Public Board Meeting

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

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

Ellie Bulmer.

13:00 - 13:00
0 min

2. Declarations of Interest

13:00 - 13:00
0 min

3. Minutes of the Meeting held on the 5 October 2023

Decision *Russell Hardy*

3. PUBLIC BOARD MINS - OCTOBER LF, FMa, KO, FM.pdf (21 pages)

13:00 - 13:00
0 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

PUBLIC BOARD ACTION LOG -DECEMBER.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 December 2023 - WVT CEO Report - BOD - FINAL v2.pdf (7 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 07 October 23.pdf (30 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:00 - 13:00
0 min

6. Items for Approval

6.1. In Year Operational Plan Review

Decision *Katie Osmond*

- 6.1 InYear Operational Plan Review_finalboard.pdf (8 pages)
- 6.1a App1_PRN00942_Letter_Addressing the significant financial challenges created by industrial action in 23-24 and immediate.pdf (3 pages)
- 6.1b App2_PerfMetrics.pdf (1 pages)

6.2. Full Business Case for Integrated Energy Solution

Decision *Alan Dawson*

- 6.3 IES - Full Business Case - Covering Report.pdf (2 pages)
- 6.3a. IES - Full Business Case.pdf (17 pages)

13:00 - 13:00
0 min

7. Items for Noting and Information

7.1. Maternity Quarterly Report

Discussion *Lucy Flanagan*

- 7.1 December 2023 - Maternity Services Board Report.pdf (5 pages)
- 7.1.1 Appendix 1 PQSM.pdf (4 pages)
- 7.1.2 PQSM October 2023.pdf (1 pages)

7.1.1. CQC Action Plan

Discussion *Lucy Flanagan*

- 7.1 CQC Action plan.pdf (1 pages)

7.1.2. CNST 10 Board Progress Update

Discussion *Lucy Flanagan*

- 7.3 CNST 10 update report.pdf (5 pages)

7.2. Policy Panel Update

Discussion *Erica Hermon*

- 7.3 Policy Panel Update.pdf (3 pages)

7.3. Health, Safety and Wellbeing Report

Discussion *Erica Hermon*

- 7.4 Trust Board Covering Report H&S Annual Report.pdf (1 pages)
- 7.4a Health Safety Wellbeing Annual Report 2022-23.pdf (22 pages)

7.4. Committee Summary Reports:

7.4.1. Foundation Group Strategy Committee 17 October 2023

Discussion *Glen Burley*

- 7.5.1 FGSC WVT Foundation Group Strategy Committee Report.pdf (7 pages)

7.4.2. Integrated Care Executive November 2023

Discussion *Frances Martin*

7.5.2 ICE Update for WVT Board.pdf (3 pages)

7.4.3. Quality Committee 28 September 2023 and 26 October 2023

Discussion *Ian James*

7.5.3 QC Summary Report Sept 23 Public.pdf (4 pages)
7.5.3.a QC Summary Report Oct 23 Public.pdf (3 pages)

7.5. Committee Minutes

7.5.1. Foundation Group Board and Action Log 1 November 2023

Information *Russell Hardy*

7.61 Draft Public FGB Minutes (WVT) - 1 November 2023.pdf (17 pages)
7.6.1a FGB Public Actions Update Report - 1 November 2023.pdf (1 pages)

7.5.2. Quality Committee 31 August 2023 and 28 September 2023

Information *Ian James*

7.6.2 QC MINUTES - AUGUST.pdf (18 pages)
7.6.2a QC MINUTES - SEPTEMBER.pdf (23 pages)

13:00 - 13:00
0 min

8. Any Other Business

13:00 - 13:00
0 min

9. Questions from Members of the Public

13:00 - 13:00
0 min

10. Acronyms

Z Acronyms - updated 08.09.23.pdf (3 pages)

13:00 - 13:00
0 min

11. Date of Next Meeting

The next meeting will be held on 7 March 2024 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 5 October 2023 at 1.00 pm
Via MS Teams

Present:

Frances Martin	FMa	Chair and Non-Executive Director (NED)
Chizo Agwu	CA	Incoming Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
David Mowbray	DM	Chief Medical Officer
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Ellie Bulmer	EB	Associate Non-Executive Director (ANED)
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Salma Ibrahim	SI	Clinical Director for Maternity Services – For Items 7.2 and 7.4
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)

Mrs Martin (Chair of the Public Board meeting and NED) advised that with the expansion of the Foundation Group, a different format for attendance at Board meetings had been agreed. The Chairman will continue to Chair the Public Board meeting and the Foundation Group Board meeting once a quarter, and Mrs Martin (Chair and NED) will Chair the remaining Public Board meeting.

Mrs Martin (Chair and NED) noted some changes to the Board of Directors, welcoming Chizo Agwu to the meeting who will be joining us as the Chief Medical Officer later this month. David Mowbray will be leaving the Trust to take up a role in the Foundation Group. Andrew Cottom (NED) left the Board at the end of September and Sharon Hill has taken up the role of NED – she was previously an ANED.

The Employee of the Month award for June was presented to Lauren Austin, Heath Care Support Worker and the Employee of the Month award for July was Sophie Wheadon, Associate Practitioner Immunology. Mrs Martin (Chair and NED) read out the reasons why Lauren and Sophie had been nominated for this award.

	The Team of the Month award for June was presented to Emma Cooke and Robyn Evans, Recruitment Team and the Team of the Month award for July was presented to the Acute Medical Unit, Ashgrove MDT, Samantha Bemand and James Bartlett. Mrs Martin (Chair and NED) read out the reasons why the teams had been nominated for this award.	
Minute		**Action**
BOD01/10.23	**Apologies for Absence** Apologies were received from Jon Barnes, Chief Transformation and Delivery Officer, Glen Burley, Chief Executive, Russell Hardy, Chairman and Jo Rouse, Associate Non-Executive Director (ANED).	
BOD02/10.23	**Quorum** The meeting was quorate.	
BOD03/10.23	**Declarations of Interest** There were no declarations noted.	
BOD04/10.23	**Minutes of the meeting held 7 September 2023** . **Resolved – that the minutes of the meeting held on 7 September 2023 be confirmed as an accurate record and signed by the Chairman.**	
BOD05/10.23	**Matters Arising and Action Log** Armed Forces Covenant/Veterans Hospital Update - (B) - The Associate Director of Corporate Governance (ADCG) will review whether the Maxims system allows for a "soft" process for recording those patients/families who do not wish to have recorded that they work/have worked in the forces. The ADCG advised that she is taking advice from Regional colleagues and establishing best practice. **Resolved – that the Action Log be received and noted.**	
BOD06/10.23	**Chief Executive's Report** The Managing Director presented the Chief Executive's Report and the following key points were noted: (a) **Outpatient Transformation –** We have gained a lot by being part of the Further Faster and Getting It Right First Time (GIRFT) initiative. Patient Initiated Follow Up (PIFU) Pathways – This is around the patient advising when they want to be reviewed. Patients tend to be reviewed less often and are in charge of their own pathway. This needs to be occurring in 5% of all pathways. Our latest data shows that we are at 4% and varies per specialty. This has been developed through a national programme which we have been part of. This is around providing best practice advice and benchmarking against other Trusts, which we are scoring all our specialties again. This is closely aligned with the PACE work which the Chief Medical Officer (CMO) is leading on. This is difficult to take forward as this requires a lot of work in the background to pull all the pathways together. It is positive for the Trust to be part of the initial pilot.	

(b) **Integration Frontrunner -** We are working with South Warwickshire NHS Foundation Trust (SWFT) as part of this national pilot. There are impressive results in the report on how long it takes to discharge patients who need to be at home. This is an issue for Herefordshire as well due to capacity limitation. The asset that we have, Hoople, (which is a company owned by Herefordshire Council, ourselves and the ICB) is a vehicle where we can rapidly replicate this work. There are opportunities for us to start to replicate this model reasonably quickly for Herefordshire.

(c) **NHS Finances –** We are in a £800m worse position for the whole NHS than expected. This is about £9m for our ICB. This is obviously off target but not as much as the entire NHS. It is the same for Wye Valley Trust – we are about £1m off target.

(d) **Surgical Update –** Surgical Robot – Adoption of this new technology has been very rapid. We now have 3 specialties active in this after their training. It has also been agreed that radical prostatectomies can be undertaken locally at the Trust rather than having to travel to Cheltenham as previously. The same Consultant will undertake this work. The Managing Director thanked Mr Akhtar for all his hard work in this area.

(e) Mr James (NED) noted the tremendous results for SWFT regarding domiciliary care waiting times. The underlying issue tends to be lack of resources for domiciliary providers to invest and recruit into the workforce. He queried whether SWFT have put in additional funding or whether this was managed within resources. The Managing Director advised that they have better and more timely processes. Work with the Discharge to Assess Board is being undertaken as improving our processes. There are different investments around access to arrangements for domiciliary care providers who are on standby who always have vacant capacity. We have worked with Hoople (who provide home care) to support with this. We have rural and remote areas which means recruitment is more difficult. We plan to replicate their model but will need additional resource.

(f) Mrs Martin (Chair and NED) thanked the surgical team for their work around the surgical robot and thanked everyone involved in the improvement in recruitment and retention.

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

BOD07/10.23 **Integrated Performance Report**

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

a) We have managed to make a lot of improvements, with the Further Faster work part of this. This is alongside managing strike action across the summer. This week has had the most impact as strikes were co-ordinated between Junior Doctors, Consultants and Radiographers for 1 day. This meant that we were planning to only run 4 out of 10 planned cancer lists during this time which is distressing for our patients. We worked with our teams to make more direct appeals to staff and were able to run 8 out of the 10 lists.

b) Elective productivity work is continuing. Valuated activity looks at the amount of work and complexity of patients and benchmarks prior to the pandemic. We are running at about 115%. We are the best in the Midlands Region currently. We are now at 120%. These are very positive results from our teams. We are undertaking 20% more work than in 2019/20.

c) People Metrics – We are in a much improved position and are sustaining this. The InTouch campaign received a lot of feedback from many of our staff.

d) Our latest SHMI figures were 101.8 which is continuing on a downward trend towards the national mean of 100. This relates to our figures from April and May, so our October figure is expected to drop to 100.

e) The Managing Director thanked the CMO for his leadership relating to mortality, which has been exemplary and the reason for this improvement.

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

BOD08/10.23 **Quality (including Mortality)**

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

(a) The CNO noted that the detail would be discussed in the Patient Experience Report, Patient Safety Incident Response Plan and the Infection Prevention Annual Report, which were all on the agenda.

(b) The CMO advised that this was a satisfactory month for mortality. The latest national data for March 2023 for the Trust was 103.1. Our local latest data is 100.3 which is more accurate. Crude mortality will lose some of the higher peaks with the next results.

(c) The convergence of expected deaths compared to actual deaths is felt to be due to the increase in quality of coding. We are making vast improvements in this area. We are now accurately representing how we are performing.

(d) Perinatal Mortality – Our numbers are still improving and we are hopeful to achieve halving our stillbirth rate by 2025.

(e) Known Expected Death Unexplained programme - We are ensuring that every death that occurs in our Trust is scrutinised in one of many ways. We are also due to roll out Medical Examiner cover for the county as well which will enable reviews of deaths in the community as well. Dr Chris Lukaris will take on the role of Lead Examiner from November.

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

BOD09/10.23 **Activity Performance**

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

(a) The COO thanked the Operational and Clinical teams for managing the strike action over the last month. It has been a real challenge maintaining elective activity during this time.

(b) Work on Urgent and Elective Care pathways, Quality Improvement Programme and valuing patient time continues despite all the challenges with the industrial action. We are continuing to make changes to our Acute floor and in the 2nd week of September we successfully opened and continue to ring fence our Frailty Same Day Emergency Care (FSDEC) facility on the Acute floor. This is staffed by Frailty Co-ordinators, Advanced Clinical Practitioners, Frailty Consultants and the virtual ward (which has also increased in size). There are on average 6 patients a day being seen through FSDEC (9 being the highest number), which is a significant reduction on bed days across our Acute site. We are also seeing direct admissions from Primary Care, the Ambulance Service and some Community colleagues. There is more to do but this is a huge step in the right direction. The Operational teams have looked at SDEC capacity over this month to review expanding the Medical and Surgical facility.

(c) The Emergency Care Intensive Support Team (ECIST) were invited to review our Urgent and Emergency Care plans. We received positive endorsement from the team. They stated that there is strong support from the Executive team and the plans recognised balancing the risk between pathways. There are good plans in place and good staff engagement. The focus now is on each speciality and their role in the pathways. We are working through this with a refresh and review of our professional standards at ward level and across the specialties. The estates changes in the Emergency Department (ED) were recognised and some of our staffing challenges in ED. There is limitation with regards our SDEC due to our estate.

(d) ECIST are continuing to support the Trust with our medical and nursing workforce and bed capacity planning.

(e) The report includes a summary of our bed occupancy and delayed discharges. When comparing the first 5 months of 2022/23 to 2023/24, there have been a slight increase in the number of patients delayed for Discharge to Assess pathways. However, the overall bed days have reduced. There is more work to do ahead of winter. Regarding the Better Care Fund, we are looking at increasing our block bookings in Nursing Homes and the Health led 'Bridging team' has been created to support Home First. There are internal processes in place that require focus and strengthening.

(f) Mrs Twigg (NED) noted we treated the largest number of patients in August and questioned whether there were any themes or reasons why this occurred. Was this due to pressures elsewhere causing patients to attend ED or just volumes of patients and was there any pattern with the time of day? The COO advised that the pattern changes on a daily basis. We are seeing 240 – 250 patients on some days and then down to 160 on others – there is varied demand. The earlier part of the week is vastly different to the end. A deep dive into what is driving this is being undertaken. Our Primary Care colleagues provide more appointments for patients than the rest of the country and are not able to provide any evidence that lack of access to GPs is driving demand in ED. Whether this increase is being driven by our elective care waiting lists is not known but this has been seen nationally.

(g) Mr James (NED) noted that SDEC is supporting demand and enabling a better outcome for patients, but in the Chief Executive's Report it noted the slight concern that SDEC could become an alternative pathway for outpatients and difficult to manage. Is there a view if this is being seen in the Trust? The COO advised that this has not been seen. It is a balance between ensuring there is enough space for clinic slots for patients returning from ED, but will be an area to watch out for.

(h) Mrs Martin (Chair and NED) recognised the huge impact of strikes, primarily for our patients waiting for care and treatment being delayed and the additional burden this puts on staff. This is a frustration which is outside of our scope to fix.

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

BOD10/10.23 **Workforce**

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

(a) We are maintaining good performance with most of our KPIs and have the lowest turnover rates for the last 4 years.

(b) We are continuing to work actively with Line Managers regarding sickness absence.

(c) The Trust remains committed to Equality, Diversity and Inclusion agenda and we promoted the NHS Inclusive week in September. We will be promoting Black History month in October.

(d) October is also Freedom To Speak Up (FTSU) month and we are working actively with our FTSU Guardian and Champions to highlight the importance of speaking up and raising the profile.

(e) Next week is the annual Health and Wellbeing week. The Trust are being supported by a host of external organisations. This is to reinforce the importance of the wellbeing of our staff.

Resolved – that the Workforce Report be received and noted.

BOD11/10.23 **Finance Performance**

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

(a) The report covers the period until the end of August, Month 5.

(b) Our financial position has deteriorated. Year to date our financial deficit stands at £13.3m, which is around £1m adverse to where we had planned to be at this point in the year. The known financial risks have been discussed in previous Board meetings, which are putting increased pressure on the delivery of our financial position.

(c) Around £700k of this variance is where we have quantified variable elective income. Up until Month 4, nationally we were required to report elective income performance in line with plan and from Month 5 we have been asked to quantify that on a year to date basis.

(d) The Trust have seen strong elective performance since June. There was a slow start at the beginning of the year with a subsequent improvement and we benchmark well. In August we were at 109% compared to 2019/20. Although this has an impact on our financial position year to date, we believe from a mitigation perspective, the sooner we can continue this strong elective performance this should provide some mitigation for the forecast position.

(e) The remainder of the variance relates to our cost performance and primarily in terms of our CPIP. We are under-delivering in terms of where we planned to be. We are about £2.3m off where we should have been at this point in the year in terms of delivery of savings. Focus does continue on driving efficiency and reducing costs. We have a number of schemes from single department opportunities to Trustwide programmes but it is important to note that capacity to deliver some of these schemes has inevitably been hampered by the loss of operational capacity as a result of the work to plan and manage industrial action.

(f) Across the System, inflationary impacts are currently running greater than funded and we are doing a piece of work across the System to ensure that we are counting this in a consistent way and will report this from the next meeting. This does mean that some of our opportunities for savings are mitigating some of these run rate pressures rather than allowing us to improve our bottom line performance.

(g) In light of some of these known risks and the year to date pressures, we are currently undertaking a mid-year review. This will help us inform our forecast outturn assumptions and identity where we may need to put some additional support and inform our planning for the 2024/25 financial year.

(h) From a capital perspective, there are no escalations to report this month.

(i) Cash – We are in a deficit plan and slightly off plan. We have therefore reinstated our weekly Cash Plan Management meetings and have mitigations in place in terms of when we are likely to require national support in terms of an application for cash. We anticipate that this will be in either December or January depending on cash flow.

(j) The Managing Director queried how much of the £0.7m broadly is related to industrial action under performance on electives. The CFO advised that this is part of what we are reviewing in the mid-year review. We know the number of cases that we have lost for each of the industrial action periods so we are now mapping this through in terms of financial impact on the variance.

(k) Mr Lappin (ANED) queried in reference to page 27 of the report regarding our current assets, he noted that we have a reduction of £24m in the 5 months so far this year. The national financial position is deteriorating, as mentioned earlier in the meeting, and we now have a major capital programme. Therefore, is it possible that we might not be able to access national cash and asked that an update be provided to the Board of Directors on the underlying cash plan before the next meeting? The CFO was happy to provide this information. **KO**

(l) Ms Quantock (NED) noted in terms of the nursing agency costs, it appears that a lot of the costs come from the specialist nurses which our preferential agency is not always able to supply and we therefore need to go out to more costly agencies. As a Board, do we have any plans for finding more affordable specialist nursing cover in the long term, eg growing our own, encouraging career training in specialist areas? The CNO advised that in agency terms when we refer to specialist nursing, we are not referring to specialist nurses who work in niche specialties providing care to particular clinical pathways. In agency terms, specialist nurses tend to be ED, Critical Care nurses, Children's nurses, Special Care Baby Unit (SCBU) nurses and midwives. There are different strategies for trying to have a more sustainable local workforce for each of these areas. For example, for Midwifery and Maternity we are doing really well. Within Critical Care we have good recruitment and therefore we can always recruit to turnover rather than vacancy factor to prevent agency use. In other areas, such as SCBU, there is a national shortage of these type of specialty roles and therefore it is really difficult to get ahead and have a local strategy to address this. It is part of our overall Nurse Agency Plan to seize opportunities and do what we can locally. The CNO and CFO were discussing recently that we only have a year left on our Master Vend contract, which is our current nurse agency provider, and we might need to think creatively about what we do moving forward with future provision for nurse agency. Mrs Martin (Chair and NED) advised that a very interesting energising discussion at the Board Workshop was held this morning around our organisational educational training development and research strategy and how we grow our own and recruit to Herefordshire.

(m) Mrs Twigg (NED) noted that we have always had an acute focus on finance but we are now seeing results that we have not seen since the pandemic around our finances and the direction that they are moving in and we are now in a position that we have not had for some time. There is a review going on in October to look at the second half of the year and I know that we are being asked to find extra savings in the second half that are now going to be greater due to our first half performance, but it is clear that we are in a difficult position. When will be see sight of the October review? It would also be helpful to spend more time looking at what the second half of the year might be, what the projections are and what the reality of the situation might be for the Trust as we go into this second half. The CFO advised that the plan is to bring the outputs of the mid-year assessment and stocktake, and therefore what it means for the forecast, as part of the standard reporting and potentially some further detail on this to Board members outside of this. The CFO was happy to share some of the outputs from this meeting prior to the next Board of Directors meeting in December. **KO**

Resolved – that:

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

(B) The Chief Finance Officer will provide an update to the Board of Directors on the underlying cash plan before the next Board of Directors meeting in December. **KO**

(C) The Chief Finance Officer will share some of the outputs from the mid-year review meeting with the Board of Directors prior to the next Board meeting in December. **KO**

ITEMS FOR APPROVAL

BOD12/10.23 **Memorandums Of Understanding with One Herefordshire Partners and the Integrated Care Board**

The Managing Director presented the Memorandums Of Understanding with One Herefordshire Partners and the Integrated Care Board and the following key points were noted:

(a) It is positive to be bringing this to the Board as we have been working on this for a long time. This is 6 months late due to negotiations between the ICB and the Local Authority in terms of commissioning for the Better Care Fund.

(b) This has now been agreed and has been delegated to the One Herefordshire Partnership. The Managing Director has not heard of anywhere else in the country where this has been done.

(c) There are a number of other services which run primarily between ourselves and Primary Care.

(d) The plan is to prove that this works and to have more areas delegated to us next year.

Resolved – that the Memorandums Of Understanding with One Herefordshire Partners and the Integrated Care Board be received and the Board of Directors gave authority to the Managing Director to sign the Memorandums Of Understanding.

BOD13/10.23 **Patient Safety Incident Response Plan**

The CNO presented the Patient Safety Incident Response Plan and the following key points were noted:

(a) The Board of Directors have previously been updated on the requirements of the National Patient Safety Strategy and our implementation of this.

(b) The draft Patient Safety Incident Response Plan (PSIRP) was presented to the July Board Workshop This plan is now based on feedback from that meeting and other stakeholders we have engaged with in the development of this plan.

(c) This PSIRP replaces the Serious Incident Framework and outlines the local approach to the investigation of adverse events. There will be certain national requirements that remain for investigating Never Events, Learning Disability deaths, obstetric incidents that meet certain criteria, and we will continue to investigate these in line with national expectations. The PSIRP allows us to prioritise our investigative resource and respond to incidents based local intelligence related to our safety profile. The plan has been developed by triangulating multiple data sources and local intelligence for the Trust where we have common themes, coming through from incidents, complaints, Serious Incidents, claims and other data sources. This has informed the plan to enable us to focus on those areas where we need to maximise learning and improve patient safety.

(d) The PSIRP has been consulted widely including the Patient Safety Committee, Clinical Audit and Effectiveness Committee and our patient safety partners (these are members of the public that have been recruited to support our patient safety agenda). We have also shared this with ICB colleagues as ultimately the ICB are required to sign off our PSIRP and it was presented to Quality Committee last month who recommended submission to the Board of Directors for approval.

(e) The implementation of the Plan is clearly going to be iterative. The development of the PSIRP is new to the whole of the NHS as is the new Patient Safety Strategy. It will be subject to regular reviews to ensure that we are focusing our resources on the priorities that we face as an organisation to maximise learning and improve patient care.

(f) Mr James (NED) noted that this is a new process and it would be very easy to see this as just one process replacing another process. As discussed at Quality Committee, he was pleased that we absolutely have our focus on improving quality of care and patient safety. There is genuine enthusiasm for this as there is the potential to improve the work that we do to these areas.

Resolved – that the Patient Safety Incident Response Plan be received and approved.

BOD14/10.23 **Board Assurance Self Certification Protecting and Expanding Elective Capacity**

The COO presented the Board Assurance Self Certification Protecting and Expanding Elective Capacity and the following key points were noted:

(a) The Board of Directors have previously been sighted on this via an email from the Managing Director. This was short notice due to some of the dates being moved by NHSE for the date of return.

(b) This was a letter that was received by all Trusts in August from NHSE around assurance that we are driving our Outpatient recovery at pace. This links with our GIRFT and Faster Further work.

(c) There are 12 key areas, key lines of enquiry that require assurance from how we are managing our waiting lists, our Patient Access Policy, PIFU, reducing DNAs and transformation in Outpatients (particularly on follow ups).

(d) There are 10 areas which we are confident that we will deliver on. There are 2 areas to focus on that are amber in the report. One is around achieving the 25% reduction in follow ups in year which is a significant challenge for us, especially as we started our position pre Covid in a challenged place in terms of the number of our patients due follow up who were past their see by date. The majority of the work with the GIRFT and the Faster Further programme is about focusing on our follow ups from our PIFU, increasing our validation and looking at the Play Books in terms of benchmarking ourselves across the Foundation Group and the other 25 Trusts across the Faster Further programme and how we can work differently. There is still lots to do regarding reducing down from 25% from our 2019/20 levels.

(e) The next area of concern is the transformational opportunities themselves. They are part of our ongoing work with the GIRFT and Further Faster programme. We have also got additional support from our Transformational Team focussing on those opportunities and working with clinical teams to ensure that we are working across the Faster Further Group to look at best practice or what we can implement in our Trust. There are various areas, particularly in Rheumatology and Dermatology that we are sharing across that Faster Further Group. This is amber due to the fact that as a Trust we are focusing on 7 key specialities although we are working through the Play Books in all of our specialities. There are 7 specialities that we are particularly focussing on before April 2024. The highest risk is the 65 week wait patient breaches waiting for their elective treatment at the end of March 2024. These are Trauma and Orthopaedic, Gynaecology, ENT, Neurology, Cardiology, Gastroenterology and Dermatology. We are confident that the transformation work will move significantly in these areas.

(f) This has already been submitted to NHSE, but the COO is seeking approval for governance purposes. At the next Foundation Group Board meeting in November, we are having a deep dive across the Foundation Group on our GIRFT and Faster Further programme and looking at the learning and opportunities across the Foundation Group.

Resolved – that the Board Assurance Self Certification Protecting and Expanding Elective Capacity be received and approved.

BOD15/10.23 **Audit Committee Terms Of Reference**

The ADCG presented the Audit Committee Terms Of Reference and the following key points were noted:

(a) There are only a few minor changes made. These were presented to the Audit Committee in September.

(b) The Local Counter Fraud Specialist has been added as a key attendee.

(c) There is a change in governance around the Quality Account with the Audit Committee not being required to review and approve these accounts but seeking assurance that they have met the reporting requirements.

Resolved - that the Audit Committee Terms Of Reference be received and approved.

BOD16/10.23 **Board and Committee Dates 2024**

The ADCG presented the Board and Committee Dates 2024 and the following key points were noted:

(a) The Managing Director queried if our July Board Workshop will be used for the End Of Year Audit Committee. The ADCG advised that the only dates that are fluid are the July End Of Year dates. Learning from the past 2 years, it is having this flexibility which is important but we will firm these up as soon as possible.

(b) The CFO advised that we are awaiting the national timetable to be published in terms of national expectations around the audit process and submission dates. Once this is received we can confirm dates.

Resolved – that the Board and Committee Dates 2024 be received and noted.

ITEMS FOR NOTING AND INFORMATION

BOD17/10.23 **Maternity CQC Report**

The CNO and the Clinical Director for Maternity Services (CD) presented the Maternity CQC Report and the following key points were noted:

(a) All maternity services are being inspected as part of the national programme on the back of Ockenden.

(b) An announced one day inspection took place in June. Only the Safe and Well Led Domains were reviewed.

(c) The report was only published yesterday, hence the late submission in the Board Pack as this could only be included once it was formally published by the Care Quality Commission.

(d) Safety Domain – Whilst this remains as “requires improvement” when noting the content of the report compared to the previous report it does show that we have made improvements in safety since the last inspection.

(e) The report highlights that we have areas for improvement in areas that we were expecting and there are already plans in place to address these. There are a limited number of must and should do's which is pleasing.

(f) It is very pleasing that the Well Led Domain has moved from Requires Improvement to Good. Therefore, our overall rating for the service has also moved from Requires Improvement to Good.

(g) The Action Plan has been developed and presented to the Quality Committee last week and will continue to be reviewed until the actions are completed.

(h) The CQC Report and the achievements within it are down to the hard work and leadership of the multi-disciplinary team (clinical and management staff) within the service.

(i) Mrs Martin (Chair and NED) noted that this is a very significant outcome and commendation to the services that we provide for women and their families in Herefordshire and Powys. She went on to thank everyone for all their hard work in achieving this. The team continue to be very ambitious in providing the best and safest care that we can.

(j) The CD advised that the Trust is fully committed to implementing any improvements suggested and congratulated everyone involved in achieving this result.

(k) Mr James (NED) endorsed the comments made with a very good outcome. Maternity services are under particular scrutiny across the county currently and it is very pleasing to have a Good assessment. The journey now starts to achieve an Outstanding rating, but this is a very good foundation on which to build.

Resolved – that the Maternity CQC Report be received and noted.

BOD18/10.23 **Maternity Services Quarterly Report**

The CNO and the CD presented the Maternity Services Quarterly Report and the following key points were noted:

(a) We continue to have good robust management of incidents that occur and events that require review. These are reviewed in line with national requirements and in conjunction with our LMNS to ensure that we have supportive peer scrutiny and objectivity when events go wrong to ensure that we maximise learning and improve safety and experience for our service users.

(b) We continue to have a low number of complaints reported in the service. The service have recognised that some complaints end up being formally managed that could have been managed informally and so they are introducing Debrief and Birth Afterthoughts to try to prevent some of this feedback turning into a more formal process.

(c) As part of the Ockenden publications, all maternity services are required to have Insights visits by the LMNS and Regional colleagues. They look at quality, safety and engagement and they provide feedback for improvements. Our next Insight visit is scheduled for 18th October.

(d) In the Workforce Section, it is pleasing to note that we undertook a huge recruitment campaign for midwives in the summer and that yielded a large number of midwives, some of who have already joined us and the remaining are due to join us by the end of the year. This has left us with a small vacancy factor within the midwifery workforce and we are hoping that we will fill all of these vacancies by the end of the financial year.

(e) CNST 10 Standards – We achieved 10 out of 10 standards last year which is very pleasing. Work is progressing to achieve compliance of all 10 standards again this year. We are now in Year 5 of this scheme. The scheme changes each year and the biggest change this year is the launch of the Saving Babies Lives Bundle Version 3. This has fundamentally changed and will require significant change and focus if we are to achieve compliance. Positively we were seen as an exemplar site in our implementation of Saving Babies Lives Version 2 which should provide a good basis on which to build.

(f) CNST 10 Standards – We are required to have Board Level Safety Champions. The CNO is the Executive Safety Champion and Mrs Martin is the NED Safety Champion. Part of the duties of a Safety Champion is to ensure that we meet on a regular basis with the Clinical Leads (doctors, nursing and midwifery Leads for Neonatal and Maternity Services) to support them with resolving safety issues or concerns and offer Board level support. The CNO and Mrs Martin (NED) met with the Clinical Leads last week and have agreed this month to support with resolving the ongoing issues around the recognised risk with maternity triage, which we have a plan to address and are hopeful to have a start date for the next phase of that work to commence soon. We have committed to support the Neonatal Unit with their Stage 1 assessment for the Baby Friendly Initiative Assessment process which is supporting women to breast feed where they choose to do so. We have offered our support both in terms of the Insight visit on the 18th October and any subsequent findings from that visit.

(g) Our Neonatal, Maternity and Obstetric colleagues did not raise any safety concerns that required the Board of Directors attention. The CNO and Mrs Martin (NED) are due to meet them again later this year in line with the CNST Standards.

(h) Mrs Martin (Chair and NED) noted that this is a very dynamic situation with a very cohesive team who are very clear about the expectations. We very much want to hear from women and families if they have any maternity issues.

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

BOD19/10.23 **Patient Experience Report**

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

(a) We continue to roll out the text messaging service and are seeing a very good response rate which is above the national average. There was a low response rate for Integrated Care community services due to not having current mobile numbers on our systems. We are working hard to improve this. The Patient Experience Committee are focusing on this.

(b) The vast majority of responses from the Friends and Family text messages are positive but there is also helpful feedback in relation to where we need to make improvements.

(c) An Improvement Group has been set up to focus on patient property. This is a national issue. Issues are not always around high value items but the items lost are important items for our patients such as hearing aids, false teeth, phone chargers etc.

(d) There were high volumes of complaints received during June and July (details within the report around the themes), with Head and Neck, ED and Womens and Childrens. This high volume led to reduced performance with response rates. The number of complaints coming into the organisation is now back within normal limits and our response times are now improving.

(e) Quality Committee received the results of the Inpatient Survey, ED Survey and the National Cancer Surveys at their meeting last week. In relation to the Inpatient Survey we have a very good overall response rate compared to other Trusts in England. We are about middle of the pack which is better than previously but we aspire to improve further. There have previously been some stubborn issues that remained an area of concern for a number of years, the CNO is pleased to report that some of these; communication, discharge and trust and confidence in doctors and nurses has much improved in this Inpatient Survey. We do have some areas of improvement, particularly communication around surgical procedures, discharge medications, timeliness of discharge and hydration and we have Workstreams for taking these areas forward. Discharge medications have always been an issue for us and are likely to continue to be a challenge given the difficulties with recruitment and workforce in our Pharmacy Department.

(f) ED Survey – ED attendance, time in the department and time awaiting admission has significantly increased year on year putting pressure on the department. This has led to disappointing results for the ED Survey and the department have pulled together an action plan focussing on communication, capacity and demand and privacy and dignity. As discussed earlier, the changes we have put in place around our Urgent and Emergency Care pathways, particularly FSDEC and other changes, we anticipate that these larger schemes will drive improvements in overall patient experience within the ED.

(g) Cancer Survey - We have once again had a good set of results. There are some areas that we need to improve in some of our cancer specialities particularly around point of contact for patients, care planning and what to expect regarding radiotherapy.

(h) The Managing Director noted that this is a generally improving picture, ED aside, and we understand the reasons for this. This is very good and needs to be celebrated and more improvement to come. In terms of driving this improvement, have we got the feedback both qualitative and the Friends and Family scores and feedback down to ward level yet so that individuals can own their own results? The CNO advised that we have and we have identified a training need for individuals not recognising how to access information and triangulate this which we have addressed.

Resolved – that Patient Experience Report be received and noted.

BOD20/10.23 **Infection Prevention Annual Report 2022/23**

The CNO presented the Infection Prevention Annual Report 2022/23 and the following key points were noted:

(a) A quarterly report is presented to the Quality Committee and monthly KPIs. This is a combination of the quarterly reports for the year and the KPIs which is a requirement of our contract.

(b) The CNO highlighted that we were an outlier for our CDiff rates – we were in the bottom 3 Trusts in the country. It is therefore pleasing to note that we finished the end of the year below the trajectory that NHSE set us.

(c) Where we did not meet our thresholds the infection reviews have taken place and we know we need to make improvements, particularly around catheter care, in doing so we should see a reduction in the gram negative bacteraemias that we have seen.

(d) The investment in the NHS Cleanliness Standards led to an expanded workforce around cleanliness and monitoring and since that time we have seen improved star ratings and standards of cleanliness in recent quarterly reports.

(e) We have been under extensive support from NHSE around cleanliness and infection prevention and they are due to re-inspect in November.

Resolved - that the Infection Prevention Annual Report 2022/23 be received and noted.

BOD21/10.23 **In-Touch Staff Engagement**

The CPO presented the In-Touch Staff Engagement and the following key points were noted:

(a) The paper outlines the comprehensive steps that we have taken to enhance the culture and working environment in the Trust as we know within the Health Service it is now widely acknowledged that in order to enhance the patient experience you have to enhance the staff experience. You do this by engaging with your staff.

(b) This engagement campaign was run over the summer months with over a 1000 staff engaging.

(c) We looked at 4 key areas (outlined in the paper) which are aligned to the Staff Survey and the NHS People Promise. This gave us the local intelligence based on what is really relevant to staff within the Trust.

(d) We have a monthly Staff Engagement Group to ensure that these actions are being implemented.

(e) Future updates will be provided to the Board of Directors on how these actions are being implemented across the board.

(f) Mrs Twigg (NED) thanked the CPO for this – this is something new that we have not had before and has obviously been a lot of hard work for the CPO and his team. Discussions held in the summer were being led by leaders in the team which is very positive.

(g) Mr James (NED) agreed with these comments noting that this has been well received following conversations he has held with staff. There are a couple of comments in the feedback from overseas nurses, and clearly this is a hugely important staff group who are doing a very good job for us. These are people who are not only starting a new job but also moving to a new country and settling here as well. Mr James (NED) was interested in the wider support as a Hereford community that we provide to those settling here. Do we engage with other services within Herefordshire with support and welcome that we provide? The CPO confirmed that we have Pastoral Officers within the Human Resources team. In addition to this, we are relaunching the Staff Diversity Group and developing an International Staff Charter and also engaging with some local community groups as well.

(h) The CNO noted that at our Annual General Meeting we celebrated receiving the Pastoral Quality Award from the Region which is wider than just our response as an employer. This is around how we link them to community groups and ensure that they have bank accounts etc, which we excel at, which is why we are seen as an exemplar site.

Resolved - that the In-Touch Staff Engagement be received and noted.

COMMITTEE SUMMARY REPORTS

BOD21/10.23 **Integrated Care Executive September 2023**

Mrs Martin (Chair and NED and Chair of the Integrated Care Executive) presented the Integrated Care Executive September 2023 and the following key points were noted:

(a) The ADCG expanded on the detail around the Discharge To Access Board in the report – the main 2 outputs from the recent Workshop were How to implement the revised process and How to understand the proportions to be allocated to each pathway and how best to resource.

Resolved – that the Integrated Care Executive Summary Report September 2023 be received and noted.

BOD22/10.23 **Quality Committee Summary Report 31 August 2023**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report 31 August 2023 and the following key points were noted:

(a) Mr James (Chair of the Quality Committee and NED) advised of the concerns raised around the Mental Capacity Act and Deprivation of Liberty Safeguards which is an issue for us for those patients with limited mental capacity or who need the protections of the Deprivation of Liberty Safeguards. We have put a lot of effort into this and a lot of training has been undertaken to raise awareness. We were disappointed as we have been anticipating that audits would have been carried out in order to demonstrate the effectiveness of this but unfortunately due to staff vacancy, this has not been able to be completed. The new member of staff has now started in post so we should be able to report back with some assurance next time.

(b) The CNO advised that we are back down to 1 member of staff in the team so unfortunately the audit that we anticipated we would undertake is not likely to happen soon. The team is very stretched currently and are only able to undertake Safeguarding cases and respond to these.

Resolved – that the Quality Committee Summary Report 31 August 2023 be received and noted.

COMMITTEE MINUTES

BOD23/10.23 **Audit Committee 15 June 2023**

Mrs Twigg (Audit Committee Chair and NED) presented the Audit Committee minutes 15 June 2023 advising that this was very year end orientated. We are now starting to include some of the financial and other governance information linked to the ICS and this will only grow in the future as we try to align ourselves to see what we can work together on.

Resolved – that the Audit Committee minutes 15 June 2023 be received and noted.

BOD24/10.23 **Quality Committee 27 July 2023**

Resolved – that the Quality Committee minutes 27 July 2023 be received and noted.

BOD25/10.23 **Any Other Business**

Mrs Martin (Chair and NED) noted that this is the last meeting of David Mowbray our CMO. He joined the Trust in 2001 as a Consultant Obstetrician and Gynaecologist and took over as CMO in 2018. She offered a huge thank you on behalf of the Board of Directors and the people of Herefordshire. The CMO has made the most significant contribution in many ways with his impeccable leadership, compassion and commitment to making things better. His curiosity and humility and humour and absolute commitment to the Nolan Principles were she felt prime examples he was exhibiting.

Mrs Martin (Chair and NED) noted that we are also saying goodbye to Robbie Dedi, the Deputy CMO and thanked him for his contribution during his tenure with the Trust.

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

BOD26/10.23 **Questions from Members of the Public**

Q1. Tissue Viability – Does Wye Valley Trust employ a full time Tissue Viability Nurse for the County Hospital? Does Wye Valley Trust employ a Tissue Viability Nurse to support the Community Nurses and Community Hospitals? In NHS England (Improvement) Pressure Ulcer Core Curriculum it states: "Pressure ulcers remain a challenge for the patients who develop them. Analysis of why patients develop pressure ulcers in healthcare settings suggest lack of education for staff is a key factor (Greenwood and McGinins 2016)… Recent data (Scholfield 2017) suggests there is inconsistency in the frequency and length of time organisations spend on focussed pressure ulcer prevention education with some embedding this in mandatory training and others not". Does Wye Valley Trust run refresher/updating education training for its staff upon pressure ulcer prevention? How regular is this refresher training? Is it mandatory? Are Health Care Assistants required to complete such training?

A1. The CNO confirmed that we do have 2.4WTE staff (4 people) within the Tissue Viability team supporting tissue viability and the team work in an integrated way across the Acute site and within Community Services. In terms of training, all Health Care Assistants receive Care Certificate training at the point of joining the organisation which includes tissue viability and pressure ulcer prevention, moisture associated skin damage and skin integrity training. Registered Nurses and Allied Health Professionals and others receive this as part of their core pre-registration training when they are at University. We provide the national online training for pressure ulcer prevention and tissue viability which is for all staff. This is not part of our mandated training but it is recommended that all relevant staff in a clinical setting should undertake this training. Compliance with this training is at a good level. We also offer bespoke training to our workforce, particularly those Tissue Viability Champions that are based at ward and clinical level. This enables them to provide on the job support to their colleagues. We also offer tissue viability training as part of our Clinical Practice Weeks which is where we take training to the ward and clinical areas and tissue viability is on a rolling programme.

Q2. Stroke Patients – Mechanical thrombectomy is a fairly new and very effective treatment for stroke patients. Does Wye Valley Trust offer, or have any plans to offer mechanical thrombectomy to its patients on a 24/7 basis? If the answers are negative then as time is of the essence for such treatment, will Wye Valley Trust transfer appropriate stroke patients to hospitals that do offer such treatment? If not, why not?

A2. The CMO advised that if a patient has symptoms of stroke it is an emergency. They need to contact 999 and come into hospital and be scanned within an hour. As long as the patient met various criteria and would be suitable for thrombolysis (dissolving the clot that has caused the stroke) they will receive this in the ED in Wye Valley Trust. If the scan also shows that you have a large vessel occlusion (this means that it is amenable to be removed mechanically with wires, then your scan will be sent to our Thrombectomy Centre, which is University Hospital Birmingham and the Interventional Stroke Radiologist will decide if that clot is amenable for removal and the patient will be transferred. If the patient is transferred within 6 hours that intervention is highly effective. We have a helicopter retrieval pathway as well. Our SSNAP audit carried out every month is the best in the West Midlands and has been for several months.

Q3. Live face to face Public Board meetings. In August 2023 the member of the public asked the Board of Directors if they intend to return to live face to face Public Board meetings. If so, when? The answer provided in the September Board papers was “The Chairman advised that the meeting today is being live streamed on You Tube. Lockdown has enabled more productivity and ecological benefits of digital meetings. Digital meetings allow more inclusion for those who are less mobile and geographically isolated”.

Whilst the member of public is not against live streaming meetings and there is some merit to the answers, however it does present a very short sighted, limited view that fails to give a full picture. In a recent report by Age UK (August 2023) Offline and Overlooked, it states that 2.7 million people aged 65 and over in the UK do not use a smartphone etc. it is time to make access to public services fair for everyone”.

Herefordshire is a low wage, sparsely populated area with an aging population. The Age UK Report gives an indication of households that are offline but it only looks at older people and not those who are struggling financially and cannot afford internet access or those who do not want it. Many older and poorer members of the public are frequent hospital users. I would suggest to Wye Valley Trust that to have truly inclusive Public Board meetings, we need to have both face to face and live streamed meetings as Herefordshire Council meetings are. Apart from the Chair, the member of the public would be interested to hear the views of other Board Members.

A3. The Managing Director felt that this was a good point and something that we need to keep under review. There is no doubt that we reach more people livestreaming and she took the point around not everyone being digitally included, but equally not everyone has access to transport. When we have met face to face, generally we have between 3 and 5 people attend and these are usually the same people attending. We are much more accessible now than we ever were. We have to get the balance right but digital has to stay as part of way that we do this.

	The ADCG advised that the September Board had 63 views, our Annual General Meeting had 720 views. Mrs Martin (Chair and NED) reiterated that we will keep this under review and we want to ensure that members of the public can observe and scrutinise the work of the Board of Directors and also feed questions and comments in. If they do not have access to this, there are local facilities and organisations who can support. **<u>Resolved</u> – that the Questions from Members of the Public be received and noted.**
BOD27/10.23	**<u>Date of next meeting</u>** The next meeting was due to be held on 7 December 2023 at 1.00 pm via MS Teams.

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

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD11/10.23 Finance Performance 05.10.23	(B) The Chief Finance Officer will provide an update to the Board of Directors on the underlying cash plan before the next Board of Directors meeting in December.	KO	Cash position reported within the IPR and plan review paper. Ongoing national process in regards forecast and therefore cash requirement. Further briefing to be shared in January.
BOD11/10.23 Finance Performance 05.10.23	(C) The Chief Finance Officer will share some of the outputs from the mid-year review meeting with the Board of Directors prior to the next Board meeting in December.	KO	Included within the plan review paper.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

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

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

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

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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1) NHS Finances and the Productivity Challenge

Elsewhere on the agenda we report on the assurances that the Trust has made as part of the national exercise which requires each Integrated Care System re-confirm finance and activity plans. As explained in the report, this was undertaken within a short timescale following on from national discussions with the Treasury. I have previously reported concerns about the overall financial position of the NHS which had been further exacerbated by the impact of Industrial Action. The NHS National CFO had asked for around £2bn of additional funding to ensure that the NHS operated within its overall financial plan. Whilst the ask was broadly predicated on the direct and indirect costs of Industrial action the NHS also faces challenges regarding general inflation, recruitment gaps and demand pressures. Unfortunately the discussions with the Treasury did not result in any additional funding on top of the extra allocation of £200m announced in July. Instead, the NGHS was asked to review national and local plans to offset the pressures. As part of this, tentative permission was given to review elective recovery plans, particularly where premium costs were planned to achieve the milestones set out in the national plan. This therefore would allow some parts of the NHS to not achieve the 65 week maximum elective referral to treatment target. In doing so, it was made clear than managing urgent care over the winter period was the more pressing priority including maintaining the planned performance on ambulance handover targets. Confirmation of performance intentions against the key national targets was therefore including in the returns alongside financial trajectories.

The review of national budgets, alongside the plan to devolve the £200m allocation did provide additional funding to ICSs. The transfer of this funding to providers was mainly transacted through an IA allocation to each system based on clinical staff headcount as well as an adjustment to the threshold above which elective activity is paid for on a 'payment by results' basis. It should therefore be noted that any planned reduction in elective performance would also result in a corresponding reduction in income for any Trust above the threshold – which I am pleased to report includes all of the Trusts in the Group. I therefore concluded that a reduction in elective activity would not only compromise care for our patients but it would have a very marginal impact on our finances. As a consequence we opted not to follow this path across the Group.

The details of the consequences of the exercise are set out elsewhere in the Board pack. In summary this leaves all four Trusts in the Group in a challenging financial position. The plans will also be reviewed by the national CFO on an ICS by ICS basis in the first week of December. This may impact on my ability to attend all of this week's Board meetings.

One of the challenges faced by the NHS is that we have seen, what is in some parts, quite a significant increase in headcount when staffing levels are compared with the pre-Covid position. In some cases these have delivered increases in activity but in many, the activity increases are minimal. As a very large consumer of public money we have a duty to explain this and to improve upon it where we can. I have therefore asked each of the Executive teams to consider how we tackle the productivity challenge as part of next year's objectives setting exercise. Our group arrangement provides a very helpful platform to tease out the differences in productivity and to seek out best practice solutions.

I have also been involved in a recent exercise to refresh a document which was previously referred to as ‘The Intelligent Board’. The document sets out best practice on how Boards should function including the types of performance indicators which should be considered. As [art of this refresh I think that it will be important to make sure that Boards spend sufficient time, and are effectively appraised on productivity measures. Whilst a focus on quality is of course one of our main concerns, it is also important for everyone to be conscious of the link between productivity and providing more care. I have never seen managing the money and maintaining high quality care as mutually exclusive and I am sure that none of our Board members do either.

On the 22nd of November, the Government set out its Autumn Statement which did not include any revisions the NHS spending plans. In addition to the pressures on revenue funding set out above, we face significant challenges regarding capital expenditure. It had been hoped that the Statement might at least make some further provision to cover the implications of the RAC concrete issue but it did not. We await to see how this will be handled within the NHS but it could lead to a reduction in our base capital allocation as a system.

2) Volunteering

At our recent ‘4 Boards’ meeting, the invited speaker at our morning workshop was Sir Thomas Hughes-Hallett. Sir Tom has had a very impressive CV including being Chair of the Chelsea and Westminster NHSFT. He is now the Chair and Founder of Helpforce. Sir Tom founded Helpforce in 2017 with the vision that everyone who visits the hospital will never be alone. A volunteer will pick them up and take them to their appointment. His vision is that they will stay with the patient, explain what the treatment involves and take the patient home afterwards and remain a companion on the patient's journey. Sir Tom recently spoke at the national Chief Nursing Conference about the volunteering activities of the Group and has flagged with us the possibility of accessing some national funding to support our ‘waiting well’ support initiative to people on NHS waiting lists.

3) Leadership Development

I recently attended a meeting of the Association of Groups (AoG) Senior Operational Leaders Network (SOLNET). The AoG are in the process of reviewing their offer to member Trusts and we have indicated our support for the continuation of a programme. In discussion with the Managing Directors and other Execs we have also agreed to establish a programme of Group webinars for our leaders, probably targeted at the triumvirates. This will draw on the skills of individuals across the Group to provide a series of ‘teach ins’ on subjects such as budgetary management, business case production, job planning etc. All of which will supplement local development programmes which are already in place and will help to skill up our leaders to help to tackle the complexity of their roles.

4) MORE FROM OUT GREAT TEAMS – Update from the Clinical Support Division – November 2023

Outpatients

Successful "Super Saturday" held in November with 9 clinics running, including 4 General Surgery hernia clinics, mini Pre-op available on day. Positive feedback from patients and consultants. Further "Super Saturday" planned for 20th January 2024. Suggestion made to specialties to forward plan weekends and look at running same specialties on weekends to make more cost effective, and improve patient experience.

The Plaster Room service has appointed a further trainee for succession planning who will be trained July 2025. This will also facilitate future virtual fracture clinic development.

To promote Oral Cancer Month the Dental team manned a stand at the front of the hospital generating lots of interest from staff and visitors. The Outpatient team looking at other stands throughout 2024 to support health promotion.

The Referral Management Team have been supporting with the national validation exercise by contacting patients over 12 weeks, by phone, letters and inputting responses. Processes are now in place to sustain going forward. Automated processes (text message portal) will be in place by end of November. Local figures are between 90% and 97%, however national reporting may be lower at around 67%.

Cancer Services

On the 1st October 2023 the 7 standards of cancer waiting times were consolidated to 3 core measures which now include Consultant upgrades, these are 28 day faster diagnosis, 31 day decision to treat and 62 day top standard. The Cancer Services team are continuing to support the Trust speciality teams to improve their performance in relation to these standards and also reduce the 63 day cancer backlog. Cancer specialities continue to have Cancer Navigators in post funded by the Cancer Alliance and they are now managed by the Cancer Services team.

Performance continues to be a concern, as a Trust we not meeting the targets, previous actions from deep dives continue to be driven with a further deep dive arranged in December. The main issues that have been identified are speciality clinic capacity, Histology reporting and clinical admin delays.

The FIT (Faecal Immunochemical Test) pathway has been worked up between Primary and Secondary Care following national guidance which is designed to assist with the management of patients with a low risk of malignancy of colorectal cancer. The pathway outlines a process of how FIT negative patients can be managed in Primary care ensuring only those patients who are FIT positive are referred in to the urgent cancer suspected pathway. It is anticipated that this pathway will reduce the number of referrals coming in to the Colorectal Service and therefore the demand placed on our diagnostic services. This pathway was recently deployed in Worcester who reported a 30% reduction in their colorectal referral numbers.

The pathway is ready to go live and just now awaiting the forms to be built in EMIS (Egton Medical Information Systems) and deployed in Primary Care.

The implementation of patient stratified follow up (PSFU) was delayed due to remote monitoring being implemented on MAXIMS, but this has now gone live in November. These pathways are set up for cancer patients on the Breast, Colorectal and Prostate pathways.

The Haematology service has maintained open and safe access with Locum recruitment but unfortunately we were unable to recruit to the substantive Consultant. We have now recruited to three trainee advanced Nurse Practitioner roles and once trained they will be able to take on some of the Consultant clinical workload. (Health Education England) HEE STAR workshop has been undertaken with short, medium and long term actions to take forward.

Diagnostic Services

The Radiology team have continued to deliver capacity significantly higher than that of 2019, which has enabled backlogs and waiting times to be significantly reduced with waiting lists for MRI (Magnetic Resonance Imaging), CT (Computed Tomography), USS (Ultrasound Scan) and DEXA (Dual Energy X-ray Absorptiometry/bone density scan), 96%; 97%; 99% and 92% within 6 weeks respectively.

Significant work to improve Radiology report turnaround time, particularly to support cancer FDS pathways has been underway over recent months, including the roll out of new report allocation officers, which has seen consistent reduction of cancer report turnaround times since June 2023 and for the first time all routine MRI and CT reports under 28 days turnaround in line with expected national standards.

Investment has been made into the Information team, with an experienced Data Manager for Diagnostic services (to cover Imaging, Audiology and Pathology) to improve our business information and reporting dashboards to more closely monitor our performance and efficiency.

Digital transformation continues with GP order comms and clinical decisions support software progressing to testing stage. Meanwhile Rapid AI for CT heads, to support speedy decision making for stroke thrombectomy pathway out of hours is planned for rollout in late November.

As part of a central CDC (Community Diagnostic Centre) international recruitment programme with NHSE, the department have offered positions to 10 international Radiographers who will be starting in post over Dec/Jan, as well as one Consultant Radiologist. Furthermore, the department has had one long term Radiologist successfully complete their CESR (Certificate of Eligibility for Specialist Registrar), with plans to offer substantive consultancy in January.

The final business case for the Hereford CDC was approved at Trust Management Board on 17/11/23 and is planned for presentation at Trust board on 7th December 2023.

Pharmacy

Pharmacist recruitment continues to be the department's biggest challenge but through internal development we have appointed to our vacant senior roles for Gastroenterology and Antimicrobial Stewardship. In January 2024 we will see the return of our Lead Pharmacist, Surgical Division from maternity leave and also the arrival of a new pharmacist as our Lead for Workforce Development. Junior grade pharmacists are still at a 50% vacancy rate and we are now moving to utilising international recruitment. We are also looking forward to three of our own pre-registration Pharmacy technicians registering in January/February 2024 and joining our Pharmacy Technician team. To support our Pharmacist recruitment we have increased our cohort of trainee Pharmacists from three to four and we have also increased our trainee Pharmacy Technician roles to 15. Both the Pharmacist and Pharmacy Technician trainees include several cross sector placements with our colleagues in Community (High Street), Mental Health and GP Practice Pharmacy sectors. We are far from recruiting to all the vacancies within the department but the skill mix and development opportunities within our department are attracting new recruits.

A knock-on-effect of the shortage of Pharmacists has been the impact on the aseptic production service within Pharmacy. This service prepares and clinically checks, amongst other medicines, the chemotherapy for our Oncology and Haematology patients. To safe guard the continuation of this vital service, this area has been prioritised reducing the risk specifically in this area.

With the expansion of the Pharmacy service since the opening of the hospital sufficient space to deliver the pharmacy service has exceeded and as a result a short, medium and long term plan to manage this has been developed. The short term plan of moving some Pharmacy staff off site has been agreed and is currently being implemented.

Pathology

Networking – process is continuing with the proposed governance model, financial baseline and operational model in development. Both the LIMS (Laboratory Information Management System) and SMP (South Midland Pathology) operations business cases are due to go to Board early in the next financial year. With the exception of point of care, there has been a change to the network wide procurement approach with a plan to adopt a 3+7 contract award. This is to allow vital end of like equipment to be replaced prior to a network wide procurement once wider engagement and the new operational model has been agreed. The communications plan for wider stakeholder engagement in network developments is due to start January 2024.

Histopathology – continue to struggle under an increased workload, disproportionately high number of urgent cases and inability to recruit consultants. We are still none the less fairing quite well compared to other Trusts regarding urgent turn round times. All Breast work is now outsourced to SWFT (South Warwickshire Foundation Trust) and Worcester, Gynaecology cases to Cheltenham and Gloucester and we are currently in the process of agreeing a contract with an outsourcing company for skin work; this will include MDT (Multi-Disciplinary Team) cover. The department is has yet to be able to utilise digital pathology to gain any turn round time advantages as it is not yet live at any other sites. We are working with the network to develop a 6 point transformation plan in line with national and regional requirements.

Microbiology – a MALDI-TOF (Matrix-assisted Laser Desorption Ionization–Time-of-Flight) was successfully purchased this month which should revolutionise some aspects of how the department works and significantly improve turn round times; we were one of the few departments in the country without this technology. We are continuing to work with Pharmacy and the Trust to improve the blood culture pathway in line with National guidelines and to increase AMR (Antimicrobial Resistance) awareness. We are likely to be one consultant down in January when our current locum leaves but currently have a number of options with medical recruitment.

Blood Sciences – main stream analysers are now in urgent need of replacement and we are currently in the process in a procurement exercise to replace this essential kit. Blood Bank is an outlier in the network in not having introduced electronic issue and still relying on paper to maintain traceability and hence MHRA (Medicines and Healthcare Products Regulatory Agency) compliance. We are working with local IT team and LIMS supplier to try to address some of these issues to put us in a better place to be able to purchase an end to end system for tracking blood products and remove paper from the system.

Mortuary – processes are now in place to charge funeral directors for length of stay. This has resulted in a significant reduction in length of stay.

5) Going the Extra Mile Awards – Quarter 2 – August to October 2023

Team of the Quarter – Quarter 2 – Kelly Moran and Laura Morris

Kelly and Laura dealt with an emergency situation on the hospital site. The situation was sudden and traumatic in nature. They both displayed expert problem solving and decision making, methodically working everything through and making sure safety precautions were taken at all stages. Kelly displayed caring and compassion in dealing with emergency contacts by phone, amidst a very complex set of circumstances. They both enacted this whilst also managing a hospital under significant pressure from a flow and discharge perspective. They remained calm and focussed throughout the shift, in spite of what happened. The way they worked was awe inspiring and humbling to see and they are both a credit to WVT.

Employee of the Quarter – Quarter 2 – Mike Willmont

Since March 2021, Mike Willmont has completed over 1,600 hours of volunteering within the very successful Pharmacy Runner service distributing medication around the hospital.

Mike was chosen due to his admirable commitment to three shifts a week, he is also quick to respond when there is a gap in the rota, and you will even see him volunteering on Christmas Day, armed with sweets.

Mike is incredibly knowledgeable, experienced and committed to the role of being a volunteer and is a valued member of the Pharmacy team. He is also very humorous, friendly and great fun to work alongside.

In addition to his pharmacy role, under supervision of ward dietitian, Mike assists with meal monitoring on the wards. To monitor meal time service to ensure patients are best prepared and supported, with good hand and food hygiene to optimise their dietary intake. The information is then collated in order to raise awareness of issues and find solutions to optimise care.

Further still, Mike helps maintain the garden by our discharge lounge, and purchases plants as a gift so patients can enjoy the view as they wait to return home.

Glen Burley
Chief Executive Officer

Integrated Performance Report

October 2023

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

The loss of some elective activity, as a result of Industrial action during October, coupled with a continued pressure on our inpatient beds has proved really challenging throughout the period since the last Trust Board meeting.

A persistent rise in patients experiencing a delayed discharge, both in Herefordshire and Powys on top of prolonged 'front-door' pressure has combined to significantly challenge patient flow and has led to poorer performance than we would want.

The number of Covid 19 positive patients increased in October with a number of outbreaks across the Trust. The number of Covid 19 cases in hospital has however reduced over recent weeks.

We have positively responded to new regional guidance regarding mask wearing in the Trust and reintroduced compulsory mask wearing across a number of clinical areas. Staff on areas not affected by the new guidance can continue to wear a mask if they wish.

Despite the pressures on elective activity the Trust continues to perform well in terms of performance against the Value Weighted Activity measure with some of the best performance across the region in this regard, however the risk of further industrial action and/or a further escalation of winter pressure does remain a cause for concern.

The recently announced national pay and condition proposal for hospital consultants offers a possible resolution for part of our workforce but it will be unclear if that is the case until later in January next year when the ballot is completed.

There continue to be real progress in our workforce metrics with real improvements in both the number of overall vacant posts we are carrying and the turnover rate of our workforce.

Our Frailty SDEC unit (Same Day Emergency Care) continues to perform well and is very much a positive addition to our 'front-door' offering. Our hospital based Virtual Ward team are now co-located with Frailty SDEC and are able to provide improved continuity and collaboration as a result. The virtual ward offering has recently been enhanced with consistent night cover and the introduction of remote monitoring, as a result, the numbers of patients being cared for on the virtual ward has notably increased.

At the start of November, a jointly led (WVT and Herefordshire Council) rapid improvement 'D2A Sprint' began to drive forward improvements and efficiencies within the whole of the supported discharge 'pathway'. The aim is to ensure that more of our patients get the support they need, when and where they need it and we do this in a way that is both sustainable and affordable.

The financial position at the end of month 7 (October) was a deficit of £17.6m which is £2.0m adverse to the planned deficit at this point in the year. As previously reported, known financial risks are putting greater pressure on delivery of our financial plan. A mid-year review was undertaken during October, subsequently feeding into a national forecast review during November; a separate paper is presented to Board this month.

Our financial position remaining challenging, and we will ensure we have significant focus on improving the Trust's run rate over the remaining months of this, and next, financial year.

Our Quality & Safety – Executive Narrative

Chizo Agwu

Chief Medical Officer

National Patient Safety Strategy and Local Patient Safety Incident Response Plan

At the last Board meeting, Board approved the Local Patient Safety Incident Response Plan and recommended this for submission to the ICB for final endorsement and approval. The plan and associated policy framework were endorsed by the ICB in November and the trust went live with PSIRF on the 1st November.

The Serious Incident panel has now become the Patient Safety Panel and processes are actively being developed with stakeholders to seek learning from multiple sources of patient safety data. This shift away from focussing on harmful incidents only, will develop incrementally over the next few months and expand understanding of our Organisational patient safety landscape.

A collaborative ICS bid for funds has been successful, and has secured training that meets PSIRF standards. This will incorporate training on patient and family engagement, using a systems approach to patient safety incident investigations and oversight. All training will be undertaken prior to April 2024 and will support staff across the ICS to gain the skills and knowledge required to transition to PSIRF meaningfully and with a shared understanding.

Lucy Flanagan

Chief Nursing Officer

Infection Prevention and Control

The winter season is upon us and since the last Board meeting we have seen an increase in the number of patients testing positive for Covid 19. During the month of October, 6 Covid outbreaks were declared and hospital onset cases increased from only 1 in July, 6 in August, 22 in September and 35 in October. We are beginning to see influenza cases, although numbers are small at present and currently we have one ward closed with a norovirus outbreak.

Following receipt of the midlands guidance on mask wearing the Trust introduced mask wearing in the urgent and emergency care pathways including the Emergency Department, Acute Medical Unit, Same Day Emergency Care and Frailty Same Day Emergency Care and across high risk areas including the intensive care unit, paediatrics, special care baby unit and Macmillan Renton Unit.

The annual round of Patient Led Assessment of the Care Environment (PLACE) Inspections is due to conclude at the end of November in line with the national mandated timescales. Whilst the published results will not be available nationally until early 2024 we are currently working through our submission data to identify areas for improvement.

Ward to Board

During October we have aligned our non executive directors (NED) to clinical areas to enable relationships to be established and allow better visibility of challenges and successes from ward to Board. Further to this Quality Committee received a proposal to change the safety walkabout process within the Trust. The proposal included recommendations for a NED link safety walkabout through direct engagement with the clinical teams and divisions and in addition Trust Board Safety Walkabouts which would include an Executive Director and senior member of the Quality and Safety Team. The proposal also included recommendations on how we might better capture feedback and track changes and improvements made.

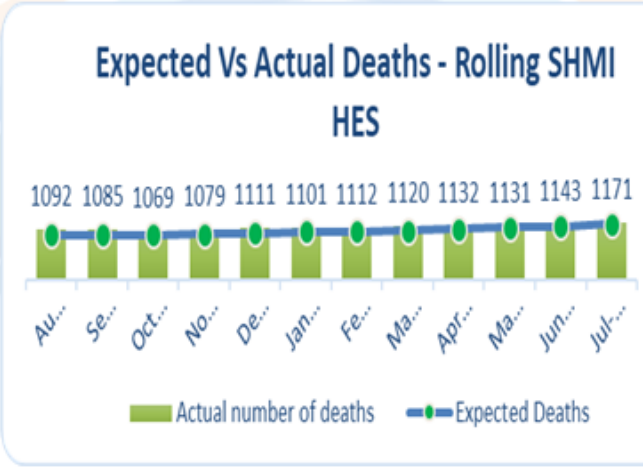
Quality and Safety – Mortality

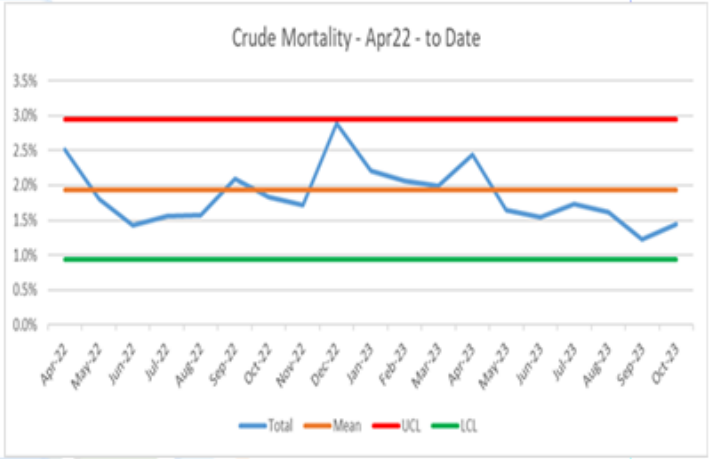
We are driving this measure because:

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
SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	Jun-23	101	0.4
SHMI (HES	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	Jul-23	101.9	0.5
SHMI (in hospital)			98.1	1.7
SHMI (out-of-hospital SHMI)			110.8	-3.14





What the chart tells us:

- The latest SHMI (NHS Digital) for the period July 2022 to June 2023 and shows Wye Valley NHS Trust at 101 which is a slight increase on the previous SHMI.
- The increase in SHMI appears to be due to increase in Pneumonia deaths .
- Our larger outlier groups of COPD, Heart Failure, Septicaemia and Fractured Neck of Femur remain steady. Despite a small increase for Stroke it remains well below the national average.
- The National Ambition, which was set out in 2010 and refers to a 50% reduction in stillbirth mortality by 2025, aims to achieve a rate of 2.6 per 1000 live births. The latest local data (November 2022 to October 2023) shows a crude un-adjusted stillbirth rate of 2.45 per 1000 live births, and is the fourth consecutive month below the National Ambition target

Key Actions:

- Pneumonia has seen an increase and we will be analysing the data to understand this increase. This will be closely monitored work will commence with the Respiratory Team to identify some metrics to audit and identify any learning, Clinical Coding are undertaking an audit to identify any potential data errors within the initial diagnosis coding.
- Work continues on developing the mortality module of Inphase module to support clear Divisional oversight of all deaths and also support roll of ME scrutiny of community deaths
- Discussions ongoing with GP Medical leads on pathways to support roll out of ME scrutiny of community deaths
- Work continues with the Divisions to ensure a robust Learning from Deaths process is put into place at WVT.

Quality and Safety - Boarding patients

The Trust introduced a Boarding SOP in October 2022 in response to the sustained pressure for beds and increased activity at the front door. The aim was to reduce the increasing risk associated with an overcrowded Emergency Department and balance the safety issues across the hospital bed base as a whole. Boarding is defined as placing a patient in an area where a bed would not otherwise be located. The original boarding process was introduced as a proactive measure by placing patients on wards in line with the profile of discharges for the day, yet is used reactively at times of extreme pressure to ease ED congestion and address ambulance off load and delays. The Trust is conscious that Boarding is far from ideal and will have an adverse impact on patient and staff experience.

Numbers of Boarders over time (April 2023 to date)

Findings and Actions:

- During October there were a total of 473 Boarding patients across the month, the vast majority being placed in medical and frailty wards, recently we have seen up to 30 Boarders at one time (overnight and during the day)
- We have received 8 concerns and complaints from patients and/or their relatives during the month of October, with limited space and compromised privacy and dignity being a key feature
- We have seen an increasing number of incident reports relating to Boarding, particularly in relation to the limited space and congestion leading to an: inability to provide physio-therapy and other care in an optimal way, difficulties managing emergency situations and staff feeling compromised in delivery of safe and good care
- Our overall strategy to improve the situation includes:
- A focus on urgently reducing the number of discharge delays in frailty—20 patient challenge event to discharge additional 20 complex discharges over a 4 week period
- Continue to optimise discharge lounge occupancy every day and bringing discharges forward - -"home by lunch"
- A zero tolerance to discharge delays on Lugg and Arrow through Winter
- Re-emphasis of reverse boarding (board your discharge admit your new admission to the designated bed space)
- MDT decision making re patient placement
- Expansion of Same Day Emergency Care [SDEC] to stream "missed opportunities" that are admitted to inpatient wards
- Increase referrals to Virtual Ward
- Discharge to Assess [D2A] work both internally and externally / Herefordshire system wide.

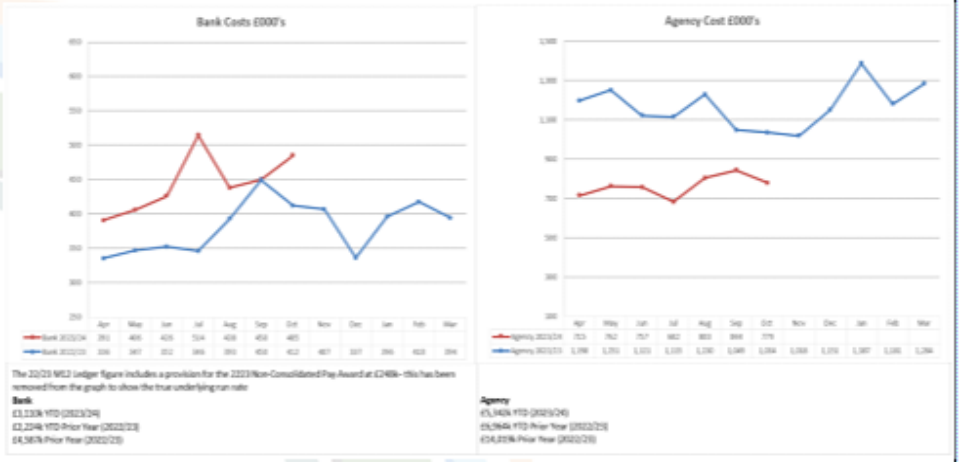
Quality and Safety – Staffing

Fill Rate and CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	96%	75%	96%	94%	10.0
Maternity Ward	83%	86%	90%	87%	5.3
Children's Ward	132%	167%	114%	104%	16.1
Lugg Ward	110%	109%	107%	127%	6.2
Wye Ward	111%	85%	118%	84%	6.8
Cardiac Care Unit	102%	88%	101%	97%	11.8
Leominster Community Hospital	119%	95%	110%	157%	6.6
Bromyard Community Hospital	104%	180%	99%	243%	10.3
Ross Community Hospital	101%	122%	102%	127%	6.3
Teme Ward	110%	50%	93%	48%	10.9
Redbrook Ward	95%	101%	100%	111%	6.7
Special Baby Care Unit	103%	-	89%	-	10.2
Intensive Care Unit	116%	-	101%	-	28.5
Gilwern Ward	152%	124%	100%	150%	7.0
Acute Medical Unit	124%	90%	98%	145%	8.4
Ashgrove Ward	132%	113%	121%	149%	8.0
Dinmore Ward	132%	79%	101%	127%	6.5
Garway Ward	109%	114%	110%	149%	7.2
Frome Ward	127%	84%	100%	106%	7.0
Arrow Ward	128%	77%	135%	82%	7.1
Women's Health	100%	100%	100%	-	8.7

There are a number of cost pressures and establishment changes that have not been reflected in the fill rate data which are driving some of the high percentage fill rates, a piece of work is being undertaken to better reflect the position.

There are a number of unfunded cost pressures that will be considered through the business planning process.



Agency demand and spend has remained relatively stable during the last few months, yet remains in an improved position when compared to the previous year.

Community hospitals, frailty and emergency medicine continue to be those areas utilising the highest volume of agency.

Frailty is due to a change in establishment not yet reflected in substantive recruitment and the unfunded posts being backfilled into frailty SDEC. ED due to front door pressures . The community hospitals have additional beds (Leominster) and patient dependency at Bromyard.

Thornbury use has reduced in month.

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

Continuing periods of Industrial Action, yet again, impacted on our operational and clinical teams during the end of September and the second week of October hindered our ability to maintain our elective capacity to its full potential.

The planning, operational implementation and recovery is becoming more and more challenging each time.

However, despite the challenges 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 116% above 2019/20 levels for the across the combined weeks of October and the second best Trust , behind our Foundation Group Colleagues at George Elliot Hospital NHS Trust, the Region for last reporting period.

There are three main areas of focus, as we approach the winter, that operational, clinical teams and myself need to maintain:

1. Improving Urgent and Emergency Care [UEC] performance
2. Improving our Cancer standards
3. Reducing our Long Waiting Elective patients

On our UEC journey there are a number of improvements we have made over the recent month. These included:

- Implementation of Ward based standards that provide a unambiguous description of the values, behaviours and patients flow standards expected across all our Trusts wards and support services. Thee have all been written and agreed by the clinical leaders and openly supported by the executive team via our Trust Management Board.
- Increasing the capacity within our Discharge Lounge. We have seen an increase is patients leaving the wards by lunchtime from 16% in August to 21% in October. This have been supported by the Integrated Care Systems [ICS] Home4Lunch campaign.
- Discharge to Access [D2A]. Improvements through the Herefordshire based work led by the Chief Transformation and Delivery Officer on the D2A acceleration work of the Herefordshire D2A Board . Within our Trust we have update and relaunched our own D2A processes with our wards including management of patients through the various Discharge pathways and setting of Estimated Discharge Dates [EDDs] that are meaningful for both clinical teams, patients and their relatives and carers.

Within our Cancer pathways there is a significant focus on improving our 28 days Faster Diagnostic Standards [28FDS]. Despite the workforce challenges within both Histopathology and Radiology we are starting to see reductions in access and reporting compared with the performance we had seen over the winter. But our 28FDS is currently off trajectory. In order to gain progress over the next few months we are reviewing the opportunities for improvement in five key cancer pathway in order to address actions. These including how we reduce the first new outpatient appointment and reducing decision making timeframes after diagnostics and informing patient rapidly after clinical plans are made.

Our Elective recovery has made some significant gains over the last month:

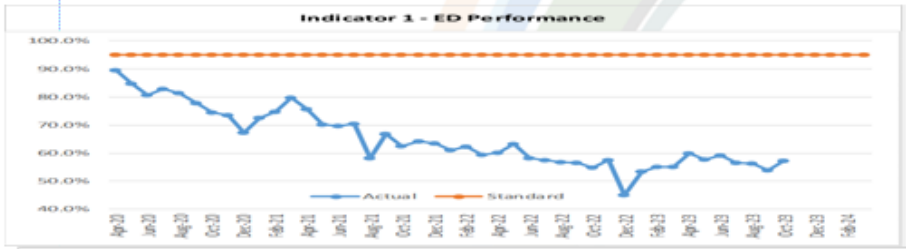
- 90% of English patients validated >12 weeks with material impact on waiting list position along with improved patient experience and responses from patients we have contacted.
- 89% of new outpatients who will breach 65 weeks by the end of March 2024 have a booked appointment before December 31st (highest in region). With digital text validation “Go Live” by the start of December.
- Perfect Pathways for orthopaedics using Getting It Right First Time [GIRFT] best practice. Two weeks in Theatres and two weeks in outpatients over the last two weeks of November has seen increased procedures per Theatre list and changes to Pre-Operative education to patients in advance improving perception of their length of stay post surgery. A similar week for Gynaecology is planed for the new year.

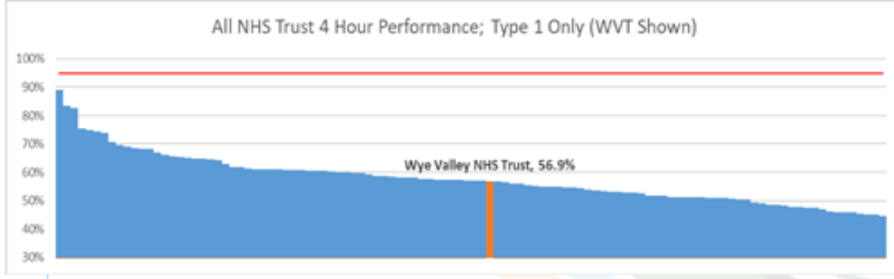
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

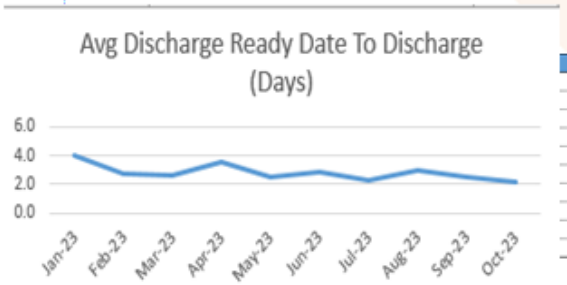
We are driving this measure because:

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







Month	AvgDischargeReadyDateToDischarge
Jan-23	4.0
Feb-23	2.7
Mar-23	2.6
Apr-23	3.6
May-23	2.5
Jun-23	2.9
Jul-23	2.2
Aug-23	2.9
Sep-23	2.4
Oct-23	2.2

Performance and Actions

- 6,293 patients attended ED in September our busiest month for over two years and our second busiest month for ED attendances. The range of attendances varied from 149 to 252, the busiest day the Trust has seen, with 203 being the average daily attendances
- 1,764 ambulances conveyed to the Trust in month. The range in month was 40 to 70. This includes 5.7% from Worcestershire [101], 3.9% from Shropshire [70] and 12.1% from Powys [215]
- Ambulance handover delays over 1hr were 6% [102] of all conveyances and 81% [1,249] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,035 of all admissions [45% of all admissions] via a Same Day pathway within no overnight admissions.
- New Discharge Ready to actual Discharge data shows an improvement in the delay for patient once they are ready to be discharged. This mirrors the reduction in the number of Medical Fit For Discharge [MFFD] delays at Community hospital sites in October, where we normally have higher numbers of MFFD patients

Actions to Address:

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

- Expand Medical and Surgical SDEC in December.
- Increase our Ward and Flow co-ordinators on our wards
- Focus on minors and non-admitted breaches within ED
- Develop and implement ED safety matrix and scoring system
- Agree and implement Primary Care/ED out of hours live appointment booking system

Risks:

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

What the chart tells us:

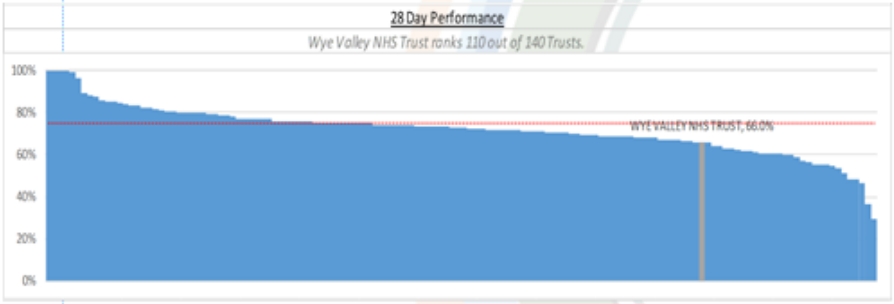
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
Septembers Type 1 4hour Performance was 57.2%

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

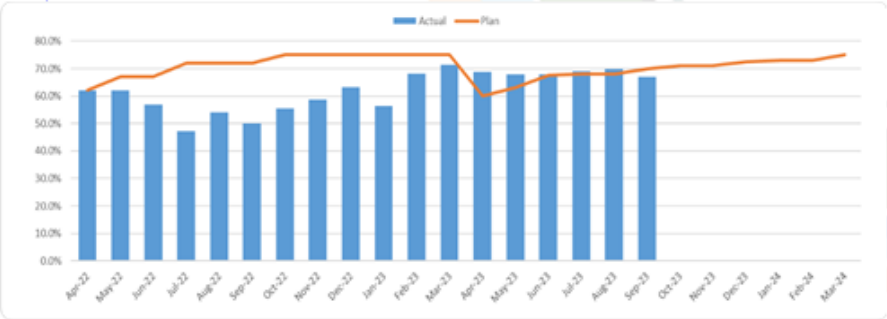
We are driving this measure because:

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



23/24 Trajectory for 28 Days



Performance and Actions

Referrals

- Cancer referrals remain high with a 43% increase compared with 3 years ago, an additional 3476 patients, also 10% above our planning assumptions for 2023/24.
- Gynaecology referrals have remained high, an increase of 18% compared to last year (209 additional referrals) and 77% increase compared to three years ago (587 additional referrals). First outpatient shortfalls are being seen in this specialty.
- Colorectal referrals have remain high at a 72% increase compared to three years ago (994 additional referrals). The faecal immunochemical test pathway went live in November, this should show a decrease in cancer referrals which will be measured in the coming months.

Main Issues impacting on performance and actions:

- Histology still have vacancies across the consultant team therefore work is continuing to be sent to other trusts, insourcing companies and bank locums. Majority of reporting is now back within 2 weeks which has shown improvement as some specialities were taking 3 weeks. Work is still being undertaken in relation to digital and how the region/other Histopathologists' will support.
- Trust has maintained the first outpatient target of 10 days in cancer specialties which some specialities are not achieving. Weekly shortfalls are being shared with specialties to organise additional clinics.
- Admin delays are currently impacting cancer performance, text messaging is being process mapped to be trialled in one speciality for patients to receive non cancerous results to improve quicker communication to patients and support the faster diagnosis standard..
- Radiology scan to reporting times have improved as they continue to use telemedicine clinic for cancer reporting, Computed tomographic (CT) colonography is now 12 days on average from scan to report time, previously this was over 30 days.

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:

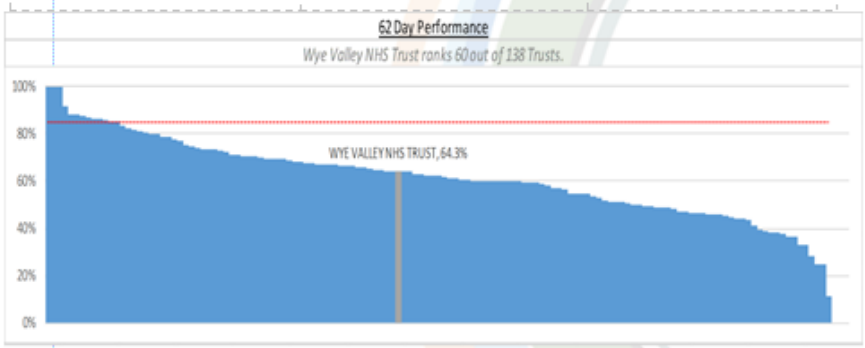
- 28 Day faster diagnosis = Performance against this target was 67% and remained below the target of 75% and below our trajectory for the month.

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



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

Performance and Actions

62 Days:

- The trust position for 62 days in September was 64% with 19 patient breaches, The pressures have been the same related to the Faster Diagnosis Standard performance, also the doctor strikes have led to cancellations.
- During September our over 62 day positon increased to 109 patients due to the challenges in FDS and 62 days.
- Endoscopy booking times have improved, lower endoscopy's are being booked at 10 days and upper endoscopy's are being booked at 7 days.

Key Actions:

- Non specific symptom pathway provisional go live date 1st February 2024—delayed due to recruitment and governance sign off.
- All specialties to continue booking first outpatient appointments within 10 days and reporting shortfalls for plans if unable.
- Our electronic patient system to be updated with cancer performance targets, to support with booking in breach order.
- Cancer navigators will now sit under cancer services to ensure robust cross cover, weekly deep dives being conducted of breaching patients to identify themes and communicated to the specialty teams.
- Further deep dive arranged in December to review actions and make further actions to improve cancer performance. Including a breakdown of Administration delays and opportunities to address within each speciality to ensure more robust processes

Risks:

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

What the charts tells us:

- 62 day Treatment standard = The Trust performance was 64.3 % against a target of 85%.
- Number of patients waiting over 63 days did increase to 109 patients at the end of Septmber compared with 87 at the end of August.

Operational Performance – Referral to Treatment Performance / Activity / Productivity

We are driving this measure because:

Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks for English patients and 26 weeks for Welsh patients from when the referral is received by the Trust either booked through the NHS e-Referral Service, or when a referral letter received. Activity plans are measured against the Trusts agreed plans as part of the annual Business Planning process with commissioners

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

Outpatient Activity		Year To Date	Charts	Apr	May	Jun	Jul	Aug	Sep	Oct
New	2019/20	35722		5026	5283	4970	5476	4554	4995	5418
	Plan This Year	38354		4822	5044	6819	4948	4407	6923	5390
	This Year	39029		4859	5437	5870	5808	5364	5662	6029
	Diff vs 19/20	3307		-167	154	900	332	810	667	611
	Variance	9%		-3%	3%	18%	6%	18%	13%	11%
	Diff vs Plan	675		37	393	-949	860	957	-1261	639
	Variance	2%		1%	8%	-14%	17%	22%	-18%	12%
	Face To Face	33117		4170	4666	4975	4917	4582	4808	4999
	Telephone/Virtua	5912		689	771	895	891	782	854	1030
	Total New	39029		4859	5437	5870	5808	5364	5662	6029
Follow Up	2019/20	76690		10402	10891	10213	11275	10372	11097	12440
	Plan This Year	74344		9126	9401	13426	9819	8223	13708	10641
	This Year	81832		10329	11562	12525	11300	12080	11972	12064
	Diff vs 19/20	5142		-73	671	2312	25	1708	875	-376
	Variance	7%		-1%	6%	23%	0%	16%	8%	-3%
	Diff vs Plan	7488		1203	2161	-901	1481	3857	-1736	1423
	Variance	10%		13%	23%	-7%	15%	47%	-13%	13%

Admissions		Year To Date	Charts	Apr	May	Jun	Jul	Aug	Sep	Oct
Elective Inpatient	2019/20	1737		289	259	256	269	212	225	227
	Plan This Year	1593		191	198	292	214	187	287	224
	This Year	1523		186	234	245	214	210	203	231
	Diff vs 19/20	-214		-103	-25	-11	-55	-2	-22	4
	Variance	-12%		-36%	-10%	-4%	-20%	-1%	-10%	2%
	Diff vs Plan	-70		-5	36	-47	0	23	-84	7
	Variance	-4%		-3%	18%	-16%	0%	12%	-29%	3%
Elective Daycase	2019/20	11969		1537	1691	1652	1877	1629	1720	1863
	Plan This Year	11815		1437	1485	2175	1522	1332	2159	1704
	This Year	11368		1331	1566	1764	1656	1665	1690	1696
	Diff vs 19/20	-601		-206	-125	112	-221	36	-30	-167
	Variance	-5%		-13%	-7%	7%	-12%	2%	-2%	-9%
	Diff vs Plan	-447		-106	81	-411	134	333	-469	-8
	Variance	-4%		-7%	5%	-19%	9%	25%	-22%	0%

Performance and Actions

Activity Summary:

- New Outpatients [OP] activity was 12% above plan in October. Elective inpatient was 3% above plan in October. Elective Day Cases was less than 1% below plan in October.

The Trust has a number of specialties where there are risks in breaching the 65 week target including:

- Orthopaedic inpatient surgery
- Cardiology follow ups appointments
- Oral Surgery inpatient surgery
- Gynaecology patients both outpatients and inpatient surgery

Plans are in place to have a reasonable level of confidence that zero breaches can be achieved by March 31st 2024 although the Trust has reported a risk of 50 breaches in Orthopaedics and 20 in Gynaecology. However, plans continue to mitigate this risk.

An agreement has been reached through the ICB for the outsourcing of orthopaedic long waiters to an independent sector provider in north Gloucestershire and Gynaecology also have the back stop of a local provider if required. A significant reduction has been made in the number of long waiting new Gynaecology outpatients and the risk now lies in those requiring further diagnostics and procedures.

Theatre Productivity

- Theatre utilisation last month was consistent with the previous month (75.8% compared to 75.9% in September) The mean number of cases per session increased last month to 3.3, an improvement on September and also the 6 month mean of 3.1
- 7 of 14 specialities achieved an improvement in month including Orthopaedics increasing to 88% and Colorectal increased utilisation performance to above 85%.
- Surgeon level deep dives in General Surgery, Urology and Vascular has led to plans to increase the number of cases per list for at least 2 surgeons
- Despite industrial action pressures during October, the total number of patients treated rose from 688 in September to 711

Risks

- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff and risks around Industrial action.
- Continued high levels of referrals

What the chart tells us:

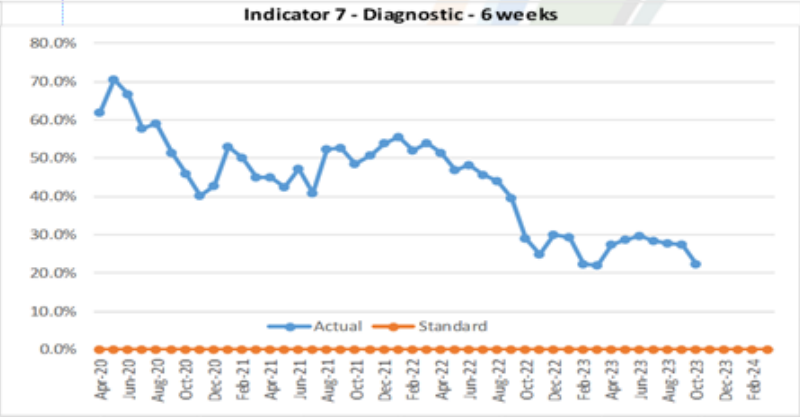
- Performance against English RTT standards in October was 58.6% - 0.9% increase since last month. Performance against the Welsh RTT standards in October was 66.2% - 1.3 % increase since last month
- Referral to Treatment Number of Patients over 104 weeks = 4 / over 78 weeks = 30 English on Incomplete Pathways Waiting List

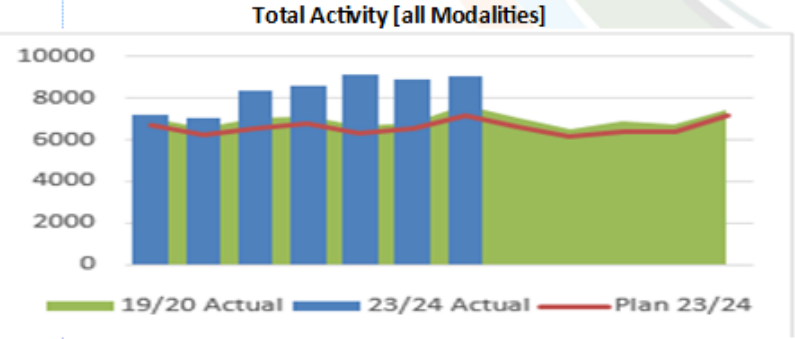
Operational Performance – Diagnostic Performance

We are driving this measure because:

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

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





Performance and Actions

Imaging:

- Magnetic Resonance Imaging [MRI] achieved 145% of 2019/20, 158% of 2023/24 plan activity last month.
- Computerized Tomography [CT] achieved 132% of 2019/20 and 130% of 2023/24 plan activity last month
- Non-Obstetric Ultrasound [NOUS] achieved 94% of 2019/20 and 109% of plan activity last month.
- Insourced radiographers supporting in-house scanners in both MRI and CT at weekends to deliver addition-al capacity
- Bone Density Scans [DEXA] waiting list is nearly within the 6 week wait target; only 15 patients >6 weeks in month 7, compared to 131 in month 1.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] on average were 3 and 4 days respectively compared with 4 and 5 days last month.
- Reporting turnaround times for MRI prostate and CTC were 2 and 5 days respectively compared with 2 and 5 days last month, while all cancer 2 week wait urgency reporting turnaround for MRI and CT achieved 1 and 2 day averages respectively in month 7

Echocardiography [Echos]:

- Delivered 190% activity above 2019/20 and 158% above 2022/23 planning levels in September with the waiting times of around 6 weeks for routine Echos. We are also looking to reduce our outsourcing for Echos as our wait to be seen is projected to reduce further with core capacity so is no longer required. The urgent patients still remain a priority and are usually seen within 3 weeks.

Endoscopy

- Delivered 102% of 2019/20 activity in September and 114%of 2023/24 activity.
- Endoscopy 13 week backlog now reduced to 3 patients without an appointment for their procedure but the backlog to be cleared by end of December
- Endoscopy 6-13 week backlog has decreased by 67% on September's position with 36 patients now undat-

Risks:

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

What the charts tells us:

- Diagnostic 6 weeks waits, overall, continue to recover from the impact Covid had on the overall waiting lists. Fluctuations in the recovery mirrors operational pressures with Covid through the various surges over the last two years.
- Reduction in the number of patients waiting over 6 weeks for a diagnostic test. 22.5% now waiting greater than 6 weeks.

Our Workforce – Executive Narrative

Geoffrey Etule

Chief People Officer

Summary of key points

As we approach winter we are seeing an increase in sickness absence largely due to short term sickness as is the case across the NHS. HR teams supported by OH and the wellbeing nurse will continue to sensitively support the management of sickness absence and the close monitoring and management of sickness absence will remain a key priority area for the HR team over the winter months. Our enhanced wellbeing provisions for staff with a dedicated staff physiotherapist and a mental health & wellbeing nurse located within the occupational health team will remain in place to offer support to staff. We are taking active steps to encourage employees to get vaccinated and monitoring of absence continues through F&PE meetings.

The BMA are seeking a new mandate for potential industrial action in 2024 and the outcome of their ballot for SAS drs and consultants will be released by Christmas. However, a new pay offer with some modernisation of the contract for consultants has been made by the government and it is anticipated that consultants will support the offer in order to end strike action. The Hospital Consultants & Specialist Association (HCSA) with 12 doctors employed at WVT have obtained a mandate for industrial action but no dates have been confirmed. Business continuity plans are in place in the event of more industrial action and we continue to maintain good relations with trade union representatives and senior clinical colleagues.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 10.6% in the past 4 years. Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 9.98% (Oct 23). Staff turnover for band 2 hcsw staff remains below 15% over the past 5 months from a previous high of 28.3% in 2022.

Active work continues to fill our vacancies through ongoing international recruitment and engagement with recruitment agencies. Over the past 2 years we have significantly reduced our substantive vacancies from 400 fte to 155 fte. 41 WVT ambassadors are supporting recruitment events for different staff groups across Herefordshire and the HR team are linking relevant line managers to DWP officers in order to run bespoke recruitment sessions to attract suitable local candidates.

We have implemented a Charter for our international staff and we are promoting the NHS Disability history month in November / December to show our support for colleagues with a disability. We are working with Group and ICS colleagues on implementing the 6 high impact actions in the NHS EDI Improvement Plan. We will be working with West Mercia Police on their race action plan over the coming year.

We have adopted the NHS Sexual Safety at Work Charter and we will have a new policy in place to raise staff awareness on this from January. Working with Group and ICS colleagues we will be rolling out active bystander awareness training to members of staff in 2024/25 to ensure employees have the confidence and support to call out any bad behaviour or conduct in the workplace.

In line with our WVT *grow our own staff* strategy, we have commenced the recruitment programme for 25 trainee nurse associates offering healthcare support workers the development opportunity through the University of Worcester programme so they can become qualified nurses in future. Our WVT leadership development programme continues to be highly rated and cohort 5 commenced in November.

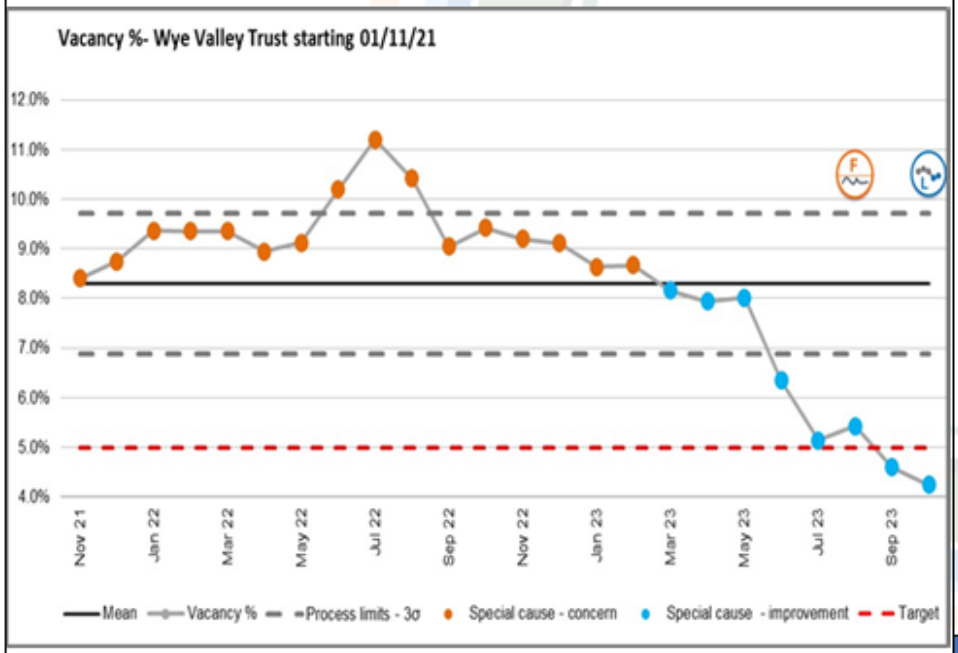
Our Workforce – Vacancy

We are driving this measure because:

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

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
9.4%	9.2%	9.1%	8.6%	8.7%	8.7%	7.9%	8.0%	6.3%	5.1%	5.4%	4.6%	4.2%

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



Performance and Actions

Through concerted efforts by HR and divisional managers we continue to see a significant reduction in our vacancies from a high of 400fte (2021) to 155 fte (Oct 23).

HCSW – . the WVT pay and career progression framework for band 2 /3 staff continues to have a positive impact on recruitment & retention and we have been able to maintain less than 20fte vacancies over the past 6 months.

N&M - we currently have 25fte vacancies which is the lowest level over the past 4 years. Since April, 77 new international nurses have joined WVT and we are on track with our international recruitment plan. Retention rates of international nurses remains excellent at 95% of those recruited since 2018 with some progressing into senior roles.

Surgical Elective Hub – We continue to work with the surgical division on the work force required for the elective hub. Currently we have recruited and welcomed 2 ODPs and 11 theatre nurses for scrub/recovery plus 3 ophthalmology nurses for 2023/24.

M&D - Fortnightly meetings with chief medical officer, medical staffing manager & strategic medical HR Lead to review progress with vacancies and cases of concern .Overseas recruitment of medics to continue throughout 2023/24. We currently have 46wte vacancies.

Pharmacy - with ongoing recruitment challenges we are now seeking international candidates and taking a number of steps including advertising all jobs as open to flexible working, extending relocation packages, highlighting opportunities for personal and career development.

Community Diagnostic Centre programme - the CDC programme for recruiting international radiographers is well under way, we have offered 10 posts for radiographers with arrivals planned for December and early January 2024. There are still 2 echo cardiologists to recruit and 2 consultant radiologists.

We are extending our recruitment events in 2024 and we will be promoting our vacancies Herefordshire wide with a series of events using WVT Ambassadors. We are also extending WVT presence at regional and national fairs to promote our job opportunities

Risks: Clinical 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 at the beginning of the financial year.

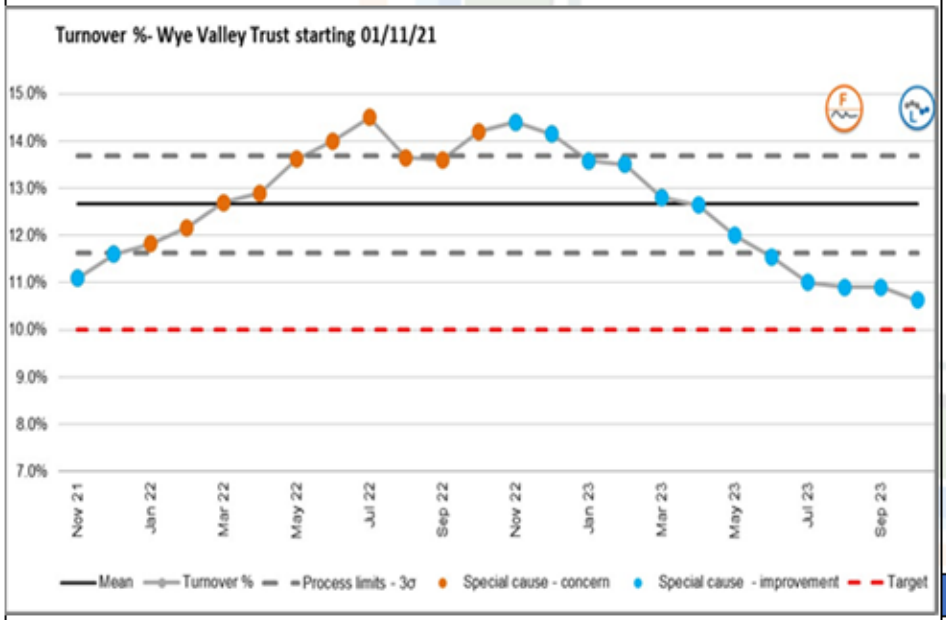
Our Workforce – Turnover

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.

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
14.2%	14.4%	14.2%	13.6%	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%	10.9%	10.9%	10.6%

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



Performance and Actions

The overall rolling 12 month turnover at Trust level is now at 10.6% for November 2022 to October 2023 which is the lowest level in the past 4 years.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 10.6% in the past 4 years.

Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 9.98% (Oct 23). Staff turnover for band 2 hcsw staff remains below 15% over the past 5 months from a previous high of 28.3% in 2022.

Recruitment into the 25 trainee nurse associate positions to commence in March 2024 through the University of Worcester is underway. This is part of our grow our own staff strategy as it offers support workers the opportunity to become fully qualified nurses in future and will enhance recruitment & retention of nursing staff at the trust over the coming years.

To aid recruitment & retention, we are promoting apprenticeships to clinical and non clinical staff. We currently have 147 apprenticeships in different departments including wards areas, finance, hr, pharmacy and podiatry.

Divisional recruitment & retention working groups are in place to analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group oversees the work of divisional groups with a focus on exit interview surveys and recruitment & retention areas of concern. This ensures actions are being progressed in a timely manner to aid recruitment & retention of staff across the trust.

Risks: Agency costs

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 in the last 9 months, which has now plateaued in the last 3 to 4 months.

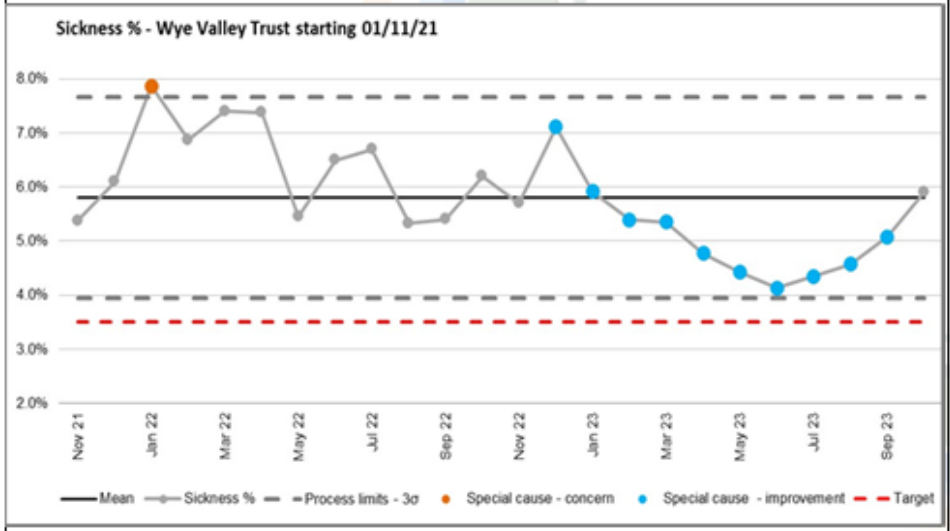
Our Workforce – Sickness

We are driving this measure because:

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.

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
6.2%	5.7%	7.1%	5.9%	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%	4.6%	5.1%	5.9%

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



Performance and Actions

Sickness absence has increased NHS wide mainly due to winter ailments and during this month, overall sickness at Trust level has increased to 5.9% with a rolling 12 month average sickness of 5.2%.

The main reasons for absence are colds/winter ailments, gastrointestinal problems, mental health issues and long term conditions.

At F&PE meetings, divisions are required to report on 6 high impact actions and to present comprehensive data on actions being taken to manage and reduce sickness absence. This includes heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

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

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

Risks:

What the chart tells us:

The rolling 12 month position shows a fluctuating picture between May 2021 and December 2022, this is mainly due to the Covid related absences, as well as other winter pressures such as Flu.

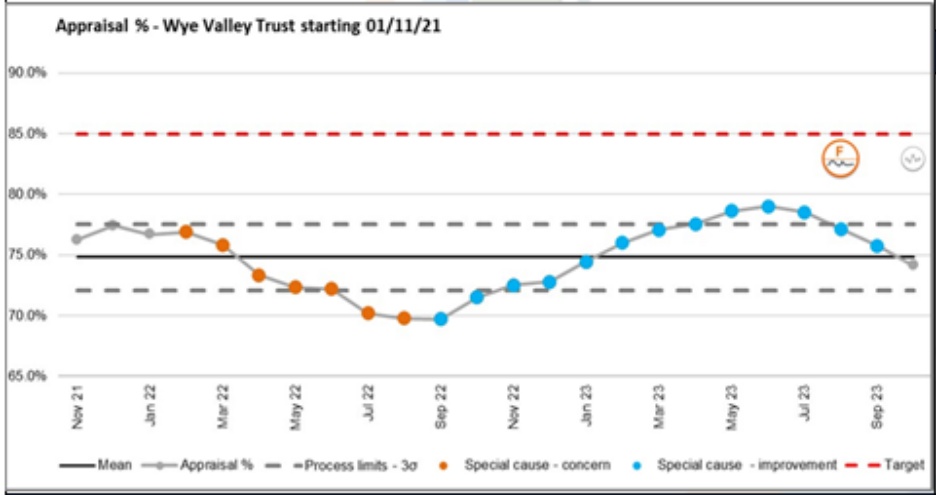
Our Workforce – Appraisal

We are driving this measure because:

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

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
71.5%	72.5%	72.8%	74.5%	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%	77.1%	75.7%	74.1%

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



Performance and Actions

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

Risks:

What the chart tells us:

The rolling 12 month position shows a fluctuating low picture across the period between May 2021 and September 2022. This is primarily due to significant operational pressures.

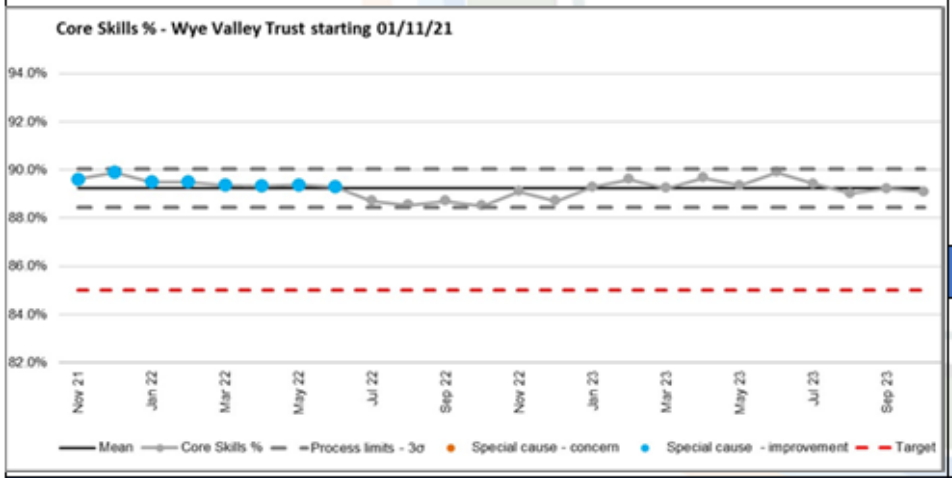
Our Workforce – Core Skills

We are driving this measure because:

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

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

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

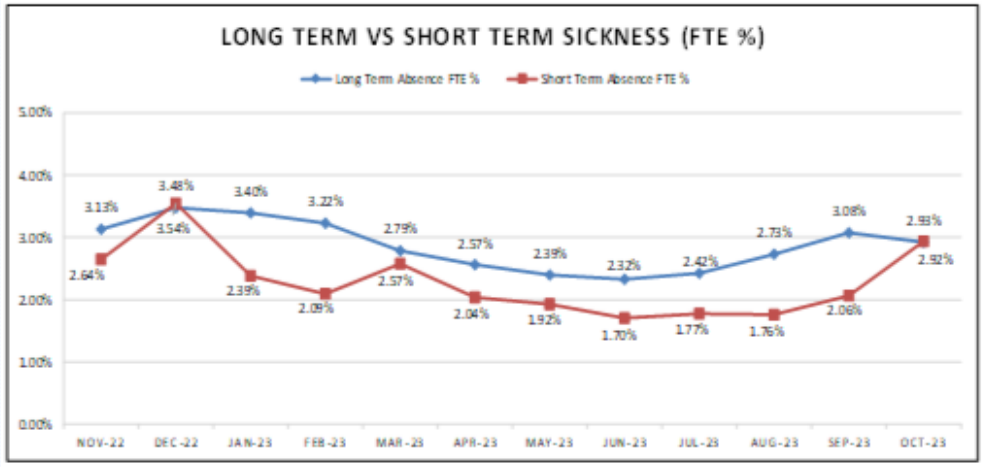
The Trust continues to make good progress in this area. This will continue to be reviewed at F&PE meetings

Risks:

What the chart tells us:

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

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



Main reason form absence - Top 5	
Cold, Cough, Flu - Influenza	34.33%
Gastrointestinal problems	15.34%
Anxiety/stress/depression/other psychiatric illnesses	10.99%
Headache / migraine	5.34%
Genitourinary & gynaecological disorders	4.85%

Chart below shows a reduction in turnover for healthcare support workers <15%

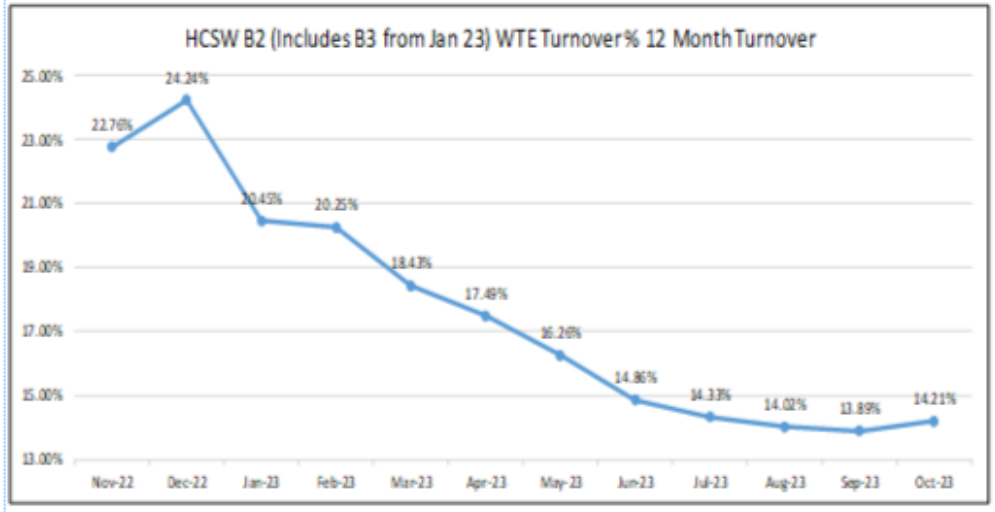
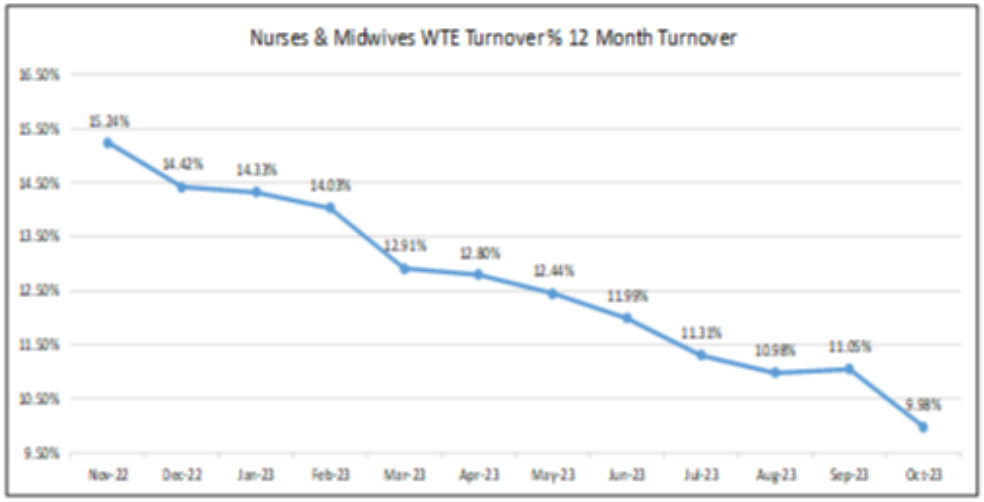


Chart below shows a reduction in turnover for N&M which is now < 10%



Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Income & Expenditure Performance

The financial position at the end of month 7 (October) was a deficit of £17.6m which is £2.0m adverse to the planned deficit at this point in the year. As previously reported, known financial risks are putting greater pressure on delivery of our financial plan. A mid year review was undertaken during October, subsequently feeding into a national forecast review during November; a separate paper is presented to Board this month.

Sustained focus on elective recovery is evidenced through a positive value weighted activity metric, and performance on variable elective income has continued to improve this month. A level of activity continues to be delivered through premium cost capacity such as outsourcing which delivers a lower margin. Delivery of our productivity work streams including theatres and outpatients will support financial improvement. Though reliance on premium cost agency workforce has significantly reduced compared to the prior year, usage remains high linked to acuity, vacancies and impact of industrial action; our controls remain in place. We continue to see the impact of inflationary pressure on our non pay spend, above the levels we had assumed within the plan. Efficiency delivery is behind plan at this point in the year; significant operational focus and cross divisional working continues to mitigate the shortfall.

The wider Herefordshire and Worcestershire Integrated Care System (ICS) position to the end of month 7 is adverse to plan, reflective of the level of challenge within the plans, premium capacity utilisation and inflationary pressures such as on medicines.

Capital

The capital programme for 2023/24 includes high value projects to deliver the new Elective Surgical Hub (ESH), a Community Diagnostics Centre (CDC) and the Integrated Energy scheme phase 2 (IES). Local capital funding has been identified to meet equipment, digital and backlog maintenance requirements and schemes are now progressing to delivery. Spend in the first seven months of the year totals £11.7m. The forecast for the year has reduced to reflect the timing of expenditure on CDC and IES across financial years. There remains uncertainty over access to national capital funding for the Frontline Digitisation programme, linked to optimisation of our Electronic Patient Record. The System is actively engaged with NHS England to seek resolution.

Cash

The cash balance at the end of October remained below plan at £15.1m, though slightly improved on the prior month as a result of the management actions in place. Our prompt payment metric remains strong though is anticipated to deteriorate over the coming months as the cash position becomes more challenging. An application for revenue support in December was made in line with previous Board approvals.

A further request for revenue support during quarter 4 will be made at the beginning of December. Though in line with previous Board approvals, **Board are asked to endorse the submission of revenue support requests for the remainder of the financial year.**

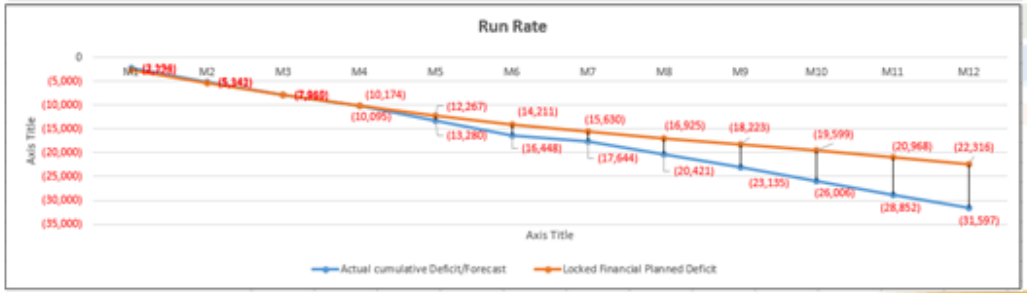
Our Finance – Year to Date Income and Expenditure

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 7 - 31st October 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	285,554	164,933	165,191	258	173
Excluded Drugs	11,954	6,973	7,630	657	150
Non Contracted Activity (NCA's)	1,635	954	979	25	(2)
Other Income for Patient Care	10,733	6,296	6,399	103	176
Donations For Non Current Assets	20,500	9,276	2,047	(7,229)	(1,622)
Other Non Patient Income	7,497	4,446	4,565	120	47
COVID Funding	332	161	58	(103)	(19)
NHSE - central (22/23 pay award)				0	0
Total Operating Income	**338,205**	**193,039**	**186,870**	**(6,169)**	**(1,098)**
Pay Expenditure	207,565	121,390	121,901	(511)	520
Non Pay Expenditure	87,801	52,163	53,966	(1,802)	(680)
Excluded Drugs	22,394	13,057	13,801	(743)	(125)
Total Operating Expenditure	**317,760**	**186,611**	**189,668**	**(3,057)**	**(285)**
EBITDA	**20,445**	**6,428**	**(2,798)**	**(9,226)**	**(1,383)**
Depreciation	13,637	7,964	8,049	(85)	(26)
Gain or loss on asset disposal	0	0	0	0	0
Interest Receivable	1,018	810	810	0	(0)
Interest Payable on Loans	265	155	127	27	4
Interest Payable on PFI	6,377	3,720	3,720	(0)	(0)
Dividends on PDC	3,868	2,256	2,256	0	0
Operating Surplus/ (Deficit)	**(2,682)**	**(6,858)**	**(16,141)**	**(9,282)**	**(1,405)**
Technical Adjustments					
Donated Assets - Additions	20,500	9,276	2,047	(7,229)	(1,622)
Donated Asset Depreciation	(864)	(504)	(544)	39	5
Donated Assets Adjustment	**19,636**	**8,772**	**1,503**	**(7,268)**	**(1,627)**
Adj. financial performance retained Surplus/ (Deficit)	(22,316)	(15,630)	(17,644)	(2,014)	222



Performance and Actions

The position at the end of month 7 (October) was a deficit of £17.6m. This was behind the current plan with an overall adverse variance of £2.0m year to date.

- Pay is overspending overall with high use of temporary staffing, and increased costs due to Industrial action, offset by some slippage on recruitment linked to capacity and unfilled vacancies. This net position includes agency — 7.0% of total pay costs in October which has increased. Medical bank use at premium rates further increases this to 10.9% 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, plus the impact of industrial action.
- The Trust has set an annual cost improvement (efficiency) target of £15.7m (of which £2.5m is a further stretch target). Delivery is currently behind plan and mitigations are being identified.

Risks:

Key Financial risks

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

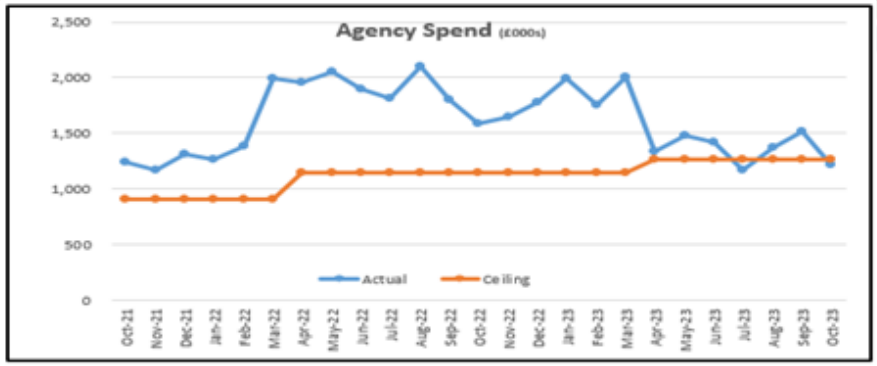
What the chart tells us:

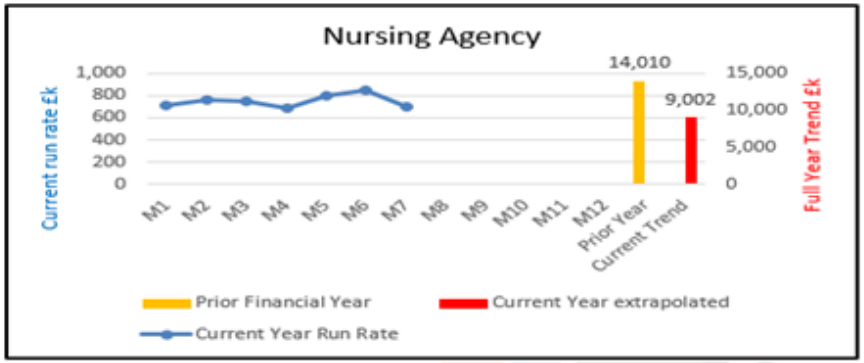
Known financial risks are starting to put greater pressure on delivery of our planned financial position. A mid year review / national exercise has taken place.

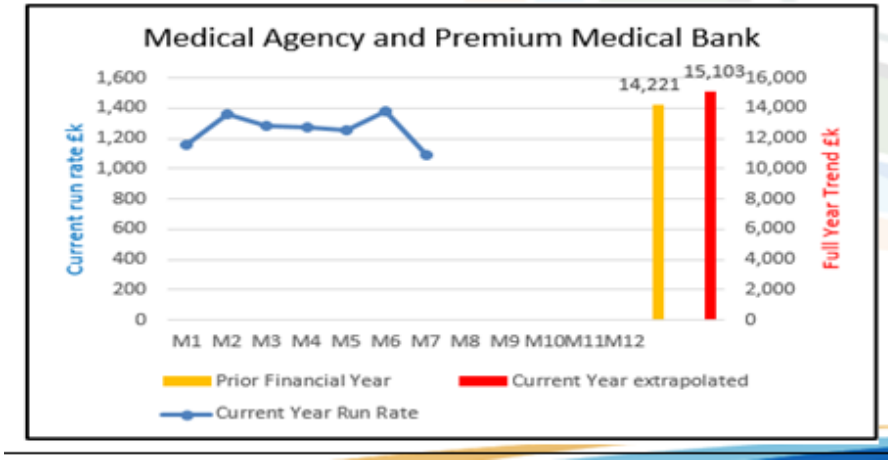
Our Finance – Agency Spend

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 7.0% 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 £9.5m. 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 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 £9.0m 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. Medical agency and bank run rates have fluctuated in year though remain higher than planned. The Trust spent £14.2m in the prior year (22-23) and the extrapolated run rate (£15.1m) would not deliver the target spend for the year. Targeted MARP schemes including enhanced controls are delivering financial improvement, though new workforce gaps, the impact of industrial action and demand / acuity pressures are eroding the benefit of this. MARP has increased the focus on medical bank requirements and the approvals process.

Risks:

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

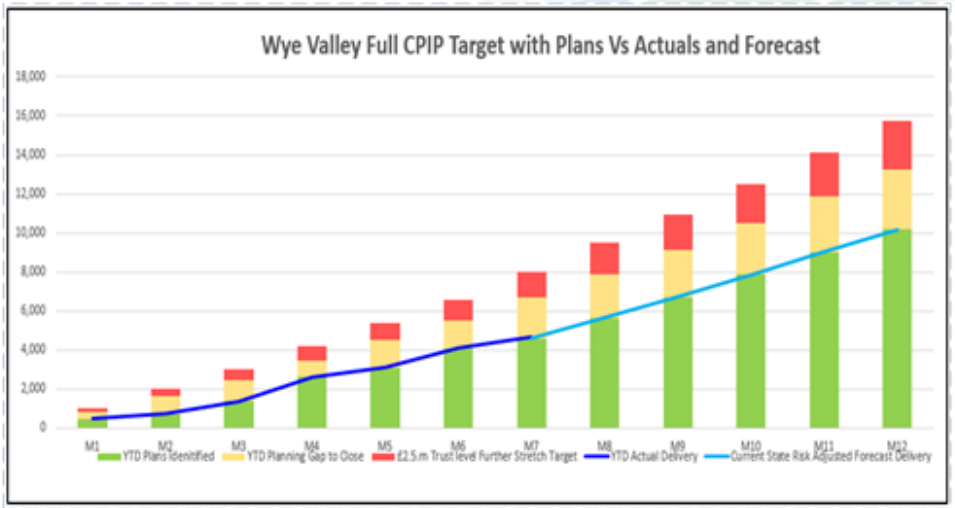
What the chart tells us:

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

Our Finance – Cost Improvement Programme

We are driving this measure because:

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



Performance and Actions

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

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

From month 6, there are no longer sufficient non recurrent mitigations to fully address the shortfall as known financial risks put greater pressure on delivery of our planned financial position.

A mid year financial review took place during October; in respect of CPIP with a focus on risk assessing delivery of existing plans and identifying potential mitigations to close the gap. Focus continues through the F&PE meetings, TMB and a refreshed monthly CPIP meeting to maximise delivery in year, albeit recognising an increased proportion will be non recurrently delivered.

Risks:

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

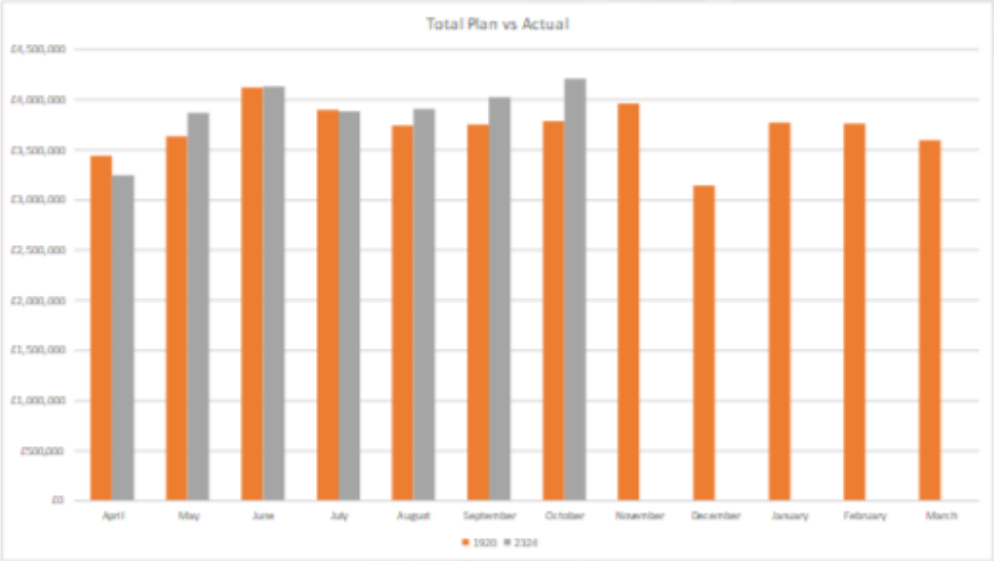
What the chart tells us:

There remains a shortfall in plans to deliver the planned level of CPIP, and delivery has been impacted by a range of factors. Focus is on converting opportunities into deliverable schemes, wherever possible recurrent schemes to support run rates into 2024/25.

Our Finance – Productivity Improvement

We are driving this measure because:

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



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

Performance and Actions

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

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

Using our financial assessment at the end of October we have reflected a small over performance of £17k. This reflects H&W ICB performance of 103.4% YTD (local assessment as national data reported in arrears), under performance across Shropshire and Gloucestershire contracts based on referral patterns, and over performance on NHSE specialised commissioning.

Nationally we anticipate further revisions to recognise the impact of industrial action but at the time of reporting month 7 this has yet to be confirmed and there also remains a risk of clawback where we do not achieve the planned levels.

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

Risks:

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

What the chart tells us:

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

Our Finance – Capital and Cash

We are driving this measure because:

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

Scheme Type	Interim Annual Plan £k	Full year Forecast £k	YTD Plan £k	YTD Actual £k	YTD Variance £k
Digital Total	1,250	1,381	566	190	376
Equipment Total	1,593	1,306	717	702	15
Estates Total	1,630	1,786	736	(357)	1,093
Total Core Operating (ICS) Capital	**4,473**	**4,473**	**2,019**	**535**	**1,484**
ESH	12,602	12,829	5,670	4,201	1,469
CDC	10,296	6,131	2,760	268	2,492
Frontline Digitalisation PDC Total	3,300	1,571	1,482	240	1,242
Total National Programme Funding Bids	**26,198**	**20,531**	**9,912**	**4,709**	**5,203**
Donated Assets/Grant IES	19,840	11,574	8,259	6,480	1,779
Grand Total	**50,511**	**36,578**	**20,190**	**11,724**	**8,466**

Cash Balance

Month	Performance	Target	Direction	Rating
August	13.7	19.9		
September	10.6	19.1		
October	15.1	19.4		

The cash balance at the end of October increased compared to previous month. This reflects an increase in accounts payable as we take action to maintain cash balances. Revenue PDC funding for the third quarter has been applied and an application is being worked up for quarter 3. Phasing of contract payments from the ICB continues to assist with payment of the quarterly PFI unitary charge.

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
August	98.8%	95.0%		
September	95.9%	95.0%		
October	98.4%	95.0%		

In October's, the Trust paid 98.4% of invoices within 30 days (99.7%. by invoice value). An increase from previous month as we continue to exceed the target for the seventh month in succession. Action taken to maintain cash balances is likely to impact performance in future months.

Performance and Actions

Capital: The overall capital expenditure at Month 7 is £11.7m which represents 32% of the total forecast. The forecast outturn position is now £13.9m lower than the original annual plan. The revised capital forecast reflects changes to nationally/ grant funded programmes. CDC and IES are now projected to spend less than planned in 2023/24 and some national digital bids in the initial plan have not been successful and have therefore been removed from the forecast.

The Year to date position in relation to Estates schemes has been affected by technical adjustments in month, however plans remain in place to fully utilise the annual budget.

Cash: The cash balance at the end of October increased compared to previous month. This reflects an increase in accounts payable as we take action to maintain cash balances. £9.89m of revenue PDC funding for the third quarter has been requested and a further application for quarter 4 is underway. Phasing of contract payments from the ICB continues 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 forecast, 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.

October 2023	2022/23	2023/24				2023/24 Full Year		
	Accounts £000s	M7 Plan £000s	M7 YTD £000s	Variance £000s	YTD Change £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:								
Property, Plant and Equipment	125,505	136,380	133,573	2,807	8,068	164,723	164,723	0
Intangible Assets	18,462	15,049	15,272	(223)	(3,190)	16,233	16,233	0
Trade and Other Receivables	573	817	573	244	0	817	817	0
TOTAL Non Current Assets	144,540	152,246	149,418	2,828	4,878	181,773	181,773	0
CURRENT ASSETS:								
Inventories	5,316	4,780	5,382	(602)	66	4,780	4,780	0
Trade and Other Receivables	21,085	13,709	17,074	(3,365)	(4,011)	13,712	13,712	0
Cash and Cash Equivalents	34,969	23,603	15,147	8,456	(19,822)	21,652	34,738	13,086
TOTAL Current Assets	61,370	42,092	37,603	4,489	(23,767)	40,144	53,230	13,086
TOTAL ASSETS	205,910	194,338	187,021	7,317	(18,889)	221,917	235,003	13,086
CURRENT LIABILITIES								
Trade and other payables	(45,361)	(26,670)	(39,615)	12,945	5,746	(27,659)	(39,019)	(11,360)
Borrowings - Loans, PFI and Finance Leases	(5,779)	(6,198)	(6,142)	(56)	(363)	(6,516)	(6,516)	0
Provisions	(55)	(46)	(46)	0	9	(46)	(46)	0
Total Current Liabilities	(51,195)	(32,914)	(45,803)	12,889	5,392	(34,221)	(45,581)	(11,360)
NET CURRENT ASSETS/(LIABILITIES)	10,175	9,178	(8,200)	17,378	(18,375)	5,923	7,649	1,726
TOTAL ASSETS LESS CURRENT LIABILITIES	154,715	161,424	141,218	20,206	(13,497)	187,696	189,422	1,726
NON-CURRENT LIABILITIES:								
Borrowings - Loans, PFI and Finance Leases	(31,138)	(28,527)	(27,524)	(1,003)	3,614	(26,415)	(26,415)	0
Provisions	(1,686)	(1,579)	(1,668)	89	18	(1,579)	(1,579)	0
Total Non-Current Liabilities	(32,824)	(30,106)	(29,192)	(914)	3,632	(27,994)	(27,994)	0
ASSETS LESS LIABILITIES	121,891	131,318	112,026	19,292	(9,865)	159,702	161,428	1,726
TAXPAYERS EQUITY								
Public dividend capital	270,216	289,314	275,280	14,034	5,064	313,521	315,248	1,727
Revaluation reserve	21,051	30,874	22,258	8,616	1,207	30,874	30,874	0
Income and expenditure reserve	(169,376)	(188,870)	(185,512)	(3,358)	(16,136)	(184,693)	(184,694)	(1)
TOTAL	121,891	131,318	112,026	19,292	(9,865)	159,702	161,428	1,726

Performance and Actions

General

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

Non-Current Assets

Non-Current assets remained largely static as capital expenditure has been approximately matched by depreciation and amortisation.

Current Assets

Accounts Receivable decreased by £0.8m compared to the previous month. Cash held increased by £4.5m in the month as a result of reduced debtors and increased creditors.

Current Liabilities

Current liabilities have increased by £3.6m compared to last month largely due to accounts receivable and deferred income.

Non-Current Liabilities

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

Taxpayers Equity

The income and expenditure reserve reflects the deficit for the year 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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 75.0%	Variable	Improvement - High		68.1%	71.3%	68.8%	67.9%	67.8%	69.0%	69.8%	66.9%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		88.8%	88.0%	81.9%	84.5%	86.2%	83.5%	86.3%	78.7%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		39.3%	63.6%	50.0%	14.8%	18.2%	47.8%	71.1%	53.8%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Common Cause	Yes	89.6%	91.1%	88.5%	74.5%	83.3%	86.7%	92.4%	87.4%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause	Yes	13	12	9	13	11	11	6	10	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Fail	Concern - Low		60.7%	54.5%	48.1%	50.4%	61.4%	69.1%	69.8%	64.3%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		0.0%	0.0%	0.0%	100.0%					
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause	Yes	74.2%	71.0%	70.4%	57.1%	75.0%	81.5%	80.8%	70.8%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Common Cause		115	89	117	112	108	72	87	109	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		102.7%	100.4%	94.1%	104.6%	103.2%	106.1%	114.0%	101.5%	114.2%
	Urgent Response > 1st Assessment completed on same day (facilitated discharge &	Primary care and community	80.0%	Pass	Concern - Low	Yes	100.0%	98.2%	96.7%	100.0%	96.4%				
	Urgent Response > 1st Assessment completed within 2 hours (admission	Primary care and community	70.0%	Variable	Common Cause		91.7%	83.3%	91.5%	76.5%	85.5%				
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Common Cause		89.2%	89.2%	90.2%	89.7%	90.8%	89.9%	90.1%	91.0%	90.8%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		96.8%	107.7%	98.9%	100.7%	98.0%	98.4%	101.8%	101.8%	104.6%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause		81.0%	82.9%	75.1%	76.2%	81.7%	81.4%	83.1%	76.9%	80.7%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Common Cause	Yes	6.6%	5.2%	9.0%	9.0%	4.6%	6.4%	3.7%	9.9%	6.6%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		112.8%	117.3%	117.7%	110.1%	108.1%	111.1%	112.5%	118.9%	119.6%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		41.1%	40.2%	40.0%	39.0%	41.0%	40.0%	42.0%	44.0%	45.0%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Concern - Low		55.1%	55.2%	59.9%	57.8%	59.3%	56.5%	56.2%	54.0%	57.2%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High	Yes	18.4%	16.2%	9.7%	14.8%	13.8%	14.0%	17.3%	15.9%	14.3%
	A&E - Time to treatment	Urgent and emergency care			Common Cause		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care			Improvement - Low	Yes	2.8%	3.1%	2.8%	2.5%	2.3%	2.3%	1.7%	1.9%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		308	263	107	225	259	178	213	181	213
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause	Yes	7.6%	8.2%	8.6%	7.9%	7.8%	7.8%	8.5%		

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>=	92.0%	Fail	Concern - Low		59.0%	58.3%	56.7%	59.3%	59.4%	57.2%	57.7%	57.7%	58.6%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>=	95.0%	Fail	Concern - Low		67.5%	67.3%	64.7%	65.1%	67.1%	68.0%	65.5%	64.9%	66.2%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care				Improvement - High		25301	25957	26503	26797	26710	26882	27963	27857	27260
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Concern - High		1391	1453	1552	1718	1688	1804	1853	1959	1981
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Improvement - Low		58	6	27	23	18	36	30	34	33
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<=	0	Fail	Improvement - Low		0	0	1	1	1	2	1	1	4
	GP Referrals	Elective care				Improvement - High	Yes	110.5%	168.1%	95.0%	100.8%	119.7%	100.0%	116.0%	118.0%	108.0%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care				Improvement - High		99.2%	116.2%	96.7%	102.9%	118.1%	106.0%	117.9%	113.0%	111.0%
	Outpatient Activity - New attendances (volume v plan)	Elective care				Improvement - High	Yes	92.7%	94.9%	100.8%	107.8%	86.1%	117.4%	121.8%	81.9%	112.0%
	Total Outpatient Activity (% v 2019/20)	Elective care				Improvement - High		102.2%	114.3%	98.4%	105.1%	121.2%	102.2%	116.9%	110.0%	101.0%
	Total Outpatient Activity (volume v plan)	Elective care				Improvement - High	Yes	104.6%	100.0%	108.9%	117.7%	90.9%	115.9%	138.2%	85.3%	113.0%
	Total Elective Activity (% v 2019/20)	Elective care				Common Cause	Yes	98.6%	103.9%	78.6%	97.0%	104.9%	89.0%	106.5%	100.0%	95.0%
	Total Elective Activity (volume v plan)	Elective care				Improvement - High	Yes	91.3%	88.1%	84.4%	97.0%	79.5%	111.2%	127.6%	80.0%	104.0%
	BADS Daycase rates	Elective care				Common Cause	Yes	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%	75.9%	75.9%	75.8%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care				Common Cause		16	16	9	22	24	30	36	30	13
	Diagnostic Activity - Computerised Tomography	Elective care				Improvement - High		137.9%	107.6%	137.8%	120.5%	139.9%	144.9%	143.7%	142.8%	130.0%
	Diagnostic Activity - Endoscopy	Elective care				Common Cause	Yes	131.4%	122.7%	50.2%	126.4%	79.4%	76.9%	93.4%	83.2%	86.0%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care				Improvement - High		142.2%	116.5%	165.8%	158.3%	171.3%	161.5%	204.4%	185.4%	158.0%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care				Improvement - Low		22.2%	22.0%	27.6%	28.9%	29.8%	28.4%	27.7%	27.6%	22.5%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care		90.0%	Variable	Improvement - High		96.3%	98.6%	96.7%	94.6%	94.0%	93.1%	93.6%	95.4%	96.2%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<=	15.0%	Variable	Concern - High		15.2%	16.2%	14.0%	19.3%	21.3%	20.9%	17.1%	23.9%	23.3%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<=	34.0%	Fail	Concern - High	Yes	60.9%	60.0%	58.8%	58.2%	57.0%	55.5%	60.0%	61.7%	63.6%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<=	60.0%	Fail	Concern - High		88.4%	86.6%	87.3%	87.5%	89.6%	91.5%	91.8%	93.4%	92.5%
	Maternity Activity (Deliveries)	Elective care				Common Cause	Yes	99.1%	117.1%	110.6%	108.8%	98.5%	91.3%	106.6%	98.5%	92.7%

Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<=	40.0%	Pass	Common Cause		6.5%	5.8%	5.8%	6.2%	6.1%	5.9%	6.0%	6.5%	6.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>=	90.0%	Fail	Common Cause	Yes	79.3%	78.4%	80.6%	82.7%	86.7%	85.5%	84.1%	85.1%	81.9%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation				Common Cause	Yes	103.4%	113.6%	99.3%	106.2%	122.7%	100.3%	116.0%	107.5%	97.0%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation				Improvement - High	Yes	110.0%	102.4%	113.2%	123.1%	93.3%	115.2%	147.0%	87.0%	113.0%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<=	25.0%	Fail	Improvement - Low		24.9%	22.6%	24.6%	23.4%	23.4%	23.4%	21.0%	21.8%	21.6%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term				Common Cause		12.4%	7.3%	13.6%	17.4%	10.0%	9.5%	11.6%	13.7%	8.6%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		102.5%	97.1%	95.0%	97.0%	97.8%	96.7%	95.5%	99.3%	99.6%
	Bed occupancy - Community Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		96.2%	95.0%	93.6%	95.4%	96.3%	94.4%	97.4%	96.1%	96.6%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<=	0	Variable	Improvement - Low		233	150	173	181	110	75	109	52	81
	Patient ward moves emergency admissions (acute)	Safe, high quality care				Common Cause		8.6%	7.3%	9.1%	7.5%	7.4%	7.3%	10.5%		
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<=	5	Variable	Common Cause	Yes	4	4	4	4	4	4	4	4	4
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<=	3	Variable	Common Cause		2	2	3	3	3	2	3	2	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%	22.2%	24.8%	26.0%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Concern - Low	Yes	57.9%	61.1%	60.4%	58.7%	58.9%	57.9%	45.4%	54.3%	43.6%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Common Cause		9.1%	6.3%	10.1%	10.9%	9.3%	10.8%	10.3%		
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Variable	Concern - High		109	110	110	111	114	115			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		102	102	102	101					
	Never Events	Safe, high quality care		0	Variable	Common Cause	Yes	0	1	0	1	0	0	0	0	0
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Concern - Low		0	0	0	0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care				Improvement - High	Yes	0	0	1	1	1	2	0	1	4
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care		44	Fail	Common Cause		3	5	5	6	6	1	0	2	3
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause	Yes	3	5	4	4	4	3	5	1	0
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<=	0	Variable	Common Cause	Yes	5	3	2	1	3	2	2	1	
	Serious Incidents	Safe, high quality care				Common Cause	Yes	30	16	6	8	6	7	6	5	
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		90.6%	90.4%	89.6%	90.8%	90.9%	90.5%	90.7%	87.9%	87.4%

Safe, high quality care	WHO Checklist	Safe, high quality care	>=	100.0%	Variable	Common Cause	Yes		99.5%			99.8%			99.4%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>=	60.0%	Variable	Common Cause	Yes	60.7%	48.8%	68.8%	88.6%	87.0%	68.8%	43.8%	44.7%	62.9%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>=	90.0%	Variable	Common Cause	Yes	33.3%	75.0%	57.1%	40.0%	0.0%	100.0%	60.0%	33.3%	100.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		82.9%	88.1%	86.7%	80.4%	88.9%	77.1%	78.6%	66.7%	83.3%
	Number of complaints	Safe, high quality care				Common Cause	Yes	18	25	20	22	42	34	22	27	35
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Improvement - Low		0	0	0	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Fail	Common Cause		26.7%	71.4%	54.5%	50.0%	33.3%	45.2%	36.4%	38.9%	24.1%
	Friends and Family Test - Response Rate (Community)	Safe, high quality care	>=	30.0%	Variable	Concern - Low		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			0.0%	76.3%	76.0%	79.6%	72.9%	73.0%	68.2%	71.8%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low		82.2%	85.0%	90.0%	89.1%	87.4%	86.2%	81.0%	86.8%	85.0%
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	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	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	94.0%	96.3%	92.9%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Improvement - High			0.0%	21.0%	21.0%	20.5%	17.0%	20.0%	19.0%	20.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High		20.2%	21.0%	19.0%	20.4%	19.0%	17.0%	15.0%	16.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause	Yes	0.0%		0.0%	0.0%	1.5%	46.0%	26.0%	22.0%	19.0%

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Common Cause		10.5%	6.9%	8.1%	8.4%	8.4%	6.8%	7.5%	8.4%	7.0%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%	77.1%	75.7%	74.1%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.6%	89.2%	89.7%	89.3%	89.9%	89.4%	89.0%	89.2%	89.1%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause	Yes	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%	4.6%	5.1%	5.9%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Fail	Common Cause	Yes	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%	10.9%	10.9%	10.6%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low	Yes	8.7%	8.2%	7.9%	8.0%	6.3%	5.1%	5.4%	4.6%	4.2%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Finance	I&E - Surplus/(Deficit) (£k)	Finance			Concern - High	Yes	(£517k)	(£355k)	(£2571k)	(£2571k)	(£2769k)	(£2184k)	(£3182k)	(£3173k)	(£1198k)
	I&E - Margin (%)	Finance			Concern - High	Yes	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance			Concern - High	Yes	£13k	£201k	£157k	£43k	(£146k)	£25k	(£1089k)	(£1229k)	£221k
	I&E - Variance from Plan (%)	Finance			Common Cause		(£0k)	(£0k)	£0k	£0k	(£0k)	£0k	(£0k)	(£0k)	£0k
	CPIP - Variance from plan (£k)	Finance			Improvement - Low	Yes	(£666k)	(£869k)	(£614k)	(£635k)	(£340k)	(£816k)	(£1069k)	(£878k)	(£1056k)
	Agency - expenditure (£k)	Finance			Improvement - Low		£1744k	£2017k	£1505k	£1505k	£1323k	£1119k	£1435k	£1410k	£1338k
	Agency - expenditure as % of total pay	Finance			Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance			Improvement - Low		£14k	(£107k)	(£57k)	(£57k)	(£114k)	(£287k)	(£227k)	(£111k)	(£409k)
	Cash - Balance at end of month (£m)	Finance			Common Cause		£22k	£35k	£19k	£19k	£25k	£21k	£14k	£11k	£15k
	BPPC - Invoices paid <30 days (% value £k)	Finance			Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance			Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	In Year Operational Plan Review
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Finance Officer**
Author:	Katie Osmond, CFO and Andrew Parker, COO
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

On 8th November NHSE published a letter to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

This report summarises the implications for the Trust, and sets out a revised financial and operational performance projection for 2023/24 for consideration and endorsement by the Board.

The Trust position forms part of the Herefordshire and Worcestershire Integrated Care System position.

2. Recommendation(s)

Due to the nationally prescribed deadline, Board were asked in line with standing order SO37[2] to endorse this report, noting the risks and assumptions made for the two-week exercise, across operational performance metrics and the financial forecast. This was completed on 21st November and is reported to the December Public Trust Board meeting for ratification.

3. Executive Director Opinion[1]

As part of the two-week national exercise we have reviewed operational and financial projections and are satisfied that the position presented in this report, and for submission nationally reflects the most likely scenario across operational performance and finance. There remains a significant degree of risk within the period, which will need ongoing mitigation.

[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.

[2] SO37: "The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive Officer and the Chair acting jointly and, if possible, after having consulted with at least two Non-executive directors. The exercise of such powers by the Chief Executive Officer and the Chair shall be reported to the next formal meeting of the Trust Board for ratification".

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***

Background

On 8th November NHSE published a letter (appendix A) from Julian Kelly (Chief Financial Officer NHS England), Dame Emily Lawson DBE (Interim Chief Operating Officer NHS England), Professor Sir Stephen Powis (National Medical Director NHS England), and Dame Ruth May (Chief Nursing Officer, England) to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

The letter set out that as a result of the financial and performance pressures, for the remainder of the financial year our agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

Recognising that ambitious plans were set on the basis there would not be significant ongoing industrial action, it acknowledges a level of unavoidable costs and loss of elective activity. Nationally, the following actions have been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.
- Reducing the elective activity target (ERF) for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year.

Systems are tasked with completing a rapid two-week exercise (by 22nd November) to agree actions required to deliver the priorities for the remainder of the financial year.

As previously reported to Board, we were already undertaking a mid-year financial review in light of financial performance to month 6 and a number of financial risks that threatened achievement of the plan.

This report summarises the outputs of the mid-year review and implications for the Trust as a result of the national letter and associated two-week exercise. It sets out a revised financial and operational performance projection for 2023/24 for consideration and endorsement by the Board.

The Trust position forms part of the Herefordshire and Worcestershire Integrated Care System (ICS) position. The exercise requires formal Integrated Care Board (ICB) and Trust Board sign-off of key finance, performance and capacity commitments for submission on 22nd November, and will be followed by review meetings with NHSE.

Given the nationally mandated deadline, endorsement of the Trust return is being made under standing order SO37: "*The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive Officer and the Chair acting jointly and, if possible, after having consulted with at least two Non-executive directors. The exercise of such powers by the Chief Executive Officer and the Chair shall be reported to the next formal meeting of the Trust Board for ratification"*.

Year to Date Position

The Trust set an ambitious operational plan for 2023/24, seeking to meet the planning requirements across operational performance, workforce and finance. The elective plan assumed high productivity within core capacity, and within the financial plan, we accepted a stretched efficiency assumption (4.6%) and noted a number of financial risks, particularly around income recovery.

Across the operational performance metrics we remain committed to delivering significant improvements in Urgent and Emergency Care (UEC), delivering improved access standards for cancer patients and reducing our long waiting 65 week elective patient waits by 31st March 2024.

Elective activity performance was low to plan in April/May though has performed well since then and we are closely managing long waiters in line with the recovery trajectories. At the end of September, for Herefordshire and Worcestershire ICB patients we were at 103.2% against a 104% target (costed activity vs. 2019/20 levels), though we are not yet consistently delivering the level of productivity we planned to within core sessions.

At the end of September (month 6), the year to date financial position was adverse to plan by £2.2m. This is reflected in table 1, below. Key drivers of the variance were:

- the impact of industrial action (direct costs and lost activity);
- excess inflation costs;
- increased urgent and emergency care demand; and
- reduced efficiency delivery (some financial improvement has inevitably been cost avoidance to mitigate other financial pressures).

Table 1: financial performance to September 2023.

Statement of comprehensive income	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year ending £'000
Operating income from patient care activities	149,480	149,753	273	301,117
Other operating income	14,165	8,819	(5,346)	36,261
Employee expenses	(103,529)	(104,480)	(951)	(206,177)
Operating expenses excluding employee expenses	(62,775)	(64,654)	(1,879)	(124,237)
OPERATING SURPLUS / (DEFICIT)	**(2,659)**	**(10,562)**	**(7,903)**	**6,964**
NET FINANCE COSTS	(4,550)	(4,527)	23	(9,646)
Surplus/(deficit) before impairments and transfers	**(7,209)**	**(15,089)**	**(7,880)**	**(2,682)**
Remove capital donations/grants/peppercorn lease I&E impact	(7,002)	(1,361)	5,641	(19,634)
Adjusted financial performance surplus/(deficit)	**(14,211)**	**(16,449)**	**(2,238)**	**(22,316)**

The materialisation of financial risk in the year to date and projected, poses a significant risk to delivery of the financial plan. On an unmitigated basis the projected outturn was modelled through the mid-year review to be in the region of £32.3m deficit, or £10m adverse to plan.

Through Senior Leaders brief, Trust Management Board (TMB) and Finance and Performance Executives (F&PE), budget holders and leaders were asked to identify and deliver mitigating actions to improve the run rate over the second half of the year. Mitigations being scoped included further stretch of existing efficiency schemes, going further on productivity improvement, review of existing grip and control measures, technical opportunities and a review of potentially unpalatable opportunities, recognising that there is an interdependency with operational performance and quality.

The mid-year review and financial improvement work was underway when the national financial challenge letter was received and has therefore fed into the two-week exercise.

National Financial Challenge & Two-Week Exercise

Together with ICS partners we have rapidly reviewed operational performance trajectories and the financial forecast, in light of the national actions (Industrial Action funding / ERF changes) and clarity on nationally agreed priorities. None of the elements can be looked at in isolation and where relevant quality impact assessments will be used to ensure decisions are balanced across operational performance, quality and finance.

Operational Performance:

Boards are required to sign off their commitment to deliver against their plans for the following headline objectives:

- Urgent and emergency care (UEC)
  - 4-hour A&E performance
  - Average Category 2 performance
- Elective and cancer
  - The March 2024 62-day backlog reduction at 2019/20 "fair share" levels.
  - Faster Diagnosis Standard performance
- Winter plan (core G&A bed capacity, escalation capacity, ambulance handover delays, virtual ward capacity, timely discharge of patients – including use of Discharge Ready Date metric).

Having reviewed performance across the metrics, the re-submission (Appendix 2) reflects a commitment to deliver against each of the objectives, with the exception of the 4-hour A&E performance metric. This metric was planned to achieve 76% performance in March 2024, though this did not recognise that we operate solely a Type 1 unit. This latest submission commits to a 70% 4-hour A&E performance in March 24 and has been reviewed with ICS partners ahead of submission. For those Trusts having Type 2 & 3 activity they typically gain overall on average a 14% increase on performance; we can't realise that additional benefit and therefore feel our revised trajectory is a realistic reflection. This level of ambition matches the top quartile of Type 1 performance across English Acute Trusts.

Within our Core bed submission there is a slight uplift from the operational planning submission made earlier in the year for 2023/24 following reconfiguration of the acute floor to create a Frailty Same Day Emergency Care area, giving 4 additional bedded spaces. This with 20 Paediatric beds gives 311 overall from a position of 307 reported previously.

Our commitment to deliver no long waiting 65 weeks patients remains a key deliverable for this year recognising that delays in treatment remain a significant clinical risk to our patients.

Our operational trajectory to deliver no 65 week waits for the start of definitive treatment for our elective patients has also been reviewed in detail and remains an ongoing plan to deliver ahead of 31st March 2024. Our current 65 week risk cohort for the end of March 31st 2024 currently stands at 2,645 patients. With current confirmed plans in place there still remains a risk to c70 patients ahead of the 31st March 2024 deadline. This is by no means a final position as clinical and operational teams continue to work on plans to mitigate. This risk was highlighted to the ICB and NHSE on the 2nd November 2023 as part of ICS reporting submissions to Midlands NHSE.

In relation to elective recovery more broadly, as part of the re-submission we have reiterated our focus on eliminating very long waits, wherever possible by achieving greater productivity through core capacity and only using additional capacity where it offers value for money and supports our ability to access ERF.

We have reviewed our elective specialties to assess the current size and profile of the waiting list, productivity and use of temporary capacity such as in/out sourcing. Use of temporary capacity is in many cases supporting our cancer and diagnostic pathways. In a limited number of cases we have been able to identify an opportunity to reduce the use of in/out sourcing and medical temporary staffing whilst maintaining 65 week performance. The financial value of these is estimated at £0.3m. For example where the substantive recruitment pipeline allows us to maintain capacity at better value for money. Where proposed changes result in reduced capacity or a risk to 65 week performance, a QIA process will be undertaken.

Financial Forecast

ICB and Trust Boards are being asked to confirm that they plan to deliver on the agreed financial targets for the year, whilst considering the quality impact assessment of plans. For the Trust the expected requirement is to deliver the planned deficit position, ensure fully worked up efficiency plans including agency reductions and an elective plan focused on productivity from core capacity.

Building on the mid-year review work, and in light of the updated national assumptions, we have validated the most likely forecast outturn pre mitigation, and progressed scoping of a range of mitigations to tackle the run rate over the remaining months of the year.

Table 2 below sets out the most likely forecast outturn before mitigation (based on YTD at Month 6), and expected mitigations. As can be seen, despite an extensive range of mitigations, the scale of the challenge is greater than can be fully resolved in the period remaining. The resultant forecast position at the time of submission is a £26.3m deficit, or £3.99m adverse to plan. This does not meet the national expectation of delivery in line with original plan.

Table 2: Financial Forecast: most likely pre and post mitigations

	£000s
Plan Deficit 2023/24	(22,316)
Mid Year review FOT adj	(9,853)
Projected "do nothing" FOT 2023/24	**(32,169)**
Mitigations:	
National: Industrial Action funding	2,000
National: ERF threshold change	939
National: ERF performance M8-12 projected	716
Cost of Capital NHSE	0
COVID testing alignment	233
Diagnostic marginal benefit (net of contract risk)	314
Powys contract	600
Cap/rev write back	(500)
SDF flexibility review (excl. diagnostics)	0
Balance sheet / technical review	800
Grip & Control actions review	60
Other Income	250
In/Out sourcing / Locum review & reprofile	300
Other - to be identified	150
Most Likely (post mitigation) FOT 2023/24	**(26,307)**
resulting variance to plan	*3,991*

There are a range of drivers of the year to date and forecast variance to plan, many of which are not readily controllable by the Trust, for example excess inflation. The mid-year review / two-week exercise has resulted in non-recurrent mitigations for many of these through the additional actions identified. Two key unmitigated drivers of the forecast deficit to plan are: the difficulty in securing agreement to an alternative tariff model for Wales (to replicate more closely the English funding model); and the stretch CPIP target remaining without mitigation (impacted by Industrial Action / high inflation requiring mitigation etc.).

The range of mitigations set out above covers all areas of spend/income and includes technical / balance sheet solutions. Work continues to identify, scope and bring into delivery any viable mitigations to support improvement in the financial outturn. Progress against delivery of this forecast, divisions' efficiency plans and any risks materialising will be routinely monitored through TMB, F&PE and Board.

Risks

The operational and financial plan was sensitive to a range of potential risks, a number of which have materialised and are evident in the year to date performance position. As part of the two-week exercise and identification of mitigations, risks have been reviewed. Key elements are described below.

Industrial Action: The operational and financial projections assume, in line with the national ask for this exercise, that there will be no further impact of industrial action over the period to March 2024. In the event that industrial action were to continue, this would be a significant financial risk to the forecast in direct cost and lost activity / ERF.

Winter period: There is a risk to managing spend in line with forecast levels, with a risk to elective activity and ERF in the event of significant pressure. We are already experiencing high demand.

Efficiency: There is a risk to delivery of the projected and planned level of efficiency given the need to balance focus across the operational priorities and finances.

Underlying Position: The majority of the mitigations identified will be non-recurrent in nature and provide very little benefit to the underlying deficit position as we exit the current financial year.

Cash: As reported to, and approved by Board previously, the in-year deficit plan resulted in a requirement to access revenue cash support to meet obligations and cash flow mitigations are being proactively managed. An application for revenue support in December is currently with the national team for decision, and a request for quarter 4 support will be made in early December. The projected adverse variance to plan will result in a further risk to the cash flow position.

Medium Term Planning: The focus on in year delivery does reduce capacity within the Trust to focus on the 2024/25 operational planning process and medium term planning. We are continuing to progress 2024/25 planning as far as possible, with an early focus on financial efficiency and productivity schemes to provide more recurrent solutions to the underlying deficit.

Recommendations

Due to the nationally prescribed deadline, Board were asked in line with standing order SO37[2] to endorse this report, noting the risks and assumptions made for the two-week exercise, across operational performance metrics and the financial forecast. This was completed on 21st November and is reported to the December Public Trust Board meeting for ratification.

To:
- ICB and Trust:
  - Chief executives
  - Chief finance officers
  - Chief operating officers

cc.
- ICB and Trust:
  - Chairs
  - Chief Nurses
  - Medical Directors

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

8 November 2023

Dear colleague

Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

We are writing to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

As a result of these pressures, for the remainder of the financial year our agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

In response, we are asking systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year.

Financial pressures in 2023/24

We asked you to set ambitious plans for 2023/24 in the context of NHS funding increasing in real terms between 2019/20 and 2023/24 to over £160bn, recognising the actions you have had to take to deal with a range of significant new pressures.

Plans were set on the basis that there would not be significant ongoing industrial action. Despite 10 months of strikes, the NHS has made progress on the delivery of the UEC, primary care access and elective recovery plans, while also displaying professionalism in planning for and managing periods of action. The strikes have nonetheless had a significant impact on patients and staff.

The impact of the more than 40 days of industrial action this financial year has created unavoidable financial costs that we estimate to be around £1 billion, with an equivalent loss of elective activity.

National action

To cover the costs of industrial action to date we are taking the following actions which have been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.

- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Discontinuing the application of holdback to the Elective Recovery Fund (ERF) for the rest of the year and formally allocating systems their full ERF funding.

Actions for ICBs and Trusts

We are asking ICBs and providers, by 22 November, to agree the steps required to live within their re-baselined system allocation and reflecting the impact of the reduced elective activity goal. Plans should be based on a scenario where there are no further junior doctor or consultant strikes.

The foundation of this reset should be protecting patient safety, including in maternity and neonatal care, and prioritising UEC so that patients receive the best possible care this winter. Progress on existing commitments on elective and primary care recovery programmes, as well as other goals, should build on that foundation.

Actions to deliver UEC performance should include the agreed investments in capacity – including beds and ambulance services – as well as other components of UEC plans, including admissions avoidance and discharge schemes. Following the additional funding and changes to the ERF threshold, these are expected to be fully implemented without further delay.

The primary focus for elective activity should be on long waits and patients with urgent care and cancer needs, including reducing the cancer backlog. Primary care plans should protect improvements in access.

In showing how you will deliver financial balance you will need to show:

- you have fully worked up efficiency plans, including the reductions in agency staffing set out at the start of the year;

- where you require flexibility on programme funding;

- an elective plan that is refocused on driving productivity from core capacity, identifying the insourcing/outsourcing and waiting list initiatives you still consider necessary within a balanced financial plan focused on the longest waits, urgent elective, and cancer care.

Returns should identify the total activity you forecast to do and the implications of any changes on the trajectory to the March 2024 65ww target, including how maintaining existing patient choice, tiering and the GIRFT programme can all support delivery (including on inpatient length of stay, day case rates and capped theatre utilisation).

The current pause in strike action is a positive step. However, it will be important to understand the alternative, and so your plans should also include an assessment of a scenario where the junior doctor and consultant strikes continue in a pattern consistent with the last four months and how those costs can be minimised as far as possible. In this scenario the focus should be on what steps you would take to minimise additional costs.

Next steps

Following yesterday's webinar with ICB and provider CEOs and Directors of Finance, we are holding a further session this afternoon with Directors of Finance.

We will schedule sessions for each individual ICB Executive and their provider colleagues from 27 November to agree proposed actions.

We know how hard you have been working to maintain progress on implementing the recovery plans for elective care, urgent and emergency care, and primary care – as well as wider Covid recovery and priority transformation programmes – in the face of extraordinary pressures from prolonged industrial action.

We hope that this letter provides the clarity you have been seeking to now enact, along with system partners, those actions necessary to balance these financial challenges with your wider responsibilities.

Yours sincerely,

Julian Kelly
Chief Financial Officer
NHS England

Dame Emily Lawson, DBE
Interim Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer, England

Acute - RLQ
WYE VALLEY NHS TRUST

NHS England

The trust board confirms its commitment to:	Confirmation (Y/N)	If not confirmed, provide a brief explanation including the basis for a revised proposed plan	Actuals		Plans				
			Period	Value	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Headline objectives									
The 4 hour system A&E performance as described in the winter plan	N	No, revised trajectory submitted based on current	Sep-23	54.0%	65.0%	63.0%	69.0%	73.0%	76.0%
The March 2024 cancer 62 day backlog position set out in the 2023/24 operational plan	Y		Sep-23	109					71
The March 2024 cancer Faster Diagnosis Standard performance set out in the 2023/24 operational plan	Y		Aug-23	69.3%					75.0%
Key enablers									
Core G&A bed capacity growth committed to within the winter plan	N	No, Amendment to 291 Adult G&A beds from 28	Sep-23	304	307	307	307	307	307
Escalation capacity committed to within the winter plan	Y				0	0	0	0	0
An ambulance handover average delay trajectory, that is consistent with the overall system-level trajectory, has been agreed by the trust Board	Y								
Discharge									
A discharge ready date metric was published for the Trust in November, and the trust Board is regularly reviewing this metric as part of a performance dashboard to drive improvement	Y	Discharge Ready Date to Actual discharge - average numbers of days to be reported in November COO Board Report.							
OR									
A discharge ready date metric was not published for the Trust in November, and the trust Board has confirmed the date of expected publication (this should be pre-March 2024)	Y/N or N/A								

Sign off	
The return must be signed off by the trust Chair and CEO on behalf of the trust board. In signing off the return the trust Chair and CEO are providing assurance that the trust Board has considered the quality impact assessment of plans and assured itself of appropriate clinical involvement in decision making.	
Approved by the trust Chair	Approved
Name:	Russell Hardy
Date:	21st November 2023
Approved by the trust CEO	Approved
Name:	Glen Burley
Date:	21st November 2023

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	**Integrated Energy Solution – Phase Two Full Business Case**
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	Project Team
Lead Executive Director:	**Chief Strategy Officer**
Author:	Peter Burke, Clive Andrews, Nick Exon
Documents covered by this report:	Integrated Energy Solution – Phase Two Full Business Case plus Appendices (appendices are not in the Board pack but are available separately for brevity).

1. Purpose of the report

The Board are asked for approval to proceed with Public Sector Decarbonisation Scheme Phase 2, namely the construction of a new energy solutions building to provide energy from electricity removing the reliance on the existing gas/oil fired steam boilers providing a reduction in CO2 and to agree the post works completion resilience solution. Funding has been sourced and secured in full via a Salix grant application.

2. Recommendation(s)

Members are asked to

- Approve the Full Business Case
- Agree the post works completion resilience solution

3. Executive Director Opinion[1]

This Phase II scheme will almost completely decarbonise the County Hospital site and support the Trust's Net Zero aspiration by eradicating the use of fossil fuel to heat the main hospital building. In the medium to long term, the infrastructure that will be installed will also present opportunities to save significant energy costs but there are a number of associated risks.

At the projected rates of energy costs for the short term the Trust will pay more for energy under this scheme as gas costs have dropped and electric costs have increased. The longer term forecast suggests this will reverse and the Trust could save large sums when the cost of electricity reduces and the cost of gas increases again.

The grant funding that the Trust has received is front-loaded into this year and delays to the scheme mean that most of the costs will be borne next year. This could lead to the Trust breaching its capital expenditure limit next year and advice is being sought on how this might be mitigated.

The operational expenditure costs of running the new equipment are significant and should be offset by the saving from not maintaining and replacing the existing PFI infrastructure. The saving from the PFI contract is not known yet and it will be some time before this is fully articulated through the change notice process.

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

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

Wye Valley NHS Trust

Full Business Case

Integrated Energy Solutions

Document Properties:

Ref. No.	WVTBC0060b
Author:	Peter Burke, Clive Andrews, Nick Exon
Executive Sponsor:	Alan Dawson
Date:	28/11/2023
Version	2.0

Amendment History:

Version	Date Created	OBC/FBC	Amendment History
1.0	06/07/2023	OBC	First version
2.0	28/11/2023	FBC	First version

Approvals:

Name	Date	Version
Trust Board	6/7/2023	OBC 1.0
Trust Management Board	1/12/2023	FBC 2.0
Trust Board	7/12/2023	FBC 2.0

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1. Introduction

The Board are asked for approval to proceed with Public Sector Decarbonisation Scheme Phase 2, namely the construction of a new energy solutions building to provide energy from electricity removing the reliance on the existing gas/oil fired steam boilers providing a reduction in CO2 and to agree the post works completion resilience solution. Funding has been sourced and secured in full via a Salix grant application.

The government set the NHS the target of reducing directly controlled carbon emissions (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

The Trust has responded to this challenge by contracting with Centrica in a multiphase project to deliver emission reducing technologies across the estate; reducing dependency on gas fired boilers in the outlying buildings, such as Trust HQ, Longfield House and the former Finance block. Phase one of the project is now complete and these measures have reduced emissions by c10% and saved more than £300k in energy costs in 22/23.

The Trust was awarded £20,196,976 in a second grant to fund Phase Two of this project and commenced work in December 2022 on concept design, with monies drawn down against the Salix payment schedule following Trust Board approval in April 2023.

The purpose of this business case is to seek approval to spend the balance of the Salix grant, complete the project, achieve the carbon savings and determine the resilience solution.

This phase of the project involves building an energy centre on the land adjacent to Gwyndra Downs (the temporary Orchard car park), housing air-source heat pumps, air to water heat pumps, electrode boilers to enable the replacement of the gas fired boilers within the PFI building as the primary source of domestic hot water and heating for the hospital. Reducing emissions is one of the key proposals within the Trust's Sustainable Development Management Plan.

Salix is a non-departmental public body owned wholly by Government and administers funds on behalf of the Department for Energy Security and Net Zero.

2. Background Information

The Trust's approach to decarbonisation commenced with the first Integrated Energy Solution (IES) business case (WVTBC0060) which was presented to the Trust Management Board (TMB) on 6th March 2020; the Board approved that Centrica be chosen as its preferred contractor to help it reduce carbon emissions and, in doing so, agreed the pursuit of carbon emission reduction over other less sustainable technologies. A detailed study of the hospital heating systems by Centrica led to the development of an Investment Grade Proposal (IGP) in December 2020, identifying energy conserving measures to be introduced to reduce carbon emissions on site.

An updated business case (WVTBC0060a) was presented to Private Board on 5th March 2021 recommending the Board approve the IGP and approve the signing of a contract with Centrica. The Trust Board instructed the delivery of Phase One of the IES project, utilising the Public Sector Decarbonisation Scheme (PSDS) grant funding of £4.729m.

Phase One involved the drilling of a ground array of 46 boreholes, installation of ground source heat pumps, air source heat pumps, solar photovoltaic panels and LED lights, along with the upgrade of air conditioning and lighting controls.

Phase One has now been completed and is saving c600 tonnes of carbon emissions per year and over £300k per annum in energy costs at current market rates, significantly outperforming the project forecast savings. Handover of these technologies to Sodexo for maintenance are in the process of being finalised.

Phase Two of the project was approved by Trust Board contingent on the second Salix Grant Fund Application being successful when submitted.

In September 2021 Salix announced a second wave of grant monies was available for application for decarbonisation projects. The Trust submitted a detailed application for £22.1m grant funding on 11th October 2021. This application was approved but oversubscribed and the grant funds were not available.

In August 2022 the Trust was notified that this situation had changed – funds had become available again. Following a technical review and assessment of cost changes in the intervening period, a revised application of £20,196,977 was submitted to Salix and this was accepted in October 2022.

The breakdown of the Phase Two grant funding is scheduled as follows the sums include VAT:

Year 1 – 2022/23	£5.750m
Year 2 – 2023/24	£13.590m
Year 3 – 2024/25	£0.856m
Total	**£20.197m**

In November 2022 TMB approved the signing of the Investment Grade Audit for Phase Two, commissioning the development of the detailed engineering designs required to change the energy infrastructure within the hospital. The Investment Grade Audit and business case for Phase Two have taken longer to deliver than anticipated due to the complexities of design and yet the scheme funding and phasing is fixed with monies not permitted to be transferred from one year to the next. The Board approved the drawing down of the Year 1 Salix grant funding of £5.75m and subsequent deferral of the grant funds into 2023/24 so that the project design could proceed and 2022/23 grant monies not be lost.

3. Critical Success Factor.

The Critical Success Factors (CSFs) for this project are:

Time

The project must complete by 2025. PSDS2 grant monies have been awarded over a multi-year basis on the understanding that the project will be completed by no later than financial year 2025/26. It is not permissible to transfer monies from one year to another.

Quality

The project must utilise non fossil fuel technologies to reduce carbon emissions; 80% by 2028/2032. The target of 3,140 carbon tonnes per annum will be exceeded with the combined PSDS1 and PDS2 projects together projected to save 3,609 carbon tonnes per annum. Salix will accept fossil fuel technologies to facilitate resilience solutions.

Cost

The decarbonisation project must be funded from the SALIX grant monies £20,196,977. There is no capital otherwise available to support this initiative. The project budget is detailed in Appendix A.

4. Provisional Phase Two Design (as detailed in the OBC)

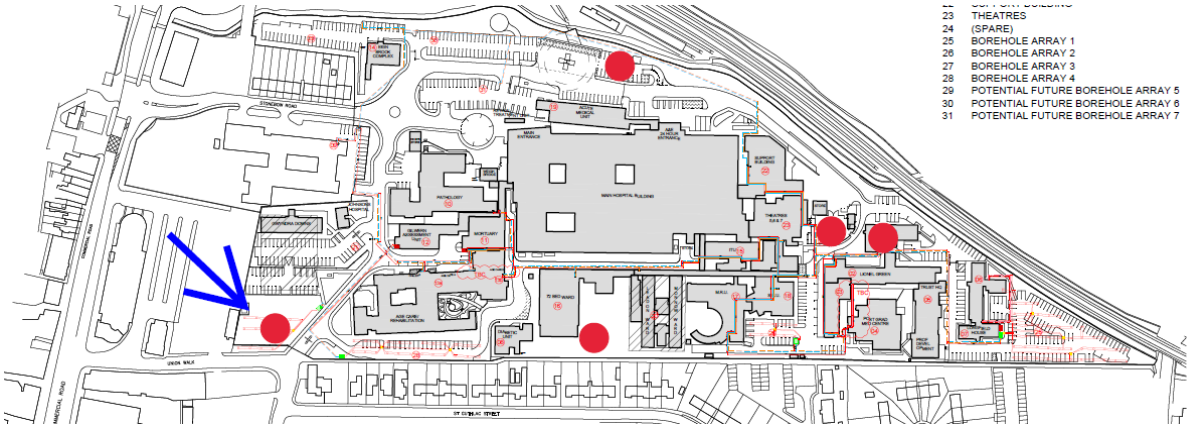
4.1 Provisional Design

The provisional design for Phase Two was based on the installation of a further 67 boreholes in car parks 1&2, extending the ground array installed in Phase One, and providing heat through ground source heat pumps to Pathology, Mortuary and Age Care. The design also included “de-steaming” the main hospital, converting the Mortuary and Age Care from central steam heating systems to electric water to water heat pumps, and installation of cavity wall and loft insulation to the Pathology and Age Care buildings.,

4.2 Energy Centre Location

The project centred on the construction of an Integrated Energy Solutions Building (IES) located on the County Hospital site, with proposals for this at the Old Finance Block, PFI \Waste Compound, New Wards Site or the Orchard Car Park site.

A review of possible locations identified in the OBC (concluded that the best and least disruptive location for the IEC is on the County Hospital Orchard site in proximity to the sub-station



4.3 Carbon Savings

Phase 1 target carbon savings of 510 CO2 tonnes per year has been exceeded with project savings calculated of 604 CO2 tonnes per year. Phase 2 was projected to save and additional 3111 3099 CO2 tonnes per year with an overall projected carbon emissions savings of 3715 3609 CO2 tonnes per year for the County site.

5. Phase Two Design

5.1 Change to the concept design

Completion of the Phase Two Investment Grade Audit has resulted in a change to the concept design because of changes to supplier costs and the need to include an upgrade to the high voltage (HV) supply to the hospital. The current design proposal is to build a new Energy Centre in the Orchard Site car park that will house Air Source Heat Pumps which feed into Water-to-Water heat pumps to provide the base heating load for the remaining hospital buildings. The location of this Energy Centre on the land adjacent to Gwyndra Downs has helped inform the final design and technologies used to reduce carbon emissions in order to meet the Government target, and by necessity requires an increase in the high voltage electrical supply to the hospital.

The design for Phase Two has been influenced by the location of the Energy Centre, the cost of the Distribution Network Operator (DNO) upgrade requirements, (and the need to stay within the Salix funding) and means that the project now excludes the ground array and boreholes proposed for carparks 1 and 2, concentrating on cascade heat pump technology (air source into water to water source).

The advantages of these changes are:

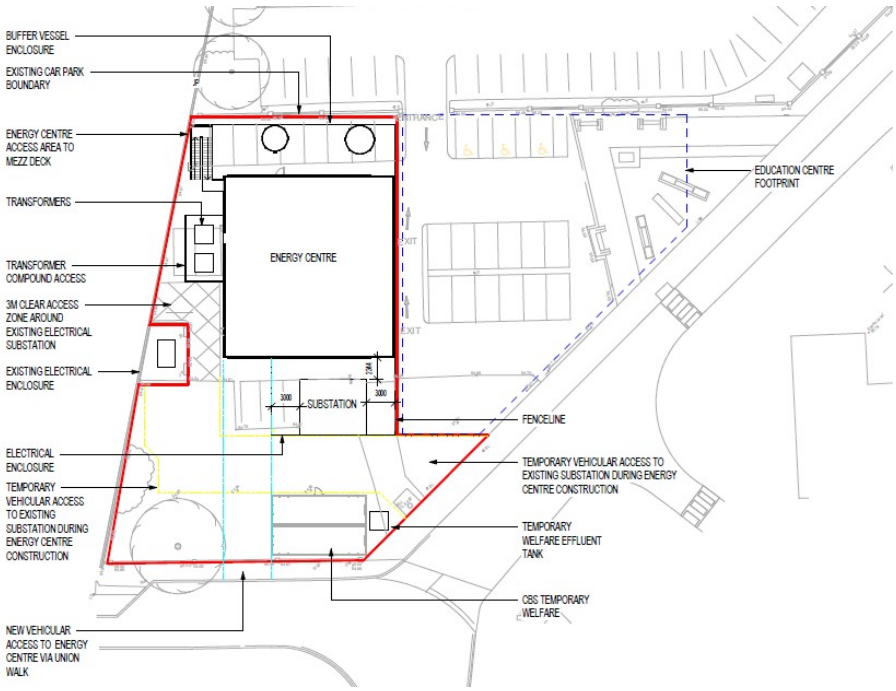
- It moves all the Heat Pumps into one central location

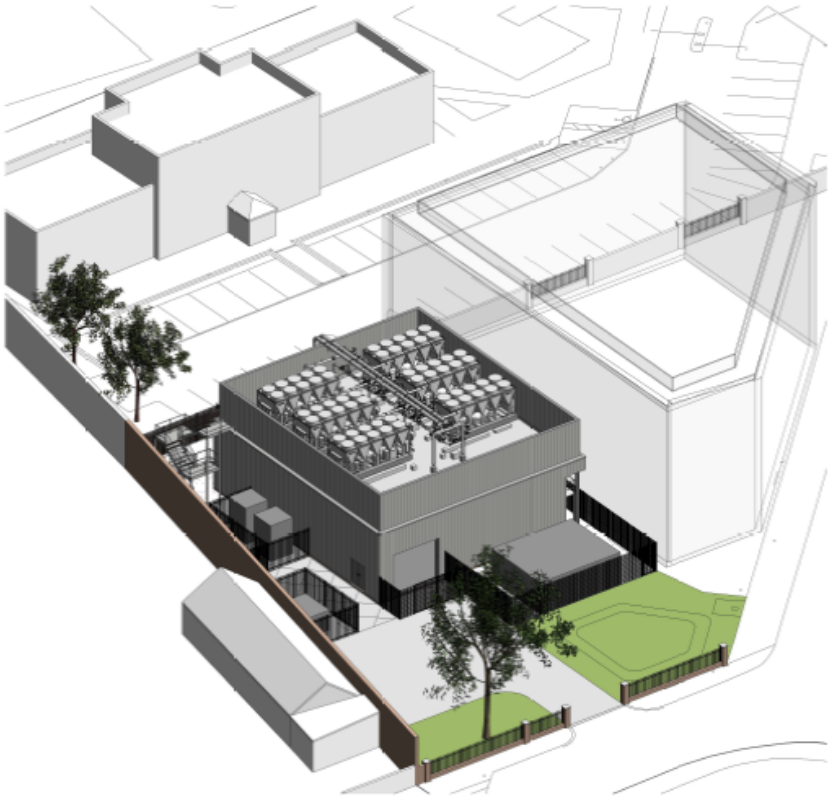
- It removes the need to drill boreholes due to the proximity of the integrated energy centre to key buildings
- It removes the need to close sections of the main visitor car park off, and means the Trust do not lose revenue from these spaces, or have to find alternative parking spaces.
- It removes the need to temporarily close the helipad
- During design it was found the proposed location for the Ground Source Heat Pump plant room was not big enough, merging it into the Energy Centre removed that as an issue
- It can keep broadly the same Carbon saving as the original concept

5.2 Interdependencies

Education Centre

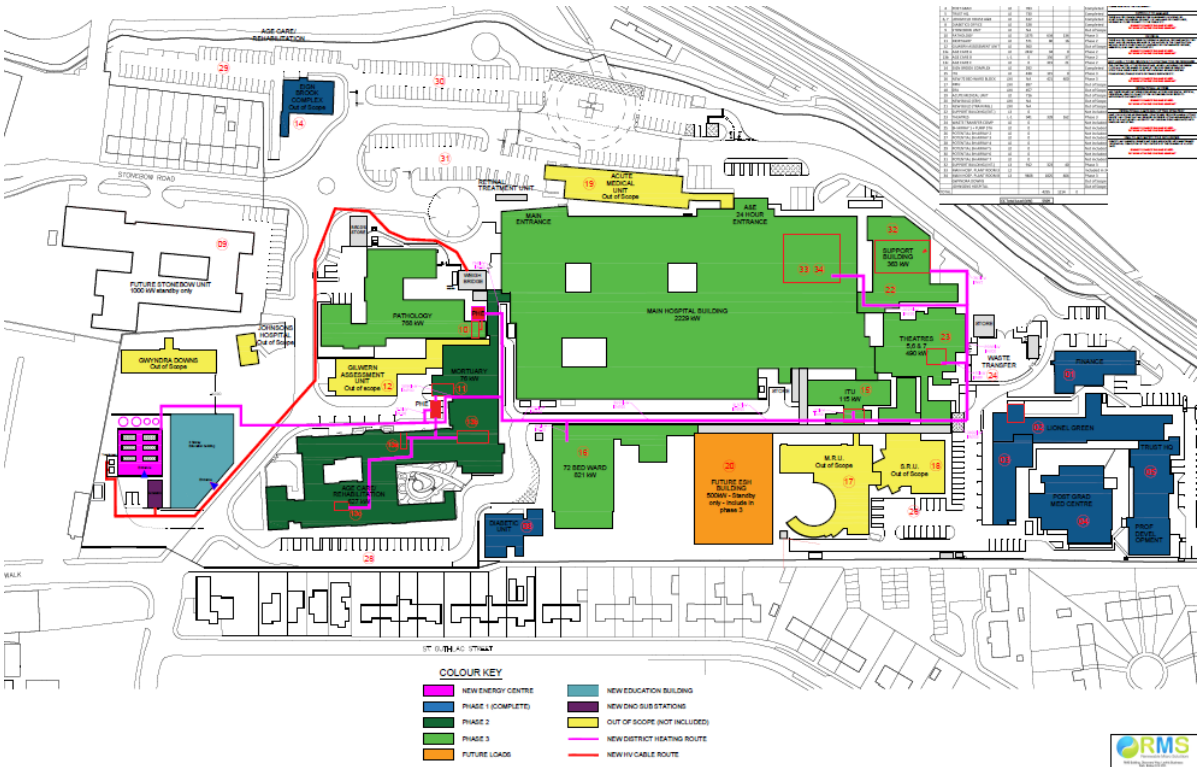
This scheme has a strong interdependence with the Trust's proposed new Education Centre because the Integrated Energy Centre (IEC), which forms part of the IES, will be located adjacent or in close proximity to the proposed location of the Education Centre on the Orchard Site. This interdependence is managed through collaboration of the project teams for both projects.





Service duct

WVT/Centrica and Mercia will accommodate the new distribution pipework within the new pre-cast concrete service duct being installed by Mercia as part of their life-cycle costing (LCC) commitment.



Other buildings

A cost analysis for adding MRU and SRU buildings to the IES has been undertaken and is currently outside the budget and considered unaffordable.

The possibility of connecting the proposed Education Centre to the new district heat network has been ruled out following a technical analysis undertaken by Arup (ref 294443 dated 19 Sept 2023 appended to this FBC. Appendix C)

5.3 Resilience

Distribution Network Operator (DNO) upgrade

Due to the power required to run the heat pumps, an upgrade of the existing High-Voltage (HV) sub-station is required. Discussions have been ongoing with the DNO (National Grid) for months to confirm the total upgrade required; this has been agreed on 7th June 2023 as being 8.5 megavolt amperes (MVA), increasing the existing 2.4 MVA supply by 6.1MVA and providing a further plus 20% resilience as recommended by the DNO. The DNO has indicated that this upgrade will result in two separate 4.25 MVA supplies feeding the hospital; each substation will provide 50% of the site load, and if one supply drops out then the other will pick up 100% of the load. Currently, the existing back-up generators are sized to keep the Hospital running in the event of a power cut and the existing interlocks controlling the back-up generators could be modified so that if one DNO feed went down then the backup generators would kick in, if required, to keep the hospital running. This provides a resilience and security of supply which may well mean that the Trust will no longer require that main gas boilers as back up to the heating system, and allow the removal of the steam pipes from the duct running along the fire road. The detailed design process will confirm this or otherwise.

The new DNO substation is proposed to be located adjacent to Gwyndra Downs and in close proximity to the proposed integrated energy centre.

5.4 Integrated Energy Centre (IEC) Design Proposal

The IEC will house three 1141kWt water to water heat pumps on the ground level. The first level will be a mezzanine deck with six 379 kWt Air source heat pumps. This is a cascade heat pump system where the air source heat pumps pre-heat the water that then passes into the water to water heat pumps which output at 80ºC into two no. 30,000ltr Thermal stores. From this point the LTHW (low temperature hot water) will be distributed to satellite plant rooms via buried and over-ground pipework. Two small, packaged plant rooms will be built to house plate heat exchangers and pumps. These plant rooms will be fed off the main distribution line. Four 500 kW electrode boilers will also be installed in the IEC to provide emergency back up in the event of mechanical failure to anyone of the heat pumps.

Centrica Business Solutions have been contracted by Wye Valley Trust to deliver a carbon saving IES scheme which includes installing a new Heat Pump Energy Centre which will provide heating and DHW (domestic hot water) to areas of the hospital which are currently fed from Steam Boilers

Under the HTMs there is a requirement to provide resilience on Heating to clinical areas. Presently this is done by having N+1 dual fuel boilers and having back-up electric generators to provide power to the steam boiler heating system in the event of loss of mains power to site.

Throughout the design process several options were considered to provide the resilience, culminating in the decommissioning and removal of the existing steam boilers from site replaced with new Low Temperature Hot Water (LTHW) Gas boilers. These boilers would not need to run in Hot Standby mode and would have instantaneous start-up in the event of a loss of power to the Energy Centre. The boilers would be connected to the existing LV electrical infrastructure which is backed up by the existing standby electric generators which would enable them to run in the event of a loss of power to the Energy Centre.

Capital costs for this option are included within the budget. The option gives the hospital new boilers for resilience which do not incur hot standby running costs.

6. Project Constraints

The key constraints of this project are:

6.1 Funding

The project is entirely funded from the secured Salix grant application and as such design constraints exist limited by affordability. Centrica will request payment by making an Application against the agreed cash flow schedule on a prescribed day each month. Centrica are obliged to demonstrate value as requested to substantiate their payment request. WVT will assess the Payment request that an invoice is raised and pass to Salix so that monies can be received and passed on. The 300K contingency will be requested on the same basis with the Trust holding this sum for their purposes.

6.2 Car Parking

The parking spaces provided by the temp Orchard car park will be lost in Jan 2024, and in part prior to that date to enable archaeological investigations (to both the IES and the Education Centre) a paper has been drafted to communicate this occurrence and offer alternative proposals (see Appendix D).

6.3 Planning Permission

The construction of the IEC and therefore the completion of this project is dependent upon planning permission being granted by Herefordshire Council. The Council planning processes have proved slow on a recent project and any delay will pose a threat to the construction programme and funding draw down. WVT & CBS have agreed a cash flow to work through this. Additionally Finance have explored mechanisms to assist.

A planning application was submitted to the Council on the 6th October and validated on the 31st October. The determination date is expected to be 25th December 2023.

6.4 Location

The IEC location is confirmed as detailed above and in the OBC.

7. Carbon and Financial Benefits Analysis

The PSDS2 project reduces the carbon emissions by 3099 CO2 tonnes per annum with an overall projected carbon emissions savings of 3609 CO2 tonnes per year for the County site. The remaining 233 CO2 tonnes will be addressed through a future project.

The Table below illustrates the separate and combined performance of the IES phases when modelled with current contractual rates (Scenario 1) and presents a sensitivity analysis through Scenarios 2 to 5, demonstrating the cost pressure avoidance benefits or costs to the Trust from changes to the gas and electricity unit prices.

Market research by Cornwall Insight, the leading energy market research company, suggests that ultimately, electricity prices are likely to become much closer to gas and that the Trust will avoid a large cost pressure.

Whilst there is a lot of uncertainty, this business case does de-risk energy costs by making WVT less reliant on volatile gas prices.

The analysis undertaken during the OBC remains accurate.

The table below seeks to identify the potential financial impact of the changes introduced in Phase 1 combined with the carbon saving proposals in Phase 2. The financial impact is modelled using 6 pricing scenarios detailed below.

Cost/Savings impact pricing scenarios		Scenario 1	Scenario 2	Scenario 2 (Update)	Scenario 3	Scenario 4	Scenario 5
Unit Rates (pence)	Gas	11.70	7.90	7.13	9.95	10.53	9.75
	Electricity	30.25	24.00	25.50	24.20	24.20	13.50
Phase 1 Adjusted Guarantee	Gas - Saving (kWh)	2,544,629	2,544,629	2,544,629	2,544,629	2,544,629	2,544,629
	Electricity - Saving (kWh)	282,625	282,625	282,625	282,625	282,625	282,625
	Total Saving (£)	383,216	268,856	253,501	321,459	336,345	286,256
Our proposal - Full Cascade + Autoclaves + Insulation	Gas - Saving (kWh)	16,888,724	16,888,724	16,888,724	16,888,724	16,888,724	16,888,724
	Electricity - Saving (kWh)	7,162,272	7,162,272	7,162,272	7,162,272	7,162,272	7,162,272
	Total Saving (£)	(184,761)	(379,663)	(616,673)	(49,194)	49,420	680,926
Total (£k)	**Phase 1 and 2 Saving**	**198,455**	**(110,807)**	**(363,172)**	**272,265**	**385,765**	**967,182**

Scenario 1	23/24 Contracted Rates
Scenario 2	WME prices for 2024/25 (as at 18 March 23)
Scenario 2 (Update)	WME prices for 2024/25 (as at 27 November 23)
Scenario 3	Electricity down 20% Gas down 15% 23/24 contracted rates
Scenario 4	Electricity down 20% Gas down 10% on 23/24 contracted rates
Scenario 5	Cornwall Insight Research Forecast 25/26 (in line with other external indicators*)

The financial modelling above illustrates that WVT will avoid £383k in energy costs in 23/24 as a result of implementing Phase One of the project. The cost of energy is currently at a 'high', partly due to increasing demand, limited supplies, a shortage of storage space and the conflict in Ukraine. Electricity prices are forecast to fall as the market becomes less reliant on gas for generation. The IES project centres on the use of electricity for heat generation reducing the use of gas (and therefore generation of carbon emissions). Should the cost of electricity reduce in relation to gas to anything like that forecast by the Cornwall Insight energy market intelligence consultant projections then in 2025 the Trust would avoid over £600k in energy costs as a result of completing Phase Two.

It is noted that the range of savings is considerable and this is due to the wide range of variables acting on future prices. The latest update of the FBC includes an update to Scenario 2 to reflect the latest estimate of 2024/25 energy prices (Scenario 2 Update). This demonstrates an increase in overall costs deriving from the change in energy usage to electricity. This is due to an increase in electricity process relative to gas since March 2023.

It is acknowledged that in the short term this will contribute to additional costs however the analysis needs to take account of longer term movements. Over the long term it is projected that gas and electricity prices will converge in part due to Government policy to ensure that cleaner energy options are cost effective. Scenario 5 in the above table is based upon work carried out by Cornwell Insights which supports this view.

In order to calculate the impact of changes to prices over time Appendix I details an analysis of the impact of energy usage change and prices based on the revised Scenario 2. The first table identifies the cost changes and is in line with the table above showing additional costs of £363k pa. However the second table adjusts gas tariffs over time to reflect a projected convergence in gas and electricity costs. The second model assumes a convergence based on a 5.5% annual increase in gas costs compared to no changes to electricity tariffs. Based on this modelling there is an overall cost saving over a ten-year period.

It should be noted that estimates of future potential savings are dependent upon the relative movement of gas and electricity prices and these are very difficult to predict hence the wide range of variables. However it should be noted that the overall use of energy is projected to more than halve reflecting a more efficient use of resources.

8. Project Budget and Costs

8.1 Capital costs identified

The total capital cost of the project is £20,197k. An analysis of the costs is detailed within Appendix A and also summarised in the table below.

IES	Budget - £k
Construction costs	16,555
Professional fees	495
Equipment	0
Project Resilience	-164
Contingency allocated	203
Inflation – FIXED COST	0
VAT	3,377
VAT Recovery (est.)	-269
Total Project Cost	**20,197**

The project plan and budget has been developed in order to be maintained within the overall funding made available detailed in Section 9.2 below. The project budget includes an estimate for partial VAT recovery in relation to eligible costs which include elements such as design fees. Advice will be sought from the Trusts VAT advisors in pursuit of this saving. In addition, a saving of £169k in relation to project resilience has been identified. This relates to the option identified in section 6.4. The option provides for a projected saving of £164k based upon the

additional Centrica costs of £606k being offset by a one-off reduction in lifecycle costs of £553k and a saving of £217k on the DNO costs already included within the construction costs.

8.2 Capital Financing

The project is funded wholly through a grant secured from Salix Finance totalling £20.197m payable over three years. The income is made available to the Trust as follows:

Salix Financing agreed

Year	Sum £
2022/23	£5,749,811
2023/24	£13,590,461
2024/25	£856,705
Total	£20,196,977

The amounts identified across years are non-negotiable.

8.3 Cash Flow

The project cash flow is included in Appendix B

Payments will fall due to the supplier once milestones defined in the grant agreement have been met. Approval is requested to release payments to the supplier where corresponding funding has been drawn down and received from Salix and the relevant milestone has been satisfactorily evidenced to have been met. To date that primarily relates to the design stage milestones.

8.4 Accounting Issues to be addressed

The cash flow forecast above is based on payments to suppliers in accordance with the contract with Centrica. As identified in Section 9.2 grant funded income from Salix is fixed on an annual basis and is non-negotiable. Payments are made to suppliers in accordance with contract milestones being delivered. The issue in accounting terms is that at year-end the Trust is effectively pre-paying for an element of the contract milestone delivery and is unable to account for the all the value of contract expenditure incurred as capital expenditure. The impact is that whilst the Trust will underspend against its CDEL target in 2023/24 reflecting a surplus of grant funded income against project expenditure recognised in Assets under construction, the reverse is the case in 2024/25 presenting the Trust with an issue in terms of hitting its CDEL target. The Trust has engaged SWFT Clinical Services to explore the technical accounting issues with a view to identifying a solution.

8.5 Operational Expenditure Costs

On completion of Phase Two Centrica will assume responsibility for the maintenance of the heat pumps and invoice the Trust £163,744 per annum. It is identified that there will be savings arising from a reduction in PFI operating expenditure and lifecycle costs associated with the changes. It has not been possible to include a value for this amount at present as it is subject to a Contract Change Notice which cannot be finalised until the exact details of the IES scheme are finalised. While it is not possible to confirm the value of the net additional costs (or savings), they should also be considered in the context of projected savings in carbon and financial terms identified in Section 8.

9. Risk Assessment

The Phase Two project will take the learning points from Phase One and as such operational risks will be mitigated with the detailed design connecting the technologies to the hospital infrastructure. Early engagement with Sodexo and Mercia Healthcare will help to ensure a risk reduced approach is taken and that this project takes into account planned lifecycle works delivered by our partners under the PFI contract.

The project risk register can be found in Appendix E. The significant risks are noted below:

Programme - the delivery of the project in line with the funding available per financial year is a challenge.

Planning permission – a full application has been submitted with a determination date of 25th December 2023.

Value for money and risk transfer from **PFI** – this phase requires a significant change to the provision of energy to the PFI and agreeing this and ensuring the best value and timely agreement is a significant piece of work. Additional project management resource has been procured to help support this.

Parking – the site does impact on the current parking provision and whilst this area is not approved for parking by the local authority the IES project will require this site to be freed up within the next year.

Technical solutions/sign off – key issues need to be confirmed including whether the removal of gas boilers will allow sufficient backup/resilience.

Provision of **additional substation** – the Trust will not be in full control of this and the nature of the additional new proposed electrical supply to site may be complicated by other landowners and/or the utility provider. The utility provider is fully engaged in the scheme but the project will be reliant on their performance.

10. Implementation Milestones

The completion date to the project is set by Salix as being June 2025.

Phase 1 fully operational	July 2023
OBC Approval	July 2023
Planning Approval	December 2023
FBC Approval	7th December 2023
Start on site	December 2023
Construction completion	April 2025
Commission and handover	December 2025

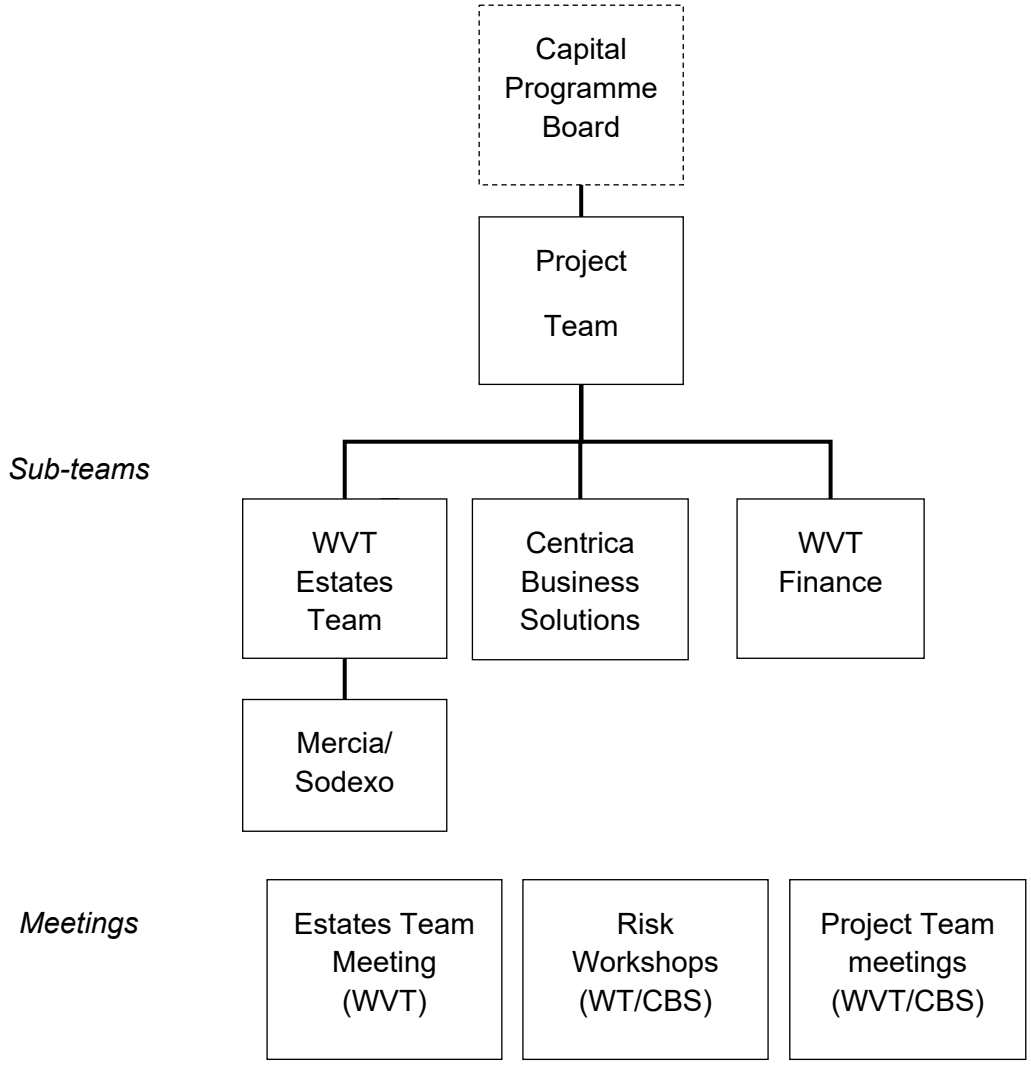
The detailed programme can be found in Appendix F.

11. Management and Commercial

11.1 Management

Management of this project is through a Project Team chaired by the Chief Strategy and Planning Officer. Membership comprises of the Estates Capital Project Management, Technical Management team, Finance, Health and Safety, Fire Safety, Security, Mercia Healthcare Ltd, Sodexo and Centrica.

Progress against project milestones will be reported through the Capital Programme Board chaired by the Managing Director. This Board has oversight of major capital projects across the Trust. The project organogram is shown below.



11.2 Maintenance

Management and maintenance of the Integrated Energy Solution when installed will be provided and guaranteed by the contractor as part of the current contract package for a period of 10 years. All other maintenance will be through the existing PFI contract.

11.3 Deed of Amendment

The deed of amendment between WVT and Centrica can be found in Appendix G.

11.4 CDEL

Section 9.4 identifies accounting issues arising from the nature of the contract and associated payments and the grant funding agreed. As indicated, the Trust is taking advice on delivering a solution to the technical accounting issue.

12. Conclusions and Recommendations

We are asking for Board Approval to proceed with Public Sector Decarbonisation Scheme Phase 2, namely the Construction of a new Energy Solutions Building to provide energy from electricity via a combination of air to air and air to water heat pumps removing the reliance on the existing gas/oil fired steam boilers providing a reduction in CO2 greenhouse gases of 3099T and to agree the post works completion resilience solution. Funding has been sourced and secured in full via a Salix grant application.

13. Appendices

The following appendices can be found as separate documents.

13.1 Appendix A – Project budget

13.2 Appendix B – Project cash flow forecast

13.3 Appendix C - Connection to the new Energy Centre District Heat Network

13.4 Appendix D – Car park closure

13.5 Appendix E – Risk register.

13.6 Appendix F – Programme

13.7 Appendix G – Deed of Amendment

13.8 Appendix H – Resilience Options Costs

13.9 Appendix I – Financial Energy savings over 10 years

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Maternity Services Quality Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To provide Trust Board with a quarterly update in line with Trust, local and national reporting requirements.

2. Recommendation(s)

Board is asked to note the updates.

3. Executive Director Opinion[1]

This report provides an overview of key activities during September and October. Board is asked to note:

- That the LMNS and region conducted an Insights visit on 18th October, the visit went well with lots of positive feedback and Quality Committee received the full report in November.
- The midwifery workforce position and cessation of agency other than in extremis is a positive achievement.
- The launch of the new website is exciting and coproduction with the MVP has been really positive
- The alignment of reporting arrangements across the foundation group has been ongoing. We must aim to have this concluded and implemented early in the new calendar year.

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

4. Please tick box for the Trust's 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***

Maternity Services Quarterly Report

Executive Summary

Maternity service reporting is largely determined by national recommendations set out in documents such as the Clinical Negligence Scheme for Trusts (Year 5), the Ockenden Report 2022 and the Single Delivery Plan for Maternity and Neonatal Services 2023. These documents also outline the responsibility of the Trust Board which is summarised as *a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.*

In order to align with the national recommendations a review of maternity reporting across the Foundation Group is underway. Whilst the report templates are to be agreed, what is required locally is the monthly submission of the PQSM report and the Minimum Data Set as standing items to Quality Committee. These are also required to be submitted to Trust Board monthly, with the Minimum Data Set being shared through Private Board. In addition to this and to ensure both Quality Committee and Trust Board have oversight of exceptions within the service, this quarterly report will meet this purpose, and will no longer include duplicated data otherwise reported through the monthly reports.

Trust Board received a maternity quality report in October 2023 which covered Q2, June, July and August. This report covers the period September and October 2023, but is not a complete quarterly report due to the exceptions that are required to be reported within a set time frame in order to meet CNST standards.

This report addresses four key questions:

- **Are we safe and how do we know?**
- **What is new and different?**
- **What are we especially proud of?**
- **What are we worried about and what are we doing about it?**

Are we safe and how do we know?

The monthly PQSM report and associated minimum data set outline the Maternity Quality Indicators.

Maternity Triage:

The service has focussed on Maternity Triage, with the planned estate improvements now underway and expected completion early December. The new policy to roll out BSOTS (Birmingham Symptom Specific Triage System) has been completed and will be approved by PAGG in December.

The workforce for triage has been templated to facilitate 2 midwives and 1 support worker 24/7 to cover the service. Of the midwives, one will be a core triage midwife and the core midwifery team has been successfully recruited to. Training for the roll out for BSOTS has been planned and is led by the Consultant Midwife. A robust audit plan is underway and the audit results to date are reassuring with the benchmark assessments. Work is also ongoing to improve the mechanisms for coding.

Currently scoring a 20 on the risk register, we expect this to reduce by February once BSOTS is fully implemented.

Insight Visit

In October, we welcomed the LMNS and members of the Midlands Perinatal Team to undertake an insight visit. We have, last week, received the formal report which has been included as appendix to this report. We are pleased with the recognition of many positive workstreams and we are addressing the areas for improvement. We will formulate the work into the wider actions for the service and escalate future concerns through exception reporting.

Workforce/Staffing

The most up to date BirthRate+ Report was undertaken in 2021. The report outlined a midwifery workforce with a reduction in the overall WTE. The Trust Board took the decision at that time to not reduce the workforce and to maintain the previous 2018 report workforce establishment. The service confirms that the actual establishments remain in line with the 2018 recommendations and the budget reflects this establishment.

With respect of this, the service outlines a true midwifery vacancy rate at 2.84wte. Maternity leave currently leaves the service with an actual vacancy rate 7.94wte; that said 6wte have been recruited and are joining the Trust between December and February. The use of agency midwifery has now ceased, with no agency shifts booked or required throughout December and January. We previously reported that specialist midwives had all committed to 1x 7.5hour shift per week in clinical practice. This has reduced significantly with the team being able to return to their full specialist roles from December, operating on a standby basis to support in short notice absence or high acuity. We have valued their support and commitment to their specialist roles and clinical duties during this time. Agency midwifery will now only be used in exceptional circumstances and close monitoring and reporting will continue.

CNST requires the service to deliver 1:1 care to all women meeting specified criteria, and reporting of this is included on the maternity dashboard. There is also a requirement for the Delivery Suite Co-ordinator to remain supernumerary with clear definitions of this also included with the CNST standards; this is also included on the dashboard. The service previously reported incidence of Delivery Suite Co-ordinator losing supernumerary status but the individual cases were Inphase reported and reviewed, and care was provided to a low risk PN which is acceptable practice and occurs rarely. The dashboard has been updated to reflect this.

What is new and what is different?

Website

Earlier this year we were granted funding from the LMNS to invest in the WVT Maternity website. We have been fortunate to benefit from the funding which has enabled a midwife to focus on this work. We extend our thanks to the midwife, MVP, communications team, and those who have supported the accessibility standards. We are now in a position to launch the website and we expect the go live within the next month.

Service User involvement

Quarterly Maternity Voices Partnership (MVP) meetings continue. Staff and service user representation is generally good, but awareness needs to be raised within our BAME and vulnerable service users groups. Work is underway to raise the profile of these meetings within those groups. The service has worked closely with the MVP to develop a 'Roadshow' where the MVP meetings now take place across the County, including in more difficult to reach areas. Additionally, collaborative work is underway between MVP and Hereford SANDS to ensure the voices of bereaved parents and families are heard and feedback is actioned. The MVP Chair has supported the MVP for more than 2 years, bringing about positive change and supporting and influencing the service, has been valued in this role. She has resigned from post due to other commitments and the MVP continues to be supported by the Co-Chair whilst recruitment is underway.

What are we especially proud of?

Caring for you

We previously shared that we signed up to the RCM Caring for You Charter on 5th May 2023 – International Day of the Midwife. This, outlines our commitment to care for midwives and support staff to facilitate them to care for women and their families. We have developed a half day study day in line with this, and the first one was held on the 17th November. The agenda included:

- Team building
- Insights work
- Coaching
- Culture influence
- Professional Midwifery Advocate sessions

Feedback from the day was positive with all candidates confirming that they value an annual team time out session. Further support has been garnered from the Employee Wellbeing Nurse. We celebrated the International Day of the Maternity Support Worker on 24th November. We recognise that support staff in our services extend beyond the specific title and this included our clinical and non-clinical support roles.

Safety Champions

The Maternity Safety Champions are working to standards set out by NHSE and those within CNST Safety Action 9. This includes meeting monthly, undertaking walk-abouts in the clinical area, direct links with MVP and meeting with the Perinatal Quad. The meetings with the Perinatal Quad offer the opportunity to review support that is required from the Board. Meeting held on the 2nd October did not raise any specific action for Board. However, an exception from the Perinatal Quad meeting held on 3rd November was to review the reporting to Board, Quality Committee and F&PE and this has been outlined in the opening chapter within the Executive Summary section of this report.

What are we worried about what are we doing about it?

Service User Feedback

After getting off to a very strong start following the launch of the Friends and Family Feedback Test being launched via a text messaging service, October saw only 2 respondents. The whole maternity team has been reminded of the importance of gathering this information and have been asked to support and encourage women to respond. We will monitor this closely.

We continue to await the publication of the CQC Service User Survey, although this is anticipated in the coming weeks.

Diabetes Service

We previously reported a small number of serious incidents that were attributable to women with diabetes. We recognised and commenced a series of learning and quality improvements to address these concerns.

The team are utilising the element 6 of the Saving Babies Lives Care Bundle as the basis for the improvements required. We have identified a substantive funding stream from NHSE that will enable us to recruit a Diabetes Specialist Midwife 0.6wte. The job description has been based on the specialist role in South Warwickshire and we aim to recruit before year end.

CNST and Saving Babies Lives Care Bundle Version3

We have updated on this in a separate report.

Appendix 1

The Perinatal Quality Surveillance Model – October 2023

1. Purpose

1.1 The purpose of this report is to provide the Trust Board, the Local Maternity System (LMS), the Regional Chief Midwife, the Integrated Care System (ICS) and Care Commissioning Group (CCG) with a monthly overview to enable consistent and methodical oversight of maternity services, provide assurance and address any arising concerns in a timely manner.

1.2 This report covers the months of October 2023

The report addresses the following key areas:

- Activity
- Perinatal Morbidity and Mortality (Inborn)
- Maternal Morbidity and Mortality
- Insight (moderate datix and above, new HSIB referrals, Healthcare Safety Investigation Branch (HSIB)/NHS Resolution/Care Quality Commission (CQC) or other organisation with a concern or request for action made directly with Trust, Coroner Regulation 28 made directly to Trust)
- Workforce
- Involvement (compliments, complaints, Staff feedback from frontline champions and service walk-abouts)
- Improvement (Clinical Negligence Scheme for Trusts) progress, Training Compliance, Continuity of Carer)

2. Background

2.1 The revised Perinatal Quality Surveillance Model was published by NHS England in December 2020 in order to identify Trusts that require support before serious issues arise. It seeks to provide a consistent and methodical oversight of all services, specifically maternity services. The model has also been developed to gather ongoing learning and insight, and to inform improvements in the delivery of perinatal services.

Wye Valley NHS Trust and its board, supported by the senior maternity and neonatal teams and the board-level Executive and Non-Executive safety champions, will ultimately remain responsible for the quality of the services provided and for ongoing improvement to these through the existing governance processes and monthly safety champions meetings. As the commissioners of maternity care, our local ICB also has a statutory role to improve quality, safety and outcomes for our patients. The quality model supports trusts and ICB's to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

The perinatal model is designed to function in the emerging architecture in the NHS, whereby Integrated Care Systems (ICS) (with full involvement of providers and commissioners) will be responsible for system planning, governance and accountability, management of performance and reducing unwarranted variation in care and outcomes. ICS are at different stages of development. It is, therefore, important that during this period of change, transitional arrangements for quality oversight are appropriate to each local system.

The 5 main principles of the Perinatal Quality Surveillance Model are:

1. Strengthening trust-level oversight for quality (helping to ensure that issues are addressed in a timely fashion without the need for external intervention).

2. Strengthening Local Maternity System and ICS role in quality oversight (enabling a system-wide view of quality).

3. Regional oversight for perinatal clinical quality (where specific insight from a range of system partners is linked into revising regional quality models through the chief midwife and lead obstetrician).

4. National oversight for perinatal clinical quality (if interventions do not resolve the quality issue or if they are so serious as to warrant immediate escalation).

5. Identifying concerns, taking proportionate action and triggering escalation at all levels of the model, the constituent parts have a clear sense of their role, remit and interventions at their disposal and of when to escalate issues.

3. Activity

The month of October saw a slight increase in the number of births from 131 up to 140. There were 3 sets of twins, taking the total number of babies born up to 146.

The induction of labour rate for September increased up to 39.3%, this has been the highest during this financial year, there is no obvious indication for the increase.

The Robson Group 5 data dropped to 87.5% for October. There were 2 mother's that had a vaginal birth following caesarean section.

4. Perinatal Morbidity and Mortality (Inborn)

There was 1 late fetal loss during the month of October.

There was 1 early neonatal death (between 0-6 days of age) during the month of October. This detail is outlined within the minimum data set. The family are being supported by the bereavement midwife.

During the month of October there was a case reportable as a maternal death to MBRRACE. All deaths of women must be reported if they have had a pregnancy in the 12 months prior to their death. The woman died from complications not related to pregnancy, and an inquest is to be held. Further detail is outlined within the minimum data set.

5. Insight

During the month of October there was 1 case reported as a moderate incident. A wider piece of work will now be undertaken across the Trust to review all outstanding EPMA reports.

There were no HSIB referable cases during the month of October.

There were no concerns raised from the Healthcare Safety Investigation Branch (HSIB) during October.

There were no Coroner Regulation 28 made with the Trust during October.

6. Workforce

There was an increase in the number of obstetric consultant rota gaps for the month of October with 284.75 hours of gaps across delivery suite and the maternity ward. All gaps were covered by existing members of the team and no locum use.

October saw a significant decrease in the number of obstetric middle grade rota gaps from 213.3 hours down to 59.25 hours. These were again covered by existing members of the team.

There were 14 rota gaps for anaesthetics during the month of October, static from the previous month's gaps. All shifts were covered by existing members of the team.

There were 43 midwifery rota gaps for October, a slight decrease on September. The majority of these gaps were filled by existing members of the team and agency midwives. The new band 5 midwives are now completing their supernumerary period and will be included in the numbers by the end of November.

There were 2 Inphase reports submitted relating to staffing during the month of October.

Our current true midwifery vacancy rate sits at 2.84wte. Maternity leave currently leaves the service with an actual vacancy rate 7.94wte with 6wte having been recruited and joining the Trust between December and February.

The audit findings for the twice daily MDT ward rounds have increased up to 96% for October.

There were no Inphase reports for the month of October for a lack of 1:1 care in labour. We continue to ensure women are provided with 1:1 care in line with national recommendations. The Delivery Suite Co-ordinator has been kept supernumerary at all times in line with CNST recommendations.

7. Involvement

There were 15 compliments received during the month of October. The Friends and Family Test text messaging continues, however there was only 2 service user that responded during the month of October. We have asked the community midwifery team to advocate for the FFT service to parents in the postnatal period as well as general communication across the maternity department in the hope that the response rate will increase. Both respondents recommended the service and gave positive feedback. The only area that scored lower was in relation to the food on the ward.

There was 1 complaint received during the month of October. The concerns were raised around communication from 1 individual member of staff. The context of this has been included within the minimum data set.

There was 1 concern raised during October. Due to small numbers and a risk of patient identification, details of this have been included in the minimum data set.

There were no concerns raised by staff during the safety champion's walkabout or to the maternity patient safety and senior management team during the month of October.

Maternity received 1 new claim within the month of October. This claims relates to a HSIB case from 2021 regarding an intrapartum stillbirth. All learning from this case was addressed immediately following the incident and on receipt of the HSIB investigation report.

8. Improvement

CNST 10 compliance overall is subject to a separate report this month, those standards subject to monthly reporting are detailed below.

We will continue to review all scenarios where a consultant obstetrician must attend and will now report on this monthly as per CNST year 5 requirements. The scenarios are as follows:

- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary
- Caesarean birth for major placenta praevia/abnormally invasive placenta
- Caesarean birth for women with a BMI > 50
- Caesarean birth < 28 weeks gestation
- Premature twins (< 30 weeks gestation)
- 4th degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal collapse e.g septic shock, massive abruption
- Post-partum haemorrhage > 2 litres where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated

During the month of October there were no scenarios as detailed above, where the obstetric consultant was required to attend.

Training compliance for the PROMPT update day continues to be monitored monthly as required for CNST compliance. Obstetric consultant figures currently sit at 100% for October with obstetric registrars sitting at 85%. The midwifery compliance has decreased down to 85%. Plans are in pace to ensure the remaining members of staff who are out of compliance will attend the November update day. CNST provided an update to safety action 8 whereby 80% compliance will still see Trusts meeting the safety action, however there must be an action plan in place to ensure the 90% is achievable. Anaesthetic consultant compliance is 100%. The anaesthetic registrars are currently sat at 50%, this has been escalated and plans are in place to increase compliance by the December deadline.

WVT - Perinatal Quality Surveillance Model

	CQC Maternity Ratings	Overall - Good	Safe - Requires improvement	Effective - Good	Caring - Good	Well-Led - Good	Responsive - Good						
	Maternity Safety Support Programme - No												
		apr-23	**mai-23**	**jun-23**	**jul-23**	**aug-23**	**sep-23**	**okt-23**	**nov-23**	**des-23**	**jan-24**	**feb-24**	**mar-24**
	Activity												
	Total number of Births	125	161	130	137	146	131	140					
	Induction of Labour rate %	32,00 %	35,40 %	37,7%	38,7%	33 %	29,00 %	39,30 %					
	Unassisted Birth rate %	47,20 %	42,90 %	43,1%	34,3%	42,50 %	35,10 %	40,70 %					
	Assisted Birth rate %	12,00 %	12,40 %	10,0%	13,1%	10,30 %	11,50 %	12,10 %					
	Robson Category Group 1 (Nulliparous, single cephalic, > 37 weeks, spontaneous labour): number of C/S in group	3	7	3	3	0	10	4					
	Robson Category Group 1 (Nulliparous, single cephalic, > 37 weeks, spontaneous labour): total number of births in the group	14	23	16	13	19	24	21					
	Robson Category Group 1 (Nulliparous, single cephalic, > 37 weeks, spontaneous labour): percentage of RC Group 1 births	21,40 %	30,4%	18,8%	23,1%	0,00 %	41,70 %	19,00 %					
	Robson Category Group 2 (Nulliparous, single cephalic, > 37 weeks, a) Induced b) CS before labour): number of C/S in group	13	22	20	17	24	17	26					
	Robson Category Group 2 (Nulliparous, single cephalic, > 37 weeks, a) Induced b) CS before labour): total number of births in the group	22	37	32	29	35	28	37					
	Robson Category Group 2 (Nulliparous, single cephalic, > 37 weeks, a) Induced b) CS before labour): percentage of RC Group 2 births	59,10 %	58,2%	62,5%	48,6%	68,60 %	60,70 %	70,30 %					
	Robson Cateogory Group 5 (G2+, Previous CS, single cephalic,>37wks (a) Spontaneous labour (b) Induced (c) CS before labour): number of C/S in group	19	26	15	27	20	21	14					
	Robson Cateogory Group 5 (G2+, Previous CS, single cephalic,>37wks (a) Spontaneous labour (b) Induced (c) CS before labour): total number of births in the group	20	30	17	27	21	22	16					
	Robson Cateogory Group 5 (G2+ Previous CS, single cephalic,>37wks (a) Spontaneous labour (b) Induced (c) CS before labour): percentage of RC Group 5 births	95,00 %	86,7%	88,2%	100,0%	95,20 %	95,50 %	87,50 %					
	Perinatal Morbidity and Mortality inborn												
	Total number of perinatal deaths												
	Number of late miscarriages 16 to 23+6 weeks excl TOP	1	0	0	1	1	1	1					
	Number of stillbirths (>=24 weeks excl TOP)	0	1	0	0	0	0	0					
	Number of neonatal deaths : 0-6 Days	0	0	0	0	0	0	1					
	Number of neonatal deaths : 7-28 Days	0	0	0	0	0	0	0					
	Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	0	0	0	0	1	0	0					
	Maternal Morbidity and Mortality												
	Number of maternal deaths (MBRRACE)	0	0	0	0	0	0	1					
	Insight												
	Number of datix incidents graded as moderate or above (total)	0	0	0	0	2	0	1					
	New HSIB SI referrals accepted	0	0	0	0	1	0	0					
	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0					
	Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0					
	Workforce												
	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	189	173	301	56,75	128,5	162	284,75					
	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	71,5	54	13	206	142	213,3	59,25					
	Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	10	4	3	7	16	14	14					
	Minimum safe staffing: midwife minimum safe staffing planned cover 48versus actual prospectively (number unfilled shifts)	83	41	62	53,84	40,8	54	43					
	Vacancy rate for midwives (black = over establishment, red = under establishment	9,83	11,26	11,26	13,09	13,09	13,85	2,84					
	Datix related to workforce (service provision/staffing)	2	6	9	14	11	27	2					
	MDT ward rounds on CDS (minimum 2 per 24 hours)	83,4%	83 %	90 %	81 %	83 %	84 %	97 %					
	One to one care in labour (as a percentage)	100,0%	100 %	100 %	100 %	100 %	100 %	100 %					
	Number of times maternity unit attempted to divert or on divert	0	0	0	0	1	1	0					
	Involvement												
	Service User feedback: Number of Compliments (formal)	17	30	21	14	22	20	15					
	Service User feedback: Number of Complaints (formal)	0	0	2	2	0	0	1					
	Staff feedback from frontline champions and walk-abouts (number of themes)	1	0	1	0	1	0	0					
	Improvement												
	Progress in achievement of CNST /10	10	TBC	TBC	TBC	TBC	TBC	TBC					
	Training compliance in maternity emergencies and multi-professional training: Midwives	89 %	87 %	82 %	94 %	89 %	98 %	85 %					
	Training compliance in maternity emergencies and multi-professional training: Obstetric Consultants	100 %	100 %	90 %	89 %	89 %	90 %	100 %					
	Training compliance in maternity emergencies and multi-professional training: Obstetric Registrars	88 %	88 %	88 %	89 %	89 %	90 %	85 %					

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	CQC Action Plan - Maternity inspection report publication October 2023
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

The board received the CQC inspection report at its meeting in October. This report covers the action plan relating to the inspection that took place in June 2023.

2. Recommendation(s)

Board is asked to note the content of the action plan.

3. Executive Director Opinion[1]

The actions when completed will fully address the findings of the CQC inspection
The risk assessments for high risk women and for the obstetric support worker role will be added to the Executive Risk Management Committee agenda in January.
Board is asked to receive further updates as required. Given the limited number of actions it is proposed that updates are provided in the quarterly updates.

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.

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	CNST Board Progress Update
Status of report:	**☒Approval ☒Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To provide Trust Board with an overview of performance against CNST Year 5 standards.

2. Recommendation(s)

Board is asked to receive the update and delegate the final internal sign off to the Quality Committee and in particular the Board level Safety champions and Chair of Quality Committee.

Board is being asked to delegate two aspects as follows:

- The declaration of compliance prior to submission in February 2024
- The review and sign off of any related submissions/documents that require trust level oversight

The delegated parties will make a recommendation to the CEO and ICB CEO for final sign off, based on their assessment.

3. Executive Director Opinion[1]

The position described in this update report is the assessment of the maternity service and local LMNS as of the end of November 2023. There are 2 months in order to continue with the work required to achieve compliance and obtain a full review from the LMNS.

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

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

[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.

CNST Year 5 Progress Report

Executive Summary

Maternity services are reporting to Trust Board progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 standards. The Board is asked to note progress against each of the 10 safety actions set out within the MIS standards.

In order to comply with the scheme, and to be eligible for payment under the scheme, Trusts are required to submit their completed Board declaration form to NHSR by 12 noon on the 1st February 2024. In line with last year's quality assurance undertaken by the LMNS, we are seeking their support with a review of each safety action again this year prior to declaration.

Within this report, there are a number of documents that require Trust level sign off. These requests are clearly identified by **bold text** in each of the relevant sections. There is no January Board meeting and therefore, **we request the delegation for sign off of CNST to Quality Committee, which will be held on the 25th January**. Given the complexities of standard 6 which is the revised version of the saving babies lives care bundle version 3 an additional review of this standard has been arranged with the board level maternity safety champions and quality committee chair.

Safety Action 1: Status - Compliant

The service is required to review all perinatal deaths above 22 weeks gestation, to a required standard using the national Perinatal Mortality Review Tool (PMRT). The qualifying period is deaths from 30th May 2023, and the service confirms there have been no deaths meeting the criteria in this time period. Under the technical guidance, Trusts who do not have any deaths meeting the criteria are required to partner with another Trust to ensure learning can be taken from reviews conducted. The team have partnered with the team at Worcester Acute Hospital Trust on monthly basis throughout this time period and are able to evidence through minutes and actions that this has been achieved. Additionally, where a woman who has received antenatal care with us and has a baby that dies in another Trust, we partner with that Trust to undertake a joint PMRT and ensure learning is taken.

Safety Action 2: Status - Compliant

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

Safety Action 3: Status – Compliant

The service is required to demonstrate that Transitional Care Services are in place to minimise separation of mothers and their babies. The pathways to Transitional Care are well established and meet the criteria as set out within this action. **Board is asked to delegate sign off of the action plan prior to full submission.**

Safety Action 4: Status – Under Review

The service is required to demonstrate an effective system of clinical workforce planning to the required standard. This is separated into 4 subcategories:

a) Obstetric medical workforce

The Trust meets the standards set out within section 1, 2 and 4 of this standard with regard to employment of long and short term locums, and the presence of the Obstetric Consultant at specified clinical scenarios as outlined in the RCOG Roles and Responsibilities document and this is reported on monthly within the PQSM report. However, the Trust is required to implement the RCOG guidance for compensatory rest for Consultants on-call, however we are not currently able to achieve the standard set out. We are able to declare compliance on the presentation of an action plan, to demonstrate how this will be achieved.

b) Anaesthetic medical workforce – compliant

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

c) Neonatal medical workforce – compliant

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

d) Neonatal nursing workforce – subject to further approval

The Neonatal nursing workforce does not currently comply with BAPM standards, yet with good rational for a small unit, this was accepted for submission in Year 4; this is subject to a further update. **Board is asked to delegate sign off of the obstetric and neonatal plans prior to full submission.**

Safety Action 5: Status – Compliant

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

Safety Action 6: Status – Awaiting Confirmation

There are 6 elements within this years' Saving Babies Care Bundle and the team have divided the work amongst the specialist roles. The requirement to achieve CNST standards is a minimum of 50% compliance with each element with a minimum of 70% overall. The LMNS are required to review the evidence and confirm compliance over 2 quarters. The first check has been undertaken and we are awaiting the result and feedback which we will share at the next Quality Committee. The team will continue to progress the work and will undergo the second review in January, every effort is being made to achieve compliance. Following the LMNS feedback. **Board is asked to delegate sign off to prior to full submission.**

Safety Action 7: Status – Compliant

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

Safety Action 8: Status - Compliant

This action is linked to the multi-disciplinary training compliance which was originally set to 90% across each professional group – to be achieved by 1st December. Since publication, NHSR have reduced

compliance to 80%, however where compliance between 80-90% is met, an action plan to meet the required 90% must be signed off by Trust Board.

The training has been met at 90% compliance across all relevant elements of the Core Competency Framework V2 across almost all staffing groups. The only exception in this report is the multi-disciplinary skills one day training (PROMPT) that has not achieved 90% compliance amongst the anaesthetists. Compliance is at 81% and therefore an action plan has been developed in line with submission requirements.

Within this safety action, there is also a requirement to sign off the 3 year Training Needs Analysis (TNA) which is completed within the national tool. **Board is asked to delegate the action plan for anaesthetists and the TNA prior to full submission.**

Safety Action 9: Status – Awaiting LMNS confirmation

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

Safety Action 10: Status – Compliant

Services are required to report 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023. We are fully compliant.

The LMNS will peer review and sign off compliance with CNST in January and their view will be considered as part of the final submission status which Board is being asked to delegate to Quality Committee and relevant personnel as required.

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Policy Panel Update
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Policy Panel, Board
Lead Executive Director:	**Managing Director**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on those policies that have been presented to and approved by the Policy Panel plus, as requested at November 2021's Board meeting, to provide assurance on the overall provision of policies within WVT.

2. Recommendation(s)

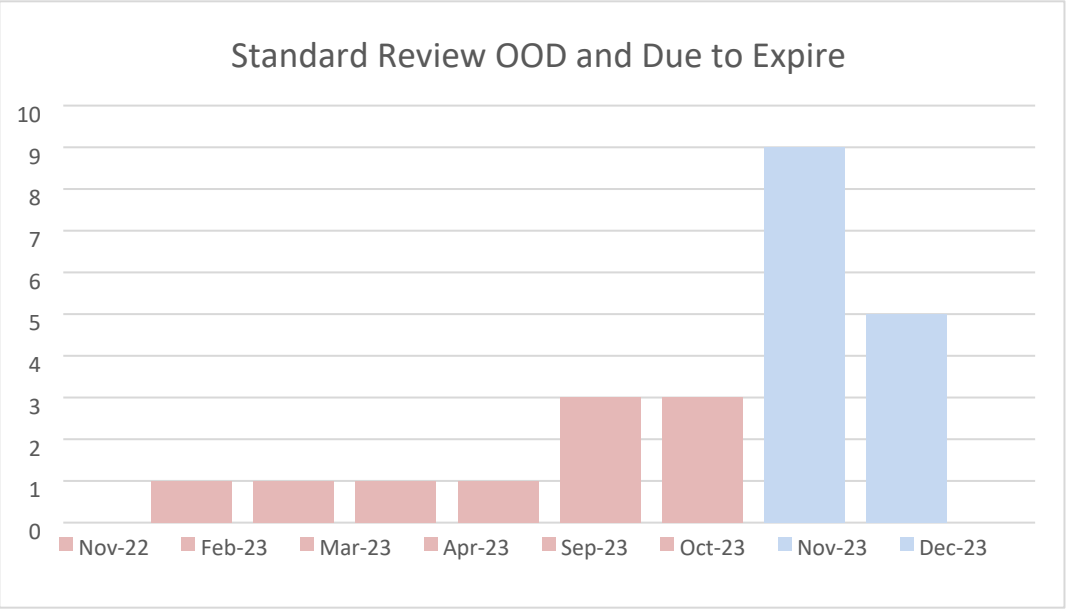
To note those policies approved by the policy panel, on behalf of the WVT Board, since it last reported to Board in June 2023.

3. Executive Director Opinion[1]

The Trust's Policy Panel, chaired by the Managing Director: ratifies policies and provides the Board with a summary; approves related documentation; ensures that documentation is presented in the Trust format and has been catalogued on the Trust database; and, monitors the adherence to the developmental processes to maintain the quality of documentation.

The table below provides an overview of the trust's position with the provision of policies.

Total # of Policies being updated (within 6 months of expiry)	Total # of Policies: Out of Date	Total # of Policies: About to Expire (within 60 days)
24 (decrease of 1 since June 2023)	**10 (increase of 5 since June 2023)**	**14 (decrease of 6 since June 2023)**



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

The panel has approved the following policies (linked to the Trust intranet) since it last reported to Board on June 1, 2023:

IC.35 Norovirus Outbreak Policy
PR.192 Mouth Care Policy
PR.S.30 Surgical Robotics SOP
HR.17 Study Leave Policy - To replace policy document with 6 standalone documents managed through Education and HR dept.
IG.05 Confidentiality Code of Conduct Policy
IC.20 Pulmonary Tuberculosis Policy
HR.81 Supervision Policy
HR.87 Criminal Records DBS Check Policy
HR.37 Capability Policy
HR.02 Disciplinary Policy
HR.89 Redeployment Policy
HR.33 Professional Registration Policy
HR.S.02 Agile Working Policy
PR.70 Injectable Medicines Policy
PR.71 Antimicrobial Policy
HR.01 Grievance Policy
PR.S.32 EZ-IO Intraosseous Vascular Access System SOP
MF.S.07 Quality Impact Assessment SOP
PR.150 Critical Care Outreach Policy
MF.30 Risk Management and Assurance Policy
HS.06 Safe Moving & Handling (including Guidelines for Managing Bariatric Patients) Policy
MF.45 Overseas Visitor Policy
PR.106 Infant Feeding Policy
PR.171 Rapid Tranquillity Policy
EP.05 Lockdown of a Trust Premise, Site or Building Policy and Procedure
EP.03 Adverse Weather and Health Planning
EP.S.05 Very Important Persons (VIPs), High Profile Patients (HPPs)
IG.10 Information Governance High Level Policy
PR.196 Diabetes Transitional Policy
PR.S.26 Boditrak Pressure Mapping SOP
PR.S.02 - Management of Nasogastric Tubes (NGT) SOP
MF.12 Foundation Group Procurement Policy
IC.30 Respiratory Virus Policy
HS.30 Prevention of Violence, Aggression, Discrimination and Harassment of Staff and Application of Sanctions Policy
PR.146 Trust Policy for the Management of Illegal and Illicit Substances within WVT
PR.135 Maternal Death Policy
IG.03 Freedom of Information Policy
HS.S.01 Display Screen Equipment
PR.155 Visitor Access Policy

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

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Health, Safety and Wellbeing Annual Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☒**Discussion**
Report Approval Route:	Health Safety and Wellbeing Committee, Executive Risk, Trust Board
Lead Executive Director:	**Managing Director**
Author:	Luan Lawson, Health, Safety and Risk Officer
Documents covered by this report:	Health Safety and Wellbeing Annual Report 2022/2023

1. Purpose of the report

This report informs the Trust Board of the activities undertaken in relation to Health, Safety and Wellbeing and the Health, Safety and Wellbeing Committee during the year April 2022 to March 2023.

2. Recommendation(s)

The Board is invited to note the Trust's Health, Safety and Wellbeing Annual Report 2022/2023.

3. Executive Director Opinion[1]

The report has been produced using the Health & Safety Executive (HSE) guidance 'managing for health & safety (HSG65)'. It provides a review on management arrangements, accident performance data, and health and safety activities that have taken place over the reporting period.

The governance arrangements in place are, in the main, good and provide assurance to the Board that legal requirements are being met and that effective health and safety standards for the protection of staff and others are implemented.

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***

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☐ ***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***

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☐ ***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.

Health Safety and Wellbeing

Annual Report 2022-2023

Authors:	Luan Lawson, Health, Safety and Risk Officer Charlotte Sturgess, Health & Safety Administrator	**Date reviewed at HSW Committee:**	October 2023
Executive Lead:	Erica Hermon, Associate Director Corporate Governance/Company Secretary	**Date reviewed at Executive Risk Meeting**	November 2023
		Date reviewed at Board of Directors	December 2023

Contents

Executive Summary

1. The management of health and safety (H&S) is a continuous process. The governance arrangements in place are improving year on year and supported by the Wye Valley NHS Trust (WVT) Employee Health, Safety and Wellbeing Strategy 2019-24. Effective management systems provide assurance to the Trust Board that legal requirements are being met and H&S standards, for the protection of staff and others, are implemented. However, this report does identify areas for development, as well as action required to improve our H&S culture.

2. The Trust's H&S legislative responsibilities to staff, patients, visitors, public and contractors remain unchanged. The Trust has an absolute duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all its employees, under the Health & Safety at Work etc. Act 1974. The implications of breaching H&S legislation can be very serious. Failure to adhere to enforcement notices and achieve compliance could lead to enforcement action, unlimited fines, prosecution or imprisonment of senior management.

3. The Trust has previously been under Health Safety Executive (HSE) enforcement action in 2019 for failure to adhere to health and legislation, specifically with regards to the safe use and management of sharps devices. It is imperative we continue to learn from this experience and engage fully with colleagues to ensure robust control measures are in place and implemented. The HSE have announced their intention to continue inspecting NHS Trusts following their 2018-2022 campaign and subsequent recommendations to manage and reduce staff incidents. The focus of their campaign were Violence and Aggression (V&A) and Musculoskeletal Disorders (MSD's). WVT must be prepared for an inspection, at any time, and ensure we can provide the appropriate legislative compliance documentation, as well as practical evidence.

4. In many ways it feels like a sense of normality has returned, following the considerable challenges presented by the coronavirus pandemic during the last few years. However, as new variants are identified, the virus will continue to present the Trust and our Private Finance Initiative (PFI) Partners, Mercia and Sodexo, with challenges. As an organisation, the Trust will be required to consider and balance future national guidance on social distancing, isolation and testing requirements, as well as managing changes to clinical practice arrangements and appropriate use of Personal Protection Equipment (PPE), while providing safe healthcare services. The complexity of the requirements upon the Trust increased as clinical services resumed and delivery increased.

5. A great deal has been achieved during another very busy and challenging time, which speaks to the commitment and dedication of staff, and we thank them all, once again.

Introduction

6. This Annual Health Safety & Wellbeing Report provides comparable analysis into the number of incidents and the standard of Health, Safety and Occupational Health throughout the Trust between periods April 1, 2022 and March 31, 2023. The report highlights good practice as well as areas where improvement is required. It also provides a focused review of the Trust's top Health and Safety priorities for 2022/23, which account for the most reported staff incidents.

7. The COVID-19 pandemic demanded an unprecedented response from all healthcare settings with its associated implications to staff and the treatment of patients. As time has progressed, new variants of the virus have emerged and the Trust continues to work collaboratively with local and national agencies to continually adapt to changing requirements to manage the health, safety and wellbeing of staff. A clearer understanding of the virus and its implications has enabled the Trust to undertake appropriate action in a more calculated and measured way, which is especially important as we head into the autumn and winter months mindful we are experiencing an increase in community cases, amongst staff and the public.

8. Throughout the year, the H&S team has continued to provide advice to all departments on a wide variety of safety topics ranging from issues including hazards associated with using chemicals, noise, building works and developing task based risk assessments. The H&S team continues to maintain expertise in aspects of occupational H&S and associated legislation in order to provide appropriate advice and guidance.

Space limitations and agile working

9. Whilst the Government lifted the need to shield some time ago, the Trust actively encourages agile and home working, where possible and appropriate to business and operational requirements. Agile working is supported by the Trusts Display Screen Equipment (DSE) procedure which identifies additional support required by staff working from home including IT and office equipment. Regular communications continue to remind staff about their H&S responsibilities in terms of compliance with adhering to safe working practices. However, as more staff return to their on-site working locations, the lack of space at Hereford County Hospital is increasingly a concern, in both clinical and non-clinical settings. As the Trust increases their delivery of patient care, recruitment and clinical space requirements can be at odds with safety working practices, and certainly in the case of back office locations, non-compliant with HSE legislation, with too many staff located in one location, despite the guidance provided by the H&S Team. Space has always been at a premium, but the concerns and risk presented related to the lack of space are escalating year on year.

Construction projects

10. Another major construction project is underway on the county site and progressing well against schedule. The Elective Surgical Hub (ESH) is being built on the footprint of the old Canadian Huts, with completion expected summer 2024. At the time of writing this report, the project has benefited from a high level of H&S compliance; a considerable achievement when taking into account the numerous and varied H&S hazards and risks presented whilst maintaining an operational hospital with access by vulnerable persons. This will present a further challenge to ensure clinical requirements can still be effectively and safety met, whilst ensuring staff and patients are kept safe during construction.

11. The temporary (tented) corridor connecting the Frailty Unit to the main hospital was required to remain in situ longer than intended, whilst the new corridor connecting the Unit to the rest of the hospital was completed in early 2023. The tented corridor presented a number of H&S concerns to staff, visitors and patients, and hazards were monitored with the assistance of Sodexo and managed by H&S and the Estates Team. The construction of the new corridor and use of the temporary corridor, without a significant H&S incident involving a staff member, patient or member of the public, is another positive and successful example of effective management of construction on site.

12. Other works have been undertaken without incident, including preparation work for the Energy Centre on the County site, which will allow the Trust to move away from fossil fuels to a more sustainable energy solution in the future, contributing to the reduction of our carbon footprint. Other minor works are being undertaken in community settings and are under constant review by H&S to ensure compliance with legislation.

Health Safety and Wellbeing Strategic Priorities

13. The Employee Health, Safety and Wellbeing Strategy 2019-24 sets out Trust commitment to providing a safe place of work for all. A safe working environment ensures the Trust is able to deliver high levels of service to our patients as well as ensuring compliance with legal responsibilities, protecting the organisation and individual Directors and Managers from legal prosecution. This report outlines the improvements made against these H&S strategic priorities as well as identifying areas for improvement.

14. The incidents reported most frequently form the top five health safety and wellbeing strategic priorities. The Trust is committed to reducing, so far as is reasonably practicable:
    - the number of sharps incidents;
    - the number of slips, trips and falls;
    - the number of incidents relating to work related stress;
    - the number of manual handling incidents;
    - incidents of V&A towards staff.

Health Safety Executive (HSE) Investigation and Intervention

15. On April 30, 2022 the HSE attended the Hereford County Hospital, following a notification of intention to inspect the Pathology Laboratories in March 2022. The purpose of the inspection was to review the Containment Level 3 (CL3) cabinet and Covid-19 testing control measures within the laboratory and was not the result of a specific incident. The HSE concluded the inspection, conducted over 1 day, without issuing any improvement or enforcement notices, or fines. There was however, some verbal adversary recommendations, which the team have addressed and completed. The success of the inspection is testimony to the great work and processes implemented by the team, often at speed, and under significant pressure.

16. In their business plan for 2022/2023, the HSE state they want to take a preventative approach to work-related lung disease, mental health at work and work-related stress and MSDs. They are focusing on these because they are the most common cause of working days lost in Great Britain.

17. During 2018-2020, the HSE conducted a number of inspections at NHS Trusts with the purpose to review how V&A and MSD's incidents were being managed. As a result of this programme of inspections, a letter was issued by HSE in March 2023 to all NHS Trusts, outlining their findings and a number of recommendations for the NHS to adopt to assist in the reduction of the number of incidents. The HSE has advised, further to the previous programme of inspections, more will follow, to ensure any assurance being provided by a Trust, is indeed being delivered at ground level. This action is in support of the HSE business plan 2022/23. The H&S Team have been working with colleagues to produce a working assurance document, which is ongoing and has been presented to the Trust Board for review. Any gaps in assurance are being addressed and will be monitored via the HSWC.

H&S Legislation

18. There have been a number of H&S legislative updates during the reporting period, with the following most pertinent to WVT:

    a. The UK's resilience to terrorism is to be stepped up, as the government announces details for the Protect Duty, now to be known as 'Martyn's Law' in tribute of Martyn Hett, who was killed alongside 21 others in the Manchester Arena terrorist attack in 2017. The draft legislation will cover all of the UK and requires venues and local authorities to have preventative action plans against terror attacks. The Trust response is being monitored via the Emergency Planning Committee (EPC), with key stake holders attending knowledge exchange events, organised by the Home Office. The EPC will provide assurance to the Trust Board in terms of planning our response and actions required with timescales, as appropriate.

b. On April 6, 2022 the Personal Protective Equipment at Work (Amendment) Regulations 2022 (PPER 2022) came into force. They amend the 1992 Regulations (PPER 1992). They extend employers' and employees' duties regarding personal protective equipment (PPE) to limb (b) workers. In summary, any individual contracted by the Trust to undertake works, but is not an employee, has the same rights to the use of any PPE provision and the appropriate training and instruction.

Health, Safety & Wellbeing Committee (HSWC)

19. The HSWC focuses upon the review and analysis of all staff health, safety and occupational health incidents, including monitoring against the top five H&S strategic priorities.

20. The Divisional reports enable the Committee to monitor Divisional health, safety and wellbeing performance, including trend analysis, deep dives and lessons learnt. The Divisions are held to account in relation to staff incidents occurring within their areas and are required to provide evidence of clear action plan implementation to improve staff safety.

21. Reporting on compliance with Statutory Standards is provided to the Committee via sub-groups including Fire, Security and Asbestos. Departments who also contribute to the meeting include Health@Work (H@W) and Education Development Centre (EDC), with an escalation route for significant risks to the Executive Risk Meeting (ERM). The reports provide assurance to the Executive Team in relation to overall H&S compliance. The HSWC is committed to monitoring Trust progress against HSE enforcement action, with significant concerns escalated as appropriate.

22. The HSWC is the main forum for health, safety and wellbeing consultation for staff within the Trust and H&S Employee and H&S Trade Union Representatives form an important aspect of the consultation process. All significant issues are shared with the Communications Team in order to ensure key safety messages are communicated with colleagues, as appropriate. Following approval by members of the Committee, the HSWC now convenes on a quarterly basis, with any decision making between Committees being approved externally to prevent delay in governance and the approval process.

Internal H&S auditing and inspections

23. The online H&S Audit is opened to Managers and Departmental Leads at the end of May each year, and the H&S Team continue to provide support to departments to complete their audits. 59 responses were received across all the Divisions for the 2022-23 Audit.

24. The audit allows for responses to be emailed back to the auditor for their records and to produce action plans for the department, as appropriate. A list of completed audits

is provided to the Divisions at the HSWC quarterly meeting, and upon request. All feedback from the responses will help make the audit more robust and more specific to Divisions going forward. The audit process assists the H&S Team to identify departments which need additional support and direction with their H&S processes.

25. Although there is no legal requirement for the Trust to conduct H&S audits, the HSE guidance document HSG65 Successful H&S Management recommends that audits are undertaken. Undertaking H&S audits forms part of WVT's commitment to H&S best practice and assists in ensuring compliance with H&S Legislation and the NHS Council Workplace H&S Standards, created in conjunction with the HSE. As with our group colleagues, the requirement is outlined in our WVT H&S Policy section 7.5.

26. Directors and Senior Managers have responsibility within their Divisions for implementing the requirements of Trust H&S policies in their areas and submitting annual audits to the H&S Team. In turn, H&S Team provide appropriate assurance to the Board of Directors that legal requirements are in place and that our control measures are effective.

27. The audit is designed to assess the key elements of H&S management, improving safety in the workplace by identifying potential risks, reducing incidents and accidents, improving communication of procedures and engaging employees in a constantly improving safety culture. The audit information is essential when responding to issues or questions regarding H&S and is key in collating vital information from departments, including risk assessments, training, resource concerns and monitoring activities.

28. The H&S Team, with support from Trade Unions and H&S Representatives, Infection Prevention Control Team (IPC) and the Estates Team, undertake routine unannounced H&S inspections. The purpose of the inspections is to highlight hazards and associated risks to the department before an incident occurs. The choice of where to inspect first can be informed by the Annual Audit. All significant risks are escalated to departmental leads for inclusion on their risk registers until the hazards can be eliminated or suitably reduced via appropriate control measures, so far as reasonably practicable.

H&S Training

29. There is a legal duty on employers to provide suitable and sufficient training to their staff. The EDC coordinate training at the Trust providing statutory and mandatory, clinical and non-clinical training courses to support staff in their roles. H&S training compliance figures are reported monthly and monitored through the HSWC. A series of core Health & Safety training courses are provided including Fire Safety, V&A (Conflict Resolution), Resilience, Moving & Handling and H&S Awareness training are provided either face to face and/or via e-learning packages. Figures provided by the EDC show a consistent number of staff attending Mandatory H&S training.

30. For the period Trust April 2022 – 31st March 2023 overall compliance rate was:

Training Course	Competency	Compliance Figure
Fire Safety.	Annual	87.16 %
NHS Conflict Resolution	3 years	92.1 %
Moving and handling. L1	3 years	92.25%
Moving and Handling. L2	2 years	77.56%
Health, Safety & Welfare	3 years	94.95%

31. There has been non-compliance with the H&S (First Aid) Regulations 1981,which requires employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work, due to the organisation not having trained subject matter experts in First Aid employed by the organisation. This has applied specifically to off-site offices where staff are based away from the Acute and Community Hospital sites

32. In the absence of an onsite/in-house first aid trainer, the Foundation Group are adopting a standard approach in terms of first aid. GMC registered Doctors, NMC registered nurses and HPC registered paramedics are classed as first aiders. Therefore, areas where these types of staff work do not need additional first aid trained staff. Further, EDC have identified non-recurrent funding for first aid training, as well as training dates for staff via an external education providers, prioritising staff based in non-hospital settings. A Managers Guide for First Aid will now be compiled and the topic is under HSWC review and monitoring.

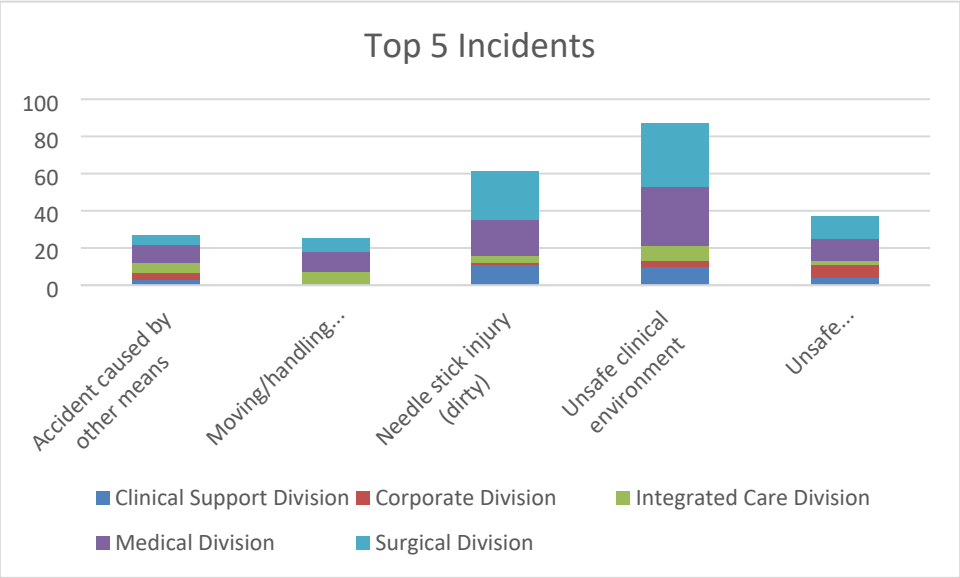
33. In addition, the H&S Team, with support from EDC and Digital Leads, have explored an e-learning package solution to provide Control of Substances Hazardous to Health (COSHH) risk assessment training for staff, linked to their ESR record. At the time of writing, the training package is near completion. In addition, H&S have created a COSHH Information Guide, approved by HSCW and loaded onto the H&S Intranet page, in order to support staff in their completion of risk assessments.

H&S incidents reported 2022 - 2023

34. There have been a total of 369 H&S incidents recorded for the reporting period 2022/23, compared with 369 in 2021/22, representing no increase in reported incidents, though the incident data differs. The number of incidents are grouped by divisions and severity below:

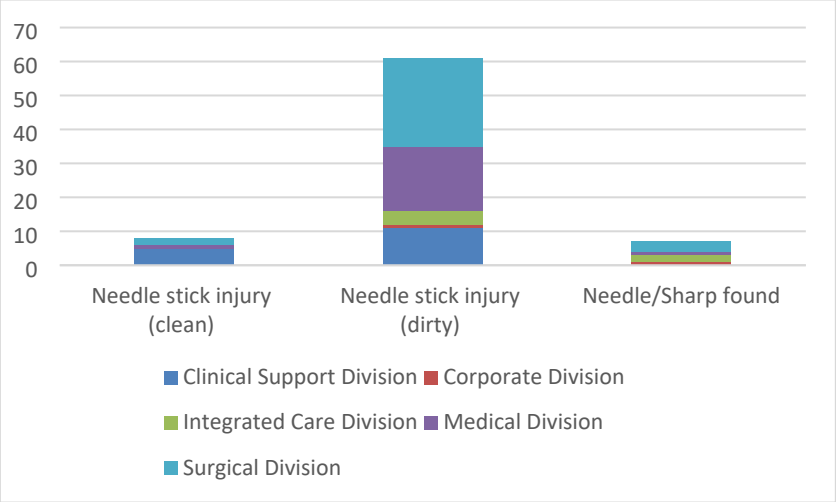
Division	No harm (2022-23)	Low (2022-23)	Moderate (2022-23)	Total 2020/21	Total 2021/22	Total 2022/23	Trends ⇧⇩
Surgical	75	51	0	99	131	128	⇩
Medical	62	40	6	86	96	109	⇧
Integrated Care	29	15	3	36	50	48	⇩
Corporate	17	6	1	23	45	26	⇩
Clinical Support	20	38	0	34	47	58	⇧
Total	**203**	**150**	**10**	**278**	**369**	**369**	⇔

35. **Incidents**. The following data provides a detailed summary of the type and cause of incidents reported during 2022/23. The graph below show the top 5 incidents reported by sub category:



36. **Needlestick incident summary**.

a. The graph below shows 76 sharps incidents reported by Division for 2022/23



b. The table below shows Needlestick injury clean, dirty and sharp needle found for 2020-2023:

Sharps Incidents				
Cause	**No. 2020/21**	**No. 2021/22**	**No.2022/23**	**Trends**
Needlestick injury (clean)	11	14	8	⇩
Needlestick injury (dirty)	40	53	61	⇧
Sharp/needle found	3	16	7	⇩
Total	**54**	**83**	76	⇩

c. There are higher numbers of dirty needle stick incidents recorded in the Surgical Division (26) compared with last year, which are being investigated. The potential harm and cost associated with sharps injuries are largely avoidable. Following enforcement action, reported incidents show a concerning negative upward trend for the second year for dirty needle stick incidents with an increase of 8 on the previous reporting period. The number of sharps incidents is too high and more safety awareness in using sharps is required to improve practice and associated incidents and injuries.

d. Of the sharps incidents across all Divisions:

- 26 sharps injuries were attributed to user error, including using non-safety insulin needles, retracting and re-sheathing needles, blood gas sampling and incidents involving taking cord blood as the main causes;
- 18 incidents, although not all causing harm, were from incorrect disposal of sharps. The main cause of injury occurred due to careless placement in sharps bin or not using bins and leaving sharps unattended;
- Nine dirty sharp incidents occurred in surgery. Some self-inflicted and some from another staff member;
- Nine blade related incidents occurred: the trend is Pathology colleagues using the microtome device;
- Five dirty sharps incidents occurred due to patient movement;
- Other incidents showed no trend.

37. The H&S Team work in collaboration with the H&S Network, which includes colleagues from the Foundation Group, to share learning, identify safe sharps devices and consider innovative ideas to assist with the reduction of sharps and exposure incidents. This information is shared with members of the Safe Sharp Working Group (SSWG) which is a sub-group of the HSWC and chaired by the Lead IPC Nurse. The group had lost some momentum during 2023, largely due to capacity issues. However, work to ensure compliance with legislation continued and there has been renewed emphasis on the group meeting, with approval at the HSWC that SSWG will continue to meet as a smaller sub-group, only inviting Divisional colleagues by exception. The team have routinely undertaken activities to benchmark and provide assurance for our current compliance status against the 2019 HSE Enforcement Action against the Trust, with this work ongoing and monitored via the HSWC.

38. The occupational health exposure incidents and monitoring reports are discussed and trends in incidents investigated. Safety devices are reviewed and any items considered by the SSWG must be reported to the Foundation Group - Clinical Procurement Group for review, comment and final approval.

39. Further to an action from the HSCW, all sharps incident reports are also directed to the appropriate Divisional Governance and Risk lead, to support investigation and learning.

40. **Slip, trip and falls summary.** The table below shows 54 slips, trips and fall incidents reported for 2020-2023

Slips, Trips and Falls				
Cause	**No. 2020/21**	**No. 2021/22**	**No. 2022/23**	**Trends ⇧⇩**
Accident caused by other means	24	36	27	⇩
Fall from height/chairs/stairs	7	5	5	⇔
Fall from level ground	16	10	11	⇧
Slip on level ground	16	14	10	⇩
Suspected/Unwitnessed Fall	2	2	1	⇩
Trip on level ground	0	0	0	⇔
Total	**65**	**67**	**54**	⇩

41. Of the 27 slip/trip/fall incidents recorded this year:
- Four incidents have been a result of slipping on a wet floor;
- Four incidents are from tripping on entry mats;
- Four incidents have been from tripping over an object on the floor;
- Two incidents have occurred in patient homes; and,
- 13 other, of which there are a variety of causes and no thematic concerns.

42. **Manual Handling Injuries Summary.** The table below shows 38 manual handling incidents reported for 2022-2023

Moving and Handling				
Cause	**No. 2020/21**	**No. 2021/22**	**No. 2022/23**	**Trends ⇧⇩**
Lifting/moving object (not patient)	7	17	13	⇩
Moving/handling patient	18	34	25	⇩
Total	**25**	**51**	**38**	⇩

43. All manual handling incidents are reviewed by H&S and the Moving and Handling (M&H) lead for the Trust. In the continued absence of a lift in the Pathology Department, previously reported incidents, linked to the transportation of patient notes and stock up and down the stairs, have been greatly reduced and the risk to staff mitigated by the introduction of an external contractor to assist with large deliveries. A

proposal for the installation of a lift in the department is ongoing in terms of design, projected costs and approval required via the appropriate governance route.

44. Of the moving and handling of patients:
- Five incidents were due to handling bariatric patients:
- Ten incidents were assisting patients mobilising to the toilet;
- Eleven incidents were manoeuvring patients for their comfort or care;
- Five incidents occurred transporting patients on trolleys; and,
- Seven other. No thematic data.

45. The Trust continues to provide M&H training for staff and actively engages with departments to provide tailored bespoke training to staff in clinical areas, as appropriate.

Major incidents reported for 2022/23 - The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

46. RIDDOR Regulations require notification to the HSE within very specific time frames. Failure to report on time leaves the Trust in breach of these requirements and liable to fines of up to £20K per occasion. Individuals deemed responsible for non-reporting can also face a period of imprisonment for up to two years.

47. Analysis of RIDDOR reportable incidents during 2022/23 show the Trust reported 14 incidents, compared with 10 incidents reported during 2021/22, an increase of four. Of the 14 reported incidents, 12 were patient incidents.

48. All patient incidents recorded for the year were due to falls, nine of which were unwitnessed. The list below provides an outline of some of the injuries sustained from these incidents:

- Four no. fractured femurs
- Fractured left pubic rami
- Fractured humerous
- Displaced orbital fracture
- Multiple rib fractures
- Two No. fractured greater tronchanter

There were two staff incidents resulting in RIDDOR's. A slip on a wet floor, resulting in a fractured wrist and a fall in a patient's home resulting in a fracture to the ankle.

49. **Appendix 1** provides an in-depth review of the RIDDOR reportable incidents for the reporting period 2022/23.

50. **V&A incidents summary.** The below table provides an overview of reported V&A statistics for 2022/23:

Year	Inappro. behaviour Patient	Inappro. behaviour Staff	Physical	Verbal	Racial	Sexual	ED	Total V&A Incident
2021-22	20	16	91	147	7	4	105	285
2022-23	30	14	100	212	14	5	126	375
% Swing	33%	14%	9%	30%	50%	20%	17%	24%

51. As the above table illustrates, with the exception of one criteria 'Inappropriate behaviour staff', there has been a notable increase in all areas of reported incidents from 2021/22.

52. During the year a full review was undertaken with primary focus on the Emergency Department (ED) due to the higher numbers of reported incidents, further taking into account numerous complaints around staff morale and other individual concerns. Subsequently, a business case was compiled whereby the existing 'enhanced dedicated portering service' would be replaced by a dedicated Security service to be based in ED, but to cover all areas of the acute site. The proposal was supported and implementation commenced in April 2023.

53. The active body worn cameras (BWC's), previously introduced in 2021/22 have continued to be used by porters (is support of the Security staff) and key Trust staff, and have assisted in de-escalation of some incidents whilst also providing evidence for cases that Police have investigated and taken to Court.

54. While concerning that incident numbers are increasing, it should be encouraging that Trust staff are reporting the incidents allowing for analysis to identify lessons learnt. The importance of reporting incidents continues to be emphasised an encouraged at Induction and other training sessions. Line Managers are also engaged via the now monthly Security Group and the HSWC.

55. Other notable improvements during 2022/23 are:

- Successful bid from WVT for an NHS England £10K grant, used for the De-escalation and Management of Incident training specifically designed for Reception Staff/Dental Access Centres and Referral Management Centre staff. 74 staff have been trained as a consequence.

- The Trust Local Security Management Specialist (LSMS) is now a panel member on the Multi Agency Public Protection Arrangements (MAPPA) meetings. This is to discuss and agree agency ways to mitigate the risk to public/staff/and service units. This has resulted in the Trust placing alerts on all the electronic patient records, highlighting the risks and appropriate mitigations.

- NHS England V&A standards are in place to assist the reductions of V&A incidents across Trusts. The Trust has undertaken an assessment against the standards and currently the Trust is 85.71 per cent compliant and 14.29 per cent partial compliance. This is a clear vindication of the work started under Project Nightingale and continued via HSWC, but also illustrates there is still much work to be done to show continuous improvement.

Occupational Health/Wellbeing summary

56. Occupational Health continue to provide support and advice to WVT. The referrals to the service has remained consistently high and Occupational Health are working towards maintaining the KPI's around this to ensure support is given in a timely manner. 57. There has also been a sustained increase in the recruitment efforts of the Trust and Occupational Health continue to support this process with the design of new forms aiming to smooth the process of on boarding.

58. An EAP scheme continues to enable staff to access 24/7 counselling support which Occupational Health continue to promote. The service has secured NHS Charities money to implement a mental health nurse to support the staff and a dedicated staff physio service which is now up and running.

59. We aim to upgrade our software system to provide easier and a more streamlined approach for recruitment

60. Occupational Health continue to provide occupational health services to external clients. We have maintained our SEQOHS accreditation and continue to work towards retaining this.

Fire Safety Management

61. Good management of fire safety is essential to ensure that fires are unlikely to occur; that if they do occur they are likely to be controlled or contained quickly, effectively and safely; or that, if a fire does occur and grow, everyone in the premises can escape to a place of relative safety and ultimate safety, easily and quickly. The fire safety management system details arrangements to implement, control, monitor and review fire safety standards and to ensure those standards are maintained by using the fire risk assessment process, which will ensure that the fire safety policy is up-to-date, the fire safety structure is adequate (roles and responsibilities), if procedures and protocols require changing, fire evacuation plans are suitable, training is being delivered, records are available and up-to-date and audits are suitable and sufficient.

62. A Joint Fire Safety Group (JFSG) meets regularly, assisting the Fire Safety Manager to implement initiatives, and demonstrates that fire safety systems are included in all relevant areas. This group reports to the HSWC. Strategy and Policy documents have been written, agreed and are current or in development. Training figures are marginally down from last year and unwanted fire signals (UWFS) have increased slightly from

the last reporting period. Quarterly audits have resulted in hazards being identified and addressed accordingly. A new fire risk assessment process is currently be rolled out across the Trust. Unwanted fire signals / false fire alarm activations will be monitored to ascertain the cause and if there are any patterns are emerging, which will be investigated and where necessary remedial action will be taken using Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions – Part H: Reducing false alarms in healthcare premises guidance.

63. All premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and where necessary, the organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable, the significant fire risks identified by the fire risk assessment process. There is currently a CEO fire safety action plan in place, which addresses concerns raised by internal staff and external agencies, which is constantly monitored and updated where necessary..

64. Where next in 2023/2024 – an overview of fire safety aims:

Maintain and improve Fire Safety Management systems details arrangements to implement, control, monitor and review fire safety standards and to ensure those standards are maintained. This is archived by the fire risk assessment and risk register process, which will highlight legal and standard guidance improvements.

- Improve the fire safety awareness training compliance figures by take into consideration all the special attributes that can pose a burden e.g. time, personal needs, engaging and relevant subject matter. And if things don't seem to work out, never blame the staff about the low numbers. Revise the training strategy with the EDC and start over.
- Reduce the number of unwanted automatic fire alarm actuations by educating building owners, responsible persons, staff and the general public can contribute significantly to false alarm reduction. Also, ensuring the correct detection is being used in the environment, such as cooking fumes and steam areas. This is mainly dependent on the use of an easy to use reporting system.
- Reduce fire hazards identified via the fire risk assessment process at regular intervals and ensuring pre-planned maintenance is undertaken.
- Review and revise evacuation procedures, drills and exercises is a crucial step to ensure that it is effective, relevant, and aligned with the organizational goals. It can help identify gaps, strengths, weaknesses, and opportunities for improvement in your learning content, delivery, and evaluation.
- Maintain monitoring of active and passive fire safety control measures, which is completed constantly by the fire risk assessment process. In simple terms, active fire protection entails detecting and stopping the fire, whereas passive fire protection involves containing a fire to prevent further spread.
- Maintain good working relationship with Stakeholders is the ability to build long-term and trusting relationships with stakeholders which is an essential element that defines the success of fire safety culture, and there is a wide range of stakeholders that directly influence this culture. By maintaining good

relationships, the groundwork for the creation of an atmosphere of support and trust, as well as the establishment of a cooperation network. As a result, the organisation can anticipate potential problems and manage stakeholders' expectations more effectively. The fire safety management system depends on all stakeholders having a 'buy-in' safety culture.

The Management of Healthcare Waste - Health Technical Memorandum (07-01)

65. The Management of Healthcare Waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection and are securely managed.

a. **County Hospital.** All waste produced at the County Hospital is managed through our PFI Partner, Sodexo, including all governance issues/responsibilities. A Pre-acceptance Audit (PAA) was recently carried out and initial highlights include: inappropriate use of medicine waste containers; different and often inappropriate methods of disposal for infusion sets and incorrect streaming of waste, particularly domestic waste in infectious waste bins. In addition, waste holds are often not secured and glass bins are not used in accordance with their purpose.

b. **General Waste.** Currently 20 per cent of domestic waste is recycled; the remaining general waste is used for heat generation so none of our waste goes to landfill. A waste stream that combines plastic bottles, tins and cans were added in a small number of locations in April 2023, with the hope that a successful trial will lead to funding for more.

c. **Community Hospitals General Waste.** 35 per cent of the general waste produced at these sites is recycled; to increase this percentage it is planned to introduce a number of recycling bins into waiting rooms and large offices in the community during 2023.

Climate Change and Challenges

66. During periods of elevated temperatures, particularly in the summer months, there are always a significant number of incident reports raised relating to staff feeling their working environment is presenting a risk to themselves, the patients who are receiving clinical care, as well as visitors and members of the public.

67. In the absence of any permanent solutions, especially where staff are working within older parts of the WVT Estate, which do not always benefit from an integrated air conditioned environment and rely solely on natural ventilation, the Trust continues to issue guidance both in clinical areas directly, updates on the Trust Intranet pages and via general communications, such as Trust Talk. The guidance highlights the importance of keeping hydrated during periods when the weather is hotter, and tools which can be used by staff to help their working conditions including taking additional breaks, time in cooler areas and wearing alternative uniforms if possible i.e. scrubs as

opposed to standard uniform while adhering with Infection Prevention requirements. In addition, portable air conditioning (AC) units are often required to help regulate the temperature during extremes.

68. It is important to note, the difficulties presented by elevated working environments are not restricted to older parts of the WVT Estate. There are challenges also present within the PFI buildings too, such as Theatres, with lists on occasion having to be moved at short notice, representing a risk to patient safety.

69. Equally important to consider are incidents raised during periods of adverse weather when heating systems either do not have the capacity to cope with demand, or are not fit for purpose. Clinical and back office locations can experience difficulties from the working environment being too cold and presenting different challenges to staff, patient and visitor safety, comfort and wellbeing. For example, members of the Executive Team, based in THQ, have been required to request additional heating, in the form of oil filled heaters, to help regulate the temperature in their offices during winter months. There have been a number of incidents in Theatres where the operating list has been delayed due to theatres being too cold/hot. Community settings have also been affected by extreme temperatures in the summer months and portable air con units were requested for these sites.

70. The concerns have an impact every year and H&S expect the number of incident reports to rise year on year, as periods of weather extremes are forecast to increase in the future. Indeed, these considerations are included within the Effects of Climate Change risk on the Corporate Risk Register and monitored via the EPC, as part of Emergency Preparedness, Resilience and Response (EPRR) and commitment to our Core Standards.

Policies

71. The following policies/procedures/guidelines have been reviewed and updated this period:

Document	Policy Ref	Date Ratified	Review Date
1/2022 – Fire five Year Safety Strategy	27/04/2022	27/04/2022	27/04/2027
HS.S.03 Fire Safety Manual SOP		March 2023	March 2026
HS.15 Security Policy and Codes of Practice		March 2022	March 2027
HS.30 Prevention of Violence, Abuse and Harassment of Staff and Application of Sanctions Policy		March 2022	March 2027

Conclusion

72. This report highlights the significant amount of great work undertaken during 2022/23 to improve the management of Health, Safety and Wellbeing in the Trust. Unfortunately, there is also evidence of negative upward trends in incidents, with staff sustaining physical or physiological injury and their wellbeing compromised as a consequence. The H&S Team continue to work with key stake holder colleagues, including the Estates Team, IPC and H@W to make progress with inspection and

assessment programmes to improve visibility and awareness relating to H&S legislative responsibilities to ensure compliance.

73. The H&S Team continue to establish lessons learnt objectives from our HSE inspections, with the support of colleagues, to aid the development of more robust processes and procedures. Divisional leads must take ownership of the activities undertaken in each department by their staff and must be able to provide assurance, with evidence, via the appropriate governance routes, safe working practices are being adhered to.

74. Another year has passed during which there have been a number of large construction works carried out on the Acute site and all key stake holders continue to work together to ensure safe working practices with the avoidance of a significant H&S event to staff, patients, visitors or members of the public. A great achievement for the Trust, considering the scale of the works and the restricted space within which many activities were undertaken.

75. As new variants are identified, the Trust will address any required changes to clinical practices, receipt and distribution of PPE supplies, organic Government and National advice relating to Infection Prevention processes, isolation and testing requirements. The Trust continues to encourage agile working, where possible and appropriate, and now has a greater understanding of the wider implications of home working and the enormous changes to the way we work clinically. How to effectively manage these changes and what further steps are required to ensure the health, safety and wellbeing of all staff, patients, visitors and the public will continue to improve as we adapt to the inevitable changes throughout the coming years.

Appendix 1 – RIDDOR reportable incidents 2022/23

Over 7 day injury preventing person from working	None reported
Dangerous occurrence	None reported.
Specified injury	**W72359 Medical Division – Emergency Dept. Unwitnessed Patient Fall** Patient in a cubicle following an initial diagnosis of a stroke, the patient tried to get himself off the trolley and had an unwitnessed fall. Member of staff found him lay on his back on the floor. Did not bump his head and originally declined any pain or injury. When they tried to mobilise the patient, patient unable to weight bear on their left leg. X-ray completed which confirmed a fracture left neck of femur. RIDDOR Notification Number: **DA939716BE** **W75315 ICD – Leominster community Hospital. Slip on level ground** Patient rang the call bell for someone to take her back to her bed from the toilet, as the response was not quick enough she decided to walk back on her own .Patient had a witnessed fall hitting her head causing a displaced orbital fracture. RIDDOR Notification Number: **E216A11D87** **W74747 Medical Division – Garway Ward. Unwitnessed Patient Fall** Elderly patient nursed in side room due to CPAP (must remain isolated for infection prevention reasons). He was assessed as safe to independently mobilise but had an unwitnessed fall on 15/07/2022. He was reviewed and no injuries noted post fall. After second fall on 18/07/2022, patient complained of pain in wrist, X-ray confirmed humerus fracture to wrist. The patient complained of hip pain and x-ray confirmed hip fracture had been sustained in addition to wrist fracture. RIDDOR Notification Number: **CCCB132D0E** **W76330 Medical Division – Ashgrove Ward. Unwitnessed Patient Fall** A bed side table fell over and on checking the patient was found on their left side on the floor. On examining the patient they complained of pain in their left hip, there was shortening of their left leg and unable to weight bear. Patient was sent for a CT scan and they were found to have a fractured neck of femur. RIDDOR Notification Number: **1171638B11** **W76452 – Medical Division – AMU. Unwitnessed Patient Fall** Patient had fall on the way to toilet on 06/08/22. Documented by medic that patient had fallen on left hand side, patient complaining of left sided back pain and unable to raise left arm for length of time. CT head requested and done with no acute changes. Chest x-ray not requested even though it is noted that tenderness and pain in left thoracic area. The patient continued to complain of pain and a chest x-ray was completed on 07/09/22 which showed multiple rib fractures. RIDDOR Notification Number: **E4F011416D**

	W72476 Medical Division – Garway Ward. Unwitnessed Patient Fall Sound heard and patient found on the floor. Patient reviewed by doctor post fall- assessed as no obvious injuries at this time, patient able to walk back into bed. Plan made for further assessment when patient more awake. Re-reviewed morning of 02/05/2022 - CT Head no changes. X-Ray requested as patient in pain declining to weight bear. Confirmed fractured neck of femur. RIDDOR Notification Number: **17513DBA14** **W76312 Medical Division- Ashgrove Ward. Unwitnessed Patient Fall** The patient had an unwitnessed fall in the side room and were found lying on their back with their head by the window frame. The patient complained of right knee and leg pain. X-ray confirmed a comminuted and fragmented intertrochanteric fracture in the right proximal femur involving femoral neck with ventral intermuscular soft tissue haematoma and diffuse extra-articular soft tissue oedema. RIDDOR Notification Number: **174DBEFB71** **W75574 ICD - Ross Community Hospital. Fall from level ground.** Patient rehabilitation after sustaining a fractured neck of femur. Mobilising with a frame and the assistance of 1.Patient had an unwitnessed fall 07/08/22 - nursing staff were aware and supporting patient to stand & transferred back to bed-space able to weight bare. No further investigations at the time. Patient was seen by therapist on 08/08/2022, who reported some hip/ pelvic pain. When patient stood to frame with assistance of 1, the patient missed their footing and fell backwards into the chair. No increase in pain but referred for an x-ray. X-ray confirmed a right trochanter displacement. RIDDOR Notification Number: **EEE7891521** **W77214 ICD – Ross Community Hospital. Fall from level ground** Patient has dementia and known to be noncompliant. Does not use call bell, nor follow requests. She was seen from the far side of the bay, standing, hesitating and when asked to use her zimmer frame, she instead moved directly towards nurse and slipped to the floor. She did not hit her head, but landed on right hip and arm. Following this fall she fractured her right greater trochanter. There is a previous SI for this patient in relation to a previous fall in September where she fractured her left #NOF. Combined investigation. RIDDOR Notification Number: **12E849B8C1** **W77750 ICD – Leominster Community Hospital. Unwitnessed Patient Fall** The patient fell from the bed whilst getting up to use the toilet which resulted in a fractured left pubic rami. RIDDOR Notification Number: **1341231711** **W77075 Medical Division - Garway Ward. Unwitnessed Patient Fall** Confused patient had unwitnessed fall resulting in right hip fracture. Investigation concluded a lack of adequate assessments in respect of falls and the provision of 1-1 enhanced care. RIDDOR Notification Number: **17513DBA14** **W81917 Medical Division - Gilwern Ward. Unwitnessed Patient Fall** Confused patient had unwitnessed fall resulting in fracture of the left neck of femur requiring surgical repair.

	Omissions in care that were identified: Appropriate levels of observation; lack of identification of injury sustained and the use of bed rails. RIDDOR Notification Number: **11B9C15016** **W78090 ICD - City Nursing Team. Staff Fall in Patient Home** Staff member fell when leaving a patients home, sustaining a fracture of the ankle. No trips hazards noted. Staff member was relayed to A&E by colleague. RIDDOR Notification Number: **888D16A16F** **W74248 – Temporary Corridor – Hereford County Hospital. Staff fall** Staff member slipped on wet floor as a result of heavy rain ingress into main corridor through temporary structure. Staff member sustained a fracture to the wrist. RIDDOR Notification Number: **83F6E393B6**

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Foundation Group Strategy Committee Report for 17 October 2023
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Executive**
Author:	Leanne Hanson, Personal Assistant
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To provide the Wye Valley Trust Board with an update on the discussions at the Foundation Group Strategy Committee meeting held on 17 October 2023.

2. Recommendation(s)

The Wye Valley Trust board is asked to receive and note the Foundation Group Strategy Committee report for the meeting held on 17 October 2023.

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] 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

Public Board meeting 7 December 2023

Foundation Group Strategy Committee Meeting – 17 October 2023

The agenda for this meeting was focused on the following key items:

Clinical Training and Education Update

The Group Heads of Education provided an update on the ongoing collaboration and information sharing within the Foundation Group. The achievements over the last 12-18 months were shared, alongside progress with the current actions.

The joint Knowledge Library Services (KLS) Strategy for 2022-25 had been approved for George Eliot Hospital NNS Trust (GEH), South Warwickshire University NHS Foundation Trust (SWFT), and Wye Valley NHS Trust (WVT), and introduced to Worcester Acute Hospitals NHS Trust (WAHT). The Quality and Improvement Outcomes Framework (QIOF) had changed for 2023, and both SWFT and GEH were scheduled to submit their self-assessment documentation in December 2023, and the NHS England (NHSE) visits and improvement conversations for both organisations were scheduled on 17 January 2024. WAHT was scheduled for 2024/25 and WVT was scheduled for 2025/26. A further update would be provided to the Committee once the NHSE visit had occurred and the full report received.

The Care Excellence Conference for Nurses and Midwives was held on 9 May 2023 which celebrated the incredible contribution from Nurses and Midwives in the local community across the Foundation Group. The event provided an opportunity to reflect and share experiences and was also used to celebrate International Nurse's week. The agenda for the day showcased services and there were several excellent speakers in attendance and provided an opportunity to share the challenging issues in nursing and midwifery.

A summary of the headlines of the NHS Long Term Workforce Plan were presented. The plan was published on 30 June 2023 and set out the NHS ambitions to address the current and future workforce challenges over a 15-year period. The plan was underpinned by 3 priority areas titled Train, Retain and Reform, and set out a £2.4 billion commitment to invest in education and training places over the next 6 years. There was particular emphasis around apprenticeships in clinical training, with a view that 22% of the workforce in 2026 would be in an apprenticeship training scheme.

Ward Accreditation

The Group Chief Nursing Officers provided the Committee with an update on how ward accreditation was being implemented across all four trusts.

The Chief Nursing Officer of WAHT explained the Path to Platinum Programme was initially launched in 2019 and was rolled out to all inpatient wards across the 3 acute sites. A total of 14 wards had currently been accredited, 13 silver and 1 bronze. Since commencing in post, she confirmed the process had been reviewed and the decision was made to pause the programme whilst further work and review took place. WAHT's ward accreditation programme would be relaunched from the beginning of November 2023 and the SWFT model would be adapted which was aligned across the Foundation Group.

The Chief Nursing Officer of SWFT explained every inpatient ward at SWFT was assessed twice over the last 2 years. The programme would be paused over the winter period due to the challenging operational pressures, however this would provide an opportunity to review and modify the methodology and elements to ensure absolute consistency which would be shared across the Group once completed. In terms of next steps, in November 2023 Board to Wards visits would be undertaken and the certificates for the last 8 months of accreditations would be presented with involvement from the Executive Team and Non-Executive Directors.

The Chief Nursing Officer of WVT explained the Trust was at the beginning of its programme journey and would be adopting SWFT's approach and methodology in undertaking a baseline and assessment across all the ward areas. A Task and Finish Group had been established, and the Trust had contributed to the adaption of a Foundation Group Standard Operating Procedure (SOP) which was in the process of being approved across all four trusts.

The Deputy Chief Nursing Officer of GEH explained a Corporate Lead Nurse had commenced in post who would be reviewing the Framework with a plan to relaunch the programme in January - February 2024 dependent on the operational pressures through winter. The programme was paused during the summer months, however an assessment across all wards had been undertaken and the Single Assessment Framework was being aligned to meet the Care Quality Commission (CQC) fundamental standards of care.

Chief Executive's Update on the Foundation Group Expansion

Since WAHT had joined the Foundation Group, the Group Advisory roles had been reviewed and conversations had been held with both the Managing Directors and Chief Medical Officers. Informatics arrangements across the organisations were being reviewed and as the Group moved forward with common dashboards, senior expertise in that area would be beneficial. Due to the various arrangements around IT across the Group, a potential Lead to oversee those outsourced arrangements was also being considered, and a further update and proposal would be presented back to the Committee in due course.

Within the Foundation Group there were a number of fragile clinical services and suitable solutions were required to ensure patients had appropriate access to clinical care in those areas either via a Foundation Group solution or in other collaborative ways. Support would be required to coordinate those various medical opportunities, and the paper presented to the Committee detailed the creation of a Group Medical Adviser role. The Advisory roles would provide advice, support, and challenge to the Chief Officers, however the Chief Officers remained accountable, and it was important the decision making, and accountability rested with the individual Boards and not at Group level.

Group Financial Challenges and Opportunities

The Group Strategic Financial Advisor highlighted the current financial challenges and the key areas of focus. He acknowledged the unprecedented operational demands across the trusts, which were furthermore challenged due to the recent industrial action and the ongoing issues around bank and agency spend, which was becoming more problematic. He noted all four trusts had challenging Cost and Productivity Improvement Programme (CPIP) targets, and the NHS overall was under substantial finance pressure. Discussions had taken place with the four Chief Finance Officers in the Group around the requirements of understanding the true costs of the industrial action and the importance of understanding the impact of inflation on costs.

All four trusts had increased levels of temporary staffing spend which was not reducing, and further grip and control was required across the organisations. Several back-office schemes had occurred across the Foundation Group and before any further corporate opportunities were initiated, the Group Strategic Financial Advisor felt it was important to review the implemented schemes to establish if they had been successful and had delivered.

Digital Updates including Digital Hubs

The Group Strategic Digital Advisor provided an update on progress with Scan4Safety. In mid-September 2023, two GS1 Scan4Safety specialists from Lancashire Procurement cluster were commissioned to undertake a review of the three existing hospitals in the Group (GEH, SWFT, WVT) and the opportunities available. Several of the key themes had been extracted from the report which were shared with the Committee and included stock distribution, standardisation, budget approval and staff efficiency. The recommendations were discussed, and the Group Strategic Digital Advisor emphasised those had not yet been approved and would require further consideration once the report had been fully reviewed. The proposed recommendations included improved delivery schedules, data-driven stock analysis, best price purchasing, optimised stock storage and streamlined ordering.

An update on the Digital Hub was provided and the Group Strategic Digital Advisor advised a Chatbot trial was due to commence in November 2023 at SWFT and the outcomes of that trial would be reported to the next Committee. A remote monitoring workshop was held in September 2023 to support the Big Moves across the Group and focused on individuals working together and reviewing pathways. The invite was extended out across both Integrated Care Systems (ICSs), Primary and Secondary Care, and Social Care colleagues, and a further workshop was likely to be held in November 2023 across the Group.

An Artificial Intelligence (AI) Steering Group had been established with representation from all four trusts, which reported into the Trust's individual Information Governance Groups (IGG). There was significant interest in AI, however there were potential information governance issues which would be discussed and addressed at those meetings.

The Chief Digital Information Officer of WAHT provided an update to the Committee on the Electronic Patient Record (EPR) which was implemented at the Trust 8 months ago. A total of 3700 colleagues had undertaken Electronic Patient Record (EPR) training and four optimisation sprints had been delivered. On 12 September 2023 IntelliSpace Critical Care and Anesthesia (ICCA) went live in the Intensive Care Units (ICUs), which was a Philips EPR module that ensured there was a seamless flow of information between ICUs and other wards, and staff in that department were now 100% fully trained.

An essential Patient Administration System (PAS) upgrade was scheduled, and WAHT had been selected as one of 16 organisations to pilot an electronic bed management system through 2023/24 into 2024/25. The team had been shortlisted for the Health Tech Newspaper (HTN) Major Projects Implementation of the Year Award and shortlisted for the Institute of Leadership Digital Leaders Award.

Innovate Healthcare Services Limited (Innovate) Update

The Chief Executive of Innovate provided an update on recruitment and explained the turnover rate continued to be low, and staff were encouraged to grow within the organisation, and for those skills to be retained.

One of the business goals was to be the ICT and digital provider by choice in Coventry and Warwickshire and Innovate was working closely with the Integrated Care Board (ICB) supporting with the generation of its digital strategy. Innovate had recently agreed to deliver the Educational Management Information System (EMIS) system to Myton Hospices with a target date of May 2024. A number of Primary Care initiatives were being supported by Innovate including digital telephony, video consultation and General Practitioner (GP) gateway projects. Project work continued, including voice automation which was currently behind schedule, but was a complex and resource intensive project and would hopefully soon be in a position to start trialling that in some of the initial areas.

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) had deferred their EPR go live date and work was progressing to fully understand the reasons for the deferral and the level of system issues versus the level of organisational challenges. An understanding of UHCW's next steps would be sought alongside the timescales and plans of when that system would be taken live again.

Significant work was being undertaken on replacing the SWFT data centres and the implementation of a new virtual server infrastructure in GEH, which would align with SWFT. The core networks in both hospitals were in the process of being replaced and the GEH Wi-Fi network would also be replaced which would ensure full resilience across both organisations.

Group Improvement Update

An update was provided from each Trust within the Foundation Group on the areas being worked on collectively and the individual challenges and opportunities going forwards.

The Chief Strategy Officer of WAHT advised a series of Rapid Improvement Workshops had been held, including a Recruitment Rapid Improvement Workshop which focussed primarily on the length of time for vacancies to be approved. This work had led to 70% of vacancies now being approved in under 14 hours rather than 10 days. Medically Fit For Discharge (MFFD) to Electronic Discharge Summary (EDS) and To Take Out (TTO) completion was also reviewed, which had seen an 84% reduction in the time taken to discharge. Work was now underway to share and spread that work rapidly across other wards.

The Chief Strategy Officer of WVT discussed the Fresh Eyes event held in the summer, which was a 2-week event with numerous staff partaking, particularly from Service Improvement Teams and Project Management teams. The staff acted as external observers within Theatres, and they asked non-specific questions which helped generate 128 ideas and actions which were currently being prioritised and worked up, some of which had already been delivered. The event was resource intensive, nonetheless, generated good will and positive ideas and it was recommended to undertake the event every 6 months.

The Chief Strategy Officer of GEH advised collective work continued in relation to Quality, Service Improvement and Redesign (QSIR) and improvement work against the new Improvement Framework and the Trust was working closely with SWFT in terms of sharing some of their good practice and the work undertaken with their Improvement Board.

The Deputy Chief Strategy Officer of SWFT explained Professor Helen Bevan, Practice for Health and Social Care Service Improvement, Warwick Business School had attended several improvement workshops in September 2023 at SWFT which provided an excellent opportunity for staff. A whole suite of improvement ideas had been pulled from those workshops which would be run through the Excel in Everything programme.

Group Research Update

The Group Director for Research and Development provided an overview on the progress of achieving a coordinated and consistent approach to Research and Development. There had been several changes since the last report, including the new full membership of colleagues from WAHT and the positive links they had with the local Medical School. Simultaneously, there were several shifts in government policy around NHS research, including a clear note from the Department of Health and Social Care (DHSE) directing NHS bodies to focus more on commercial research and trials. More recently was the establishment into Horizon Europe, the EU Research and Innovation Programme 2021-2027, which provided a series of opportunities as a Group. There was also the NHS Long Term People Plan, the expansion of Medical Schools, and the introduction of a commitment by both this Government and any future potential opposition Government, to double the number of Medical School places.

There was a solid infrastructure within each of the four trusts with both research and development leads and managers supporting each of the departments, and also expanding academic Non-Executive Director roles to support each of the trusts in thinking about teaching and research. The report provided further detail on a series of next steps for the coming year and into March 2025 and the Groups support was required for that programme of work.

Robotics Update

The Chief Medical Officer of GEH explained Robotics was not yet implemented at the Trust, nonetheless, there was significant enthusiasm from the surgical Directorate who had been linking in with SWFT, and further expertise could also be obtained from WAHT. The colorectal surgeons had met with the Group Chief Executive and were in the process of writing a robotics business case. A site visit had been undertaken to review and consider the infrastructure and estate and the implementation would initially be colorectal, however Urologists were also interested alongside Gynaecology.

The Chief Medical Officer of WAHT explained the Trust had acquired a robot last year which was purchased through charitable funds. Two experienced senior consultant urologists had completed their training and over 100 robotic prostatectomies had been undertaken to date which allowed the waiting list to be reduced. Two robotic operations per list were being completed with the aspiration to increase to three, and the Trust was also embarking on colorectal surgery, and two experienced laparoscopic rectal cancer surgeons had completed their training and had undertaken a total of 17 cases and were progressing to more complicated disease. The next steps were to progress to Gynaecology, with experienced Gynaecology laparoscopic surgeons ready to commence their training.

The Chief Medical Officer of SWFT explained a robot was commissioned in May 2023 with colorectal surgery cases being undertaken. The two surgeons who were trained and proctored had completed 31 cases, largely colorectal cancerous infections, and some hernias. In terms of next steps, training would be rolled out to other colorectal surgeons followed by Gynaecology and Urology.

The Managing Director of WVT provided an update on behalf of the Chief Medical Officer and explained Urology, Gynaecology and Colorectal had surgeons who were operating with the robot and more surgeons were now being trained. The implementation of the robot had resulted in a positive effect on recruitment with two General Surgeon vacancies now filled.

Pharmacy Aseptic Unit Proposal

The Clinical Director, Pharmacy of WVT and the Project Manager Coventry and Warwickshire ICB, presented a proposal to undertake an aseptic services review to assess the best ways to work as one partnership to address shared issues. The review across all the trusts would assess the current unit's condition, location, capacity, production capability and the Medicines and Healthcare products Regulatory Agency (MHRA) licensing status. Staffing models would also be reviewed including cross site working potential, skill mix and contingency plans. A national piece of work was also being undertaken in the background with the aim of creating a 'mega unit' in each region to support with the resilience of the aseptic market which had predominately been reliant on the commercial sector and had been fragile for several years. The delivery of that national programme was likely to be in 5-10 years' time, therefore regional advice was for local groups of trusts to move forward with redesigning local services rather than waiting for the delivery of the national review.

An update on the outcomes of the aseptic services review be provided to the Committee in 4 months' time.

Recommendation

The Board of Directors is asked to receive and note this report.

Glen Burley
Chief Executive

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Update from the Integrated Care Executive (ICE)
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	ICE
Lead Executive Director:	
Author:	Erica Hermon on behalf Frances Martin
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the WVT Board on the ICE meetings held in November 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]

COMMUNITY MENTAL HEALTH TRANSFORMATION PROGRAMME

ICE noted that:

- The programme had been running for 3 years and would be ending in March 2024.
- The model continued to be strengthened, seeing processes refined and alignment between Herefordshire and Worcestershire.
- There was a focus on creating neighbourhood mental health teams, working alongside PCNs
- PROMS uptake had increased, ensuring that care planning was centred on patient need.
- Planning was ongoing for co-location with PCNs.

Current pressure points:

- Vacancies at 11%. Staff retention remains as priority.
- Care notes data restoration is putting pressure on staff capacity.
- Accommodation in Herefordshire is not fit for purpose. A business case is being developed to consider rental of alternative accommodation.

ICE determined that there is a need to improve the data reporting and, in turn, the analysis that ICE require mindful of the need to avoid duplication of reporting. This would be addressed ahead of the next meeting.

URGENT COMMUNITY RESPONSE (UCR)

ICE noted that:

- UCR have extended their opening hours to 8.00am – 6.00pm.
- Docobo was now live and all staff were trained.
- Planning was ongoing to expand the Hospital@Home service.
- Some services (such as falls response) were now referring directly to UCR, rather than contacting 999.
- UCR were working more closely with virtual ward.

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

- The new UCR dashboard had been streamlined with implementation of new templates and single referral process.
- There were some business continuity concern with the level of medical cover for ACPs during periods of staff absence (for example, as a result of industrial action and sickness). The UCR team were working with Herefordshire General Practice (formerly known as Taurus Healthcare) GPs twice a week.

To avoid conflating UCR and virtual ward, these would be reported separately to ICE going forward with a reporting format being developed accordingly.

DISCHARGE TO ASSESS (D2A)

ICE noted that:

- The Better Care Fund had been agreed.
- There is significant financial pressure and need to drive savings of approx. £300K.
- Herefordshire Council were facilitating a 6-week sprint event with a view to setting objectives and look at future options to deliver a financial improvement plan.
- A significant numbers of patients were receiving support at home to avoid admissions but there was a continued need to ensure the timely discharge of patient no longer needing inpatient care. At the time of the meeting, there were 68 in-patients (38 from Herefordshire) who fell in to this category, adding to the hospital's pressures and impacting on elective care.
- A data analyst was being recruited to work with D2A and BCF providing improved and comprehensive data for D2A and other BCF services, plus improving on the data currently being reported to ICE.

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

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Quality Committee 28 September 2023 Summary Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	NA
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and Quality Committee Chair
Documents covered by this report:	NA

1. Purpose of the report

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

2. Recommendation(s)

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

3. Executive Director Opinion[1]

NA

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

Quality Improvement

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

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

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

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Research and Development – Annual Report 2022/23 and Q1 Report 2023/24

The Trust continues to 'punch above its weight' in the promotion of and engagement with R&D and we have strong and visible leadership from the ACMO who reported good support from the CNO and ACNO. We are 11th in the West Mids for our recruitment into trials. It was reported that governance of trials is now much improved through a monthly governance meeting and that trials are now much better integrated into the work of Divisions. Stronger links with Foundation Group partners are also being developed.

The importance to the Trust of developing a positive R&D profile particularly in terms of recruiting high calibre staff was emphasised as was the need to incorporate R&D in the wider Academic Plan for the Trust and the work of the new Education Centre.

Quality Priority – Improving Patient Experience – Cancer Patient Survey Results

Committee noted an excellent response rate to this survey (64% compared to national return of 53%) and positive feedback relating to patients being given their diagnosis in an appropriate place and patients having a review by their GP practice. In 5 areas however the Trust scored below expected range including patients having a main point of contact, patients' care plans being reviewed, provision of advice and information and information about research opportunities.

Given the concerns about these latter areas, Committee requested a follow-up report on implementation of follow-up actions.

Quality Priority – Improving Patient Experience – Emergency Department Survey Results

Committee noted a good response rate (best in the Group) and positive responses particularly around patients experience of coming to ED in terms of waiting times to see a Dr or Nurse and help with symptoms while waiting; also ED providing a safe environment.

Committee also noted the lower scores in areas including privacy, having enough time for discussion with staff and provision of information about possible future symptoms and side-effects from medication.

Committee noted the particular pressure on ED as an important backdrop to these results; equally that ED bears the brunt of what are wider system challenges – hence part of the response is to support wider change.

Committee was given assurance that those issues that are in the control of ED – particularly around care and treatment and related to communication are being addressed, and noted the actions already taken and in train to improve patient experience in these areas.

Quality Priority – Improving Patient Experience – In-Patient Survey Results

Committee was assured to note that in 50% of the areas surveyed, the Trust has improved its scores, with 26% remaining around the same and 24% worsening.

Of concern was 1 new area regarding patients being given appropriate information before and after an operation or procedure.

In terms of previous concern areas we have seen an improvement generally in communications scores and patients feeling questions are being answered. Nutrition scores have improved overall, but not food quality itself. Leaving hospital scores have improved generally but worsened around information about medicines.

Patient Experience Committee will be leading the improvement response. Committee noted that SWFT has the 2nd best results in the country and was assured that we are in contact to share best practice.

Quality Priority – Improving Patient Experience – Quarterly Report and Thematic Review of Complaints.

Committee noted the ongoing roll-out and success of the Family and Friends Test text messaging survey, which now includes Maternity Services and work to ensure we have phone numbers on our systems. Loss of patient property continues to be an issue and we now have a Working Group to address this as part of the work programme of the Patient Experience Committee.

Committee noted that overall complaints numbers are reducing but so are our response rates. Key areas include Orthodontic Services, Womens and Childrens and Obstetrics and Gynaecology. Key themes in ED reflect wider patient experience feedback.

Quality Priority – Improving the Experience of the Deteriorating Patient (Verbal)

This new sub-Committee has now met twice and is finalising its scope and TOR. Committee asked for a written update following the next meeting of the sub-Committee.

Quality Priority – Ensuring Best Practice in Provision of Nutrition

Committee was concerned that following a never-event regarding placement of a naso-gastric tube we are still to finalise our revised policy and procedure. Committee was assured that this has been agreed and is awaiting final sign-off.

Following significant improvement in MUST scores in our Community Hospitals we have used the learning to bring focus to improvements on the acute hospital site. This work is now being audited and will be reported to QC in the next update.

Local surveys and PLACE audits are now focussing on food quality generally in response to previous national in-patient survey results.

Quality Priority – Infection Prevention – Board Assurance Framework

Committee received an assessment based on the national Infection Prevention BAF. Committee was assured that areas identified for further work are aligned with our current focus through the Improvement Plan. A key risk remains the area of anti-microbial stewardship due to staffing gaps in Pharmacy though a member of staff returning after retirement will give capacity to address the majority of issues in this area.

Quality Priority - Mortality

Committee noted the continuation in the reduction in our overall mortality scores and in particular noted our strong perinatal numbers where we are well below the national ambition set for 2025. with reductions too in areas of fractured neck of femur and heart failure and improvements in the depth of coding.

Patient Safety Response Plan

Committee received the draft Patient Safety Response Plan produced in response to the new national framework. Committee praised the work that had gone into the new process and noted the positive response from the ICB. Committee noted that the new approach will involve a lot of learning-by-doing and looked forward to reviewing progress in due course.

Divisional Quarterly Report – Integrated Care Division

Committee noted the report and highlighted the improvements in children's therapy waiting times, work with Care Homs and PCNs. Improving patient care through addressing acquired pressure

ulcers remains the key area of concern and in being addressed as part of the new patient safety response approach, including the different challenges for community nursing services.

Divisional Quarterly Report – Clinical Support Division

Committee noted the report which highlighted the challenges across the range of CSD services where staffing gaps remain the number 1 issue – particularly in Radiology, Pathology and Pharmacy.

Committee was concerned to be clearer about the impact from these challenges on patient quality and safety and asked for this to be a focus of future reports.

Maternity – Monthly PQSM Report

Committee received the monthly PQSM report and noted:

- The significant improvement in the staffing position following the work over recent months.
- Family and Friends text messaging has been well-received with a high response rate and positive feedback

Staffing Report

Committee noted that the additional pressures on staffing due to front-door pressures and the impact of boarded patients and the maintenance work on ITU, resulting in an increase in agency spend.

Clinical Effectiveness and Audit Committee Summary Report.

The report from the CEAC was noted and Quality Committee highlighting the issue of chest-drains, where we have differing procedures in ED and in Surgical Division. Committee was assured that the work is in-train to establish a pan-hospital policy.

Report to:	**Public Board**
Date of Meeting:	**07/12/2023**
Title of Report:	Quality Committee 26 October 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

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

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Quarterly Safeguarding Reports – Quarter 2 2023/24

Committee received the quarterly safeguarding reports for adults and for children as well as the report on looked after children. Committee noted the revised format which adopts the "Working Well, Off-Track, Concerns and Escalations" framework and sharpens the focus of discussion and facilitates better assessment of assurance.

Committee noted in particular the strengthening a staffing in Adults Safeguarding with the recruitment of the MCA/DoLS lead and the Domestic Abuse lead. Of some concern was the increase in adult safeguarding referrals to the Trust, though in practice few of these are pursued as safeguarding maters and we will work with partners to ensure appropriateness of referrals.

Committee was concerned about the lack of progress in finalising funding for the dedicated Trust post in The Multi-Agency Safeguarding Hub (MASH). The ICB has agreed to fund this post, but we are still awaiting final sign-off. Committee noted the significant efforts being made to provide leadership to the wider system work to improve services to children and welcomed the opportunity afforded by the links with Leeds health and care system and the chance to work with Leeds Teaching Hospitals NHS Trust. To strengthen Board awareness of safeguarding it was agreed to organise a dedicated training session for Board members.

For Looked After Children (LAC), the major concern remains our inability to meet timescales for initial health assessments and Committee will continue to focus on this going forward.

Child Protection and LAC are part of the wide range of Trust services to children and where we face a number of quality challenges including waiting times for Community Paediatrics. Committee was pleased to note the work being done internally and with the help of the Region to review wider working arrangements and best practice.

Quality Priority – Ensuring Patients Receive Timely Critical Medications

This programme aims to reduce missed and delayed critical medications, with an initial focus on medication for Parkinson's Disease patients. Initial work has focussed on raising the profile and awareness of this work and we have seen modest improvements in the timeliness of medications though it is too early to draw conclusions. The next phase of work will develop more focussed work with wards to target improvement actions as well as widening data collection to other critical medicines.

Quality Priority – Pressure Ulcer Quarterly Report

The Trust is bringing renewed focus to this priority through the lens of the new Patient Safety Incident Response Framework (PSIRF) and this was the 1st report to Committee detailing that work. What this allows is better understanding of the data and underlying issues and a more informed response. However there are extensive reasons causing harm rather than a few key issues hence responses need to be tailored to issues in different services. Equally 60% of pressure damage for inpatients originates before people come into hospital giving us wider system issues to be addressed.

Committee was assured by the renewed focus in this area and the level and comprehensiveness of detail across the Trust and the progress in using the new PSIR Framework. However we need to see this translated into actions and improvements.

Quality Priority – Improving Infection Prevention and Control.

Committee was concerned to hear that the regional visit to assess cleanliness progress with the aim of removing the need for intensive support had been pushed back from September to December following an informal visit that had concluded we were not ready. Our cleanliness audits show overall good compliance with standards and good progress, however we clearly have issues and the view was that the focus needs to be on local ownership and management oversight. This has been the focus of discussions and ever effort is being made to address shortfalls with a view to being compliant at the December formal assessment.

It was noted that nonetheless our C-diff reportable infections are at about the trajectory set nationally.

Quality Priority – Ensuring Mortality Levels Remain within Expected Levels.

Committee noted the continued reduction in the Trust's headline SHMI figure which stands at 100.1.

Divisional Quality Report – Surgical Division

Surgical Division presented a comprehensive report and discussion focussed on:

- Gynaecology where there are challenges with waiting times for initial appointments. Validation of the witing lists has identified significant opportunities for virtual rather than face to face appointments with 29% being delivered virtually in the week prior to the report. This work has reduced waiting times from 65 to 42 weeks.
- Paediatric services – where staff shortages are impacting waiting times and work is being done to secure locum in-sourcing as well as to prioritising those waiting

Maternity – Monthly PQSM Report

Committee received the monthly PQSM report and noted:

- The continued excellent progress in recruitment and an overall improving staffing position following the work over recent months.
- How the Midlands Escalation Policy is impacting on diverts of patients. This is clearly appropriate in cases of significant safety issues but we need to monitor our use of diverts and use of thresholds.

Staffing Report

Committee noted the positive changes in both sickness and vacancy rates. However our use of agency has increased of late, partly due to operational pressures and use of unfunded beds. Matrons have agreed to review the position as part of work of the Finance and Performance Executive.

Patient Safety Committee Summary Report.

The summary report highlighted concerns with the VTE programme and slippage in assessment compliance and need for more clinical input to the Thrombosis Committee. Some slippage is due to systems issues but Committee was concerned that we are losing the Deputy CMO who has provided leadership in this area and we need leadership "drive" to maintain momentum. QC will continue to focus on this area.

Deteriorating Patient Terms of Reference and Workplan

Committee welcomed the formalisation of the TOR and Action Plan following verbal updates at the last 2 meetings. This is another area where leadership will need to be agreed by the new CMO and Deputy CMO.

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

WVT Minutes of the Public Foundation Group Boards Meeting
Held on Wednesday 1 November 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
Chizo Agwu	(CA)	Chief Medical Director WVT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Frances Martin	(FM)	NED WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Jo Rouse	(JR)	NED WVT
Nicola Twigg	(NGi)	NED WVT

In attendance:

WVT:

Jon Barnes	(JB)	Chief Transformation Officer WVT
Ellie Bulmer	(EB)	Associate Non-Executive Director WVT
John Burnett	(JBu)	Head of Communications WVT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Geoffrey Etule	(GE)	Chief People Officer WVT
Kieran Lappin	(KL)	ANED WVT
Frank Myers	(FMy)	ANED WVT

GEH:

Catherine Free	(CF)	Managing Director GEH
Natalie Green	(NG)	Chief Nursing Officer GEH
Gavin Hawes	(GH)	Communications and Engagement Manager GEH
Mark Hetherington	(MH)	ANED GEH
Julie Houlder	(JH)	NED GEH
Haq Khan	(HK)	Chief Finance Officer GEH
Rosie Kneafsey	(RK)	ANED GEH
Jenni Northcote	(JN)	Chief Strategy Officer GEH
Gertie Nic Philib	(GP)	Chief People Officer GEH
Sarah Raistrick	(SR)	NED GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Jackie Richards	(JR)	ANED GEH
Robin Snead	(RS)	Chief Operating Officer GEH
Umar Zamman	(UZ)	NED GEH

SWFT

Charles Ashton	(CA)	Chief Medical Officer SWFT
Varadarajan Baskar	(VB)	Deputy Medical Director SWFT
Adam Carson	(AC)	Managing Director SWFT
Oliver Cofler	(OC)	ANED SWFT
Sarah Collett	(SC)	Trust Secretary SWFT/GEH
Richard Colley	(RC)	NED SWFT
Phil Gilbert	(PG)	NED SWFT

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

WVT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Paramjit Gill	(PG)	NED SWFT
Harkamal Heran	(HH)	Chief Operating Officer SWT
Oli Hiscoe	(OH)	ANED SWFT
Kim Li	(KL)	Chief Finance Officer SWFT
Simon Page	(SP)	NED SWFT
David Spraggett	(DS)	NED SWFT
Ellie Ward	(EW)	Deputy Chief Nursing Officer SWFT (deputising for Fiona Burton)
Sue Whelan Tracy	(SWT)	NED SWFT
Leigh Tranter	(LT)	Communications SWFT

WAHT:

Christine Blanchard	(CB)	Chief Medical Officer WAHT
Tony Bramley	(TB)	NED WAHT
Neil Cook	(NC)	Chief Finance Officer WAHT
Richard Haynes	(RH)	Director of Communications WAHT
Helen Lancaster	(HL)	Chief Operating Officer WAHT
Michelle Lynch	(ML)	NED WAHT
Karen Martin	(KM)	NED WAHT
Julie Moore	(JM)	NED WAHT
Richard Oosterom	(RO)	NED WAHT
Tina Ricketts	(TR)	Director of People and Culture WAHT
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
Sue Sinclair	(SS)	ANED WAHT

Foundation Group:

Vanessa Nicholls	(VN)	GEH Board Secretary (deputising for the Foundation Group EA)

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

MINUTE		**ACTION**
23.074	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Yasmin Becker (NED SWFT); Fiona Burton (Chief Nursing Officer SWFT); Paul Capener (ANED GEH); Andrew Cottom (NED WVT); Becky Hale (Chief Commissioning Officer SWFT); Erica Hermon (Associate Director of Corporate Governance / Company Secretary WVT); Sharon Hill (ANED WVT); Colin Horwath (NED WAHT); Simone Jordan (NED GEH); Vikki Lewis (Chief Digital Officer WAHT); Anil Majithia (NED GEH); Simon Murphy (NED/Deputy Chair WAHT); Jo Newton (Director of Strategy and Planning WAHT); Katie Osmond (Chief Finance Officer WVT), Bharti Patel (ANED SWFT) and Mary Powell (Head of Strategic Communications) and. **Resolved – that the position be noted.**	

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
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WVT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

MINUTE		ACTION
23.075	**DECLARATIONS OF INTEREST** Frank Myers (ANED WVT) declared his appointment as Chair of Community First Herefordshire and Worcestershire. Standing down as NHS's longest serving Non-Executive Director in December 2023, the Group Chairman took time to thank Frank Myers for his hard work and commitment during his tenure at WVT and wished him well in his new role. **Resolved – that the position be noted.**	
23.076	**GEH PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the GEH public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.077	**SWFT PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the SWFT public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.078	**WVT PUBLIC MINUTES OF THE MEETING HELD ON 2 AUGUST 2023** **Resolved – that the WVT public Minutes of the meeting held on 2 August 2023 be confirmed as an accurate record of the meeting and signed by the Group Chairman.**	
23.079	**CHAIRMAN'S REMARKS** The Group Chairman welcomed to the Foundation Group: • Chizo Agwu as the new Chief Medical Officer for WVT, and • Oli Hiscoe, Oliver Cofler and Bharti Patel as new Associate Non-Executive Directors for SWFT. A note of thanks was also extended to WVT's former Chief Medical Officer, David Mowbray, who had taken up appointment as Chief Medical Advisor for SWFT Clinical Services Ltd. With the Foundation Group celebrating a number of special days throughout November 2023 like Remembrance Day, the Group Chairman spoke proudly of the close working relationship with veteran organisations across the Foundation Group, as part of the signed covenant with the Veterans Covenant Healthcare Alliance. On behalf of the Foundation Group, the Group Chairman took the time to thank veterans and their families for their enormous commitment to service over the years.	

MINUTE		ACTION
	Other special events being celebrated as part of the Foundation Group's Equality, Diversity and Inclusion (EDI) agenda throughout November 2023 included Diwali; Transgender Awareness Week; UK Disability Month; Islamophobia Month and White Ribbon Day. **Resolved – that the Chairman's Remarks be received and noted.**	
23.080	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.080.01	Foundation Group Performance Report (Minute 23.058 refers) The Managing Director at WVT informed the Foundation Group Boards that work to understand how many diagnoses of cancer each trust had in their Emergency Departments (EDs) remained ongoing. Whilst Information Leads were confident that the data could be produced, it was noted that this may take some time as changes to Information Technology (IT) systems may be required in order to provide an accurate position. **Resolved – that the Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust.**	**JI/CF/AC**
23.081	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chairman provided an overview on some of the interesting topics covered at the Foundation Group Boards Workshop earlier that day. Presentations included 'Big Move' updates on the work being done around Carbon Reduction, of which the Foundation Group was at the forefront of within the NHS, and the Home First agenda which updated on the important work happening as a whole with partners across health, social care and the voluntary sector to help provide the right care for patients in the right place and by the right team. A focused discussion also took place on agency and locum controls across the Foundation Group, which had indicated early signs of progress in agency and locum reduction. A presentation then followed by Guest Speaker Sir Thomas Hughes-Hallet from Helpforce, who spoke positively about the work of volunteers and the important role they played within the NHS. With GEH recognised at the National Helpforce Champions Awards in October 2023, the Group Chairman thanked the GEH Head of Patient Experience and Volunteering and team for their phenomenal volunteering work which had won them the Volunteering Collaboration of the Year Award. With volunteering known to be beneficial for one's health, and vital in enabling the NHS to provide better care for the citizens we served, the Group Chairman	

MINUTE		ACTION
	encouraged anyone considering volunteering to contact any of the four organisations to express an interest in becoming a valued member of the team. Reflecting on those Board Workshop presentations heard earlier that day, the Group Chief Executive remarked that this had reinforced the opportunity across the Foundation Group for sharing some of the great practice that was happening. In particularly on areas like the Carbon Reduction Big Move, which in all four trusts had shown action underway, and a lot of engagement with different disciplines and staff that meant carbon reduction was being positively looked at from all angles. Opportunities for shared learning across the Foundation Group had also seen great progress being made around agency and locum controls. **Resolved – that the position be noted.**	
23.082	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director at WVT provided the Foundation Group Boards with an overview of the performance at WVT. She informed the Foundation Group Boards that for the period July to September 2023, WVT had been ranked top performing Trust across the region for delivering on average 117% of its value weighted elective activity; compared with pre-Covid elective activity in 2019/20. Although an area for celebration, WVT recognised that there were still opportunities to explore and improve theatre productivity further. The Managing Director at WVT explained that whilst WVT's performance against the national 28 Day Faster Diagnosis Standard (28 Day FDS) remained on track, delays in histopathology reporting had been sighted as one of the main issues impacting on performance. Despite outsourcing arrangements and mutual aid being in place, this had led to longer turnaround times and thus, extending waiting times for patient's diagnosis and treatment. Notwithstanding, she highlighted a real opportunity for Chief Medical Officers across the Foundation Group to lead the way on a histopathology network solution to improve reporting times for all patients across the Foundation Group. Raising WVT's ED performance as an area for concern, the Managing Director at WVT reported that one of the biggest drivers for underperformance had been the deterioration in medically fit for discharge patients, who had been delayed in hospital. Notwithstanding, she was confident that following the recent delegation of the Better Care Fund, this would provide opportunity for improved ownership as to how resources would be used across Herefordshire; particularly to help drive improvement around Discharge to Assess (D2A) pathways. Other opportunities to help improve ED performance via the Virtual Ward model included going live that day with Docobo, a system that enabled patient's vital signs to be monitored remotely and the Surgical Same Day Emergency Care (SDEC) facility that would go live later that month.	

MINUTE		ACTION

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

For context, the Group Chairman explained that keeping patients in an acute setting when fit for discharge cost the NHS approximately £300 per night, opposed to £50 per night for a domiciliary care package in the community. Acknowledging that more could be done to improve the HomeFirst model, he stressed that without the support of social care and domiciliary care providing capacity in the community, this not only posed a risk of hospital acquired decline for the patient but also meant a significant net loss to the taxpayer, of approximately £250 per day, per patient.

Nicola Twigg (NED WVT) queried if there was any specific reason why breast cancer related 28 Day FDS statistics were particularly low for WVT. As previously mentioned, the Managing Director at WVT explained that the deterioration in performance had been due to delays in histopathology reporting and thus, reiterating a big opportunity to improve histopathology by networking the service across the Foundation Group to ensure turnaround times remained consistent for patients across all four trusts.

The Managing Director at SWFT provided the Foundation Group Boards with an overview of the performance at WVT. Reporting an incredibly busy month for SWFT's ED during September 2023, he highlighted that despite higher attendances, the A&E 4-hour performance was better when compared with the same period in 2022/23, maintaining SWFT's place within the top ten trusts nationally. Record number of attendances had also been seen through WVT's SDEC areas in September 2023; positively reflecting the level transformation work happening within Emergency Care Services.

The Managing Director at SWFT highlighted significant concern as to the high number of patients arriving via intelligence conveyancing (IC) from West Midlands Ambulance Service (WMAS). He reported that during September 2023, SWFT admitted 81 'out of area' patients of which a number had been deemed inappropriate. With 'out of area' patients often proving difficult to discharge; impacting on both length of stay (LoS) and bed occupancy, and with the number of IC cases increasing month on month, the Foundation Group Boards was informed that the Trust was working with WMAS and the Integrated Care Board (ICB) to address the issue, as this was a particular concern heading into winter.

Updating on Cancer Services, the Managing Director at SWFT explained that one of the biggest challenges for the Trust had been around the sustained increase in Cancer two week wait (2WW) referrals seen in recent months. Despite this, SWFT had made notable improvements in the 28 Day FDS and good progress in reducing the number of patients waiting over 62 days for treatment; placing SWFT ahead of the fair shares Integrated Care System (ICS) trajectory. With the majority of SWFT's oncologist cover provided by University

MINUTE		ACTION
	Hospitals Coventry and Warwickshire NHS Trust (UHCW), the Managing Director at SWFT assured the Foundation Group Boards that the Trust continued to work with UHCW to improve waiting times for first oncology appointments. Focussing on Referral Time to Treatment (RTT) performance, the Managing Director at SWFT was pleased to report a continued reduction in 65 week waits, with SWFT on track to eliminate both admitted and non-admitted elective waits by 31 March 2024. Good progress had also been made on reducing 52 week waits, supported by the learning from the Getting it Right First Time (GIRFT) Further Faster programme and general improvements seen across specialties in elective care. The Managing Director at SWFT celebrated the Trust's improvement work done with the Endoscopy Service. Achieving over 98% utilisation in recent months had ranked SWFT favourably as one of the highest performing organisations within the country. The Group Chairman invited questions and perspectives, but no further comments were raised. The Managing Director at GEH provided the Foundation Group Boards with an overview of the performance at GEH. With high bed occupancy a consistent theme to that experienced across the Foundation Group, the Managing Director at GEH explained that this had been particularly challenging for GEH, inevitably impacting on flow and performance metrics. In order to maintain flow, she reported that extra capacity had been opened, with patients (where safe to do so) boarding on wards to help maintain safe care for patients. The Managing Director at GEH reported that the Trust's A&E 4-hour performance continued to perform well when compared nationally, with a slight improvement seen in the performance metric for September 2023. It had also been positive to note that GEH continued to perform well in regard to low numbers of ambulance handovers waiting over 60 minutes. Notwithstanding, GEH had seen the number of ambulances waiting between 30 and 60 minutes increase, something the ED was keen to eliminate so that patients could be admitted and treated as soon as possible. With sickness absence rates remaining high, the Managing Director at GEH assured the Foundation Group Boards that a lot of work had been done around staff wellbeing and supporting individuals to manage sickness levels. An area which would continue to be an ongoing focus for the Trust. Although GEH's position regarding the Cancer 28 Day FDS had been as predicted, the Foundation Group Boards were informed that the Trust was forecasting some deterioration in that position over the coming months due to some fragility around staffing in the Urology Service. Although staffing issues had been mitigated, this and the impact of industrial action were likely to have some effect on urology pathways, given the need for specialist consultants to	

MINUTE		**ACTION**

deliver the whole of the cancer pathway, including things like Multi-Disciplinary Team (MDT) meetings, which were important for decision making in cancer.

Focusing on RTT performance, the Managing Director at GEH was pleased to report that GEH continued to have low numbers of patients waiting over 65 weeks for treatment. Whilst there had been an increase in the number of patients waiting over 52 weeks, the Trust remained focused on treating long waiters and providing mutual aid to patients in gynaecology from UHCW.

For context, the Group Chairman remarked that as a result of SWFT and GEH performing relatively well on ED and Maternity performance, this had seen an increase in demand for both trusts, which combined meant that they were providing circa 60% of the ED and Maternity flow for Coventry and Warwickshire.

The Group Chairman invited questions and perspectives, but no further comments were raised.

The Group Chief Executive on behalf of WAHT provided the Foundation Group Boards with an overview of the performance at WAHT.

The Group Chairman announced that as of 6 November 2023, Stephen Coleman would take up position of Managing Director at WAHT.

On behalf of the Foundation Group Boards, the Group Chief Executive thanked the Head of Information at WVT for coordinating the Performance Report across the Foundation Group. He also thanked WAHT's Information Team for producing the Trust's data in line with the rest of the Foundation Group as having a consistent overview enabled the Foundation Group to get to the heart of performance issues and opportunities.

With WAHT subject to a degree of regional scrutiny on performance as a tier two level Trust, the Group Chief Executive remarked that WAHT's A&E 4-hour standard and ambulance handover times remained the Trust's biggest cause for concern. The Trust was therefore focusing on flow and opportunities to do more activity through SDEC.

Positive to note that WAHT's mortality figures remained within expected range, the Group Chief Executive was particularly pleased to report the WAHT's theatre utilisation performance was ranked the strongest across the Foundation Group, achieving 87% on the uncapped touch time indicator, presenting a real opportunity for shared learning.

With WAHT's cancer performance ranked as a significant outlier 12 months ago, it had been positive to report that performance had been on a steady improvement trajectory with performance around 2WWs and 28 Day FDS on track. Acknowledging that Cancer 62-day waits were longer than would like,

MINUTE		ACTION
	the Group Chief Executive was hopeful that the GIRFT Faster Further programme would lead to further improvement in the future. The Group Chief Executive informed the Foundation Group Boards that WAHT had been removed from tier two monitoring in respect of its RTT 52 week wait performance. Whilst positive, he highlighted that with RTT performance at 49% and a worryingly increase in 52 week wait numbers, this was something the Trust would need to focus on. However, he was optimistic that the opening of additional theatres last month at the Alexandra Hospital would provide that additional capacity moving forward. Asked by the Group Chairman to give an overview on NHS England's (NHSE's) Ten-Point Plan (10PP) initiated to improve WAHT's performance, the Group Chief Executive explained that the 10PP's main focus was an emphasis on flow and the need to improve processes within the hospital. In particular around medical specialities as that would enable patients to be pulled from ED and treated by the right speciality and discharged home as early as possible. There was also an opportunity identified within the 10PP to have more HomeFirst and supported discharges through community services. Elements within the 10PP also included the need to focus on improving WAHT's approach to staff, like improving areas like car parking, to help improve on sickness absence levels and organisational recruitment, and simplifying the Trust's approach to improvement by having as many people as possible trained in improvement methodologies so that they could be responsive to immediate issues like flow. The Group Chairman invited questions and perspectives, but no further comments were raised. The Group Chairman remarked that despite best endeavours by all four trusts within the Foundation Group to deliver the level of service they aspired to for the citizens they served, he wanted to apologise on behalf of the Foundation Group Boards to patients and their families for the long waits being experienced. An apology was also extended to ambulance crews hindered by capacity constraints delaying patient handovers. **Resolved – that the Foundation Group Performance Report be received and noted.**	
23.083	**OUTPATIENT PRODUCTIVITY** The Chief Operating Officer at WAHT opened the presentation on outpatient productivity. This set out the progress being made across the Foundation Group in the delivery of improving outpatient productivity and how that aligned with the transformational work happening and the Further Faster programme.	

MINUTE		**ACTION**

With the appointment of a Group Analyst in October 2023, the Chief Operating Officer at WAHT was pleased to report that the role would be supporting the outpatient productivity peace of work, using internal and external benchmark data to help further identify opportunities for improvement.
In more detail the presentation focused on the work around the Further Faster programme, Patient Initiated Follow Up (PIFU), NHSE Transformation Ask and any other national involvement initiatives like the NHS Elective Recovery Programme and GIRFT.

Having identified a number of similarities from each of the Trust's Outpatient Transformation Programmes, the Foundation Group Boards were notified of three key areas of focus which would be driven collectively by the Foundation Group to improve productivity; which included:

a) improving communication to our patients;
b) using IT to support improvements around productivity, and
c) undertaking specialty deep dives and service reviews.

Focusing on RTT performance for each of the organisations, the Chief Operating Officer at WAHT talked through those factors driving the increase in waiting list numbers, together with the combined actions being taken by the Foundation Group to address that increase. It was noted that with the exception of WAHT who had seen a slight decrease in the number of patients on the waiting list, performance charts for SWFT, GEH and WVT had shown a gradual increase in their waiting list position.

Focusing on Cancer 2WW performance, the Chief Operating Officer at WAHT reported that all four organisations had seen a significant increase in Cancer 2WW referrals across a range of specialities. However, it had been particularly interesting to note that the pattern in 2WW surges had been very similar across the Foundation Group. The Chief Operating Officers would therefore undertake a deep dive into that 2WW referral pattern to help understand and predict where surge areas were likely to arise for particular specialities and help understand what that meant for the rest of the pathway, particularly around cancers.

The Chief Operating Officer at WVT explained that PIFU was a patient led activation of their follow up appointment, based on their symptoms and individual circumstances. Emphasising that PIFUs should not be used in place of discharging patients appropriately, it was noted that this would be a key measure that would need to be embedded correctly across the Foundation Group. With all four trusts currently at different stages in delivering PIFU, particularly within specialty plans, it had been positive to note that there was clear clinical leadership and pathways being developed. He remarked that looking at best practice across the 28 trusts involved in the Faster Further programme and looking at case studies and benchmarking, together with using the average and mean across PIFU, would be key for the Foundation Group; including the need to look at local solutions where case studies could be amended as necessary.

MINUTE		ACTION

Opportunities being considered by the Foundation Group included PIFU case studies to drive down Do Not Attends (DNAs) for new appointments and patient reactivation rates for PIFU specialties. Although nationally GIRFT evidence suggested that most patients returned less often when empowered to manage their own follow up pathway.

With DNAs a core area of focus of operational delivery in outpatients, the Foundation Group Boards were informed that Chief Operating Officers were focusing on a number of opportunities and solutions using GIRFT best practice to minimise the impact of unused appointments. In particular through using digital solutions and working with the Volunteer Service to make reminder calls in services with the highest DNA rates.

Focusing on outpatient utilisation, the Foundation Group Boards were briefed on the approach being taken to adopt the 6-4-2 scheduling process commonly used in theatre processes to reduce clinic cancellations. As part of the Faster Further programme it was noted that there had been job plans, best practice and specialty based best practice clinic templates released to help trusts improve outpatient utilisation. There would also be a focus on clinic comparison data including the percentage of follow ups and percentage of new patients at specialty and subspecialty level.

With varying degrees of success across the Foundation Group in regard to virtual appointments, the Foundation Group Boards heard that there were areas which clinical teams could take learning from in terms of best practice. There were also various examples across the Foundation Group around getting virtual clinics right and striking the right balance, so that appointments were adding value to the patients' treatment and pathway. Discharge rates for virtual appointments versus face-to-face appointments would also be an area of focus.

With SWFT, GEH and WVT fortunate to be part of NHSE's GIRFT Further Faster programme lead by Professor Tim Briggs, the presentation outlined some of the opportunities implemented by other member trusts to improve a number of outpatient and inpatients metrics. Whilst WAHT would join the second phase of the Further Faster programme, the Chief Operating Officer at SWFT explained that by virtue of working together as a Foundation Group had provided an opportunity to build a solid foundation for shared learning, and with a Group Analyst in place to make sure that Model Hospital data was accurate across the Foundation Group, that would enable the trusts to accurately measure and compare performance.

Drawing out areas of best practice across the Foundation Group which included GEH's focus on health inequalities and volunteering, SWFT's focus on

MINUTE		ACTION

endoscopy utilisation, WVT's focus on validation and WAHT's approach to reducing DNAs, the Foundation Group Boards were informed that with such positive work happening within each trust, the Chief Operating Officers were really keen to share approaches and learning in order to adopt and replicate areas of best practice to drive those benefits across the Foundation Group.
Recognising that the work being done across the Foundation Group had been extremely beneficial, the Chief Operating Officer at GEH highlighted that whilst there were commonalities in the task ahead, there were also commonalities in the challenges impeding not only current performance but also the Foundation Group's ability to deliver collective improvements around outpatient productivity like, industrial action, impact of emergency pressures, increased referrals and workforce availability.

Concluding the presentation, the Chief Operating Officer at GEH outlined some of the initiatives being collectively worked on as a Foundation Group in order to share best practice, take learning from other trusts and develop Group-based solutions to help drive forward improvements.

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

Taking time to thank the Chief Operating Officers, the Group Chairman remarked on how pleasing and encouraging it had been to see the level of cross Foundation Group discussion happening to drive forward improvements.

Remarking on Jackie Richard's (GEH NED) comment in the Microsoft Teams chat box, which suggested the use of digital solutions to help patients manage appointments and improve DNA performance, the Group Chairman remarked that whilst he welcomed the approach to find digital solutions at pace as part of the Faster Further work to improve productivity, he counselled for digital solutions to be identical to enable conformity and economies of scale across the Foundation Group.

With the Patient Initiated Digital Mutual Aid System (PIDMAS) a new phenomenon across the NHS, the Group Chief Executive sought views from Chief Operating Officers as to how the implementation of that was going.

Overall, the Chief Operating Officers reported a similar position in regard to the number of patients expressing an interest to travel for treatment since recently going live with PIDMAS. Whilst early feedback had indicated some reluctance from patients wanting to travel further than 50 miles with visiting, travel and accommodation cited as areas of concern, overall patients had been keen to opt for the PIDMAS solution. Initial thoughts on the process itself had also highlighted learning around the need to refine the administration process as currently this was proving time consuming.

MINUTE		ACTION
	Resolved – that the Outpatient Productivity Update be received and noted.	
23.084	**FOUNDATION GROUP BOARDS CALENDAR OF MEETINGS 2024/25** The Group Chairman presented the Foundation Group Boards 2024/25 Calendar of Meeting for consideration and approval. The Group Chairman invited questions and perspectives, but no further comments were raised. **Resolved – that the Foundation Group Boards Calendar of Meetings for 2024/25 be approved.**	
23.085	**GENDER PAY GAP ANNUAL REPORT** The Chief People Officer at WAHT introduced this report. Taken as read, the paper set out the rationale for the report, the overarching position when exploring the Gender Pay Gap across each trust within the Foundation Group when comparing data between 2022/23 and 2021/22 and actions being taken by each organisation to address any inequalities in pay, in order to improve staff experience, retention and maintain each trust's reputation, as a fair and equitable employer. For clarity, it was explained to the Foundation Group Boards that although there was no scope to offer bonus payments to colleagues on Agenda for Change (AfC) Term and Conditions (T&Cs), there was a national requirement to contractually offer Clinical Excellence Awards (CEAs) for medical and dental staff. The Chief People Officer for GEH presented the key headlines which included the following: a) on average there was an 80% / 20% female to male split across most of the trusts. b) upper quartile for pay broadly showed GEH, WAHT and WVT consistent at circa 60% female to 30% male, with the exception of SWFT who had a much higher 84% female to 16% male split, reflecting the outsourcing of Estates and Facilities and auxiliary staff. c) lower middle and lower quartile for pay, again was broadly in line across GEH, WAHT and WVT with a circa 85% / 15% female to male split, with SWFT's lower quartiles circa 75% / 25% female to male, as a result of outsourcing Estates and Facilities, and d) across all four organisations there had been an increase to the mean and median salary; with a corresponding increase in the pay gap across	

MINUTE		**ACTION**

GEH, WAHT and GEH. WVT reported an improved position with a decrease in their 2022/23 Pay Gap.

With the Chief People Officers committed to ensuring an equitable workforce across the Foundation Group, a number of consistent actions to respond to and improve the gender pay gap were outlined as follows:

e) leadership programmes offered as an opportunity to support and develop colleagues to move into more senior roles.
f) a focus on being a flexible employer, enabling manager skills to support an increased compassionate and flexible workplace.
g) offering inclusive or reverse mentoring to not only support female colleagues but also focus on all nine protected characteristics which should see an improvement in terms of the Foundation Group's Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).
h) talent for all sessions to identify aspirant talent and put support and development opportunities in place.
i) using staff networks to help identify problems and understand what interventions were needed to address them.
j) promoting and embedding inclusive recruitment toolkits across the Foundation Group to help reduce bias across recruitment processes, and
k) work with colleagues as part of the EDI agenda to develop a levelling up programme that supports international nurse recruits into senior roles within the Foundation Group.

With the CEA bonus historically given out on an application basis, it was noted that since Covid, CEAs had been shared out on a fair shares basis giving everyone eligible an equal share.

In addition, the Foundation Group Boards were informed that the Foundation Group had also signed up to the Sexual Safety at Work Charter and that the Chief People Officers would be working together over the coming year to look more closely as to whether each trust had ample female representation at all senior levels and likewise, looking at whether the workforce was representative of the local community.

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

Responding to Grace Quantock's (WVT NED) question in the Microsoft Teams chat box, the Chief People Officer at WAHT confirmed that all trusts in the Foundation Group did measure the pay gap between other protected characteristics under the WDES, WRES and NHS Rainbow Badge Scheme. This was also addressed through a positive recruitment process, with

MINUTE		ACTION
	interviews guaranteed for colleagues with protected characteristics if they met the person specification for Bands 8a and above with a view to expanding that offer to lower bands going forward. In order to get a more meaningful measure regarding the gender pay gap, the Managing Director of WVT suggested a further breakdown which showed the female/male pay gap by professional group and across each of the nine protected characteristic areas. The Chief People Officer at GEH confirmed that there was a more detailed breakdown available, however the Gender Pay Gap was a nationally prescribed report, which provided the granular data across the different protected characteristics within the WRES and WDES reports, different genders and different staff groups. The Group Chairman asked that the Chief People Officers presented the Gender Pay Gap report back to their respective Trust Boards, which included a more granular breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic groups, to give added assurance that women or colleagues from those protected characteristic groups were not being disadvantaged in terms of pay. With Birmingham City Council recently declaring itself in a state of 'effective bankruptcy' as a result of being sued by employees for unequal pay under the Equality Act 2010, the Group Chairman asked if there was a potential risk of such a claim being brought against the NHS. The Chief People Officer at GEH explained that there had been an unequal pay risk with the introduction of AfC back in 2005 but was assured that was far less of a risk now in terms of how the NHS undertook job evaluation and reviewed posts. With the introduction of AfC T&Cs initially aimed at addressing equal pay issues, the Group Chief Executive remarked that in his opinion the data now exposed opportunities for improvement around equality issues relating to things like progression, training and providing flexible working opportunities. **Resolved – that,** **(A) the Chief People Officers include a detailed breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic, and** **(B) the Gender Pay Gap Annual Report be received and noted.**	**CPOs** **CPOs**
23.086	**ANY OTHER BUSINESS**	
23.086.01	Glen Burley – 40 Years Service in NHS Celebrating the Group Chief Executive's 40 years of service in the NHS, the Group Chairman recapped on his career history that commenced back on 1 September 1983 as a Finance Trainee in the then South Warwickshire Health Authority.	

MINUTE		ACTION
	From then, the Group Chief Executive took on a variety of roles throughout his career and was seconded to SWFT from 1 October 2006 as Chief Executive and formally appointed substantive on 1 April 2008. With such a significant, broad-based career spanning the past 40 years, the Group Chairman remarked on how fortunate the citizens of Warwickshire were to have him join as SWFT's Chief Executive back in 2008. In keeping with the Group Chief Executive's approach to sharing interesting and general facts that happened during the years for colleagues receiving long service awards, the Group Chairman shared the a number of facts from 1983 when the Group Chief Executive joined the NHS and 2006 when he was seconded to SWFT as the Chief Executive. Recognising the Group Chief Executive for his extraordinary commitment as a public servant and speaking highly of his conviction, clarity of thought and desire to improve and drive performance, the Group Chairman on behalf of the Foundation Group Boards thanked the Group Chief Executive for his valued and continued commitment to the NHS. **Resolved – that the position be noted.**	
23.087	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS** No questions were raised. **Resolved – that the position be noted.**	
23.088	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
23.089	**APOLOGIES FOR ABSENCE**	
23.090	**DECLARATIONS OF INTEREST**	
23.091	**GEH CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.092	**SWFT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.093	**WVT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 2 AUGUST 2023**	
23.094	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
23.095	**ANY OTHER CONFIDENTIAL BUSINESS**	

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

WVT Minutes of the Foundation Group Boards Meeting Held on 1 November 2023

MINUTE		ACTION
23.096	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 7 February 2024 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chairman) Date: 7 February 2024
Russell Hardy

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

PUBLIC ACTIONS UPDATE: FOUNDATION GROUP BOARDS MEETING – 7 FEBRUARY 2024

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
23.080.01 (01.11.2023) 23.058 (02.08.2023) Foundation Group Performance Report	The Managing Directors ensure analysis takes place to compare cancer diagnosis from ED attendance across each Trust.	J Ives / A Carson / C Free	Whilst Information Leads were confident that the data could be produced, it was noted that this may take some time as changes to Information Technology (IT) systems may be required in order to provide an accurate position.
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	- Chief Operating Officers are in the process of recalculating theatre productivity to include an indication of the resource cost per unit.
23.084 Gender Pay Gap Annual Report	The Chief People Officers include a detailed breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristic.	G Nic Philib / G Etule / T Rickets	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 31 August 2023 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Eleanor Bulmer	EB	Associate Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Associate Non-Executive Director
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
David Mowbray	DM	Chief Medical Officer
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Mehmood Akhtar	MA	Associate Medical Director, Surgical Division – Left during Item 9
Sadhia Akhtar	SA	Cervical Screening Programme Lead – For Item 5.1
Jonathan Boulter	JB	Associate Chief Operating Officer, Surgery
Lynn Carpenter	LC	Quality and Safety Matron
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
Val Jones	VJ	Executive Assistant (for the minutes)
Tony McConkey	TM	Clinical Director, Pharmacy & Medicines Optimisation – Arrived during Item 5.1
Sue Moody	SM	General Manager - Acute and Countywide Services
Kate O'Shea	KOS	General Manager, Women and Children's Directorate – For Item 5.1
Jo Sandford	JS	Freedom To Speak Up Guardian – For Item 16
Rachael Skinner	RS	Integrated Care Boards Representative
Emma Smith	ES	Divisional Nurse Director, Surgery
Emma Wales	EW	Associate Chief Medical Officer, Medical Division

QC001/08.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Natasha Owen, Associate Director of Quality Governance.	
QC002/08.23	**QUORUM**	
	The meeting was quorate.	
QC003/08.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/08.23	**MINUTES OF THE MEETING HELD ON 27 JULY 2023**	
	QC008/07.23 – Mortality – To read: Stroke – We have the 8th lowest mortality rate in the *country.*	

	<u>Resolved</u> – that with the one agreement amendment, the minutes of the meeting held on 27 July 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	
QC005/08.23	**<u>ACTION LOG</u>**	
	(a) QC005/07.23 – Action Log – (B) – The Deputy Chief Medical Officer advised that the discussion around reviewing how the Regulation 28 Report to Prevent Future Deaths being discussed at Safety in Sync related to delays in patients presenting in the Community and some delays from Shropshire to Herefordshire ambulances. Action can be closed as Safety in Sync discussion not required. (b) QC010/07.23 – Division Quarterly Report – Surgical Division – (B) – Meeting arranged with the Quality and Safety Matron on 5 September to discuss InPhase in more detail. An update will be provided at the next Audit Committee. (c) QC006/07.23 – Quality Priority – IPC (Cleanliness/C-Diff) – (B) – Sodexo will be invited to the meeting when the Cleanliness Priority is being presented. Agreed to close this action. (d) QC007/07.23 – Quarter 1 2023/24 Safeguarding Reports – (B) – The Lead Nurse Adult Safeguarding to facilitate communication between Care Homes, Wye Valley Trust and the Local Authority regarding the Adult Safeguarding Referral process to ensure appropriate referrals are made and other methods are used to resolve quality issues. To feedback via Quality Committee in quarterly reports. (e) QC007/07.23 – Quarter 1 2023/24 Safeguarding Reports – (C) – The Named Nurse Safeguarding Children to send the list of Board members who have not yet undertaken their Safeguarding training to the Chief Nursing Officer (CNO). Bespoke training along with a leaflet will be organised for those who are not compliant and those who have just recently joined the Trust. (f) QC014/07.23 – Quality Priority – Pressure Ulcer Report – (B) – There is strong compliance for CQUINS for both the Acute and the Community. The dashboard has been delayed due to Maxims.	**HF**
	<u>Resolved</u> – that: **(A) The Action Log be received and noted.** **(B) The Named Nurse Safeguarding Children to send the list of Board members who have not yet undertaken their Safeguarding training to the Chief Nursing Officer. Bespoke training along with a leaflet will be organised for those who are not compliant and those who have just recently joined the Trust.**	**HF**

	BUSINESS SECTION	
QC006/08.23	**COLPOSCOPY REPORT**	
	The Cervical Screening Programme Lead (CSPL) and the General Manager, Women and Children's Directorate (GM) presented the Colposcopy Report and the following key points were noted: • We are mandated as part of this service to report to the Quality Committee twice a year. • An action from the last meeting was to provide more detail around the demands of the service and the number of attendances. The data has been included in the report, which shows an increase over the years. There was a slight reduction in activity in 2021 due to Covid, but this then increases due to the delays in tests being undertaken. • We are managing to keep up with the demand but this is not without challenge. One Colposcopist is on long term sick leave and we have not been able to backfill this role. • Workforce – We are just embarking on training a Nurse Colposcopist as this is a difficult role to appoint to. A Registrar Colposcopist will also start in post shortly. We are keen for Specialist Doctors to train in this area, with a couple interested in this post. • We are delivering consistently good performance and are achieving our KPIs. • A quarterly Programme Board was held where NHSE and Public Health England met with us to discuss our risks and performance. This meeting has been stood down and we now provide a quarterly exception report instead. We are keeping in touch via email whilst they reorganise and decide on next steps. The meeting included our Worcester colleagues which was a useful learning session. • The Managing Director noted that our performance for offering treatment within 4 weeks appears low and queried whether this was due to patients not opting for treatment. The CSPL advised that it is not possible to separate patients receiving conservative treatment for high grade CIN. We are looking at how we can manage this. This is nationally how we have to report. Future reports will contain more detail around the breakdown of the figures for patients. • The Managing Director also noted that the format for the numbers of patients being seen in the service is not clear. This will be changed for the next report.	**SA/KOS** **SA/KOS**

	• The Managing Director did not feel that the data is necessarily showing the increase in demand. The CSPL advised that we are seeing demand for Colposcopy patients but also patients with a suspicious looking cervix or abnormal symptoms which have all impacted on the service. Data for patients referred by their GP and the Screening Programme will be shown separately in future reports.	**SA/KOS**
	• The Managing Director noted that the table on histology does not contain any narrative and appears to show that performance has halved. The CSPL advised that the risk of the shortage of Histopathologists is on the Risk Register. The narrative around this and the trajectory for recovery will be included in the next report.	**SA/KOS**
	• Mr James (Chair of the Quality Committee and NED) noted that the Colposcopy Report is presented to provide assurance on the quality and safety of this service, but queried what we are doing about these challenges. This is on the Risk Register but we need more information around how this is being addressed.	
	• Mrs Twigg (NED) suggested using the format for the Divisional Reports which breaks down key areas for review. This will enable a consistent structure from which we can clearly pick out key information.	**SA/KOS**
	• Mrs Twigg (NED) found from a non-clinical background, that it was difficult to be aware of what is conservative management and of any risks that we need to be aware of. The report needs to contain assurance of what this means for non-clinical members to understand.	**SA/KOS**
	• Mrs Martin (NED) was keen to understand the length of waits for histology.	**SA/KOS**
	• Mrs Martin (NED) was interested to know how we benchmark across the ICS and within the Foundation Group. The GM will seek to undertake this for the Trust and quarterly within the Foundation Group.	**SA/KOS**
	<u>Resolved</u> – that : **(A) The Colposcopy Report be received and noted.**	
	(B) Future Colposcopy Reports will include more detail around the breakdown of patients being offered treatment within 4 weeks and whether they are opting for conservative treatment.	**SA/KOS**
	(C) Clarity around the format for the numbers of patients being seen in the service will be provided in the next Colposcopy Report.	**SA/KOS**
	(D) Data for patients referred by their GP and the Screening Programme will be shown separately in future Colposcopy Reports.	**SA/KOS**

	(E) Future Colposcopy Reports will use the same template as the Divisional Reports to enable consistent reporting. **(F) Future reports to contain assurance of what is meant by conservative treatment for non-clinical members to understand.** **(G) Length of waits for histology to be included in the next Colposcopy Report.** **(H) To benchmark our performance for the Trust and quarterly within the Foundation Group.**	**SA/KOS** **SA/KOS** **SA/KOS** **SA/KO**
QC007/08.23	**INFECTION PREVENTION SUMMARY REPORTS**	
	The Lead Infection Prevention Nurse (LIPN) presented the Infection Prevention and Control Annual Report 2022/3 and the Infection Prevention Quarterly Report 2023/24 Quarter 1, which were taken as read, and the following key points were noted: Infection Prevention and Control Annual Report 2022/3 • Positively, the Infection Prevention Service ended on a lower trajectory for C-Diff and E.coli cases. Over recent years, we have been under scrutiny for our C-Diff cases. Our threshold was adjusted for this year and we aim to stay under trajectory. • We have implemented the National Cleaning Standards which has seen a change to monitoring. There is a lot of assurance provided from the campaign around cleaning and estates work. The Infection Prevention annual campaign #Wyeclean launched in May 2022. This involves more training for clinical staff in relation to clinical equipment cleans. • We achieved the NHSI threshold for the Trust of 0 MRSA bacteraemia cases. • We are looking at our MSSA bacteraemia cases. We achieved or were below our threshold for all of these. A review is undertaken of any possible link back to invasive devices. • It was a challenging winter with 73 outbreaks reported. Of these, 60 related to Covid, 8 to flu and 5 to norovirus during the last financial year. • From April 2022 the Trust has undertaken Surgical Site Infection (SSI) surveillance for hip and knee surgery and will participate in each of the 3 month data collection periods in the future. This showed outlier rates although numbers are low (3 cases) in hip Orthopaedic surgery, which one of our Consultant Orthopaedic Surgeons is monitoring. There are no trends. Our rates are slightly higher but our denominator patient cases are low which will skew the figures.	

	• There were a number of inspections undertaken during the year. In November, NHSE and ICS colleagues raised concerns with cleanliness standards which led to our improvement plan. NHSE are planning to come back and inspect us on 31 October. We have received a lot of support from ICS colleagues and NHSE. • In relation to the 3 surgical site infection cases the CNO advised that these 3 cases were complex hip revisions which were discussed at the last Infection Prevention Committee. These cases were also discussed with Oswestry who support our conclusion that these were revisions at high risk of developing infection and did not represent a systemic issue. • The Infection Prevention Improvement Plan is on track for delivery with some minor delays. • Mrs Hill (ANED) noted that E-coli is sometimes related to the patient's condition and whether diet can reduce this susceptibility to these infections. The LIPN advised that the organisms for these underlying conditions are varied. There is nothing that could have been done differently to prevent the bacteraemia for these patients. All care management for these patients is reviewed and for anyone who died. Additional work is being undertaken reviewing mortality reviews to see if anything else could be done. No themes have been seen. <u>Infection Prevention Quarterly Report 2023/24 Quarter 1</u> • Our yearly threshold for C-Diff cases is 43. We ended Quarter 1 on 17 cases, against a threshold of 11 cases at this point in the year. At the end of August, these numbers appear to have stabilised. • Our E-Coli cases threshold for the financial year was 30. Ideally we would have had between 7 – 8 cases in June, we had 19 cases. • MSSA – There is no external threshold. We have been seeing an increase over the last few years and wanted to keep a track of these cases. We have therefore set our own threshold, agreed at the Infection Prevention Committee, of 1 for the year. We are on track to achieve this. • There is concern regarding hand hygiene and C-Diff. Bare below the elbows is the predominant issue and not taking off gloves. The team are working with staff around this and clinical cleanliness. There is a lot of work occurring in clinical settings to improve clinical practice. This is part of our ongoing Improvement Plan. • We undertook a deep dive into our E-coli numbers. In total, 21 cases were reviewed. Of these, 18 were linked to the patients underlying condition and 3 due to lapses in care due to clinical cleaning, hand hygiene and antibiotic prescribing. We have shared this information with the ICS as well as the reviews undertaken.	

	• A deep dive into our MSSA cases is also being undertaken to ensure that we keep track of these. The majority are linked to the patients underlying condition. • The main reason for our bacteraemia cases is linked to invasive devices, predominately urinary catheter lapses in care. Documentation is not clear in some cases when the device was inserted or removed and whether this device was checked on a regular basis. The HOUDINI Urinary Catheter Removal Protocol will be promoted during September across all clinical areas. • The CNO advised that a cluster review of each bacterium is discussed at the Infection Prevention Committee. Any learning from cluster reviews is assessed for action required and these are added to our overall improvement plan. • The Clinical Director, Pharmacy & Medicines Optimisation advised that the Pharmacy Department have managed to recruit to the Antimicrobial Stewardship Technical role. This should help reduce issues around antimicrobial stewardship. • The LIPN advised that the Infection Prevention Team started to take over the Fit Mask Service in November and fully in April. There is an 85% compliance with staff requiring testing. We are working through this dataset to get full assurance. We are changing some of the data to provide more assurance and to be in line with national guidance. • Improvement Plan – We worked on this with NHSE and the ICS. A large number of actions have already been completed, with ¾ of the actions completed by the end of the quarter. We have met the deadline for starting work but a lot of work is still ongoing. • Mrs Twigg (NED) was concerned about the agency figures – 67% of bare below the elbow and hand hygiene issues were due to agency staff. What control do we have over their training and performance? What do we do as a Trust to ensure that we are managing this? The LIPN advised that historically and through Covid, all agency staff were provided with a leaflet to read when they came on shift. We have discussed with the Education Department around changing the introduction for agency as well as new staff. A lot of face to face instruction was provided prior to Covid and we are looking to restart this at the end of September for these staff. This demonstration will be undertaken out of the clinical area. • The CNO advised that we only use Framework Agencies. To get onto the Framework, Agencies have to demonstrate how they recruit and train their staff to ensure that they have the statutory and mandatory training required. There is a standard approach to infection prevention practices taken across the NHS and therefore all staff should be familiar. There is a process whereby we can register any concerns around an individual nurse if we have any issues.	

	• The CNO advised that the Infection Prevention Inspection with NHSE may move to November. At the end of the month, the NHSE Infection Prevention Nurse is spending a day with the team and sitting on a Review Panel to provide support and ensure that we have all the support needed prior to this visit. • Mr James (Chair and NED) questioned whether we do report back to the Agency if a nurse is of concern. The LIPN confirmed that we do. Staff are given 2 strikes for minor offences (eg wearing false nails and not removing them on their second shift) before being reported, or obviously immediately if there is a major concern. The Associate Chief Nurse, Medical Division advised that herself and the Divisional Nurse Director, Surgery also escalate any concerns at the weekly Master Vend meeting as well. • Mr James (Chair and NED) noted that we have invested heavily in this issue yet we are still having challenges. Are we improving in this area? Is there anything further we need to do or would figures be worse without this intervention. The LIPN advised that figures would be worse. With investment in the Infection Prevention Team we are now able to look at this in more detail. This in turn causes us to find more areas to review. We have noticed a slight increase in CPE infections over the last few months. We discussed this with Microbiology who advised that with changes put in place, they are now able to identify these infections sooner. A deep dive around this is being carried out. • The Chief Medical Officer (CMO) was concerned that we have a lot of older equipment in the labs which require upgrading to enable us to be more responsive and accurate with our antibiotic prescribing. He asked his Executive colleagues to look carefully at any bids coming through relating to this.	
	<u>Resolved</u> – that the Infection Prevention Summary Reports be received and noted.	
QC008/08.23	**<u>QUALITY PRIORITY – MCA AND DOLS UPDATE REPORT</u>**	
	The Associate Chief Nursing Officer (ACNO) presented the Quality Priority – MCA and DoLs Update Report and the following key points were noted: • As noted in the Executive Director Opinion, due to significant gaps in the Safeguarding Adult Team during the last quarter, this report is limited to providing an update on training figures. • Essential training has slightly improved but more audit work needs to be done. • The new Advanced Practitioner for MCA and DoLs commences on 1 September. One of her primary objectives will be to start this audit process.	

	• Mr James (Chair and NED) queried when this audit will be completed. The ACNO advised that a sample of records will be reviewed initially and then a larger sample later on to enable some initial findings. A lot of work has been done in investing in on-line and face to face training. • The Associate Chief Medical officer, Medical Division advised that this audit is very important. If we are not careful, we just focus on training rates and not whether this training is being put into practice. • Ms Quantock (NED) queried what part of the training includes the patient voice or patient engagement or whether this could be included if not. The CNO advised that online training contains patient stories which is part of a national training programme. The ACNO will review what is included for face to face training.	**RH**
	<u>Resolved</u> – that: **(A) The Quality Priority – MCA and DoLs Update Report be received and noted.** **(B) The Associate Chief Nursing Officer will review whether face to face training for MCA and DoLs includes patient stories or the patient voice.**	**RH**
QC009/08.23	**<u>DIVISION QUARTERLY REPORT – MEDICAL DIVISION</u>**	
	The Associate Chief Nurse, Medical Division presented the Division Quarterly Report – Medical Division and the following key points were noted: • There was a decrease in the number of Serious Incidents received during this quarter. We continue to see pressure ulcers as Serious Incidents and have developed 2 Frailty Service Development Plans. • These Development Plans address key areas including skills for nursing teams, documentation, quality improvement and processes. We had 47 incidents in May and 34 in June with a further reduction in July to 27. We are seeing really positive improvements. • The Division has received 2 Regulation Reports from the Coroner, both included pressure ulcer care concerns. They were fully reviewed along with our existing Programme Plan. • The Fall Prevention Service Plan is a new initiative in Frailty. We have had a reduction in falls but an increase in falls with harm. A deep dive was undertaken into 14 falls – 9 were considered low harm, 3 moderate harm and only 1 Serious Incident. There is good engagement with the MDT Team and compliance with falls training has improved.	

	• There are still key areas to focus on – Completion of Lying and Standing BPs; AFLOAT re-assessments; correct interpretation of assessment level of enhanced care and retrieval methods to be documented. • We are focusing on falls in the Emergency Department (ED). The plan is to escalate these plans to the other Divisions. • There were no external visits during this period. However, Jessica Huntley, Care Quality Commission Inspector (CQCI) from Birmingham and Solihull Team visited on 16 August to visit Dinmore Ward and ED. This was following two Safeguarding referrals submitted to the Care Quality Commission in close proximity in relation to the Frailty Wards and concerns relating to standards of care and communication. The CQCI was updated in relation to our improvement plans and the proposed Quality Improvement Programme for ED. • Respiratory Team – An incident occurred related to an ITU step down and confusion as to whose responsibility it was to call for Physiotherapy out of hours. A pilot scheme is being undertaken on Arrow Ward advocating the Nurse in Charge to call the out of hour's Physiotherapists as opposed to Medics and has so far been successful. A review will be undertaken in the next 3 months and the plan is to roll the process out across other wards in readiness for the winter pressures. • A poster regarding domiciliary NIV patients has been displayed on every ward providing an overview of domiciliary NIV and CPAP safety implementations. • We are especially proud of Jenny Weaver, one of the Senior Sisters from ED who was invited to the Reception to mark 75 years of the NHS at 10 Downing Street on Wednesday 5 July 2023. • The Operational Support Manager in ED has been working on a project with the Autistic Project Partnership Board to improve the experience of patients attending ED with autism and sensory needs. Service users have advised that their experience in ED was much better than on previous visits. • We are concerned around the poor performance in relation to our KPIs and length of stay in ED. Incidents are increasing since the closing and reopening of the Ambulatory Area in ED along with the impact of the waiting room by the Front Door along with a delay in triage. • Patients in ED waiting over 24 hours continues to be of concern along with having boarders on wards during the day and night.	

	• Complaints and concerns are increasing in these areas. The Deputy General Manager and the General Manager are now in post to support with this in the future and on some of the key areas around complaints and concerns. The Matron has also been taken off the Level 2 On Call Rota to provide senior oversight and support. • Due to an increase in incidents of stroke, a deep dive is being undertaken into these. • The lack of a Frailty Same Day Emergency Care (SDEC) service is of concern. A Quality Impact Programme was designed and shared with the Executive to improve quality and conditions for the workforce in Medical SDEC, Frailty SDEC and the Virtual ward. • The ED Patient Survey has been delayed and will be presented in September. • The Associate Chief Medical Officer, Medical Division advised that Virtual Wards started in April and were fully functional in May. This is for patients who would previously have been admitted to an inpatient bed. There have been 204 patients so far cared for on a Virtual Ward. The majority are general medical patients. There have been some readmissions from the Virtual Ward, which is expected, with only 5 in August. • The Associate Chief Medical Officer, Medical Division gave two different scenarios for patients who could have been looked after on a Virtual Ward, and the more positive outcomes if they were not admitted. • The Deputy CMO advised that we need to ensure that Virtual Wards are fully utilised with a wider programme of work needed to make them bigger and better in the future. The Associate Chief Medical Officer, Medical Division felt that currently the issues are more operational than quality and are used well by Acute Medicine. They will be used more by Frailty once the Frailty SDEC is opened. We are working with specialities to discuss which patients can be looked after at home with some of the issue around managing risks. • Mr James (Chair and NED) questioned whether the plan is to review this learning or have an iterative roll out. The Associate Chief Medical Officer, Medical Division advised that from a quality perspective, all incidents and complaints relating to the Virtual Ward are reviewed. Only 1 complaint related to the Virtual Ward and this was due to a breakdown of care not being put in place although the Trust had been advised it had been. We also plan to look at which types of patients are using this service.	

	• Mr James (Chair and NED) asked for a regular update on the Virtual Wards. The Associate Chief Medical Officer, Medical Division will include this in the Divisional Report including a summary of statistics, our admission rates, complaints and concerns etc. • The CMO queried if surgery are maximising the Virtual Wards. The Associate Chief Medical Officer, Medical Division advised that this is difficult as we would need Surgery Consultant input if we looked after surgical patients. The Divisional Nurse Director, Surgery advised that there were a large number of surgical patients recently that appeared to be suitable to use this service in the interim. The Lead ACPs reviewed these patients to see if any of them would be suitable to use the Virtual Ward, but they were all too acutely unwell. This will be reviewed as a Division for the future. The Associate Chief Medical Officer, Medical Division advised that the vision for the Virtual Ward is to have a Virtual Hospital with Virtual Wards within it. • The Managing Director felt that there was really good learning from the Virtual Wards now that they have been set up and we need to understand more about them. We need a bespoke surgical project to understand what they require to use them. The Associate Chief Medical Officer, Medical Division advised that we are ensuring that we have ACPs in the Community who are also trained up to deal with complex specialties. • The Managing Director queried if there is an opportunity for a Cardiology Virtual Ward for patients waiting for surgery. She was aware that there is clinical nervousness around this but a higher level of support and oversight might help along with reassurance that patients will not lose their place for a bed. The Associate Chief Medical Officer, Medical Division had asked the Cardiology Team about this, but they do not feel that this is a viable option. There are clinical risks related to their concerns with only a few patients possibly suitable. The Managing Director felt that it would be useful to understand what other areas on doing on this. • The Managing Director noted that the report talked about the impact of Digital Nurse Noting on the falls risk assessment and asked for more detail around this. The Associate Chief Nurse, Medical Division advised that this mainly focusses on duplication. A Working Group is trying to condense this down and concentrate the process. • Mrs Martin (NED) asked if volunteers are supporting with “Afternoon Tea” on Frailty. The Associate Chief Nurse, Medical Division confirmed that they will be. This is a new initiative that is just being rolled out.	**EW** **EW**
	<u>Resolved</u> – that: **(A) The Division Quarterly Report – Medical Division be received and noted.**	

	(B) To include an update on Virtual Wards in the Medical Divisional Report including a summary of statistics, our admission rates, complaints and concerns etc. **(C) To review where other Trusts are caring for their Cardiology patients waiting for surgery in connection to using a Virtual Ward.**	**EW** **EW**
QC010/08.23	**<u>MORTALITY REPORT</u>**	
	The CMO presented the Mortality Report and the following key points were noted: • As noted in the Executive Opinion, this is a positive report. There has been a further drop overall in our SHMI with a further drop since. • Our fractured neck of femur and heart failure results have also had an impressive drop. • Coding has improved with a further depth of coding improvement. • Our perinatal statistics are reassuring. • We are finalising the Medical Lead for our Medical Examiners. We have also refreshed the Medical Examiners Strategy. • Mrs Hill (ANED) noted that in the Acute Medical Unit Reviews a lack of use of Care Bundles was noted – who is responsible for this. The CMO advised that this is a local issue. The Care Bundles are available but there has been a slippage in usage. • Mrs Martin (NED) questioned if a patient is admitted with a Respect form, whether this information goes back to the PCNs. The CMO advised that this does not occur systematically. The Associate Chief Medical Officer, Medical Division advised that it is important to realise that even with the best plans in place these can fail for a number of reasons. Feedback is given on a case by case basis. • The Managing Director advised that we are due to have a digital Respect from soon which will enable everyone to have access to this, particularly for the Ambulance Service who will be able to access this in the patient's own home. • The CNO advised that such cases have been discussed at the Serious Incident Panel. A Round Table was requested with key stakeholders to see what we can learn from a case where a patient fell with harm but should not have been in hospital.	
	<u>Resolved</u> – that the Mortality Report be received and noted.	

QC011/08.23	**MATERNITY – PQSM REPORT**	
	The Matron for Quality and Safety presented the Maternity – PQSM Report, which was taken as read, and the following key points were noted: • Robson Group 5 are the highest group having a caesarean section. This has been discussed with the LMNS. They plan to meet monthly and will be focusing on implementing the iDecide tool for informed decision making. This is being used in Worcester instead of the BRAIN tool (Benefits, Risks, Alternatives, Intuition, Nothing) as a different way to inform patients and their partners. This is already on Badgernet. • There have been no perinatal losses or HSIB cases during June. • There has been a significant increase in middle grade gaps due to 1 vacancy and 1 Clinician requiring supernumerary support. All shifts are being covered by existing staff. • Two complaints have been received – the details were provided in the meeting. • We are looking at CNST Year 5, initially with a benchmarking exercise. There are no issues with Recommendations 1, 2, 4, 5, 7, 9 and 10. An in-depth review is being undertaken with regards Safety actions 3 (Transitional Care), 6 (Saving Babies Lives version 3 implementation) and 8 (MDT training) which will require further work and review due to an increased expectation on Trusts for Year 5. There has been a lot of additional information for Safety Action 6 which a new element around diabetes. • The CNO advised regarding the CNST 10 Standards, obstetric care is high risk and is the highest expenditure for claims against Trusts. This identified good practice and if all Standards are achieved, the Trust has a reduction in their premium. The Standards are revised every year. The latest Scheme was just published a couple of months ago. Regarding Standard 6 (Saving Babies Lives), we are seen as one of the best Trusts in the Region for our Version 2 Saving Babies Lives but a new Care Bundle (Version 3) has since been released that we need to review ourselves against. • The CNO advised that for Standard 9 (Board oversight of Maternity Services and Safety Champion interaction), some improvements have been suggested around this to standardise reporting to the Board of Directors on Maternity Services across the Foundation Group. We are aiming to achieve all 10 Standards this year – we achieved all 10 last year.	
	Resolved – that the Maternity – PQSM Report be received and noted.	

QC012/08.23	**STAFFING REPORT**	
	The Divisional Nurse Director, Surgery presented the Staffing Report and the following key points were noted:: • This was a busy month from a Front Door perspective. There has been an increase in the number of surgical and orthopaedic patients. • The decant of ITU had an impact on staffing. This was closed for 2 weeks at the end of July/beginning of August when they moved into Day Case. • The Day Case, Ambulatory ED and corridor escalation areas had to be staffed as well during this period. We also saw a large number of boarding patients during July and August (during the day and night time). There were also high fill rates in some of our ward areas to support patients with high acuity. There was also an increase with our RMN needs for adults and Paediatrics. A lot of work has been carried out around reducing our RMN usage and we continue to review requests to see whether we require a RMN or whether Band 2 support is appropriate. During this period, RMN support was required for each case. • Agency spend has increased slightly in month (3.8WTE) along with an increase in Bank usage. The highest area was the Frailty block. This was due to a number of boarders overnight. • There has been an increase in incidents over the period, mainly due to lack of staff. Fill rates with ID Medical have decreased slightly which usually occurs over school holidays. We monitor this during our weekly meetings. • Thornbury usage had declined, but is expected to increase in August. • The CNO has asked for further analysis around the increase in Bank usage. We spend nearly £100k on Bank staff last month compared to the previous month. We want to convert Agency to Bank staff, but we were over established with 133WTE shifts. Nursing establishment appears to show we lost over 60WTE in the last month which does not feel correct. The Managing Director noted that in Month 4, the budget was taken out for the Medical Escalation Unit as this was closed for 3 months during the winter. This is probably the majority of the reason for this reduction.	

	• Mr James (Chair and NED) questioned where we are with the biannual review of staffing and acuity. The Divisional Nurse Director, Surgery advised that 2 papers are being presented to the Trust Management Board regarding recommendations after this review (additional staffing for ITU and the Frailty Block). A second review has been undertaken with analysis being completed next month and a future paper being presented to the Quality Committee. At the end of the year, the revised national tool should be published this accounts for people requiring 1-2-1 care and mental health needs and will help with analysis of our case mix.	
	Resolved – that the Staffing Report be received and noted.	
QC013/08.23	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The Deputy CMO presented the Patient Safety Committee Summary Report, which was taken as read, and the following key points noted: • The Boditrack Pressure Mapping System Standard Operating Procedure was accepted but this raised wider issues as discussed previously. • New Patient Safety Incident Framework – Thematic reviews will be undertaken as there are common themes coming through when the information is triangulated. We need more detail around delays in clinical assessment etc. • An update on Serious Incidents was received and a discussion on how the ICB are agreeing on reporting as we move from the Serious Incident Framework to the Patient Safety Incident Response Framework. • Discussion was held around external visits and how we are made aware of these, anticipate them and then report on them. • Mr James (Chair and NED) queried the resources available for Patient Safety Incident investigations. The CNO advised that this was agreed when discussed previously around whether we adopt the National Framework for Training and Educating Staff to undertake investigations which requires significantly more resource. We agreed not to adopt this Framework as we have a number of staff internally trained to investigate incidents. We have made the baseline level of education available for all staff. At this stage we are not going to send staff for the 5 day training session unless we identify a skills deficit when we adopt the framework. We want to test this and try this approach before committing more resources to this. We are not the only Trust to plan to do this. We will pause this for now but might need to have additional resources for this in the future. The Deputy CMO noted that we will have a small number of Route Cause Analyses in the future which may mean we need to train a small number of staff to review them rather than the current process.	

	<u>Resolved</u> – that the Patient Safety Committee Summary Report be received and noted.	
QC014/08.23	**<u>PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT</u>**	
	The Quality and Safety Matron presented the Patient Experience Committee Summary Report, which was taken as read, and the following key points were noted: • There was no meeting held in July. • There is positive engagement with a new format for the Committee which is well attended. • A summary of the Urgent Emergency Care Survey was discussed which will be presented in full to the Quality Committee in September. Feedback around the local action plan, feedback from Friends and Family and ongoing monitoring will be fed back through the Patient Experience Committee. • There are some ongoing concerns regarding the management and storage of patient property. A Working Group is being set up around this. • There was a spike in complaints during June and July. A number of concerns were escalated to complaints due to lack of a timely response. Additional training around this action was agreed. Complaints and PALS are actively working with staff around this. • Patient concerns regarding end of life will be shared with the End Of Life Forum to triangulate and to include in their improvement work. • A thematic review will be brought back in the next Quarterly Report on the complaints and concerns review. • Mr James (Chair and NED) raised his concern that we are not dealing with concerns as they arise which then comes through as a complaint. The Associate Chief Nurse, Medical Division advised that most concerns (18) related to ED. There is currently not enough capacity in the Department to deal with these. Wards are more proactive with this. • Mr James (Chair and NED) queried if the ED issue is part of a patient experience issue or a more general issue. The CNO advised that we received 50 complaints in June and 48 in July. We usually receive about 20. These related to Head and Neck, Womens and Children and ED. We know about the issues for Head and Neck, with Womens and Children a mixture of issues (possessions going missing, timeliness, waiting times, pain relief etc). We have asked for further analysis around this to find out the issue in Womens and Childrens as this is not around obstetric care as we only received 4 complaints around this during this period.	

	• The Divisional Nurse Director, Surgery advised that the gynaecology theme is around communication still. Some of these complaints are around long waits, communications and procedures (treatment plans being changed). We will have an in-depth look at this and bring back an update to the Quality Committee and the Finance and Performance Executive meeting where it was raised yesterday. • Ms Quantock (NED) advised that the suggestion of using a patient tray was discussed in Audit Committee, which has been trialled in Wales, but was not sure what happened with this. The Divisional Nurse Director, Surgery will find out an update for the Community as well as the Acute Trust.	**ES**
	Resolved – that: **(A) The Patient Experience Committee Summary Report be received and noted.** **(B) The Divisional Nurse Director, Surgery will find out the outcome of the suggestion of the use of patient trays in the Community and Acute Trust.**	**ES**
	CONFIDENTIAL SECTION	
QC015/08.23	**SERIOUS INCIDENT REPORT**	
QC016/08.23	**PREVENTION OF FUTURE DEATHS REPORT**	
QC017/08.23	**LUCY LETBY VERDICT (LOCAL ACTION/FTSU)**	
QC018/08.23	**ANY OTHER CONFIDENTIAL BUSINESS**	
QC019/08.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 28 September 2023 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 28 September 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
Sharon Hill	SH	Associate Non-Executive Director
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
In attendance:		
Mehmood Akhtar	MA	Associate Chief Medical Director, Surgical Division – Arrived during Item 6
Kat Barker	KB	Cancer Services Manager
Chris Beaumont	CB	Mortality Project Manager – For Item 12
Robbie Dedi	RD	Deputy Chief Medical Officer – Arrived during Item 8
Ingrid Du Rand	ID	Associate Chief Medical Officer, Research and Development – For Item 5
Rachael Hebbert	RH	Associate Chief Nursing Officer
Steve Heptinstall	SHe	Cancer Professional Lead - For Item 6
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Leah Hughes	LH	Operational Clinical Lead Radiographer – Arrived during Item 3.1
Val Jones	VJ	Executive Assistant (for the minutes)
Sue Moody	SM	General Manager - Acute and Countywide Services
Hannah Phillips	HP	Temporary Staffing Manager - Observing
Emma Smith	ES	Divisional Nurse Director, Surgery
Amie Symes	AS	Associate Director of Midwifery – For Items 16 and 20
Emma Wales	EW	Associate Chief Medical Officer, Medical Division
Lou Weaver	LWe	Matron for ED – For Item 7
Laura Weston	LW	Lead Infection Prevention Nurse – For Item 11

QC001/09.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from David Allison, Associate Chief Operating Officer, Medicine, Tony McConkey, Clinical Director, Pharmacy & Medicines Optimisation, David Mowbray, Chief Medical Officer, Rachael Skinner, Integrated Care Boards Representative and Nicola Twigg, Non-Executive Director.	
QC002/09.23	**QUORUM**	
	The meeting was quorate.	
QC003/09.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	

QC004/09.23	**MINUTES OF THE MEETING HELD ON 31 AUGUST 2023**	
	Resolved – that the minutes of the meeting held on 31 August 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	
QC005/09.23	**ACTION LOG**	
	(a) QC014/08.23 – Patient Experience Committee Summary Report – (B) – The Divisional Nurse Director, Surgery discussed the use of patient trays in the Community and Acute Trust with the Locality Manager, Nursing who advised that a local company provided the trays for Bromyard Hospital. This has not been rolled out further as this was a trial. They are a useful item but are not a cheap option. The General Manager - Acute and Countywide Services sent a photograph of the tray to Mrs Bulmer (ANED) who will review these when she visits the hospital. The Managing Director suggested that charitable funds may be an option for purchasing these trays. The Chief Nursing Officer (CNO) agreed that the Patient Experience Committee will take this forward to review. Action now complete. (b) QC009/08.23 – Division Quarterly Report – Medical Division – (B) – To include an update on Virtual Wards in the Medical Divisional Report – This action has now been superseded.	
	Resolved – that the Action Log be received and noted.	
	BUSINESS SECTION	
QC006/09.23	**RESEARCH AND DEVELOPMENT**	
	The Associate Chief Medical Officer (ACMO), Research and Development (R&D) presented the Research and Development Reports and the following key points were noted: Annual Report • The ACMO, R&D took over as lead in the 2nd half of the quarter. • All trials have now recommenced post Covid, with 643 patients recruited into trials. We have recruited into 23 trials and are 11th in the West Midlands for our recruitment which is very positive for our size. • All Trusts have commercial trials open which is also positive from a financial point of view. Wye Valley Trust have not had any commercial trials for some time. We now have one open and are in the process of opening a second one. • We have opened a sponsored study into Stroke. This is a multicentre trial and is fully recruited to. • A list of all studies recruited to is included in the report and the specialties involved. A number of trials have closed but we are still collecting data.	

	• Staffing – We have been supported with a Lead Research Nurse, a Research Midwife and a 0.6WTE Research Practitioner. Staffing was low when the ACMO R&D came into post and there was not a clear structure of the demands of trials. The team had a successful Away Day where time was spent mapping trials against the competency framework and against Agenda For Change for our staff. This showed that Band 7 staff were undertaking duties that a Band 3 could be doing. Therefore, tasks were reallocated and job plans updated accordingly. This created more capacity within the team. We have also adopted an intensity tool – we can now map each trial against this and against our staff capacity to understand exactly what capacity is required. This allows us to recruit to full capacity within the team and has been very successful. We are expecting even more benefit from these changes to show in the next financial year. We also looked at updating our Research page on the intranet to be more transparent and reviewed the Research Strategy. • NIHR provided some salary uplift and some financial support for trials that were paused. We used this money to retain all our staff and services. Part of the intensity assessment was to look at the financial breakdown of each trial to ensure that we breakeven or make money rather than it being of cost to the Trust. This is discussed with the Chief Medical Officer if we need to undertake a trial if there is a cost. • The Trials Team do not sit within a Division and therefore no governance structure to link into. The CNO and the Associate CNO have supported the team around this and they are now linking into support. A monthly Governance Review Meeting has been set up along with reviewing InPhase in addition to processes already in place. Pharmacy support is of concern due to their staffing concerns. We have had to pause some trials as they were not safe to continue without this support. • The Managing Director thanked the ACMO, R&D and her team for the huge amount of work undertaken. She was pleased to see that stroke research is going on and was keen to see the results for our patients. We know that our inputs are good as we are Regionally at the top for our SSNAP work and our mortality rates are low. We now need to understand our clinical outcomes. <u>Quarter 1 Report</u> • We have restructured and reassessed the team. • There are a couple of trials that we have not been recruiting to for some time which we reviewed and evaluated and closed. • During Quarter 1, 118 patients were recruited to 18 Research Trials. We opened 4 new trials during this time. We are now 11th in the league table for recruitment. • We are looking at sponsoring another trial.	

	• There was one Serious Incident within the team regarding consent. We are now using an Edge Database which is very efficient and allows us to record all data on it. We have updated to H3 now which allows us to map intensity to do everything we need. • We are attending Audit and Education afternoons where we seek potential for clinical trials. Ultimately, we would like someone identified in every department for R&D. We also want to roll out the Principle Investigator to more than just Consultants, ie AHP as well. • Mrs Hill (ANED) questioned how the team are engaging with the wider profession regarding the Education Centre being built. A Board Workshop was held around this as part of the Academic Plan which involves research. The ACMO, R&D advised that we are exploring opportunities with our Foundation Group colleagues along with Clinicians being appointed to undertaken research and clinical sessions with virtual working. Monthly meetings are held with all R&D Leads within the Foundation Group to enable closer working and to discuss joint trials as we do not always have the numbers to recruit to some trials. • Mr James (Chair of the Quality Committee and NED) thanked the ACMO, R&D for her leadership, noting that research is now linked into Divisions and across the Foundation Group which is very positive. <u>R&D Strategy</u> • This is for information only as further review is required with the Chief Medical Officer. • Mrs Frances (NED) questioned how we quantify this and our outcomes for our patients and our recruitment in the future – this is hard to achieve. The ACMO, R&D advised that there is an implementation plan which includes more SMART measures.	
	<u>Resolved</u> – that the Research and Development Reports be received and noted.	
QC007/09.23	**<u>Cancer Patient Experience Survey Results</u>**	
	The Cancer Professional Lead (CPL) presented the Cancer Patient Experience Survey Results and the following key points were noted: • The survey was sent out to adult patients with a confirmed primary diagnosis of cancer in the months of April, May and June 2022. • **WVT Responses** - Of the 446 patients surveyed, 287 responded with a response rate of 64%. Nationally the response rate was 53%.	

	• **Executive Summary** - There were 2 questions above expected range – "Q15 - Patient was definitely told about their diagnosis in an appropriate place" and "Q52 - Patient has had a review of cancer care by GP practice". There were 5 questions below expected range – "Q17 - Patient had a main point of contact within the care team", "Q26 - Care team reviewed the patient's care plan with them to ensure it was up to date", "Q41 - Beforehand patient completely had enough understandable information about radiotherapy", "Q45 - Patient was always offered practical advice on dealing with any immediate side effects from treatment" and "Q58 - Cancer research opportunities were discussed with patient". • **CPES = Questions above expected range** – Q15 – We were above age range for lung and prostate cancer but below age range for 45 – 54. We remain watchful that these figures do not decline and are reviewing the Breaking Bad News Guidelines. Q52 – A monthly One Herefordshire meeting is held and we have excellent links with our GP colleagues. • **CPES = Questions below expected range** – Q17 – We were below age range for Urology, Prostate and Haematology (known period of instability during this time which may also reflect in next year's survey). For Urology and Prostate, patients are given team CNS contact details as staff work part-time. This is being reviewed in light of these results. Q41 – We were below expected range for Prostate and ages between 55 – 64. All patients are given relevant information regarding their radiotherapy, but this may be due to the gap between this being received and the appointment being held. Moving patient information over between systems during this time may also have caused issues. Radiotherapy @ Hereford undertook their own survey in 2022/23 (results included in the report). Both teams re reviewing the results from this local survey. Q45 – Haematology were below range – we are not sure why this occurred unless it was related to internal changes to medical workforce during this period. It has also been discussed with staff that they need to repeatedly mention dealing with side effects from treatment. Q58 – Breast and ages 45 – 54 and 85+ were below range. The Trust have Breast staff vacancies and therefore do not have any Breast Studies open. We are always reviewing this and there may be a locum member of staff able to act as Primary Investigator in the near future. • **Next Steps** - Included in the report is a breakdown of next steps for those questions that we continue to do well and those that require improvement. Regarding research, we are over-recruiting to cancer trials which is good news. • The CNO questioned regarding checking that care planning is up to date, is this Consultant or AHP led? The CPL advised that this begins with the Consultant but there is a multidisciplinary team involved. He will check whether the Consultant needs to lead.	**SHe**

	• The CNO queried compared to previous surveys, how we are regarding support for cancer patients on the wards as in previous years we have scored low for this area. The Cancer Services Manager advised that during the Trust's Cancer Week, ward walks were undertaken with feedback from wards advising that more support is needed along with inpatient support. We are working on improving this. The CPL has tasked the Information Centre Team to provide more information. We are ensuring that inpatients are receiving cancer support from the Clinical Teams and information required for themselves and their families. • The CNO noted the new platform for information giving and questioned whether we still have Information Leaflets as well. The CPL advised that we have paper leaflets back out post Covid. We are utilising a hybrid model. • The CNO suggested that an update on progress could be included in the Integrated Care Divisional update. Mr James (Chair and NED) noted that there are clearly important findings and areas that we can improve on. From an assurance perspective, it would be useful to have an update. The CPL and Associate Director of Quality Governance will discuss when most appropriate to bring an update back to the Quality Committee and in what format. • Mrs Martin (NED) noted that an above expected range of patients were told their diagnosis in an appropriate place and asked if we have appropriate provision in the Emergency Department (ED) for these conversations. The CPL advised that as part of Cancer Week we visited various inpatient areas and discussed this issue. Most areas feel that they have more accessibility for private areas, a response is awaited back from ED on their provision.	**SHe/NO**
	<u>Resolved</u> – that: **(A) The Cancer Patient Experience Survey Results be received and noted.** **(B) The Cancer Professional Lead and the Associate Director of Quality Governance will discuss when most appropriate to bring an update back to the Quality Committee on the Cancer Patient Experience Survey Results and in what format.**	**SHe/NO**
QC008/09.23	**<u>EMERGENCY DEPARTMENT SURVEY RESULTS</u>**	
	The Matron for ED presented the Emergency Department Survey Results and the following key points were noted: • **Background** – Benchmarking for response rates to the survey was undertaken with the 4 members of the Foundation Group. Wye Valley Trust had the highest response rate. • **Background** – Some of the national comments made on ED are included in the presentation. We need to support locally and trustwide regarding staffing issues.	

	• **CQI Comparison 2018 – 2022** - There has been a year on year increase on the average number of attendances, average length of stay, average time to be seen, average time to admission decision and complaints between this period. • **The Results and comparison with Foundation Group** – Wye Valley Trust are the lowest on a number of areas. However, we are not amongst the lowest scoring in the national survey. • **Best and worst performance relative to national average** – Our top five scores compared with the national average are: Section 2 Waiting Q11, Section 7 Leaving A&E Q44, Section 2 Waiting Q8, Section 2 Waiting Q7 and Section 6 Environment an facilities Q32. Our bottom 5 scores compared with the national average are: Section 7 Leaving A&E Q38, Section 4 Care and treatment Q23, Section 3 Doctors and nurses Q20, Section 7 Leaving A&E Q39 and Section 3 Doctors and nurses Q3. • **Bottom five scores** – More detail was provided within the presentation on these areas. Regarding care and treatment, this is a difficult issue at times due to lack of space. • **Thematic Issues and Actions Taken** - *Leadership* – we have increased the number of Band 6 nurses, Senior Nurse Care Review is on Symphony, ECIST have visited the Trust and an ED Engagement Summit was held with a number of workstreams agreed following this. *Communication* – Department MDT Huddles now held twice daily, Researching bespoke training package for all ED staff regarding communication skills and resilience training and targeted autism training for staff. *Capacity V Demand* – ED Safer Nursing Care Tool data review completed. Further liaison with ECIST to review the data collected and Business Case completed for medical staffing. • **Detailed action plan to address bottom five scores** – The actions were included in the presentation. There are a number of practical things that we can do as a department to improve these scores. • **Further work…..** – Focus on implementing and adhering to Trust Wide Internal Professional Standards, Length of stay of patients in ED waiting for a bed and waiting to be seen needs to decrease, Ownership of other departments/wards regarding their discharge blockers, Wellbeing of staff is key – Work on the current ED environment is required, review of current models of communication with both staff and patients/relatives to be completed. • **Feedback/Comments** – A selection of comments were included in the presentation. There were a number of positive comments received. • Mr James (Chair and NED) noted the increased pressure in ED and understands that this is the backdrop to the survey.	

	• The Managing Director acknowledged that some of these results are not want staff want. The Matron for ED advised that this can be disheartening for staff but they are determined to improve upon them. • The Managing Director noted that a whole system response focussing on this is required. There are various changes in place which will help with this. She was disappointed on the patient perspective on care and treatment – this is an area for the team to think about. We also need to consider how we best support staff with personal resilience and communication skills, but it also needs ownership for those areas that are for ED to improve upon. • The Associate Chief Nurse, Medical Division advised that ideally we would get our vacancy factor in ED reduced, with a lot of work going on to get to this point. We have seen some positive impacts on ED already with AMU now reducing length of stay which will reduce the burden on ED.	
	Resolved – that the Emergency Department Survey Results be received and noted.	
	QUALITY PRIORITY – PATIENT EXPERIENCE	
QC009/09.23	**NATIONAL PATIENT EXPERIENCE SURVEY RESULTS**	
	The Associate Director of Quality Governance (ADQG) presented the National Patient Experience Survey Results and the following key points were noted: • The presentation provides an overview of the quantative data. We are above average for the response rate which is positive. • This is the first time that we have looked at how many patients are living with a long term health condition – 76%. This detail will enable us to compare how we manage these patients in the longer term. • Overall, we improved for 50% of the results, 26% remained the same and 24% worsened. Overall, these results are similar to other Trust in all areas bar the rating of the quality of food which continues to decline. • **Doctors** – We improved in 3 areas under this section, but worsened with regards to patients understand the answers they received back from the doctor. • **Nurses** - We improved in 3 areas, remained the same in 1 and worsened with regards to whether patients felt there were enough nurses on duty to care for them whilst they were in hospital. • **Care and Treatment** – We improved in 2 areas, remained the same for 5 and worsened with regards staff looking after the patient involving them in decisions about their care and treatment.	

	• **Operations and procedures** - We worsened in all 3 areas compared to last year's scores. • **Leaving Hospital** – We improved in 6 areas, remained the same for 3 and worsened in 2 areas. This was around notice of leaving hospital and information around medicines being taken home. • **Dignity and Respect** – We improved in both areas. • **Overall Experience** - We improved in both areas. • **Long Term Conditions** – This is a new focus in this survey • We are not giving patients the opportunity to feedback regarding their care. Communication between staff and patients in some areas also need to improve. • Overall there was an improvement in communication and patients feeling that their questions are being answered, having confidence with staff treating them and regarding dignity and respect. Work we are undertaking is having a positive impact. • A new area of concern is around information being given to patients before or after an operation/procedure. This was discussed at the Patient Experience Committee. We are looking at qualitative data around this area to improve. • Nutrition – Questions around this have seen an improvement although not food quality itself. • Next Steps – These results were discussed at the Patient Experience Committee and keys areas of concern highlighted. The actions from all the surveys presented to the Quality Committee will be brought together into 1 overall action plan. • Mr James (Chair and NED) was pleased to see an improvement in feedback for patients. • Mrs Hill (ANED) noted that 97% of respondents were white and questioned whether that is representative of our patient cohort. The ADQG advised that we need to review this and we have asked the National Team if they provide the survey in different languages. This was a local sample of patients in October, and discussions have been held around gathering more regular local feedback rather than waiting until next year. The plan is to undertake this on a rolling basis to gather more representative data locally. • The Managing Director was encouraged to see 75% of our results have stayed the same or improved. South Warwickshire NHS Foundation Trust were 2nd best in the country so we have some way to go to match their results, but we can learn from their success. The CNO is in contact with her colleagues around sharing best practice.	

	<u>Resolved</u> – that the National Patient Experience Survey Results be received and noted.	
QC010/09.23	**<u>QUARTERLY PATIENT EXPERIENCE REPORT</u>**	
	The ADQG presented the Quarterly Patient Experience Report and the following key points were noted: • The report contains feedback from our Friends and Family text messaging service. Maternity are now fully rolled out with this. All Outpatient services are accessing the service. Paediatrics and the Community are the only remaining areas to take on this service. • Some services have approached the team regarding the use of a QR code as an option. This did not work previously as this was accessed via posters. Services want to give patients the opportunity to utilise this option to undertake the survey whilst still in the Trust. We are looking at options to enable this. We are linking to Formic to enable a full picture to be viewed. • We are receiving an above average response rate for this service which is overwhelmingly positive month on month. Day Case are receiving the most positive results. • Clinical Support Division are only receiving a 5% response rate. When this was reviewed at the Patient Experience Committee, it was found that only 50% of patients were receiving text messages. When this was further explored, it was found that many patients did not have a mobile telephone number on the clinical system. We are reviewing this issue. Patients are often using IPads and Kindles, so technology is not a barrier in most cases. • There has been an increase in the number of complaints and concerns regarding loss of patient property. These are usually not high value items, but obviously important to our patients. We are setting up a Working Group for this to co-ordinate the improvement work being undertaken. The Policy will be updated once we have this in place. Immediate actions have been undertaken whilst this is occurring.	
	<u>Resolved</u> – that the Quarterly Patient Experience Report be received and noted.	
QC011/09.23	**<u>THEMATIC REVIEW OF COMPLAINTS</u>**	
	The ADQG presented the Thematic Review of Complaints and the following key points were noted: • The number of complaints received and response rates are included in the report.	

	• There was a significant spike in complaints in June and July. A review of every contact at that time was undertaken and this came out at 90. Some of these were "comebacks" and some have been de-escalated. • The main 3 areas of concern were the Orthodontic Services, Womens and Childrens and Obstetrics and Gynaecology – details are included in the report. There were also clear themes from ED. • Numbers of complaints are reducing but we are also seeing a drop in our response rates. We need to stabilise and improve this. • Ms Quantock (NED) questioned if there was an option for us to provide emotional support or signposting around Orthodontics, eg specialist support such as "changing faces". The Divisional Nurse Director, Surgery advised that this has been discussed previously. Issues are around individuals not wanting to go to school or University until their teeth are corrected. We are offering support but until the correction takes place this will remain an issue. We can review this again but it is a very difficult situation. The Managing Director noted that we do not have the workforce available to help in this particular area and mental health services for young people have long waiting lists. • Mr James (Chair and NED) noted that we need to ensure that these issues are appropriately reviewed. The Divisional Nurse Director, Surgery advised that these are reported through the Finance and Performance structure and a thematic review for Womens and Childrens is being undertaken. .	
	<u>Resolved</u> – that the Thematic Review of Complaints be received and noted.	
QC012/09.23	**<u>QUALITY PRIORITY – IMPROVE THE MANAGEMENT OF THE DETERIORATING PATIENT</u>**	
	The Deputy Chief Medical Officer (DCMO) provided a verbal update on the Quality Priority – Improve the Management of the Deteriorating Patient and the following key points were noted:: • The second meeting of the Deteriorating Patient Committee has been held. This is one of our Quality Priorities and we have not had a Committee in place previously. We are currently working on the Committee remit, membership etc. • There is good attendance with medical staff from across Divisions, Education and Nursing. • A draft Terms Of Reference has been broadly agreed. • We are using incidents and any information we have on the management of the deteriorating patient to improve care.	

	• The plan is to set up an exemplar framework as we did for VTE and other areas through the Trust. Recommendations internally and externally along with guidance will be reviewed to rate whether we are meeting them or not. We need a boarder strategy on how we will manage this in the longer term. • CQUIN Results – There have been delays in assessment, particularly medical and identifying the deteriorating patient in the first instant. The team have presented a longer term strategy which is an aspirational model. • Mr James (Chair and NED) questioned when there will be a further update to provide to the Quality Committee. The DCMO will present an update, including the Terms Of Reference and workforce following the next meeting of the Deteriorating Patient Committee. • Mrs Martin (NED) noted that the Royal Berkshire NHS Foundation Trust have a good process for Martha's Rule and was keen that we do not wait for instructions but proceed with this. The DCMO advised that we will be building on this as we progress with the Committee. The CNO advised that she has asked the Quality & Safety Matron to co-ordinate work on Martha's rule.	**RD**
	<u>Resolved</u> – that: **(A) The Quality Priority – Improve the Management of the Deteriorating Patient verbal update be received and noted.** **(B) The Deputy Chief Medical Officer will present an update on the Deteriorating Patient Committee including the Terms Of Reference and workforce after their next meeting.**	**RD**
QC013/08.23	**<u>QUALITY PRIORITY – ENSURE TRUST MEETS BEST PRACTICE REQUIREMENTS FOR NUTRITION</u>**	
	The Associate CNO presented the Quality Priority – Ensure Trust meets Best Practice Requirements for Nutrition and the following key points were noted: • This report is based on the measures agreed at the last Quality Committee. • NG Tube Safety – We are still waiting for the Policy to be finalised. Currently it can take Radiology 7 – 10 days to report. The Nutritional Specialist Practitioner is leading on this educational package to ensure that the relevant Consultants are signed off to approve these NG placements. • Parenteral Nutrition – This continues to be administered on Surgical Wards and ICU. We are looking at whether we also include this on some of our medical wards, eg Lugg Ward. Scoping work is being carried out around how many patients require this and how we ensure that this is undertaken safely with staff correctly trained.	

	• MUST Nutritional Scoring Data – The results for our Community Hospitals are included in the report. There was a dip in results but these are increasing again. There has been increased focus on this area which is showing dividends. • The results from applying the CQUIN measures to the County Site will be included in the next report following an audit around the use of MUST tools and actions from them in the autumn. • Digital Dashboard – We are awaiting for this to be available to enable senior nurse to have oversite of patient's nutritional MUST scores. This will enable them to see in "real time" which patients have had their assessments completed. • Patient Food Scores – Our most recent patient surveys around quality of food was positive for the Community Hospitals and Acute site. We are waiting for further data but the PLACE Audits also include patient feedback around meals which is occurring in October which we will triangulate. • A gap analysis was undertaken regarding the national standards for Healthcare food and drink. We need to have a Trust Food and Drink Strategy in place. We can work with our ICS colleagues on some areas, eg Community Dietician. • The Mouth Care Guideline and national survey has been launched. • Mr James (Chair and NED) noted that hydration has been picked up in the Inpatient Surveys around patients not having enough to drink. The Associate CNO advised that we are picking this up in our Strategy but we are also going to be reviewing this as a separate issue. • Mr James (Chair and NED) queried when the Nasogastric Tube Policy will be ratified. The DCMO was not aware of any delay to this. The Operational Clinical Lead Radiographer advised that we are waiting for the connection to send images through to TMC. We are just finalising the contact in the next couple of days.	
	<u>Resolved</u> – that the Quality Priority – Ensure Trust meets Best Practice Requirements for Nutrition be received and noted.	
QC014/09.23	**<u>INFECTION PREVENTION BOARD ASSURANCE FRAMEWORK</u>**	
	The Lead Infection Prevention Nurse (LIPN) presented the Infection Prevention Board Assurance Framework (BAF), which was taken as read, and the following key points were noted: • This has been updated nationally and changed substantially since it was last presented.	

	• This was received in March with the Infection Prevention Team reviewing with this with the Quality and Safety Team regarding the changes made. • These changes have aligned the Framework to the Health and Social Care Act 2008. There are 10 areas that we have to adhere to. • There are 14 elements that we know that we need to do more work on which we are partially compliant on. • Following our internal audit, we were aware of the areas to improve upon to provide additional assurance. Additionally, the NHSE Inspection last November picked up on some of these elements, eg taps, hand washing, basins and flushing etc. Estates and Sodexo are looking at the facilities available. We are unable to confirm that we are fully compliant until all these have been returned. • The main reason for non-compliance around antimicrobial stewardship is the lack of this role in Pharmacy. A member of staff is retiring and returning to this post which will enable the majority of this area to then be compliant. The other 2 elements are already on the Risk Register regarding antimicrobial stewardship. • Isolation practices, cleaning of our environment and identification of our patients – This has been flagged previously as an issue and is part of our Improvement Plan with pieces of work already being carried out. • We are confident that we can become compliant with the BAF, there are just some elements that require progressing. All actions are being captured onto on action plan even though they are also on the BAF. • Ms Quantock (NED) queried if the water safety plans have an element of climate changes and risk of flooding etc built into them. The LIPN advised that this would be overseen by the Water Management Group. • The CNO thanked the LIPN and the Consultant Microbiologist for managing the workload related to the BAF. During Covid, NHSE mandated review for submission and completion to the Board. Although completion of the BAF is no longer mandated, it is deemed good practice.	
	<u>Resolved</u> – that the Infection Prevention Board Assurance Framework be received and noted.	
QC015/09.23	**<u>MORTALITY REPORT</u>**	
	The Mortality Project Manager (MPM) presented the Mortality Report, which was taken as read, and the following key points were noted: • There has been a positive trend for our mortality rates this year.	

	• The number of actual deaths is continuing on a downward trend towards the national mean with an improvement in our coding. • Our in-hospital crude mortality rate is at 1.8% which is very positive. • The majority of our outlier groups sit within or below the expected rates of deaths. Heart failure is slightly below expected, hence a full review of all deaths in the last 12 months was undertaken. There were no clinical concerns or themes identified. We are reviewing our data to ensure that all patients are being correctly coded. • An update on our perinatal numbers is included in the report. When benchmarked to the national average, we have some impressive results. We are well below the national ambition set for 2025 of halving the number of perinatal deaths. • The results from the national Hip Fracture Annual Report are included, including benchmarking against 5 quality measures. This is mainly very positive with the majority above the national average. The couple of concerns are related to patients coming into ED and getting into a specialist bed (this is related to a capacity issue) and patients supported to receive bone protection. Ensuring that patients receive prompt and appropriate surgery – the national average is 56%, the Trust is at 67%. Mr James (Chair and NED) noted the importance of vigilance and diligence around this. • Mrs Martin (NED) questioned how much the improvement in coding our palliative care patients is associated with the reduction in our rates. We need to use SDEC more and not admit patients unnecessarily and review our Foundation Colleagues performance. The MPM advised that a small working group meets monthly to break down the figures and benchmark locally and nationally. Clinical Coding review every death with a symptom code and ensure that they get a firm diagnosis which is really helpful. We are still trying to get to the bottom of the palliative care issue which is being picked up in the Community Hospitals as part of our Palliative Care Plan. • Mrs Hill (ANED) noted that we are a real outlier regarding bone protection and queried whether this was more a system level issue as this related more to Primary Care. The MPM advised that this is a medication issue which sits within the hospital process and not with Primary Care, but is an area that is being reviewed. • The Managing Director noted that we admit directly to a specialist ward was was unsure why our results were low. Overall, this is a very good result. • The Managing Director highlighted that our admission rate is high and that we are an outlier on a number of measures. The MPM is undertaking an analysis of this to understand what is driving this and an update will be included in the next report.	**CB**

	<u>Resolved</u> – that: **(A) The Mortality Report be received and noted.** **(B) An update will be provided in the next Mortality Report on the background to the Trust being an outlier on a number of measures and our high admission rates.**	**CB**
QC016/09.23	**<u>DRAFT PATIENT SAFETY RESPONSE PLAN</u>**	
	The ADQG presented the Draft Patient Safety Response Plan and the following key points were noted: • This is our local plan that will replace the Serious Incident Framework and has been discussed at a number of forums. • Governance – We went out to consultation with the Patient Safety Committee and the Clinical Effectiveness and Audit Committee as well as our patient safety partners. • Feedback was that this was a technical document. It has been agreed to develop a 2 page summary of the plan to make it more "live" for our patients and public. • It has also been taken to the ICB for a first review, where it will ultimately need to be signed off. Positive feedback was received with minimal comments made that are easy to integrate. • If approved today, this will be presented to the next Board of Directors and then to the ICB for final approval. The plan is to commence using this from 1 November. • The CNO advised that a Board Workshop was held on this previously with a lot of detailed work behind this which the Board of Directors were kept informed of. The Chairman felt that this was the most clear and concise way of producing this plan across the Foundation Group. • The General Manager - Acute and Countywide Services advised that this has been trialled through the Pressure Ulcer Panel since 1 June. This is a very iterative process which we will learn from over time.	
	<u>Resolved</u> – that the Draft Patient Safety Response Plan be received and approved for submission to the Board of Directors.	

QC017/09.23	**DIVISION QUARTERLY REPORT – INTEGRATED CARE DIVISION**	
	The General Manager - Acute and Countywide Services presented the Division Quarterly Report – Integrated Care Division and the following key points were noted: • The biggest area of concern for the Division, and the 3 Serious Incidents declared during this period were related to pressure ulcers. • Complaints – There are a couple of complaints still open, but none received during June or July and only 2 in August. A couple are waiting closure following a meeting with the complainants. • Controlled Drugs Audit – Overall this was a positive result. • Mortality Review – This process continues and we are linking Community Hospital colleagues in with Primary Care colleagues. Good learning is coming out of this. • Care Home work – We are ensuring that Care Home residents get the best care possible and are working with the Primary Care Networks and Care Home to get care plans in place. • Stroke Service – We continue to achieve a SSNAP B score. We are doing really well each quarter and are the top of the league in the West Midlands. • Compliments – Details included of some of the compliments received during this period. • Children's Therapy Waiting Times – Following additional funding received from the ICB in the spring, we are now making massive inroads into our waiting times. • Recruitment – This is always an area of concern. The expansion of roles such as Advanced Clinical practitioners and First Contact Practitioners in Primary Care has depleted our core staff. • Pressure Ulcers – As part of the PSIRF work, we are having Divisional Learning Plans to try to learn from every incident. Community Hospital wards and District Nursing teams work very differently. We need to work out how we can best support our most vulnerable patients, even when they do not always want any support.	
	Resolved – that the Division Quarterly Report – Integrated Care Division be received and noted.	

QC018/09.23	**DIVISION QUARTERLY REPORT – CLINICAL SUPPORT DIVISION**	
	The Operational Clinical Lead Radiographer (OCLR) presented the Division Quarterly Report – Clinical Support Division, which was taken as read, and the following key points were noted: • Over the last quarter, there has been an increase in the number of incidents being reported. This is due to over-reporting from new staff members. Training has been put in place. • There are 2 ongoing Serious Incidents. • There were 5 complaints received and 1 comeback. • Radiology – An Allocation Officer is now in post who will support the Division. Money has been allocated for recruiting overseas Radiographers and Radiologists. Interviews have taken place and 6 Radiographer positions were filled with interviews planned for a further 4 positions. CT and MRI waiting lists are now down to 6 weeks and non-obstetric ultrasound waiting lists have also reduced due to recruitment. Reporting capacity in Radiology remains of concern. • Pathology – A new part-time POCT manager has been appointed. Bidirectional reporting in the new digital pathology system has now been signed off. A local Consultant Rheumatologist is acting as the Clinical Lead for the Immunology Service. Recruitment and retention is of concern for Histopathology and there was no interest in the Microbiology posts. • Pharmacy – A Pharmacist for antimicrobial stewardship, Deputy Chief Pharmacist and the Lead of Education and Training have all been appointed. There is still concern around the staffing position despite these appointments. The OCLR was proud of the resilience of the tam who are continuing to dispense with high accuracy. • Patient Access – Several Outpatient areas have been merged. We have started some pre-op mini screening through Outpatient which is proving successful. Plaster Trainers have now completed their training. The Referral Management Centre are working hard to support cancellations during the ongoing strikes. • Cancer Services – A Cancer Lead has been allocated to the nonspecific symptom pathway. The Cancer Support Officer post has been recruited to. We are especially proud of our Palliative Care team who are the finalists in the Hereford Times for a Health and Social Care Award. We have also recruited to a further 2 ACPs in Haematology. There are no substantive posts in Haematology. • Mr James (Chair and NED) questioned around 62 day cancer waits. The OCLR advised that there are still some concerns and challenges around this. Radiology reporting times are having an impact on this. There is a lot of work to reduce CTPAC but this is mainly around staffing challenges.	

	• The Managing Director was not getting a sense of "so the impact is" from the report. The next report will draw out of the impact of issues.	**LH**
	<u>Resolved</u> – that: **(A) The Division Quarterly Report – Clinical Support Division be received and noted.** **(B) The next Clinical Support Division Report will draw out the impact of any issues reported.**	 **LH**
QC019/09.23	**<u>MATERNITY PQSM REPORT</u>**	
	The Associate Director of Midwifery (ADM) presented the Maternity PQSM Report, which was taken as read, and the following key points were noted: • This report cover 2 months due to the timing of the meetings. • Activity has increased to 137 births in July (with one set of twins total is 138). In August this rose again to 146 (with 2 sets of twins total was 148). • Induction for labour rates for July remained consistent for the year. There are no concerns. • There was 1 fetal loss in July – the ADM provided details of the case. • There was 1 late fetal loss in August – the ADM provided details of the case. • There were no moderate incidents in July but 2 in August. The ADM provided details of the incidents and learning identified. The 2nd case met HSIB criteria. • There was a slight increase in rota gaps in July. These were all covered by existing members of the team. This improved during August. • There was a decrease in middle grade gaps in July which is positive. There were anaesthetist gaps in July and August but these were all covered. • The midwifery gaps in July and August were largely covered by Bank and Agency staff. Any concerns are raised on InPhase. • We have a 13.09 maternity vacancy rate. Once the newly qualitied starters commence in October and November, we will be down to 4WTE vacancies. We have a further 4 applicants due to qualify next year. • There were 14 compliments received in July.	

	• Friends and Family text messaging service engagement was launched in August, seeing a 26% engagement which is above the Trust's average of 21%. A positive response rate of 94% was received in response to the question recommending the Trust's maternity services to friends and family. • There were 2 complaints received in July and none in August. • There have been 4 complaints received so far this year, this is significantly lower than previously. • The multidisciplinary team have completed our benchmarking against the CNST standards. We are working hard to achieve all 10 areas this year. There is some transitional care work to do on this which is an area that we were challenged on last year. Safety Action 6 - Saving Babies Lives version 3 is very complex and we are receiving support from the LMNS around this. • During July there were a couple of incidents with 1 case in August requiring a Consultant to attend. There was 1 case where we could not evidence that a Consultant had attended. We have gone back to the team regarding this. • Training compliance is included in the report. We are close to achieving the 90% target required by 1 December. Plans are in place to enable achievement. • The CNO queried when the Maternity Continuity of Carer paper referenced in the report will be presented. The ADM advised that a target date of January has been set, but as this has been significantly delayed, she will review if this is able to be presented sooner.	
	Resolved – that the Maternity PQSM Report be received and noted.	
QC020/09.23	**STAFFING REPORT**	
	The Associate Chief Nursing Officer, (ACNO) Surgical Division presented the Staffing Report and the following key points were noted: • We continue to see high attendances in ED and high patient admissions. This has meant the utilisation of Escalation Areas during the summer months. Last month saw an increase in boarding patients, especially overnight. • Decant from ITU occurred during the end of July/beginning of August to allow maintenance to be undertaken in ITU. This required additional beds to be opened in Bromyard to accommodate this. • Frailty SDEC has opened to support frail patients coming through the front door. This is having a positive impact already.	

	• Escalation beds have reduced in ED which should reduce the need for escalation staffing in ED but we may need to open Day Case overnight as an Escalation area. There is no establishment for overnight staffing, so we will be need to utilise Agency and Bank staff. • Fill rates have increased on particular wards – details are included in the report. There has also been an increase in 1-2-1 care due to frail patients in the community. A paper is being presented to the Trust Management Board following recommendations from a previous Biannual Review on staffing. • Vacancy rates continue to improve. We are seeing a slight increase in sickness with September seeing an increase with staff off with Covid, colds etc. • Due to all of the above, we have seen an increase in agency spend by 20WTE. The highest usage is in Community Hospitals due to additional beds and the 1-2-1 care requirements. The second highest area is ED – there are plans in place to try to recruit to this area. • The Biannual Review was presented to the Quality Committee a few months ago. The next review is due in November. When benchmarked against national safeguarding for staffing, our AHP levels are not compliant. We are planning to include this information for the November report. A new tool is becoming available to enable us to access our acuity and dependency for adults which we will use for our Winter Acuity review. We will also be able to be more flexible around our 1-2-1 care which we can document. • Mr James (Chair and NED) queried how the Acuity and Dependency reports coming to Quality Committee relate to the biannual report being presented to the Trust Management Board. The ACNO, Surgical Division advised that the tool on Allocate (Safe Care) looks at acuity on a daily basis and helps us to move staff to areas where they are most needed. The Safer Nurses Care tool is data collection over a month with specially trained nurses looking at the detail and producing the numbers for acuity. They work side by side but are more in-depth for the biannual reviews. • The Managing Director queried why we cannot use the daily Safer Staffing Review for our review. The ACNO, Surgical Division advised that any member of staff can undertake this acuity review whereas the more detailed report is undertaken over a 21 day period by trained staff. The tool used is accredited and endorsed by NICE. This provides more oversight and scrutiny of data collected, hence more accurate. The Managing Director felt that it would be helpful to have a comparison of the 2 systems which will provide us with assurance if they provide the same numbers. The ACNO, Surgical Division advised that the numbers are similar but it is a national requirement to undertake the biannual reviews.	

	• The CNO advised that the biannual review is required by the National Workforce Safeguards. This ensures consistency of staffing reviews.	
	Resolved – that the Staffing Report be received and noted.	
QC021/09.23	**CLINICAL EFFECTIVENESS AND AUDIT COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Clinical Effectiveness and Audit Committee Summary Report and the following key points were noted: • The Chest Drain Audit was received from the ED Consultant. This created good debate around insertion of chest drains. This will be presented to the Finance & Performance Committee for further discussions. Risks are being mitigated. • End Of Life Care Audit – A presentation was given by the Consultant in Palliative Care which promoted a lot of discussions. • The insertion of PICC lines and wider issues associated with this along with the 2 audits were the key topics discussed and detailed are included in the report. • Mrs Martin (NED) was concerned around the ongoing issues around chest drains. The Associate Chief Medical Officer, Medical Division advised that the audit was a retrospective audit from 2019 – 2022. There were low numbers involved – about 1 per month. A lot of actions have been put in place since the audit was undertaken and a Serious Incident occurring in ED. The Policy in place around inserting chest drains in ED, ICU and the Medical Division is robust. There is a gap in the Policy as the Surgical Division often use different methodology. The Policy is due further review later this year. The Associate Chief Medical Officer, Surgical Division is leading on this review and the plans to make this a pan hospital Policy. The Policy was in place when the incident occurred but this was not followed. Training has also been undertaken. • The DCMO advised that this is part of a broader issue. Staff need to undertake a number of procedures to be competent. The Trust, as other Trusts do, trust the professionals that they are undertaking procedures that they are competent to do. More training is needed and SIM training to ensure staff are signed off to undertaken this procedure.	

	• Mrs Martin (NED) noted that taking consent appears to be a basic need that is not always being taken. The Associate Chief Medical Officer, Surgical Division advised that we are reviewing documentation on the retrospective audit. Verbal consent may have been taken, but as the LocSSIP was not followed every time, there is no evidence of this recorded. The LocSSIP used in ED and the Medical Division requires a tick box to be completed to state that consent has been taken. The DCMO advised that we have been less robust with the use of LocSSIPs than we should be and we need to tighten up on consent taking procedures. There are around 40 LocSSIPs in the Trust which are not all in date, which we are working on. • The Associate Chief Medical Director, Surgical Division advised that the majority of chest drains are undertaken in ED where it is not always appropriate/possible to take consent. • Mrs Martin (NED) queried whether the results and actions from the audit are being monitored. The Associate Chief Medical Director, Medical Division advised that these were discussed at the Finance and Performance meeting held the previous day along with another audit being undertaken to gain more up to date data which will be presented back to the Clinical Effectiveness and Audit Committee.	
	Resolved – that the Clinical Effectiveness and Audit Committee Summary Report be received and noted.	
	CONFIDENTIAL SECTION	
QC022/09.23	**DRAFT CQC MATERNITY REPORT**	
QC023/09.23	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC024/09.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 26 October 2023 at 1.00 pm via MS Teams.	

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council
HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HSE	Health & Safety Executive

HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MASD	Moisture Associated Skin Damage
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document
PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review

RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur