Public Meeting

Thu 07 September 2023, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Russell Hardy

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 6 July 2023

Decision *Russell Hardy*

3. PUBLIC BOARD MINS JULY FM, LF, KO.pdf (16 pages)

13:00 - 13:00
0 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

4. PUBLIC BOARD ACTION LOG -SEPTEMBER.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 7th September 2023 - WVT CEO Report - BOD - FINAL v1a.pdf (6 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 04 July 23.pdf (32 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/David Mowbray*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:00 - 13:00
0 min

6. Items for Approval

6.1. Nursing Workforce Skill Mix Business Case

Decision *Lucy Flanagan*

- 6.1 August 2023 Front Sheet Full Business Case.pdf (1 pages)
- 6.1a August 2023 Full Business Case TNA 5-6 Final Board.pdf (17 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 - Board Update 07.09.23-final.pdf (8 pages)

7.2. Board Assurance Framework and Divisional Operational Risk Register

Discussion *Erica Hermon*

- 7.2 Covering BAF and Risk Report for Board.pdf (2 pages)
- 7.2 BAF for Board.pdf (2 pages)
- 7.2a High Risks for Board.pdf (3 pages)

7.3. Armed Forces Covenant/Veterans Hospital Update

Discussion *Erica Hermon*

- 7.4 Armed Forces Covenant covering report for Board.pdf (2 pages)
- 7.4a 20230830 Armed Forces Presentation.pdf (18 pages)

7.4. Committee Summary Reports:

7.4.1. Integrated Care Executive 10 July 2023 and 14 August 2023

Discussion *Frances Martin*

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

7.4.2. Quality Committee 29 June 2023 and 27 July 2023

Discussion *Ian James*

- 7.5.2.1 QC Summary Report June 23 Public.pdf (3 pages)
- 7.5.2.2 QC Board Summary Report - July 23 Public.pdf (3 pages)

7.5. Committee Minutes:

7.5.1. Audit Committee Internal Audit Report Review 26 May 2023

Information *NICOLA TWIGG*

- 7.5.1 AC - INTERNAL AUDIT REPORTS REVIEW MINUTES.pdf (7 pages)

7.5.2. Foundation Group Board and Action Log 2 August 2023

Information *Russell Hardy*

- 7.6.1 Draft Public FGB Minutes (WVT) - 2 August 2023.pdf (14 pages)

7.6.1a FGB Public Actions Update Report - 2 August 2023.pdf (1 pages)

7.5.3. Quality Committee 25 May 2023 and 29 June 2023

Information *Ian James*

7.5.3a QC minutes - MAY 2023.pdf (17 pages)
7.5.3b. QC minutes - JUNE 2023.pdf (15 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 26.06.23.pdf (3 pages)

13:00 - 13:00
0 min

11. Date of Next Meeting

The next meeting will be held on 5 October at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 6 July 2023 at 1.00 pm
Via MS Teams

Present:

Russell Hardy	RH	Chairman
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)
Katie Osmond	KO	Chief Finance Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Ellie Bulmer	EB	Associate Non-Executive Director (ANED)
Alan Dawson	AD	Chief Strategy and Planning Officer
Robbie Dedi	RD	Deputy Chief Medical Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Salma Ibrahim	SI	Clinical Director for Maternity Services – For Item 7.3
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Den McPherson	DMc	Freedom To Speak Up Guardian – For Item 7.1
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)
Sarah Parry	SP	Associate Chief Operating Officer, Integrated Care Division
Amie Symes	AS	Associate Director of Midwifery – For Item 7.3

	The Employee of the Month award for February was presented to Natalie Jenkinson, Consultant Geriatrics and the Employee of the Month award for March was presented to Lucy Sweeting, Speech and Language Therapist. The Chair read out the reasons why Natalie and Lucy had been nominated for this award. The Team of the Month award for February was presented to Sharon Davies and Clare Honeyborne, Housekeepers, Medical Division and the Team of the Month award for March was presented to the Patient And Liaison Advice Service Team. The Chair read out the reasons why the teams had been nominated for this award. The Chairman welcomed the new Associate Non-Executive Directors to the Board meeting.	
Minute		**Action**
BOD01/07.23	**<u>Apologies for Absence</u>** Apologies were received from Jon Barnes, Chief Transformation and Delivery Officer, Glen Burley, Chief Executive, David Mowbray, Chief Medical Officer, Andy Parker, Chief Operating Officer and Jo Rouse, Associate Non-Executive Director.	

BOD02/07.23	**Quorum** The meeting was quorate.
BOD03/07.23	**Declarations of Interest** There were no new declarations received.
BOD04/07.23	**Minutes of the meeting held 1 June 2023** **Resolved – that the minutes of the meeting held on 1 June 2023 be confirmed as an accurate record and signed by the Chairman.**
BOD05/07.23	**Matters Arising and Action Log** **Resolved – that the Action Log be received and noted.**
BOD06/07.23	**Chief Executive's Report** The Managing Director presented the Chief Executive's Report and the following key points were noted: (a) NHS@75 – The Executive Team visited areas across the organisation yesterday to talk to staff and give out birthday cards to celebrate the 75th birthday of the NHS, and to thank staff for all their hard work. Staff are in good spirits despite the pressures that they are under. (b) The National Workforce Strategy has now been published. This contains a lot of information and a lot of positives. There are a few things missing – it does not deal with issues around the ongoing industrial action or mention capital, but overall this aligns very much with our Strategy and our "grow your own" regarding staffing and the use of apprentices. This was discussed in detail at our Board Workshop held this morning. (c) Further, Faster – We are part of this national programme to reduce waiting times, in particular in Outpatients. There is good engagement with this and aligns to a lot of work that is being carried out in the Foundation Group around sharing good practice between specialists. We are also looking at tackling Theatre productivity. This week we started a new approach to this. A number of Executives and NEDs spent time in Theatres observing processes and looking for ways to improve. This is a real opportunity for lots of small marginal gains for productivity. (d) National Urgent Emergency Care Recovery Plan – This is on the agenda. Our preparations for winter are part of this plan. This includes all the elements that are in the National Plan. (e) Care Quality commission Inspection of Maternity Services – The formal feedback will be presented to the Board meeting once received. Feedback on the day was positive around the strengthening of our leadership in Maternity. We are slightly misaligned with best practice, but some of our policies are slightly out of date.

(f) National Volunteering Taskforce - The Managing Director thanked our volunteers for all their hard work and in particular our younger volunteers, many of whom go onto start their careers in the NHS.

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

BOD07/07.23 **Integrated Performance Report**

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

a) At the recent Monthly Leaders' Briefing, the Managing Director focussed on the need to make improvements over the next few months in elective and emergency pathways prior to winter. We need to do all that we can to prepare and improve our productivity. There is a lot of focus on these areas.

b) Looking back at last winter and the pressures that we were under, at the very peak we had an additional 100 beds to our normal 300 Acute beds on site. There was also an associated increase in pressure ulcer damage that went alongside this. We are doing all we can in the hospital and with our Community teams to get our pathways as effective as we can.

c) There is an opportunity for the delegation of the Better Care Fund to One Herefordshire to be able to manage these resources within that fund. This is not yet finalised, but the Managing Director was confident that it will be agreed in the next few weeks. There is an opportunity through this integrated assurance, particularly through the Integrated Care Executive, to drive this joint funding to create better and slicker pathways.

d) The Managing Director's main concern is around our general cancer performance. The Trust has been in the top third for our 62 day standards but this has dropped over the last few months. A lot of work is going into improving this, but this will take time. Some of this is related to demand and some to diagnostic capacity.

e) Positively, last month we started to see an improvement on our HR metrics, and again this month. We are on course to be under 4% for sickness in June, which is a target we have not achieved previously. A lot of work is being carried out with our management team and health and wellbeing support in place to enable this improvement.

f) Stroke mortality is one of our fragile services with a briefing in the Private Board. We are the top 1 or 2 Trusts in our Region for our SNAPP Stroke Audit for many months. This is reflected in our mortality rates – we are in the top 10 Trusts for patients who have suffered a stroke in the country.

g) The Chairman noted the importance of continuing to be self-critical of ourselves. Harm occurs due to us working at such a level of pace with the associated challenges we have due to demand, and it is important that we are open about this. It is encouraging that colleagues speak up about concerns, which we have a good history of.

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

BOD08/07.23 **Quality (including Mortality)**

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

(a) Our year end position for the CQUIN Programme was a strong performance with 4 out of the 6 achieved. For the 2 not achieved the first was not achieving NHS Frontline worker compliance with flu vaccination (we ended up being in the middle of the pack for this when we compared our performance against the rest of the NHS). We narrowly missed achievement of the Pneumonia CQUIN. This was due to one minor element relating to documentation of the severity score for patients which we have since changed through our electronic reporting system in the Emergency Department (ED). Importantly, we achieve the timeliness of X-Ray and the prescribing and administration of antibiotics.

(b) The CNO is concerned around avoidable pressure damage to our patients. The number is low, but higher than we would want. This has increased nationally but we need to aspire to prevent any cases occurring. The Quality Improvement Plan was presented to the Quality Committee a few months ago. A Working Group has also been set up, which is led by the Associate Director of Quality Governance, whose job it is to ensure oversight of this plan. The focus is on education, training and clinical practice of frontline workers.

(c) The Quality Priority for critical medications is included in the report. This is around ensuring patients receive timely critical medications. All medications are important, but nationally a number have been deemed as time critical. We have selected those medications we need to focus on from using local intelligence and are including Parkinson's medications, insulin, antibiotics and opiates. We have also signed up to the national Parkinson's medication "Get it on Time" campaign with our Foundation Colleagues. A baseline audit in May of our performance around Parkinson's medication showed good compliance, but there is always room for improvement. This will be reported quarterly to the Quality Committee.

(d) The DCMO advised that our standardised mortality rate is dropping. We expect this to reduce further as the previous spikes in the graphs fall away.

(e) There has been particular improvement in our fractured neck of femur and stroke rates (we are now in the top 10 in the country).

(f) We continue to have issues around our palliative care coding with ongoing work around this. This impacts on our overall mortality rates and how this is calculated.

(g) Heart Failure – There have been several reported rises in mortality rates. The Cardiology Team have been reviewing relevant sets of patient's notes for any learning identified.

(h) Work is being undertaken looking at learning from deaths in ED and concerns raised to help us identify any issues we may face in the Department.

(i) VTE – This is now business as usual, but has taken sometime to achieve. We undertook a look back exercise looking at Hospital Acquired Thrombosis (HAT). We had put a lot of new processes in place to achieve this including working with the Quality and Safety Team. There have been no recorded HAT since the beginning of last year. We have developed a backlog for the second review for HAT due to the implementation of InPhase, but this will be resolved in the near future.

(j) VTE Assessment – We are still running below the 95% national target. It is encouraging to see that even if patients are not receiving this assessment, almost all patient are prescribed the appropriate prophylaxis. Maxims will be set up so that the prescriber is only able to prescribe the prophylaxis if the process for the VTE assessment has been completed (this upgrade to the system is due in September).

(k) VTE Exemplar Status – We have almost achieved all the criteria for this. We just need to achieve the 95% standard before we can apply to join.

(l) Mrs Martin (NED) queried what was being done this year to prevent vaccination fatigue again. What approach is being taken to encourage staff to protect, themselves, families and patients. The CNO advised that we have been notified of the Flu Campaign but not for the Covid vaccination yet. We have learnt lessons from last year regarding the timing of receipt of the flu and the Covid vaccinations and not giving them together.

(m) Ms Quantock (NED) questioned regarding the timely critical medications, are there any plans to expand this to Addison's and adrenal insufficiency. The CNO advised that currently we are focusing on just those medications that our local intelligence highlights that we have room for improvement. There would be no reason to not expand the included medications once we get to grips with these.

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

BOD09/07.23 **Activity Performance**

The Associate Chief Operating Officer, Integrated Care Division (ACOO) presented the Activity Performance Report and the following key points were noted:

(a) This has been another busy month with 257 our highest Accident & Emergency daily attendances. This is about 20% higher than we normally see.

(b) We have been working hard with regards the industrial action and future planned dates. We are also working hard to mitigate risks and minimise the amount of elective activity that we have to cancel.

(c) Urgent and Emergency activity is at 76% of plan. We are reviewing how to improve on this. There is work around the Front Door that we could do differently to improve our performance.

(d) Discharge To Assess – This service was pulled together for Covid to ensure that acute beds were available for anyone needing admission. We have reviewed this process as a System to see what worked and what did not work quite so well. We reviewed whether we are providing value for money and whether this process is working well for our patients. A Workshop was held a few weeks ago with the Local Authority and some of our Providers to see what we can do to improve the patient experience and ensure that we are spending the money wisely. A report will be presented through the Discharge To Assess System Board and through the Integrated Care Executive.

(e) We are ahead of plan for the majority of our pathways. We are struggling with cancer pathways with a lot of actions to try to recover this.

(f) 28 day diagnosed cancer pathway is slightly behind plan. This is mainly around Radiology and Histopathology. Deep dives are being undertaken to understand the issues.

(g) 62 day standard is behind plan. The main risk is around vacancies.

(h) We are above plan for new Outpatients and Inpatients (excluding Endoscopy) for May. Getting It Right First Time are working with Outpatients to enable improvements.

(i) Diagnostics – Cardiac patients are waiting for echocardiograms mainly due to staffing issues. Additional staffing is being sought to reduce waits Temporary staff are commencing in post later this month. We are also recruiting to General Surgeon vacancies, who will also support with this backlog.

(j) Mr James (NED) noted that a lot of work has taken place to reduce and clear our 78WW elective activity but numbers appear to be increasing. Is this due to patients being cancelled due to the industrial action? The ACOO advised we have 14 complex patients in Orthodontics and Max Fax to date. We are working with Worcester to try to resolve this. **SP**

(k) The Chairman noted that looking at the amount of elective work we are doing year to date, we are still running at below activity compared to 2019/20 and questioned what the key reasons for this were. The Managing Director advised that this is primarily around Endoscopy as we are behind plan. Staffing issues are the main reason with staff being sourced to resolve this. The ACOO will add more granular detail to this response.

<u>Resolved</u> – that:

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

(B) The Associate Chief Operating Officer, Integrated Care Division will provide more granular detail to the reasons why we are running behind for our elective work compared to 2019/20. **SP**

BOD10/07.23 **Workforce**

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

(a) HR Performance Indicators – We are still seeing a significant reduction in figures. Staff turnover and vacancies continue to reduce. Sickness absence is down to below 4%, it was over 8%.

(b) Our Staff Engagement – The InTouch Campaign is going very well. A report will be presented to the September Board. **GE**

(c) We continue to actively work with the Department of Work and Pensions to try to promote job opportunities and careers in the Trust for local people.

(d) Health and Wellbeing – We are piloting the 1m steps campaign run by Diabetes UK to get people healthier. We are supporting and encouraging staff to take part in the NHS Parkrun this Saturday.

(e) Equality, Diversity and Inclusion – We are supporting the South Asian Heritage month during July and August.

(f) We are working with senior managers and medical staff to ensure we have robust plans in place to support patients during the ongoing industrial action.

(g) Over the coming months, we will be working actively with the ICS and Foundation Group Colleagues to address the Workforce Plan. This was discussed in detail during the Board Workshop held this morning.

(h) Mr Cottom (NED) found the graph showing long and short term sickness helpful as short term sickness often shows how well staff are being supported. This is an indicator of a good improvement in this area.

Resolved – that:

(A) The Workforce Report be received and noted.

(B) The Chief People Officer will provide an update In Touch Campaign to the September Board meeting. **GE**

BOD11/07.23 **Finance Performance**

The Chief Finance Officer (CFO) presented the Finance Performance Report as at Month 2 and the following key points were noted:

(a) We are marginally ahead of plan. There is a degree of caution due to the level of risk in the plan and the level of improvement still to be delivered.

(b) The System, Regional and National positions are also seeing a level of financial risk.

(c) Spend has increased since April for agency but remains lower than last year due to targeted actions taken.

(d) CPIP – We under delivered in month. We are focussing on ensuring that the programme is fully identified as soon as possible.

(e) Activity volume against 2019/20 – We are not delivering fully to plan and this presents a degree of risk around the inclusion of elective recovery income. We are performing above levels in 2019/20 although the figures do not appear to show this due to case mix complexity.

(f) There are no exceptions to report regarding cash. We have asked for cash support during the second half of the year, linked to the planned deficit.

(g) Mr Cottom (NED) felt that there was more reasons to be concerned reading this report than last month's report.

(h) The Chairman asked as we are now in July, if the CFO was equally or more worried around agency spend. The CFO advised that she was equally worried. Agency actions taken are showing traction and we need to sustain them to ensure further step down of our agency usage. We are also seeing pressures in terms of non-pay spend and we need to deliver full efficiency within the CPIP plan. There is a lot to be achieved during this year.

(i) The Chairman noted for reassurance that comparing the Finance and Performance Committees' grip across the Foundation Group. Wye Valley Trust has the best functioning and most effective meetings.

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

ITEMS FOR APPROVAL

BOD12/07.23 **Foundation Group – Worcestershire Acute Hospitals NHS Trust**

The Managing Director presented the Foundation Group – Worcestershire Acute Hospitals NHS Trust Report and the following key points were noted:

(a) The Chairman noted that this has been previously discussed in detail in the Private Board.

(b) The Chairman provided background to this advising that the Foundation Group currently have 3 full members: Wye Valley NHS Trust, South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust which commonly share a Chief Executive and Chairman. Worcestershire Acute Hospitals NHS Trust Board have requested to become full members of the Foundation Group. Each Board needs to approve Worcestershire Acute to become a new full member. So far the other Foundation Group members have approved this.

(c) The Managing Director advised that the 3 existing Trusts in the Foundation Group have benefited from the Group membership with an improved journey which would not have been possible without this group.

(d) Leadership capacity and capability will be via the Chief Executive and Chairman. They will be directly supported by the Managing Directors of the Trusts and the Boards of Directors, but also from the regional and national profile they benefit from.

(e) Benchmarking and sharing best practice will only enhance with Worcestershire Acute joining the group.

(f) This proposed change will enable Wye Valley Trust to find more innovative solutions for our fragile services which would be difficult to negotiate. This will be of benefit for our population that we all serve.

(g) Mr Myers (ANED) queried the view of NHSE on this proposal. The Chairman advised that they are very supportive.

(h) The plan is for Worcestershire Acute to join the Foundation Group as full members on 1 August 2023.

Resolved – that the proposal for Worcestershire Acute Hospitals NHS Trust to join the Foundation Group as full members be received and approved.

BOD13/07.23 **NHS Joint Forward Plan**

The Chief Strategy and Planning Officer (CSPO) presented the NHS Joint Forward Plan and the following key points were noted:

(a) This paper has been developed over a long period of time at System Level and with support from the CSPO and colleagues.

(b) This is here for endorsement as approval is at ICS Level.

(c) This includes a joint local Health and Wellbeing Board Strategy which has been recently agreed.

(d) The main document outlines the shift to a more preventative approach across the System. This is about caring and looking after people in the right setting along with improved quality of care and at a reduced cost.

(e) Appendix 1 sets out the high level plans for services. There is a long set of priorities but there is a high level plan against each one.

(f) Appendix 2 identifies how key enabling strategies will be delivered to support the improved outcomes described in the core areas of focus.

(g) It is recognised that the role of the One Herefordshire Place based collaborative is one of the main delivery arms of this approach which is very important.

(h) The next step is to deliver a summary of this Plan for staff and members of the public. A medium term financial strategy underpins this.

(i) Mrs Twigg (NED) noted that the Health and Wellbeing Strategies are obviously different but working to the same goals and felt that it was a shame that we could not have produced one Strategy. The CSPO confirmed that they are similar but different as this just represents two different sets of thinking. The Health and Wellbeing Board is part of the Herefordshire Council and part of our ICB and we need to reflect what their members think.

(j) Mr James (NED) noted that the presentation referenced Herefordshire working but a “Herefordian” might struggle when reading the document to find that. He suggested that we start local and then go to the System to explain this clearly.

Resolved – that NHS Joint Forward Plan be received and the Herefordshire and Worcestershire Joint Forward Plan be formally endorsed.

ITEMS FOR NOTING AND INFORMATION

BOD14/07.23 **Freedom To Speak Up Annual Report**

The Freedom To Speak Up Guardian (FTSUG) presented the Freedom To Speak Up Annual Report and the following key points were noted:

(a) The Chairman thanked the FTSUG for all her hard work as she is leaving the Trust.

(b) The FTSUG advised that additional time has been invested for more ring-fenced time for the new FTSUG. This is now for 3 full days including the Civility Saves Lives work.

(c) Over 400 staff have attended Speaking Up Sessions regarding Freedom To Speak Up. More staff need to complete the Level 2 e-learning training (this is not mandatory).

(d) There has been a 25% increase in Freedom To Speak Up events.

(e) There has been an increase in inappropriate behaviours and staff safety and wellbeing.

(f) Lessons Learnt – We need to ask our staff to help. The aim is to assist staff to be aware of the many challenges regarding the use of language and help them be compassionate and inclusive, whatever their position is, by putting themselves in everyone's position

(g) Team Champions are a useful resource. The incoming FTSUG will continue to recruit to areas where there are gaps or staff leave.

(h) The National Guardian's Office expects Trusts to manage handovers of the FTSUG. What the Trust has put into place goes far beyond what is expected and the FTSUG thanked the Trust for all their support.

(i) The Managing Director thanked the FTSUG for developing this role within the Trust.

(j) Mr James (NED) also thanked the FTSUG for the way she is managing the handover to the new post holder and asked if there was anything that can help us to improve staff's ability to speak up. The FTSUG advised advocating peer messengers, try to manage issues immediately (especially behavioural issues) and having a second person viewing the facts with an unbiased view. Basic intervention often prevents further issues and reoffending.

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

BOD15/07.23 **Patient Experience Quarterly Report**

The CNO presented the Patient Experience Quarterly Report and the following key points were noted:

(a) Due to the transition from Datix to InPhase, the content of the report is reduced.

(b) The Friends and Family Test text service is working really well with a number of responses, the majority of which are positive. There are some attitude and communication elements that we need to work on. The detail is provided to the Divisions to enable them to review fully and improve on areas highlighted. This information is provided on a regular basis to the Patient Experience Committee.

(c) The link to our local survey via the Friends and Family Test text service has yielded few results and has not proven as successful as we had hoped. The volunteers have however been eliciting real time feedback from patients across the wards and this has proven a successful method, which will repeat throughout the year.

(d) It is pleasing that the Patient Experience Committee is back up and running with a real focus. Ideally we need medical input for this Committee, but the CNO was aware of the difficulties of staff having available time to attend.

Resolved – that the Patient Experience Quarterly Report be received and approved.

BOD16/07.23 **Maternity Services Quarterly Report**

The Associate Director of Midwifery (ADM) and the Clinical Director, Maternity Services (CD) presented the Maternity Services Quarterly Report, which was taken as read, and the following key points were noted:

(a) There were 3 Serious Incidents reported in Quarter 4. The cases are outlined in the report. We need to report this information regarding compliance for CNST.

(b) Two cases were reported to MBRRACE. The women and families involved are being supported by the Bereavement Midwife and offered referral to the new Petals Counselling Service.

(c) Complaints – Over the course of the year, we have seen a marked reduction in the number of complaints received. There were 10 received across the financial year. This is a reduction from 19 the previous year.

(d) Compliments – The data was not available for Quarter 4 due to the changeover of systems. There were 17 compliments received in April and 16 in May.

(e) There has been a change to training compliance which has dropped to below 90%. We need to obtain 90% for CNST. The definition of compliance from CNST is not clear and this has been raised as a query and we are awaiting confirmation.

(f) CNST has been launched for Year 5 for which we are undertaking a gap analysis. We achieved full compliance during Year 4.

(g) The LMNS undertook an Insights visit in April and the feedback was largely positive with a small number of focussed actions required. We were due to have a further visit and the service had asked the LMNS to support with the additional 15 Immediate and Essential Actions.

(h) The Maternity Voices Partnership has received further funding for the coming year which will be partly used to improve the groups represented at Maternity Voices Partnership.

(i) We have undertaken a Workforce Review to facilitate the first steps of service modelling. We are working towards a model that can transition to include Maternity Continuity of Carer.

(j) The ADM is very proud of the teamwork being seen, noting the marked improvement on the maternity rosters.

(k) Our current vacancy rate is 2.4WTE, which increases to 9 including maternity leave. We have recruited some midwifes during Quarter 4 but there have also been some resignations. The Trust's Open Recruitment Day was very positive with a number of new starters joining us in September.

(l) All 4 international recruits have passed their OSCE.

(m) Caring For You – We have signed up to the commitment of providing good working facilities and environment for our midwifery workforce.

(n) There have been a series of events over the months. The Maternity Facebook Group pages celebrated a different midwife each day.

(o) The ADM is concerned about the Diabetes Service. Work is being carried out around this already regarding how the service is being run. There is no significant risk around this and this is not on the Risk Register. The new element of the Saving Babies Lives Care Bundle was launched in May and this is being used as the basis for the improvements required.

(p) Final Ockenden Review – We received technical guidance in May showing compliance for the final plan.

(q) Maternity Triage is still on the Risk Register as a risk score of 20 regarding lack of space.

(r) The CD took over the role in November. This is a challenging role but the team are very supportive. There is also support from Consultant colleagues with an open door policy with staff. We are aware of our weaknesses and are improving the service we provide.

(s) The Chairman queried if there was any further support that the Board could offer. The ADM advised that having a stable Board was very helpful. She felt her voice was heard and valued, was supported and able to raise risks. The CD met regularly with the LMNS and felt very supported. She asked that we continue to promote training.

(t) Mr James (NED) noted the issue around Triage noted in the report and asked if there is a plan to resolve this. The CSPO advised that this is in the Capital Programme with Sodexo working up a Change Notice. We expect the work to be carried out in the current year.

Resolved – that the Maternity Services Quarterly Report be received and noted.

BOD17/07.23 **Security Update Report**

The CSPO presented the Security Update Report and the following key points were noted:

(a) This is being provided following a question raised by a member of the public. This is an opportunity to highlight the improvements that have been made.

(b) We have had a new security service in place for a few months. This is provided by Sodexo through our PFI contact. Staff are feeling safer on site having them around. Staff are also reporting more incidents which is encouraged through induction and training sessions.

(c) The Chairman noted regarding the increase in violence and aggression towards staff that it is totally unacceptable for our staff to be faced with either physical or verbal aggression by a patient or family member. All our staff are trying to do the best for our patients.

Resolved – that the Security Update Report be received and approved.

BOD18/07.23 **Divisional Operational Risk Register**

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

(a) There has been a lot of work going on with risk including moving to the new InPhase system. Training has been provided to ensure risk scores align with the risk appetite agreed by the Board of Directors. We need to be clear around how we score and evidence the register.

(b) This is a live document which is an ongoing piece of work.

(c) The Chairman was concerned that we are not emphasising the risk and consequences of the ongoing industrial action occurring and asked that the ADCG consider this. **EH**

Resolved – that:

(A) The Divisional Operational Risk Register be received and noted.

(B) The Associate Director of Corporate Governance will consider the risk and consequences of the ongoing industrial action. **EH**

BOD19/07.23 **Preparing for Winter**

The ACOO presented the Preparing for Winter Report, which was taken as read, and the following key points were noted:

(a) We need to find better ways to look after our patients than we did last year. Details of this are in the report.

(b) The schemes vary in risk with the details around the level of risk included. This includes the bed occupancy gap that we expect and the use of Gilwern Ward.

(c) The Managing Director felt that this was a good piece of work trying to detail what the improvements are and how many beds that relates to.

(d) The Managing Director highlighted the financial risk around the lack of funding for Gilwern Ward for the second half of the year. There is a lot more work required to mitigate this risk.

(e) The ACOO advised that she is meeting the other COOs across the Foundation Trust to share opportunities as well as learning.

Resolved – that the Preparing for Winter Report be received and noted.

COMMITTEE SUMMARY REPORTS

BOD20/07.23 **Foundation Group Strategy Committee 23 May 2023**

Resolved – that the Foundation Group Strategy Committee Summary Report 23 May 2023 be received and noted.

BOD21/07.23 **Integrated Care Executive 16 May 2023 and 12 June 2023**

Mrs Martin (Chair of the Integrated Care Executive and NED) presented the Integrated Care Executive 16 May 2023 and 12 June 2023, which were taken as read, noting that the Memorandum Of Understanding is expected to be presented to the next meeting to be signed off.

Resolved – that the Integrated Care Executive Summary Report 16 May 2023 and 12 June 2023 be received and noted.

BOD22/07.23 **Quality Committee Summary Report 25 May 2023**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report 25 May 2023 and the following key points were noted:

(a) Mr James (Chair of the Quality Committee and NED) noted the exciting development of receiving hospital care at home with the Virtual Wards. Questions were raised at the meeting to ensure that good quality care is provided and around safety concerns. A further report is coming back to the Quality Committee.

(b) The Chairman noted that it is better to have a Virtual Ward with one set of risks than having patients waiting in corridors with different risks. This is an issue over time that we need to review.

Resolved – that the Quality Committee Summary Report 25 May 2023 be received and noted.

COMMITTEE MINUTES

BOD23/07.23 **Audit Committee 16 March 2023**

Mrs Twigg (Audit Committee Chair and NED) presented the Audit Committee minutes 16 March 2023 noting that they were light on Internal Audit Repots as we are behind with some of these. An extra meeting is being held in May to cover these.

Resolved – that the Audit Committee minutes 16 March 2023 be received and noted.

BOD24/07.23 **Any Other Business**

Mr Cottom (NED) noted that he is a Director of Hoople. This is a Limited Company with Shareholders including the Local Authority and Wye Valley NHS Trust. Hoople also have unallocated shares. Their turnover is around £22m with 560 staff. They cover a range of services including IT, Payroll, building and some Social Care services. Our relationship with them is with IT for which we are required to provide a Director to be a Director of Hoople Limited. Mr Cottom (NED) has held this role for the past 8 years. Mrs Twigg (NED) will be taking over this role as Mr Cottom (NED) will be leaving the Trust. Mr Cottom (NED) will Chair the End of Year meeting in July and Mrs Twigg (NED) will take over from the August meeting.

Resolved – that the Any Other Business be received and noted.

BOD25/07.23 **Questions from Members of the Public**

Q1. Does the Wye Valley Trust Board intend to return to live, face to face Public Board meetings? If so, when?

A1. The Chairman advised that the meeting today is being live streamed on You Tube. Lockdown has enabled more productivity and the ecological benefit of digital meetings. Digital meetings allow more inclusion for those who are less mobile and geographically isolated.

Q2. It is unfortunate that there is a Server runtime error that prevents members of the pubic from accessing the Trust Board papers for today's meeting.

A2. The Chairman apologised for any inconvenience caused, noting that this issue has now been resolved.

Q3. Stroke Services – Does the appointment of a new Locum Consultant for Stroke Services mean that there is now 24/7 cover for stroke admissions, including weekends and nights?

Some Herefordshire (and Powys) stroke patients living in more rural areas have a much longer transfer time to reach hospital than is the case in more urban areas of the West Midlands. This is primarily a West Midlands Ambulance Service problem, but as such, travel time can be crucial to stroke patients. It is a concern. Do Wye Valley Trust staff attempt to monitor the detrimental effort of long transfer times for stroke patients?

Does Wye Valley Trust Board engage with the Ambulance Trust to try to improve these transfer times in and attempt to meet national guidance response times? Has there been any progress in this matter?

A3. The DCMO advised that we have always had 24/7 Stroke cover but not on site. We have an out of hours network. For new stroke patients, it is decided if they need thrombolysis through this network. During the day, this is a face to face review. Access to Stroke Consultants is very good, which is confirmed with our SNAPP score results. We are continuing to look at new models of care, particularly with Worcester.

The DCMO advised that ambulance response times are largely owned by the Ambulance Service themselves. We work closely with them to enable ambulances to leave the Trust quickly. The average waiting time for Category 2 Stroke falls into about 36 minutes – we have to achieve 90% in 40 minutes. For conveyance times, this is around 100 minutes. Clearly this may impact on some stroke outcomes and this time is likely to be longer in rural areas. Due to the nature of our rurality, this is always going to be an issue. There are also some delays in patients calling – we need more public health work around this Other models with ambulance conveyances are very complex and not a safe model we want to move forward with as the evidence is not robust.

The Chairman noted that if you live in a rural area a long way from facilities, it will always be more difficult to get an ambulance out in the timeframe required.

Q4. How well are the new Sodexo security arrangements working? Has there been an increase/decrease in verbal/physical assaults upon Wye Valley Trust staff?

A4. This was covered in the report on the agenda.

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

BOD26/07.23 **Date of next meeting**

The next meeting was due to be held on 7 September 2023 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, THURSDAY 7 SEPTEMBER 2023

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD09/07.23 Activity Performance 6 July 2023	(B) The Associate Chief Operating Officer, Integrated Care Division will provide more granular detail to the reasons why we are running behind for our elective work compared to 2019/20.	SP	Details of 2023/24 activity compared with activity 2019/20 is included in the Operational Performance – Referral to Treatment / Activity section of the Integrated Performance Report.
BOD18/07.23 Divisional Operational Risk Register 6 July 2023	(B) The Associate Director of Corporate Governance will consider the risk and consequences of the ongoing industrial action.	EH	The risk (#1682 described below) is on the register and has been reviewed at Executive Risk Management and the Internal Audit meetings: There is a risk that Wye Valley Trust (WVT) will not be able to provide safe and effective care to patients during periods of industrial action. There is also a risk to the health and well-being of staff who are not taking industrial action because of the increased likelihood of stress and moral injury from this incident and the pressure to provide safe services. The controls have led to the risk being scored as a consequence of 4 and a likelihood of 3. As a 'moderate' 12 risk, it does not come to Board.
ACTIONS IN PROGRESS			
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	A paper outlining the actions and cultural improvements being made following the Intouch staff engagement campaign will be presented to the Board in October.

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

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

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

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

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

1) Conviction of Neonatal Nurse – Lucy Letby

Following the outcome of the trial of Lucy Letby, the NHS has expressed profound apologies to all of the families. These unspeakable crimes have shocked and sickened staff across the NHS, just as they have the entire nation. These acts were a betrayal of patient trust, and we appreciate how distressed and concerned this can leave people feeling. The Department of Health and Social Care has announced that there will be an independent, non-statutory inquiry into the events at the Countess of Chester Hospital NHS Foundation Trust.

Although these appalling crimes were the actions of a single individual, this case is a stark reminder of how important it is that the NHS listens carefully to the concerns of patients, families and staff. We continue to monitor a wide range of quality and safety indicators and have well established policies which encourage and support staff to speak up. We also regularly welcome our Freedom to Speak up Guardian to talk to us at our public Board meetings. Our Chairman has written to the Non-Executive Chairs of our quality and safety committees across the Group asking them to discuss the report at their next meetings and to provide assurance back to each Board on our local arrangements. Our Group model will also facilitate sharing of best practice on related issues between the four Trusts.

2) Managing Urgent and Emergency Care alongside Elective Recovery

I was fortunate to be invited to attend the second NHS Recovery Summit which was held in July. As with the first event in January, a series of themed meetings took place over the course of a day. The main focus was the need to ensure that the NHS returns as quickly as possible to its pre-Covid levels of productivity with corresponding access times. The meeting took place in the context of the revisions already made to minimum performance expectations set out in this year's planning guidance. The true change in productivity in urgent and emergency care is really hard to assess as there have been many changes to patient pathways. With growth in same day emergency care, admission avoidance pathways and virtual wards, the patients who are admitted to hospital are generally of a higher acuity. Many of the alternative pathways require the oversight or virtual input of hospital based specialists, so this activity also needs to be measured and suitably weighted alongside the more traditional counts of admissions and attendances.

It should also be noted that Elective care recovery has been severely impacted by the ongoing industrial action. Despite this, the overall Regional position has moved from worst performing to second best performing. Generally from a Group perspective, elective recovery has been good although it is recognised that the Herefordshire and Worcestershire system went into Covid with longer waiting times and hence face a tougher battle to achieve the national milestones. There is of course a direct relationship between managing UEC pressures and delivery of elective recovery. This has been historically well recognised across the Group. Our 'Operation Ringfence' initiative has helped to demonstrate this and has further reinforced the mindset of cancellation avoidance.

As part of the Urgent and Emergency Care recovery plan for some months now Tier 1 and Tier 2 Trusts and systems have been receiving targeted support from the national and regional teams. The material used for this has now been issued as a 'universal offer' to all. For the part of the NHS not identified for targeted support, this 'offer' represents a range of solutions which can be put in place to improve flow i.e. not mandated but advisable.

3) Winter Planning Letter

This year's Winter Planning letter was refreshingly published at the end of July. This allows sufficient time for systems to finalise plans and to submit their winter updates in early September. This has been structured to provide additional guidance on top of the system plans submitted at the start of the year. These plans also set out how the additional funding for discharge, bed occupancy reduction, virtual wards etc. was committed and profiled over the year. Colleagues in social care were particularly pleased to see that continuation of last year's funding was clarified at an early stage and that it continues into 2024/25.

Whilst the creation of a joined up overall winter plan is a responsibility of each ICS, it was useful to see 'Job Cards' for all parts of the system. These set out the respective roles of Ambulance Trusts, Primary Care, Acute Providers etc. These all relate to the 10 High Impact Interventions set out in the UEC Recovery Plan in January. Trust like ours (Acute and specialist NHS trusts) are expected lead the delivery of high-impact interventions 1-4 as set out below:

1. **Same day emergency care (SDEC)**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty:** Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay:** Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care (iUEC) pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. This includes through:
a. Delivering improvements in ambulance handover times b. Ensure documented internal professional standards are in place for rapid specialty in-reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the emergency department in line with these standards. Put in place mechanisms to monitor performance against these standards and take action to course correct delivery where required.
4. **Community bed productivity and flow:** Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.

- Ensure that general and acute beds are available and open in line with the agreed 2023/24 ICB Operating Plan – including escalating the number of beds as needed in line with the winter addendum to this plan. This includes monitoring and reducing occupancy in the run up to Christmas.
- Focus on improving performance against the four-hour standard for type one attendances, to contribute to the overall A&E performance target of 76%.
- Continue focused efforts on patients attending A&E who spend more than 12 hours in department from arrival to discharge, admission or transfer.
- Ensure clear arrangements for early referral to care transfer hubs where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance, operational grip and decision-making and to support intermediate care capacity and demand planning.
- Ensure that sufficient capacity is in place to protect the elective pathway for both adults and children and young people – with clear triggers in place to open additional non-elective capacity in line with the winter addendum to the 2023/24 Operating Plan.
- Ensure actions to improve the primary and secondary care interface set out in the Primary Care Access Recovery Plan are implemented with system wide understanding of pressures across the totality of the UEC pathway including primary care.
    - Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period, including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza.
    - Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to on-board both health and care workers to the right part of the pathway utilising 'mutual aid' arrangements where needed and supplemented by digital solutions.
    - Ensure that a robust plan is in place for the vaccination of staff, volunteers and patients against influenza and that plans are in place to rapidly respond to any other vaccination programme recommended by the Joint Committee on Vaccination and Immunisation (JCVI)

4) UEC Performance - Capital incentive

For the first time a capital incentive has been offered to those Trusts which exceed the national performance objective. This is based on achieving at least 90% on the Category 2 ambulance handover 30 mins standard on average over Q3 and Q4 and delivering at least 80% on the A&E performance standard in Q4.

5) NHS Workforce Plan

As reported verbally at our July meeting the first long term (15 year) NHS Workforce plan was published around the time of the 75th Birthday. This was linked to a £2.4bn funding pledge although there is still a lack of clarity on how much of the funding pledge is additional money as opposed to assumed productivity improvements. There is also as yet no mention any supporting capital, although such matters would traditionally be covered in the Government's Autumn Spending Statement.

The plan has three main themes:

- *Train* - Substantially growing the number of doctors, nurses, allied health professionals and support staff.
- *Retain* - A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options including pensions.
- *Reform* - Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements

The report includes a number of pledges which are aimed at reducing vacancies. This includes:

- Doubling medical school training places to 15,000 by 2031/32, with more places in areas with the greatest shortages.
- Increasing the number of GP training places by 50% to 6,000 by 2031
- Nearly doubling the number of adult nurse training places by 2031, with 24,000 more nurse and midwife training places a year by 2031
- Providing 22% of training for clinical staff through apprenticeship routes by 2031/32
- Introducing medical degree apprenticeships with pilots running in 2024/25 so that by 2031/32 around 2,000 medical students will train by this route
- Training more NHS staff domestically – the plan anticipates that in 15 years' time, we would expect around 9-10.5 % of the workforce to be recruited from overseas compared to nearly a quarter now
- Ensuring that more than 6,300 clinicians start advanced practice pathways each year by 2031/32
- Increasing training places for nursing associates (NAs) to 10,500 by 2031/32 – by 2036/37, there will be over 64,000 nursing associates working in the NHS, compared to 4,600 today.
- Further pension scheme reform, with an aim to retain 130,000 staff working in the NHS for longer.

6) Fit and Proper Person Test (FPPT) Framework

NHS England published a new Fit and Proper Person Test (FPPT) Framework for board members in August 2023. Further information, together with the Framework and accompanying documents, can be found on NHS England's website by clicking on the following link: NHS England » NHS managers and leaders

The FPPT Framework is in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member. It has been designed to be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations. However, ensuring high standards of leadership in the NHS is crucial and the Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations. The FPPT applies to Executive and Non-Executive Directors of Integrated Care Boards, NHS Trusts and Foundation Trusts, NHS England and Care Quality Commission, for interim as well as permanent appointments.

Personal data relating to FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). We have therefore communicated to all Board members (voting and non-voting) in the Trust whose details will be included in ESR. By doing so directors have been afforded the opportunity to object if they have concerns regarding the proposed use of their data.

The Chief People Officer and Trust Secretary are working through the implications and ensuring processes are in place to comply with the new Framework.

7) MORE FROM OUT GREAT TEAMS – Update from the Integrated Care Division – September 2023

The Integrated Care Division have been providing increased focus, during the last quarter, on increasing our capacity and improving productivity. This includes improving District Nursing productivity by clarifying criteria for housebound patients, reducing missed visits, increasing clinic activity where possible and working closely with primary care teams to reduce duplication of work.

Within our urgent response teams we have been able to support the rollout of the Acute Medicine and Frailty Virtual Ward, providing support in the community to patients on the ward. During the first phase we have been providing an ACP to attend the daily MDT, whilst also supporting the care required in a person's home. We are currently reviewing the activity to ensure we are maximising every opportunity, whilst also ensuring that we are still able to provide the 2 hr Urgent Community Response function to existing referrers within our community.

We have also been able to increase capacity within our new Hospital @ Home Bridging service. This service provides a "holding" function for those patients waiting discharge via Pathway 1, where Home First (a service ran by Hoople on behalf of Herefordshire Council) do not have the capacity to discharge once a patient does not meet the Criteria to Discharge. We are clear that this function may only need to be temporary, whilst we support the Discharge to Assess review mentioned below.

The bridging team have supported a higher number of discharges than expected based on the staffing numbers, and a process is in place to ensure that the patient receives a seamless transfer to Reablement services once capacity becomes available. More importantly we have agreed a process with our Council colleagues that sees the Reablement of patients commence as soon as they are discharged rather than waiting for the Reablement service to take over the patient. We see this as critical in supporting the patient to maximise opportunity for regaining independence.

The Division are leading on a review of our Discharge to Assess service, working in collaboration with system colleagues. This involves a complete review of current process, demand and capacity to ensure that we are utilising funding appropriately and maximising resource, whilst also ensuring we provide the best outcomes for patients on exiting the pathway.

The division is leading on a project to review and map out all the Children's health services provided by the trust, across all 4 divisions. This will start in September and help the trust create an improvement plan to reduce the long waits currently seen in some of our services.

8) Going the Extra Mile Awards – April and May 2023

Team of the Month April 2023 - Cellular Pathology

The Cellular Pathology Team are the first in the West Midlands to go both technically and clinically live with digital pathology.
Key individuals who have gone the Extra Mile this month are, Andrea Johnson (manager), Rashmi Rao (Digital Clinical Lead), Dan Nation (IT Lead), as well as the Admin and Lab Team for their support.

Employee of the Month April 2023 – Jemma Davis

Jemma has started and maintained quarterly meetings with all of her CNN colleagues to discuss current topics, share learning, articles and expertise in order to increase the knowledge and skills for the whole community nursery nurse team. She has helped increase the quality of the contact that staff have with families. Jemma is a great asset to the team and this innovative idea has been great for the learning and confidence for the whole team as well as providing a space for peer supervision.

Employee of the Month May 2023 – Nichola Ashforth

Nichola went above and beyond yesterday by supporting a challenging patient who was refusing to be discharged. The patient was very anxious about their symptoms and how they would manage at home. Nichola sat with the patient and provided sound clinical reassurance and provided ways in which they could be also be supported by the Early Supportive Discharge Team. This resulted in the patient gaining enough confidence to be discharged with virtual support. Nichola demonstrated immense compassion and patience to turn this situation around, I am very proud that she is a member of the respiratory team.

Team of the Month May 2023 – Lynne Stamp & Team

During our consultants job plan changes, Lynne and her team have cancelled and rebooked several clinics, several times, which was then followed by further cancellations due to the Junior Doctor Strikes. They have been up against it, but worked hard to support us the best they can, which takes so much pressure away from the Orthopaedic Team, which we are so grateful for. Thank you Lynne and all your team!

Glen Burley
Chief Executive Officer

Integrated Performance Report

July 2023

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

The summer of discontent for medical staff in the NHS has continued during the summer months. This has been well managed by managerial staff and senior clinicians to reduce the impact on patients. The latest ballot results where 98.4% of junior doctors voted to continue strike action and the coordination for the first time of consultant and junior doctors taking industrial action at the same time is a further escalation that will absorb even more time to manage rotas, rearrange patient care and provide on-site coordination.

I would like to pay tribute particularly to our divisional and corporate management teams who alongside the disruption of the ongoing industrial action have made considerable strides in implementing our operational and productivity improvement plans. This includes redesign of the acute floor, getting it right first time, going further faster, theatre improvement and cancer week initiatives. We still have a long way to go to deliver on the ambitions we have set out to improve urgent care performance and meet waiting time targets but are on track.

Urgent care has remained very challenging over the summer with high levels of demand compounded by bed closures to accommodate the decant of ITU whilst planned preventative maintenance and improvements were completed. This meant that overnight boarding remained a feature of managing ambulance off loads and our community hospitals needed to open additional beds. The changes to triple the size of the SDEC area incorporating a 24/7 frailty assessment and SDEC facility are well advanced and should be in place by the end of the month. In the meantime the virtual ward is increasing its capacity but has not yet achieved the numbers of patients that we need to decongest the acute hospital site as much as possible. The continued delay to agreeing the Better Care Fund (BCF) between the ICB and Herefordshire County Council is not helping us to improve discharge pathways at the pace we would wish.

By the end of September all patients waiting over 78 weeks will have been treated with the exception of those waiting for orthodontic treatment. This is being managed on an ICS wide basis. The last 6 weeks of benchmarked activity delivery across the region (up until mid-July) show WVT has delivered the highest level of value weighted activity as a proportion of 2019/20 of all providers— at well over 100%. A significant achievement.

There are financial consequences to delivering the elective activity and the additional bed capacity as temporary staffing has risen. We are still within our financial plan with a £10.1m deficit at the end of month 4 although the risks of CPIP under delivery become more acute over the coming months.

The improvement in our HR metrics are in part how the financial plan is still on course with vacancies, turnover and sickness all improving or maintaining a good position. The business case presented to the board today sets out our strategic approach to developing our local workforce and creating a sustainable and high quality nursing workforce for the future.

Patient experience has been adversely affected by the acute site congestion and long waiting times and we have seen a rise in patient complaints which is very regrettable. To end on a positive note our mortality measured by SHMI has reduced once more to 103 and we anticipate that it will be at 100 in the near future.

Our Quality & Safety – Executive Narrative

David Mowbray

Chief Medical Officer

Patient Safety

The Trust has now developed a draft Patient Safety Incident Response Plan (PSIRP) which outlines the Trust's approach to improving our Patient Safety culture in line with the new national Patient Safety Strategy. The plan will be presented at Quality Committee in September and Board in October with an aim of 'go live' with the Patient Safety Incident Response Framework (PSIRF) from the 1st November 2023.

The Trust has a plan in place with the Integrated Care Board to support in transitioning from the Serious Incident Framework to the Patient Safety Incident Response Framework by handling investigations and learning from incidents in line with the new ways of working during August– October. This will greatly support the Trust to move to the new framework and embed the new governance to support the implementation of the PSIRP.

Lucy Flanagan

Chief Nursing Officer

Patient Experience

The Trust continues to rollout the Friends and Family Test text messaging to all services provided by the Trust. Delays have been encountered due to pressures within the Informatics team, the team are working hard to get on top of this and we hope to roll out to the following outstanding areas in the forthcoming weeks

- Maternity (all locations excluding delivery suite which has been implemented)
- Paediatrics
- Outpatients (excluding Oxford Suite which has been implemented)
- Community services

Quality

The Trust has received the draft report of the CQC maternity services inspection that took place in June. Factual accuracy review is being undertaken and development of the initial action plan has commenced. We should expect formal publication of the report in the forthcoming months

Quality and Safety – Mortality

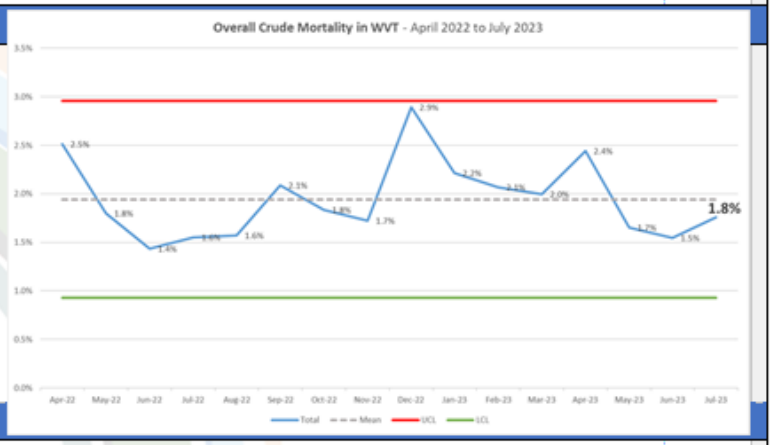
We are driving this measure because:

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

Data

Indicator	Description/Notes	Data month	Month Actual	Change	Direction of Travel
SHMI (NHS Digital)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Feb-23	102.2	0.9	▲
Weekday Admission			102.0	-0.2	▼
Weekend Admission			102.9	4.3	▲
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Apr-23	103.0	-0.4	▼
Weekday Admission			102.9	0.0	▼
Weekend Admission			103.4	-1.7	▼

CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths
Chronic Obstructive Pulmonary Disease	Apr-23	115.23	27.77	32
Congestive Heart Failure		126.39	49.85	63
Fractured Neck of Femur		103.33	33.87	35
Pneumonia		98.92	160.74	159
Septicemia		104.53	81.32	85
Stroke (*Acute Cerebrovascular Disease*)		77.28	87.99	68



What the chart tells us:

The latest **SHMI** (*HES Based*) from May 2022 to April 2023 shows Wye Valley NHS Trust at an encouraging 103.0. This small reduction continues the overall downward trend, and now sits just above the national mean. Latest **crude mortality** rate for July 2023 is 1.8% for all admissions, which remains below our mean, and representative of previous year's data for the same time period.

An overall positive month for our key mortality outlier groups, with the latest figures (*May 2022 to April 2023*) indicating some significant reductions in areas of recent concern.

- **#NOF** mortality has reported one of its largest reductions this month, and now sits only just above the national average for SHMI at **103**. There is continued work on the agreed action plan, focussing on key areas including clinical coding.
- **Heart Failure** has reported a sizeable reduction of over 8 points for the latest 12 month rolling period, with the latest SHMI at **126**. A focused clinical audit of 12 cases will be taking place in response to the elevated SHMI for congestive cardiac failure. A coding audit of the cases has already been undertaken, and will be incorporated in the final report.
- **Sepsis** and COPD mortality rates have also had small reductions, and now sit firmly within the 'as expected' ranges for their areas.
- Only two small rises were reported this month, **Pneumonia** and **Stroke**, reporting SHMI's of 98 and 77 respectively. Both of these groups still report well under the national average.

Latest **stillbirth rate** (*August 2022 to July 2023*) **2.45** deaths per 1000 live births. This remains well on track to achieve the National Ambition target by 2025. In addition, the **extended perinatal rate** for the same period, shows a reduction to **3.07** deaths per 1000 live births. Both of these latest rates are amongst some of the lowest reported at WVT.

Key Actions:

- There has been continued work with the Clinical Coding Task and Finish group, and the development of an action plan outlining the key actions and next steps. The action plan can be found at the end of this report, with the forward plan to provide a regular update on the progress of the group through this monthly report.
- Interviews for our new Lead Medical Examiner will take place in early September. Details of the new appointment will be in next month's report. The successful candidate will be tasked with completing an initial service level review, in both preparation for the rollout and to highlight areas that could be improved to ensure we meet the latest guidance.
- Initial work with our Medical Division to produce a clear and understandable mortality dashboard, which allows them to see the latest mortality statistics for their area, including feedback on any deaths identified as 'unexpected'.

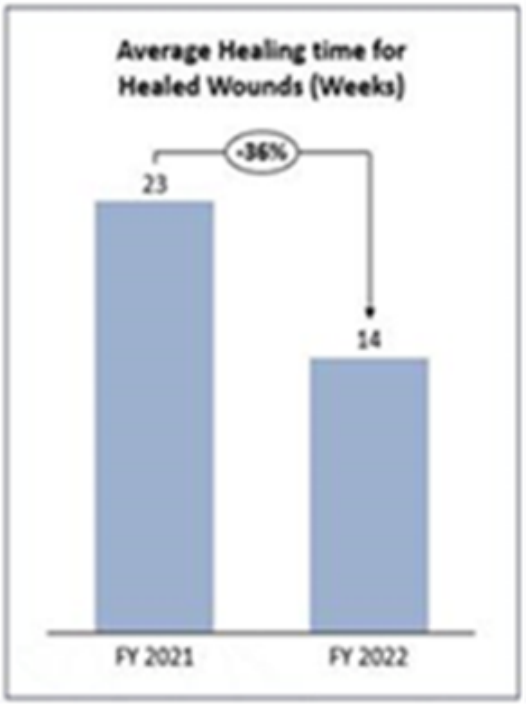
Quality and Safety – Commissioning for Quality and Innovation

We are driving this measure because:

These are the Commissioning for Quality and Innovation (CQUINS) that the trust agreed as part of the 23/24 contract and to support our quality priorities

Data

The five national indicators adopted by the Trust for 2023/24					
No	**Area**	**CQUIN**	**Compliance Measure**	**Q1**	**% Q1**
CQUIN 05	Medical	Identification and response to frailty in emergency departments	10% - 30%	●	73%
CQUIN 06	Clinical Support	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service.	0.5% - 1.5%	N/A	Whole period result
CQUIN 07		Recording of and response to NEWS2 score for unplanned critical care admissions	10% - 30%	●	26%
CQUIN 12	Trustwide	Assessment and documentation of pressure ulcer risk (acute & community)	70% - 85%	●	81%
CQUIN 14	Integrated Care	Malnutrition screening for community hospital inpatients	70% - 90%	●	88%
Additional CQUINs that will be reported on in 2023/24					
CQUIN 01	Trust wide	Flu vaccinations for frontline healthcare workers	75% - 80%	N/A	N/A
CQUIN 13	Integrated Care	Assessment, diagnosis and treatment of lower leg wounds	25% - 50%	●	54%



What the chart tells us:

- The chart shows the performance for each CQUIN at the end of quarter 1. Performance is strong across all CQUINS
- CQUIN 06 is measured through a national data set at the end of the year, performance is being tracked through our local pharmacy systems and the Q1 position is 1.5 %
- The autumn/winter vaccination programme is not due to commence until October/November—performance monitoring commences in Quarter 3 and 4
- We continue to participate in the national wound care strategy programme and have excellent wound healing rates as can be seen in the second chart
- Pressure ulcer risk assessment is a key performance measure and applicable to community and acute hospital this year. The current measure is based on random selection of eligible patients —with the introduction of the new nursing dashboard we hope to measure performance for all patients from October onwards
- The deputy CMO has established a deteriorating patient working group , which will look at how we manage acutely unwell patients, this group will take forward any learning or improvements required in relation to CQUIN 07

Quality and Safety – Complaints

We are driving this measure because:

Learning from patient experience to drive improvement is a trust quality priority;

Data

Month	April	May	Jun	Jul
Number of complaints	23	23	50	41

Division	June	July	Total
Corporate	2		2
Clinical Support	2	3	5
Integrated Care	0	1	1
Medicine	25	17	42
Surgery	21	20	41
TOTAL	**50**	**41**	**91**

Directorate	June	July	Total
Corporate	2	0	2
Diagnostics Services	1	0	1
Patient Access	1	0	1
Cancer Services	0	3	3
Acute & Countywide	0	1	1
Acute and Emergency Medicine	18	4	22
Ambulatory & Frailty	4	6	10
Medicine	3	7	10
Head, Neck & Orthopaedics	6	7	13
Surgical Specialties	5	1	6
Theatres and Critical Care	3	3	6
Women's and Children's	7	9	16

What do the charts tell us

The Trust has seen a sharp increase in the number of complaints received per month in June and July 2023. The directorates highlighted in red note the areas where the majority were received.

Key Actions:

- A thematic review of all complaints received in the 'red' directorates has been undertaken and the findings presented to Patient Experience Committee in August. The Head, Neck and Orthopaedic directorate complaints are attributed to known issues with the Orthodontics service.
- There are no main themes from those incidents in the women's and children's division although debrief following traumatic birth was a feature in some; the service are working hard to offer this. The shared waiting space between gynae and maternity services features negatively in a small number of gynae complaints, particularly for individuals who may be experiencing miscarriage having to share the same waiting area. The teams have made improvements to the space but segregation of the waiting areas is not possible in the available space.
- The Emergency Department themes include; waiting times, timely administration of pain relief, delays in triage process, storage and handling of personal belongings and staff attitude and behaviours including staff from departments outside of the ED. The Emergency department survey findings and actions being taken to improve patient experience will be presented to Quality Committee in September.
- A request for specific action plans has been assigned to the relevant divisions to be presented at Patient Experience Committee in September 2023.
- A theme across all services is complaints being logged due to lack of response to concerns registered with PALS. A focussed piece of work will be undertaken to establish how this process can be improved to provide those affected by the complaint with a timely resolution and avoid the need for a formal investigation where possible.

Quality and Safety—Maternity Reporting—minimum data set

Wye Valley NHS Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Maternity Safety Support Programme	No

	2023								
	April	May	June	July	August	September	October	November	December
Findings of review of all perinatal deaths using the real time data monitoring tool	1 stillbirth at 25+5 weeks gestation	No perinatal deaths	No perinatal deaths	No perinatal deaths					
Findings of review all cases eligible for referral to	1 Case reported	No HSIB reportable	No HSIB reportable cases	No HSIB reportable cases					
The number of incidents logged, graded as moderate or above and what actions are being taken	Moderate incident (HSIB case above)	No moderate of above incidents reported	No moderate or above incidents reported	No moderate or above incidents reported					
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	obstetric consultants 100%, obstetric registrars 88%, midwives 89%	obstetric consultants 100%, obstetric registrars 88%, midwives 87%	obstetric consultants 90%, obstetric registrars 88%, midwives 82%	obstetric consultants 90%, obstetric registrars 89%, midwives 86%					
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	obstetric consultant rota gaps - 71.5 hours, obstetric middle grade rota gaps - 189 hours (hours covered internal bank) midwives - 83 rota gaps - covered internally/bank and	obstetric consultant rota gaps - 54 hours, obstetric middle grade rota gaps - 173 hours (all covered through bank/locum or internal cover midwives - 41 rota gaps - covered through bank, agency and	obstetric consultant rota gaps - 13 hours, obstetric middle grade rota gaps - 301 hours (all covered through bank/locum), midwives - 62 rota gaps covered through bank, agency and specialist team	data not available					
Service User Voice feedback	17 compliments, 0 complaints	30 compliments, 0 complaints	21 compliments, 2 complaints	compliment data not availabe, 2 complaints received					
Staff feedback from frontline champions and walk-abouts	Theme of the month - Diabetes management	Theme of the month - Management of Sepsis. Discussed Midlands maternity and neonatal escalation policies. Update on blood culture	Staff requested that the outpatient area (Antenatal clinic) be improved - completed. Theme of the month - Informed decision making	Theme of the month - breastfeeding and tongue tie service. Static birthpool decomissioned					
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	CQC maternity inspection undertaken	Draft CQC report received					
Coroner Reg 28 made directly to Trust	0	0	0	0					
Progress in achievement of CNST 10	10	ongoing assessment	ongoing assessment	ongoing assessment					

What the chart tells us:

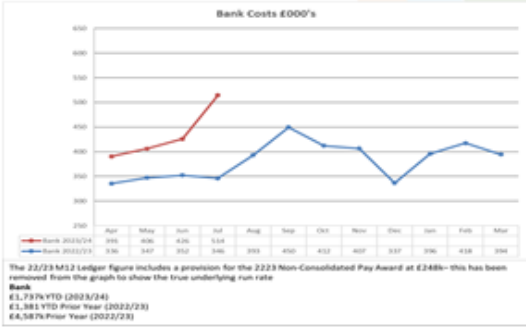
This chart includes the minimum data set reporting requirements for the Clinical Negligence Scheme for Trust Standards . Quality Committee receive the full Perinatal Quality Surveillance Model Dashboard and full data set each month and a more detailed maternity quarterly report. The reporting cycle and detail required for Board is work in progress and the approach is being developed across the foundation group. Whilst this work progresses the minimum data set will be reported to Board in order to meet the CNST requirements.

The safety walkabouts led by the board level executive and non executive safety champions are established and always include an update on the "theme of the month". The theme of the month is planned a year ahead and focusses on those themes or areas where improvements are required and generally derived from complaints, incidents or service user feedback.

There are a low number of complaints reported which is pleasing to note. The are no themes for the 4 received so far this year, with one relating to a delayed debrief following birth, one relating to the attitude of one member of staff which has been addressed and the others relating to ultrasound scanning and gynaecology care post delivery.

Quality and Safety – Staffing

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	CHPPD
Primrose Unit	103%	73%	95%	100%	8.9
Maternity Ward	86%	89%	90%	94%	5.9
Children's Ward	131%	118%	124%	97%	21.8
Lugg Ward	106%	101%	101%	129%	6.4
Wye Ward	119%	78%	117%	88%	7.1
Cardiac Care Unit	100%	101%	100%	100%	12.2
Leominster Community Hospital	114%	104%	104%	145%	6.7
Bromyard Community Hospital	108%	121%	100%	145%	8.1
Ross Community Hospital	100%	111%	100%	106%	5.9
Teme Ward	102%	50%	79%	52%	10.9
Redbrook Ward	94%	105%	100%	103%	6.8
Special Baby Care Unit	92%	-	85%	-	20.2
Intensive Care Unit	115%	-	99%	-	28.3
Gilwern Ward	149%	103%	100%	115%	6.7
Acute Medical Unit	122%	99%	91%	145%	8.8
Ashgrove Ward	118%	74%	100%	140%	7.5
Dinmore Ward	133%	77%	99%	108%	7.0
Garway Ward	106%	97%	103%	137%	7.2
Frome Ward	110%	96%	103%	108%	6.9
Arrow Ward	141%	84%	160%	86%	8.3
Women's Health	102%	92%	100%	-	8.8



The NHS England fill rate report (blue chart), summary headlines as follows:

- Gilwern and paediatric excess fill relates to establishments not aligned to working staffing models . These are being reviewed
- In addition the paediatric ward required RMN support for the majority of the month to support children and young people with complex needs
- The frailty wards had a number of dependent patients requiring additional support
- Arrow Ward had a high number of NIV patients
- Teme—HCA fill was adjusted due to low bed occupancy and the staff provided support in other areas
- The community hospitals have been support a number of dependent patients at risk of falls and Bromyard had additional beds open during this period

There has been 682 K spent on nurse agency during month 4, this is 433 K less than the same month last year. Whilst the demand for agency has reduced from circa 700 shifts per week in March to circa 350 shifts per week in June we have seen an increase in July particularly the latter half of the months due to annual leave/school holidays.

There has however been a significant hike in bank spend, whilst we aim to convert agency to bank the level of agency and bank use is considerably high. Further analysis is being undertaken to understand what is driving this.

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

July saw going pressure of Industrial Actions with Junior Doctors , Consultants and Radiographers, whilst, logistically, it was challenging to maintain appropriate levels of staffing to maintain our Urgent and Emergency Care [UEC] pathways operational and clinical teams pulled together to ensure, locally, our ability to maintain services was one of the best in the region.

Our elective patients and productivity ,however, was impacted significantly and challenged our ability to reduce the long waiting patients waiting over a year and a half for treatment. Our end of July position was disappointing with 36 patients in total, 31 English and 3 Welsh, waiting for treatment, however, our teams remained focused to prevent and reduce any long waiters as we move forward into September.

However, our Value Weight Activity [VWA] comparison against 2019/20 based on, not just activity number, but complexity and treatment received shows our Trust as over 100% above 2019/20 levels but the leading Trust in the Region for last reporting period.

Despite the challenges there has been a number of improvement events and actions in order to ensure we are forging ahead with our Trust objectives to increase productivity and reduce waiting times.

One of the key improvement projects for our Elective patients over the remainder of the year is to deliver:

- No patients who will be waiting for treatment at 65 weeks by March 2024 will be dated for a new outpatient appointment by 31st October and seen by 31st December 2023
- A stretched target of no patients who will be waiting 52 weeks for treatment by March 2024, on an outpatient waiting list, will be seen by March 2024
- No patients who will be waiting for treatment at 65 weeks by the 31st March 2024 will be treatment by 31st March 2024

In order to deliver these targets we are working across our Foundation Group and other Trusts across England in the Getting It Right First Time [GIRFT] Faster, Further programme to benchmark and share best practice from each other and utilise the skilled and knowledge of the GIRFT team.

The transformation team are working with operational and clinical specialities across the Divisions to improve efficiency and productivity which will lead to increased capacity across elective pathways. The aims are to:

- Improve effective referral management
- Validate our waiting lists to ensure patients receive communication about their waits
- Reducing patients who did not attend for their appointments
- Reduce the need for follow-up appointments including opportunities to discharge patients of our waiting lists and increase the volume of patients on Patient Initiated Follow-ups [PIFU]

The team are focusing of supporting, in particular, Seven key specialities that present the largest risk in terms of long waiting patients by the end of March 2023 by highlighting areas of transformation through tools provided by GIRFT to either implement best practice or adopt and consider how we can improve through a Wye Valley approach. Already we have seen increased PIFU in some of are key specialities, reduced DNAs and increased outpatient utilisation.

During July we also had two other improvement events across two weeks with our Theatre Suite and a Trustwide Cancer Week.

Our Theatres Improvement event was positively received by all staff who were involved and a comprehensive action plan has developed and being worked through including training and education regarding Theatre scheduling and improved communication and process for ward to theatres patient flow.

Our Cancer week saw education sessions for clinical and operational teams on how to improve the cancer pathway for patients. Along with our local Healthwatch interviewing patients and highlighting what we did well but also where we can make improvements and changes. The impact of this Cancer week saw a reduction in the patients waiting 62 days for treatment and a further event will be held in Spring 2024.

Lastly our Medical Division team have presented their plans to improve our UEC provision across our Emergency Department [ED] and Same Day Emergency Care [SDEC] provision to be implemented over the autumn period. This will see an expanded SDEC ,on the Acute Floor ,to maximise missed opportunities for patient streaming on this pathway, provide additional SDEC operation hours and combining an increased 24/7 Virtual Ward .

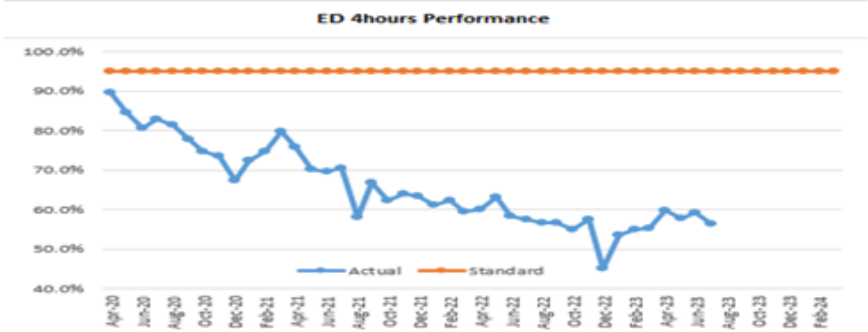
These plans along with our other Valuing Patients Time work streams and strengthening our System out of hospital discharge provision will be the foundations of our winter resilience.

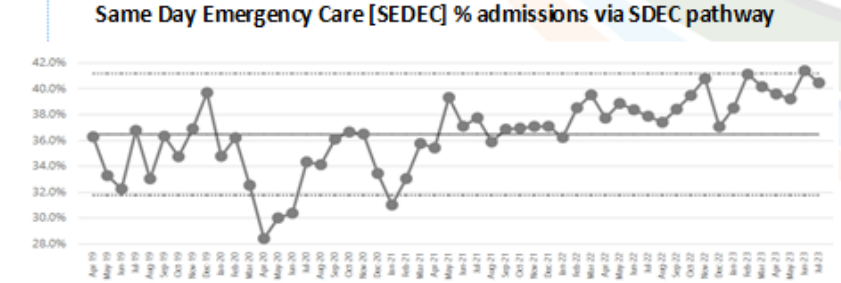
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

We are driving this measure because:

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

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





Performance and Actions

- 6,119 patients attended ED in July which made the month the busiest since for the last two years. The range of attendances varied from 165 to 242, with 1968being the average daily attendances and over 13 days with greater than 200 attendances .
- 1,787 ambulances conveyed to the Trust, our second busiest month over the last twelve months. With the daily average being 58 per day. The range in month was 43 to 73. This includes 4% from Worcestershire [71], 5.5% from Shropshire [97] and 11% from Powys [199]
- Ambulance handover delays over 1hr were 6.4% of all conveyances [100] 81.4% of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 823 of all admissions via a Same Day pathway within no overnight admissions.

Acute Floor Actions to Address:

- UEC Action Plan finalised to cover all elements of transformation/transactional change to deliver 76% and deliver change ahead of winter pressures.
- Increase SDEC physical capacity to ensure patients that can be managed via a SEDC pathway can we streamed from away from ED and are not admitted to inpatient wards.
- Bring together the Medical/Surgical SDEC along with the re-implementation of Frailty SDEC and Virtual Ward to ensure the variety of teams can work together to stream patients on the most appropriate post-SDEC pathway
- Implement overnight capacity for care of elderly SDEC patients overnight to be streamed from ED and care plans started ready for senior facility review each morning.
- Complete the Ward "Way we Work" charters for inpatient and support department to define patient centred values, behaviours and effective patient flow
- Emergency Care Intensive Support Team [ECIST] guidance and review of new models and refresh of demand and capacity modelling across our ED.

Risks:

- Sustained pressure in ED attendances and continued challenges with demand and high acuity with fluctuating high levels of attendances and Ambulance conveyances
- System / Trust patient flow constraints due to workforce and capacity.

What the chart tells us:

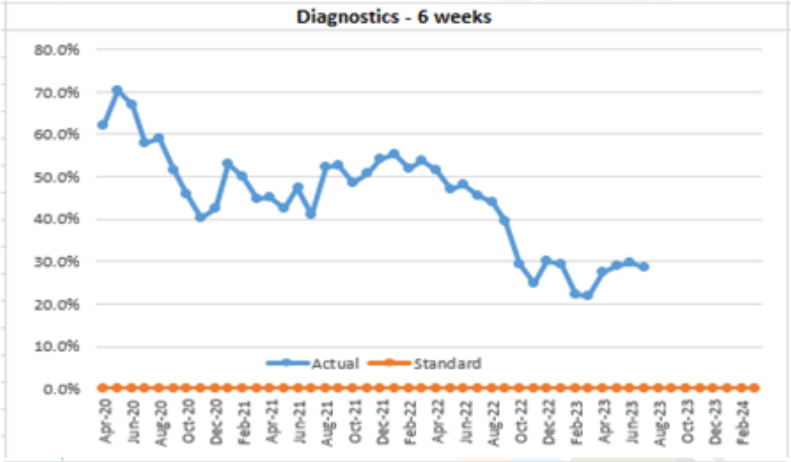
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
WVT Type 1 ED performance is 80 / 129 English Trusts for July 2023

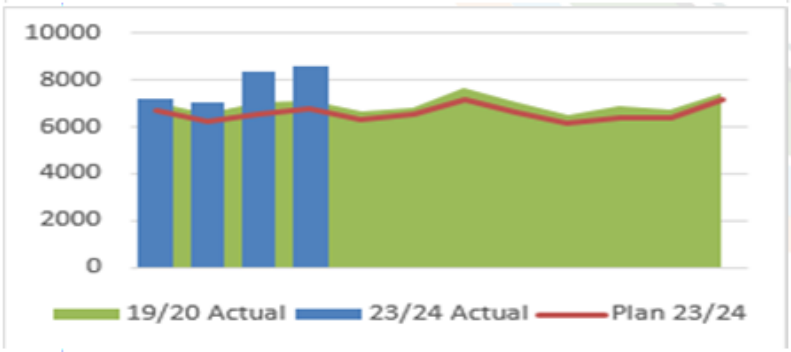
Operational Performance – Diagnostic Performance

We are driving this measure because:

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

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





Performance and Actions

.Imaging:

- Magnetic Resonance Imaging [MRI] achieved 152% of 2019/20 activity last month, supported by additional staffed capacity plan via mobile MRI 12 days per month, Computerised Tomography [CT] achieved 147% of 2019/20 activity last month.
- Non-Obstetric Ultrasound achieved 102% of 2019/20 activity last month. 2.8 WTE vacancies now filled.
- Insourced radiographers supporting in-house scanners in both MRI and CT at weekends to deliver additional capacity
- Maximum appointment wait times for MRI prostate and CT Colon on average were 3 and 19 days respectively.
- 93% of imaging waiting list less than 6 weeks wait.

Echocardiography [Echos]:

Delivered 38% above plan for July. However, August will be more challenged due to annual leave, the waiting times for echo's remain at around 11/12 weeks. Insourcing is to continue to support this position, with an expected decrease in waiting times forecast for September onwards. The majority of patients, excluding those that are patient choice are now able to be seen within <13 weeks. When compared to a waiting time of > 35 weeks last July this is a significant improvement.

Endoscopy:

During July Endoscopy delivered 9% above plans . However there are some significant challenges over the summer with annual leave, sick leave and industrial action, all impacting on capacity. Other actions for Endoscopy include:

- 14 additional lists set up over September. Looking to increase this activity further to help us clear the backlog of cancer patients in order to reach local target of procedure within10 days of referral.
- Non-medical endoscopist taking on an additional list per week starting in September
- New General Surgery Consultants due to start by October 2023 will increase capacity by twos lists per week upon completion of induction.
- The Surgical Division will be undertaking a two week Endoscopy Improvement Event in October 23 to formulate a deliver plan on the back of the success of the Theatre Improvement week.
- Endoscopy Productivity monitor being worked on for with the information team to report on session usage / utilisation and planned / actual activity scheduling and Joint Advisory Group [JAG] for Endoscopy points per session

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:

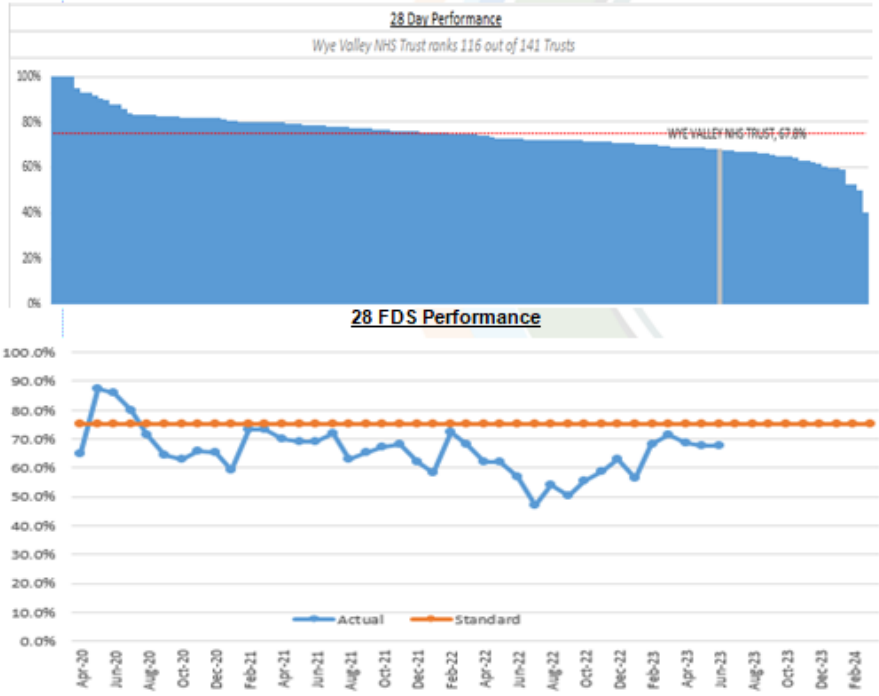
- 28.4% of patients now waiting greater than 6 weeks. / Activity for July was 28% above plan across all Diagnostics

Operational Performance – Cancer Performance—28 Days Fast Diagnosis Standard [FDS] [June 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 36% increase compared with 3 years ago, an additional 2981 patients, also 6% above our planning assumptions for 2023/24.

Main Issues impacting on performance and actions:

- Radiology reporting still is a concern and is impacting FDS but has shown improvements since sending all 2ww scans out to a outsourcing company. Anticipate that this will show improvement by September. WVT diagnostic cancer weekly meeting is continuing.
- Histology still have vacancies across the consultant team therefore work is being sent to Worcester and South Warwickshire NHS Foundation Trust [SWFT] for breast. insourcing company and bank locums for other, reports can take 2-3 weeks to be sent back. Work is still being undertaken in relation to digital and how the region/other Histopathologists' will support. Main concern is delay in template prostate biopsy, audit being undertaken to identify if further testing earlier in the pathway would be beneficial.
- In some specialties in times of leave there can be delays in clinical administration. Agreement to have buddy systems or meetings arranged with cancer lead weekly to go through within all specialities .
- Looking at clinical noting to update cancer pathway and support FDS "clock stop".
- Meeting arranged with two further hospitals outside of ICB and foundation group who are meeting FDS performance for actions for us to take forward
- To look at text messaging for patients to receive non cancerous results to improve communication to patients and support FDS.
- Average cancer 2ww reporting turnaround times have decreased across CTC (10%) , MRI (32%) and CT (78%). MRI Prostate reporting average has increased from last month from 3 days to 3.4 days. This remains an area of significant focus for the Clinical Support Division.

Risks:

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

What the charts tells us:

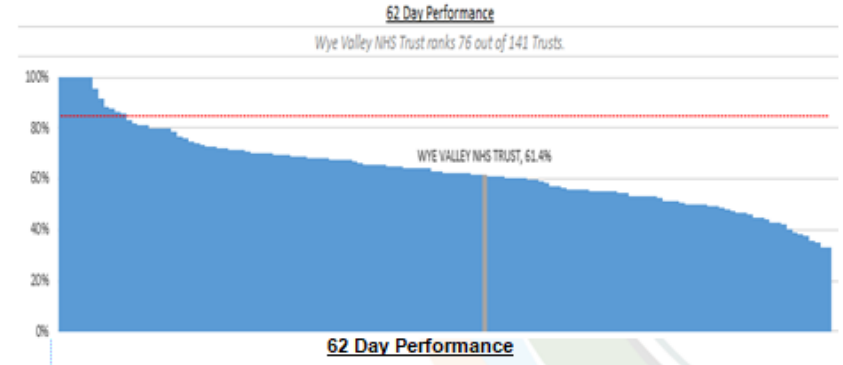
- We have maintained our performance at 67.8%, the same as May and predict July's performance will be 69%

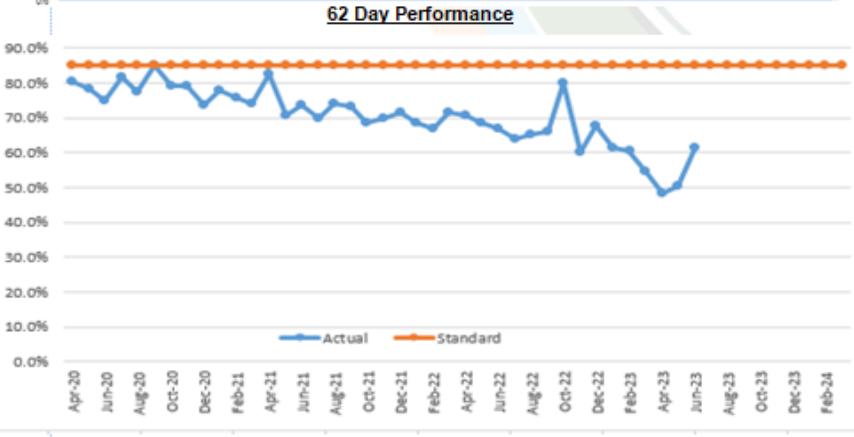
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [June 23]

We are driving this measure because:

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

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





Performance and Actions

62 Days:

- The trust position for 62 days in June was 61.4% with 30 patient breaches, The pressures have been the same related to the Faster Diagnosis Standard [FDS] performance, also theatre capacity and consultant vacancies.
- During August our number of patients above 63 days for treatment or removal from a cancer pathway got down to 73 patients, which is within trajectory of 74 for the month.

New cancer performance changes—3 core measures:

- 28-day Faster Diagnosis Standard – diagnosis or ruling out of cancer within 28 days of referral (target 75%)
- 31-day Treatment Standard – a first treatment within a month of decision to treat for all cancer patients (target 96%)
- 62-day Treatment Standard – a first treatment within two months of referral or consultant upgrade (target 85%)

Key Actions:

- Briefing paper to be presented in relation to cancer performance changes and how we manage these locally to Trust Management Board and then socialising with operational and clinical teams.
- Non specific symptom pathway now has a clinical lead and provisional go live date 1st October 2023
- All specialties to be booking first OPA within 10 days
- Consolidate learning from Wye Valley Cancer week and including in forward plans.

Risks:

- Histopathology / Radiology vacancies—further workforce challenges 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 61.4% against a target of 85%.
- Number of patients waiting over 63 days did reduce to 73 at the end of the June. Our best position post-Covid.

Operational Performance – Referral to Treatment Performance / Activity / Productivity

We are driving this measure because:

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

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

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

Outpatient Activity		Year To Date	Charts	Apr	May	Jun	Jul
New	2019/20	20755		5026	5283	4970	5476
	Plan This Year	21633		4822	5044	6819	4948
	This Year	21981		4859	5436	5875	5811
	Diff vs 19/20	1226		-167	153	905	335
	Variance	6%		-3%	3%	18%	6%
	Diff vs Plan	348		37	392	-944	863
	Variance	2%		1%	8%	-14%	17%
Follow Up	2019/20	42781		10402	10891	10213	11275
	Plan This Year	41771		9126	9401	13426	9819
	This Year	45660		10328	11569	12507	11256
	Diff vs 19/20	2879		-74	678	2294	-19
	Variance	7%		-1%	6%	22%	0%
	Diff vs Plan	3889		1202	2168	-919	1437
	Variance	9%		13%	23%	-7%	15%

Admissions		Year To Date	Charts	Apr	May	Jun	Jul
Elective Inpatient	2019/20	1073		289	259	256	269
	Plan This Year	895		191	198	292	214
	This Year	904		186	233	246	239
	Diff vs 19/20	-169		-103	-26	-10	-30
	Variance	-16%		-36%	-10%	-4%	-11%
	Diff vs Plan	9		-5	35	-46	25
	Variance	1%		-3%	17%	-16%	12%
Elective Daycase	2019/20	6757		1537	1691	1652	1877
	Plan This Year	6619		1437	1485	2175	1522
	This Year	6255		1329	1562	1760	1604
	Diff vs 19/20	-502		-208	-129	108	-273
	Variance	-7%		-14%	-8%	7%	-15%
	Diff vs Plan	-364		-108	77	-415	82
	Variance	-6%		-7%	5%	-19%	5%

Performance and Actions

Activity Summary:

- New Outpatients [OP] activity was 17% above plan in July
- Elective inpatient was 12% above plan in July
- Elective Day Cases was 5% above plan in July
- 2023/24 Activity compared with the delivery of 2019/20 activity for first 4 months of the year:

Outpatients remains above the levels seen in 2019/20 the difference is within elective inpatients and day cases. Factors impacting on activity number shortfalls of c650 patients:

Haematology service: Reduction due to the changes within the service and other providers support c300 patients shortfall

Maxillo-facial service: Reduction due to service level agreement not being delivered by provider c80 patients shortfall

Ophthalmology: Reduction due to ceasing the use of insourcing provider in 2023/24 which would of seen c180 patients

Orthopaedics: Reduction in outsourcing to previous Welsh Independent Provider and reduced additional sessions due to standardisation of additional payments in 2019/20 c100 patients

Productivity

Theatres dropped in month due to 73.6% Capped Model Hospital utilisation challenges with Industrial Action and other operational issues related to the essential maintenance works.

Outpatients clinic utilisation continues to improve to 85% utilisation [90% target utilisation] with the both the percentage of patients who Did Not Attend [DNAs] clinic dropping to 5.5% [5% target] and is one of the lowest in the Region.

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

RTT Performance:

- Performance against English RTT standards in July was 57.2% - 2.2% decrease since last month.
- Performance against the Welsh RTT standards in May was 68% - - 0.9% increase since last month
- Referral to Treatment Number of Patients over 104 weeks = 2 / over 78 weeks = 36 English on Incomplete Pathways Waiting List

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

With ongoing industrial action across the NHS, the main focus of the Trust is to continue to ensure appropriate service plans are in place to provide a safe service to our patients. Following junior doctors strike action in July and August, we now await the results of the current ballot for further monthly industrial action. The second Consultants' industrial action takes place this month with further dates planned 19th-20th September and 2nd-4th October.

There is likely to be a small knock on effect on the HR KPIs but the overall picture is showing improvements in the main in staff turnover reduction, a further drop in vacancy levels and reduction in agency spend. However we are seeing a slight downward trend for July in sickness absence, in appraisal completion and core training; most likely through a combination of commencement of the summer holiday season and a focus on keeping services running during annual leave and industrial action periods.

Employee turnover has been steadily reducing month by month and it has reduced to 11% in July. We have seen a further reduction in turnover for nurses & midwives which is now at 11.31% (15.24% in Nov 22). Healthcare Support Worker turnover has also further reduced from 28.3% (Jul 22) to 14.33% (a 50% reduction in 12 months) and this is attributable to our ongoing concerted efforts in recruitment & retention activities and the WVT career progression scheme that was implemented at the end of last year.

From a recruitment perspective, WVT will be participating in a number of recruitment and careers events during September and October in partnership with DWP and ICS colleagues. The Recruitment Hub @ Franklin Barnes has also been open since July and is available for recruiting managers to utilise in recruiting staff and in providing information on the different careers available within the Trust. DWP colleagues will be utilising this facility to conduct on site interviews and training for potential WVT applicants.

Following the comprehensive staff engagement campaign, the themes of the *Intouch 2023* survey have been identified and these together with key actions will be communicated and presented in September. The annual NHS Staff Survey will be launched by the end of September and will run until the end of November 2023. This will for the first time include a separate survey for Bank only workers which will provide the organisation with feedback from such an important part of the overall WVT workforce.

The HR & OD teams are planning the second HR Roadshow across the Trust covering all sites which will take place during week commencing 9th October and this is being run in conjunction with staff side colleagues and FTSU Guardian/Champions. During the same week WVT's annual Health & Wellbeing week will be running with a variety of wellbeing events and workshops available to all staff.

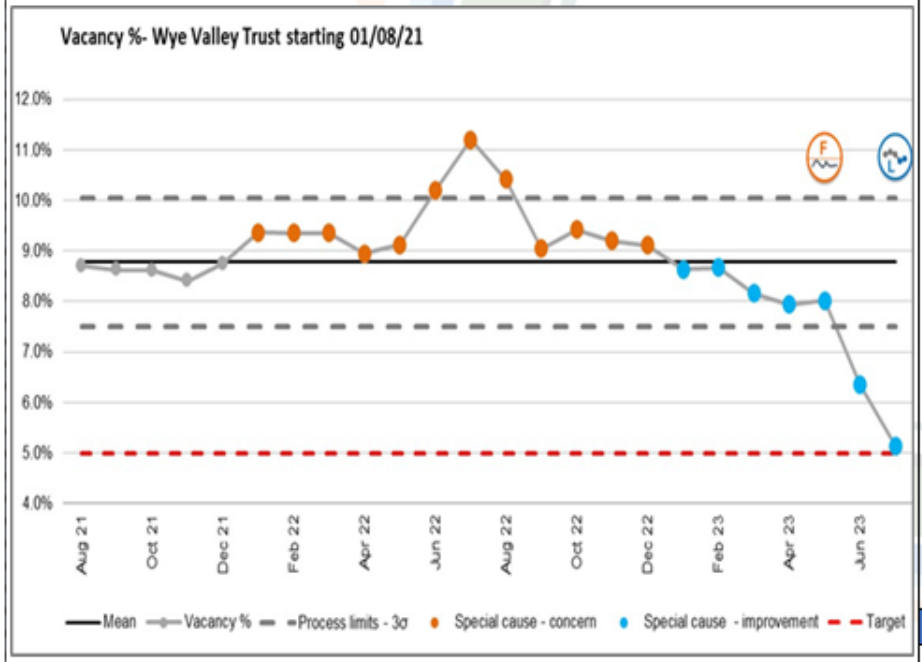
Our Workforce – Vacancy

We are driving this measure because:

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

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
11.2%	10.4%	9.0%	9.4%	9.2%	9.1%	8.6%	8.7%	8.7%	7.9%	8.0%	6.3%	5.1%

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



Performance and Actions

HCSW – the success of our HCSW programme continues with pro-active recruitment and the gap at 17/08/23 is 25.59wte (from 82 wte in July 2022). This has increased slightly due to establishment changes increasing the resource demand. From the latest recruitment a further 18 offers have been made. Work with DWP continues and there are further careers events and another bootcamp planned during September and October.

N&M - By the end of August, WVT will have welcomed a further 47 international nurses to the Trust and to date 103 nurses have passed their OSCE exams which is again a success story. We are extremely pleased to have been awarded the NHS Pastoral Care Quality Award in August, which provides kudos to WVT recognising our work in international recruitment and demonstrating our commitment to staff wellbeing both to potential and existing employees.

AHP – through the ICS AHP international recruitment programme, we been successful in recruiting an Occupational Therapy (OT) which is in addition to the Podiatrist recruited from South Africa.

M&D - the Junior Doctor changeover is by far the busiest time of year for Medical Recruitment team who have successfully on boarded over 100 Doctors in training. Positively many of our junior doctors want to continue working with us on the temporary staffing bank and have been registered. Also, this month we have recruited a Consultant Otolaryngologist. A great example of flexible working in action as this Consultant was working with us as a locum and the tailored JD gave an opportunity to work flexibly. Overseas recruitment of medics to continue throughout 2023/24. We currently have 54.84wte vacancies (at end July'23).

The new Recruitment Hub @ Franklin Barnes opened in July and this is generating interest with several enquiries from members of the public. The hub is available to be used by recruiting managers for all roles, for career clinics, promoting apprenticeships and work placements and there are plans for DWP colleagues to periodically utilise the space for joint work with us in promoting and recruiting to roles in WVT.

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, with a large improvement over the last 2 months down to a decrease in substantive budget along with an increase in staff in post.

Our Workforce – Turnover

We are driving this measure because:

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

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
14.5%	13.7%	13.6%	14.2%	14.4%	14.2%	13.6%	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%

Assurance	Variation	Data Quality Mark
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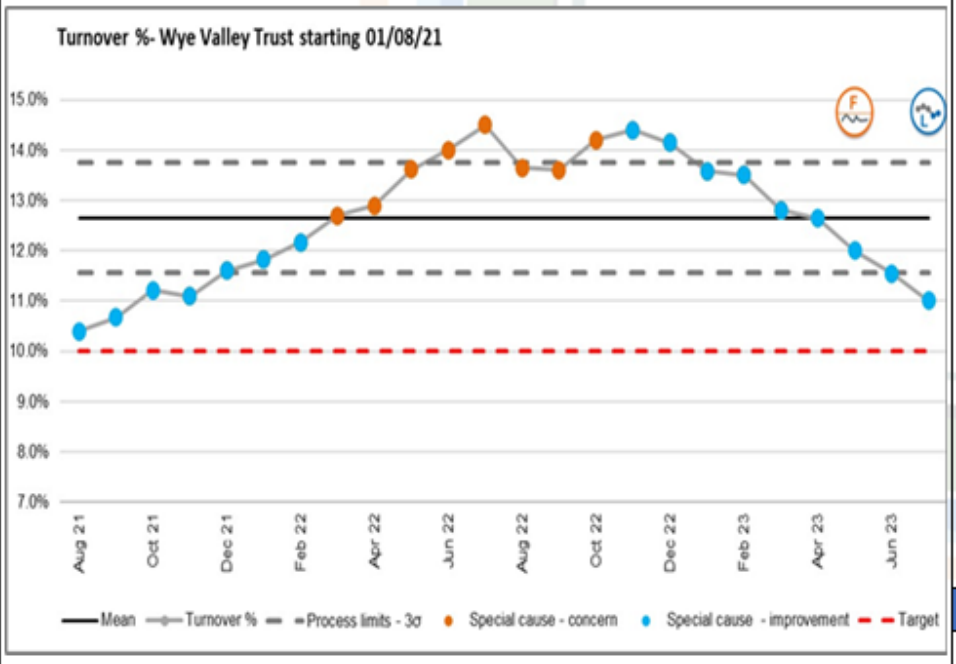


Performance and Actions

The overall rolling 12 month employee turnover at Trust level continues to reduce and is now at 11.0% for August 2022 to July 2023, with an average for the previous 12 month's turnover being 13.1%.

We are seeing the benefits of implementing areas included in the Retention Call to Action plans within each of the Divisions which are supported by the HR team. Progress monitoring and learning is also reported at the monthly Trust-wide Recruitment & Retention Steering Group

Turnover in the healthcare support worker group continues to reduce and is now at 14.33%. This is almost 2% lower than in May and a 50% reduction in turnover since July 2022.

Turnover rates for Band 5 nurses and midwives has also further reduced to 11.31% in July (compared to the highest rate of 15.24% in November 2022). Whilst we are successful with recruiting and retaining international nurses, there is still a need to provide further development opportunities and growing our own workforce and this is to be considered in a proposal to create more opportunities for Band 6 senior nursing roles and a bigger cohort of registered nurse associates at Band 4, to be taken forward in September.

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 8 months.

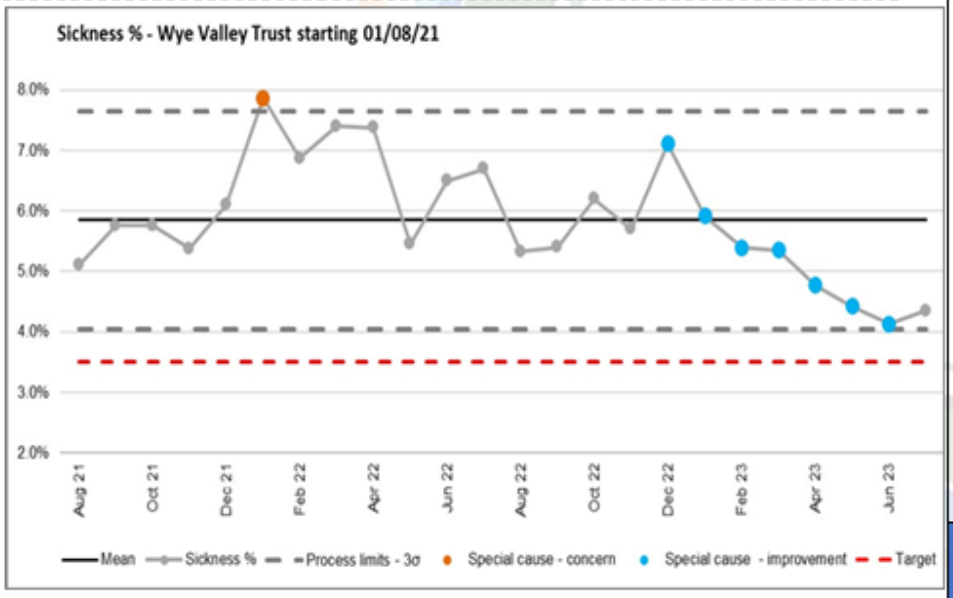
Our Workforce – Sickness

We are driving this measure because:

Due to increased scrutiny and higher levels since the pandemic. We are 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.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
6.7%	5.3%	5.4%	6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%

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



Performance and Actions

During this month, overall sickness at Trust level has increased slightly to 4.3%, but this is still lower compared to a rolling 12 month average sickness of 5.3%. The slight increase is mainly due to short term sickness absence. The top 5 reasons for sickness absence across the Trust are reported this month to be gastro-intestinal problems and cold/cough/flu (highest recorded reasons), anxiety/stress/depression, headache/migraine and MSK.

The HR Operations team are working closely with line managers to ensure that episodes are monitored and acted upon as appropriate and any areas of concern are escalated. Sickness absence reporting and actions continue to be a focus at the divisional F&PE meetings, providing an understanding of trends and actions that such as return to work interview monitoring and sickness reviews and Health@Work support, training provided at group and one to one level as required and highlighting other support such as the EAP service. The Trust now also has in post a Staff Mental Health Wellbeing Nurse on a pilot basis as well as a staff fast track physio service, both of which are seeing positive early impacts for staff who have used these services to date.

The HR team are continuing to work with areas to educate on the benefits of recording menopause related sickness absence and a project is being planned to increase the level of declaration of disability status to allow us to better analyse linked absence and interventions required. This will be included in our communications/conversations with staff during the HR Roadshow in October.

Risks: Sickness levels are likely to increase over the winter period.

What the chart tells us:

The rolling 12 month position shows a fluctuating picture between May 2021 and December 2022, 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 6 months to pre pandemic levels, with only a slight increase in the last month.

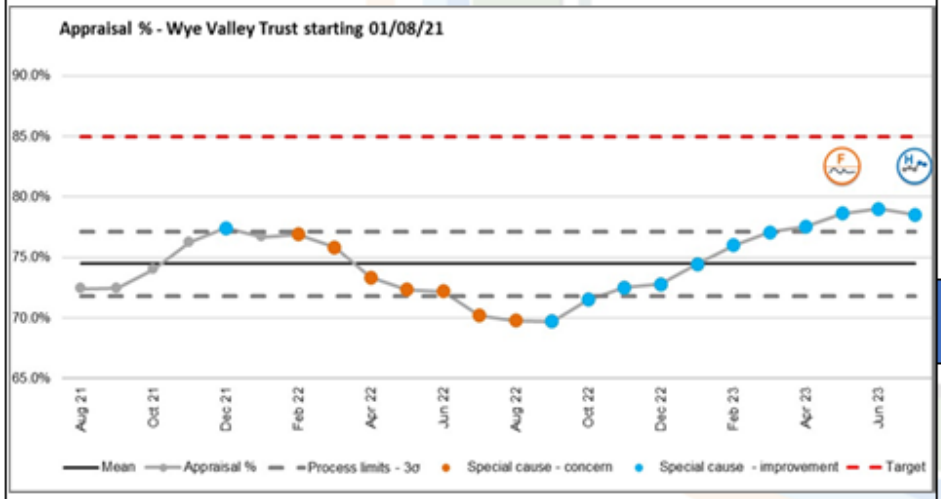
Our Workforce – Appraisal

We are driving this measure because:

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

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
70.2%	69.8%	69.7%	71.5%	72.5%	72.8%	74.5%	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%

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 and ongoing industrial action 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 wellbeing and development appraisal conversations with staff.

Performance appraisals will continue to be a monitored at F&PE meetings in 2023/24 and divisional leaders have been asked to ensure recovery plans are in place for outstanding performance appraisals and mandatory to be completed over the next few months.

Risks:

What the chart tells us:

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

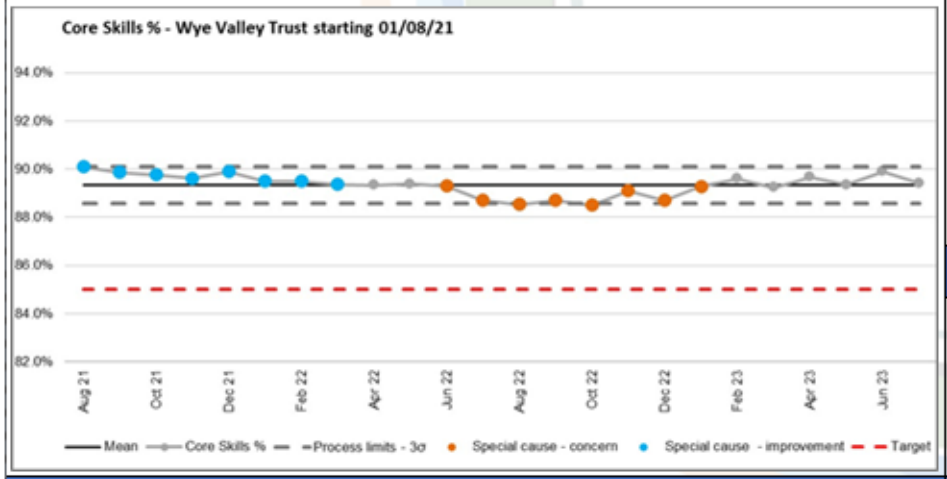
Our Workforce – Core Skills

We are driving this measure because:

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

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

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



Performance and Actions

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

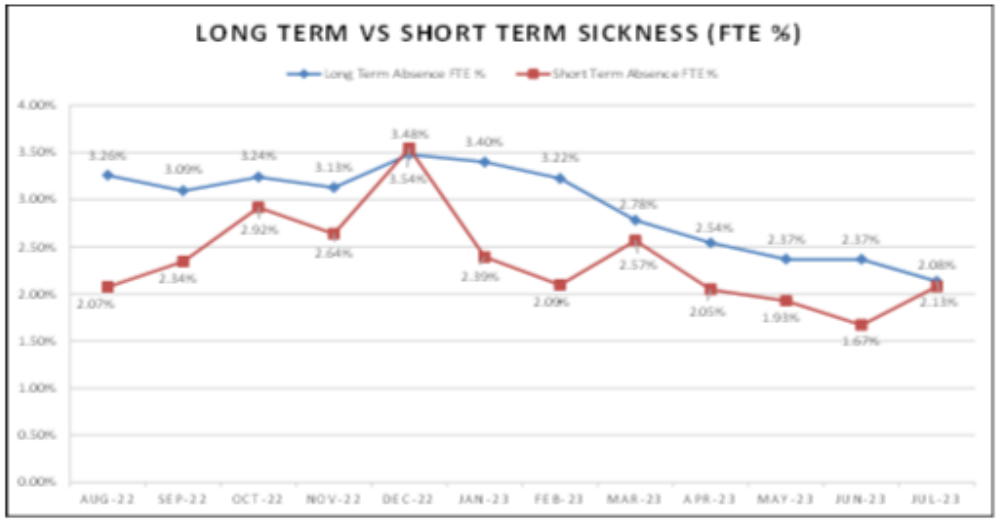
Risks:

What the chart tells us:

The rolling 12 month position remains fairly consistent across the period between July 2021 and July 2023.

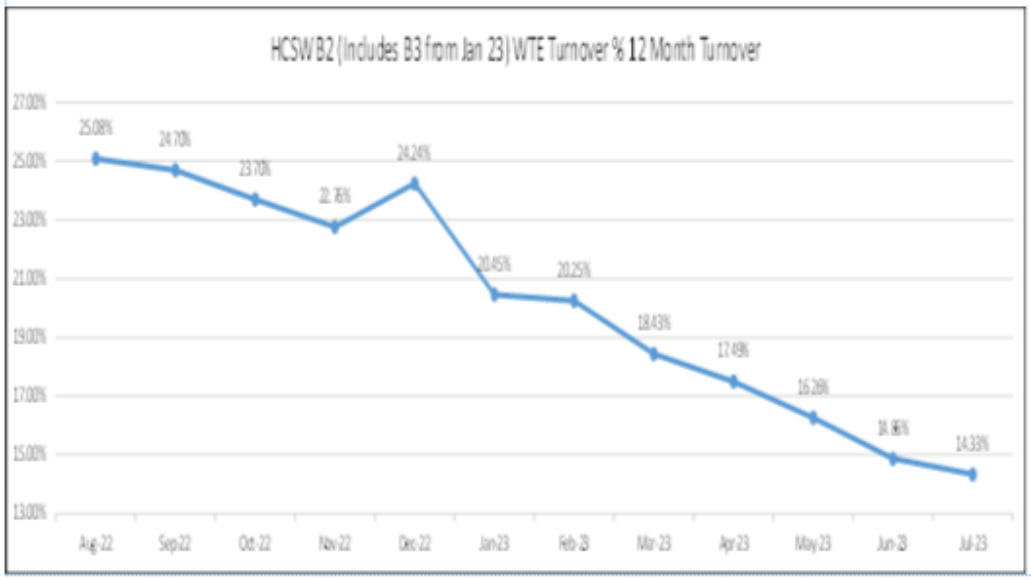
WVT charts on sickness absence & staff turnover for band 2 HCSW and Nurses & Midwives

Continuing rigorous management / HR actions leading to a reduction in long-term sickness absence. Short-term absence has increased resulting in an overall increase in overall sickness absence by 0.2% to 4.3%. This is mainly attributable to an increase in Gastrointestinal problems and Headaches/Migraine related absence.

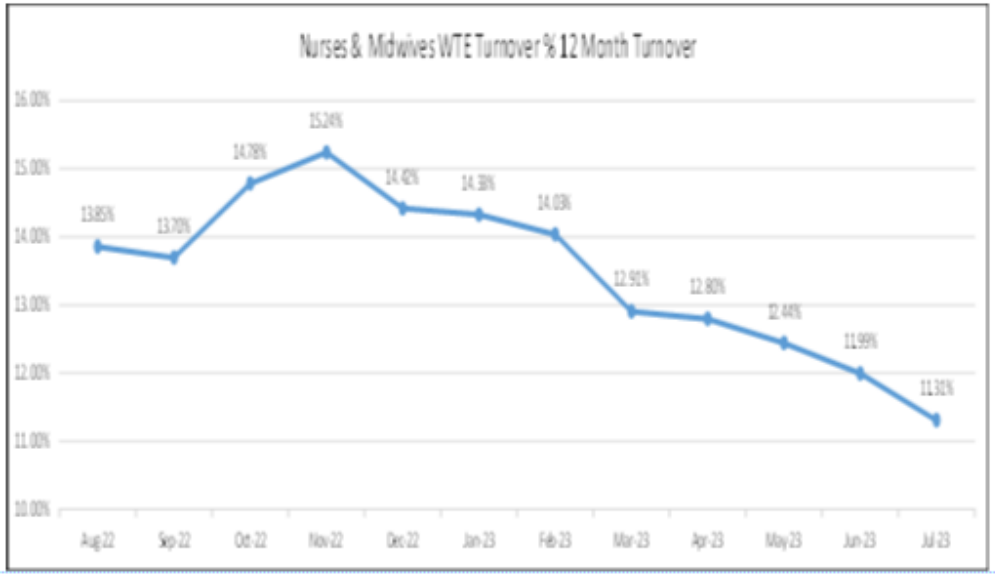


Main reason for absence - Top 5 - July 23	%
Gastrointestinal problems	22.70 %
Cold, Cough, Flu - Influenza	18.23 %
Anxiety/stress/depression/other psychiatric illnesses	11.01 %
Headache/migraine	7.25%
Other musculoskeletal problems	6.64%

The chart below shows a reduction in the annual turnover for our HCSW workforce



The chart below shows a continuing reduction in annual turnover for N&M workforce over the past 5 months.



Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Financial Plan 2023/24

Our planned in year Income and Expenditure deficit is £22.3m though it is important to note that the recurrent underlying position of the Trust continues to run at a greater level of deficit, once non-recurrent items are removed. Across the system enhanced financial controls are in place or being implemented.

Income & Expenditure Performance

The financial position at the end of month 4 (July) was a deficit of £10.1m. Although this is broadly on plan year to date there are a number of financial risks to delivery in year, and recurrently. Focused activity to reduce reliance on premium cost agency workforce has resulted in a significant reduction in the nursing agency run rate compared to the prior year, and also reductions in medical agency. Sustaining this will be a challenge over the coming months given expected demand and the ongoing impact of industrial action. We continue to see the impact of inflationary pressure on our non pay spend. Delivery of our efficiency requirements and productivity improvement are key to securing delivery of the plan. Efficiency delivery is behind plan at this point in the year and significant operational focus continues to mitigate the shortfall.

The wider Herefordshire and Worcestershire Integrated Care System (ICS) has a planned deficit for 2023/24. The system position to the end of month 4, is adverse to plan, reflective of the level of challenge within the plans and premium capacity utilisation.

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 has taken place to agree the final programme. Spend in the first four months of the year totals £8m.

Cash

The cash balance at the end of July decreased in line with the plan. This reflects an increase in accounts receivable and current capital expenditure. 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 have been implemented to ensure requests for revenue cash support are only made where necessary. Revenue cash requirements were reviewed for Q2 and no PDC cash has been applied for.

Our Finance – Year to Date Income and Expenditure

We are driving this measure because:

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

STATEMENT OF COMPREHENSIVE INCOME - To Month 4 - 31st July 2023 - 2023/24

	2023-24 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Contract Income	282,751	92,793	92,745	(49)	150
Excluded Drugs	11,954	3,985	4,465	480	262
Non Contracted Activity (NCA's)	1,635	545	545	(0)	(0)
Other Income for Patient Care	10,238	3,487	3,507	20	14
Donations For Non Current Assets	20,500	4,152	5,751	1,599	(1,641)
Other Non Patient Income	7,365	2,498	2,485	(14)	(74)
COVID Funding	332	107	33	(74)	(74)
NHSE - central (22/23 pay award)			0	0	0
Total Operating Income	**334,775**	**107,567**	**109,530**	**1,963**	**(1,364)**
Pay Expenditure	204,136	68,802	68,366	437	(392)
Non Pay Expenditure	87,479	29,981	30,474	(493)	(39)
Excluded Drugs	22,394	7,455	7,680	(225)	120
Total Operating Expenditure	**314,009**	**106,238**	**106,519**	**(281)**	**(310)**
EBITDA	**20,766**	**1,329**	**3,010**	**1,681**	**(1,674)**
Depreciation	13,704	4,568	4,614	(45)	(4)
Gain or loss on asset disposal	0	0	0	0	0
Interest Receivable	766	432	432	0	0
Interest Payable on Loans	266	89	69	19	56
Interest Payable on PFI	6,377	2,126	2,126	(0)	(0)
Dividends on PDC	3,868	1,289	1,289	0	0
Operating Surplus/ (Deficit)	**(2,682)**	**(6,310)**	**(4,655)**	**1,656**	**(1,622)**
Technical Adjustments					
Donated Assets - Additions	20,500	4,152	5,751	1,599	(1,641)
Donated Asset Depreciation	(864)	(288)	(311)	23	6
Donated Assets Adjustment	**19,636**	**3,864**	**5,439**	**1,576**	**(1,647)**
Adj. financial performance retained Surplus/ (Deficit)	**(22,316)**	**(10,174)**	**(10,095)**	**80**	**25**

Performance and Actions

The position at the end of month 4 (July) was a deficit of £10.1m. This was marginally ahead the current plan with an overall favourable variance of £80k year to date.

- Pay is underspending overall with some slippage on recruitment linked to capacity and unfilled vacancies. This net position includes agency — 7.91% of total pay costs in July which remains static. Medical bank use at premium rates further increases this to 12.4% of overall pay. This is driven by volume and price.
- The plan includes a significant level of additional capacity provided to achieve the operational plan, particularly recovering elective activity.
- We continue to experience significant cost pressures in staffing and non pay cost linked to the urgent care pathways, increased volumes and acuity of patients and ongoing inflationary impacts.
- The Trust has set an annual cost improvement (efficiency) target of £15.7m (of which £2.5m is a further stretch target). Delivery is currently behind plan and mitigations are being identified.

Risks:

Key Financial risks

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

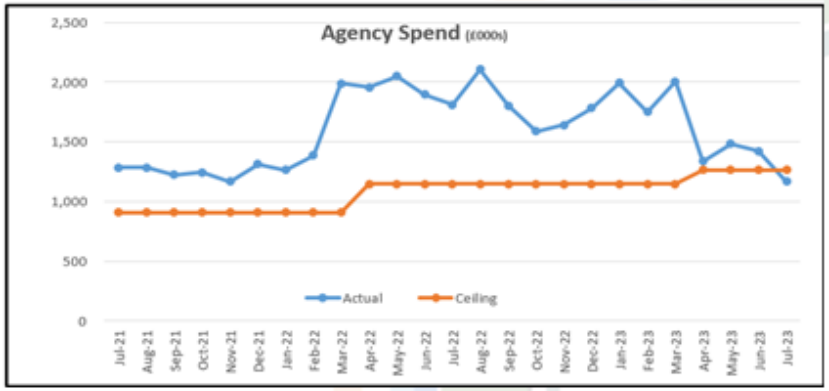
What the chart tells us:

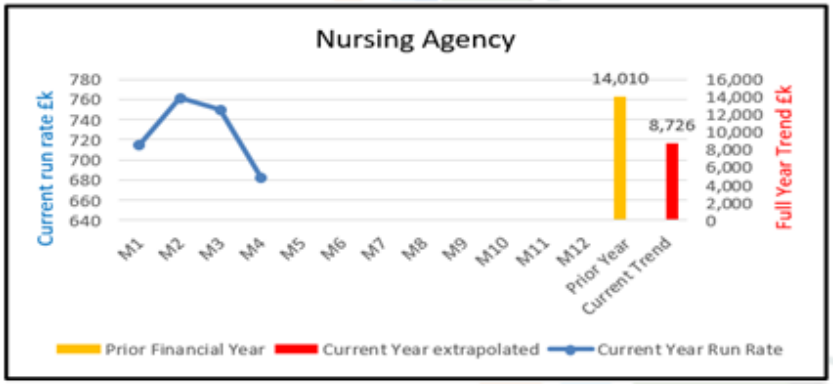
The Trust is currently on target to deliver a deficit of no more than £22.3m though significant risk remains at this point in the year.

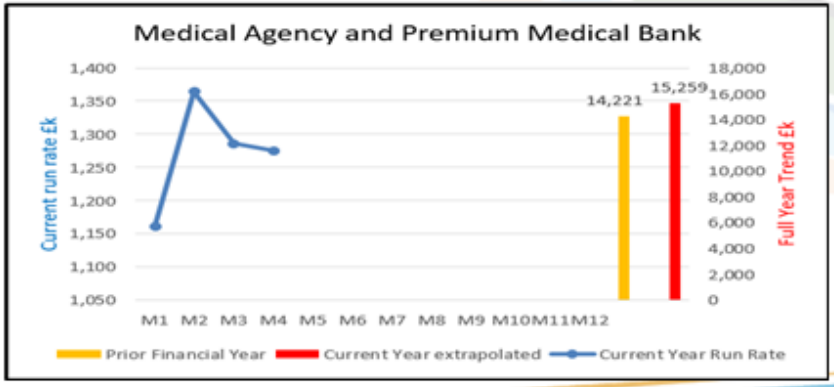
Our Finance – Agency Spend

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 represents 7.91% of total pay costs year to date. This benchmarks poorly, and is above the NHS Agency Cap Ceiling. There is still a considerable way to get back to an acceptable baseline trend, although the marked reduction in month 1 particularly on Nurse Agency usage has broadly been maintained to date. All agency spend year to date (and excluding premium cost medical bank) has been £5.4m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** Increased control actions through NARP, together with the new Master Vend contract rate changes have shown improvement since the prior year. The Trust spent £14.0m on nurse agency in the prior year (22-23) and the extrapolated current year position would be £8.7m which is more in line with 21-22.
- **Medical staffing agency and premium cost bank:** Commercial agency and Internal Medical Bank often have a correlation depending upon availability and route into the Trust. Medical bank typically still involves high premium rates, even if marginally lower than agency on average. In month 1 we saw a small decrease in the run rate for medical agency and bank, this has increased in month 2, with further reductions in month 3 & 4. The Trust spent £14.2m in the prior year (22-23) and the extrapolated run rate (£15.3m) 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

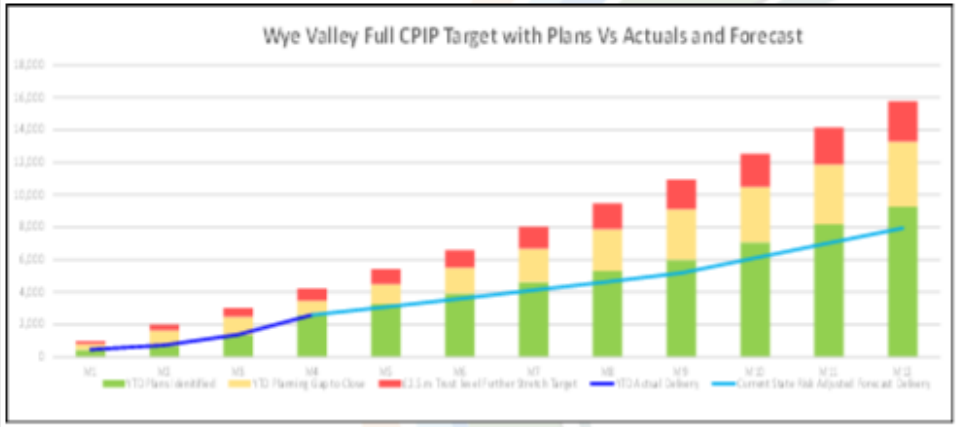
What the chart tells us:

Agency (and premium medical bank) 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 4 there is still a large shortfall in identified recurrent schemes. Inflationary impacts and increased demand mean that some of the financial improvement is cost avoidance to stabilise the run rate rather than delivery of recurrent efficiency to improve the bottom line. Increased scrutiny and oversight is in place including weekly progress tracking and escalation through TMB and F&PE meetings.

Although this drives an adverse variance from plan in month 4, the full effect of this is non recurrently being 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 CPIP guidance and governance, training programme being launched. Progress will be closely monitored and routinely reported to the Board.

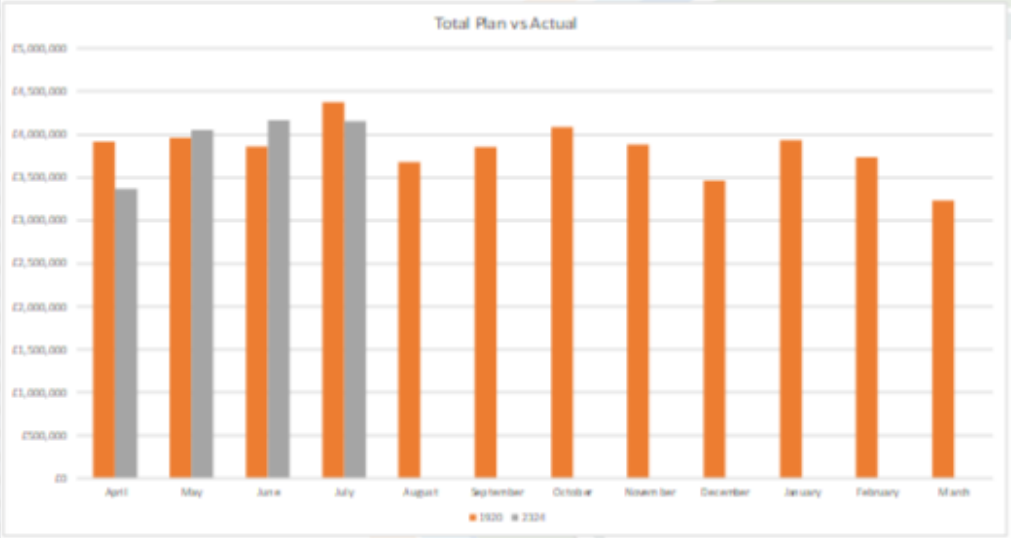
What the chart tells us:

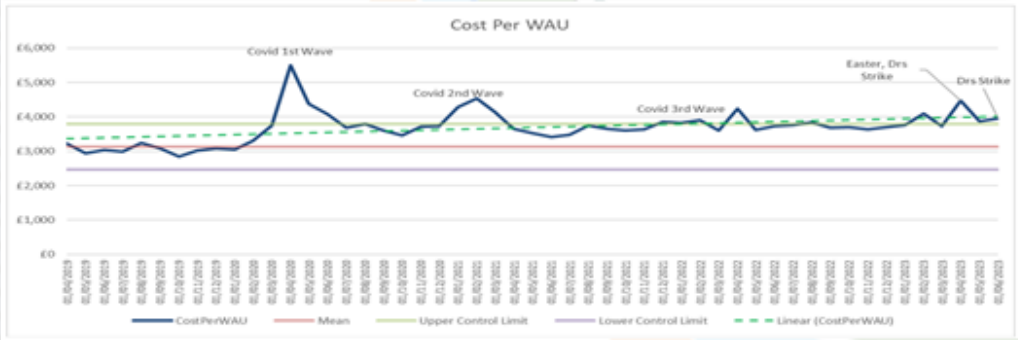
Focus is on converting opportunities into deliverable schemes, particularly recurrent schemes to mitigate the financial risk of underachievement against this programme and into 2024/25.

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.





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 monitoring shows that for July elective activity in terms of volume was 101% of 19/20 and in financial terms (see chart) 95%. It is mainly driven by over performance in outpatients with inpatients at 89%. Overall we are behind YTD (98% of 19/20) and this gives us a degree of risk associated with the inclusion of elective income in our financial position.

Nationally we understand the 106% will be revised downwards to recognise the impact of industrial action but this has yet to be confirmed and there remains a risk of clawback where we do not achieve the planned levels.

Cost per Weighted Activity Unit (calculated and reported one month in arrears) remains above the target level. 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 system elective activity . Mitigation - Additional capacity funding provided to the Divisions, close monitoring of activity performance and productivity.

What the chart tells us:

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

Our Finance – Capital and Cash

We are driving this measure because:

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

Scheme Type	Interim Annual Plan £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Digital Total	1,250	273	242	31
Equipment Total	1,593	346	226	120
Estates Total	1,630	355	117	238
Total Core Operating (ICS) Capital	**4,473**	**974**	**584**	**390**
ESH	12,602	2,730	1,629	1,101
CDC	10,296	260	68	192
Frontline Digitalisation PDC Total	3,300	714	0	714
Total National Programme Funding Bids	**26,198**	**3,704**	**1,698**	**2,006**
Donated Assets/Grant IES	20,600	4,463	5,751	(1,288)
Grand Total	**51,271**	**9,141**	**8,032**	**1,109**

Cash Balance

Month	Performance	Target	Direction	Rating
May	18.5	22.1		
June	24.8	21.2		
July	20.6	20.5		

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

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
May	97.7%	95.0%		
June	98.2%	95.0%		
July	97.8%	95.0%		

July's results indicate that on a volume basis, the Trust paid 97.8% of invoices within 30 days exceeding the target for the fourth month in succession. The performance measured by invoice value was 92.3%, below the target.

Performance and Actions

Capital: The overall capital expenditure at Month 4 is £8.032k which represents 16% of total budget spent, the YTD position against plan is showing an overall under-spend of £1.1m. This underspend is mainly due to the National Programme Funding bids now expecting to incur costs later in the year, especially around ESH and Frontline Digitalisation. This is balanced with costs occurring earlier in the year for IES against plan. The current expectation is that National Programme expenditure will be in line with the full year plan.

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

Risks:

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

What the chart tells us:

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

Our Finance – Statement of Financial Positon

We are driving this measure because:

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

July 2023	2022/23	2023/24			
	Accounts £000s	M4 Plan £000s	M4 YTD £000s	Variance £000s	YTD Change £000s
NON-CURRENT ASSETS:					
Property, Plant and Equipment	130,133	127,446	132,104	(4,658)	1,971
Intangible Assets	13,834	15,743	16,492	(749)	2,658
Trade and Other Receivables	573	817	573	244	0
TOTAL Non Current Assets	**144,540**	**144,006**	**149,169**	**(5,163)**	**4,629**
CURRENT ASSETS:					
Inventories	5,316	4,780	5,112	(332)	(204)
Trade and Other Receivables	21,085	13,709	17,547	(3,838)	(3,538)
Cash and Cash Equivalents	34,969	21,220	20,556	664	(14,413)
TOTAL Current Assets	**61,370**	**39,709**	**43,215**	**(3,506)**	**(18,155)**
TOTAL ASSETS	**205,910**	**183,715**	**192,384**	**(8,669)**	**(13,526)**
CURRENT LIABILITIES					
Trade and other payables	(49,794)	(26,489)	(41,782)	15,293	8,012
Borrowings - Loans, PFI and Finance Leases	(5,779)	(5,942)	(7,070)	1,128	(1,291)
Provisions	(55)	(46)	(46)	0	9
Total Current Liabilities	**(55,628)**	**(32,477)**	**(48,898)**	**16,421**	**6,730**
NET CURRENT ASSETS/(LIABILITIES)	**5,742**	**7,232**	**(5,683)**	**12,915**	**(11,425)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**150,282**	**151,238**	**143,486**	**7,752**	**(6,796)**
NON-CURRENT LIABILITIES:					
Borrowings - Loans, PFI and Finance Leases	(31,138)	(30,519)	(27,798)	(2,721)	3,340
Provisions	(1,686)	(1,579)	(1,677)	98	9
Total Non-Current Liabilities	**(32,824)**	**(32,098)**	**(29,475)**	**(2,623)**	**3,349**
ASSETS LESS LIABILITIES	**117,458**	**119,140**	**114,011**	**5,129**	**(3,447)**
TAXPAYERS EQUITY					
Public dividend capital	270,216	273,686	270,216	3,470	0
Revaluation reserve	26,991	30,874	28,199	2,675	1,208
Income and expenditure reserve	(179,749)	(187,682)	(184,404)	(3,278)	(4,655)
TOTAL	**117,458**	**116,878**	**114,011**	**2,867**	**(3,447)**

Performance and Actions

General

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

Non-Current Assets

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

Current Assets

Accounts Receivable increased by £1.8m compared to the previous month. This is due to an increase sales ledger debtors due to quarterly invoicing cycles. In addition there is an increase in the VAT debtor, awaiting receipts from HMRC. Cash held decreased by £4.2m in the month as a result of increased debtors and capital expenditure.

Current Liabilities

Current liabilities increased by £4.3m compared to last month largely due to the receipt in advance of the profile payment. This has been partly offset by reduced TAX/NI liabilities with month 3 being skewed by pay award and back pay.

Non-Current Liabilities

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

Taxpayers Equity

The income and expenditure reserve reflects the deficit to date.

Risks:

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

What the chart tells us:

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

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 75.0%	Variable	Common Cause	Yes	56.3%	68.1%	71.3%	68.8%	67.9%	67.8%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		89.5%	88.8%	88.0%	81.9%	84.5%	86.2%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		77.3%	39.3%	63.6%	50.0%	14.8%	18.2%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	81.7%	89.6%	91.1%	88.5%	74.5%	83.3%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Improvement - High		14	13	12	9	13	11	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Fail	Concern - Low		61.5%	60.7%	54.5%	48.1%	50.4%	61.4%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		33.3%	0.0%	0.0%	0.0%	100.0%		
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Concern - Low		58.5%	74.2%	71.0%	70.4%	57.1%	75.0%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Common Cause	Yes	123	115	89	117	112	108	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High	Yes	113.1%	102.7%	100.4%	93.8%	104.3%	102.7%	105.2%
	Urgent Response > 1st Assessment completed on same day (facilitated discharge &	Primary care and community	80.0%	Pass	Common Cause	Yes	99.2%	100.0%	98.2%	96.7%	100.0%	96.4%	97.8%
	Urgent Response > 1st Assessment completed within 2 hours (admission	Primary care and community	70.0%	Variable	Common Cause		90.2%	91.7%	83.3%	91.5%	76.5%	85.5%	79.7%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Common Cause		89.2%	89.2%	89.2%	90.2%	89.8%	90.7%	89.9%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		95.8%	96.8%	107.7%	98.9%	100.7%	98.0%	98.4%
	Ambulance handover within 15 minutes	Urgent and emergency care	>= 95.0%	Fail	Common Cause								
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause		77.0%	81.0%	82.9%	75.1%	76.2%	81.7%	81.4%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High		9.2%	6.6%	5.2%	9.0%	9.0%	4.6%	6.4%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		114.7%	112.8%	117.3%	117.8%	110.3%	108.6%	111.4%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		38.5%	41.1%	40.2%	39.6%	39.2%	41.4%	40.5%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High	Yes	19.3%	18.4%	16.2%	9.7%	14.8%	13.8%	14.0%
	A&E - Time to treatment (median)	Urgent and emergency care			Common Cause		0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care			Common Cause	Yes	2.9%	2.8%	3.1%	2.8%	2.5%	2.3%	2.3%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High	Yes	288	308	263	107	225	259	178
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Concern - Low		7.4%	7.2%	8.3%	7.1%			

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		58.6%	59.0%	58.3%	56.7%	59.3%	59.4%	
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		66.7%	67.5%	67.3%	64.7%	65.1%	67.1%	
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care			Improvement - High		24974	25301	25957	26503	26797	26710	
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Concern - High		1446	1391	1453	1552	1718	1688	
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		94	58	6	27	23	18	
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		0	0	0	1	1	1	
	GP Referrals	Elective care			Common Cause	Yes	100.3%	110.5%	168.1%	94.5%	100.8%	119.4%	98.2%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care			Improvement - High	Yes	100.7%	99.2%	116.2%	96.7%	102.9%	118.2%	106.1%
	Outpatient Activity - New attendances (volume v plan)	Elective care			Improvement - High	Yes	81.1%	92.7%	94.9%	100.8%	107.8%	86.2%	117.4%
	Total Outpatient Activity (% v 2019/20)	Elective care			Improvement - High	Yes	105.3%	102.2%	114.3%	98.4%	105.1%	121.1%	101.9%
	Total Outpatient Activity (volume v plan)	Elective care			Improvement - High	Yes	95.0%	104.6%	100.0%	108.9%	117.7%	90.8%	115.6%
	Total Elective Activity (% v 2019/20)	Elective care			Common Cause	Yes	92.0%	98.6%	103.9%	78.6%	96.8%	104.8%	87.8%
	Total Elective Activity (volume v plan)	Elective care			Improvement - High	Yes	80.4%	91.3%	88.1%	84.4%	96.8%	79.4%	110.3%
	BADS Daycase rates	Elective care			Common Cause	Yes	83.9%	83.7%	82.7%	76.7%			
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause					77.0%	78.7%	78.5%	73.6%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care			Common Cause		16	16	16	9	22	24	30
	Diagnostic Activity - Computerised Tomography	Elective care			Improvement - High		140.6%	137.9%	107.6%	137.8%	120.5%	139.9%	144.9%
	Diagnostic Activity - Endoscopy	Elective care			Common Cause	Yes	121.7%	131.4%	122.7%	50.2%	126.4%	79.4%	76.9%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care			Improvement - High		132.4%	142.2%	116.5%	165.8%	158.3%	171.3%	161.5%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care			Improvement - Low		29.4%	22.2%	22.0%	27.6%	28.9%	29.8%	28.4%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Common Cause		89.3%	96.3%	98.6%	96.7%	94.6%	94.0%	93.1%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Concern - High	Yes	14.5%	15.2%	16.2%	14.0%	19.3%	21.3%	20.9%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Improvement - Low	Yes	63.3%	60.9%	60.0%	58.8%	58.2%	57.0%	55.5%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High		87.0%	88.4%	86.6%	87.3%	87.5%	89.6%	91.5%
	Maternity Activity (Deliveries)	Elective care			Common Cause	Yes	70.1%	99.1%	117.1%	110.6%	108.8%	98.5%	91.3%

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.3%	6.5%	5.8%	5.8%	6.2%	6.2%	5.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Common Cause	Yes	78.1%	79.3%	78.4%	80.6%	82.5%	86.7%	85.4%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation			Concern - Low	Yes	107.1%	103.4%	113.6%	99.3%	106.2%	122.5%	99.8%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation			Improvement - High	Yes	101.5%	110.0%	102.4%	113.2%	123.1%	93.2%	114.6%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Fail	Improvement - Low		25.9%	24.9%	22.6%	24.6%	23.4%	23.2%	22.9%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term			Common Cause		9.9%	12.4%	7.3%	12.0%	13.7%	9.2%	9.5%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		97.0%	102.5%	97.1%	95.0%	97.0%	97.8%	96.7%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		97.3%	96.2%	95.0%	93.6%	95.4%	96.3%	94.4%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<= 0	Variable	Common Cause		517	233	150	173	181	110	75
	Patient ward moves emergency admissions (acute)	Safe, high quality care			Common Cause		10.9%	8.6%	7.3%	9.1%	7.5%	7.4%	7.4%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Variable	Concern - High		5	4	4	4	4	4	4
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause		3	2	2	3	3	3	3
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Common Cause			22.7%	22.0%	19.5%	22.5%	24.6%	17.9%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Common Cause			57.9%	61.1%	60.4%	58.7%	58.9%	57.9%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Improvement - High	Yes	10.2%	9.1%	6.3%	10.2%	11.0%		
	HSMR - Rolling 12 months	Safe, high quality care	<= 100	Variable	Concern - High		109	109	110	110			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Improvement - Low		101	102	102				
	Never Events	Safe, high quality care	0	Variable	Common Cause	Yes	0	0	1	0	1	0	0
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Concern - Low		0	0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care			Common Cause	Yes	0	0	0	1	1	1	2
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care	44	Fail	Common Cause		0	3	5	5	6	6	1
	Number of falls with moderate harm and above	Safe, high quality care			Common Cause		1	3	5	3	4	3	3
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<= 0	Variable	Common Cause	Yes	9	5	3	2	1	3	1
	Serious Incidents	Safe, high quality care			Common Cause	Yes	10	30	16	6	9	7	8
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Concern - Low		89.7%	90.6%	90.4%	89.6%	90.7%	90.6%	87.5%

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Safe, high quality care	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Common Cause	Yes			99.5%			99.8%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Improvement - High	Yes	71.7%	60.7%	48.8%	68.8%	88.6%	87.0%	68.8%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Improvement - High	Yes	80.0%	33.3%	75.0%	57.1%	40.0%	0.0%	100.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause		76.9%	82.9%	88.1%	86.7%	80.4%	88.6%	74.3%
	Number of complaints	Safe, high quality care			Concern - High	Yes	19	18	25	22	20	46	38
	Number of complaints referred to Ombudsman	Safe, high quality care	<= 0	Variable	Improvement - Low		0	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>= 90.0%	Variable	Common Cause	Yes	50.0%	26.7%	71.4%	33.3%	100.0%	66.7%	50.0%
	Friends and Family Test - Response Rate (Community)	Safe, high quality care	>= 30.0%	Variable	Concern - Low		0.0%	0.0%	0.0%	0.2%	0.1%	0.1%	
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes			0.0%	76.3%	76.0%	79.6%	72.9%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		100.0%	82.2%	86.2%	90.0%	89.1%	87.4%	86.2%
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes	100.0%	100.0%	100.0%	81.8%	100.0%	100.0%	
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause	Yes			0.0%	21.0%	21.0%	20.5%	17.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		1.0%	20.2%	21.0%	19.0%	20.4%	19.0%	17.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Concern - Low		4.0%	0.0%		0.0%	0.0%	1.5%	

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Common Cause	Yes	12.0%	10.5%	6.9%	8.1%	8.4%	8.4%	6.8%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	74.4%	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.3%	89.6%	89.2%	89.7%	89.3%	89.9%	89.4%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Improvement - Low	Yes	5.9%	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Fail	Improvement - Low	Yes	13.6%	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low	Yes	8.6%	8.7%	8.2%	7.9%	8.0%	6.3%	5.1%

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
Title of Report:	Business Case – Nursing Skill Mix Changes
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Direct
Lead Executive Director:	**Chief Nursing Officer**
Author:	Lucy Flanagan, Chief Nursing Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To present the business case for nursing skill mix changes.

2. Recommendation(s)

TMB has recommended this business case for presentation to Board for approval in September.

3. Executive Director Opinion[1]

A proposal to change the skill mix across wards, ED and community hospitals was presented to TMB in June and at the July Board workshop. The fully costed business case is attached.

This business case aims to provide a long term sustainable nursing workforce model and builds on the changes already introduced for health care support staff. Evidence from our work to date has proven to aid recruitment and retention of these groups of staff.

Board is asked to support the preferred option – option 3. This option is ambitious, yet achieves the desired skill mix rapidly and represents better value for money in the longer term.

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

BUSINESS CASE

Title:	Nursing skill mix changes – Recruitment and Retention
Ref. No.	WVTBC0119
Author:	Lucy Flanagan/Sarah Hall
Executive Sponsor:	Chief Nursing Officer
Date:	September 2023

1. Introduction and Background Information

This business case aims to provide a long term sustainable nursing workforce model and builds on the changes already introduced for health care support staff. It will fundamentally change the skill mix of nursing registrants based in our ward settings, Emergency Department, Day case and Community hospitals across WVT.

The evidence from our work to date has been proven to aid recruitment and retention of these groups of staff.

The case has two components which are independent from each other, yet the introduction of both will achieve more opportunities for existing and new staff and will create a more sustainable workforce in the longer term. The introduction of both components also represents better value for money.

The first component is to introduce more senior nursing (band 6 positions); this will aid retention and improve quality by ensuring that there are more experienced staff in our wards and departments through enhanced career development opportunities within the trust.

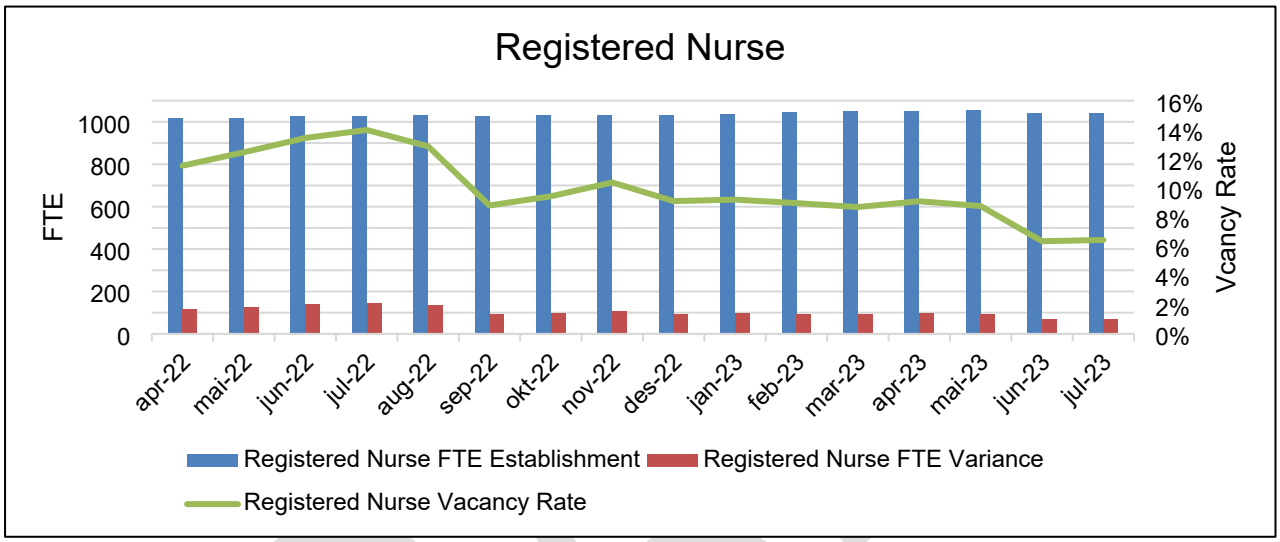
The second component is to expand the number of registered nursing associates (band 4 positions) thus creating career development opportunities for existing health care support workers. Ideally this would be through an expanded offer, to this group of staff over and above the number of training places normally offered each year. By expanding the number of training places the trust can achieve the required number of qualified nursing associates rapidly, return on investment sooner and reach the targeted skill mix changes within 2 years.

Ultimately the expansion of band 6 and band 4 roles will lead to a reduction in band 5 vacancies and the skill mix changes will provide for a more locally grown sustainable workforce and ongoing career opportunity and development from entry level health care support worker through to registrant and beyond.

2. Current Position

Registered Nurses

The trusts overall registered nurse vacancy position (all grades excluding nursing associate) has sat at circa 100 WTE vacancies for over a year; despite successful international nurse recruitment campaigns as can be seen in figure 1, although the position has improved to 67 WTE in recent months . This case, along with the international nurse recruitment plan for this year should see this vacancy position eradicated, although mindful that our establishment will increase in 2024 with the operationalisation of the elective hub.



Staff Group	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	May-23	Jun-23	Jul-23
Registered Nurse FTE Establishment	1017.41	1018.68	1024.27	1025.13	1028.68	1025.73	1028.93	1030.38	1030.16	1034.27	1044.09	1048.48	1049.7	1053.59	1039.4	1042.28
Registered Nurse FTE Variance	117.41	126.96	137.71	143.37	132.37	90.41	97.1	107.04	93.85	95.26	93.68	91.2	95.55	92.38	66.08	67.14
Registered Nurse Vacancy Rate	12%	12%	13%	14%	13%	9%	9%	10%	9%	9%	9%	9%	9%	9%	6%	6%

Figure 1

The trust relies heavily on international recruitment to fill band 5 nursing positions, local domestic recruitment and newly qualified pipelines account for relatively few recruits per year.

That said, we are more successful in filling band 6 roles from both within our existing workforce and via the external market.

We know that patient case mix has changed significantly over the last decade with hospital admitted patients being sicker and frailer, as those who are less sick are cared for closer to home. The current workforce model has relatively few band 6 roles and a high proportion of band 5 nurses unlike other professional groups such as midwifery and allied health professional roles that tend to have a richer skill mix.

This business case seeks to increase the number of band 6 roles in those areas highlighted in figure 2 below, thus leading to the provision of senior nursing leadership 24/7 and 365 days per year in those areas where this is deemed necessary. The overall establishment will remain the same, and as band 6 posts are recruited they will replace a band 5 vacancy, thus creating the desired skill mix change.

There is a fairly ambitious target to recruit all of the band 6 posts by the end of the financial year 23/24. Assumptions have been made that 50% of the posts will be recruited externally and 50% from existing workforce.

Area	Increase in B6 WTE required
A & E	-
AMU (Acute Medical Unit)	-
Arrow (Respiratory) Ward	1.19
Ashgrove Ward	1.19
Bromyard CH - Nursing	4.19
CCU	2.47
Childrens Ward	0.59
Daycase	3.19
Dinmore Ward	1.59
Discharge Lounge & MDCU	-
Frome - Emerg Gen Surg/Trama21	-
Garway Ward	2.19
ITU/HDU	-
Leominster CH - Nursing	2.19
Lugg Ward	1.66
Primrose Elective Gen Surg	4.59
Redbrook – Trauma	2.59
Ross CH - Nursing	0.19
SCBU	-
Teme Elective Orthopaedic	3.19
Women's Health	4.19
Wye Ward	1.26
Total WTE	**36.46**

Figure 2

Registered Nursing Associates

The trust currently has an establishment of 37.61 WTE Band 4 nursing associates, although carries a vacancy factor of 15.81 WTE. The vacancies are backfilled with band 5 registered nurse posts either through substantive recruitment where this is possible yet mainly through agency given the band 5 vacancy factor. This business case seeks to add a further 22.91 WTE nurse associate (band 4) posts into the establishment by converting 22.91 WTE band 5 posts in to band 4 posts, therefore aiming for a target establishment of circa 60 WTE. The additional band 4 posts will be assigned to the clinical areas as can be seen in figure 3. Those areas with no changes are either due to already reaching their target band 4 establishment, or have a skill mix that is unable to support additional band 4 nursing associates.

Area	B5 to be substituted with B4 (WTE)
A & E	5.72
AMU (Acute Medical Unit)	2.59
Arrow (Respiratory) Ward	-
Ashgrove Ward	-
Bromyard CH - Nursing	-
CCU	-
Childrens Ward	2.60
Daycase	2.60
Dinmore Ward	-
Discharge Lounge & MDCU	-
Frome - Emerg Gen Surg/Trama21	2.60
Garway Ward	-
ITU/HDU	-
Leominster CH - Nursing	-
Lugg Ward	1.60
Redbrook – Trauma	2.60
Ross CH - Nursing	2.60
SCBU	-
Teme Elective Orthopaedic	-
Wye Ward	-
Total WTE	**22.91**

Figure 3

As part of the Trust's "grow our own" strategy and through use of the apprenticeship levy, we have an agreement as part of our existing financial plan for an ongoing Trainee Nurse Apprenticeship programme to recruit eight Health Care Support Workers each year to train to become Qualified Nursing Associates.

There are a small number of existing trainees due to qualify by the spring of 2024 and a further 5 training places have been offered to commence in September 2023. If the trust continues with this approach it would take until 2028/29 to have trained and filled the existing vacancies and the additional roles.

This business case seeks to offer more training places to support up to 25 WTE trainee nursing associates in March 2024, this would enable the target establishment to be achieved much sooner (end of March 2026). The Trust has approached higher education centres and can confirm that a spring intake of 25 could be supported in time to take advantage of the HEE funding.

In terms of expanding our training offer; the limiting factor to date has been the financial investment required upfront to expand this workforce more rapidly. Whilst all training costs are covered through the apprenticeship levy, the trust has been required to pay the apprentice 100% of their salary, release the trainee for 30% of their time (for placement and university related activity) and backfill the gap through existing or temporary workforce, meaning each post costs 130% salary.

Since the draft case was presented to Trust Management Board last month, funding has been made available through Health Education England of 4k per trainee per year for all trainees recruited by end of March 2024. We anticipate being able to take advantage of this funding subject to some points of clarity that are being pursued. For transparency the finance section includes the costs of this case with or without this funding offer.

In addition, the Integrated Care System and Board are looking to support organisations with funding for nursing associate and registered nurse degree apprenticeships. This is subject to ongoing discussions and nothing has been agreed to date.

3. Drivers for Change

The NHS Long Term Workforce Plan published in June 2023 recognised the need to transform and reform the NHS workforce, describing this as a "once in a generation opportunity to put the NHS on a sustainable footing to deliver high quality patient care now and in the long term". The plan was developed on a backdrop of over 112000 vacancies across the NHS as of March 2023, with a recognition that immediate actions must be taken now if we are to bridge the workforce gap and meet the needs of the future NHS.

The long term plan sets out the case for change and includes a number of recommendations; this business case meets the following recommendations: an expansion in new roles such as nursing associates, increasing the number and proportion of apprenticeships and creating new opportunities and retaining existing talent.

With the workforce challenges in mind, the Trust set its strategic objectives for 23/24 recognising that workforce was a key priority including:

- Being a flexible employer
- Improving recruitment, retention and employment opportunities through flexible working practices and career pathways with One Herefordshire partners
- Develop a 5 year 'grow our own workforce plan'

The strategic objectives state specifically that we will build on the success of the healthcare support worker initiative, the Trust will extend the approach to nursing associate and registered nurse degree apprenticeship roles, developing an end to end career pathway for nursing.

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

4.1. Project Objectives

The objective of this project is to implement a long term sustainable nursing workforce through fundamentally changing the skill mix of nursing registrants based in our ward settings, Emergency Department, Day case and Community hospitals across WVT. The project is fully supported by senior nursing staff from across those areas where these changes impact.

4.2. Critical Success Factors (CSFs)

Overall

Reduce the number of Band 5 vacancies by 61 WTE and achieve an overall registered nurse/nursing associate vacancy factor of no more than 5% of our overall establishment by 2026.

Senior Registered Nurses

Increase the number of band 6 roles by 36 WTE thus leading to the provision of senior nursing leadership 24/7 and 365 days per year in those areas where this is deemed necessary by April 2024.

Registered Nursing Associates

Support a further 25 WTE health care support staff to train to become a nurse associate (band 4) in Spring 24 with a view to qualifying in 2026

4.3. Benefits

Category	Description of Benefit	How benefit will be measured
Quality	Staff satisfaction at ward level improved due to less ward moves to cover gaps	Reduction in redeployment numbers on health roster
	Improved continuity of care and quality of care for our patients	Number of shifts covered by agency compared to the baseline Improved quality indicators
	Senior nursing leadership provided 24/7 in relevant areas	Number of shifts covered by B6 or above according to establishment
Strategic intentions	Grow our own workforce including career development for health care support workers and registered nurses	Skill mix changes as described in the case will be fully achieved: 36 WTE additional band 6 roles 23 WTE additional band 4 roles 16 WTE band 4 vacancies recruited to Commensurate reduction in band 5 roles Number of WTE recruited from existing workforce for both band 4 and band 6 roles
Financial	Reduced agency reliance	Agency spend in relevant areas
Workforce	Improved recruitment/retention	Vacancy position (band 6, 5, 4) Turnover rates (band 6, 5, 4)

5. Options Appraisal

In developing this business case we have considered the following three options:

Option 1 - Do nothing to increase band 6 opportunities and maintain existing nursing associate annual plan.

This option would not fulfil the ambition to develop a more sustainable workforce. Trainee

nursing associates would continue to be recruited at a rate of eight per year. Some skill mix changes would be achieved in the longer term 2028/29.

Pros

- Expenditure will continue at existing levels.

Cons

- This option would not achieve the desire to provide more senior leadership 24/7 – 365 days per year.
- The trust may continue to lose band 5 nurses seeking career progression due to limited opportunities at WVT.
- The band 5 vacancy factor is likely to persist for longer thus driving agency spend

This is not the preferred option.

Option 2 – Implement the band 6 skill mix changes and continue with the existing nurse associate annual plan

Pros

- Senior leadership cover provided 24/7 – 365 days per year
- Retention of band 5 nurses will improve due to more career development opportunities

Cons

- Increased budget impact due to higher cost of band 6 salary
- Target band 4 establishment not achieved until 2028/29

This is not the preferred option

Option 3 – Implement the band 6 skill mix changes and expand the band 4 trainee nursing associate offer through a larger cohort of trainees in 2024

Pros

- Senior leadership cover provided 24/7 – 365 days per year
- Target band 4 establishment achieved by 2026
- Represents better value for money overall
- Fulfils trust strategic objectives to grow our own, improve retention and provide more career opportunities
- Band 4 skill mix changes partially offsets the additional cost of the band 6 increase

Cons

- Requires upfront investment and carries some risk in terms of funding sources being available

This is the preferred option as it is deemed better value for money

6. Financial Analysis

Cost Type	Cost Sub-Type (Delete/Add rows as necessary)	Description of Cost (narrative not numbers)
Capital	No Capital Impact	
Revenue	Workforce	B6 element includes agency saving for staff recruited externally. TNA includes cost of backfill element (30%) and cost saving of replacing B5 with B4 once qualified.
	Recruitment costs	Assumed within current Trust establishment
	Training	Assumed in house and through Apprenticeship Levy to higher education provider

Band 6 24/7 Cover

The organisation has consistently had a high level of B5 Registered Nursing vacancies, these have been covered by high cost agency staff. Recruitment and retention of International nurses has reduced this, however there is still difficulty in recruiting domestic recruits into these posts. With increased demands on the services, a proposal to improve the recruitment and retention of staff is to have Band 6 cover for 24/7 to ensure there is always senior nurse experienced leadership on every shift. In order to provide this for relevant wards this is an increase of 36.46 WTE Band 6's. (Figure 2 – page 3 demonstrates the areas where increases are required).

The planned trajectory is shown in the table below

There is a fairly ambitious target to recruit all of the band 6 posts by the end of the financial year 23/24. Assumptions have been made that 50% of the posts will be recruited externally and 50% from existing workforce. The external recruitment will reduce vacancy and will displace 0.80 WTE agency (i.e. 3 new band 6 per month displacing 2.40 WTE agency).

WTE	2324											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Recruitment plans - B6 (assuming 50% external)	0	0	0	0	0	0	0	6.08	6.08	6.08	6.08	12.14
Cumulative plans B6 Increase								*6.08*	*12.16*	*18.24*	*24.32*	*36.46*

£000s	2324											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Recruitment plans - Increase B6 (50% External)	0	0	0	0	0	0	0	6	11	17	23	34
Agency Saving for 50% external recruitment (assumes diplacing 0.80 WTE agency)								(8)	(17)	(25)	(33)	(50)
Total Cost/(Saving) In month								*(3)*	*(5)*	*(8)*	*(11)*	*(16)*
Cumulative cost/(Saving)	***0***	***0***	***0***	***0***	***0***	***0***	***0***	**(3)**	**(8)**	**(16)**	**(27)**	**(43)**

Although there is an increased cost for the Band 6 24/7 cover, this change would ensure that there is senior nurse leadership on each shift and therefore reduce the need for high cost agency. Other benefits would include an improved quality of care for the patients, with consistent care on all shifts.

Expand the number of registered Nursing Associates (current plan)

The board approved an ongoing Trainee Nurse Apprenticeship programme to recruit 8 Health Care Support Workers each year to train to become Qualified Nursing Associates. The organisation has since identified that there are a further 22.91 WTE of Band 5 Nursing roles that can be substituted with a Band 4 Nurse Associate. These are outlined in the table in Figure 3 (page 4).

This trajectory shows the current plan to support 8 trainee nursing associates per year

Current trajectory with intake of 8 students each year for the next 5 years

WTE	2324	2425	2526	2627	2728	2829	2930	3031
Total Active TNAs in Training at M12 - WTE	8.00	13.00	16.00	16.00	16.00	16.00	8.00	-
Total Increase to B4 workforce once qualified at M12 - WTE	6.00	9.00	14.00	22.00	30.00	38.00	46.00	54.00
£000s								
Band 3 Budget already in place (70% Clinical Time) - All Cohorts	(193)	(254)	(308)	(334)	(334)	(334)	(237)	(70)
Recurrent Saving - Changing skillmix from B5 to B4	(50)	(122)	(223)	(349)	(499)	(649)	(799)	(948)
Band 3 Salary Cost (100% pay of which 70% is Clinical) - All Cohorts	276	363	440	477	477	477	338	99
Total Annual Cost £000s/(Annual Saving £000)	33	(13)	(91)	(206)	(356)	(506)	(697)	(918)

Nursing Associates (Expanded offer)

This approach aims to offer 25 WTE training places in March 24 which is the remaining gap to be filled assuming all current trainees and those commencing in September 23 qualify as planned.

Assuming full recruitment to current gap in Feb 24 with intake of 8 students each year for the next 5 years

WTE	2324	2425	2526	2627	2728	2829	2930	3031
Total Active TNAs in Training at M12 - WTE	8.00	30.00	25.00	-	-	-	-	-
Total Increase to B4 workforce once qualified at M12 - WTE	6.00	9.00	14.00	39.00	39.00	39.00	39.00	39.00
£000s								
Band 3 Budget already in place (70% Clinical Time) - All Cohorts	(193)	(679)	(566)	0	0	0	0	0
Recurrent Saving - Changing skillmix from B5 to B4	(50)	(122)	(223)	(730)	(730)	(730)	(730)	(730)
Band 3 Salary Cost (100% pay of which 70% is Clinical) - All Cohorts	276	969	808	0	0	0	0	0
Total Annual (Cost £000s)/Annual Saving £000	33	169	19	(730)	(730)	(730)	(730)	(730)

The model for both the current and expanded TNA offers include backfill at current rates and assumes each nurse will be paid at a B3 salary – 70% of this will be clinical so the cost for the programme is the 30% supernumerary element. The model assumes all the course fees will be funded from the apprenticeship Levy at no cost to the organisation. No increase in costs have been factored in for any additional pastoral support needs or additional on boarding requirements.

Nursing Associates Expanded offer and band 6 skill mix changes – preferred (Option 3)

This is the preferred option to implement the band 6 skill mix changes and expand the band 4 trainee nursing associate offer through a larger cohort of trainees in 2024. This option provides the 24/7 cover of senior leadership throughout the year whilst aiming to deliver a full repertoire of Trainee Nurse Associates. Not only will this fit the trust objectives to 'grow our own' but should also reduce the heavy reliance of high cost commercial agency.

The table below outlines the overall costs/ (benefits) for the organisation to implement option 3. Overall this option should deliver savings within the first year due to the offset of high cost commercial agency, providing that we can recruit 50% of the B6 nurses externally starting from November 23. The investment in TNA growth should be offset by the B6 savings generated.

WTE	2324	2425	2526	2627
Total B6 posts added (Cumulative)	36.46	36.46	36.46	36.46
TNAs in training at 31st March each year	8.00	30.00	25.00	-
Total in B4 once qualified at the 31st March each year (including those already in the pipeline)	6.00	9.00	14.00	39.00

£000s	2324	2425	2526	2627
Increase in Band 6 cost per year (differential from B5 to B6 only)	90	405	405	405
Agency Saving for 50% external recruitment (assumes diplacing 0.80 WTE agency)	(133)	(598)	(598)	(598)
Total B6 Cost/(Saving) per year	***(43)***	***(193)***	***(193)***	***(193)***
Cost of TNA (Backfil element only - 30% of time)	83	291	242	0
Saving - Skillmix change from B5 to B4 (once qualified)	(50)	(122)	(223)	(730)
Total TNA Cost/(Saving) per year	***33***	***169***	***19***	***(730)***

Total Cost/(Saving) for B6 & B4 Per year	**(10)**	**(24)**	**(173)**	**(923)**

Anticipated HEE funding £4k per nurse per year	*0*	*(100)*	*(100)*	*0*
Potential Cost/(Saving) for B6 & B4 Per year with Anticipated HEE funding	**(10)**	**(124)**	**(273)**	**(923)**

Cumulative cost/(Saving) - Whole Project	**(1,330)**

The costing has been considered without the impact of the HEE funding which is available at £4k per nurse per year of the course. Funding is available for trainees signed up by 31st March 2024. The criteria for funding has stated that this cannot be used to offset the salary cost of the trainees, however there is potential to use this funding in order to support the pastoral needs of the trainees. Therefore the anticipated funding value has been included in the table above to show the full impact of the project.

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

7.1. Critical Assumptions

Registered Nurses

- Once the band 6 is recruited, they will be appointed into a band 5 vacancy which will change the skill mix and therefore the budgeted establishment will be amended within the division to reflect this reduction
- For clinical areas that do not have band 5 vacancies the band 6 posts will be recruited through natural turnover and not through an increase in overall establishment

Nursing Associates

- Each trainee will be paid a Band 3 salary of which 70% of this time will be clinical. The additional funding requirement for each trainee is limited to the 30% supernumerary element of their B3 salary. It is assumed that the 70% Clinical time will be funded from existing vacancies over the next few years.
- The apprenticeship levy will pay for 100% of the TNA tuition fees, which total approximately £15k per apprentice.

- Once the trainee has qualified, they will be appointed into a Nurse Associate post which will change the skill mix from a B5 to a B4 and therefore budgeted establishment will be amended within the division to reflect this reduction in budget.

7.2. Risk Assessment

- This model assumes that 50% of all band 6 vacancies will be recruited externally and agency costs will be offset from November 2023
- This model assumes the 30% backfill at band 3 standard rates through bank or existing workforce. Where shifts are backfilled by higher grade or agency there will be increased costs for the 30% supernumerary element.
- For the new posts, this assumes that there will be vacancies at band 5 level once the TNA has qualified, which they will fill at a Band 4 therefore generating a saving on the differential of B5-4. It has been identified as part of the review that there are 22.91 WTE posts that can transfer from a B5 to a B4.
- The Trust may struggle to recruit 25 WTE trainee nursing associates in one large cohort – a survey of existing workforce is currently being conducted to gauge where numbers may land
- The case assumes the higher educational centres can host an additional cohort in March 2024 as initially proposed (this is also dependent on recruitment commencing in September 2023)
- This case has not explored the infrastructure required to support a larger cohort of trainees. The education team are set up to support the current intake of eight new apprenticeships per year.
- If a large cohort is supported there will be a large number of health care support worker vacancies when the cohort qualifies in 2026 which would need to be planned for accordingly
- This case assumes a 100% retention and pass rate for all trainee nursing associates

7.3. Quality Impact Assessment

The quality impact assessment can be made available to the Board, yet the main areas are summarised here.

Patient Experience

- Senior nurse on duty 24/7 – 365 days per year
- Vacancies reduced/ less agency reliance and consistent continuity of care
- Improved quality outcomes

Staff Experience

- More career development opportunities
- Improved recruitment and retention
- Reduced likelihood of being moved from base ward to cover gaps elsewhere

7.4. Equality Impact Assessment

The case has a positive impact for all of our patients and in particular those who are vulnerable, older, or have a disability as they will be cared for by a substantive workforce who can provide high quality continuity of care.

8. Impact on other areas of the trust

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

This proposal has not explored the wider infrastructure required to support a larger cohort of trainees. The education team/ pastoral roles are set up to support the current intake of eight new apprenticeships per year. A larger cohort would need an expansion of practice education and this is being considered as part of a separate review.

9. Implementation Timeline

Registered nurses

Recruitment into the band 6 roles can start with immediate effect; the case sets a fairly ambitious target to have achieved full recruitment by the end of the financial year.

Nursing Associates – time critical

In order to recruit the desired number of trainee nursing associates and achieve the timetable prescribed by the higher education centres for a Spring Intake the selection process will need to begin in September.

The nursing associates will need to be recruited onto the programme by March 2024 to receive HEE funding (subject to points of clarity referenced earlier).

10. Leadership and Project Management

Role	Name
Senior Responsible Officer (SRO)	Lucy Flanagan, Chief Nursing Officer
Senior Nursing Lead	Emma Smith, Associate Chief Nursing Officer – Safe staffing lead – for clinical areas Rachael Hebbert – ACNO – Educational aspects
Associate Director of Education	Chris Wood

Role	Name
Recruitment lead (band 6 posts)	Charlene Abberley, Recruitment Team Leader
Apprenticeship lead (band 4 posts)	This post is subject to confirmation of recruitment

The recruitment into the band 6 nursing roles will in the main be led by the divisions and be treated as business as usual with support from the recruitment team.

The selection process and on boarding for the trainee nursing associates will require a degree of intensive communication and coordination in the next 2-3 months and will be coordinated by those individuals identified in the table above.

11. Workforce Plan

This case sets out skill mix changes to the existing ward based and relevant department establishments. The critical assumptions and risks clearly identify the challenges associated with delivering the case fully within the target timescales.

12. Conclusions and Recommendations

In line with the national workforce strategy and trust strategic objectives, Trust board is asked to support the preferred option – option 3.

This business case aims to provide a long term sustainable nursing workforce model and builds on the changes already introduced for health care support staff. It will fundamentally change the skill mix of nursing registrants based in our ward settings, Emergency Department, Day case and Community hospitals across WVT.

The case fulfils the strategic ambition for growing our own workforce strategy by offering career development from health care assistant entry level through to senior registered nurse and will improve recruitment and retention across these staff groups.

13. Appendix A – EQUALITY IMPACT ASSESSMENT (EIA) FORM

Please read EIA guidelines when completing this form

Section 1

Name of Lead for Activity:	Lucy Flanagan
Job Title:	Chief Nursing Officer

Details of individuals completing this assessment	**Name**	**Job Title**	**Email Contact**
	Lucy Flanagan	**Chief Nursing Officer**	**Lucy.flanagan@wvt.nhs.uk**
	Rachael Hebbert	**Associate Chief Nursing Officer**	**Rachael.Hebbert@wvt.nhs.uk**
	Daniela Locke	**Deputy Chief People Officer**	**Daniela.Locke@wvt.nhs.uk**
Date assessment completed		**30th August 2023**	

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Nursing skill mix change			
What is the aim, purpose and/or intended outcomes of this Activity?	To offer career development opportunities as part of the trusts grow our own strategy			
Who will be affected by the development & implementation of this activity?	☒	Service User	☒	Staff
	☒	Patient	☒	Communities
	☒	Carers	☐	Other
	☒	Visitors	☐	_____
Is this:	☒ Review of an existing activity ☐ New activity ☐ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)	Staff survey Vacancies, turnover and retention figures Agency spend and reliance Patient acuity and dependency information			
Summary of engagement or consultation undertaken (e.g. who, and how, have you engaged with, or why do you believe this is not required)	Working group including HR, senior nursing and educational representatives			
Summary of relevant findings	This provides improved continuity of care for patients by reducing reliance on temporary workforce and providing a more sustainable workforce model.			

Section 3

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

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

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?			
Risk identified	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Time frame**

How will you monitor these actions?
Not applicable

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)
As part of the business case evaluation process

Section 5

Please read and agree to the following Equality Statement

Equality Statement

- All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
- WVT will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

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

Signature of person completing EIA:	
Date signed:	30th August 2023
Comments:	
Signature of Lead for this activity:	
Date signed:	30th August 2023
Comments:	

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
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 wide range of critical digital programmes are in progress, with material funding associated with the National Frontline Digitisation agenda. Work on the refresh of the digital strategy has commenced and will come to Board over the coming months.

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 Programme	Implementation	March 2025 (Phase 3)	Y	A	Y
		EPMA Integration (Allergies, labs, VTE)	Development / Testing	December 2023	Y	A	Y
	GP Order Comms		Development / Interface Testing	December 2023	Y	A	Y
	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	On Hold	Y	On Hold	On Hold
	Clinical Systems Management (formerly BAU Service Re-design)		Implementation	Before end August 2023	Y	Y	G
	Synertec My NHS Communications		Project start/ Implementation	December 2023	Y	Y	G

Points of Escalation

Project	Summary (Description, Impact and Mitigation)	Type (Note, Issue or Risk)	RAG (Post Mitigation)
EPR Programme	Outpatient Clinical Noting went live in Haematology on the 19th June with just 2 areas now remaining to go live – Dermatology planned for the 18th September and the CDC planned for the 9th October. The Remote Cancer Monitoring (PSFU) 3 month pilot, which commenced on the 15th May, is progressing well with a view for this to go-live on the 31st August if no issues are highlighted. Limited Project and Testing resource remains a risk however recruitment is progressing for 2 further Test Analysts within the CSG and an additional Project Manager and a Business Analyst have now been successfully appointed to the EPR Team. The EPR Phase 3 Programme Plan is being finalised with reference to the IMS Roadmap, and this is being updated in parallel with the programme resource plan. Draft Business cases and the procurement process is now also progressing for the ED System replacement and Single Sign on projects with technical options being evaluated. The SRO is in the process of bringing forward business analysis and process mapping work which will both support the business	Risk	A

	case and enable advancement of work that will need to take place once the business case is approved. A draft project plan for pilot specialty for the Patient Portal has now been submitted to the ICB to meet the deadline for the first stage funding. The draft document for the Frontline Digitisation Funding Bid has also now been submitted to NHS England.		
EPMA Integration	The Better Med Open EP functionality updates were applied following the successful OpenEP upgrade. VTE screening functionality has now been made available in the test environment and testing has begun, although some configuration issues will need to be addressed before this functionality can be progressed through UAT. Collateral has now been shared between IMS MAXIMS and EPRO with regards to the Patient in context interface in order to enable a decision on the agreed API specification. A joint roadmap has been requested from the suppliers to outline when the functionality can be installed on the WVT servers so that UAT can take place. It is anticipated that the EPRO release which will include Patient in context links and Pharmoutcomes functionality will be into UAT by the end of quarter 3 of the current financial year. Work will be undertaken with the Clinical Safety Officer and system users to test the unidirectional solution and associated processes to mitigate potential risks. The imperative is to develop a fully integrated bi-directional interface as the phase 2 delivery.	Risk	A
GP Order Comms	Following high level escalations with IMS Maxims they have agreed to prioritise GP order comms delivery by providing the functionality separately from Maxims version 17. A patch release to enable this to be included as part of Maxims version 16.3 is now due to go LIVE in September. Project kick off meetings with IMS, MedCurrent and internal stakeholders have now commenced to discuss resourcing and delivery timescales for the Radiology clinical decision support module. Resource planning is underway for support of the Hereford Medical Group pilot and further roll out to GP Practices and work is continuing to reset expectations and communicate progress with stakeholders to ensure continued engagement. Suppliers are having ongoing discussions regarding how to deliver the solution to reduce further delays.	Issue	A

Telecoms Upgrade Programme	The draft business case was submitted to the July Digital Programme Board for review and approval. This was endorsed by the Board with a view this should be taken to TMB for further review. The initial County site telecoms survey has now been completed and the discovery of all telephony assets, sites and services across the Trust continues. Work is progressing well on re-tendering mobile phone contracts onto the new framework to achieve significant cost savings for the Trust. Work is also continuing to liaise with Estates to understand the PFI details regarding telephony provision. Project Board members have been agreed and the first meeting was held at the beginning of August. A stakeholder presentation took place on the 14th July for senior managers across the Trust in order to introduce the project & promote understanding & engagement.	Note	G
e-Rostering – Medical	Discussions are ongoing regarding the leads for further Allocate work required for this year. This includes Medical e-Rostering, e-Rostering for Community Hospitals and other Clinical staff and Medical job planning. The scope of this project is being reviewed by the project sponsor. The requirement and frequency of updates will be evaluated following the outcome of the review.	Note	A
Voice Recognition	The procurement and contract process is taking place and is being led by Hoople. The Trust has introduced a pause prior to contract signature because Worcestershire Acute are currently investigating the same solution and the potential for a larger/ combined contract is to be explored. The grace period for the pilot has now ended and billing has been received from T-Pro for the June usage. A PO has been raised to fund this centrally for an initial period until the project finances have found their footing. Planning and communication for a roll out to an initial 100 users has commenced.	Note	On Hold
Clinical Systems Management (formerly BAU Service Re-design)	The Benefits Manager and Clinical Functions Manager posts were successfully appointed to in June. Work is on-going with Hoople on the delivery of the non-pay work streams and a draft project plan has now been written. The eLearning platform is currently going through testing with API's to be configured. Feedback has been sent to Hoople regarding the configuration of the e-ticketing system which is also currently being tested. The self-service password reset functionality is currently with Hoople for set up. The out of hours phase 1 pilot will continue until September, with an options appraisal drafted for phase 2 to include costings and consultation amongst colleagues, once lessons learned have been evaluated. A digital new starter form has now been drafted to enable the digitisation of network access requests. This is currently out for consultation with stakeholders, Recruitment and Information Governance.	Note/ Risk	Y

Synertec My NHS Communications	Project initiated to use the Synertec “My NHS Communications” hub to send letters to patients via a digital hub in order to make cost savings. This is an interim solution until replacement by the “My Health and Wellbeing” patient portal. The scope of the project and project resources have been confirmed and project planning is ongoing. The verification upload process has been agreed and the initial test upload it being created to enable synertec to confirm the technical design and build dates. Work has started to collate WVT owned patient information leaflets with an initial approach agreed with the Communication and Patient Experience Teams though this may need to be reviewed. Mindwave will provide early life technical support for patients registering with the app. Uncertain long term technical support for patients may be an issue but impact is thought to be minimal based on feedback from Leeds Hospital Trust based on their experience.	Note / Issue	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 capital position, on digital schemes for July 2023.

Division	Specialty	Proposal	Values Plan £k	YTD Actual 2324 £ks
Clinical Support	**Corporate Digital**	Digital Pathology Macropath		- 5
Clinical Support Total				**- 5**
Corporate Digital	**Corporate Digital**	Allocate (formerly E-Rostering)	100	75
		APEX (pathology) replacement	100	-
		Business Intelligence and Data Warehouse	1,000	-
		Cyber security	-	- 3
		Device Replacement	500	- 3
		Digital Dictation/Speech recognition	100	-
		ED System Replacement	500	-
		EPR	500	108
		GP Order comms		59
		Hoople Infrastructure replacement	600	7
		ICB project Trust resources incl Rhapsody comm ports, remote patient monitoring and Trust interfaces	200	-
		IT UPS Replacement		6
		Single Sign on	500	-
		Smaller IM&T schemes	150	-
		Telecoms & Pagers	200	-
		Virtual Clinics and OPD self service	100	-
Corporate Digital Total			**4,550**	**249**
Grand Total			**4,550**	**244**

Version 1 22020304

The YTD July expenditure is 5.37% of the annual plan value. Many projects have not got up and running fully yet so expenditure will follow later in the year. Most of the expenditure in month relates to EPR. There is still a prioritisation exercise that needs to be undertaken so budgets may change in future.

Place based Strategic Projects

Project	Stage	Key activity
Digital Pathology	Implementation/ Validation	West Midlands Digital Histopathology Operational Group has now been established to develop regional SLA's to assist with benefits realisation. The LIMS supplier, Sectra and Pathology IT continue to work on the reporting interface post technical go live. Procurement of an additional scanner to facilitate 100% scanning has been completed. A business case for additional revenue to increase storage and case licencing will be presented in the current financial year. The project is currently working through clinical evaluation but is now live at WVT. Further updates are anticipated to be less frequent as the project progresses across partner organisations.
Remote Monitoring	Pilot / Scoping	The remote cancer monitoring pilot is progressing well with a go-live anticipated for the 31st August unless any issues are reported.
Advice and Guidance	Scoping	Requirements and funding are being explored.
Virtual Wards	Scoping	Work is ongoing to extend the use of DOCOBO and remote monitoring to see how the number of patients on virtual wards can be increased without the need to increase staffing levels.

IM&T Strategy and Upcoming Opportunities

Opportunity	Route	Status
Community Diagnostic Hub	Regional Programme	A Project Manager has now been appointed to support the Digital implementation of the Community Diagnostic Hub and Stroke AI.
Virtual Desktop/Single sign on.	DCF (Digital Capabilities Framework) Requirement.	Procurement and evaluation exercise with suppliers has commenced with a target of the end of October.
ED System Replacement.	Trust Digital Strategy and MDF (Minimum Digital Foundations) Requirement.	The Project Manager and Business Analyst to support this project started in late July.

Messages

- The August Digital Programme Board took the format of a dedicated digital strategy workshop. The potential for a broader digital and data strategy was explored now the essential EPR foundations are nearing completion and the output of this workshop will feed into a Board workshop due to take place in October following which the Trusts new digital strategy will be developed.
- An opportunity has arisen to bid for additional capital funding via the ICB due to a regional underspend on the Frontline Digitisation Programme. The Trust has submitted bids totalling £1,000k in connection with essential client device modernisation and an anticipated financial shortfall on current projects.
- The ICB Best Use of Resources (Digital) is seeking to formalise principals concerning organisational involvement in its cost reduction projects. A principal of “in by default” has been proposed and clarity is being sought from partner organisations regarding their involvement in current projects. The Trust is already committed to Mobile Voice & Data and Unified Communications. Managed Print and the Wide Area Network procurement will be considered at the September Digital Programme Board. It is anticipated that it will be in the Trust’s interest to be involved in both.

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
Title of Report:	Board Assurance Framework (BAF) and Divisional Operational Risk Register
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	BAF as at 31 August 2023 High Risks 15+ as at 31 August 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, plus the divisional operational risks.

2. Recommendation(s)

The WVT Trust Board is invited to note:

- The risks to delivery of WVT's strategic objectives 2023/24; and,
- The operational risks (rated 15 and above) being carried by divisions within the Trust.

3. Executive Director Opinion[1]

The BAF is a live document which details the risks of achieving the Trust's 2023/24 strategic objectives. This document is continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives. As requested at the Board meeting in July 2023, the BAF now also reflects the direction of travel: the consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.

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

There are ongoing improvements with this data, its analysis and presentation with the introduction of the Trust's new incident and risk management system, InPhase. All historic risk data has been pulled through to the new system and, alongside the implementation of recommendations from an internal audit, is being reviewed to ensure effective risk management processes and governance continues.

[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***

Risk Id	Legacy ID	Risk Title	Risk Type	Risk detail	Date added to Register	Review date due	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Monitoring Committee	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
54	1547	**BAF 2023/24** Ability of system to manage flow across the urgent and emergency care pathway	Strategic	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.	25-Apr-22	30-Oct-23	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 • Winter Plan 2023/24 • Discharge to Assess Board	•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 initiatives /schemes untested.	(Multiple)	29-Aug-23	•System wide silver and gold calls. •Finance and performance executive reporting •Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board.	• System oversight of discharge delays and capacity. • Better Care Fund not yet reporting to the Integrated Care Executive. •Winter Plan and capacity bridge analysis.	→
56	1605	**BAF 2023/24** Availability of Capital Funds to meet Trust's Strategic Objectives	Strategic	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.	05-Aug-22	01-Sep-23	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	Trust Management Board	22-May-23	•Project teams and programme board structure in place for major schemes. • Capital Planning and Equipment Committee •Trust Management Board •Financial reports to Board		→
58	1114	**BAF 2023/24** Clinical and support staff recruitment and retention	Strategic	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	30-Oct-23	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. •'Deep dives' and analysis into areas of high turnover, vacancies, exit interviews and new starter surveys. •Contract management and monitoring data of Master Vendor and Direct Engagement use. including monitoring of agency price cap.	•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.	(Multiple)	23-May-23	•HR Directors weekly ICS meeting. •P&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 •WARP 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.	→
59	1115	**BAF 2023/24** Delivery of the Digital Strategy	Strategic	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.	22-Jul-20	30-Oct-23	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.	(Multiple)	31-Aug-23	•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	→
62	1540	****BAF 2023/24** Maturity of Integrated Care Executive	Strategic	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.	19-Apr-22	30-Oct-23	Jane Ives	15	3	4	12	6	Regular reporting by ICE to the One Herefordshire Partnership Board and the Wye Valley NHS Trust Board	Variable attendance at ICE Incomplete dataset Better Care Fund not yet agreed	Board of Directors	29-Aug-23	One Herefordshire Partnership	ICE Terms of Reference pending MOU publication	→
63	1541	**BAF 2022/23** Maturity of Primary Care Networks	Strategic	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.	19-Apr-22	30-Oct-23	Jane Ives	15	3	4	12	6	•National DESs (directed enhanced services) •Agreed PCN priorities •Joint appointment between WVT and Taurus of Director of Strategy and Partnerships	Variable PCN maturity and delivery	Board of Directors	29-Aug-23	•One Herefordshire Partnership •Integrated Care Executive •Improving availability of data to support reporting	Sufficient PCN-level management oversight	↓

65	1308	****BAF 2023/24** Recruitment to Health and Social Care Teams to Support Patients at Home	Strategic	Recruitment to Herefordshire community health and social care teams (including Homefirst and Community Interface) is insufficient to support all people who require care at home	29-Apr-21	30-Oct-23	Jane Ives	16	4	3	12	8	•Discharge to Assess (D2A) Board established July 2023 •Workforce Strategy and recruitment campaign in place for Homefirst recruitment.	•Ongoing Homefirst vacancies •Better Care Fund not yet agreed •Home care market insufficient to meet demand.	Board of Directors	29-Aug-23	•One Herefordshire Partnership Board - quarterly performance review of home care market. •Integrated Care Executive - monitoring vacancy position. •Integrated care finance and performance executive. •D2A Board monitoring of Homefirst delivery.	Incomplete information to Discharge to Assess (D2A) Board	↓
66	1116	**BAF 2023/24** Risks to productivity and operational capacity plans and delivery	Strategic	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	30-Oct-23	Andy Parker	25	5	3	15	10	•Recovery and Restoration plan (under regular review) •Escalation and surge plan •Ringfenced elective pathways •Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. •Group and system-wide mutual aid •Activity plans. •Clearly documented value for money assessment of additional flexible capacity options as part of business case process.	•Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. •Ongoing impact of industrial action. •Productivity plans based on GiRFT faster further programme	(Multiple)	29-Aug-23	•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. •Local and regional value-weighted activity is above 100% of 2019/20 levels.	None Identified	↓
1686		**BAF23/24** Improving Cleanliness Standards	Compliance with 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	30-Oct-23	Lucy Flanagan	20	4	3	12	8	•Contractual cleaning schedule to meet nationally published (2021) standards •Regular meetings with PFI providers to resolve issues as they arise	•Standard of cleaning. •Consistency of delivery.	(Multiple)	29-Aug-23	•NHSE inspections •Infection Prevention Audit Programme •Monitoring team providing regular local inspection against the 2021 standards •Infection KPIs identifying change/trends •Commissioner peer review	None Identified	→
1687		**BAF23/24** One Herefordshire delivery of responsibilities contained within the MOU	Strategic	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	30-Oct-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	(Multiple)	31-Aug-23	•Monthly reports to ICE •One Herefordshire agreement of the MOU, enabling consensus.	•Defined reporting mechanism to assure delivery against the MOU.	→
1688		**BAF23/24** Delivery of Academic Programme	Strategic	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	30-Oct-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.	Trust Management Board	23-May-23	Project planning meetings	Scope of project not yet defined. Quotative and qualitive impacts of projects to be determined through national best practice.	→

Risk Id	Legacy ID	Risk Title	Risk Type	Risk detail	Date added to Register	Review date due	Division	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Monitoring Committee	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
67	1448	The Covid pandemic has resulted in increased waiting times for planned care patients	Compliance with standards	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	12-Jan-22	31-Jul-23	Corporate Division	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.	(Multiple)	14-Jun-23	•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	•Work with Primary Care to agree and develop shared waiting list management approach.	⇨
89	1702	A&E not requesting Radiology electronically	IT	There is a risk of missed scan requests/request errors/requesting delays for radiology from the Emergency Department due to ED using paper requests and not the EPR system/order comms. This could potentially lead to an adverse outcome for a patient.	08-Mar-23	31-Aug-23	Clinical Support Division	Daniel Harding	15	3	5	15	3	Paper requesting being used by ED Ongoing discussion for ED to use duplicate systems to ensure accuracy and quickest route for scan requests	Errors Delays in Radiology receiving requests Not a firm agreement in place for ED to request electronically	Clinical Support Quality Board	31-Jul-23	Incidents related to paper requesting monitored monthly at Radiology Governance Meeting.	Number of incidents relating to errors on paper forms is increasing	⇨
274	1422	Delayed transfers of inpatients waiting for cardiac surgery at UHB	Clinical Care	There is a risk to inpatients waiting for cardiac surgery due to lack of surgical capacity at UHB. This could lead to harm to patients and hospital acquired infection and can result in a higher mortality rate.	07-Nov-21	21-Aug-23	Medical Division	Jay Richards	20	4	4	16	8	•Daily review on ward by Cardiology consultant •Escalated by wards to tertiary center	•Unable to treat patients at WVT •Unable to secure bed at tertiary hospital	Executive Risk Management	19-Jul-23	Feedback at divisional risk meeting. Directorate team are engaged with Midlands Cardiac Pathway Improvement Programme (NHSE - Midlands).	Communication channels between WVT and the tertiary centres are not clear, so we do not have clear information on how the capacity risk is being managed elsewhere.	⇨
279	1359	Delays transferring wardable patients from specialist areas	Clinical Care	There is a risk of delays in returning patients from specialist areas to ward based care, Due to poor surgical flow and high capacity. Which has the potential to lead to patients remaining unnecessarily in specialist areas and results in delayed care for admitting patients, rehabilitation goals and poor patient experience.	07-Jul-21	23-Aug-23	Surgical Division	Helen Byard	15	3	5	15	3	• Escalation to Clinical Site Manager and Bed flow meetings and robust communication with the Patient flow coordinator, theatre coordinator and the NIC of the wards. To instigate a warning to the ward of the ETA of pt from specialist area. • Datix incidents reported when delays occur in wardable patients • Patients clinical condition will continue to be monitored, inclusive of NEWS Score and Clinical observations assessments • Specialist area safety Huddles to ensure that situation is monitored and appropriate Escalation to Division for support	• Unavailability of ward staff to assist with transfer • Lack of adequate nurse staffing levels on wards • Levels of high capacity • Delays could lead to out of hours patient transfer from Critical Care, which breeches GPICS guidance		24-Jul-23	• ICNARC data reviews the discharge data and how often the GPICS standards are breeched.	Reliance on staff capturing data accurately.	⇨
316	1626	Education Centre - Delivery of clinical education	Financial	A risk arises that the Trust will be unable to deliver the training it is contractually obliged to deliver. In addition to this resulting in a potential breach of contract, the lack of training capacity has a significant adverse impact on medical education within Herefordshire. A further impact of this is that medical training and recruitment will suffer. At a time when Herefordshire needs to be able to attract and retain medical staff, the loss of training and education capacity could have a severe impact on services. There is also the risk of reputational damage to the Trust arising from perceptions of poor quality medical education arising from lack of facilities. The overall impact is that the Trust could struggle to attract and retain sufficient medical staff to deliver healthcare.	03-Oct-22	10-Jan-23	Corporate Division	Jayne Clarke	20	4	5	20	12	Project set up under the leadership of the Director of Planning to look at the delivery of new Education facilities. The initial plan for this is to utilise charitable funds to at least part fund the delivery. The options for a charitable fund raising appeal are being considered. Council have agreed to access capital funds. Campaign Project Manager in place. Spellar Metcalfe accommodation made available (from summer 2024) and suitable pending build completion.	The success of the project and therefore reduction and management of the risk related to clinical education is dependent upon the ability to finance and build the new education centre. No suitable alternative educational space has been identified in the event of not being able to complete the new building. A "plan B" for how to manage a delay in the completion of the building is being worked up with estates colleagues. If inflation increases the overall costs beyond £10million, then the project is in jeopardy. Build timescales mean not open until late 2025 at the earliest.	Workforce & Development Committee		Exec led project board - chaired by Director of planning Strategic Education Centre funding raising committee - chaired by the Trust Chairman Hoople and Herefordshire council as strategic partners supporting the project and financing options through these partners Architect engaged	Definitive financing options not confirmed with partners Charitable fundraising challenges in current cost of living climate Business case not yet complete and requires Board sign off and final costings from architect which could increase in financial climate. RIBA stage 2 report awaited to confirm costings.	⇨
387	1561	Failure to meet needs of children due to > 52 weeks wait for first appointment	Clinical Care	There is risk of adverse health outcomes for young children arising from waiting more than 52 weeks from referral to see a community paediatrician. Children who are not assessed promptly to identify their health needs and intervention needed in a timely manner are at risk of short term health harm and long term disadvantage arising from inequality of access to health care. Unmet developmental, learning or emotional needs can adversely impact on behaviour, emotional and social development with risk of educational disadvantage and high rate of school exclusion. Health needs not being met increases risk of disability, failure to achieve potential and shorter life expectancy.	24-May-22	31-Aug-23	Surgical Division	Julie Vickers	20	4	5	20	6	Consultant screens all referrals to ensure appropriate gatekeeping. Other professionals requested to support for interim management or deferral of referral. Long waiting referrals being reviewed, and some now taken off caseload as reaching age that able to access other services. L Declining new referrals if will reach age to access other service within 8 months as will not be seen at CDC in that timescale. Creating lots of communication challenging these actions however. No second appointment after DNA for some clinics to optimise capacity. Community Paediatricians ceased to provide neurodevelopmental follow up for high risk infants born prematurely to create clinic capacity. (Regional Neonatal Network standard to provide follow up) Regular Consultant review of overdue follow ups to cull or divert caseload which is V time consuming. Two consultants and one specialty doctor have regularly undertaken additional clinics weekends/weekdays to manage urgent caseload with identified clinical risks but this does not impact on long waiting referrals. Budget agreed for additional consultant clinics is not adequate to impact on service. Additional funding has been agreed in business planning to expand the team by 2 consultants / b7 CNS. All subspeciality services have been reviewed to identify further efficiencies and create capacity but no more to be made.	Caseload is escalating and impact of Covid on preschool children is not sufficiently recognised or scoped. Referrals not expected to fall in the short term, waiting times can not be reduced or managed without additional clinic capacity. Additional money provided is not adequate to resource staffing levels needed. Consultants have undertaken additional work for more than three years due to staffing shortage and are exhausted. All three consultants are at or near retirement age and cannot maintain additional workload intensity. Another consultant is needed to increase clinical capacity (across entire service) and reduce waiting times. This has now been agreed , post being advertised in July. One consultant is currently absent from the team. Other services can not pick up majority of work either because needs expertise of paediatrician or alternative appropriate resource not available. Lack of skill diversity means all clinical work is managed by consultants. Would be cost effective to recruit skill mix with band 7 and band 4 to add to clinical team as some work does not need consultant to deliver. Additional funding may be insufficient for three days of a band & specialist nurse or unattractive for recruitment as funding only short term agreement. Long term investment has now been agreed. Anticipate further increase in referrals, particularly from schools as children's difficulties have not been contained and managed.	Divisional Governance and Risk Meeting		Consultant screens all referrals to ensure appropriate gatekeeping. Other professionals requested to support for interim management or deferral of referral. Long waiting referrals being reviewed, and some now taken off caseload as reaching age that able to access other services. Likely will wait again for those. Declining new referrals if will reach age to access other service within 8 months as will not be seen at CDC in that timescale. Creating lots of communication challenging these actions however. No second appointment after DNA for some clinics to optimise capacity. Community Paediatricians ceased to provide neurodevelopmental follow up for highrisk infants born prematurely to create clinic capacity. (Regional Neonatal Network standard to provide follow up) Regular Consultant review of overdue follow ups to cull or divert caseload.(Very time consuming). Two consultants and one specialty doctor have regularly undertaken additional clinics weekends/weekdays to manage urgent caseload with identified clinical risks but this does not impact on long waiting referrals. Budget agreed for additional consultant clinics is not adequate to impact on service. Reviewing options to use this consultant allocated money for short term part time band 7 nurse instead to support service for cost efficiency. Long term investment has now been agreed. Locum doctor working in ASD service 2 days a month. All subspeciality services have been reviewed to identify further efficiencies and create capacity but no more to be made.	Caseload is escalating and impact of Covid on preschool children is not sufficiently recognised or scoped. Referals not expected to fall in the short term, waiting times can not be reduced or managed without additional clinic capacity. Additional money provided is not adequate to resource staffing levels needed. Consultants have undertaken additional work for more than three years due to staffing shortage and are exhausted. All three consultants are at or near retirement age and cannot maintain additional workload intensity. Another consultant is needed to increase clinical capacity (across entire service) and reduce waiting times. Other services can not pick up majority of work either because needs expertise of paediatrician or alternative appropriate resource not available. Lack of skill diversity means all clinical work is managed by consultants. Would be cost effective to recruit skill mix with band 7 and band 4 to add to clinical team as some work does not need consultant to deliver. Additional funding may be insufficient for three days of a band & specialist nurse or unattractive for recruitment as funding only short term agreement. Long term investment has now been agreed. Anticipate further increase in referrals, particularly from schools as children's difficulties have not been contained and managed. Consultants very close to burn out after three years of constant need to do extra clinics which is not improving waiting times. Staff are at risk of burn -out.	⇨
390	1555	Failure to meet Statutory Standards for Health Needs of Children in Care	Compliance with standards	There is inadequate clinical capacity to see Children In care for statutory health assessments (Called IHA or Initial Health Assessment) within the specified statutory timescales. There is risk of harm to children in care through unidentified and unmet health needs. Health does not fulfill its responsibilities contributing to decision making about safeguarding a child, as health reports are not available within the timescales of statutory processes. There is failure to provide statutory standards of care, creating a regional inequality in access to health care. There is risk of reputational harm for WVT, particularly when practice standards in Children's Services is under national scrutiny, and our services closely interface. Close scrutiny of Children in Care health services is expected in the Ofsted and CQC inspections due this year and there is risk of poorer inspection outcomes due to this failure of duty of care.	11-May-22	22-Aug-23	Surgical Division	Fiona Goodwin	15	3	5	15	6	Medical workforce are doing additional clinics over and above ordinary work load. GP lead contacted to see if would offer a modified IHA for children new into care who cannot be seen within statutory time frames. Would not replace need for an IHA but reduce risk of unidentified health needs. Consultation with childrens service to understand pattern of referrals. Discussing need for so many permanence planning reports whih are very time intensive and appear to be over requested. 'hot ' clinics now in some job plans to manage short term demands. Expansion of work force agreed , post to be advertised in July 2023..	Demand can not be met without further medical resources.	Divisional Governance and Risk Meeting	21-Jul-23	Medical workforce are doing additional clinics over and above ordinary work load. GP lead contacted to see if would offer a modified IHA for children new into care who cannot be seen within statutory time frames. Would not replace need for an IHA but reduce risk of unidentified health needs. Consultation with childrens service to understand pattern of referrals. Discussing need for so many permanence planning reports whih are very time intensive and appear to be over requested.	Demand can not be met without further medical resources. Additional workforce agreed - post to be advertised in July 2023.	⇨

687	1595	Lack of health psychology	Clinical Care	There is currently no provision for health psychology for children and young people who have long term health conditions outside of diabetes. It is well recognised the impact that a diagnosis of a life limiting condition can have on a young person and currently there is no specialist psychology to support them. This has a significant impact on their well-being. Crucial in both acute and community paediatrics.	14-Jul-22	24-Aug-23	Surgical Division	Julie Vickers	16	4	4	16	8	NICE Guidance NG61: End of life care for infants, children and young people with life-limiting conditions NG206 Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management Business case for establishment of service to be submitted.	Lack of funding available for service development opportunities There is no Health psychology service currently commissioned. CAMHS will not see these patients as they do not have a mental health condition.		25-Jul-23	No identified assurance as no service provision	No service provision	→
731	1696	Lack of Respiratory Support Unit (RSU)	Clinical Care	There is a risk of patients receiving sub optimal care on Arrow due to lack of Respiratory Support Unit (RSU) which has led to patient harm resulting in an externally reportable Serious Incident (SI).	20-Feb-23	06-Aug-23	Medical Division	Felicity Archer	20	5	3	15	10	1. The respiratory service has developed an NIV bay. However this bay is not a defined area but is a virtual bay. This means the four beds identified for the use of NIV were created anywhere on the ward depending on patient need. 2. All ward nursing staff have achieved competencies in caring for patients on NIV/ CPAP/ HFNO	1. No overnight Consultant Respiratory medical cover 2. No Senior Respiratory Physiotherapist (guidelines B7 physio 7 days/ week service) 3. No dedicated Respiratory Pharmacist (guidelines 7 days/ week service) 4. Increased ward pressure due to boarding patients 5. Lack of dedicated NIV bed despite agreement for one ring-fenced bed 6. Lack of dedicated RSU results in patients not receiving complex care and management from appropriately trained nursing/ medical & AHP staff 7. Lack of Consultants to cover 7 day service 8. Lack of ITU step down support for respiratory patients	(Multiple)	06-Jul-23	Discussed at; Directorate meetings FP&E Respiratory meeting SI panel Exec Risk Meeting	Lack of identified resource is preventing resolution of the risk.	→
756	215	Lack of sufficient consultant histopathologists	Workforce	There is a risk of collapse of the local histopathology service due to insufficient consultant histopathologists. This will lead to delays in patient care, inability to report biopsies locally, reduced/no MDT attendance, potential misdiagnosis and increased stress/sickness levels in the existing staff complement.	03-Nov-11	30-Oct-23	Clinical Support Division	Julie Davies	20	4	4	16	8	•Locums employed in the department •Suitable work sent to backlogs or bank •Support from Worcester/SWFT/UHCW	•Locums not always available •A lot of work is not suitable for sending to backlogs	(Multiple)	21-Jul-23			→
789	1415	Long waits in ED caused by a lack of flow potentially results in excess mortality and other significant negative outcomes.	Clinical Care	There is a risk of prolonged waits in ED due to a lack of timely bed availability which will potentially result in excess mortality and other adverse outcomes.	03-Nov-21	17-Sep-23	Medical Division	Richard Wells	25	5	4	20	10	•Bed flow meetings / pathways in ED 24/7 •Level 2, 3 & 4 OOHs •Improved Operational support for escalation (only available 08:00 - 16:00) that is guaranteed Mon to Fri •Social Distancing Measures / PPE worn by staff & patients •Full Hospital Protocol - this has now been enhanced with the 'Enabling Flow SOP' which was launched on 4 Oct 22 •Herefordshire Gold and Silver meetings •Weekly exec COVID Meetings •Patient Flow Escalation Policy and Procedure PR.121 •Daily review of medical and nursing establishments •Inpatient Covid escalation plans for Blue patients – medical •Patients and ITU •Integrated Complex Discharge team on site with Adult social care •Consultant ward rounds on all wards across every weekday •New Enabling ED Flow SOP * Medical staff pulled from SDEC (or other area) to prloritise highest priority.	•Completion of full ED SOP; •Reliance on last minute staffing ED escalation areas is not robust. WVT ED does not adhere to the RCEM guidance (Nursing Workforce Standards for Type 1 Emergency Departments October 2020); * There is a lack of medical capacity to fulfill all functions across the Directorate when ED outliers are present. •No updated/entirely appropriate Trust-Wide Escalation Policy, especially relevant for OOH. There is therefore potential that all clinical spaces will be occupied in ED resulting in care in inappropriate locations including inability to offload from ambulance and care on corridors, increasing transmission risk for infectious diseases; •Wards do not currently use evidence-based tools to optimise patient flow; •There is a requirement for more 'lean' processes across the Trust e.g. patient handovers, communication inter-department, discharge planning; •Capacity of internal and external supporting services/partners e.g. community, mental health and diagnostics; •Discharge coordinators are not yet in-place though funding is approved and recruitment has begun (impact to be assessed).	(Multiple)	17-Aug-23	•Tri to Tri •Directorate Tri •F&PE •Trust risk review meeting •It is at the core due to being fundamentally link to achieving the UEC challenge of minimum 76% on the 4 hour target by march 24. •From a personal view staff morale is also dependent on achieving the risk target and it is therefore in every therefore present in all that we do (values) . •Discussed at Quality Committee, this able it to become a Trustwide risk. •Directorate Risk meeting. •ED Summit • All unexpected deaths added on inphase and reviewed monthly by matron and mortality team	•Not standing agenda item for Quality Committee •Not standing agenda item for patient experience committee.	→
969	1492	Nurse Staffing below baseline establishment in ICU	Financial	There is a risk of continuing non compliance with GPICS Nurse staffing standards due to a lack of investment into the baseline nursing establishment which has the potential to lead to non ICU trained nursed deployed to support ICU and result in poor health and wellbeing for staff.	24-Jan-22	23-Aug-23	Surgical Division	Tracy Hamer	20	4	4	16	8	1. Suspension of Critical Care Outreach service 2. Cancellation of Elective admissions 3. Use of temporary staffing office bookings for critical care trained nurses (long lining where possible to provide continuity and consistency) 4. Staffing roster signed off 12 weeks in advance by Directorate Matron to identify shifts at risk 5. Non substantive ICU registrants working within WVT with existing or prior critical care tacit experience and explicit knowledge are prioritised for support at times of redeployment 6. Daily staffing review to establish appropriate skill mix of staff depending on the acuity and clinical risks 7. Practice development nurse has an ongoing Foundation study days for redeployed registrants 8. Minimum of 2 band 6 critical care trained nurses per shift (1 co-ordinator per zone) 9. Psychological support inclusive of health and wellbeing for all staff inclusive of feedback mechanisms and welfare checks 10. Agreement to over recruit in ICU to support sickness and maternity leave.	1. Nursing staff unfamiliar with environment 2. Uncertainty in relation to availability of critically care trained nurses from agency 3. Non substantive ICU registrants working within WVT with existing or prior critical care tacit experience and explicit knowledge are not always made available to staff the unit and cannot be released 4. Staff not released to attend foundation training 5. Limited trained capability within the team to recognise early signs and symptoms of PTSD. 6. During out of hours (weekends) there is reliance on level 2 staffing holder to review risks associated with staffing the surge capacity 7. Insufficient band 6 wte within the substantive staff - therefore reliance on overtime or bank to cover the required coordinator requirement.		24-Jul-23	Monitoring the use of temporary staffing requirements via financial reports and ALLOCATE Monitoring incidents weekly to identify any trends relating to the use of temporary staffing	Approval for temporary staffing not always approved.	→
979	1135	Obstetrics, Gynaecology,Paediatric Administration and Clerical workforce gaps	Workforce	There is a risk to the sustainability of service delivery within Obstetrics & Gynaecology , paediatric and community paediatric administrative services. 1 full time vacancy b3 in O/G 1 wte vacancy B3 in community paediatrics. new staff some of whom are not experienced in the specialty who will require training and support ; this has an impact on the other team members and can affect the quality of the work delivered. typing backlog currently in o/g and community paediatrics. 2.5 month delay in letters being sent.	15-Aug-20	15-Mar-23	Surgical Division	Kate O'Shea	12	4	4	16	6	1. Use of Bank Admin and Clerical staff in obstetrics and gynaecology and community paediatrics. 2. Goodwill by existing staff members within the teams. 3. some staff covering extra hours. 4. B3 interviews for community paeds completed , staff member starts in February 2023. 5. B3 post in O/G has been re-advertised , interviews to be held in Feb 2023. 6. post appointed to on 17.2.23.	1. Concern due to inexperienced staff working in the team and lack of continuity. 2. Risk that more staff will go off sick due to working extra hours to support the department. 3. Inability to recruit from Bank Staff due to such limited numbers registered.	Workforce & Development Committee		We have some staff who are consistently working extra hours.	The extra hours being worked are not sufficient to manage the volume of work in respect of typing , hence there is a backlog an potential delay in actions being updated in maxims. (O/G /Community paediatrics). current longstanding vacancies in both teams.	↑
1180	1488	Risk of delays in maternity triage due to space and current staffing model	Workforce	There is a risk of substandard service delivery due the lack of physical space in maternity triage, which could lead to women not being able to be seen and monitored in a timely manner. Being unable to provide space has a significant risks to safe and timely midwifery care resulting in serious incident not limited to poor patient experience and poor staff well being and mental health. There have been 2 recent intrapartum stillbirths where triage was felt to be a contributory factor.	17-Jan-22	24-Aug-22	Surgical Division	Amie Symes	15	5	4	20	6	During escalation specialists midwives will provide additional support to maternity triage during the week Rostered maternity support worker in maternity triage 24/7 with night shift cover New SOP implemented detailing process for escalation and conflict of clinical opinion Initial score 15 however recent HSIB findings have identified triage as a greater risk and therefore increased to 20	Unpredictable workload Not all specialist midwives feel competent to work in maternity triage and specialise midwives only work the hours of 08.00-16.00hrs Maternity support worker assigned to maternity triage 24/7 however there are multiple times the maternity triage roster is not covered by a maternity support worker due to challenges to recruit to this role/agency cover	Quality Committee	24-Jul-23	1. Performance audit running monthly and reported to Maternity Governance meeting monthly. 2. Incident reporting specific to maternity triage is reviewed rapidly and discussed as an MDT 3. Progress reported via quarterly exception report to Quality Committee and Trust Board / bi-monthly to F&PE.	Missed incidents unreported / missed near misses that could facilitate learning.	↑

1317	1191	Risk of patient harm due to Pharmacy Service reduced capacity/staffing	Workforce	There is a risk of harm to patients due to the increase in demand on Pharmacy Staff through COVID-19 (Vaccination and treatment), implementation of EPMA, the expansion roles in primary care, expansion of bed base (GAU), implementation of virtual ward, and the inability to recruit into posts in a timely manner, which has led to a lack of workforce capacity and reduced availability of the Pharmacy Service. There is also a lack of availability of locum pharmacists. This has resulted in an inability to meet statutory requirements, a reduction in staffs health and wellbeing resilience, potential increase in medication errors, less timely provision of service less support for procedure, financial review, and strategic development for Divisions/Directorates. There is also an impact on availability of pharmacist time to support clinical trials within the Trust due to the lack of availability of GCP trained pharmacists. This reduces the access to clinical trials within the Trust for our patients.	08-Dec-20	30-Aug-23	Clinical Support Division	Tony McConkey	20	4	5	20	4	•Prioritisation of clinical service at ward level and technical services to reduce risk to patients and maintain capacity. •Searching for two locum pharmacists but not appointed yet. Flexible working requests considered for all roles	•Insufficient pharmacist numbers to cover all ward areas and maintain policy and procedure development for Divisions/Directorates •No readily available additional cover (locum or bank). •Medium to long term threat of pharmacy staff shortage due to expansion in services in all sectors.	(Multiple)	27-Apr-23	Pharmacy staffing reviewed weekly by COO and CMO with Disvion Lead and CD of Pharmacy. Incident reports completion for medicines related incidents, complaints and PALs concerns. •Rota indicating all areas are covered adequately if possible. •Completion of medicines reconciliation at ward level, turnaround time KPIs. •Staff overtime records and sickness records and turnover. •Staff concerns and wellbeing issues raised. Bi monthly report to Patient Safety Committee/Quality Committee on risk status via the Medicines Safety escalation report	None	
1388	733	Risk to harm and delivery of community pediatrics service	Workforce	There is risk of harm to children due to the failure to assess and intervene in a timely way once a referral has been made, given the numbers waiting to be seen by a Community Paediatrician.	09-May-18	29-Aug-23	Surgical Division	Kate O'Shea	20	4	5	20	8	•Additional clinics being undertaken by 2 substantive consultants and 1 specialty doctor to reduce backlog. Small amount of funding agreed in business planning to support extra clinics being undertaken. •Unfilled vacancies have now been filled so service is now restored back to the 2017 WTE staff level. •Pre-Assessment support: •Support Health Visitors, nursery staff, portage and Speech and language therapy to offer a level of community based support whilst awaiting assessment. Limited however due to non- specialist skill set. •Diagnostic pathway revised to be more flexible, with acceleration of the diagnostic process for selected children. Efficiency has improved to increase the number of children being assessed however still fails to meet capacity. •Training of allied professionals through multidisciplinary training forum has been delivered - improves support and understanding. . expansion of workforce agreed, additional consultant to be advertised July 2023. Locum consultant working 2 days a month in ASD service .	•Not meeting statutory requirements in any subspeciality discipline. •Long waiting times for ASD assessment; submitted as a separate risk. •Additional consultant requested in business planning, not yet approved. •ENS requested in business planning , not yet approved. A •specialist nurse would fulfil NICE standard as SCN coordinator and also contribute clinically to diagnostic and post diagnostic service. •Coordinate management of waiting lists, collation of multisource information, production of complex reports.	(Multiple)	21-Jun-23	Weekly monitoring PTL meetings in place - currently 0 78 week breaches	Only able to monitor 78 week breaches not children waiting over 52 weeks	
1473	1403	Single Lead Orthodontics Service has become fragile and unstable.	Clinical Care	There is a risk to patient care due to the Orthodontics service being a single lead service coupled with the Consultant retiring in March 2022 and a National shortage of Orthodontic specialists. This has lead to the Orthodontics service becoming fragile and unstable in its entirety and has resulted in significant waiting times for both Herefordshire and Powys patients and has the potential to result in the service being unable to be being provided as of the 1st April 2022 in Herefordshire, this could cause potential harm to patients and the Trust. Following return of consultant following retirement he is not currently available for work. We have no employed medical staff available, are unable to recruit and their are no agency locums.	13-Oct-21	23-Aug-23	Surgical Division	Vanessa Lewis	20	4	5	20	6	1. Fragile insource arrangement with Eden . However will increase sessions as we go through year 2. Issue being led at ICS level.	No substantive staff currently available	(Multiple)	24-Jul-23	Contract with Eden	Eden contract is not delivering the required amount of activity. No provision in July. There is no urgent service and there is a lack of ability to see patients experiencing problems at short notice.	
1610	893	Trust inability to comply with Fracture neck of femur pathway	Clinical Care	There is a risk of increased harm to patients who have been admitted with a fractured neck of femur due to the inability to meet some sections of the integrated care pathway, which has the potential to lead to increased mortality rates and non achievement of best practice tariff, resulting in negative national prominance and continuing to be a national outlyer in fractured Neck of Femur.	26-Jun-19	23-Aug-23	Surgical Division	Sharon Wood	20	3	5	15	9	•#NOF integrated pathway in place. •Anaesthetic representation at daily trauma meeting. •Process to utilise CEPOD theatre should the opportunity arise •Process to cancel elective T&O surgery to accommodate trauma surgery. •Weekly tracking of Best Practice Tariff #NOF pathway to highlight the themes of why the pathway is not being followed. Issued by the informatics team which feeds into the #NOF clinical lead for review and comment. •Ring fenced #NOF bed now on Dinmore rather than Redbrook •Golden Patient. •Dedicated trauma anesthetist to optimise #NOF patients in a timely fashion for theatre. This is not happening as yet •3 Trauma Theatre sessions per week (increase in sessions in negotiation with the Consultants).	•Gaps in staffing on Dinmore leading to issues with skill mix amongst the team. •Time spent in ED prior to transfer when Dinmore ward is full and at time of pressure. dedicated anaesthetist not available No fixed Saturday trauma - theatre staffing is preventing this	Surgical Quality Board	24-Jul-23	Monthly #NOF meetings to review pathway compliance and general key themes.	No fixed Saturday trauma theatre list, theatre staffing is currently impacting on compliance.	
1704		Delivery of Financial Plan and improving underlying position	Financial	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.	22-May-23	31-Aug-23	Corporate Division	Katie Osmond	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.	(Multiple)	22-May-23	Productivity Board routine monitoring of activity plan. Monthly F&PEs review of CPIP delivery. MARP and NARP routine review of action plan and compliance with controls. Integrated performance report to Board. CPIP Audit Report	Trust policies and processes require strengthening to ensure regular monitoring and reporting.	
1722		Lack of physical space with the Pharmacy Department	Estates	The pharmacy department's physical footprint is not fit for purpose. The workforce number has increased from 25 to over 100 since the department was built (originally designed for 40 people) and the budget for medicines has increased from £2.5m to £29m (over ten fold increase). There is a risk that we will be unable to store anymore refrigerated items due to lack of space to put a fridge. The corridors/offices are currently being used as storage and dispensing areas not meeting IPC standards. No. of toilets isn't compliant with the Workplace (Health, Safety and Welfare) Regulations 1992. Full workforce establishment total - approx 115. No. of toilets within the department - 2 (unisex - used by both genders). Health & Safety risk due to walkways being used as storage - trip hazards, risk of falling objects. Inability to meet the cleanliness standard - Pharmacy consistently achieving a 1 star rating. The volume to workload and of staff in a small area considerably contributes to our insufficient cleanliness standard. The Pharmacy workforce is significantly understaffed meaning that tasks cannot be carried out to the desired standard.	19-Jun-23	19-Sep-23	Clinical Support Division	Tony McConkey	20	4	4	16	4	Flexible working patterns, including the facilitation of remote working where appropriate. Space saving - high level shelving, archiving, lockers, additional storage.	Temporary solutions. Allowing staff to work remotely leaves the department physically short if there is a increased workload.	(Multiple)		QA Inspection for aseptic services Health & Safety Inspection Cleanliness Audit InPhase Incidents Dispensing Turnaround Times Near Misses Error rate audits Staff Survey	No gaps	NEW

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
Title of Report:	Armed Forces Covenant
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Presentation on the Armed Forces Covenant and local delivery

1. Purpose of the report

To present a summary of WVT's duties under the Armed Forces Covenant, giving a local context.

2. Recommendation(s)

The WVT Trust Board is invited to note how the Trust is meeting and delivering its duties under the Armed Forces Covenant

3. Executive Director Opinion[1]

NHS England is committed to raising standards among healthcare providers of Veterans' services. Healthcare for the Armed Forces community: a forward view is seen as a companion document to the NHS Long Term Plan (LTP) and outlines the commitments NHS England is making to improve the health and wellbeing of the Armed Forces community.

Wye Valley NHS Trust recognises the value serving personnel, reservists, veterans and military families bring to our organisation. We strive to support the employment of service spouses and partners and seek to support our employees who choose to be members of the reserve forces, including by accommodating their training and deployment where possible. As a signatory to the Armed Forces Covenant, which is enshrined in law through the Armed Forces Act, we endeavour to uphold the key principles of the Covenant:

- no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen;
- in some circumstances, special treatment may be appropriate especially for the injured or bereaved.

Further, Wye Valley NHS Trust is accredited as a Veterans Covenant Healthcare Alliance (VCHA) organisation. The VCHA is a group of NHS providers, including acute, mental health, community, and ambulance trusts that have agreed to be exemplars of the best care for, and support to, the Armed Forces Community.

As a member of the Herefordshire Armed Forces Covenant Partnership, a cross-sector partnership, we work collaboratively to address local issues within Herefordshire's Armed Forces Community.

[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***

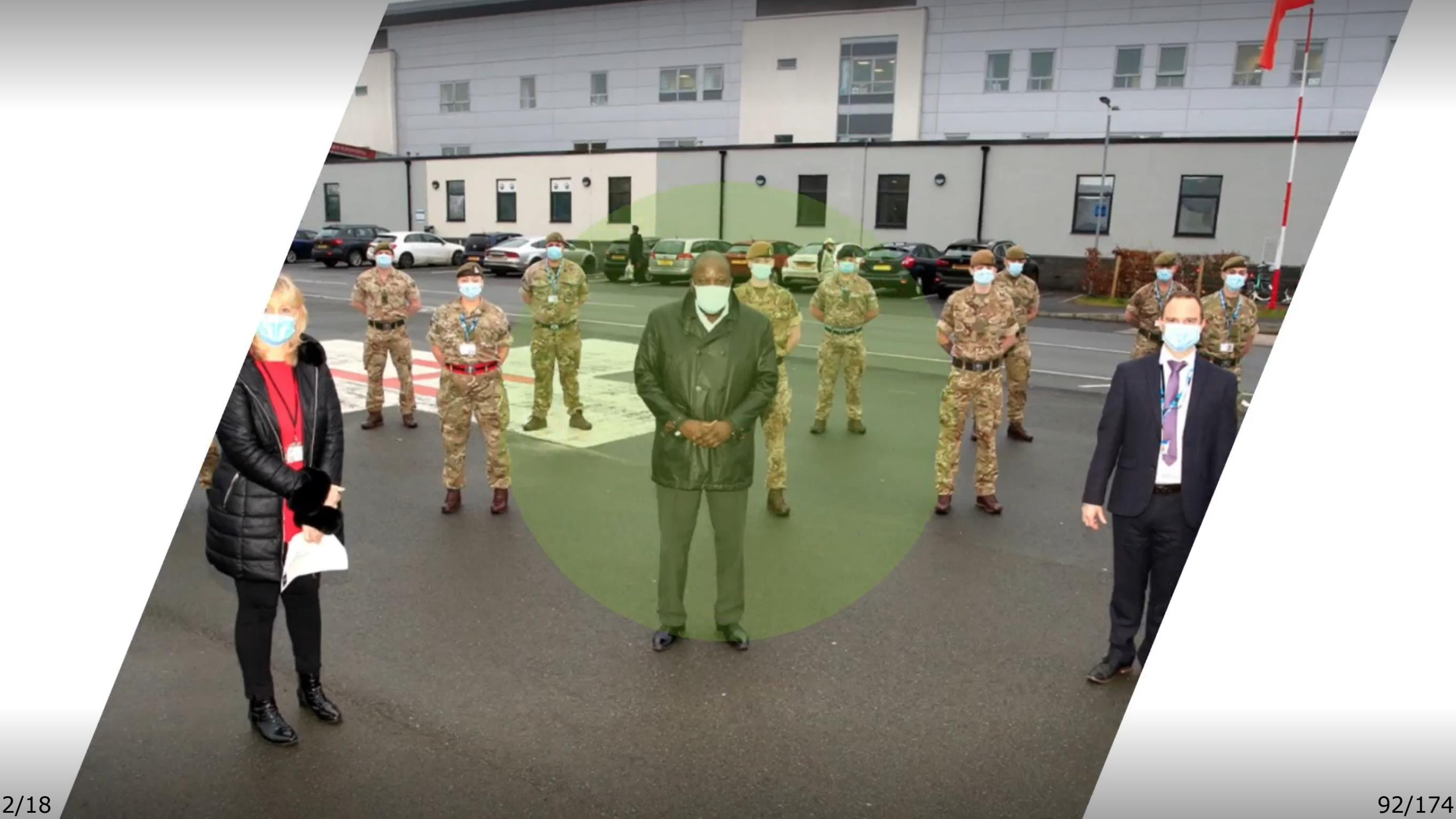
ARMED FORCES COVENANT

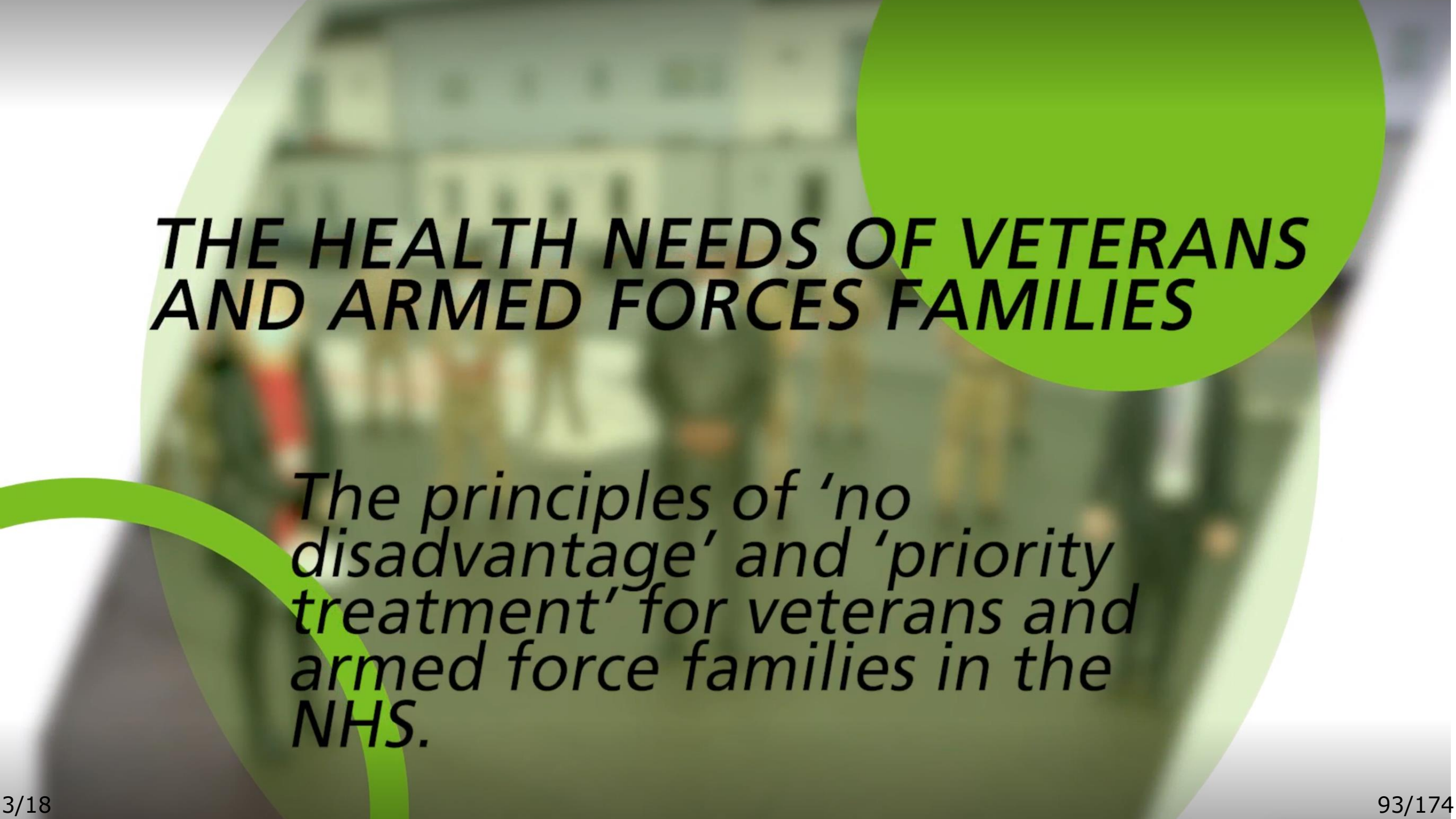
EMPLOYER RECOGNITION SCHEME

SILVER AWARD 2021

NHS
Wye Valley
NHS Trust

VETERAN AWARE





THE HEALTH NEEDS OF VETERANS AND ARMED FORCES FAMILIES

The principles of 'no disadvantage' and 'priority treatment' for veterans and armed force families in the NHS.

What is the Armed Forces Covenant?

IS A LEGAL OBLIGATION ON CERTAIN PUBLIC BODIES TO PAY DUE REGARD TO THE COVENANT PRINCIPLES WHEN EXERCISING CERTAIN FUNCTIONS.

2 KEY PRINCIPLES
OF THE THE ARMED FORCES COVENANT DUTY

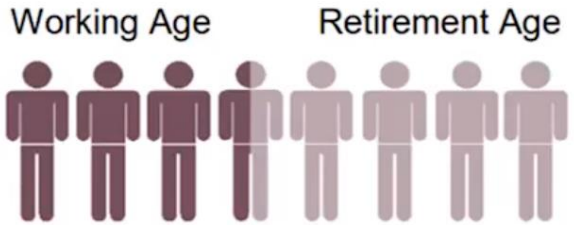
1. The Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services
2. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

A veteran is someone who has served in the armed forces for at least one day.

It is projected that **in 2028** there will be approximately **1.6 million** UK Armed Forces veterans residing in Great Britain.

For every 80 veterans residing in Great Britain in 2028, it is projected that:

35 veterans will be of working age (aged 16-64), and 45 veterans will be of retirement age (aged 65+).

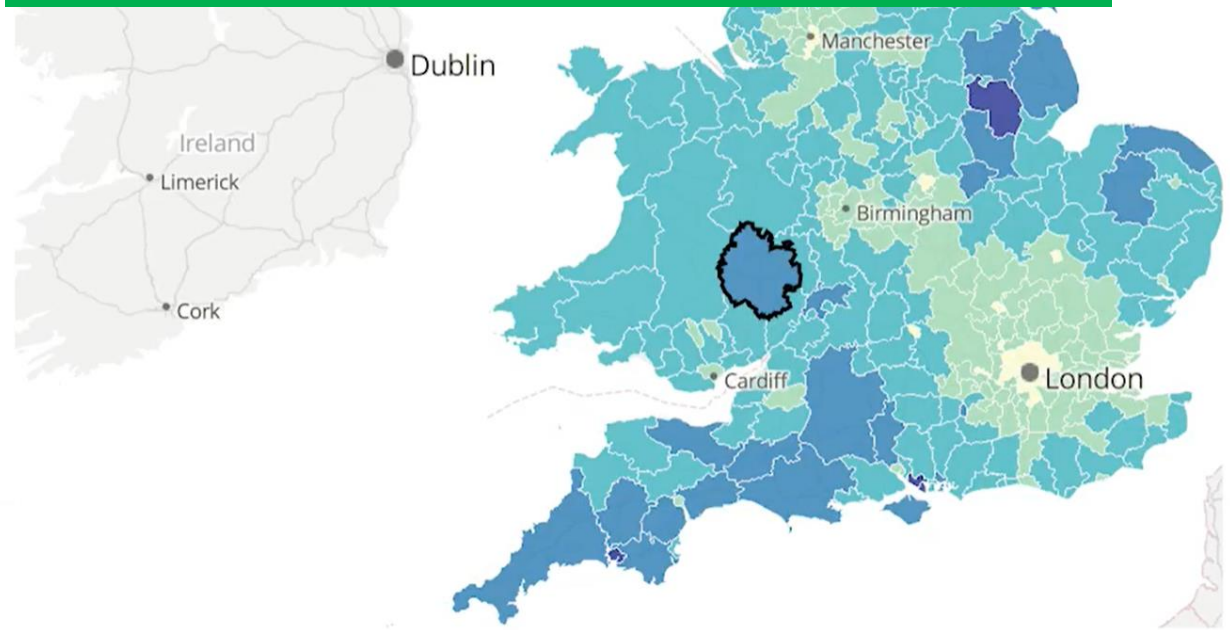


Ten veterans will be female, and 70 veterans will be male.

National Context

As at 2019:

- **2500 Serving Personnel**
- **1600 Family Members, of which**
- **1144 are of school age (2022 data)**
- **A number are serving as reservists**



Local Context

Source: Official ONS 2021 census

Herefordshire Armed Forces Covenant Partnership

www.herefordshire.gov.uk/armed-forces

Working together for the benefit of the Armed Forces Community in Herefordshire

MILITARY CHARITIES

SSAFA- The Armed Forces Charity
Royal British Legion
Help for Heroes
Veterans Support Centre in Hereford
First Light Trust
Defence Medical Welfare Service

HEREFORDSHIRE COUNCIL

Elected Armed Forces Champion
Strategic Housing
Schools/Early Years
Talk Community

BUSINESS COMMUNITY

Armed Forces Friendly Employers
over 100 in Herefordshire
3 Counties Defence & Security Group

ARMED FORCES COMMUNITY

Hereford Garrison
West Midlands Brigade
Reserves & Cadet Forces

Herefordshire Armed Forces Covenant Partnership

www.herefordshire.gov.uk/armed-forces

Working together for the benefit of the Armed Forces Community in Herefordshire

OTHER HEALTH & WELL BEING PROVIDERS

The Cart Shed

Hereford and Worcester Age UK

Turning Point Drug & Alcohol Services

RELATED ORGANISATIONS

West Mercia Police

Education & Training Providers

NMiTE

NHS

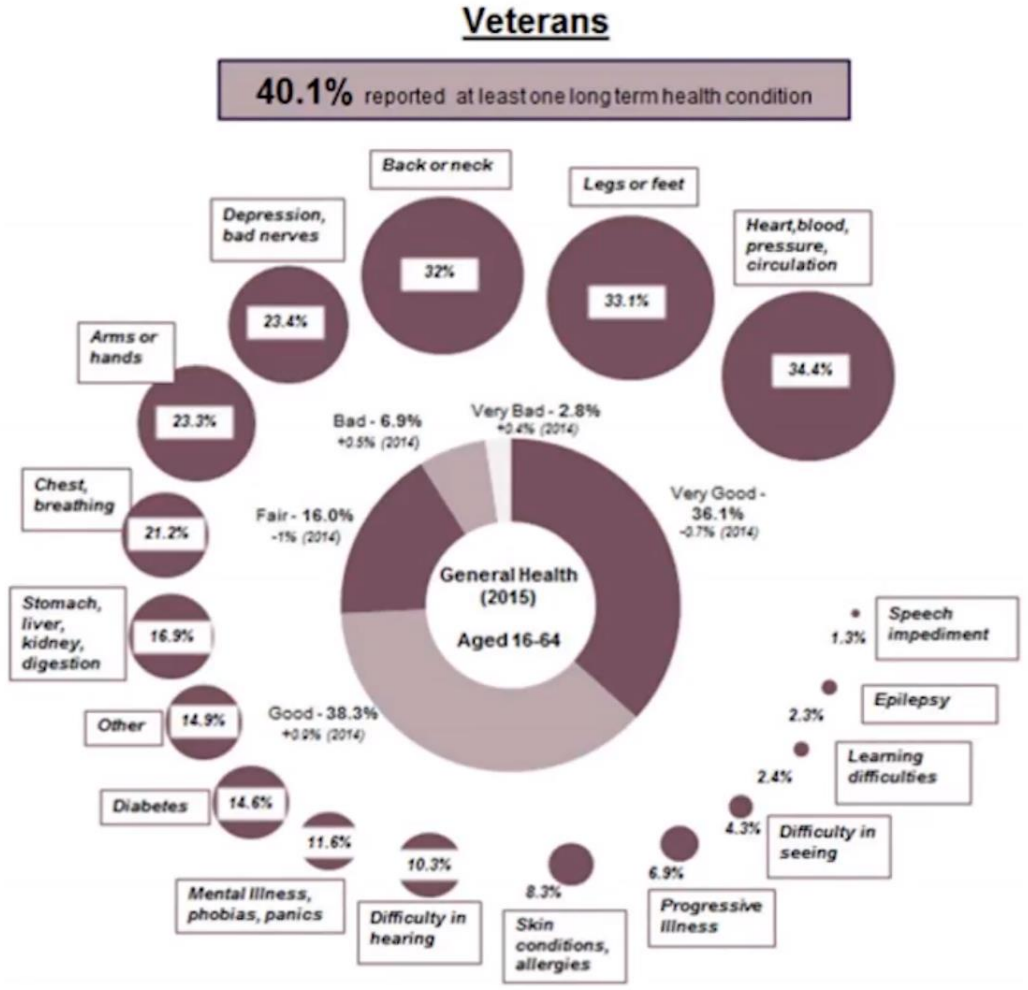
Hereford County Hospital and Wye Valley NHS Trust

Hereford and Worcester Health and Care NHS Trust

GP Practices

ARMED FORCES COVENANT

Figure 2: General health status and long term health conditions[1] reported by UK Armed Forces veterans and non-veterans[2] aged 16-64 residing in Great Britain, estimated percentage[3]
2015



Veteran's Health Needs

Defence Medical Welfare Service

Free & Confidential

A welfare and wellbeing service for the armed forces community, veterans, and their families.

0800 999 3697

referrals@dmws.org.uk

DMWS
Defence Medical Welfare Service
Supporting the frontline

Tailored Service

Confidential person-centred service. Supporting families, children and individuals in their time of need.

0800 999 3697

referrals@dmws.org.uk

DMWS
dmws.org.uk


NHS
The Veterans Mental Health and Wellbeing Service
The first call for help takes courage
Op COURAGE: The Veterans Mental Health and Wellbeing Service
OpCOURAGE

Veterans & Armed Forces

Families

Families of service personnel and veterans also face particular stresses and pressures.

Help is available from the service charities for them too.

Pressures

Stresses

- Separation from partner during tours and training
- Anxiety / fears for service members' safety
- Coping with bereavement after death of service member

Dislocation

- Frequent disruptive relocations (including interruptions to centres for treatment and doctors)
- Living abroad and away from extended families
- Limited opportunities for short term commitment employment

Veterans' families

- Changing employment and economic circumstances of veteran
- Adjusting to new way of life
- Dealing with medical consequences of service life

Veterans & Armed Forces Families

https://www.wyevalley.nhs.uk

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- Dealing with medical consequences of service life

ARE YOU A VETERAN, IN AN ARMED FORCES FAMILY OR A RESERVIST?

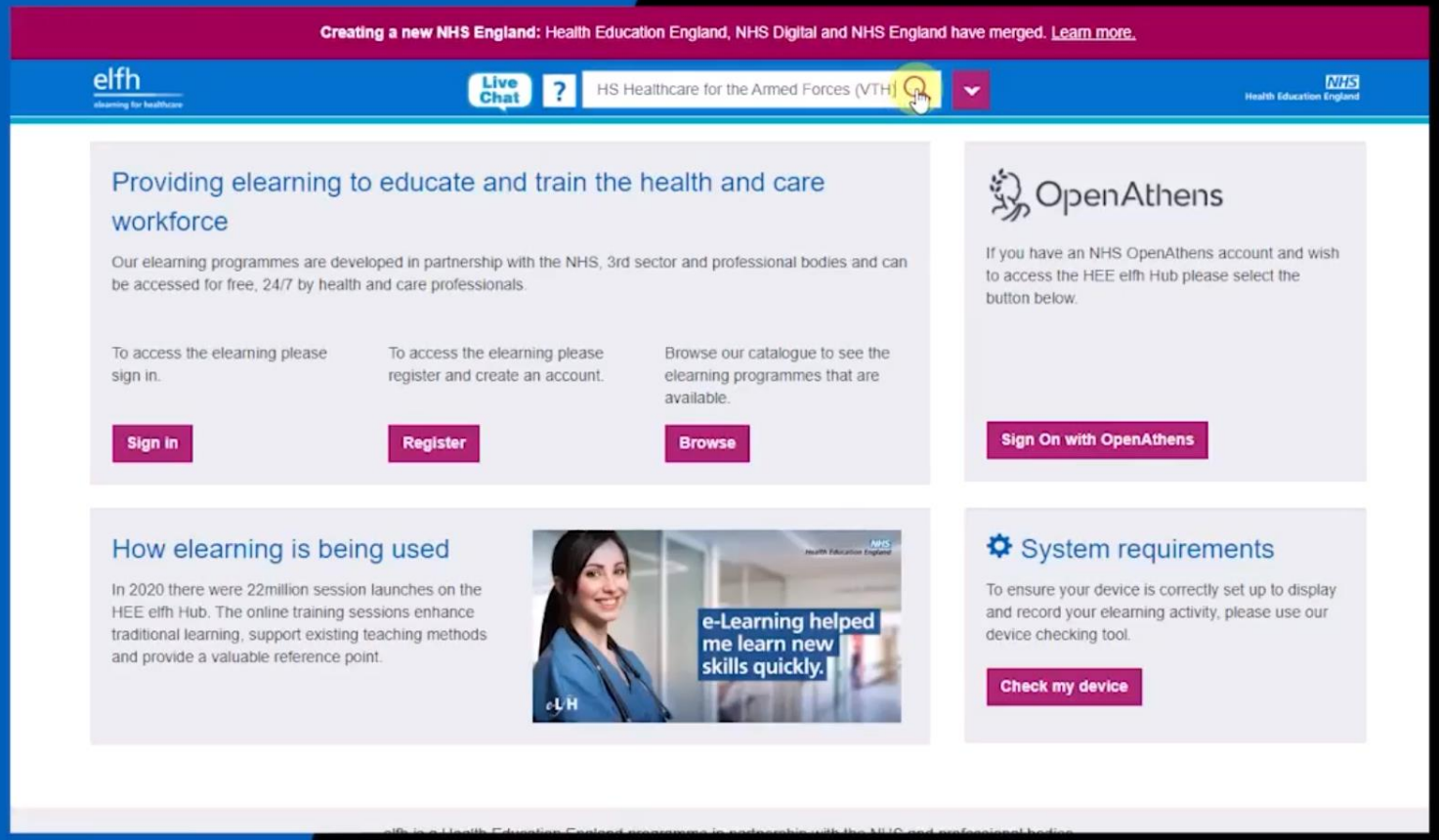
ARE YOU A VETERAN, IN AN ARMED FORCES FAMILY OR A RESERVIST?

- HR.40 Special Leave Policy that incorporates guidance for staff and managers

- HR.86 Flexible Working Policy that aims to encourage staff to consider flexible working arrangements.

This will include access to induction, mandatory and other training, and appraisal review.

NHS Healthcare for the Armed Forces (VTH)



Online Training can be found on HEE's e-LfH Website
https://portal.e-lfh.org.uk

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
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 10 July 2023 and 14 August 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]

MENTAL HEALTH TRANSFORMATION PROGRAMME

- This is now the final year of the existing programme and clarity was required around the agreement of future priorities and deliverables and to agree where the energy and resources should be focused. It was agreed that, notwithstanding ICE agreement or not of the identified priorities, it was essential that improved reporting and more robust performance tracking was required in order to provide assurance to ICE and to allow members to easily and clearly identify progress. That said, the performance data position was improving from the current position of only 3 months of data.
- A review of the framework was necessary to ensure a patient-centred system with a named key worker alongside a Care Plan based on patient need.
- Recruitment assurance was provided; there was an appropriate skill mix and sufficient staffing workforce in Herefordshire with only 16 per cent vacancies. There was a renewed focus on retention of current staff including improvements in induction, support, review and development. Notwithstanding the assurance, workforce continued to be the key risk to effective programme delivery.
- Good progress was being made on the plan for Mental Health Practitioner expansion.
- 2,500 patients had met the agreed target under care thus far. The referral from the GP waiting times target of 90 per cent was currently at 84 per cent, with initial conversations within 4 weeks.
- A key Issue continues to be the availability of clinic rooms and accommodation resulting in face to face interventions being compromised. Solutions were being explored before possible escalation to the One Herefordshire Partnership.

URGENT COMMUNITY RESPONSE

- From June 2023, WMAS referrals were being received via the WMAS portal. This had improved data collection.
- Remote patient monitoring using Docobo was progressing. Staff have been trained and the equipment received albeit awaiting calibration
- The Hospital at Home Bridging Team's oversight of delays had improved and the core handler vacancies are now fully recruited to.
- Looking forward, there was an expectation of improved data results as a consequence of the recent improvements.

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

DISCHARGE TO ASSESS (D2A)

- D2A had first been introduced in response to COVID (established in 9 just day). As expected, there is now a need for a full review; a not insignificant task which would commence with a workshop with partners and providers
- The D2A Board had met for the first time and agreed a project plan. The Board will monitor the plan and be clearer around patient outcomes.
- ICE established that it was essential for the programme review to add value, focussing on outcomes, alongside quality, finance, activity, workforce and performance considerations. It was important to understand the baseline position and the use of resources.

ENHANCED HEALTH IN CARE HOMES (EHCH)

- A programme review had taken place in May 2023. All elements of the EHCH were included in the review and identified focus areas of dementia and workforce.
- Expressions of interest from care home managers, to form a steering group to look at the design of the work programme, have been sought and it is hoped to set up the group within the next few weeks. The group will focus on a more collaborative approach and how to develop data packs to provide information across a range of metrics, including falls, ED attendance, and dementia diagnosis rates.
- The dashboard continues to be developed to ensure information is recognised by PCNs and highlights areas of interest for action
- Support from ICE has been requested to support work to increase care using Urgent Community Response, to ascertain if more detailed data might be available from WMAS and for WVT to undertake an audit of care home conveyances.
- During COVID, the care home service had access to an Advanced Nurse Practitioner out of hour's direct line which was also available between 9-5 on Saturday and Sunday, to help admission avoidance. Funding for the service is no longer available but it was considered that re-exploring this option would be of benefit. It was agreed that these discussions would be well placed to start at the regular Safety in Synch meetings.

FALLS SERVICE

- The Falls Responder service contract expires in 2024 and a re-tender is needed as soon as possible. The ICB have made a proposal to lead on the procurement, involving the Council and PCNs.
- The service is performing well and data is positive in terms of speed of responses with 98 per cent of calls being dealt with within one hour and the number of people who are supported having less falls afterwards.
- ICE agreed that further analysis is required to understand the volumes and overall needs for the service and it was determined that a discussion at a Transformation Tuesday meeting would provide a good starting point.

OVERNIGHT NURSING

- The internal quality assurance reporting mechanism for the service has changed and is now reporting twice a year. The next report will be in October 2023.
- Activity remains steady with no complaints. There has been an increase in young palliative people since COVID and this data is being captured.
- The risk around workforce resilience remains high with only three employees available to cover three nights per week. Although budgetary constraints have limited recruitment of additional capacity, an advert was in place to recruit temporary bank staff to cover gaps.

URGENT COMMUNITY RESPONSE

- A new process has been implemented for all referrals in order to provide better data reporting.
- A procedure was being developed for tissue adhesion and skin laceration to support referral requests.
- The programme was now in a position to implement one single referral route ensuring that once a referral is completed it is sent to the correct place. Further, the length of call time has reduced from 9.5 minutes to 4 minutes which has resulted in less calls being missed. The overall feedback received is that patients are now having a better experience.

- August has been the first month of reporting accurate data to ICB.

Despite the Better Care Fund not yet being agreed, a BCF Group was being re-established to enable review of all projects to feed into ICE

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***	

Report to:	**Public Board**
Date of Meeting:	**07/09/2023**
Title of Report:	Quality Committee 29 June 2023 Summary Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	NA
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and Quality Committee Chair
Documents covered by this report:	NA

1. Purpose of the report

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

2. Recommendation(s)

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

3. Executive Director Opinion[1]

NA

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

Quality Improvement

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

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

☐ ***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.

Quality Priority – Improving Patient Experience – Quarterly Report

Committee received the quarterly report for the last quarter of 2022/23 and noted the positive progress that has been made in reconvening the Patient Experience Committee as part of the governance framework for the Quality Committee. This will now play a key role in co-ordinating patient engagement, feedback and learning across the Trust.

Good progress has been made in improving Family and Friends Test responses through text messaging and the number of responses means that wards can better engage with the messages being fed back. It had been hoped to use F&FT texts also to promote use of postal surveys but the numbers have decreased.

Committee noted that complaints numbers reduced in 22/23 but response times still fall below the expected standards. A lot of work is being done to address this, but needs more focus in some service areas to address delays.

Quality Priority - Mortality

Committee noted the continuation in the reduction in our mortality scores. We continue to make good progress with our previous outlier groups and we were pleased to note that the Trust is now 10th best in the country for stroke morbidity. There are some concerns around heart-failure deaths which are now subject of a thematic audit and review. Committee questioned the position and progress regarding palliative care coding which a Task and Finish Group is addressing and for which we need an end-date.

Committee also noted the progress in standardising our approach to learning from deaths through our internal structured judgement reviews operating alongside the reviews by the Medical Examiner service.

Quality Priority – Improving the Management of the Deteriorating Patient

Committee received a verbal update on the establishment of a new Deteriorating Patient Committee as a means to co-ordinate a review of escalation processes to ensure we are able to identify patients at risk and before they deteriorate using their NEWS score. This is linked to a 23/24 CQUIN and is being chaired by the DCMO and will work closely with the Resuscitation and Critical Care Committees.

Quality Priority – Improving Nutrition

Committee received an update on work to ensure best practice in nutritional management together with areas of focus for the current year including naso-gastric management, continued focus on MUST scores, improving food scores from in-patient surveys and implementing new national standards.

Quality Priority – Ensuring Patients Receive Timely Critical Medications

This work, which is a CQUIN for 23/24, will be co-ordinated by the Medicines Safety Committee (MSC) and will focus initially on medication to patients with Parkinson's Disease where there are known issues with missed or delayed doses. This also follows the Foundation Group signing up to the national Parkinson's Medication campaign. Other prescribing areas to be included will be determined by the MSC and Quality Committee will receive reports throughout the year.

Divisional Quarterly Report – Integrated Care

Committee received a comprehensive divisional report and focussed in particular on:

Ross Hospital – Huge improvements in a number of areas including significant reductions in vacancy rates and a real focus on key areas for improvement including MUST scores and falls. Committee emphasised the need for this to continue.
Stroke Services – Excellent work is maintaining our high standards of care as reflected in our national "SSNAP" scores.
Serious Incidents – particularly pressure ulcers - remains the main issue of concern. This poses particular challenges for community patients and this is being addressed with support from the Pressure Ulcer Panel and the recruitment of a new specialist practitioner to support improvement of skin care.

Divisional Quarterly Report – Clinical Support

Committee received a comprehensive divisional report and focussed in particular on:

Pathology – good collaboration with the West Midlands Imaging Network and pride in being the first Trust in the region to go live with digital pathology
Pharmacy – continued staffing challenges but positive news in the expansion of our training places for both Pharmacists and Technicians.
Cancer – we are meeting our 2-week targets but our 62-day performance is deteriorating
Staffing – challenges in radiology impacting on reporting over coming months and plaster technicians in outpatients.

Committee also received an update on the response and action plan following the Human Tissue Authority visit. We are up to date with responses and actions, however, we are seeking advice from the HTA in a number of areas.

Quality Priority – Maternity

Committee received the monthly PQSM report and noted that Maternity Services have a CQC inspection this week which has limited attendance at the Committee meeting.

Quality Priority – Improving VTE Risk Assessment Compliance

Committee received an update presentation on work to achieve our 95% standard for VTE assessments. We need this to attain national exemplar status and it is a regulatory requirement for CQC. This work continues, however the outcome for patients is to ensure that there are no avoidable hospital-acquired-thromboses and we have had none in the period from January 2022 to date.

Patient Safety Committee Summary Report

Committee received the update report and note in particular the quality improvement project to reduce frailty falls and the reconstitution of the Resuscitation Committee.

Quality Account

Committee approved the Quality Account following some minor amendments after submission to Board.

Report to:	**Public Board**
Date of Meeting:	**06/07/2023**
Title of Report:	Quality Committee 27 July 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:

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 – Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Good progress has been made in delivering training including bespoke sessions in key clinical areas including ED which have been well received. Committee was pleased with this positive development and noted that there is also anecdotal evidence of the impact on clinical practice. The next report will include the results of a formal practice audit to provide assurance. Committee also noted the concern regarding likely impact on training of a vacancy in the Safeguarding Team and the work with the ICB to mitigate this impact

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Quality Priority - Mortality

Committee noted the continuation in the reduction in our mortality scores with continued reductions in both our in-hospital and out-of-hospital deaths. Committee noted the significant reduction in fractured neck of femur related deaths and the reduction of stroke deaths to 84, having previously been an outlier.

Quality Priority – Infection Prevention

Committee noted that we had 42 C-Diff cases in 22/23 against a target of 44. This remains our major challenge: we benchmark well regarding our other reportable bacteraemia and are not an outlier. Committee noted the current focus on hand hygiene and bare-below-the-elbow including the issues related to over-use of gloves since the pandemic. There are also challenges with compliance for agency, locum and bank staff which need to be picked up as contractual issues where appropriate. Good progress is being made in the Improvement Plan delivery and it was reported that there are no concerns with the progress.

Committee also received its first reformatted report from the Infection Prevention Committee (IPC) which summarises key issues from the reporting sub-committees. This report focussed on cleanliness where there has been sustained improvement and we are now above expected standards in all clinical areas. Quality Committee also reviewed and approved the IPC Terms of reference and its Forward Planner.

Divisional Quarterly Report Medicine

Committee received a comprehensive divisional report and focussed in particular on:

Virtual Wards – Do we understand the quality and safety assurance challenges associated with this new clinical approach? Committee asked for further discussion of some ‘real life’ stories to develop our understanding.
Serious Incidents – The need to address issues associated with pressure ulcers and with falls, including potentially assessing all frail patients/patients over a certain age as ‘at risk’, addressing issues with nurse noting re assessments and reassessments.

Quality Priority – Maternity

Committee received the monthly PQSM report and a report on the LMNS ‘touch-point’ visit.

Committee focused in particular on our “Robson Group” rates in the PQSM report and asked for further input from the lead Obstetrician to understand better how we assess these to assure quality of the service. Committee also noted the good improvements in the recorded level of MDT ward rounds to 92%.

The LMNS report recorded findings from a preliminary visit prior to a more formal visit in conjunction with NHSE in June. This identified a number of areas where we would need to provide evidence to demonstrate appropriate performance levels and overall it was an accurate reflection of our service. Issues identified will be picked up prior to the full visit in June.

Quality Indicators

Mixed-sex accommodation breaches remains a major area of concern and the Committee will continue to review this. We were pleased to note the improvement in response times for complaints.

Quality Account

Committee approved the Quality Account prior to submission to Board.

Nurse Staffing Report

Committee complimented the work done to reduce use of agency staff where numbers have fallen significantly – including down 50% in ED and a 50% reduction in Health care Support worker agency staff.

Clinical Effectiveness Committee Summary Report –

Noted

Patient Experience Committee Summary Report

Quality Committee welcomed the first report from the reinstated Patient Experience Committee and noted its important role in helping to improve and assure service quality and safety.

WYE VALLEY NHS TRUST
DRAFT Minutes of the Audit Committee – Internal Audit Reports Review
Held on 26 May 2023 at 9.30 am
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair and 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
Erica Hermon	EH	Associate Director of Corporate Governance/Company Secretary
Asam Hussain	AH	RSM Risk Assurance Services LLP
Ian James	IJ	Non-Executive Director (NED)
Val Jones	VJ	Executive Assistant for the minutes
Heather Moreton	HM	Head of Commissioning, Contracts and Income
Frank Myers MBE	FM	Associate Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Grace Quantock	GQ	Non-Executive Director (NED)

Minute		Action
ACIA001/05.23	**APOLOGIES FOR ABSENCE**	
	Apologies were noted from Andrew Cottom, Vice Chair, Non-Executive Director, Lauren Parsons, Senior Manager, Audit & Assurance, Deloittes LLP and Bradley Vaughan, RSM Risk Assurance Services LLP., Manager, Local Counter Fraud Service.	
ACIA002/05.23	**QUORUM & DECLARATION OF INTEREST**	
	The meeting was quorate. No declarations of interest were noted.	
	REVIEW OF INTERNAL AUDIT REPORTS	
ACIA003/05.23	**COST AND PRODUCTIVITY IMPROVEMENT PROGRAMME (CPIP)**	
	RSM, UK Internal Auditors (IA) presented the Cost and Productivity Improvement Programme (CPIP) Report, which was taken as read, and the following points were noted:- ○ A partial assurance opinion was provided. This was due to the Trust not having a robust and effective grip on the CPIP process in place. Some of the normal processes were stood down during Covid. ○ It has been highlighted in the report that staff need to get back into the habit of CPIP identification again. A high proportion of the schemes are non-recurrent which places more strain and challenge on the next year.	

	○ A robust challenge is needed regards the CPIP scheme with the Check and Challenge meetings not in place as previously. The guidance also requires updating and refreshing. ○ The Chief Finance Officer (CFO) advised that the findings were consistent with our self-assessment. With the scale of the CPIP that we committed to in 2023/24, we need to be committed to the challenge and ensure that we have rigour and processes in place. The plan has been taken through the Trust Management Board (TMB) where the findings and actions were discussed. The refreshed guidance was already in draft form when this audit was undertaken. Most of the actions are already being worked on are or committed to. It would be helpful for the organisation to see what "good" looks like in terms of a delivery programme. ○ Mrs Twigg (Chair of the Audit Committee and NED) felt that this was an opportune time for discussions from top to bottom of the organisation on our CPIP but questioned whether completing all the actions within the timescales set was achievable. The CFO agreed that they were tight deadlines but this was needed if we are to achieve our CPIP target, and was comfortable with the plans for all staff completing the HFMA CPIP online training session with the embedding of this taking time. ○ Mr Myers (ANED) was concerned that 100% of the audit was carried out remotely. The IA advised that the majority of the audit required paper documentation with interviews with Trust staff being held via MS Teams. The team did visit the site for other audits, eg the Cleanliness Report. If it was felt necessary to come onto the site they would, but they were able to undertake the audit remotely on this occasion. ○ The IA Partner advised that since Covid they have reviewed how they interact with organisations. If they are undertaking observational audits this will always be carried out on site, for data audits these are mostly undertake off site but the team will come in to verify if needed. ○ The CFO felt that reports are being produced quicker than previously and for this audit it was important for the IA to undertake a stock take of progress and understand the ownership around this. Further audits will be able to be undertaken on site as appropriate. The IA Partner advised that this was an advantage of being on site and able to visit staff for the information required. ○ Mr James (NED) queried if there were any particular concerns around ownership of this audit and with it being undertaken virtually. The IA advised that there were concerned around this audit in regard to the number of non-recurrent schemes to meet the CPIP target. There needs to be more operational thinking in in Divisions to take ownership of more recurrent schemes. ○ Mrs Twigg (Chair and NED) queried whether the Trust have been slower reacting to achieving our CPIP plans, especially recurrent savings, compared to elsewhere. The IA advised that all saving related areas were common findings for a number of Trusts.	
	<u>Resolved</u> – that the Cost and Productivity Improvement Programme (CPIP) Report be received and noted.	

ACIA004/05.23	**<u>DISCHARGE PLANNING</u>**	
	The IA presented the Discharge Planning Report and the following points were noted:- ○ The IA advised that this was a positive report with a Reasonable Assurance opinion provided. ○ The Clinical Consultant who visited the Trust was very pleased with the Trust's practices on their visits. They noted that staff placed patients at the centre of decision planning. ○ The role of the Discharge Co-ordinators was very positive and would be ideal to be expanded across all ward areas. ○ There was an action raised around finding a solution to ensure that all medical and nursing staff were available for the multi-disciplinary team meetings. ○ There also needs to be a greater understanding of why the Shropshire Commissioners are experiencing the longest waits for Community beds and what they are doing to reduce waiting times as these impact upon bed availability within the Trust. ○ Pharmacy staff vacancies are impacting on the ability to dispense medicines and is an area that needs improvement. ○ Reverse Boarding Policy – This helped in the short term but there is now concern that this is impacting on staff morale. ○ Mr Myers (ANED) felt that this report reflects well on the areas that we have discussed in Board of Director meetings and describes a balanced picture with the assurance provided. ○ The CFO advised that this report was discussed at TMB and agreed it reflected what we were expecting. This enabled discussion around the "so what" and the quality of decision making prompted some helpful discussion at the meeting. ○ Mr James (NED) felt that this was a positive report on the whole. The recording of expected data discharge is clearly used in diffident ways and he was concerned that sometimes this was recorded differently and then shifted as patient circumstances changed. We need to ensure that we not shift the expected date of discharge due to this and keep to the original date planned. ○ The IA Partner advised that they were overseeing this review in a number of other areas and that the reports were not as positive as it was for the Wye Valley Trust.	
	<u>Resolved</u> – that the Discharge Planning Report be received and noted.	

ACIA005/05.23	**CONSULTANT JOB PLANNING**	
	The IA presented the Consultant Job Planning Report the following points were noted: ○ The IA advised that a Partial Assurance opinion was provided ○ Job planning completion and sign off requires improvement. At the time of the review, only 35.29% of all Consultant job plans had been signed off for 2023/23. Job plans are also exceeding 48 hours – hence not adhering to the Working Time Regulations. Of the job plans reviewed, some showed inconsistencies with objectives not always being captured. More work is needed in this area. ○ The IA noted that it is unusual to give positive assurance in this area. ○ The CFO advised that Consultant Job Planning was requested as we are doing targeted work on this area and knew that further work was required. We are not where we want to be with this but there is richer information available than a year or two ago. We are putting more rigour into the job planning process by using Allocate and we are able to put challenge around this and more transparency. The real test of the effort and energy being put into delivery will be seeing improvement in twelve months' time. ○ Mr Myers (ANED) noted that this is one of our major cost elements in the Trust and queried if there are enough resources allocated to the policing of this. The CFO advised that she will review this and provide an update. We do have more resources and focus then when she first arrived at the Trust. The Job Planning Committee is also in place with key members of staff attending which feeds into the MARP meetings. ○ Mrs Twigg (Chair and NED) noted that it was not clear around the timescales on the action log if actions had been completed. ○ Ms Quantock (NED) felt more assured with the more detailed information being provided, noting that there is more resource in place but processes are now more complex post Covid and queried whether there is sufficient resource for the current environment. ○ The CFO advised that at the next full Audit Committee meeting in June, an update will be provided on the Job Planning Committee to provide more context around the work that the Chief Medical Officer (CMO), Deputy CMO and colleagues are undertaking. It was agreed to invite the Deputy CMO to the next meeting.	**KO** **KO**
	Resolved – that: **(A) The Consultant Job Planning Report be received and noted.** **(B) The Chief Finance Officer will review the resource available around job planning and the use of Allocate.**	**KO**

	(C) The Chief Finance Officer will invite the Deputy Chief Medical Officer to the June meeting of the Audit Committee to provide more background around the Job Planning Committee and associate work around this area.	**KO**
ACIA006/05.23	**<u>CLEANLINESS STANDARDS AUDIT</u>**	
	The IA presented the Cleanliness Standards Audit and the following points were noted:- o The team reviewed 47 different areas and checked evidence to support compliance. Of the areas reviewed, 39 showed evidence of these standards which is positive. Eight areas had further work required. o A helpful session was held with the Chief Nursing Officer and Sodexo around actions to be taken forward. o One action agreed was around better visibility, discussion and challenge of these standards at the Estate and Facilities Group and PFI meeting. o Mr James (NED) advised as Chair of the Quality Committee he will discuss with the Chief Nursing Officer to ensure that all the changes around cleanliness and infection prevention are being captured.	**IJ**
	<u>Resolved</u> – that **(A) The Cleanliness Standard Audit be received and noted.** **(B) Mr James (NED) will discuss with the Chief Nursing Officer to ensure that the changes around cleanliness and infection prevention are being captured.**	**IJ**
ACIA007/05.23	**<u>KEY FINANCIAL CONTROLS – ACCOUNTS PAYABLE AND ACCOUNTS RECEIVABLE</u>**	
	The IA presented the Key Financial Controls – Accounts Payable and Accounts Receivable and the following points were noted:- o This report received a positive opinion with reasonable assurance. o This is the first time that the IA have looked at Shared Financial Services. o There are some areas of improvement required. One of which is around the need for robust procedures for approval of credit notes - ie an audit trail showing the process for chasing from another area and processes in place to check supplier details. o The Associate CFO has discussed these findings with the Shared Financial Services.	
	<u>Resolved</u> – that the Key Financial Controls – Accounts Payable and Accounts Receivable be received and noted.	

ACIA008/05.23	**RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (DRAFT)**	
	The IA presented the Risk Management and Board Assurance Framework (Draft) and the following key points were noted: ○ The IA advised that a Partial Assurance opinion was provided which is not unusual for this area. ○ The review acknowledged that there is a very small team with a number of absences which has placed a challenge on the usual processes. However, the staff are mindful to manage and review strategic and operational issues and are managing day to day issues. An audit trail is needed for this which was lacking in the last year. ○ During this period, there was also the added challenge of the implementation of InPhase. This is expected to assist with a number of the issues raised in the report. ○ There were 2 low priority actions agreed. ○ The Associate Director of Corporate Governance agreed with the findings of the report. The introduction of InPhase is an ideal opportunity to review our reporting processes and ensure triangulation in the future. This was a remote audit. ○ Mrs Twigg (Chair and NED) noted the useful suggestions made in the report which we can build upon.	
	Resolved – that the Risk Management and Board Assurance Framework (Draft) be received and noted.	
ACIA009/05.23	**DRAFT HEAD OF INTERNAL AUDIT OPINION 2022/23**	
	The IA Partner presented the Draft Head Of Internal Audit Opinion 2022/23 and the following points were noted:- ○ This is in draft as the IA are awaiting the Tool Kit to be completed but the Positive Opinion provided so far is very unlikely to change. ○ Further enhancements are needed to be made as the Trust continue on this journey. ○ There are very few “green” reports this year as the IA were asked to review some problem areas. There is reassurance for the IA that the Trust are acting on these recommendations. It is positive that the Trust are using the IA in this positive way and not just asking for reviews on areas where we expect a “green” response. The CFO confirmed that the IA were directed to areas that we felt we needed support on and was grateful that a pragmatic, balanced report had been provided.	
	Resolved – that the Draft Head Of Internal Audit Opinion 2023/23 be received and noted.	
ACIA010/05.23	**AOB**	
	There was no further business to discuss.	

ACIA011/05.23	**DATE OF THE NEXT MEETING –** **15th June 2023 – 9:30 a.m. – 12:00 p.m. for End of Year Audit Committee**	

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

WVT Minutes of the Public Foundation Group Boards Meeting
Held on Wednesday 2 August 2023 at 1.30pm via Microsoft Teams
In Parallel with GEH, SWFT and WAHT

Present:		
Russell Hardy	(RH)	Group Chairman
Glen Burley	(GB)	Group Chief Executive
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Frances Martin	(FM)	NED WVT
David Mowbray	(DM)	Chief Medical Officer WVT
Katie Osmond	(KO)	Chief Finance Officer WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Nicola Twigg	(NT)	NED WVT
In attendance:		
WVT:		
Jon Barnes	(JB)	Chief Transformation Officer WVT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
John Burnett	(JBu)	Head of Communications WVT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sharon Hill	(SH)	ANED WVT
Kieran Lappin	(KL)	ANED WVT
Frank Myers	(FMy)	ANED WVT
Jo Rouse	(JR)	NED WVT
SWFT:	(VB)	Operational Chief Medical Officer SWFT (deputising for the Chief Medical Officer SWFT)
Varadarajan Baskar		
	(YB)	Non-Executive Director (NED) SWFT
Yasmin Becker	(FB)	Chief Nursing Officer SWFT
Fiona Burton	(AC)	Managing Director SWFT
Adam Carson	(SC)	Trust Secretary GEH/SWFT
Sarah Collett	(RC)	NED SWFT
Richard Colley	(PGi)	NED (Non-Voting) SWFT
Phil Gilbert	(SG)	Head of Strategic Communications SWFT
Sophie Gilkes	(PG)	Chief Strategy Officer SWFT
Paramjit Gill	(HH)	Nominated NED SWFT
Harkamal Heran	(KL)	Chief Operating Officer SWFT
Kim Li	(SM)	Operational Director of People and Workforce GEH (deputising for the Chief People Officer GEH/SWFT)
Sara MacLeod		
	(SP)	Chief Finance Officer SWFT
Simon Page	(MP)	NED SWFT
Mary Powell	(SWT)	NED SWFT
Sue Whelan Tracy		
GEH:	(CF)	Managing Director GEH
Catherine Free	(NG)	Chief Nursing Officer GEH
Natalie Green	(GH)	Communications and Engagement Manager GEH

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

WVT Minutes of the Foundation Group Boards Meeting Held on 2 August 2023

Gavin Hawes	(JH)	NED GEH
Julie Houlder	(HK)	Chief Finance Officer GEH
Haq Khan	(RK)	NED GEH
Rosie Kneafsey	(SJ)	NED GEH
Simone Jordan	(AM)	NED GEH
Anil Majithia	(JN)	Chief Strategy Officer GEH
Jenni Northcote	(SR)	NED GEH
Sarah Raistrick	(NR)	Chief Medical Officer GEH
Najam Rashid	(RS)	Chief Operating Officer GEH
Robin Snead	(UZ)	NED GEH
Umar Zamman		

WAHT:	(RB)	Head of Communications WAHT
Rebecca Bourne	(CB)	Chief Medical Officer WAHT
Christine Blanchard	(TB)	NED WAHT
Tony Bramley	(CH)	NED WAHT
Colin Horwath	(HL)	Chief Operating Officer WAHT
Helen Lancaster	(CM)	NED WAHT
Karen Martin	(SM)	NED WAHT
Simon Murphy	(RO)	NED WAHT
Richard Oosterom	(TR)	Director of People and Culture WAHT
Tina Ricketts		

Foundation Group:		
Chelsea Ireland	(CI)	Foundation Group EA (Board Administrator)
David Moon	(DMo)	Group Strategic Financial Advisor

There were five SWFT Governors and three members of the public also in attendance.

MINUTE		ACTION
23.051	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Charles Ashton, Chief Medical Officer (SWFT), Andrew Cottom, Non-Executive Director WVT), Becky Hale, Chief Commissioning Officer (SWFT), Erica Hermon, Associate Director of Corporate Governance/Company Secretary (WVT), Sarah Moppett, Director of Recovery and Care Excellence (SWFT), Gertie Nic Philib, Chief People Officer (SWFT/GEH), Sarah Raistrick, Non-Executive Director (GEH) and David Spraggett, Non-Executive Director (SWFT). **Resolved – that the position be noted.**	
23.052	**DECLARATIONS OF INTEREST** There were no declarations of interest. **Resolved – that the position be noted.**	
23.053	**GEH PUBLIC MINUTES OF THE MEETING HELD ON 3 MAY 2023** **Resolved – that the GEH public Minutes of the meeting held on 3 May 2023**	

MINUTE		ACTION
	be confirmed as an accurate record of the meeting and signed by the Group Chairman.	
23.054	**SWFT PUBLIC MINUTES OF THE MEETING HELD ON 3 MAY 2023** **Resolved – that the SWFT public Minutes of the meeting held on 3 May 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.055	**WVT PUBLIC MINUTES OF THE MEETING HELD ON 3 MAY 2023** **Resolved – that the WVT public Minutes of the meeting held on 3 May 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.056	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.056.01	Chairman's Remarks The Group Chairman started the Foundation Group Boards meeting by welcoming WAHT to the Foundation Group. WAHT joined the Foundation Group as full members on Tuesday 1 August 2023. The Group Chairman expressed that he was looking forward to sharing their journey as part of the Foundation Group. The Group Chairman took the time to thank all of his Executive colleagues across the Foundation Group during the disruption to services caused by the ongoing strikes. He expressed how impressed he was to see their response and leadership during a time of uncertainty. On the back of this he also thanked all front-line teams for their continued commitment to come to work despite the pressure faced, which had helped minimise the disruption to services. **Resolved – that the position be noted.**	
23.056.02	Group Analytics Update (Minute 23.007 refers) The Chief Operating Officer at GEH informed the Foundation Group Boards that services data would be covered in the Group Analytics Board Update under the main agenda item (Minute 23.059 refers). **Resolved – that the position be noted.**	
23.057	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chief Executive provided an overview of the Foundation Group Boards Workshop and explained that the format started with a guest speaker, followed by performance comparative data across the Foundation Group. The Group Chief Executive informed the Foundation Group Boards that the presentation provided by Guest Speaker Sarah Jane Marsh, National Director	

MINUTE		ACTION
	of Urgent and Emergency Care, was particularly interesting with some of the wider issues around the winter plan and urgent care performance. He continued that organisations within Integrated Care Systems (ICSs) received the winter planning letter in July 2023, which set out the roles of each organisation as well as the ICSs. The Group Chief Executive confirmed that winter plans were now being pulled together on the back of the letter, and being founded on the plans that were already in place for emergency care in ICSs. The Group Chief Executive highlighted the prevention session from the Foundation Group Boards Workshop. The presentation reminded colleagues of the importance of ensuring suitable investments and resources being given to prevention, but that also there were some shorter-term impacts on prevention that could be done such as patient education to prevent readmission. The Group Chief Executive informed the Foundation Group Boards that there was also a responsibility as anchor institution to help change things such as housing and education. The Group Chairman added that the Foundation Group was very conscious of its Council colleagues and how they did an enormous amount of work on prevention, and the Foundation Group needed to be working with them to support the work and provide better outcomes and better starts in life for its communities. **Resolved – that the position be noted.**	
23.058	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director at WVT provided the Foundation Group Boards with an overview of the performance at WVT. She highlighted that all Trusts within the Foundation Group were facing difficulty with Industrial Action still taking place, in particular the Junior Doctors and Consultant strikes. However, she took the time to praise the incredible effort from teams to minimise the impact of these and thanked the Group Chairman for his acknowledgement of that. The Managing Director at WVT informed the Foundation Group Boards that WVT had struggled with their Emergency Department (ED) performance, however offered assurance that best practice and shared learning was being sought from SWFT and GEH to continue to improve this area. The Managing Director at WVT expressed her concern for ED due to the Trust facing extreme highs in their ED attendance that mimicked winter pressures and scenarios. There was a range of reasons for this however, the main one was that the Trust had seen a significant increase in demand for emergency care. She explained that there was an improvement project across the Herefordshire and Worcestershire (H&W) system on how to transform Urgent Care over the next three years. This project had three areas of focus, pre-hospital, in hospital and discharge. The Manging Director at WVT explained that pre-hospital focused on the Urgent Community Response service and Packages of Care, in hospital included the finalisation of the Trust's plans to expand their Same Day Emergency Care (SDEC) area, as well as being clear on professional standards, and post discharge included the redesign of the Discharge to Assess (D2A) process.	

MINUTE		ACTION

The Managing Director at WVT explained that WVT had seen an improvement in their 28 Day Faster Diagnosis Standard, and the teams believed that by October 2023 they would be in a sustainable place. This was an important improvement for both patients but also clinical outcomes. The Managing Director at WVT continued by informing the Foundation Group Boards that she was most proud of WVT's sickness levels dropping and remaining low after a lot of work had been done to improve staff health and wellbeing. She highlighted that the Trust's current sickness levels were the lowest she had seen.

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

The Group Chief Executive highlighted WVT's SDEC performance, and they already received positive regional attention for this. However, he queried how much SDEC should Trusts be aiming to do and if WVT was improving SDEC space, then how was the Trust ensuring it was protected during times of increased activity. The Manging Director at WVT responded that the Trust should be doing around 40% if not 50% of SDEC. Protecting the beds would be difficult, however the Trust's intention would be to never bed in SDEC and ensuring robust plans were in place operationally to support that not happening.

The Managing Director at SWFT highlighted ED performance at SWFT, and that 2022/23 was a difficult year. Due to this SWFT started 2023/24 focusing on establishing SDEC and flow, which paid off with April, May and June 2023 all nearly at or above the national target. The Manging Director at SWFT expressed that this was a significant achievement and thanked the teams considering that May 2023 was one of SWFT busiest months on record, which was then surpassed by June 2023 being the Trust's busiest day with 378 attendances. The Managing Director at SWFT expressed that the inconsistency was a challenge as it made managing the pressures difficult. He added that SWFT was seeing an increase in Mental Health patients that end up stranded in ED which was an ongoing concern and was affecting staff wellbeing. However Integrated Care Board (ICB) colleagues were supporting SWFT with this.

The Managing Director at SWFT addressed the increase in Medically Fit for Discharge (MFFD) and explained that it was an area of focus with a targeted approach to ensure tracking coding and responding to challenges appropriately, this would then be rolled out to other wards. The Managing Director at SWFT took the time to address the impact of the Warwickshire Community Recovery Service, which SWFT had worked with Social Care and system colleagues on. The service had seen a significant decrease in pathway one exit delays for Warwick Hospital since being launched and, though still in its early running days, was showing real benefit. The Managing Director at SWFT briefly provided an update on Cancer services, which remained a concern for the SWFT and there had been a significant increase in referrals for two week waits (2WW) in June and July 2023, however, was also one of the areas he was most proud of with the 28 Day Faster Diagnosis Standard. The

MINUTE		ACTION
	Manging Director at SWFT celebrated the Trust's reduction in staff absence and vacancy rates. The Managing Director at SWFT informed the Foundation Group Boards that SWFT had been chosen as the first acute site to be given Elective Hub accreditation and were part of the Going Further Going Faster work, which aimed to eliminate wait times over 52 weeks by the end of the 2023/24 year. The Chief Operating Officer at SWFT and her team had done a fantastic job at improving this area so far where we were 111% above our elective activity. The Group Chairman invited questions and perspectives and of particular note were the following points. The Group Chief Executive added that the Foundation Group met with the Getting it Right First Time (GiRFT) team about Going Faster Going Further and it was reassuring to see how SWFT was performing. However he added interestingly the Patient Initiated Follow Up (PiFU) pathway was not resulting in many patients coming back to the Trust, and therefore indicated that the Trust was getting in a better place when it came to informing patients of what to expect post discharge. The Managing Director at GEH explained that the pressure being faced by WVT was very similar to the pressures faced by GEH. She explained that despite meeting the national 4 hour standard, it was lower than what the Trust would have liked to be seeing during the summer months. The Managing Director at GEH added that GEH's biggest challenge was around bed occupancy of 100% and the highest sickness rate in the Foundation Group which was causing additional challenges for staff. However, despite that, GEH was still doing great work on the 1 hour ambulance delays and the ED team were recently rated Good following their Care Quality Commission (CQC) inspection which was a brilliant achievement given the challenges faced. The Managing Director at GEH expressed that the 28 Day Faster Diagnosis Standard was a challenge for GEH and the teams were doing a lot of work about that, and by the end of Summer 2023 an improvement should be seen. She highlighted that Elective Recovery for patients waiting over 52 weeks had improved with very low numbers. GEH continued to work with colleagues across the Foundation Group and across the country on the GiRFT work to try and improve and learn about what more could be done. The Managing Director at GEH highlighted GEH's MFFD numbers being lowest in the Foundation Group, which had been supported by the Community Recovery Service. She echoed the Managing Director at SWFT's comments about Community Recovery Service and added that it was a brilliant piece of collaborative working across the system. The Group Chairman invited questions and perspectives and of particular note were the following points.	

MINUTE		ACTION
	The Group Chief Executive highlighted that GEH hotel services staff were included in GEH's absence rates, whereas for SWFT and WVT they were not so it was something to be aware of and take into account. However, the Allied Health Professionals (AHPs) absence was a little high and was an area to focus on. The Group Chief Executive commented on the 2WW referral data comparative across the Trusts, and he recommended further analysis. He wondered whether there was a higher proportion of cancer detected in ED in WVT given the different levels of 2WW referrals per capita. Mrs Houlder (NED GEH) thanked the Managing Directors for their update around performance in each Trust. She requested assurance around how the Trusts were ensuring patient experience was being maintained through the increase in demand on services. The Managing Director at WVT assured the Foundation Group Boards that there was a lot of effort that went into making sure staff continued to focus on their patient experience, and that staff were increased appropriately to care for patients as expected. However, the Trusts should be under no illusion that there would not be an impact on patient experience as it would be difficult to maintain. However, the Trust would do all it could to mitigate that. The Managing Director at SWFT echoed the Manging Director at WVT's points and expressed that the Trusts learnt a lot over winter 2022 and know what to focus on to ensure a better position. The Managing Director at GEH agreed with the other Managing Directors in the Foundation Group and added that when patients were in areas, they should not be they were risk assessed and ensured they were being cared for in a dignified way. She also noted that the patient feedback for GEH had recently been very positive despite the pressures faced by the department. All of the Managing Directors assured the Foundation Group Boards that the Senior Nursing teams were focused on patient experience and ensuring standards were being met despite challenges. **Resolved – that** **A) the Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust, and** **B) the Foundation Group Performance Update be received and noted.**	**MDs** **MDs**
23.059	**GROUP ANALYTICS UPDATE** The Chief Finance Officer at GEH introduced the Group Analytics Update and took the time to thank the Managing Director at WVT for her support and leadership with launching chairing the Group Analytics Board (GAB) to date. The GAB would now be chaired by the Managing Director at SWFT. The Chief Finance Officer at GEH provided an overview of work to date which focused on infrastructure, standards, and standardisation. An overview of the GAB work included the roll out of Power BI, implementing data quality kite marks, the creation of the Foundation Group Performance report, standardising the monthly Information Performance Reports across the Foundation Group and starting work to standardise the monthly Trust performance packs.	

MINUTE		ACTION
	The Chief Finance Officer at GEH informed the Foundation Group Boards of the GAB work plan for the next twelve months, which would focus on the more strategic elements of the Foundation Group's Strategy around culture and creating an information led culture. This included running workshops across the Foundation Group on what an information led culture would look like, and what was needed to get there. The Chief Finance Officer at GEH added that the workshops would also include consideration of inclusion of services data and how to create the headroom to do those things to enable the focus to shift. The Chief Finance Officer at GEH highlighted the challenges faced to be able to continue with the Group Analytics work which was resourcing. He explained that the GAB had done well to get to where they were with limited investments which was due to the extremely hard work by the three Heads of Information and their teams. However, there was the impending Electronic Patient Record (EPR) implementation which would increase the workload of their teams. There was a need for additional investment to continue with the work and a process was in place to recruit to a Group Analytics role, which would also look at how to share data across the Foundation Group in a much more efficient way. The Chief Finance Officer at GEH added that the GAB was also looking at local universities supporting with recruitment, short term capacity and how they could support with some of the more advanced analytics with artificial intelligence. WAHT joining the Foundation Group would also provide additional capacity, and another team to learn from. The Managing Director at SWFT expressed how the GAB was a good example of collaborative working across the Foundation Group. He explained that there were a variety of excellent skills that had been able to come together and progress work. He added that the next step would be the interesting part which would take a lot of effort across the Foundation Group, as they started to discuss culture change and getting people to start using data and information in a different way. The Group Chairman invited questions and perspectives and of particular note was the following point. Mrs Whelan Tracy (NED SWFT) congratulated the entire GAB team on moving the work of the GAB forward. She queried whether there had been any external benchmarking regarding the capability and capacity, and would the GAB be working with ICSs to support them with similar work. The Chief Finance Officer at GEH explained that the GAB was working on capability and capacity at the moment and were using a recent document that had been released from NHS England on this and 'what good looked like'. He added that in regard to ICS support it would be around data sharing in a more efficient way, but there was a need to create the capacity to do this first. **Resolved – that the Group Analytics Update be received and noted.**	
23.060	**DEEP DIVE INTO ADDITIONAL PERFORMANCE MEASURES – THEATRE PRODUCTIVITY**	

MINUTE		ACTION
	The Chief Operating Officer at WVT opened the presentation regarding theatres productivity. He explained that the Chief Operating Officers across the Foundation Group had been working together and with clinical teams to look at where the opportunities were, as well as using the GiRFT programme to help theatre productivity. The Chief Operating Officer at WVT explained that all three Trusts were focused on protecting elective surgery and ensuring beds would be available for patients on the day of surgery, he added that all three Trusts had a theatre recruitment plan, and there was shared learning with the aims to reduce waiting lists as well as the reliance on outsourcing. The Chief Operating Officer at WVT presented an overview of each Trust's activity in quarter one of 2023/24 in comparison to quarter one of 2019/20. There were various reasons why productivity in 2023/24 was less than in 2019/20 which included case mix, additional bank holidays, industrial action and theatre maintenance. The Chief Operating Officer at WVT touched on the importance of reporting being aligned across the Foundation Group and therefore a joint definition of Theatre Utilisation (Capped) and Theatre Utilisation (Uncapped) had been agreed. Capped Theatre Utilisation equalled the sum of each patient's touchtime over available theatre time, cut off at session scheduled end. Uncapped Theatre Utilisation equalled the sum of each patient's touchtime over available theatre time. The Chief Operating Officer at SWFT provided the Foundation Group Boards a detailed presentation on Capped Touchtime Theatre Utilisation. She explained that GEH ended June 2023 at 65%, SWFT was just above 85% and WVT was at just above 78%. She added that it was important to try and ensure each Trust was using the same definition and that all Integrated Performance Reports (IPRs) reflected the definition moving forward. The Chief Operating Officer at SWFT explained that, following a review of the metrics and deep dive of the data quality in addition to a validation exercise undertaken by the Operational Teams, there had been an increase in capped touchtime utilisation by just over 12% for GEH from January to April 2023. She assured the Foundation Group Boards that an action plan on how as a Foundation Group this could be improved was in place. She informed the Foundation Group Boards that SWFT used to report uncapped touchtime therefore figures were higher. However, SWFT was aware that certain specialities were not hitting target and had opportunities for improvement, for example Ophthalmology and Ear, Nose and Throat (ENT). The Chief Operating Officer at SWFT continued by providing detail on the WVT data, and that it identified issues when reporting real-time data entry and functionality. She explained that there was a need to ensure across the Foundation Group theatre scheduling at speciality level was being scheduled in the same structured way around 6-4-2. The Chief Operating Officer at SWFT assured the Foundation Group Boards that as a Foundation Group the Chief Operating Officers had been working to ensure that the work reconciled with Model Hospital and GiRFT. The Chief Operating Officer at SWFT explained that, as part of the Theatre productivity work, the Chief Operating Officers looked at themes across the Foundation Group. She explained that part of improving utilisation was about accountability and robust governance arrangements and it was important that teams were empowered, and services geared up to solve problems on the day.	

MINUTE		ACTION
	The Chief Operating Officers looked at a few keys themes, but it was important to ensure data driven change was happening which led them onto late starts and early finishes to ensure theatre utilisation was where it needed to be. The Chief Operating Officer at SWFT explained that there had been steady and consistent improvement at GEH around theatre lists starting on time, which had been a collective effort across directorates with the right cultural change. SWFT had seen a small improvement in main theatre lists starting on time and there had been a 6% reduction in lists finishing early. WVT had identified issues with real-time data entry and getting that data right was key to making improvements that were needed to be made. However, WVT had identified that patients in some specialties took longer to anaesthetise and therefore was key to schedule accordingly for those specialties. In addition to late starts and early finishes, on the day cancellations were identified as a key theme that needed improvement. On the day cancellations were patients cancelled on the day of surgery for clinical, non-clinical or patient related reasons. As a Foundation Group the Chief Operating Officers had agreed to adopt 'Operation Ring-Fence' to reduce on the day cancellations. This included protecting elective beds for surgeries, implement learnings from SWFT's escalation process for no on the day cancellations, review pre-operative guidance and instructions to the patients to reduce clinical and patient cancellations, and increase the use of digital technology for patient reminders, two way texting and digital pre-operative assessments with patients questionnaires to be completed remotely to ensure patients were fully informed without the need for face to face appointments. The Chief Operating Officer at GEH rounded up the presentation on theatre productivity and highlighted the depth of work that had taken place to improve theatre productivity across the Foundation Group. He added that the work had been a Foundation Group effort from all the operational teams working together at different levels to capture the learnings. The Chief Operating Officer at GEH provided an overview of the solution themes including an explanation of the 6-4-2 theatre scheduling process, which was used widely across the country. 6-4-2 stood for, six weeks, four weeks and two weeks and the process was that at six weeks theatre schedules were locked down, at four weeks patients were confirmed and booked into the theatre lists, and at two weeks a final check that the booked patients were fit for surgery, and confirmation that the list could proceed as planned. The Chief Operating Officer at GEH continued by providing the Foundation Group Boards with the planned next steps for theatre utilisation which included reconciliation to Model Hospital and GiRFT alignment of data, the appointment of the Group Data Analyst and implementation of learnings from SWFT on scheduling approach and orthopaedic length of stay and GEH on rollout. The Group Chairman invited questions and perspectives and of particular note was the following point. The Group Chief Executive thanked the Chief Operating Officers for a useful presentation, and he reinforced the fact there were big opportunities for improvement, as well as ensuring figures were absolutely accurate. The Group	

MINUTE		ACTION
	Chief Executive emphasised that with reliable data, the level of clinical engagement was important, and therefore wondered whether percentages were the right way to record the data. He recommended potentially looking at an indicative cost per minute indicator, and how much financial waste there was by individual list which could encourage improvement.	**COOs**
	Resolved – that **A) the Chief Operating Officers look into recording theatre utilisation data by cost per minute rather than by a percentage, and** **B) the Deep Dive into Additional Performance Measures on Theatre Productivity presentation be received and noted.**	**COOs**
23.061	**SAFE STAFFING OVERVIEW (TO INCLUDE NURSE PER BED RATIO)** The Chief Nursing Officer at WVT presented the Safe Staffing presentation to the Foundation Group Boards on behalf of the Chief Nursing Officers from across the Foundation Group. She explained that the presentation focused on safer Nurse staffing in particular which came into focus after the Mid-Staffordshire NHS Foundation Trust inquiry after wards were shown as having inadequate ward cover. She added that there had since been several guides published to support making decisions around safer staffing, including how to determine what was safe for different specialties. The Chief Nursing Officer at WVT explained that each guide referred to evidence-based tools to guide decision making, which had to be used in conjunction with professional judgement of Senior Nurses and in the context of clinical quality indicators and outcomes for patients. She continued that one of the criticisms of guidance that existed during the Mid-Staffordshire NHS Foundation Trust inquiry and prior to it was that staffing was assessed based on staff to bed ratios, which would not have taken into account differing patient needs, therefore evidence-based tools enable Trusts to measure the need of patients, case mix, equity and dependency. The Chief Nursing Officer at WVT explained that Trusts were required to complete audits twice a year at a minimum, where the evidence-based tools then guided the recommended staffing requirements alongside professional judgement based on ward layout, medical cover for the wards and other factors. The Chief Nursing Officer at WVT informed the Foundation Group Boards that the national guidance referred to comparing data to peers which was what as a Foundation Group, the Chief Nursing Officers had done. She explained that after comparing data of the same specialties and assuming a similar case mix, staffing was broadly comparable across the Foundation Group. The Chief Nursing Officer at WVT provided an overview of the different graphs within the presentation and the different figures they reported, including vacancy rates and national data at Trust level. The Group Chairman invited questions and perspectives and of particular note was the following point.	

MINUTE		ACTION
	The Group Chairman queried whether in terms of nursing ratios that the Trusts were safe. The Chief Nursing Officer at SWFT assured the Foundation Group Boards that SWFT's budgeted numbers were safe, but the actual numbers were sometimes challenged. The Chief Nursing Officers at GEH and WVT agreed with the Chief Nursing Officer at SWFT's comments. **Resolved – that Safer Staffing Overview presentation be received and noted.**	
23.062	**ANY OTHER BUSINESS** There was no further business discussed. **Resolved – that the position be noted.**	
23.063	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
23.063.01	Question from a SWFT Public Governor (West Stratford and Borders) The following question was submitted by the Public Governor in advance of the meeting: *'In the light of the increasing number of A & E attendances, what insight has the analysis of the causes of attendances shown across the Group?'* The Chief Operating Officer at SWFT explained that SWFT did a monthly analysis to understand the cause and monitor whether this had identified more than one reason. It was partly due to seasonal changes and partly due to growth across all services. However, SWFT was working with ICB colleagues to signpost patients for support elsewhere. The Chief Operating Officer at GEH informed the Foundation Group Boards that the level of critically sick patients attending A&E had increased and was putting pressure on the Trust's intensive care service, which showed that patients were not being over admitted it was down to a general increase in A&E attendances. The Chief Operating Officer at WVT echoed the other Chief Operating Officers comments and that Trusts were still facing some of the backlash from Covid-19 where patients were presenting with more complex conditions. **Resolved – that the position be noted.**	
23.063.02	Question from a Member of the Public – Mr Chris Lewandowski *'What is the average waiting time for children who need dental surgery in each of the three hospitals?'* The Chief Operating Officer at SWFT informed the Foundation Group Boards that SWFT had one paediatric patient waiting for dental surgery and therefore	

MINUTE		ACTION
	the Trust did not have a wait as such, however there was a wait for Orthodontics but not for anyone waiting a dental procedure. The Chief Operating Officer at GEH explained that GEH's paediatric work was very limited, and was predominantly for children with special needs, and their longest wait was for 50 weeks with additional lists being put on to bring that wait down. The Chief Operating Officer at WVT informed the Foundation Group Boards that WVT's paediatric waiting list for a dental procedure as an outpatient was 18 weeks and as an inpatient was 30 weeks. There were a couple of patients over 52 weeks but there was a plan in place for them over the coming weeks. The Chief Operating Officer at WVT added that WVT were having trouble with their orthodontics pathway which they were working with ICB colleagues to resolve. **Resolved – that the position be noted.**	
23.063.03	Question from a Member of the Public *'The figures in the report show that all three hospitals had increased pressures in their emergency departments. Why are the WVT 4-hour standards significantly lower than the other two hospitals? When will the UEC Plan start showing improvements in the 4-hour standard for WVT?'* The Group Chairman took these questions as previously covered in the Foundation Group Performance report (Minute 23.058 refers). **Resolved – that the position be noted.**	
23.063.04	Question from a Member of the Public *'What is being done to enhance Endoscopy capacity at WVT? Have you been able to solve your work force problems in this area?'* The Chief Operating Officer at WVT assured the Foundation Group Boards that the issues surrounding Endoscopy were slowly improving following significant workforce issues during 2023/24. He continued that this would see further improvement over the coming months with new consultants starting and extra funding for additional capacity. **Resolved – that the position be noted.**	
23.063.05	Question from a Member of the Public *'The situation of the number of patients occupying beds when fit for discharge is a considerable concern. The comments regarding non-Herefordshire patients is noted and adds to the concerns. What assurances can the Board/CEO give that there will be significant improvements in this area before the "Winter Pressures" start?'* The Group Chairman assured the Foundation Group Boards that there was a phenomenal amount of work underway with Place partners and in 'One Hereford' to ensure new ways of working together. The Group Chief Executive	

MINUTE		ACTION
	added that he was more comfortable with the robustness of data across the Foundation Group and being clear where patients were in their pathways. He explained that Trusts with a tighter grip on their data were actually reporting higher delays in their discharges due to understanding more where their patients were in their pathways. The Foundation Group as a whole had a strategy to support domiciliary care which in turn would support discharges and capacity and he offered assurance that winter plans would be based around keeping figures to a minimum. **Resolved – that the position be noted.**	
23.064	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
23.065	**APOLOGIES FOR ABSENCE**	
23.066	**DECLARATIONS OF INTEREST**	
23.067	**GEH CONFIDENTIAL MINUTES OF THE MEETING HELD ON 3 MAY 2023**	
23.068	**SWFT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 3 MAY 2023**	
23.069	**WVT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 3 MAY 2023**	
23.070	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.071	**ANY OTHER BUSINESS**	
23.072	**ELECTRONIC PATIENT RECORDS CONTRACT (GEH/SWFT ONLY)**	
23.073	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 1 November 2023 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chairman) Date: 1 November 2023
Russell Hardy

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

PUBLIC ACTIONS UPDATE: FOUNDATION GROUP BOARDS MEETING – 2 August 2023

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
23.058 (02.08.2023) Foundation Group Performance Report	The Manging Directors the Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust.	J Ives / A Carson / C Free	C.F on 23.08.2023 - GEH operational teams continuously monitor the 2WW referral numbers. The referral data in the performance report is indicative of the increase in referral numbers over the last 12 months particularly in colorectal, urology and breast services. Referral patterns are regularly discussed with Primary Care partners and monitored through Cancer Board.
23.060 (02.08.2023) Deep Dive into Additional Performance Measures – Theatre Productivity	The Chief Operating Officers look into recording theatre utilisation data by cost per minute rather than by a percentage.	H Heran / R Snead / A Parker	C Free on 23.08.2023 - Chief Officers are currently in the process of recalculating theatre productivity to include an indication of the resource cost per unit.
REPORTS SCHEDULED FOR FUTURE MEETINGS			

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 25 May 2023 at 1.00 – 4.00 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
David Mowbray	DM	Chief Medical Officer
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Felicity Archer	FA	Matron, Medical Division – For Item 9
Sarah Ashwood	SA	Matron for Quality & Safety (Maternity)– For Items 10 and 11
Jo Clutterbuck	JC	Dietician, Therapy Services – For Item 9
Rachael Hebbert	RH	Associate Chief Nursing Officer
Val Jones	VJ	Executive Assistant (for the minutes)
Sue Moody	SM	General Manager - Acute and Countywide Services
Rachel Murray	RM	Clinical Quality Improvement & CQUINs Manager – For Item 13
Rachael Skinner	RS	Integrated Care Boards Representative
Emma Smith	ES	Divisional Nurse Director, Surgery
Emma Wales	EW	Governance Lead, Medical Division
Laura Weston	LW	Lead Infection Prevention Nurse – For Items 7and 17

QC001/05.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Mehmood Akhtar, Associate Medical Director, Surgery, Robbie Dedi, Deputy Chief Medical Officer, Sarah Holliehead, Associate Chief Nurse, Medical Division, Frances Martin, Non-Executive Director, Tony McConkey, Clinical Director, Pharmacy and Medicines Optimisation, Natasha Owen, Associate Director of Quality Governance and Amie Symes, Associate Director of Midwifery	
QC002/05.23	**QUORUM**	
	The meeting was not quorate.	
QC003/05.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/05.23	**MINUTES OF THE MEETING HELD ON 27 APRIL 2023**	
	Resolved – that the minutes of the meeting held on 27 April 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/05.23	**ACTION LOG**	
	(a) QC014/03.23 – Clinical Audit and Effectiveness Summary – (B) – The Chief Nursing Officer (CNO) confirmed that the Clinical Effectiveness and Audit Committee held a discussion around LocSSIPs and logging the safety checklist. This is progressing well. (b) QC006/04.23 – Quarter 4 Safeguarding Quarterly Reports – (B) - Meeting arranged for 6 June 2023 between the Named Nurse Safeguarding children and the Advanced Practitioner MHA, MCA, DoLS to discuss feasibility of providing joint safeguarding training and HSIB report recommendations / action planning.	
	Resolved – that the Action Log be received and noted.	
	BUSINESS SECTION	
QC006/05.23	**RESEARCH REPORT**	
	Item deferred to the June meeting.	
QC007/05.23	**QUALITY PRIORITY – MCA AND DOLS**	
	The Associate Chief Nursing Officer (ACNO) presented the Quality Priority – MCA and DoLS and the following key points were noted: • The training update is highlighted in the report, including actions taken on how to embed this training. This is Essential To Role training. There is also some analysis in the report. The Advanced Practitioner MHA, MCA, DOLS/Lead Nurse Adult Safeguarding has provided some bespoke training for specific areas – one was in the Emergency Department (ED) following an incident. This has been very well received with positive feedback. • Further assurance is needed on how this has been embedded in clinical practice. A further audit of notes will be undertaken now the Policy has been updated. We are also continuing to review incidents. If a practice issue is identified then individual training is offered to support the staff member. • The CNO was pleased to note the number of staff, particularly doctors that find bespoke training sessions more beneficial than on line training. There is a risk that this training offer may not continue due to imminent staffing gaps within the safeguarding team. • The Chief Medical Officer (CMO) advised that he has been involved with three complex Consent and Best Interest meetings where Clinicians have asked for assistance and demonstrated ownership which is progress and positive. • Mr James (Chair of the Quality Committee and NED) noted that proof of the impact on practice is key, which the comments made by the CNO and CMO show that this is occurring.	

	• The Managing Director congratulated the team on the progress made, but was concerned around the impending vacant role in the safeguarding team and questioned whether there was any support available from the ICS or ICB. The CNO had discussed this with the CNO, ICB who has arranged for the Designated Nurse, ICB to meet with the ACNO. The ACNO confirmed that the meeting has taken place with the situation discussed, and the CNO, ICB has gone back to discuss plans for support. Interviews are planned for a MCA and DoLS Specialist whilst working with ICB colleagues regarding oversight in terms of high level Lead Nurse function for the team.	
	Resolved – that the Quality Priority – MCA and DoLS be received and noted.	
QC008/05.23	**QUALITY PRIORITY - MORTALITY REPORT**	
	The CMO presented the Quality Priority - Mortality Report and the following key points were noted: • Another positive month with reductions in both our in and out of hospital deaths. There were concerns around our out of hospital deaths previously, but there has been a significant fall in numbers now. • There has also been a significant drop in fractured neck of femur deaths. • Stroke is performing particularly well – our SHMI is 84. We received a very good SNAAP audit as well, which the team should be congratulated on. • The Managing Director queried how the planned discussions were progressing in terms of changing how we report our HSMR figures. The CMO advised that he had met with the Mortality Project Manager to discuss this issue as their belief is that this is due to a persistent coding issue. We possibly need more coders to benefit from the changes proposed, but the CMO will discuss in more detail in the Executive Directors meeting. • The Integrated Care Boards Representative noted that the week day HSMR was 110 and the weekend rate was 105 – this was often the other way around, and queried if there had been any discussions held around this. The CMO advised that there had not. We use the HSMR as a reliable measure to review any areas of concern. We need to address our issues first. If we were not capturing the true mortality risk to patients, we would be seeing a higher number of out of hospital deaths as this is all connected.	
	Resolved – that the Quality Priority - Mortality Report be received and noted.	

QC009/05.23	**QUALITY PRIORITORY – INFECTION PREVENTION QUARTERLY REPORT**	
	The Lead Infection Prevention Nurse (LIPN) presented the Quality Priority – Infection Prevention Quarterly Report and the following key points were noted: • There have been 8 C-Diff cases. Frome Ward had 2 cases, but on review, these were not linked to time and place. There were 6 lapses of care noted on review. The same trends were picked up as previously: antimicrobial stewardship, hand hygiene, commode cleanliness and bare below the elbow. There was also a delay noted in staff taking samples. Work is ongoing regarding refreshing practice on how and when to take a sample. • We ended the financial year on 42 C-Diff cases against a trajectory for the Trust of 44. We are continuing to work on our improvement plan with an aim to reduce numbers. • There were 7 E.coli cases in the quarter. All were reviewed and 2 cases of lapses in care were identified. This was due to hand hygiene and bare below the elbow practices. We ended the financial year on 30 cases against a threshold of 39. • Klebsiella bacteraemia – There were 5 cases in the quarter. The one case still being reviewed is for a patient on ITU. The remaining 4 cases reviewed show 1 case with poor staff compliance with handy hygiene and bare below the elbow practices, the other 3 cases were noted to have no lapses contributing to the bacteraemia acquisition. We have breached the threshold of 8 cases (ended on 15).The new threshold set remains at 8. This is a challenge to bring this number down. • Pseudomonas – There were no new cases reported. We breached the threshold set with the last case reported in October. • Other HCAI bacteraemia – Of the 9 other bacteraemia, we have 21 cases in total. The majority have been reviewed, with just 3 cases pending. Reviews have identified lapses in hand hygiene and bare below the elbow. • Information around hand hygiene practices is included in the report. We are not the only organisation with this issue, some of which is due to the over use of gloves since the pandemic. Staff are using gloves rather than gelling or maintaining good hand hygiene practices. The Clean Hand Campaign is being launched to remind staff that gloves are not always required.	

	• We have only 1 Covid positive patient today with no outbreaks. During the quarter, there were 146 hospital onset patient cases with 20 outbreaks linked to Covid. Two outbreaks required ward closures with wards being kept open for the other 18 outbreaks with bays or side rooms used for positive patients to maintain patient flow and optimise bed use. Six patients died in the quarter with Covid on their death certificate. The relatives have received a Duty Of Candour letter with the deaths being reviewed as part of a cluster review. • Flu – The peak of this was during December but has tailed off since then. There were 46 cases reported during this period which is very low. There was one outbreak of flu in one setting which only lasted a short period of time. • Norovirus – 5 wards had outbreaks. Areas were kept open with the use of bays and side rooms to contain the virus. • A lot of work is continuing around commode cleaning and hand hygiene. A couple of areas reviewed whether they actually needed commodes and removed toilet aids as they were not required. • Infection Prevention Improvement Plan – Good progress has been made on this following the NHSE review. Of the actions set, 46% have been achieved. Three actions have progressed now (noted in report as not progressing). There is very positive support from NHSE, with the LIPN working closely with the NHSE Lead along with Away Days with the Lead Nurse and support in progressing actions in the action plan. • Mr James (Chair and NED) questioned if there were concerns around any of the actions or blockages. The LIPN advised that there were no concerns. There were issues around receiving data from Sodexo, but this is now progressing. • The CNO noted that apart from C-Diff, we benchmark well regarding our other reportable bacteraemia and are not an outlier. We manage our infections and outbreaks in a positive way. . Our C-Diff numbers are still too high, yet other Trusts positions have worsened which means we are no longer an extreme outlier. • The LIPN was asked to explain how lapses in care contributing to the infection are assessed and how audit results are correlated to the infection acquisition. All cases are reviewed and there are certain measures to look at, eg Hand Hygiene audits and Commode and Environmental audits. The question is asked "Would the patient have had an infection regardless of the results? If staff had poor hand hygiene practice, would this influence the patient's risk?" All cases are reviewed with the clinical notes and checked for time lines against other cases linked to time and place. There may be lapses in practices in an area which may not be attributable to patients care – we need to review how the patient acquired the infection. We also review record keeping to ensure assurance can be provided.	

	• Mr James (Chair and NED) queried regarding the lapses of care, whether the profile has changed from last year to this year. The LIPN advised that this has not changed. We are tending to see the same themes picked up each time. • Mr James (Chair and NED) noted that we need to know whether the C-Diff headline figures still shows us as an extreme outlier. The LIPN advised that the equation used is external to us and we are not able to match the figures published for the Trust using this. We are currently in communication with NHSE to find out how this is calculated so that we can calculate these figures internally and report accurately taking out Community Hospitals. The CNO advised that UKHSA colleagues are also not aware how we get two different sets of figures, and we are asking for help with this. If we use our data and take out Community Hospital beds, we would still be deemed as an outlier. • Mrs Twigg (NED) noted that our figures are better this year than last year but proportionally we had more patients this year than last. Therefore, there is a bigger improvement that it appears. • Mrs Twigg (NED) highlighted that the hand hygiene and bare below the elbow section commented that Agency, Bank and Locum staff have the lowest compliance and questioned how we control and effect this and whether this is in their contract. The LIPN advised that we do liaise with our Master Vendor (agency provider). We need to ensure that these staff are aware of our competencies when they arrive, that said our practices are no different from any other organisation as the standards are from national guidance. • The Managing Director queried whether EPMA has a role to play with antimicrobial stewardship to improve prescribing. The CNO advised that a review of the antimicrobial formulary took place with changes to particular antibiotics over a year ago. Ordersets were also introduced to ensure adherence to best practice in terms of antibiotic selection and duration, but these are optional for use. As these are not mandated, Clinicians can independently prescribe outside of the Ordersets. Some further changes to antimicrobial prescribing are being launched next month. Given the significant workforce gaps in Pharmacy, we have not been undertaking antimicrobial stewardship audits. We have recently been able to recruit an Antimicrobial Stewardship Pharmacy Technician so these will restart soon. • The Managing Director queried if fit mask testing is a resilient service. The LIPN advised it is now back with the Infection Prevention Team. There are data issues currently, hence not being able to produce a report this time. We are still offering a 5 day a week service but with reduced hours and are meeting current demand. The next steps are to review the longer term service that can meet the retest requirements for relevant staff.	

	• Mr James (Chair and NED) noted that only 32% of annual audits are completed in the report. The LIPN advised that the Infection Prevention annual audit is required. We have been advised to carry this out quarterly rather than annually to make this more manageable. During Quarter 4, due to demands on the service along with taking on fit mask testing, this meant that there has not been capacity to carry this out. The LIPN had discussed this with NHSE who advised that only one other organisation is undertaking the audit quarterly rather than annually. From April the new programme of work was initiated which will mean that one area is audited each 12 months to make this more achievable.	
	Resolved – that the Quality Priority – Infection Prevention Quarterly Report be received and noted.	
QC010/05.23	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT (TOR AND FORWARD PLANNER)**	
	The CNO presented the Infection Prevention Committee Summary Report (TOR and Forward Planner) and the following key points were noted: • This forms part of the changes to the Quality Committee – we had agreed to strengthen our Sub-Committee reporting into Quality Committee. The last Infection Prevention Committee meeting was held on 28 April, with the Committee meeting monthly. • A number of Sub-Committees report into the Infection Prevention Committee – the Cleanliness Report presented this month. There have been sustained improvements from Sodexo and our own cleaning against the national standards. We are now above expected standards in all clinical areas which is very positive. We participate in the national Surgical Site Infection Audit for hip and knee surgery. The Committee received reports for Quarter 3. Wye Valley Trust SSI rate was 1.6% for total hip replacement against a national rate of 0.8% and for knees 6.3% against a national rate of 1.1 %. All cases with the exception of one were patient reported infections and do no contribute to the data reported externally. We plan to present the audit findings at Safety in Sync as there may be an issue with primary care antibiotic prescribing in some cases • The Committee also received an overview of the Blood Culture Audit. We are required to undertake this as part of our NHS contract. This reviews whether the right volume of blood was taken from a patient and whether the specimens were loaded onto the machine within 4 hours of the blood being taken. Over 80% of specimens were loaded within 4 hours. Only 7% of samples were taken with the correct volume of blood. We only provide 2 blood culture bottles for analysis and Best Practice suggests 4. The Blood Culture Policy is being updated and will be presented back to the Committee in June with education sessions being provided across the Trust in July regarding this change of practice by the Consultant Microbiologist.	

	• The Pulmonary Tuberculosis Policy, which was updated in line with the Infection Prevention manual and changes to the estate, was approved. • The Board Assurance Framework was presented to the Committee for review. We are fully compliant in most areas. The national team issued a further update on that date, so this will be reviewed and taken back to the Committee next month. This will then be presented to the Quality Committee and Board of Directors. There are no areas of concern to the existing report or with the new update released. • The Improvement Plan Update was noted. Positive feedback was also received from NHSE. • The Infection Prevention Forward Planner and Terms of Reference were reviewed (included in the pack) which require Quality Committee approval. • The Health Care Associated Infection Panel Terms Of Reference were presented and approved. • Mr James (Chair and NED) noted that assurance to be provided to the Quality Committee was not included in the Infection Prevention Committee Terms Of Reference. The CNO will amend.	**LF**
	<u>Resolved</u> – that: **(A) The Infection Prevention Committee Summary Report (TOR and Forward Planner) be received and approved.** **(B) To add in the Infection Prevention Committee Terms Of Reference that they provide assurance to the Quality committee.**	**LF**
QC011/05.23	**<u>DIVISION QUARTERLY REPORT – MEDICINE</u>**	
	The Matron, Medical Division, Governance Lead, Medical Division and Dietician, Therapy Services presented the Division Quarterly Report – Medicine, which was taken as read, and the following key points were noted: • In April, a new Virtual Ward was opened for a mix of acute medicine and frailty patients. There were between 5 to 8 patients per day in the first week. There were a few teething problems as expected and two compliments received. • The Clinical Practice weeks were restarted in May post the Covid pandemic. The timetable is included in the report. • CQUIN05 – Identification and response to frailty in Emergency Departments –There was some concern that we would not be able to achieve this, but this is progressing well.	

	• The Divisional "Shout Out" newsletter has been developed to encourage staff to input positive new stories to share. An example is included in the report. • There has been an increase in externally reportable Serious Incidents in relation to falls with harm. The Acute Frailty Lead has developed an action plan for the Division. We are trying to match staffing to our acuity levels. We have assurance that Wards are completing the twice daily acuity data which forms part of the Safer Staffing Reviews. Our baseline staffing report does not always accurately reflect patient's acuity levels, with the Frailty Wards the first to be reviewed. • The Division recognise that our VTE compliance needs improvement with action being taken to improve this. We have not had a Governance Lead in the Division for a while, with Dr Wales now taking on this role and discussing the process with key staff. • As detailed in the report, the footprint of our ED has been reduced. The Trust received notice in May from the Care Quality Commission that an anonymous whistle-blower had raised concerns around the safety in ED following the closure of Ambulatory. We responded to the Care Quality Commission, and received a good response back regarding the information provided. • At the ED Summit held last week, we looked at reducing the footprint in ED and keeping the Ambulatory ED closed. Over 80 members of staff attended, with nearly 50 in the room, the remainder virtually. Good discussions were held around options. No final decision was made on the day due to the large numbers involved. Survey Monkey has been used to enable feedback on the ideas raised with responses due by 31 May. The team visited George Eliot NHS Trust after this Summit as their ED works extremely well. Their set up was very different to ours, but there are a number of areas that we could improve in our unit. • Ms Quantock (NED) was interested in an update on Dementia training and queried if it was possible to link up with the wider Herefordshire Dementia Policies on building a dementia friendly community. It sounds as though staff are enthusiastic about training and this may be another option for funding and linking in with other areas. The Matron, Medical Division advised that this is monitored through our Vulnerable Patient Group which has a standing agenda item on dementia which the Acute Frailty Lead links in with this as well as out of hospital work.	

	• The CNO was concerned around pressure ulcers, particularly those that are avoidable. It would be helpful to understand from the Division why they think the numbers are increasing. Data analysis has shown that that the larger increase is in medicine rather than frailty and asked if the improvement plan could be replicated in medicine. The CNO felt that the idea of classing all frail patients as high risk of pressure damage until assessed as otherwise was very useful and asked the Division if we had sufficient equipment to take this approach. The Matron, Medical Division advised that the contributable factor is the Digital Nurse Noting system in terms of accurate and timely assessment and reassessments. The Pressure Ulcer Panel and the Falls Panel found that this is a cause in most of our Root Cause Analysis and forms part of the action plan for most of these cases. There are obviously other contributable causes as well. The Divisional Nurse Director, Surgery was concerned around the number of agency Health Care Support Workers, but with the decrease in our vacancies this should hopefully show an improvement. We need to address this as part of the Clinical Practice weeks as well. The Dietician, Therapy Services confirmed that the Division are trying to increase the number of substantive staff and reduce agency for this reason as well as improving in a number of other areas. Mr James (Chair and NED) noted that there is a serious cost issue associated with agency staff but we also need to be aware of the high numbers of agency staff impact on the quality of care provided. • Mrs Twigg (NED) asked for "real life" stories around the virtual wards to be on the agenda to enable the NEDs to hear about the key facts and for quality reassurance for the Quality Committee. • The General Manager - Acute and Countywide Services advised that there is a nationally agreed framework for falls. This means that anyone over 60 is at high risk or aged 50 or over with co-morbidities, is routinely high risk and suggested that this be used for pressure ulcers as well. We need to have a new approach to pressure ulcers. • Mr James (Chair and NED) queried if the ED footprint that we currently have can be flexed as required. The Dietician, Therapy Services confirmed that this is the case. We have returned back to the pre-Covid footprint but flex into Ambulatory when we are particularly busy, but discussion is ongoing on how we use this part of the estate in the future. This is not an ideal place to work in with a high number of complaints received. • Mr James (Chair and NED) questioned whether patients experience anything differently when seen in Ambulatory ED. The Dietician, Therapy Services advised that patients come into the main ED but are then moved. In Ambulatory ED there are three different waiting areas with patients ideally being seen sooner. The Dietician, Therapy Services will ensure that patient incidents, concerns and complaints regarding these changes are monitored.	**FA/EW** **FA/EW**

	<u>Resolved</u> – that: **(A) The Division Quarterly Report – Medicine be received and noted.** **(B) "Real life" stories around the virtual wards to be presented to the Quality Committee to enable the NEDs to hear about the key facts and for quality reassurance for the Quality Committee.** **(C) Patient incidents, concerns and complaints regarding the changes within the Emergency Department will be monitored.**	 **FA/EW** **FA/EW**
QC012/05.23	**<u>PQSM REPORT</u>**	
	The Associate Chief Midwifery Officer (ACMO) presented the PQSM Report, which was taken as read, and the following key points were noted: • There has been a significant increase in the number of births across March – 151 births and 153 babies (2 sets of twins). • Robson Group 5 – Nineteen women fitted this criteria with three having vaginal births and sixteen having a repeat caesarean section. Of these sixteen women, two attempted vaginal births unsuccessfully, fourteen requested a repeat section. Six of the women had experience two or more previous caesarean sections. • The new Consultant Midwife has started in post and is shadowing clinic regarding VBAC to review the pathway. • There were two foetal losses during March – details of which were provided to the Committee. Both families are being supported by the Bereavement Team. • There were two Serious Incidents in March – details of which were provided to the Committee. • There was a decrease in the midwifery rate to 0.19WTE. The MDT ward round has improved from 38 to 92%. Anaesthetic is up to 85% and the Obstetric team to 98%. • There were no complaints received in March. • Training reduced to 87% due to a number of new starters. There are plans in place to address this. • The Managing Director highlighted that the Robson Categories included in the report do not appear to have changed and queried if we should be seeing an improvement. The ACMO advised that it is difficult to reduce numbers as we need to give women choice. The ACMO will ask the Lead Obstetrician to attend future Board of Directors meetings to provide clinical support.	**SA**

	• Mr James (Chair and NED) queried if we know what "good" looks like and how we can compare our Robson Group 5 figures with other Trusts. The CNO advised that the Obstetrician and Gynaecologist is leading on a Robson Group Audit. If completed in time, to include in the next PQSM Report for more assurance.	**SA**
	Resolved – that: **(A) The PQSM Report be received and noted.** **(B) The Associate Chief Midwifery Officer will ask the Lead Obstetrician to attend future Board of Directors meetings to provide clinical support.** **(C) To include the Robson Group Audit in a future PQSM Report.**	**SA** **SA**
QC013/05.23	**MATERNITY SERVICES EXCPETION REPORT – LMNS VISIT**	
	The CNO and the Matron presented the Maternity Services Exception Report – LMNS Visit and the following key points noted: • The CNO introduced the report advising that post Ockenden, the LMNS are required to have oversight of our maternity services and to undertake Insights visits and Touch Point visits. The LMNS undertook a touch point visit in April. The findings of this visit then lead to the key lines of enquiry for the more formal visit in June which will be undertaken by the Region and the LMNS. • Post Ockenden, the Trust had 7 Immediate and Essential Actions with a further 15 introduced in March 2022. The Midlands perinatal Team undertook an Insight Visit in May 2022, specifically reviewing performance against the original Immediate and Essential Actions. • In the report, some of the elements of the Immediate and Essential Actions have been downgraded from Green (May 2022 assessment) to amber (April 2023 visit). This is not a cause for concern and is due to a more in-depth review for each element. We know from the LMNS feedback that they are not concerned and they were confident where we were not fully compliant we had a clear plan to get there. • The Executive Summary highlights a few areas that require addressing prior to the June inspection, particularly serious incident reporting to Board. The CNO has asked the Director Of Midwifery at South Warwickshire NHS Foundation Trust and George Eliot NHS Trust to work with us on this. • At the last visit, the team identified lack of clarity around Junior Doctor cover for services across seven days and nights a week as this was inconsistent. We need to ensure this is clarified for the team visiting in June. The forthcoming CQC inspection was also noted.	

	• The Managing Director queried if we felt that the feedback from Insights visit was a fair and accurate description. The Matron agreed that it was. They dug deeper into the detail which we need to improve upon. The CNO advised that there were a further two areas that were initially marked as amber, but on challenge, have moved back to green and was confident the LMNS were treating this fairly and consistently. • Mr James (Chair and NED) asked if South Warwickshire NHS Foundation Trust had had their Care Quality Commission inspection and Insight visit so that we could learn from their experience. Secondly, we need to be Inspection ready as we know the Insight visit date and need to be prepared for this. The CNO advised that the Associate Director of Midwifery had conducted a mock inspection for another Trust which we were able to learn from. We are also in touch with the Foundation Group to pick up intelligence from them. The CNO has also attended a Regional CNO meeting where findings from early inspections were presented which she has fed back to the Associate Director of Midwifery. Key areas of focus are triage and assessment of women and how they are risk assessed in triage and safety netted with 'eyes on' if they are moved to a waiting area. We need to ensure that our Maternity Standard Operating Procedure is up to date and audited regularly. These are the main themes from Units already inspected.	
	Resolved – that the Maternity Services Exception Report – LMNS Visit be received and noted.	
QC014/05.23	**QUALITY INDICATORS REPORT**	
	The CNO presented the Quality Indicators Report and the following key points were noted: • The CNO advised that the data in this report is not validated due to timings, but will be for the Board pack. • We continue to be an extreme outlier for mixed sex breaches and the Region are interested in our position and what we are doing around this. • Numbers are higher in April than March, and Ward areas with high figures in March are not where we expected them to be. We expected Wye Ward, ITU and CCU to be high as they are high care areas but not these numbers. Some progress has been made but not the reduction in areas expected. • We only authorise a mixed sex breach if not doing so would prevent an ambulance being able to offload and creating patient concern in ED. Mixed sex breaches feature in all Bed Capacity meetings and how quickly they are being resolved.	

	• The Serious Incident Report is presented bi-monthly to the Quality Committee with a breakdown of April's incidents included in the report, with pressure ulcers the main area. • The CNO has flagged with the Informatics Team why we cannot pull through our Cleaning Standards as we do have these figures. • It is very pleasing to note the improvement in the complaint response times, with 65% responded to in the timeframe. • The Friends and Family information was not available for this report. • Mr James (Chair and NED) queried if the validation issue is a monthly occurrence. The CNO advised that during a five week month this is not an issue, this only occurs when we have a four week month. • Mr James (Chair and NED) queried if beaches on CCU should not occur. The CNO confirmed this, as these are avoidable. There are a lower number in ITU as the Site Team are focussing on moving patients from this area. When a mixed sex breach occurs, the numbers counted do not just include the patient themselves but all the patients in that bed space, eg one patient in a bay of four patients' breaches but all four will be counted in the breach, which will increase to eight on day two if this continues. • The Managing Director suggested the Quality Indicators being presented directly to the Board of Directors, rather than having invalidated figures being presented at the Quality Committee as all the information undergoes a deep dive already. Mr James (Chair and NED) agreed with this suggestion to prevent duplication. A further discussion will be held around this approach.	**LF**
	<u>Resolved</u> – that: **(A) The Quality Indicators Report be received and noted.** **(B) Further discussion to be held around the process of presenting the Quality Indicators Report to the Board of Directors.**	**LF**
QC015/05.23	**<u>QUALITY ACCOUNT</u>**	
	The Clinical Quality Improvement & CQUINs Manager presented the Quality Account and the following key points were noted: • This meets the national requirements and has been distributed for comments and feedback. The final version will be presented at the Board of Directors meeting next week.	

	• The CNO advised that we require statements from the ICS and Healthwatch. It has been agreed to submit the Quality Account to the Board of Directors with the ICS statement to follow due to timings. This will be received prior to the time of publication. The proposal is for any material feedback to be raised by exception to Board Members.	
	Resolved - that the Quality Account be received and approved for submission to the Board of Directors.	
QC016/05.23	**NURSE STAFFING REPORT**	
	The Associate Chief Nursing Officer presented the Nurse Staffing Report and the following key points were noted: • There is a reduced report this month due to the data not being available in time. HR reporting will be included next month. • There is a reduction in fill rates this month – we are still seeing a number of incidents that require 1-2-1 care which is reflected in the fill rates. This appears to be a national issue. • The new tool should be available in the autumn due to the change in acuity of patients nationally. • There has been a decrease in incidents in the month, down to twenty one. This is due to effective fill rates and an increase in substantive staffing and a reduction in agency numbers. • There has been a significant reduction in agency usage – nearly 84WTE from the previous month. The highest area for agency usage is ED. They have managed to half their usage which is very impressive. • Thornbury usage is reducing month on month. • Last year there was a peak in Health Care Support Worker agency usage which has reduced this year. Last year was 30.6WTE on average each week, whereas this year it has been a 16.2WTE average each week. • In June, the biannual report to the Committee will be presented with the full acuity data.	

	• Mrs Twigg (NED) queried how we start to triangulate the data around the reduction in agency usage to ensure that we have enough staff and are not reducing care ,to ensure that we have the evidence that we have the right number of staff for assurance. The CNO advised that the Establishment Review will be presented to the Quality Committee which brings quality outcomes, establishment and acuity outcomes together. This agency reduction is driven by two major factors – the reduced footprint in ED and the additional beds at the Community Hospitals are now closed. The CNO did not have any concerns around safety but is concerned around frailty due to the increase in incidents. The establishment is not quite right yet hence the review. The use of temporary staff is not the answer as they do not always provide high quality care or continuity of care. • Mr James (Chair and NED) noted that the report does not describe the reasons why agency usage has reduced. We are hoping to see substantive staff numbers increasing through recruitment and retention so that underlying agency usage reduces. The CNO advised that the Board version of the report contains more detail around this. In February 2022 we had 82WTE Health Care Support Worker vacancies – we are now down to around 19WTE. We have also seen an improvement in our turnover rate as well as an improvement in our vacancy rate for Registered and Overseas Nurses but not at the same rate. Vacancies, sickness and maternity rates are all improving as well.	
	Resolved - that the Nurse Staffing Report be received and noted.	
QC017/05.23	**CLINICAL EFFECTIVENESS COMMITTEE SUMMARY REPORT (TOR AND FORWARD PLANNER)**	
	The CMO presented the Clinical Effectiveness Committee Summary Report (TOR and Forward Planner), which was taken as read, and the following key points were noted: • There has been a lot of positive work around clinical audits. We were an outlier for the NELA audit in 2017/18. Following a lot of focus, we are seeing quality improvements with our mortality rates. This is a very powerful message on how you can make improvements through clinical audit. • Echocardiography audit – This is for patients with suspected cardiology failure. Due to the improvements made, we now have echocardiograms for patients in a very short space of time. • The Integrated Care Boards Representative noted that the report indicates a national problem with some Trusts regarding the application of the ABR audit. Audit outcomes and assurance and reassurance is very strong for Regional and National colleagues regarding Wye Valley Trust.	

	• The Managing Director queried if the National Ophthalmology audit is being undertaken. The CMO advised that the Trust is not undertaking this as the team have not yet agreed on which system to choose for Electronic Patient Records.	
	Resolved - that the Clinical Effectiveness Committee Summary Report (TOR and Forward Planner) be received and approved.	
QC018/05.23	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The Patient Experience Committee Summary Report was taken as read and the following key points were noted: • The Managing Director questioned whether Friends and Family text results are being fed back to ward level. The CNO advised that discussion was held at the Committee on how to access this information. The ACNO advised that there are currently issues ensuring that the right level of detail is coming through. When we are able to access this, it is very useful and positive feedback. The Managing Director noted that it is also useful to drive improvement through less positive feedback as well. • The CNO advised that she had undertaken the Envoy training which was very useful. This enabled the user to access a number of functions and to drill down into the detail. • Regarding the maternity Friends and Family text service, cleansing is required to filter out the safeguarding children. Currently we cannot find a systematic way to do this, hence the delay. Colleagues are speaking to the Foundation Group on how they have managed this issue. • Mr James (Chair and NED) was pleased that this Committee was in place again and welcomed having the reports reinstated.	
	Resolved - that the Patient Experience Committee Summary Report be received and noted.	
QC019/05.23	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC020/05.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 29 June 2023 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 29 June 2023 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer – Intermittent attendance due to managing CQC Inspection priorities.
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director – Arrived during Item 6.
Natasha Owen	NO	Associate Director of Quality Governance – Left after Item 17
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Mehmood Akhtar	MA	Associate Medical Director, Surgery – Arrived during Item 6
Kerry Anelli	KA	Integrated Care Boards Representative
Chris Beaumont	CB	Mortality Project Manager – Attended for Item 5
Julie Davies	JD	Consultant Clinical Scientist and Clinical Director Pathology – For Item 10
Helen Byard	HB	Matron Directorate of Theatres & Anaesthesia
Robbie Dedi	RD	Deputy Chief Medical Officer
Rachael Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Leah Hughes	LH	Operational Clinical Lead Radiographer
Amanda James	AJ	Matron Surgical Specialities
Val Jones	VJ	Executive Assistant (for the minutes)
Hamza Katali	HK	Associate Medical Director, Clinical Support - Arrived during Item 6
Tony McConkey	TM	Clinical Director, Pharmacy & Medicines Optimisation – Left after Item 8
Sue Moody	SM	General Manager - Acute and Countywide Services
Rachael Murray	RM	Clinical Quality Improvement & CQUINs Manager
Emma Wales	EW	Associate Medical Director, Medical Division - Arrived during Item 5

QC001/06.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Claire Carlsen, Associate Chief Operating Officer, Clinical Support Division, David Mowbray, Chief Medical Officer, Emma Smith, Divisional Nurse Director, Surgery, Rachael Skinner, Integrated Care Boards Representative and Amie Symes, Associate Director of Midwifery.	
QC002/06.23	**QUORUM**	
	The meeting was quorate when the Chief Nursing Officer was in attendance.	
QC003/06.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	

QC004/06.23	**MINUTES OF THE MEETING HELD ON 25 MAY 2023**	
	Resolved – that the minutes of the meeting held on 25 May 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	
QC005/06.23	**ACTION LOG**	
	(a) QC012/05.23 – PQSM Report – (B) – The Chair will discuss with the Chief Nursing Officer around the Lead Obstetrician also attending Quality Committee to provide clinical support. (b) QC014/05.23 – Quality Indicators Report – (B) – It was formally agreed that the Quality Indicators Report will be reported directly to the Board of Directors meeting.	**IJ**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) The Chair will discuss with the Chief Nursing Officer around the Lead Obstetrician attending Quality Committee to provide clinical support for the PQSM Report.**	**IJ**
	BUSINESS SECTION	
QC006/06.23	**RESEARCH REPORT**	
	Item deferred to the September meeting.	
QC007/06.23	**PATIENT EXPERIENCE QUARTERLY REPORT**	
	The Associate Director of Quality Governance (ADQG) presented the Patient Experience Quarterly Report and the following key points were noted: • We finished the year with a good reduction in the number of complaints received, about 100 less than the previous year. • There have been some delays with the InPhase integration with complaints. We are currently not able to see the response rates from February, but this should be resolved for the next report. • One complaint was reported to the Parliamentary and Health Service Ombudsman and was partially upheld due to the loss of patient property and some communication issues. This case occurred during the pandemic. More significant concerns were raised regarding clinical care and processes not being upheld. A comment was made around how well we followed national guidance at the time. A response letter is being written to the family. The Patient Experience Committee are discussing the Patient Property Policy to improve on this.	

	• Friends and Family text data from text messages - We are in line with the national response rates. Day Case are routinely getting good responses. We are able to undertake a thematic analysis from comments from the free text. A Trustwide overview is provided in the report. This is largely positive with only a few negative responses. More detail around key themes will be provided in the next few months. Divisions will undertake a similar analysis for patient experience. • Surveys – We have tried various ways to receive more feedback from patients. We initially had a good response from the locally devised postal surveys, but over time this number has decreased. We have only received one response from the local Inpatient Survey which was sent out with the Friends and Family text. We are going to reconsider how best to enable patients and visitors to provide feedback. We are also looking at using volunteers on a more formal basis to obtain real-time feedback. • The Managing Director queried what the actual concerns raised by the Ombudsman were. The ADQG advised that they requested the patient's notes and they reviewed our response regarding the care provided. The Specialist Advisors look at the whole process and any areas that they do not agree with are upheld. We admitted that we did not follow our own Policy for the patient's property. The Associate Chief Nurse, Medical Division advised that they wanted more detail to ensure that there was better bereavement communication. • Mrs Twigg (NED) noted how impressed she was on her recent ward visit with the passion of staff and how leaders are looking at Friends and Family feedback. • Mrs Twigg (NED) noted the importance of triangulating information about lost property. Financial losses were discussed at the last Audit Committee (which Mrs Twigg Chairs), as there are some huge losses. We need to ensure that the correct person is dealing with this as there is a quarter on quarter increase in pay outs. • Mrs Twigg (NED) noted that the volume of complaints is staying consistent but the time to deal with them is nowhere near the 90% that we need to be achieving. We run the risk of having more Ombudsman issues if we miss deadlines for complaints. The ADQG agreed that there is an increased risk. The team do keep in touch with the complainant if we go over the agreed timeframe. There were only three referrals to the Ombudsman in the last twelve months, and only one was investigated, so the conversion rate is low. • The Matron Surgical Specialities advised that digitalisation with nursing documentation is a major factor now as there is no longer a paper disclaimer for patients to sign. There are discussions around how to resolve this issue.	

	• The Mortality Project Manager advised that the Medical Examiners are picking up on some of these areas to prevent further issues developing. • Mr James (Chair of the Quality Committee and NED) advised that Mr Myers (ANED) had raised this issue at a meeting previously and found that how we deal with patient property is not as efficient as it could be. The ADQG advised that we are working with the Mortality Team and reviewing how this is being dealt with in different areas. • Mr James (Chair and NED) queried how all the Patient Experience work is being tied together. The ADQG advised that the Committee has been re-established with the first meeting held in April. We are starting to get the structure back in place and discussed patient engagement in a lot of detail at the last meeting. We are also reinvigorating the Patient Safety Committee as well. Mr James (Chair and NED) felt it would be useful to have an update to the Board of Directors to ensure that the patient voice is being heard. • Mr James (Chair and NED) was keen to include the question in the National Inpatient Survey around asking patients about quality of care received in the work that we are doing now, as we have historically scored lowly on this area. The ADQG advised that she had seen the embargoed initial results for this survey, with a slight improvement in this area, but not as much as required.	
	Resolved – that the Patient Experience Quarterly Report be received and noted.	
	CONFIDENTIAL SECTION	
QC008/06.23	**Serious Incident Report**	
	BUSINESS SECTION	
QC009/05.23	**QUALITY PRIORITY - MORTALITY REPORT**	
	The Mortality Project Manager (MPM) presented the Quality Priority - Mortality Report and the following key points were noted: • The latest SHMI was 104 for December. Crude mortality deaths are also down and are considered to be within normal summer ranges. The latest figures for May shows a significant reduction in deaths at 1.2%. • Outlier Groups – We are now the 10th best for morbidity rates for stroke in the country. This is the second largest group for our mortality. We have seen a sustained and stable reduction in numbers. • Fractured Neck of Femur numbers are reducing back down to numbers seen prior to the spikes. We expect them to continue to improve down to under 100, with a dedicated resource for this.	

	• Heart Failure – There is slight concern around this area. A thematic audit of deaths over the last twelve months has been undertaken with an action plan of any areas of concern being brought back to the Committee for review. • Sepsis and pneumonia are both within expected ranges. • Coding measures – A Task and Finish Group has been set up to review what the measures mean and how they are impacting our mortality figures and financially. We need to understand why we have such high figures compared nationally along with issues around palliative care coding. We need to understand why these patients are being coded how they are. • MBRRACE 2021 - This is a positive picture compared nationally. We are in the top 20 for mortality rates. • Learning from Deaths – The Medical Examiner Service is working well, with 100% of deaths being reviewed. This is working well across the Community as well. • We need a standardised approach for our Structured Judgement Reviews (SJR). These are occurring across the Trust but in silos. We are revisiting the process to ensure that all learning is being extracted. The Emergency Department and Primary Care are working with us as key areas who add a lot to these reviews. • The Deputy Chief Medical Officer (DCMO) queried if InPhase has the functionality to produce the information on the SJR as was the case for Datix. The MPM advised that this facility is being reviewed. • Mr James (Chair and NED) queried when the Task and Finish Group will have finished their review around coding as we need to get to grips with this issue for palliative care. The MPM advised that he had a meeting planned with the Managing Director and the Chief Finance Officer to discuss this. If this issue can be resolved, this will reduce our HSMR and SHMI figures. • Mr James (Chair and NED) noted that of all the cases reviewed by the Medical Examiners, there were two that required further investigation and queried how the internal SJR link in with the Medical Examiners reviews to prevent doing the same thing twice. The MPM advised that the Medical Examiner review is quite basic and is nationally driven. If they flag any concerns, this then leads to a full review of the whole patient journey, and not just the last few days of their care which the Medical Examiner reviewed. This process needs to be me more robust. • The DCMO noted the drop in numbers for stroke and queried if the cause for the decrease in this rate was known. The MPM advised that the In Hospital deaths have not changed much, the main change is to the Out Of Hospital deaths which have reduced considerably.	

	• The MPM advised that in hospital deaths for stroke is remaining static at about 100, with the Out Of Hospital deaths at about 140. Stroke and pneumonia numbers are reducing, which were our main areas of concern. The Managing Director felt that there was a sense that if we are consistently meeting standards this number should improve. Mr James (Chair and NED) noted that often just focusing on an area enabled improvement. The MPM advised that the improvements were due to a number of small changes rather than one major change.	
	Resolved – that the Quality Priority - Mortality Report be received and noted.	
QC010/06.23	**QUALITY PRIORITY – IMPROVE THE MANAGEMENT OF THE DETERIORATING PATIENT**	
	The DCMO provided a verbal update on the Quality Priority – Improve the management of the deteriorating patient and the following key points were noted: • The DCMO Chairs the Deteriorating Patient Committee which has been set up to ensure improvements in specific areas in the Trust. This is a multi-disciplinary type meeting with various specialities involved. • The first meeting held with Clinicians was a scoping meeting around what we want to concentrate on as this is such a huge topic. The Terms Of Reference have been agreed. • The plan is to review escalation processes as this can sometimes cause difficulties. We are working on how to audit this using Maxims as currently this requires a lot of manual work to achieve. It is expected that education along with Standard Operating Procedures and Policies will be required. Once completed, we will then review the wider strategy for what we want to deliver for our patients. • We do not have numbers of patients who are being escalated, and this is something that we need to know. We are reviewing how we can produce this data. • The Committee links in with the Resuscitation Committee (which the DCMO also Chairs) which has a refined and controlled Terms Of Reference. The DCMO will sit on both the Resuscitation Committee and the Critical Care Committee to enable continuity. • We need to be able to identify patients before they deteriorate via their NEWS score. This cannot currently be done automatically. A manual review was undertaken of two patients (which took an hour) to review responses and escalations. A larger team is therefore needed to undertake these reviews. • We have a CQUINN running in parallel to this.	

	• The Managing Director was pleased with the scope of this meeting. There will be clear options that we will need to work up so that we can make decisions around next steps. The DCMO advised that the Committee are trying not to find a solution before the problem is determined.	
	<u>Resolved</u> – that the verbal update on the Quality Priority – Improve the management of the deteriorating patient be received and noted.	
QC011/06.23	**<u>QUALITY PRIORITY – NUTRITION UPDATE</u>**	
	The Associate Chef Nursing Officer (ACNO) presented the Quality Priority – Nutrition Update, which was taken as read, and the following key points were noted: • This is continuing as a Quality Priority from last year. • The Quality Committee were asked to consider the following focus in order to sustain improvements and ensure best practice in relation to nutritional management with discussion held around: - Continuing to look at Nasogastric Management - MUST CQUIN score for Community Hospitals and County Site (there have been considerable improvements) - Development of a digital dashboard identifying MUST score completion and re-assessment - Ongoing audit of quality of MUST completion and associated indicate actions – more detail is include in the report about what is being done next - Improved food scores within In-patient Surveys – Some improvement has been seen and the focus has been widened to include meal service and hydration - National Standards for healthcare food and drink – The review and gap analysis has been fully completed - Consider feedback and compliance following the launch of the mouth care guideline and national survey – This is currently taking place with a link in Trust Talk. There is also a Mouth Care guide on the intranet. - Consider the development of bespoke surveys focusing on food provision. • Mr James (Chair and NED) queried regarding naso-gastric management in light of recent Never Events, who signs off that the tube is in the correct place. The DCMO advised that this has turned out to be a very complex issue. A meeting was held this week with key staff to confirm a plan. Radiology will ideally report these scans where possible. If not, a competent Consultant who has been through the training can report. There is also an arrangement for out of hours and weekend reporting. • Mr James (Chair and NED) queried how we keep the high quality for MUST scores during normal day to day duties. The ACNO advised that the Digital Nurse Noting dashboard will help with this issue.	

	<u>Resolved</u> – that the Quality Priority – Nutrition Update be received and noted.	
QC012/06.23	**<u>QUALITY PRIORITY – ENSURING PATIENTS RECEIVE TIMELY CRITICAL MEDICATIONS</u>**	
	The Clinical Director, Pharmacy & Medicines Optimisation (CD) presented the Quality Priority – Ensuring patients receive timely critical medications presentation and the following key points were noted: • **Background** - The Foundation Group signed up to the national Parkinson's medications campaign to improve safety of patients with Parkinson's disease when in our care. There are known local issues with missed doses or delayed doses of time critical mediations outside of Parkinson's medication expanded scope of the priority for the Trust. The Self Administration Policy is not being utilised as frequently at the Trust. • **What is critical medication?** – The Trust's Critical Medications Guideline includes the critical medicines definition. This outlines the medications classed as critical. There is also NICE Guidance around what falls into this category. • **Action to be taken for Critical Medications** – All medicines on this list MUST be administered within two hours of the prescribed time EXCEPT antibiotics in SEPSIS, these MUST be given within an hour. If the medicine is not available in the clinical area, then a supply should be obtained as a matter of priority. • **Scope of the priority** – Initial discussions identified as a minimum the priority will include: Parkinson's medications, Insulin, Opiates and Antibiotics. • **Governance and oversight** – The scope of priority will be discussed at the Medicines Safety Committee on 13 July 2023 for approval. The proposal to the Patient Safety Committee will be presented in August 2023 with initial audit data to benchmark against. The Medicines Safety Committee will have direct oversight of the priority and audit data will be included in the Medicines Safety reports to the Patient Safety Committee. A deep dive analysis and updates on improvement work will be reported to the Quality Committee regularly throughout the year. • **Aims** – To reduce missed and delayed doses of critical medication and to work with Foundation Group colleagues to improve the care of Parkinson's patients by ensuring their medications are received on time every time. • **How will be know how we are doing?** – To reduce missed or delayed doses of critical medication – Audit of critical medications using EPMA and monitor by drug group and identify areas of concern to develop targeted action plans and take to the Medicines Safety Committee for approval. However, we will focus on Parkinson's medication in the first instance.	

	• **How will be know how we are doing?** - To work with Foundation Group colleagues to improve the care of Parkinson's patients by ensuring their medications are received on time every time. - There are a number of actions behind this aim (included in the presentation). • **Parkinson's dataset** – For Parkinson's treatment during May: 94.9% of prescribed doses were administered. 88% of prescribed doses were given with one hour of the prescribed time. 1.3% were true missed doses, ie avoidable. EPMA gives us an exact position on timely prescribing and medications given. • **Next Steps –** Comparing Wye Valley Trust data to the Foundation Group. Expand the data set to the wider critical medicines list. Have monthly data monitoring. Align the Trust to the Foundation group Improvement Project. Feedback findings to wards and agree improvement actions via ward based Medicines Champions. Review the Self Administration of medicines procedure to ensure opportunities are maximised to deliver timely medicines administration and promote patients independence. Agree reporting of progress via the Medicines Safety Committee, Patent Safety Committee and the Quality Committee. • The Associate Chief Medical Officer, Medical Division advised that the introduction of EPMA has had a huge difference to auditing medications. This has shown that there is an issue with Parkinson's medication not being given correctly, with a review of this being undertaken. • The Associate Chief Medical Officer, Medical Division noted that the latest National Parkinson's Disease Audit recommended that all hospitals have a local Parkinson Guideline incorporating Levodopa prescribing within thirty minutes of the prescribed time and questioned whether we were signing up to this in our Policy. The CD advised that we will monitor against this target. The Associate Chief Medical Officer, Medical Division advised that getting the right medication at the right time can have a huge difference to these patients, who tend to require long stays in hospital as well. The CD advised that we are working with the data we have. If a medication is not prescribed, this does not get into the data set and we need to work out how we can get around capturing this. Mr James (Chair and NED) queried if we could measure the thirty minute prescribing window. The Associate Chief Medical Officer, Medical Division advised that it would be really helpful data to have. The CD confirmed that this can easily be achieved using EPMA to acquire this data and could easily sign up to this if approval was given. • Ms Quantock (NED) advised that the Diabetes Safety Forum had held their first meeting and had discussed patient medicine regimes. All were welcome to attend this meeting.	

	• The Managing Director questioned how well we were doing with self-medication for patients. The CD advised that there are two Policies around this – the Self-Medication Policy (very complicated) and the Self-Administration Policy (which is less complicated). There are a limited group of medications that we want patients to take responsibility for. We need to separate these out to ensure that we concentrate on each one and make it easier for patients to access their medications. This may still be high risk but it is vital that the patient maintains control over their medications. Despite this Policy, there is low uptake in patients self-administrating. This is probably due to an education issue on the wards. The Associate Chief Medical Officer, Medical Division advised that the Policy has been promoted recently following an incident. The Policy was sent out via Matrons and Sisters meetings to highlight.	
	Resolved – that the Quality Priority – Ensuring patients receive timely critical medications presentation be received and noted.	
QC013/06.23	**DIVISION QUARTERLY REPORT – INTEGRATED CARE**	
	The General Manager - Acute and Countywide Services (GM) presented the Division Quarterly Report – Integrated Care and the following key points noted: • Serious Incidents, pressure ulcers and falls are the main issues in the Community, which are also of concern across the Trust. The GM is taking the lead with the Pressure Ulcer Panel to improve numbers. A Critical Care Practitioner has been recruited who will be key to reviewing the improvement of skin care. • Falls are of concern as although numbers remain static, the number with harm have increased. • Patient Safety Incident Response Framework – The GM felt that this new process for pressure ulcers was a positive move towards enabling learning from incidents and enabling an Improvement Plan to be produced. • Complaints – The Division have had low numbers: none received in March, three in April and two in May. The GM is an advocate of meeting with complainants where possible to discuss their concerns. There has been a 29% reduction in complaints from last year. There were 35 complaints received regarding the Leominster Community Hospital IG breach have skewed these figures. • New and Different – We are struggling to achieve better response rates for our Friends and Family. There are plans to improve this. • MUST Audits for Bromyard are dipping – we are reviewing the background to this. • Cleanliness scores are positive for Community Hospitals – we are consistently achieving 5 stars.	

	• Stroke – There are a huge number of therapists involved in stroke. Maintaining our SSNAP B score is an amazing achievement. • There have been a number of engagement events across the Division with good learning from these. There has been a positive response from staff from the face to face meetings. • Ross Community Hospital Improvement Journey – There has been a huge improvement in this Community Hospital (slides showing the journey are included in the pack). There has been a large reduction in vacancy rates with a focus each day on the week on a different area – eg MUST Mondays, Training Tuesdays, Waterlow Wednesdays, Thirsty Thursdays and Falls Fridays. • The Managing Director noted the deep seated culture that was present at Ross Community Hospital, and the need to ensure that we do not allow this culture to return and the need to continue to focus on this. The GM advised that the two Matrons in the Division are doing an excellent job around this, and are aware of the need to ensure focus is kept on this area. The Associate Chief Operating Officer sent a letter to all staff setting out the standards expected which we will not tolerate dipping below. • Mr James (Chair and NED) noted the difficulties for the District Nursing service around treating pressure ulcers in patient's homes. There is positive work being done in Community Hospitals and queried if this was transferable into the Community. The GM advised that this was a very different process as we are not responsible for patients 24 hours a day as we are in hospital. Vulnerable patients, who have capacity, can refuse our offers of help, which is our main concern.	
	<u>Resolved</u> – that the Division Quarterly Report – Integrated Care be received and noted.	
QC014/06.23	**<u>DIVISION QUARTERLY REPORT – CLINICAL SUPPORT (INCLUDING HTA VISIT UPDATE</u>**	
	The Consultant Clinical Scientist and Clinical Director Pathology (Consultant), the Professional Lead, Clinical Support Division and the Bereavement Midwife presented the Division Quarterly Report – Clinical Support (including HTA Visit presentation) and the following key points were noted: • There are a number of open incidents across the Division, partly due to the introduction of InPhase. There are plans in place to reduce these. • There was one Serious Incident during the period with reporting ongoing. • There were nine complaints received, six of these have been responded to and closed (one with a face to face meeting) and one has been extended due to a member of staff being off sick.	

	• Radiology - National funding has been approved for the Hereford City Community Diagnostic Centre in April 2023 for the full award of £16.36m. • There is continued collaboration and integration as part of the West Midlands Imaging Network, with good participation in Special Interest Group events such as Paediatric imaging. • Pathology – We are the first Trust in the West Midlands to go technically live with digital pathology; working with all stake holders for clinical go live. • Investment in the Point Of Care Testing team to allow support for community diagnostics, We are working closely with the Associate Chief Medical Officer, Integrated Care on the project • Pharmacy – There is reduced staffing but we are very proud of our staff's resilience. There is a high volume of staff working flexible arrangements to cover these shortages. Expansion of our training placements across Herefordshire has increased with four trainee Pharmacist placements from August 2023 and fifteen trainee Pharmacy Technician posts including cross sector placements from September 2023. • Cancer – There has been an increase in oncology treatments but we are still managing the 2 week deadline. • Patient Access – We are doing well with our Friends and Family feedback in Outpatients. We are now looking at rolling this out in other parts of the Directorate. There is good staff flexibility around covering weekend clinics at short notice. • Concerns – Staffing in Radiology remains an issue. Reporting capacity over the next few months is of concern. We are heavily reliant on an outsourcing company currently. • Pathology – There are significant staff pressures due to the lack of Consultant availability. • Cancer Services – The Macmillan Renton Unit expansion was not agreed. We are therefore looking at the best use of this estate with the capacity we have, with a meeting with the Estates team for a walk around. • Outpatients – There are concerns around the Plaster Technicians due to a vacancy. Staff are covering additional sessions but there are still gaps. • The Managing Director was concerned about the 62 day cancer target across all Divisions, but noted that reporting needs to be pulled together in this report for an overview. This position has deteriorated over the last few months.	

	HTA Visit • All responses had to be submitted by the 30 April 2023 deadline. This has been extended by a month (originally March) due to technical issues. • There are still a number of outstanding actions. There has currently been no feedback from the HTA in relation to matters where the Trust has sought support. • An overview was provided of the outstanding actions. • **Summary** – **Key progress areas** – All Standard Operating Procedures have been completed. Three months' notice given to Funeral Directors for charging for length of stay. Plan for temperature monitoring and alarm testing in place. • **Areas of concern** – Lack of feedback from the HTA on evidence and request for advice on paediatric training, CCTV and Risk Assessments. Lack of progress with some maintenance jobs. • Mr James (Chair and NED) noted that there are a number of issues that we need a steer from the HTA and queried if anything further has been done to escalate matters and if no further response is received, do we take what we consider is appropriate action and advise them of what action we have taken. The Consultant confirmed that we have taken appropriate action and advised the HTA of this. With regards escalating, it is not clear who we can escalate to. • Ms Quantock (NED) found the presentation very useful updating on the work being done and our responsibilities as a Trust, and agreed that we need to move forward even if there is no response received from the HTA. Mr James (Chair and NED) agreed with these comments, noting that we should still raise these issues with the HTA around the lack of support/response. • Mr James (Chair and NED) raised a question previously asked around the fact that aspects of this action plan sit across different services in the Trust and questioned if the team was getting the support needed from across the Trust. The Bereavement Midwife advised that a good response was received from most of the actions raised initially. Mainly the outstanding issues are related to the Paediatric post mortems and we need an external view from the HTA to clarify what information they require.	
	Resolved – that the Division Quarterly Report – Clinical Support (including HTA Visit presentation) be received and noted.	
QC015/06.23	**MATERNITY PQSM REPORT**	
	Resolved - that the Maternity PQSM Report be received and noted.	

QC016/06.23	**QUALITY PRIORITY – IMPROVE VTE RISK ASSESSMENT COMPLIANCE**	
	The DCMO presented the Quality Priority – Improve VTE Risk Assessment Compliance presentation and the following key points were noted: • The Thrombosis Committee was reinvigorated a couple of years ago, partly due to the number of Root Cause Analyses relating to thrombosis not being reviewed. We have about 60 to review. There were a number of themes found with various improvements put in place. • This was partly carried out as we want the Trust to use the VTE Exemplar Framework to drive improvement in prevention, management and treatment of thromboses. VTE risk assessment on the framework currently stops the Trust from applying for Exemplar status (need to achieve around 95%). Currently, about 30 Trusts are Exemplar Sites. • Completion of VTE rates does not mean that this is the only way that patients receive thrombosis treatment. This is often given if required without a VTE being completed. We have completed the review process for 321 hospital acquired thromboses (HAT) since January 2020. 21 were avoidable, therefore 93.5% were unavoidable. There have been no avoidable VTE's recorded since January 2022. • Whilst we are not meeting the 95% standard regarding VTE assessment, the processes we have put in place regarding appropriate prophylaxis measures are such that we have eradicated avoidable clinical harm. The correlation between VTE assessment and development of HAT is weak. • We have identified any gaps and closed these. We are now just finding minor issues and training staff in these areas. • One avoidable thrombosis has recently occurred and is waiting to be reviewed through the Thrombosis Committee. • Ensuring VTE assessments are completed will be easier when Maxims and EPMA are able to connect to each other. • A review of cases where a HAT has occurred is undertaken. This has partly reduced due to the introduction of InPhase. • Mr James (Chair and NED) noted that we need to achieve 95% for our VTE assessment to achieve Exemplar status as well as this being an issue picked up the Care Quality Commission on their last visit, and queried when the issue between EPMA and Maxims will be resolved. The DCMO confirmed that this is being actively pursued but is not aware of the timeframe involved.	

	<u>Resolved</u> - that the Quality Priority – Improve VTE Risk Assessment Compliance presentation be received and noted.	
QC017/06.23	**<u>NURSE STAFFING BIANNUAL ACUITY AND DEPENDENCY REVIEW</u>**	
	This is being presented to the Trust Management Board for a view on the recommendations. It was therefore agreed to present this back to the Quality Committee after these discussions were held.	
QC018/06.23	**<u>PATIENT SAFETY COMMITTEE SUMMARY REPORT</u>**	
	The DCMO presented the Patient Safety Committee Summary Report, which was taken as read, and the following key points were noted: • A Specialist Report was received on the Quality Improvement Project – Frailty Falls Cluster. A comprehensive quality improvement plan was developed to focus on improving the areas of concern found following a review. This was a fantastic piece of work with a high level of education being undertaken to reduce avoidable falls with harm. • Resuscitation Committee – This was paused in 2019 with the first meeting held recently. These will now be held monthly. • Mr James (Chair and NED) queried if the thematic themes for falls that were picked up in the Divisional Reports and Serious Incidents were all being discussed at this meeting. The DCMO advised that we are triangulating themes around falls to develop a broader plan.	
	<u>Resolved</u> - that the Patient Safety Committee Summary Report be received and noted.	
QC019/06.23	**<u>QUALITY ACCOUNT</u>**	
	This was being brought back to the Quality Committee to formally approve the final version of the Quality Account. This has been reviewed at the Board of Directors and the Chief Nursing Officer and the Chair of the Quality Committee were delegated to finally approve.	
	<u>Resolved</u> – that the Quality Account be received and approved.	
	CONFIDENTIAL SECTION	
QC020/06.23	**<u>PREVENTION OF FUTURE DEATHS REPORT</u>**	
QC021/06.23	**<u>ANY OTHER BUSINESS</u>**	
	There was no further business to discuss.	
QC022/06.23	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 27 July 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
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur