinise the cases but also to provide support to our clinicians when completing death certification paperwork. In addition, there have been clear robust pathways and processes to support our community colleagues to refer their patient in to the service.

The medical examiner service currently reviews over 90% of all hospital deaths, supporting bereaved families through a streamlined process to reduce the delays to get their loved ones death certificates and cremation paperwork. There are significantly better relationships developed with our local Coroner and Registry Offices, reducing any delays or issues with issuing death certificates.

Based on feedback from the Regional Medical Examiner Office, the rollout across all community-based deaths is delayed to the summer 2023. The Trust will commence the roll out of the service prior to the national start date, in order to embed and refine the processes earlier. There has been strong engagement from all key stakeholders, and the team are looking forward to expanding their service to offer an equitable service to all Herefordshire's families.

Objectives

With the positive progress made so far in our mortality rates during 2022-23, we would like to build on these further in 2023-24, and utilising a simple but effective approach of achieving the following:

- Embedding a robust Learning from Deaths process, ensuring a clear flow for learning, and escalation any causes for concern.
- Sustain an 'as expected' level of mortality within the Trust.
- Successfully implement a Medical Examiner Service across Herefordshire.
- Sharing good practice and learning from mortality reviews and audits amongst our colleagues within the Foundation Group and across the ICS.
- Continued support for our key mortality outlier groups, working with the clinicians and operational team to identify and address areas of concern.
- Develop a local surveillance system to monitor the rates of infant mortality within Herefordshire, allowing us to take a proactive approach to responding to any significant changes with the rate.

3. To reduce Clostridioides Difficile infection rates

The Trusts most recent inspection of the hospital in relating to Infection Prevention practices was in October 2022 and consisted of a review team of specialist advisors to NHS England (NHSE), Hereford and Worcestershire Integrated Care Board (ICB) and UK Health Security Agency (UKHSA). This inspection was following on from previous inspections in October 2021 and March 2022.

The Infection Prevention Improvement Plan (IPIP) 2022-2024 has been developed following this inspection, with the support from National Health Service England (NHSE) and NHS Herefordshire & Worcestershire Integrated Care System (ICS) Infection Prevention leads.

The creation of the Infection Prevention Improvement Plan allowed the ability to:

- Streamline workload and focus.
- Remove the duplication of information.
- Review all action plans, combining into the one overall improvement plan.
- Introduce realistic timeframes for completion of elements of the action plan.
- Align content and actions to and as national guidance is updated.
- Establish a Task and Finish Group to ensure continued trajectory against targets.

The plan contains 46 actions, which can be categorised by theme:

- CDI management.
- Cleaning.

- Standard Infection Control Precautions.
- Estates.
- Water management.
- Quality.

Action deadlines have been set throughout the remainder of the financial year 2022-23 and 2023-24. Additional actions may be added as work progresses and following the introduction/changes of any national or local guidelines.

In addition to the Infection Prevention Improvement Plan, the past twelve months have seen several initiatives introduced to help reduce our Clostridioides difficile infection rates:

- The Lead Infection Prevention Nurse and Consultant Microbiologist continue to work with Integrated Care Board colleagues to develop a joint Clostridioides difficile reduction strategy.
- The Lead Infection Prevention Nurse participates in the NHSE Regional Task and Finish Group focusing on Clostridioides difficile infection improvements.
- The Infection Prevention annual campaign #WyeClean was launched in May 2022. Promoting the techniques and practices required to maintain clean safe patient equipment and environment.

Whilst progress has been made over 2022-23 with this quality priority the Trust and Infection Prevention team continue to take our Clostridioides difficile infection rates seriously. 2023-24 will see work continue on achieving targets set through the Infection Prevention Improvement Plan, reduction strategy and reduction plan. Support continues to be provided to the Trust by NHSE working closely with our Infection Prevention team, Matrons and Senior Nurses highlighting where practice can be improved.

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

NHS Trusts investigate patient safety incidents (reported by staff) and complaints (reported by persons affected by the services we provide). Traditionally separate teams, with clear frameworks and standards applied to how they should be managed, oversee these processes. However, both types of feedback can detail potential harm to a patient, or, an incident and complaint about the same issue can be reported and both requiring investigation. In order to ensure that learning is sought from these cases, and importantly a timely and detailed apology is offered to the persons affected the Trust has taken a different approach to managing incidents and complaints.

The patient safety team and complaints team now work under the leadership of the Trust Quality and Safety Matron. This allows for efficient review of the content of incident reports and complaints to ascertain the correct form of investigation required. It allows intelligence from complaints to feed into the Trust Serious Incident panel, recognising that patients are also raising potential incident within a complaint.

This change supports the future directions for Trusts in improving their patient safety culture by ensuring we are listening to our patients and using their feedback to improve the services we provide and acknowledge where things went wrong for them. A principle of the National Patient Safety Strategy.

Implementation of the National Patient Safety Strategy continued in 2022-23, with the Trust meeting all the national milestones including;

- Launching the National Patient Safety Syllabus.
- Recruitment of Patient Safety Partners.
- Patient Safety Specialists creating links with their Trust Board to ensure implementation met the local and national objectives.

To support the Trust to meet the new reporting standards for patient safety incidents, and to better triangulate the feedback from staff and patients in relation to patient safety, the Trust invested in a new clinical governance system replacing DATIX with InPhase Oversight. The new system not only meets the national requirements for how incident should be reported but allows the Trust to review incidents and complaints alongside clinical risk, providing a more efficient way to understand how safe are our services and develop more meaningful and targeted improvement opportunities.

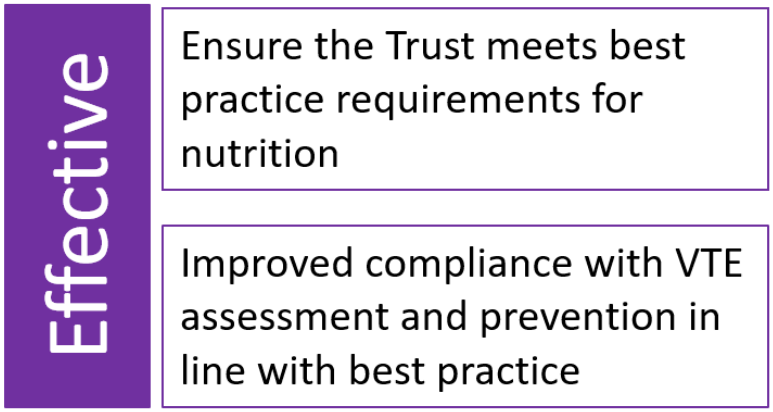
The Trust, alongside Primary Care partners, launched the 'Safety in Sync' forum providing a space for colleagues from healthcare organisations across Herefordshire to discuss quality and safety issues and work collaboratively to drive improvement with the patient at the heart of those discussions. Staff reported that discussing quality and safety concerns at Safety in Sync had allowed them to;

- Link to key contacts in the system to drive improvement.
- Have access to wider resources (IT, comms, etc.) to support their project.
- Gain additional project team members.
- Link to networks and other forums to support the project.
- Increase their knowledge and understanding of how system partners work.
- Provide direct solutions and actions as a result of forum discussions.

This way of working allows for issues arising from complaint and incidents to be reviewed and improvements accelerated by working together as a system rather than individual organisations.

In 2022-23 the Trust also re-launched its Safety Bites bulletin to share learning with all staff from key cases or thematic review of incidents and complaints that could apply across the Trust.

Quality Priorities - Effective



5. Ensure the Trust meets best practice requirements for nutrition

Nutrition has continued to be a quality priority for the Trust for 2022-23. The scope of the priority for 2022-23 included the following measures/projects:

- Improve oversight (governance) of meeting nutritional standards.
- Nasogastric feeding management.
- MUST scores CQUIN for community beds.
- MUST scores CQUIN measures to be applied to acute hospital beds.
- Improved food scores within in patient surveys, PLACE and other sources of patient feedback.

Developments so far have seen progress made with this quality priority.

Improve oversight of nutrition

The Nutritional Steering Group (NSG) now meets quarterly with agreed terms of reference and good engagement. This group has an oversight of all elements related to nutrition from patient meal survey reviews to complex clinical nutritional management. A Nutritional Care Group and a Nutritional Support Group meeting has now commenced in the intervening months, which report into NSG quarterly. NSG reports into Clinical Effectiveness and Audit Committee within the WVT governance structure to ensure appropriate escalation.

The Nutritional Care Group is led by our Lead Dietician and focusses on all aspects of food and meal provision within Wye Valley. Due to operational pressures, a sufficient level of engagement in the Nutritional Care Group has been difficult to attain. Therefore, the Lead Dietician has developed a roving meeting model visiting individual ward areas in order to gain traction and real time feedback. The Nutritional Support Group focusses on the more complex areas of nutritional support including parenteral and nasogastric feeding and is led by one of the gastroenterology consultants alongside the Nutrition Specialist Practitioner.

Nasogastric (NG) feeding management

A cross-divisional business plan for a Nutrition Specialist Practitioner (NSP) post was successful. The Nutrition Specialist Practitioner, recruited this year, is leading on NG placement/ management and leads the Nutrition Support Team alongside the

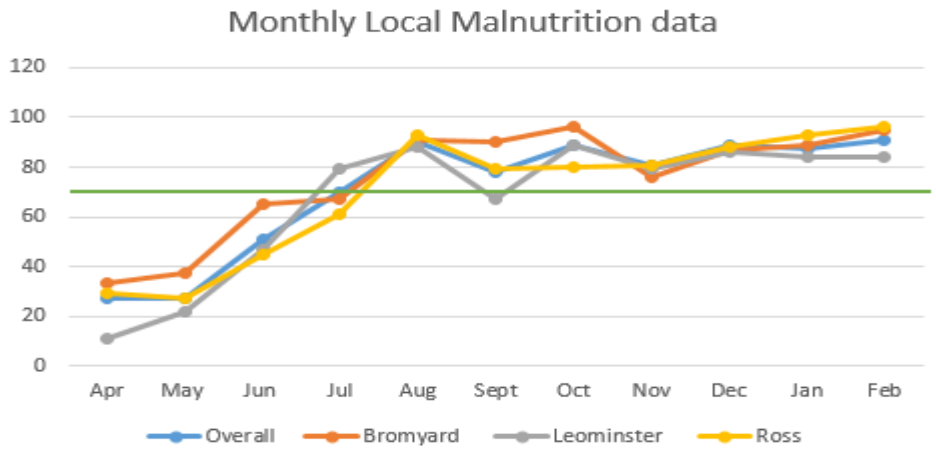
Gastroenterology consultant lead. Following feedback from HM Coroner in relation to a never-event of a misplaced NG tube, the NSP is working with the Deputy Chief Medical Officer to develop an agreed process for checking of tube placement.

MUST (Malnutrition Universal Screening Tool) scores CQUIN for community beds

'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines that can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. Effective nutritional screening and care planning is fundamental to the provision of high quality care. This CQUIN was selected in order to identify correct application of the assessment tool and documentation thereof.

Quarter 1-3 results indicated clear improvement made following the successful implementation of an improvement plan following the initial Q1 results. The Community Hospital staff are to be commended for their efforts with this.

The table below details the monthly improvement trajectory for individual community hospital sites.



MUST scores CQUIN measures to be applied to acute hospital beds

As part of the quality focus on nutrition, WVT have decided to measure completion of MUST scores across the acute hospital bed base on a random selection of cases. This will allow a comparison to be made, identification of good practice and dissemination across the organisation. The first quarter of 22/23 has focused on the Community Hospital CQUIN, as this is a contractual requirement. The data for the acute hospital is now being collected. The Dietetic team are now auditing MUST assessment for patients on the County Hospital site and results will be reported back into the Nutritional Steering Group and Quality Committee.

Improved food scores within in patient surveys

The re-introduction of Patient-Led Assessments of the Care Environment (PLACE), which include ward food assessment, will provide additional information to enable us to address these issues. The first of our PLACE inspections was carried out in November 2022 and the full report is expected at the end of March 2023.

The development of the Nutritional Care group as an adjunct to NSG in the next few months will enable sufficient time and effort to discuss food provision and to produce an action plan for improvements. Food safety will continue to report through the IPC committee structure.

The NHS England publication "National Standards for healthcare food and drink" has now been launched containing eight key standards the Trusts will be required to deliver. Sodexo colleagues are currently undertaking a gap analysis against the standards and will make recommendations for actions required to meet these standards which will progress through the Nutritional Steering Group for escalation.

The focus on nutrition as a quality priority has been a key driver in the progress made during the year, however there is more work to do to embed and ensure improvements provide consistency in relation to patient safety and experience. The Trust recognises this and nutrition continues to be a Quality Priority for the Trust going into 2023-24.

6. Improved compliance with VTE assessment and prevention in line with best practice

For 2022-23, the Trust has continued to make improvements with VTE assessment and prevention in line with best practice, focusing on continuity with stable, improved and sustained practice and compliance in addition to working towards meeting the VTE exemplar framework.

At the beginning of 2022, the Trust were able to identify:

Areas of good practice:

- VTE strategy in place.
- Risk assessment tools utilised.
- Auditing has been carried out in some areas, with the plan to continue this across all areas.

Areas requiring further action:

- VTE champions to be implemented.
- Improvements required to achieve 95% completion of risk.

The Trust is now in a position where it is felt they are meeting, or have plans to meet all the criteria of the Exemplar Site Status with the exception of the requirement 'to consistently achieve a 95% completion of VTE risk assessment', in line with the National Quality requirement.

What we have achieved

- The introduction of electronic risk assessment and reporting systems and tools that are fully embedded into practice.
- The past 12 months have witnessed the commencement of implementing VTE champions; with a VTE Champions Role Description being created and plans to commence recruitment for a range of staff including Nurses, HCA's, Doctors, and Pharmacists.
  Badges and promotional material have been supplied by Thrombosis UK to support with this.
- An updated patient information leaflet has been developed and approved in line with NICE guidance. The patient reader panel were involved in reviewing and

contributing to the design, with changes made to reflect their comments. Paper copies of the leaflet will be available to patients and via the WVT website.

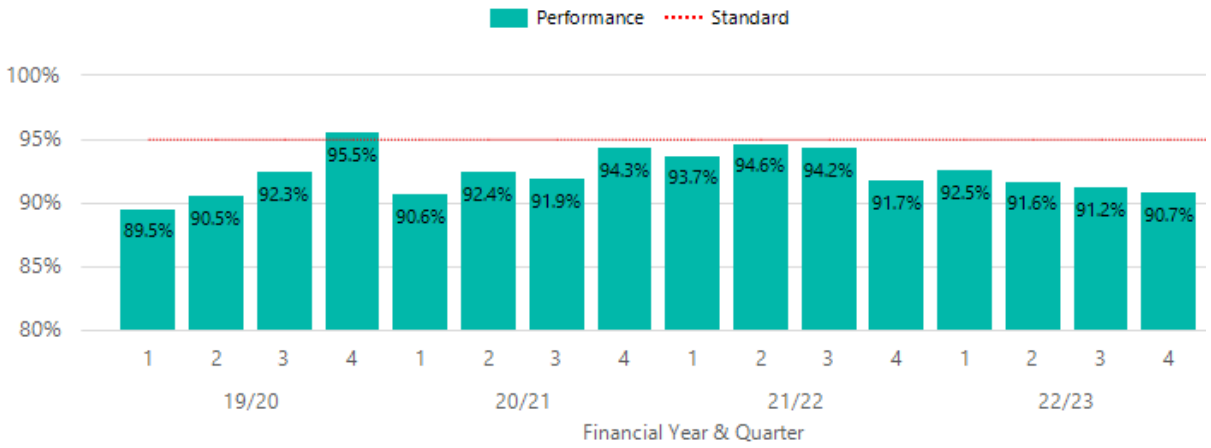
- VTE training is now available via the intranet, with plans for it to become mandatory from April for relevant staff groups.
- Clinicians reviewing reported VTE cases have made good progress. Originally the Trust had a backlog of 62 cases when the process was commenced using the electronic reporting system, by March 2023 there was just one remaining in the system awaiting review. The Trust is now in a position where the number of cases at all stages remain at acceptable levels.

What we still need to achieve

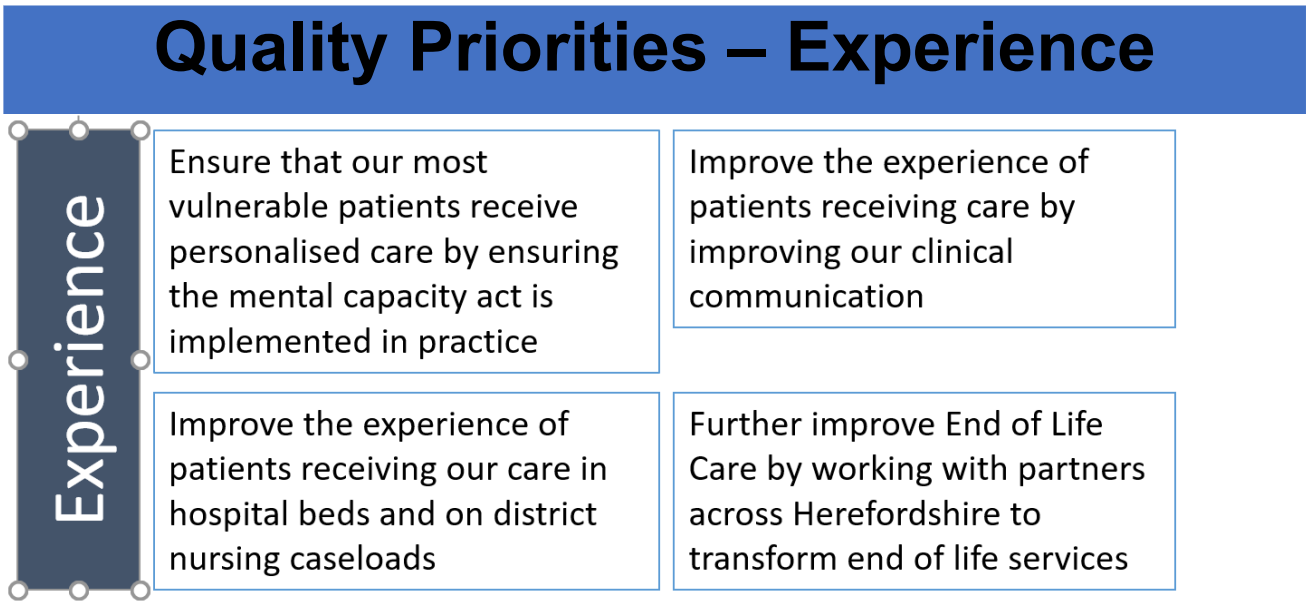
- Groups of patients were identified who were 'assumed' to have had an assessment. The groups under this category are currently being reviewed to reduce the number of those with 'assumed compliance'. Getting this right is key to achieving exemplar status and focus will continue through to 2023-24 to ensure our reporting issues are resolved and we no longer "assume compliance" when a patient enters a clinical area.
- The Duty of Candour process is currently under discussion prior to implementation.

2022-23 saw the Trust report 0 avoidable cases out of the 90 reported, reviewed and closed since January 2022. Clearly reflecting an improvement in the preventative care carried out at the Trust.

The Trust are currently achieving 90.7% compliance with VTE risk assessments for the period January to March 2023.



Moving forward into 2023-24, the Trust understands the importance of VTE assessment and prevention and VTE will continue as a Quality Priority for the next twelve months.



7. Ensure that our most vulnerable patients receive personalised care by ensuring the mental capacity act is implemented in practice.

The Mental Capacity Act 2005 (MCA) was introduced in 2007 to empower and protect vulnerable persons over the age of 16 years in England and Wales. It enables people to plan ahead for a possible loss of capacity and provides a framework for decision-making on behalf of those who are unable to make at least some decisions for themselves.

It has two overarching aims:

- To promote autonomy of decision making for all.
- To protect vulnerable adults from harm.

The Act was amended in 2009 to provide safeguards for people who need to be cared for or treated under significant restrictions (the Deprivation of Liberty Safeguards, DoLS).

During the pandemic, our services had adapted and changed to meet the new needs of patients in our care. This includes patient's cared for in different ward areas for longer periods of time, and virtual clinics being used. These changes have exposed areas of our system that require improvement to ensure that patients are being cared for appropriately in line with the Mental Capacity Act; being consented correctly and personalising the care we deliver to vulnerable individuals with complex needs. Following our recent unannounced CQC inspection in October 2022, whilst we were highly commended for our new MCA/DoLS policy and associated flow charts the CQC also highlighted the same areas of our system that require improvement.

The Trust acknowledges this is a wide-ranging improvement initiative and over the coming 12 months, the following actions will be taken:

- Analysis of uptake of training in order to target education.
- Include MCA/DOLs education in clinical practice week schedules.
- Focus on MCA/DOLs training compliance through F&PE.

- MCA/DOLs medical champion proposed for each division to promote training attendance and act as a local resource.
- Re-audit of patient records.
- Attendance at training sessions will be mandated following any escalation of concern or incident reported via our electronic reporting system.
- Offer further bespoke training sessions for medical staff and wider multi-disciplinary team.

To enable us to deliver against the action plan, it has been agreed that the implementation of the mental capacity act will continue as a quality priority into 2023-24.

8. Improve the experience of patients receiving our care in hospital beds and on district nursing caseloads

The Trust receives a wealth of feedback from patients and their carer's in relation to the services we provide. However, there is often a data lag in relation to the when the patient received care and when we receive the feedback. In order to improve the care of our patients we first needed to ensure we were getting real time feedback to proactively respond to concerns raised or share learning on what went well.

During 2022-23 the Trust rolled out a series of local patient surveys bespoke to the service they had used; inpatient (acute), inpatient (community), district nursing and outpatients. This feedback shows an improvement in some of the key areas that were routinely scoring low on the national inpatient survey. Key areas of concern were around waiting times and food quality. The feedback in relation to the District nursing service was very positive with patients satisfied with the service and the communication in relation to their visits.

The Trust also implemented a text messaging service to receive real time feedback from patients in line with the national Friends and Family test initiative. As highlighted in section 2 the feedback is largely positive.

The Trust, in collaboration with patient partner, developed a Patient Engagement charter to set out the vision for engaging with patients in a meaningful for way for both patients and the Trust.

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

A key area of concern for a number of years has been clinical communication. This includes;

- Staff and patient interactions during care and treatment.
- Discharge information.
- Sharing information between health care providers.
- Communication with carers.

The Trust continues to focus on this, understanding that communication is a big challenge and good communication is key to good experiences of care. The National Inpatient Survey noted that the Trust has made an improvement in clinical communication in the last 12 months, however information on discharge and between health care providers specifically was still a concern.

In 2022-23 the Trust launched the Valuing Patients Time programme board which seeks to address these issues and empower patients to know what their plan of care is, when they should expect to be discharged to their preferred place of care and what happens after discharge. Each division contributes a bespoke improvement plan to the programme which is monitored centrally by the Trust Transformation team. Links have been made with the programme board and the Patient Experience Committee to assess the impact of the improvement plans on patient experience going into 2023-24.

10. Further improve End of Life Care by working with partners across Herefordshire to transform end of life services.

WVT have made a commitment during 22/23 to further improve End of Life Care by working with partners across Herefordshire to transform End of Life services.

- ReSPECT (Recommended Summary Plan for Emergency Care & Treatment) plans are now used widely throughout Herefordshire to capture conversations and recommendations made for care and treatment in an emergency.

  As patients are often not able to make decisions about their priorities of care or treatment in an emergency, discussing what they would want to happen in advance is important. ReSPECT forms are currently paper copies which are the property of the individual patient and should accompany them wherever they go. Many respect forms originate in primary care and can now be produced digitally and held on their Shared Care Record (SCR). There will shortly be an opportunity to view this through WVT digital systems.

  ReSPECT now has a home in the reformed WVT End of Life forum and this year a member of the medical team presented an audit of forms including both quantitative and qualitative data. Recommendations from this audit will help to inform education sessions to be planned.

- NACEL (National Audit of Care at End of Life) audit. An action plan was developed following the audit findings to target our improvements. Some of the areas to be addressed were
  - to enhance quality of care provided to families/carers by recognising the importance of their needs;
  - recognising dying patients earlier and support for staff providing End of Life care.

  A medical and non-medical clinical fellow for End of Life care are currently being recruited who will provide education to target these areas in our action plan and effectiveness will be monitored through the End of Life Forum.

- Single point of access and service transformation. Several meetings have taken place between key partners focussing on a single point of access for end of life care. Colleagues from St Michael's Hospice, Integrated Care and Specialist Palliative Care are currently discussing what is required and how this might be amalgamated into current community service provision. This important aspect of End of Life Care will be continued into 23/24.

- ICS self-assessment as a baseline for improvement. WVT engaged in several workshop sessions with the ICS in 22/23 in order to inform their work on the NHSE

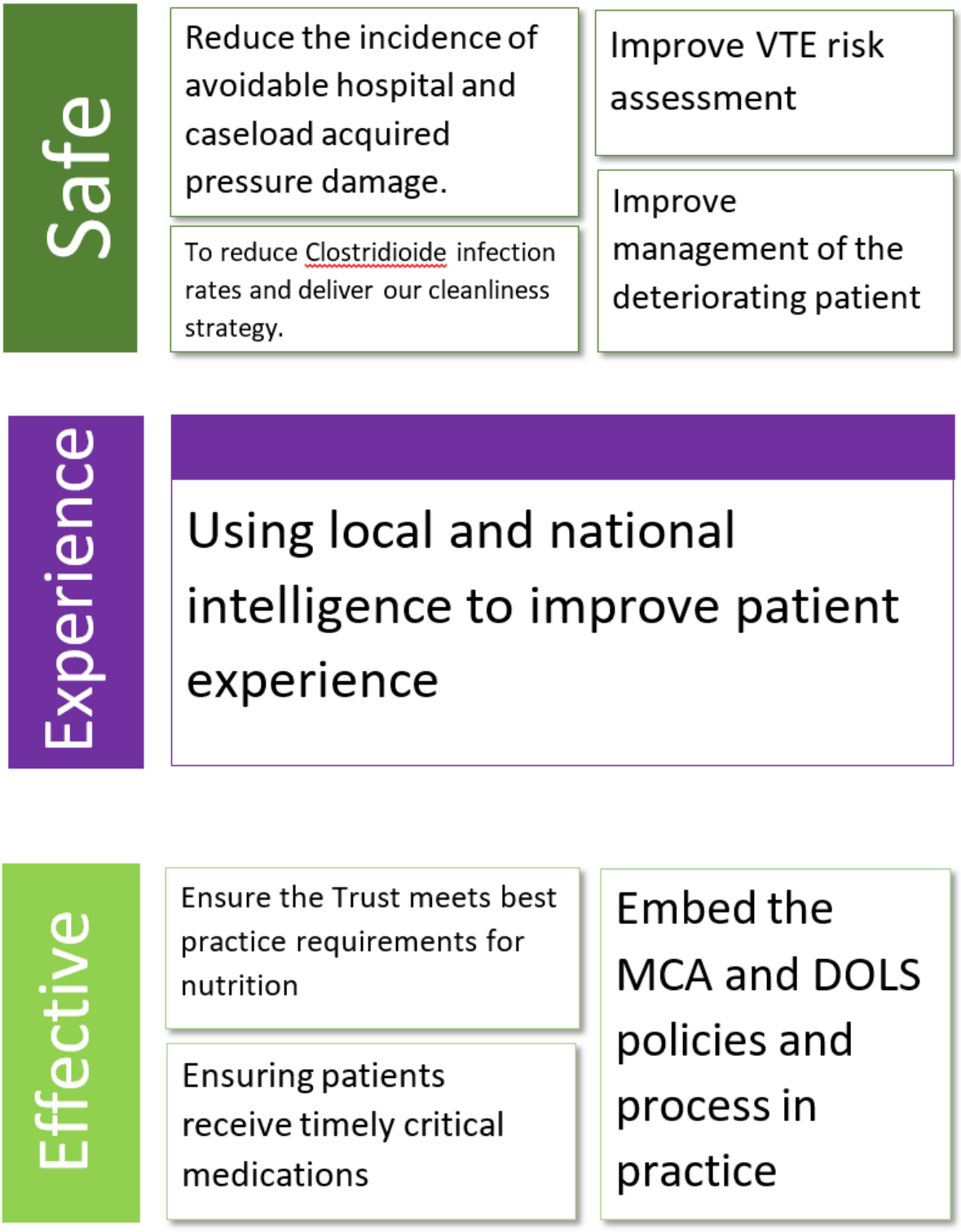
Ambitions for End of Life care. Feedback from the ICS with a compilation of results and focus on actions is awaited.

Quality Priorities:

The Year Ahead

Trust Objectives 2023-24

QUALITY PRIORITIES 2023-24



External Statements of Assurance

Statement of Assurance- NHS Herefordshire and Worcestershire Clinical Commissioning Group – Rachel Skinner and Kerry Anneli

TO BE ADDED

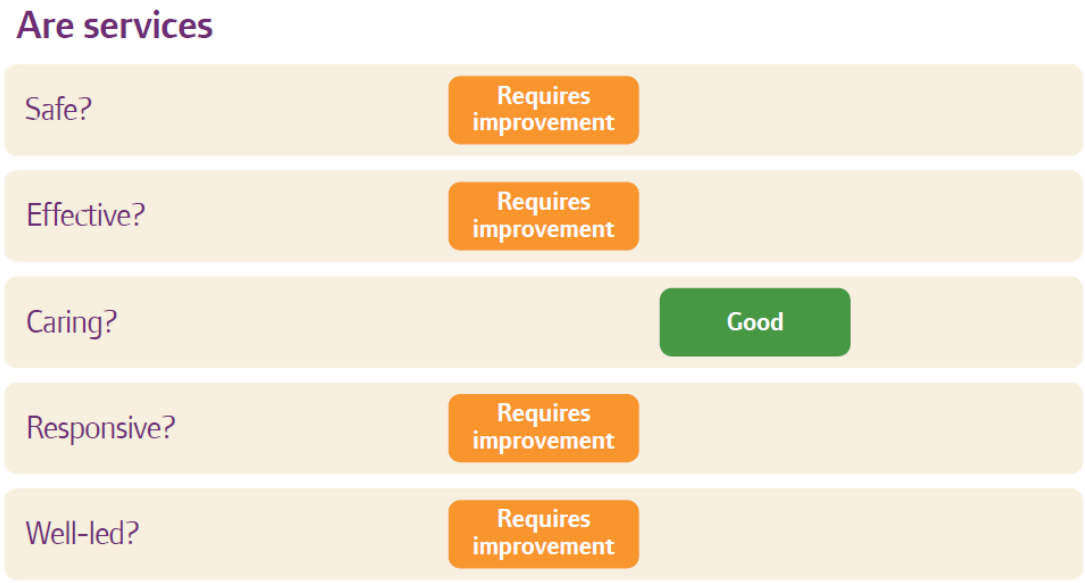
TO BE ADDED

Appendices

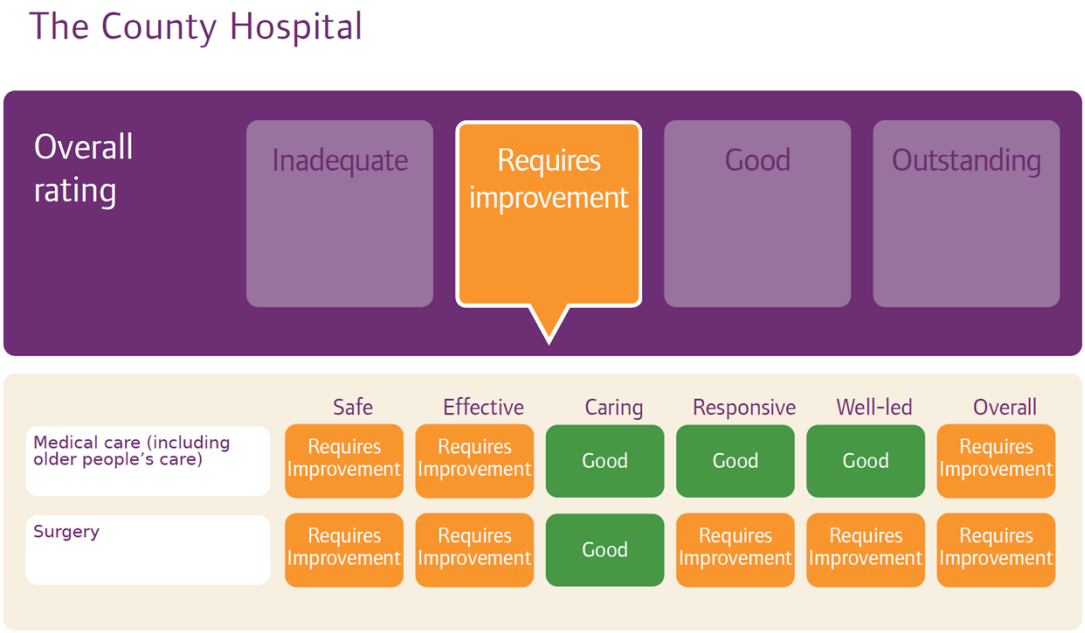
Appendix 1

CQC Ratings Tables

Acute Site ratings



Most recent inspection rating changes



Community Services

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good →← Mar 2020	Good →← Mar 2020	Good ↓ Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020
Community end of life care	Good ↑ Mar 2020	Good ↑ Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020
Community dental services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good ↑ Mar 2020	Good ↑ Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020

Appendix 2
National Audit & NCEPOD Compliance

Eligible National Audits	WVT participation in 2022-2023	% of required cases submitted (where applicable) (position at 31/03/2023)	Comments
College of Emergency Medicine (CEM) Infection Prevention	✓	N/A	Report not yet due to be published
College of Emergency Medicine (CEM) Mental health self-harm	✓	N/A	Report not yet due to be published
Major Trauma Audit (TARN)	✓	All eligible cases submitted	Continuous data collections – all eligible cases submitted Data published quarterly online
Case Mix Programme (CMP)	✓	100%	Data reported quarterly - National Annual Report not yet due to be published
National Lung Cancer Audit (NLCA)	✓	N/A	Report not yet due to be published
Oesophago-gastric Cancer (NAOGC)	✓	100%	National Oesophago-Gastric Cancer Audit (NOGCA) 2022 Report - published January 2023
National Audit of Breast Cancer in Older Patients (NABCOP)	✓	100%	National Audit of Breast Cancer in Older Patients: Annual report 2022 – published May 2022
Bowel Cancer (NBOCAP)	✓	94%	National Bowel Cancer Audit Annual Report 2023 - published January 2023
Prostate Cancer	✓	N/A	Annual report 2022 – Prostate cancer services during the COVID-19 pandemic (NPCA) - published January 2023
Cardiac Rhythm Management (CRM)	✓	All eligible cases submitted	Continuous data collection – National Audit of Cardiac Rhythm Management: 2022

			Summary report – published June 2022
National Audit of Cardiac Rehabilitation	✓	100%	Continuous data collection – all eligible cases submitted National report published October 2022
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	25%	MINAP - Management of Heart Attack: 2022 Summary Report – published June 2022
National Heart Failure Audit	✓	83%	National Heart Failure Audit: 2022 Summary report – published June 2022
National Diabetes Audit - Care processes and treatment targets	✓	All eligible cases submitted	National Diabetes Audit, 2020-21 Report: Care processes and treatment targets – report published July 2022
National Pregnancy in Diabetes Audit	✓	All eligible cases submitted	Report not yet due to be published
National Diabetes Foot Care Audit	✓	N/A	National Diabetes Foot Care Audit Interval Review: July 2014 - March 2021 – published May 2022
National Diabetes Inpatient Safety Audit	✓	All eligible cases submitted	National Diabetes Inpatient Safety Audit: An annual survey of GIRFT recommended staffing, systems and pathways – published July 2022
UK Parkinson's Audit	✓	N/A	Report not yet due to be published
National Audit of Dementia	✓	N/A	Report not yet due to be published
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	All eligible cases submitted	Annual SHOT Report 2021 - published July 2022
National Maternity and Perinatal Audit (NMPA)	✓	All eligible cases submitted	National Maternity & Perinatal Audit Clinical Report 2022 - published June 2022
National Hip Fracture Database	✓	All eligible cases submitted	The National Hip Fracture Database report on 2021:

			Improving understanding - published September 2022
Fracture Liaison Database	✓	N/A	Rebuilding FLSs to meet local patient need (FLS-DB) – published January 2023
National Inpatient Falls Audit	✓	All eligible cases included	National Audit of Inpatient Falls Annual Report 2022 – published November 2022
National Joint Registry (NJR)	✓	All eligible cases included	National Joint Registry 19th Annual Report 2022 – published November 2022
National PROMS Programme	✓	N/A	Reporting has currently been paused and a date has not yet been given when publications will resume but Wye Valley continue to submit data
NPDA National Paediatric Diabetes	✓	All eligible cases included	National Paediatric Diabetes Audit Annual Report – published April 2022 Parent and Patient Reported Experience Measures (PREMs) 2021 – published September 2022
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	All eligible cases included	National Neonatal Audit Programme (NNAP) Summary report on 2021 data – published November 2022
National Audit of Seizures and Epilepsies in Children and Young People	✓	All eligible cases included	Epilepsy12 Report (England and Wales 2019-21) Children and Young People – published July 2022
UK Cystic Fibrosis Registry (Adults & Children)	✓	Data only collected on Children	UK Cystic Fibrosis Registry 2021 Annual Data Report - published September 2022
National Paediatrics Asthma Secondary Care	✓	All eligible cases included	Child and Young person asthma 2021 organisational audit - summary report Published June 2022

National Child Mortality Database	✓	N/A	Thematic Report: Sudden and Unexpected Deaths in Infancy and Childhood – published December 2022
Cleft Registry and Audit NEtwork (CRANE)	✓	All eligible cases included	Cleft Registry and Audit NEtwork Database 2022 Annual Report – published December 2022
National Asthma & COPD Audit Programme (NACAP) Adult Asthma and COPD 2021 Organisational audit	✓	N/A	Adult Asthma and COPD 2021 organisational audit – published June 2022
National Asthma & COPD Audit Programme (NACAP) Combined reports	✓	N/A	Drawing breath, a single 'state of the nation' view of the care of people with asthma and COPD in England and Wales. This report is the first to combine data on asthma, COPD and pulmonary rehabilitation across primary and secondary care services – published January 2023
National Pulmonary Rehabilitation Audit	✓	N/A	Pulmonary Rehabilitation 2021 Organisational Audit: Summary report – published July 2022
National Smoking Cessation Audit	✓	N/A	National Smoking Cessation Audit 2021_ Management of Tobacco Dependency in Acute Care Trusts – published July 2022
National Outpatient Management of Pulmonary Embolism	✓	N/A	Report not yet due to be due to published National Outpatient Management of Pulmonary Embolism Audit 2021 – published October 2022
National Audit of Rheumatoid and Early Inflammatory Arthritis	✓	All eligible cases included	National Audit of Rheumatoid and Early Inflammatory Arthritis Year Four Annual Report – published October 2022
Sentinel Stroke National Audit programme (SSNAP)	✓	All eligible cases included	Sentinel Stroke National Audit programme (SSNAP) Post-Acute Organisational Audit

			Report - published December 2022
National Emergency Laparotomy Audit (NELA)	✓	All eligible cases included	NELA 8th Annual report (Jan 2020 to November 2021) – published February 2023
Society for Acute Medicines Benchmarking Audit (SAMBA)	✓	All eligible cases included	Society for Acute Medicines Benchmarking Audit (SAMBA) National Audit of Acute Medical Care in the UK 2022 - published November 2022
BAUS Urology Audits – Muscle Invasive Bladder Cancer Audit	✓	N/A	BAUS Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder (MITRE) Audit National Summary Results published August 2022
National Audit of Care at the End of Life	✓	All eligible cases included	National Audit of Care at the End of Life Third round of the audit (2021/22) report - England and Wales – published July 2022
UK Kidney Association – Acute Kidney Injury Registry	✓	N/A	Report not yet due to be published
National Ophthalmology Database Audit	X	N/A	The Trust does not participate in this audit but cataract outcome data is collected and reported locally
Inflammatory Bowel Disease (IBD) Registry	X	N/A	The Trust has temporarily withdrawn participation in this audit due to staff resources within the gastroenterology team, with a plan to re-join currently under review
National Cardiac Arrest Audit (NCAA)	X	N/A	The Trust has temporarily withdrawn participation in this audit due staff resources within the resuscitation team, with a plan to re-join as soon as possible

National Confidential Enquiries (NCEPOD)			
Eligible National Audits	**WVT participation in 2022-2023**	**Cases submitted**	**Eligible National Audits**
Maternal, Newborn and Infant Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes all maternal and child deaths to programme **Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report** - Published November 2022 **MBRRACE-UK Perinatal Mortality Surveillance Report 2020 -** Published: October 2022 **Perinatal Mortality Review Tool – Fourth Annual Report** Published: September 202
Medical & Surgical Clinical Outcome Review Programme	NCEPOD	N/A	Contributed to the programme via **Disordered Activity?** **A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure** - Published December 2022 **National Confidential Enquiry into Patient Outcome and Death: Review of Health Inequalities Short Report** – published April 2022 **A Picture of Health - Bridging the gap between physical and mental healthcare in adult mental health inpatient settings** – Published May 2022
Mental Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Mental Health Clinical Review Programme when required **National Confidential Inquiry into Suicide and Safety in Mental Health – Annual Report–** published April 2022

Child Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Child Health Clinical Review Programme when required – This year the studies are as follows: **Testicular Torsion** – not yet due to be published **Transition from child to adult health services** – not yet due to be published

Appendix 3

Comparable data summary from data available to the Trust from NHS Digital

NHS Digital provides the following data relating to national reporting requirements in the Quality Account. The coordinated March Release of data has been postponed due to the merger of NHS Digital and NHS England

> *"The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing. This report provides information about the indicators updated in this release.*
>
> *Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators.*
>
> *As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made on the publication page in due course."*
>
> *See link NHS Outcomes Framework Indicators - March 2022 release - NHS Digital*

A number of sites were visited to allow us to include as much data information as possible, which highlighted that a number of national data collections systems had been suspended. Resulting in the content of the table being condensed compared to 2021-22.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2021/22)	0	1	1.7	10	0	Hospital Onset cases. Latest 2021-22 Previous 2020-21 (29/09/2022 release) ***Complete***
MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to reduce incidence of MRSA and so improve the quality of services, by ensuring its strict cleaning, hygiene, hand-washing regimes, and bare below the elbows practice is adhered to. The trust also has a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.						
Indicator	**WVT latest available**	**WVT previous**	**NHS E Ave**	**NHS E max**	**NHS E min**	**Remarks**
NHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile	43	31	42.3	186	0	Trust cases. Hospital onset & . Latest 2021-22 Previous 2020-21 (Hospital & Healthcare associated)
Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)						

Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and so the quality of services, by learning lessons from these investigations, sharing with the clinical areas and presenting at the Trust's Safety Summit meetings.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported October 2019 - March 2020	76.1	69	25.4	110.2	0.00	Reported as per 1,000 bed days. Acute non specialist Trust s 2019-20.Previous period October 2018 - March 2019
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported Severe or death October 2019 - March 2020	0.20	0.18	0.10	0.50	0.00	Reported as per1000 bed days. Previous period October 2018 - March 2019

5.6 Patient safety incidents reported (formerly indicators 5a, 5b and 5.4) - NHS Digital

Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents including serious incidents, the outcome of investigations are shared throughout Divisional and Directorate governance meetings. Serious incident investigation key findings and actions are presented to the Quality Committee each month to ensure there is robust scrutiny.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level (current November 2019 - October 2020 Band 2	1.0130	1.0098	1.0130	1.1775	0.6782	Data is banded 1-3 high to low Previous period October 2019 – September 2020 lower numbers improvement
Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period November 2019 - October 2020	31%	30%	36%	59%	8%	Reported as a percentage of all deaths. Previous time period (Oct 2019 - Sept 2020

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current
Previous data
https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2021-02

Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by maintaining the implementation of the Mortality strategy and supporting quality improvement work in relation to mortality alerts and learning from deaths.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
National Inpatient Survey: Responsiveness to inpatients' personal needs 2020/21	74.5	64.2	74.5	85.4	67.3	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs. Trusts were asked to select a sample of patients who were discharged from hospital in July. Previous data 2019/20 ***Updated***

Link to National Inpatient Survey
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4.2-responsiveness-to-inpatients-personal-needs

Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q21d – 2021)	63	71	67	90	44	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2021 Previous December 2020
Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work (Q21c-2021)	61	70	58	78	39	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2021 survey latest available

NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com)

Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.

Appendix 4

Contracted Services 2022-23 - Contract Monitoring Services

SURGICAL	MEDICAL	INTEGRATED CARE	CLINICAL SUPPORT
General Surgery	Plastic Surgery	Physiotherapy	Palliative Medicine
Urology	Accident & Emergency	Occupational Therapy	Anti Coagulant
Breast Surgery	General Medicine	Dietetics	Chemical Pathology
Colorectal Surgery	Gastroenterology	Orthotics	Haematology
Upper GI	Endocrinology	Speech & Language	Radiology
Vascular Surgery	Hepatology	Podiatry	Audiology
Trauma & Orthopaedics	Diabetic Medicine	Medical Inpatients (Community Beds)	Pathology
ENT	Rehabilitation	Community Nursing Inc. Specialist Com.Nursing	
Ophthalmology	Cardiology		
Oral Surgery	Transient Ischaemic Attack		
Orthodontics	Dermatology		
Anaesthetics	Respiratory Medicine		
Paediatrics	Respiratory Physiology		
NeoNatology	Thoracic Surgery		
Gynaecology	Nephrology		
Obstetrics	Neurology		
Midwifery	Clinical Neurophysiology		
ITU	Rheumatology		
SCBU	Geriatric Medicine		
Community Child Health	Minor Injury Units		
Community Dental	High Dependancy Unit		
Podiatric Surgery			

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Quality Committee Terms of Reference and Forward plan
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Documents covered by this report:	Quality Committee - draft terms of reference, sub structure and forward plan

1. Purpose of the report

To present the Quality Committee terms of reference and forward plan to Board for approval.

2. Recommendation(s)

Quality Committee have reviewed the terms of reference and forward plan at their meeting on April 27th 2023 and recommended submission to Board for formal approval.

3. Executive Director Opinion[1]

The document represents the function of the Quality Committee following a review earlier this year. There are no major changes to the terms of reference and the forward plan has a stronger emphasis on strengthening subcommittee reporting and a focus on the Trust Quality Priorities for 23/14.

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

Quality Committee

Terms of Reference

1. Purpose

1.1 The purpose of the Quality Committee is to provide assurance to the Board that the services provided by the Trust are being delivered in a high quality and safe manner, and provide a quality of care we would want for ourselves, our families and friends'**.**

1.2 The Quality Committee has delegated responsibility to ensure that the Trust is fulfilling its statutory duties, complying with national standards and achieving its own strategic objectives in respect of the provision of high quality clinical care

1.3 As a Sub-Committee of the Board, the Quality Committee will fulfil this purpose through; receiving reports that cover the breadth of the quality agenda and from those committees that report into the Quality Committee*.

1.4 Reports will be provided for assurance and provide the opportunity for scrutiny and challenge with regard to all aspects of quality, clinical safety and patient experience and ensure that where necessary lessons are learnt and implemented throughout the organisation.

1.5 The Committee will promote an organisational culture, aligned with the Trust values; **Compassion**, **Accountability**, **Respect** and **Excellence**, that strives for continuous improvement through oversight of the Trust quality priorities.

*The Committee sub structure and the functions associated with the quality agenda are referenced at the end of this document.

2. Membership

2.1 Members of the Committee are:

- Three Non-Executive Directors
- Chief Nursing Officer
- Chief Medical Officer
- Managing Director
- Deputy Chief Medical Officer
- Associate Director of Quality Governance

2.2 In attendance:

- Deputy Chief Nurse Herefordshire and Worcestershire ICS
- Associate Chief Nursing Officer
- Associate Chief Medical Officers for each division (when divisional reports are due)*

- Divisional Associate Chief Nursing Officers /Associate Director of Midwifery/Professional clinical leads for each division (when divisional reports are due)*
- Associate Chief Operating Officers will be expected to attend when their divisional report is due
- Clinical Director, Pharmacy
- Quality and Safety Matron (Corporate)
- Chair of the Clinical Effectiveness and Audit Committee
- Chair of the Patient Safety Committee
- Chair of the Patient Experience Committee

*Divisional management representatives are invited but not mandated to attend all meetings

2.3 Other officers of the Trust will be invited to attend for appropriate agenda items where they are the lead.

2.4 Where a member is unable to attend routinely, an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.

3. Duties of the Committee

3.1 In order to support the wider objectives of the Trust, the Quality Committee will focus on the following priorities for the year ahead as published in the Trust Quality Account.

- To reduce Clostridioide infection rates and deliver our cleanliness strategy
- Reduce the incidence of avoidable hospital and caseload acquired pressure damage
- Improve compliance with VTE assessment and prevention in line with best practice
- Improve management of the deteriorating patient
- Using local and national intelligence to improve patient experience
- Ensure the Trust meets best practice requirements for nutrition
- Embed the MCA and DOLS policies and process in practice
- Ensuring patients receive timely critical medications

3.2 In furtherance of achievement of its purpose, particular duties of the Committee are to:

- Oversee the development and implementation of the Trust's Quality Priorities
- Receive, review and sign off the annual Quality Account (given timings of data and audit requirements, sign off may well be virtual)
- Receive data and trends relating to quality priorities, patient safety and patient experience and provide assurance to the Board on performance and undertake 'deep dives' as appropriate at the discretion of the committee
- Receive reports demonstrating compliance with relevant national standards and regulatory requirements
- Receive reports in line with the Trust External review process and any associated actions pertaining to any national enquiry, regulatory review or relevant external inspection undertaken

- Have oversight of all Quality Impact Assessments related to), clinical service developments or transformation through assurance reporting of the Clinical Effectiveness and Audit Committee
- Agree the terms of reference and work plans for each of the sub committees it is responsible for
- Receive reports related to the workforce safeguards and establishment reviews
- The Committee will receive a quarterly update from each division plus obstetrics and maternity, these reports will include quality improvements and remedial action being taken to address any quality, outcome, safety or patient experience concerns.

3.3 In addition the committee will:

- Delegate authority to the sub committees of the committee for the approval and ratification of relevant policies.
- Ratify any significant policy/ procedure, identified by the Chief Nursing Officer/Chief Medical Officer/ Associate Director of Quality Governance that the Board may need to be sighted on.
- Receive reports on any Internal Audit of a clinical nature following a referral via the Audit Committee.

4. Chair

The Board shall appoint one of the Non-Executive members to be Chair of the Committee

5. Agenda setting and work plan

The Chief Nursing Officer shall have:

- Corporate oversight of agenda preparation
- Corporate oversight of an annual programme of work for the Committee to approve
- Ensure that the annual programme aligns to the commissioner quality contractual requirements

6. Quorum

A quorum shall be two Non-Executive Directors (one of which could be the Committee Chair), two Executive Directors (one of which must be the Chief Nursing Officer or the Chief Medical Officer) and the Associate Director of Quality Governance or a delegated deputy

7. Frequency of Meetings

The Committee shall normally meet monthly. The Chair may call an additional or special purposes meeting if he/she considers one is necessary.

8. Notice of Meetings

Unless otherwise agreed, notice of each meeting, including venue, time, date agenda and supporting papers, shall be provided with members no later than five working days prior to the date of the meeting.

9. Minutes of Meetings

The Committee shall be supported by the Executive Assistant who is appointed to oversee the Quality Committee, whose duties in this respect will include:

- 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 are maintained.
- Ensuring that minutes and actions are circulated to the Chair for comments within 5 working days of the meeting and to the other members for comments within 10 working days.

10. Accountability

10.1 The Committee is accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference, seek the relevant information from employees and all employees are directed to cooperate with any request made by the Quality Committee

10.2 In line with NHS England publication 'Enhancing board oversight A new approach to Non-executive director champion roles' the Committee has Non-Executive representatives as members to provide oversight to the Board on Quality and Safety priorities.

10.3 The Board of Directors has delegated responsibility to the Quality Committee for oversight of the Workforce Safeguards, establishment reviews and staffing reports.

11. Reporting Responsibilities

11.1 The minutes of the Quality Committee will be formally recorded and submitted to the Board. Any confidential matters will be identified as such in the minutes and separately recorded. The Chair will provide a brief written report to the Board (a month in arrears) meeting drawing attention to significant developments, highlighting areas where further assurance is required and matters requiring Board decisions.

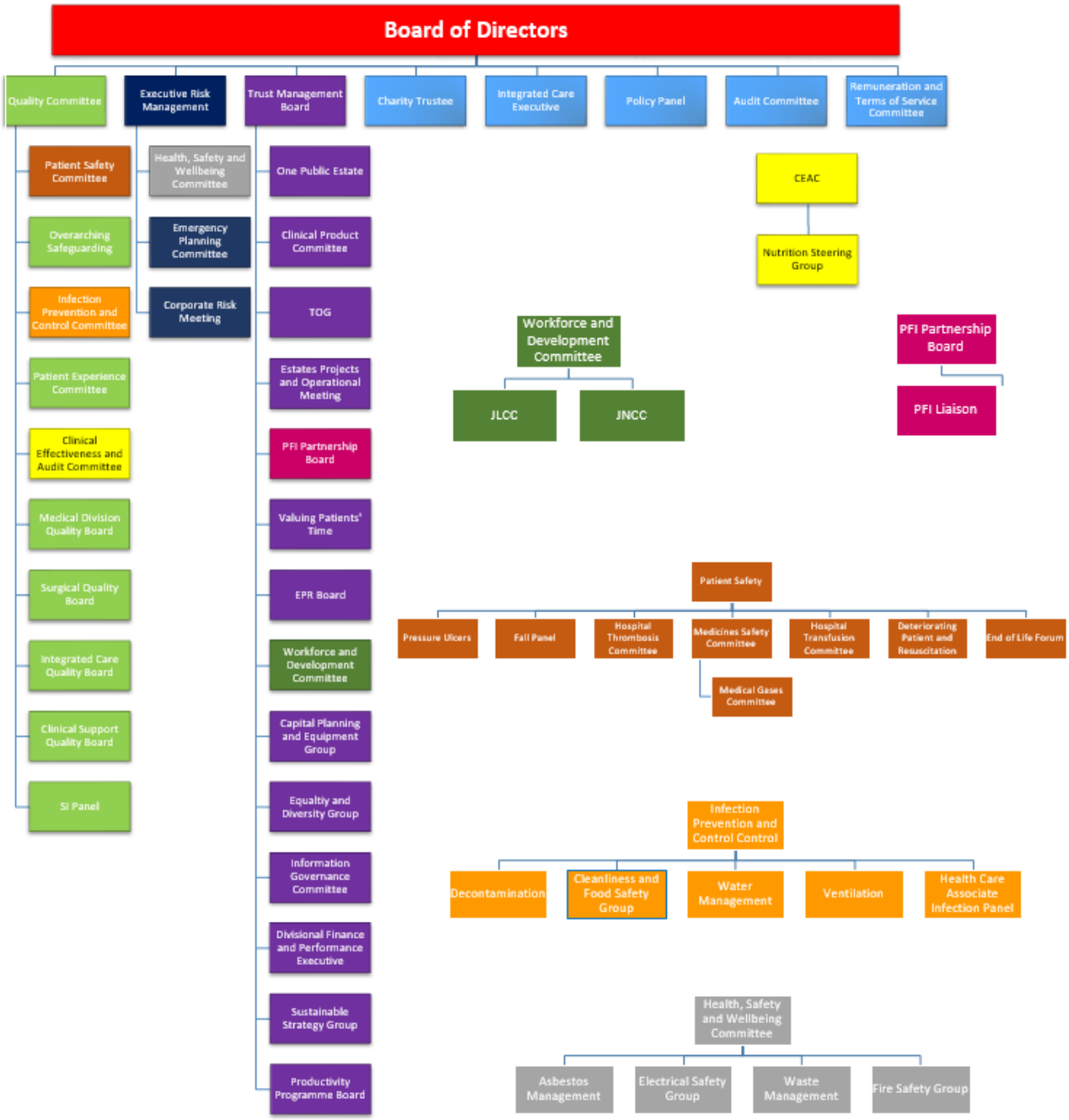
11.2 The Committee will review its work annually to highlight key issues in the development of the Trust's clinical activities and their management, as well as the effectiveness of the Committee.

12. Review

These Terms of Reference will be reviewed annually and recommendations made to Board of Directors for approval.

13. Approval

Date of approval: Approving Body: Board of Directors



Version 1 22020304

	Reporter/ Author (Lead)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Divisional reports													
Surgery	Emma Smith	x			x			x			x		
Maternity	Amie Symes	x			x			x			x		
Medicine	Sarah Holliehead		x			x			x			x	
Integrated Care	Sarah Parry/ Sue Moody			x			x			x			x
Clinical Support	Claire Carlsen			x			x			x			x
Sub- committee reports													
Clinical Effectiveness and Audit Committee (CEAC)	Hamza Katali/ Natasha Owen		x		x		x		x		x		x
Patient Safety Committee (PSC)	Robbie Dedi/ Natasha Owen	x		x		x		x		x		x	
Patient Experience Committee (PEC)	Natasha Owen		x			x			x			x	
Infection Prevention and Control Committee (IPC) ***to include sub group reports where required***	Lucy Flanagan/ Laura Weston		x			x			x			x	
Quality Priority deep dives													
To reduce Clostridioide infection rates and deliver our cleanliness strategy	Laura Weston	x			x			x			x		
Improve VTE risk assessment	Robbie Dedi	x				x				x			
Reduce the incidence of avoidable hospital and caseload acquired pressure damage	Sue Moody	x											
Improve management of the deteriorating patient	Robbie Dedi			x			x			x			x
Using local and national intelligence to improve patient experience	Natasha Owen		x			x			x			x	
Ensure the Trust meets best practice requirements for nutrition	Rachael Hebbert			x			x			x			x
Embed the MCA and DOLS policies and process in practice	Rachael Hebbert		x			x			x			x	
Ensuring patients receive timely critical medications	Tony McConkey			x				x				x	
Annual reports/ Board Oversight reports													
Committee TOR and forward planner	Natasha Owen	x											
Quality Account	Lucy Flanagan/ Natasha Owen		x										
Additional routine reports													
Safeguarding quarterly reports	Rachael Hebbert	x		x		x		x		x		x	
SI report	Natasha Owen	x		x		x		x		x		x	
Quality Indicators report	Lucy Flanagan/ Natasha Owen	x	x	x	x	x	x	x	x	x	x	x	x
Staffing Reports	Emma Smith	x	x	x	x	x	x	x	x	x	x	x	x
Mortality monthly report	David Mowbray/Chris Beaumont	x	x	x	x	x	x	x	x	x	x	x	x
Research	Ingrid Du Rand	x			x			x			x		
External review reports													
CQC report and action plan	Lucy Flanagan/ Natasha Owen	x			x			x			x		
HTA inspection report and action plan	Julie Davies		x										
National Surveys (exception report)													

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Board Assurance Framework (BAF)
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐ **Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon
Documents covered by this report:	BAF as at 23 May 2023

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WVT's strategic objectives for 2023/24.

2. Recommendation(s)

The WVT Trust Board is invited to approve the BAF, identifying any gaps in risk to delivery of WVT's strategic objectives 2023/24.

3. Executive Director Opinion[1]

The BAF has been refreshed to reflect the risks of achieving the Trust's 2023/24 strategic objectives. This document will be continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives and going forward will also reflect the direction of travel (meeting a recommendation from a recent internal audit).

The Trust's 'high' risk register will be provided to Board in July 2023. Most recently, the incident and risk management system for the Trust has changed from DATIX to InPhase. All historic risk data is in the process of being pulled through to the new system. Once at full operational capability, InPhase will be able to provide triangulation between risk, incidents and claims. In the meantime, alongside the implementation of recommendations from the recent internal audit, 'historic' risks are being reviewed, a data cleanse is taking place and new risks continue to be added to InPhase. In particular, the Board are requested to note the inclusion of the risk below to the risk register. The Board can be assured that risk management processes and governance continues, seeing risks reviewed bi-monthly by the Executive Risk Management Committee, with a deep dive of each divisions' risk registers taking place on a rotational basis.

[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.

Risk Title	Risk detail	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls
Delivery of Financial Plan and improving underlying position	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) required; impact of inflationary pressures; and, risk to achieving the full income target. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and shortfall in cash to meet obligations.	20	4	4	16	12	•CPIP devolved as part of divisional budgets for identification and delivery. •CPIP targets agreed by divisions. •Established process for identification and monitoring of CPIP delivery. •Action plans in place for MARP and NARP. •Activity Plan implementation.	•National inflationary pressures. •Process of early identification and capture of full CPIP plan. •Trust policies and processes require strengthening to ensure compliance. •Lack of recurrent efficiencies within the programme. •Lack of medium term financial plan.

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***

Risk Id	Risk Title	Risk detail	Date added to Register	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance	Monitoring Committee	Last Updated	Supplementary Information
54	**BAF 2023/24** Ability of system to manage flow across the urgent and emergency care pathway	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.		Andy Parker	20	4	4	16	8	•Trust Capacity meetings allowing visibility of the issues and escalation. •Investment in additional ward discharge coordinator capacity. •Enabling flow SOP in place (with proactive boarding on all acute wards) •System wide silver meetings.	•Standardization of discharge processes and planning of admission across patient settings. •Ability for out of area partners to respond to the repatriation of patients. •Gaps in Homefirst provision and Discharge to Assess settings. • Shortfalls in staffing at ward level creating delays in discharge planning. • Additional financial burden as a result of inability to mitigate additional activity at the 'front door'. • Winter Plan 2023/24	•Finance and performance executive reporting •Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board.	• System oversight of discharge delays and capacity. • Discharge to Assess Board not yet set up (expected June 23) • Better Care Fund not yet reporting to the Integrated Care Executive. • Winter Plan and capacity bridge analysis.	(Multiple)	23-May-23	Strategic objective(s) 2023/24: 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
56	**BAF 2023/24** Availability of Capital Funds to meet Trust's Strategic Objectives	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivering of key estates and investment being made on Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to an ability to procure essential equipment resulting in adverse impacts on healthcare delivery.		Alan Dawson	15	3	3	9	9	•Capital planning and prioritisation of key schemes and equipment • Holding contingency funds for adhoc emergency requirements •Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	•Ability to determine emergency capital spend requirements •Approval of capital fund applications • Capital funding provided is not sufficient to meet whole requirement	•Project teams and programme board structure in place for major schemes. • Capital Planning and Equipment Committee • Trust Management Board •Financial reports to Board		Trust Management Board	22-May-23	
58	**BAF 2023/24** Clinical and support staff recruitment and retention	There is a risk to achieving the Trust's strategic objectives due to staff shortages and being unable to recruit to clinical, nursing and support staff vacancies, resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	21-Jul-20	Geoffrey Etule	20	4	3	12	8	•Recruitment and retention initiatives: plan for clinical staff; ICS-wide support worker recruitment campaign; international recruitment; 'golden hello' for hard to recruit role; TRAC recruitment system; flexible working policy; career and pay progression framework. •Allocate Project Plan (which oversees implementation of innovative job planning) to allow adaptive use of existing workforce negating the need for recruitment by making best use of resources • Workforce and OD Strategy and Leadership Development Programme - developing skills and competencies of managers to enable improved recruitment and retention. • Analysis into areas of high turnover, vacancies, exit interviews and new starter surveys. •Contract management and monitoring data of Master Vendor and Direct Engagement use. including monitoring of agency price cap.	•Clear medical workforce plan that addresses opportunities within ICS. •Full implementation of e-rostering in clinical areas. •Temporary Staffing engagement and deployment policy. • Enhanced workforce planning and development support for managers. • National shortage of clinical staff both Medics and Registered Nurses. • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes. • Uncertainty of the impact of industrial action. • Cost of living impact on recruitment and retention. • Availability of national workforce to inform WVT 5 year 'grow our own' workforce plan.	•HR Directors weekly ICS meeting. •F&PE reports • E-rostering project board to deliver against plan. • JNCC and Equalities group receive quarterly update on workforce issues. •Staff recruitment and retention working group. • Integrated Performance Report to Board •MARP and NARP (reinstated in August 2022). • Weekly MD-led vacancy review panel - reviews all non-clinical recruitment. •Health and Wellbeing Group to review and assess effectiveness of health and wellbeing initiatives to support recruitment and retention.	• Lack of assurance that the master vendor contract will meet required agency fill rates which leads to use of higher cost tiers within the contract and other agencies - due to ongoing National shortage of clinical staff. • Expediency of ICS-wide initiatives.	(Multiple)	23-May-23	Strategic Objective: Workforce - Improve recruitment, retention and employment opportunities by implementing more flexible employment practises including the creation of joint career pathways with One Herefordshire partners
59	**BAF 2023/24** Delivery of the Digital Strategy	There is a risk of a delay to the delivery of benefits and the future capital funding of the Digital Strategy due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.		Katie Osmond	16	4	3	12	8	•Trust and Foundation Group Digital Strategies •Programme Team •IT Project Managers •Programme Director with programme oversight. •Clinical reference group which provide clinical acceptance and engagement in any proposed solutions •Monthly review of programme progress against plan.	•Change management training of staff •Staff engagement. •Work pressures and availability of staff to be released to attend training. •Lack of resilience in resource plan. •BAU is not established sufficiently to allow effective transition to new ways of working. •Impact of the introduction of digital strategies across all stakeholders. •Uncertainty in national priorities for delivery of digital strategies.	•Capital Planning and Equipment Ctte. •Bi-monthly Board paper to Trust on digital progress. •Internal audit review of EPR •NHS Digital review •Digital programme board with overview of projects to determine critical path, overlap and staff impact.	None Identified	(Multiple)	22-May-23	Strategic Objective(s) 2023/24: 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

66	**BAF 2023/24** Risks to productivity and operational capacity plans and delivery	There is a risk that the Trust will not be able to achieve its productivity and activity plans as a result of factors due to: vacancies; pace of productivity improvements; access to outsourced capacity; and, sub-optimal urgent care pathway. This may severely impact on the delivery of productivity and operational capacity plans that deliver safe and timely elective, emergency and urgent care. All factors, either individually or collectively, could significantly decrease the level of available capacity and productivity.	22-Jul-20	Andy Parker	25	5	4	20	10	• Recovery and Restoration plan (under regular review) • Escalation and surge plan • Ringfenced elective pathways • Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. • Group and system-wide mutual aid • Activity plans. • Clearly documented value for money assessment of additional flexible capacity options as part of business case process.	• Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. • Uncertainty of the impact of industrial action.	• Daily reporting and escalation. • Trust operations group - weekly. • Restoration Meeting. • ICS restoration and recovery oversight group • Productivity Board • Finance and Performance Executive reports. • Integrated Performance report to Board.	None Identified	(Multiple)	22-May-23	Strategic Objective(s) 2023/24: Reduce waiting times for admission for patients who need urgent and emergency care by reducing demand and optimising ward based care. Increase theatre productivity by increasing the average numbers of patients on lists and reducing cancellations
67	**BAF 2023/24** The Covid pandemic has resulted in increased waiting times for planned care patients	The covid pandemic has resulted in large numbers of planned care patients waiting much longer for assessment and treatment . There is a risk that the delay in assessment and/or treatment will lead to patients coming to harm during this time that would have been avoided had treatment been more timely		Andy Parker	20	4	4	16	8	• Inpatient waiting list is 'risk' stratified (P codes) and patients are booked for assessment and/or treatment based on clinical need and where this is equal in chronological order. • Diagnostic waiting list is 'risk' stratified (D codes) and patients are booked for assessment and/or treatment based on clinical need and where this is equal in chronological order. • Specialities have undertaken periodic waiting list reviews and communicated with patients regarding any change in their condition • Waiting list stock take (Harm and Risk Review) undertaken and reported to Quality Committee • Long-wait patients (over 15 weeks) on outpatient waiting list written to on a rolling basis each week. • Weekly review of long waiting patients and plans • Weekly reports including waiting list position (including long waiters), P and D code completeness and activity	• Due to capacity constraints the Trust is unable to rapidly deliver sufficient activity to recover wait times to acceptable levels • Sharp rise in 2ww and urgent referrals has adversely impacted specialty ability to commit sufficient resource to treat long waiting routine patients • Specialty-led waiting list reviews have not provided universal coverage of the whole waiting list • No mechanism by which to ensure patients are not coming to harm as a result of continued delays. • Health inequalities within the existing waiting lists. • ICS response to existing and emerging fragile services.	• Weekly PTL meetings review 'long waiting' cohorts and specialty plans - escalated to F&PE and TMB. • Quality Committee. • Productivity Board • Finance and performance executive • ICS-led recovery and restoration • Regional recovery and restoration • Audit of waiting lists completed	• Work with Primary Care to agree and develop shared waiting list management approach.	(Multiple)	22-May-23	Strategic Objective(s): Quality Improvement: Reduce waiting times for diagnostics, elective and cancer care.
1686	**BAF23/24** Improving Cleanliness Standards	There is a risk that WVT will fail to deliver improvements to cleanliness standards which could lead to increased infection rates.	04-May-23	Lucy Flanagan	20	4	3	12	8	• Contractual cleaning schedule to meet nationally published standards	• Standard of contracted cleaning.	• CQC inspections • Infection Prevention Audit Programme • Monitoring team providing regular local inspection against the 2021 standards • Infection KPIs identifying change/trends		(Multiple)	04-May-23	Strategic Objective(s) 2023/24: Reduce our infection rates by delivering improvements to our cleanliness and hygiene regimes
1687	**BAF23/24** One Herefordshire delivery of responsibilities contained within the MOU	There is a risk that One Herefordshire will be unable to make improvements to 'working in a more integrated way' due to an inability to achieve consensus. This includes being unable to realise the potential benefits of the MOU (containing new responsibilities for the Better Care Fund) between the ICB and One Herefordshire.	04-May-23	Jon Barnes	9	3	2	6	6	• Terms of Reference for ICE to provide oversight of delivery of the MOU. • Availability of shared data	• Finalised and signed MOU	• Monthly reports to ICE • One Herefordshire agreement of the MOU, enabling consensus.	• Defined reporting mechanism to assure delivery against the MOU.	(Multiple)	04-May-23	Strategic Objective(s): Reduce discharge delays by working in a more integrated way with One Herefordshire partners through the Better Care Fund (BCF)
1688	**BAF23/24** Delivery of Academic Programme	There is a risk that WVT may be unable develop an effective academic programme in a timely manner due to being unable to quantify the scope as a result of the range of services provided, necessary resources (including finance) and delivery models required to achieve improvements to patient care.	11-May-23	David Mowbray	10	2	5	10	4	• Project oversight in place: Executive lead; Research and development lead; Associate CMO for education.	• Scope and project plan. • Project management.	• Project planning meetings	• Scope of project not yet defined. • Quotative and qualitive impacts of projects to be determined through national best practice.	Trust Management Board	23-May-23	Strategic objective(s) 2023/24: 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:	**01/06/2023**
Title of Report:	Modern Slavery Act Statement
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	TMB, Board
Lead Executive Director:	**Chief People Officer**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To present the WVT Modern Slavery Act 2015 statement for approval.

2. Recommendation(s)

The Trust Board are requested to approve the statement below before it is made public facing.

3. Executive Director Opinion[1]

WVT aims to follow good practice and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our Supply chain. This statement sets out actions taken by WVT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls. Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business. In preparing the following statement, procurement, education, HR and communication colleagues have been consulted and assurance can be given to the Board that the appropriate measures (as described below) are in place:

> "**MODERN SLAVERY ACT 2015**
> **Wye Valley NHS Trust statement 2023/2024**
>
> This statement is made on behalf of the Board of Wye Valley NHS Trust with regards to the Modern Slavery Act 2015 which requires large employers to be transparent about their efforts to eradicate slavery and human trafficking in their supply train.
>
> The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery, which includes servitude, being forced or deceived into work, not being able to leave freely and easily without threat to themselves or their family resulting in undesirable or unsafe conditions. Under the Act, eligible organisations must publish an annual statement in line with their financial year end. The Act places an obligation to state the steps WVT will take to or has taken to detect and deal with forced labour or human trafficking in the supply chain.
>
> WVT aims to follow good practise and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring all our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be at risk of modern slavery/human trafficking.

[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.

WVT are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. Our supply chain includes procurement of medical services, medical and other consumables, facilities management, utilities and waste management. For clarity, the 'supply chain' has a much wider implication than just the purchasing of goods and services carried out by procurement teams. It includes the supply chain of the carrying out of its own business. Our supply chain 'in carrying out its own business' includes HR recruitment for permanent staff, bank and agency staff and other bought in medical and non-medical consultants.

The Trust continues to develop ethical policies and procedures to reflect our commitment to act ethically in all our business relationships, developing and implementing effective controls to ensure slavery and human trafficking is not taking place within our supply chains. WVT will identify which policies require the addition of appropriate reference to the Modern Slavery Act 2015 and its requirements. These policies will be updated in line with policy ratification process for approval if required.

Training is provided to those involved in the supply chain and the rest of the organisation as part of the Trust's safeguarding role. The Trust provides learning, as required by the Core Skills Training Framework which includes Modern Slavery Act, which includes an awareness of human trafficking and forced labour and provides advice on what to do if this is suspected. The module is mandatory for all new staff and refresher training, and participation can be monitored and reported on if required.

The Trust will work to identify and mitigate risk and put in place contractual terms which will allow the Trust to gain assurance that slavery and human trafficking have no place in our business".

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***	

Foundation Group Strategy Committee

TERMS OF REFERENCE

Remit	The Foundation Group Strategy Committee advises the Boards of South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust and George Eliot Hospital NHS Trust on all matters relevant to identifying and sharing best practice at pace. The Committee have the ability to benchmark with other Associate Members of the Group and bring them into the Committee to do so.
Accountability Arrangements	The Committee is accountable to the Board of Directors of each Trust and is authorised by the Boards to investigate any activity within its terms of reference. It is also authorised to: • seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Committee. • ensure the engagement of all Board members in the formation and execution of strategy • decide upon, and require officers to implement, appropriate action to ensure achievement of, or to correct deviation from, the strategic objectives agreed by the Boards.
Responsibilities	The Committee will advise the Boards on the following matters; **Strategic Financial and Operational Planning** • developing strategy and investment plans, including finance, IT, estates, and commercial development • overseeing processes which benchmark clinical outcomes and productivity across the Group supporting the implementation of best practice solutions • developing new working models for corporate functions • developing new business models to progress the development of integrated health and care • developing and executing a communications strategy • developing and maintaining business development capacity and capability across the Group • determining the framework that supports each provider's organisational objectives and targets • developing and supporting achievement of operating, business, efficiency and delivery plans • identifying, reviewing and mitigating strategic risks • proposing and implementing joint working with partner organisations where collaborative approaches will yield tangible improvements and/or efficiencies • overseeing service transformation and pathway redesign

Membership/ Attendance	Members of the Committee are: • Chair of the Trusts • Chief Executive of the Trusts • A Non-Executive Director from each Trust • Managing Director from each Trust • Chief Medical Officer (or equivalent) from each Trust • Chief Strategy Officer from each Trust • Group Strategy Advisor • Group Strategic Financial Advisor • Other Group Advisors • Representatives from Key Partner Organisations (as agreed by the Chair or Chief Executive • Board Level Representatives of Associate Members Other officers of the Trust may be invited to attend as required. Where a member is unable to attend routinely, an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	The Chair of the Committee will be the Chair from the Trusts.
Quorum	A quorum shall be six members which will include two Non-Executive Directors (one of which could be the Chair), the Chief Executive and a Managing Director. The quorum should include either a NED or MD from Wye Valley NHS Trust and George Eliot NHS Trust.
Reporting Arrangements	The minutes of the Foundation Group Strategy Sub-Committee will be formally recorded and submitted to the respective Boards of Directors. Any confidential matters will be identified as such in the minutes and separately recorded. Each Non-Executive Director of the Foundation Group Strategy Sub-Committee will provide a brief report to the following Board of Directors meetings drawing attention to significant developments, highlighting areas where further assurance is required and matters requiring Board decisions. The Committee's agendas and meeting papers will be made available to all Board members of the respective Boards of Directors. The Committee will review its work annually to highlight key issues in the development of the Groups Operational and Financial Strategies and their management, as well as the effectiveness of the Committee.
Frequency of Meeting	The Committee shall normally meet quarterly. The Chair may call an additional meeting if they consider one is necessary.
Administration	The Committee shall be supported by a member of the Corporate Support staff, whose duties in this respect will include: • Preparation of agenda in consultation with the Chair

	• Collation and circulation of papers/ presentations in advance of the meeting • Taking the minutes and agreeing these with the Chair • Keeping a record of matters arising and seeking updates on action points
Date Approved	Committee on 22 March 2022 Board of Directors of South Warwickshire NHS Foundation Trust – 6 April 2022 Trust Board of Wye Valley NHS Trust – 5 May 2022 Trust Board of George Eliot NHS Trust – 5 April 2022
Date Review	Committee Review Date: February 2023 Board Review Date: April 2023

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	WVT Digital Programme Update
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Digital Programme Board
Lead Executive Director:	**Chief Finance Officer**
Author:	David Warden, Associate Director of IM&T and Clare Williams, IM&T Project Support Manager
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To provide an update on the current status of the Trust's Digital Programme.

2. Recommendation(s)

The Board is asked to note the content of this report.

3. Executive Director Opinion[1]

A range of projects and activities continue under the oversight of the Digital Programme Board, primarily focused on driving our digital maturity.

The key risks to delivery of the digital strategy remain availability of funding for investment in digital, and capacity within the digital workforce.

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.

Overview of Inflight Projects

Strategy Stream	Programme	Workstream	Project Stage	Project End	Point for Escalation (Below)	Project RAG	Financial RAG
Clinical Systems	GDE	EPR Phase 2	Implementation	March 2023	Y	A	Y
		EPMA Integration (Allergies, labs, VTE)	Development	May 2023	Y	A	Y
	GP Order Comms		Development	September 2023	Y	A	G
	Telecoms Upgrade Programme		Scoping/ Pre Business Case	TBC	Y	Y	G
	e-Rostering - Medical		Implementation	July 2023	Y	A	A
	Voice Recognition Pilot		Business Case	TBC	Y	G	G
	Clinical Systems Management (formerly BAU Service Re-design)		Implementation	March 2023	Y	Y	G

Points of Escalation

Project	Summary (Description, Impact and Mitigation)	Type (Note, Issue or Risk)	RAG (Post Mitigation)
EPR Phase 2	The Team are now testing the next release for MAXIMS and it is planned this will be released into production in the next 4-6 weeks, assuming there are no issues. Outpatient clinical noting has gone live for the MS and Epilepsy Teams over the last few weeks with no major issues reported. Remaining Outpatient areas are due to go-live with clinical noting over the next 3-4 months. Documents for over 18's went live in the shared care record on the 24th April. A pilot for remote cancer monitoring commenced on the 15th May, with a few select users, to review whether MAXIMS as designed will fit requirements. Limited Project Management resource remains a risk and recruitment to 1 x Project Manager and 1 x Business Change Analyst vacancies is now in progress. Suitable on-site accommodation is still to be identified for the EPR Trainers to support project Go-lives and this also remains a risk.	Risk	A

EPMA Integration	Work is ongoing with the suppliers to complete the interface for VTE screening and it is anticipated this will be completed ready for testing by the end of May. Stakeholders will then be engaged to schedule a roadmap to make this functionality live, and to provide support for system changes. A technical issue, which is causing delays to the planned EPMA and drug dictionaries update, has been identified. Work is underway with the suppliers to apply a patch so the solution for this issue can be tested. The suppliers continue to work together on the Patient in context links and testing is anticipated to begin in June. A go-live date for this functionality is anticipated for August 2023.	Issue	A
GP Order Comms	The Team are currently waiting for a software release from IMS MAXIMS into the test environment which is due shortly. Once received testing will begin as soon as possible. The Team are also making plans to implement Radiology clinical decision support. Funding was received for this work at the end of last financial year in response to a bid submitted by Radiology. Work is underway to align this with the IMS MAXIMS roadmap as other suppliers are involved in delivery. The current plan is for a pilot to take place with Hereford Medical Group in May, however this can only be confirmed once the software has been received from IMS MAXIMS.	Issue	A
Telecoms Upgrade Programme	The Telephony audit, which includes the mapping of service users and stakeholders and completing a master asset and service list, is currently underway. Meetings with ICS contacts have commenced. It is proposed for WVT to lead on an ICB-wide telephony solution procurement with the intention to maximise cost savings by combining requirements where possible. The initial focus will be on mobile phone contracts, in order to benefit from an immediate cost saving related to the reduction of the mobile phone estate, and a move to better value contracts. The draft business case is almost complete.	Note	G
e-Rostering – Medical	The job planning committee is meeting monthly for data driven discussion. The job planning audit rated the Trust as having partial assurance over its job planning processes. The audit has provided recommendations that the job planning committee was already in the process of implementing, or will implement as part of the 23/24 job planning round. Lessons learnt were reviewed and the next steps outlined.	Note	A
Voice Recognition	The business case was approved in principal at the May Trust Management Board. More clarification around the terms of the contract and financial commitment with the preferred supplier is required and this is being investigated by the Project Manager.	Note	G

Clinical Systems Management (formerly BAU Service Re-design)	The Benefits Manager and Clinical Functions Manager posts are currently out to advert. The pilot for the out of hour's service commenced 27th March. Risks associated with lack of a training room on site to deliver support at go-lives and recruitment to senior posts still remains. The Non-pay work streams, namely the upgrade to the training system, delegated account management and access to the service desk platform, are now underway with weekly meetings taking place between Hoople and the CSG.	Note/ Risk	Y

Project RAG Key

(G) No risk to delivery	(Y) Minimal risk to delivery	(A) Reasonable risk to delivery	(B) Serious risk to delivery	(R) Extreme risk to delivery
Project on Track	Awareness of risks to delivery being managed	Action defined and has/is being taken to ensure delivery.	Action undefined but required to ensure delivery.	Delivery of Project compromised. Decisive action required.

Programme Financial Health Check

The table below shows the final capital position on digital schemes for 2022/23.

Division	Specialty	Proposal	Plan £k	YTD Actual £k	Variance £k
Clinical Support	Haematology/ Pathology	Cellavision for blood film reporting	£50	£50	£0
Clinical Support	Radiology	21/22 cf CRIS Communicator	£6	£4	£2
Clinical Support Total			£56	£54	£2
Corporate Digital	Corporate Digital	EPMA (Integration completion)	£86	£93	(7)
Corporate Digital	Corporate Digital	GP Order comms	£230	£178	£52
Corporate Digital	Corporate Digital	EPR	£1,210	£1,134	£76
Corporate Digital	Corporate Digital	ICS Project - Trust resources	£30	£0	£30
Corporate Digital	Corporate Digital	STP project Trust resources	£0	£2	(2)
Corporate Digital	Corporate Digital	Telecoms & Pagers	£50	£49	£1
Corporate Digital	Corporate Digital	Allocate (formerly E-Rostering)	£385	£343	£42
Corporate Digital	Corporate Digital	Front line Digitalisation	£750	£750	£0
Corporate Digital	Corporate Digital	I-Refer	£280	£241	£39
Corporate Digital Total			£3,021	£2,791	£230
Medical	Cardiology	21/22 cf Tomcat Upgrade	£6	£0	£6
Medical Total			£6	£0	£6
Corporate Digital	Cyber security	Cyber security	£56	£58	-£2
Cyber Security PDC Total			**£56**	**£58**	**-£2**
Grand Total			**£3,139**	**£2,903**	**£236**

The overall position shows an under spend of £236k against the final plan. This relates to a number of small under spends and a reconfiguration of costs to Frontline Digitisation to ensure the PDC funding was utilised. The final plan has reduced slightly as the Cyber funding received was £31k lower than expected.

Place based Strategic Projects

Project	Stage	Key activity
Digital Pathology	Implementation/ Validation	The Trust is now clinically live, training has been completed and slides for MTT purposes should start to be shared later this month. There have been some issues with reporting and work is ongoing to provide a solution on this which will unlock more benefit. The Project Board continues to meet to oversee issue management and the development of reporting.
Video Consultations	Business as Usual	The Trust has implemented Microsoft Teams to enable services to continue to use video consultation where needed. Since the end of Covid 19 measures the telephone has proved to be the more popular platform with both patients and clinicians for the majority of remote consultations. Future updates will be occasional as no further project work is planned in this area.
Remote Monitoring	Pilot / Scoping	Requirements and funding are being explored. An initial pilot has commenced.
Advice and Guidance	Scoping	Requirements and funding are being explored.
Virtual Wards	Scoping	EMIS templates are being developed with support from CSG.

IM&T Strategy and Upcoming Opportunities

Opportunity	Route	Status
Community Diagnostic Hub	Regional Programme	Recruitment of a Project Manager to support the Digital implementation of the Community Diagnostic Hub and Stroke AI is being explored.
Virtual Desktop/Single sign on.	HIMSS and MDF (Minimum Digital Foundations) Requirement.	Outline case supported in principle, procurement exercise being scoped to enable full business case to be developed.
ED System Replacement.	Trust Digital Strategy and MDF (Minimum Digital Foundations) Requirement.	The first phase business case has now been approved and recruitment is underway to appoint a Business Analyst and Project Manager to the EPR Programme Team. Initial expectations are that go-live is likely to be in October 2024.

Messages

- The Digital Programme Board has authorised the allocation of limited resources to enable the Trust to participate in the ICB sponsored pilot of Robotic Process Automation. A Trust steering group is being established to agree which opportunities to pursue within the initial 2-3 automations available to the Trust.

- The Trust submitted its draft Digital Maturity Assessment (DMA) responses ahead of the original March deadline. Subsequent peer review took place within the ICB. The Trust was paired with Worcestershire Acute Hospitals NHS Trust for formal peer review. Following the peer review phase a small number of responses were revised before the final submission deadline of the 15th May. The majority of the Trusts responses were at levels 2 and 3 with higher attainment in areas that have been subject to recent investment such as electronic prescribing. Digital citizen access to services was the Trusts lowest scoring area. Patient portal functionality currently being developed by the ICB will improve this.

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Policy Panel Update
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Policy Panel, Board
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on those policies that have been presented to and approved by the Policy Panel plus, as requested at November 2021's Board meeting, to provide assurance on the overall provision of policies within WVT.

2. Recommendation(s)

To note those policies approved by the policy panel, on behalf of the WVT Board, since it last reported to Board in March 2023.

3. Executive Director Opinion[1]

The Trust's Policy Panel, chaired by the Managing Director: ratifies policies and provides the Board with a summary; approves related documentation; ensures that documentation is presented in the Trust format and has been catalogued on the Trust database; and, monitors the adherence to the developmental processes to maintain the quality of documentation.

The table below provides an overview of the trust's position with the provision of policies.

Total # of Policies being updated (within 6 months of expiry)	Total # of Policies: Out of Date	Total # of Policies: About to Expire (within 60 days)
25 (increase of 16 since March 2023)	**5 (no change since March 2023)**	**20 (increase of 14 since March 2023)**

The panel has approved the following policies (linked to the Trust intranet) since it last reported to Board on March 2, 2023:

IG.S.09 Subject Access Request SOP
IG.S.10 Managing Health Records for Adopted Children, both WVT electronic systems and paper records Policy
IG.S.11 Transgender Health Records
PR.184 Malignancy of Undefined Origin (MUO) & Cancer of Unknown Primary (CUP) Operational Policy
PR.S.29 Malignancy of Undefined Origin (MUO) & Cancer of Unknown Primary (CUP) Diagnosis and Treatment SOP
MF.36 Managing Conflict of Interest Policy
EP.11 Senior Manager On Call Guidance Policy
HS.S.03 Fire Safety Manual SOP
EF.06 Cleanliness Policy
IC.39 Influenza Management Policy
IC.16 Multi Resistant Gram Negative Infection Prevention Policy
PR.188 Non-Medical Authorisation of Blood Transfusion
PR.186 Blood Transfusion Training Policy

[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.

IG.64 Data Protection Impact Assessment Policy
HD.S.01 Outpatients medical notes
IC.38 Clinical Cleaning Policy
IC.19 – Exposure Incident (Sharps and Body Fluid Exposures) Policy
IC.04 Infection Control Bed Management Policy
PR.S.27 Care of the nephrostomy patient: in the acute trust, community sites or at home
PR.S.28 - Delivering thrombolysis for in-patient stroke presentations
HR.26 Freedom To Speak Up Policy
IG.S.08 Transferring and receiving confidential information policy (SOP to replace policy IG.41)

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***

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Audit Committee Summary Report 16 March 2023
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	Select Director
Author:	Nicola Twigg, Chair of Audit Committee/NED
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To brief the Board on the main issues arising from the Audit Committee held on 16 March 2023.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

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

Quality Improvement

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

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

☐ Reduce waiting times for diagnostics, elective and cancer care

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

Integration

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

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

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

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

Sustainability

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

☐ Stop adding paper to medical records in all care settings

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

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

Workforce and Leadership

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

☐ Develop our managers' skills and system leadership capability

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

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

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

Wye Valley NHS Trust
Trust Board Meeting – 1 June 2023
Summary of Audit Committee (AC) meeting held on 16 March 2023

MATTERS FOR PARTICULAR ATTENTION

Implementation of InPhase -
The Quality & Safety Matron presented a progress update on the InPhase implementation, the new risk management system at WVT. The current digital risk management system, Datix, reports into two systems which will be replaced by a single system, the Learning from Patient Safety Event service (LFPSE). The new system will support patient safety learning, support patients to report their own incidents and provide a two way system which can extract data for learning. The timeline for the proposed deadline for cut off for the old system is the 30 September 2023, with all Trusts using a test system by the 31 March 2023. This will result in a change of process in respect to Board Assurance Framework (BAF) and risk assurance and this will be fully outlined at the next full Audit Committee.

Internal Audit –
RSM, UK Internal Auditors (IA) presented the IA progress report. Financial Sustainability (Final report), Cost and Productivity Improvement Programme (CPIP) (Draft report) and the Discharge Management report (Draft report) with not significant findings. The Long List for next year was discussed and agreed in principal subject to final executive agreement. It was noted that 5 reports remained unfinished and therefore a one off separate meeting has been agreed to cover these reports prior to next full Audit Committee.

External Audit, Audit Plan Sign Off for 2022/2023
Deloittes LLP, External Auditors (EA) presented the Audit plan for 2022/23. Four significant risk areas for this year were highlighted within the audit plan, these included recognition of NHS revenue, classification of capital expenditure, completeness of year end accruals and provisions and management override of controls. All parties confirmed confidence in meeting year end timescales having applied learning from pressures experienced in the previous year.

Financial Submission 2023
The CFO provided an update on the Financial Submission for 2023/2. There are a couple of risks not reflected in the plan which will require mitigation. Based on the draft plan that was submitted at the end of February per the national timetable there was a planned deficit of £50.4 million. A number of assumptions were not concluded and it was discussed that further improvement before final submission would be needed. Board had a robust discussion around Agency spend and level of ambition versus level of credibility for plan that can be delivered and reflects the real run rate

OTHER MATTERS

Report	Discussion / Recommendation
Governance Mapping	Governance Meetings have been mapped and apportioned into Tiers 1, 2 and 3 relevant to their importance and they are now ready to publish. All meetings have Chairs, Terms of Reference and feedback to Board. Quality of meeting output will now be reviewed. This will now be added to AC as a standing agenda item.
Business Continuity	Simon Mortimore, Head of Information Technology, Hoople Group Limited and John Gwilliam, Head of Clinical Systems gave a presentation on WVT IT Continuity and Disaster Recovery

Counter Fraud	Plan for next year was agreed and LCFS had completed the local proactive exercise on Conflicts of Interest, with two low priority actions identified. A request was made to encourage for increased completion of the Counter Fraud Culture Survey.
Management of conflicts policy and declarations of interest –	The policy was viewed and discussed, linking assurance to targeted groups and it was agreed that awareness was to be raised further though Trust Talk.
Updated Standing Orders	Audit Committee approval of the WVT updated standing orders and Standing Financial Instructions (SFI's) which have now been aligned within the Group.
Losses & Compensations	The Losses and Special Payment made during the third quarter (Q3) compared to the previous year were discussed alongside benchmarking for Pharmacy Losses across the Group however only George Eliot Hospital (GEH) and Wye Valley Trust (WVT) supplied information at this time,
Single Tender Waiver	The Procurement team provided a comparison from August 2022 to March 2023 against the same period last year

Prepared by:-
Nicola Twigg, Chair of Audit Committee

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
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 on 14 February and 3 April 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]

Primary Care Network (PCN) Development

In recent months, significant progress has been made with improvements to governance alongside the provision of data seeing dashboards updated to have oversight of West Midlands Ambulance Service (WMAS), 111 and general practice elements. Further deep dives are taking place to better understand WMAS conveyance data. This progress has improved focus on areas such as A&E activity, frailty and RESPECT. Additionally, the following areas continue to be developed:

- Dementia diagnosis using Diadem tools. A pilot is ongoing with the ICB and WBC PCN using Diadem, working with enhanced health in care home teams.
- Enhanced health in care homes with built-in cyclical reporting. Data will go to the Care Home Support programme and will highlight to each network the areas requiring attention.
- Mortality data, linking in with WVT, to look into care home residents who had been admitted to WVT and died within 30 days of discharge, in order to understand if there are any themes that require addressing.

Notwithstanding these significant advances, digital remains the biggest risk to timely PCN development.

Feedback from the last care home providers meeting revealed some uncertainty on how to access urgent community response which is being addressed.

PCNs are currently setting priorities using the National Maturity Matrix. An update will be brought to the next meeting once the MoU is signed.

Urgent Community Response (UCR)

Referral numbers continue to increase and the number of missed calls has reduced. The main referral source is category 3 patients being pulled from WMAS 'stack'; significant benefits have been realised by working within the WMAS 'stack' process. During the doctor's strike, there was an increase in referrals of 20%.

[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.

An area of concern had been the recording of UCR activity on EMIS and the disparity between the data being recorded by Worcestershire; the models are very different which had caused issues when comparing data. Discussions have taken place with ICB colleagues to work through the issues and the team are confident with the data we are now submitting for all 9 clinical conditions.

Discharge to Assess (D2A)

The newly formed D2A board will allow all elements of the process to be joined up. The first meeting of the board is planned for June 2023 and the meeting will report to ICE formally from then on. It is planned that the board will also pick up quality oversight and the skills deficit following conversations with the local authority. Data has started to be captured to inform areas for urgent work.

Overnight Nursing Service

Sickness within the team had necessitated silver call escalation. That aside, it remains a quality service with KPI activity remaining static although anecdotally the team feels there has been an increase in activity, specifically with end of life patients. Given this, further analysis of the data is taking place.

There have been discussions between Taurus and WVT regarding provision of a twilight service from 8.00-12.00pm. This has been agreed in principle and now requires a plan to be put in place.

Work is also ongoing on to establish a single point of access for urgent care, seeing a conversation at One Herefordshire, pulling all resources in to a single out of hours 24/7 service. Not only would this improve the service, it would also provide economies of scale and deliver the service in an affordable and sustainable way.

Community Mental Health Transformation Programme

Community mental health transformation has been live for two years, this will be the third and final year. A formal stocktake has recently taken place with NHS colleagues against key deliverables; the programme is looking to reach 70% completion. The model sees a Clinical Lead/Manger in place for each PCN and key workers aligned to GPs with appointments every 30 minutes - urgent referrals can be made to duty workers/team manager. Limited access to clinical rooms has necessitated more virtual appointments but discussions are in progress, including with WVT, regarding a more efficient use of accommodation.

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***

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Quality Committee 30 March 2023 Summary Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	N/A
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James NED and Quality Committee Chair
Documents covered by this report:	N/A

1. Purpose of the report

The Trust Board is asked to receive and note this summary of items discussed.

2. Recommendation(s)

For information.

3. Executive Director Opinion[1]

N/A

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

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

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

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

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

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

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

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

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

☐ Develop our managers' skills and system leadership capability

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

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

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Quality Priority - Nutrition

The Committee was pleased to note the progress reported in the Nutrition update: in particular the improvement in nutrition screening scores in community hospitals and the start of the process to introduce the same screening measures to the Hereford site. Committee also noted the new national food standards and the work of the Nutrition Steering Group (NSG) to assess how we can meet and use these to support patient experience.
We also picked up the need to provide for people who cannot use the usual sets of weighing scales, which was a learning point in a recent LeDeR review, and agreed to ask the NSG to review how we can better monitor hydration alongside other nutrition considerations.

Quality Priority - Mortality

Committee noted the continued improvement in our SHMI scores and the continuing work to ensure we are recording palliative care appropriately through a joint Task and Finish Group with Foundation Group partners. Committee was also assured by the report of no care concerns following the recent review of stroke mortality. Agreed our CQUINS for 23/24 following discussions between Trust and the Herefordshire and Worcestershire ICB. The 5 selected continue our quality focus on pressure ulcers and nutrition, recognise our recent Serious Incident challenges around recognising and responding to deteriorating patients, support our recovery work in Urgent and Emergency Care by focussing on our response to frailty and give a new impetus to our work to improve communications with community pharmacists about changes to medicines for discharged patients.

Quality Priority – Maternity

Committee received the Q3 Quarterly report and the monthly PQSM report.
We noted the planned work to understand better our “Robson Group” data and what this is telling us about our overall rate of caesarean sections and how this breaks down across the Robson categories. We were pleased to note the appointment of a consultant midwife and the work to fill midwife vacancies.
In recent months we had concerns about the need to improve multidisciplinary working so were pleased to note improvements in the reporting of data for ward rounds and handovers.

Quality Indicators

We discussed a significant rise in Serious Incidents (SI’s). While this included a rise in pressure ulcers it was ascribed mainly to the requirement to record covid-related deaths as SI’s. We agreed in future to separate-out the covid-related numbers to better assess comparative data.
Committee was concerned to learn of a 2 recent events involving insertion of a nasogastric tube. These have yet to be assessed by the SI Panel but are concerning following a recent Never Event and we discussed the need for a possible wider review of practice and possible involvement of the ICB to support us.

Quality Priority – Same Sex Accommodation Policy

Committee approved the Same Sex Accommodation Policy which has been updated post-Covid and in line with new national guidelines. We agreed that the Committee would continue to review breaches of the policy.

Working Effectively to Assure Quality

Further to a review of the operation of the Committee and its reporting groups and sub-committees we considered some evolutionary changes designed to strengthen consistency of reporting, to avoid duplication in reporting and to ensure effective delegation to our sub-committees. Equally we need to ensure we are focussing on our quality priorities and getting the balance right between our overview of quality across the Trust and deep-dive activity where required. Committee agreed the revised approach and noted that we will continue to reflect on this over the coming months.

Workshop – Cleanliness Roles and Responsibilities

In its final session the Committee welcomed the Regional NHS lead for Infection Prevention and Control (IPC) who set out the context IPC including its legal and regulatory framework, the importance of key reports including and subsequent to Francis and the important role of the Board in the leading the IPC agenda including the need to look behind the data, the need to triangulate information and the importance of walking the floor.

It was particularly helpful to reflect on the importance of “fresh eyes” to challenge the work we do and the benefits in this regard that we getting from working more closely with our NHS regional colleagues.

Report to:	**Public Board**
Date of Meeting:	**01/06/2023**
Title of Report:	Quality Committee 27April 2023 Summary Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	N/A
Lead Executive Director:	**Chief Nursing Officer**
Author:	Nicola Twigg NED and Acting Quality Committee Chair for April QC
Documents covered by this report:	N/A

1. Purpose of the report

The Trust Board is asked to receive and note this summary of items discussed

2. Recommendation(s)

For information.

3. Executive Director Opinion[1]

N/A

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

Quality Improvement

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

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

☐ Reduce waiting times for diagnostics, elective and cancer care

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

Integration

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

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

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

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

Sustainability

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

☐ Stop adding paper to medical records in all care settings

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

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

Workforce and Leadership

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

☐ Develop our managers' skills and system leadership capability

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

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

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

Quality Priority – Safeguarding

The Q4 Safeguarding Quarterly Report was presented for adults and children.

In respect of Adults, we are continuing to see an upward trend of safeguarding referrals with 214 in quarter 4. Support continues to be given by phone and routine review despite small size the team have a high clinical presence. Initial Health Assessments do continue to be an issue and further training is being given in this respect and good take up and completion figure seen.

Regarding Children, again workload continues to be pressured due to volumes albeit there has been a reduction in children with Child Protection plans at the end of the quarter. Again training levels have been sustained and are improving in many areas. Mash coverage is struggling and issue placed on Operational Risk Register but ICB have agreed to look at a business case to fund an increase in cover. We are awaiting sign off of a recent responsibilities for safeguarded children audit and actions will be presented in due course.

Looked after children numbers also continue to increase with many out of area. Medical consent continues to be a challenge but is being given high profile. Dentistry provision was discussed and we are seeing positive improvements due to relationship building with local dentists. Immunisation figures were also strengthening at 83%.

Quality Priority – Pressure Ulcers

A new simplified report was presented and the improvement plan discussed. Overall, pressure ulcer incidents across Herefordshire and Powys are increasing. This is particularity post pandemic and is being seen across the country. Since April 2021, there has been a steep increase in pressure ulcers

The Associate CNO is leading a piece of work for staff induction at all levels and a Clinical Practise Week has been agreed to give further focus on tissue viability, pressure ulcers and wound management. Work also continues with Frailty.

A number of key actions are being undertaken including addressing the key concerns from Serious Incidents regarding general staffing skills and knowledge for pressure ulcers by having a training programme for tissue viability assessment and grading and discharge aftercare.

Quality Priority - Mortality Report

Committee was pleased to note the continuing improving situation with regard to the Trust's relative scores against the mortality indices. A fractured neck of femur report was included this month showing a spike in out of hospital figures however underlying health issues were the overall cause of death.

Quality Priority – Maternity - Quarterly Report

Committee received an update report noting there has been a significant improvement in our staffing numbers and recruitment drive with positive interest from a recent Midwife Recruitment Day. A full workforce review is due by the end of May.

Other issues discussed included CNST, where have declared compliance and are awaiting the final information on this. There have been a small number of Serious Incidents attributable to women with diabetes. A Task and Finish Group has been set up to review the service and working across the whole MDT to facilitate this. Ockenden Insight Visits have taken place with a full review due in June and no particular issues found at this time.

Quality Priority – Maternity – PQSM Report

The report was discussed and an update given on Neonatal Network configuration and also Maternity Voices Partnerships highlighted to help women with guidance for making decisions linked to their pregnancy and birth choices.

Surgical Division Quarterly Report

Key points noted from the discussion included an increase in open Serious Incidents and the actions being taken to address. The divisions audit programmes are progressing well with only Breast Cancer Services for Older People outstanding. VTE compliance is improving month on month. Complaints remain an area of concern but a process to address has been put in place and improvements are being seen already.

Agency spend remains a concern due to vacancies and cover during the Junior Doctors strike but robust plans are in place to address and Nurse Agency usage already showing positive improvements.

Whilst other concerns were raised the committee was given clear actions and evidence that issues were being addressed and counter balanced with examples of good practise.

Staff Nursing Report

The Chief Nursing Officer gave a report which included a positive position for agency use in April which we will see in the data at our May meeting.

Quality Committee Terms Of Reference and Forward Plan

Changes were agreed to include removal of Chief Operating Officer attendance and to continue to include the new style Serious Incident Report.

Patient Safety Committee Summary Report

The Committee received the Standard Operating Procedure for Robotic Surgery and the audit of standards for the Radiology Events and Learning Meetings (REALM) for the first time. The Medicines Safety Committee raised a concern in relation to the lack of progress with diabetes improvement and the lack of a Diabetes Safety Committee and it was agreed that we need to explore this being set up as we have continued to see insulin incidents.

Radiology Critical & Incidental Reporting Presentation

A six monthly update was provided post implementation of this system outlining very positive progress. The CMO has suggested that this project should be recommended for a HSJ Safety Award due to the number of findings not being picked up immediately previously.

CQC Action Plan – Quarterly Update

A regular update was provided and it was agree to formally close all completed and resolved actions.

Draft Quality Account

A verbal update was given and agreement made to circulate full and final draft version to all committee members prior to May meeting and presentation to Board in June

Place Inspection Results

Results were presented from an inspection that was undertaken in November and December 2022. This was well supported by Patient Assessors who volunteered to support this inspection. Results were generally positive and above average and we have improved across every element in comparison to the 2019 PLACE Inspection. There are two elements where we are under the national average - Cleanliness (just under) and Privacy and Wellbeing (3% under). The committee was assured that plans are in place to address the shortfalls and continue the areas of improvement.

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 8 December 2022 at 9:30 a.m. – 11:10 a.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
Mike Gennard	MG	RSM Risk Assurance Services LLP., Partner, Internal Audit
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP
Asam Hussain	AH	RSM Risk Assurance Services LLP.
Ian James	IJ	Non-Executive Director
Daniela Locke	DL	Associate Chief People Officer (for agenda item 6.1.1)
Katie Osmond	KO	Chief Finance Officer
Frank Myers, MBE	FM	Associate Non-Executive Director
Bradley Vaughan	BV	RSM Risk Assurance Services LLP., Manager, Local Counter Fraud Service

Minute		Action
AC001/12.22	**APOLOGIES FOR ABSENCE**	
	Mr Cottom (NED & Chair) introduced the meeting and announced that from today's meeting the responsibility of Chairing future Audit Committee meetings will be handed over to Mrs Twigg (NED). The new Chair commented that the meeting was recorded for the purpose of producing the minutes. Apologies were noted from Erica Hermon, Associate Director of Corporate Governance/Company Secretary and Grace Quantock, Non-Executive Director.	
AC002/12.22	**QUORUM & DECLARATION OF INTEREST**	
	The meeting was quorate. No declarations of interest were noted.	
AC003/12.22	**MINUTES OF THE MEETING HELD ON THE 15 SEPTEMBER 2022**	
	The minutes were agreed as an accurate record of the meeting.	
	Resolved – that the minutes of the meeting held on the 15 September 2022 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	

AC004/12.22	**MATTERS ARISING AND ACTIONS**	
	The completed actions on the action log were noted. **AC6.5/06.22 – Waiting List Initiatives (WLI's).** Benchmarking exercise currently underway to review WLI rates across partners/group and Policy/procedures to be reviewed. Timescale to be discussed with the Chief People Officer. An update was provided stating that benchmarking is being undertaken across the Group and ICS. It was reported that the Chief Medical Officer will meet with clinicians regarding rates over the next few weeks. The Chief Finance Officer (CFO) commented that work is being undertaken through a job planning exercise and the medical agency reduction programme (MARP) to strengthen the policy and procedures and to obtain consistency across the organisation. The original completion date in the Audit Plan specified the end of January as the completion date and the CFO commented that this should be achievable, but an update will be provided through the audit actions. **ACTION CLOSED** **AC08.3/06.22 – Losses and special payments report – Quarter 4 2021/22** Benchmarking on Pharmacy losses to be presented at the December Audit Committee. The Committee queried the reason why the information was not available from South Warwickshire NHS Foundation Trust (SWFT), as they should be available from the last SWFT Audit Committee Minutes. The CFO agreed to contact SWFT to progress. **ACTION CLOSED** **AC05.1/03.21 – Risk Management Deep Dive and IM&T Programme** – Clarity required on the scope expected by the Audit Committee from Divisions to avoid duplication of reporting of risks. Following a discussion it was agreed that the Associate Director of Corporate Governance (ADoCG) continue with the piece of work on Governance Mapping to understand how risks and processes are applied within each team, Division and Directorate. A timescale of a few months was suggested for the completion of the work and the new Chair of Audit Committee Mrs Twigg (NED) will work with the ADoCG in the New Year as part of the handover process. Following the handover, a decision will be taken through the Audit Committee as to whether the deep dives within the organisation would be beneficial. An update on Governance Mapping to be presented at the December meeting with the focus on risk to provide assurance to the Audit Committee. Due to the ADoCG unable to attend the meeting due to sickness, it was agreed to defer the action until March 2023 and the Chair will discuss Governance Mapping with the ADoCG offline before the next meeting. **ACTION** **AC05.3/09.22 – SFI Refresh –** Confirmation received that SFI's have been amended to reflect repeat orders on the same supplier ahead of Board approval. **ACTION CLOSED.**	**NT/EH**

	AC05.3/09.22 – SFI Refresh – Action to improve clarity of SO's and SFI's within the induction programme and wider training forms part of the Financial Sustainability self-assessment action plan. Progress will be routinely reported through the action plan to Audit Committee. **ACTION CLOSED.** **AC06.2/09.22 - Recommendation Tracker** – Medical Workforce Management revised date to be AGREED once assurance is received by the CFO over the BMA/local negotiating committee dispute involving annual leave policy for medical and dental and if further implications for the Trust are likely. Confirmation was received that the issues and work is ongoing on policy to achieve acceptable refresh. Agreed action to remain on action log to monitor outcome. **ACTION** **AC06.2/09.22 – Recommendation Tracker** – SFI's, single tender waiver now added to quarterly Audit Committee agendas. **ACTION CLOSED.** **AC07.1/09.22 – AC07.1/09.22 – LCFS Progress Report** – Mr Cottom (NED) to discuss sickness and return to work interviews with the Chief People Officer to obtain his perspective and what can be achieved to obtain further assurance by the Audit Committee. Agreed that an update will be provided to the Audit Committee offline. **ACTION** **AC07.1/09.22 – AC07.1/09.22 – LCFS Progress Report** – It was confirmed that the LCFS and Mr Myers (ANED) had discussed mandate fraud offline. **ACTION COMPLETED.** **AC08.2/09.22 – Losses and compensation** - Finance team have included the recovery process for prescription bad debts in the losses and compensation report. **ACTION COMPLETED.** **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. **ACTION** **AC08.3/09.22 – Tender waiver update** – It was confirmed that the service provided by the telephone language line service is included within the procurement work plan to review opportunities across Group. **ACTION COMPLETED.**	**KO** **AC** **KO**
	<u>Resolved</u> – that **(A) The Action Update be received and noted.**	
AC005/12.22	**<u>GOVERNANCE</u>**	
	• This agenda item was not discussed due to the absence of the Associate Director of Corporate Governance/Company Secretary at the meeting.	

AC006/12.22	**INTERNAL AUDIT**	
AC06.1./12.22	**IA PROGRESS REPORT**	
	RSM, UK Internal Auditors (IA) presented the IA progress report and the following points were noted:- • The key messages were reported. It was confirmed that one final report had been issued since the last meeting, Effective Recruitment and Retention. Three audits are currently in progress which include, Consultant Job Planning, Cost Improvement Programme and the draft Financial Sustainability, however it was noted that the latter was almost finalised; • The IA continue to track progress against the action tracker. As of the 30 November 2022, there were 20 actions on the tracker, of which four have been closed off as implemented; two have been closed off as superseded and 14 have not reached their agreed target implementation dates. No extension dates have been requested for actions; • With regard to the status of audits, all dates have been agreed except Discharge Management, which is still awaited; • Approval was requested by the IA to delay the Audit of Trust Wide Non-Clinical Compliance Audits to Quarter 4 to enable the Standard Operating Procedure (SOP) to be embedded. The Audit Committee Chair asked for any objections to the push back to Quarter 4, no objections were noted therefore the request from IA was AGREED; • It was reported that the Key Performance Indicators (KPI's) delivery by the IA were almost hitting the 10 day target, with an average of 12 days turnaround target currently being achieved.	
	Resolved – that **(A) The IA progress report be received and noted.** **(B) The Audit Committee AGREED to the request for the Audit of Trust Wide Audits to be delayed until Quarter 4.**	
AC06.1.1/12.22	**EFFECTIVE RECRUITMENT AND RETENTION**	
	RSM, UK Internal Auditors (IA) presented the effective recruitment and retention report and the following points were noted:- Daniela Locke, Associate Chief People Officer (ACPO) attended the meeting to provide a HR perspective. • It was noted that the IA team have been working with the Head of Recruitment, Associate Chief People Officer and the Chief People Officer on the recruitment review; • The itemised areas identified were discussed for consideration, these included:-	

	○ The promotion of staff benefits on the Trust website and the introduction of others available at other Trusts; ○ Refreshing the 'Work with us' section to make it more attractive and informative; ○ Review content of the job advertisements to promote the benefits of working at the Trust to attract staff; ○ Promote the Trust's commitment to being an employer that welcomes job applications from all sectors of the community, in respect of equality, diversity, inclusion to attract people from other groups to work for the Trust; ○ Determining other recruitment methods; ○ Raise awareness of, or introduce references to apprenticeships, student placements, work experience, unskilled jobs, graduate positions and return to practice opportunities as no focus was apparent on the website; ○ Translating the Trust's website into other languages in order to widen the audience of its job vacancies; ○ Improved recruitment record keeping to provide a full audit trail; ○ Understanding that conversations are taking place between managers and staff to persuade staff not to leave and the actions required to put this in place; ○ Adopt a more formal approach to exit interviews to enable staff to openly express their concerns and provide feedback to fully understand the reason for leaving. • The Associate Chief People Officer (ACPO) commented on the paper and reported that a number of the actions were already in place; • It was highlighted that the external facing website required appropriate and additional resources to update and build, especially the marketing element; • It was noted that a business case will be submitted to request investment for additional resources to the recruitment team to assist with a focus on retention and actions; • Education and training is also identified as an area that requires further investment to include transactional processes, engagement and coaching of line managers; • Mr James (NED) welcomed the piece of work which resonates with areas within recruitment and retention that have already been identified. Marketing within other companies have been reviewed and the examples of good practice identified required incorporating within the marketing aspect of the website; • Mr James (NED) other comment related to exit interviews and the shift required from exit interviews to stay interviews. A conversation at the commencement of the employment to promote staff to stay at the Trust was suggested, as many staff leave in the first year of joining. It was noted that staff need to be asked what more the Trust can do for the staff member to obtain a better work life balance and identify any issues that arise; • Mr Cottom (NED) commented that the report was rather light on retention with a focus on the good work being undertaken on	

	recruitment. Under Management Comments which states that "The Trust will consider adopting a more formal approach to exit interviews …" It was noted that there should be a specific action against exit interviews, with a formal approach to feedback to the Audit Committee. Especially as concern was expressed at the last Board meeting over the amount of staff resigning in a single month at the Trust; • The Audit Committee Chair welcomed the report and commented that the process is important for retaining staff and recruiting staff to the Trust. With regard to staff leaving the Trust and their exit interviews, it would be interesting to distinguish the difference between clerical and medical/nursing staff and include in the report; • The Chair raised the issue of ownership of leadership training and coaching, which seemed to be available from Board level down to level two and three, but diminished at lower levels; • The practicality of all actions being completed by the ACPO by March 2023 was highlighted. An action plan with realistic dates of individual actions was suggested for discussion at the Recruitment and Retention Steering Group to provide a more granular focus on individual actions in a timely way; • The ACPO responded that the action plan was submitted to the Corporate Finance & Performance Executive (F&PE) which included data on exit interviews and new starter surveys. The ACPO agreed that a more targeted strategy and action plan to support this was required, particularly focusing on retention. The Chair commented that as the report was an internal audit report, an update should be presented back to Audit Committee. Feedback quarterly to Audit Committee felt too long and it was noted that some of the actions would not be completed by the end of March 2023. Mr James (NED) represented the Non-Executive Directors at the monthly Recruitment & Retention Steering Group and it was suggested that the outcomes from that monthly meeting are circulated to representatives of the Audit Committee; • The IA confirmed that the recommendations would be reported on the tracker and an update would be available at the next Audit Committee. It was agreed as an action that the IA will revisit the action dates with the ACPO and update the action tracker. Updates would be monitored through the Recruitment and Retention Steering Group and shared with all Non-Executive Directors. **ACTION** • Mr Myers (ANED) commented that the Trust were not doing enough regarding retention and exit interviews, a new approach is required and work life balance was not solely attributed to all staff leaving the Trust. It was felt that the Trust Management Board (TMB) could better embrace the importance of retention and exit interviews. The CFO commented that more focus was being provided through the Finance & Performance Executive (F&PE) meetings, which is the way forward; • The Chair thanked the ACPO for attending the meeting.	**IA/DL/IJ**
	<u>Resolved</u> – that	

	(A) The effective recruitment and retention report be received and noted. **(B) IA to add recommendations on the tracker and update provided at the next Audit Committee.** **(C) Internal Audit to revisit the action dates with the Associate Chief People Officer on the tracker.** **(D) Updates to be monitored through the Recruitment & Retention Steering Group and updates provided by Mr James (NED) as representative to all Non-Executive Directors.**	
AC06.1.2/12.22	**FINANCIAL SUSTAINABILITY SELF-ASSESSMENT**	
	RSM, UK Internal Auditors (IA) presented the financial sustainability self-assessment report and the following points were noted:- • It was noted that the Financial Sustainability Self-Assessment report in still in draft; • The purpose of the report is to outline the focus within the NHS on improving financial sustainability and regaining financial grip whilst balancing operational activity, workforce demands and recovering from the impact of the Covid-19 pandemic; • The self-assessment areas were outlined by the IA and informed the Committee that all NHS bodies were required to self-assess themselves between 1 – 5, to provide evidence for scores 4 and 5 and actions required for scores of 1, 2 and 3. All actions identified were to be implemented by the 31 January 2023; • The IA concluded that of the 72 statements in the self-assessment, the Trust scored itself 4 or 5 on 49 occasions (68%). From this the Trust has identified a total of 54 actions to drive further changes for the Trust's Financial Framework; • The IA commented that the evidence provided supported the reasoning in the self-assessment. In all cases the rationale provided was supportive of self-assessments and the Trust had gone above and beyond in terms of using the exercise to make a difference and have an impact on continuous improvement; • The CFO commented that this was approached by the Senior Managers being allocated one section each to lead on. The questions were considered both in terms of the self-assessment and to take stock from an improvement perspective going forward; • Mr Cottom (NED) commented that the only way forward is for Wye Valley NHS Trust to achieve a breakeven position. It was noted that the report is closely aligned with the previous report, recruitment and retention, which is clearly a large part of the financial challenge; • The Trust is overspent, but it was noted that it was not an internal control issue, could this be a cultural issue from the top? The CFO responded that following a difficult planning round and the number of systems in deficit, it was hoped that the exercise would signal areas of opportunity to address some of the deficits. The exercise was not providing the answers as the questions were more about process and grip rather than the actual driver of the financial position;	

	• Deloittes (IH) responded that the Section 30 Notice will remain until there is break even over a three year period, therefore it will take a number of years to break even or achieve a surplus to reach a position. Recruitment and Retention leads to higher agency costs and the high cost of PFI leads to a higher funding problem. The Trust has remained in deficit due to a combination of these issues, together with historical underfunding. Underfunding is typically seen in a rural area, where visits within the community can take longer than in an urban locality, which is not built into the funding system; • The CFO commented that as part of the allocation adjustment for rurality payments there are eight organisations, seven systems that are now identified through the allocation of methodology as having an unavoidable cost of smallness for rurality. It was noted that this year is the first year that commissioning has passed an amount of money, £3.6 million to the Trust. The issue is that this figure does not capture the real cost of rurality. A national team is working with the Trust to identify the driver and cost and to understand if it is simply a result of the geography and location and the provision of certain services. The team has issued the Trust with a data request to provide intelligence to shape the future approach to allocations. It was noted that the final outcome will not be available until 2025/2026; • The Chair confirmed that there were seven years remaining on the PFI contract with a possible life cycle figure of £16 million available. The CFO commented that the structural deficit figure was more likely to be around £20 million to £25 million with PFI being part of this figure; • Mr Myers (ANED) highlighted productivity figures and how these are gauged within the Trust for productivity in back office. The Chair commented that productivity cannot be measured when people are in the office for clerical and service work. Mr Cottom (NED) commented that the Trust's default position is to go to the funding and not look at the costs. It was Mr Cottom's (NED) opinion that post Covid by default the Trust is funded for PFI and funded for rurality. The CFO commented that if the Trust could eradicate the vast majority of agency premium and have a more sustainable and stable workforce then this would it assist with closing the gap; • Mr James (NED) commented that the audit report states that the Trust have reasonable financial controls on accountancy and asked what else can be done and if the financial position was shared across the organisation. The CFO responded that in terms of the checklist, that features culture, training and development, which provide the lower scores, this is not about rigour and people having ownership, it shows that this cannot be evidenced. There is ownership, but there is more the Trust can do to reinforce ownership; • The Chair was informed by the IA that actions will be added to the tracker and updates provided. NHSEI may want to utilize these to further seek assurance that the actions on self-assessment have been addressed. The Chair requested that the dates set are realistic and the CFO commented that the wording is double checked and that the IA do	

	not overpromise on delivery. It was noted that a roadmap would be available to take forward by the 31 January 2023.	
	Resolved – that **(A) The financial sustainability self-assessment report be received and noted.**	
AC06.2/12.22	**RECOMMENDATION TRACKER**	
	RSM, UK Internal Auditors (IA) presented the Internal Audit Management Actions Tracking Report and the following points were noted:- • The purpose of the report will provide the Audit Committee on progress made in respect of previous internal audit findings and agreed management actions; • The IA confirmed that there were 20 actions on the tracker, four had been implemented, two had been superseded and 14 had not yet been reached; • The Audit Committee did not provide any questions to the IA on the report.	
	Resolved – that **(A) The Recommendation Tracker be received and noted.**	
AC06.3/12.22	**INTERNAL AUDIT PLAN**	
	Mr Cottom (NED) requested that the process going forward regarding the Internal Audit Plan is discussed and the following points were noted:- • IA will provide a long list for discussion at the March Audit Committee meeting. The CFO commented that a one page risk landscape would be beneficial to all for pre reading. **ACTION** • The Chair suggested a separate short meeting with the Non-Executive Directors to feed into the long list, which would then be shared with the Executive Directors and returned to the Audit Committee. The IA confirmed that the long list was available and would be shared before Christmas to enable the meeting to take place. The Chair confirmed that the long list will be distributed to all the Non-Executive Directors and a short meeting will be arranged at the end of January for thoughts and feedback. **ACTION** • It was agreed that the Chair and the Chief Finance Officer would meet on a regular basis and feed back to Executives.	**IA** **NT**
	Resolved – that **(A) The Internal Audit Plan be received and noted.**	

	(B) Internal Audit to provide copy of long list and one page risk landscape to Chief Finance Officer before March Audit Committee. **(C) The Chair to send long list, together with one page risk landscape document to Non-Executive Directors for discussion at meeting before the end of January meeting.**	
AC07/12.22	**COUNTER FRAUD**	
AC07.1/12.22	**LCFS PROGRESS REPORT**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Progress Report Plan and the following points were noted:- • The LCFS work plan provides an update in respect of counter fraud work since the last Audit Committee and covers the reporting period 26 August 2022 to 17 November 2022; • The LCFS confirmed that sessions took place at the Trust in International Fraud Awareness week and were well attended and good feedback was provided. It was noted that future sessions will be rolled out; • The commencement of the proactive exercise is near completion and the reports will be issued to the CFO for finalisation and then submission for information to Audit Committee; • Four referrals have been received in the year, which is an increase on previous years. Cases opened included telephone scams, phishing emails, individual undertaking private work for consultants in NHS time and an individual identified as an imposter undertaking shifts whilst posing as another member of staff; • The theft of £120,000 from the Trust was prevented following an alert; • Mr Myers (NED) commented on the National Fraud Initiative regarding agency staff working whilst working elsewhere. The LCFS responded that there are no plans to increase the scope of the National Fraud Initiative. The LCFS suggested a further conversation offline to update with Mr Myers (NED), but it was noted that there is currently no intention of increasing their range. **ACTION**	**LCFS/FM**
	Resolved – that **(A) The LCFS progress report was received and noted.** **(B) The LCFS to update Mr Myers (NED) offline regarding agency staff working whilst working elsewhere.**	
AC07.2/12.22	**TENDER WAIVER BENCHMARKING REPORT**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Progress Report Plan and the following points were noted:- • The report was taken as read; • The CFO commented that is was helpful to receive benchmarking compared to other organisations;	

	• Mr Myers (NED) commented on the figure of average value, and whether further understanding should be available on this figure. The Chair commented that from the number of waivers per £1 million budget and average value within the report would be difficult to identify if the Trust is an outlier. It was agreed as an action that the LCFS provide further detail of the areas to the Audit Committee. **ACTION** • The CFO commented on the value, which was the number of waivers for the use of the private sector to provide clinical activities for e.g. the Nuffield and others that sat outside the national framework contract for outsourcing. These would have been big value, due to clinical activity contracts but a small number. It was noted that there were likely to be some smaller value purchases that should have been input as part of the waiver process, but due to historic practices these may not have been consistently recorded. It is expected that once these waivers are incorporated following the strengthened processes, the numbers will increase, but at a smaller value. It was agreed as an action that Finance will check if the waivers were attributed to outsourcing. **ACTION** • Mr Myers (NED) raised the issue of the single tender waiver for £300k and questioned if this should have been raised within the Board report. Mr Cottom (NED) responded and confirmed that the Board approved the private sector issue; • It was agreed as an action that the CFO check the governance process for single tender waivers and obtain the information on the 10 single tender waivers and the completion dates and provide an overview. **ACTION**	**LCFS** **KO** **KO**
	<u>Resolved</u> – that **(A) The tender waiver benchmarking report was received and noted.** **(B) LCFS to provide further detail of the areas of the number of waivers per £1 million budget and average value to the Audit Committee.** **(C) Finance to investigate if the smaller waivers were attributed to outsourcing.** **(D) The Chief Finance Officer to check the governance process for single tender waivers and obtain completion dates on the 10 single tender waivers and provide an overview.**	
AC08/12.22	**<u>FINANCIAL FOCUS</u>**	
AC08.2/12.22	**<u>LOSSES AND COMPENSATION</u>**	
	The Chief Finance Officer (CFO) presented the Losses and Compensation and the following points were noted:- • The Audit Committee was requested to consider the issues outlined in the report involving the comparison between Quarter 2 2022/23 and Quarter 2 2021/22, the Benchmarking of Pharmacy Losses across the Group for 2021/22 and the recovery process for prescription bad debts; • The CFO commented that there were no specific issues to report this month;	

	• Mr Myers (NED) queried if there was a benchmark on Pharmacy wastage and whether this is a typical figure, could this be negligence e.g. out of date stock. Pharmacy reported losses for blood stock wastage for Quarter 2 of £4,412.85 and Pharmacy of £32,489.42; • The Chair commented that a tour of Pharmacy had taken place and the Clinical Director of Pharmacy had reported that a check on dates had taken place and the main reason for the loss was over stock. The Chair reported that Wye Valley NHS Trust (WVT) had come out favourably compared to George Eliot Hospital (GEH); • The ACFO included a table for cost comparison for WVT and GEH overall drug spend. It was noted that South Warwickshire Foundation Trust (SWFT) do not collect the information in the same way. The ACFO confirmed that the information will continue to be provided for WVT and GEH and the ACFO will endeavour to obtain information from SWFT to obtain a comparison. **ACTION** • The Chair highlighted the £3k compensation under legal obligation in the report in Quarter 2. The CFO responded that this cost related to legal fees for an IG breach by a member of staff accessing data that they should not have. As a Duty of Candour the individuals involved were contacted and some pursued legal claims against the Trust as a result. The case was reported to the Information Commissioners Office who were satisfied that the Trust had taken all appropriate action and the individual was dismissed as a result.	**CA**
	<u>Resolved</u> – that **(A) The Losses and Compensation Payments report was received and noted.** **(B) The Associate Chief Finance Office to obtain information from South Warwickshire Foundation Trust to obtain cost comparison for drug spend.**	
AC08.3/12.22	**<u>SINGLE TENDER WAIVER UPDATE</u>**	
	• This agenda item was discussed in agenda item AC07.2/12.22.	
	<u>Resolved</u> – that **(A) The Tender Waiver update was received and noted.**	
AC009/12.22	**<u>EXTERNAL AUDIT</u>**	
AC09.1/12.22	**<u>AUDIT PLAN FOR 2022/23</u>**	
	Deloittes LLP, External Auditors (EA) presented the Audit plan for 2022/23 and the following points were noted:- • The EA (IH) commented that very productive sessions had taken place with the CFO, ACFO and the team regarding resources for the work,	

	the learning and improvements to be made from last year and how the process can be streamlined; • The EA confirmed that the deadline for submission of the Audit plan is the 30th June 2023. An interim audit is scheduled to take place in February 2023, the outcomes of which will be reported at the Audit Committee on the 16th March 2023; • The EA confirmed that although there are Bank Holidays and a half term within the year, it was noted that the date would not pose a problem as there is flexibility for staff working to submit the plan. The EA proposed that the Audit plan is circulated before the 16th of March to enable members to read and provide the opportunity for formal sign off at the next Audit Committee. **ACTION** • It was noted that the Trust is now required to include comparatives for the fair play disclosures, which were optional for 2021/22. Following the lessons learned last year and the difficulties around changes to remuneration and disclosures and fair play disclosures, it is hoped that this will run more efficiently this year; • The Chair commented that timelines had been discussed and it was proposed that the dates of the Audit Committee are reviewed around Year End. **ACTION** • The EA suggested that the Audit plan is completed and a meeting arranged as late as possible to enable the work timetable to be completed; • Mr Cottom (NED) highlighted the IFRS 16 and the work involved. The recommendation by the EA is that the management present an accounting paper and asked if Board required clarification on how items are classified e.g. assumptions on capital. The EA responded that the team have worked through and audited and updated papers have been submitted and it was noted that there is very little difference in disclosures that have been submitted. The main issue raised by EA was the PFI contract as it is expected that there may be an override on the budget; • The ACFO commented that with regard to IFRS 16, the PFI contract will be addressed in the next financial year. The ACFO also raised that when the accounting policies paper is presented in March ahead of the final accounts, the impact of what IFRS 16 has done to the financial position in terms of the increase to the asset base and the accounting impact, which is reasonably minimal, when it comes to income expenditure will be included in the policies paper for the next meeting. **ACTION**	**EA** **NT/KO** **CA**
	<u>Resolved</u> – that **(A) The Audit Plan for 2022/23 report was received and noted.** **(B) Audit plan is circulated before the 16th of March to enable members to read and provide the opportunity for formal sign off at the next Audit Committee.** **(C) Audit Committee dates to be reviewed around Year End.**	

	(D) The Associate Chief Finance Officer to include impact of IFRS 16 within the policies paper for the next Audit Committee.	
AC09.2/12.22	**TIMETABLE FOR COMPLETION OF 2022/23 ACCOUNTS**	
	Deloittes LLP, External Auditors (EA) presented the Audit plan for 2022/23 and the following points were noted:- • The timetable for completion of 2022/23 accounts was taken as read.	
	Resolved – that **(A) The timetable for completion of 2022/23 accounts was received and noted.**	
AC10/12.22	**AOB**	
	• No other business was noted.	
AC12/12.22	**DATE OF THE NEXT MEETING – 16 March 2023 - 9:30 a.m. – 12:00 p.m.**	

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

Minutes of the Public Foundation Group Boards Meeting
Held on Wednesday 3 May 2023 at 1.30pm via Microsoft Teams

Present:

Russell Hardy	(RH)	Group Chairman
Glen Burley	(GB)	Group Chief Executive
Andrew Cottom	(AC)	Non-Executive Director (NED) WVT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Frances Martin	(FM)	NED WVT
Katie Osmond	(KO)	Chief Finance Officer WVT
Jo Rouse	(JR)	NED WVT
Nicola Twigg	(NT)	NED WVT

In attendance:

WVT:

Jon Barnes	(JB)	Chief Transformation Officer WVT
Claire Carlson	(CC)	Deputy Chief Operating Officer WVT (Deputising for the Chief Operating Officer WVT)
Alan Dawson	(AD)	Chief Strategy and Planning Officer WVT
Robbie Dedi	(RD)	Deputy Chief Medical Officer WVT (Deputising for the Chief Medical Officer WVT)
Geoffrey Etule	(GE)	Chief People Officer WVT
Fiona Gurney	(FG)	Communications Officer WVT
Erica Hermon	(EH)	Associate Director of Corporate Governance and Company Secretary WVT
Frank Myers	(FMy)	Associate Non-Executive Director (ANED) WVT

SWFT:

Charles Ashton	(CA)	Chief Medical Officer SWFT
Varadarajan Baskar	(VB)	Operational Chief Medical Officer SWFT
Ravi Basi	(RB)	Deputy Chief Finance Officer SWFT (Deputising for the Chief Finance Officer SWFT)
Yasmin Becker	(YB)	NED SWFT
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(ACa)	Managing Director SWFT
Sarah Collett	(SC)	Trust Secretary SWFT/GEH
Richard Colley	(RC)	NED SWFT
Phil Gilbert	(PGi)	NED (Non-Voting) SWFT
Paramjit Gill	(PG)	Nominated NED SWFT
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sarah Moppett	(SM)	Director of Care Excellence SWFT
Gertie Nic Philib	(GP)	Chief People Officer SWFT/GEH
Simon Page	(SP)	NED SWFT
Mary Powell	(MP)	Head of Strategic Communications SWFT
David Spraggett	(DS)	NED SWFT
Sue Whelan Tracey	(SWT)	NED SWFT

GEH:

Catherine Free	(CF)	Chief Medical Officer GEH
Natalie Green	(NG)	Chief Nursing Officer GEH

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WYE VALLEY NHS TRUST (WVT)
Minutes of the Foundation Group Boards Meeting Held on 3 May 2023

Haq Khan	(HK)	Chief Finance Officer GEH
Rosie Kneafsey	(RK)	NED GEH
Anil Majithia	(AM)	NED GEH
Jenni Northcote	(JN)	Chief Strategy Officer GEH
Sarah Raistrick	(SR)	NED GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Robin Snead	(RS)	Chief Operating Officer GEH
James Turner	(JT)	Head of Communications and Engagement GEH
Umar Zamman	(UZ)	NED GEH

Foundation Group:

Chelsea Ireland	(CI)	Foundation Group EA (Board Administrator)
David Moon	(DMo)	Group Strategic Financial Advisor

There were four SWFT Governors also in attendance.

MINUTE		ACTION
23.027	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Simone Jordan (NED WVT), Kim Li, Chief Finance Officer (SWFT), David Mowbray, Chief Medical Officer (WVT), Andy Parker (Chief Operating Officer (WVT) and Grace Quantock (NED WVT). **Resolved – that the position be noted.**	
23.028	**DECLARATIONS OF INTEREST** The Chief Nursing Officer at SWFT declared that her brother had been appointed as Group Finance Director of Acacium Group Limited. **Resolved – that the position be noted.**	
23.029	**GEH PUBLIC MINUTES OF THE MEETING HELD ON 1 FEBRUARY 2023** **Resolved – that the GEH public minutes of the meeting held on 1 February 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.030	**SWFT PUBLIC MINUTES OF THE MEETNG HELD ON 1 FEBRUARY 2023** **Resolved – that the SWFT public minutes of the meeting held on 1 February 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.031	**WVT PUBLIC MINUTES OF THE MEETING HELD ON 1 FEBRUARY 2023** **Resolved – that the WVT public minutes of the meeting held on 1 February 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.032	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.032.01	Completed Actions	

MINUTE		ACTION
	All completed actions were listed as complete on the action log as part of the meeting papers. There were no outstanding actions. **Resolved – that the position be noted.**	
23.033	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP WORKSHOP** The Group Chairman provided the Boards with an overview of the Foundation Group Boards Workshop presentations, which included a presentation from NHS Providers Chief Executive, Julian Hartley. The Group Chief Executive also highlighted the 'Big Moves' progress report presentations on 'Supporting Domiciliary Care' and 'Be a Very Flexible Employer'. Both presentations linked to the Foundation Group's Strategy. He emphasised the importance of the Foundation Group being flexible employers to help tackle the workforce crisis. The Group Chief Executive discussed the Integration Front Runner work taking place in Warwickshire to support Domiciliary Care which was also learning from the One Herefordshire Partnership work which was also taking place. The national Frontrunner pilot would be reporting back to the National Discharge Taskforce. As part of this programme, we are measuring the amount of time patients were waiting for discharge, not just how many were waiting. The Group Chief Executive explained that Julian Hartley's presentation explained the national move to widen improvement training across the NHS which was launched at a recent national Chief Executives session. He celebrated the Foundation Group's positive culture around improvement, and that in response to the new national strategy we would look to move to more staff being trained in improvement skills and widening it to Place partners. The Group Chief Executive informed the Boards that the Foundation Group had been selected for a national sprint programme to improve waiting times in outpatients, which was currently being explored alongside the Chief Operating Officers **Resolved – that the overview of key discussions from the Foundation Group Workshop be received and noted.**	
23.034	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director at WVT provided the Boards with an overview of WVT's performance and she highlighted three focus areas for the Trust. The first focus area was 4hr performance in the Emergency Department (ED). The Managing Director at WVT explained that WVT performance was below that of GEH and SWFT, however there was intensive staff engagement work taking place as well as an improvement and redesign plan. The Managing Director at WVT clarified that this would include a reduction in the size of ED, which the Trust had expanded significantly during the Covid-19 Pandemic however, this was proving to be causing a hindrance to flow through the department. She added that part of the improvement plan would include looking at WVT's Care at Home Strategy, including the use of Virtual Wards and the Discharge to Assess (D2A) model.	

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	The Managing Director at WVT highlighted the Cancer 28 Day Faster Diagnosis Standard, which had improved over the last quarter. She informed the Board that WVT's 62 day performance was the best out of all three Trusts in the Foundation Group, however improvement of the regional rating was still required. The Managing Director at WVT assured the Board that Mortality and Summary Hospital-Level Mortality Indicator (SHMI) was continuing to improve with a continuous focus led by the Chief Medical Officer at WVT. She explained that there was however an issue with Hospital Standardised Mortality Ratio (HSMR), which was a common theme across the three Trusts in the Foundation Group. The Managing Director at WVT informed the Boards that resolving the issues around Palliative Care coding would make WVT better than the national average, therefore there was a piece of Foundation Group-wide work to improve this. The Managing Director of WVT highlighted that the ED performance was one of her biggest concerns, along with reaching year-end financial balance and the potential consequences if the wrong decisions were made. The Managing Director at GEH informed the Boards that GEH had been performing above the national average, however since October 2022 they had seen a gradual decrease in the ED 4hr performance standard, similarly to that of WVT. She elaborated that the decrease directly linked to bed occupancy which, although showing as 100%, didn't reflect the patients in bed occupancy which was over 100%. The Managing Director at GEH explained that work was taking place to improve capacity and reduce length of stay. She added that despite the challenge with capacity, GEH's ambulance handover times had improved to be one of the best in the country. The Managing Director at GEH drew attention to the cancer performance and challenges, especially with the increased demand and the 28 Day Faster Diagnosis Standard. She highlighted that patients waiting 62 days had been a concern however an MDT meeting had been held to address the waiting list and expedite the patients' treatment. This was running on a monthly basis moving forward. The Managing Director at GEH highlighted that Referral to Treatment (RTT) performance was good nationally, and the three patients that had been waiting 78 weeks for treatment had now received treatment resulting in GEH meeting the national standard by year end. She added that 52 week wait figures had increased but this has been planned due to maintenance work taking place on three of the theatres attached to the day procedures unit, however this had now improved flow in that area in prep for summer. The Managing Director at GEH informed the Boards that Medically Fit For Discharge (MFFD) did have a downward trend, however work with the community response teams were underway to ensure patients were being discharge home as soon as possible. The Managing Director at SWFT noted that ED performance over the last quarter remained challenged following a difficult winter, however improvements were starting to be seen. He explained that SWFT teams had learnt from the winter period to improve flow in particular, worked on initiatives to improve Same Day Emergency Care (SDEC), and also converted the Medical Assessment Unit (MAU) to be a short stay area. The Managing Director at SWFT informed the Boards that the improvement work had paid off and	

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	performance in April 2023 was over 80%. He added that Ambulance Handover times continued to improve and alongside ED in general. The Managing Director at SWFT informed the Boards that Cancer continued to be a concern and was his biggest area of concern, particularly cancer performance in Colorectal, which had had its highest referral month at the end of 2022. He assured the Boards that the operational teams were working on pathway redesign and understanding the new norm of increased demand. SWFT met the 78 weeks wait standard and were working towards being at no 52 week waits by the end of 2023/24. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chairman highlighted the increase in demand for cancer services and thanked the operational teams for focusing their attention on improving the efficiency of cancer services across the Trust. However, he explained that there had been a lot of discussions across Coventry and Warwickshire by the Chief Operating Officers relating to the supply of cancer consultants and services. The Group Chairman sought assurance whether that was improving. The Chief Medical Officer at SWFT explained that there had been intensive work on improving cancer services for the system and improvement was being seen due to Oncologists doing extra sessions, and a Locum had been employed to start in June 2023. However, the underlying problem was a capacity vs demand gap and therefore a more complicated review process was underway. The Chief Medical Officer at SWFT assured the Boards that he was pushing for an immediate arrangement to be implemented to bridge the capacity vs demand gap in the interim and this was being discussed at the next meeting in May 2023. Mr James (NED, WVT) highlighted that the performance data for MFFD was segmented into pathways dependant on how much support patients need to go home, however noted that it would be helpful to see how many patients were on each of the pathways. He added that this was the same for staff sickness, where the data was segmented into staff groups rather than the reason for absence which would be helpful to know enable improvement work. The Group Chairman thanked all three Trusts for achieving the 78 week performance standard of no patients waiting longer than 78 weeks for treatment, especially to have achieved this alongside the increased pressures with the numerous strikes that had taken place and the increase in demand. **Resolved – that the Foundation Group performance report be received and noted.**	
23.035	**VIRTUAL WARDS CAPACITY** The Chief Operating Officer at GEH introduced the Virtual Wards deep dive and provided an overview of the Operational Steering Group for the Foundation Group which focused on deep dives into services. He informed the Boards that involvement in the Operational Steering Group included all three Chief Operating Officers from the Foundation Group, associated deputies and senior	

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operational leaders. The Chief Operating Officer celebrated the success of the Operational Steering Group and how positive the feedback had been from members regarding sharing best practice and creating new connections.

The Chief Operating Officer at GEH presented a presentation on Virtual Wards Capacity which detailed some positive patient feedback, and the crucial role that Virtual Wards played in Capacity Plans during winter across all three Trusts in the Group. He explained that Virtual Wards are there to try and avoid admission, by managing patients remotely in their own home environment. As part of Virtual Wards work was also underway to try and get patients out of hospital quicker.

The Chief Operating Officer at GEH informed the Boards of the challenges faced by Virtual Wards which included:clinical confidence needing to be improved to enable more success; and, projections of increased activity being capped at the current levels due to funding restrictions. He added that recruitment into the required roles for staffing the Virtual Wards remained difficult, as well as data systems and connectivity issues especially for community colleagues in rural areas. The Chief Operating Officer at GEH explained that all Trusts were committed to delivering their capacity plans, and virtual wards was a standard approach to providing acute care for people without taking up acute beds.

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

The Group Chief Executive highlighted that Virtual Wards was part of one of the Foundation Group's strategy 'Big Moves' seeing 'home first supported by technology and partnerships'. He noted that the presentation showed variation in each Trusts' approach to Virtual Wards and the specialties it covered. The Group Chief Executive queried whether, as a Foundation Group, the ambition was big enough for what could be achieved. He acknowledged that clinical confidence needed to be built, however each Trust had significant resource and capacity to gain from improving Virtual Wards capacity. The Group Chief Executive also commented whether the staff for Virtual Wards could be more generic and have a team that worked between community and the acute.

The Group Chairman echoed the Group Chief Executive's points and highlighted that as Foundation Group the current plan was working at 250-260 Virtual Ward beds. If performance was working at the standard of the Trust with the best practice, the Foundation Group would be looking at closer to 400 beds which would make a huge difference to flow and capacity.

The Chief Nursing Officer at SWFT thanked the Chief Operating Officer at GEH for an informative presentation, however agreed with the Group Chief Executive that clinical confidence needed to be built by sharing best practice scenarios that were already happening within the Foundation Group. She queried why recruitment was challenged as it hadn't been a problem in the community as such. The Chief Operating Officer at GEH explained that recruitment was difficult due to how specific the roles were, whereas historically models had more flexibility. The roles for Virtual Wards needed more acute experience but from people who wanted to work in the community.

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	The Managing Director at WVT informed the Chief Operating Officer at GEH that she would be interested to see the operational plan and understand how Virtual Wards were working successfully. She explained that the figures in the presentation should be more of a baseline minimum rather than the top of what could be achieved. Mr James (NED, WVT) sought assurance that creating Virtual Wards, to free up physical beds in the hospital, would not become an additional service and cause more work. The Group Chairman informed Mr James that by freeing up physical acute beds, more elective work could take place and help clear the large backlog. He explained that if physical beds were being taken up by new patients, then that should be taken as a success. The Group Chief Executive added that Virtual Wards was the key to facilitating and contacting capacity in the right wards with the right staff. Dr Raistrick (NED, GEH) queried whether patients in the community would be able to access Virtual Wards through a different pathway compared to going via A&E assessment. The Chief Medical Officer at SWFT informed Ms Raistrick that the patients on Virtual Wards were patients having active medical intervention so would not need to go via A&E, teams can link in directly with the Virtual Wards team. **Resolved – that Virtual Wards capacity deep dive be received and noted.**	
23.036	**SAME DAY EMERGENCY CARE (SDEC)** The Chief Operating Officer at SWFT provided a presentation on SDEC. SDEC was where patients could be treated by a specialist on the same day and were therefore less likely to be admitted and if they were it reduced their length of stay. The Chief Operating Officer at SWFT highlighted that the benefits of SDEC meant that it was the way patients on an emergency pathway should be treated and the way of achieving that was not bedding patients into those areas. However, winter pressures and when demands high it was incredibly difficult to not use free beds when patients were waiting in areas not suitable. The Chief Operating Officer at SWFT informed the Boards that across the Foundation Group there were 12 SDEC areas, Frailty, Medicine, and Surgical at each Trust, as well as Paediatrics and Early Pregnancy at SWFT. Each Trust had tried to improve each area. GEH put a hard stop of bedding into SDEC areas in June 2022 and since then there had been a significant improvement of attendance in SDEC at the Trust. The Chief Operating Officer at SWFT continued that GEH also looked into their criteria for admission to SDEC, and if patients didn't meet the criteria, why. This work changed the focus of the type of patients that met criteria and increased admissions. GEH increased their senior decision maker hours and NHS England (NHSE) asked the Trust to be included in their NHS Elective Accelerator Programme. The Chief Operating Officer at SWFT informed the Boards that SWFT had similar issues to GEH with being unable to avoid bedding into SDEC areas during periods of significant operational pressures. She explained that following this SWFT trialled a 7-Day PDSA (Plan, Do, Study, Act) in January 2023 to	

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	address the issues with bedding into SDEC areas. As part of the PDSA the Trust provided an additional 230 hours across 7 days, which demonstrated the importance of not bedding patients into SDEC areas. It also strengthened the Trust's relationship with General Practitioners as well as West Midlands Ambulance Service (WMAS), direct referrals through 111 algorithms and reduced time to triage to 16 minutes. The Chief Operating Officer at SWFT confirmed that WVT faced the same bedding into SDEC challenges but had managed to resolve the issues by building a purpose build SDEC unit which were not available to bed patients in. WVT's Frailty SDEC Unit was still on a ward and therefore work was taking place to try and resolve this, including the possibility of co-locating Frailty SDEC and Virtual Ward. The Chief Operating Officer at SWFT explained that moving forward the operational teams wanted to work towards a join dashboard for benchmarking, along with moving towards a 'Never Event' style governance. This would ensure that if there was ever a need to bed into SDEC areas an investigation into why would take place and what learnings could be taken from the event. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive was pleased to see how SDEC areas had evolved over the years, which had been a necessary evolution to build confidence that the pathways were effective. He added that it was important to ensure future work would help right size SDEC based on the demographics to ensure their potential was not being restricted by capacity. The Chief Medical Officer at GEH queried whether making SDEC fully integrated had been explored. The Chief Operating Officer at SWFT confirmed that the potential of integrating SDEC had been discussed, predominantly around nursing staff, however this had not created as many benefits as expected however this was definitely needing to be explored further. **Resolved – that the SDEC deep dive be received and noted.**	
23.037	**FASTER 28 DAY DIAGNOSIS** The Associate Chief Operating Officer at WVT presented to the Boards an update on the Faster 28 Day Diagnosis Standard. She started by explaining that the Faster 28 Day Diagnosis Standard was put in place in October 2021 to ensure patients would be diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer. The Associate Chief Operating Officer at WVT informed the Boards that for patients who get diagnosed with cancer within the 28 Days would start their treatment as soon as possible. This was introduced in October 2021, as part of the NHS long term plan with the aim that by 2028 55,000 more people each year would survive their cancer for five years or more, and 75% of people with cancer would be diagnosed at an early stage (stage one or two). The Associate	

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	Chief Operating Officer at WVT emphasised just how important the Faster 28 Day Diagnosis Standard was to deliver. The Associate Chief Operating Officer at WVT explained that there was variation each month between the three Trusts, however significant improvements towards meeting the Faster 28 Day Diagnosis standard had been evident since February 2023. Nationally the Foundation Group was sitting in the lower performance quartile and therefore continued improvement needed to be made. She explained that challenges shared across the Foundation Group included not having a 'One Stop' Oncology clinic, which was trying to be pulled together. There was also delays across all tumour sites in Histopathology turn around times, and therefore a 7-day turnaround time standard was trying to be established as well as maximising the work flow. The Associate Chief Operating Officer at WVT highlighted that one of the delays faced in Cancer was due to the admin delays regarding the turnaround of results letters. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive expressed the importance of working on improving and establishing innovative ways of working to ensure staff are not just working longer and harder to combat issues. Mr Myers (NED, WVT) raised his concerns regarding the administrative delays and backlog, as this should be an area that the Foundation Group can resolve quite easily. The Associate Chief Operating Officer at WVT explained that work had started to create a cross cover system for admin teams to ensure work wasn't dropped, particularly in cancer services, during periods of sickness and leave. **Resolved – that Faster 28 Day Diagnosis deep dive be received and noted.**	
23.038	**FOUNDATION GROUP BOARDS SCHEDULE OF BUSINESS FOR 2023/24 FOR APPROVAL** The Boards approved the schedule of business for 2023/24. **Resolved – that Foundation Group Boards schedule of business for 2023/24 be approved and ratified.**	
23.039	**STAFF SURVEY RESULTS OVERVIEW AND ACTION PLAN** The Chief People Officers took the Staff Survey results overview and action plan as read, with the view that the results had been discussed at length in each Trust's Board meetings. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive echoed the Chief People Officers comments regarding the results having been discussed at each individual Trust Board, he	

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	also explained that the data provided in the report supported the 'Big Move' presentation received in the Foundation Group Boards Workshop. Mrs Kneafsey (NED, GEH) queried what the plans were to increase response rate moving forward. The Chief People Officer at GEH/SWFT explained that there were numerous plans in place to try and increase response rate, including regular conversations from leaders throughout the year, and reassuring staff that their feedback contributes to positive change. **Resolved – that the Staff Survey results overview and action plan be received and noted.**	
23.040	**ANY OTHER BUSINESS** No further business was discussed. **Resolved – that the position be noted.**	
23.041	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
23.041.01	Question from a Member of the Public - Mr Chris Lewandowski The following question was submitted by member of the public, Mr Chris Lewandowski, in advance of the meeting: *'Nationally there seems to be a shortage of beds for both adult and children needing mental health care. In some areas of the country this has led to mental health patients, including children, being, perhaps inappropriately, placed in mainstream hospitals. What is the situation in Herefordshire?'* The Manging Director at WVT explained that there was very rarely an issue with Adult patients needing mental health care being stuck in an acute bed, however there was an issue with Children and Young People. However, she emphasised that the number varies but has not been higher than around four. The Managing Director at WVT offered assurance that there was national work taking place to improve mental health beds capacity. **Resolved – that position be noted.**	
23.041.02	Question from a SWFT Public Governor (West Stratford and Borders) The Public Governor queried what complex infections could be managed remotely through virtual wards due to the size of the ward being quite large. The Chief Medical Officer at SWFT informed the Public Governor that it was for infections that needed intravenous antibiotics where a line can be put in for the patient to inject themselves. These infections are things such as Endocarditis (an infection of the heart) and other deep boned or abdomen infections.	
23.042	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
23.043	**APOLOGIES FOR ABSENCE**	

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
WYE VALLEY NHS TRUST (WVT)
Minutes of the Foundation Group Boards Meeting Held on 3 May 2023

MINUTE		ACTION
23.044	**DECLARATIONS OF INTEREST**	
23.045	**GEH CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2022**	
23.046	**SWFT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2022**	
23.047	**WVT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 NOVEMBER 2022**	
23.048	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.049	**ANY OTHER CONFIDENTIAL BUSINESS**	
23.050	**DATE AND TIME OF NEXT MEETING** The next meeting would be held on 2 August 2023 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chairman) Date: 2 August 2023
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
WYE VALLEY NHS TRUST
GEORGE ELIOT HOPITAL NHS TRUST

PUBLIC ACTIONS UPDATE: FOUNDATION GROUP BOARDS MEETING – 3 May 2023

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
REPORTS SCHEDULED FOR FUTURE MEETINGS			
23.007 Group Analytics Update (1 February 2023)	The Group Analytics Board include services data as part of their future project work.	Jane Ives / Haq Khan	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 23 February 2023 at 1.00 – 3.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director
David Mowbray	DM	Chief Medical Officer
Natasha Owen	NO	Associate Director of Quality Governance.
Grace Quantock	GQ	Non-Executive Director
In attendance:		
Mehmood Akhtar	MA	Associate Medical Director, Surgery Division – Arrived during Item 4
Sarah Ashwood	SA	Matron for Quality and Safety – For Items 12 and 13
Robbie Dedi	RD	Deputy Chief Medical Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division – Arrived during Item 6
Tony McConkey	TM	Clinical Director, Pharmacy and Medicines Optimisation – Arrived during Item 4 and left after Item 9
Sue Moody	SM	General Manager, Acute and Countywide Services
Sara Powell	SP	Matron for Womens and Childrens
Rachael Skinner	RS	Integrated Care Boards Representative – Left after Item 9
Laura Weston	LW	Lead Infection Prevention Nurse – For Items 7, 8 and 9

QC001/02.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Lynne Kedward, Associate Chief Operating Officer, Surgery, Emma Smith, Divisional Nurse Director, Surgery and Nicola Twigg, Non-Executive Director.	
QC002/02.23	**QUORUM**	
	The meeting was quorate.	
QC003/02.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/02.23	**MINUTES OF THE MEETING HELD ON 26 JANUARY 2023**	
	Resolved – that the minutes of the meeting held on 26 January 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/02.23	**ACTION LOG**	
	(a) QC009/12.22 – (B) – Quality Priority – Mental Capacity Act Implementation – The action for discussing how to bring greater rigour to mandatory training for clinicians has been superseded as this is now reviewed at the Finance & Performance Executive meetings following the Care Quality Commission findings. The MCA and DOLS training rates will be included in future MCA Reports to the Quality Committee. (b) QC007/01.23 – (B) – Quarter 3 2022/23 Safeguarding Reports – A meeting was held with the Chief Nursing Officer (CNO), Managing Director, Corporate Director, Herefordshire Council and the Named Nurse for Safeguarding to discuss safeguarding issues. It was agreed to hold a further meeting with the Chief Transformation and Delivery Officer (CTDO) discussing these issues with ICB colleagues. The CTDO will discuss with the Managing Director whether to write a letter on discussions held to date. It was agreed that a letter from the Quality Committee was not required at this time. The letter would make clear our concerns to the Local Authority and our wish to have an open and honest discussion around how we can work better together and provide support for each other.	**RH**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The MCA and DOLS training rates will be included in future MCA Reports to the Quality Committee.**	
	BUSINESS SECTION	
QC006/02.22	**DRAFT QUALITY PRIORITIES**	
	The CNO presented the Draft Quality Priorities and the following key points were noted: • These were presented to the Trust Management Board (TMB) and are required on an annual basis. They also form part of the Annual Quality Accounts received at the Annual General Meeting. • Previously, the Quality Accounts have been audited externally with prescriptive requirements around them. This year, they are not required to be audited. • The CNO has reviewed how the Foundation Group and other Trusts are agreeing on their Quality Priorities (QP), and they are still proposing nine or ten for safety, experience and effectiveness. • The report includes the original selection of the QP for 2023/24. In the main, these have been rolled over from this year as we recognise the work that is still required in relation to these areas. The Care Quality Commission also identified many of these areas in their recent inspection.	

	• A number of CQUINS for 2023/24 have also been identified which the Committee may wish to include. • There are too many QP in the report to accept them all. Discussion was held at TMB around which they would select. There has been limited feedback from Divisions due to current operational pressures. From the CNO's perspective, there are a couple of items, in the table that could be described as business as usual. These are still a priority and will be regularly reported on, eg Mortality and the implementation of the National Patient Standards (the National Patient Strategy has to be implanted and reported on). • The broader quality priorities for discussion are the five bullet points within the report which should be the focus of the wider discussion. It has been proposed to adopt the Frailty CQUIN with discussion around whether a broader frailty priority should be developed. As no one has come forward to lead on this, the CNO suggested that we keep this to the focus of the CQUIN. • The Deteriorating Patient is being overseen through the Resuscitation Committee which the Deputy Chief Medical Officer (DCMO) is Chair and it was felt that this should be adopted as a QP. • Maternity Services has a focussed quality improvement plan due to Ockenden and Kirkup reports and should be kept separate from the QP's. • The CNO asked for views on whether Children and Young Peoples Services in light of the recent Ofsted inspection should be a QP • The Foundation Group have asked all trusts to sign up to the Parkinson's Medication Campaign "get it on time". Given the recent Care Quality Commission findings, it was felt that we should broaden the priority to include audits of all critical medications. • The CNO suggested reducing the QP to 9 or 10 which seems a reasonable number to cover. • Mr James (Chair of the Quality Committee and NED) summarised – we have a list of 9 QP, if we take off Mortality and Patient Experience as business as usual and consider adding in the broader deteriorating patient aspect and critical medication including the Parkinson's Medication Campaign (which we have already signed up to) we just need to agree whether to add in Children and Young People. • Mrs Martin (NED) agreed with this summary and wanted to ensure that maternity's focus on escalation is included within the deteriorating patient QP. She also felt that we should include Children and Young People as this is does not fit in with business as usual due to care being provided in various areas.	

	• The Integrated Care Boards Representative noted the importance of considering the number of areas to prioritise and to have a specific number to focus on and do well with. The Quality Accounts is a public facing document which needs to be taken into consideration. Ie, what would your patients expect you to prioritise in terms of improvement? Communication comes through as a theme and you need to ensure that what is written is patient centred to ensure that what is important to patients is listened to. The Integrated Care Boards Representative agreed with Mrs Martin's comments regarding maternity and Children and Young People or linking into other QP. The Associate Director of Quality Governance noted that the Valuing Patients Time Programme links a lot of this. • Ms Quantock (NED) felt that maternity is a priority, especially with bedding in the Ockenden Report. She liked the suggestion from Mrs Martin (NED) of not excluding the deteriorating aspect and to include Children and Young People, with the new Finance & Performance Executive (F&PE) meeting held yesterday. • The Managing Director noted that we need to have fewer QP – she agreed that Children and Young People is a priority, but would struggle to be able to iterate what that is at the moment. There are a number of discussions and forums with the Local Authority scoping how we work together along with the new F&PE meeting for C&YP which she felt were more suitable than setting this as a QP. We also have a complete action plan for maternity which brings all quality improvements together and did not feel that this was an area for the trust wide quality priorities. • The CNO confirmed that maternity services has a large amount of reporting around it and will be included in the Quality Account regardless of whether it is a QP. She agreed with the comments around communication yet had tried to be less specific and would expect that communication would be included as a measure in the overarching patient experience quality priority. We are using local and national intelligence to improve patient experience including communication. • Mr James (Chair and NED) highlighted the comment made around the Quality Account being a public facing document and areas that might be expected to be included and questioned whether we can include narrative in the Quality Account around areas not specifically a QP. The CNO confirmed this does occur. There is guidance on content of the Quality Account which include a number of areas over and above the QP. The Integrated Care Boards Representative agreed that this is the Trust's opportunity to reflect on areas to the local population.	

	<u>Resolved</u> – that the Draft Quality Priorities be received and approved with agreement to remove Mortality as BAU. Remove the patient safety strategy and patient experience standards as these have to be implemented regardless and to add in wider deteriorating patient and the critical medications priorities. It was agreed that Maternity and C&YP are the focus of separate improvement plans and not to be included.	
QC007/02.23	**<u>CQUINS 2023/24</u>**	
	The Associate Director of Quality Governance presented the CQUINS 2023/24 and the following key points were noted: • We have to develop a local incentivised programme of 5 CQUINS and report data on all CQUINS applicable to our services. There are 11 CQUINS applicable to our services Appendix 1 includes all 11 CQUINS. . • There are three options for the local incentivised programme – these have been discussed internally and against our proposed priorities and factor in resource and capacity, they have also been discussed with ICB colleagues. • Option 1 – Internal Trust Selection. Option 2 – ICB preferred option. Option 3 – Compromise between Options 1 and 2. Option 3 was the preferred option at TMB. • National requirements came into play last year for submission. Due to the resource required to do this, we reviewed the balance of risk last year in trying to resource and not fulfilling all the requirements or actively deciding not to fulfil all aspects and not resource them, which was what was agreed. We therefore propose to submit nil returns again this year where the capacity to resource the data collection is too onerous. Regionally and Nationally we have not attracted interest due to this decision. • Section 3 of the report includes a table which highlights that whichever option we choose, the number of CQUINS that we can provide data on. This is a slightly better position than last year but we are not able to resource this in its entirety. • Mr James (Chair and NED) queried if Pharmacy was able to deliver the pharmacy CQUIN due to the current challenges. The Clinical Director, Pharmacy confirmed that this is achievable and already being delivered. • The Integrated Care Boards Representative noted the useful and helpful discussion held around the guidance, negotiation between the Trust and the Commissioners and was happy to support Option 3 and submitting data for what is available.	

	<u>Resolved</u> – that the CQUINS 2023/24 be received and support the Trust Management Board recommendation to adopt Option three for our local programme, approve the data submission proposal linked to Option three, acknowledge that the resource required to submit to all CQUINS in the programme is not achievable, that the data submission plan, focusing on the CQUINS linked to local improvement priorities, and where there are established data collection methods in place is the appropriate process and partially mitigates the risk of not fulfilling the full national requirements and accept the risk of not fully meeting the national requirements for data collection.	
QC008/02.23	**<u>QUALITY PRIORITY - Q3 INFECTION PREVENTION UPDATE</u>**	
	The Lead Infection Prevention Nurse (LIPN) presented the Quality Priority - Q3 Infection Prevention Update, which was taken as read, and the following key points were noted: • The report noted a MRSA bacteraemia being reported – this has since been reviewed and was not a MRSAB. This was a reporting error and so we are back to zero MRSA bacteraemia for the Trust. • C-Diff – We reported twelve cases throughout this quarter. These have been reviewed and lapses in care were noted with hand hygiene, bare below the elbows, clinical cleaning, estates issues and in a couple of cases, inappropriate anti-microbial prescribing which caused an increased risk of infection. • We were slightly above trajectory in December, with one case above. However, we have been given an increase in an additional ten cases allowed from last year. • E-Coli – There were four cases identified with no lapses of care found on review which is positive. • One review is outstanding regarding a case of pseudomonas which is with the Consultant Microbiologist (due to a reduction in workforce). • There has been a large increase in Covid and flu cases during the latter part of 2022. The report includes some of these figures with 149 Covid cases and 12 outbreaks linked to Covid during this quarter. Operationally we try to keep areas open where it is safe to do so but for two of the outbreaks the areas were closed to admissions and discharges. There was daily communication with the Site Team around the appropriateness of admission to these sites along with agreement from the Infection Prevention Team. During this quarter, eight patients have died following developing COVID during their admission. Five of these patients were linked to Outbreak incidents and are under review in the linked Outbreak Incident reviews.	

	• There was a huge rise in flu cases in December with 320 patients in the Trust. Of these, 317 were Type A, 2 were Type B and one patient was both Type A and Type B. The Type B patients were all children and were reported externally. • There were seven flu outbreaks yet with Infection Prevention Team oversight no areas were closed. Patients were isolated in side rooms or cohort bays. • The Managing Director queried if we have national benchmarking data in relation to our C-Diff figures. The CNO advised that we are currently 77 out of 137 Trusts which is a much improved position. This is not due to an improvement in our performance, but a deterioration in other Trust's figures. We are therefore no longer under scrutiny from that perspective. We are still continuing to try to reduce our C-Diff numbers and implement our C-Diff improvement plan. • The Informatics Team are talking to the National and Regional teams to produce our data in line with national data to enable better benchmarking. • At the end of December, the NHSE Midlands issued Midlands IPC management of Influenza cases in acute settings. We had to benchmark against the principles published. We developed two Risk Assessments following this which were approved at the Gold Command. • The CNO noted that the 2 risk assessments covered the isolation of flu contacts as we were not compliant with the Regional Principles. Our practice mirrored that of many other Trusts and also aligns across the Foundation Group and ICS. • The second risk assessment included the different isolation periods for flu positive cases that can be titrated to operational pressures including the extremis measure enabling appropriate patients being stood down at day 3. • We had an external inspection from the NHSE in October. The Infection Prevention Improvement Plan was developed following this. Audit results have been included and we are declaring lapses of care for some patients with C-Diff regarding commode cleanliness, noting that the majority of commodes are clean with 90% clean in Quarter 3.	
	<u>Resolved</u> – that the Quality Priority – Q3 Infection Prevention Update be received and noted.	

QC009/02.23	**QUALITY PRIORITY – Q3 INFECTION PREVENTION IMPROVEMENT PLAN**	
	The LIPN presented the Quality Priority – Q3 Infection Prevention Improvement Plan and the following key points were noted: • At the inspection in October, a number of issues were raised. Visible standards were reviewed when the team visited. • The LIPN has met with the Assistant Director of IPC, NHSE (AD) to work through an action plan and put in measures to improve/streamline our auditing to enable more time to make improvements. There was also a lot of duplication found and a review of all action plans was taken to combine into one overall improvement plan. The AD also advised that a more realistic timeframe for completion for some elements was needed for the action plan. • The breakdown of the discussions held is included in the report with set themes following discussion with the AD. This commenced in in October and has been tweaked a number of times due to changes to national guidance or increased prevalence with infections. This is therefore be a fluid document. • We have achieved all areas planned for Q3. Regular meetings are held with the AD and colleagues in the ICS. • A Task and Finish Group has also been set up to ensure that we are on track with targets. • The document went to the Infection Prevention Committee in January and was approved, but advised that more realistic timeframes were still needed. • Mr James (Chair and NED) noted the positive working with the ICS and NHSE as well as taking ownership of the issues. The LIPN confirmed that the ICS are being very supportive, ensuring that all actions are worded correctly and explains what we are trying to achieve. • The CNO advised that the NHSE had offered support to the Trust, which we have accepted, with the AD attending the next Quality Committee meeting to deliver training to colleagues regarding assurance around infection prevention. She is also coming to work with the Infection Prevention team for a team “away day” and with the Matrons and Senior Nurses around what they should be looking for regarding infection prevention measures, cleanliness walkabouts and shadowing them in practice.	

	• The DCMO queried where we are regarding antimicrobial prescribing in terms of antimicrobial stewardship and whether a specific piece of work is needed alongside this. The LIPN advised that there is an Improvement Plan for this alongside a separate workplan. The Clinical Director, Pharmacy advised that the issue is around the lack of Pharmacists. We are back out to advert for a Pharmacy Technician and Senior Pharmacist (this post has been advertised a number of times). The DCMO noted that we are trying to resolve the issue with the same groups of staff that we are struggling to recruit and wondered whether the wider clinical body would be able to support with input and leadership. The Clinical Director, Pharmacy agreed that there are benefits to the new EPMA system to a degree but this is still partly a manual system. Mr James (Chair and NED) agreed that this is something for the team to discuss and agree a plan of action. • Mrs Martin (NED) questioned how much of the antimicrobial prescribing can be done remotely and across the Foundation Group and how much needs to be done locally. The DCMO advised that there is some system wide prescribing but a number of the measures are patient specific. Within the CQUIN discussed earlier, there is an algorithm that you can work through for each patient but this takes fifteen minutes to undertake and needs to done daily which is not realistic. • The CNO advised that we did review the antibiotic formulary last year and changed some of the antimicrobial stewardship arrangements and as part of the antimicrobial stewardship strategy included order sets, however, this is an option for EPMA rather than a mandatory field. In addition, we were hoping to introduce antimicrobial ward round but due to the gaps in the microbiology team this has not been possible.	
	<u>Resolved</u> – that the Quality Priority – Q3 Infection Prevention Improvement Plan be received and noted.	
QC010/02.23	**<u>CLEANLINESS REPORT - QUARTER 3</u>**	
	The LIPN presented the Cleanliness Report – Quarter 3 and the following key points were noted: • We have seen improvement with scores as quarters have gone on. In the appendix, there is a breakdown on individual wards showing the percentages and star ratings as part of the requirement is to provide both figures. • The audit system changed in this quarter to the formic data set. Following this change, we noticed some glitches with the formulary regarding the star ratings. Therefore the star rating is not accurate in this report but these are being worked on to try to be resolved for the next report. The percentage scores are accurate.	

	• The last quarter has seen the introduction of new Efficacy Audits. This has been implemented since January and takes place again next week. The figures and compliance will be included in the next Cleanliness Report. • We are working on the rectification times (details within the report). When issues are identified, we need to rectify them and make improvements within a certain timeframe. The process is still being fully developed. • An external audit is planned for March as part of the Cleanliness Standards Review. This will include an external body alongside our monitoring team to ensure that the findings are a true reflection of the standards found. • This week, Internal Audit are reviewing our implementation of the cleaning standards. An update will be provided in the next report. • The Cleanliness Strategy is being developed by the CNO and David Stock regarding an integrated strategy to improve our approach to cleanliness across the organisation. There needs to be clear accountability and assurance that everyone knows their roles and how to undertake this. • Ms Quantock (NED) highlighted that estates has come up as an issue and the difficulties in improving this and queried whether we are checking on how other hospitals are dealing with working with older estates. The CNO advised that a Regional presentation on C-Diff infection rates and cleanliness found that older estates and PFI hospitals struggle with the backlog of maintenance, therefore this is not an issue unique to this Trust.	
	<u>Resolved</u> – that the Cleanliness Report – Quarter 3 be received and noted.	
QC011/02.23	**<u>MEDICINES SAFETY COMMITTEE REPORT</u>**	
	The Clinical Director, Pharmacy and Medicines Optimisation (CD) presented the Medicines Safety Committee Report and the following key points were noted: • The first missed dose report from the Electronic Prescribing and Medicines Administration system is included in the report and is acknowledged not to be easy to interpret. Work is underway to improve this. This stems from the Care Quality Commission visit. The EPMA system works with the administering of medicines going green or red if this is not given. The Care Quality Commission are expecting us to comment on any missed doses and felt that we should not be administering the next dose until a comment is made. We are not able to do this with our current system. We have tried to reassure the Care Quality Commission that the likelihood of a missed dose being noticed is very low with the report showing that there are only 0.1% of “red” doses that did not include a reason for the missed dose. They were comfortable with this.	

	• The CD highlighted that missed doses and the reasons have not been regularly reported. Currently 97% of doses are given on time. The system is complicated and is in the process of being developed. This is live data so we know what is going on and more robust than previously when we were not aware of this information. • The Managing Director felt that 97% was very high and questioned whether there was any benchmarking to compare this figure. The CD advised that when compared to other EPMA users, this is an expected figure. The average is around 95%. • Mr James (Chair and NED) queried how a missed dose is recorded if a patient is off the ward or refuses the medication. The CD advised that we can go back retrospectively and add this information but the system will still note this as a late/missed dose. • The CNO advised that we can now pull reports off the system with the Nurse in Charge of the ward able to audit shift compliance if time allows. This is an additional task for staff, but if just for clinical medications, this may be achievable. • The Managing Director noted that the issue may be with prescriptions not always being prescribed in a timely way which the EPMA system will not advise. The CD noted that this is critical for Parkinson's for timely medications being given. The CNO advised that Parkinson's medications are to be given at odd times outside of standard drug rounds, so if it is prescribed we can measure that. • The Medical Gas Committee now sits under the Medicines Safety Committee, which the CD Chairs. The aim is to ensure that we bring together the clinical sides of gas usage and the logistics of having the pipework in the right place and handled correctly. A National Patient Safety Alert came out in January around accessibility of piped oxygen, especially due to the increased bed occupancy in Trusts, staff experience and lack of availability of cylinders. The CD was pleased to advise that within three days of the alert being issued, a Medical Gas Committee was convened with the actions reviewed. A Risk Assessment was undertaken immediately with a follow up meeting being held later this month. • Staffing in Pharmacy is continuing on a downward trend, with vacancy rates at 55%. • There is a huge amount of work going on in the Pharmacy Department, the Trust and at ICS level to try to mitigate the risks in the immediate future and also the medium to long term. We have linked with education providers to increase capacity to train more staff. There is also ongoing work with the Primary Care Networks and the ICB within Herefordshire with the One Herefordshire Pharmacy approach to attracting staff. We are prioritising work with chemotherapy provision one of the highest priorities. We are working with Gloucester Royal for more support.	

	• A Locum Pharmacist is starting on 6 March who can also work remotely in terms of clinical checking. .	
	Resolved – that the Medicines Safety Committee Report be received and noted.	
QC012/02.23	**QUALITY PRIORITY – MORTALITY REPORT**	
	The Chief Medical Officer presented the Quality Priority – Mortality Report and the following key points were noted: • There is an improving picture. Regarding the unexplained findings with regards some of the statistics, this is now clearing a coding issue which we are starting to address. The Mortality Project Manager held a session yesterday with South Warwickshire Foundation Trust regarding this as they are now having similar issues. We are proposing to use the model that University Hospitals Birmingham. • We have eight GP applicants for the Medical Examiners posts which is very positive. Interviews were held yesterday. • Mr James (Chair and NED) noted that this is a positive position compared to where we were a few months ago. • The Managing Director queried the fractured neck of femur figures which are higher than previously. The Chief Medical Officer advised that our figures have been higher. We did manage to get them a lot lower but they have now increased. There is ongoing work around this with meetings held to address. He is now more confident around this area.	
	Resolved – that the Quality Priority – Mortality Report be received and noted.	
QC013/02.23	**COLPOSCOPY REPORT**	
	The Lead Colposcopist, Cervical Screening Programme Lead and the (LC) General Manager, Women and Children's Directorate (GM) presented the Colposcopy Report with the following key points were noted: • Performance is improving. Over the last 18 months all KPIs have been achieved. • From a screening point of view, there are no issues to raise. • Cytology performance is within standard and targets are improving. • The main issue is histopathology due to the number of staff who have left. This is on the Risk Register. • We are re-advertising for a Nurse Colposcopist due to being unsuccessful previously.	

	• A new Consultant is joining the team and is taking on the Cervical Screening Lead role. • There has been a huge increase in the number of referrals to Colposcopy. A lot of work and effort has gone in from the teams to attain our KPIs due to this. We are maintaining our performance which is a credit to our team and the wider team involved. • A Business Meeting was held around histology with a lot of positives arising from this to try and improve the situation and review options. We also have support from Worcester and South Warwickshire NHS Foundation Trust. • The CNO queried the low rate of 45% for an offered date of treatment. The LC advised that not all high grade biopsies require treatment. In many circumstances we now offer conservative management, eg defer due to pregnancy. The CNO noted that the report suggests that 5 out of 11 patients only achieved their offer date. The GM advised that five patients did not achieve their date due to clinical reasons, eg they did not need clinical treatment after discussion at the MDT meeting. This is reported as a breach but the data is reported as an Exception Report at the Programme Board with Region. Future reports will include commentary around the reasons why patients have not been offered a date for treatment. • The Associate Chief Medical Officer, Clinical Support Division noted that the overall referral rates for HPV have increased and queried the plans for Nurse Colposcopists. The LC advised that HPV patients are deferred for the first three years. Therefore, the impact only occurred from September last year and staff have so far managed to cope with this additional activity. Nurse Colposcopists are wanted for the Trust for consistency of care, and nationally all Trusts have them in post apart from Wye Valley. We have advertised the post and changed this to a training post to enable more interest. The GM advised that there may be more internal interest now. The next Colposcopy report will include a 5 year look back on the numbers of patients attending for Colposcopy.	**TB/KO** **TB/KO**
	<u>Resolved</u> – that: **(A) The Colposcopy Report be received and noted.** **(B) Future Colposcopy Reports will include commentary around the reasons why patients have not been offered a date for treatment.** **(C) The next Colposcopy report will include a 5 year look back on the numbers of patients attending for Colposcopy.**	**TB/KO** **TB/KO**

QC014/02.23	**STAFFING REPORT**	
	The CNO presented the Staffing Report, which was taken as read, and the following key points were noted: • The report covers the January performance data. This was a very difficult month in terms of additional patients on wards, escalation areas open etc causing high fill rates. • Included in the report is a sample of the data from the Safe Care module. The data indicates that we are seeing an increase in acuity and dependency of our patients at the current time. A snapshot of the data is included within the report which shows that nightshift staffing levels meet patient demand yet our day care hours do not always meeting the level of demand. • Also included is a breakdown of nursing and midwifery vacancies along with the Healthcare Support Workers details. This position is improving but not at the rate required, hence the low fill rates. We still have a high level of Registered Nursing vacancies at 95. • It has been approved in principle at the TMB for a further 120 international nurse recruits for 23/24. This was approved ahead of the Board of Directors due to the deadline to submit an external bid to Health Education England as a funding support offer for international recruitment. • Sickness rates are above the expected rate of 3.5% at 4%. This is driving some of the demand for agency. • The detail around the agency demand including cost and usage is in the report. From March, a more detailed report will be presented to the Board of Directors on agency data. • Mr James (Chair and NED) noted the difficult of drawing conclusions from the fill rate table which depends on the number and acuity of patients which will flex. The CNO advised that it is a national requirement to include this table and agreed in isolation it does not provide useful information. The safecare data is more meaningful yet only just embedding. • We are currently undertaking a biannual acuity and dependency audit in the Community Hospitals and inpatient wards which will enable a more meaningful report to be presented. This will be presented back to the meeting in due course.	
	Resolved – that the Staffing Report be received and noted.	
QC015/02.23	**PQSM REPORT**	
	The Matron for Quality and Safety (Matron) presented the PQSM Report, which was taken as read, and the following key points were noted: • Activity in December was stable.	

	• The Matron met with the Chief Medical Officer to discuss Robson groups. • There was one late miscarriage at 16 weeks in December. The family are being supported by the Bereavement Midwife. • There was one antenatal stillbirth in January. A rapid review and PMRT was held in Worcester with no concerns found. The patient is being supported by the Bereavement Team. • There were significant workforce gaps in midwifery in December, mitigated by specialist midwifery support and agency. Positively, there are now three new starters in post. • One concern was received which was upgraded to a complaint after review. This was due to lack of dignity and privacy. The mother was in agreement to this change. • MDT compliance – This is being monitored including anaesthetic handover. This is due to take place twice a day on the Delivery Suite. This was only 32% in December as we cannot evidence this is occurring, as the sign in sheet is not completed. There have been 42 episodes where we cannot confirm that an anaesthetist was present. This has been escalated and February showed an improved picture. This will continue to be monitored closely. • The Associate Chief Medical Officer, Clinical Support Division felt that an IT solution should be simple for attendees to sign in and out. • The Managing Director questioned whether the issue was around the anaesthetist not attending or not signing in. The Matron was not sure which the issue was. Following this issue being highlighted, there has been an improvement. • The Managing Director felt that instant reporting should not be difficult, this is a requirement to attend as part of their job plan. The Chief Medical Officer advised that colleagues are overseeing this with the Obstetric Lead raising the concern at the Anaesthetic Governance meeting which is formally minuted. • Mrs Martin (NED) questioned whether there was a Standard Operating Procedure in place. She was keen to see the process and who owns this. The Matron will look into this. • Mr James (Chair and NED) questioned who leads the MDT as we need to ensure everyone signs in or the Lead takes responsibility. The Matron will review whether this is possible and raise this at the next Co-ordinators meeting.	**SA** **SA**

	• Mr James (Chair and NED) questioned the prospect of filling the maternity rota gaps with agency staff when needed. The Matron advised that the problems will ease with the three new recruits and the international recruits starting. It is also looking more positive from a recruitment perspective. • Mrs Martin (NED) noted the two patients with a BMI of over 50 which seems very high and asked at what stage BMI is calculated. The Matron advised that booking weight is used for BMI. We are seeing an increase in BMI for our patients. • The CNO advised that she has discussed recruitment with the Associate Director of Midwifery with around twenty one midwifes wanting to apply. The CNO has recommended that maternity should recruit to turnover and include maternity leave if we have several candidates who are successful rather than turn candidates away. .	
	Resolved – that: (A) The PQSM Report be received and noted. (B) The Matron for Quality and Safety will review the process for anaesthetic handover compliance including whether there is a Standard Operating Procedure in place. (C) The Matron for Quality and Safety will raise the issue of attendees signing in at the anaesthetic handover at the next Co-ordinators meeting.	**SA** **SA**
QC016/02.23	**MATERNITY SURVEY**	
	The Matron presented the Maternity Survey presentation and the following key points were noted: • The Care Quality Commission survey was carried out in February 2022 for all ladies who gave birth. • **WVT Demographics** - Communication went out for the 2023 survey to improve feedback from patients. The demographics remain the same. • **Summary of Findings at WVT -** Comparison with other Trusts - We were about the same for 47 questions, better for 1 and worse for 2. Comparison with results from 2021 – Not much change for 40 questions, better for 1 and worse for 5. • **WVT Scoring** - We had 5 top scores for above average results for England but we also had 5 of the bottom scores as well. These are areas that we are aware that we need to improve upon.	

	• **Benchmarking – Antenatal Care** - There was a slight decline in 2 areas around choice of birth. We are educating staff on the options for mothers and promoting home birth where applicable. There is also confidence building for our midwives following Covid and the ambulance strikes. George Eliot Hospital did well on these questions and we are linking in with them on how we can improve. • **Benchmarking – Antenatal Care continued** - There are no major concerns around our antenatal care. We need to ensure that all women feel listened to and have enough time with staff to discuss any issues. • **Care during pregnancy** – Our score declined from 9 to 8.1 regarding mental health support during pregnancy. We are improving access to mental health support through our website. We are also enabling patients with self help and support and promoting healthy minds. • **Refocus on antenatal care** - More face to face appointments are wanted by our patients. This is with antenatal support was well as postnatal and for breastfeeding. • The theme of the month is around trauma informed care, with learning from complaints as well to ensure wider learning. We follow a patient through their pathway to better understand this along with sharing patient stories. • **Labour and Birth** - We need to promote our leaflet more with patients. This is available on Badgernet, but not all patients log into this. • The core triage team is available to help support running triage and to enable more time for patients contacting us with concerns. • **Staff caring for you** – We scored well in this area and benchmarked well. We have seen an increase in requests for a debrief after labour. We are reviewing how we can best support with this, along with looking at introducing a daily Midwifery Walkabout. • **Question D7 -** Formulate a trial of partners staying – work collaboratively with MVP – This score has improved but is still low. We need to ensure that the concerns raised by the Maternity Voices Partnership (MVP) are met along with baby tagging in place before we could support partners staying overnight. • **Question F13** - Review content in mandatory training re: mental health and the roles and responsibilities of the midwife (i.e. beyond signposting, can begin with advice re: self-help tips and signs to observe etc) – We need to ensure that midwifes are communicating this and advising patients who to contact. This information will also be available on the new website.	

	• **Question 14** - Develop PN leaflet and PN information for the website – The MVP noted the lack of information and we are looking at putting together a post-natal leaflet. • An action plan has been produced which is monitored monthly at the QIR meeting. • The Chief Medical Officer noted that we are doing poorly regarding the question around information given around induction, which the Foundation Group are doing well with. This is also the Robson Group where we have a high section rate and wondered whether there may be a connection. It is worthwhile thinking about giving patients more information around this which may lead to more confidence for mothers and a reduction in our caesarean rates. • The Managing Director noted that there is a lot to be proud about in this survey. There is little choice for mothers to be in Herefordshire apart from homebirth, with more options available at George Eliot Hospital and so did not feel this was an area of concern for a rural population. • The CNO advised that we had received an escalation call from the ICB advising that the Region had stated that our survey results were significantly deteriorating and they were concerned, given the results the CNO is not clear where the region were coming from. There is also some really good practice for us to share with and learn from the Foundation Group. • The CNO questioned the timescale for the new website to be up and running. The Matron advised that a draft site was planned by the end of the year. There are issues around this but the Matron will obtain an update around this. • The CNO noted the issues around partners being present more could be partly due to Covid. Women are feeding back that they want partners with them overnight after giving birth but there are issues around the large number of people in wards if this occurred. We need to co-produce with the MVP to ensure that we are doing the right thing. Obviously the tagging system for babies is critical to this. • Ms Quantock (NED) noted the importance of work around recognising the different ways that trauma can show up and also around patient expectations – ie women wanting their partners with them on the ward but we need to explain that this would involve sharing the ward with other people, sometimes men, which may not be acceptable for all patients. • Mr James (Chair and NED) was pleased that we are performing well in some areas with further improvement wanted which is important, as well as areas where we have challenges.	**SA**

	• Mr James (Chair and NED) noted that these survey results are always a year behind and therefore anything we do now may not impact in the next survey, taking two years to show any impact and questioned where suggestions for improvement are being picked up. The Matron advised that the action plan is discussed at the monthly QIR Forum and our MDT meetings. • Mrs Martin (NED) was pleased to see the comparison with the ICB and Foundation Group services. The table with the results was not clear where we are deteriorating. If we are sharing this with mothers and families, we need to ensure that this information is easy to understand, eg "you said, we did" approach. • The Associate Director of Quality Governance confirmed that the points raised would be picked up, recognising that we are always reporting data a year behind. Our local solution to this is for more timely feedback with our Friends and Family text messaging service which is planned for roll out for maternity as well.	
	<u>Resolved</u> – that: **(A) The Maternity Survey be received and noted.** **(B) The Matron for Quality and Safety will confirm the timetable for the launch of the new maternity website.**	**SA**
QC017/02.23	**<u>PATIENT EXPERIENCE REPORT</u>**	
	The Associate Director of Quality Governance presented the Patient Experience Report and the following key points were noted: • The Friends and Family text messaging was introduced last year – there has been a significant response to this and we are meeting, and indeed exceeding the national response rate. Our response rates are also very positive. • We are using live dashboards for services to improve reassurance with a roll out of text themes to the Emergency Department, Maternity and Paediatrics next. We are discussing extending this to the District Nursing service. • The Outpatient Transformation Programme is using this date to inform and track changes occurring there. • The National Inpatient Survey results were presented to the Quality Committee previously. In November, our volunteers undertook an abridged version of the survey for our patients. There were four key areas and three new areas of concern added from this year. Communication and food quality were still found to be an issue but we have more positive feedback on other areas. We are reviewing how these issues are already being tackled in the Trust. It is critical that we track these areas and to link them with patient experience.	

	• We have received 206 complaints year to date. Based on previous figures, we are expecting a reduction in the number of complaints received this year compared to last. Three cases are being reviewed by the Ombudsman to see whether they wish to investigate further. One has since been stood down with the second suggesting a facilitated meeting to mediate with the complainant and the Trust. • We are consistently not achieving our 30 day target of responding to complaints. The report includes divisional performance and the response rate range. Medicine are doing particularly well. A deep dive into communication around complaints is being undertaken. • There is a lot of detail within the report around response times with a huge variation within the Divisions. This information has been shared with the Divisions with a mapping process needed to understand the reasons for these differences. This will be monitored through the Patient Experience Committee and potentially the F&PE. • Complaints around communication are increasing year on year with communication to patients and carers the biggest cause for concern. The Medical and Surgical Divisions are the main areas of concern with a need to focus on improvement in this. This will be taken to the Patient Experience Committee when it is relaunched in April. • We need to continue getting local feedback and we will continue to roll out surveys. The transformation work in outpatients is a prime example of how we can use patient experience intelligence to transform services and we are also linking the work to the valuing patients time programme. • The Managing Director noted that an escalation process is needed within Divisions to ensure timelines are met and a consistent level of quality. There is almost always something valid in a complaint that we can learn from. There needs to be a focus in Surgery especially as they are lagging behind Medicine. • Mr James (Chair and NED) questioned regarding our communication issues, who is doing well and where can we learn from. Secondly, regarding food, is there something we can do differently to try to improve this ongoing issue. The CNO advised that food quality was an issue that the Patient Experience Committee were reviewing but was overtaken by other issues. Now that we have the new Nutritional Group being set up, we will be able to highlight this issue here. We can have meaningful discussions with our Sodexo colleagues using our Place Inspection results and the National Inpatient Survey.	
	<u>Resolved</u> – that the Patient Experience Report be received and noted.	

QC018/02.23	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The DCMO presented the Patient Safety Committee Summary Report and the following key points were noted: • A couple of Policies were agreed with agreement on making Policies more formalised and consistent. • The Never Event regarding the NG tube was discussed at the Coroner's Inquest. The DCMO provided the background to this case. A lot of work around this has already occurred with the doctor involved undergoing training prior and after this event. Discussions are occurring around mitigating this risk as much as possible. It was also discussed at the Coroner's Court around only Radiologists being able to interrupt these scans, which needs to be added to the Policy. There are occasions when an NG is fitted and a scan performed but reporting is not able to take place in a timely manner. There are a number of Consultants who could interpret this which may be a solution. There is a meeting next week to review and reword the Policy.	
	Resolved – that the Patient Safety Committee Summary Report be received and noted.	
	CONFIDENTIAL SECTION	
QC019/02.23	**SERIOUS INCIDENT REPORT**	
QC020/02.23	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC021/02.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 30 March 2023 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 30 March 2023 at 1.00 – 3.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director
David Mowbray	DM	Chief Medical Officer
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Julie Davies	JD	Consultant Clinical Scientist/Clinical Director Pathology – For Item 6.1
Robbie Dedi	RD	Deputy Chief Medical Officer
Rachel Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Val Jones	VJ	Executive Assistant (for the minutes)
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division – Arrived during Item 4
Abbi Maddox	AB	Matron for Community and Antenatal services – For Items 5.3 and 5.3.1
Tony McConkey	TM	Clinical Director, Pharmacy and Medicines Optimisation – Left partway through Item 7
Sue Moody	SM	General Manager, Acute and Countywide Services
Kirsty Morgan	KM	Regional Lead, IPC – For Item 7
Rachael Skinner	RS	Integrated Care Boards Representative
Emma Smith	ES	Divisional Nurse Director, Surgery

QC001/03.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Lynne Kedward, Associate Chief Operating Officer, Surgery.	
QC002/03.23	**QUORUM**	
	The meeting was quorate.	
QC003/03.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/03.23	**MINUTES OF THE MEETING HELD ON 23 FEBRUARY 2023**	
	Resolved – that the minutes of the meeting held on 23 February 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/03.23	**ACTION LOG**	
	(a) QC015/02.23 – HTA Visit – Mortuary Report and Actions – The review of the process for anaesthetic handover compliance including whether there is a Standard Operating Procedure in place and to raise the issue of attendees signing in at the anaesthetic handover at the next Co-ordinators meeting will be covered on the agenda under the PQSM Report. (b) QC016/02.23 – Maternity Report – Confirmation of the timetable for the launch of the new maternity website will be covered on the agenda under the Maternity Quarterly Report. (c) QC017/11.22 – Perinatal Mortality Review – (D) – Any exceptions on the Perinatal Mortality Review will be included in the Maternity Divisional Report. Action to be closed as included in Forward Planner. (d) QC013/02.23 – Colposcopy Report – Items to be included in future reports. Action to be closed as Colposcopy Report included on Forward Planner. (e) QC008/01.23 – Quality Priority – Mortality Report – (B) - The results from the data collection from the Stroke audit area awaited. Agreed to close this action as they will be included in a future Mortality Report. (f) QC008/01.23 – Quality Priority – Mortality Report – (C) – Discussion was held at the March meeting of the QRD around comparing different mortality reviews and outcomes, and it was agreed that this will be picked up as part of their work programme.	
	Resolved – that the Action Log be received and noted.	
	BUSINESS SECTION	
QC006/03.23	**QUALITY PRIORITY – NUTRITION**	
	The Associate Chief Nursing Officer (ACNO) presented the Quality Priority – Nutrition update, which were taken as read, and the following key points were noted: • Our Nutritional Steering Group is now operational with the two subgroups – the Nutritional Care Group which is led by our Lead Dietician which covers everything to do with patient food and the Nutritional Support Group which oversees the more technical aspects of nutrition in terms of energy management etc. • The new Nutrition Specialist Practitioner is also now in post. • There has been huge progress in the malnutrition screening scores in Community Hospitals from Quarter 1 following the improvement work which has been sustained and improved on to Quarter 3. We are now on target to meet the CQUIN.	

	• We have applied these CQUIN measures to our Acute hospital bed base, with a snapshot included in the report of all of our wards throughout the County Site. There is a lot to work on with an action plan from the Lead Dietician to lead these improvements. • In terms of the improved food scores, the PIACE - Patient Led assessments of care environments were only released last week so these have not yet been reviewed to compare results. There is a lot of work nationally with regards to standards for hospital food for healthcare. • The ACNO clarified that the appendix letter that refers to the Named Responsible Person is in relation to one aspect of the eight national standards for hospital food that were launched. These eight national standards are far reaching and we are undertaking a gap analysis with Sodexo to see where we are at as a Trust in terms of a baseline. There is a maturity matrix within the standards to enable us to see how we are progressing. The plan is to bring our actions on how we can best meet these standards through the Nutritional Steering Group. • Mrs Twigg (NED) questioned where the ACNO was getting the support from Sodexo to enable the changes that need to be made for our patients. She was interested in how our patients feel about the changes as food is often one of the main issues for patients. The ACNO confirmed that there was more buy in from Sodexo colleagues now with meetings set up to support this. It is different for Community Hospitals as our own staff supply the food and these scores are generally good. • Mr James (Chair of the Quality Committee and NED) noted that we have worked with Sodexo around cleanliness and infection prevention with a shared interest in taking pride in what we do rather than treating them as a subcontractor which is positive. • The Integrated Care Boards Representative noted that weight and BMI recording was a learning point from a recent LeDeR case and queried how assured the Trust are around being able to weigh patients who are not able to use the usual set of scales and asked for this to be taken to the Nutritional Group. The General Manager, Acute and Countywide Services advised that new weighing scales on Wye Ward (Stroke Ward) have been purchased which are more like a pat slide than using a hoist. • The Integrated Care Boards Representative noted that there is also the issue around patients who are under nourished and need to be supplemented to help with their physical care along with those who are admitted with a high BMI that adds complications to their health needs and queried if there is a process that someone identified with a high BMI is linked into ongoing community services and support post discharge. The ACNO noted that there has always been a gap in this area as we do tend to concentrate on malnutrition.	**RH** **RH**

	This is something that can be picked up with colleagues in the Integrated Care Division as patients with a high BMI are often transferred from the Acute to a Community Hospital bed where there is the specialist equipment available. There may also be a link with Primary Care that needs to be reviewed. • The Chief Medical Officer (CMO) is dealing with a Serious Incident with a potential for dehydration as the central feature and queried if this is something that the Committee oversees and whether there is any auditing around this. The ACNO advised that this issue is not reviewed separately, the Committee review the complex aspects of feeding, and eg PEG feeding but this is something that could be added on in addition to review. The Deputy CMO advised that we have had an issue with fluid balance previously on a gastroenterology ward but was not aware of a regular fluid balance audit. The Junior Doctors on the Frailty Wards are undertaking audits around fluid balance being correctly audited and we need some recommendations around how we might roll this out wider in the Trust. If patients are medically fit for discharge (mainly in the Community Hospitals), there is often the assumption that some of the observations are not required as they are capable or feeding and hydrating themselves. • The Chief Nursing Officer (CNO) advised that a review of the PIACE results will be presented to the next Quality Committee. Overall, it is a positive position for the Trust. Out of 19 of the 32 domains we were above the national average. In terms of our domains for each hospital site, progress has been made in nearly all of the domains against our baseline in 2019. The Organisation of Food domain stands out – this is about the food service and how it is delivered to patients rather than the taste. There is clearly some work to do around this, particularly in the Community Hospital sites around service delivery. • Ms Quantock (NED) questioned if developing nutrition work included patients with dietary and/or religious food restrictions eg celiac, vegetarian, kosher etc? This was particularly linked around nutrition and pre-diabetes, prevention and screening. The ACNO will review this.	**RH** **RH**
	<u>Resolved</u> – that: **(A) The Quality Priority – Nutrition be received and noted.** **(B) The Associate Chief Nursing Officer will discuss weight and BMI recording for patients who are not able to use the usual set of scales at the Nutritional Group.** **(C) The Associate Chief Nursing Officer will discuss with the Integrated Care Division the process for someone that is identified with a high BMI and whether they are linked into ongoing community services and support post discharge.**	**RH** **RH**

	(D) The Associate Chief Nursing Officer will ensure that dehydration is added on in addition to review at the Nutritional Group. **(E) The Associate Chief Nursing Officer will review whether developing nutrition work includes patients with dietary and/or religious food restrictions eg celiac, vegetarian, kosher etc.**	**RH** **RH**
QC007/03.23	**QUALITY PRIORITY – MORTALITY REPORT**	
	The CMO presented the Quality Priority – Mortality Report and the following key points were noted: • The SHMI continues to improve and is the best in the group. The HSMR has lifted a little but this is due to coding. We continue to investigate our palliative care coding across the \Foundation Group and the Mortality Project Manager is putting together a Task and Finish Group with the three coding teams. • We are maintaining a good level of mortality reviews. The CMO was concerned to see three LeDeR deaths this month and was keen to find out if there was any local learning. • Reduction in perinatal mortality - We have been misreporting stillbirths but not in a way that is of concern. It appears that we are doing satisfactorily with extended perinatal mortality and are following the trajectory but the trajectory for stillbirths does not appear to be changing. The CMO and Mortality Project Manager reviewed this in more detail and found that the lines were incorrect so the updated graph for next month will be more reassuring as we are actually on track for both areas. • The CMO confirmed that there are no care concerns following the Stroke Review. The Managing Director reiterated how reassuring this report was and noted that she is always concerned about understanding what our clinical outcomes are in terms of permanent disability and how that compares which is very difficult to find. • The Managing Director queried if our palliative care recording was more average, is there a feel for how this would change our HSMR. The CMO advised that our figures would be average if this coding was accurate. • Mrs Martin (NED) noted the positive number of Medical Examiners from general practice and the One Herefordshire Workshop held this week and questioned whether we have colleagues from psychiatry. Social Care and learning disabilities who are part of this process, to provide a different aspect. The CMO advised that the Medical Examiner process currently only has GPs recruited. The Mortality Committee in May will have a new format with a full representation of all areas mentioned and we can triangulate via this route. The LeDeR route is more formal in its review and these areas are well represented.	

	• Mr James (Chair and NED) queried the process around learning disability deaths as these will be reviewed around the LeDeR process and how this will be reported back to the Quality Committee. The Integrated Care Boards Representative advised that any person with a learning disability who dies in any NHS Trust has a Subjective Judgement Review in that Trust and at the same time is referred to the LeDeR Programme. This is a national learning programme so does not replace any of the statutory process such as a Coroners review or Serious Incident. This is not an investigation, it is about extracting learning. Any learning for the Trust would be fed through to the representatives from the Trust attending the meetings and a number of forums linked to the LeDeR Programme. If there are particular actions where we feel that the Trust could contribute to an improvement for learning, we link with the key staff in the Trust. If required, we can carry out a thematic review. As a System, we do very well supporting people with learning disabilities to die out of hospital, and in Herefordshire in particular. • Mr James (Chair and NED) questioned who carries out the local reviews. The Integrated Care Boards Representative advised that this is carried out by the ICB as it has to be carried out by individuals outside of the direct provision but we involve people in local services when the review is undertaken. If there was something high risk that was found, this would be reported back though the Trust.	
	Resolved – that the Quality Priority – Mortality Report be received and noted.	
QC008/03.23	**MATERNITY QUARTERLY REPORT**	
	The Matron for Community and Antenatal Services (Matron) presented the Maternity Quarterly Report, which was taken as read. Due to the slight delay in the report (reporting stood down in December and January) and Quarter 4 being presented at next month's Quality Committee, there were no questions raised as Committee members were already up to date with the report content due to other discussions in recent months. The CNO advised that from a governance point of view, the report was presented for the purpose of the minutes so as not to compromise future CNST compliance.	
	Resolved – that the Maternity Quarterly Report be received and noted.	
QC009/03.23	**PQSM REPORT**	
	The Matron presented the PQSM Report and the following key points were noted: • There was a reduction in our total number of deliveries in January.	

	• We are undertaking a review of our Robson Group data around percentages of our caesarean sections and how these groups are made up. Further work will be undertaken as a multi-disciplinary team with the Obstetricians to understand this reporting and the breakdown of the Robson categories. • We have now recruited to the Consultant Midwife post, starting mid-April. This will allow us to involve them in this piece of work as well as the wider work looking at how we detail on the Badgernet record, eg time spent with our patients, their understanding of patient choice etc. A lot of work is being undertaken around personalised care planning. This is partly due to the Ockenden Report follow up but also due to feedback from our patients. • There was one stillbirth over 24 weeks (baby born at 36 weeks) with a Rapid Review held, with no care concerns identified. Rapid Reviews are always multidisciplinary and include external input from another Trust. The cause of death was likely to be due to a cord incident. We are providing the family with ongoing bereavement support. • There was one neonatal death recorded in January at 19 weeks gestation. There has been a preliminary finding of a potential congenital abnormality (awaiting results). • There was a complex case in January involving a mother who had an invasive placenta. There was a major haemorrhage which was followed by a hysterectomy. There was a robust MDT following this due to the amount of input into this lady's care and the outcomes of this review was that the admission and care was deemed appropriate and that there was good practice and multidisciplinary working. • Interviews for midwives in the Trust are currently taking place with the plan to significantly reduce our vacancy rate. Due to our internal midwives in post and with the successful recruitment drive enabling a high number of interviews taking place there is a possibility that we will be able to fill all of our current vacancies. The international midwives are receiving a lot of support with a good process in place to support them over the next two years. • Focus has been undertaken on handovers, which was an action from a previous meeting, particularly the signing of the handover sheets. An audit for February and March has shown that data for March has improved. The March data showed that the Anaesthetists had completed 23 out of 30 days with two of those days when they were in theatre. There is also a process in place to escalate should the right staff not be at handovers or ward rounds. • We received 29 compliments in January for the Maternity Ward and Delivery Suite with one complaint received. We are reviewing our complaints with our Governance Meeting held yesterday.	

	• There are three ongoing complaints that are being investigated. Key themes are communication and attitude. We are reviewing what care is being received on the ward overnight, eg post-natal women who require additional support with breastfeeding. • We completed the 15 steps a couple of months ago and we are working to implement some of these findings, eg trying to have a quiet space at night whilst enabling staff to support patients if needed. We are also looking at the debrief process to ensure that patients are receiving all the information that they require and be more multidisciplinary. • There is a new PROMPT process in place which should enable our training figures to improve. • The action around the training for the new maternity website was noted by Mr James (Chair and NED). The Matron confirmed that this is now in its final stages of development. • Ms Quantock (NED) queried what the criteria is for accessing counselling services currently regarding a traumatic birth and what the signposting might be like for people who are not eligible to access within the current parameters. She also noted that the report mentions that a midwife has been funded to attend Birth Trauma Resolution training in terms of complaints and was trying to understand if that midwife would be undertaking the debriefs based on that training or whether will they be training to then train other midwives as well. The Matron advised that our Birth Trauma Resolution training has been rolled out over the last couple of years. This will mean that we have 6 or 7 midwives that we can gradually phase in to undertake the debriefs. The Antenatal Clinic provision at the moment and the pathways are under a huge amount of review in terms of improving the quality of care, but also the patient journey which will include debriefs at the time of VBAC clinics which will also include our Consultant Midwife. We often find women coming back for a subsequent pregnancy want to go back over their previous delivery even though they are being counselled on a potential vaginal birth following caesarean section. This will enable a number of different pathways to be running. At the moment we have mild, moderate and acute within the Perinatal Mental Health team. The Matron was involved in a discussion this morning where it was noted that 49% of our case loads of women suffer with anxiety and depression and we want to tighten that pathway for those women accessing a more supportive network. • The CNO noted that the Continuity of Carer data has been blank on the dashboard for the last few months because the national position on this changed and left that to local determination. In January we recruited into the Continuity of Carer Project Manager post and she is focussing on those groups of women who might have poorer outcomes than others, eg our Eastern European population, teenage mums and those living in deprived areas. The plan is to bring our outline plan for delivering Continuity of Care for those women towards the end of May.	

	<u>Resolved</u> – that the PQSM Report be received and noted.	
QC010/03.23	**<u>QUALITY INDICATORS</u>**	
	The CNO presented the Quality Indicators and the following key points were noted: • The CNO noted that it had been agreed that we would bring the Quality Indicators with an Executive Summary (none this month due to the CNO's leave) rather than a detailed report given that the timing of the indicators being received in relation to the papers being published. • Mixed sex accommodation breaches are reducing but are still high and we are still an outlier for this. What will enable these to reduce further is our operational scrutiny of potential breaches. We do authorise breaches if this prevents a delay to an ambulance handover. Prior to Covid when mixed sex breaches were very rare, we only saw between about 8 and 14 a month. The Policy (being discussed later on the agenda) will help staff to understand what they need to count and when they need to count it. We believe that there was an element of over counting during Covid due to the complexities involved. • There has been a significant rise of Serious Incidents this month. This has been driven largely by the increase in the number of pressure ulcers that are acquired or deteriorate in our care and the backlog of Covid deaths. Nationally we are required to record any hospital acquired likely or definite hospital acquired Covid where Covid features on the death certificate as an individual Serious Incident regardless of whether there were any omissions in our care or not. This process takes quite some time due to the complexity of this. • There was a possible further Never Event earlier this week regarding the incorrect placement of a nasogastric tube and feed. On further review, this is very complex and therefore may not meet the criteria for a Never Event. Detailed discussion will be held at the Serious Incident Panel tomorrow. Also in the last 24 hours we have had another near miss nasogastric feeding incident that again will be discussed at the Serious Incident Panel. The CNO is concerned around this with a lot more work required around this issue. These incidents may need reviewing at the most appropriate forum with the ICB to discuss what further work is required to strengthen our processes. The Deputy CMO is facilitating discussions around the Policy position agreement made at the Clinical Audit and Effectiveness Committee around who could interpret the placement of the nasogastric tube post X-ray. The Deputy CMO advised that the suggestion was that, as in some other Trusts, Radiologists are the only staff to report these scans. There has been some debate with the Consultants whether this is warranted as a number of Consultants are competent to read these X-rays.	

	The main issue is around locums and new doctors reviewing them. ITU is another area that has nasogastric tubes and have never had a Never Event and are confident in their processes. Discussion was held about rewriting the Policy and we are close to finalising this. • Mr James (Chair and NED) noted regarding the Covid deaths being reported as Serious Incidents, it will be very difficult to understand the data and questioned whether there was some way of reporting these separately from other Serious Incidents. The CNO will review how this can be reported. • Mr James (Chair and NED) queried if the issue regarding the timing of receiving the KPIs to enable them to be included in the report has been resolved. The CNO advised that this issue has not yet been resolved resulting in the KPIs either being left out or the data not being validated and the information sent to the Board of Directors updated and therefore different to the information received by the Quality Committee. This also duplicates the amount of work for the Quality Team. The CNO is discussing with the Chief Finance Officer if there is a way to resolve this issue. Even if this can be resolved, this still requires a member of the Quality Team to present the report twice. The rest of the Foundation Group only review the data at the Board of Directors meeting. In the interim we are providing the KPIs in the report if they are available and ask the Non-Executive Directors if they have any questions at Quality Committee. Mr James (Chair and NED) summarised that the proposal is to receive the KPIs as early as possible, but they will be received at Quality Committee in whatever form they are and we can then raise any issues with a more formal presentation at Board. This proposal was agreed. The CNO will include in her Executive Summary any KPIs that are of concern to allow questions to be raised in the meeting.	**LF**
	<u>Resolved</u> – that: **(A) The Quality Indicators be received and noted.** **(B) The Chief Nursing Officer will review how Covid deaths being reported as Serious Incidents can be reported separately in future Quality Indicators Reports.**	**LF**
QC011/03.23	**<u>PROVISION OF SAME SEX ACCOMMODATION POLICY</u>**	
	The CNO presented the Provision of Same Sex Accommodation Policy and the following key points were noted: • The principles around mixed sex accommodation were presented to the Quality Committee last year and agreed. Unfortunately the Policy was not then updated. The Covid pathways and management of Covid have changed significantly since that agreement, which therefore meant some of the principles that we had signed up to at that previous Quality Committee are no longer appropriate.	

	• The report is an agreed position for the reporting of sleeping accommodation breaches which is an externally reportable measure. This policy does not cover best practice around single sex accommodation. This is about sleeping breeches, and what is a justified breach and unjustified breach. • The Policy has been simplified to enable frontline nurses to understand what does and does not need to be reported. • We should only be seeing breaches within ITU, Coronary Care, the stroke unit and the Respiratory Unit for patients who are requiring enhanced respiratory support. So while the person's clinically unwell and needs a high degree of care, that breach is justified. If the patient becomes medically fit to be stood down from the high care area, they then become an unjustified breach and need counting. The policy also includes a clock stop for overnight to prevent unnecessary patient moves. • We are technically supposed to count all mixed sex accommodation breaches even those that are justified breaches. In practice this would mean that every single day Coronary Care and ITU would have to count their breaches as this is basically an open spaced area. The CNO is worried that we will create an industry of reporting for frontline clinical teams, give this she has had a conversation with the Integrated Care Boards Representative around this issue. As this is a national requirement, it was agreed with the Integrated Care Boards Representative to discuss this at the Quality Committee. • Mrs Frances (NED) noted the difficulties of trying to comply with the complexities of the national requirement around reporting breaches and agreed that we need to find a solution to this perhaps with a spot audit. Secondary to this is the need to understand the process for the adhoc unjustifiable breaches and who has the authority to make those decisions and what the consequences are so that we can make, if necessary, adjustments to our estate or the way that things are configured in order to reduce them. We are trying to make people's experience feel as comfortable as possible within the more legitimate claims about having access to the right clinical care at all times. We need to find a solution that helps all of us to be assured that we're doing the right thing. • The Integrated Care Boards Representative agreed that we need to have confidence that people are doing the right thing for the right reason with the Trust wanting to keep an eye on those breaches where this is not usual. At the meeting held with the CNO, she advised that these issues are discussed at the Capacity Bed meetings. Therefore the suggestion of a spot audit or a check on how we are capturing this data is the right thing to do.	

	• Mr James (Chair and NED) queried how we will know how well we are doing picking up on areas where there should not be any breaches and how they will be audited. The CNO advised that applying this Policy will enable us to count those breaches that should not have occurred, eg if a patient is medically fit to step down and breaches that occur in areas that they should not. In terms of daily operational management the Bed Management Board has been adapted to capture mixed accommodation breaches at every single bed meeting and that we could look back at that retrospectively and audit that information to pull off some more granular information around the length of time patients wait once they have been declared medically fit. • Mr James (Chair and NED) summarised that the Committee are being asked to approve the Same Sex Accommodation Policy and that we are supporting the view that we do not report internally on justified breaches due to the increased reporting burden for frontline teams once this has been confirmed by the CNO that this is in line with the rest of the Foundation Group.	
	<u>Resolved</u> – that the Provision of Same Sex Accommodation Policy be received and approved whilst supporting the view that we do not report internally on justified breaches, subject to checking position of other Foundation Group Trusts.	
QC012/03.23	**<u>NURSE STAFFING REPORT</u>**	
	The ACNO presented the Nurse Staffing Report and the following key points were noted: • We continue to see large numbers of patients coming through the Emergency Department (ED), often daily over two hundred. At extreme times this has been up to two hundred and forty. • To enable us to function in ED and to avoid the front door pressures, we are continuing with our Enabling Patient Flow Policy. This is our boarding process on our ward areas. This was often up to twenty five patients in February but we have seen a decrease in March. • We have been able to reduce night time boarding during this period which is a positive. • There have been a number of escalation areas open across the Trust to enable us to accommodate the volumes of patients coming in (that did close during February) along with our patients who are awaiting packages of care and Community Hospitals. Our Day Case Unit has also been utilised as an inpatient area as well as within our frailty block having additional bed base there to support additional patients.	

	• During this period our Intensive Care area has seen a very high level of activity. During the winter months we have been up to occupancy levels of around 118% at times which has meant that we have had to come out of our current eight bed base and go into Theatre Recovery. At times, we have also had an additional three patients in there as well. During the last week we have been able to move back to the Intensive Care areas with just the usual eight beds. • Fill rates throughout February are therefore high with a number of areas above 100% fill due to the need for additional nurses to cover wards or escalation areas. • The team have also been looking at our Establishment Reviews. A presentation was given to the Committee last year around how we collate acuity dependency data to ensure that our ward and clinical areas are staffed at the correct establishments. • We have just undertaken our biannual establishment review which was completed in February with the data being collated and an update will be presented to a future meeting. Areas covered included ED, Childrens and inpatient areas. In April we are undertaking full establishment reviews in areas such as outpatients, Theatre, ICU and MacMillan Renton Unit. • Vacancies throughout February have been fairly stable. We have seen a slight increase in trained nurse vacancies. There are 120 overseas nurses coming in the new financial year adding to the nurses that we are recruiting. There have also been some very positive recruitment events for maternity. • Band 2 recruitment is seeing an improving picture. We are currently using about 160 shifts per week for Band 2 agency which we are working hard on reducing. Work is also ongoing in retaining this staff group which has a high turnover rate by having Boot Camps to ensure people are aware of what is expected from them and what the job involves along with appropriate training. A number of Band 2 staff are going on to take their nurse training or nursing associate training. • There has been a slight reduction in agency spend this month which is positive but this is still higher than we would want it to be across the Divisions. We are working hard without our CPIP plans for the next financial year to reduce agency spend right down. • We have agreed a new rate card with ID Medical from April which should also see a reduction in costs. • We are also trying to recruit to all of our vacancies across Band 2 and Band 5 level along with over recruitment as well so that we are recruiting for our turnover and not just our vacancies.	

	• The CNO noted that there are two different vacancy positions for Healthcare Assistants (HCA) in the report. One is the Divisional Tracker that says that our HCA vacancy rate is 61 WTE across Integrated Care, Medical and Surgical Divisions. The other is the Vacancy Recruitment table which suggests that the position is much improved from this. The CNO confirmed that the first table comes from the Finance Ledger and that the second one from the Recruitment Team who count who is coming in month so provides a more agile reflection of where the vacancy position will get to. The table includes March's recruitment figures which is why we are seeing an improved picture. The table is showing our opening vacancy position, then our starters and leavers in month, which leaves us with our closing position. We then have those that are being offered positions which leaves us with a closing position of just under 40 WTE vacancies in March at the time of the report being written. We have then offered another 21.6 WTE which brings us down to the 16 WTE vacancies. • Ms Quantock (NED) queried where our international nurses are coming from and is it very varied. This was in relation to an item in the national press around international nurses being recruited but also needed in their own countries. The ACNO advised that we have three Recruitment Agencies which we work and the countries are very varied. We are not getting European nurses applying. In relation to our recruitment events, we are now attracting students who will be qualifying in September. Previously we did not have international nurses applying for the difficult to recruit areas such as ITU, ED and the Childrens Ward but this is now changing which is helping with our vacancies. • The CNO advised that there is now something called the Ethical Recruitment guide and there are red listed countries where we cannot recruit from, which we are complying with. The list was updated last week with further areas where they need their nurses to stay. The vast majority of WVT international nurses come from the Philippines and India.	
	<u>Resolved</u> – that the Nurse Staffing Report be received and noted.	
QC013/03.23	**<u>REVISED APPROACH TO QUALITY COMMITTEE</u>**	
	The Associate Director of Quality Governance (ADQG) presented the Revised Approach to Quality Committee with the following key points noted: • This report pulls together the discussions held discussed at the previous meeting, looking at our governance structure and how that can be effective in providing us with assurance. The pack also contains the Quality Committee subcommittee structure which has matured over the last few years.	

	• One of the slides provides a snapshot of what the Forward Planner looked like up until this year and the huge amount of information, reports and topic areas that the Quality Committee covers. Over the past few years CEAC and the Patient Safety Committee have picked up these and reporting is covered in the subcommittee summary reports. • Some of the issues that we talked about back in October was the lack of consistency in how our subcommittees report and there was some duplicate reporting for expert leads, reporting the same report into various Committees before coming to Quality Committee. Over the past few years, we have seen pausing and deferring of reporting due to our operational pressures and the unusual situations we have found ourselves in. This means that we have missed valuable information that comes from the Divisions and that quality reporting. • Our new core reporting proposal is that we have our Divisional Quarterly Reports, working with the Divisions to enable a more user-friendly template. We have standardised our subcommittee reporting, so some subcommittees report quarterly to follow their meeting dates, and some bimonthly. There will be a real focus on Quality Priorities and the deep dives being presented on key topics and any mandated reporting that is required to be discussed by the Quality Committee or to be discussed here prior to being presented to the Board of Directors. There are also a few other reports that sit outside of this remit, eg the Quarterly Safeguarding Reports, Quality Indicators, Staffing Report and the Serious Incident Report that still need to be presented to the Quality Committee. • There are a further few topics that do not fit into these categories that need discussion, eg external reviews and the associated action plans, implementation of new systems and Policies and processes, national surveys and any national reports that are not related to our Trust but we would like to undertake a gap analysis and some quality work to ensure that we are not having similar issues that have not been reported elsewhere. When looking at these topics, we need to consider the urgency for assurance and whether our subcommittee structure provide that assurance or does it need to come directly here to meet those Board oversight requirements. • Mr James (Chair and NED) felt that the discussions held previously were around what is the focus response we have in Quality Committee and how do we make best use of this meeting. Having strengthened our subcommittee structure we need to ensure that we are not duplicating by having reports being presented again to the Quality Committee. We need to ensure that presenters feel that they are adding value by presenting to this Committee. • The Integrated Care Boards Representative suggested that a number of national surveys and reports would come through the Divisional Governance structure anyway which would enable discussions on speciality specific areas.	

	• The Integrated Care Boards Representative felt that it would be useful for the Quality Committee to understand the progress resolution and mitigation around some of our quality specific risks and where they were considered and overseen. • The CNO fully supported the Quality Committee having more oversight of the Quality Priorities (we have signed up to the 2023/24 Quality Priorities) and was keen for this to be a major focus for this Committee. The CNO felt that there was more work to do around the subcommittee reporting. Patient Safety Committee and CEAC are excellent examples with a number of reports now being presented directly to them and covered in the summary reports to the Committee with any escalations highlighted. The Infection Prevention Committee is not yet at this stage and the CNO suggested in future a summary report being presented to the Quality Committee. More detailed reports would still be presented on Cleanliness and C-Diff which are two of our Quality Priorities. The Patient Experience Committee was another example that could mirror the other Committees providing summary reporting. The CNO also agreed with the comment around Divisional review, eg the Maternity Survey being presented in the Maternity Quarterly Report. • The ADQG will update the draft Forward Planner with comments made today and present the updated version to the next Quality Committee. • Mr James (Chair and NED) felt that the updates from the subcommittees should focus on the "need to know" escalation rather than a long narrative. We need to be assured that the Committees are doing what they need to do so that we can take our assurance from this on behalf of the Board of Directors. The ADQG agreed that summary reports are very useful and that presenters need to have the confidence that this is what the Quality Committee require rather than a long a narrative. There are also a number of reports that sit behind this report, so if there was ever any cause for concern, they could always be added as appendences for discussion.	**NO**
	<u>Resolved</u> – that: **(A) The Revised Approach to Quality Committee received and noted.** **(B) The draft Forward Planner with comments made from the March meeting will be presented to the April Quality Committee.**	**NO**

QC014/03.23	**CLINICAL AUDIT AND EFFECTIVENESS SUMMARY REPORT**	
	The Chair of the Clinical Audit and Effectiveness Committee/Associate Chief Medical Officer (ACMO), Clinical Support Division presented the Clinical Audit and Effectiveness Summary Report and the following key points were noted: • The last meeting was held in March and will then be held bimonthly. This meeting had a full agenda. • At the end of February, we had concluded around 270 audits on our Audit Programme. We are progressing well in around 265 of these audits. • Of the five not progressing, four are due to some limited delays and are national audits. These have been published nationally and we have sent our data but we are waiting for the leads in various specialties to look at the data to produce their executive summaries in addition with action plans. Only one audit is not progressing well which is due to capacity issues within the Department - this is the Inflammatory Bowel Disease audit. This triggered a debate at the meeting around how Clinicians deal with the difficulties of backlogs and post Covid clinical issues alongside completing a paper audit. The Surgical Team felt that admin support was required to help Clinicians to undertake these audits. This will be discussed with the CMO and CNO around support for either completing these with additional support or in some cases not completing if they have clinical priorities. • There have been very good results regarding our Community CQUINS. Only two CQUINS have not been achieved the target. However, we have had quality improvements each quarter although we have not reached the national target. The first is Community Acquired Pneumonia which is all completed bar not being able to document the severity scores. This has been resolved and we are hopeful that we will be able to achieve this in the fourth quarter. The second is Flu Vaccination as we have not achieved the target, which is a national issue. Many people are not as compliant post Covid as prior. • Our LocSSIPs CQUIN is progressing very well. Currently we have around 68 invasive procedures logged onto our LocSSIPs along with Standard Operating Procedures and checklists for the LocSSIPs. The ACMO, Clinical Support Division went on to explain the reason for LocSSIPs. There is now more focus on not just completing a checklist but focusing on the process of team work ensuring everyone participates.	

	• The Malignancy of an undefined original cancer of unknown primary Policy was presented and approved at the Committee. The ACMO, Clinical Support Division explained the process for referring patients with this type of cancer. This now includes Advanced Practitioners who have formed a Cancer of Unknown Origin Group who Clinicians are able to contact to undertake relevant investigations. There is also a Lead in Cheltenham to contact and an MDT of Unknown Origin. • Audits have always focussed on the process and not how we execute and ensure that Action Plans are met. The Committee are now looking at a template to ensure that the audit results are easy to report by Clinicians and trying to find a way of assessing the risks of the results, ie low, medium and high with the higher risks being added to the Risk Register and presented to the Committee to ensure Divisional ownership of these risks. • Mr James (Chair and NED) queried re our governance process overall, how the ACMO, Clinical Support Division felt that the Clinical Effectiveness and Audit Committee is operating fulfilling its brief. The ACMO, Clinical Support Division felt that the Committee was operating well and supports Clinicians in following the correct procedures. We can provide assurance to some of the newly developed Policies and procedures. The CNO agreed that the clinical engagement at both the Patient Safety Committee and Clinical Effectiveness and Audit Committee is very positive. We have a large number of interested Clinicians adding value to the discussions and ensuring that we focus on the right things. The CMO reiterated these comments and felt that the Committee is being recognised as a body where people have to engage with. • The Deputy CMO queried regarding the LocSSIPs, noting that that NatSSIPs are taking this in a slightly different direction, where on Maxims these can be recorded as staff are beginning to develop their own procedural templates within Maxims but they do not link in with the LocSSIPs. He queried whether a conversation is being held around this to ensure that everyone is following the same template and to ensure that these can be audited on Maxims. The ADQG will review this and what is being filled out by whom and how. • The ACMO, Clinical Support Division agreed that Maxims has made auditing easier to undertake but the initial stages have not made this easier. Previously when this was paper based, the whole team would complete it. We need to ensure that there is a multidisciplinary team approach to completing this.	**NO**
	<u>Resolved</u> – that: **(A) The Clinical Audit and Effectiveness Summary Report be received and noted.**	

	(B) The Associate Director of Quality Governance will review the background how who is filling out the LocSSIPs and how on Maxims.	**NO**
	CONFIDENTIAL SECTION	
QC015/03.23	**HTA VISIT – MORTUARY REPORT AND ACTIONS FOLLOW UP**	
QC016/03.23	**CLEANLINESS ROLES AND RESPONSIBILITIES**	
QC017/03.23	**ANY OTHER BUSINESS**	
	• The CNO advised that the Neonatal Network introduced a proposal about cot reconfiguration across the Region and there was due to be a meeting last month. The proposal is around a reduction of cot capacity, particularly for Wye Valley Trust, that would have a significant impact on mums and babies. The meeting was cancelled at the last minute and has been rebooked for 31 March. This delay has enabled us to do some more data analysis. We are not in a position to support the reduction of neonatal cots that they are recommending due to the significant impact for mums and babies that would have to be subject to a wider Quality Impact Assessment. • The Managing Director queried whether we have undertaken the stranded cost analysis as part of this. The Managing Director felt that this would be helpful as we would not reduce the cost by very much if we reduce the number of cots which would be a strong argument. The CNO agreed noting that this is our concern. We have undertaken a high level analysis that shows that we could not reduce the Consultant or the nurse workforce as we are already on the minimum that we could have. Therefore we would still be left with the all of the costs that we have currently.	
	Resolved – that the Any Other Business be received and noted.	
QC018/03.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 27 April 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
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
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
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