Public Board Meeting

Thu 07 March 2024, 13:00 - 14:30

Microsoft Teams

Agenda

13:00 - 13:00
0 min

1. Apologies for Absence

13:00 - 13:00
0 min

2. Declarations of Interest

13:00 - 13:02
2 min

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

Decision *Russell Hardy*

3. PUBLIC BOARD MINS - DECEMBER LF, AD, FMa.pdf (16 pages)

13:02 - 13:05
3 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

Board Workshop Update

3a. PUBLIC BOARD ACTION LOG -MARCH.pdf (1 pages)

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Discussion *Glen Burley*

4. 7 March 2024 - WVT CEO Report - BOD.pdf (5 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

WVT IPR Month 11 February 24~v2a.pdf (31 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 *Suzi Joberns*

13:35 - 13:55
20 min

6. Items for Approval

6.1. Climate Change Adaptation Plan

Decision *Alan Dawson*

- 6. 20240307 CCAP Covering Board.pdf (2 pages)
- 6a. 20240215 WVT Climate Adaptation Plan FINAL.pdf (24 pages)

6.2. Trust Objectives 2024/25

Decision *Alan Dawson*

- 8. Trust Objectives - TRUST BOARD FINAL.pdf (6 pages)

13:55 - 14:25
30 min

7. Items for Noting and Information

7.1. EPRR Core Standards

Discussion *Andrew Parker*

- 9. EPRR Report Cover Sheet - Board Response - 26 Feb 2024.pdf (3 pages)
- 9a. Core Standards Action Plan (as of 9 Jan 2024)- 2023-2024.pdf (6 pages)

7.2. Patient Experience Quarterly Report

Discussion *Lucy Flanagan*

- 10. Patient Experience Report February 2024- Board report.pdf (11 pages)
- 10a. Appendix 1 Maternity survey CQC 2023.pdf (30 pages)

7.3. CQC Report and Action Plan - Emergency Department

Discussion *Lucy Flanagan*

- 11. CQC report and action plan.pdf (2 pages)
- 11a. INS2-17891588991 - RLQ01 The County Hospital - FINAL REPORT.pdf (44 pages)
- 10b. Copy of CQC Action Plan Feb '24 v2.pdf (1 pages)

7.4. Maternity Quarterly Report

Discussion *Lucy Flanagan*

- 12. February 2024 - Maternity Services Report.pdf (6 pages)

7.5. Staff Survey

Discussion *Geoffrey Etule*

Embargoed until Thursday 7 March

7.6. BAF and High Risks and Risk Appetite

Discussion *Erica Hermon*

- 14. Covering BAF and Risk Report for Board - March 2024.pdf (2 pages)
- 14a. BAF Risks - February 2024 - Final~v1.pdf (2 pages)
- 14b. February 2024 - 15-25 High Risks Review EH - Final~v1.pdf (11 pages)
- 14c. 20240111 WVT Risk Appetite Template.pdf (1 pages)

7.7. Committee Summary Reports:

7.7.1. Audit Committee Report and Minutes

Discussion *NICOLA TWIGG*

- 15.2 AC Front Sheet.pdf (1 pages)
- 15.2a Audit Summary Dec 23.pdf (1 pages)
- 15.2b Audit Committee minutes - September 2023.pdf (16 pages)

7.7.2. Integrated Care Executive February 2024

Discussion *Frances Martin*

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

7.7.3. Charity Trustee Report and Minutes

Decision *Grace Quantock*

- Charity Trustee minutes October 2023 - final.docx.pdf (7 pages)

7.7.4. Quality Committee Reports and Minutes

Discussion *Ian James*

- 15.4.aa QC MINUTES - OCTOBER.pdf (22 pages)
- 15.4a. QC Summary Report November 23 Public2.pdf (2 pages)
- 15.4.bb QC MINUTES - NOVEMBER.pdf (18 pages)
- 15.4b QC Summary Report Dec 23 Public final.pdf (3 pages)
- 15.4.ccQUALITY COMMITTEE MINUTES - DECEMBER.pdf (16 pages)

7.8. Committee Minutes

7.8.1. Foundation Group Board and Action Log 7 February 2024

Information *Russell Hardy*

- 16.1 . Draft Public FGB Minutes - 7 February 2024.pdf (16 pages)
- 16.2 FGB Public Actions Update Report - 7 February 2023.pdf (2 pages)

14:25 - 14:25
0 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

14:30 - 14:30
0 min

10. Acronyms

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

14:30 - 14:30
0 min

11. Date of Next Meeting

The next meeting will be held on 4 April 2024 at 1.00 pm

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

Present:

Russell Hardy	RH	Chairman
Chizo Agwu	CA	Chief Medical Officer
Glen Burley	GB	Chief Executive – Arrived during Item 4
Lucy Flanagan	LF	Chief Nursing Officer - Left partway through the meeting
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FMa	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Clive Andrews	CA	Senior Finance Manager - For Item 6.2
Jon Barnes	JB	Chief Transformation and Delivery Officer
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Erica Hermon	EH	Associate Director of Corporate Governance
Christian Homersley	CH	Associate Chief Estates Officer - For Item 6.2
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Amie Symes	AS	Associate Director of Midwifery - For Items 7.1, 7.1.1 and 7.1.2

	The Chairman noted that this is the last Board of Directors meeting for Frank Myers (ANED). Frank has been a NED at the Trust for 12 years – the longest serving NED in the county! He thanked Frank once again for his extraordinary work, he is an absolute example for what public service means and thanked him on behalf of the Herefordshire population. The Employee of the Month award for Quarter 2 was presented to Mike Willmont, Volunteer. The Chairman read out the reasons why Mike had been nominated for this award. The Team of the Month award for Quarter 2 was presented to Kelly Moran and Laura Morris, Clinical Site Managers. The Chairman read out the reasons why the Kelly and Laura had been nominated for this award.	
Minute		**Action**
BOD01/12.23	**<u>Apologies for Absence</u>** Apologies were received from Ellie Bulmer, Associate Non-Executive Director.	

BOD02/12.23 **Quorum**

The meeting was quorate.

BOD03/12.23 **Declarations of Interest**

Mr Myers (ANED) advised that he had been appointed the Chair of Community First in Herefordshire and Worcestershire. This includes the Recovery and Wellbeing College contract which was issued by the Chief Strategy and Planning Officer and signed off by the Chief Executive, Integrated Care Board.

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

BOD04/12.23 **Minutes of the meeting held 5 October 2023**

.

Resolved – that the minutes of the meeting held on 5 October 2023 be confirmed as an accurate record and signed by the Chairman.

BOD05/12.23 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD06/12.23 **Chief Executive's Report**

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

(a) **NHS Finances and the Productivity Challenge** – The Report sets the scene for this and it is on the agenda. There has been a long and difficult discussion around NHS funding. The ask was for about £2bn to come into the NHS mainly on the back on industrial action, pressures and inflationary pressures. The Treasury were unable to provide any additional funding, with only £200m additional funding in the summer provided. This was not allocated to the System. This funding along with the additional funding from national budgets has been pushed out to the ICS and Trusts, such as Wye Valley NHS Trust, on head count due to direct and indirect costs of industrial action. The NHS was asked to review national and local plans to offset the pressures. One option was to slow down elective recovery. It is positive that across the Foundation Group we have not taken this option up. We are planning to review this and try to deliver our Financial Plan alongside the original pledges on performance**.** There will be some tweaks on the trajectory for Urgent Care but we still plan to undertake all the planned work we agreed at the start of the year. This is a very challenging position for us.

(b) Head count in the NHS caused discussion. This has increased over the last few years from 15 – 20% and has increased post Covid. Some of this is due to delivering more activity, increasing our quality and increases in Midwifery staffing. We need to review our head count increase and will do this as part of our planning cycle this year to ensure best value.

(c) Intelligent Board – There have been open conversations around productivity. If we improve, we can deliver better and / or more care.

(d) **Volunteering** – We had an excellent talk from Sir Thomas Hughes-Hallett at the Foundation Group Board meeting. This was followed up at the Chief Nursing Officer conference. The Chief Nursing Officer (CNO) has been in touch to discuss the positive work we are doing at Wye Valley and the opportunities and innovative ways of working.

(e) **Leadership Development** – We are seeking this at Foundation Group level now that we have 4 great Trusts working together. We will bring the middle management cohort together to deliver teachings etc.

(f) **More From Our Great Teams – Clinical Support Division** – There is a very positive update from the Outpatient team referencing some work they are doing regarding Super Saturdays. This is also part of the work we are doing with the national Faster Further Programme.

(g) Cancer Services – There is a lot of work occurring in this challenging area. We need to ensure that we address the Cancer 62 day backlog. There is increased demand but there is a lot of innovation and changes to pathways to enable delivery of faster care.

(h) Diagnostics – Updates on what is occurring in this area are included in the Report including regarding our Pharmacy team. They are challenged with recruitment and details are included around how they are addressing this. Pathology Team – they are contributing towards the cancer pathways. It is good to see support from the Foundation Group around Histopathology and progressing with networking.

(i) Mrs Martin (NED) noted that we have to focus on Urgent and Elective Care as we do not want our long waiters to cease to be a priority for us and we will continue to manage this despite the funding challenges. The Chairman advised of the discussions held in the Board Workshop around the positive work with our Primary Care colleagues in the One Herefordshire Partnership to try to ensure that more care is provided at community level.

(j) Mrs Twigg (NED) noted the increase in head count and questioned whether we understand how quickly new starters become effective in post and how long it takes for them to become embedded in their role and be part of the productivity cycle. However qualified and experienced a person may be, we may have different IT systems for them to learn. The Chairman noted that we have had a lot of experienced members of staff retiring over the years who are the most productive. The CEO advised that we cannot just look at head count activity through a financial or analytical model, we need to understand their skills as well. Changes to IT will hopefully increase productivity. A number of staff are agency or temporary staff who do not understand local systems and processes as well and tend to cost more.

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

BOD07/12.23 **Integrated Performance Report**

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

a) We have seen the impact of the industrial action that took place during September and October in this Report. There was also a cost impact as well. However, we still remain one of the highest performing Trusts, often the best in the Region, compared to the 2019 baseline. It is good to see the numbers of patients waiting over 52 weeks coming down. Waiting lists have been going up but these are now starting to reduce. This is due to the activity that we have undertaken alongside productivity improvement.

b) It is hoped that the Consultants will accept the deal that the BMA has recommended to them. It is disappointing that there is further Junior Doctor action planned to take place during the Christmas period, it is hoped that this will be resolved soon. A lot of planning takes place to mitigate the risks during this action. It is hugely concerning and will have an impact on our planned Elective Care.

c) During this time we had an unannounced Care Quality Commission Inspection in the Emergency Department (ED). We will be seeing a huge amount of redesign in this area along with the Frailty Same Day Emergency Care (SDEC) and the Virtual Ward. This was also discussed with our GP colleagues in the Board Workshop held this morning. Surgical SDEC is also planned to be opened before Christmas. We are seeing a hugely pressured ED which is very congested with some exhausted staff.

d) Ambulance Handovers – This is an area that we are really concentrating on. This is a whole system approach with the Trust having as much a part to play and responsibility regarding this as everyone else. We need to ensure that ambulances are released from ED to respond to calls, which is an area we do well on. This is also part of the reason for reducing the congestion in ED and the reason why we have the Boarding Policy. We are aware of the pressures on staff and patient with this.

e) There is a lot of ongoing work with the Social Care Pathway, Discharge To Assess Discharge Pathways are being reviewed with the Chief Transformation and Delivery Officer and the Corporate Director. Community Wellbeing at Herefordshire Council. This will take time but will make a difference.

f) The Managing Director noted her concern around our cancer performance.

g) Our staffing metrics are good. The Managing Director confirmed that the new immigration rules for international recruits being able to bring dependents is not impacting on our overseas recruitment. Many are nursing and medical staff and bring their families with them and it is important for them to do so to create a new life. However, this is very worrying for social care. The NHS is very dependent on international recruitment.

h) Our financial position is a little adrift from where we would want it to be at this point in the year.

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

BOD08/12.23 **Quality (including Mortality)**

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

(a) At the last meeting, the Patient Safety Incident Response Plan was presented and approved. The associated Framework and Policies have been endorsed by our Integrated Care colleagues. We moved successfully onto the Patient Safety Incident Response Framework (PSIRF) in November.

(b) A national document has been published for the Serious Incident Framework and the Local PSIRF which enables us to close down the old process quickly and start the new process. We are working with colleagues on any Serious Incidents that remain open to bring them to conclusion as soon as possible.

(c) With winter upon us we have seen some infection outbreaks and additional pressures on services. We saw an increase in patients with Norovirus and Covid positive cases along with flu as expected. We do everything we can to keep areas open for admissions and discharges and isolate patients appropriately. This can increase the pressure on the Front Door and our bed base. The CNO asked the public to get their vaccinations and wear face masks when asked to do so to keep patients and staff safe.

(d) NEDs have been identified to link with front line colleagues and wards to increase visibility from ward/clinical areas to Board. Colleagues have welcomed this opportunity. A revised approach to Patient Safety Walkabouts (PSW) was approved at the Quality Committee last week. PSW will take place with NEDs and also a schedule of Exec led walkabouts. This will include a new revised approach of collating information and board level oversight.

(e) In October 2022 we introduced the Boarding Policy. This was designed to ease and reduce pressures and decongest ED and enable timely ambulance offloads. There are 2 types of Boarding – Proactive where we choose to board patients against predicted discharges. We move the patient to a space and the new patients into the bed. Reactive is when we Board patients in a non-designated space and the patient may have to stay in this space for a period of time. We know that this is not a good experience for our patients who are without a call bell and facilities that are offered in a bed space. This is not good for staff experience with the additional pressures caused. Included in the Report, the number of Boarders has been increasing and in October we had a peak of 489 Boarders overall and our highest number in one day being 30 Boarders.

(f) Our patients are surprisingly very obliging and considerate of the space they are in and rarely raise concerns. However, we are seeing an increasing number of complaints and feedback from staff around how care is compromised and the space needed to deal with emergency situations and privacy and dignity is compromised. The long term strategy is not to have more beds but to have care closer to home, avoid admission where possible with pathways, home by lunch plan and the use of the Virtual Ward. A monthly report is presented to the Quality Committee on boarders and additional measures which will be presented to the Board of Directors as required.

(g) The Managing Director asked how many patients are ready for discharge but are unable to be due to social care issues. The Chief Operating Officer (COO) advised that the latest figure is 44. This is a mixture of patients from Herefordshire, Powys and Worcestershire.

(h) The CEO noted that in addition to these patients, there are a number of other patients we could discharge ourselves, which is an area that we need to improve upon. We know for individual patients boarding is not ideal but we are doing this due to other patients waiting in the community and balancing this urgent need. We need to ensure that the public understand our balance of judgement in making these decisions.

(i) The CMO advised that the 12 month rolling SHMI has slightly increased. The data is showing that further increases over the next few months are expected. This is due to an increase in pneumonia deaths. There has also been a slight increase in stroke deaths but our Stroke SHMI remains very good and is one of the best in the country.

(j) We continue to work towards expanding the Medical Examiner scrutiny of community deaths and hope to have this in place before 1 April.

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

BOD09/12.23 **Activity Performance**

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

(a) There are 9 days of industrial action planned, 3 immediately post the festive period. We are very busy planning and preparing for this. The COO thanked all the teams in advance of dealing with this on top of the normal winter pressures. We are continuing to focus on improving Urgent and Elective Care and our cancer standards. Our non-elective waiting patient numbers are improving.

(b) There is a huge amount of work ongoing, and it is not possible to put all of the detail of this work into the report.

(c) The Frailty SDEC is being co-located with another ward on the Acute Floor. We have expanded the Discharge Lounge and are hoping to reduce the number of boarding patients by increasing the Discharge Lounge capacity with both floor space and resource. We have seen an increase in utilisation and percentage of patients leaving the ward by lunchtime. This has increased from 15 – 22%.

(d) The Chief Transformation and Delivery Officer is leading on the Discharge To Assess work. There is a lot of work occurring across the Trust including standardising the estimated discharge date and ensuring this links in with our discharge planning process along with increasing the number of Discharge and Flow Coordinators.

(e) Our biggest concern is cancer which is mirrored by the ICS and Regionally. This is driven by the increase in numbers and our 28 day standard being off trajectory. There is a lot of work with the teams to address this. Deep dives are ongoing currently within the 5 main specialties with the biggest challenge – Upper and Lower GI, Breast, Gynae and Urology. We are looking at sending text messages to patients with benign results to provide reassurance to patients that they do not have cancer. This will stop their 28 day clock. Super Saturday sessions are also increasing in January and Quarter 4. We have faecal testing in Primary Care which has recently gone live which should reduce our Endoscopy cancer referrals from anything between 15 and 25%, therefore maximising our Endoscopy capacity. We have Cancer Navigators starting in Histology to drive down some of the barriers and issues within our Histology reporting and specimen reviews.

(f) Long Waiting Electives - There is a lot going on around this area. We are working across the Foundation Group to maximise our mutual aid offering. Positively, in October, we were the highest Trust in the Region for our percentage of risk 62WW patients as of March, with this cohort of patients being offered their first appointment in December. We are now focusing on our 52WW patients waiting at the end of March, with their first Outpatient appointment being booked by the end of March.

(g) We have validated over 90% of our patients who have waited over 12 weeks. Diagnostics are above plan and theatre utilisation is improving.

(h) We undertook a 2 week Perfect Orthopaedic Week which has increased our use of Theatres.

(i) The CEO agreed that our Cancer Further Faster Diagnostic Standard is the area that we can make most improvements, it was the 62 day backlog triggering national interest which we need to carefully manage. The COO agreed, noting that we are currently slightly off trajectory having to get to 71 by the end of March. We stand at 108 as of today. This is an improving picture which we are monitoring on a daily basis.

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

BOD10/12.23 **Workforce**

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

(a) Our staff turnover continues to improve. We now have the lowest turnover for 4 years. We are also continuing to take active steps to fill our clinical vacancies over the coming months.

(b) We now have the Charter for International Staff in place which shows our support for our international staff.

(c) We have also adopted the NHS Sexual Safer Charter. This reaffirms our commitment to eradicate harassment and bullying in the workplace.

(d) We are delivering and expanding on our "grow our own strategy" with 25 trainee Nursing Associates commencing their placements at the University of Worcester in March.

(e) We are actively promoting the Disability History Month to raise awareness and support for those with a disability.

(f) We will continue to manage sickness absence over the winter months in a compassionate way.

(g) The Chairman noted that the CPO gave a presentation at the Board Workshop on Equality and Diversity, which is a real focus for us going forward.

Resolved – that the Workforce Report be received and noted.

BOD11/12.23 **Finance Performance**

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

(a) The report covers the year to date position until the end of October, Month 7.

(b) Our position remains stable in month, our year to date deficit stands at £17.6m £2m adverse to plan. As discussed already during the meeting, there are significant pressures on our finances. A separate paper on the agenda sets out our assessment of the forecast.

(c) As the CEO's Report covered, we are experiencing the same challenges across the wider NHS around inflation, recruitment challenges and demand pressures. They will all contribute to our adverse variance to plan.

(d) We are reporting under delivery on our Efficiency Programme and as a result of that, we have increased our oversight of this and through our mid-year review later on the agenda. We have focused on mitigations improving the run rate between now and the end of the year and into next year although recognising much of this is likely to be delivered non-recurrently at this point and we do need recurrent, sustainable solutions.

(e) In terms of the elective performance, the COO has already described our sustained focus on elective recovery and we have seen this translated through in terms of variable elective income which has continued to improve. For a year to date perspective by the end of October this is on plan. Large elements of this activity is delivered through temporary capacity which inevitably has a lower margin financially and so that ongoing focus on productivity is absolutely key in terms of that improvement.

(f) Capital spend is just under £12m year to date. There is some tension around the phasing of some of the funding available on national programmes and we are working with National and Regional colleagues to mitigate this across the year end.

(g) Our cash support for December has been approved nationally. We have submitted the application for support during Quarter 4 and as part of this process we do need Board endorsement to those new support requests. We did cover this at the beginning of the year, but we are asked explicitly on a re-submission for Board endorsement for support for these cash requests.

(h) The CEO advised that we have had our National Review Meeting with the CFO. One of the areas that we do need to look at more carefully is our agency usage. We have heard about the promising numbers in recruitment and turnover in the CPO's Report. The CEO felt that we should have another look at some of the processes around agency nurse approvals which has been raised with the Executive Team. We also need a general tightening up on this over the final part of the year which should bring us back on plan.

(i) Mr Lappin (ANED) questioned regarding the request for cash for £9.8m for PDC funding, is this subject to dividends? The CFO advised that we have just received the paperwork so she will need to review this, but her understanding was that we would be. **KO**

(j) Mr Lappin (ANED) queried that if this request is subject to dividends, to what extent is this covered by the costings in the capital developments associated with the requests for extra funding opposed to just getting extra PDC funding to cover overspends. The CFO will review this and provide an update. **KO**

(k) Mr Lappin (ANED) noted that the CFO mentioned another request in Quarter 4 but this did not give a value. The CFO advised that this was submitted last week and will share the amount. This was based on the revised forecast outturn and a daily cash assessment over that Quarter. **KO**

(l) Mr Lappin (ANED) asked if we could see the cash plan that underpins all of this. The CFO agreed that this would be provided. **KO**

<u>Resolved</u> – that:

(A) The Finance Performance Report be received and noted with approval given for additional cash funding.

(B) The Chief Finance Officer will provide confirmation on whether the request for £9.8m for PDC funding is subject to dividends. **KO**

(C) The Chief Finance Officer will review to what extent the request for additional cash for PDC funding is covered by the costings in the capital developments associated with this request. **KO**

(D) The Chief Finance Officer will provide the amount of the cash request made in Quarter 4, submitted just prior to the December Board of Directors meeting. **KO**

(E) The Chief Finance Officer will provide the cash plan which underpins the cash borrowing for PDC funding. **KO**

ITEMS FOR APPROVAL

BOD12/12.23 **In Year Operational Plan Review**

The CFO presented the In Year Operational Plan Review and the following key points were noted:

(a) As discussed in the meeting, NHSE wrote to us on 8 November and the letter is included in the papers.

(b) The Report summarises the implications of this and our revised financial and operational performance projection for the remainder of the year.

(c) Due to the nationally prescribed deadline the Board of Directors were asked, in line with our Standing Financial Instructions, to endorse this ahead of the deadline of 21 November. It is reported today for ratification.

(d) We had already started work on a mid-year review, taking stock of where we were and what that meant for the forecast. We aligned the 2 exercises into 1 given the timelines.

(e) What the Report sets out is based on the performance in the first half of the year, and prior to mitigation, our unmitigated forecast suggested we would be up to £10m adverse to plan. As a result of the review work that we have undertaken and clarification of the national funding assumptions, we have been able to undertake a series of mitigations which are set out in the paper. This has reduced the outturn gap to about £4m at this point. The 2 key drivers for this variance in the forecast are primarily difficulty around an alternative tariff model for our Welsh activity and the stretch efficiency target we took as part of the planning cycle which remains unmitigated due to the pressures that we have experienced in year. The CEO has already updated on the conversations with the National team in their Review Meeting this week.

(f) As it stands today, the CFO did not envisage any further mitigations that will move the forest outturn beyond the numbers that are presented today although we will continue to review this including agency and any other options for us to continue to improve that number. Clearly, with the next phase of the industrial action recently announced, there remains a significant risk in terms of the assumptions that have led to this forecast.

(g) Regarding how this gets reported externally, we are currently undertaking a Month 8 close down process and given that the national review work around the forecast remains ongoing, we will not be formally revising the forecast ahead of conclusion of those national reviews. We are anticipating that the formal reporting of the revised forecast will occur through the national processes during Month 9.

(h) The COO advised that the only thing we adjusted slightly was our UEC 4 hour performance measure at the beginning of the year. We had stated that we would be at 76% by the end of March. We have reviewed this based on the fact that we are a Type 1 Consultant led only ED and we do not have any Type 3 Walk in Centres, Minor Injury Units or Urgent Treatment Centres. In agreement with the ICB, we have reflected our position to deliver a 70% position by the end of March. Outside of this, delivering our long waiters and delivering our cancer standards and maintaining our core general and adult bed base remains static and as we originally stated at beginning of the year.

(i) The CEO advised that discussion had been held at the National Meeting, as discussed earlier in the meeting around the additional funding from the government to support industrial action and other cost pressures that is from the English Government. There is an issue relating to the activity that we deliver for Wales (mainly Powys). As part of the resolution to our financial challenge, will be to pursuing some additional funding from the Welsh Government to cover that.

(j) Mr James (NED) noted that the paper talks about a mid-year review, yet we are now well beyond this now and to acknowledge that our ability to make significant changes in spend is therefore limited by that factor.

(k) Mr James (NED) highlighted that we have focused absolutely on our elective challenge in the current year, and he was very conscious when he heard about the letter that it could have undermined what we were doing. We have all our staff absolutely focused on this and he was very pleased that we have found a way of sticking with the plan and what we are doing and putting patients first, notwithstanding that we do have these financial challenges.

Resolved – that the In Year Operational Plan Review be received and endorsed.

BOD13/12.23 **Full Business Case for Integrated Energy Solution**

The Chief Strategy and Planning Officer (CSPO), the Senior Finance Manager and Associate Chief Estates Officer presented the Full Business Case for Integrated Energy Solution and the following key points were noted:

(a) The CSPO advised that the scheme will deliver greener energy for the County Hospital site. It will cover 95% of the site with the first phase which we have already delivered.

(b) There have been various iterations of this scheme presented to the Board of Directors in the past. This is funded by a national grant from the government. It reduces over 3000 tonnes of carbon on our site.

(c) The location for the building is shown in the paper and planning permission has been submitted for this site.

(d) It works via a water to water and air source heat pumps and delivers the heat to the site by electricity. This requires an upgrade of the Substation on the site, which is covered in the Report.

(e) There are some issues around the Cost Benefit Analysis. The table in the document sets this out in a variety of scenarios. There have obviously also been massive energy cost fluctuations. When the Outline Business Case was presented earlier in the year, there was a limited loss in the short term and a larger gain in the longer term. We have asked our suppliers for the latest costs for gas and electricity, and as it stands, this will cost us more in the short term in this model (around £360k per year), but in the long term with the forecast of charges, there could be around £1m in savings.

(f) Phasing of Funding - There will be an underspend this year and an overspend next year. We are looking at ways to deal with this regarding the accounting from one year to the next, but we are not yet at full resolution around this.

(g) Financial Risk - The operational expenditure risks for this are significant, around £164k a year payable to Centrica, our partners on this scheme. We expect that this will be offset by the costs for our existing infrastructure on this site which is currently in a PFI contract. We are working with our PFI partners to disaggregate those costs but this will obviously take some time. We expect these costs to offset the Centrica costs of operating the new system, but we cannot demonstrate this with any certainty to the Board today that that is the case and therefore there is a risk.

(h) This is a really exciting opportunity for the Trust. This is the second phase of the plan and will take us a long way to delivering net zero carbon for the estate on this site and a greener source or energy.

(i) The CEO was very supportive of this, and it is the right thing to do. He has flagged the issue of the pricing with politicians as well as it should not cost us more to decarbonise the NHS.

(j) Mrs Twigg (NED) advised that pre-Board Meetings are being held with some of the NEDs and the CFO and CSPO to discuss these Business Cases in more detail. She felt for governance purposes, it would be useful to have a summary of the questions and answers in the minutes to record that we have scrutinised the plan and asked the wider questions. The Chairman agreed with this suggestion. **KO/AD**

(k) The CFO was supportive of this initiative and this is clearly the right thing to do but it creates a tension in the organisation to mitigate in 2024/25 in terms of the short term challenge in the event that the energy prices do not change.

<u>Resolved</u> – that:

(A) The Full Business Case for Integrated Energy Solution be received and approved.

(B) A copy of the questions and answers from the pre-Board Meetings on the Business Cases presented to the Board of Directors be included in the Board Minutes for governance purposes. **KO/AD**

ITEMS FOR NOTING AND INFORMATION

BOD14/12.23 **Policy Panel Update**

Resolved – that the Policy Panel Update be received and noted.

BOD15/12.23 **Health, Safety and Wellbeing Report**

The Associate Director of Corporate Governance presented the Health, Safety and Wellbeing Report and the following key points were noted:

(a) This aligns with HSE guidance.

(b) One of the top 5 incidents was unsafe clinical environment. Discussions were held in regard to this at the Board Workshop around updates to the Estates Strategy as these incidents in main relate to adverse or extreme weather events. It would be useful to align the Estates Strategy with the requirements of climate change and the changes going forward.

(c) There have been a large number of construction events on site without any major incident so far. Estates staff and contractors are working together to ensure safe working practices.

(d) We are seeing an increase in violence and aggression incidents. We are reinforcing the need for staff to report all incidents. The Security Meeting is Chaired by the CSPO with a number of measures put in place, eg CCTV now linked to the Police Station and body cams being worn by some staff. We are working with the Police and other partner organisations on how to reduce levels of violence and aggression at this meeting.

(e) Mrs Martin (NED) highlighted the right for staff and members of the public to be safe in the Trust and the Trust will not tolerate people who exploit this.

(f) The Chairman reiterated the Trust's zero tolerance to violence and aggression. No member of the public has the right to be abusive or threatening to any staff. It is wholly unacceptable for any member of staff to suffer any abuse and we will take all steps that we can to hold them to account.

(g) The Managing Director drew a link between these numbers increasing and the long waits patients are experiencing which is causing fear and frustration, although this does not excuse this type of behaviour. If we reduce these pressures, this will also have an impact on violence and aggression.

(h) Ms Quantock (NED) suggested regarding the issues with the climate crisis and mitigations with hydration and air conditioning, we look to other countries to see how they deal with these issues.

Resolved - that the Health, Safety and Wellbeing Report be received and noted.

BOD16/12.23 **CNST 10 Board Progress Update**

The Associate Director of Midwifery (ADM) presented the CNST 10 Board Progress Update, which was taken as read, and the following key points were noted:

(a) This is a challenging set of revised safety actions for year 5 of the scheme. There are 10 actions with sub actions to roll out. We achieved compliance with all 10 actions last year and are working towards achieving the same target for this year.

(b) The paper identified the areas in which we perceive that we are compliant, subject to the LMNS peer review process.

(c) Due to the timings and structure of the Board meetings, the paper is asking Board for delegation of final review and sign off of the standards to Quality committee and ultimately the CNO as the Executive Champion, Mrs Martin (NED) as the NED Champion and Mr James as the Chair of the Quality Committee.

(d) There is only one area of further review and this is Saving Babies Lives. This is almost a separate entity in its own right but is considered within CNST. We have had an interim check with our LMNS colleagues and at this stage they are satisfied with the progress being made. We need to achieve 70% overall with a minimum of 50% in each of the 6 Domains. We are currently at an overall percentage of 56%. For our Diabetes Element we are not achieving 50% yet but we have clear plains and timelines in place. We are expecting to achieve compliance with all elements

Resolved – that the CNST 10 Board Progress Update be received and delegation given to the Quality Committee for the final internal sign off.

BOD17/12.23 **Maternity Quarterly Report**

The ADM presented the Maternity Quarterly Report, which was taken as read, and the following key points were noted:

(a) We are expecting the Maternity Triage area to be handed back in 2 weeks' time. We appreciate the work undertaken to get this back in the timeframe. We know that the other elements that we have been planning with our core teams around this will enable us to see the differences that we were anticipating.

(b) Workforce and Staffing - Throughout December and during January we are not expecting to use any agency or Bank unless there are exceptional circumstances. This is a huge achievement.

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

BOD18/12.23 **CQC Action Plan**

Resolved – that the CQC Action Plan be received and noted.

COMMITTEE SUMMARY REPORTS

BOD19/12.23 **Foundation Group Strategy Committee 17 October 2023**

Resolved - that the Foundation Group Strategy Committee 17 October 2023 be received and noted.

BOD20/12.23 **Integrated Care Executive November 2023**

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

(a) The Chairman advised that discussion has been held with our Primary Care colleagues around the benefits in the future of joint appointments across the system. This is something that we will pursue.

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

BOD21/12.23 **Quality Committee Summary Report 28 September and 26 October 2023**

Mr James (Chair of the Quality Committee and NED) presented the Quality Committee Summary Report 28 September 2023 and 26 October 2023 and the following key points were noted:

(a) There were a suite of Patient Feedback Reports regarding Cancer Patients, ED Patients and Inpatients. It is positive in the Outpatient Report that 50% of indicators have improved and 25% have stayed the same.

Resolved – that the Quality Committee Summary Report 28 September 2023 and 26 October 2023 be received and noted.

COMMITTEE MINUTES

BOD22/12.23 **Foundation Group Board and Action Log 1 November 2023**

Resolved – that the Foundation Group Board minutes and Action Log 1 November 2023 be received and noted.

BOD23/12.23 **Quality Committee 31 August 2023 and 28 September 2023**

Mr James (Chair of the Quality Committee and NED) noted that the Summary Report are detached from the minutes as they do not tie in with the timings of the meeting. In future, the Report and minutes will be linked.

Resolved – that the Quality Committee minutes 31 August 2023 and 28 September 2023 be received and noted.

BOD24/12.23 **Any Other Business**

(a) The Chairman once again thanked Mr Myers (ANED) for his enormous contribution over the last 12 years.

(b) The Chairman also thanked all the staff for all their hard work during the industrial action and their families for all their support.

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

BOD25/12.23 **Questions from Members of the Public**

Q1. International recruitment of nurses and midwives (Workforce Report) - I understand that there is a red list of countries (nations that have their own pressing health challenges, from which it would be unethical to recruit from. I understand that government guidance prohibits recruitment from these counties. However, some NHS Trusts are still accepting recruits from these countries. Has the Wye Valley Trust Board or will the Wye Valley Trust Board give an undertaking not to recruit from red list countries?

A1. The CPO confirmed that we follow the NHS Code of Practice for international recruitment and do not recruit international staff from red list countries and have no intention of doing so in the future.

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

BOD26/12.23 **Date of next meeting**

The next meeting was due to be held on 7 March 2024 at 1.00 pm via MS Teams.

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

AGENDA ITEM	ACTION	LEAD	COMMENT
BOD11/12.23 Finance Report 07.12.23	(B) The Chief Finance Officer will provide confirmation on whether the request for £9.8m for PDC funding is subject to dividends.	KO	Confirmed that yes revenue PDC funding is subject to PDC dividends at 3.5%.
BOD11/12.23 Finance Report 07.12.23	(C) The Chief Finance Officer will review to what extent the request for additional cash for PDC funding is covered by the costings in the capital developments associated with this request.	KO	This request is for revenue PDC which is funding to support the working capital requirements due to being in deficit. In the Trust's plan for 2023/24, the need for £18.6m of revenue PDC funding was highlighted with the PDC dividend implication built into the I&E plan. The cost of PDC dividends relating to capital PDC funding are factored into the relevant business cases (e.g. Elective Surgical Hub, Community Diagnostic Centre).
BOD11/12.23 Finance Report 07.12.23	(D) The Chief Finance Officer will provide the amount of the cash request made in Quarter 4, submitted just prior to the December Board of Directors meeting.	KO	£10.9m was requested for Quarter 4, however the actual amounts drawn each month are subject to the submission of updated cash-flow forecasts to NHSE. The updated cash-flows show an improved position therefore the Trust only expects to draw £8.1m of the £10.9m originally requested.
BOD13/12.23 Full Business Case for Integrated Energy Solution 07.12.23	(B) A copy of the questions and answers from the pre Board Meetings on the Business Cases presented to the Board of Directors be included in the Board Minutes for governance purposes.	KO/AD	The Business Case Discussion Meeting with NEDs is informal and un-minuted. It is proposed that the main themes from these discussions are recorded in the covering paper for business cases so that there is a record of the main discussion topics.
ACTIONS IN PROGRESS			
BOD11/12.23 Finance Report 07.12.23	(E) The Chief Finance Officer will provide the cash plan which underpins the cash borrowing for PDC funding.	KO	Propose that the Associate CFO runs through the cash plan with Mr Lappin.

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Chief Executive Officer Update Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Board of Directors
Lead Executive Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive Officer
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

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

2. Recommendation(s)

For Information

3. Executive Director Opinion[1]

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

4. Please tick box for the Trust's 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. CQC Report - Urgent and Emergency Care

Following an inspection of our Emergency Department, the Care Quality Commission (CQC) has given the department an overall “Requires Improvement” rating due to concerns over patient safety, although it recognised our staff as very caring. The Trust's overall rating remains as 'Requires Improvement.

CQC inspectors made an unannounced three-day visit to the Emergency Department in early December and followed up with a further one-day inspection later that month. The CQC’s report, which is included later in the Board pack, references overcrowding and “difficult” conditions in ED caused by the limited size of the department and patient volumes. As we often discuss at Board meetings, we prioritise off-loading of ambulances due to the risks for patients who are experiencing an emergency. Ambulance hand-over performance is better at the Hospital than the regional average, but this adds to the volume of patients in the department. The inspectors noted that the layout and “significant limitations with space” meant that it was difficult to hold confidential conversations with patients, and despite staff members’ best efforts, patients’ privacy and dignity were sometimes compromised. We were also criticised for a high reliance on agency staff and computer systems which were “not fit for purpose”

More positively, the CQC reported that staff were kind and trying to provide good care to patients, describing them as “discreet and responsive” treating patients in a “respectful and considerate” manner. In turn, patients told the inspectors that staff treated them well with kindness.

The return visit confirmed progress in a number of areas with improved governance, improved child specific training for staff, improvements to the children’s area, and an increase in the number of clinical staff, which included the introduction of a nurse and healthcare assistant to monitor patients in the waiting room 24 hours a day.

Over the past few years, we have seen an increase in the number of patients attending the Department but also increasing acuity. Whilst more space would help with congestion in the department, the bigger issue is poor flow into the Hospital. We still have a high number of patients in the Trust’s acute and community beds who are medically fit for discharge but who can’t be sent home for a variety of reasons. We will continue to strive to put the right solutions into place rather than creating more capacity, at higher cost to hold patients in the wrong setting.

2. March A&E Performance Target

In the 2023/24 Planning Guidance the NHS was asked to deliver improvements in A&E waiting times and ambulance handover delays. One target associated with A&E waits was to deliver at least 76% against the 4 hour waiting times target during March. We have put a number of additional measures into place over March to seek to deliver better against this standard. The changes that we are implementing will help us to test improvements to flow which may be sustainable into 2024/25. We recognise that it would be challenging to deliver this standard at present, as well as the issues reported above the likely overspill of the impact of industrial action at the start of the month will be further exacerbated by the impact of an Easter Bank Holiday weekend at the end of the month.

3. 2024/25 Planning Guidance

As previously reported to Board, publication of the Planning Guidance to support 2024/25 contracts and finance has been delayed. We have seen some draft guidance, but it is currently unclear when this will be finalised. The information received to date at least helps to clarify a number of questions relating to tariff uplifts and funding for Integrated Care Systems. At this stage we do not know what the performance expectations are for next year. These are still being negotiated with the Government in the context of the deterioration of the overall financial position of the NHS which was reported before Christmas. It is anticipated that the final publication will include a requirement for further improvements in elective long waits, the cancer Faster Diagnostic Standard, Ambulance Response times and waiting times in Emergency Departments. Whilst these are likely to be incrementally less ambitious than anticipated a year ago, they will nonetheless still be very challenging with demand continuing to rise and capital and revenue funding restricted.

Whilst all Integrated Care Systems are expected to manage within their financial allocations, clearly many are already struggling to do so. The draft guidance makes it clear that any overspends will need to be repaid although repayments will be capped at a maximum of 0.5% of allocations and will not be repayable until 2 years after the year in which the deficit arose. This new ruling has a material impact on System resources in 2024/25.

Despite the uncertainty, we are using the draft guidance to support budget setting, however the absence of clarity on some performance standards makes the supporting capacity planning work more difficult.

4. 2024/25 Financial Plans

As referenced above, the Trust is in the process of setting budgets and activity pans for next year based on a set of assumptions which have not yet been clarified. However, our initial financial planning submission projects a deterioration in our deficit. As ever, there are complex range of variables involved, some of which require further work or clarification. Over the past few years, we have been working with national finance colleagues to examine the structural nature of an element of our deficit. This has looked at the additional costs associated with delivering healthcare in rural area, including our Herefordshire and Powys catchments. With the support of national finance experts, we previously demonstrated that delivering healthcare in our extremely rural environment adds around £25m to our cost base. There are only a small number of localities nationally which can make such a special case. Time has moved on since the original analysis and hence inflationary pressures may have taken this to nearer to £30m. The first cut of our numbers however currently stands at around £45m deficit. Work is underway to understand this and to reduce it where we can.

Since March 2020, the overall employed headcount of the organisation has risen by around 617 staff. Over the same period, our establishment budget has risen by 545 staff. We do not appear to have seen a reduction in temporary labour costs to match this improvement in vacancies. We plan to increase our establishment further next year including through investments in Elective Hub capacity. It will be important to ensure that any increases in staffing are income backed (such as through Elective Recovery Fund income) or reduce temporary labour costs.

As a consequence of the position we face, we will be looking carefully at all cost pressures and previously approved business cases to ensure that the costs and any associated income are at the levels planned.

5. Further Strike Action by Doctors

As I write this report the BMA have announced that Junior doctors will carry out a further five full days of strike action before the end of February. By the time we meet as a Board, this will have taken place. The strike ran from 7am on Saturday 24 February to 11.59pm on Wednesday 28 February. Although the BMA had also suggested that negotiations could continue if the Secretary of State granted a four-week extension to the current strike mandate, which expired on 29 February.

The BMA are also re-balloting junior doctors on both strike action and action short of striking and urging them to vote yes to both options. The ballot runs until 20 March and, if successful, would give the BMA a mandate until the autumn. Previous ballots have resulted in very strong support for strikes on turnouts of more than 70 per cent. Since March 2023, junior doctors have staged 10 strikes over a total of 34 days.

Consultants also recently rejected the government's pay offer, although this was by a very narrow margin.

It is not for me to comment on the politics of this or on the behaviour on either side of the negotiations, but we desperately need a resolution. Despite the valiant efforts of other clinicians and NHS managers, patients are being harmed by this dispute. Even though we have maintained urgent and emergency services, any treatment delay brigs risk and potential harm. Also, the cancellation and re-booking of patients and the coordination of cover arrangements over each strike day ties up clinical and management time which could be better spent on tackling our more strategic challenges. As you can see from our finance report later in the agenda, the added costs have led to a further deterioration in NHS finances.

6. MORE FROM OUR GREAT TEAMS - Update from the Medical Division

Since our last report the level of pressure has continued to be high and along with continued strike action the challenges for the Division have persisted. As in previous reports the team has responded with energy and creativity to meet the challenges and have continued with plans to improve services alongside the challenges of ensuring flow through the hospital continues.

Urgent and Emergency Care

We continue to have high numbers of patient in our Emergency Department a lot of whom have a high level of acuity. There has been a 22.93% growth in Emergency Department admissions (average 200 attendances per day) which has made the efficiency and safety of the department challenged. This has subsequently been echoed by the Care Quality Commission (CQC) following an unannounced inspection in December 2023.

Despite these difficulties the team as continued with its transformational activity along with planning our response to the CQC inspection. The service has also submitted an Emergency Department medical staffing business case and will submit an Emergency Department nursing business case in due course.

Quality improvement initiatives include:

- the optimisation of Medical SDEC following successful co-location of services with Virtual Ward and ED that have been applauded by NHSE Transformation Team
- plans to maximise Virtual Ward through further engagement at a planned summit
- ongoing schemes to increase streaming and support Urgent & Emergency Care improvement plans to improve 4hr performance, targeted improvement of non-admitted breaches, minors and paediatric performance. Performance improvement, progress and positive impact is sought throughout March.

Ambulatory and Frailty

Since November Stroke services have had access to new brain imaging analysis software, Rapid AI, which will improve the speed and accuracy of clinical decision making for thrombectomy and thrombolysis interventions. We are working closely with Worcester Acute Hospital Trust to improve our out of hours arrangements. Having successfully appointed to our first Stroke ACP we are looking at ways to expand and develop an ACP workforce to improve resilience and future proof Stroke services.

Frailty Same Day Emergency Care (FSDEC) services are continuing to provide high quality of care to frail patients. There are a number of 2024 initiatives underway to maximise the productivity if FSDEC, to include an awaited BI dashboard co-designed between key clinicians, the management team and information analysts. Geriatrician recruitment continues to be a considerable success story, with our 6th Consultant position currently advertised.

There is now an established secondary care led Diabetes MDT running in all Herefordshire Primary Care Networks (PCNs). With the help of the Diabetes Practice Nurse Lead, we are continuing to achieve system-wide improvements to T2DM care, promoting right skills, right time and right place. The next planned step is to extend the success of this initiative's approach, so that supporting vulnerable, frail and complex patients with diabetes spreads even wider across the community, developing Tier 3 of the DiAST model.

Plans for Wye Valley to assume Lead Provider for Dermatology services across Herefordshire and Worcestershire are well underway. A Programme Board with representation from both Trusts has been established, with delivery groups meeting regularly to ensure all necessary requirements are in place by 1st April 2024. This year has seen significant increases in demand and concerning challenges to capacity for Skin Services at WVT, with the 62-day pathway struggling to cope with the impact of our mutual aid agreement with Malvern GP Practices. However, with substantial changes successfully implemented in January we saw the delivery of our first ‘spot’ clinics for urgent suspected Cancer patients. Coupled with a ‘super surgery’ week this has been the start of see-and-treat opportunities. The clinical team have managed to maintain 28-day FDS throughout the year, an impressive achievement.

Speciality Medicine

Our Cardiology team have been working hard to reduce their waiting list. We have had a GP working with the team to review our long waiting patients so that we can target the most clinically urgent patients and the Medical team are putting on extra clinics to see these patients. We are also working with our radiology team to reduce the waits for our cardiac catheter patients.

Our respiratory team have also been working hard to ensure that patients are not waiting for appointments or tests. We have also been successful in recruiting a GP with specialist interest and a cancer navigator to help support the team to optimise the lung cancer pathway.

Glen Burley
Chief Executive Officer

Integrated Performance Report

February 2024

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

The start of the calendar year has been particularly challenging with the expected 'winter pressure' bearing down on our clinical and operational teams, with industrial action and infection control outbreaks exacerbating the position.

The pressure on our bedded capacity and on the Emergency Department has been significant throughout the Winter and has resulted in an Emergency Department that is often congested and a hospital that has limited patient 'flow' and a reliance on utilising 'boarding spaces'.

The CQC conducted an unannounced Core Service Inspection in our Emergency Department in December 2023 and subsequently reported a number of safety concerns including the following:

- A congested emergency department
- Delays in the delivery of time critical medicines
- Long waits to be seen and waiting for a hospital bed

Limited oversight of patients in waiting areas

The CQC have rated the department rated 'inadequate' for safety and 'requires improvement' overall. This is downgraded from the previous rating of 'good'.

It is important to note that the CQC did rate the department 'good' for the caring domain.

Some remedial work has already been undertaken and an action plan has been developed to tackle the remaining issues, more detail regarding this is covered later in these papers.

The executive team led a workshop with clinical and operational leaders at the beginning of February to try to better understand the drivers of the current 'bed-pressures' experienced across the Trust's inpatient areas. Whilst more work is required to gain a fuller understanding of these issues it is clear that a significant rise in the numbers of patients waiting for a supported discharge, an overall rise in the length of stay for patients that are admitted overnight and a small increase in the numbers of patients admitted, all contribute to an increased pressure on inpatient capacity of circa 60 beds.

The workshop then looked at what actions we can take in the short, medium, and long term to address some of these issues and further details of that discussion and conclusions are covered later in these papers.

Our delivery of elective activity is positive despite the challenges we face. We have seen strong performance against 2019/20 activity levels achieving 118% of value weighted activity. We have also been able to ensure that all patients waiting over 52 weeks for their first outpatient appointment have an appointment booked before the end of March 24

Our financial position at the end of January was £3m more over-spent than we had originally planned. As a result of the industrial action, we have formally revised our year-end target to an overspend of £26.9m. Achieving this revised position from our current position remains a significant challenge. The Herefordshire and Worcestershire plan is also adverse to plan.

Work continues to develop and enhance our organisational culture with Civility and Respect training already in place and plans for this year for an 'active bystander awareness' training programme. We have seen material improvements in staff turnover rates and a significant reduction in our vacancies falling from 400 to 140 full time posts vacant and early Staff Survey (2022/23) results show positive progress and are encouraging – more detail will be shared with Board in April.

Our Quality & Safety – Executive Narrative

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

CQC Inspection– Emergency Department

The CQC undertook an unannounced inspection of the Emergency Department in December 2023. The service rating stayed the same at 'Requires Improvement' with good care and examples of learning noted.

The service are committed to continuing to make improvements to the department and have developed an action plan in response to the recommendations in the final report. This is being presented to Board.

Patient Led Assessment of the Care Environment - PLACE

The PLACE inspection results for WVT as a whole have recently been published by NHS digital and a summary of the overall scores compared to the national average are provided in the table below. The full results are currently being reviewed and will be presented to the Quality Committee at the April meeting

Domain	National average score 2023	WVT overall score 2023
Cleanliness	98.1	98.39 ↑
Condition, Appearance & maintenance	95.91	97.08 ↑
Dementia	82.54	75.25 ↓
Disability	84.25	77.43 ↓
Combined Food	90.86	90.52 ↓
Privacy, Dignity & wellbe-ing	87.49	80.98 ↓

Deteriorating Patient Committee

The renewed Deteriorating Patient Committee has reconvened and recently reviewed its terms of reference and membership. The Committee is currently focussing on a number of key areas for improvement including:

- Development of a live dashboard
- Review and refresh of hospital at night
- Expansion of critical care outreach 24/7
- Review of HDU capacity and / or the introduction of a high care area
- Implementation plan for Martha's rule

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

SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Sep-23**	102.8	*0.7*
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Oct-23**	100.6	*-2.1*
SHMI (in hospital)			96.0	*-2.2*
SHMI (out-of-hospital SHMI)			111.4	*-1.94*

What the chart tells us:

- Latest nationally reported **SHMI** (*NHS Digital*) from October2022 to September 2023 shows Wye Valley NHS Trust at **102.8**, which a reduction of 0.7 since last reporting period. The HES-based SHMI, which does offer an advanced forward view, indicates an even more positive position of **100.6** for the 12 month rolling period up to October 2023.
- **Crude mortality** rate for January 2024 was **1.82%** for all admissions, which includes both planned and unplanned admissions to the Trust.
- This month is **lowest perinatal mortality rates ever reported at WVT**. The latest rolling 12 month data period (*February 2023 to January 2024*) shows both the 'Extended Perinatal' and 'Stillbirth' rates significantly fell to **1.81 deaths per 1000 live births**. There were **0** neonatal or perinatal deaths reported for January 2024. This latest reduction has been part of a longer term downward trend, and having already attained the target set out in the National Ambition, the Trust looks set to maintain this.
- This month has seen several of our outlier groups reporting small rises, though COPD and #NOF have reported more significant rises to 121.6 and 122.9 respectively. On a more positive note, our sepsis mortality rates has reported a 3.90 reduction to 104.6, continuing a return nearer the expected levels.
- A further improvement in our '**Depth of Coding**' for both live and deceased patients, which continues to improve nearer the peer and national mean. Our '**Co-morbidity**' scoring continues to out perform against our peer and national mean.

Key Actions:

- Continued progress has been made with the roll out of the **Medical Examiner**, including the development of a short clear information pack, which outlines the key changes to our colleagues in the community. The team are currently setting up meetings in the community to promote these forthcoming changes and inviting GP's to start working with the service before the official go-live. In addition, the team are also working on the development of an EMIS template to support GP's when referring, which will be able to act as both a referral for the ME and Coroner service. There has been significant development of the In-Phase functionality to support the new workflows and managing the increasing incoming information.
- As part of the plans to re-establish a **Learning from Deaths** committee, we are currently identifying the clinical mortality leads for all the various key areas across all Trust Divisions. A session is planned for next month with the leads, which will provide an introduction to the role and include mortality review training. Our aim is to provide an equal foundation for all leads with a clear set of expectations to support the ongoing programme. The first Learning from Deaths committee will be held in April 2024.

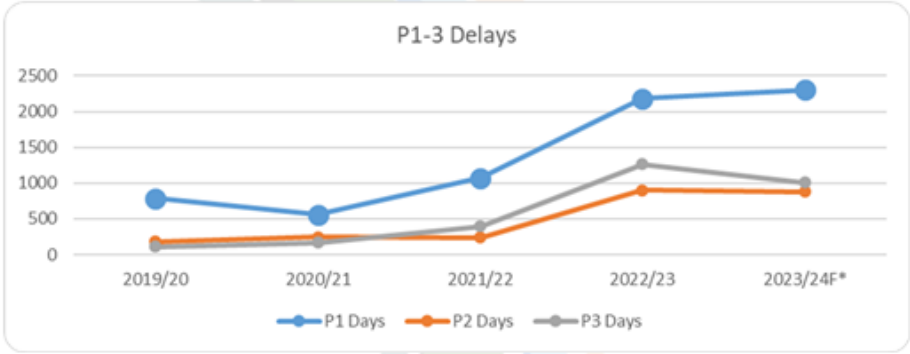
Quality and Safety – Boarding

We are driving this measure because:

The Trust introduced a Boarding SOP in October 2022 in response to the sustained pressure for beds and increased activity at the front door (ED). The aim was to reduce the increasing risk in the ED and balance/ spread the risk to patient safety by utilising a measured approach to boarding patients in areas a bed would not otherwise be located. Boarding continues to be an active process and requires oversight to assess the impact on the quality and safety of patient care

Data

	Boarders			ED	Outliers				
Date	Total	Boarders	Escalations	Admissions	Total	Medical	Surgical	MFFD	Discharge Lounge
01/01/2024	38	23	15	49	35	24	10	57	8
02/01/2024	47	29	18	55	40	24	14	53	17
03/01/2024	47	30	17	53	24	14	10	59	14
04/01/2024	43	25	18	65	28	14	13	73	16
05/01/2024	39	21	18	72	26	22	4	81	16
06/01/2024	29	17	12	56	18	12	6	71	10
07/01/2024	32	19	13	58	18	13	5	75	7
08/01/2024	39	22	17	62	22	17	5	65	15
09/01/2024	39	22	17	64	20	15	4	81	14
10/01/2024	40	25	15	52	26	19	5	75	18
11/01/2024	29	17	12	65	30	23	6	57	12
12/01/2024	34	22	12	59	32	27	5	50	13
13/01/2024	30	20	10	51	25	21	4	73	5
14/01/2024	32	21	11	46	31	21	10	54	9
15/01/2024	38	21	17	45	29	23	5	52	10
16/01/2024	38	23	15	62	24	14	10	86	17
17/01/2024	36	25	11	65	22	14	8	86	13
18/01/2024	39	26	13	60	31	24	7	76	15
19/01/2024	37	25	12	65	24	22	2	68	14
20/01/2024	35	27	8	49	19	16	3	70	4
21/01/2024	36	26	10	50	21	17	4	66	9
22/01/2024	43	26	17	56	36	20	16	66	18
23/01/2024	44	27	17	64	37	21	16	82	15
24/01/2024	42	25	17	57	36	21	15	88	12
25/01/2024	33	21	12	50	34	11	23	89	11
26/01/2024	34	19	15	52	38	29	7	77	13
27/01/2024	30	18	12	45	33	31	1	72	1
28/01/2024	33	17	16	47	32	29	2	45	4
29/01/2024	38	20	18	70	48	37	10	92	12
30/01/2024	39	26	13	54	35	32	2	64	14
31/01/2024	38	26	12	52	29	24	5	67	13



What the chart tells us:

- The left hand chart shows the number of boarders, escalation beds, admissions, patients who are medically fit for discharge and the utilisation of discharge lounge for the month of January. The colours denote an improved (green) or deteriorating position (red) when compared to the preceding month.
- The extent of boarding has increased and higher most days when compared to January. Boarding overnight has become the norm rather than in extremis and patients can board for a prolonged period of time. The number of boarders peaked on 3/1/24 at 30 (the maximum number the trust can accommodate is 34)
- The use of the Discharge Lounge continues to improve, but improvement largely between 11-15.00 hrs and Mon-Fri. Use of DL over past 4 weeks has been better but still variable . There is now a 'live' discharge lounge dashboard to make this more visible. 75% of patients using the DL are Medical patients.
- The second chart above shows the increasing number of delayed discharges per year. These rising numbers are driving the congestion and pressures seen in the ED and wider bed base.
- Through 2023/24 to date, on average 92 patients are in Acute beds on the last day of each month that do not meet criteria to reside.

Key Actions:

- Continue to optimise discharge lounge occupancy every day against new criteria and additional spaces, and aim to utilise the lounge earlier in the day
- Re-emphasise the appropriate clinical selection of patients to Board and encourage teams to report incidents where criteria for boarding is being breached
- Refocus reverse boarding as the priority when patients not suitable for discharge lounge
- Monitor the impact of new ward-based Flow & Discharge Co-ordinator role
- Ensure boarding/patient selection and use of discharge lounge is part of ward huddles
- Focus on the work streams identified from Acute Hospital Capacity Workshop held on 5.2.24

Quality and Safety – Mixed Sex Accommodation Breaches

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

Data

Quality of care, access and outcomes	Responsible Director	Standard	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Mixed Sex Accommodation Breaches	Chief Nursing Officer	0	75	109	52	81	49	28	24

	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Total admissions	2270	2187	2215	2326	2435	2339	2306
Patients affected by an MSB	45 (1.98%)	68 (3.1%)	39 (1.76%)	37 (1.59 %)	35 (1.43 %)	20 (0.85 %)	16 (0.69%)
Occasions	17	39	14	23	13	8	7
Areas	AMU Frome Day Case Wye	AMU ITU Primrose Redbrook Wye	AMU Frome Wye	AMU Wye	AMU Wye	AMU Wye	Ross Wye

Top 3 Breach rate (Midlands region)

Oct	Rate	Nov	Rate	Dec	Rate
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	44.5	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	28.5	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	17.5
WYE VALLEY NHS TRUST	12.1	WYE VALLEY NHS TRUST	6.5	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	5.2
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	5.9	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	5.1	WYE VALLEY NHS TRUST	4.4

Findings and Actions:

The number of individual breaches reported in line with national policy is shown in the first table and reported in the Board KPI pack.

The second table breaks this down to total number of patients affected (some patients may have more than one breach reported due to reporting metrics) and the number of occasions a breach occurred. As can be seen the number of occasions a decision is taken to allow a breach can lead to a large volume of breaches and a number of patients who are affected multiple times due to the counting rules.

In the context of total admissions month on month this is a small percentage of patients which has reduced month on month since August, despite operational pressures.

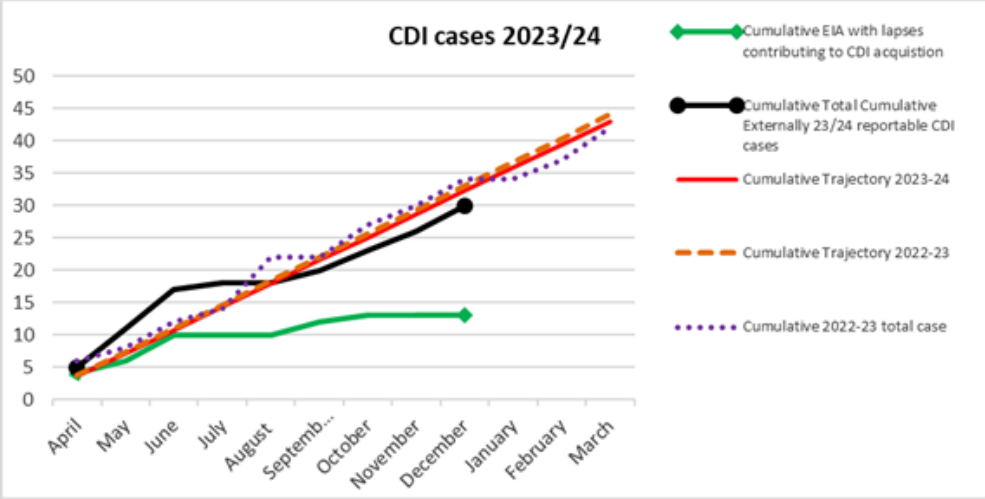
The areas affected by breaches remain consistent and predominantly seen in AMU and Wye ward. The reasons for this are known and impacted by patient flow. A previous deep dive into Wye ward breaches identified that the ward had been placing patients outside of Trust process. Assurances were made that this was resolved so further work is required to identify new potential areas for improvement. A similar exercise is recommended in AMU.

The national team report the rate of breaches per 1000 finished consultant episodes (from the previous year sourced from HES). The Trust is flagging as a outlier regionally. In Q3 the Trust were in the top three highest breach rates for the region (Midlands), however this is reducing. We would anticipate this will continue to reduce in Q4 based on January confirmed figures and indicative numbers for February.

Quality and Safety – Infection Prevention and Control

The Trust seeks to reduce clostridioide difficile infection rates driven through improved compliance with the national cleanliness standards.

Data



Q3 2023	Audits completed	5 star	4 star	3 star	2 star	1 star
FR1	87	47 (54%)	25 (29%)	12 (14%)	3 (2%)	0
FR2	129	74 (57%)	27 (21%)	17 (13%)	8 (6.5%)	3 (2.5%)
FR3	15	12 (80%)	1 (6%)	1 (6%)	0	1 (6%)
FR4	59	50 (85%)	3 (5%)	5 (8.5%)	0	1 (1.5%)
FR5	13	12 (92%)	1 (8%)	0	0	0
FR6	21	20 (95%)	1 (5%)	0	0	0
TOTAL	**324**	**215 (66%)**	**58 (18%)**	**35 (11%)**	**11 (3.5%)**	**5 (1.5%)**

Findings and Actions:

In Q3 the Trust reported 10 clostridioide difficile (CDI) cases. This brings the total year to date of 30 cases. This is below the quarter end threshold of 32 cases against a full year trajectory of 43. To support the aim to reduce cases the Trust has;

- Sought support from the ICS with data analysis, peer review and the development of the overarching CDI reduction strategy.
- Participated in the NHSE West Midlands collaborative working group
- Implemented Antimicrobial stewardship, commode cleanliness training and the #StoolSmart campaign

As part of the implementation of a joint Cleanliness strategy with Sodexo, the Trust has moved to a new software tool for the recording of cleanliness audits (Ambinet). The quarter three results showed a significant decline in scores particularly for clinical and estates scoring and the results were presented to Quality Committee in February. To better understand the results, monitoring was undertaken using both systems and this highlighted the following;

- The old software system (FORMIC) had to be set up manually to meet the national audit requirements, whereas the new system is configured automatically.
- It is possible FORMIC had provided inaccurate scores due to clinical cleaning having fewer responsibility criteria creating a smaller denominator
- Star ratings were not affected and the number of areas achieving 4 stars and above continues to improve
- Q4 will be the first full quarter using the new system (Ambinet) which will provide further assurance
- The results for January and February are showing improved scores
- The breakdown of areas of concern (identified in the audit) is being reviewed so that we can target remedial actions accordingly by prioritising those that present the greatest risk

Our Performance – Executive Narrative

Andy Parker
Chief Operating Officer

December and January, as predicted, were challenging months for all our operational and clinical teams, which are reflective in some of our overarching Key Performance Indicators across the periods.

Industrial Action by the British Medical Association Junior Doctors continued pre and post the Christmas / New Year period adding significant pressure to our Urgent and Emergency Care [UEC] and Elective pathways on top of the usual winter pressures. Significant amounts of planning and oversight went into ensuring all risks and issues were mitigated.

The continued balance to maintain our UEC patient flow, decongest our Emergency Department [ED], ensure rapid handover from Ambulance crews arriving at our ED, maintain high level of elective activity, whilst maintaining cancer pathways, protecting our long waiting patients and delivering increased diagnostics throughput is as challenging as ever.

Over December, and the beginning of January, we delivered over 118% of Value Weighted Activity [VWA] comparison against 2019/20 based on, not just activity number, but complexity and treatment. Regionally the average is c107% and we remain the one the top three Trusts each week across the Region. We also delivered our own internal elective activity plans across both December and January.

We have also maintained a reduction in the number of patients waiting greater than 6 weeks for a diagnostic test to 22% [just above the 15% requirement] delivered improved Cancer 28 day Fast Diagnosis Standard [FDS], reducing our patients waiting over 65 weeks for elective treatment and ensuring all patients who have waited 52 weeks on an elective pathway have had their first outpatient appointment by the end of March 2024.

Since October 2022 we have been utilising our Enabling Flow Standard Operating Procedure to support flow, to decongest our ED, by reverse boarding an appropriate patient for discharge or transfer to release a bed space for a new patient in additional unconventional care bed spaces. This has led to continued overreliance on these additional bed spaces for the last sixteen months along with continue use of escalation beds across our acute and community hospital sites. A position which we cannot maintain or normalise.

In order to address these issues a cross section of staff [medical, nursing , support , management and Executives] met in February to review the current position in an Emergency Activity Workshop. Not just to understand the issues that were driving our current position but agreeing the main priorities to address and improve our position.

The main high level Priorities that were agreed, that will be monitoring via our Valuing Patients Time Board, are:

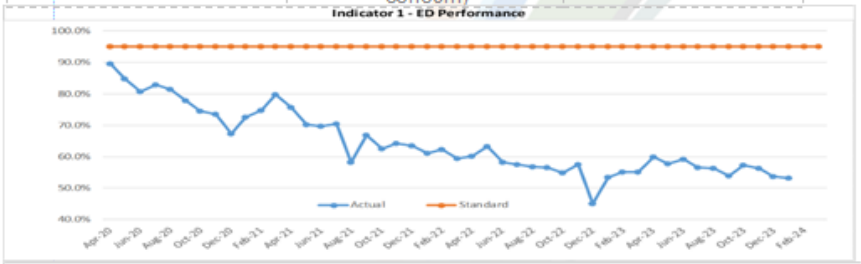
- Remodel our Virtual Ward approach and maximise utilisation across the major inpatient specialties.
- Relaunch Community Integrated Response Hub and promote use of its resource/capability
- Work to improve ED access and streaming to primary care service
- Develop a solution for GP access to urgent specialty advice
- Maximise / Increase use of Same Day Emergency Care [SDEC] solutions and an agreed way to access specialty support
- Provide timely access to diagnostic support
- Strengthen 7-day working across clinical and support services
- Utilise Day Surgery Unit capacity once the Elective Surgical Hub is operational to create additional inpatient capacity
- Undertake full demand and capacity review to determine what additional bedded capacity is required
- Continue to work with system partners and the Discharge to Access [D2A] Board to maximise flow and reduce delayed discharges

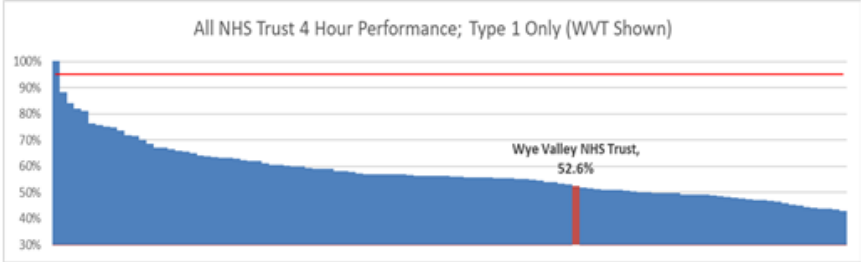
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

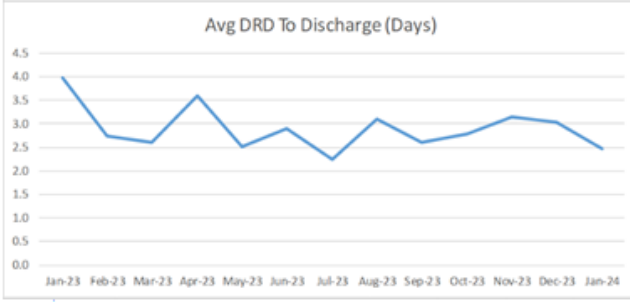
We are driving this measure because:

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	Avg DRD To Discharge
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	3.1
Sep-23	2.6
Oct-23	2.8
Nov-23	3.2
Dec-23	3.0
Jan-24	2.5

Performance and Actions

- 5,843 patients attended ED in January. The range of attendances varied from 160 to 246 with 189 being the average daily attendances
- 1,784 ambulances conveyed to the Trust in month. The range in month was 46 to 74. This includes 11.4% from Powys [203]
- Ambulance handover delays over 1hr were 20% [317] of all conveyances and 65% [1,014] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,015 of all admissions [43% of all admissions] via a Same Day pathway within no overnight admissions.

Actions to Address:

Current plans for Test of Change in March with oversight via Valuing Patients Time Programme Board [VPTB]:

- Increase use of Virtual Ward and focus on increased use of Outpatient Parenteral Antibiotic Therapy (OPAT) Service
- Implement senior streaming at ED reception Streaming involve staking a brief history and performing basic observations if appropriate. This information may also be used to streaming a patient to the most appropriate pathway early and their support triage prioritisation.
- Increase the capacity within our minors area, both workforce and physical capacity
- Increase Medical SDEC capacity by undertaking some clinical task outside of the acute floor footprint
- Increase the cohort of patient eligible for Surgical SDEC
- Increase the capacity with Primary Care to receive an increased number of patients booked into in hours and out of hours clinics.

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:

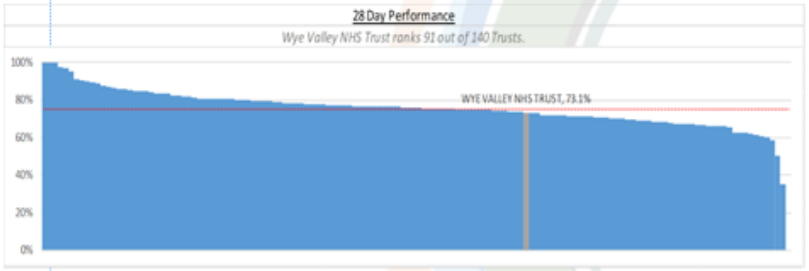
Performance consistently above 80% early in the period but as volume of attendances started to increase with relaxation of national COVID rules and IPC challenges performance started to suffer. Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances.
January Type 1 4hour Performance was 53.2%

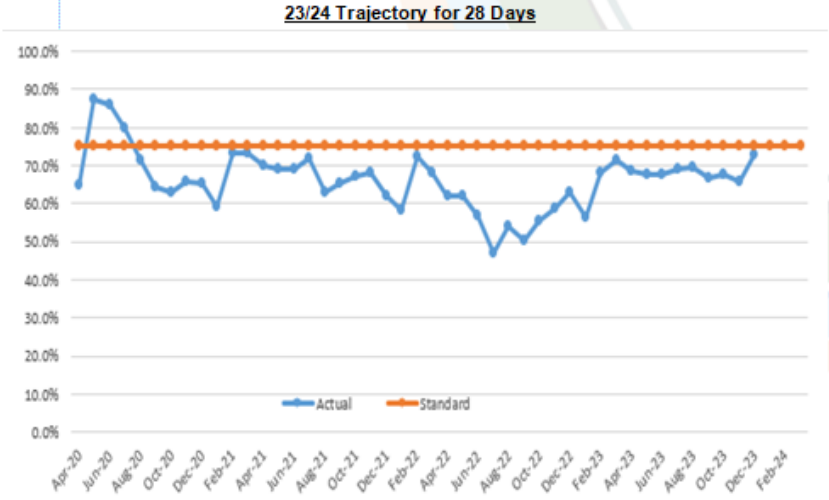
Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [December 23]

We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 75% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer and 85% start first treatment within 62 days.

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





Performance and Actions

Referrals

- Cancer referrals remain high with a 48% increase compared with 3 years ago, an additional 33814 patients, also 11% above our planning assumptions for 2023/24.
- Skin referrals are high, an increase of 43% compared to three years ago (709 additional referrals) and 35% above our planning assumptions for this year (additional 607 referrals). We are continuing to accept Malvern cancer referrals where we see an average of 8 per week.
- Colorectal referrals have remain high at a 70% increase compared to three years ago (959 additional referrals). The faecal immunochemical test pathway was delayed and went live February 2024 due to technical issues in primary care, we will monitor the decrease in cancer referrals over the next few months.

28 day performance

- The trusts position for 28 day performance in December 69% and anticipated to be 72% in January.

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. Internal work is being undertaken to generate a dashboard for visibility of turnaround times to highlight any bottlenecks in the pathway to improve. Work is still being undertaken in relation to digital and how the region/other Histopathologists' will support.
- Trust has set a directive that all cancer first outpatient appointments are booked within 7 days of receiving referral and monitored weekly at the cancer patient tracking list meeting. Shortfalls are shared regular with specialties to organise additional clinics.
- Magnetic resonance imaging [MRI] scans are currently being booked at 14 days for cancer compared to the target of 7 days. A second mobile MRI scanner is due on site 26th February.
- Radiology scan to reporting times have improved as they continue to use telemedicine clinic for cancer reporting, all scans are being reported within a maximum of 3 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:

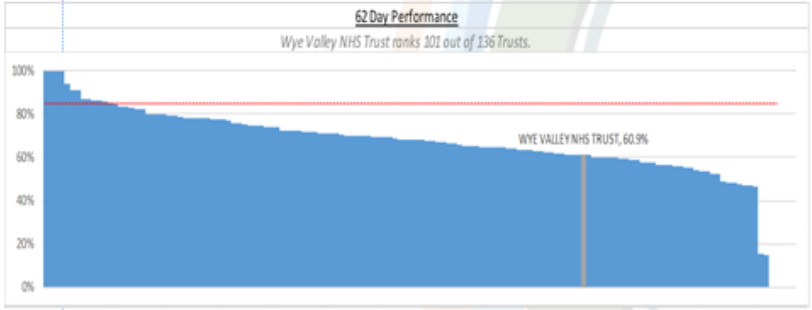
- 28 Day faster diagnosis = Performance against this target was 69% and remained below the target of 75% and below our trajectory for the month.

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

We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two 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 December was 61% with 21 patient breaches, The pressures have been the same related to the Faster Diagnosis Standard [FDS] performance with bottlenecks earlier on in the pathway.
- For both December and January our over 63 day position increased to 117 for both months due to the challenges in the FDS and 62 days.
- Endoscopy booking times continued to improved, lower endoscopy's are being booked at 9 days and upper endoscopy's are being booked at 8 days, the aim for the department is 7 days.
- There have been pre op challenges due to shortages in staff where specialties have been waiting up to 10 days for an appointment, from March there will be a daily drop in service for cancer patients.

Key Actions:

- Non specific symptom pathway provisional go live date 1st May 2024—delayed due to local and external governance sign off needed.
- All specialties to continue booking first outpatient within 7 days and reporting shortfalls for plans if unable.
- Upper gastrointestinal [GI] are implementing telephone triage clinics to encourage more patients to go to straight to test.
- Our electronic patient system to be updated with cancer performance targets, to support with booking in breach order.
- Further specialty meetings arranged in February to review a 100 patient deep dive to generate new actions to improve actions across all sites, with diagnostics in attendance
- Collating a signed agreement from each team of cross cover in times of leave so cancer results are reviewed and actioned within 5 working days

Risks:

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

What the charts tells us:

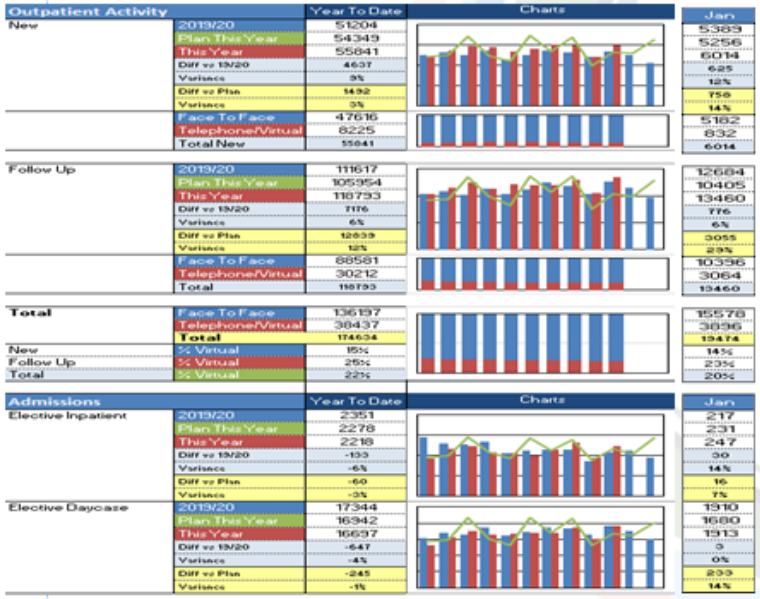
- 62 day Treatment standard = The Trust performance was 58% against a target of 85%.
- Number of patients waiting over 63 days did increase to 117 patients at the end of December compared with 126 at the end of November.

Operational Performance – Referral to Treatment Performance / Activity / Productivity

We are driving this measure because:

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

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



Performance and Actions

Activity Summary:

- New Outpatients [OP] activity was 14% above plan in January. Elective inpatient was 14% above plan in December. Elective Day Cases was on plan for December.

We are confident that we will have only 3 patients breaching 78 weeks at the end of March 2023.

These patients all require cornea transplant tissue. This have been escalated to NHS England's Regional team as part of the Integrated Care Systems [ICS] weekly assurance calls to support sourcing tissue so we can treat these patients in March.

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

- Orthopaedic inpatient surgery

Additional lists agreed in March to reduce numbers of 65 week breaches. We continue to discuss Mutual Aid across the Foundation Group and via the Digital Mutual Aid System [DMAS].

- Cardiology follow ups appointments

Super weekend clinics are planned in March to reduce this number along with "desktop" validation that have provided successful across other specialities as part of the Getting it Rights First Time [GIRFT] schemes.

- Ophthalmology inpatients

Additional lists across March along with utilisation independent sector capacity across the ICS.

It is estimated that we will have c50 breaching 65 weeks by the end of March 2023 but we are confident we can clear all 65 weeks by May 2024.

<u>Theatre Productivity</u>

- Impact of challenges with Intensive Care Unit [ICU] escalating into Theatre Recovery from the 4th to the 17th January impacting on list population and Theatre throughput. A third of all cancellations in January were due to capacity constraints. The fall in mean patients per session and overall utilisation was as a result of postponing only the cases that the Division were unable to bed, rather than cancelling full lists of patients.

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:

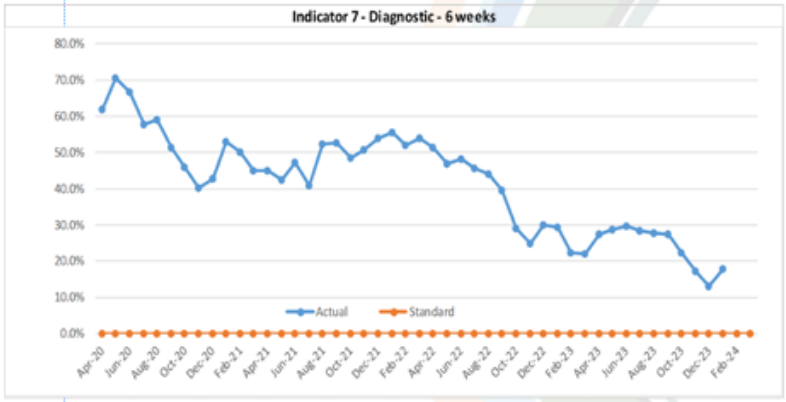
- Performance against English RTT standards in January was 57.2% - 0.7% decrease since last month. Performance against the Welsh RTT standards in October was 66.8% - 1.3 % increase since last month
- Referral to Treatment Number of Patients over 104 weeks = 1 English over 78 weeks = 5 English and 4 Welsh patients on Incomplete Pathways Waiting List

Operational Performance – Diagnostic Performance

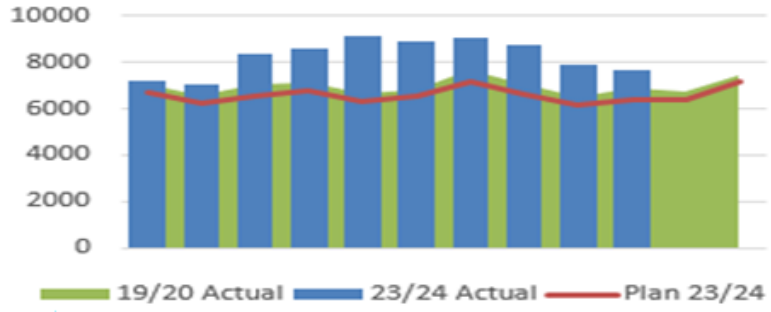
We are driving this measure because:

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



Total Activity [all Modalities]



Performance and Actions

Imaging in Month 10:

- Magnetic Resonance Imaging [MRI] achieved 104% of 2019/20, 114% of 2023/24 plan activity last month.
- Computerized Tomography [CT] achieved 127% of 2019/20 and 125% of 2023/24 plan activity last month
- Non-Obstetric Ultrasound [NOUS] achieved 95% of 2019/20 and 110% of 2023/24 plan activity last month.
- Bone Density Scans [DEXA] scanning and report distribution is currently paused due technical concerns raised by the rheumatology team, the is under urgent investigation with the supplier and MES, with Exec-led management team meeting weekly.
- Maximum appointment wait times for MRI prostate and CT Colonoscopy [CTC] on average were 7 and 14 days respectively compared with 3 and 7 days last month.
- Reporting turnaround times for MRI prostate and CTC were 1 and 2 days respectively compared with 2 and 5 days last month, while all cancer 2 week wait urgency reporting turnaround for MRI and CT achieving less than 3 day averages respectively in month 10.

Audiology:

- Audiology 6 week wait position in month 9 was 56.3%, compared to a month 8 position of 46.8%.
- Audiology 13 week waiters improved in month 9, now 55 patients reduced from 134 in month 6 driven by paediatric patients. There is a trajectory of recovery of the 13 week wait position by year end.

Echocardiography [Echos]:

- Delivered 115% above 2022/23 planning levels in January. We are aiming to get the 6 week backlog to less than 5% in April/May and reduce the need for insourcing support for 24/25.

Endoscopy

- Despite delivering more activity in December than 19/20, overall Endoscopy was behind plan for January.
- Overall cancer references are being seen in 10 days but this needs to reduce to 7 days if we are to improve and maintain our Cancer 28 FDS.
- Additional Endoscopist has been appointed to backfill sessions along with improved ring fenced slots for suspected cancer.

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 over last 4 months . End of January 17.9% now waiting greater than 6 weeks.

Our Workforce – Executive Narrative

Geoffrey Etule
Chief People Officer

Summary of key points

Industrial action by junior doctors continues to present significant operational challenges and we remain hopeful that a solution can be found to end the strikes very soon. Consultants voted narrowly to reject the new pay offer and discussions are ongoing to seek a solution. No further dates for strike action have been announced. The BMA are balloting junior doctors and seeking another mandate to take industrial action between April and September 2024 in the event of not reaching an agreement with the government.

With severe operational challenges and winter ailments we have seen an increase in sickness absence NHS wide over the past 3 months. HR teams supported by OH, the staff physiotherapist and staff mental health & wellbeing nurse continue to sensitively support the management of sickness absence and the close monitoring and management of sickness absence remains a key priority area for the HR team. Our enhanced wellbeing provisions for staff are still in place and the monitoring of absence continues through F&PE meetings.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 10.1% in the past 4 years. Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 8.66% (Jan 24). Staff turnover for band 2 hcsw staff now stands at 13.34% (Jan 24) 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 140 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. 3 volunteers have been recruited by the HR department on a pilot scheme to assess the benefits of using volunteers in non clinical areas.

We promoted LGBTQ+ month to show our support and ongoing commitment to equality, diversity & inclusion. We also supported the NHS Race Equality Week at the Trust working with Group EDI leads.

Following publication of the *Too Hot To Handle* report on racism in the NHS, we are working with our trade union reps and Freedom to Speak Up Guardian to implement the key recommendations of the report.

Working with the Freedom to Speak Up Guardian, we are delivering Civility & Respect training sessions and we will be rolling out active bystander awareness training to members of staff in 2024/25 to enhance the working environment and culture at the Trust.

16 healthcare support workers will be commencing the trainee nursing associate programme through the University of Worcester programme in March so they can become qualified nurses in future.

Initial results received for the Trust on the NHS Staff Survey (2022/23) indicates that we continue to make good progress and have seen significantly higher results in 6 out of 9 elements of the NHS People Promise for staff. The full Survey will be presented to the Board in April.

Building on the *Connecting Staff with Nature* programme with the University of Derby, we have developed a comprehensive Health & Wellbeing Strategy for staff and this will be presented at the next Board meeting following ratification by TMB in March.

Our recruitment work with DWP Officers in helping to find employment for local people has been recognised as an example of best practice and will feature as a national case study over the next few months.

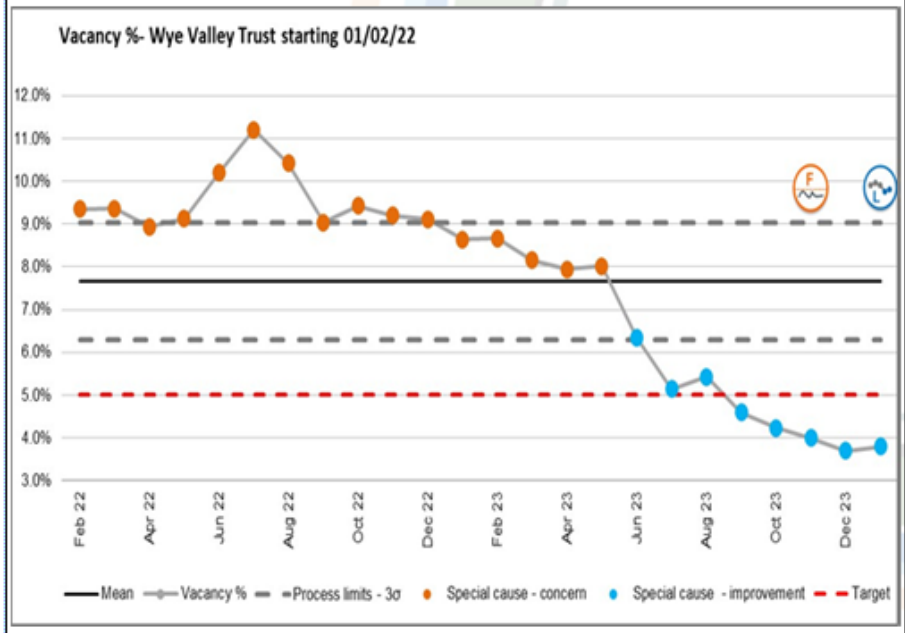
Our Workforce – Vacancy

We are driving this measure because:

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
8.6%	8.7%	8.7%	7.9%	8.0%	6.3%	5.1%	5.4%	4.6%	4.2%	4.0%	3.7%	3.8%

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 140 fte (Jan 24).

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 year.

N&M - since April, 95 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 402 individuals 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. 2 ODPs, 15 theatre nurses for scrub/recovery and 3 ophthalmology nurses have been recruited.

M&D - Fortnightly meetings with chief medical officer, medical staffing manager & strategic medical HR Lead to review progress with vacancies and cases of concern. 2 consultant anaesthetist and 2 consultants in emergency medicine were appointed in January. 1 consultant in T&O was appointed in February. Overseas recruitment of medics to continue in 2024/25. We currently have 40.3wte vacancies.

Pharmacy - with ongoing recruitment challenges we are now seeking to recruit 4 clinical international pharmacists 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 staff is well under way and 10 radiographers are due to start in March.

Working with the ICS recruitment leads we are extending our recruitment events in 2024 and we will be promoting our vacancies Herefordshire wide with a series of events using 41 WVT Ambassadors. We are also extending WVT presence at regional

Risks: Clinical vacancies

What the chart tells us:

Significant improvements in filling vacancies at the Trust over the past year.

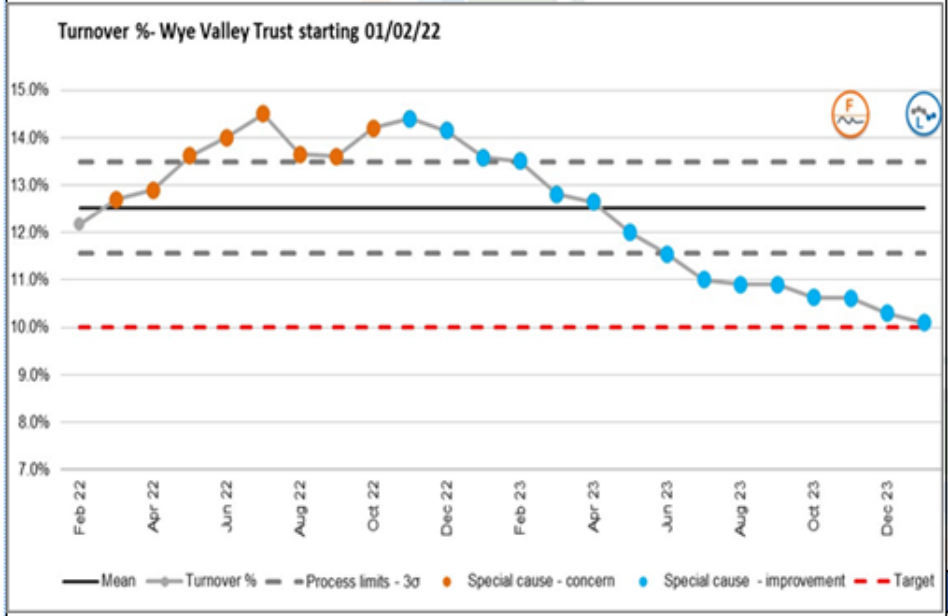
Our Workforce – Turnover

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.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
13.6%	13.5%	12.8%	12.6%	12.0%	11.5%	11.0%	10.9%	10.9%	10.6%	10.6%	10.3%	10.1%

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 overall rolling 12 month turnover at Trust level is now at 10.1% for January 2024.

Staff turnover continues to improve and we now have the lowest turnover rate at WVT from a high of over 15% to 10.1 % in the past 4 years.

Turnover for qualified nurses & midwives has reduced from 15.24% (Nov 22) to 8.66% (Jan 24). Staff turnover for band 2 hcsw staff now stands at 13.34% (Jan 24) from a previous high of 28.3% in 2022.

To support our grow our own staff strategy, 16 healthcare support workers will be commencing the trainee nursing associate programme through the University of Worcester programme in March so they can become qualified nurses in future. This will enhance recruitment & retention of nursing staff at the trust over the coming years and reduce our reliance on international staff.

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.

All divisions have a comprehensive call to action retention plan and 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: Growing staff turnover

What the chart tells us:

Detailed work on reducing staff turnover has led to a decreasing trend in the last 14 months.

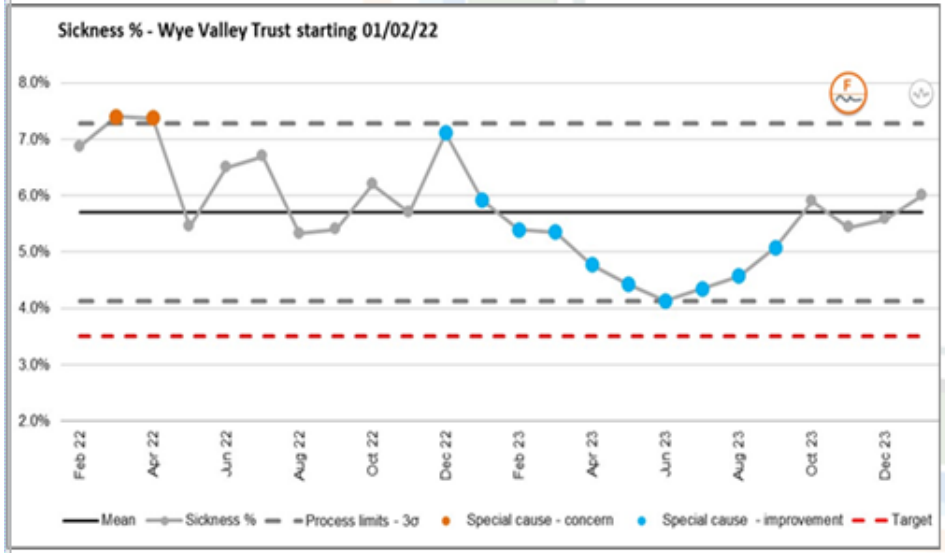
Our Workforce – Sickness

We are driving this measure because:

Aiming to reduce sickness absence so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staffing namely agency.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
5.9%	5.4%	5.4%	4.8%	4.4%	4.1%	4.3%	4.6%	5.1%	5.9%	5.4%	5.6%	6.0%

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



What the chart tells us:

Operational pressures and winter ailments have led to an increase in sickness absence over the past few months

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 6.0% 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.

The Audit report on sickness absence is being addressed with divisional leads at F&PE meetings. Divisions have been asked to address the areas of concern highlighted and to report on actions being taken to manage and reduce sickness absence. Divisional teams are required to present absence reports at F&PE meetings with absence heat maps, costs, no. of sickness 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. A comprehensive health & wellbeing strategy (helping you to help yourself) has been developed offering support and calling on staff to take more ownership and responsibility for their wellbeing.

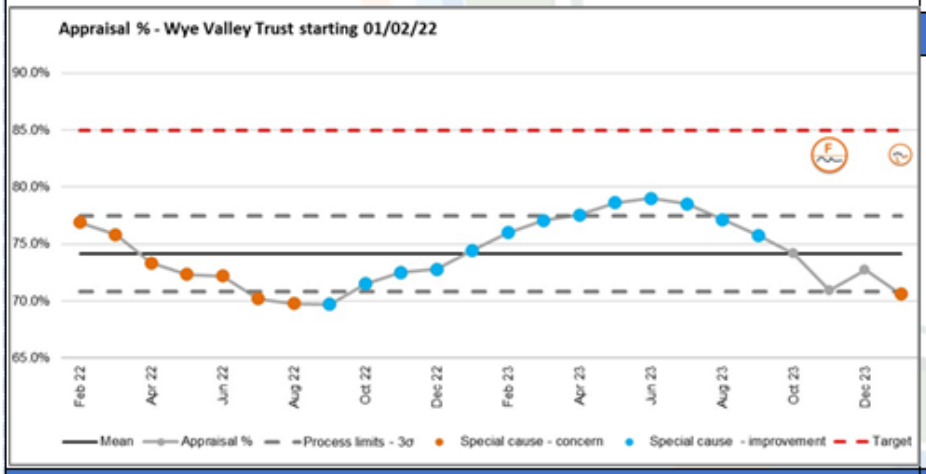
Our Workforce – Appraisal

We are driving this measure because:

To make sure staff feel heard and valued maintaining high standards of care for patients.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
74.5%	76.0%	77.1%	77.5%	78.6%	79.0%	78.5%	77.1%	75.7%	74.1%	70.9%	72.7%	70.6%

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

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

Risks:

What the chart tells us:

Severe operational pressures and industrial action are impacting on management capacity to complete performance appraisals.

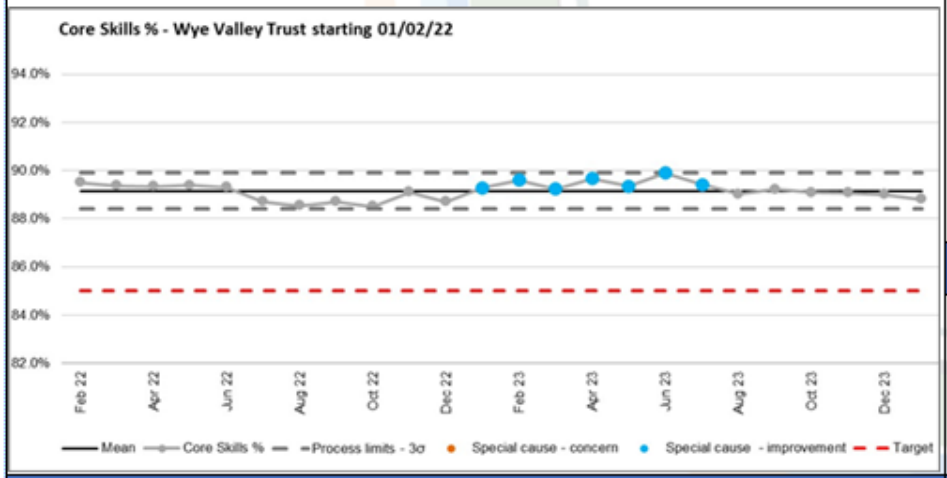
Our Workforce – Core Skills

We are driving this measure because:

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
89.3%	89.6%	89.2%	89.7%	89.3%	89.9%	89.4%	89.0%	89.2%	89.1%	89.1%	89.0%	88.8%

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

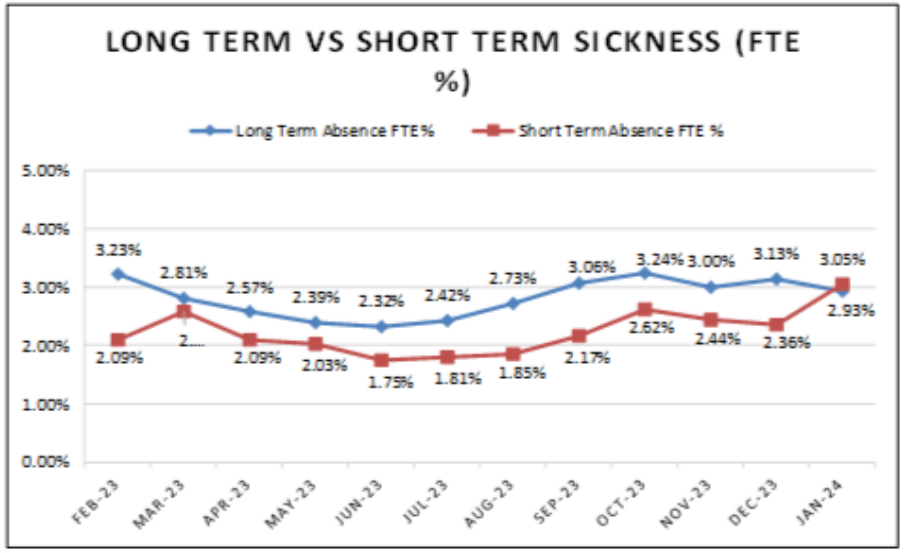
The Trust continues to make good progress in this area. This will continue to be reviewed at F&PE meetings.

Risks:

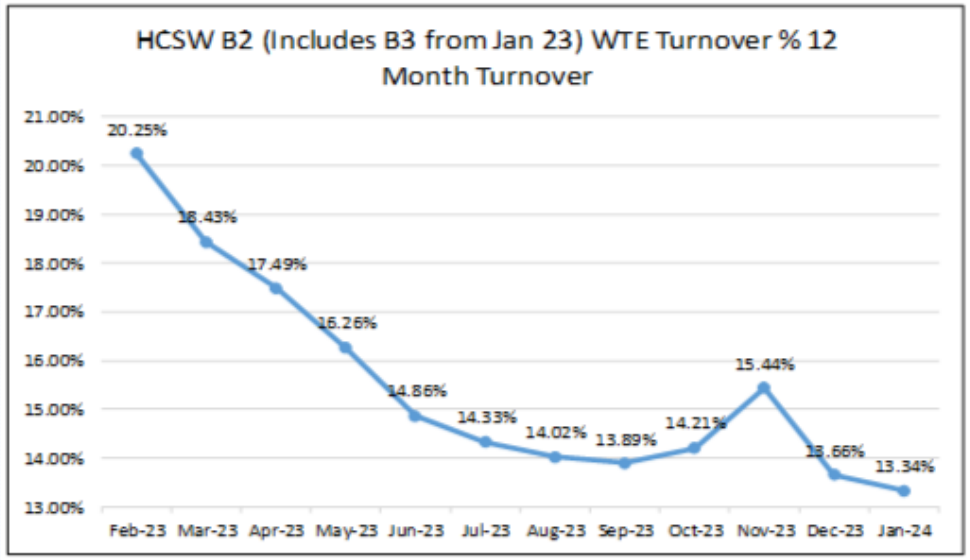
What the chart tells us:

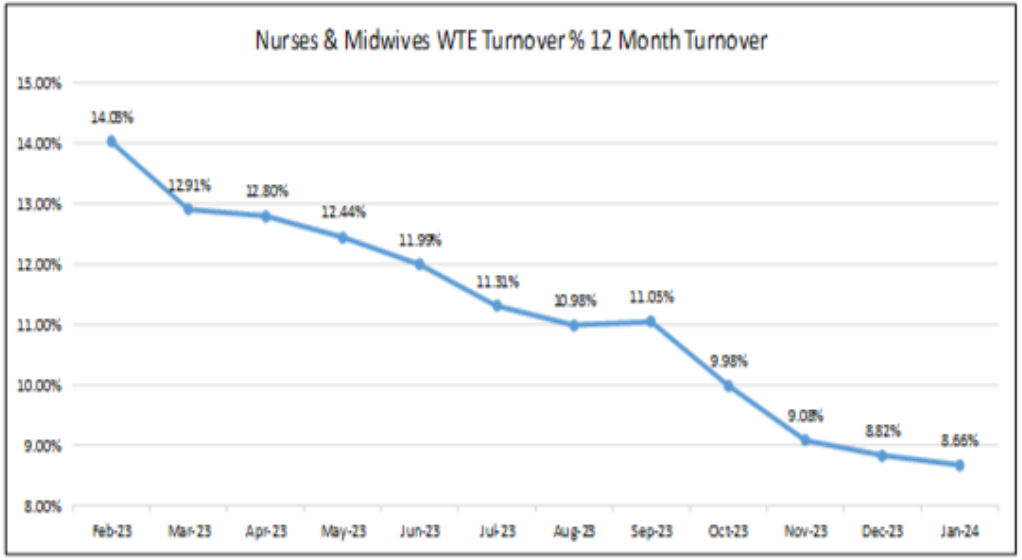
The rolling 12 month position remains fairly consistent above target over the past year.

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 coming months. We continue to see significant reductions in turnover rates for healthcare support workers and nurses/ midwives.



Main reason for absence - Top 5 - January 24	%
S13 Cold, Cough, Flu - Influenza	30.88 %
S25 Gastrointestinal problems	18.90 %
S10 Anxiety/stress/depression/other psychiatric illnesses	11.64 %
S16 Headache / migraine	5.35 %
S15 Chest & respiratory problems	5.19 %





Our Finance – Executive Narrative

Katie Osmond
Chief Finance Officer

Income & Expenditure Performance

The financial position at the end of month 10 (January) was a deficit of £22.6m which is £3m adverse to the planned deficit at this point in the year. A mid year review was undertaken during October, subsequently feeding into a national forecast review during November. At that point our forecast outturn was £26.3m, with the national assumption that there would be no further strike action. Given the impact of strikes in December and the anticipated impact in January the forecast outturn has been formally revised to £26.9m. The YTD deficit is marginally adverse to this forecast and the revised forecast remains challenging, particularly given continued operational pressures and further industrial action at the end of February.

Sustained focus on elective recovery is evidenced through a positive value weighted activity metric, and performance on variable elective income and we are maintaining our year to date performance against 19/20. 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 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 10 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). Expenditure for the first ten months of the year totals £23.4m. The forecast for the year has reduced to reflect the timing of expenditure on CDC and IES across financial years. For the IES scheme, this is expected to cause a CDEL overspend in 2024/25 of £8m (subject to year end valuation) as the associated grant income is unable to be deferred. This has been escalated to the regional capital team.

Cash

The cash balance at the end of January reduced marginally from December but remains higher than plan at £22.6m as a result of the management actions in place. Our prompt payment metric deteriorated in November and December as the cash position became more challenging and had to be tightly controlled. Revenue PDC support of £9.9m was received in mid December which led to an improvement of the prompt payment metric in January. An MOU is in place for further revenue PDC support draws in quarter 4, with the amounts approved each month being variable depending on the latest cash position. £0.8m has been requested for February and £7.3m for March.

The cash position is expected to remain challenging in 2024/25 and the Board is therefore asked to approve further applications for Revenue PDC support as and when required.

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 10 - 31st January 2024 - 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	286,009	237,116	242,395	5,279	984
Excluded Drugs	12,847	10,693	11,206	513	230
Non Contracted Activity (NCA's)	1,635	1,362	1,650	288	60
Other Income for Patient Care	10,733	9,580	8,978	(602)	(32)
Donations For Non Current Assets	20,500	15,606	8,204	(7,402)	3,697
Other Non Patient Income	8,102	6,605	6,762	157	57
COVID Funding	332	264	277	13	(9)
NHSE - central (22/23 pay award)				0	0
Total Operating Income	**340,158**	**281,227**	**279,472**	**(1,755)**	**4,988**
Pay Expenditure	208,573	173,805	177,174	(3,369)	(910)
Non Pay Expenditure	88,116	73,816	78,466	(4,650)	(1,135)
Excluded Drugs	23,287	19,391	20,125	(734)	(316)
Total Operating Expenditure	**319,977**	**267,012**	**275,765**	**(8,753)**	**(2,360)**
EBITDA	**20,181**	**14,215**	**3,707**	**(10,508)**	**2,628**
Depreciation	13,637	11,368	11,276	92	15
Gain or loss on asset disposal	0	0	0	0	0
Interest Receivable	1,282	1,198	1,198	0	(0)
Interest Payable on Loans	265	221	180	41	0
Interest Payable on PFI	6,377	5,314	5,314	(0)	(0)
Dividends on PDC	3,868	3,223	3,223	(0)	(0)
Operating Surplus/ (Deficit)	**(2,682)**	**(4,714)**	**(15,088)**	**(10,374)**	**2,643**
Technical Adjustments					
Donated Assets - Additions	20,500	15,606	8,204	(7,402)	3,697
Donated Asset Depreciation	(864)	(720)	(728)	8	(1)
Donated Assets Adjustment	**19,636**	**14,886**	**7,475**	**(7,410)**	3,698
Adj. financial performance retained Surplus/ (Deficit)	(22,316)	(19,599)	(22,564)	(2,964)	(1,055)

Performance and Actions

The position at the end of month 10 (January) was a deficit of £22.6m. This was behind the current plan with an overall adverse variance of £3.0m 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 — 7.9% of total pay costs in January which has remained static from the previous month. Medical bank use at premium rates further increases this to 16.1% 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

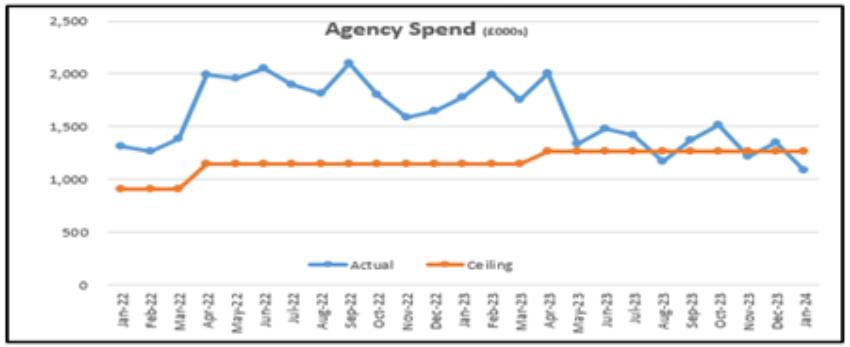
What the chart tells us:

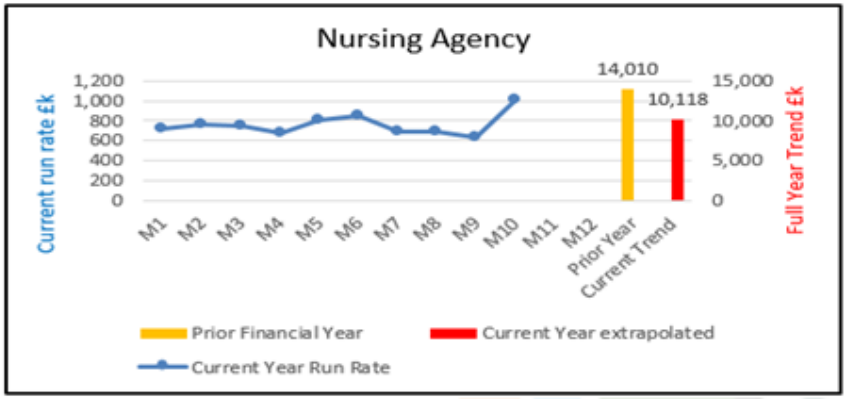
Known financial risks are starting to put greater pressure on delivery of our planned financial position. A mid year review / national exercise has taken place.

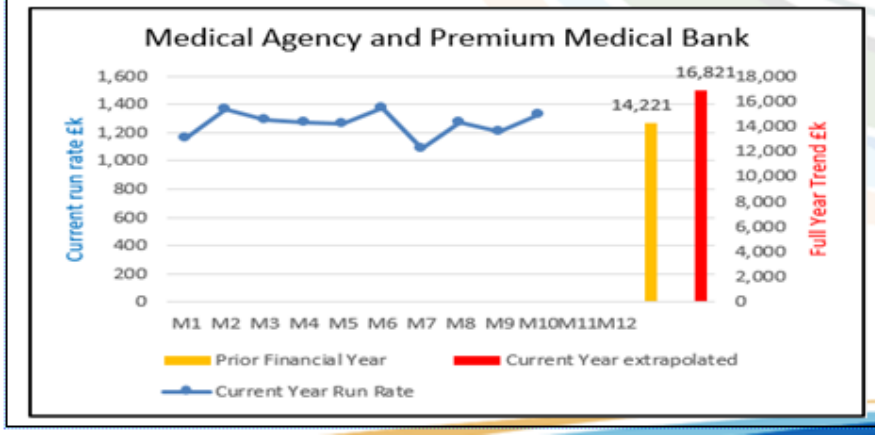
Our Finance – Agency Spend

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 7.9% 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 £13.4m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** Increased control actions through NARP, together with the 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 £10.1m 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 (£16.8m) 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

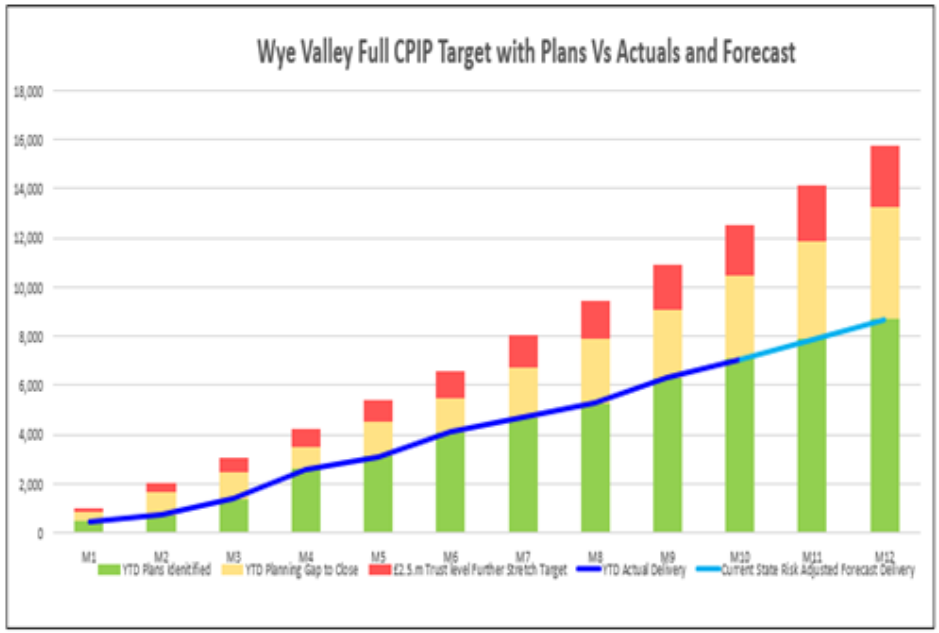
What the chart tells us:

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 102% of 19/20 activity (OP New, Inpatient/daycase & endoscopy. OPFU's are capped at 75% of 19/20 activity.) This is a further reduction to reflect the impact of industrial action.

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 and earn Elective Recovery Funding (ERF).

Using our financial assessment at the end of December have reflected over performance of £1.8m. This reflects H&W ICB performance of 106% YTD (local assessment as national data reported in arrears), achieving the Shoshire target, under performance on the Gloucestershire contract based on referral patterns, and over performance on NHSE specialised commissioning.

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:

- Deterioration in the operational performance 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:

Despite the significant operational challenges activity levels are recovering 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	1,550	963	523	440
Equipment Total	1,593	1,581	1,221	1,336	(115)
Estates Total	1,630	1,343	1,253	60	1,193
Total Core Operating (ICS)	**4,473**	**4,473**	**3,437**	**1,919**	**1,518**
ESH	12,829	12,829	9,660	8,180	1,480
CDC	10,296	4,900	5,760	656	5,104
Frontline Digitalisation PDC Total	3,300	740	1,762	3	1,759
Total National Programme	**26,425**	**18,468**	**17,182**	**8,839**	**8,343**
Donated Assets/Grant IES	20,600	12,937	13,622	12,637	985
Grand Total	**51,498**	**35,879**	**34,241**	**23,395**	**10,846**

Cash Balance

Month	Performance	Target	Direction	Rating
November	18.9	19.8		
December	23.5	20.2	↑	
January	22.6	20.6		

The cash balance at the end of January reduced slightly compared to previous month but remains higher than planned. The main reason for the higher balance is the level of capital cash held to ensure cash is drawn in sufficient time to enable payments to be made.

Better Payment Practice Code

Month	Performance	Target	Direction	Rating
November	84.0%	95.0%		
December	43.1%	95.0%	↓	
January	95.9%	95.0%		

In January, the Trust paid 95.9% of invoices within 30 days (78.6% by invoice value). An increase from the previous two months, when we missed the 95% target due to action taken to maintain cash balances.

Performance and Actions

Capital: The overall capital expenditure at Month 10 is £23.4m which represents 65% of the total forecast. The forecast outturn position is £15.6m lower than the original annual plan and reflects changes to nationally funded programmes. CDC is projected to spend less than planned in 2023/24 (as agreed with NHSE) and some bids in the initial plan have not been successful and the forecast reflects this.

Cash: The cash balance at the end of January reduced slightly compared to the previous month but remains higher than planned. The main reason for the higher balance is the level of capital cash held to ensure cash is drawn in sufficient time to enable payments to be made. An MOU has been received for revenue support PDC in quarter 4, although the actual drawdown values NHSE approve will vary depending on the up to date cash position each month. 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, continue to require careful management over the next few months and into the new financial year.

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.

January 2024	2022/23	2023/24				2023/24 Full Year		
	Accounts £000s	M10 Plan £000s	M10 YTD £000s	Variance £000s	YTD Change £000s	Plan £000s	Actual £000s	Variance £000s
NON-CURRENT ASSETS:								
Property, Plant and Equipment	125,505	147,527	141,582	5,945	16,077	164,723	164,723	0
Intangible Assets	18,462	15,211	14,508	703	(3,954)	16,233	16,233	0
Trade and Other Receivables	573	817	488	329	(85)	817	817	0
TOTAL Non Current Assets	**144,540**	**163,555**	**156,578**	**6,977**	**12,038**	**181,773**	**181,773**	**0**
CURRENT ASSETS:								
Inventories	5,316	4,780	5,373	(593)	57	4,780	4,780	0
Trade and Other Receivables	21,085	13,709	20,628	(6,919)	(457)	13,712	13,712	0
Cash and Cash Equivalents	34,969	25,441	22,564	2,877	(12,405)	21,652	34,738	13,086
TOTAL Current Assets	**61,370**	**43,930**	**48,565**	**(4,635)**	**(12,805)**	**40,144**	**53,230**	**13,086**
TOTAL ASSETS	**205,910**	**207,485**	**205,143**	**2,342**	**(767)**	**221,917**	**235,003**	**13,086**
CURRENT LIABILITIES								
Trade and other payables	(45,361)	(26,688)	(43,721)	17,033	1,640	(27,659)	(39,019)	(11,360)
Borrowings - Loans, PFI and Finance Leases	(5,779)	(6,390)	(6,608)	218	(829)	(6,516)	(6,516)	0
Provisions	(55)	(46)	(46)	0	9	(46)	(46)	0
Total Current Liabilities	**(51,195)**	**(33,124)**	**(50,375)**	**17,251**	**820**	**(34,221)**	**(45,581)**	**(11,360)**
NET CURRENT ASSETS/(LIABILITIES)	**10,175**	**10,806**	**(1,810)**	**12,616**	**(11,985)**	**5,923**	**7,649**	**1,726**
TOTAL ASSETS LESS CURRENT LIABILITIES	**154,715**	**174,361**	**154,768**	**19,593**	**53**	**187,696**	**189,422**	**1,726**
NON-CURRENT LIABILITIES:								
Borrowings - Loans, PFI and Finance Leases	(31,138)	(27,033)	(25,200)	(1,833)	5,938	(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)**	**(28,612)**	**(26,868)**	**(1,744)**	**5,956**	**(27,994)**	**(27,994)**	**0**
ASSETS LESS LIABILITIES	**121,891**	**145,749**	**127,900**	**17,849**	**6,009**	**159,702**	**161,428**	**1,726**
TAXPAYERS EQUITY								
Public dividend capital	270,216	301,600	291,306	10,294	21,090	313,521	315,248	1,727
Revaluation reserve	21,051	30,874	21,050	9,824	(1)	30,874	30,874	0
Income and expenditure reserve	(169,376)	(186,725)	(184,456)	(2,269)	(15,080)	(184,693)	(184,694)	(1)
TOTAL	**121,891**	**145,749**	**127,900**	**17,849**	**6,009**	**159,702**	**161,428**	**1,726**

Performance and Actions

General

The table identifies the statement of financial position as at 31 January 2024 against the plan.

Non-Current Assets

Non-Current assets increased by £6.8m in month due to capital expenditure (offset by depreciation and amortisation).

Current Assets

Accounts Receivable have decreased by £2.4m compared to the previous month. Cash held decreased by £1m in the month.

Current Liabilities

Current liabilities have reduced by £1.7m compared to last month largely due to accounts payable as payments have been released from cash balances upon receipt of revenue support PDC.

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 and PDC has increased due to receipt of additional funds for both central capital schemes and revenue support.

IFRS 16 PFI liability re-measurement

This will be reflected in the balance sheet prior to year end and will significantly increase non-current liabilities and reduce the income

Risks:

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

What the chart tells us:

Current assets outweigh current liabilities, largely due to the year to date deficit.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 75.0%	Variable	Improvement - High		67.8%	69.0%	69.8%	66.9%	67.9%	65.8%	72.9%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		86.2%	83.5%	86.3%	78.7%	86.4%	80.4%	88.3%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Common Cause	Yes	18.2%	47.8%	71.1%	53.8%	71.4%	53.3%	90.5%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Concern - Low	Yes	83.3%	86.7%	92.4%	87.4%	78.4%	80.0%	73.8%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer			Common Cause	Yes	11	11	6	10	14	9	8	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Fail	Concern - Low		61.4%	69.1%	69.8%	64.3%	48.4%	64.0%	57.5%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause						50.0%	100.0%	100.0%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		75.0%	81.5%	80.8%	70.8%	55.2%	81.0%	73.9%	
	Cancer: number of urgent suspected cancer patients waiting over 62 days	Cancer			Common Cause		108	72	87	109	113	126	117	
Primary care and community services	Community Service Contacts - Total	Primary care and community			Improvement - High		103.2%	106.2%	114.2%	101.7%	115.2%	104.8%	107.0%	121.0%
	Urgent Response > 1st Assessment completed on same day (facilitated discharge &	Primary care and community	80.0%	Pass	Concern - Low	Yes	96.4%							
	Urgent Response > 1st Assessment completed within 2 hours (admission	Primary care and community	70.0%	Variable	Concern - Low	Yes	50.0%							
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Improvement - High		90.8%	89.9%	90.1%	91.0%	90.8%	90.8%	91.1%	90.1%
Urgent and emergency care	A&E Activity	Urgent and emergency care			Improvement - High		98.0%	98.4%	101.8%	101.8%	104.6%	104.7%	103.0%	103.4%
	Ambulance handover within 30 minutes	Urgent and emergency care	>= 98.0%	Fail	Common Cause		81.7%	81.4%	83.1%	76.9%	80.7%	73.0%	73.6%	64.4%
	Ambulance handover over 60 minutes	Urgent and emergency care	<= 0.0%	Variable	Concern - High	Yes	4.6%	6.4%	3.7%	9.9%	6.6%	12.1%	13.2%	20.1%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care			Improvement - High		108.1%	111.1%	112.5%	118.6%	119.1%	113.0%	114.2%	117.5%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		41.0%	40.0%	42.0%	44.0%	45.0%	40.0%	39.0%	41.0%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Concern - Low		59.3%	56.5%	56.2%	54.0%	57.2%	56.3%	53.6%	53.2%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care			Improvement - High		13.8%	14.0%	17.3%	15.9%	14.3%	16.0%	17.3%	19.1%
	A&E - Time to treatment	Urgent and emergency care			Common Cause		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		2.3%	2.3%	1.7%	1.9%	1.7%	1.9%	1.8%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		259	178	213	181	213	253	230	305
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause	Yes	8.4%	8.5%	8.7%	8.7%	8.7%	8.8%		

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>=	92.0%	Fail	Concern - Low		59.4%	57.2%	57.7%	57.7%	58.6%	59.6%	57.9%	57.2%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>=	95.0%	Fail	Concern - Low		67.1%	68.0%	65.5%	64.9%	66.2%	67.4%	65.5%	66.8%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care				Improvement - High		26710	26882	27963	27857	27260	26915	27031	26837
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Concern - High		1688	1804	1853	1959	1981	1782	1636	1446
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<=	0	Fail	Improvement - Low		18	36	30	34	33	18	16	7
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<=	0	Fail	Improvement - Low		1	2	1	1	4	4	3	1
	GP Referrals	Elective care				Improvement - High	Yes	119.9%	99.9%	116.6%	118.2%	110.1%	117.0%	97.5%	102.6%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care				Improvement - High		118.1%	106.1%	117.8%	113.3%	111.2%	112.9%	100.6%	111.6%
	Outpatient Activity - New attendances (volume v plan)	Elective care				Improvement - High	Yes	86.1%	117.4%	121.7%	81.8%	111.8%	88.5%	121.2%	114.4%
	Total Outpatient Activity (% v 2019/20)	Elective care				Improvement - High		121.1%	102.1%	117.0%	109.8%	101.4%	110.1%	101.0%	107.8%
	Total Outpatient Activity (volume v plan)	Elective care				Improvement - High	Yes	90.9%	115.8%	138.3%	85.6%	112.9%	92.9%	132.4%	124.3%
	Total Elective Activity (% v 2019/20)	Elective care				Common Cause	Yes	104.9%	88.6%	107.1%	99.9%	95.5%	100.7%	91.2%	98.1%
	Total Elective Activity (volume v plan)	Elective care				Improvement - High	Yes	79.6%	111.4%	128.3%	79.9%	104.4%	84.0%	111.8%	103.0%
	Elective - Theatre utilisation (%) - Capped	Elective care	>=	85.0%	Fail	Common Cause		78.5%	73.6%	75.9%	75.9%	75.8%	78.6%	77.8%	74.4%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care				Improvement - High	Yes	24	30	36	30	15	29	31	69
	Diagnostic Activity - Computerised Tomography	Elective care				Improvement - High		139.9%	144.9%	143.7%	142.8%	129.7%	129.6%	119.4%	124.9%
	Diagnostic Activity - Endoscopy	Elective care				Improvement - High	Yes	79.4%	76.9%	93.4%	83.2%	86.3%	131.1%	158.0%	142.8%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care				Improvement - High		171.3%	161.5%	204.4%	185.4%	158.1%	180.9%	148.0%	113.6%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care				Improvement - Low		29.8%	28.4%	27.7%	27.6%	22.5%	17.2%	13.2%	17.9%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care		90.0%	Variable	Common Cause	Yes	94.0%	93.1%	93.6%	95.4%	96.2%	92.9%	92.2%	91.3%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<=	15.0%	Variable	Concern - High		21.3%	20.9%	17.1%	23.9%	23.3%	22.9%	23.8%	24.3%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<=	34.0%	Fail	Concern - High		57.0%	55.5%	60.0%	61.7%	63.6%	66.0%	64.9%	63.8%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<=	60.0%	Fail	Concern - High		89.6%	91.5%	91.8%	93.4%	92.5%	92.6%	92.5%	88.4%
	Maternity Activity (Deliveries)	Elective care				Improvement - High	Yes	98.5%	91.3%	106.6%	98.5%	92.7%	97.0%	95.1%	140.6%

Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<=	40.0%	Pass	Common Cause	Yes	6.1%	5.9%	6.1%	6.4%	6.8%	6.5%	6.9%	6.5%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>=	90.0%	Fail	Common Cause		86.7%	85.5%	84.1%	85.1%	81.9%	86.3%	83.6%	83.3%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation				Improvement - High	Yes	122.6%	100.2%	116.7%	108.2%	97.1%	108.9%	101.2%	106.1%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation				Improvement - High	Yes	93.3%	115.1%	147.2%	87.6%	113.5%	95.1%	138.2%	129.4%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<=	25.0%	Fail	Improvement - Low		23.4%	23.4%	21.2%	22.0%	21.7%	20.7%	20.2%	20.0%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term				Common Cause		9.2%	9.5%	10.3%	12.2%	5.7%	6.9%	8.1%	2.8%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		97.8%	96.7%	95.5%	99.3%	99.6%	99.6%	98.8%	100.0%
	Bed occupancy - Community Wards	Safe, high quality care	<=	90.0%	Variable	Concern - High		96.3%	94.4%	97.4%	96.1%	96.6%	100.0%	99.2%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<=	0	Variable	Improvement - Low		110	75	109	52	81	49	28	24
	Patient ward moves emergency admissions (acute)	Safe, high quality care				Common Cause		7.4%	7.3%	10.5%	7.1%	9.4%	8.7%	8.1%	
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<=	5	Variable	Common Cause	Yes	4	4	4	4	4	4	4	4
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<=	3	Variable	Common Cause		2	2	3	2	2	2	3	2
	Medically fit for discharge - Acute	Safe, high quality care		5.0%	Pass	Common Cause		24.6%	17.9%	22.2%	24.8%	26.0%	23.3%	21.0%	22.7%
	Medically fit for discharge - Community	Safe, high quality care		10.0%	Pass	Concern - Low	Yes	58.9%	57.9%	45.4%	54.3%	43.6%	39.4%	43.6%	50.1%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care		5.0%	Pass	Improvement - High		9.4%	10.8%	10.2%	10.9%	11.3%			
	HSMR - Rolling 12 months	Safe, high quality care	<=	100	Fail	Concern - High		114	116	118	115	111			
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<=	100	Fail	Improvement - Low		101	103	103	103				
	Never Events	Safe, high quality care		0	Variable	Concern - Low		0	0	0	0	0	0	0	0
	MRSA Bacteraemia	Safe, high quality care		0	Variable	Concern - Low		0	0	0	0	0	0	0	0
	MSSA Bacteraemia	Safe, high quality care				Common Cause	Yes	1	2	0	1	4	4	2	1
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care		44	Fail	Common Cause		6	1	0	2	3	3	4	3
	Number of falls with moderate harm and above	Safe, high quality care				Common Cause	Yes	4	2	5	1	0	6	3	2
	Pressure sores (Confirmed avoidable Grade 3,4)	Safe, high quality care	<=	0	Variable	Common Cause	Yes	3	2	2	1				
	Serious Incidents	Safe, high quality care				Common Cause	Yes	6	7	6	5				
	VTE Risk Assessments	Safe, high quality care	>=	95.0%	Fail	Concern - Low		90.9%	90.5%	90.9%	89.1%	88.5%	89.8%	87.9%	86.1%

Safe, high quality care	WHO Checklist	Safe, high quality care	>=	100.0%	Variable	Common Cause	Yes	99.8%			99.4%			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		87.0%	68.8%	43.8%	44.7%	62.9%	64.3%	48.1%	53.5%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>=	90.0%	Variable	Common Cause	Yes	0.0%	100.0%	60.0%	33.3%	100.0%	100.0%	0.0%	50.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>=	80.0%	Variable	Common Cause		88.9%	77.1%	79.1%	70.0%	85.2%	90.9%	89.3%	75.0%
	Number of complaints	Safe, high quality care				Common Cause	Yes	51	40	21	30	35	34	25	27
	Number of complaints referred to Ombudsman	Safe, high quality care	<=	0	Variable	Common Cause	Yes	0	0	0	0	1	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>=	90.0%	Variable	Concern - Low		31.4%	50.0%	41.9%	36.8%	31.4%	52.2%	17.6%	35.0%
	Friends and Family Test - Response Rate (Community)	Safe, high quality care	>=	30.0%	Variable	Concern - Low		0.1%							
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause		79.6%	72.9%	73.0%	68.2%	71.8%	73.1%	72.9%	77.0%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Concern - Low		87.4%	86.2%	81.0%	86.8%	85.0%	87.9%	82.0%	85.7%
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause	Yes	100.0%							
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>=	95.0%	Variable	Common Cause		100.0%	100.0%	94.0%	96.3%	92.9%	89.7%	87.2%	96.7%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>=	25.0%	Variable	Improvement - High		20.5%	17.0%	20.0%	19.0%	20.0%	19.0%	19.0%	21.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>=	30.0%	Fail	Improvement - High		19.0%	17.0%	15.0%	16.0%	15.0%	15.0%	15.0%	18.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>=	30.0%	Variable	Common Cause		1.5%	46.0%	46.0%	26.0%	22.0%	32.8%	31.0%	23.0%

People

Sub Domain	KPI	Subject		Target	Target Expectation	Variation	Exception	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>=	6.4%	Variable	Common Cause		8.4%	6.8%	7.5%	8.4%	7.0%	7.1%	6.1%	7.9%
	Appraisals	Looking after our people	>=	85.0%	Fail	Concern - Low		79.0%	78.5%	77.1%	75.7%	74.1%	70.9%	72.7%	70.6%
	Mandatory Training	Looking after our people	>=	85.0%	Pass	Concern - Low		89.9%	89.4%	89.0%	89.2%	89.1%	89.1%	89.0%	88.8%
	Overall Sickness	Looking after our people	<=	3.5%	Fail	Common Cause	Yes	4.1%	4.3%	4.6%	5.1%	5.9%	5.4%	5.6%	6.0%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<=	10.0%	Fail	Improvement - Low		11.5%	11.0%	10.9%	10.9%	10.6%	10.6%	10.3%	10.1%
	Vacancy Rate	Looking after our people	<=	5.0%	Fail	Improvement - Low		6.3%	5.1%	5.4%	4.6%	4.2%	4.0%	3.7%	3.8%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Finance	I&E - Surplus/(Deficit) (£k)	Finance			Common Cause	Yes	(£2769k)	(£2184k)	(£3182k)	(£3173k)	(£1198k)	£425k	(£1506k)	(£2906k)
	I&E - Margin (%)	Finance			Common Cause	Yes	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance			Improvement - Low	Yes	(£146k)	£25k	(£1089k)	(£1229k)	£221k	£1720k	(£208k)	(£3427k)
	I&E - Variance from Plan (%)	Finance			Common Cause		(£0k)	£0k	(£0k)	(£0k)	£0k	£0k	(£0k)	(£0k)
	CPIP - Variance from plan (£k)	Finance			Improvement - Low		(£340k)	(£816k)	(£1069k)	(£878k)	(£1056k)	(£862k)	(£841k)	(£708k)
	Agency - expenditure (£k)	Finance			Improvement - Low		£1323k	£1119k	£1435k	£1410k	£1338k	£1382k	£1087k	£1482k
	Agency - expenditure as % of total pay	Finance			Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance			Improvement - Low	Yes	(£114k)	(£287k)	(£227k)	(£111k)	(£409k)	(£366k)	£520k	(£2959k)
	Cash - Balance at end of month (£m)	Finance			Common Cause	Yes	£25k	£21k	£14k	£11k	£15k	£19k	£24k	£23k
	BPPC - Invoices paid <30 days (% value £k)	Finance			Common Cause	Yes	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance			Concern - High	Yes	£1k	£1k	£1k	£1k	£1k	£1k	£0k	£1k

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Climate Change Adaptation Plan (CCAP)
Status of report:	☒**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Sustainability Group, Trust Management Board
Lead Executive Director:	**Chief Strategy Officer**
Author:	Lee Stockton
Documents covered by this report:	Climate Change Adaptation Plan

1. Purpose of the report

To share and seek approval for the Trust's first CCAP. This action relates back to an ambition set out in the Trust's Sustainable Development Management Plan.

2. Recommendation(s)

That members note and approve the Climate Change Adaptation Plan

3. Executive Director Opinion[1]

Whatever you believe about the causes of climate change It is obvious to all that our climate is changing and weather events that were seen as one in thirty years events are now commonplace. We can demonstrate this based on events across our own estate. Our Sustainable Develop Management Plan highlighted the need for an adaptation plan, which has been developed based on the plans of other NHS Trusts. Last year, HM Government released The Third National Adaptation Programme (NAP3) and the Fourth Strategy for Climate Adaptation Reporting document. The report sets out an expectation that guidance to build resilience in both infrastructure and service delivery in the health and social care sectors will be forthcoming over the next two years. This plan is therefore a pre-cursor to a more detailed plan in the future which will be based on national guidance but members of the Sustainability Group felt that the Trust needed to act now to mitigate some of the worst effects of climate change.

[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

Climate Change Adaptation Plan 2024– 2028

Introduction

Climate change refers to long-term shifts in temperatures and weather patterns. These shifts may be natural, but since the 1800s, human activities have been the main driver of climate change, primarily due to the burning of fossil fuels (like coal, oil and gas), which produces heat-trapping gases. (United Nations Definition).

This Plan, alongside identifying adaptation leads, will achieve the requirements of the Trust's Sustainability Development Management Plan (SDMP). It will be reviewed annually and presented to the Trust's Board alongside Sustainability updates.

The Met Office said in its UK Climate Projections: Headline Findings published in August 2022 that general climate trends are

> 'showing an increased chance of warmer, wetter winters and hotter, drier summers along with an increase in the frequency and intensity of extremes.'

Total rainfall may decline but the intensity of summer and winter rains could increase, leading to surface water flooding. Droughts could lead to water shortages as well as impact surface water runoff leading to flooding. Not every winter will necessarily be rainier than the one before, and not every summer will be dry, but both trends could have big impacts.

It is expected that Climate Change will lead to physical and mental health impacts (e.g. fatalities, injuries and trauma, heat-related illness) and there could be system pressure leading to poorer health outcomes. The Local Climate Adaptation Tool has been used to identify health risks, however greater data analysis is required to identify specific vulnerabilities.

This Climate Change Adaptation Plan (CCAP) has identified the risks and actions to begin to adapt services to a changing climate within areas such as governance, data gathering, procurement, building adaptations, education and awareness raising and an improved response to weather events.

Whilst it is important for Emergency Preparedness, Resilience and Response (EPRR) teams to be involved, however, if done well, climate change adaption will reduce the need to enact emergency or business continuity plans.

Adapting to the future climate

> The UK will face significant further changes in climate to 2050 and beyond, even if the world is on a Paris-aligned emissions trajectory. By 2050 the heatwave of 2018 will be a typical summer, summer rainfall could fall by as much as 24% and winter rainfall increase by as much as 16%, changes that will impact our wellbeing, the natural environment and the economy… But adaptation remains the Cinderella of climate change, still sitting in rags by the stove: under-resourced, underfunded and often ignored."
>
> — Baroness Brown, Chair of the Adaptation Committee, Climate Change Committee, June 2021

There is now a significant effort by the NHS to reduce carbon emissions and achieve Greener NHS targets. However, even if the Trust and others eliminate all emissions today, the climate will still change and there remains a need to adapt to those changes.

Extreme weather events are already becoming more frequent and intense, impacting the NHS due to increased patient numbers and, or exacerbation of existing health conditions as well as affecting supply of goods and services which in turn affect our ability to deliver care. Climate change impacts include extreme heat and cold, storms and flooding. We must therefore consider how we make our service resilient and adapt to the known and likely risks. This goes beyond creating business continuity plans but recognising change and including adaptations in business as usual.

The further we all fall short on mitigation, the more we will need to adapt.

This plan is a high level first attempt to describe the challenges that the Trust faces and the adaptations required to mitigate those challenges.

In 2023 HM Government released The Third National Adaptation Programme (NAP3) and the Fourth Strategy for Climate Adaptation Reporting document. The report sets out an expectation that guidance to build resilience in both infrastructure and service delivery in the health and social care sectors includes actions carried out by the Department for Health and Social Care (DHSC), NHS England, and UKHSA who will:

- implement the Adverse Weather and Health Plan, which was published in April 2023, to support local and national organisations to prepare, build and respond to future adverse weather events to protect lives and promote health and wellbeing
- review and update NHS' standards for facilities' resilience planning by 2025
- support NHS Trusts and Integrated Care Boards in incorporating climate change adaptation within their Green Plans by 2027
- include adaptation measures in the NHS Standard Contract for NHS buildings and services from 2023

As NHSE develop these standards, guidance and measures over the coming years the Trust will need to update its plans accordingly and in more detail and therefore this plan needs to be viewed as the first version of an iterative document.

Contents

1. Climate Change impacts

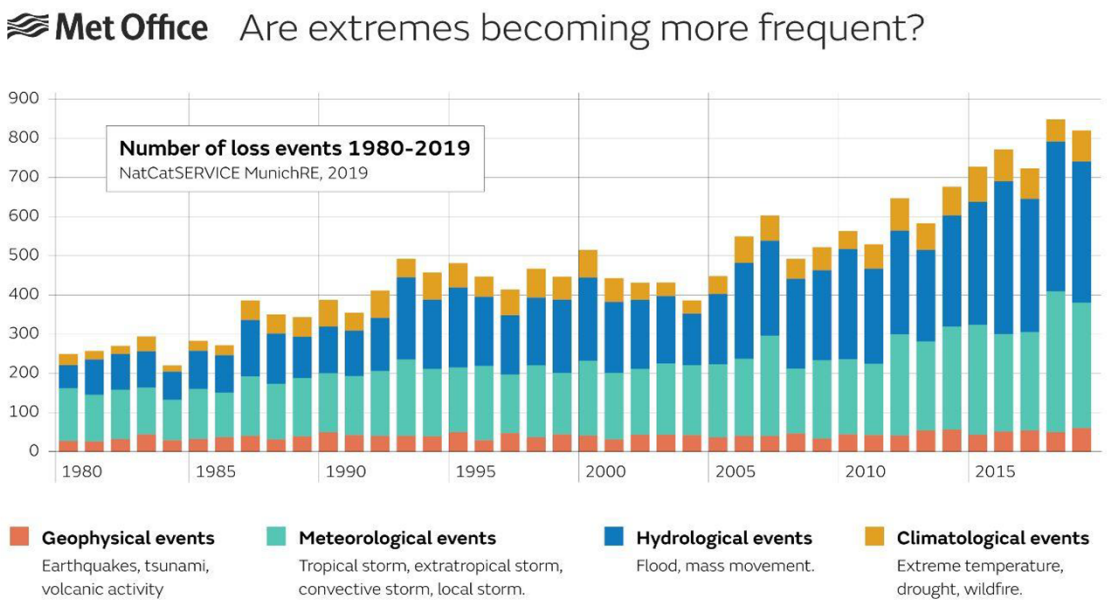
The Central England temperature records show that the most recent decade is 1°C warmer than the pre-Industrial period; whilst this doesn't sound significant, the earth is finely balanced and any change has consequences. The effects of climate change are already apparent, the UK is particularly at risk of drought, flooding and extreme weather events, all of which threaten our water, food, infrastructure and supply systems.

The Met Office states in its UK Climate Projections: Headline Findings V4 published in August 2022 that

> "General climate change trends projected over UK land for the 21st century in UKCP18 are broadly consistent with earlier projections (UKCP09) showing an increased chance of warmer, wetter winters and hotter, drier summers along with an increase in the frequency and intensity of extremes."

Total rainfall may decline but the intensity of summer and winter rains could increase, leading to surface water flooding. Droughts could lead to water shortages as well as impact surface water runoff leading to flooding. Not every winter will necessarily be rainier than the one before, and not every summer will be dry, but both trends could have big impacts.

Figure 1: Increase in extreme weather events



This Met Office graph shows an increasing trend for all extreme events displayed.

The Trust has identified the climate change that could impact their buildings. See Appendix 1. However, these risks can mask local vulnerabilities.

2. Climate and health

Figure 2 below shows how the climate in England is warming; each stripe representing a year, with darker red indicating higher temperatures. It is clear that England is warming up, and with that, there is an impact on health which the NHS needs to be prepared for and adapt to.

Figure 2: Warming stripes

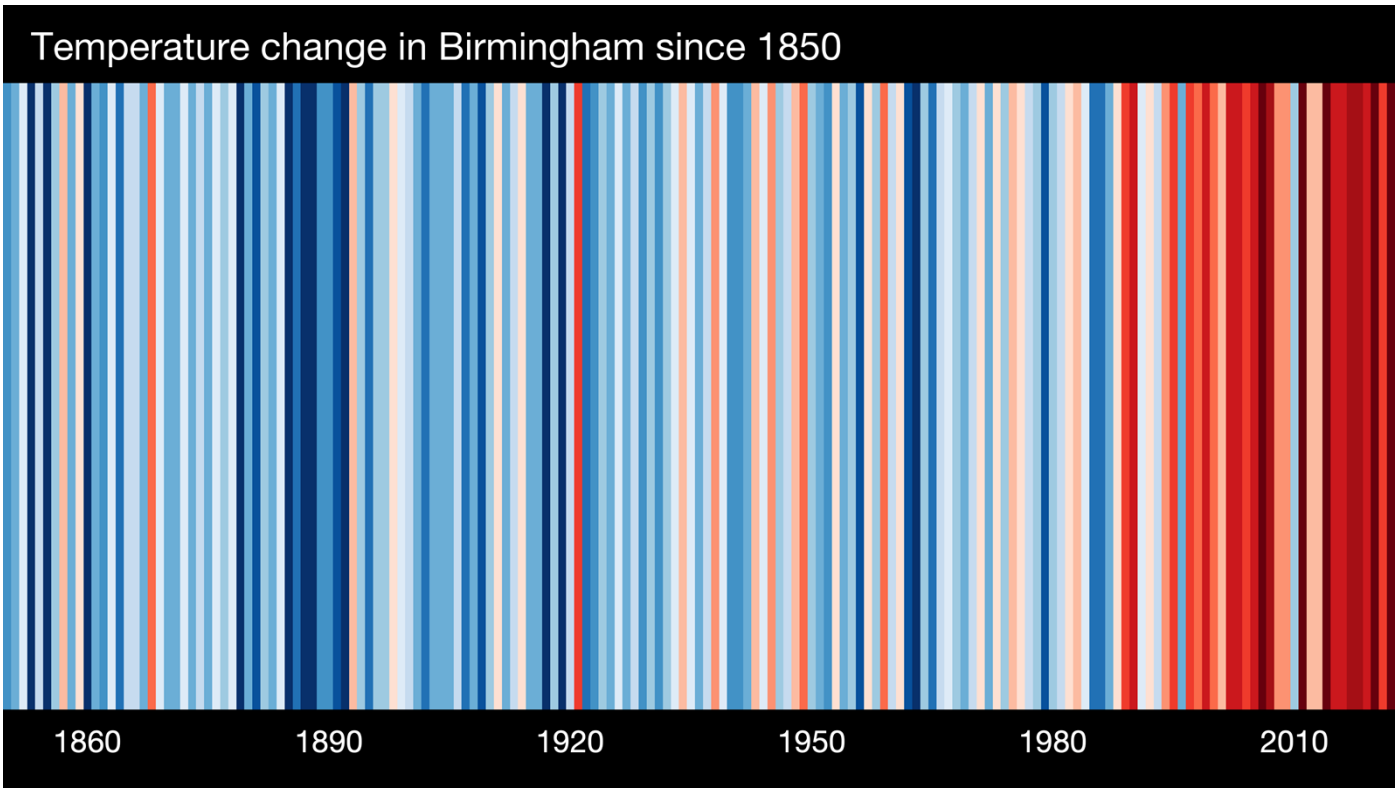


Image credit: University of Reading, Prof Ed Hawkins. Temperature increase from 18840 to 2022 #ShowYourStripes

A warming climate affects health in three main ways:

Impact		Health impact
Extreme weather	• Heatwaves • Flooding • Wildfire • Storms • Drought	• Physical and mental health (e.g. fatalities, injuries and trauma, heat-related illness) • Sunlight (UV risk) • Ozone risk • Cardiovascular failure
Planet's life-support systems	• Rising sea levels and water quality impacts • Changing patterns of zoonotic and vector-borne disease (for example malaria, dengue fever) • Increased allergens • Reduced pollination and crop failure leading to food shortages	• Incidence and exposure to marine and freshwater pathogens. Diarrheal disease, cholera, harmful algal blooms • Respiratory allergies, asthma • Malnutrition

Effects on our social systems	• Livelihood loss, • Rising prices of food and fuel, • Supply chain disruption, • Conflict or forced migration • Food scarcity/ food poverty	• Mental health impacts • Malnutrition • System pressure leading to poorer health outcomes

The climate crisis affects our ability to safeguard the health of the population and therefore tackling it as a determinant of health is crucial to our role as health and care professionals. Adaptation for health and social care falls into two categories:

Patient volume and need	Operational delivery
Climate change could negatively impact the physical and mental health and wellbeing of our residents which could affect the volume and pattern of demand.	Our infrastructure and supply chains need to be prepared for and resilient to weather events and other crises (e.g. buildings, communications, emergency service vehicles, models of care) and supply chain (e.g. fuel, food, consumables and medical equipment supplies)

Using the Local Climate Adaptation Tool[1] at local authority level for Herefordshire, the following health impacts have been identified and RAG rated. However, at this macro level, it can hide vulnerabilities by geography or demography. Further research will be needed to consider the local impacts on our estate, staff, patients and the goods and services we depend on.

Health impact	Herefordshire	
Cold related deaths	Decreasing	
Cardiovascular deaths	Increasing	
Cerebrovascular deaths	Increasing	
Cognitive performance & the ability to learn	Decreasing	
Sleep disruption & disorders	Increasing	
Cold related morbidity	Decreasing	
Respiratory deaths	Increasing	

Below we consider different impacts, our past exposure to them, expectations in the future and how we may adapt to them. A summary of actions is included at the end of the plan, including a requirement to work with the (Integrated Care Board) ICB to ensure they are aware of the risks and considering this as part of commissioning of services.

[1] Local Climate Adaptation Tool (lcat.uk) currently beta testing stage. Will review in more detail as one of the actions in this Plan.

3. Impacts and adaptation options

The tables below detail the impacts each Hospital has been exposed to in the past, future expectations and how we can adapt to these potential impacts.

a. Flooding

Flood risk for specific sites is included in Appendix 2.

Surface Water and Ground water (flash floods)	County	Bromyard	Leominster	Ross
Past Experience	N/A	N/A	N/A	N/A
Data and future projections	Increased localised surface water flooding, potentially affect internal deliveries and logistics, workforce attendance and supply chain			
Adaptation Considerations	Mapping of local roads to identify where closures can cause access issues			
	Access to specialist support (e.g. 4x4) that can drive through localised flooding			
	Review flood risk assessments for all health premises where WVT provides services			
	Identify flood risk hotspots to avoid			
	Map risk to a wider number of sites. Sustainable drainage systems to help reduce risk of localised flooding			
	Sustainable drainage systems to help reduce risk of localised flooding			

River flooding	County	Bromyard	Leominster	Ross
Past Experience	Eign Brook flooded carpark and Monitoring office 3 times since 1995	N/A	N/A	N/A
Data and future projections	Potential for increased risk (frequency and area affected)			
	Increased risk to community-based services such as maternity.			
	Increased risk of disruption to transportation (staff, patients and supplies)			
	Potential flood risk to landlord sites affecting WVT staff/ services			
Adaptation Considerations	• Identify flood risk hotspots			
	• Map risk to a wider number of sites			
	• Relocate away from flood risk where possible			

b. Heat waves

Drought	County	Bromyard	Leominster	Ross
Past Experience	Water drought restrictions; impact the outdoor space. No supply interruptions			
Data and future projections	Longer drought periods			
Adaptation Considerations	Maintain drinking water tanks			
	Drought resistant planting in landscaped areas			
	Grey water collection*			
	Provision of advice to patients			
	Sub metering, Publicising saving water,			
	Increased fire risk			

* Consideration of infection prevention concerns.

High temperature	County	Bromyard	Leominster	Ross
Past Experience	Overheating incidents 9 2022/23	No reported overheating incidents 2022/23	No reported overheating incidents 2022/23	No reported overheating incidents 2022/23
	Regular high temperatures on top floor of main building	Regular high temperatures	Regular high temperatures	Regular high temperatures
	Requirement to wear PPE exacerbates impacts of high temperatures	Requirement to wear PPE exacerbates impacts of high temperatures	Requirement to wear PPE exacerbates impacts of high temperatures	Requirement to wear PPE exacerbates impacts of high temperatures
	Summer 2022 Heatwave produced failures in critical infrastructure such as freezers and critical air conditioning			
Data and future projections	More frequent higher temperatures for longer duration.			
Adaptation Considerations	Assess and adapt building fabric to adapt to current and future need. Consider shading for buildings, external shading (including tree cover) at inpatient sites, natural ventilation, disperse heat in areas such as kitchen and servery.			
	Future proof new building design and construction in line with Net Zero Carbon Building Standard			
	Cool spots in buildings.			
	Improved insulation			

UV radiation	County	Bromyard	Leominster	Ross
Past Experience	N/A	N/A	N/A	N/A
Data and future projections	Difficult to predict. Hotter peak daytime temperatures could discourage exposure to the most harmful effects. However, potential for more sunburn and cancer due to harmful UVB radiation.			
	Cloud cover levels may increase or decrease due to global warming. Changes in cloud cover and air pollution (e.g. smoke from wildfires) could reduce UVB exposure			
	Potential benefit for Vitamin D synthesis if more exposure.			
	General education about the harmful effects of UV exposure to continue.			
	The benefits of more outdoor activity with appropriate clothing and sunscreen may outweigh the negative effects of managed UV exposure.			
Adaptation Considerations	Sunscreen for staff and patients.			
	Outdoor shaded areas (natural i.e. trees and man-made such as sails)			
	Consideration of immediate and long-term health impacts from projected changes			

Farmland and forest fires	All Sites
Past Experience	N/A
Data and future projections	Wildfires in the county, which may affect staff or patients but impact not recorded.
	Trust buildings not directly affected
Adaptation Considerations	Public health advice for staff and patients.
	Digital tools to enable patients to be seen in other locations if access to sites affected by fire.
	Firebreaks in vegetation near key sites

c. Cold conditions

Cold snaps	All Sites
Past Experience	Staff access to/from work during snow storms. Workforce absence due to external factors e.g. school closures/ childcare responsibilities.
	Onsite slips, trips and falls, high number of patients with broken limbs
	Gritting runs can be erratic, shortage of major routes, large hills on most of the main routes into the county
Data and future projections	Increased awareness and inclusion in winter planning
	Cold weather information through global emails and other social media
Adaptation Considerations	Continue with current planning arrangements
	Emergency on site accommodation, catering and 4x4 volunteers are already in place and have been used

d. Storms and winds

Storms and high winds	All Sites
Past Experience	Roads blocked due to storm debris
	Drains and water courses blocked due to more leaves, twigs and larger items
	Roof damage,
	Restricted access to patients in the community/ missed appointments
	Workforce absence
Data and future projections	Greater frequency and intensity of named storms
Adaptation Considerations	Revise PPM schedules to address areas of concern
	Condition surveys undertaken, suitability of roofing materials and other impacted building elements is assessed
	Plan for disruption to power supply, liaise with National Grid, particularly to non-hospital sites.

e. Vector and water borne diseases

Disease type and prevalence	All Sites
Past Experience	N/A
Data and future projections	Increased likelihood of disease outbreaks of existing or novel infectious diseases.
	Could impact volume of community nursing patients.
Adaptation Considerations	Review risks of onsite or nearby standing or flowing water and potential for increased water borne disease.
	Take a lead from UK Health Security Agency on this issue. Continued support from infection prevention team Work with public health to communicate with public regarding risks

f. Supply of food

Food supply	All Sites
Past Experience	Climate change impacts affecting harvests overseas and in the UK and therefore supply costs.
Data and future projections	Lack of access to affordable, fresh food could impact nutrition of service users, staff and our catering team ability to supply meals.
	Limited choices of food could contribute to malnutrition and more strain on acute hospital admissions. Fresh produce costs may increase
Adaptation Considerations	Raise awareness of sustainable diets with colleagues, and patients.
	Diversify supply chain.
	Allotment options.
	Government and NHS nationally looking at the issue of food security
	Working with catering suppliers to improve the sustainability of the food they offer.
	Review policies and practical arrangements for Trust and inter-Trust storage of food and stockpiling capacity in case of supply chain disruption.
	Work with Procurement teams and our supply chains to identify adaptation and resilience work of suppliers themselves.

g. Air quality

Aeroallergens	County	Bromyard	Leominster	Ross
Past Experience	Hereford City has one Air Quality Management Area covering part of the A49 from Holmer to Belmont Road	No Air Quality Management Areas currently	Leominster has one Air Quality Management Area between Bargates and Dishley Street	No Air Quality Management Areas currently
	Herefordshire's air quality problems are mainly related to traffic.			
	Many patients resident in areas with poor quality air during increased temperatures, pollution aeroallergens trigger increased volume and severity of respiratory			
Data and future projections	Localised poor air quality if nearby wildfires with resulting health impacts Commissioning of services to respond to increased respiratory illness			
Adaptation Considerations	Monitor outside and indoor air pollution. Review if ventilation needs upgrading.			
	Working with the Council to monitor outside air pollution, effects of Green Travel Plan EVs to be assessed and further adaptations could be developed in light of this.			
	Work with local authority to improve accessibility, air quality and safety, and ease congestion.			
	Monitor outside and indoor air pollution. Discuss with Maintenance if ventilation needs upgrading.			
	Maintain and improve green spaces, planting species that can help reduce air pollution (based on expert input). Secondary benefits of carbon capture and reducing water flow.			
	Work with ICB, Population Health teams and other organisations to be prepared for changes in need associated with air quality. Reduced demand associated with improvements as a result of cleaner vehicles may be offset by deteriorating air quality associated with increased temperature, wildfires and storms.			
	Heat decarbonisation plan produced and plans in place to remove gas boilers.			

4. Our services

Climate change has been identified as the most important health threat of the century, but it is also the “greatest opportunity to redefine the social and environmental determinants of health”. Everyone working in health and care needs to prepare for and be equipped to respond to the health impacts of the climate crisis .

-Climate and health: applying All Our Health, Office for Health Improvement & Disparities, May 2022

2.

All of the above impacts can affect the Trust’s ancillary and clinical services. It is recommended that the operational plans for each of the relevant services below, includes a new section to consider adaptation opportunities that will preclude or delay the need to enact Business Continuity Plans (BCP).

In future, it is anticipated that amended operational plans will feed into this document to highlight the breadth and depth of adaptation and any enable stakeholders to consider synergies or replication within other services.

Ancillary	Clinical
Patient & Staff Travel	Pathology Services
Waste Services	Pharmaceutical supplies
Linen & Laundry Services	Community nursing
Catering Services	Palliative care
Sterile Services	Urgent Care
Supplies/ Stores Management	Infectious disease outbreaks
Utility provision	Respiratory conditions
Digital services	

It is recommended that future suppliers submitting tenders identify their climate change adaptation plan within the social value section of the tender.

a. Estates

To create a climate resilient estate, wherever practical buildings will need to:

- Have capacity to cope with rising temperatures,
- Be designed to deal with surface water drainage and flooding, including flood barriers, sand bags, reverse flow stops for toilets etc.
- Be built with sustainability in mind.
- Retrofitted to green standards and ensure buildings are insulated.
- Provide resilience to the shortage of energy and water.
- Change behaviour for working patterns and locations, to reflect the changing landscape and social needs of the area served.

Thus minimising the risk to individuals (both patients and staff).

[2] Climate and health: applying All Our Health - GOV.UK (www.gov.uk)

Where this is not practical due to limitations of the Estate, this will need to be reflected in the organisations Business Continuity Plans (BCPs).

b. Fleet preparation and transport advice

To be prepared for more extreme weather conditions in future, our staff will need to:

- Reduce journeys e.g. through planning and digital solutions like virtual appointments or tools.
- Regularly review where staff are and patient need/ hotspots are to ensure skilled staff are available for caseload redistribution in case access barriers arise.
- Not drive through flood waters.
- Ensure communication channels identified with staff so they know when there are roads closed due to flooding or other event, e.g. tree blockage.
- Build in resilience for a zero-emission fleet in the event of power cuts through battery storage and onsite renewable energy generation.

d. Operational preparation

To prepare our clinical colleagues we will need to:

- Understand the impact that extreme weather events will have on specific services (hence consideration within Operational plans and BCPs).
- Discuss with corporate and HR colleagues, the impact that extreme weather events will have on staff, which in turn may impact service delivery.
- Understand the changes in volume of patients with specific needs resulting from climate change, e.g. PTSD after extreme events, respiratory or cardiovascular health impacts.
- Understand who is most vulnerable, where they are and how to adapt services to meet their needs, e.g. if there are road closures affecting community care or power or internet disruption affecting home treatment or virtual appointments.
- Work with the ICB, public health and other organisations to understand the impact of climate change on health inequality and vulnerability.

5. Adaptation actions

> Adaptation in relation to health and social care are actions or processes that reduce mortality and morbidity associated with climate change, while strengthening the sector's capacity to provide a high standard of care while the climate changes
> -Third Health and Social Care Adaptation Report, 2021

3

WVT has recognised that adaptation is needed, identifying the climate hazards that could affect our infrastructure, staff or patients; and has forged links with Herefordshire Council, acknowledging that joint working will be required to address local climate adaptation.

Each section below details actions the Trusts will take to begin to address climate change adaptation requirements.

a. Collaboration and governance

1. Establish a Climate Change Adaptation working group.
2. Engage the ICB/ICS to influence adaptation needs across the region and increase activity across Herefordshire and Worcestershire; sharing learning and good practice.
3. Identify the internal governance for climate change adaptation activity and links with local organisations such as across the Foundation Group, property landlords such as NHS Property Services and local authorities.
4. Work with Local Resilience Forum to identify local risks and Public Health team to communicate risks across the area.

b. Identify local climate impacts

1. Complete an internal or consultant led adaptation project to identify local hotspots for climate change risks.
2. Map (increased) risk of flooding for all sites within the organisation.
3. Review the performance of our buildings.
4. Document infrastructure network connectivity and interdependencies.
5. Conduct further research will be needed to consider the local impacts on our estate, staff, patients and the goods and services we depend on, identify specific vulnerabilities and co-dependent determinants of health.
6. Identify adaptation actions that provide resilience (see Section d.).

c. Procurement

1. Increase awareness of climate change adaption requirements with suppliers.
2. All future tenders request tenderers to identify their climate change adaptation and resilience plan within the social value section of the tender.
3. Identify the critical path within the supply chain and any issues that may arise with an extreme weather event, and identify an alternative before the event occurs.

4. Consider appropriateness of regional hubs for stock, e.g. reduce reliance on one location for example one laundry provider.
5. Work to identify any providers with high dependency at place (for example supply key stock) and consider mitigations to address.
6. Encourage suppliers to apply for the NHS England Evergreen Framework to enable Trusts to identify 'greener' suppliers (Due to launch in 2023).

d. Practical adaptations

1. Consider evidence-based practical changes on site to mitigate direct impacts of climate change such as:
    i. Development of green infrastructure[3];
    ii. Sustainable urban drainage;
    iii. Provision of cooling shelters;
    iv. Install permeable or cool pavements on site;
    v. Encourage active travel (to counter the negative health impacts of climate change);
    vi. Passive cooling (mechanical cooling if essential); Improve ventilation;
    vii. Install cool roofs (e.g. reflective surfaces) or green roofs and walls;
    viii. External shading and shutters and internal blinds or curtains;
    ix. Mediation of heat risk e.g. change daily routines or location of specific groups or services to minimise impacts of heatwaves;
    x. Communicate heat health action plans, particularly to vulnerable staff and patients.

e. Raising awareness

1. Education, training and raising awareness and communicating the need to adapt will be important in the short term. Lack of knowledge is a barrier to change therefore we need better communication of climate risks for managers and (frontline) staff.
2. Training requirements and guidance on how to respond to extreme weather events, including for community staff.
3. It is also important for people to understand how serious a threat extreme temperature and heat can be. Heatwave plans do protect the public during the alert periods (hottest days) but are known to be less effective when no alert is issued. People do not take heed of the advice about hot weather, perhaps because people often feel positive about warm summer days and do not see the risk to health. At most it may cause discomfort. As a consequence, many people, including the most vulnerable, do not act always act in their own best interest.

[3] Use nature-based solutions to reduce flooding in your area - GOV.UK (www.gov.uk)

f. Improved response to weather events

1. Consider adaptation opportunities in service specific operational and business continuity plans.
2. Start to record impacts so they can be monitored and reported on, trends identified, and further adaptations made. Consider how this can be integrated within and between organisations, e.g. develop an adverse weather event reporting procedure and share between Trusts.
3. Mapping of staff, service users and climate vulnerable hotspots.
4. Information, including targeted warning systems, support to individuals and organisations who may be most at risk, to help them take basic action to be more resilient to climate change influencing fundamental changes in behaviours.
5. Social impacts of climate change - migration, transient populations or community resilience.

6. Adaptation Plan timetable

Topic area	Action	2024	2025	2026	2027	2028
Collaboration and governance	1. Establish a Change Adaptation working group.					
	2. Create individual activities to achieve the aims of the Plan.					
	3. Identify the internal governance for climate change adaptation activity and links with local organisations such as the Foundation Group, property landlords such as NHS Property Services and the local authorities					
	4. Work with Local Resilience Forums to identify local risks and Public Health teams to communicate risks across the area.					
Identify local climate impacts	5. Complete an internal or consultant led adaptation project to identify local hotspots for climate change risks.					
	6. Review risk of flooding.					
	7. Assess the performance of our buildings.					
	8. Infrastructure network connectivity and interdependencies.					
	9. Further research will be needed to consider the local impacts on our estate, staff, patients and the goods and services we depend on, identify specific vulnerabilities and co-dependent determinants of health.					
	10. Identify actions to adapt.					
Procurement	11. Increase awareness of climate change adaption requirements with suppliers.					

Topic area	Action	2024	2025	2026	2027	2028
	12. All suppliers of goods and services to identify their climate change adaptation plan within the social value section of the tender.					
	13. Identify the critical path within the supply chain and any issues that may arise with an extreme weather event, and identify an alternative before the event occurs.					
	14. Consider appropriateness of regional hubs for stock, e.g. reduce reliance on one location for example one laundry provider.					
	15. Work to identify any providers with high dependency at place (for example suppliers of key stock) and consider mitigations to address.					
Practical adaptations	16. Consider practical changes on site to mitigate direct impacts of climate change					

Topic area	Action	2024	2025	2026	2027	2028
Raising awareness	17. Raising awareness and communicating the need to adapt will be important in the short term. Lack of knowledge is a barrier to change therefore we need better communication of climate risks for managers and (frontline) staff.					
	18. Training requirements and guidance on how to respond to extreme weather events, including for community staff.					
Improved response to weather events	19. Consider adaptation opportunities in service specific operational and business continuity plans.					
	20. Start to record impacts so they can be monitored and reported on, trends identified, and further adaptations made. Consider how this can be integrated within and between ICS organisations, e.g. develop an adverse weather event reporting procedure and share between Trusts.					
	21. Mapping of staff, service users and climate vulnerable hotspots.					
	22. Information, including targeted warning systems, support to individuals and organisations who may be most at risk, to help them take basic action to be more resilient to climate change influencing fundamental changes in behaviours.					
	23. Social impacts of climate change - migration, transient populations or community resilience.					

Appendix 1: NHS Trust climate change projections

Climate change projections for Hereford

Season	Weather impact	Global temperature	County Hospital	Bromyard Community Hospital	Leominster Community Hospital	Ross On Wye Community Hospital
			HR1 2BN	HR7 4QN	HR6 8JH	HR9 5AD
Summer	Hottest day	Current (1991-2019)	34.1C	34.0C	33.5C	34.3C
		2C global warming	36.1C	36.3C	35.6C	36.3C
		4C global warming	40.8C	40.6C	40.3C	40.7C
	Summer days above 25C per month (on average)	Current (1991-2019)	3	3	2	3
		2C global warming	7	7	6	7
		4C global warming	16	16	14	17
	Rainy days	Current (1991-2019)	9	9	9	9
		2C global warming	8	8	8	8
		4C global warming	6	6	6	6
	Wettest days	Current (1991-2019)	56mm	51mm	43mm	57mm
		2C global warming	56mm	53mm	46mm	63mm
		4C global warming	62mm	58mm	49mm	63mm
Winter	Hottest day	Current (1991-2019)	17.8C	17.8C	17.4C	18.1C
		2C global warming	18.0C	18.1C	17.6C	18.3C
		4C global warming	19.6C	19.7C	19.3C	19.5C
	Rainy days	Current (1991-2019)	11	11	11	11
		2C global warming	11	11	11	11
		4C global warming	11	11	11	11
	Wettest days	Current (1991-2019)	63mm	78mm	70mm	59mm
		2C global warming	58mm	74mm	64mm	60mm
		4C global warming	61mm	67mm	67mm	60mm

Source https://www.bbc.co.uk/news/resources/idt-d6338d9f-8789-4bc2-b6d7-3691c0e7d138

Appendix 2: Flood risk

Flood risk according to NHS Flood Risk Tool Kit

Site	Risk level	
	Surface water flooding	River flooding
County Hospital HR1 2ER	High 100m	High 100m
Bromyard Community Hospital HR7 4QN	High 250m	High 100m
Leominster Community Hospital HR6 8JH	High 100m	Medium 500m
Ross Community Hospital HR9 5AD	High 100m	High 500m

Workbook: Flood Risk Toolkit (england.nhs.uk)

Flood risk according to Government long term flood risk

Site	Risk level	
	Surface water flooding	River flooding
County Hospital	Low Risk	Very low risk
Bromyard Community Hospital	Low Risk	Very low risk
Leominster Community Hospital	Low Risk	Very low risk
Ross Community Hospital	Very low risk	Very low risk

Your long term flood risk assessment - GOV.UK (check-long-term-flood-risk.service.gov.uk)

In the past 33 years there have been three floods at Wye Valley sites, all at the County Hospital, in each case an area of the car park and a single story self-contained office building have been flooded by Eign Brook, no clinical areas were directly affected and work-arounds have been put in place for the flooded area.

Assessment of flood risk of additional buildings will be completed during the timescale of this plan, liaising with property landlords such as NHS Property Services and the local authority.

Appendix 3: Legislation and Guidance

- Civil Contingencies Act 2004
- Public Services (Social Values) Act 2012
- Climate Change Act 2008
- Climate Change Act 2008 (2050 Target Amendment) Order 2019 enacting a Net Zero target by 2050
- NHS Sustainability Strategy, Sustainable, Resilient, Healthy People and Places (2014-2020)
- National Adaptation Programme (2018)
- Health and Social Care Act 2022
- UK climate change risk assessment (CCRA)
- HM Treasury's Sustainability Reporting Framework
- Public Health Outcomes Framework
- Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013
- The Stern Review 2006; the Economics of Climate Change
- Health Protection Agency (HPA) Health Effects of Climate Change 2012
- The National Adaptation Programme 2013: Making the country resilient to the changing climate
- Department of Environment, Food and Rural Affairs (DEFRA) 25 Year Plan

International

- United Nations (UN) Sustainable Development Goals (SDG's) 2016
- World Health Organisation (WHO) toward environmentally sustainable health systems in Europe 2016
- World Health Organisation (WHO) Health 2020; European policy for Health and Wellbeing
- World Health Organisation (WHO) Europe – Social Determinants and the Health Divide
- The Global Climate and Health Alliance; Mitigation and Co-benefits of Climate Change

Health specific

- The Marmot Review 2010: Fair Society, Healthy Lives
- NHS Standard Contract Sustainable Development requirements
- Sustainable Development Strategy for the Health and Social Care System 2014-2020
- Saving Carbon, Improving Health: a NHS carbon reduction strategy
- Adaptation to climate change for health and social care organisations
- The Carter Review 2016
- National Institute for Clinical Excellence (NICE) Physical Activity: walking and cycling 2012
- Health Technical Memoranda (HTM)'s and Health Building Notes (HBN)'s
- NHS Long Term Plan aims to reduce fleet air pollutant emissions by 20% by 2023/24 and to support the government's target to reduce emissions by 80% by 2050
- Principle 6 – NHS Constitution
- Public Health Outcome Framework
- Sustainable Transformation Partnerships (STP) Plans
- Lord Carter's review into unwarranted variation in NHS ambulance trusts 2018
- NHS Operational Planning and Contract Guidance 2020/21

Trust Specific

- Air pollution https://www.herefordshire.gov.uk/business-1/environment-pollution
- Adverse Weather Plan (EP.03) wvt-intranet.wvt.nhs.uk/media/66767/adverse-weather-plan-ep03-wvt-trust-wide-policy.pdf
- Business Continuity Policy (EP.07) wvt-business-continuity-policy-ep07-wvt-trust-wide-policy.pdf
- Climate predictions https://www.bbc.co.uk/news/resources/idt-d6338d9f-8789-4bc2-b6d7-3691c0e7d138 Based on Met Office climate figures
- Emergency Planning Response and Resilience (EPRR) policy (EP.04) https://wvt-intranet.wvt.nhs.uk/media/63117/emergency-planning-response-and-resilience-eprr-policy-ep04-wvt-trust-wide-policy.pdf
- Gov. UK Flood risk summary for the area Your long term flood risk assessment - Check your long term flood risk - GOV.UK (check-long-term-flood-risk.service.gov.uk)
- Local Climate adaptation tool https://lcat.uk/
- Met Office ukcp18 deadline finds V4 Aug 22 https://www.metoffice.gov.uk/binaries/content/assets/metofficegovuk/pdf/research/ukcp/ukcp18_headline_findings_v4_aug22.pdf
- Show your strips #ShowYourStripes
- Temperature and rainfall predictions https://www.bbc.co.uk/news/resources/idt-d6338d9f-8789-4bc2-b6d7-3691c0e7d138

Report to:	**Public Board**
Date of Meeting:	**7th March 2024**
Title of Report:	Trust Objectives 2024/25
Status of report:	**☒Approval ☐Position statement ☐Information ☐Discussion**
Report Approval Route:	N/A
Lead Executive Director:	**Chief Strategy Officer**
Author:	Alan Dawson, Chief Strategy and Planning Officer
Documents covered by this report:	N/A

1. Purpose of the report

To seek approval for the Trust's objectives for the 2024/25 planning year.

2. Recommendation(s)

That members approve the Trust Objectives.

3. Executive Director Opinion[1]

The attached objectives will form the priorities for the Trust in 2024/25. They have been developed in an iterative fashion, with the input of executives and non executives, the Trust Management Board and Group colleagues. These objectives reflect the priorities in the Trust Strategy and the known planning guidance at the time of development.

The Executive Team lead for each objective is listed and where appropriate the relevant KPIs are listed.

4. Please tick box for the Trust's 2022/23 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.

Introduction

The annual Trust Objectives signal the Board's key priorities for the coming year. These take account of Trust strategy, local priorities and national planning guidance.

Once approved, the objectives will be communicated across the Trust, used to shape the individual objectives of Executive Directors and of teams. Divisional objectives will be developed to support the delivery of the Trust objectives and these will be approved at management board.

These objectives will also be used to develop underpinning action plans and measures which will populate our Board Assurance Framework. The communications teams across the Group will also create a consistent approach for communicating them to all stakeholders to maintain the shared themes, whilst reflecting the local essence of them. The objectives are presented under each of the six pillars of the Trust Strategy; Quality, Digital, Workforce, Sustainability, Productivity and Research.

Quality

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

Lead: Chief Transformation and Delivery Officer

Urgent and emergency care is a key priority for the One Herefordshire Partnership (1HP) and therefore for the Trust. Partners have developed a blueprint for urgent and emergency care in Herefordshire that will require approval through an ICB process linked to the tender of urgent and emergency services. The Trust will work with partners to develop a business case that delivers the blueprint for improved care at lower cost and will hopefully be granted permission to deliver this scheme.

Key Performance Indicators: Development and delivery of the business case

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

Lead: Chief Transformation and Delivery Officer

Linked to the delegated management of the BCF, the Trust will work with partners through the Integrated Care Executive to review the performance, spend and outcomes of integrated services that support discharge. This will encompass Hospital at Home, developing a sustainable and affordable solution for Discharge to Assess and technological solutions to support people in their own homes for longer.

Key Performance Indicators: Stranded (7 & 21 Day); Criteria to reside

Links to Big Move 5: Home First supported by technology and collaboration

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

Lead: Chief Nursing Officer

Children's services has been an area of increasing focus for all 1H partners, as embodied in the Health and wellbeing Board's strategic priority of 'Best Start in Life'. Delivery of the associated implementation plan is crucial to delivering a transformed approach and improving the offering for children.

Key Performance Indicators: Delivery of the Implementation Plan

Digital

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

Lead: Chief Finance Officer

Part of the Trust's Digital Strategy: the current IT system within the Emergency Department (ED) has limited interoperability with other Trust systems. The Trust's main electronic record has ED functionality and the Trust is proposing to migrate to this system for improved interoperability, integration and functionality in order to improve care to patients.

Key Performance Indicators: IT project performance reports

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

Lead: Chief Finance Officer

Part of the Trust's Digital Strategy and a continuation of a similar objective from last year: great strides have already been made to eradicate paper records and these are expected to continue with the further roll out of the strategy.

Key Performance Indicators: Outpatient and Inpatient noting roll-out (%), % reduction in transport of patient notes

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

Lead: Chief Transformation and Delivery Officer

A key 1HP priority in order to reduce waste and duplication in the management of patient care pathways. Shared records have been adopted in a small number of settings and the usage continues to increase, benefitting patients. The Trust plans to continue to support both developments in the functionality of patient's records and increase the usage of shared records.

Key Performance Indicators: Shared record utilisation, shared record settings

Sustainability

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

Lead: Chief Medical Officer

The Trust will review its existing analysis of fragile services, completed alongside Worcestershire Acute Trust in 2022, and refresh this, working at System and Foundation Group level to seek sustainable solutions that provide a stronger footing for some of our smaller specialities.

Key Performance Indicators: Services provided through a lead provider approach, volume of mutual aid

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

Lead: Chief Transformation and Delivery Officer

Work completed to date has shown that for some long term conditions, outpatient referrals can be avoided by working closely with primary care networks (PCNs) and general practice. The Trust intends to review whether some services can shift their capacity into the community to avoid hospital referrals.

Key Performance Indicator: Implementation of LTC strategies

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

Lead: Chief Strategy and Planning Officer

Subject to planning permission being granted, the Trust will complete its phased Integrated Energy Solution plans with the building of centre on the Orchard Site at the County Hospital. The build will continue through 2024 and be functional in autumn 2025 and this major infrastructure scheme will impact across the Trust providing significant carbon reduction benefits on completion.

Key Performance Indicator: Project progress reports

Links to Big Move 3: Lead the NHS on carbon reduction

Workforce

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

Lead: Chief People Officer

A continuation of previous objectives that forms the long-term delivery of the Trust's Workforce Strategy, aligned to the NHS Workforce Plan.

Key Performance Indicators: Vacancy rate; turnover rate; staff survey results

Links to Big Move 2: Be a very flexible employer

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

Lead: Chief Strategy and Planning Officer

This objective is very much in response to feedback from our workforce and reflects an ambition in the Trust's Green Plan. Access to green spaces and catering options are known to be important for staff health and wellbeing. The Trust has plans to review and improve its green spaces and is working with partners to improve the catering offer.

Key Performance Indicators: Staff survey results, staff engagement feedback

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

Lead: Chief People Officer

Following a review of the Trust's performance against Equality, Diversity and Inclusion (EDI) objectives it has been proposed that the Trust should integrate its EDI objectives into everyday working for all staff to deliver tangible improvements rapidly.

Key Performance Indicators: Staff survey results

Productivity

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

Lead: Chief Operating Officer

The Elective Surgical Hub (ESH) opens in July 2024 and is not just a significant capital scheme but also signifies a major change in the way elective activity is managed both clinically and operationally. This dedicated building should herald an increased level of productivity and efficiency that will markedly improve patient waiting times. This is therefore of crucial importance to the Trust and the way it delivers into the future.

Key Performance Indicators: Theatre productivity and utilisation, patient cancellations, pre-operative pathway productivity

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

Lead: Chief Strategy and Planning Officer

Our Community Diagnostic Centre (CDC) will be minimally operational in March 2025 and fully open in the summer. As with the ESH, the CDC represents a significant departure from current practice, streaming high volume, lower complexity patient diagnostics away from the main hospital in order to drive up productivity and reduce waits. The CDC is therefore a top priority for the Trust in terms of pathway development, staff recruitment and patient preparation. Progress on this and the ESH scheme will be monitored through the Capital Programme Board and reported through to the Board.

Key Performance Indicators: Project progress reports

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

Lead: Managing Director

Following on from the devolving of responsibility of the Better Care Fund (BCF) to the 1HP under a memorandum of understanding, part of the work plan for 1H partners is to fully understand the system productivity across Herefordshire rather than in organisational silos. The 1HP has been considering for some time how it might measure system productivity and, to this end, an investment has been made in a 1HP system analysis function.

Key Performance Indicators: Set of indicators agreed and routinely reported at 1HP and associated governance.

Research

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

Lead: Chief Medical Officer

Essentially finalising, approving and delivering the Trust's Research Strategy. The aim is to foster a culture of research, innovation; working in partnership with others so that the Trust can offer the best, most efficient, and patient-centred ways of delivering care. The Trust will build on existing successes to improve patient care by developing an academic programme that will grow participation in research, increasing both the number of departments that are research active and opportunities for patients to participate.

Key Performance Indicators: Research participation; Number of studies open, number of staff and patients participating in research.

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

Lead: Chief Strategy and Planning Officer

A key element of the Academic Programme is to build up the Trust's educational facilities in order to meet the future training needs, in volume, breadth and quality. The Trust is developing a business case for a building on the County Hospital site that not only meets the needs of future learner but acts as a community asset for local residents. With support from Herefordshire Council, the project should take off in 2024 with delivery anticipated in 2026.

Key Performance Indicators: Business case development and approvals

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Emergency Preparedness, Resilience and Response [EPRR] Core Standards Report 2023-2024
Status of report:	☐**Approval** ☒**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	EPRR Committee
Lead Executive Director:	**Chief Operating Officer**
Author:	WVT Emergency Planning Officer
Documents covered by this report:	EPRR Core Standards 2023-2024 and WVT EPRR Action Plan 2024

1. Purpose of the report

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

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

All NHS organisations are required to undertake a self-assessment against the Core Standards relevant to their organisation. The Core Standards consists of 10 domains which are divided into 66 separate standards that NHS organisations are required to meet across EPRR continuum.

The 10 domains contained within the EPRR Core Standards follow:

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

Of these 66 standards WVT were assessed by NHSE/ICB to be fully compliant with 52 standards, and partially compliant with 13 and 1 non-compliance. In addition to the Core Standards, NHS England conducted a 'deep dive' exercise focused on training for 2023-2024.

Achieving an overarching position organisationally of partial compliance with a score of 78%.

This is an improvement from a Non-complaint position in 2022-2023.

The following areas WVT were non-compliant (numbers align to each core standard):

2. Governance - EPRR Trust Wide Policy.
12. Maintain Plans - Infectious Disease
13. Maintain Plans – New & Emerging Pandemic.
14. Maintain Plans – Countermeasures.
15. Maintain Plans – Mass Casualties.
19. Maintain Plans – Mass Fatalities.
23. EPRR Training & Exercise– Live exercise.
30. Response - Sitreps.
39. Cooperation - Mutual Aid Agreement.
44. Business Continuity (BC)–BC Policy Statement.
45. BC – BC Scope & Objectives.
50. BC – Evaluation.
53. BC – Suppliers and Providers assurance.
58. CBRN - Planning Arrangements.

In 2022-2023, WVT were non-compliance (scoring 76%) following check and challenge period. Improvement areas which influenced grading for 2024, includes training, documentation collaboration with NHSE, and delivery.

EPRR Training Delivery

WVT conducted 9 EPRR training and desktop exercises for the Q3/Q4 2023, with 2 Business Continuity exercises.

Lessons Learnt Log

WVT maintains a comprehensive lessons learnt log with extracts gaps identified during incidents, training and exercises. 70 initial actions/ 35 closed/ 21 actions in progress/ 14 remain open.

Areas where actions remain open: lock down: Hazmat & CBRN; Suspect Package, Bomb Threat, Marauding Attacker; Business Continuity; and Adverse Weather and Health Plan.

Business continuity, critical incidents and major incidents
WVT has dealt with the following events:

- Three x Business continuity events – Network Cable Outage (single event), phone outage, and power outage.
- Eleven x Industrial Actions – West Midlands Ambulance Service, Junior Doctors, Consultants and Radiographers.
- One x Maternity Escalation – Capacity.
- One x ITU Escalation – Capacity.

WVT 2024-2025 Action Plan

Action Plan focus areas:

- New Plans and SOP Development:
  - ICC Setup plans to cover sitrep.
  - Mass fatalities.
  - Business Continuity Management Strategy.
- WVT EPRR plans – Update plans against latest guidance, submit for collaboration with NHSE and monitor and maintain plan currency.
- Business Continuity – Business Continuity Management Strategy to be finalised, and WVT plan guidance template is be cascaded to divisions.

  BCMS Key Performance Indicators
  - Alignment with direction from NHSE and ISO 22301.
  - Every Ward, Department and Division having a bespoke BC Plan by 2025.
  - All BC plans used within the trust set to a standardised template by 2024 and reviewed within last 12 months as a minimum.
  - All Wards and Departments completing in depth BIA, and updating risk registers at least annually to identify emerging risks
  - Meeting recovery time objectives (RTO) and Recover Point Objectives (RPO) set out in BC plans when dealing with BC incidents
  - 100% of incidents being closed down with 'After Incident Reports' written and lesions identified being passed to Divisional Directors and the EPRR Team
  - Meeting the NHSE Business Continuity Core standards objectives with full compliance in 2024.
- EPRR Training & Awareness – Continued development of WVT EPRR portfolio of presentations and exercises to cover all plans and training needs. Training to extend to Level 2 staff and 4 executives. Loggists and Trust wide EPRR awareness.
- Plan Exercising and Testing – Provision of bi-monthly or quarterly exercising and testing of EPRR plans. WVT will conduct a live evacuation and shelter exercise in Q2 2024, furthermore there is a requirement to conduct a live CBRN exercise by Q2.
- Communication Testing – Regular bimonthly testing of communications response teams and red phones.
- Resources

2. Recommendation(s)

Click or tap here to enter text.

3. Executive Director Opinion[1]

Significant work has been undertaken across the last year to improve the Trusts response to the Core Standards.

Along with improve our Core Compliance form last year there were areas of Good Practice recognised by the NHS England team which included our detailed lockdown plans, the delivery of a number of virtual and table top exercise with teams and our incident learning processes.

There is continued work to do over the next year to become Substantially / Fully Complaint but I would like to highlight to the Board the significant progress made to date.

4. Please tick box for the Trust's 2022/23 Objectives the report relates to:

Quality Improvement

☐ **Improve the experience of patients receiving care by improving our clinical communication**

☒ **Improve patient safety through implementing change as we learn from incidents and complaints across our system**

☐ **Reduce waiting times for diagnostics, elective and cancer care**

☐ **Develop a new integrated model for urgent care in Herefordshire improving access times and reducing demand for hospital care**

Integration

☐ **Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meets demand on the day**

☐ **Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level**

☐ **Improve quality and value for money of services by making a step change increase in the range of contracts that are devolved to the One Herefordshire Partnership**

☐ **Join up care for our population through shared electronic records and develop a patient portal to transform patient experience**

Sustainability

☐ **Create sufficient Covid-safe operating capacity by delivering plans for an ambulatory elective surgical hub**

☐ **Stop adding paper to medical records in all care settings**

☐ **Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain**

☐ **Increase elective productivity by making every referral count, empowering patients and reducing waste**

Workforce and Leadership

☐ **Improve recruitment, retention and employment opportunities by taking an integrated approach to support worker development across health and care**

☐ **Develop our managers' skills and system leadership capability**

☐ **Continue to improve our support for staff health and wellbeing and respond to the staff survey**

☐ **Further develop place based leadership and governance through the one Herefordshire Partnership and Integrated Care Executive**

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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG.	Action to be taken	Timescale
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. <u>Evidence</u> Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	**Partially compliant**	Closed –Policy approved	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	**Partially compliant**	Increased EPRR visibility with IPC	Q2 2024
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Partially compliant**	Training required.	By Q1 2024

14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	**Partially compliant**	IPC Review underway, EPC approval, training required.	By Q1 2024
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	**Partially compliant**	Review required and approval by PRG/ EPC	– Q1 2024
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Partially compliant**	WVT Mass fatalities plan to be developed	Q2 2024

23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	**Partially compliant**	Follow up action: • live exercise at least once every three years • command post exercise every three years.	By Q1 2024
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	**Partially compliant**	Development of ICC handbook	Q1 2024
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	**Partially compliant**	Sign off of Mutual Aid Agreement	Q1 2024

44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	**Partially compliant**	To be updated against NHSE C&C notes.	Q1 2024
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	**Partially compliant**	To be updated against NHSE C&C notes.	Q1 2024
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	**Non Compliant**	KPIs to be added to plan –	

53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	**Partially compliant**	Further engagement with procurement to embed EPRR requirements regarding assurance of Providers and Suppliers business continuity arrangements.	
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	**Partially compliant**	To be updated against NHSE C&C notes.	

Core Standards Assurance Outcome – Sept 2023
13 Areas of Partial Compliance

1 Area of Non-Compliance

66 Separate Core Standards – 13 Partial Compliance/ 1 Non-Compliant = 52 areas complied with. (discounting any fractional scoring for partial).

52/66 x 100 = 78%

Substantially Compliant - The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards

Partial Compliant - The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards

Non-compliant - The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Patient Experience Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☒**Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To update the Board on the progress in key areas for improving patient experience, supporting the delivering of the Trust quality priority for 2023-24.

2. Recommendation(s)

The Board are asked to note;

- Positive results in the national maternity survey
- Continued increase overall in 2023 in complaints and concerns compared to 2022.
- Response times to complaints and concerns does not meet the Trust standards.
- Family and Friends Test (FFT) scores remain high however there is a slight downward trend in response rate, dipping slightly below the national average for the first time since introducing the text messaging service.

3. Executive Director Opinion[1]

The data is accurate at the time of reporting. The numbers of open and overdue complaints is of concern and needs addressing as a priority. The maternity survey results are to be celebrated. A more detailed analysis of themes arising from complaints, concerns and FFT feedback needs to be undertaken at divisional/ specialty level and should be included in the divisions quarterly reports.

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

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

Patient Experience Report

Introduction

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

Friends and Family Test (FFT)

The Trust are now using a text messaging services to receive feedback in line with the national Friends and Family test programme.

FFT text message service rollout

The text messaging service is now live in the following services;

- All inpatient areas (inc. community beds)
- All outpatient departments (last report only Oxford Suite rolled out)
- Maternity

Outstanding are the following services below;

- Community Services
- Paediatrics

Since last reporting the team have been exploring adding Radiology to the text messaging service. As this was not in the original contract, scoping has commenced to understand how we make this work.

FFT Results

Below is the FFT results data from October 2023 – December 2023.

Headlines

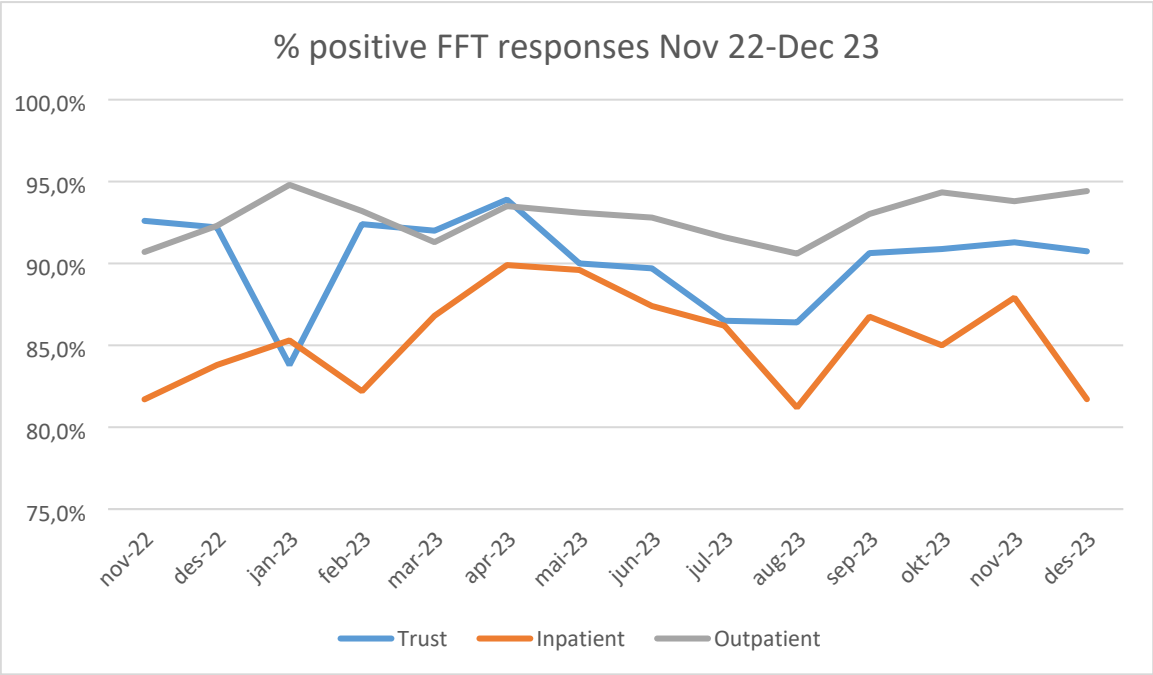
Between 1st October 2023- 31st December 2023;

- The Trust has sent 59,170 messages for feedback.
- 13,715 responses were received (18.96% response rate overall)
- 90.99% of our patients have given positive feedback.
- 15.75% patients gave further comments in regards to how they scored their experience.

Quantitative Data

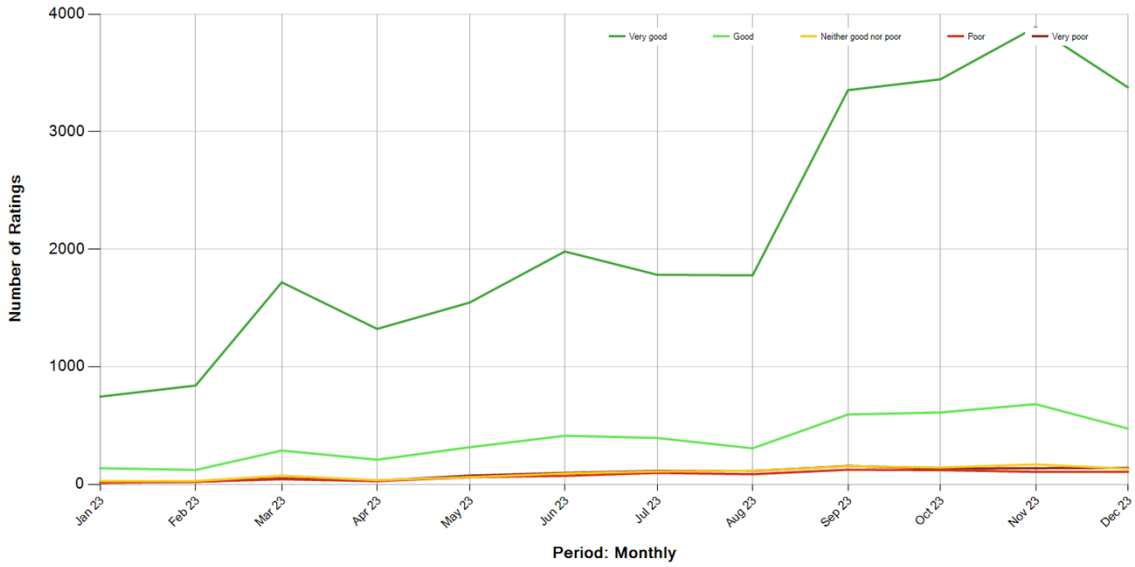
Our latest results in the table and chart below, are the percentage of responses that scored their experience positively (recommendation rate).

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Trust	92.6%	92.2%	83.8%	92.4%	92.0%	93.9%	90.0%	89.7%	86.5%	86.4%	90.63%	90.88%	91.29%	90.74%
Inpt	81.7%	83.8%	85.3%	82.2%	86.8%	89.9%	89.6%	87.4%	86.2%	81.2%	86.75%	85.0%	87.91%	81.71%
OP	90.7%	92.3%	94.8%	93.2%	91.3%	93.5%	93.1%	92.8%	91.6%	90.6%	93.02%	94.34%	93.80%	94.42%



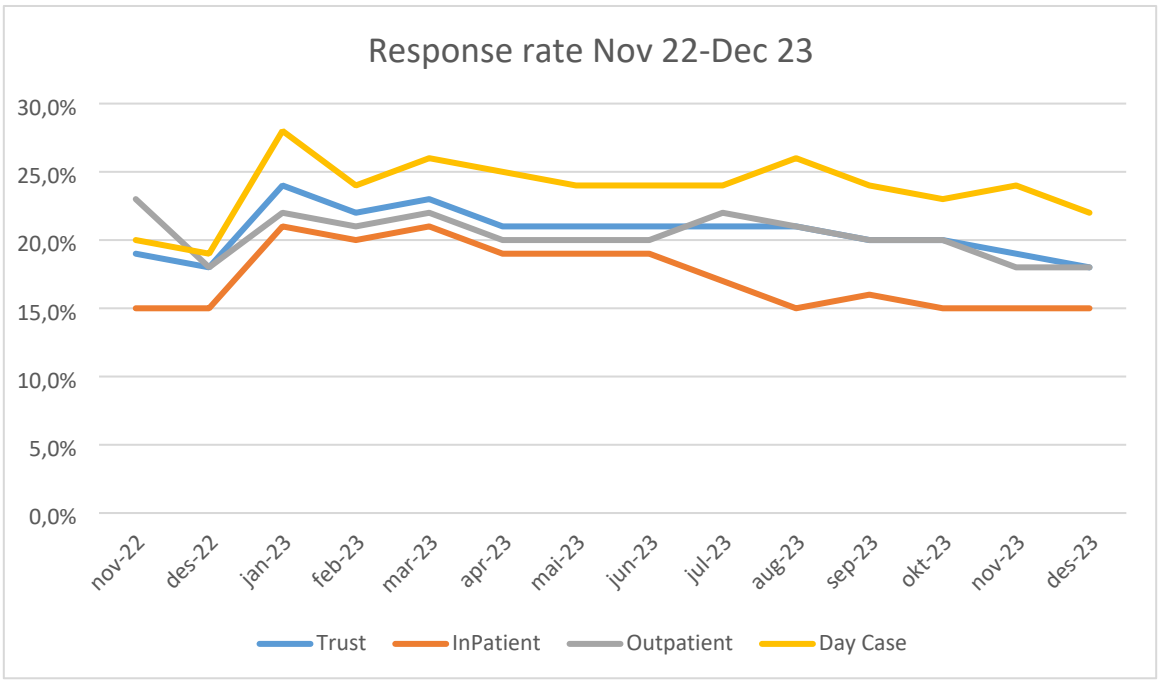
Overall, we continue to see the highest satisfaction ratings in outpatients, at a consistent level each month, inpatients shows a fluctuating picture in comparison but showing an overall downward trend in positive responses.

The chart below shows the actual response received by patients and overwhelmingly the most popular response is 'very good' month on month.



Since moving to text messages, the Trusts average response rate is 21%, however this was declined in the last quarter to 18.75%, the lowest quarterly response rate since commencing with the service. A breakdown by service type is shown in the table and chart below.

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Trust	19%	18%	24%	22%	23%	21%	21%	21%	21%	21%	20%	20%	19%	18%
Inpatient	15%	15%	21%	20%	21%	19%	19%	19%	17%	15%	16%	15%	15%	15%
Outpatient	23%	18%	22%	21%	22%	20%	20%	20%	22%	21%	20%	20%	18%	18%
Day case	20%	19%	28%	24%	26%	25%	24%	24%	24%	26%	24%	23%	24%	22%

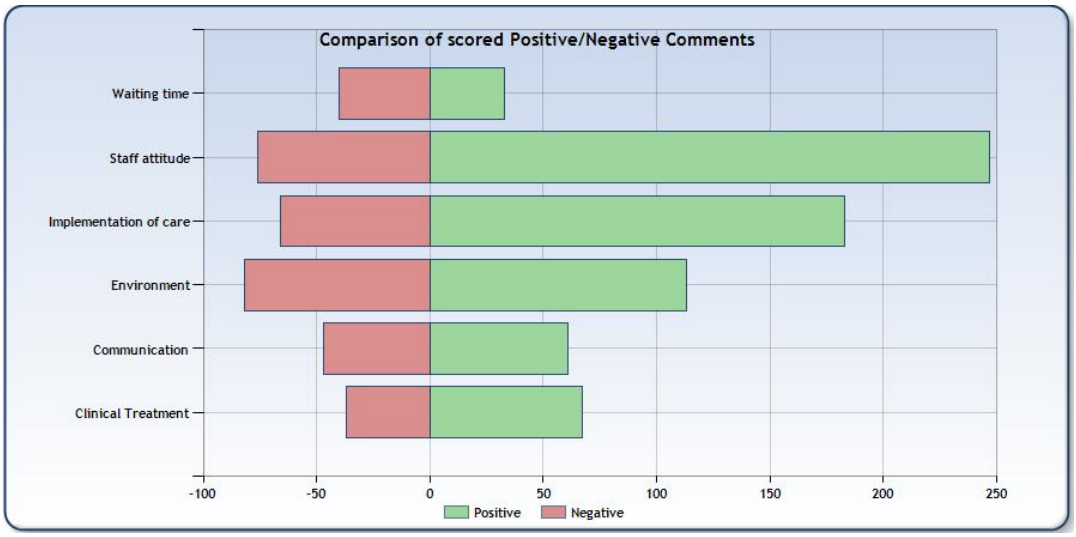


Qualitative Feedback

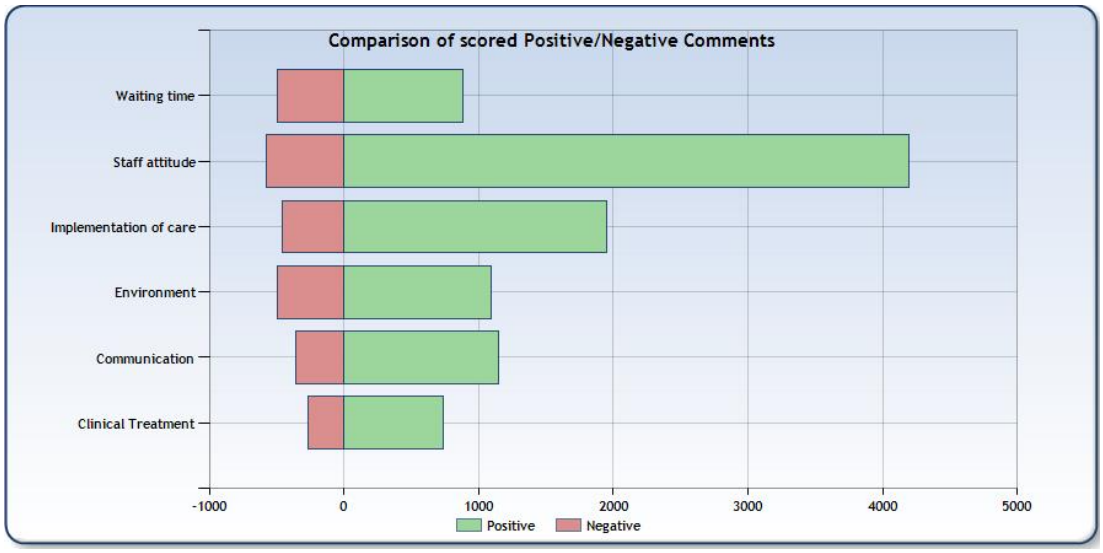
After patients have answered the initial FFT question, they are asked for comments. The free text comments message provides a wealth of qualitative data. The Envoy systems allows themes to be identified and categorises the qualitative feedback thematically and by the negative or positive nature of the comment.

The charts below show the top 6 themes broken down by inpatient and outpatient responses for this quarter.

Inpatient responses



Outpatient responses



Overall outpatient areas have the most positive feedback. However in both inpatient and outpatient areas, for each theme, the positive feedback outweighs the negative. In particular relating to staff attitude.

Divisions undertake the same analysis of this data and identify areas of good practice and areas for improvement. Divisions are presenting at Patient Experience Committee (PEC) throughout Q4, with a view to regular reporting throughout the year being implemented. The analysis and discussion at PEC has allowed triangulation of feedback and identified trust wide areas of improvement such as signage and way finding.

The Sister for Outpatients presented the FFT data for the department at PEC. This covers 26 specialties. Patient feedback is shared in staff newsletters, at staff meetings and is displayed throughout the departments. Where a patient has identified a member of staff by name the feedback is given to the employee personally prior to the feedback being displayed.

The feedback posters are also laminated and distributed so they are visible to staff and patients.

The positive approach to how this data is used both to generate improvement but also to share with staff has celebrated as good practice. Staff appreciate receiving the feedback and was seen as a motivator and reassurance they are valued in their role.

This year's Quality Accounts will have a section highlighting the 'You said, we did' action taken across the Trust in response to FFT feedback.

Surveys

Since last reporting the following annual survey results have been published;

- National Maternity Survey

National Maternity survey

Headlines

The national survey results were published in February 2024 (appendix 1). The national survey provides direct feedback from women about their experience of maternity care, including antenatal care, labour and birth and postnatal care.

The Trust were in the five top performing Trusts in the region for all of the 8 main categories which include, the start of your care during pregnancy, antenatal check-ups, during pregnancy, your labour and birth, staff caring for you, care in the ward after birth, feeding your baby, and care at home after birth. The Trust score has significantly increased in eight areas compared to the previous year's results, with no regression in any of the areas, remaining about the same as other Trusts. The Trust is above the national average for the majority of areas in the survey.

The Trust has also scored in the top five Trusts nationally for:

- being able to speak to the midwife as much as the patient wanted
- being given appropriate information before induction of labour
- being taken seriously if raising an issue
- being able to access support and advice round the clock for feeding your baby
- receiving help and advice in the six weeks after the birth of your baby

Complaints

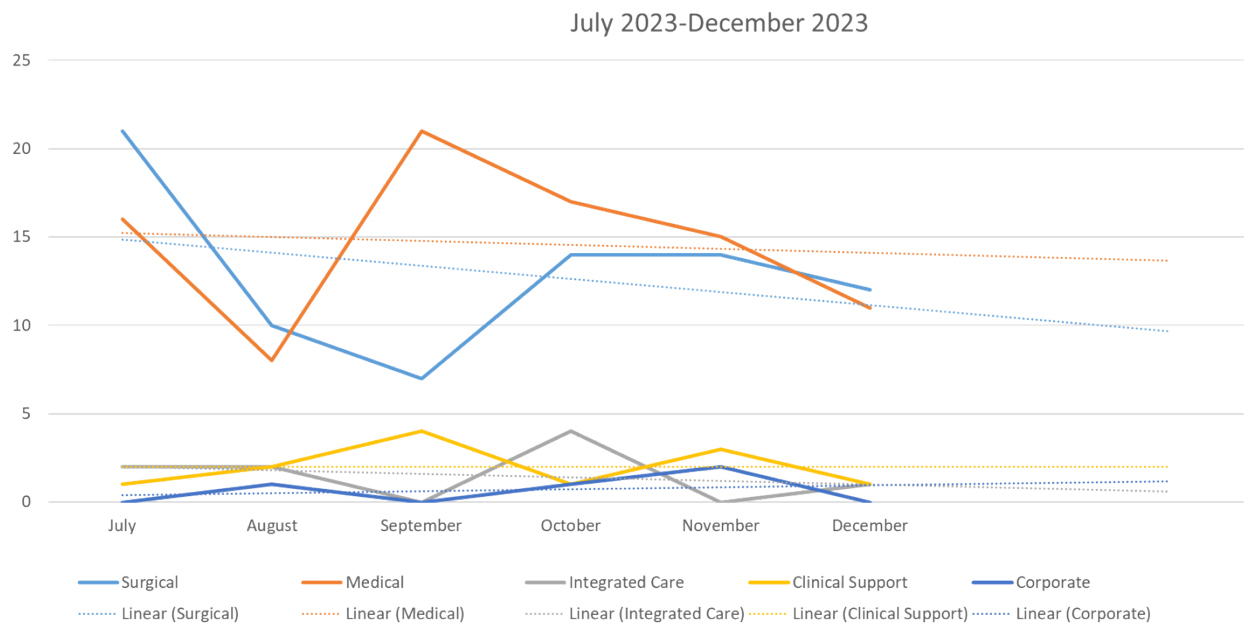
This section of the report provides;

- KPI data update
- Analysis of complaints position by Division.
- PHSO model complaint guidance

Complaints data

KPI	September	October	November	December
Number of complaints 2022	18	22	19	18
Number of complaints 2023	36 ↑100%	40 ↑82%	36 ↑89%	26 ↑44%
Complaints resolved in timeframe	36.8%	31.4%	52.2%	17.6%

A comparison of Q3 data between 2022 and 2023 show a significant increase in the number of complaints received. However the chart below shows that overall there is a downward trend in complaint numbers month on month since the peak in July.



Complaints position

There were 133 open complaints noted at the time of Patient Experience Committee, with 103 (77%) of these overdue.

Division	Open Complaints	Overdue Complaints
Medical	59	43 (73%)
Surgical	63	52 (83%)
Integrated Care	2	1 (50%)
Clinical Support	4	3 (75%)
Corporate	5	4 (80%)
TOTAL	133	103

The table below shows that the directorates with the highest number of open complaints as;

- Women's and Children's (29)
- Head, Neck and Orthopaedics (23)
- Acute and Emergency (38)

These are the same directorates as previously reported in September 2023.

Further analysis of overdue complaints found that 33 (32%) cases were either awaiting sign off, had a meeting pending or the final responses had been sent but the case had not been closed on InPhase. Prioritising these administrative elements of the complaints process will improve the position. This has been shared with the Divisions and there was a clear commitment to progress this.

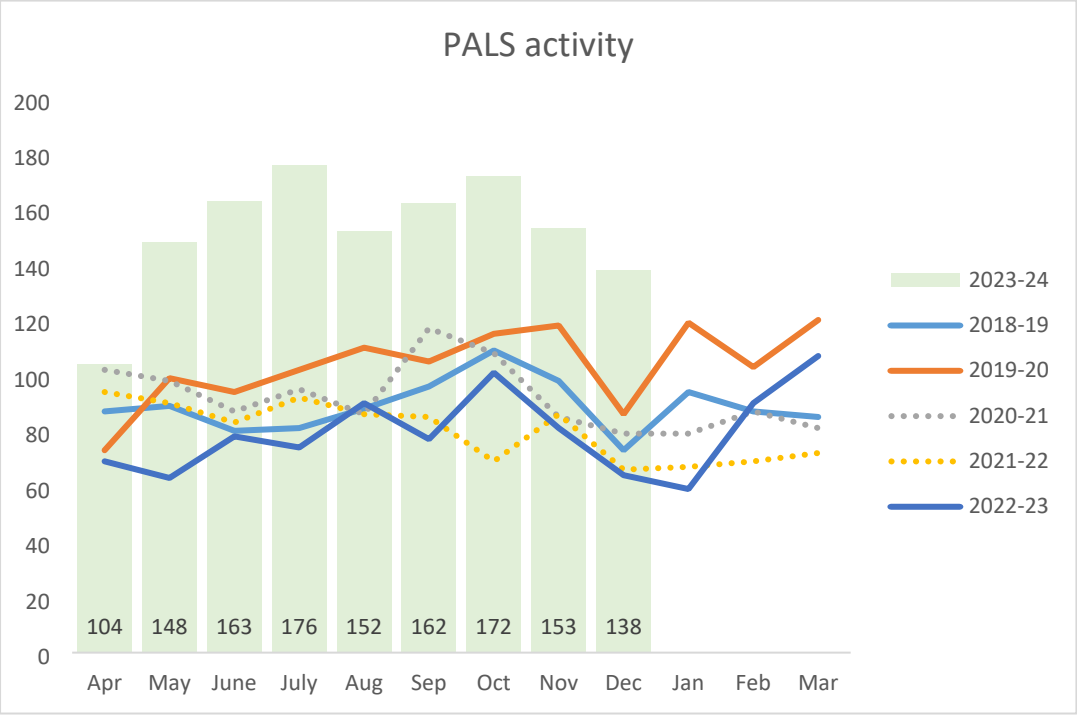
Complaint response times

Responses times have not improved and continue to vary month on month with the best response rate being 52% (November) since April 2023. When looking at 2022 overall versus 2023, the response rate has worsened.

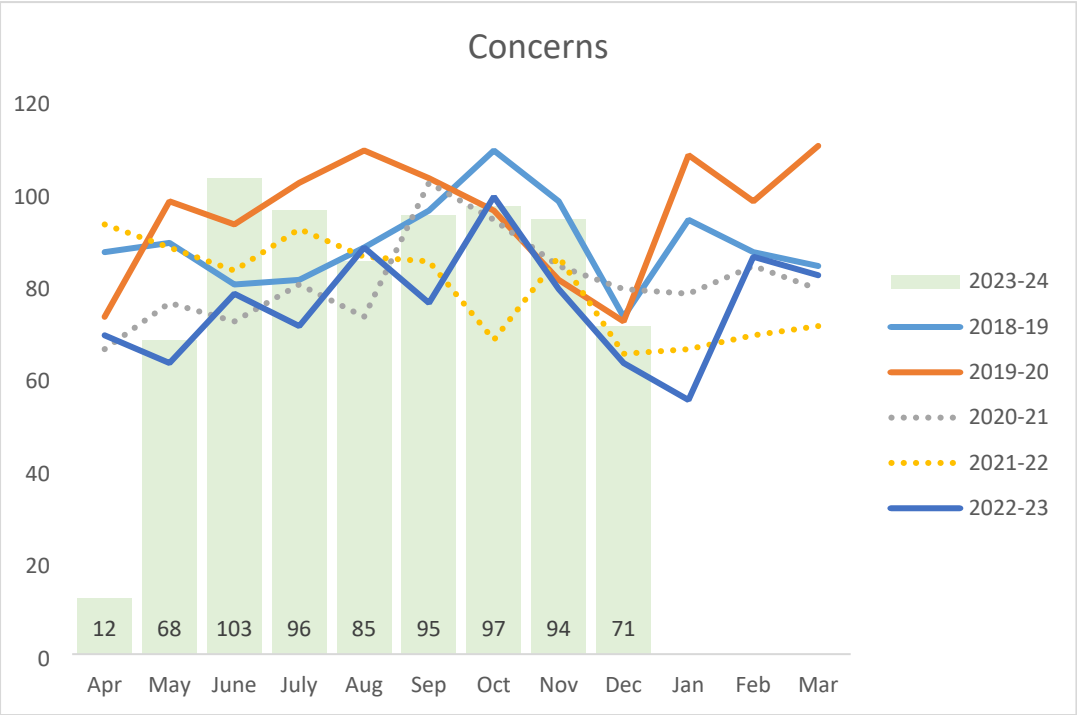
Complaints response times over a calendar year were analysed, based on Trust total of 278 closed complaints between January 2023 and December 2023. This showed that 75% of complaints were processed within 69 days, with the Trust average being 64 days. This is a worsened position compared with 2022 when the Trust average was 58.5 days.

Concerns

After undertaking the in depth analysis of complaint response times, a similar review of concerns was conducted. Whilst concerns do not have a statutory mandated response time, the Trust standard for resolving a concern is 5 days. The chart below details the contacts with the Trust PALS service; this includes concerns, enquiries and compliments. Overall the activity in PALS has increased significantly in 2023-24.

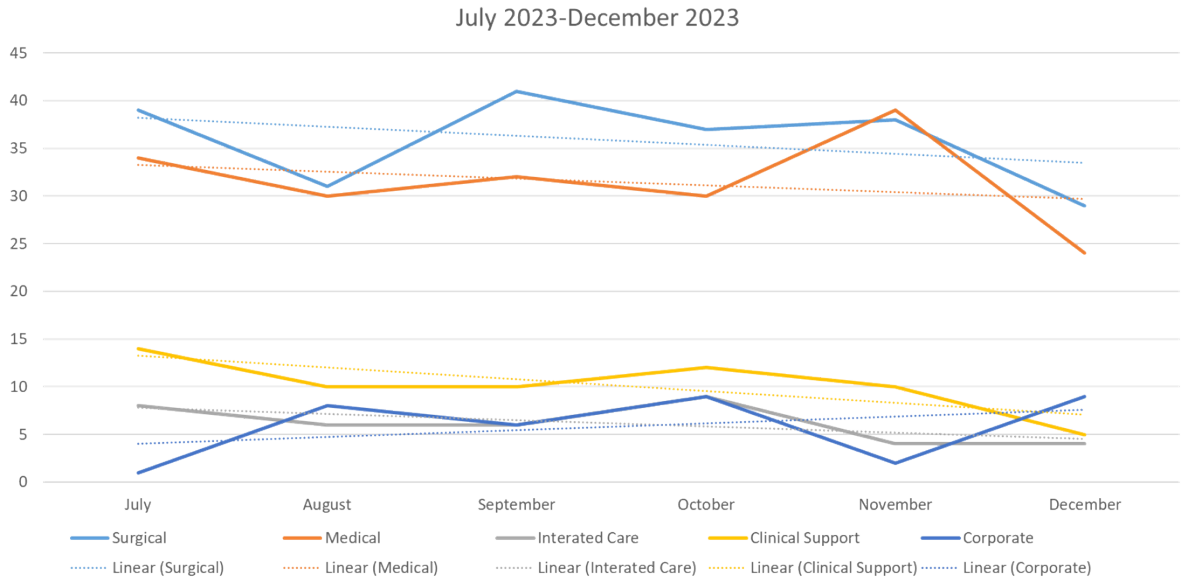


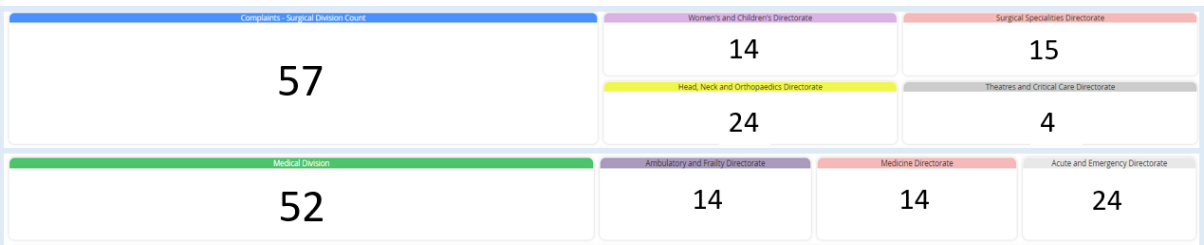
This shows the amount of activity of the PALS teams. Compliments are documented and shared with the relevant areas, or services send in a record of compliments to be logged centrally. Enquiries are simple questions that the PALS team will seek the answer to and respond. Concerns require investigation by the service/ area involved and a response provided by that service to the person raising the concern. This can be done via email or telephone, or in some cases a meeting will be arranged.



Concerns have not significantly increased in the last 12 months but overall numbers have been higher since the start of the pandemic.

The breakdown of concerns by division mirrors complaints; medical and surgical receive the majority of concerns. Similarly Head, Neck and Orthopaedics and Acute and Emergency directorates have the highest number of open concerns.





There is similar issues with overdue concerns and response times as there are with complaints.

At the time of reporting 83% of open concerns were overdue. When reviewing the last 500 concerns, the average time to resolve a concern is 29 days. Similar issues were identified where close dates are not being added to records. It was also highlighted at PEC that where handlers are reassigned, matrons were not made aware and therefore could not monitor responses being undertaken in a timely manner. The PALS team will ensure matrons are copied into any changes to concern handlers moving forward. In addition the team meet with colleagues in areas with a high volume of concerns and support to respond to those concerns.

PHSO Model Complaint Guidance

There have been significant changes to the NHS complaint standards and PHSO guidance regarding model complaint and concern handling. The guidance will act as a key tool for the Trust to improve both the complaints and concerns process. The team will undertake a gap analysis to determine where WVT's processes could be aligned with best practice guidance. This will be undertaken prior to review of the Trust Complaints Policy over Q4 2023-24 (gap analysis) and Q1 2024-25 (policy review) and will be overseen by PEC.

Conclusion

Whilst FFT feedback remains largely positive we are seeing a downward trend with response rates. This might be due to maternity coming online where response rates are currently lower than other services. This is being monitored.

Complaints and concerns continue to increase which impacts the Trust ability to meet the response time standards. Administrative issues have been identified which we expect to make a small impact however delays are largely operational. A programme of work is being developed to look at the new best practice guidance and improve current policies and processes to combat this.

The maternity survey results are positive and mirror the improvements in the service that saw the CQC rating move to 'Good' earlier this year. PEC will be incorporating updates on patient survey results and related action plans on a rotational basis throughout the year and will provide assurance through routine reporting to Quality Committee going forward.

NHS Maternity Services Survey 2023 Benchmark Report

Wye Valley NHS Trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

207 invited to take part

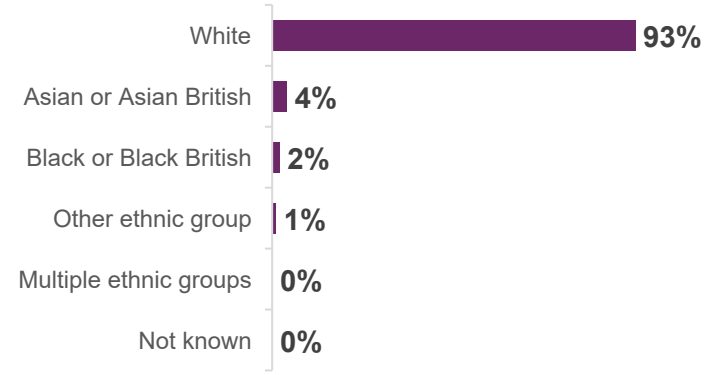
107 completed

54% response rate

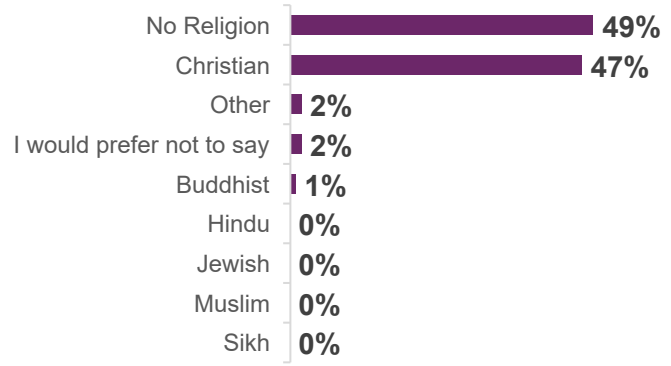
41% average trust response rate

49% response rate for your trust for 2022

ETHNICITY



RELIGION



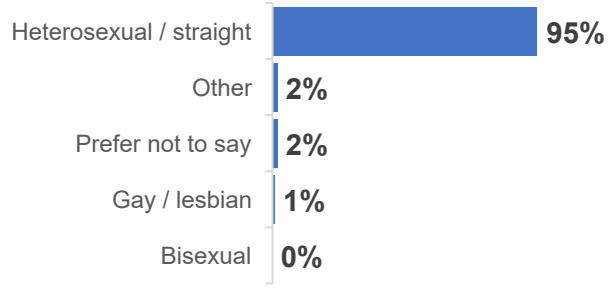
PARITY

How many babies have you given birth to before this pregnancy?

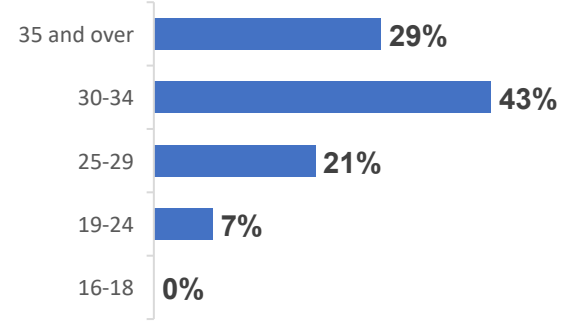
of respondents gave birth to **their first baby.**

SEXUALITY

Which of the following best describes how you think of yourself?



AGE

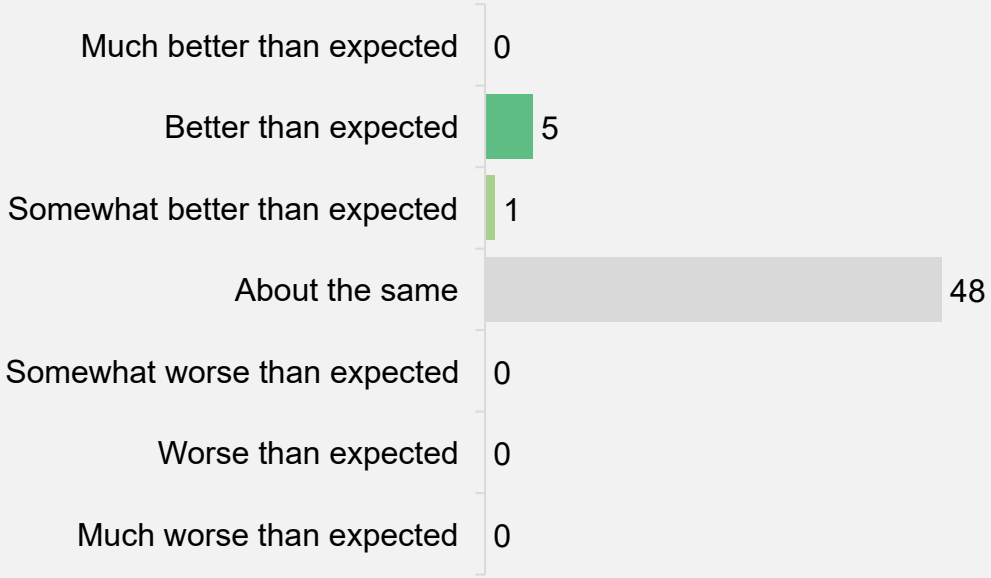


Please note that demographic information is unweighted.

Summary of findings for your trust

Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.



Comparison with results from 2022

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2022 results.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with average trust score across England)

Bottom five scores (compared with average trust score across England)

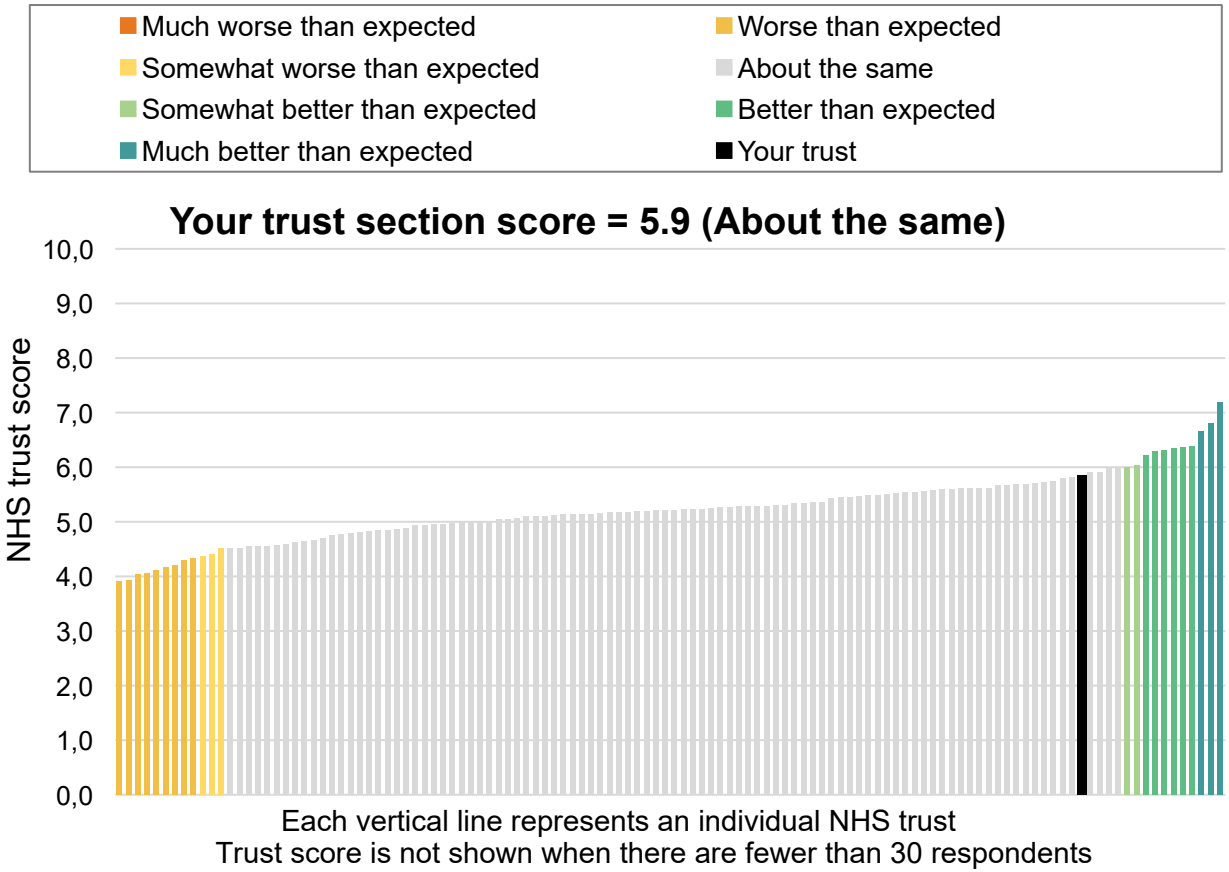
Benchmarking

Antenatal care

The start of your care during pregnancy

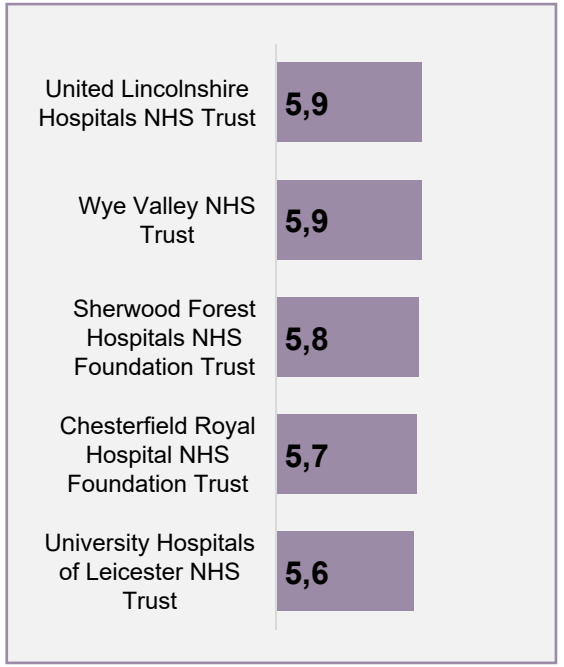
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

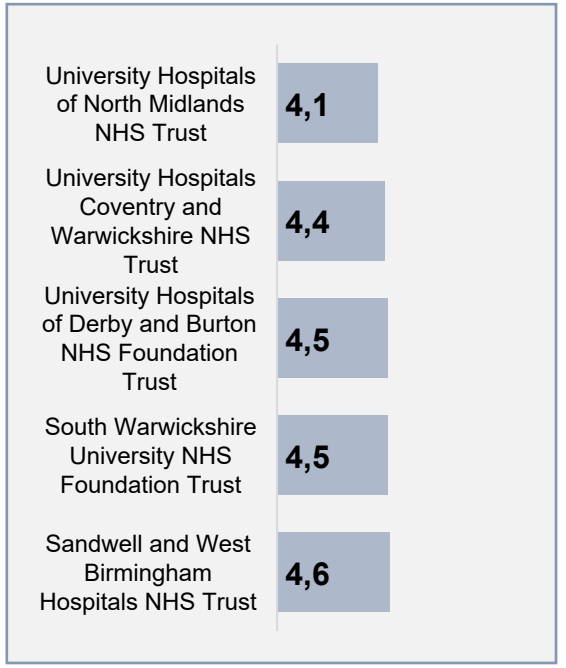


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



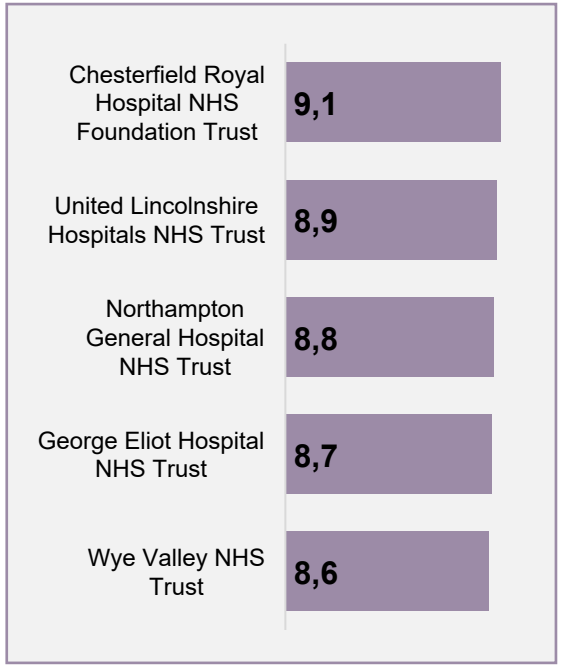
Antenatal check-ups

Section score

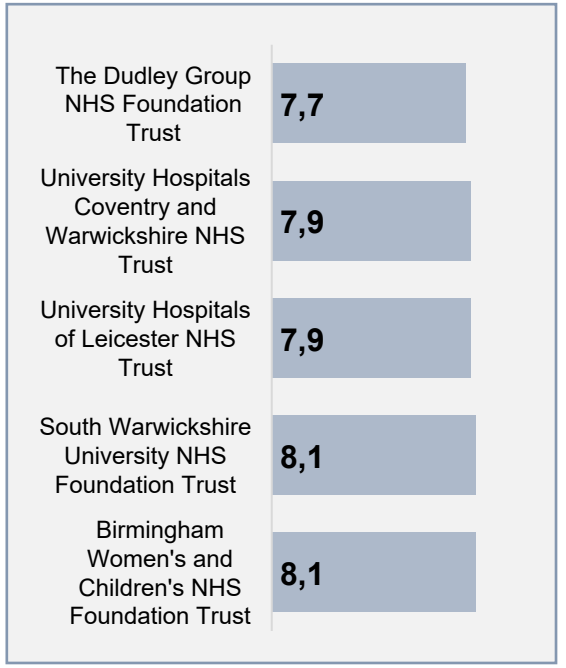
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B7 to B10. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



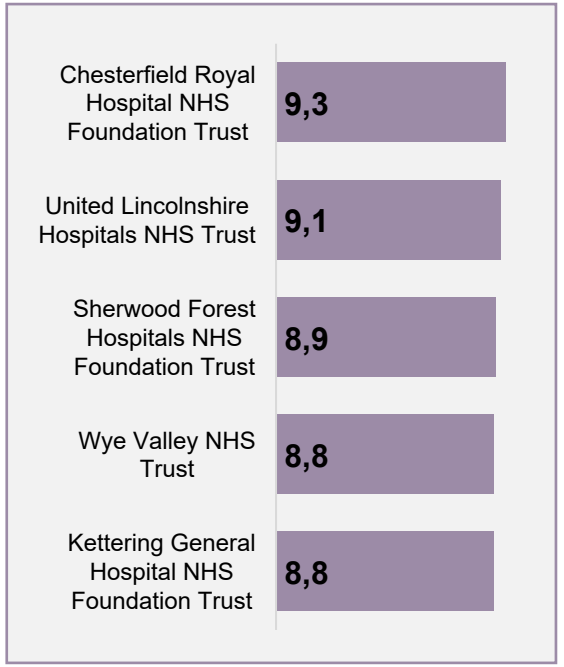
During your pregnancy

Section score

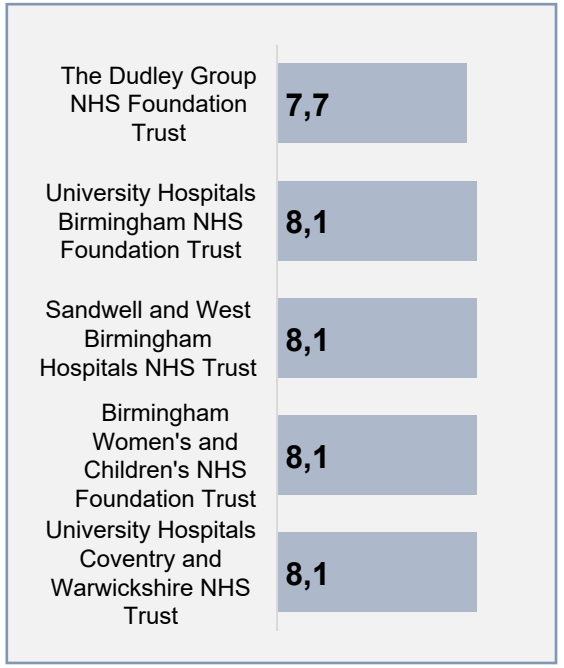
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B11 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores

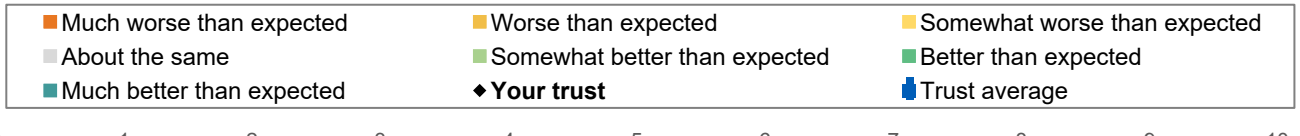


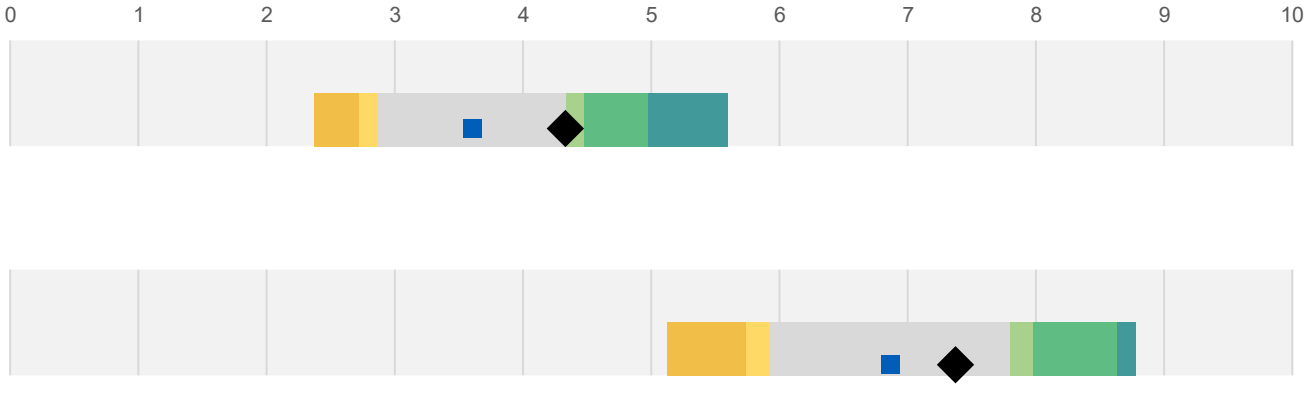
Trusts with the lowest scores



Benchmarking - Antenatal care

Question scores: Start of your pregnancy





B3. Were you offered a choice about where to have your baby?

About the same

B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?

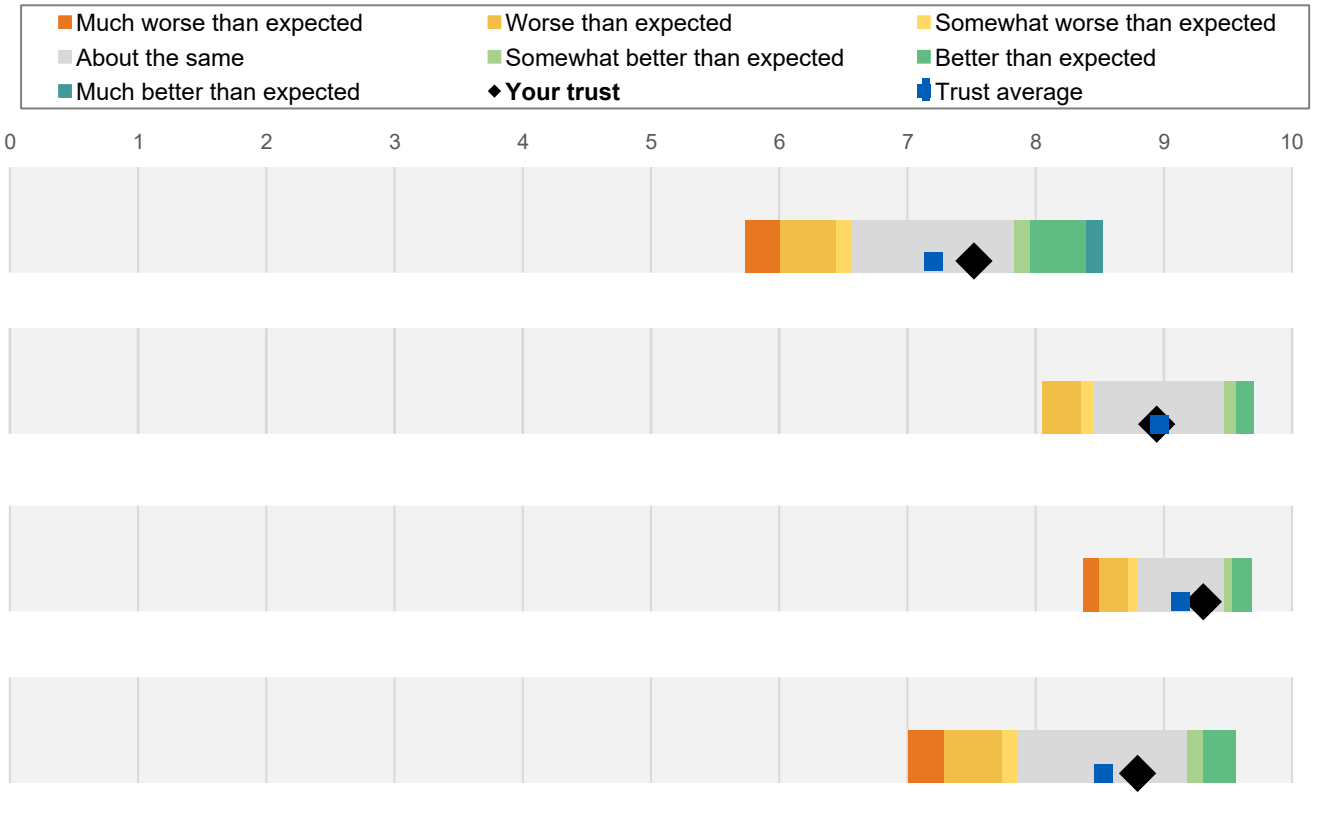
About the same

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
85	4.3	3.6	2.4	5.6
96	7.4	6.9	5.1	8.8

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: Antenatal check-ups

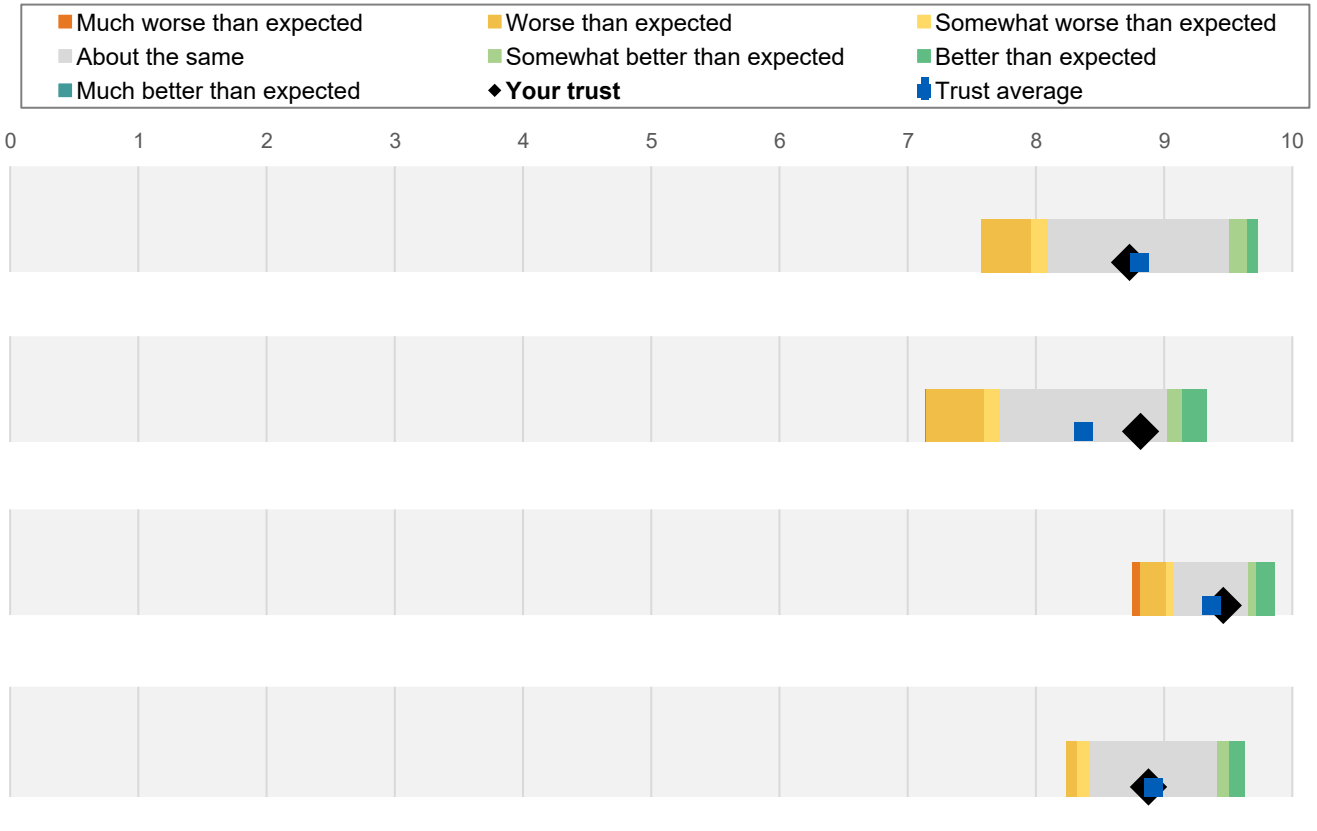


		All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	98	7.5	7.2	5.7	8.5	About the same
B8. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	99	8.9	9.0	8.1	9.7	About the same
B9. During your antenatal check-ups, did your midwives listen to you?	99	9.3	9.1	8.4	9.7	About the same
B10. During your antenatal check-ups, did your midwives ask you about your mental health?	98	8.8	8.5	7.0	9.6	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy

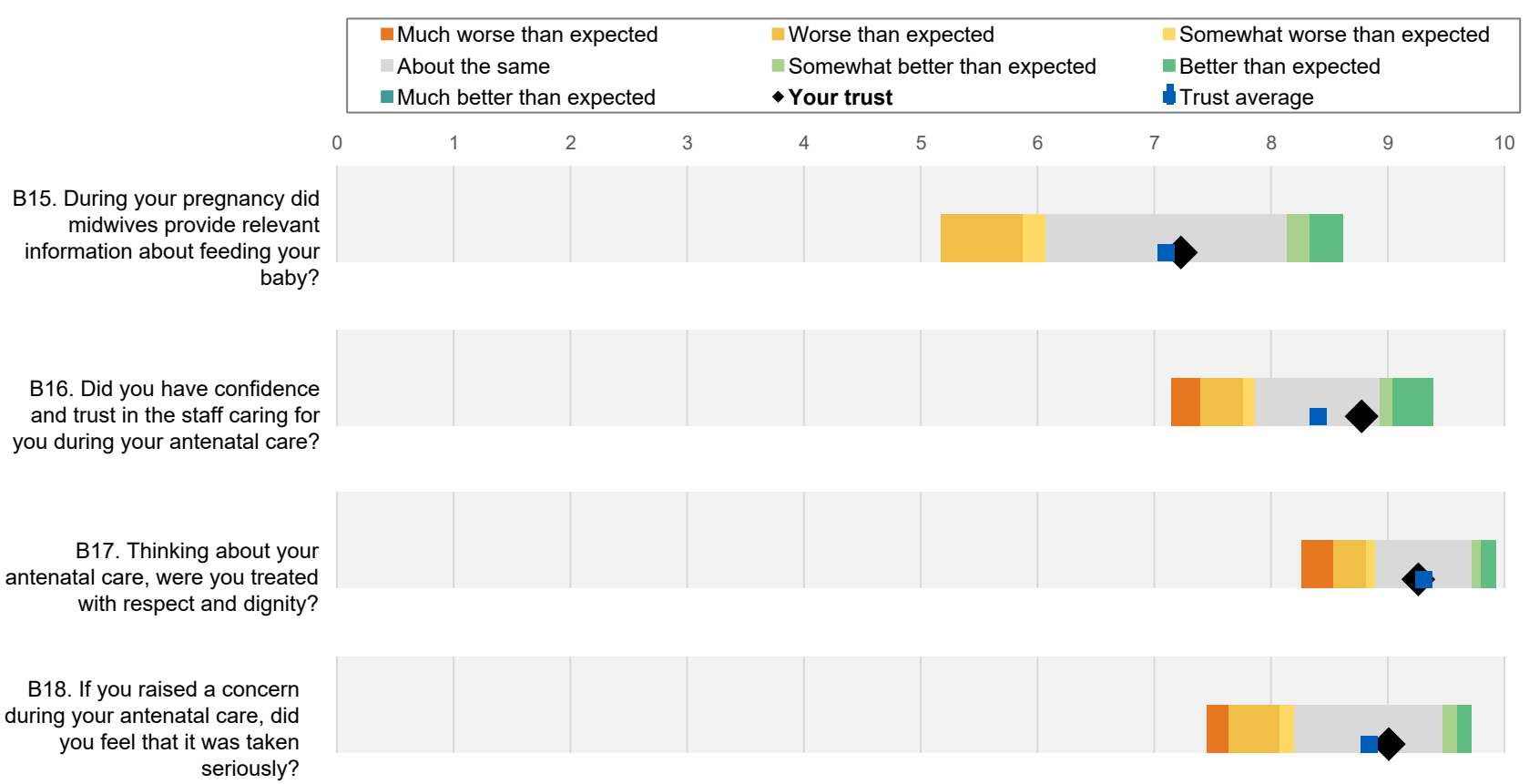


		All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
B11. Were you given enough support for your mental health during your pregnancy?	67	8.7	8.8	7.6	9.7	About the same
B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	94	8.8	8.4	7.1	9.3	About the same
B13. Thinking about your antenatal care, were you spoken to in a way you could understand?	99	9.5	9.4	8.8	9.9	About the same
B14. Thinking about your antenatal care, were you involved in decisions about your care?	99	8.9	8.9	8.2	9.6	About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B15. During your pregnancy did midwives provide relevant information about feeding your baby?	98	7.2	7.1	5.2	8.6
B16. Did you have confidence and trust in the staff caring for you during your antenatal care?	99	8.8	8.4	7.1	9.4
B17. Thinking about your antenatal care, were you treated with respect and dignity?	99	9.3	9.3	8.3	9.9
B18. If you raised a concern during your antenatal care, did you feel that it was taken seriously?	76	9.0	8.8	7.4	9.7

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

Labour and birth

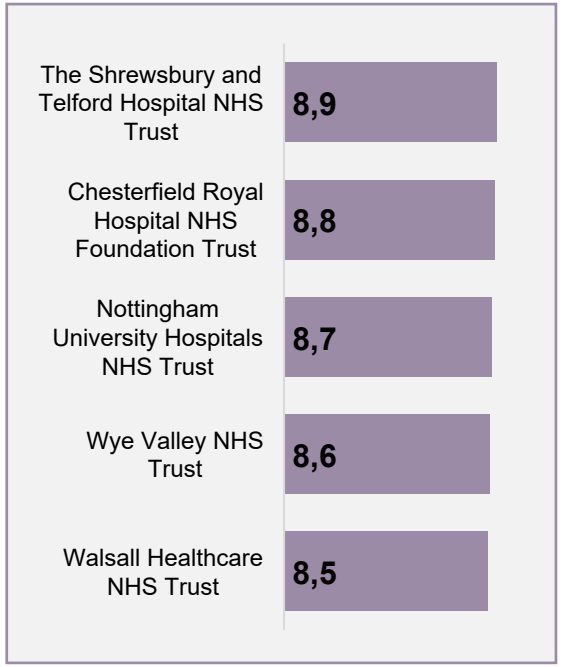
Your labour and birth

Section score

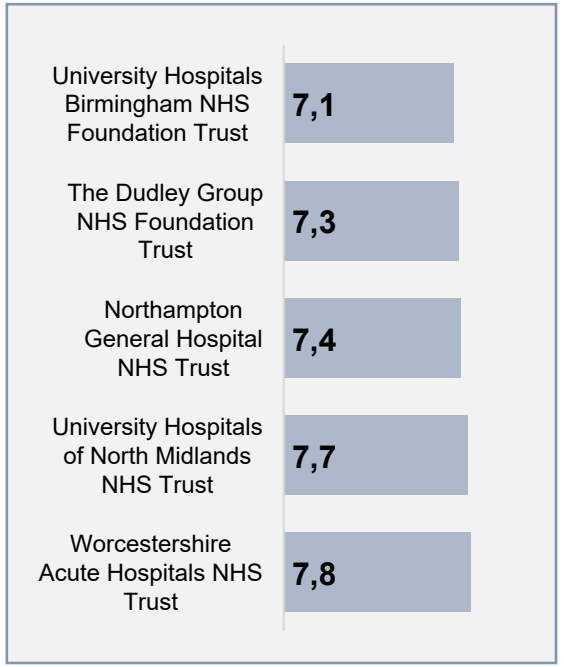
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



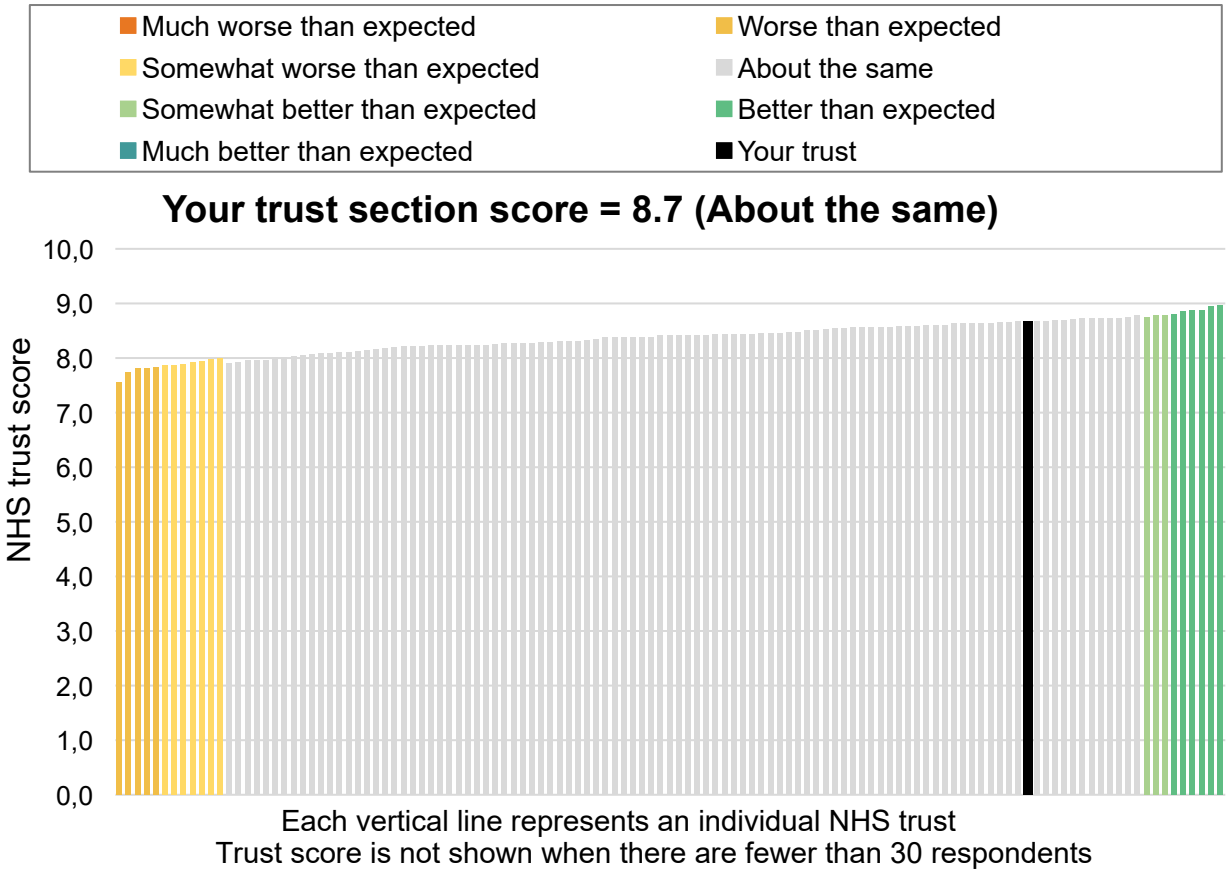
Trusts with the lowest scores



Staff caring for you

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 and C12 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

Trusts with the highest scores

United Lincolnshire Hospitals NHS Trust	8,7
Wye Valley NHS Trust	8,7
Chesterfield Royal Hospital NHS Foundation Trust	8,7
The Shrewsbury and Telford Hospital NHS Trust	8,6
Walsall Healthcare NHS Trust	8,5

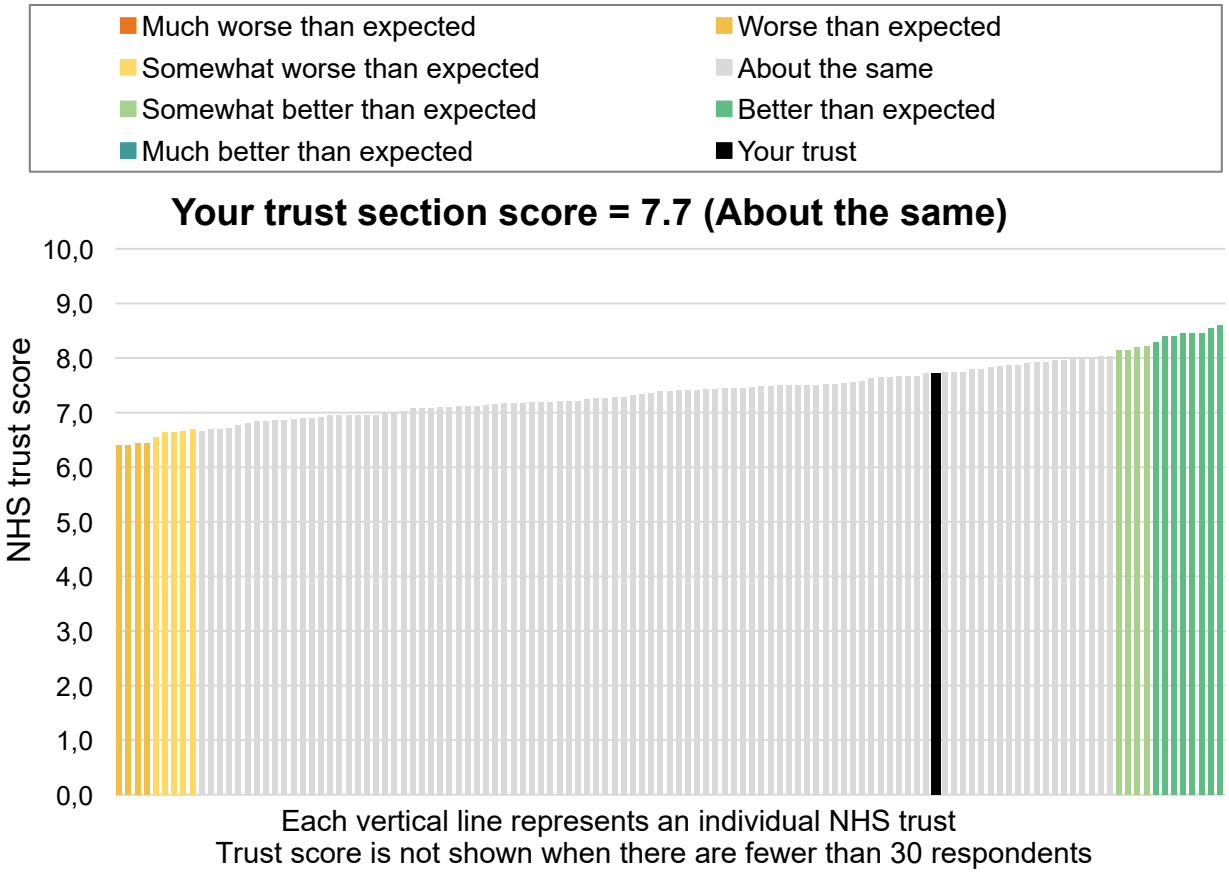
Trusts with the lowest scores

The Dudley Group NHS Foundation Trust	7,6
University Hospitals Birmingham NHS Foundation Trust	7,8
University Hospitals Coventry and Warwickshire NHS Trust	8,0
University Hospitals of Leicester NHS Trust	8,0
Northampton General Hospital NHS Trust	8,1

Care in the ward after birth

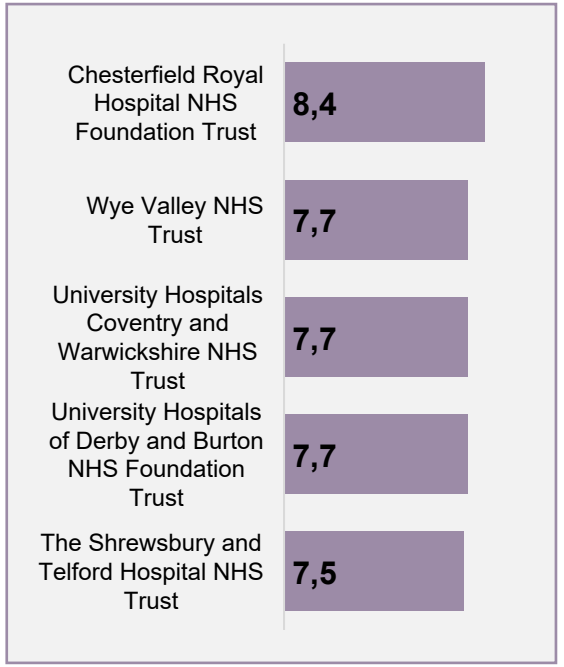
Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

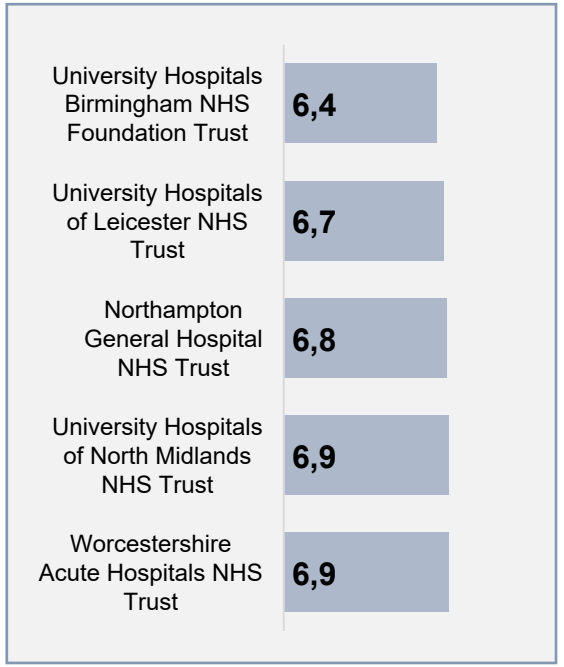


Comparison with other trusts within your region

Trusts with the highest scores

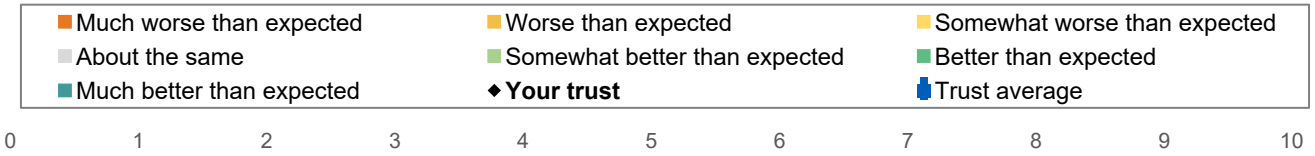


Trusts with the lowest scores



Benchmarking - Labour and birth

Question scores: Your labour and birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C4. Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour?	40	8.8	8.2	6.1	9.5
C5. And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	39	8.3	7.0	4.9	9.4
C6. Were you involved in the decision to be induced?	40	8.8	8.7	7.0	9.8

About the same

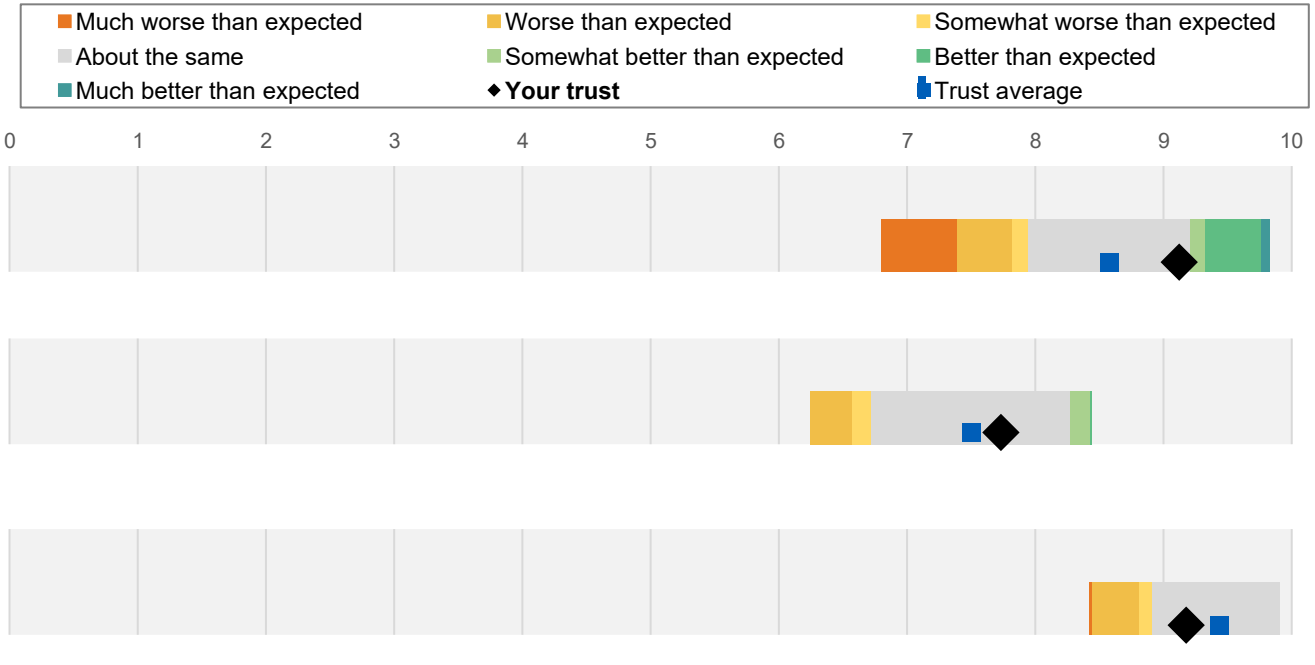
Better

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Your labour and birth



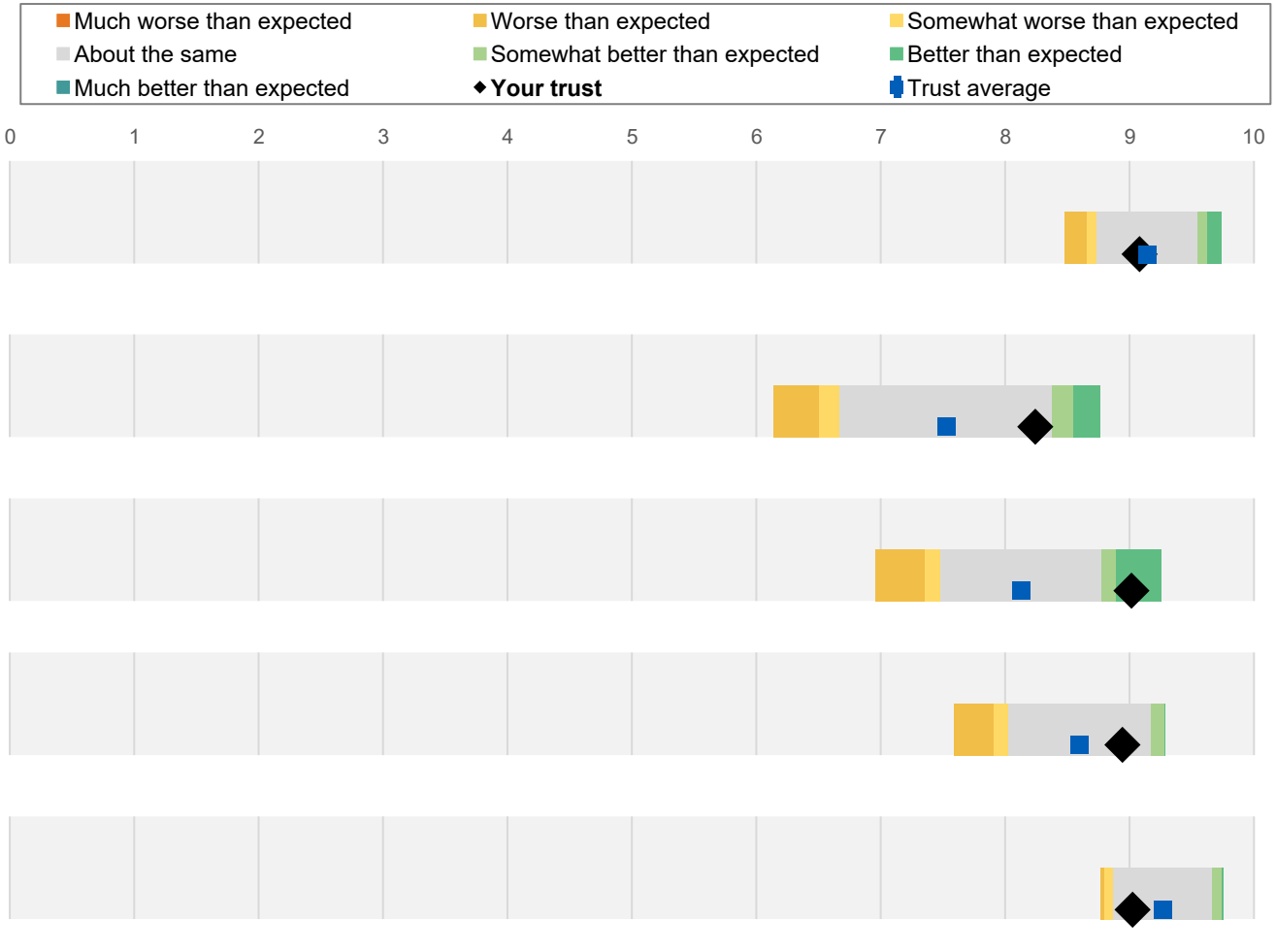
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	75	9.1	8.6	6.8	9.8
C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	81	7.7	7.5	6.2	8.4
C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	106	9.2	9.4	8.4	9.9

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C10. Did the staff treating and examining you introduce themselves?	104	9.1	9.1	8.5	9.7
C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	106	8.2	7.5	6.1	8.8
C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?	76	9.0	8.1	7.0	9.3
C14. During labour and birth, were you able to get a member of staff to help you when you needed it?	103	8.9	8.6	7.6	9.3
C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	107	9.0	9.3	8.8	9.8

About the same

About the same

Better

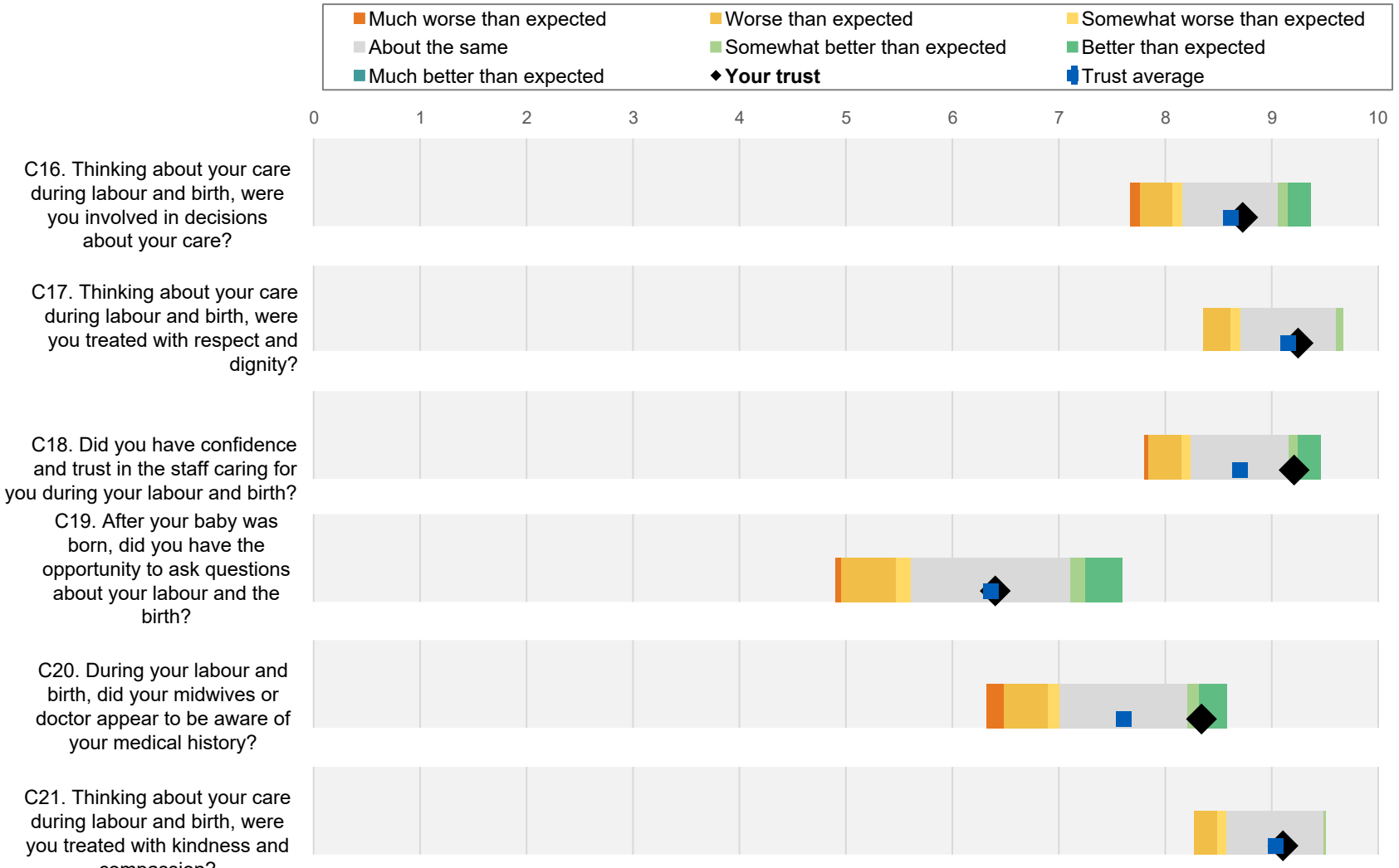
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you

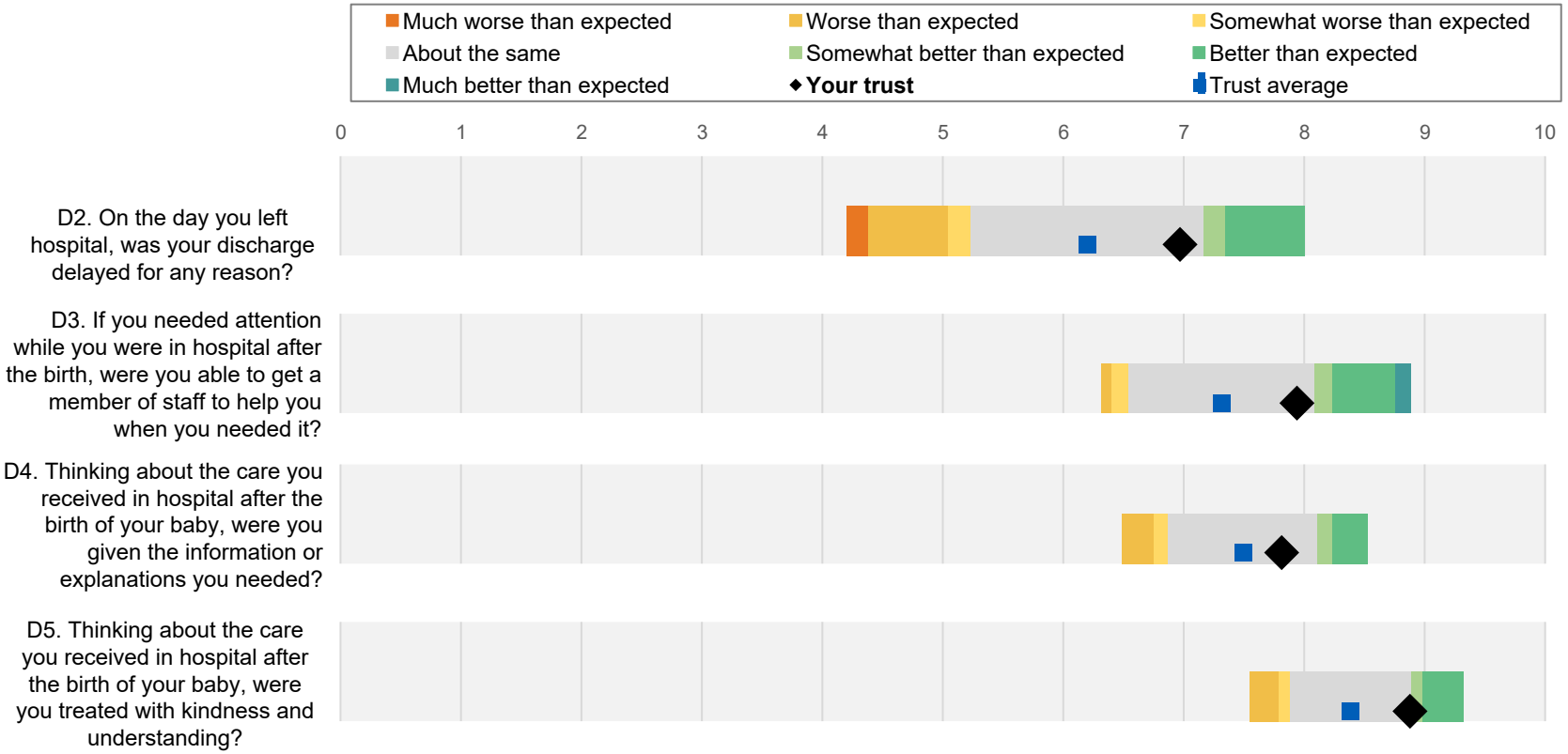


	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?	106	8.7	8.6	7.7	9.4
C17. Thinking about your care during labour and birth, were you treated with respect and dignity?	107	9.2	9.2	8.4	9.7
C18. Did you have confidence and trust in the staff caring for you during your labour and birth?	107	9.2	8.7	7.8	9.5
C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	97	6.4	6.4	4.9	7.6
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	97	8.3	7.6	6.3	8.6
C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?	106	9.1	9.0	8.3	9.5

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth

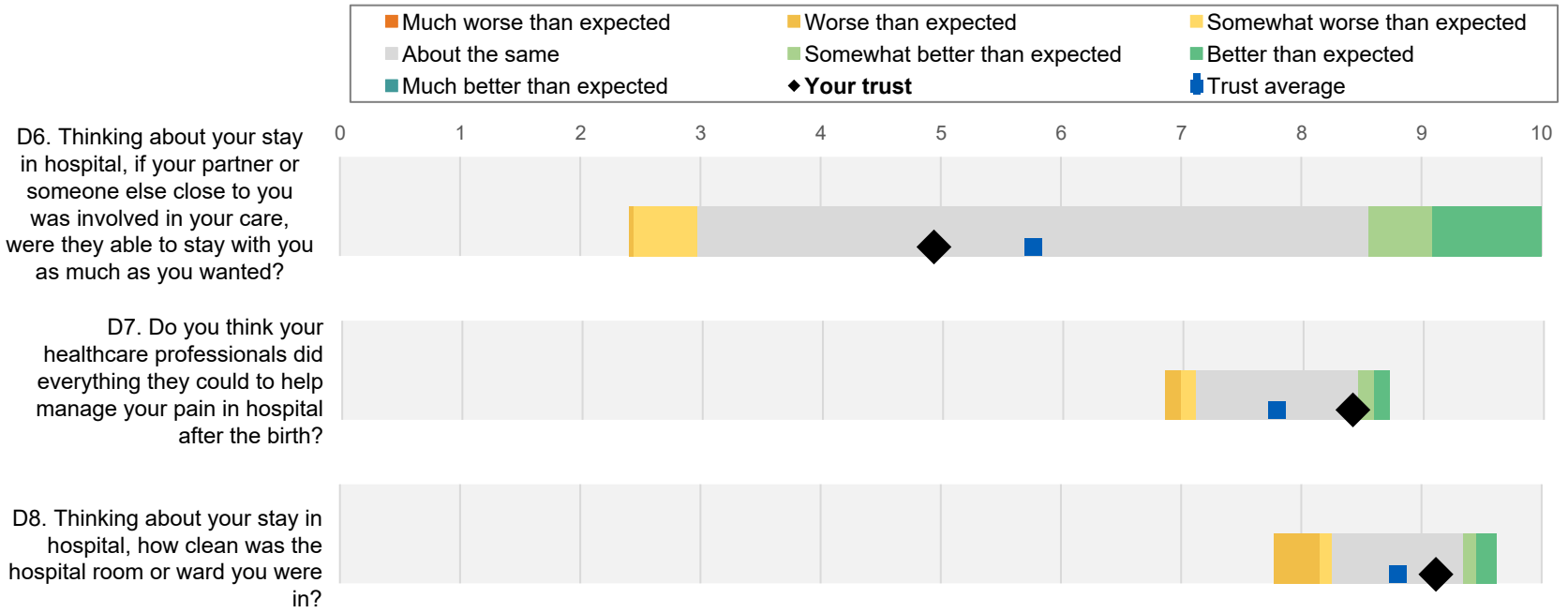


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	105	7.0	6.2	4.2	8.0
About the same	94	7.9	7.3	6.3	8.9
About the same	105	7.8	7.5	6.5	8.5
About the same	105	8.9	8.4	7.5	9.3

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	104	4.9	5.8	2.4	10.0
D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?	96	8.4	7.8	6.8	8.7
D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	103	9.1	8.8	7.8	9.6

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking

Postnatal care

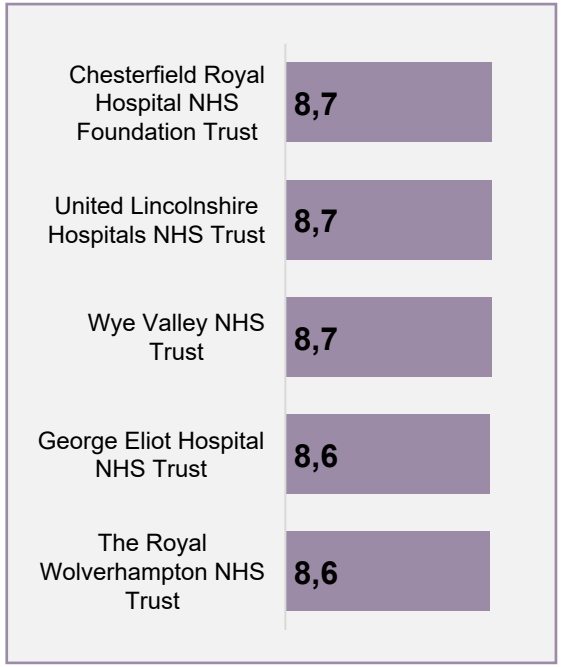
Feeding your baby

Section score

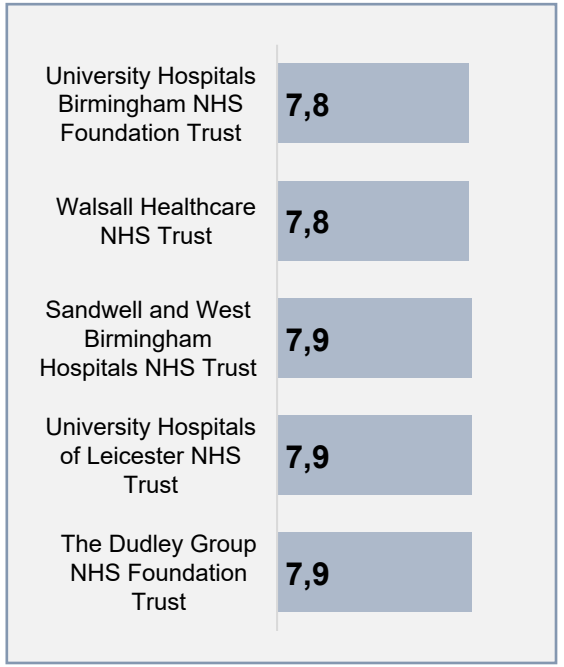
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



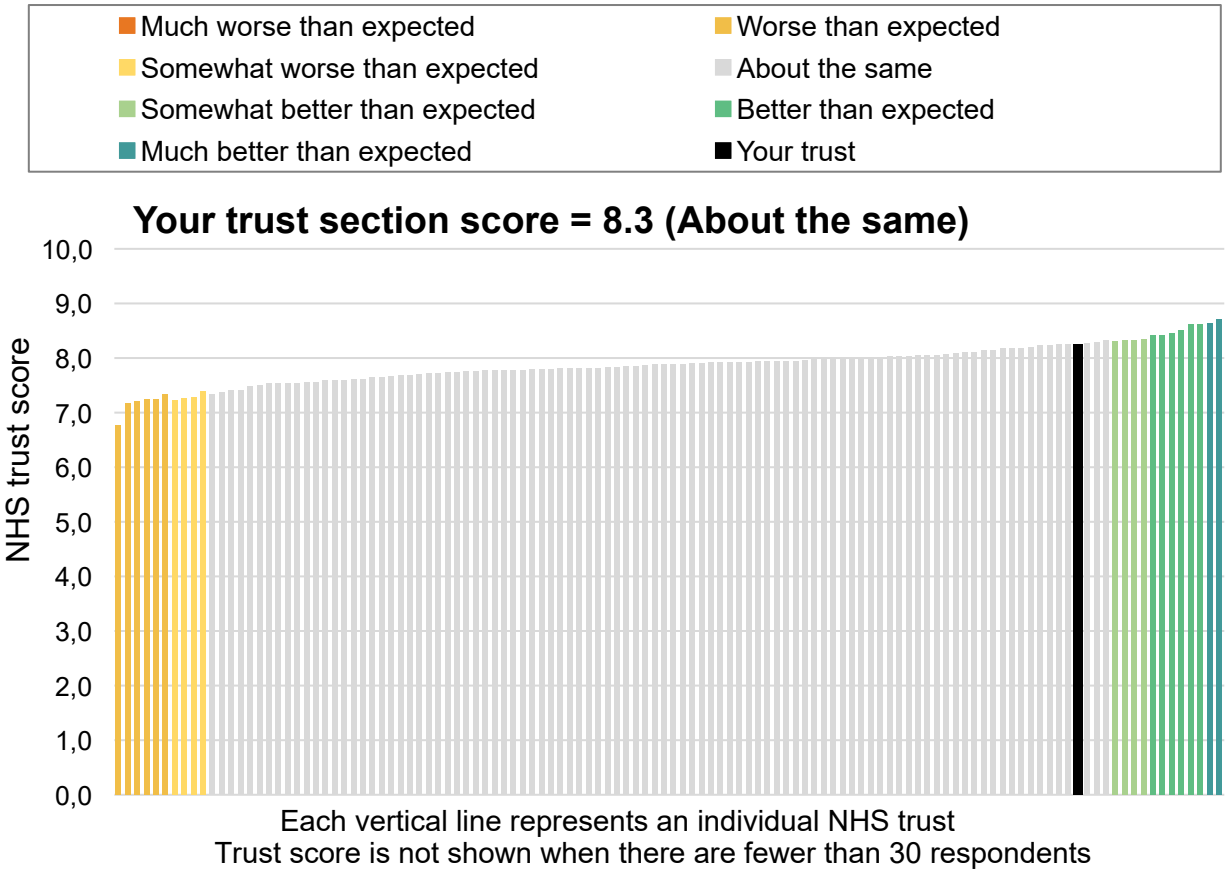
Trusts with the lowest scores



Care at home after birth

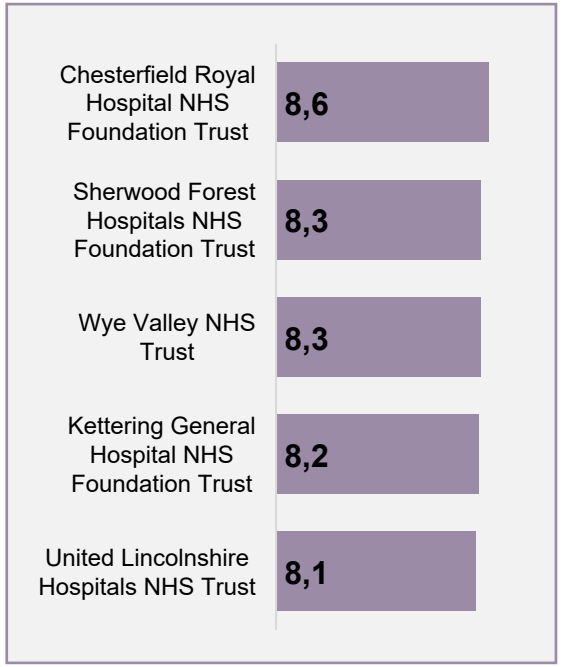
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

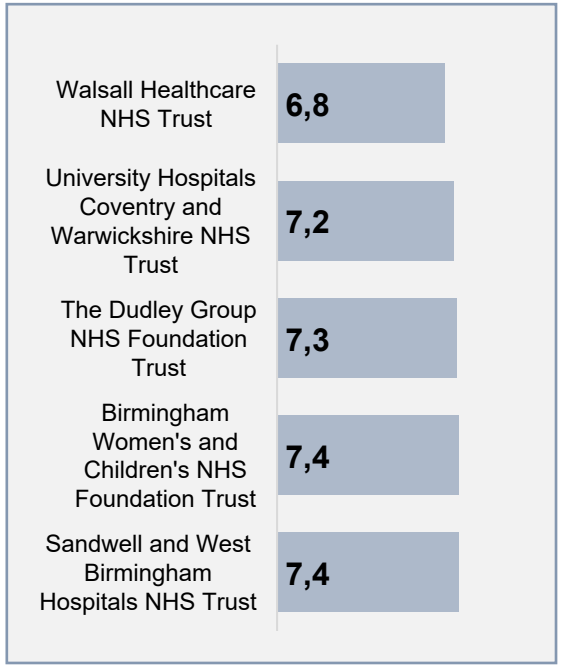


Comparison with other trusts within your region

Trusts with the highest scores

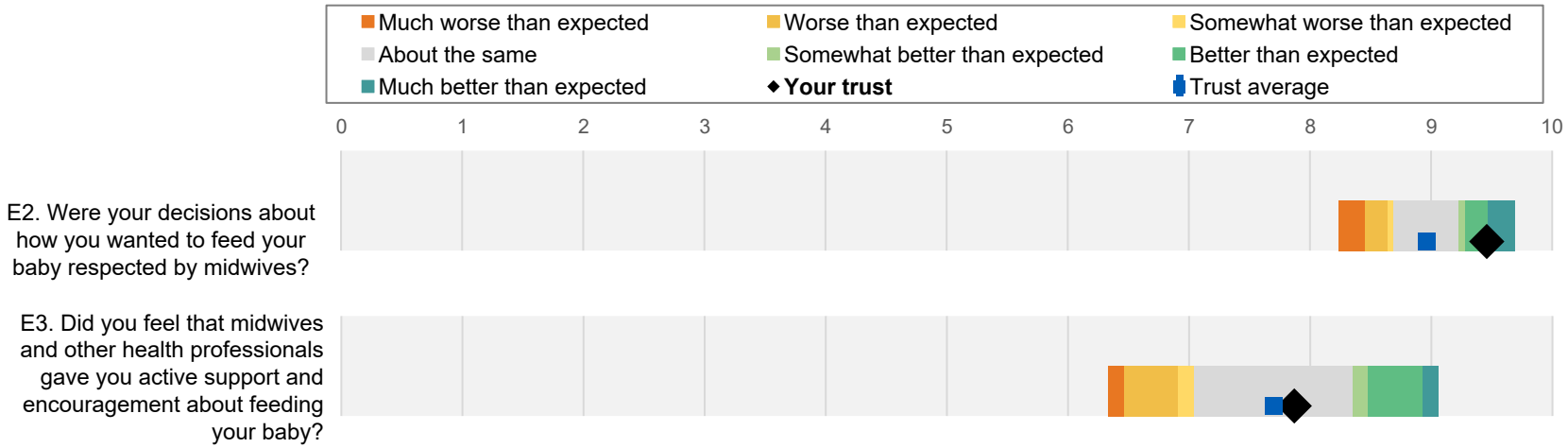


Trusts with the lowest scores



Benchmarking - Postnatal care

Question scores: Feeding your baby

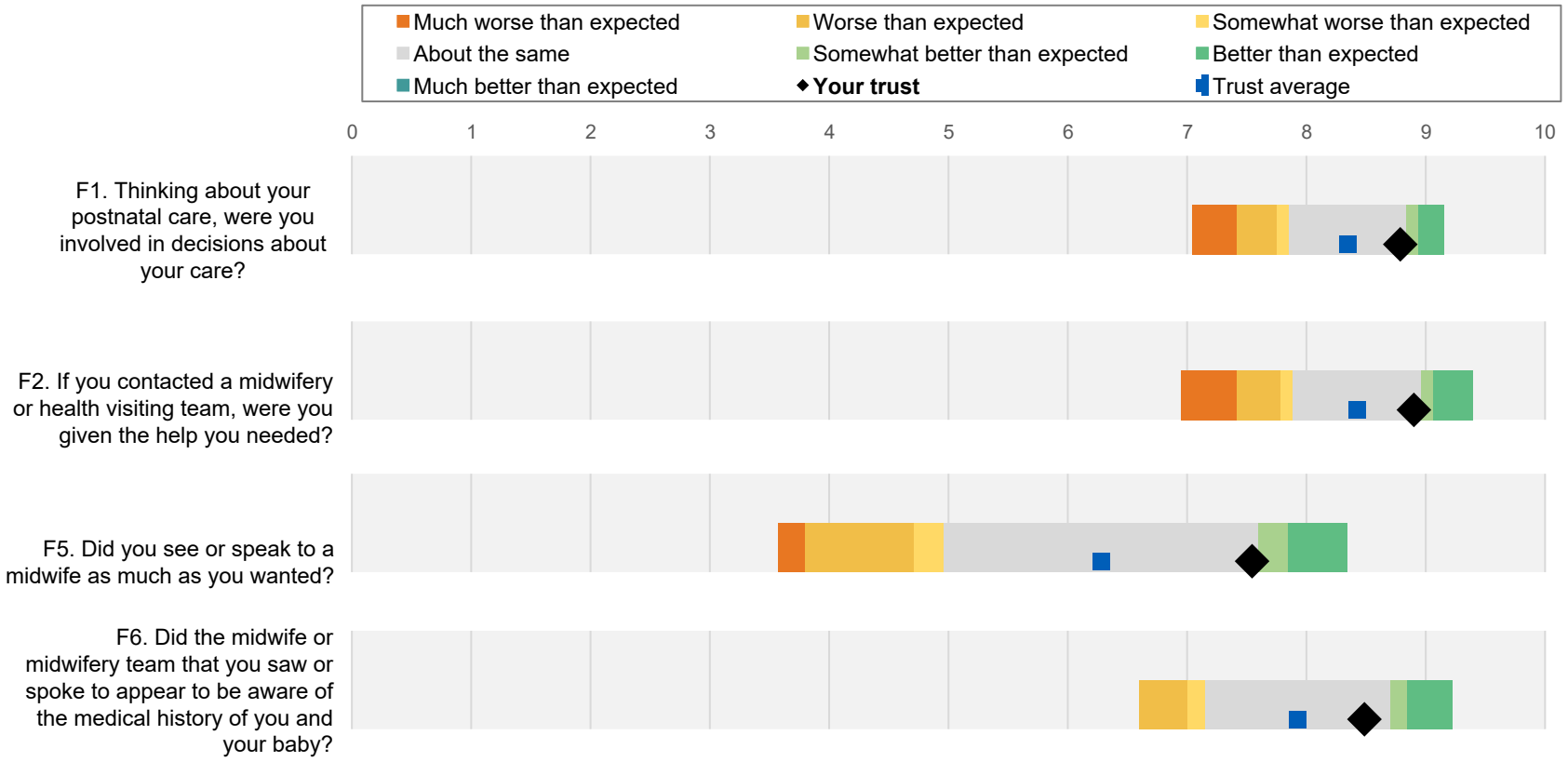


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
107	9.5	9.0	8.2	9.7
106	7.9	7.7	6.3	9.1

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



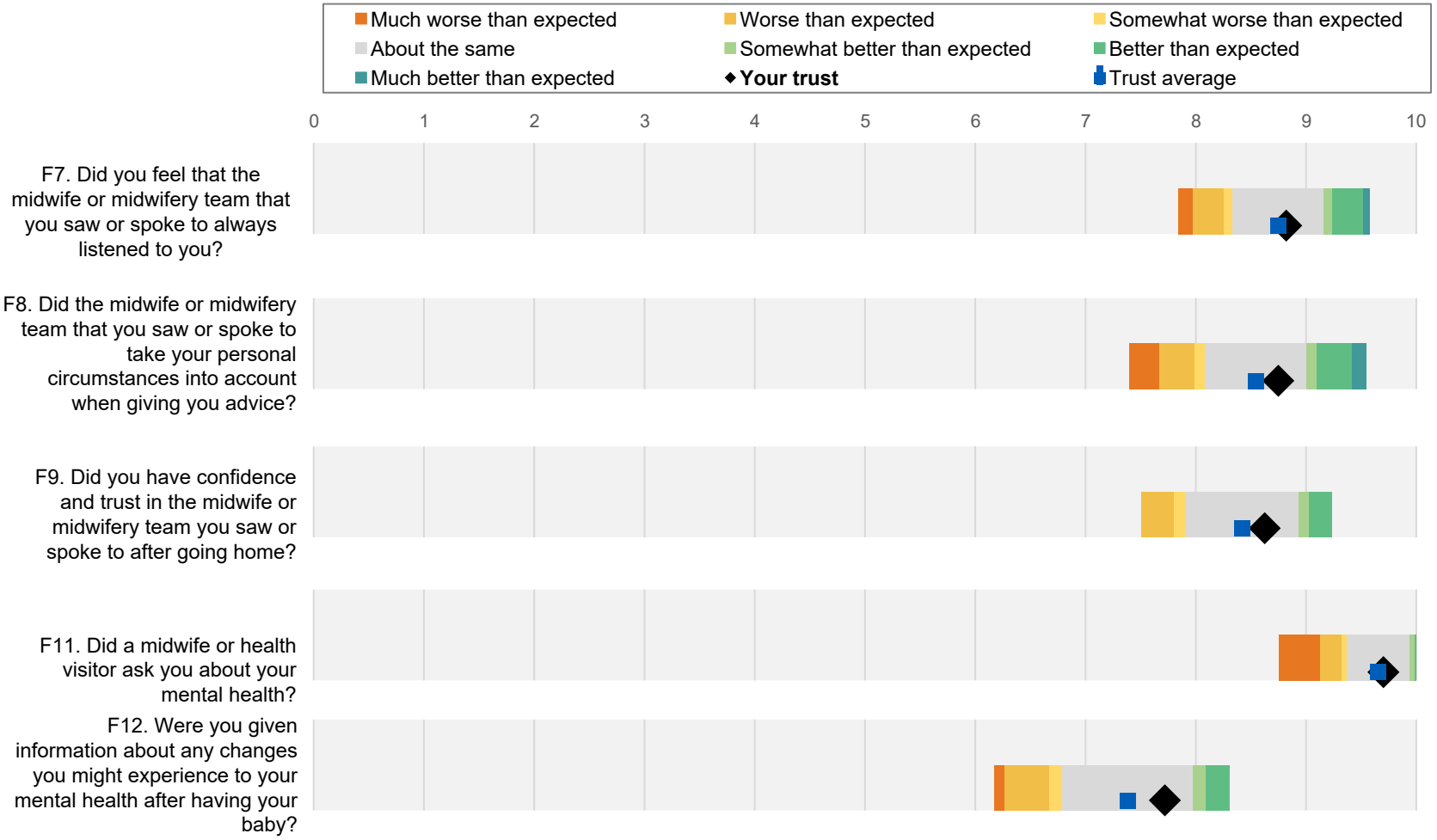
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F1. Thinking about your postnatal care, were you involved in decisions about your care?	102	8.8	8.3	7.0	9.1
F2. If you contacted a midwifery or health visiting team, were you given the help you needed?	88	8.9	8.4	6.9	9.4
F5. Did you see or speak to a midwife as much as you wanted?	105	7.5	6.3	3.6	8.3
F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	90	8.5	7.9	6.6	9.2

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



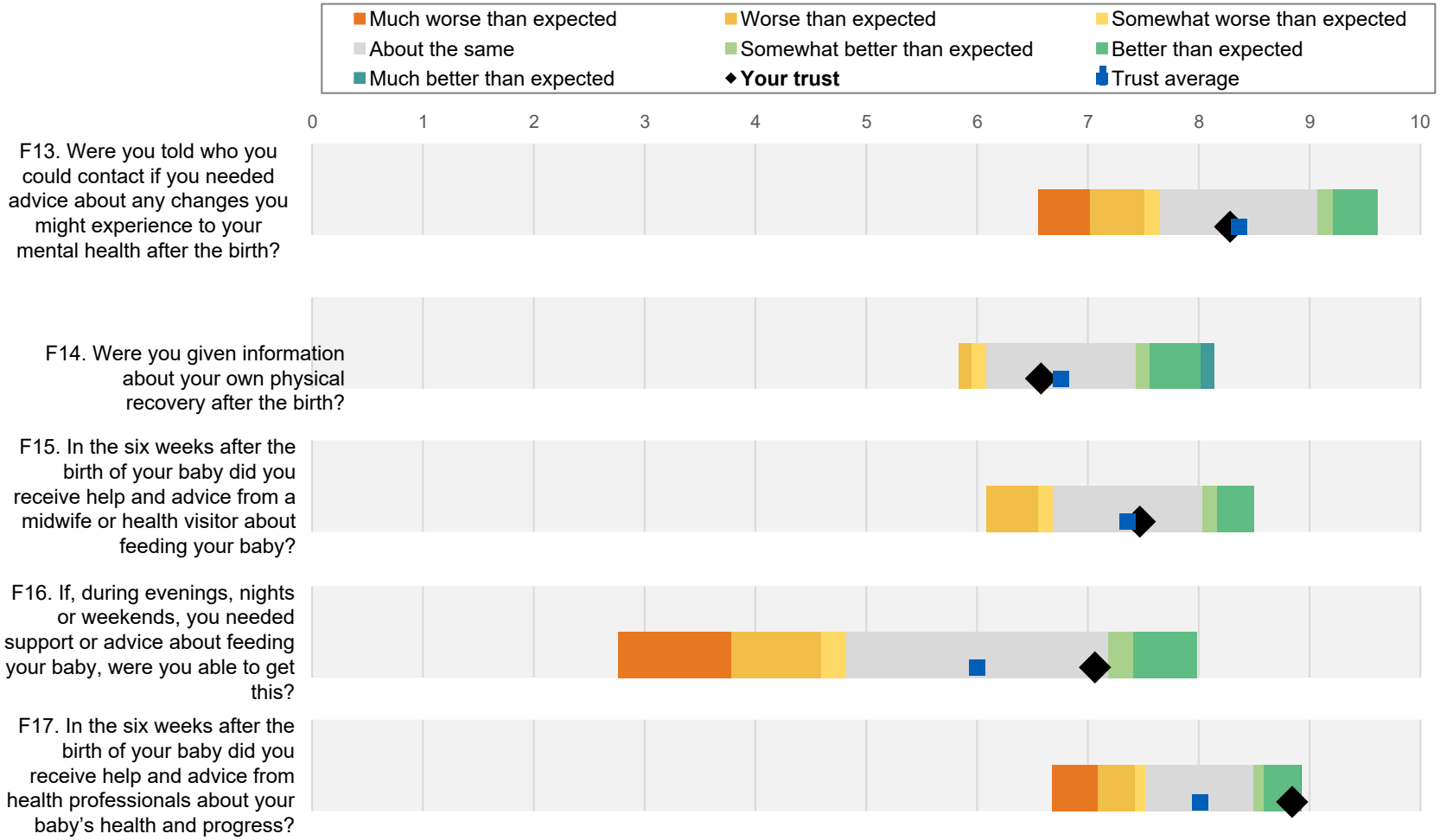
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	103	8.8	8.7	7.8	9.6
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	101	8.7	8.5	7.4	9.5
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	105	8.6	8.4	7.5	9.2
F11. Did a midwife or health visitor ask you about your mental health?	105	9.7	9.7	8.8	10.0
F12. Were you given information about any changes you might experience to your mental health after having your baby?	101	7.7	7.4	6.2	8.3

About the same

Trust score is not shown when there are fewer than 30 respondents.

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score	
F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	87	8.3	8.4	6.6	9.6	About the same
F14. Were you given information about your own physical recovery after the birth?	103	6.6	6.8	5.8	8.1	About the same
F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	93	7.5	7.4	6.1	8.5	About the same
F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	50	7.1	6.0	2.8	8.0	About the same
F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	101	8.8	8.0	6.7	8.9	Better

Trust score is not shown when there are fewer than 30 respondents.

NHS Maternity Survey 2023

Results for Wye Valley NHS Trust

Where maternity service users' experience is best

- ✓ Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Maternity service users being given appropriate information and advice on the risks associated with an induced labour, before being induced.
- ✓ Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Maternity service users feeling that if they raised a concern during labour and birth it was taken seriously.
- ✓ Maternity service users receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.

Where maternity service users' experience could improve

- ○ Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- ○ Partners or someone else close to the service user were involved in their care as much as they wanted to be during labour and birth.
- ○ Maternity service users being spoken to in a way they could understand during labour and birth.
- ○ Maternity service users being given information about their own physical recovery after the birth.
- ○ Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where maternity service users experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where maternity service users experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

This survey looked at the experiences of individuals in maternity care who gave birth between January and March 2023 at Wye Valley NHS Trust. Between May and August 2023, a questionnaire was sent to 207 individuals. Responses were received from 107 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	CQC report and action plan – Emergency Department
Status of report:	☐**Approval** ☒**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Provide Name and Job Title
Documents covered by this report:	CQC final inspection report and action plan

1. Purpose of the report

To present the CQC inspection report and associated action plan

2. Recommendation(s)

To receive the report and action plan and pursue any key lines of enquiry

3. Executive Director Opinion[1]

The CQC conducted an unannounced inspection of the Emergency Department on the 5-7 December and revisited on the 20th December.

Given the initial findings of the CQC visit a review meeting was held on the 8th December, an initial action plan was agreed and action taken to address immediate safety concerns. Regular performance review meetings have been held with the clinical team, division and relevant Executive Directors on an ongoing basis since the visit.

The original action plan is included in this report and as can be seen the majority of actions have been completed or commenced.

The regulatory actions and suggested actions from the final inspection report have been added to the overarching action plan and require submission to the CQC by 25th March.

ED specific performance review meetings will continue and oversight of the action plan will be managed through the Quality Committee.

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

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

Wye Valley NHS Trust

The County Hospital

Inspection report

County Hospital
Union Walk
Hereford
HR1 2ER
Tel: 01432355444
www.wyevalley.nhs.uk

Date of inspection visit: 5 December to 7 December 2023 and 20 December 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at The County Hospital

Requires Improvement 

Urgent and emergency care was delivered by the emergency department (ED) based at County Hospital, Hereford. It provides consultant-led emergency care and treatment 24 hours a day, 7 days a week to people across Herefordshire and further.

The ED was split into different sections; 'resus', for patients who required immediate lifesaving treatment or resuscitation, 'majors', for patients with serious and life-threatening conditions; and 'minors', for patients who had minor injuries. There was a triage area or 'pitstop' where all patients were assessed and a 'fit to sit' area in majors for patients who were awaiting further tests or a bed in majors. There was a same-day emergency care unit which saw ambulatory patients who needed treatment or tests and could be discharged home after this.

There was a paediatric area used to treat children and young people, including a waiting area. There was a waiting room for patients who had made their own way to the department as well as a waiting area for patients waiting for treatment for minor injuries. In addition to these areas an internal corridor was used to hold and treat up to 4 patients when the department was at capacity.

We inspected this service on 5, 6 and 7 December 2023 (first visit) and did a follow up inspection on the 20 December 2023 (second visit). This was an unannounced full core service inspection looking at urgent and emergency care. We checked the quality of the services in response to being made aware of emerging risks within the department.

Urgent and emergency services

Requires Improvement

Our rating of this location went down. We rated it as requires improvement because:

- There was a risk that a deteriorating child might not be quickly identified. This was as staff working in the children's department had not all completed paediatric life support training, paediatric competencies, and children's safeguarding training.
- The layout of the department meant some patients were not visible to the staff responsible for their safety and welfare. However, this had been improved between our inspection visits.
- Non-clinical reception staff were expected to navigate patients to the minor injuries waiting area when they were not trained in clinical decision making.
- There were insufficient medical staff at consultant level and nursing staff to care for patients and keep them safe without using high numbers of bank, agency, and locum staff. The consultant numbers were significantly below the recommendations of the Royal College of Emergency Medicine and there was not a paediatric emergency consultant, in line with the requirements of the Royal College of Paediatric and Child Health.
- The environment and premises did not always keep people safe. The department was crowded at times, and this led to patients being cared for in areas not designed for patients, such as the corridor, and remaining on the back of an ambulance, for sometimes long periods of time.
- The service did not always ensure staff had updated life support and safeguarding training to keep people safe.
- Staff did not complete and update risk assessments for each patient or keep good care records. They did not identify or quickly act upon patients at risk of deterioration. The staff did not always recognise, assess, and treat patients in line with sepsis guidelines. There was a risk of a deteriorating patient not being picked up through ongoing clinical risk assessments. Staff did not always take regular patient observations in line with their local guidelines.
- Staff did not ensure all patients had their medicines on time and this included time critical medicines, and patients were not always offered regular food and drink.
- There was poor flow in the hospital due to capacity and delays in getting patients safely discharged. This meant many patients remained in the department for long periods of time. The service could not always be delivered to meet the changing needs of the local population. Services had evolved, patient numbers had increased, there were long waiting times and the service did not meet demand.
- Due to full and overstretched capacity in the urgent and emergency care system, patients could not always access the service when they needed it and sometimes had to wait a long time for treatment.
- There were poor and ineffective governance processes within the department. Although there was a basis for good governance, it did not demonstrate positive action and change, learning, improvement or provide assurance of safe and quality care. There was a lack of regular and consistent audit, risk management and learning from incidents. Where audits occurred, actions were not implemented to drive improvement.

However:

- The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection, although hand-washing was not always carried out when required. They kept equipment and the premises visibly clean.

Urgent and emergency services

- Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other**.** Key services were available 7 days a week.
- Staff mostly treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. There were pressures in the department due to high numbers of patients and a department that was no longer able to cope with demand and capacity. Staff worked their hardest to care compassionately for these patients in a difficult environment.
- Leaders were visible and approachable for patients and staff.
- Staff felt respected, supported and valued. There was a good teamwork-based culture in the department. Staff were clear about their roles and accountabilities.
- All staff were committed to improving services, even though they needed time and space to make this work. Following feedback to the senior leadership team after our first visit on site, improvements were underway to address in earnest many of the concerns we raised.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but not everyone had updated or completed it.

Nursing staff received and mostly kept up-to-date with their mandatory training, although the department was not quite achieving the trust target. The mandatory training was comprehensive and met the needs of patients and staff. Training was completed either during a face-to-face training day or through completing e-learning modules. Overall training completion figures for the staff in the emergency department (ED) was 80.3% which was below the trust target of 85%.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was supported by the clinical practice development nurse whose focus was around education and training. All staff were within a team which was led by a band 6 nurse. They looked at their teams' training and encouraged staff to book onto training to maintain compliance. However, we were told this was not working well at present due to high pressures within the department. The staff were responsible for updating and booking onto their training themselves. Staff mostly chose to do their online training at home due to time constraints at work.

All staff had to be compliant with different levels of life support training depending on their banding or level. Healthcare assistants needed basic life support training; 53% had updated this this. Band 5 and 6 staff nurses needed immediate life support (ILS) and paediatric immediate life support (PILS) training; 79% of staff had completed ILS and 67% had completed PILS. The ED staff covered the paediatric area within the department overnight. The lack of specialty training available for ILS and PILS training was on the departmental risk register with several mitigations to manage the risk which included using trained staff in the children's team working elsewhere in the hospital. On our second visit, managers told us they had arranged two PILS training days specific for ED staff in January and February 2024 and booked staff onto these; this would significantly increase compliance.

Urgent and emergency services

Medical staff received and kept up-to-date with their mandatory training. Medical staff training showed an overall mandatory training compliance rate of 86.8%.

We saw 75.8% of staff had completed training on recognising and responding to patients with mental health needs and dementia. Staff could access support from specialist teams and nursing staff when needed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had updated or completed training on how to recognise and report abuse and not all staff were aware of who to inform if they had concerns.

Staff did not always update their training specific for their role on how to recognise and report abuse. The nurses and support staff training compliance was 79% for safeguarding adults level 2 and 68% for safeguarding children level 3. The compliance for medical staff for safeguarding adults level 2 was 87% and 82% for safeguarding children's level 3; the trust target for all levels was 85%.

There was a risk from staff looking after children overnight not having completed their level 3 safeguarding training and a risk of them not picking up all signs of abuse as a result, or acting upon them as required. There was no evidence of failure to identify risk, but the training was not at the right level to provide the safety net required. The band 5 and 6 nurses staffed the paediatric area overnight. However, managers told us they did not ensure these staff members had completed safeguarding children's level 3 training. We raised this with the trust, and managers created a 6-week plan for all nurses to have completed this training by the end of January 2024. They also created a database to identify who had completed the training to ensure only trained staff were allocated to the paediatric area. We saw on our second visit this was happening.

Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Most staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a referral pathway, however it involved an email referral and not all staff had an NHS email account. Some staff said they were not sure of the process and would inform the nurse in charge, and two told us they felt they needed more input and training on safeguarding. Safeguarding policies and pathways were up-to-date and accessible to staff through the trust's intranet. Staff had access to the trust's safeguarding lead for advice.

There was patient information on recognising signs of specific abuse on display within the department. Children identified as being at risk would be referred to the trust's safeguarding team and to the local authority. There was a system to make staff aware of known concerns about children and families.

Staff were aware of the Mental Health Act 2005 and the holding powers that doctors and nurses had. Staff got the advice from their mental health colleagues as required; they were available 24 hours a day, 7 days a week. Staff reported they were very supportive and easy to access. There was a pathway to follow for children who presented with mental health conditions with a clear risk assessment tool.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection, although hand-washing was not always carried out when required. They kept equipment and the premises visibly clean.

Urgent and emergency services

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact. Furnishings, such as chairs and flooring were wipeable and easy to clean. There was enough personal protective equipment (PPE) available for staff to equip themselves for the different levels of protection required within the department. Staff mostly followed infection prevention and control (IPC) principles including the use of PPE. Hand hygiene sinks, hand gel and PPE were available throughout the department. Staff were bare below elbows for effective handwashing and wore surgical masks as currently required by policy. Staff wore disposable gloves and aprons, when required, for example when assisting patients with personal care. However, we noted a lack of regular handwashing when observing staff delivering care and treatment on both our first and second visits.

Managers audited staff compliance with IPC practices including hand hygiene and cleaning. Hand hygiene audit results for August and September 2023 were 100% and yet decreased to 50% for October 2023. They audited whether staff were bare below the elbow, and they were 87% compliant for August and September 2023 and increased to 100% compliant in October 2023. However, there were no action plans associated with these audits. They were either blank or did not have an expected action or completion date.

The department took action when risks or issues around IPC were identified. The department had undergone an external audit in September 2023 which showed poor infection control practices. Following this, managers organised a project team for six weeks to resolve this. The team completed a deep clean of all areas of the department and the maintenance team repaired areas which needed improving such as ceiling tiles and other IPC risks. The team did a full stock take and decluttered areas which prevented good cleaning and increased their auditing to weekly. They also developed a new cleaning checklist and reviewed the role of the housekeepers. Since then, they had an assistant practitioner who worked regular supernumerary shifts with the focus of improving the IPC and educating staff on the cleaning. They had previously received 2 stars in their IPC audit. This had increased to 4 stars on 1 December 2023 and the previous week was 5 stars.

The service generally performed well for cleanliness although actions taken when results were not optimal were not in evidence. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits were completed monthly by the IPC nurse looking at the whole environment. The results varied between 50% and 75% for August to October 2023. However, there was no action plan to increase compliance. There were two regular domestic staff who cleaned the department between 6am and 8pm. There were no cleaners in the department at night and any cleaning was carried out by the nursing team and support services assistants. However, due to the increased patient numbers within the department, this was not always possible. This meant the cleaners spent the first part of their shift catching up on the cleaning from overnight. The cleaners were audited weekly, and failings were addressed immediately; we saw evidence of this within the cleaners' records.

Guidance was available for staff in the trust's IPC policy. The policy described all protocols required to maintain a good level of cleanliness, infection control and hygiene. The staff could get further IPC information from the infection control nurses who attended the department weekly. We were told they were very accessible and approachable.

Staff were not all compliant with their training in IPC and hand hygiene. Training data showed 62.5% of nursing staff and 71% of medical staff had completed IPC level 2 training. This was below the trust target of 85%.

Side rooms were available for patients when isolation was required, and staff told us how they would manage the risks associated with transmittable infections. This was in line with best practice.

Data showed there had been no infection control cases reported in 2023. This included E-coli, MRSA and MSSA bacteraemia.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The design of the environment did not always meet national guidance and did not always allow good patient flow. The department was small and cramped for the number of patients it saw. This meant it was cluttered and patients were being cared for within areas which were unsuitable, such as the corridor.

There were some risks from the environment in the children's area not being fully secured or free of manageable risks. The area was located next to the adult department but operated as an independent unit, thus separating the children's and adult's emergency care pathways as recommended by national standards. It had two trolley bays and two rooms, one of which had two trolleys. There were also seats for patients who were waiting. Of these rooms, one had a door which was not secured and opened immediately into the ambulance bay outside. The other room had unsecured access to the main waiting room. One of these rooms had consumables in which could pose a risk to children such as needles, scissors, and sharps bins.

On our second visit, we found the paediatric rooms had been made secure and safe. The two exit doors in the clinical rooms were locked with no unauthorised access into the area in or out. The team working in the area were able to unlock the doors from inside easily if needed in an emergency or for required access. The clinical areas had also been decluttered from medical or other equipment that might pose a risk to children or others. However, we saw there was no emergency call bell within clinic room 1. This meant in an emergency, staff could not be alerted quickly.

The service was taking steps to limit delays for patients arriving by ambulance and ensure patients were safe, although there was not always oversight of patients held in spaces not intended to provide care or treatment. The department was working hard to limit as much as possible the delays faced by ambulances when handing over patients. However, this often resulted in patients being held in a narrow corridor on a trolley for indeterminate lengths of time and with limited oversight. Also, relatives or carers accompanying the patient often had nowhere to sit or made the area crowded and harder to navigate when the corridor was not designed for this purpose. We saw all four internal trolley spaces in the corridor were in use constantly whilst we were on site over the three days. There was a nurse who was assigned to look after the patients in this corridor, but they were required or needed to step away at times.

In November 2023, 556 patients were cared for in the internal corridor and 1,313 were cared for in the pitstop corridor chairs. In order to improve the oversight, we recognised on our first visit was not ideal at all times, a healthcare assistant was delegated to look after and oversee the patients in the corridor 24 hours a day alongside the nurse. We observed the care and treatment being carried out with kindness and the patient receiving an apology for the situation from the nurse, despite there being difficulties maintaining privacy and dignity for patients.

There was poor visibility of patients for their safety and welfare in waiting areas, although steps had been taken to address this problem after our first visit. The main walk-in waiting area for patients and those with them was mostly not visible to the reception staff and there were no CCTV cameras to monitor patients. Staff told us they were due to have a mirror fitted to increase visibility for reception staff, but this had not happened.

However, following our first visit where we highlighted the safety risks from poor visibility, a nurse coordinator now oversaw the main waiting room alongside a healthcare assistant and was based in the area. They supported the patients waiting with regular communication and safety and welfare checks. This was supported 24 hours a day to provide

clinical safety to patients waiting for further procedures or triage. The only concern for the nurse overseeing the patients in the waiting room was with the number of patients to support. At the time of our visit, they were looking after up to 15 patients who were required to have some form of check every hour. We were told this was almost impossible to achieve safely with the constant flow of patients.

The service had a 'pitstop' area and a 'fit to sit' area. The pitstop was used to assess and triage patients who were either brought in by ambulance or were walk-in. This was staffed by three nurses, a healthcare assistant and a senior doctor at all times. These patients were moved to an area within the department following assessment. However, often due to the lack of space, this could be back into the waiting area or onto one of the nine chairs outside the pitstop called 'post pitstop'.

The 'fit to sit' area was an ambulatory area with nine recliner chairs. This had limited space and was mostly used for patients waiting for a cubicle to become free in majors. However, there was no criteria for staff to follow for patients who were appropriate to be placed in this area. Due to the lack of cubicles available, patients often remained in this area for long periods of time. For example, we saw on the 7 December 2023, an 89-year-old patient had been in the department for 19 hours and had been in a chair overnight. We also saw cardiac patients who needed monitoring were in the 'fit to sit' area for long periods.

Following requirements from NHS England to provide additional support to EDs, the trust had established a medical same-day emergency care (SDEC) service and a frailty SDEC service. There were plans for a surgical SDEC service to open on 18 December 2023, but this had been affected by strike action by junior doctors. The SDEC was open from 8am until 8pm and could take up to 24 patients. It had strict criteria to accept patients which included a National Early Warning Score (NEWS2) of under four and the patient being independently mobile. It was staffed by two advanced nurse practitioners, two nurses and a healthcare assistant.

Most patients directed to SDEC were discharged the same-day and could be asked to come back for non-urgent investigations usually the following day. For example, we joined an 11am doctors meeting where it was decided a patient from majors could be discharged home and brought back into SDEC the following day for further tests.

Non-clinical reception staff were required to navigate patients to the minor injuries waiting area when they were not trained in clinical decision making. The layout of the department meant there was no visibility of the minors waiting area and a risk a patient could deteriorate, and staff would not be immediately aware. Patients who attended with suspected minor injuries were sent to the minors area which was located off the main waiting area. This was staffed by two emergency care practitioners from 8am until 9.30pm, 7 days a week. The team saw between 15 to 20% of the patients who attended ED. If patients attended with a minor injury when the department was closed, they were seen by the doctors in majors or directed to see their GP.

There had been a lack of consistent checking of emergency trolleys and the equipment they carried. However, on our second visit, all the trolleys with equipment used for resuscitation were now locked with a tamper proof seal and most had been checked each day. On our first visit it was noted there were multiple gaps in the checking process. For example, for one of the trolleys, the daily check was completed for 18 days in September 2023, 19 days in October 2023 and 18 days in November 2023. The monthly check was not done for two out of three of these months. On our second visit we noted this had been addressed and there was only one gap in checking in the time since our previous visit. All three trolleys had a tamper proof seal, but on our first it was broken for two of the trolleys which were both kept in patient cubicles. This was resolved for our second visit and now a priority for the senior nurse.

We checked at least 30 consumables across both visits and found two out of date; these were disposed of immediately.

Urgent and emergency services

Staff could not always access equipment required for emergency situations quickly. There were no trauma packs or haemorrhage packs within the resuscitation room. There was a chest drain drawer, but this mostly contained dressings. Staff told us equipment had been removed when the area was 'decluttered' and not replaced.

There were insufficient treatment, assessment areas and waiting room space to accommodate all the patients attending the department. Patients were often held on the back of ambulances until space became available for review. All ambulance patients were seen in pitstop. Walk in patients were booked in at the main reception area. After booking in, patients were directed to wait in the main waiting area, children's waiting area, or minors to await triage. All patients were triaged in the pitstop area or children's area and were asked more details about their condition and directed to the appropriate area to wait or commence treatment.

The mental health room was not a suitable environment for assessment. Mental health assessment rooms should follow the guidance of the Psychiatric Liaison Accreditation Network and best practice. However, the managers were aware of the risks. It was on the departmental risk register and there were plans to make improvements. The designated mental health room was a cubicle within the majors' area. The assessment room had only one exit point, when it should have two doors, and there were potential ligature points such as sink taps. The door allowed patients to lock themselves in from the inside or lock staff in preventing escape and it did not open outwards. There was no access to a toilet in the department which was ligature safe. The service was due to recomplete a full mental health risk assessment of the environment in January 2024.

The mental health environment was poor for patient safety, and staff did not always act to keep people safe. We spoke to a patient who had presented with mental health concerns, and they said the staff did not understand mental health and assumed drug or alcohol usage as the reason for their mental health decline. They felt 'invisible' and were not checked on often. They said the environment was poor as they were in a room without a window, and this made them feel anxious.

Patients could not always reach call bells and staff did not always respond quickly when called. We saw a number of patients who did not have a call bell in reach and all patients who were cared for on the corridor did not have a call bell. At times, patients or their families would need to shout when they needed assistance. We saw on a few occasions there were patients cared for in the corridor who shouted for help and staff walked past them and did not attend them. We fed this back to the managers who delegated a healthcare assistant 24 hours a day to assist the nurse looking after these patients to always ensure oversight.

The trust had a protocol for how to respond to a patient who had left without being seen or while awaiting treatment. If a patient took the decision to leave the department, and staff were concerned for their welfare, they had a process to follow with the other emergency services (ambulance and fire services) to endeavour to get help to the patient. Contacting the police was a last resort or if there was a fear for the patient's safety or that of others.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments. Safe disposal of waste was audited monthly, and the department was consistently 100% between August and October 2023.

Assessing and responding to patient risk

Staff did not always assess and manage risk well. There was a risk that a deteriorating patient was not identified and acted upon quickly as staff did not always complete risk assessments for each patient promptly; this included regular observations. There was a delay in assessment and treatment for some patients when the department was full due to the lack of flow through the hospital.

Urgent and emergency services

Staff did not always complete risk assessments for each patient on arrival, using a recognised tool, in a timely way. Medical staff did not routinely assess patients while on the ambulance. Whilst all patients were handed over on arrival, some patients waited several hours before being admitted into the department.. However, if the patient was deteriorating and there was no bed available, doctors would review the patient on the ambulance and start any treatment where possible. There was no protocol staff used to review the patients who were waiting on ambulances for longer periods of time.

The triage process followed evidence-based practice and patients were graded in accordance with the seriousness of their injury. There was a colour-coded scale on the computer programme to give a visual appearance of those patients who would need a more urgent review. The time the patient had been in the department was also colour coded to indicate those waiting longer than the national standard waiting time and give a visual warning to staff about delayed treatment, particularly when both more high-risk trigger colours were indicated. On occasion, when a patient was reviewed first by a doctor the colour coding system was not effective as triage was a process not required to be followed.

We looked at 12 sets of records and found 3 out of the 12 patients did not have a completed triage. If the patient was seen by the consultant, they did not always have a formal triage completed. This meant it was not always easy to determine the patient's clinical priority and patients were not always seen in order of clinical need, they were mostly seen in order of attendance. When asked, staff were not always aware of who was the sickest patient in the department.

There were standard templates in the triage area to follow for consistent processes for specific conditions. For example, the early pregnancy triage tool triage process described what needed to be done in each case; any warning signs to escalate to a clinician; what tests or examinations would be required; and what to do in emergency situations, such as high early warning scores.

In the main waiting area, the department used a process of asking patients to sit in either red chairs, if they had not been triaged, or blue chairs if they were waiting for the next steps. With a crowded waiting room, it was unclear whether this was helpful. One patient we met who had been triaged was anxious they could not find an empty blue chair for themselves and their relative to use, so had taken a red chair.

Walk in patients were not always assessed or given treatment in a timely manner. There was a risk that unwell patients could be left in the waiting area without triage for a long period of time without staff knowing the patient was at risk of deterioration. For example, on 7 December 2023, a consultant told us a patient was in the waiting room overnight for nearly three hours prior to being triaged. As the time to initial assessment increased, there was no clear escalation plan of how patients would be triaged, and risks could be mitigated. Following our second visit, managers had assigned a nurse to the waiting room who could also assist in triage if delays were increasing. Otherwise, patients were reviewed within pitstop in time order and there were no systematic triage processes in operation.

Triage performance had improved. Standards set by the Royal College of Emergency Medicine (RCEM) state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. Not all patients were seen for a clinical triage within 15 minutes of arrival. However, the department's performance for triage within 15 minutes had improved from 40 minutes in August 2023 to an average of 24 minutes at the time of inspection. Senior staff reduced the risks associated with delays to triage by allocating experienced nurses to work in triage.

There was a risk that the consultants' time within the pitstop area was not being best used. We found there was clear ambition to have a senior doctor managing pitstop 24 hours 7 days a week cover. This allowed for early investigations and early senior decision making and specialty referrals, as well as the ability to discharge patients after early senior review. The model of senior doctor assessment was a recognised RCEM ED assessment. However, the lack of a separate

triage for walk in patients meant there was a risk that "well" patients were seen and assessed by a senior clinician before a sicker patient, merely because they arrived earlier. There was also a risk that less experienced junior doctors over investigated less acute patients and low acuity patients were being seen by a consultant which may not always be the best use of resources.

Staff used a nationally recognised tool to identify deteriorating patients, but they did not always complete observations in a timely manner. We saw NEWS2 were not always completed regularly and patients with high NEWS2 (indicating risk) were not reassessed or monitored hourly in line with guidance. For example, on our first visit, we saw a patient had arrived with a respiratory condition. Their first set of observations were taken at 10.42pm on 6 December 2023; they were not then taken again until 6.45am on 7 December 2023. We looked at 12 sets of records and found in all 12 records observations were not recorded hourly as required. Senior nurses told us NEWS2 should be completed hourly. Patients remained in the department for long periods of time and at times had periods of between 4 to 6 hours without a NEWS2 being recorded. We fed this back to the trust, and senior staff told us the clinical skills trainer would provide focused NEWS2 competency and refresher training which would commence on 11 December 2023 and continue throughout January 2024. During our second visit, we were told this had started happening. Managers also reminded the staff through their daily safety huddles about the importance of completing and recording clinical observations.

Managers were not aware of the poor compliance with completing observations and the risk of staff not detecting a deteriorating patient. The service did not audit NEWS2 completion. However, following our feedback the managers took action to improve compliance. They completed an audit of 8 sets of notes which showed a slight improvement with completion of observations. It showed 4 out of 8 patients had their observations completed every 1 to 2 hours. Actions to improve compliance included regular auditing and learning was to be cascaded through safety huddles.

During our second visit, we reviewed 4 sets of notes. We found the frequency of observations had improved in the daytime, but they were still not completed hourly overnight. One patient went 6 hours without any observations. This was again fed back to the managers. We were advised there would be weekly audits of the documentation with results shared with staff where the standard was not met. Following our second visit, we were sent an audit which showed an improvement in frequency of observations for patients with a NEWS2 of 5 or above. For example, the average time between observations for a patient with a NEWS2 of 8 in November 2023 was 75 minutes; this had decreased to 57 minutes between 15 December and 28 December 2023. Connected to this audit, managers had developed a standard operating procedure for patient observations. This gave further guidance about when staff should be taking observations and when to escalate to the doctors. Data showed that at the time of our inspection 81% of nursing staff had completed NEWS2 practical competency training and 83% had completed their e-learning training although this was below the trust target of 85%.

Staff told us they did not have time to complete observations and management recognised this. Following our first visit, they put a further healthcare assistant 7 days a week allocated to the area of most pressing need as identified by the nurse in charge. They assisted with NEWS2 observations which meant the nurses had more time to complete other tasks.

The staff in the children's area completed paediatric early warning scores. The trust sent us an audit of five sets of records which showed these were completed in a timely manner.

Not all staff had a good awareness of assessment and treatment of sepsis (the sepsis 6 bundle) and did not always act promptly to reduce the risks associated with sepsis. We looked at compliance with the sepsis 6 bundle within patient records.

Urgent and emergency services

Sepsis 6 compliance was audited in April 2023 by the medical team. They looked at 46 patients who identified as septic between January to February 2023. They found the average time to be reviewed by a doctor was 6 hours and 53 minutes, the average time for the first dose of antibiotic to be given from the time of presentation was 7 hours 54 minutes. Following the inspection, managers completed a sepsis audit which showed 5 patients out of 10 scored as red flag for sepsis. Of these, two patients were not appropriately identified in the screening process. No bundles were recorded on the electronic system for the patients. Results showed four out of five patients received antibiotics with the mean time to prescription of 2 hours and 16 minutes and mean time to administration of 3 hours and 9 minutes.

Actions from this audit included training staff on the screening tool in triage, promoting the use of sepsis bundle in triage and to re-audit in January 2024.

On our first inspection visit we saw nine out of 12 patient records had a completed sepsis screen on assessment. We found three of these nine patients were given a diagnosis of potential sepsis. Of these three patients, two were given antibiotics but neither were given within 1 hour as required, and the sepsis 6 bundle was not initiated or completed. We raised this with senior staff who told us they intended to do focused teaching sessions and remind staff in their daily safety huddles about the importance. On our second visit, we saw posters around the department highlighting sepsis and staff had started using the sepsis bundle in paper form. The computer systems had been updated so when a patient scored a NEWS2 of three or higher, staff were prompted to complete a sepsis screening tool. This was one of their triggers for assessing patients for sepsis.

A clinical dashboard had been developed to monitor NEWS2. This dashboard highlighted if any patient in the department had a NEWS2 of 5 or higher, if their observations had been completed within the hour, and whether the sepsis screen had been completed and antibiotics given. This meant the nurse in charge had better oversight of these patients. On our second visit, the dashboard showed all patients with a NEWS2 of 5 or higher had up to date observations taken within an hour. Staff told us sepsis had been discussed widely in safety huddles and training sessions had commenced.

The service sent a further sepsis audit which was completed on 22 December 2023. This showed four patients who had a NEWS2 of 5 had been correctly identified; this was an improvement from the previous audit. All patients received antibiotics with the mean time to prescription of 37.5 minutes which had improved from 2 hours 16 minutes in the previous audit and most other elements of the sepsis 6 had been completed. However, there was no sepsis 6 paperwork that had been completed. Staff planned to reaudit in January 2024 and promote the use of sepsis bundle paperwork in triage. Following our first visit, the managers developed a new standard operating procedure to identify and manage patients with sepsis within the department.

Staff were not always aware of specific risk issues due to the lack of completion of some assessments. We were not assured that pressure area care and tissue viability was managed well within the department. We saw some risk assessments were completed well, such as falls risk assessments and frailty scores. However, not all risk assessments were always complete. Staff used the ‘Anderson’ risk assessment tool to look at the patient’s risk of developing a pressure ulcer; it should be completed within the first hour of the patient being in the department.

We looked at 8 sets of notes and found the Anderson tool had not been completed in 5 out of 8 sets of notes. Two of these patients were in their 80s and stayed overnight on a recliner chair in ‘fit to sit’ without their pressure areas being checked. Where it had been completed in three sets of notes, they were not completed within an hour of admission; 2 of them were 11 hours after admission to the department. We saw on 7 December 2023, a patient in ‘fit to sit’ was noted to have a red sacrum at 2.45am and again at 9.46am but there were no measures to reduce the risk of this developing into a pressure ulcer.

Urgent and emergency services

Staff did not always act to prevent or reduce risks. Nurses told us they did not routinely use fluid balance charts even where it was critical to the patient. For example, fluid balance was not always recorded if the patient had a catheter or sepsis where input and output was indicative of a patient's condition. We saw examples of this when we reviewed patients' notes. Following our second visit, we saw posters in the department prompting staff to complete fluid balance charts. Paperwork had been reorganised to make it more accessible to the nurses and teaching and training had started. Managers were going to audit compliance through the documentation audit.

Patients were not always been routinely monitored through regular observations. Observations were carried out sporadically and inconsistently. Nurses documented them in different places, and meant it was hard to determine whether it had been undertaken. One nurse told us it was documented in the 'patient safety checklist' and another told us they documented it within the nursing notes. All notes we checked showed regular observations did not occur every 1 to 2 hours. At our second visit, we were told that the system had been updated to mandate the patient safety checklist completion with each set of observations. The compliance to the patient safety checklist was not covered in the newly developed documentation audit, but it was added while we were on site.

Initially there was no clinical oversight of the waiting room which meant there was a risk that a deteriorating patient could be missed. This was improved following our feedback and following the first inspection visit, the trust added an extra nurse to work with the 'front door' team of nurses to do regular observations of the waiting room. They were also supported by a healthcare assistant from 10am until 10pm. Staff told us the waiting area felt safer and felt reassured knowing there were staff observing the patients.

Patients were, at times, left unattended who were high risk within the majors area housing bays 11 to 15. Staff told us it was a risk to patient safety when there was only one staff member allocated to the area as they were not able to always remain in the bay. For example, when they transferred patients to other areas within the hospital. The area was intended to be staffed by a band 5 nurse and healthcare assistant. On 6 December 2023, we saw a patient with dementia nearly fall out of bed when the nurse left the bay unattended. They were found by another member of staff who walked through the area. The nurse had transferred a patient to another area which had left the bay unattended. We were told not all patients within this bay were always triaged and could be brought from the ambulance into this area. They would bypass the pitstop area in certain busy times where they would otherwise be triaged. We were told that if a patient had not been triaged within 20 minutes, the staff covering the area would complete this themselves.

Patient risks for developing venous thromboembolism (VTE – blood clots) were assessed. Patients should be risk assessed for developing VTE when remaining in the department for longer than clinically intended and we saw that happened. We looked at 3 patient records who had been within the department for over 14 hours and they all had a completed VTE risk assessment and appropriate preventative treatment prescribed. The trust were also reviewing its VTE policy for routinely undertaking VTE risk assessments in the ED due to the increasing length of stays for patients.

There was good support for adults with a mental health crisis. The service had 24-hour access to mental health liaison and responsive specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had good support from the mental health team who advised and assisted staff with mental health issues. In November 2023 the average time to referral was 2 hours and 53 minutes.

Staff did not always have a good understanding of mental health and consider the ongoing risks for mental health patients. They did not always ensure the patient was getting the right level of care required. We observed a patient who was in the mental health assessment cubicle in majors on 6 December 2023 who had attended with self-harm concerns and had self-harmed within the waiting area. They were visibly upset. We saw the patient try to get staff attention and

was ignored. There was a lack of interaction from staff, the patient was not checked on by staff regularly and risk assessment not completed within a timely manner. We asked to see the risk assessment. This colour coded the patient's risk which led to enhanced observations if deemed appropriate; this had not been completed for this patient. This meant there was a risk that the patient was not observed frequently enough and would cause further harm.

There was good support for children with mental health needs. The paediatric area had access to the children's and adolescent mental health service and used a risk assessment to assess children presenting with mental health issues. Staff were able to get support from registered mental health nurses within a few hours where required to support these children.

Staff did not always share key information to keep patients safe when handing over their care to others. Patients who were transferred to a ward from the department did not have a written handover completed. The nurse did this verbally and printed off clinical information from the computer system as the ward nurses did not have access to the ED electronic system. Patients who were discharged to a care setting were not sent with a discharge letter or a transfer document and we were told that often a verbal handover was not given. This meant care home staff were not always aware of what had happened to the patient while they were in hospital.

Not all patients were wearing their hospital-issue wristbands to provide identification and prevent communication errors. The department used a system which provided patients with identification wristbands on arrival. We noticed 4 patients had no wristbands on and 5 patients who were carrying their wristbands rather than wearing them and one was being carried by a parent and not the young person. We saw the lack of wristbands on patients was discussed in the November 2023 divisional quality governance meeting including concerns that medicines were given to patients with no wristbands. There was no action from the meeting to improve compliance with wristbands.

There was good oversight of patients for the senior team in the department. Each computer in the department had access to a patient management screen which displayed an overview of patients. It showed the length of time each patient had been in the department, or on an ambulance, or were waiting for triage, or treatment. Managers saw where the greatest risks were and moved staff and resources around accordingly. A patient flow facilitator was based in the department every day and liaised with site managers, matrons, and doctors to access beds for patients as soon as possible. Risks were discussed at regular bed meetings every day; these were held four times throughout the day.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe and complete basic tasks at times, although measures had been taken to improve this. Staff told us there were not enough staff to care for the number of patients and they felt it was unsafe as they did not always have time to deliver safe care. This was evident with some of the issues found including lack of timely observations, poor risk assessment and poor record management. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but this did not meet the demand of the patients in the department. The Royal College of Nursing (RCN) Nursing Workforce Standards within a Type 1 ED require the nursing workforce to be determined by looking at a number of things. This includes using a baseline emergency staffing tool (BEST). The BEST ratio for low dependency patients is one nurse to 3.5 patients. There were times where there were three nurses within pitstop who had more than 30 patients to look after; they were not always low dependency patients.

Urgent and emergency services

Nurse staffing levels had been established as 14 nurses and 5 healthcare assistants per day shift and 13 nurses and 5 healthcare assistants at night. The number of nurses and healthcare assistants matched the planned numbers on the day we inspected. Managers had increased the numbers by 2 nurses day and night in September 2023 following an increase in incidents in the 'fit to sit' area. There were six band 7 nurses sisters who worked within the department to support the nurses. They were not counted in the nursing numbers (supernumerary) and enabled therefore to step in when there was sickness or support for staff or patients was required. There was a matron in charge and visible within the department.

Some nursing staff told us they did not have time to fulfil their roles. We saw examples of this where medicine was overdue by three hours and patient observations were not completed in a timely manner. We raised this with senior staff in the trust who were responsive. They added a nurse and two healthcare assistants to the department 7 days a week to support the team. During our second visit, staff told us the increase in staff had improved the care for the patients.

The service had 6 emergency nurse practitioners (ENP) who worked autonomously within the minor's department; there were no vacancies within this area. Most shifts had 2 ENPs who covered the department from 8am to 9.30pm.

There were 5 advanced care practitioners who worked throughout the ED. They worked staggered shifts throughout the daytime and reviewed patients alongside the doctors.

There was a high vacancy rate and a relatively junior nursing team needing extra support. The service had a vacancy rate in the department of 21.4%; we were told this were for band 5 nurses. The trust had a rolling advert out to recruit band 5 nurses. Meanwhile, the staffing gaps were covered by regular agency and bank staff. They had recruited 13 overseas nurses who required support and training during their preceptorship year.

There was a risk due to not all ED staff nurses looking after children overnight having completed paediatric immediate life support (PILS) training, safeguarding children's level 3 training and paediatric nurse competencies. This led to a potential risk of them not picking up a deteriorating child and acting appropriately. There was no evidence of failure to identify risk, but the training was not at the right level to assure safe care at all times. Also, managers told us they did not have a process to ensure these staff members had completed the appropriate training. We highlighted this with the trust who put in immediate mitigations to ensure that from 8 December 2023 only staff who had completed PILS training, safeguarding level 3 and the RCN competencies for paediatrics were allocated to cover the paediatric area overnight. Data shared after the inspection showed 14 members of staff out of 73 were compliant with all three. Where it was not possible to provide a fully trained nurse, the trust's paediatric ward would provide a nurse, or the nurse's training would be risk assessed. For example, it would be deemed low risk if the competency or training was out of date by a month.

We were informed by senior managers after the inspection of a plan to train all staff over the following 6 weeks; they aimed to have all staff trained by the end of January 2024. They had also assigned PILS as a mandated competency within the roster. This meant when they were completing the staffing rota, they were required to ensure during each night shift there was someone who was PILS trained to cover the paediatric area. During our second visit, the managers told us they had linked up with the paediatric practice educator who was going to provide drop-in learning sessions for the nurses as well as assisting with signing off competencies for the nurses where able. The paediatric area was staffed in the daytime by an experienced paediatric nurse and healthcare assistant who were provided by the paediatric ward during the hours of 7.30am and 7.45pm, 7 days a week.

There was a reducing turnover in nursing staff. The department turnover of nursing staff had decreased from 13% in September 2023 to 9.9% in November 2023. This was below the trust target of 10%. Managers told us they had a turnover of international nurses who had completed with 12-month preceptorship programme in September 2023 and had moved to a different area. They had recently recruited more international nurses into their team who were supported by a buddy team.

The service had fluctuating sickness rates. The sickness rate for September to November 2023 was an average of 5.7%. The sickness rate for qualified nursing staff fluctuated between 0.7% and 7.9% in 2023; the trust target was 3.5%. The sickness rate for healthcare assistants had considerably decreased in 2023 from 18% in January to 1.6% in August 2023.

The service had a high but reducing number of bank and agency nurses on shift. Agency nursing numbers had decreased from 31% in September 2023 to 25% in November 2023. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Most agency staff were regular staff who knew the department and were experienced ED nurses. There was an average over the same time period of 9.2% of shifts which were covered by bank nurses. Of these shifts there were 5.8% unfilled shifts in September 2023 which decreased to 2% of shifts unfilled in November 2023.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There was a significant shortfall in the recommended number of consultants working in the service, and no paediatric emergency medicine consultant. However, managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe and relied on regular locum consultants to reduce the risks and increase the safe staffing levels within the department. There were 3.2 full-time consultants employed. The department had three consultants per day, working staggered shifts to provide senior presence from 8am to 7pm, Monday to Friday. There were two consultants at the weekend providing cover until 9pm. This did not meet the RCEM recommendation of 16 hours consultant presence every day. The trust had recently appointed one of their regular locum consultants for a substantive post commencing in January 2024 and were interviewing for another two substantive posts. The senior leadership team had submitted a business case to increase their consultant cover to ten full-time consultants which would ensure cover in line with RCEM recommendations; this was awaiting approval by the executive board. The consultant vacancy rate was on the departmental risk register. This had not changed since our previous inspection where we found consultant levels did not meet the RCEM requirements. The control measures included long term locum cover and additional hours covered by ED consultants. The low consultant numbers meant quality improvement work was delayed and it impacted on the department's ability to have emergency medicine trainees due to the supervision required.

Not all medical staff had completed advanced life support training for adults and children which meant there was a risk of them not recognising a deteriorating patient and not acting appropriately. There was no evidence of failure to identify risk, but the training was not at the right level to assure safe care at all times. Managers were unable to ensure every shift had a senior doctor who had advanced paediatric life support and advanced life support due to the low staffing levels. We saw 54.2% of medical staff had completed either immediate life support or advanced life support and 4.2% had completed the equivalent for paediatrics. To mitigate the risk, managers relied on support from other trained staff in the hospital. There was a paediatric consultant who provided an on-call service and on-call intensive care

anaesthetists; this was arranged to provide further paediatric advanced life support (ALS). Additionally, the hospital's medical on-call team who attended the department when requested were all ALS trained. We were told there was a plan to provide training to doctors to ensure adequate life support training was available. However, this risk was not on the departmental risk register.

An on-call consultant covered the out of hours period 7 days a week. Each night shift had two specialist doctors and two junior doctors who worked alongside the consultants. There were advanced care practitioners on throughout the day who assisted the medical staff with reviewing the patients. There was always a junior doctor assigned to paediatrics 24 hours a day, with a specialist doctor assigned to support.

The service had high but reducing vacancy rates for medical staff. There was an overall vacancy rate of 16.3%; 40% of this was consultants and 20.2% was middle grade doctors with a total of 5.23 full-time equivalent staff vacancies.

The service used high levels of locum doctors due to a high number of vacancies. There were a high number of unfilled shifts although this fluctuated and was reducing. Managers told us they could employ locum doctors without too much delay when they needed additional medical staff. They used reliable regular locum staff who they said provided a good quality of cover. Managers made sure locum doctors had a full induction to the service before they started work. We spoke to a locum registrar who said they had received a good induction and found it a very supportive environment to work in. The service used 250 hours of locum time in September 2023, and this increased to 613.5 in November 2023. These hours were for speciality doctors and consultants with 553.5 hours used for specialist doctors in November 2023. The reason for this high number was 3 permanent doctors left over this time period and there were doctors' strikes. The service had a high number of unfilled shifts. In September 2023, there were 19% of shifts unfilled but this reduced to 6.75% in November 2023.

Sickness rates for medical staff were lower than the trust target of 3.5%. The sickness rate for medical staff between September to November 2023 was 1.1%.

There was access to senior medical staff for training and development. The junior doctors had focused training every three weeks for an afternoon. Speciality doctors had teaching on Friday afternoons. We were told this was mostly well attended. We spoke to a junior doctor and a foundation year doctor who both confirmed they had regular programmed time for teaching and training and had received induction when they started in the department. They were satisfied with the way the rotas were managed and they both told us they had access to senior staff when they needed advice, including out of hours.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not clear and were not always completed. However, they were stored securely and easily available to all staff providing care.

Patient notes were not always comprehensive. We looked at 12 records and found hourly observations, checklists, risk assessments and fluid balances were poorly completed in all 12 notes we looked at. All notes were electronic but a number of different systems were used.

There were ineffective care plans in the system for patients needing to stay in the department for longer periods due to delays in discharging to wards. There was an electronic system for ED which was designed for patients who remained in ED for less than four hours. However, due to the lack of flow through the department, patients were staying for long periods of time while waiting for beds but the systems were not programmed to support care and treatment for long stay patients. Staff did not have appropriate long-stay risk assessments for patients who remained in the department or

appropriate medicine charts. This meant risk assessments and medicine management relied on the nurse remembering to complete them rather than a system prompt. Once the patient moved from to the wards, their records were held on a different computer system. When patients transferred to a ward, this lack of shared systems meant there were occasional delays as staff had to print all the patient's notes prior to transfer as the wards could not access the emergency department system.

The trust were aware there was a problem with the lack of a joined-up system and were planning on moving the emergency department across onto the system used in the rest of the hospital. However, this was not due to happen until at least the end of 2024.

Staff told us the patient record systems were difficult to use and inconsistent. We were told it was difficult to see what the plan for patients was, their clinical needs, when a patient had been reviewed by a speciality and what care had been completed. Staff were aware basic checks did not get well documented all the time.

Managers were not aware of the omissions we found within the patient documentation as they did not audit their medical records. Following our inspection, they completed an audit on the documentation. They found the same issues we had found including lack of regular observations, patient safety checklists poorly completed, poor sepsis 6 completion and implementation and a lack of fluid balance charts. As a result, they told us they were going to audit the patient records monthly and implement changes to improve the quality of the records.

Records were stored securely on a computer system. All staff could access notes easily with their own login and password. All agency staff were given secure access to the systems while working in the department.

Medicines

The service did not use systems which enabled them to safely prescribe, administer, record and store medicines.

Due to a poor medicines management system, staff were not always able to follow the systems and processes when safely prescribing, administering, and recording medicines. Not all medicines were given on time and records were poor. An electronic recording system was used that was specific to the ED. Although it was a good visual tool for staff, it did not provide the required medicines information necessary to ensure the safe prescribing and administration of medicines. It was not always easy or clear to see if patients had been given their medicines. It did not link in with any other digital platforms which were used trust wide. For example, the trust used an electronic prescribing and medicines administration (ePMA) system however, ePMA was used within the ED and only used once patients had been accepted by a specialty. This meant there was a gap in up-to-date medicines information for patients.

There was a particular impact for patients prescribed time critical medicines if they were not prescribed or administered on time. There was no alert on the system for these medicines. For example, on 6 December 2023, we saw a patient had been prescribed antibiotics for sepsis at 1pm and they had still not been given by 3.40pm. They were prescribed on the ePMA system which did not alert the nurse they were overdue. It relied on the nurse being aware of the prescription and the time it was due.

The system also allowed for medicines to be prescribed without documentation of up-to-date allergies or other medicine history. We were told the trust was aware and were in the process of updating and implementing a new system into ED. This was not on the ED risk register despite the managers being aware of the risks associated with the use of different systems within the department.

Urgent and emergency services

Some patients had not been administered their medicines at the prescribed time. We saw three patients in the pitstop area had not had their medicines administered an hour after they had been prescribed. Of these patients, two of them had not received their pain relief and one patient had not received medicines to help a respiratory condition. We were told it was due to nurse capacity and there had been no time to administer the medicines. We saw medicines were given with no drug history or allergies recorded in the notes.

Patient group directions, a set of authorisations for non-medical prescribers to be able to give certain agreed medicines, were available and up-to-date within the department.

Medicines records were not always accurate or up-to-date. There was a risk that medicines were forgotten by either the nurse or doctor as the online system did not include a medicine chart. Each medicine had to be individually prescribed when needed. Documentation of medicines administration including routes of administration and specific times of administration were not always completed on the medicine records reviewed. It was difficult to follow a patient's pathway regarding prescribing and administration.

Information on missed doses of medicines was not currently available for the emergency department. It was not possible to undertake an audit for learning and improvement with the current available systems and processes.

The allergy status of patients was not always recorded. This meant allergies were not always highlighted and there was a potential for a medicine error. We saw on the 7 December 2023, a patient in the 'fit to sit' area was given two different antibiotics intravenously without having a wristband on or allergy status documented.

Staff did not always store or manage medicines safely or securely. Medicines storage areas seen were locked and secure with access only to authorised staff. However, medicines were not always managed and stored safely which was mainly due to some disorganised storage arrangements. In the 'clean utility' medicine storeroom we observed loose strips of medicines not in their original containers, with no coordinated system to easily locate a medicine. In the same-day emergency care area we found some out-of-date medicines had not been disposed of safely. These issues were also identified in medicines storage audits. There was a lack of individual staff responsibility to ensure medicines were stored following trust policy. This increased the potential risk of a medicine error, or a medicine not being located.

Resuscitation medicines required in an emergency were stored in tamper-evident boxes which followed Resuscitation Council UK guidance. Staff recorded safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency, but they did not pick up the requirement for them to be tamper-evident.

Controlled drugs (CD) were stored safely and securely with access restricted to authorised staff. As required, checks were undertaken and recorded by two staff twice a day. Checks of CDs showed they were within date and stock balances were accurate. The staff completed CD audits monthly. The November 2023 audit showed an increase in CD administration and recording compliance from 67% in the resuscitation area to 82% and an increase in compliance from 76% in September 2023 to 83% in October 2023 at the nurse's station.

The staff completed a safe and secure handling of medicines audit. Results from the 12 December 2023 audit showed 83% compliance. For each area of non-compliance there was an action to make improvements.

Staff did not always follow national practice to check patients had the correct medicines. There was a lack of a clear system to check and record what medicines patients were prescribed at home or by their GP. For example, the 'drug history' section on the electronic system was not completed in 11 out of 14 records reviewed.

Urgent and emergency services

Staff learned from medicine safety alerts and incidents to improve practice. The trust had an electronic system for recording incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported.

The trust had a Medicines Safety Officer in line with NHS England directives. They investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

The service commenced an audit of the patient notes following the inspection. They looked at 8 sets of notes and found 2 out of 8 patients did not receive their medicines within 60 minutes of it being prescribed. However, there was no action plan provided to us for assurance of learning and improvement associated with the audit.

Incidents

Managers investigated incidents but they did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff recognised and reported incidents and near misses and reported them appropriately.

There was no formal learning from incidents that happened in the department which meant staff could miss out on key learning and improvements required from incidents. Staff we asked were not able to tell us about any changes which had been made in the department following an incident. We were told learning from incidents was given at the safety huddles which were at the beginning and end of each shift and general learning was shared in an encrypted social messaging group. However, there was no mechanism for informing staff who did not attend the huddle or use the messaging group, so it was not clear all staff were included, updated or involved.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received feedback from investigations of incidents they had recorded but did not always receive feedback from incidents from the department. Doctors told us they had huddles 3 times a day and incidents were occasionally discussed during these. Although 4 junior doctors we spoke to could not recall any discussions around serious incidents in the department.

Managers did not always share learning with their staff about incidents that had happened elsewhere. Staff told us they had ‘Feedback Friday’ and ‘Wisdom Wednesday’ newsletters where learning was shared from events that happened within the medicine directorate. We looked at three examples of Feedback Friday and Wisdom Wednesday newsletters and found there were no incidents or learning shared on these. We did not see any examples of incident feedback to staff within the department. Staff did not meet to discuss the feedback and look at improvements to patient care. Team meetings did not occur regularly, and staff were not able to tell us about improvements that had been made following incidents that had occurred. However, the trust had a patient safety panel every Friday where incidents were discussed that had occurred in the trust that week. The sisters attended this meeting for learning but there was no evidence of this being shared with the department.

The service had no ‘never events’ in the department in 2023. Never events are serious incidents or near misses which should not happen if safety systems and processes are followed. The most common incident categories were implementation of care and ongoing monitoring; access, admission, transfer, discharge; and medicine incidents.

Not all available information was shared with staff. A monthly matron’s ‘exception report’ was produced about important data and events, but key information from this was not disseminated to staff. This meant the department were not assured there was always learning from incidents and changes made to improve practice. The reports detailed

the incidents over the month and looked at the top themes. We looked at October and November 2023 exception reports (where they reported on the previous month's data). They showed there had been an increase in incidents with harm. These had increased from 18 in September 2023 to 22 in October 2023; five of these were moderate harm. All moderate harm incidents were reviewed by the division and a rapid review was completed where needed. However, with staffing pressures, there was a high number of incidents still to review, although this was reducing. Although learning was not evident following incidents, managers debriefed and supported staff after any serious incident. They did a 'hot' debrief immediately after an incident and then had a 'cold' debrief one to two weeks later. This gave the staff time to process how they felt about the incident.

There was a lack of assurance that learning was disseminated or embedded from serious incidents. We looked at 2 serious incident (SI) reviews from January and February 2023. These were detailed and comprehensive. One of the SIs was a cluster of incidents relating to patient's suffering pressure damage to their skin. It was found in the incident review that risk assessments were not completed in a timely manner, there was inadequate documentation of pressure damage and failure to use effective pressure relieving equipment. We looked at 8 sets of notes specifically looking at whether the pressure damage risk assessments (Anderson Tool) had been completed. Despite the serious incident findings, we found risk assessments had not been completed in 5 out of 8 sets of notes and pressure relieving equipment was not in use when indicated.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed two serious incidents and saw duty of candour had been undertaken and letters sent to all patients and families involved.

Is the service effective?

Requires Improvement ↓

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. However, actions were not always implemented from clinical audits to improve patient outcomes or care and treatment.

Guidelines and pathways were not always up to date or referencing national guidance. We saw that the guidelines and pathways for illnesses, such as diabetic ketoacidosis and sepsis, were available on the trust's intranet, however a few of them were out of date or lacked referencing from national guidelines. For example, we looked at the guideline for chronic obstructive pulmonary disease which had no references and was out of date. We also looked at the sepsis policy which had no author, no date, and no references to Sepsis UK. The reference used was 'Kidney Injury, April 2016' which was not an appropriate reference for a sepsis guideline.

The service used some of the National Institute for Health and Care Excellence (NICE) guidelines to ensure care was evidence-based but not all care was evidence-based and provided in line with guidance. For example, the service used up to date NICE support tools such as selecting people under 16 for a computerised tomography (CT) head scan (NG232) (2023) but it did not follow NICE NG51 sepsis guidelines.

The managers did not always action results found from clinical audits and make changes needed to improve care for patients. While the service participated in clinical audits which enabled them to show care was being provided in line with national recommendations and best practice, they did not always create action plans and put the actions into place. For example, the service completed a sepsis audit in April 2023 and found they did not always follow sepsis screening guidelines. We did not see any actions implemented from this sepsis audit and the service had not re-audited to check compliance. We saw that sepsis screening guidelines were still not followed. The sepsis 6 pathway was not used effectively and in all the records we checked for patients being treated with sepsis, they did not receive their antibiotic treatment within the 1-hour nationally recommended timeslot.

In accordance with national guidance, the department had a stroke pathway that ensured patients were seen promptly and there were good outcomes. The service provided rapid clinical assessment and CT scans with the option of an air ambulance transfer for the patient if they required thrombectomy at another specialist site. Stroke staff used a trust-approved application on their mobile phones to view the CT scans which enabled rapid responses. This meant the team could see and diagnose the scans promptly and treatment was able to be given. The stroke specialist nurse told us significant investment and research had been given to develop stroke care within the emergency department with good results. Outcomes of patients who had a stroke were collected and were mostly above national average. The sentinel stroke national audit programme showed a compliance of 97.6% for the trust which was higher than the national average of 93.2%. Data showed 100% of patients had a full stroke screening on arrival to the hospital; this was higher than the national average of 94.4%.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health.

Staff did not always make sure patients had enough to eat and drink. The service were delivered a selection of sandwiches in the kitchen, but if there was an influx of patients, these could run out. We did not see patients were always offered drinks regularly. When looking at the patient notes, it was not always clear when drinks or food had been offered. We looked at four sets of notes on our second visit and found three out of the four patients had been offered either one or two drinks; they had all been in the department over 14 hours. While some patients told us they were offered regular drinks, we spoke to a number of patients who had been in the department for more than 4 hours and they told us they had not been offered any food or drink, some of these had stayed overnight.

There were no drinks or food facilities in the waiting area. These were found within the SDEC corridor and just outside the waiting room. Not all patients knew these were there and we found patients or those supporting them could be waiting for 8 hours without a drink. Following the inspection, 2 extra staff members were placed in the waiting room and on our second visit, we saw drinks were being offered.

There was hot food available for patients at 12pm and 5pm. Healthcare assistants did a breakfast round which offered cereal and toast to patients who had stayed overnight.

Staff did not fully and accurately complete patients' fluid and nutrition charts where these were clinically indicated. We saw patients who were receiving fluid through a drip, patients who had been catheterised and a patient with acute kidney injury who did not have a fluid balance chart. On our second visit, staff had started using fluid balance charts for patients where clinically indicated. We were told training sessions were being provided to staff around the use of fluid balance charts and their importance.

Urgent and emergency services

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and did not always give pain relief in a timely way.

Staff assessed patients' pain using a recognised tool but did not always do this regularly or give pain relief in line with individual needs and evidence-based practice. Patients pain was routinely asked as part of the national early warning score assessment, but this was not completed regularly for all patients. Observations were not recorded regularly for most patients in the records we checked. Staff did not always check pain and giving pain relief was inconsistent. We looked at 12 sets of notes and we saw examples of when pain was assessed, and pain relief given. However, it was not clear from the notes whether patients' pain was regularly checked, and staff did not always check the effectiveness of analgesia.

Patients did not always receive pain relief soon after it was identified they needed it or requested it. On 7 December 2023, two patients within the pitstop area told us they had been waiting for over an hour for pain relief. We asked the nurse who was looking after them why they had not received it and they told us they had not had time to give it to them. Another patient told us they had to repeatedly ask for pain relief from different staff and it took a while to get any.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They created actions from the findings to make improvements. However, due to low consultant numbers, they did not always have time to make the improvements needed.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. Outcomes for patients were mixed. Some were positive, consistent, and met expectations, such as national standards but some fell below national standards.

Staff completed the Royal College of Emergency Medicine audits on an annual basis, made actions to improve compliance, but did not always make sure they were completed. The audits included 'Consultant Sign off", 'Infection Prevention and Control (IPC)' and 'Pain in Children'. The consultant sign-off audit from 2022 showed 30% of patients had a consultant sign-off; this had since improved to 60% in 2023. The percentage of high-risk patients in 2022 who had consultant sign-off prior to discharge was 6.3%; this was worse than the national average of 35%. The audit showed 100% of consultants and senior specialists completed their own documentation following a patient review. There was no data available that showed consultant sign off for unplanned readmissions within 72 hours in children under 18 years of age and fever in babies under the age of 1 for 2022. However, 2023 data showed only 15% of these patients were documented to be seen or discussed with a consultant. The service was implementing key actions including further education to improve documentation compliance and allocating consultants in ED two administration hours on each shift to complete documentation and improve compliance. These results were discussed with the medical staff in July 2023.

There was good compliance with IPC screening, but not with the resultant actions taken to protect patients and others. The IPC audit showed good compliance with screening patients for infectious diseases, COVID-19 and vulnerable conditions on arrival; the department was better than the national average for all these metrics. This was a considerable improvement from the previous audit. However, they were worse than the national average where only 10% of patients where they had identified vulnerability were isolated in a side room and 75% of patients identified as potentially infectious being in an appropriate area; the national results for these were 24% and 80% respectively. There was an associated action plan which included education and improving the use of infection control checklists.

Improvements needed from audit findings were not always acted upon including acting on pain relief for children. We were told that due to the low number of consultants within the department, they did not always have time to put findings into practice and focus on quality improvement. The pain in children audit showed they were significantly higher (68%) than national average (38%) for administration of analgesia to children in moderate pain within 30 minutes of arrival and for re-evaluation of their pain following a dose of analgesia. However, only 31% of children had their pain assessed on arrival or at triage, this was lower than the national average of 54%. The audit showed only 28% of children in severe pain had analgesia administered within 30 minutes of arrival whereas the national performance was 58%. There was an action plan which included review of triage to ensure pain was identified early and education around pain assessment tools. These were due for completion in October 2023 and the audit had not been updated to show if these had been completed.

There was a lack of meaningful audit around patient outcomes. Managers were not fully sighted on issues within the department such as lack of completion of regular observations, lack of sepsis 6 compliance and delays in medicine administration as documentation audits were not completed. Where audits were completed, action plans were not always completed, and staff were not aware of the audit results. This meant changes were not always made as staff were not aware of the lack of compliance. Audit results were discussed by the managers within governance meetings, but these were not fed back to staff in the department. Staff told us they did not hear about any audit results apart from the most recent infection prevention and control audits as there had been a big focus on improving compliance.

There was evidence patients had good treatment on their first visit and most did not require a revisit to the department. Evidence showed the service had a lower than expected risk of re-attendance or similar to the England average from January to July 2023; the reattendance rate had fluctuated between 7% and 9%.

Competent staff

The service did not always make sure staff were fully competent for their roles. Staff performance review (appraisal) rates were low which meant staff were not always supported to develop.

There was a lot of demand on senior nursing staff to support a relatively junior workforce in nursing. Staff told us there was a high number of junior nursing staff who required support from the nurse in charge and often there were quite a few on shift at once which could be a challenge. Junior staff were working through their competencies and training but required support for some of these throughout their shifts. However, the department was fully established with band 6 and 7 roles and these staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

There was a gap in competency in emergency response for staff looking after children. As we have reported above, not all staff looking after children overnight had completed the required training to recognise or safeguard a deteriorating child.

Managers gave all new staff a full induction tailored to their role before they started work. This was comprehensive and ensured staff had specific training relative to the department prior to starting. New starters had an inhouse preceptorship programme for 12 months. The clinical practice development nurse (PDN) supported the learning and development needs of staff. They ensured training was completed and booked, and new starters were given extra support if needed.

There were a high number of new recruits to support, and this was a risk to overall staff competency. There were 17 new staff members in the nursing team which meant the PDN was struggling to ensure they were trained and provide the

support needed. This risked the department having a fall in overall staff competency. We were told the PDN, and education team found it hard to deliver all the training required to ensure competency for all the nurses in the department. Following the inspection, the managers recognised the training needs were high and compliance was not achievable with 1 PDN. Therefore, they were advertising for a second PDN for the department.

There was good support to new staff from their peers. There was a buddy team which had been set up which had 8 members of staff ranging from band 2 to band 6 who supported the new starters. This was set up by a band 6 international nurse who wanted to ensure there was a good support system particularly for the international nurses.

High pressures in the department meant that training and competencies were not being completed in a timely manner. All staff were assigned a team which was led by a band 6 nurse. They were responsible for identifying any training needs their staff had and giving them the time and opportunity to develop their skills and knowledge. However, we were told this did not always happen and the band 6s were not always able to support their teams with their development.

There was good quality training where time permitted. The service used the Royal College of Nursing competency booklets for emergency nursing. These were very comprehensive and covered all aspects of nursing within the department. The training for this was provided by the education team. The training team also ran a programme of skills to ensure the nurses remained up-to-date such as venepuncture, cannulation, and electrocardiogram training.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. In 2023, 53.5% of staff had received an appraisal. This was much lower than the trust target of 90%. During our second visit, the managers told us they had assigned a band 7 nurse to each band 6-led team to try to drive improvement with appraisal compliance. They aimed to improve by 20% by March 2024. The practice development nurse had developed a QR code for the staff to scan which took them directly to their self-reflection form which was required to be completed prior to the appraisal. This made it more accessible for staff to complete. When appraisals did take place, staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

There were link nurses within the department who assisting with training and educating the staff in certain areas such as blood transfusion, tissue viability, medicines and mental health where time constraints allowed.

There were low numbers of substantive consultants in the department which meant trainee doctors took priority for supervision over doctors without training posts. Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors told us the consultants and senior doctors were supportive and offered supervision where needed. We were told they were given regular teaching sessions which were well attended. As part of the national programme of revalidation, consultant appraisal rate was 100%.

There was no paediatric trained consultant within the emergency department. The Royal College of Paediatric and Child Health requires each emergency department treating children to have one paediatric emergency medicine (PEM) consultant. The senior leadership had not recognised the requirement for a PEM consultant and considered the department below the threshold due to the number of children seen. However, this was no longer a mitigating factor. There was a recruitment consultant advert live at the time of the inspection which was generic for both a PEM consultant and standard emergency medicine consultants. This included paediatric training within the job specification to provide improved paediatric competency, but this was not driving recruitment for a specific PEM consultant. The team were otherwise supported by the paediatric unit doctors and a senior paediatric doctor on call 24 hours 7 days a week.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The doctors had a patient review huddle three times a day throughout their shifts. This meant the consultant had an overview of the patients within the department and the care that was required. We observed a huddle, and the consultant was providing the junior doctors with advice regarding the pathway required for the patient.

Managers actively worked together throughout the hospital to improve the flow through the hospital and ease the pressure in the emergency department. The service worked well with the patient flow team and bed management team. However, bed occupancy at the hospital was high. The patient flow coordinator worked with ward staff to identify beds and help move patients from the emergency department and onto a ward. The hospital managers held bed meetings four times a day where they reviewed number of patients, performance against the 4-hour standard, staffing and bed availability. This resulted in plans being drawn up for individual patients. We saw during the meetings plans were made to improve the flow in the hospital. For example, on 7 December, the decision was made to increase the number of patients 'boarding' on the wards from 17 to 25. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. This was to ease the pressure within the ED as there were 20 patients who were waiting for a bed.

We were told that doctors, nurses, porters, cleaners, healthcare assistants and any other support staff all had good communication, a good rapport and worked well together.

The emergency nurse practitioners told us they worked well with the whole department. They were able to refer patients to services easily. For example, they had a patient who had fallen and needed assistance at home. They referred them to the frailty same-day emergency care team who arranged any social needs or admission if required. They said the frailty service enabled them to see more patients.

Specialty services supported the ED but more needed to be done to help with patient flow. The managers had produced, currently in draft, an ED internal professional standards document. This was to determine a standard required to enable ED to undertake relevant tests, treat the patient and request for a bed for the patient. However, there were concerns from the medical staff in the ED about support to them from speciality teams. The internal professional standards document required specialities to review their patients in ED within 30 minutes of receiving the referral. Data showed in the first two weeks of December, the psychiatric team took the longest to review their patients with an average time of 4 hours and 2 minutes; they saw 63 patients within these two weeks. The medical team saw the highest number of patients with 1,022 reviews; the average time to outcome was 2 hours 36 minutes which was similar to the orthopaedic teams. We spoke with the chief medical officer who told us work had been started with medical teams across the trust to find solutions and improved working practices to prioritise patients needing a consultation in the emergency department to help with the flow and the wellbeing of patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The team worked closely with the mental health liaison team to ensure these patients had specialist input where required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Urgent and emergency services

The emergency department was open 24 hours a day, every day, all year round. Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. If patients had full capacity, staff gained consent from patients for their care and treatment in line with legislation and guidance and where it was possible to obtain.

Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a mental health liaison team who advised on mental health issues. They were on site from 8am to 10pm and off site but on-call overnight. The staff reported they were very supportive. They also would see children aged 16-18 years old who had been seen by a clinician.

We saw that 75.8% of staff had completed their training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was lower than the trust target of 85%.

Staff we spoke with did not have good knowledge of the Mental Health Act. This meant if someone had been detained under the Mental Health Act, there was a risk staff would not fully understand how to protect their rights. Patients who lacked capacity to fully engage in treatment decisions and patients who had thoughts of self-harming and or ending their life were given 1 to 1 support where possible. We saw evidence that staff could get an agency mental health nurse to support with enhanced observations.

The mental health liaison team reviewed the patients and supported staff with the care. We looked at a set of records for a patient who was in the department with mental health concerns. There was a completed risk assessment and a referral to the mental health team who had assessed the patient promptly. They had put a detailed plan of support in place for discharge into the community through the crisis team. The staff told us the mental health team were supportive and prompt with their assessments. There was a monthly meeting with the mental health team, consultant, and ED sisters where they discussed support pathways, triage and frequent attenders.

The staff worked well together. There was a policy for restrictive intervention and restraint where security and porters were asked to support until the patient had calmed down. Some security and porters had received mental health first aid training and felt confident to assist the department where needed. One porter had received star of the month for supporting a mental health patient.

There was a pathway to follow for paediatric patients who presented in the department with mental health conditions and a child and young person's mental health assessment matrix which was completed. This enabled staff to ensure the patient was getting the right level of care required.

Is the service caring?

Good ➔➔

Urgent and emergency services

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness. However, due to the crowding in the department and the difficult environment there were some concerns around patient's privacy being met at all times. This was recognised by staff who were doing as much as was practicably possible to support privacy and dignity for patients.

We found staff were kind and trying their best to provide good care. Staff were mostly discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. However, the department was often crowded which meant staff were struggling to care well for their patients and always meet their needs.

We saw some excellent examples of good care and had some comments from patients including "staff were terrific and kept me up-to-date", "staff really helpful and the queue of patients is not their fault" and "wonderful, amazing staff". However, patients within 'fit to sit' had some examinations behind screens which did not always maintain their dignity. There was not enough space for all of the patients attending, and they were not always cared for in the most appropriate area. Some patients were held on a corridor with moveable screens to provide dignity when being examined. However, these screens had gaps in them and did not fully shield the patient.

Sometimes, patient information was hard to keep confidential in conversations. Due to the layout of the department and significant limitations with space, patients' private information could sometimes be overheard in a number of areas. Limitations in space made this largely unavoidable, but staff commented how they found it uncomfortable. Staff and also some patients were also wearing face masks, and this made communication more difficult and there was often the need to raise voices. The pitstop area was small and cramped and was a thoroughfare at times. Ambulance handovers were taken in the pitstop area in cramped conditions and information was able to be overheard by patients waiting. This too was largely unavoidable due to the limited space.

Managers recognised that lack of privacy was an issue. In response, they had converted a 'mini laboratory' into a new space to support clinical conversations. Staff told us they moved patients into a cubicle or the new space if a procedure needed performing or a private conversation, but this was not always possible due to the high volume of patients being seen.

The department had created a space to try to improve privacy for patients and ringfenced 2 assessment cubicles within majors. We saw these in constant use while we were there for assessing and examining patients. Managers acted upon the results of the urgent and emergency care survey in 2022. One of their lowest scores was for privacy when being examined. This was 7.9 out of 10 which was lower than the national average of 8.8.

Within the paediatric area, if staff needed further support with children and keeping them entertained, they contacted the hospital's play specialists from the ward who came to assist.

Emotional support

Staff mostly provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs and worked hard to meet them as much as possible.

Urgent and emergency services

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw the staff interact kindly with patients throughout the department including while they were being cared for in less suitable areas of the department.

We had mostly positive feedback from patients who recognised the difficult environment staff were working within. Some patients told us communication could be poor at times when they were not sure what was happening, and others told us staff had "gone out of their way to help" and they felt listened to.

The nurses were very supportive within the paediatric area. They told us they supported families after discharge. They gave an example of a patient who was struggling with their mental health following a family death and they had referred them to an agency to help with their bereavement.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The CQC urgent and emergency care (UEC) survey 2022 report showed the trust scored 8.2 out of 10 for being listened to. The patients mostly felt the health professionals listened to what they had to say. Patients we spoke to generally felt listened to by the team.

Staff talked to patients in a way they could understand, using communication aids where necessary. There were interpreting services available when required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Where necessary staff supported patients to make informed decisions about their care. We observed staff explaining to patients, carers and relatives the choices they had, and they were given time to think and reflect. When we spoke to them, most patients were aware of the options available to them, to help make decisions.

Patient feedback was passed onto the staff either in the safety huddles or in newsletters. We saw in the October 2023 'shoutout newsletter' a patient had written "A&E team deserve a medal. Our daughter was seen within 5 minutes of checking in by a consultant, who was so kind and efficient." and "the nurses who dealt with me did so swiftly, with professionalism and care. I was sorted within two and a half hours" and "really impressed, everyone was so friendly, efficient, caring and attentive even though they were working under constant pressure for hours on end."

The feedback from the CQC UEC survey 2022 was average. They scored "about the same" as other trusts in England for all 9 sections of the survey. They scored worse for the questions regarding involving family, friend or carers and them having enough opportunity to talk. However positive comments included "the staff were attentive and caring but were stretched by the number of patients attending", "I was treated with a kind and gentle way by everyone who helped me that day" and "we were very impressed by the dedication and hard work of staff working in difficult conditions, overcrowding etc."

Is the service responsive?

Requires Improvement 

Urgent and emergency services

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

Although there had been improvements with the creation of additional services, managers were not able to provide services to meet the needs and rising demand of the local population. Services had evolved, patient numbers had increased, but the service did not always meet demand. This resulted in patients waiting for long periods of time to be seen in the department and to be moved out of the department into a hospital ward. The waiting area was often crowded along with all other areas of the department. The patient's waiting area was small for the number of patients attending and not all areas could be seen by the receptionists such as the minor's corridor. There was an appropriate waiting area for children.

However, senior manager analysed capacity and demand daily. They recognised the risks and capacity concerns were high on the risk register. However, mitigations were only making limited inroads to improve flow and improve the waiting times for patients in the department. The increased demand meant the staff were not always able to ensure all patients were safe and well cared for. Due to the lack of time, staff resources and some poor record systems, patients were not having their observations completed regularly, medicines were delayed, and risks were not always assessed in a timely manner.

Not all facilities and premises were appropriate for the service being delivered. There were not enough cubicles in majors to care for the number of patients in the department. This meant patients were cared for in the corridors on trolleys and within the waiting room. Patients spent long periods of times, often more than 12 hours, in recliner chairs and on trolleys.

There was a service to divert less urgent patients to a nurse-led service. The service had a minor injuries department staffed by emergency nurse practitioners from 8am to 9.30pm daily and saw 15 to 20% of patients who attended the department.

The same-day emergency care department (SDEC) was seeing a high volume of patients compared nationally. Although it was helping with capacity constraints for the emergency department, the unit was often full and did not have enough space to take all patients who could have been diverted there throughout the day. Patients who were seen in the SDEC were discharged the same-day and if they needed further treatment, they were often brought back the next day into SDEC. This helped to relieve the pressure within the emergency department. However, staff told us SDEC was often too busy treating patients brought back in from the previous day that there was not enough space to take new patients from that day. The lack of availability of capacity in SDEC was on the department's risk register. However, over the last year, the SDEC was responsive to patients and saw a high volume. The activity rate had been above both the regional and England average. In September 2023, the SDEC rate for Hereford County Hospital was 44.8% compared to the England mean of 37.9%. This placed Hereford County Hospital in the top 25% of trusts in England.

The service had a 'virtual ward' which was run by advanced nurse practitioners. This is where care was provided at home to alleviate the pressures on hospitals. The role of the virtual ward was admission avoidance. There were 15 beds under acute medicine and five under the frailty speciality. The hospital at home team saw these patients and monitored them. They reviewed the patient list in the emergency department and selected appropriate patients for this service.

The service did not always have suitable facilities to meet the needs of patients' families. Due to the lack of space in the department, relatives or visitors were often standing around as there was not enough seating for them. However, there was a relative's room within the department for private conversations if required.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports so they had all the right and most important information about the patients. We saw there were sensory boxes available. These included fidget toys, noise cancelling headphones and fiddle toys for people with high levels of anxiety or cognitive impairment. There was a notice in the waiting room telling patients of the availability of sensory boxes and what was available to support people who were neurodiverse. For example, there was a quiet space in the paediatric waiting area.

Dementia training was provided by the trust within the mandatory training; 84% of nursing staff had completed this.

The reception desk had a lower section for patients who were in a wheelchair to communicate effectively and there was equipment available for patients who had hearing impairment.

The trust had improved their frailty service for patients. There was a dedicated frailty team and area within the same-day emergency care unit. There were 6 beds for overnight care where needed as well as 4 chairs. It had strict criteria to accept patients. Staff reviewed and selected the most appropriate patients to stay overnight and avoid admission to the wards with a view of then being discharged home. They also admitted patients from ambulances; we saw three patients on the 6 December 2023 who were admitted directly from ambulances. This reduced the pressure within the emergency department.

There was limited written information in other formats. The service had information leaflets available, but they were only available in English. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Receptionists told us patients often used their phones to translate which was quicker.

The crowding in the department made it difficult to provide areas for some patient's cultural or personal needs. Some areas of the department provided mixed sex accommodation overnight such as the 'fit to sit' area. This was permitted and within national guidance on mixed sex rules in emergency care, but it was difficult for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

Staff had access to communication aids to help patients become partners in their care and treatment. There were some pictorial guides so people with hearing, learning or speaking difficulties which could help communicate basic needs, such as for pain relief.

We spoke to a patient who had Down's syndrome and their carers who were accompanying them. The patient was happy with the care and where they were situated within the department. The carers told us the provisions for patients with learning disabilities (LD) were good. There were two LD liaison nurses who they had called in advance to arriving who

were described as 'fantastic'. They were going to come and see the patient while they were in the department and had previously attended a 'best interest' meeting with them. We were told if carers or the patient did not pre-phone prior to their arrival, the staff arranged it, and they were seen by the LD team most of the time. However, they said on this visit no staff had looked at the patients LD 'This is me' passport despite it being highlighted to them.

There was support for children with a learning disability. There was a specialist learning disability paediatric nurse on the ward who would support the paediatric department if required. The paediatric team had support from the child and adolescent mental health service for complex discharges.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They escalated the need to extra support to the matron and offered 1 to 1 care. However, there was no appropriate area for patients who had learning difficulties and who might have displayed challenging behaviour. Funding had been requested to provide a suitable area.

Access and flow

People could usually access the service when they needed it. However, this was not always promptly as waiting times and arrangements to admit, treat and discharge patients were not meeting national standards. However, there had been a concerted effort to reduce ambulance handover delays. The department recognised the risk to the community of ambulances being held up to handover patients.

Managers monitored waiting times but were unable to make sure patients could access emergency services when needed and receive their treatment within agreed timeframes and national standards. When we visited at 8pm on 5 December 2023, there were 67 patients in the department with the longest patient waiting 10 hours 44 minutes and 26 patients had been waiting over 4 hours. The waiting times increased over the few days we were in the department. On 7 December 2023, at 11am there was a patient who had been there for 26 hours, there were 42 patients in the department and over 20 patients waiting for beds.

Managers were aware of capacity issues and created solutions to try to increase the flow through the department. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national standards for ED care were not met. Many staff told us, and we saw it ourselves, the department was crowded, and some patients experienced long waits which resulted in not meeting everyone's privacy and dignity at all times and potential additional clinical risk. There were some systems to manage the flow of patients through the ED and to discharge or to admit patients to the hospital when capacity was critical. The main solution included 'boarding' patients on the wards and increasing this number to provide more beds. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. The trust had implemented a flow model in October 2022 where they 'boarded' patients on the ward. This was happening daily. While we were there, the hospital increased the capacity of patients being boarded from 17 up to 25 patients across the wards to improve the flow in the ED.

Senior managers constantly addressed the capacity in the department, but with limited options for success due to pressures throughout the health and care system. They could view the length of time each patient had been in the department, and what they were waiting for, including speciality reviews or bed admissions. The computer dashboard displayed the number of patients arriving from ambulances and who walked in. The data was discussed at bed meetings four times a day, or more if there were increased operational pressures. These meetings were well run and discussed relevant issues, such as demand, capacity within the hospital, as well as the level and safety of staffing. During our inspection, the safety status of the department was categorised as "severe pressure". All senior staff identified flow through the department as the most significant challenge. Due to capacity and flow issues, the staff were looking after

patients from the previous day due to the lack of beds, while also reviewing and treating 200 plus new patients per day. Capacity and flow issues were escalated to the site team. However, the team were struggling due to the lack of flow. For example, on 7 December 2023, we observed within the 11am safety huddle, the team discussed that the hospital was short of 50 beds for patients waiting for care and treatment.

Patients often did not always receive treatment within agreed timeframes and national standards. The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival seeing a decision-making clinician should be less than 1 hour. In 2023, the median time to treatment had consistently increased to above the England average from 49 minutes in January 2023 to 72 minutes in July 2023.

Along with all EDs in England for around seven years, the department consistently failed to meet the 4-hour waiting standard. There was some improvement in meeting the 4-hour standard over a 12-month period; the percentage was 44.3% in December 2022, and 52.9% in December 2023. In November 2023, 40% of patients waited over 4 hours for a clinical decision about their onward care. This was against the NHS constitutional standard that patients should wait no more than four hours for a decision about their onward care or discharge home.

With a concerted departmental effort, there was a relatively improved performance in patients being handed over from ambulances. The department recognised the risk to the community of ambulances being held waiting to handover patients. The department had seen the percentage of ambulance handovers taking over 60 minutes fluctuate above and below the England average (mostly below or better than). In October 2023, performance showed 81% of ambulances were offloaded in 30 minutes and 94% in less than an hour. From 4 to 10 December 2023 staff took an average of 32 minutes and 49 seconds to receive ambulance handovers. This was better than the regional average of 1 hour 9 minutes. During this time there had been a maximum wait for a handover of 3 hours 34 minutes. Data showed 83% of handovers took less than 1 hour and 73% took place in less than 30 minutes.

There were too many patients waiting for more than 12 hours on a trolley, but this had recently improved.

- Patients' median total time in ED was consistently longer than the England average.
- From March 2023 to July 2023, the England average length of stay decreased from 182 minutes to 170 minutes while at County Hospital, the average was 238 minutes.
- There was a decrease in the number of patients waiting more than 12 hours from the decision to admit to admission from 346 in December 2022, to 226 in December 2023; this was better than the Midlands average.

The service had improved its arrangements for transferring ambulance patients in which allowed ambulances to be freed up more quickly. The hospital was ranked 6 out of 20 hospitals in its region for its handover time for 4 to 10 December 2023 with an average handover time of 32 minutes 49 seconds. The pitstop area provided swift handover with ambulance staff and one we observed between the ambulance team and the pitstop team was efficient and effective.

The department had daily issues with finding beds for patients, we saw managers actively trying to resolve this and find solutions. There were five patients on the 6 December 2023 who were waiting cardiology beds with monitoring which were not available. One was moved out of resus and transferred to the major's area while awaiting a bed.

Following the inspection, senior staff informed us the trust had changed its pathway for patients who have suspected or known myocardial infarction who cannot be appropriately placed within the emergency department. The new pathway meant these patients would be transferred directly to the cardiology ward regardless of bed capacity so they could receive specialist management, monitoring, and oversight. They were also going to develop further exclusion criteria for the 'fit to sit' area to ensure appropriate escalation processes were used for higher risk patients.

Urgent and emergency services

More people than average left the department before being seen. This is indicative of patients being made to wait too long to be seen. The percentage of people who left the department before being seen for treatment was mostly above the Midlands and England averages. From January to July 2023 the percentage increased from 4.6% to 7.5%. Patients who chose to leave the department before assessment or treatment were given advice as to any risks that they were taking where possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them, but they did not always share lessons learned with all staff.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. The complaints were reviewed by the matron and general manager and allocated to staff based on theme. There was a consultant assigned to reviewing complaints and we were told they were very responsive. Managers told us they phoned patients to try to resolve the complaint informally.

However, managers did not always share feedback from complaints with staff for learning, improvement and development and the number received were increasing. Staff were not aware of complaint themes or changes that had been made following a complaint. We were told that feedback was given either within safety huddles or within an encrypted closed messaging application. There was a risk that staff would be miss these communications and be unaware of changes needed to improve. The service had a higher-than-average number of complaints compared to other areas in the trust. They had received 74 complaints in 2023. These had steadily been increasing from below 5 in May 2023, to 27 in October 2023. The main themes were waiting times, communication, length of stay in the department and mis-diagnosis.

The service clearly displayed information about how to raise a concern in patient areas. There were information boards around the department telling patients how they could make a complaint and how to get support from the Patient Advice and Liaison Service (PALS). We attended a meeting which was held weekly with the PALS team and a band 7 sister to discuss any recent concerns and plans to address them before they became formal complaints. They had received 18 concerns through PALS in November 2023. We observed a concern discussed in detail and a plan was made for dealing with it.

We saw there were limited actions from the complaints received in the department to make improvements. The governance team produced a monthly assurance report. This described the complaints received and looked at themes found. They were reviewed at governance meetings, but no actions taken to make improvements.

Staff knew how to acknowledge complaints and patients received feedback from the trust after the investigation into their complaint.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Urgent and emergency services

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leaders had the skills and abilities to run the service, although were struggling with the demands on everyone's time and priorities. The senior leadership team for emergency care was led by a team with the matron, ED clinical director, and ED general manager. They were supported by senior staff at a divisional level. The ED team had good levels of operational knowledge to lead the department in pressurised circumstances. There was an emergency care consultant who was responsible for clinical care in the department and another who was responsible for the governance. They worked alongside the leadership team to provide local leadership direct to the department. The senior leadership team met monthly to discuss quality in the department although they had adjoining offices and had informal discussions daily.

Leaders were supportive of their staff and caring about the service. There was a team of band 7 nurses who managed and ran the department and were managed by the matron. We were told they were approachable, always listened and gave regular feedback. The managers were visible in the department. There were two or three on each day with at least one of them assigned to work clinically; they did not work any night shifts. We saw a dedicated and professional team of staff across all grades. They all had respect for each other, and their roles and they were proud of their team. It was clear from all staff we spoke with that leaders were supportive of their staff and passionate about their service. They were aware of how the ED environment and pressures in the workplace affected the welfare of their staff. They supported the staff who worked hard and tried to ease the pressures of working in such a busy environment.

Senior staff in the department were fully aware of the challenges they faced and felt the full responsibility of delivering a safe service for all. The medical team and the nursing team worked well together and spoke highly of each other's abilities and support.

Staff development was encouraged. Nurses told us they were encouraged to apply for more senior roles within the department. This meant they were fully recruited in the senior roles such as band 6 and 7 and had vacant band 5 posts as these staff had progressed within the department.

Vision and Strategy

The service had objectives for what it wanted to achieve but they were not always achievable in the current pressures. Leaders were working on a strategy to turn the vision into action. The vision was focused on the sustainability of workforce as it supported safe patient care.

At the time of our inspection, the vision for the department was focused on improving the flow of patients through the hospital but due to capacity pressures there was limited progress. The delay in discharging patients safely from ward beds meant there was still poor flow through the department which led to long delays for the patient's needing admission. The trust had a standard operating procedure (SOP) called "enabling proactive flow from ED" which included 'boarding' of patients to release the pressures within the ED. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. The aim of this SOP was to not have patients boarding on the wards out of hours. However, when pressures were high, this would inevitably happen, and we were told this currently happened every day. As well as failures to discharge due to pressures for care packages in the community, the pathways the hospital used to move patients promptly into community beds were failing due to a similar lack of bed capacity.

There was quality improvement plan, or vision, which had two key ambitions for 2023/24:

Urgent and emergency services

1. Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred, or discharged within 4 hours by March 2024, with further improvement in 2024/25.
2. Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

To achieve these objectives, the department had a number of initiatives and sustained improvements to enable improved patient safety including reduction in 'time to be seen' and time to treatment or discharge; demand and capacity planning for more appropriate staffing levels; improved patient safety through increased quality of care; and improved flow and reduced crowding through further development of alternatives to the emergency department.

A strategy was being produced to sit alongside the vision for the service. The main focus was to improve the numbers, skills and experience of the workforce. The senior leadership recognised the environment unlikely to significantly improve in the short or medium terms, and focusing on the workforce could have a bigger impact. The premise of the workforce plan was to ensure early, consistent senior decision making throughout the emergency care pathway. The plan and recommendations were based on national evidence, local analysis and were aligned to the strategic objectives of the organisation. It had been developed by the service and underpinned by a focus on early continuous assessment, rapid treatment, and discharge. Implementation of the proposed model would mean staff could deliver a comprehensive consultant led service 7 days a week in line with national guidelines.

Managers had identified issues within the demand and capacity due to a low workforce and not having adequate resources. They reviewed the nursing and medical workforces to identify the gaps. They looked at where the busy periods were, recommended an alternative shift pattern which would allow them to review the true demand and put a strategy to the executive team. They had recently put in a business case for an investment to create a more senior medical workforce. This included a further five consultants and eight middle grade doctors to be in line with the Royal College of Emergency Medicine requirements for senior staffing within the department. Based on the analysis they had completed, they felt the strategy to recruit more senior staff would meet the current demand for patients seen.

The trust had increased the capacity within the department by expanding same-day emergency care (SDEC) and adding a frailty SDEC service and later in December 2023, a surgical SDEC service. The department also had capacity within the virtual ward which, again, it wanted to expand further to increase capacity.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care but due to pressures and the capacity of the department, they were not always enabled to deliver high quality care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Nurses and doctors spoke highly of each other and worked well as a team. There was a good understanding between staff in different roles and the pressures they each faced; there was an inclusive culture. We observed staff working well together and communicating as a team.

Nursing staff said they knew who to approach if they had concerns and some told us they had raised issues with line managers or matrons in the past and had been supported and encouraged in this process. Staff told us they felt comfortable in reporting incidents, there was a no blame culture and they always received individual feedback.

Clinical leaders were visible in the department, and it was clear they were respected by their teams. We were told some senior staff worked clinically in the department to cover staff shortages and help teams deal with the workload. There were daily safety huddles where staff could raise issues.

Urgent and emergency services

Junior doctors spoke positively of their training experiences and said their consultants were very approachable.

There was a wellbeing nurse who visited the department regularly to offer support to staff and education around mental health and wellbeing.

One of the paediatric nurses won the 'going extra mile award' for assisting with an adult collapse in the waiting room. They were really pleased to have won this and felt part of the emergency department team.

However, the department was often overwhelmed with patients and there was not always enough staff to carry out all the required tasks in a timely manner. Some staff did not feel this was always recognised by all of the managers and they did not always step in to help when required. They felt upset that patients were in the department for hours.

Governance

Leaders did not operate effective governance processes. Audits were completed but actions were not always taken to make improvements. Staff at all levels were clear about their roles and accountabilities but they did not have regular opportunities to meet, discuss and learn from the performance of the service.

The governance processes were not effective. Audits were not used effectively to drive improvement and information was not shared with staff. There were systems to assess, monitor and improve the quality of care but these did not always ensure changes were made. The department had monthly governance meetings where they reviewed performance, incidents, complaints, and audits. Staff told us they were not aware of what was discussed in governance meetings and information was not shared to ensure improvements were made. For example, at the 14 November 2023 governance meeting, the team discussed issues regarding discharging patients with cannulas in and not being sent home with medicines following adverse incidents reported. They discussed how the discharge checklist was not being utilised properly. An action plan was drawn up to make improvements including a standard operating procedure and mandating this checklist on their electronic records. However, we were told by a number of staff that there were no discharge checklists and no actions to take had been fed back about patients being discharged with cannulas.

The groundwork for governance was undertaken, but the follow-up, identifiable improvements, re-audits and learning were not in evidence. The governance team produced an 'exception report' for the department which was presented monthly. It included incident data, the risk register, patient falls data, training and appraisal data for staff and audit results. We looked at October and November 2023 reports. The data was analysed for each of these areas but there was no clear action plan with an owner to ensure improvement was driven forward in areas where needed.

Managers were not aware of some of the issues we found while on inspection due to a lack of comprehensive governance, an effective audit programme, and learning from incidents. Some audits were completed to assess and monitor the quality of care. However, we did not see audits for documentation, NEWS2 compliance and medicines management. Patient observations and monitoring were not recorded regularly, the sepsis 6 bundle was not well used, fluid balance charts were not used for high-risk patients and time critical medicines and other medicines were not administered on time.

There was learning from incidents around poor observations and escalation of concerns which had not been learned from. In an incident involving a patient in 2023, the investigation found there was a lack of regular observations and abnormal observations were not escalated. We also found observations were not completed regularly in the notes we

looked at. Following the inspection, audits were implemented to improve compliance. We saw a documentation audit including NEWS2 completion and sepsis audit had been completed. However, the action plans associated were brief, did not contain an owner or completion date. Therefore, it was difficult to know whose responsibility it was to implement the changes and when and how they would be completed.

There were good quality audits, but with no outcomes. Some audits did not contain action plans so there was no evidence of actions made to improve compliance. For example, the matron completed an infection prevention assurance checklist and a matron's audit of the department bi-monthly. These looked at all areas of the department in depth including clinical practice, infection prevention, staff knowledge and safety of all areas. However, there was no associated action plan. We saw there were some of the same issues in the October 2023 audit as in the December 2023 audit and it was unclear if there were any actions to make improvements. Furthermore, the band 7 nurses completed a weekly assurance audit. We looked at four of these from November and December 2023. We found these were completed but mostly did not contain actions. We saw concerns about poor compliance with processes and records remained unchanged. For example, on the 27 November 2023 weekly assurance audit, the nurse highlighted that sharps bins were incorrectly assembled, old 'I am clean' stickers were on equipment and disinfectant sachets were stored in an unlocked cupboard, these same issues were found at the 4 December 2023 audit and neither had actions to rectify this.

The managers were not fully aware of all the risks in the department. For example, they did not ensure the nurses who covered the paediatric ED overnight had sufficient training in paediatric immediate life support, safeguarding children's level 3, and paediatric competencies; this was not on the department risk register. Following the inspection, the managers provided assurance that only competent trained staff were covering the department overnight.

Although the trust had implemented new pathways for patients, there was a lack of effective strategy for managing the poor flow within the department when it escalated and the outcomes for patients. The managers actively discussed the poor flow daily and moved patients through the department when possible. However, patients were consistently not receiving treatment within agreed timeframes and national standards and staying in the department for long periods of time. There was no clear short-term strategy for improving the flow for the patients and sustaining any improved flow.

There was no formal feedback for staff to learn and make improvements within the department. Full departmental team meetings or something equivalent for staff did not happen. The department had team meetings for admin staff, clinical managers and matron meetings for the band 7's and 6's. For example, we looked at minutes from the band 6 and 7 meeting in November 2023 where they discussed infection prevention and control measures, appraisals, and the role of the nurse in charge, However, there were no clear actions in the meeting for making improvements. They did not discuss training, incidents, complaints, feedback from governance meetings or audits. We did not see any minutes for team meetings for bands 2 to 5. Staff told us they had them occasionally but had not for a while. We were told they were unable to hold a full team meeting for all staff grades due to the nature of the service, but an alternative format which worked for staff had not been implemented.

Following our second visit, the matron created a draft governance newsletter to keep staff informed. It detailed the top risks, complaint themes, incident themes and new policies within the department. However, it did not go into detail and areas for improvement. This was due to be circulated in January 2024 once it was finalised and agreed. The matron had also implemented several new standard operating procedures. These included initial clinical assessment and use of the Manchester triage tool, care of patients in the waiting room, and identification and management of sepsis in patients over 18 years in the emergency department. On our second visit we could see this was making a positive difference for staff and patients.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and create actions to reduce their impact.

Although there was a process for identifying, recording, and managing risks, the leadership team were not aware of all the risks in the department or how to identify them. The service had a risk register which was monitored by the leadership team. It was also overseen at an executive level through the trust's board assurance framework. The risk register was discussed within the monthly risk review meeting. We looked at the minutes and action plan from 11 September 2023 meeting. We saw risks were added onto the risk register and action plan was updated to ensure the risks were escalated. However, it was clear managers were not aware of all the risks in the department. There were several risks we identified on inspection which were not on the risk register. These included:

- Poor environment including lack of visibility in the waiting room.
- .
- Computer systems which are not fit for purpose and lead to further risks for the patients.

The department risk register listed 18 risks. The highest risk was the risk of harm to patient due to long waits within the ED. We were told the most significant current risks in the department were shortage of staffing and skill mix and crowding for patients. However, these risks were not on the risk register. Staff we spoke with were not aware of the risks on the risk register including band 6 and 7 sisters. Following our inspection, the matron produced a governance newsletter which detailed the top risks in the department.

Risks remained for patients who were waiting a long time in the ED. It was not possible to mitigate all the risks associated with running the department at over capacity. Where there were high numbers of patients in the department it was difficult to have thorough oversight of every patient. Due to expansion to help overcapacity, and a department not designed for the space it now occupied, some areas of the waiting area and corridors had limited visibility. Risks existed for patients to deteriorate rapidly without being detected. These issues with safety and visibility of patients had not been recognised and were not on the risk register.

There was a lack of evidence of learning from avoidable deaths. Mortality and morbidity (M&M) meetings were scheduled to take place monthly but were mostly cancelled due to lack of consultant availability due to vacancies and operational pressures. We were told the ED governance lead held quarterly M&M meetings but there was no written evidence of these taking place. However, the governance team did review some patient deaths. The leadership team submitted an M&M review in February 2023 to the trust overarching M&M review which looked at 2 patients who died in the ED. The learning that was taken from the notes was that end of life booklets were not being completed and nursing staff were documenting on behalf of the medical team. However, they found expected deaths were acted upon in a timely manner and staff prioritised patient comfort and in-depth discussions with family were evident. There were no actions from this meeting. Following the inspection, the trust told us they were going to address the lack of M&M meetings. They had two new consultants starting in January and February 2024 and the trust told us M&M meetings were going to be held monthly and minuted.

Information Management

The service did not always collect reliable data. Staff were required to use several different information technology systems which were not efficient. Staff could not always find the data they needed to understand performance, make decisions and improvements. However, the information systems were secure, but some records were left open and unattended.

Data collection and record management in the department was not always reliable. Staff were required to use two different computer systems for the patients records and a third for medicines. This made it difficult to effectively audit patients' data and see the patient's clinical pathway through the department. Notes were then printed when the patient was moved to a ward within the hospital. The managers acknowledged the difficulties the trust's computer systems had and the impact they had on efficiency and understanding safety and quality care. There was a long-term strategy to move the ED computer system to the same one used by the rest of the hospital. However, the current timescale was 2025. There was no interim solution to improve the information management in the department and the risks for patients. This was fed back to the managers who told us they would audit the data and aim to improve and implement changes where necessary.

At times, some patients' electronic records were left unattended and not all staff had updated training in data security. There were three instances on our second visit where we saw patients' electronic records left open on unattended computer screens. These were in areas where they could be accessed by unauthorised people with a risk to them being tampered with or viewed. Not all staff had updated their training around information governance and data protection. Data showed 61% of medical staff and 65% of nursing staff had completed information governance and data security mandatory training. This was lower than the trust target of 85%.

Engagement

Leaders actively and openly engaged with staff to plan and manage services. However, there was limited feedback gathered to be able to engage with the views and experiences of patients.

Managers engaged with staff to gather their views on changes they wanted to make in the department. In May 2023, the leaders held an ED summit where over 80 members of staff attended. Staff completed an 'ideas' survey at the end of the summit to ensure managers captured all staff views. An action plan was created against issues which had arisen and for each area within the department. Actions included opening the reception areas further, so patients were more visible, nurse allocation to the waiting room and protected autism areas. While not all actions had been completed, there was clear documentation about how managers were wanting to make improvements within the department, and timescales to do so.

There were a number of newsletters within the department which kept staff informed and they could contribute to. They had 'Wisdom Wednesday', 'Feedback Friday' and 'Shoutout Newsletter' every few months. Wisdom Wednesday focused on different teaching themes, for example, March 2023 focus was stroke care and August 2023 was safeguarding children. Feedback Friday was more focused on updates. For example, November 2023 reminded staff about wearing masks in certain areas, building work that was happening and car parking. The Shoutout Newsletter gave information for the medical division including ED. They had a 'shout out' section where staff could praise other team members. For example, in October 2023 there was a comment which said, "Thank you for the ED team, you are all fantastic". They also had patient experiences which included good feedback from patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The patients were invited to complete a friends and family test. The response rate was low (18%) between 11 November and 11 December 2023. The service struggled to get a good response from patients which was not unlike other emergency departments. The results showed 71% of responses were positive and 19% were negative. There was otherwise limited engagement with patients to get feedback and no plans seen to improve the response rate to the friends and family test.

Urgent and emergency services

Learning, continuous improvement and innovation

All staff were committed to improving services, even though time and space was needed to make this work. Following feedback to the senior leadership team after our first visit on site, improvements were underway to address in earnest many of the concerns we raised.

The service had benchmarked its processes with another urgent care service within their foundation group. They were keen to make improvements for the patients and reduce the risks.

On our second visit, we saw the staff on all levels had engaged with the feedback given and made changes to make improvements and increase compliance in many areas. We found the staff responsive and keen to show us the improvements they had made following our first visit and were enthused by further improvements they planned to make.

Areas for improvement

Action the service must take to improve:

- The provider must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks through carrying out and documenting regular observations, clinically-led navigation of patients through the department provided by trained and experienced staff, managing patients medicines on time, assessing and responding to deteriorating patients and responding to any risks such as sepsis, pressure ulcers, falls or patients in pain. (Regulation 12 (2) (a)(b): Safe care and treatment).
- The provider must ensure it has sufficient numbers of suitably qualified, competent, skilled and experienced staff who receive such appropriate training to carry out the duties they are employed to perform and ensure staff are trained to the right competency in safeguarding and life support. The provider must have sufficient medical staff to run the department safely and effectively including a paediatric emergency medicine consultant. (Regulation 18 (1) (2) (a): Staffing).
- The provider must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks through effective and safe care to patients needing ongoing treatment but unable to have timely access to a hospital bed. (Regulation 12 (2) (a)(b): Safe care and treatment).
- The provider must ensure there are systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. It must assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity. The service must have an effective governance system, risk profile and audit programme to be assured it is providing safe quality care and knows and addresses where it should improve. (Regulation 17 (1) (2) (a)(b): Good governance).

Action the service should take to improve:

- The service should improve the safe and proper management of medicines are stored safely and appropriately. (Regulation 12).
- The service should ensure improved arrangements for offering food and drink to patients who have been waiting a long time to be seen, transferred or discharged.

Urgent and emergency services

- The service should consider how it uses patient identification, such as wristbands, to determine if this is working effectively.
- The service should consider improving the response when requesting patient feedback.
- The trust should ensure the privacy and dignity of all patients is maintained at all times.

Our inspection team

How we carried out the inspection

We inspected this service on 5, 6 and 7 December 2023 (first visit) and did a follow up inspection on the 20 December 2023 (second visit). The first visit was an unannounced full core service inspection looking at urgent and emergency care. We checked the quality of the services in response to emerging risks within the department. We visited all areas of the emergency department including the waiting rooms, resuscitation, minors, majors and same-day emergency care services.

The team that inspected the service comprised 4 CQC inspectors, a mental health inspector, a medicines inspector and 2 specialist advisors with expertise in emergency medicine. The inspection was overseen by an operational manager and deputy director.

During both visits we spoke with around 50 staff members including nursing staff, healthcare assistants, ambulance staff, cleaners, doctors and managers. We spoke to 35 patients and 9 relatives or carers, and we reviewed 16 patient records.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Ref	Area of Concern/CQC Action statement	Regulation	Actions	Lead	Deadline	Status: Complete/Commenced/ Not started	RAG Rating
MUST DO	The provider must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks through carrying out and documenting regular observations, clinically-led navigation of patients through the department provided by trained and experienced staff, managing patients medicines on time, assessing and responding to deteriorating patients and responding to any risks such as sepsis, pressure ulcers, falls or patients in pain.	Regulation 12 (2) (a)(b): Safe, care and treatment.	**Documenting & Regular Obs** 1.Regular observations SOP in draft requires ratification and dissemination. 2.Audit meeting with Audit Leads outstanding - date TBC. **Clinically-led Navigation** Implement GP navigator for minor illnesses and injuries in ED in March 7 days per week 10 hours per day cover. Implement band 6 in ED reception to compliment GP in addition to waiting room nurse and HCA 7 days per week 10 hours per day cover with admin support. Teams GP in hours booking slots to be confirmed. **Managing patient medicines on time** No outstanding actions - mitigation in place see actions from immediate action plan (ref CQC.ED.19-22) **Assessing and responding to deteriorating patients** No outstanding actions - mitigation in place see actions from immediate action plan (ref CQC.ED.23-36) **Sepsis/ Pressure ulcers/ Falls/ Patients in Pain** **In addition to the immediate actions outlined in our letter to the CQC in Dec 2023 (Sepsis refresher training and NEWS2 refresher and competencies training) a rolling audit programme was implemented immediately following the inspection to monitor these areas. The audit is undertaken and the results reviewed by Divisional tri. Areas of concern are immediately reviewed and discussed with staff. Broader evaluation of the audits will be addressed below in relation to the Regulation 17 Must do recommendation to improve governance and oversight of quality and safety.**	LW FD JB	31.03.2024	Commenced	
MUST DO	The provider must ensure it has sufficient numbers of suitably qualified, competent, skilled and experienced staff who receive such appropriate training to carry out the duties they are employed to perform and ensure staff are trained to the right competency in safeguarding and life support. The provider must have sufficient medical staff to Run the department safely and effectively including a paediatric emergency medicine consultant.	Regulation 18 (1) (2) HC: Staffing.	**Ensure it has sufficient numbers of suitably qualified, competent, skilled and experienced staff who receive such appropriate training to carry out the duties** Implementing new internal database to capture ED specific skills To reflect this internal database on ESR is a larger piece of work likely to take time to complete. **Safeguarding & Life Support (PILS)** In the immediate feedback letter we stated we would identify the relevant staff and ensure staff undertook PILS training within 6 weeks (end of Jan). This is progressing, yet there are some staff who need to receive this training. the team continue to liaise with the resus team to ensure that all available dates are utilised. Risk 691 (created in 2021) relates to this. The Paediatric nursing team are providing staff if there is a skills deficit in the department. The longer term plan (once recruitment is achieved) will be to provide a paediatric trained nurse 24/7. **The provider must have sufficient medical staff to Run the department safely and effectively including a paediatric emergency medicine consultant.** ED medical staffing business case submitted to TMB for approval on 01.03.24 to increase consultant, SpDR and ACP workforce in ED.	FD TR LW SB	30.04.2024	Commenced	
MUST DO	The provide must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment by ensuring all that is reasonably practicable to mitigate any such risks through effective and safe care to patients needing ongoing treatment but unable to have timely access to a hospital bed.	Regulation 12 (1) (2)(b): Safe, care and treatment.	Mitigation in place immediately following inspection with the implementation with senior nurse review of all patients waiting over 6 hours. Symphony has been updated to provide space for this to be documented. The service leadership team need to evaluate the impact of this action on patient safety and mitigating risk of harm whilst in the department. In addition to internal review a benchmarking exercise will be undertaken across Foundation Group providers to assess if there is opportunity to further improve this oversight. The Regular Observation SOP will be updated to reflect this review where required.	LW	31.03.2024	Commenced	
MUST DO	The provider must ensure there are systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. It must assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity. The service must have an effective governance system, risk profile and audit programme to be assured it is providing safe quality care and knows and addresses where it should improve	Regulation 17 (1) (2) (a)(b): Good governance.	A review of the service governance processes and structure is underway. Gaps identified in leadership and work in progress to build governance into job planning for new ED consultants. Service to work with Q&S team to develop a dashboard for Q&S KPIs, formalising the audit programme to include national and local audit with clear lines of reporting and escalation on issues relating to quality and safety of patients.		30.04.2024	Commenced	
SHOULD DO	There service should improve the safe and proper management of medicines are stored safely and appropriately		Senior nurse checks in place. Weekly assurance audit under review by Matron to include drug cabinet checks. Discuss with Pharmacy their capacity to support with medicine management as has previously been done. This is linked to a known Trust risk in relation to vacancies in Pharmacy.	LW	30.04.2024	Commenced	
SHOULD DO	The service should ensure improved arrangements for offering food and drink to patients who have been waiting a long time to be seen, transferred or discharged.		Commenced discussions with Sodexo required to increase frequency of provisions. Secure a place in Majors where the hot lock can be plugged in Meeting to be held with ED volunteers to explore maximising their services to provide a drinks round in majors, for example. Consideration of increasing number of meal time volunteers in the department.	LW	Ongoing	Commenced	
SHOULD DO	The service should consider how it uses patient identification, such as wristbands, to determine if this is working effectively.		Widen the space in reception for people to put their hands underneath the screen in ED reception for reception to do rather than first clinical contact as an additional action to the mitigation in place.	LW	02.01.2024	Complete	
SHOULD DO	The service should consider improving the response when requesting patient feedback.	Regulation 12	For FFT feedback, Quality team to engage with ED Matron for additional support due to high volumes of feedback and plan to improve response. ED reception admin process to be reviewed to ensure patient details checked Provide update on Monthly directorate governance newsletter Patient feedback to be a standardised agenda item in directorate monthly meeting	RM LW	Ongoing	Commenced	
SHOULD DO	The trust should ensure the privacy and dignity of all patients is maintained at all times.		Currently using privacy and dignity screens to mitigate some of the issues noted in the report. Sufficient screens are in place in the corridor. Departmental assessment space has been increased to provide confidential space for discussions. The department will engage with foundation group providers to identify further opportunities to improve patient privacy and dignity within the footprint of the department.	FD LW	31.05.2024	Commenced	
WVT ACTIONS PREVIOUSLY IDENTIFIED							
CQC.ED.02	Documentation **IDENTIFIED AS MUST DO**		Review and update the audit tool	LW	31.01.24	Commenced	
CQC.ED.03	Emergency equipment checklists and tamper proofing		Daily reminder in staff huddles to ensure checks are completed	LW	Daily	Complete	
CQC.ED.04	Emergency equipment checklists and tamper proofing		Safety walkabouts for spot-checks	Execs	08.12.23	Complete	
CQC.ED.05	Emergency equipment checklists and tamper proofing		Resus team spot-checks	GT	08.12.23	Complete	
CQC.ED.06	Fit to sit/pit stop/waiting room – visibility and oversight		Doubling flow SOP updated to ensure MI patients go directly to Lugg ward	AP	14.12.23	Complete	
CQC.ED.07	Fit to sit/pit stop/waiting room – visibility and oversight		Review finalised enabling flow SOP to ensure it reflects the accurate position re cardiac patients and Lugg boarders	AP	15.01.24	Complete	
CQC.ED.08	Fit to sit/pit stop/waiting room – visibility and oversight		Ensure all CSM's are sighted on the enabling flow SOP	LW	15.01.24	Completed	
CQC.ED.09	Fit to sit/pit stop/waiting room – visibility and oversight		Agree MI pathway to Lugg Ward	AP	14.12.23	Complete	
CQC.ED.10	Fit to sit/pit stop/waiting room – visibility and oversight		Further exclusion criteria beyond myocardial infarction will be developed for the fit to sit area and associated Enabling flow SOP and escalation processes developed	AP	19.12.23		
CQC.ED.11	Fit to sit/pit stop/waiting room – visibility and oversight		Review the fit to sit SOP to ensure it includes criteria of conditions that ideally should be excluded	DA	15.01.24	Commenced	
CQC.ED.12	Fit to sit/pit stop/waiting room – visibility and oversight		Add an additional health care assistant to support those patients on the corridor to ensure there is oversight at all times and that the patients core care needs are met.	LW	14.12.23	Complete	
CQC.ED.13	Fit to sit/pit stop/waiting room – visibility and oversight		Add an additional registered nurse to the front door team 24/7 and a HCA 10.00 to 22.00.	LW	14.12.23	Complete	
CQC.ED.14	Fit to sit/pit stop/waiting room – visibility and oversight		Consider estate changes to pit stop environment - minor changes	LW/Estates	31.01.2024	Commenced	
CQC.ED.15	Fit to sit/pit stop/waiting room – visibility and oversight		Consider estate changes to pit stop environment - major works. Potential to split the paediatric room.	LW/Estates	3-6 months Mar-Jun 24	Commenced	
CQC.ED.16	Fluid balance		Benchmark current practice across the foundation group	LW	19.01.24	Completed	
CQC.ED.17	Fluid balance **IDENTIFIED AS MUST DO**		Develop an observations and monitoring SOP for ED which will include fluid balance and other care needs.	LW/FD/DA	19.01.24	Commenced	
CQC.ED.18	IT System		Undertake an audit to determine the current practice of medication prescription and administration within the ED.	EW	12.12.23	Complete	
CQC.ED.19	Prescribing administering medications		The Department will undertake spot audits to provide assurance of compliance. Examples include prescribing and administering antibiotics within the golden hour for sepsis, pain relief etc.	EW	19.01.24	Ongoing	
CQC.ED.20	Prescribing administering medications		All stat doses of medication required by the patient due to being present in ED, are prescribed and administered in a timely manner on Symphony	LW	31.01.24	Commenced and subject to audit	
CQC.ED.21	Prescribing administering medications		Implement process to ensure all patients remaining in the department due to long waits have regular medications prescribed on EPMA	LW	08.12.23	Complete	
CQC.ED.22	Prescribing administering medications		ACMD to convene a meeting with, Katie Jenkins James Bartlett, Faye Dagger, ED nurse, John Gwilliam and Sarah Gulliland to discuss and agree the process for implementation.	EW		Complete	
CQC.ED.23	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Confirm if obs/ NEWS data can be extracted from Symphony	NO	08.12.23	Complete	
CQC.ED.24	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Evaluate Obs data and develop further actions	ALL	15.12.23	Complete	
CQC.ED.25	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		ED team to refine search criteria of data provided	ED Dept/ Informatics	15.12.23	Complete	
CQC.ED.26	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Complete internal NEWS nurse led audit	LW	15.12.23	Complete	
CQC.ED.27	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Agree the frequency for review of NEWS data	ED Dept	13.12.23	Complete	
CQC.ED.28	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Confirm where the sepsis care bundle should be documented/initiated	LC	08.12.23	Complete	
CQC.ED.29	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		ED will audit sepsis quarterly as a minimum	MP	31.01.24	Commenced	
CQC.ED.30	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Wider review of sepsis to be undertaken when NICE guidance is published at the end of Jan	EW/CA	29.02.2024	Commenced	
CQC.ED.31	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Staff will be reminded through daily safety huddles of the importance of completing and recording clinical observations and the need to escalate to the nurse in charge if they are not able to undertake these in a timely way.	LW	08.12.23	Complete	
CQC.ED.32	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		ED team to add clinical measures to ED dashboard	ED Dept		Complete	
CQC.ED.33	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		ED team to add safety thermometer measure to ED dashboard	ED Dept	26.01.24	Commenced	
CQC.ED.34	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Discussion with Informatics and estates to have live dashboard visible within ED on screens.	ED Dept/ Grant/ Estates	22.12.23	Complete	
CQC.ED.35	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Rapid review of patient case raised verbally during inspection including :- RI.ISI187206 RI.ISI452726 RI.ISI903016	EW	07.12.23	Complete	
CQC.ED.36	Management and Oversight of Deteriorating Patient (Inc. Sepsis management)		Align symphony triggers to the deteriorating patient/NEWS 2 policy triggers	LW	31.01.24	Commenced	
CQC.ED.37	Paediatric environment		Risk assessment of Paediatric ED environment	SP/LW/DA	07.12.23	Complete	
CQC.ED.38	Paediatric environment		Temporary padlock added to Paeds room door to ambulance bay	SP/LW/DA	07.12.23	Complete	
CQC.ED.39	Paediatric environment		Order new digilock for paeds door to ambulance bay	SP/LW/DA	07.12.23	Complete	
CQC.ED.40	Paediatric staffing		Review Paediatric Intermediate Life Support (PILs) training for all ED registered nurses	LW	31.01.24	Commenced	
CQC.ED.41	Paediatric staffing		Identify out of those trained how many have the specific competency training and Safeguarding level 3 training	LW	14.12.23	Complete	
CQC.ED.42	Paediatric staffing		Paediatric competency pack	AA	12.01.24	Commenced	
CQC.ED.43	Paediatric staffing		Send paediatric competency pack to Chief of Nursing	LW	12.01.24	Complete	
CQC.ED.44	Paediatric staffing		Consider whether longer term backfill from paeds should be 24/7	SH	31.03.2023	Agreed	
CQC.ED.45	Paediatric staffing		Review the next 6 weeks to see how many gaps there are and liaise with Sara Powell to support with filling the gaps from the Paediatric unit	LW/SP	14.12.23	Complete	
CQC.ED.46	Paediatric staffing		Pursue dates for PILS if necessary to ensure all staff are trained within the 6 weeks to ease pressure on backfilling from paediatrics.	LW	31.03.24	Commenced	
CQC.ED.47	Paediatric staffing		Liaise with Carolyn Trew to set a PILs skills icon on Allocate. In the interim it will be highlighted on the hard copy of off duty in ED.	LW/CT		Completed	
CQC.ED.48	Paediatric staffing		Liaise with Carolyn Trew to set a PILs skills icon on Allocate. Roster template to be rebuilt with PILS as a mandated skill on the roster the same as the NIC shift	LW/CT	31.01.24	Commenced	
CQC.ED.49	Privacy and dignity		Converted mini lab into a quiet space to support spaces for clinical conversations	ED Dept	30.11.23	Complete	
CQC.ED.50	Staffing		Add in an additional health care support worker 7 days per week who will be allocated to the area of most pressing need as identified by the nurse in charge	LW	14.12.23	Complete	
CQC.ED.51	Staffing		Discussion to take place regarding staffing needs and to perfect the ED staffing model. To also include a meeting with ECIST	LF	29.2.24	Meeting held - business case to be developed	
CQC.ED.52	Training		Liaise with Resus regarding the following: o Bespoke ED PILS training dates within the next 6 weeks o Additional NEWS2 training – to include liaising with NEWS3 trainers across the Trust o Additional sepsis training	LC	08.12.23	Complete	
CQC.ED.53	Training		Liaise with Education regarding reporting for PILS/NEWS2 reports (and other resus courses)	LC	08.12.23	Complete	
CQC.ED.54	Training		Provide a list of ED specific competencies that should be mandatory for the team	LW/FD	19.01.24	Commenced	
CQC.ED.55	Training		Liaise with the education team to have competencies added to ESR	LW/FD	31.01.24	Commenced	
CQC.ED.56	Training		Rebuild roster template for nursing staff fully to reflect revised ED staffing	LW/Band 7's	31.01.24	Complete	
CQC.ED.57	Triage		Implement nurse led triage for all patients as per SOP	AE/ LW	15.12.23	Complete	
CQC.ED.58	Triage		Implement extended triage	FD/SB	31.01.24	Commenced	
CQC.ED.01	Documentation		Commence documentation audit to include frequency of nursing observations, escalation of NEWS, time to triage, and the completion of appropriate risk assessments/care bundles.	LW	15.12.23	Complete	

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
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:	

1. Purpose of the report

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

2. Recommendation(s)

Board is asked to note the update.

3. Executive Director Opinion[1]

The scrutiny placed on maternity services nationally has led to a complex set of reporting requirements in order to provide assurance on the safety of our services. The team are currently scoping the requirements and committees and forums where these need to be discussed. The intention is to clearly set out our plan by the end of March 2024 with implementation from the new financial year.

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

Maternity Services 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. 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 for Board with the minimum data set provided in the private session.

Trust Board received a maternity quality report in November 2023 which covered the period September and October 2023; it was not a complete quarterly report due to report timing determined by a requirement to meet CNST standards within a timeframe. This report covers the period November 2023 – January 2024.

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 which are not duplicated in this report. The YTD rolling data is noted as:

Maternity Newborn Safety Investigations (MNSI) / formerly HSIB:

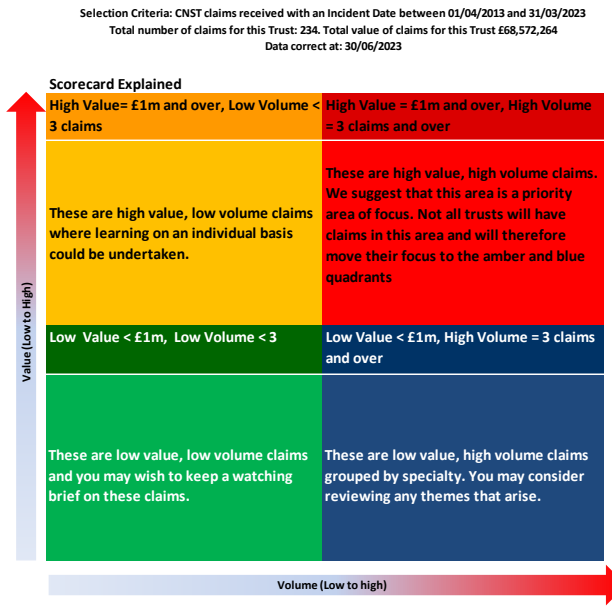
MNSI Cases Year to Date (23/24)	
Total referrals	1
Referrals rejected	0
Investigations ongoing	0
Investigations complete	1
Current active cases	0

Perinatal Mortality:

The table below outlines the Trust held perinatal mortality data. It should be noted that the latest MBRRACE report available to the Trust is 2021, and therefore this data has been included below.

Extended Perinatal Deaths Year to Date (23/24)					
	Rolling 12 month Number	Rolling rate 12 months per 1,000 births	Number (2021)	Trust Adjusted Rate (2021)	National Average (2021)
Stillbirth (>24 weeks)	3	1.8	7	2.8	3.29
Neonatal Death (up to 28 days after birth)	0	0	1	0.52	1.5
Perinatal total	3	1.8	8	3.33	5.2

Claims Scorecard:



OBSTETRICS currently sits within the YELLOW segment. When considering the high value that is generally associated with maternity claims, this is not unexpected. It is noted that YELLOW is on the low end scale of the volume of claims. It is common that claims can be filed several years after an incident due to awaiting ongoing development assessments. It is therefore imperative that assurance is given around our robust reporting, investigating and learning processes.

Saving Babies Lives:

Saving Babies Lives Care Bundle Version 3 was released at the end of May 2023. NHSE launched a new tool to support a standardised approach to implementation and assessment which includes quarterly LMNS reviews of evidence. The CNST Year 5 standard required a 70% compliance overall and 50% in each element which we achieved and can be seen in the national tool table below. The expectation is that all elements are fully implemented by 31st March 2024 and we continue to make progres son this work. Our next quarterly LMNS review and update will be undertaken in March.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	89%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	84%	Partially implemented	80%	CNST Met

Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme (MIS) Year 5:

Following Trust Board delegated responsibility for assurance and oversight to Quality Committee and Maternity Safety Champions, we are pleased to report that following a full review by the LMNS, we reported full compliance with CNST standards.

We are reviewing the Board reporting requirements at present, and we look forward to the publication of MIS year 6 which we anticipate in May 2024.

Three Year Maternity Delivery Plan

NHSE published the Three Year Maternity Delivery Plan in March 2023, and following this the Midlands Perinatal Midlands team provided a tool kit for the progress and monitoring of actions. This is currently planned for review in the next LMNS Insight Visit, due to take place on 27th March and we will update further in the next quarterly report.

What is new and what is different?

Maternity Triage:
The service has moved into its newly refurbished space which has seen a significant improvement in patient care and experience; and generally an improved experience for staff working in the area. BSOTS is launching at the end of March and further progress on this will be reported through this forum.

There have been no incidents associated with maternity Triage for >3 months and therefore the risk on the risk register has been closed to reflect this.

Service User involvement
Quarterly Maternity Voices Partnership (MVP) meetings continue. We are very fortunate to have recently appointed a new co-chair who has a wealth of experience in this area and will complement the current group. Staff and service user representation remains generally good, but awareness needs to be raised within our BAME and vulnerable service users groups. We have been working together to improve the Equity and Equality agenda items:

- Theme of the month across the service has been 'Hidden Disabilities'
- The LMNS and MVP have funded training for staff at the Queer Birth Club which is aimed at enhancing awareness and engagement. Service user representatives have been small in numbers but the training should support mechanisms to increase this.

What are we especially proud of?

Workforce/Staffing
The most up to date BirthRate+ Report was undertaken in 2021. CNST standards require a workforce review to take place every 3 years. The service is currently engaging with the Birthrate+ team to scope a new review. Current establishment reports the service is over-recruited by 2.8wte. Maternity leave currently leaves the service with a vacancy rate of 6.7wte and in view of this the true vacancy is 3.9wte. We are not actively recruiting to these current vacancies; recruitment is planned for Band 5 midwives for the September cohort.

All agency ceased in maternity services in November 2023 and there is now a significantly reduced bank in addition to this. It is also important to note that the sickness rate in January for midwives in the inpatient maternity service is currently at 3.79% and has been on a steady decline month on month for the last 6 months.

CQC Maternity Survey Result
We were pleased to receive our CQC maternity survey report for 2022/23. This data enables us to identify key areas for continued improvement. We are very pleased that we have made significant improvement in 8 key areas, with no areas of decline.

The report sets out the benchmark across the Region and highlights the Top Five and Lowest Five performing Trusts across 8 key domains. Wye Valley NHS Trust featured in the top 5 results for each of the 8 domains. We congratulate our workforce on their efforts in delivering excellent care, and we extend thanks to those who responded, allowing us to gather this invaluable data. We will deliver an action plan in the next quarterly report.

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

QC Inspection / Action Plan

Following CQC inspection in 2023 we developed an action plan to address the should/must do actions:

Must/ Should	CQC Action Statement	Lead	WVT Actions	Monitoring method	Monitoring Committee/ Group/ Report (and frequency)	Position at time of reporting	Target date for completion	Progress Notes/comments
Must	The service must ensure staff follow the triage assessment process including the completion of a risk assessment and timeframe to be seen from arrival.	Ami George	This work was implemented in May 2023, however evidence was not requested by the CQC. An audit has been sent to the CQC within factural accuracy. The service continues to monitor performance of this on a monthly basis.	Audit	Maternity Governance	Compliant	01/09/2023	
Must	The service should ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out hourly.	Sian Jenkins / Pooja Munjal	Monthly Fresh Eye audits are undertaken and perfromance has been improving month on month. This evidence was not requested by the CQC but has been provided for factual accuracy.	Audit	Maternity Governance	Compliant	01/09/2023	
Must	Systems or processes must be established and operated effectively to monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. These must include the checking of emergency equipment, auditing of triage processes, ensuring all guidance meets national standards and reviewing grading of harm reported in incidents in accordance with national guidance.	Amie Symes	Emergency equipment checks are undertaken in maternity with satisfactory results. These will continue managed by Annette Arnold	Audit	Maternity Governance	Complete	31/10/2023	
			Theatre safety equipment has been raised with theatre teams and we are currently reviewing a process for the safety checks to be reported into maternity services. Annette Arnold	Audit	Maternity Governance	In progress	31/10/2023	Awaiting theatre update
			Triage audits are in place as per above action. Ami George	Audit	Maternity Governance	Complete	01/09/2023	Audit templates complete - reporting to continue.
			Guideline performance and management requires an overhaul as the process is not running effectively. This will be reviewed by Sarah Ashwood.	PAGG	Maternity PAGG	In progress	31/03/2024	
			Review and provide assurance to process of reviewing moderate harm cases in line with National guidance. Sarah Ashwood	Policy	Divisional Governance	Compliant	31/10/2023	
Must	The service must ensure staff training compliance with mandatory training, including safeguarding training and specific maternity training to meet the local training compliance requirements. All staff must receive annual appraisals	Amie Symes	Review and devise strategies to achieve compliance across all areas relating to this. Data reported to F&PE bimonthly	Process / Strategy	F&PE	Compliant	01/01/2024	
Must	The service must be assured that the role of the surgical assistant is risk assessed to ensure that the role is carried out by staff with the right level of qualification and additional training.	Amie Symes / Salma Ibrahim	Revise the training material and competency assessment tool. This was being performed annually but must now be biannual in line with Job Description.	Process	Maternity Governance	Complete	01/09/2023	
			Risk Assessment to be presented to Quality Committee	Report	Quality Committee	In progress	31/03/2024	As met with Consultants (Obs & Anaesthetics) Feb 2024 - to complete risk assessment and report in March.
Must	The service must ensure that all risks associated with women and birthing people requiring level 1 care are assessed. This should include the risks associated with the safe care of patients with an arterial line and training for staff looking after patients who are acutely ill and requiring additional observation and care.	Anaesthetics / Annette Arnold	Process, policy and training were all revised in early 2023. This was shared with the CQC in factual accuracy and it is believed this is complete.	Process	Quality Committee	In progress	31/03/2024	Review of this with relevant leads has identified further improvements were required to the pathway. Pathway is drafted, TNA outlined and in place and QIA in circulation for comment. Will take through PAGG in March 2024.
Should	The service should ensure effective communication tools are used when handovers take place at all shift changes and handovers between different areas	Annette Arnold	Tool are in place but required audit to monitor effectiveness and compliance	Audit	Maternity Governance	In progress	30/05/2024	Ongoing as not met >80% consistently.
Should	The service should continue to audit cleanliness in line with national standards and improve compliance.	Annette Arnold / Abbi Maddox	Matrons complete this and report to IPC. Regular and robust reporting needs to be maintained.	Audit	IPC Committee	Complete	01/12/2023	
Should	The service should consider triage call abandonment rates are monitored.	Ami George	Audit undertaken monthly but must commence reporting in Maternity Governance	Audit	Maternity Governance	In Progress	01/04/2024	Audit templates complete - reporting to commence. Needs to be added to the governance agenda as standing item
Should	The service should ensure all staff are aware of the location of emergency equipment.	Annette Arnold	Informaiton shared across workforce - complete. AA to link with theatres to ensure all staff are sighted on this.	Strategy	Maternity Governance	Complete	31/10/2023	
Should	The service should ensure an equality impact assessment is included within incident reviews.	Sarah Ashwood	SA to link with NO to identify and implement requirements.	Process / Policy	Quality Committee	In progress	31/03/2024	

Version 1 22020304

Obstetric Theatres

Following a number of concerns over many years, raised both internally and by agencies such as the CQC, there is currently a review of the provision of Obstetric Theatre. Current provision is a single Obstetric Theatre within the maternity setting, and the service is able to identify a need for a second theatre, with clinic risk and service efficiencies aligned to this. The plan has been to move elective work to the new theatres when this is complete later this year, however concerns have been raised that this will not fully mitigate the risk. A case was taken to Trust Management Board in February of this year, with a request to undertake a more detailed scoping exercise to try and facilitate a second Obstetric Theatre within the existing estate. This was agreed, with a timeline of 8 weeks assigned to the work. Further updates will be reported in this arena.

Maternity Continuity of Carer

Maternity Continuity of Carer has been on the NHS agenda for a number of years. Known to improve outcomes for women, birthing people, babies and their families, this is a model of care that is nationally recommended. Following publication of the Ockenden Report in 2022, NHSE made recommendations that if Trusts were not operating at full establishment, they were no longer mandated to deliver this model of care.

We have been developing a business case to set out a series of recommendations for sustainable and effective roll out of the Maternity Continuity of Care model. The proposals will see the service address health inequalities and deliver an enhanced model of care to those set out in the NHS strategy addressed as CORE20PLUS5. The model will be presented at the Finance and Performance meeting on the 27th March and subsequently presented to Trust Management Board on 5th April.

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Board Assurance Framework (BAF) and Divisional High Risk Report Analysis of Risk Appetite
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management
Lead Executive Director:	**Managing Director**
Author:	Louise Robinson, Deputy Company Secretary
Documents covered by this report:	1) BAF as at 27th February 2024 2) High Risks 15+ as at 27th February 2024 3) Risk Appetite Analysis

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WVT's strategic objectives for 2023/24 and a review of the current operational High Risks (rated 15 and above).

In addition, the analysis of the recent Risk Appetite process for information.

2. Recommendation(s)

The WVT Trust Board is invited to note:

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

3. Executive Director Opinion[1]

The BAF is a live document which currently details the risks of achieving the Trust's 2023/24 strategic objectives utilising the Incident and Risk Management system, InPhase. This document is continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives.

As requested at the Board meeting in July 2023, the BAF now also reflects the direction of travel: the consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.

The Board Assurance Framework will be aligned to the Trust's new strategic objectives for 2024/25 and will be presented to the Board in April 2024.

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

Following a recent process, the resulting analysis of the Trust Board's 'Risk Appetite' using the ICS methodology sent to all Board members, is attached for your information. This Risk Appetite will inform the Trust's business cases and strategic objectives going forward.

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

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

Risk Id	Risk Title	Risk Type	Risk detail	Date added to Register	Review date due	Division	Risk Owner	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Last Updated	Assurance	Gaps in Assurance	Direction of Travel
54	**BAF 2023/24** Ability of system to manage flow across the urgent and emergency care pathway	Strategic	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.	25-Apr-22	26-Mar-24	Corporate Division	Andy Parker	20	4	4	16	8	•Trust Capacity meetings allowing visibility of the issues and escalation. •Investment in additional ward discharge coordinator capacity. •Enabling flow SOP in place (with proactive boarding on all acute wards) •System wide silver meetings • Winter Plan 2023/24 Discharge to Assess Board	•Ability for out of area partners to respond to the repatriation of patients. •Gaps in Homefirst provision and Discharge to Assess settings. •Shortfalls in staffing at ward level creating delays in discharge planning. • Additional financial burden as a result of inability to mitigate additional activity at the 'front door'. • Winter Plan initiatives /schemes untested. Inability for Powys to respond to discharge pressures in a timely manner	26-Feb-24	•System wide silver and gold calls. •Finance and performance executive reporting •Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board. Standardization of discharge processes and planning of admission across patient settings. Ward Based Dashboards Better Care Fund oversight by both One Herefordshire Partnership and Integrated Care Executive. Winter Plan and capacity bridge analysis.	System oversight of discharge delays and capacity.	
56	**BAF 2023/24** Availability of Capital Funds to meet Trust's Strategic Objectives	Strategic	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivering of key estates and investment being made on Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to an ability to procure essential equipment resulting in adverse impacts on healthcare delivery.	05-Aug-22	09-Mar-24	Corporate Division	Alan Dawson	15	3	3	9	9	•Capital planning and prioritisation of key schemes and equipment •Holding contingency funds for adhoc emergency requirements •Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	•Ability to determine emergency capital spend requirements •Approval of capital fund applications •Capital funding provided is not sufficient to meet whole requirement	09-Feb-24	•Project teams and programme board structure in place for major schemes. Capital Planning and Equipment Committee •Trust Management Board •Financial reports to Board Operational Planning Process		
58	**BAF 2023/24** Clinical and support staff recruitment and retention	Strategic	There is a risk to achieving the Trust's strategic objectives due to staff shortages and being unable to recruit to clinical, nursing and support staff vacancies, resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	21-Jul-20	11-Mar-24	Corporate Division	Geoffrey Etule	20	4	3	12	8	•Recruitment and retention initiatives: plan for clinical staff; ICS-wide support worker recruitment campaign; international recruitment; 'golden hello' for hard to recruit role; TRAC recruitment system; flexible working policy; career and pay progression framework. •Allocate Project Plan (which oversees implementation of innovative job planning) to allow adaptive use of existing workforce negating the need for recruitment by making best use of resources •Workforce and OD Strategy and Leadership Development Programme - developing skills and competencies of managers to enable improved recruitment and retention. •'Deep dives' and analysis into areas of high turnover, vacancies, exit interviews and new starter surveys. •Contract management and monitoring data of Master Vendor and Direct Engagement use. including	•Clear medical workforce plan that addresses opportunities within ICS. •Full implementation of e-rostering in clinical areas. •Temporary Staffing engagement and deployment policy. •Enhanced workforce planning and development support for managers. •National shortage of clinical staff both Medics and Registered Nurses. • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes. • Uncertainty of the impact of industrial action. • Cost of living impact on recruitment and retention.	12-Feb-24	•HR Directors weekly ICS meeting. •F&PE reports •E-rostering project board to deliver against plan. •JNCC and Equalities group receive quarterly update on workforce issues. •Staff recruitment and retention working group. •Integrated Performance Report to Board •EMARP and NARP (reinstated in August 2022). •Weekly MD-led vacancy review panel - reviews all non-clinical recruitment. •Health and Wellbeing Group to review and assess effectiveness of health and wellbeing initiatives to support recruitment and retention.	• Limited assurance that the master vendor contract will meet required agency fill rates which leads to use of higher cost tiers within the contract and other agencies - due to ongoing National shortage of clinical staff. • Expediency of ICS-wide initiatives.	
59	**BAF 2023/24** Delivery of the Digital Strategy	Strategic	There is a risk of a delay to the delivery of benefits and the future capital funding of the Digital Strategy due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.	22-Jul-20	15-Mar-24	Corporate Division	Katie Osmond	16	4	3	12	8	•Trust and Foundation Group Digital Strategies •Programme Team •IT Project Managers •Clinical Systems Governance Board provides clinical acceptance and engagement in any proposed solutions or changes •Monthly review of programme progress against plan. •Clinical Systems Group has been established to manage systems in BAU. •Engagement with the national frontline digitisation programme.	•Change management training of staff •Staff engagement. •Work pressures and availability of staff to be released to attend training. •Lack of resilience in resource plans. •Impact of the introduction of digital strategies across all stakeholders. •Uncertainty in national priorities for delivery of digital strategies.	15-Feb-24	•Capital Planning and Equipment Ctte. •Bi-monthly Board paper to Trust on digital progress. •Internal audit reviews •NHS England participation in governance forums •Digital programme board with overview of projects to determine critical path, overlap and staff impact. •Clinical Systems Group - maintenance and monitoring of BAU. •Reporting to the national frontline digitisation programme.	Uncertainty around NHSE Frontline Digitisation funding for IMS Maxims solutions based on historic Procurement concerns.	

62	**BAF 2022/23** Maturity of Integrated Care Executive	Strategic	Risk is that reporting to ICE is immature, therefore, does ICE have sufficient information to manage the services detailed under the MOU	19-Apr-22	29-Mar-24	Corporate Division	Jane Ives	15	2	3	6	6	Regular reporting by ICE to the One Herefordshire Partnership Board and the Wye Valley NHS Trust Board. MOU including BCF agreed with ICB	Less variable attendance at ICE Improved dataset completeness	22-Feb-24	One Herefordshire Partnership ICE ToR		
63	**BAF 2022/23** Maturity of Primary Care Networks	Strategic	There is a risk that Primary Care Networks are unable to achieve their objectives in support of the One Herefordshire Partnership in reducing inequalities and improving sufficiently the health and wellbeing of Herefordshire's residents given their immaturity.	19-Apr-22	29-Mar-24	Corporate Division	Jane Ives	15	3	3	9	6	• National DESs (directed enhanced services) • Agreed PCN priorities • Joint appointment between WVT and Taurus of Director of Strategy and Partnerships	Variable PCN maturity and delivery	22-Feb-24	• One Herefordshire Partnership • 1H Integrated Primary Care Board • Improving availability of data to support reporting	Sufficient PCN-level management oversight	
65	**BAF 2022/23** Recruitment to Health and Social Care Teams to Support Patients at Home	Strategic	The Homefirst Team does not have sufficient capacity to meet the demand for discharges in a timely way	29-Apr-21	22-Mar-24	Corporate Division	Jane Ives	16	4	3	12	8	• MOU with delegated authority for BCF to 1HP Discharge to Assess (D2A) Board established July 2023 • Workforce Strategy and recruitment campaign in place for Homefirst recruitment.	• Around 10% Homefirst vacancies • Better Care Fund resources not yet understood in sufficient detail • Home care market improved and meeting majority of demand. Concern that referral processes are too complex and take more than target of 1 day from referral to discharge	22-Feb-24	• One Herefordshire Partnership Board - quarterly performance review of home care market. • Integrated Care Executive - monitoring vacancy position. • Integrated care finance and performance executive. • D2A Board monitoring of Homefirst delivery.	Incomplete but improved information to Discharge to Assess (D2A) Board Incomplete but improved information to ICE	
66	**BAF 2023/24** Risks to productivity and operational capacity plans and delivery	Strategic	There is a risk that the Trust will not be able to achieve its productivity and activity plans as a result of factors due to: vacancies; pace of productivity improvements; access to outsourced capacity; and, sub-optimal urgent care pathway. This may severely impact on the delivery of productivity and operational capacity plans that deliver safe and timely elective, emergency and urgent care. All factors, either individually or collectively, could significantly decrease the level of available capacity and productivity.	22-Jul-20	26-Mar-24	Corporate Division	Andy Parker	25	5	3	15	10	• Recovery and Restoration plan (under regular review) • Escalation and surge plan • Ringfenced elective pathways • Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. • Group and system-wide mutual aid • Activity plans. • Clearly documented value for money assessment of additional flexible capacity options as part of business case process.	• Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. • Ongoing impact of industrial action. • Productivity plans based on GiRFT faster further programme	26-Feb-24	• Daily reporting and escalation. • Trust operations group - weekly. • Restoration Meeting. • ICS restoration and recovery oversight group • Productivity Board • Finance and Performance Executive reports. • Integrated Performance report to Board. • Local and regional value-weighted activity is above 100% of 2019/20 levels.	None Identified	
1686	**BAF23/24** Improving Cleanliness Standards	Compliance with standards	There is a risk that WVT will fail to deliver improvements to cleanliness standards which could lead to increased infection rates.	04-May-23	13-Mar-24	Corporate Division	Lucy Flanagan	20	4	4	16	8	• Contractual cleaning schedule to meet nationally published (2021) standards • Regular meetings with PFI providers to resolve issues as they arise Responsibility matrix setting out required standards and responsibilities for achievement	• Standard of cleaning. • Consistency of delivery. Inconsistent monitoring	14-Feb-24	• NHSE inspections • Infection Prevention Audit Programme • Monitoring team providing regular local inspection against the 2021 standards • Infection KPIs identifying change/trends • Commissioner peer review Matron routine reviews	Frequency of routine reviews compromised at times of operational pressure Change in electronic audit tool December 2023 - highlights false assurance for previous 12 months - now being closely monitored	
1687	**BAF23/24** One Herefordshire delivery of responsibilities contained within the MOU	Strategic	There is a risk that One Herefordshire will be unable to make improvements to 'working in a more integrated way' due to an inability to achieve consensus. This includes being unable to realise the potential benefits of the MOU (containing new responsibilities for the Better Care Fund) between the ICB and One Herefordshire.	04-May-23	28-May-24	Corporate Division	Jon Barnes	9	3	2	6	6	• Terms of Reference for ICE to provide oversight of delivery of the MOU. • Availability of shared data Discharge to Assess Board commenced 2023/24 BCF Operational Group commenced Autumn 2023	• Finalised and signed MOU for 2024/25	27-Feb-24	• Monthly reports to ICE • One Herefordshire agreement of the MOU, enabling consensus. MOU finalised and signed (ICB and 1HP) in place for 2023/24	• Defined reporting mechanism to assure delivery against the MOU.	
1688	**BAF23/24** Delivery of Academic Programme to improve our Research Profile	Strategic	There is a risk that WVT may be unable develop an effective academic programme in order to improve our research profile due to a lack of resources including finance, manpower and delivery models required to achieve improvements to patient care.	11-May-23	18-Mar-24	Corporate Division	Chizo Agwu	10	2	3	6	4	Project oversight in place: Executive lead; Research and development lead; Associate CMO for education. Narrowed scope in place focusing on the research strategy	Scope and project plan - to be reviewed in Workshop in February 2024. Project management.	19-Feb-24	Reviewed under normal research meetings Workshop in February 2024 planned	Scope of project not yet defined.	

Risk Id	Risk Title	Risk Type	Risk detail	Date added to Register	Division	Initial Risk Rating	Current Consequence Score	Current Likelihood Score	Current Risk Rating	Target Risk Rating	Controls	Gaps in Controls	Assurance	Gaps in Assurance
789	Risk of adverse patient events due to long stay within ED resulting in overcrowded department	Clinical Care	There is a risk of long patient stays in ED, due to poor flow within the urgent care pathway, which leads to an overcrowded department. This has, could, will lead to patient harm, (falls, pressure area damage, delirium, poor patient experience, suboptimal care; food, fluids, observations, medication and escalation of the ill patient) and privacy and dignity. It also leads to increased delays in ambulances offloads. Due to the congestion in ED and high levels of boarders on the wards, patients in ED are now being cared for in inappropriate areas forcing staff to work outside of SOPs. This is evidenced by increasing numbers of InPhases showing near misses.	10-Oct-23	Medical Division	20	4	5	20	4	Colour coded identification on Symphony of patients in department in excess of 6, 12, 18 and 24 hours. 1. Pressure area damage; Risk 1788 Repose mattress toppers on trolleys Ability to utilise hospital beds (space permitting) Anderson tool on Symphony High risk patients highlighted to site team for ward bed transfer Comprehensive nursing handovers within ED Senior nurse checklist completed Howard Wright trolleys introduced within ED, providing 48 hour pressure relief. 2. Delirium / Mental Health / Learning Difficulties Level of frailty determined at triage. Frailty SDEC opened to reduce length of time patients stay in main ED. Autism Care Pathway work led by	1. ECIST review of SNCT data - Awaited 2. Inconsistent use of existing tools 3. Surgical SDEC; when opened should reduce number of patients waiting within ED 4. Involvement with T&O 5. Virtual ward; under utilisation and lack of surgical input preventing surgical patients to be admitted to virtual ward. 6. Internal professional standards; productive meetings held with medical division & surgical division. 7. Additional ED trolley's with pressure relieving qualities. 8. Lack of workforce plan relating to ED and Acute medicine consultants. 9. Use of acute physician SPA time to manage ED outliers impacts on time to implement improvements. 10. ED Matron pulled operationally impacting on implementation of improvements 11.Overall Demand & Capacity model work up & ECIST feedback review	Monthly ED Mortality meetings Directorate Tri Directorate Risk Meeting Tri to Tri Divisional Quality Governance Meeting Quality walkabouts by Divisional Tri F&PE Executive Risk Meeting Quarterly update to Quality Committee; standardised agenda item in medical division report. * All unexpected deaths added onto Inphase and reviewed by Division * All moderate harm and above pressures ulcers reviewed at PUP with engagement from B7 sisters. * Visible leadership from B7 sister * Senior Nursing Review checklist * 6 hourly checks reflective of intentional nurse rounding. * Operational meetings - gaps in staffing	1. Resilience within the multidisciplinary workforce. 2. Ward implementation of agreed Ward Standards; promotion of flow and reduce congestion within ED. 3. Professional standards agreed, but inconsistently implemented. 4. Junior nursing workforce and clinical skills. 5. Confirmation from ECIST re; nursing establishment. Update 19/02/24: -Nursing Business Case to be submitted in due course -ED medical staffing business case submitted 16.02.24 for approval -Ward standards agreed and implemented November 2023 -ED internal professional standards and working better together document implemented for medical staff
1317	Risk of patient harm due to Pharmacy Service reduced capacity/staffing	Workforce	There is a risk of harm to patients due to the lack of registered pharmacy staff nationally including agency staff. This is currently resulting in reduced ability to maintain/develop medicines related policies and procedures and maintaining governance processes including audit across the Trust (specifically controlled drug storage audits). Delays in the processing of medicines orders including inpatient, discharge and outpatient supplies. Inefficiencies due to all dispensing taking place within the pharmacy dispensary instead of ward based where possible.	08-Dec-20	Clinical Support Division	20	4	5	20	4	•Prioritisation of clinical service at ward level and technical services to reduce risk to patients and maintain capacity. •Searching for two locum pharmacists but not appointed yet. •Flexible working requests considered for all roles.	•Insufficient pharmacist numbers to cover all ward areas and maintain policy and procedure development for Divisions/Directorates •No readily available additional cover (locum or bank). •Medium to long term threat of pharmacy staff shortage due to expansion in services in all sectors.	•Pharmacy staffing reviewed weekly by COO and CMO with Division Lead and CD of Pharmacy. •Incident reports completion for medicines related incidents, complaints and PALs concerns. •Rota indicating all areas are covered adequately if possible. •Completion of medicines reconciliation at ward level, turnaround time KPIs. •Staff overtime records and sickness records and turnover. •Staff concerns and wellbeing issues raised. •Bi monthly report to Patient Safety Committee/Quality Committee on risk status via the Medicines Safety escalation report	None

1581	Theatre Ventilation	Compliance with standards	Non-compliance with HTM03-01 - non-compliance with statutory requirements. The lack of Theatre environmental control presents a quality, compliance, operational, infection control, Health & Safety, Clinical/Patient & Staff safety risk. The following concerns with theatre temperature and humidity have been identified: • Theatres department AHU is past HTM03-01 recommended lifespan (HTM03.01 10.7 & Part B 1.51) • No temperature control within theatres which can be adjusted appropriately by Theatres staff (HTM03.01 Part B 3.85). • Instrument panels are not	21-Jul-21	Surgical Division	25	5	4	20	5	1. Daily temperature monitoring by staff 2. Escalate temperature issues when identified to estates department to rectify. 3. Planned preventative maintenance 4. List cancellation or curtailment for patient and staff safety	1. When night staff, who monitor temperatures, are busy in theatre with emergencies, do not get the opportunity to raise the issue of increase in temperature. 2. No trust ventilation policy in place – HTM03-01 part B Section 2.22 3. Escalation via estates department still causes delays in lists and/or some cancellations waiting for temperature to stabilise 4. Control panels within theatres inadequate to enable staff to adjust temperatures in line with HTM03-01 requirements 5. Planned preventative maintenance consistently deferred 6. Controls mitigate elements of risk domains identified but cannot mitigate non-compliance with standards, national guidance or regulatory requirements.	1. HTM03-01 2. Monitoring of Incident reporting and any associated elective cancellations to indicate and assure existing controls maintain current level of risk relative to Safety of patients and staff and theatre efficiency.	1. Non-compliant with HTM03-01 2. Inconsistencies in incident reporting. Incident reports/cancellation data is reactive not proactive.
1703	Ongoiung concern: Paediatric Allergy Service	Clinical Care	There is no funded establishment for a paediatric allergy nurse specialist (CNS) - making WVT a national outlier. All regional units (DGHs) have an allergy nurse. There are no allergy services in primary care locally and no expertise in paediatric allergy. Children in Herefordshire are entirely dependent on the services offered by the allergy team. This post is currently not funded and is provided in bank hours. Hereford is at risk of losing its paediatric allergy service following the anticipated retirement of the nurse currently provided specialist allergy care on the bank. The allergy service is dependent on CNS appointment:	22-May-23	Surgical Division	20	4	5	20	4	Use of bank staff with relevant experience and skills.	Outside of budget Unable to recruit into substantive post due to no commissioned service	Staff available with skills to fill on bank basis	No sustainability should bank nurse not work any further shifts.
1704	Delivery of Financial Plan and improving underlying position	Financial	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) required; impact of inflationary pressures; and, risk to achieving the full income target. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and shortfall in cash to meet obligations.	22-May-23	Corporate Division	20	4	5	20	12	CPIP devolved as part of divisional budgets for identification and delivery. CPIP targets agreed by divisions. Established process for identification and monitoring of CPIP delivery. Action plans in place for MARP and NARP. Activity Plan implementation. Enhanced financial controls.	National inflationary pressures. Process of early identification and capture of full CPIP plan. Trust policies and processes require strengthening to ensure compliance. Lack of recurrent efficiencies within the programme. Lack of medium term financial plan.	Productivity Board routine monitoring of activity plan. Monthly F&PEs review of CPIP delivery. MARP and NARP routine review of action plan and compliance with controls. Integrated performance report to Board. CPIP Audit Report ICS Finance Forum - NED-led to oversee system financial performance. System Investment and Expenditure Ctte - Management-led oversees adherence to the enhanced financial	Trust policies and processes require strengthening to ensure regular monitoring and reporting. CPIP plans not fully identified to meet targets.

1781	Harm to patient and staff due to lack of appropriate Mental health assessment room	Clinical Care	There is risk of harm to patients and staff due to no suitable assessment room provided in ED majors area (risk assessment and management of patients who are high risk of self harm or absconding from the Emergency department). There is a risk that patients who are high risk of self harm/overdose/harm to others could abscond from the Emergency Department. This is due to lack of staffing and space to deliver existing processes to manage these situations. This has resulted in a patient absconding from the ED whereupon she overdosed on paracetamol and subsequently died. Room (5) being used currently	17-Aug-23	Medical Division	20	5	4	20	15	Triage and risk assessment on arrival 1:1 supervision when deemed necessary leaving doors open Panic alarm in the room and fully functional. Policies: Trust wide: MCA/DOLs, Enhanced observation. ED: Post triage metal health triage within symphony that dictates level of supervision. environment: Mental health space in cubicle 4 and 5 of majors, which is immediately adjacent to nursing base and ED nurse in charge desk locked access to department.	Ligature and self harm risks remain in room Room does not have 2 exits Doors allow patients to lock themselves and staff in. Doors do not open outwards Doors do not have window/viewing panels No panic alarm or working emergency buzzer; COMPLETED Holes in the walls; completed Poor state of decoration; completed unnecessary fixtures and fittings No ligature free bathroom (taps, locks, door handles) More than 1 patient requiring safe room at times. Space within crowded department to deliver on the policies Staffing to deliver on policies Update 19/02/24: Awaiting final quote for related estates works to make the MH rooms safe in ED. Risk score remains at 20 due to ligature	Escalated to Matron, DGM, GM Update 20.09.23- MH office identified within ED footprint to support the MH team and patients in the department for cubicle 4 (+cubicle 5 on a flexible basis) to be used. Request with estates has been made and a quote is awaited for the works required to make cubicle 4 and 5 a suitable space for MH patients. Quote is anticipated on 02.10.23 following which if financial approval is sought, the works can proceed. Further update will follow once a quote has been received and next steps agreed. Update 16.11.2023- Meeting held with MHLT on 06.11.2023 to update with plans to provide MHLT admin office that have been delayed as we undertake transformation initiatives with a number of new operational demands in light of the changes	uncertain timescale 16/11/2023 - plan in place for clinical space. Office space to be actualised following SDEC changeover. 19/12/2023- SDEC changeover taking place 19/12/23 and virtual ward moving out of their current space which will create available MHLT office space as agreed. Will actualise over the next week. For an assessment space, the estates quote is awaited circa £100k anticipated in estates works. MH in ED has been added to the Medical Division capital planning 23/24 bidding priorities as there is no funding at directorate level to fund these works. Quote and capital planning awaited for next financial year. Update 19/02/24: Continue to work with MH colleagues and ED to ensure Majors cubicle 5 is as safe as possible while the estates
34	Quality assurance of clinical pre-operative assessment	Clinical Care	There is a risk of patient cancellation on the day of surgery or of an unfit patient proceeding to surgery due to inadequate assessment of fitness to proceed (assessment of functional status, optimisation of comorbidities, nutritional status, psychological preparedness) by the preoperative assessment service leading to potential patient harm. Safety (4) Quality (4) Complaints (2) Statutory (3) Reputation (2) Service (2) Financial (3) Business (1) Environment (1)	05-Dec-22	Surgical Division	20	4	4	16	4	The controls are POA consultant anaesthetic review. Anaesthetist and surgeon on the day of surgery. 2 pre-operative assessment nurses have undertaken the preoperative training model with the Pre-operative Association. All new appointments need to undertake these training models until they are able to work independently.	Human Error in the downstream of the POA triage process. All new appointments need to undertake these training models until they are able to work independently, but this needs funding. We are currently funded for four courses a year for a two part training model. Lack of reported system for identifying changes in health between day of pre-operative assessment and day of surgery. Especially for those who are less health literate.	Incident reporting system on day cancellation of unfit patients and clinical incidents of patient harm if an unfit patient proceeds to surgery. These when submitted are reviewed by preoperative team leads. MAXIMS reporting of reason for on day cancellation	Poor adherence to incident reporting system. Lack of flexibility of MAXIMS to pick up POA reasons.
54	**BAF 2023/24** Ability of system to manage flow across the urgent and emergency care pathway	Strategic	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places a risk to quality of care.	25-Apr-22	Corporate Division	20	4	4	16	8	• Trust Capacity meetings allowing visibility of the issues and escalation. • Investment in additional ward discharge coordinator capacity. • Enabling flow SOP in place (with proactive boarding on all acute wards) • System wide silver meetings • Winter Plan 2023/24 Discharge to Assess Board	• Ability for out of area partners to respond to the repatriation of patients. • Gaps in Homefirst provision and Discharge to Assess settings. • Shortfalls in staffing at ward level creating delays in discharge planning. • Additional financial burden as a result of inability to mitigate additional activity at the 'front door'. • Winter Plan initiatives /schemes untested. Inability for Powys to respond to discharge pressures in a timely manner	• System wide silver and gold calls. • Finance and performance executive reporting • Daily Trust-wide capacity meetings. • One Herefordshire Partnership and Integrated Care Executive reports • Monthly oversight by Herefordshire Discharge to Assess Board (starting June 23). • Valuing Patients' Time Board. Standardization of discharge processes and planning of admission across patient settings. Ward Based Dashboards Better Care Fund oversight by both One Herefordshire Partnership and Integrated Care Executive. Winter Plan and capacity bridge analysis.	System oversight of discharge delays and capacity.

67	The Covid pandemic has resulted in increased waiting times for planned care patients	Compliance with standards	The covid pandemic has resulted in large numbers of planned care patients waiting much longer for assessment and treatment . There is a risk that the delay in assessment and/or treatment will lead to patients coming to harm during this time that would have been avoided had treatment been more timely	12-Jan-22	Corporate Division	20	4	4	16	8	• Inpatient waiting list is 'risk' stratified (P codes) and patients are booked for assessment and/or treatment based on clinical need and where this is equal in chronological order. • Diagnostic waiting list is 'risk' stratified (D codes) and patients are booked for assessment and/or treatment based on clinical need and where this is equal in chronological order. • Specialities have undertaken periodic waiting list reviews and communicated with patients regarding any change in their condition • Waiting list stock take (Harm and Risk Review) undertaken and reported to Quality Committee • Long-wait patients (over 15 weeks) on outpatient waiting list written to on a rolling basis each week. • Weekly review of long waiting patients and plans	• Due to capacity constraints the Trust is unable to rapidly deliver sufficient activity to recover wait times to acceptable levels • Sharp rise in 2ww and urgent referrals has adversely impacted specialty ability to commit sufficient resource to treat long waiting routine patients • Specialty-led waiting list reviews have not provided universal coverage of the whole waiting list • No mechanism by which to ensure patients are not coming to harm as a result of continued delays. • Health inequalities within the existing waiting lists. • ICS response to existing and emerging fragile services.	• Weekly PTL meetings review 'long waiting' cohorts and specialty plans - escalated to F&PE and TMB. • Quality Committee. • Productivity Board • Finance and performance executive • ICS-led recovery and restoration • Regional recovery and restoration • Audit of waiting lists	• Work with Primary Care to agree and develop shared waiting list management approach.
274	Delayed transfers of inpatients waiting for cardiac surgery at UHB	Clinical Care	There is a risk to inpatients waiting for cardiac surgery due to lack of surgical capacity at UHB. This could lead to harm to patients and hospital acquired infection and can result in a higher mortality rate.	07-Nov-21	Medical Division	20	4	4	16	8	• Daily review on ward by Cardiology consultant • Escalated by wards to tertiary center	• Unable to treat patients at WVT • Unable to secure bed at tertiary hospital	Feedback at divisional risk meeting. Directorate team are engaged with Midlands Cardiac Pathway Improvement Programme (NHSE - Midlands).	Communication channels between WVT and the tertiary centres are not clear, so we do not have clear information on how the capacity risk is being managed elsewhere.
316	Education Centre - Delivery of clinical education	Financial	There is a risk that the Trust will be unable to deliver the increasing training requirement that it will be contractually obliged to deliver over the next 5 years due to the lack of physical and workforce training capacity. This will potentially lead to quality, financial, reputational and service delivery harm, not limited to: - Future breach of NHSE contract to a value exceeding £6M - Unavailability of clinical education within secondary care in Herefordshire. - Loss of recruitment and retention potential, impacting on clinical services. - Reputational damage arising from perceptions of poor quality medical education	03-Oct-22	Corporate Division	20	4	4	16	8	- Project set up under the leadership of the Director of Planning to look at the delivery of new Education facilities. - Charitable fund raising appeals. - Council have agreed to access capital funds. - Campaign Project Manager in place. - Spellar	- Availability of sufficient funding/finance. - Exceeding current Capital Departmental Expenditure Limit - No suitable alternative educational space has been identified. - Inflationary increases on the overall costs. - Build timescales - 2025 at the		
583	Injury to staff due to lack of lift in pathology	Health & Safety	There is a serious risk of injury to staff and damage to equipment and deliveries due to the building having no lift which has the potential to lead to service disruption and will result in delays in patient diagnosis/results/reports.	17-Dec-21	Clinical Support Division	20	4	4	16	4				

687	Lack of health psychology	Clinical Care	There is currently no provision at all for health psychology for children and young people who have long term health conditions. It is well recognised the impact that a diagnosis of a life limiting condition can have on a young person and currently there is no specialist psychology to support them. This has a significant impact on their well-being in their short term and long term care. There is a risk of harm to the patients in the longer term. This post is crucial in both acute and community paediatrics. This has previously been requested in business planning but not approved.	14-Jul-22	Surgical Division	16	4	4	16	8	NICE Guidance NG61: End of life care for infants, children and young people with life-limiting conditions NG206 Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management	Lack of funding available for service development opportunities There is no Health psychology service currently commissioned. CAMHS will not see these patients as they do not have a mental health condition.	No identified assurance as no service provision Children and Young People Board (Assurance given in Surgical Risk Register Review meeting held on 20/12/2023)	No service provision
702	Lack of medical capacity for Autism Assessment and post diagnostic intervention	Clinical Care	There is risk of poorer outcomes for children with Autism Spectrum Disorder (ASD) and their families, due to long waiting times for assessment and lack of provision of appropriate intervention following diagnosis. Delayed diagnosis and intervention leads to increased challenging behaviour, risk of school exclusion, adverse impact on education and social opportunities and increased mental health burden for both the child and family.	18-Jan-21	Surgical Division	20	4	4	16	4	Increased pre-assessment support: from Health Visitors, nursery staff, portage and Speech and Language Therapy, drop in clinics, offering advice whilst waiting assessment. Diagnostic pathways revised to increase efficiency, shortening diagnostic process for selected children. Training of other professionals, e.g.health visitors, by the ASD team to improve support and inform ASD approach pre- and post-diagnosis. Increased referral rates with improved recognition; does not improve capacity Additional funding for specialist SaLT has improved congestion. Consultants doing additional clinics within and in addition to job plan to meet additional capacity. Locum consultant covering 2 clinics	Additional ASD training for results in increased recognition and therefore increased referral rates. Increased numbers of ASD clinics within job plan means a reduction in other community paediatric services, e.g. special school clinics. Consultants providing high numbers of additional clinics is not sustainable and will lead to increased sickness and burnout. Lack of skill-diversity within the team means that this will fall to a small number of consultants. Recruitment of additional posts on hold until NHSE service/workforce review completed. Planned ICS review and development of a Herefordshire and Worcestershire CYP Neurodevelopmental Care Pathway for ASD & ADHD may affect how the service is commissioned in the future. Band 4 assistant practitioner/ASD co-ordinator is currently a 12 month fixed-term post (part-funded by ICS), extended by 6 months, funding for substantive	Weekly PTL meetings in place to monitor long waiters. ICS review of ASD services across Herefordshire & Worcestershire. Internal and NHSE review of process and service/workforce. Monthly community paediatric performance meeting held with Trust Executive.	Patients referred for MDA not monitored on PTL as under "active monitoring".

733	Lack of SACT trained nurses to provide SACT treatment to patients; resulting in potential delays or breaches.	Workforce	There is a risk that cancer patients will have their SACT treatment delayed due to lack of qualified SACT nurses being able to administer treatment safely. Of the 6.21 WTE band 5 SACT trained nurses, MRU currently have: 1.27 WTE vacancy 4.94 band 5 in post non SACT trained (not to complete training until January 2025) In post: 1.5 WTE SACT trained band 5 nurses however 1WTE has just put in notice (Feb 2024) which will leave 0.5WTE SACT trained nurses from April 2024 Agency/bank to support with this gap, still leaving a gap of 3.74 WTE for administering	12-Nov-21	Clinical Support Division	16	4	4	16	4	1.Workload is very fluid due to the nature of SACT treatments; there can be delays throughout the week, therefore staffing is reviewed daily - staff are often moved to cover other days if there have been significant delays to treatment and we are able to do this. 2.Liaise with clinicians to move patients as able to other days where it is deemed there are more staff. 3.Staff are working additional shifts to cover where they can. 4. Staff are completing some work remotely (pre chemotherapy assessments) on their days off, getting paid bank to ensure there are enough nurses on the floor to administer SACT. 5.Band 7's/lead SACT nurse work clinically to support the workload.	1. Some staff are on flexible working contracts and so are not always able to move as easily. 2. Patients are not always able to move to alternate days due to the time frame of their blood results. 3. The same staff are doing this, there is a risk of fatigue and potential increased sickness as a result of this. 4. Band 7/Lead SACT nurse have their own workload to complete; competing priorities. Risk of fatigue. Increase risk of errors. 5. CNS have their own workload to achieve so they will not always be able to support. 6. The trust have a contract with the Agency and are unable to review the rate of pay for SACT trained nurses.	Monitored monthly via this risk and through Allocate when completing rotas for SACT trained staff Monitoring capacity/Chemocare diary vs staffing levels on daily basis	Non availability of bank/agency nurses to cover service. Increase in referrals, increase in treatment availability which has an impact on chair capacity and doesn't account for patient delays
756	Lack of sufficient consultant histopathologists	Workforce	There is a risk of patient harm due to insufficient local histopathologist which will lead to a lack of 100% MDT cover, some urgent cases having to the outsourced and delays or lack of local 2nd opinions and hence diagnostic delays.	03-Nov-11	Clinical Support Division	20	4	4	16	8	•Locums employed in the department •Suitable work sent to backlogs or bank •Support from Worcester/SWFT/UHCW	•Locums not always available •A lot of work is not suitable for sending to backlogs		
960	Non-compliant timing of preoperative assessment national recommendations	Clinical Care	There is a risk of non-compliance with national guidelines, due to the pre-op taking place within the 2 weeks before TCI, leading to suboptimal timing of the pre op assessments of patients, results in insufficient time to fully optimise patients with subsequent cancellations, wasted theatre resources and poor patient experience.	21-Apr-21	Surgical Division	20	4	4	16	4	1. Final Anaesthetic pre-operative assessment on the day of surgery which can halt the surgery i.e. cancellation on the day of surgery. 2. Action for control - creation of TCI list underway	1. Clinical error on the day of surgery due to lack of time causing non identification of life or limb threatening risk.	1. Monitoring of Incident reporting to assess if controls are effective	2. Inconsistencies/no guarantees of incident reporting - remains reactive rather proactive assurance
974	Community Hospital Nursing Agency Spend	Financial	There is a risk of financial deficit due to the use of agency staff in achieving safer staffing levels across all wards within the Community Hospitals. There has been a consistent increase in acuity and independence levels of patient transfer to Community Hospital and our safer staffing audits completed bi-annually over the last 18 months has consistently shown that all sites are under established. This has resulted in financial overspend in nurse agency use which will lead to a trajected negative year end position.	29-Jul-20	Integrated Care Division	20	4	4	16	4	1. Challenge Board Data scrutinised weekly at CH Sisters Meeting 2. Training & support provided to B7/6's on interpreting Challenge B data 3. Ward exception reports 4. #CHworkingtogetherasone - viewing rosters between sites 5. Checklist process for filling gaps on rosters 6. Tier 1, 2 & 3 agency control (90% of agency to be from Tier 1). 7. Thornbury monitoring.	1. Poor uptake of tier 1 agency, mostly tier 2 2. Operational pressures increasing bed occupancy regularly at Bromyard and Leominster Community Hospitals 3. Consistent increase in both acuity and independence levels of patient transfers to the Community Hospitals - Having to staff above usual establishment 4. No resilience in staffing numbers - regularly using agency staff to cover leave and sickness	Weekly monitoring increased	uncontrolled absences and lack of oversight

1682	Industrial Action	Emergency Planning	There is a risk that Wye Valley Trust (WVT) will not be able to provide safe and effective care to patients during periods of industrial action. There is also a risk to the health and well-being of staff who are not taking industrial action because of the increased likelihood of stress and moral injury from this incident and the pressure to provide safe services. Winter UEC pressures, protracted strike action and levels of participation by Junior Doctors.	24-Apr-23	Corporate Division	20	4	4	16	12	•The Trust receive 2 weeks notice of industrial action in accordance with section 234A of Trade Union and Labour Relations (Consolidation Act 1992) enabling contingency planning. In preparation for Industrial Action Clinical teams are asked to: 1.Review the resources available to staff services over the strike period. 2. Development of comprehensive plan outlining the type and duration of the Industrial Action and its likely effects on delivery of patient care. Central to the plan is the mitigation through governance, preplanning, operational activities, recovery phase. Underpinning the plan is organisational three levels of response (strategic, tactical and operational) providing emergency coverage, including rotas detailing staff coverage during the Industrial	Whilst Industrial Action Plans endeavour to cover every eventuality, inevitably gaps in patient care coverage may appear: •Union(s)/ organisation(s) orchestrating the industrial action, and which staff members are participating in the industrial action and the level of participation. •Those participating in Industrial Action do not have to announce their intention to participate until the day of the Industrial Action, therein creating a level of unknown of service delivery impact until the actual day. •The union or specialisation participating in the Industrial Action may hinder possible mitigation, for example Consultants are able to 'act down', however there is no mechanism in place to cover for Consultants should they elect to take industrial action. •Some IA notices give notice not to derogate any services nationally or	Reporting to Tactical Operations Group, Incident Coordinating Centres (Strategic, Tactical and Operations), Industrial Action Preplanning meetings and Integrated Care Board enabling regional support as appropriate.	
1686	**BAF23/24** Improving Cleanliness Standards	Compliance with standards	There is a risk that WVT will fail to deliver improvements to cleanliness standards which could lead to increased infection rates.	04-May-23	Corporate Division	20	4	4	16	8	•Contractual cleaning schedule to meet nationally published (2021) standards •Regular meetings with PFI providers to resolve issues as they arise Responsibility matrix setting out required standards and responsibilities for achievement	•Standard of cleaning. •Consistency of delivery. Inconsistent monitoring	•NHSE inspections •Infection Prevention Audit Programme •Monitoring team providing regular local inspection against the 2021 standards •Infection KPIs identifying change/trends •Commissioner peer review Matron routine reviews	Frequency of routine reviews compromised at times of operational pressure Change in electronic audit tool December 2023 - highlights false assurance for previous 12 months - now being closely monitored
1722	Lack of physical space with the Pharmacy Department	Estates	The pharmacy department's physical footprint is not fit for purpose. The workforce number has increased from 25 to over 100 since the department was built (originally designed for 40 people) and the budget for medicines has increased from £2.5m to £29m (over ten fold increase). There is a risk that we will be unable to store anymore refrigerated items due to lack of space to put a fridge. The corridors/offices are currently being used as storage and dispensing areas not meeting IPC standards. No. of toilets isn't compliant with the Workplace (Health, Safety and Welfare) Regulations 1992. Full workforce establishment total - approx 115.	19-Jun-23	Clinical Support Division	20	4	4	16	4	- Flexible working patterns, including the facilitation of remote working where appropriate. - Space saving - high level shelving, archiving, lockers, additional storage. - Office space at St Owens Chambers on a temporary basis - lease runs out in 18 mo			

1750	Availability of accommodation for the Medical Examiner Service	Estates	There is a risk that the medical examiner service will not be able to take on all death certification across Herefordshire without larger office accommodation on the county hospital site and near to the mortuary/bereavement services, allowing for essential meetings with medical staff. This will result in the service not meeting or there being a delay in the statutory timescales and resulting in the delay of funerals, stress for bereaved families.	20-Jul-23	Corporate Division	16	4	4	16	4	Currently not providing certification for ALL Herefordshire deaths. Statutory requirements not being enforced until April 2024.	Facilitation of move of HHR to Gardner Hall. Ability to provide service for all of Herefordshire	Reports to Regional Medical Examiner Office	None identified
1762	Replacement of 4 Aseptic Isolators	Compliance with standards	There is a risk of our Technical Services Department not being able to manufacture aseptic products (inc. Chemotherapy) due to the unreliability of the current cabinets. 4 of the cabinets are approximately 15 years old and frequently breakdown requiring an engineer to come out and repair the cabinet. Due to the age of the cabinets, they are beyond full repair and the some of the parts that are required to fix the cabinets are no longer produced by the manufacturer (ENVAIR). The potential impact on the production of aseptic products is catastrophic - particularly affecting cancer services.	08-Aug-23	Clinical Support Division	20	4	4	16	4		- Exceeded life cycle by 8 years resulting in more regular failures - Downtime		
1845	Dexa reporting	Clinical Care	There is a risk of patients with Osteoporosis being misdiagnosed due to information contained within the current Dexa report being incomplete, misleading and that there are inadequate comparisons. Which could potentially lead to over/under diagnosis or no treatment being provided to patients with Osteoporosis and result in adverse patient outcomes including delays to cancer treatment.	05-Dec-23	Clinical Support Division	16	4	4	16	4		- Delay with Dexa reporting as currently reports not being produced - reports stopped ??		

1874	Sub-optimal care due to reduced capacity in Respiratory CNS team	Clinical Care	There is a risk of reduced clinical activity in the CNS team due to sickness and vacancies. This temporary reduction in workforce impacts all speciality services supported by the Respiratory CNS team. Which could lead to patients not being reviewed as per local and national guidelines This results in poor patient outcomes and poor morale within the Nurse Leadership Team.	13-Feb-24	Medical Division	16	4	4	16	8	1. Consultants covering CNS clinics in the immediate term 2. Urgent patients triaged to be seen and added to other clinic lists 3. Staff cancelling annual leave to support	1. Consultants covering CNS clinics not sustainable and impacts on Consultant clinic activity 2. Staff taking annual leave 3. Sickness with unknown return dates 4. Financial implication of Consultants covering CNS clinics	1. Lead Clinical, Matron and DGM to undertake weekly review of clinical activity and cross cover	1. Vacancies in CNS team not yet recruited to, interview date 20th February 2024 2. Delay in start dates of successful candidates due to notice periods 3.Variable capacity for Consultants to cover CNS clinics due to own workload
45	potential harm to day case patients	Clinical Care	Inappropriate allocation of patients to Day Surgery Ward may result in patient harm and poor patient experience, with an inappropriate staffing skill mix potentially resulting in wider sub-optimal care. Instances of LOS of inpatients exceeding 48hours are not uncommon currently. The facility is also non-compliant in a large number of areas and not fit for purpose for use for inpatients. 1.Non-compliance with HBN 04:01 Adult in-patient facilities (summary attached to risk) 2.Risk to elective patients - Covid-19 positive patients have been admitted to Day Case as inpatients from A&E, resulting in potential contraction of virus to elective surgery patients.	10-Feb-22	Surgical Division	25	5	3	15	10	1.Day Surgery Unit Standard Operating Procedure 2.Critical Care Outreach Support 3.Dedicated outlier medical consultant allocated. 4.Roster management reviews via ALLOCATE bridging document - 3 monthly 5.Training of substantive and temporary workforce to improve awareness of deteriorating patient pathway. 6.PR.121 Patient Flow Escalation Policy	1.No permanent matron for Directorate, temporary support not always immediately available 2.Critical Care Outreach can be suspended and currently only operates 7.30am until 8pm 3.PR.121 over-estimates Day Case capacity and requirements not complied with, particularly individual patient risk assessments 4.Outlier medical consultant not always available – based on Gilwern Ward. Junior doctor cover not escalated for number of outlying patients. 5.No Day Surgery operational policy 6.No education lead within the Department 7.Staff time not protected for additional training to meet needs of non-day surgery patients 8.Temporary workforce attendance on training days 9.No AHP Cover/support 10.Current Staffing compliment	1.Monitoring Incident reports to assess effectiveness of controls 2.Monitoring Inpatient Activity level on Day Surgery Ward 3.Daily safety huddles 4.Narrative regarding patients received and risk assessment	1.Inconsistency in Incident reports – reactive rather than proactive 2.Information regarding patient type not always received, particularly risk assessments - non-compliant with policy
66	**BAF 2023/24** Risks to productivity and operational capacity plans and delivery	Strategic	There is a risk that the Trust will not be able to achieve its productivity and activity plans as a result of factors due to: vacancies; pace of productivity improvements; access to outsourced capacity; and, sub-optimal urgent care pathway. This may severely impact on the delivery of productivity and operational capacity plans that deliver safe and timely elective, emergency and urgent care. All factors, either individually or collectively, could significantly decrease the level of available capacity and productivity.	22-Jul-20	Corporate Division	25	5	3	15	10	•Recovery and Restoration plan (under regular review) •Escalation and surge plan •Ringfenced elective pathways •Use of the private sector; outsourcing options have a formal agreement in place for routine continued use of private facilities. •Group and system-wide mutual aid •Activity plans. •Clearly documented value for money assessment of additional flexible capacity options as part of business case process.	•Increase in non-elective activity leading to capacity constraints for emergency admissions and impacts on recovery and restoration plan. •Ongoing impact of industrial action. •Productivity plans based on GiRFT faster further programme	•Daily reporting and escalation. •Trust operations group - weekly. •Restoration Meeting. •ICS restoration and recovery oversight group •Productivity Board •Finance and Performance Executive reports. •Integrated Performance report to Board. •Local and regional value-weighted activity is above 100% of 2019/20 levels.	None Identified

89	A&E not requesting Radiology electronically	IT	There is a risk of missed scan requests/request errors/requesting delays for radiology from the Emergency Department due to ED using paper requests and not the EPR system/order comms. This could potentially lead to delays in requesting scans and adverse outcomes for patients.	08-Mar-23	Clinical Support Division	15	3	5	15	3	- Paper requesting being used by ED - Ongoing discussion for ED to use duplicate systems (Symphony/Maxims) to ensure accuracy and quickest route for scan requests			
423	Fragility of the Haematology service at Wye Valley	Clinical Care	There is a risk of not providing clinical care to Haematology patients under the care of WVT due to all substantive consultants leaving the Haematology department. This could lead to increased waiting times for routine and urgent patients and delays in cancer patient pathways, which could result in poorer outcomes for patients. This also impacts the labs where there will be no clinical leadership.	20-Apr-22	Clinical Support Division	25	5	3	15	5	•3 locum consultant secured •Band 7 trainee ACP in post •Lab supporting agreed with Coventry/ Warwick •Out of hours urgent films when on call virtual process agreed with Worcester • Out of hours on call filled • In hours on call filled • Some treatment patients at other trusts, most back at WVT • Insourcing available if needed • Heam/SACT navigator in post	•Locum contract only requires one week notice •Unsuccessful recruiting to all substantive posts •Competency restraints •Blood bank cover - which impacts surgery, maternity and emergencies, needed named consultant to authorise out of hours •3.6 WTE consultant vacancies and 1 WTE AS long term sickness • All substantive consultants have resigned	• Audit of waiting lists • CSD monthly governance meeting • Limited number of incidents relating to risk • Adverts for posts advertised • F+PE	• ICB options not agreed • National shortage of qualified staff
457	Harm from failure to provide safe environment arising from lack of suitably qualified Estates staff in PFI contract.	Estates	In the PFI contract Estates duties are largely outsourced and there is a significant assurance gap in relation to the capacity and capability of the current workforce. This lack of resource in key roles could result in a number of issues including, but not limited to, failure of systems (ventilation, heating, water, power, building fabric, medical gases, fire safety and decontamination. This has the potential to cause patient harm through accident, injury or sub-optimal care (e.g. through failure which causes impact on infection prevention measures or loss of facility). This includes having appropriate staff to manage safe systems of work, e.g. reviewing suitability of	23-Mar-22	Corporate Division	20	5	3	15	5	Incident reporting Existing staff Trust oversight	Key roles not filled Those in post not suitably qualified Repeated incidents where this issue may be root cause - e.g. turning off fire alarm and not turning back on, not sealing tiles within theatres, missing ventilation installation and maintenance in major projects, welding below a sprinkler etc	Governance Meetings	Poor performance/reporting to governance meetings

731	Respiratory Support Unit (RSU)	Clinical Care	There is a risk of sub optimal care on Arrow ward in patients requiring intensive respiratory support (NIV/nasal oxygen), due to lack of RSU or HDU. Which has previously led to patient harm resulting in an externally reportable Serious Incident (SI). There have been no SI's since this incident relating to the lack of a RSU.	20-Feb-23	Medical Division	12	5	3	15	6	1. Arrow ward has 16 respiratory beds (capacity 24) 2. Nursing staff on Arrow are rostered appropriately to number of patients on NIV, including additional staff if required to support 1 registered nurse to 2 patients on NIV. 3. Poster re; domiciliary patients displayed on every ward, providing an overview of NIV and CPAP safety implementations. 4. Daily maxims report of all inpatients on domiciliary and NIV sent to respiratory physiology teams. STOPPED - no capacity 5. All ward nursing staff have achieved competencies in caring for patients on NIV/ CPAP/ HFNO.	1. No Senior Respiratory Physiotherapist (guidelines B7 physio 7 days/ week service) 2. No dedicated Respiratory Pharmacist (guidelines 7 days/ week service) 3. Increased ward pressure due to boarding patients 4. Lack of dedicated NIV bed despite agreement for one ring-fenced bed 5. Lack of Consultants to cover 24 hour, 7 day service 6. Lack of ITU step down support for respiratory patients 7. No capacity to review the email of Dom NIV patients 8. Lack of level 2 care beds in the trust with high acuity in patient cohort recognised in nursing staffing, not medical model 9. Lack of middle grade doctors - all consultant delivered, not sustainable without recruitment	Discussed at; Directorate meetings FP&E Respiratory meeting SI panel Exec Risk Meeting	No Trust wide plan for L2 HDU
1610	Trust inability to comply with Fracture neck of femur pathway	Clinical Care	There is a risk of increased harm to patients who have been admitted with a fractured neck of femur due to the inability to meet some sections of the integrated care pathway, which has the potential to lead to increased mortality rates and non achievement of best practice tariff, resulting in negative national prominence and continuing to be a national outlier in fractured Neck of Femur.	26-Jun-19	Surgical Division	20	5	3	15	10	•#NOF integrated pathway in place. •Anaesthetic representation at daily trauma meeting. •Process to utilise CEPOD theatre should the opportunity arise •Process to cancel elective T&O surgery to accommodate trauma surgery. •Weekly tracking of Best Practice Tariff #NOF pathway to highlight the themes of why the pathway is not being followed. Issued by the informatics team which feeds into the #NOF clinical lead for review and comment. •Ring fenced #NOF bed now on Dinmore rather than Redbrook •Golden Patient. •Dedicated trauma anesthetist to optimise #NOF patients in a timely fashion for theatre. This is not happening as yet •5 Trauma Theatre sessions per week (increase in sessions in negotiation with the Consultants).	•Gaps in staffing on Dinmore leading to issues with skill mix amongst the team. •Time spent in ED prior to transfer when Dinmore ward is full and at time of pressure. dedicated anaesthetist not available No fixed Saturday trauma - theatre staffing is preventing this	Monthly #NOF meetings to review pathway compliance and general key themes.	No fixed Saturday trauma theatre list, theatre staffing is currently impacting on compliance.
1720	Emergency Alarm activation in theatres	Health & Safety	There is a risk with the current system of summoning aid in the event of an emergency which must be available at all times and quickly identifiable.	15-Jun-23	Surgical Division	25	5	3	15	5	1. Theatre co-ordinators react and immobilise all theatre staff on activation of the alarm.	1. when numbers are low in theatre i.e. anti-social hours 2. No central communication base within theatres department to assist Action - Revised location for any alarm location panel to be investigated	1. we have been informed by estates that this will be resolved. it was raised directly to the PFI and Estates teams 2. Proposed replacement system December 2023 Monitor effectiveness of controls via incident reporting	1. we have been waiting 18 months with no likelihood of a resolution 2. Specification of proposed system unknown. 3. Incident reporting data inconsistent

Risk Levels / *Key Elements*		**0. NONE - Avoid** Avoidance of risk and uncertainty is a key system objective	**1. LOW- Minimal** 'As low as reasonably possible' (ALARP) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**2. MODERATE – Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**3. HIGH – Open** Willing to consider all potential delivery options and accept a degree of inherent risk while also providing an acceptable level of reward (and VfM)	**4. SIGNIFICANT – Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**5. SIGNIFICANT – Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
FINANCE	***How will we use our resources?***	Avoidance of financial loss is a key objective. We have no appetite for financial loss. We are only willing to accept the low-cost option as VfM is the primary concern. Tight controls in place with limited devolved decision taking authority.	We are only prepared to accept the possibility of very limited financial risk. VfM is the primary concern. Strong central control with limited devolved decision taking authority.	**We are prepared to accept possibility of some limited financial risk. VfM is the primary concern but willing to consider other benefits or constraints. Resources are generally restricted to existing commitments. Strong central control is the default but some devolvement of decisions is accepted.**	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not being the overarching factor. Resources are allocated in order to capitalise on opportunities. We carefully balance central control with devolvement of decisions.	We will invest for the best possible return and accept the possibility of increased financial risk. Resources allocated without firm guarantee of return. We tend to devolve decisions with lower levels of inherent risk.	We will consistently invest for the best possible return for stakeholders, recognizing that the potential for substantial gain outweighs inherent risks. Our default is to devolve decisions where possible, only keeping central control for decisions with the highest levels of inherent risk.
REGULATION	***How will we be perceived by our regulators?***	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of some limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	**We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.**	We are willing to accept decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders
PEOPLE	***How will we develop our people?***	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approached to workforce recruitment and retention are not a priority and will only be adopted if established and proved to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	**We are prepared to accept the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention and developmental opportunities for staff.**	We will pursue workforce innovation. We are willing to take risks which may have impact on our people but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but is worthwhile due of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
QUALITY	***How will we deliver safe services?***	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely necessary.	Our preference is for risk avoidance. However if necessary, we will take decisions on quality where there is a low degree of inherent risks and possibility of improved outcomes and appropriate controls are in place.	**We are prepared to accept the possibility of short term impact on quality outcomes with potential for longer-term rewards.**	We are willing to take decisions on quality where there may be higher inherent risks but potential for significant longer-term gains.	We seek to take high risk decisions on quality in pursuit of significant gains and mitigation to our other risks.
REPUTATION	***How will we be perceived by the public and our partners?***	We have no appetite for any decisions that could lead to additional scrutiny or attention on the organisation. External interest in the organisation viewed with concern.	Our appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	We are prepared to accept the possibility of limited reputational risk as long as appropriate controls are in place to limit the risk.	**We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.**	We are willing to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
INNOVATION	***How progressive and innovative do we want to be?***	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or established and proved to be effective in a variety of settings	Tendency to stick to the status quo, innovations in practice generally avoided unless really necessary. Systems/technology developments limited to improvements to protection of current operations & practice.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	**Innovation pursued –desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery.**	Innovation is the priority– consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery.

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Audit Committee Summary Report 14 December 2023
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	Select Director
Author:	Nicola Twigg, Chair of Audit Committee/NED
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

To brief the Board on the main issues arising from the Audit Committee held on 14 December 2023.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2022/23 Objectives the report relates to:

Quality Improvement

☐ Improve the experience of patients receiving care by improving our clinical communication

☐ Improve patient safety through implementing change as we learn from incidents and complaints across our system

☐ Reduce waiting times for diagnostics, elective and cancer care

☐ Develop a new integrated model for urgent care in Herefordshire improving access times and reducing demand for hospital care

Integration

☐ Make care at home the default by utilising our Community Integrated Response Hub to access a range of community responses that routinely meets demand on the day

☐ Reduce health inequalities and improve the health and wellbeing of Herefordshire residents by utilising population health data at primary care network level

☐ Improve quality and value for money of services by making a step change increase in the range of contracts that are devolved to the One Herefordshire Partnership

☐ Join up care for our population through shared electronic records and develop a patient portal to transform patient experience

Sustainability

☐ Create sufficient Covid-safe operating capacity by delivering plans for an ambulatory elective surgical hub

☐ Stop adding paper to medical records in all care settings

☐ Reduce carbon emissions by delivering our Green Plan to reduce energy consumption and reduce the impact of the supply chain

☐ Increase elective productivity by making every referral count, empowering patients and reducing waste

Workforce and Leadership

☐ Improve recruitment, retention and employment opportunities by taking an integrated approach to support worker development across health and care

☐ Develop our managers' skills and system leadership capability

☐ Continue to improve our support for staff health and wellbeing and respond to the staff survey

☐ Further develop place based leadership and governance through the one Herefordshire Partnership and Integrated Care Executive

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

Wye Valley NHS Trust
Trust Board Meeting – 7 March 2024
Summary of Audit Committee (AC) meeting held on 14 December 2023

MATTERS FOR PARTICULAR ATTENTION

PFI Services Contract Payments –
Following a review supported by external Consultants, a number of issues have been identified regarding over payments of contracted services linked to the PFI contract, some historical dated over the past 20 years many of which have not been supported by available historic records. The block payment system and limitations thereof were discussed. The financial implication of not paying the block payment to the PFI contract would be a risk to the organisation however the Audit Committee have requested further assurance regarding the current legal position in this respect.

Internal Audit –
RSM, UK Internal Auditors (IA) presented the IA progress report. Strategic workforce planning received a Reasonable Assurance rating which was pleasing and whilst Advisory only the Business Case Process report highlighted many areas of assurance but also has suggested timely further actions in respect of post-implementation evaluations.

External Audit, Audit Planning Improvements
The Associate Chief Finance Officer (ACFO) presented the draft annual accounts and audit process improvement plan. The report provides a summary of the improvement plan produced to address issues encountered during the 2022/23 annual accounts and audit process. It outlines the processes which are in place to monitor progress and identified the progress made to date; Deloittes LLP, External Auditors (EA) were happy with these plans and believed they would make a positive difference in order to address the delays seen at year end last year.

Consultant Planning
The latest position was discussed and agree for 6 monthly updates to allow for concerns over change of personnel which has led to some delays in completion. Appointment of new Director of Medicine and Associate Director of Medicine should mean this is back on track and have more traction before the June report.

OTHER MATTERS

Report	Discussion / Recommendation
Losses & Special Payments	Patient Property losses have increased and a full report was requested for Feb 2024 Audit Committee also working closely with Quality Committee on this issue.
Foundation Group TOR	Agreed of TOR to align at Foundation Group level
Single Tender Waiver	The Single Tender waivers report covers the period from April through to November 2023. 10 waivers are listed within the report, which is an Increase from the same period last year. Now that the 'No purchase order No pay' has been introduced this provides better visibility on where contracts are in place or where spend is committed and provides the opportunity to challenge and question on value for money

Prepared by:-
Nicola Twigg, Chair of Audit Committee

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 27 September 2023 at 9:30 a.m. – 12:00 p.m.
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
Andrew Cottom	AC	Vice Chair, Non-Executive Director (NED)
In attendance:		
Lynne Carpenter	LC	Quality & Safety Matron (For agenda item 5.4)
Mark Coton	MC	RSM Risk Assurance Services LLP., Assistant Manager, Internal Audit
Mike Gennard	MG	RSM Risk Assurance Services LLP., Partner, Internal Audit
Erica Hermon	EH	Associate Director of Corporate Governance/Company Secretary (ADoCG)
Sharon Hill	SH	Associate Non-Executive Director (ANED)
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP
Asam Hussain	AH	RSM Risk Assurance Services LLP.
Kieran Lappin	KL	Associate Non-Executive Director
Tony McConkey	TMcC	Clinical Director of Pharmacy (For agenda item 8.3)
Heather Moreton	HM	Associate Chief Finance Officer (ACFO)
Frank Myers MBE	FM	Associate Non-Executive Director (ANED)
Katie Osmond	KO	Chief Finance Officer (CFO)
Manjit Sandhu	MS	RSM Risk Assurance Services LLP., Senior Consultant & Lead Local Counter Fraud Specialist
Bradley Vaughan	BV	RSM Risk Assurance Services LLP., Manager, Local Counter Fraud Service
Laura Weston	LW	Service Lead, Infection Prevention & Control (For agenda item 6.4)

Minute		Action
AC001/09.23	**APOLOGIES FOR ABSENCE**	
	The meeting was recorded for the purpose of producing the minutes. Apologies were noted from Lauren Parsons (Senior Manager, Audit & Assurance, Deloittes LLP) Ian James (Non-Executive Director) Jo Rouse (Associate Non-Executive Director) Bradley Vaughan (Manager, Local Counter Fraud Service, RSM Risk Assurance Services LLP) and Mike Gennard (Partner, Internal Audit, RSM Risk Assurance Services LLP).	
AC002/09.23	**QUORUM & DECLARATION OF INTEREST**	
	The meeting was quorate. No declarations of interest were noted.	
AC003/09.23	**MINUTES OF THE MEETING HELD ON THE 15th JUNE 2023**	
	The minutes were agreed as an accurate record of the meeting.	

	Resolved – that the minutes of the meeting held on the 15th June 2023 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC03.1/09.23	**MINUTES OF THE AUDIT COMMITTEE (CONCLUDE SIGN OFF OF ANNUAL ACCOUNTS)**	
	The minutes to conclude the sign off of the Annual Accounts that took place on the 4th September 2023 were agreed as an accurate record of the meeting.	
	Resolved – that the minutes of the meeting held on the 4th September 2023 be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC004/09.23	**MATTERS ARISING AND ACTIONS**	
	The complete actions were noted as completed on the action log. The actions in progress were reviewed and updated. AC08.2/09.22 - Losses & compensation – Mr Myers (NED) questioned the process of loss of personal effects by patients and it was agreed that a proposed next steps is undertaken and brought back to a future Audit Committee. An exercise was proposed for Quarter 3 to review the areas that have received the most frequent level of loss of patients' effects on the wards and undertake direct engagement with ward sisters to put process in place to minimise losses. The findings and learnings will be presented in Quarter 4 to Audit Committee. The issues have been raised at both Board and Quality Committee and is presented as financial losses at Audit Committee. Mrs Twigg (The Chair & NED) commented on a project to introduce a tray on the ward for patient's effects. Mr Myers (ANED) commented that a left luggage approach with lockers for patients should be considered. It was agreed that an update be presented at the next Audit Committee and Mrs Twigg (The Chair & NED) will speak to Ian James (NED) for a Quality Committee perspective. **ACTION** AC06.1/03.23 – Losses and compensation – Internal Audit to share Effective Recruitment & Retention report and report to be distributed to Non-Executive Directors and wider committees. **ACTION COMPLETED** AC05.1/03.23 - Governance Mapping – agreed this will be discussed as part of the agenda. The meeting structure governance chart has now been shared with Governance leads and the Associate Chief Operating Officers from the Divisions. Discussions are ongoing with the Divisions to provide an opportunity and obtain assurance that links are being made up to Board level and that the requirements for the new Code of Governance are being met and evidence ahead of the RSM Governance audit in November. **ACTION COMPLETED** AC05.1/03.23 - Governance Mapping – Governance mapping to include the reporting mechanism and frequency to be distributed with the minutes. Presented to Trust Management Board (TMB) and wider distribution. **ACTION COMPLETED**	**KO/NT**

	AC05.1/03.23 - Governance Mapping – The Associate Director of Corporate Governance (ADoCG) to investigate the reporting route of the midwifery and maternity directorate and feed back after the meeting. It was confirmed that the reporting route for midwifery and maternity is via the Surgical Division and also through their Finance & Performance Executive meeting. **ACTION COMPLETED** AC03.4/06.23 – Governance mapping – Governance mapping was presented on the agenda of the September Audit Committee to receive assurance. **ACTION COMPLETED.** AC03.5/06.23 – New Risk Management Framework policy and procedures – draft – A review of the scaling on the consequence scores within the financials of the policy has been completed, the policy has been updated and re-issued and presented to Executive Risk Committee. Staff across the Trust are being trained on the new policy linked to In Phase. **ACTION COMPLETED.** AC03.6/06.23 – DHCS Gateway 5 Review Report (Hutted Wards) – The lessons learnt report to be presented at the September Audit Committee. The internal end of the project review had not been completed by September. The Chief of Strategy & Transformation (AD) requested that the lessons learnt report be presented to a future meeting. It was agreed to carry over to the December Audit Committee. **ACTION** AC1A005/05.23 – Consultant Job Planning – The Consultant Job Planning presentation was distributed to the Audit Committee. Agreed to distribute to the new NED's and ANED's of the Committee. **ACTION COMPLETED** AC07.1/06.23 – LCFS Annual Report 2022/23 – Chief Finance Officer has signed page 335 of the LCFS Internal Audit Plan 2023/24 and returned to Internal Auditors. **ACTION COMPLETED** AC1A005/05.23 – Consultant Job Planning – Consultant Job Planning to be added as an agenda item to the December Audit Committee and every six months thereafter. The Job Planning Committee is established and ongoing. Job Plans are currently in the planning round in readiness for Business Planning. It was noted that there is a degree of risk with changeover of personnel, but there is consistency within the Medical workforce team. **ACTION** AC002/09.23 – Quorum & Declaration of Interest – The ADoCG to send a summary of the discussions to the remaining Committee for approval as the Audit Committee meeting held on the 4 September was not quorate. The membership states that three NED's and quoracy is two, one of which requires financial experience. Mrs Twigg (The Chair & NED) commented that following this month the Audit Committee will not be quorate. The ADoCG has raised quoracy with Mrs Twigg (The Chair & NED) and Deputy Chair and confirmation was received that a plan is in place. NHSE have also been made aware. **ACTION CLOSED**	**Alan Dawson** **Michael McDonagh**

	AC004/09.23 - Final Draft WVT Accounts – Confirmation that the figures in the Staff Costs within the Draft WVT Accounts have been updated and amended. **ACTION CLOSED.** AC004/09.23 - Final Draft WVT Accounts – The Auditors Letter Summary Findings and Annual Accounts will be made available as separate documents. **ACTION CLOSED** AC055.1/09.23 – Draft External Audit Report and Opinion – The ADoCG will meet with the External Auditors to discuss the working and evidence around the new governance arrangements. The information has been collated and evidence provided as part of the agenda. **ACTION CLOSED** AC055.1/09.23 – Draft External Audit Report and Opinion – The Chief Finance Officer (CFO) will bring an initial perspective of the timing and the process for the signing off of the Annual Accounts and Annual Report for 2024 to the next Audit Committee. **ACTION CLOSED** Mrs Twigg (The Chair & NED) advised that at the end of this meeting the Internal and External Auditors will be excused from the meeting to enable the Committee to hold a private session. It was agreed that the Internal Auditors (IA) would discuss any concerns separately with Mrs Twigg (The Chair & NED) as an exception.	
	Resolved – that the Action update be received and noted.	
AC005/09.23	**GOVERNANCE**	
AC05.1/09.23	**AUDIT COMMITTEE TERMS OF REFERENCE**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented the draft Audit Committee Terms of Reference and the following points were noted:- • No significant changes were confirmed, other than changing dates and the Terms of Reference have been cross referenced with Foundation Group colleagues are aligned with their Terms of Reference; • Item 2.8 was highlighted by Mrs Twigg (The Chair & NED) regarding Audit Committee members being suitably trained to enable effectiveness to fit into the fit and proper test. The ADoCG confirmed that a meeting is taking place with HR and the Deputy Chair to discuss implementing the training and monitoring process and an update will be provided at the next meeting. **ACTION** • Item 7a. Duties – Governance, Risk Management and Internal Control - It was confirmed that the Quality Accounts are reviewed at Quality Committee and not at Audit Committee. The External Auditors (IH) commented that the Audit Committee need to understand the reporting requirements for the preparation of the Quality Accounts to be assured, but do not necessarily need to review the report. It was	**EH**

	agreed that the Audit Committee will review the procedures and seek assurance that the quality accounts present accurate data and meet the reporting requirements as prescribed nationally; • Item 2.4 – It was agreed that the Local Counter Fraud Service (LCFS) should be included in the membership list for the meeting. **ACTION** • Item 7d. – Other Assurance Functions – The CFO highlighted reference to the ICS which might have an impact on the governance of this organisation. Mrs Twigg (The Chair & NED) will add Consistency with ICS members on agenda of upcoming meeting with ICS. **ACTION**	**EH** **NT**
	<u>Resolved</u> – that **A) The Audit Committee Terms of Reference be received and noted.** **B) Update on the implementation of training and the monitoring process for Audit Committee members.** **C) LCFS to be included in the membership of the Audit Committee Terms of Reference.** **D) Consistency with ICS members to be added to the agenda of the upcoming meeting with ICS.**	
AC05.2/09.23	**<u>CODE OF GOVERNANCE</u>**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented an update on the Code of Governance and the following points were noted:- • The purpose of the report is to provide a more detailed oversight regarding the new code of governance and the measures being taken to provide assurance to the Committee that effective processes are in place; • The ADoCG commented that providers adopt a, 'comply or explain' approach, which has been taken in the report and will have to be evidenced through the Annual Report going forward. The disclosure requirements have been included of the new code together with the evidence. Recommendations have been included to incorporate assessing and monitoring culture; • The ADoCG advised that the report is a live document and input was required from the Committee. Mrs Twigg (The Chair & NED) requested that a copy of the 13 page Code of Governance for NHS Providers – Compliance Review report is sent as a separate document. **ACTION** • The MOU has been written and is awaiting signature and provides delegations from the ICS down to partners or One Herefordshire to deliver contracts etc. The MOU links into the Better Care Fund (BCF) which is partially NHS and partially Council funding. The funding is earmarked for services and activities in local areas, for example the discharge to assess pathway and falls prevention. The MOU should provide better visibility on how BCF funds are spent and will be reported through the Integrated Care Executive;	**EH**

	• Mr Myers (ANED) commented on the Recommendation section. The ADoCG confirmed that three NED's are required to possess one of the bullet points that apply to them. Mr Myers (ANED) has expressed to Mrs Twigg (The Chair & NED) that the background of the NED's seem to be migrating towards people with experience of the Health Service. The ADoCG stated that within the Code of Governance the recommendation is to have a NED with a clinical background, which is currently lacking at the meeting. A REMCO will be proposed to discuss this issue; • Mr Myers (ANED) commented on the length and content of the minutes for Board and sub committees and challenged if an alternative method of capturing the meeting could be investigated. The ADoCG responded that the Committees are also being recorded or live streamed and if this method would suffice in audit terms and if a summary of the conversation could be captured instead of full minutes. Mrs Twigg (The Chair & NED) questioned that the comments in the Chat are not always captured in the Minutes, especially at Public Board. The ADoCG suggested that a Board workshop is arranged as part of the annual effectiveness review. **ACTION** • The ADoCG requested that the Audit Committee members populate the Code of Governance for NHS Providers – Compliance Review table to feed into the workshop that will be arranged.	**EH**
	<u>Resolved</u> – that **A) The Code of Governance be received and noted.** **B) Code of Governance for NHS Providers – Compliance Review report to be sent to Audit Committee Chair.** **C) A Board Workshop to be arranged to include discussion on the capturing information from meetings as part of the annual effectiveness review.**	
AC05.3/09.23	**<u>GOVERNANCE MAPPING</u>**	
	The Associate Director of Corporate Governance & Company Secretary (ADoCG) presented an update on governance mapping and the following points were noted:- • Mrs Twigg (The Chair & NED) requested that PFI Expiry Committee is added to the WVT Governance Structure. **ACTION** • The CFO confirmed that a Hereford Medical Council (HMC) does take place involving a meeting of clinicians, but the meeting takes place in isolation. The ADoCG to reflect HMC in the WVT Governance Structure**. ACTION** • The Governance Structure will inform the Audit by RSM, Internal Auditors (IA) being undertaken in November. RSM have been requested to consider some of the new Code of Governance issues to complete a spot check. The IA's confirmed that a revised scope will be undertaken and will be built into the Governance Review.	**EH** **EH**

	Resolved – that **A) The Governance Mapping be received and noted.** **B) PFI Expiry Committee to be included in the WVT Governance Structure 2023.** **C) The Hereford Medical Council meeting to be reflected in the WVT Governance Structure.**	
AC05.5/09.23	**CONTRACT MANAGEMENT**	
	The Chief Finance Officer (CFO) presented an update on the Procurement Shared Service Contract Management process and the following points were noted:- • An agreed formal contract register has been developed across Wye Valley Trust (WVT), South Warwickshire Foundation Trust (SWFT) and George Eliot Hospital (GEH) to review contract management and renewals to obtain good practice; • All providers are moving to the NHSE tool Atamis, which allows all providers to load contracts on to one platform; • The tool will be able to load KPI is to become part of a central hub for tracking; • The team are working with Internal Audit suppliers at GEH to allow access to some of the suppliers and training to areas that hold contracts; • The introduction of No Purchase Order, No Pay has seen a much improved position in terms of compliance, with more spend being related to contracts and more visibility now available; • The CFO is pleased with the progress the Procurement team has made; • Mrs Twigg (The Chair & NED) suggested that it would be beneficial to see an example contract to see the process and the cost benefits; • Mr Myers (ANED) commented that it would be beneficial to undertake a Board Workshop on Atamis to ensure that the tool is being utilised effectively and to obtain assurance that full advantage is being taken. It was agreed that the CFO would discuss with the Procurement team to hold a joint workshop. **ACTION** • Procurement is being tracked through the Foundation Group Strategy meeting and an update on the Shared Service will be presented at a future Audit Committee. **ACTION**	**KO** **March Agenda**
	Resolved – that **A) The Contract Management update be received and noted.** **B) A joint workshop to be held by Procurement on the effectiveness of the Atamis tool.** **C) An update to be presented at the March Audit Committee on the Procurement Shared Service.**	

AC006/09.23	**INTERNAL AUDIT**	
AC06.1/09.23	**FINAL ANNUAL INTERNAL AUDIT PLAN**	
	RSM, UK Internal Auditors (IA) presented the Final Annual Internal Audit Plan and the following points were noted:- • The Audit Plan brings to a formal close the audit work undertaken by IA from 2022/23. The Annual opinion presents a positive position, stating that the organisation has an adequate and effective risk management and governance however there are some further enhancement to be undertaken; • Nine pieces of work were undertaken last year, of which three were positive assurance opinions, three negative, where actions were agreed with advisory actions. All actions are tracked through ongoing action tracking; • Within Management Actions, there are two positive opinions and two negative opinions. The second most positive assurance opinion was achieved; • Mrs Twigg (The Chair & NED) commented that the ANED's will be more involved with IA going forward and the challenge for the Trust are to follow up on actions and achieve completion; • Mr Cottom (NED) commented that an improvement was met within the governance arrangements and commended the IA on the service received by RSM.	
	Resolved – that the Final Annual Internal Audit Plan be received and noted.	
AC06.2./09.23	**IA PROGRESS REPORT**	
	RSM, UK Internal Auditors (IA) presented the IA Progress Report and the following points were noted:- • The IA commented that a good start had been achieved on delivering the Audit Plan for this year; • There are currently two reports in draft, the Business Case Process Review and the Strategic Workforce Planning Review. Once reviewed they will be issued to members once finalised; • IA will commence seven audits in September. It was suggested that an additional Audit Committee may be required to review these reports; • There were 78 management actions on the Trust's action tracker, with the majority on the Financial Sustainability review. The Finance team at the Trust has set themselves additional actions as a developmental piece and these will be followed up this month; • 14 actions have been closed off as fully implemented; • 30 actions not yet completed; • 34 actions still in progress – being implemented category; • 20 requests have been received to extend implementation dates;	

	• Mrs Hill (NED) requested clarification on the missing target date within management responses and asked if work pressures or the lack of responsiveness from management was the reason. IA confirmed that there were no intentional delays on the KPI's and draft turnaround, once draft reports are issued further clarification is often sought. This year IA will attempt to bring the KPI closer to 10 days, it is currently at 17 days.	
	Resolved – that the IA progress report be received and noted.	
AC06.3/09.23	**RECOMMENDATION TRACKER**	
	RSM, UK Internal Auditors (IA) presented the Recommendation Tracker and the following points were noted:- • Mrs Hill (NED) questioned the 'Actions with New Revised Target Dates' as there are several 'not yet due' comments. The IA responded that the process commences six weeks before the Audit Committee and can overrun; • Mrs Twigg (The Chair & NED) requested that the initial date is reviewed where other work is prioritized. If original dates for January and we are still looking at them in September, these are the dates to review. We have got to be pragmatic as well as pushing for completion; • The IA confirmed that there are 78 actions, with a significant number relating to the Financial Sustainability, these are the actions that the Finance team have set themselves. Many will fall off following a review of evidence, there should be a reduction in actions by December.	
	Resolved – that the Recommendation Tracker update be received and noted.	
AC6.3.4/09.23	**CLEANLINESS STANDARDS AUDIT**	
	Laura Weston, Senior Lead, Infection Prevention presented the Cleanliness Audit update and the following points were noted:- • The CFO provided the background to the report commenting that the Cleanliness Standards Audit report was presented at the an earlier meeting in May; • Laura Weston, Senior Lead Infection Prevention (LW) updated the Committee. When the audit was undertaken externally, a large proportion of data flagged up that items had been missed; • A review of the Cleanliness Committee took place and assurance is now provided regarding the narrative of actions and the structure of the meeting has now changed; • It was reported that audits are undertaken at different times of the day and information is logged; • Clinical areas remain a challenge and timeframes have been discussed. The contract with Sodexo is an issue, even though	

	processes are in place. The September deadline with Mercia was confirmed as not being achievable from a contract point of view but within the cleanliness policy their roles are outlined and Mercia have approved the policy; • Following a walk around on the wards, Mrs Twigg (The Chair & NED) recommended that all the new Non-Executive Directors (NED) and Associate Non-Executive Directors (ANED) undertake a Cleanliness visit and LW agreed to facilitate. Agreed that an e mail would be sent by the LW to all new NED's and ANED's to invite to undertaken Cleanliness walk arounds. **ACTION** • Mr Myers (ANED) questioned if we are receiving the service from Sodexo that we are purchasing. It was agreed that the LW would contact the Senior Facilities and Contracts Manager to obtain further narrative on the service to provide Mr Myers (ANED) with further assurance. **ACTION** • LW did confirm that an improvement is being seen with regard to cleaning scores and the Trust was compliant with the majority of nursing aspects with the Cleanliness report. The full governance process is discussed at Quality Committee, who follow through on all of the actions; • With regard to the PFI element, Mr Myers (ANED) questioned how big is the contract, how much money is involved and how much special project management dedication is involved. It was agreed that the Chief of Strategy and Planning would provide information on the elements of the contract that are not being delivered. **ACTION** • The IA commented on the report stating that that the Trust were compliant with the care standards. For the vast majority of areas the Trust was doing well and was clean. It was noted that the contract in place for Sodexo was out of date; • LW commented that when a cleanliness audit is undertaken all elements are reviewed and broken down into contract clean, clinical or estates issues that prevent the cleaning to be undertaken. The results are fed back to the different areas; • Mrs Twigg (The Chair & NED) confirmed that the Sodexo contract is being renegotiated.	**Laura Weston** **Laura Weston** **Alan Dawson**
	<u>Resolved</u> – that **(A) The Cleanliness Audit update be received and noted.** **(B) The new Non-Executive and Associate Non-Executive Director to be invited to undertake cleanliness walk arounds.** **(C) The Senior Facilities and Contracts Manager to be contacted to obtain further narrative on the service provided by Sodexo to provide further assurance.** **(D) The Chief of Strategy and Planning to provide information on the elements of the PFI contract that are not being delivered.**	

AC05.4/09.23	**IN PHASE UPDATE**	
	The Quality & Safety Matron (LC) presented the In Phase update and the following points were noted:- • The Quality & Safety Matron (LC) presented on the progress against the patient safety strategy and the management of the new digital management system; • The new national Learning from Patient Safety Events (LFPSE) has now been implemented and In Phase (Digital Management System), which will be available from the end of September. This will provide the capability to use LFPSE. Many other Trusts still use Datix and have been unable to make the transition at this time. Once all Trusts can demonstrate they transfer to new mechanism all systems will be decommissioned, but there is no sign of a deadline as yet; • In Phase has replaced Datix, which reported on incident, complaints, concerns and risks. With In Phase the same functionality is available, but with the addition of a claims app, action planning app and an oversight app, bringing different sources from a dashboard; • All modules are live, apart from the oversight module. Engaging with supplier and ward management teams to obtain what is required; • No drop in reporting through transition was noted; • The ADoCG commented on the key milestones where they say live, they are in continual development. From the risk perspective the ADoCG is still trying to use the system; • There are data quality challenges, the team are spending time extracting data. In Phase have offered some solutions; • IA commented on data quality and patients being able to report their own incidents and the governance around this. LC responded that this is a future capability and is not available at present. Patients are to raise issues with ward staff; • Mr Myers (ANED) commented that the key is in the training. LC responded that training has been a challenge. Over 50 drop in sessions have taken place, FAQ's in Trust Talk and a dedicated e mail to staff has been sent. In Phase have agreed to visit the Trust to provide an event and share demo's; • LC confirmed that patients would be able to access the system at any time in their journey pre admission, inpatient or post admission.	
	Resolved – that the In Phase update be received and noted.	
AC08.3/09.23	**LOSSES AND SPECIAL PAYMENTS REPORT – QUARTER 4 2022/23 & QUARTER 1 2023/24**	
	The Chief Finance Officer (CFO) presented the Losses and Special Payments report – Quarter 4 2022/23 and Quarter 1 2023/24 updates and the following points were noted:- • Tony McConkey, Clinical Director of Pharmacy (TM) provided an update on the papers and explained the reasoning behind the losses	

	within the medicines. Expired stock is the biggest loss within medicine and often fluctuates. In terms of 21/22 expired stock was £99k, in 22/23 expired stock was £165k, up until Month 5 this figure is currently standing at £100k; • TM provided an explanation on how expired stock is generated. This involves changes in clinical practice, patients who have unusual needs, the buy-in of particular stock and keeping stock for urgent need, which goes out of date; • The aim is to have a limit of 0.5% of turnover. Up until 21/22 Pharmacy were below that percentage. The main drivers for the recent uplift in the last quarter were high levels on stock, which went out of date. A seasonal influenza vaccine has been costed differently this year. A £10k wastage on a cancer care drug was reported following a change from using the usual drug to a generic product. It was noted that there is a £29 million turnover for drugs. Unit costs for some of the drugs can be very costly; • In the last 18 months the Pharmacy staffing has been critical, especially around Aseptics; • It was reported that staffing can take between six months (Pharmacy Assistant) and five years (Pharmacist) to train; • Mrs Hill (NED) commented on the lack of space in Pharmacy and asked if anything can be done from a wider Foundation Group to share medicines across the Foundation group to hold a lower level of stock. TM responded that the complexities of holding a wholesale dealers licence and movement of medicines stock is not allowed as the Trust do not hold a licence; • Mr Myers (ANED) commented on the property losses and the evidence that a proper process is being undertaken. The CFO responded that patients will be written to and advised not to bring jewellery into hospital, but a broader discussion will take place at the December meeting.	
	<u>Resolved</u> – that the Losses and Special Payment report – Quarter 4 2022/23 and Quarter 1 2023/24 updates was received and noted.	
AC6.3.1/09.23	**<u>GIFTS AND HOSPITALITY BENCHMARKING</u>**	
	RSM, UK Internal Auditors (IA) presented the Gifts and Hospitality Benchmarking update and the following points were noted:- • The paper was taken as read. No exceptions were noted.	
	<u>Resolved</u> – that the Gifts and Hospitality Benchmarking update be received and noted.	
AC6.3.2/09.23	**<u>REACTIVE BENCHMARKING</u>**	
	RSM, UK Internal Auditors (IA) presented the Reactive Benchmarking update and the following points were noted:-	

	• The paper was taken as read. No exceptions were noted.	
	Resolved – that the Reactive Benchmarking update be received and noted.	
AC07/09.23	**COUNTER FRAUD**	
AC07.1/09.23	**LCFS PROGRESS REPORT SEPTEMBER 2023**	
	The Local Counter Fraud Specialists (LCFS) presented the LCFS Progress Report September 2023 and the following points were noted:- • The paper was taken as read; • Completion of the Gifts and Hospitality Benchmarking Report. Staff responses were in line with the rest of the client base; • Targeted training is planned during Fraud Awareness week in November; • Mrs Hill (ANED) commented on the outcomes based metrics on the two Awareness sessions. Only four people attended over two sessions. The efficiency of these sessions was questioned. The LCFS confirmed that they would send information on Awareness session out to all client base; • The ADoCG commented on the benchmarking data and if this is national or WVT for gifts and hospitality. LCFS confirmed that this is across the client base. With regard to Declarations of Interest, communications have been sent. The ADoCG asked what the legal basis is for taking legal action and legal precedent. The Trust need to be sure of our position and ensure that it is mitigated. LCFS commented that all staff are to declare any outstanding declarations or appointments; • IA commented that with a declaration, the register should be reviewed to ensure that at key intervals individuals can be challenged due to procurement activity. It is about managing the conflict in these situations. It was agreed as an action that the Sanctions and Redress Policy be shared by LCFS and a paper produced to clarify on declarations of interest. **ACTION** • Mr Myers (ANED) commented on the language with regard to Declaration of Interest and Conflict of Interest. It was agreed as an action that a paper within the Charities Commission Guidance is distributed to the Audit Committee. **ACTION** • Mrs Hill (NED) commented on the referrals, that four of the five referrals are workforce related and asked if these are being discussed within Workforce Committees to address the issues e.g. working whilst sick, timesheets, etc, It was agreed that the CFO will discuss with the Chief People Officer and provide update at the December meeting. **ACTION**	**LCFS** **FM** **KO**
	Resolved – that **(A) The LCFS Progress Report September 2023 was received and noted.**	

	(B) The Sanctions and Redress Policy be shared by LCFS and a paper to be produced by the LCFS to clarify on declarations of interest. **(C) Mr Myers to send through the paper outlining Declaration of Interest and Conflict of Interest within the Charities Commission Guidance.** **(D) The Chief People Officer to confirm that workforce related issues e.g. referrals are being discussed within the Workforce Committee.**	
AC09/09.23	**EXTERNAL AUDIT**	
AC09.1/09.23	**2022/23 ACCOUNTS CLOSE**	
	The External Auditors (EA) presented the on the 2022/23 Accounts update and the following points were noted:- • One final query is being worked through relating to IFRS16; • The final version of the Annual Report and Accounts, which is being resolved by the ADoCG; • It was noted that EA are very close to signature on the 2022/23 Accounts, which are currently being reviewed by the ADoCG and should be finalised on the 28 September 2023; • Breakpoint in the contract about work going forward. Additional costs have been forwarded to the CFO for discussion at the private section of the meeting.	
	Resolved – that the 2022/23 Accounts Close update was received and noted.	
AC09.2/09.23	**2023/24 AUDIT PLAN**	
	• Work has not commence on the 2023/24 Audit Plan.	
	Resolved – that the 2023/24 Audit Plan update was received and noted.	
AC08/09.23	**FINANCIAL FOCUS**	
AC08.1/09.23	**ICS FINANCIAL REPORTING/GOVERNANCE UPDATE**	
	The Chief Finance Officer (CFO) presented the ICS Financial reporting/governance update and the following points were noted:- • The Enhanced Financed Controls, Investment Expenditure Forum and the ICS Finance Forum reporting were presented, which link to the Financial Sustainability audit and outstanding recommendations and controls; • The Trust is subject to a number of financial controls by NHSE; • Control measures have been in place since July, which are being adhered to; • From an ICS perspective, the Investment and Expenditure Forum has been implemented and bring system partners together to manage	

	mandated financial controls. The forum is running as a check and challenge to avoid delays for recruitment; • It was agreed as an action that the Operational Planning Monitoring dashboard will be distributed to the Committee. **ACTION** • The future direction of the Finance Forum, links back to Terms of Reference. This meeting is Non-Executive Director led and the purpose of the meeting is to oversee financial performance across the system; • There will be a need from this Trust to consider our own governance and how this feeds into the ICS governance; • Mrs Twigg (The Chair & NED) commented that three people from the ICS have been invited to Audit Committee; • Mrs Hill (NED) commented that at the Finance Forum there will be a heightened focus from the ICS on workforce and agency costs. It was noted that Mrs Hill (NED) now represents WVT on the ICS Finance Forum, which will feed into this Committee.	**KO**
	Resolved – that **(A) The ICS Financial reporting/governance update was received and noted.** **(B) The Operational Planning Monitoring dashboard will be distributed to the Committee.**	
AC08.2/09.23	**INVESTMENT AND EXPENDITURE FORUM**	
	• This section of the agenda was covered in the agenda item AC08.1/09.23.	
	Resolved – that the Investment and expenditure forum update was received and noted.	
AC08.4/09.23	**SINGLE TENDER WAIVERS**	
	It was agreed that the Single Tender Waivers will be presented at the December Audit Committee. **ACTION**	**KO**
	Resolved – that **(A) Single Tender Waivers to be presented at the December meeting.**	
AC10/09.23	**AOB**	
	• Mrs Twigg (The Chair & NED) thanked Andrew Cottam, (NED) for his help and support over the past nine years as Chair of Audit Committee. • Mrs Twigg (The Chair & NED) wished for this point to be minuted following the issue raised at the PFI Expiry Committee that took place	

	this week. The meeting highlighted the payments made to Sodexo for work they had not completed, which will be followed up with the Chief of Strategy & Planning; • Mr Myers (ANED) commented on the PFI contract and the concern over the maintenance of Trust buildings that were sold in 2005. Mrs Twigg (The Chair & NED) will discuss with Executive Directors and Non-Executive Directors to follow up on this conversation regarding monitoring and reacting to concerns**. ACTION** • IA also encouraged the Non-Executive Directors to use IA if any concerns that have been raised to contact IA from a governance perspective to pursue; • Mrs Twigg (ANED & Chair) commented that the long and short list via IA felt more collaborative this year.	**NT**
	A) The Executive Directors and Non-Executive Directors to discuss monitoring and reacting to concerns e.g. PFI Contract.	
AC12/09.23	**<u>DATE OF THE NEXT MEETING</u>** **14th December 2023 – 9:30 a.m. – 12:00 p.m. via TEAMS**	

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
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 February 2024.

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]

ENHANCED CARE IN CARE HOMES

Taurus Healthcare provided an update on enhanced care in care homes, highlighting the following:

- GP practices have done a lot of work to standardise personalised care and support plans for a single service across Herefordshire
- Work was underway by CIRH and PCN teams to support care homes. Feedback from care providers is that the offer from CIRH is still not clear, resulting in low use of the service
- The dementia pilot continues and a further update will be brought to the next meeting.
- A mortality audit had been undertaken with WVT.
- Care homes were to be invited to undertake further audits to ascertain the reason for conveyances and to establish where there were opportunities for conveyances to be avoided by providing the right support and training.
- Two new care homes had been announced for Herefordshire: one in Leominster, which is supported by a big GP practice with a stable workforce; the other in Colwall which would put pressure on a small GP practice.
- Dashboard data and care record sharing was yet to be resolved although work continued to provide a solution but that this was still some way off.
- There had been good feedback on the ICS faculties to support workforce development in social care and midwifery although some care homes perceived that the faculties were too NHS-focussed and did not provide a wider understanding of social care. They needed to focus on recruitment in to care homes and to improve training opportunities.

ICE considered that the recruitment and retention in to adult social care was a significant concern and that this was to be considered by the ICS workforce group. Of increasing concern for the adult social care workforce were changes to overseas recruitment, which is heavily relied upon. Across the West Midlands, there were examples where provider licences had been suspended for international recruitment as they have not understood the obligations fully or had not complied.

[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 meeting considered Section 106 and if there was consideration for planning permission for new care home facilities to safeguard and ensure there were resources available. It was noted that care homes had not historically fallen under the S106 umbrella given the capital funding. Consequently, it was not possible to get funds for staffing but there was a need to make the local authority planning departments aware of the pressures that care homes put on GP practices. It was noted that there was more innovative ideas about how we respond to care home applications being considered in consultation with Worcestershire PCNs.

LOCAL ENHANCED SERVICES (LES)

The Head of Primary Care, NHS Herefordshire and Worcestershire, gave a presentation on the 2024/25 commissioning intentions for local enhanced services (LES) for Herefordshire.

- There was recognition that there will be a challenging financial position next year in these services
- Funding has been secured for 3 years which aligns with self-contract. The Strategic Commissioning Committee had agreed some principles on how PLACE can design and shape these services going forward to ensure integration
- Is proposed that a deep dive take place in Q1 to look at how services were performing and, importantly, how they were benefitting patients.
- Women's health is undertaken under a LES contract in Worcestershire, but not in Herefordshire. Further work was essential to understand where the work will go to in Herefordshire and to look at anything that can be done to work in collaboration to bring some of those services out in the community in the same way as Worcestershire.

BETTER CARE FUND (BCF)

The BCF is a collection of grants from Government that have been pooled together. Each grant has its own conditions (which were presented to ICE by theme).

ICE were updated on the following report from month 9 year to date forecast:

- There continues to be improvement but there remained some overspend of the BCF in hospital discharge due to purchases in the care market to meet demand. This overspend was being offset by underspend in other areas hence the overall position across the BCF was at break even
- This month's ICE report showed a comparison of spot purchase costs and activity for discharge facilitation.
- For care homes, cost and activity tend to correlate; home care is subject to more variation as invoices for beds tend to be paid on a monthly basis but care hours are invoiced on number of hours delivered and may be a lag in invoicing.
- The use of beds has gone up during the winter period as expected.
- There was a need to continue to re-design discharge services so that contracted services consume the majority of activity and spend less on spot purchase as this is much more expensive.

It was noted that the discharge to assess provision in Herefordshire is below where it needs to be using 30-40 additional beds compared to 2019 and driving a lot of the current congestion in ED and a bottom up D2A exercise will be undertaken. A data report will be brought to ICE with a finance section, improvement plan, performance metrics and exception report.

In response to a question as to our confidence that contracts for care home beds will result in sufficient spend reduction to meet the plan, ICE were advised that contracting is blocked and will reduce spend to break-even. That said, although there were a range of actions around discharge services, there was low confidence that this will reduce spend further in year.

Planning guidance was pending consideration; guidance had been due to be published in January 2024 but was still awaiting approval. A plan would be produced seeing the first draft based on rolling everything forward with known inflationary changes.

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

Minutes of the Charity Trustee
Held on 12th October 2023
Via MS Teams

Present:

Frank Myers MBE	FM	Chair and Associate Non-Executive Director (ANED)
Glen Burley	GB	Chief Executive
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Geoffrey Etule	GE	Chief People Officer
Alan Dawson	AD	Chief Strategy and Planning Officer
Lucy Flanagan	LF	Chief Nursing Officer
Russell Hardy	RH	Trust Chairman
Erica Hermon	EH	Associate Director of Corporate Governance and Company Secretary
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director
Kieran Lapin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FMa	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Grace Quantock	GQ	Non-Executive Director (NED)

In attendance:

Katie Farmer	KF	Charity Fundraiser
Heather Moreton	HM	Head of Commissioning, Contracts and Income
Vicky Roberts	VR	Executive Assistant – For the minutes from recording

Minute		Action
CT01/10.23	**Apologies for Absence**	
	Apologies were received from: David Mowbray, Chief Medical Officer, Nicola Twigg, Non-Executive Director, Ian James, Non-Executive Director	
CT002/10.23	**Quorum**	
	The meeting was quorate.	
CT003/10.23	**Declarations of Interest**	
	There were no new declarations of interest.	
CT004/10.23	**Minutes of the meeting held on 29th June 2023**	
	The following amendments will be made to the minutes of the meeting held 29th June: Noted apologies Frances Martin Page 3/6.2 agreement to proposal to create a dedicated health and wellbeing fund for staff be noted as resolved.	

	Page 3/6.3 Funds 'were' moved to amend to funds 'were going to be moved'	
	Resolved – that the minutes of the meeting held on 29th June be amended and brought for final approval on 14th December	
CT005/10.23	**Matters Arising and Action Log**	
	All actions were reviewed and updated.	
	Resolved – that: The Action Log updates be received and noted	
CT006/10.23	**ITEMS FOR REVIEW AND ASSURANCE**	
	6.1 Charity Fundraising Update Katie Farmer, Charity Fundraiser gave an update on fundraising activities. The report was taken as read and the following points highlighted: To note that this week is baby loss awareness week. Work on the memorial garden is underway but has seen some delays. It is looking extremely promising financially, with some donations already received and more promised. The garden is now planned to be open for Spring 2024. Legacies and donations. The charity has received 2 notable donations, one of £10,000 and one of £20,000. Neither of these donations were sent directly to the Fundraiser, but were received via individual departments, with the respective departments subsequently sending their individual thanks. In light of the decision at the last meeting of the Charity Trustees, that the Chief Strategy and Planning Officer, Managing Director and Trust Chairman are to be notified of any donations received over £5,000 and realising there are a proportion of donations that are received directly by departments, all staff have now been informed of this process and should, in future, be forwarding details to the Charity Fundraiser to action. A donation towards the bereavement suite has been promised by the local Masonic Lodge. Alison Bolton, Fundraising Campaign Director and Katie Farmer will collect the donation together. This will also provide a good opportunity to talk about the education centre. The Chief Strategy and Planning Officer (AD) gave an update on the Education centre: Alison Bolton is now in post as Campaign Director and is compiling a high level strategy for approach around the Education Centre. There has been a delay with the business case and, as many charitable grants rely on production of a business case, has delayed the process.	

	We continue to submit bids, although this has now exhausted locally, we are using Grant Finder to identifying funds which can be applied for from across the country. Also ran a workshop for trust staff, who put forward a number of good ideas. A plan will be brought to next fundraising group meeting. The following comments were made: Mr Myers (ANED and Chair) referenced the donation from the local masonic lodge and asked if there is a process in place to inform of such donations as he does not feel comfortable with donations happening that the trustees are not aware of. The Charity Fundraiser (KF) noted that many donations, go through general office and on to individual departments before being sent to finance. Throughout the Covid pandemic, many departments sent their own thank you letters and this has continued. This was really helpful but does give rise to occasions when Trustees are not aware of a donation. Ms Quantock (NED) referred to the piece in the report relating to National Baby Loss Week and the memorial garden and the fact that we are hoping to receive further donations asked if this is something we are hoping to increase with awareness or, are we doing certain things to actually take advantage of that week as an awareness week, for example, social media or press articles. The Fundraiser (KF) confirmed that a communications plan is already in place and that there is also a sign on the garden gate with QR code link for donation. It was also noted that a raffle and cake sale had taken place recently which had internally raised £2,000. It is felt that this year, with help of SANDS, a really good job had been done to raise awareness. The Trust Chairman (RH) noted that the staff Facebook page at WAHT was very good, and has a high level of staff engagement. Mary Power at SWFT met with Richard Haynes to see how SWFT can work from the Worcester approach with their own Facebook page and suggested that the Chief People Officer (GE) may want to reach out to Richard and Mary as this is a very powerful way to get staff engaged with things such as fund raising. Mr Myers (ANED and Chair) asked for clarity regarding the comment on the bereavement suite and 'the hope that the need for public fundraising will not be as great'. The charity Fundraiser (KF) confirmed that as the fund was not starting from zero, as previously, that it was attracting money without too much effort as people are already aware of it. Mr Myers (ANED and Chair) requested more information on fundraising for the Education Centre and it was agreed that Alison Bolton would be invited to the next meeting to give an outline of the programme. It was noted that most NEDs were not as sighted as they may be on media and do not have access to WVT intranet on a regular basis. It was therefore suggested that perhaps a bulletin could be sent out with updates.	**AD** **AD** **KF**

6.3 Re-Investment of Charitable Funds

The Associate Chief Finance Officer (HM) re-visited the options to re-invest charitable funds and invited comments on future plans:

It was previously proposed to move funds to a CCLA bank account. Due to the high turnover in junior members of finance staff and HM being new to the post, wanted to take the opportunity to review the options available.

It was noted that there have also been some changes in interest rates and an updated options paper will be brought to the next meeting in December. In the meantime would like gather views on the degree of acceptable risk and to understand the options. Previously the view was not to invest in high risk funds, leaving low risk options as in a traditional bank/building society savings account or low risk investment funds.

Kieran Lapin, (ANED), pointed out that the CCLA is not covered by the £85,000 government guarantee and should this be taken into account when considering this as an investment opportunity. He was also conscious that we are investing significant sums and none of the lower risk accounts would be covered by the government guarantee. HM confirmed that the revised options appraisal would state whether an account is part of the government guarantee but, as mentioned, would not apply as the monies invested will be significantly more than £85,000.

The Chief Executive (GB) noted that this work is being explored elsewhere in the group so some comparing of notes would be beneficial. He also noted that the other consideration, as well as interest rates is ease of access and the need to make sure that funds are not tied up as it is the Trustees' duty is to spend.

Sharon Hill, (NED), noted her agreement with the need to review options as an interest rate of 1.1% earning on current interest compared to 4% in market is poor. Question whether we have any restriction on term and whether we tie funds up. There needs to be a suite of options that cover risk options of funds and availability.

The Chief Finance Officer (KO) noted that original conversations took 2 things into account – the total balance of funds and our intended spend profile. With a large proportion of that spend around education centre with a fixed timeline. There may now be more certainty around ability to tie some funds up for a longer period given a timeline for the education centre project. To be spending for benefit of patients and staff, colleagues previously focussed broadly on low risk instant access, not wanting to tie funds up. This will be kept in mind, also where treasury management policy comes in in terms of regular review and reset.

There was some concern regarding a further delay in waiting until the next Committee meeting to make a decision. It was therefore agreed for The Chief

	Finance Officer (KO) to make a recommendation for the shorter term. e.g. move funds to the CCLA account with immediate effect and subsequently review other options w	**KO**
	Mr Myers (ANED and Chair) also offered the assistance of finance at HCF who have a considerable amount of flow through money and are dealing with this on a daily basis.	
	6.4 Quarter 1 Finance Report	
	The Associate Chief Finance Officer (HM) presented the Quarter 1 Finance Report. The report was taken as read and the following points were noted:	
	More funding has been received and more has been spent in quarter 1 of this year than in Quarter 1 of the previous year.	
	Quarter 1 income has seen some high value legacy receipts. The main items of expenditure were the purchase of 2 cough assist machines and bereaved parents' counselling.	
	End of Quarter 1 saw a net increase in funds of £234,000, which brings a balance of £2.7M. There were no significant receipts or outgoings in Quarter 2.	
	The Trust Chairman (RH) commented that it was good to have money in the bank if we need to spend it and if we are not able to spend it then need to attract maximum interest.	
	Mr Myers (ANED and Chair) noted that at a recent ward round at the hospital he had noted that there appears to be low awareness that charitable funds are available to be applied for among staff members. It that it would seem that we are still not getting the reach of communication out to trust staff.	
	The Trust Chairman (RH) noted that this was a common problem across the foundation group that, despite best efforts to tell people there is still a surprising level reticence, ignorance, and forgetfulness about reaching out to the charity or knowing how to reach out. Raising colleague awareness is something that needs to be done more generally.	
	It was agreed to review communication to trust staff and try to encourage more awareness and hence more use of funds.	**KF**
	Draft Accounts Financial Year Ending 31st March 2023	
	The Associate Chief Finance Officer (HM) also presented the draft accounts for the financial year ending 31st March 2023. The report was taken as read and the following points were noted:	

	There had been no change in numbers since Quarter 4, which reported in June 2023. A recap of 2023 shows a net increase in funds of £1.27M Following up with Deloitte for the results of the audit of 2021-22 and await a date for 2022-23 audit. It is hoped to get these completed and signed off within the next few months. The questionnaire on accounting policies was attached for information.	
	Resolved – that: **(A) The fundraising and finance updates were received and noted.** **(B) It was noted that some NEDs were not as sighted as they may be on media and do not have access to the intranet on a regular basis. It was therefore suggested that a bulletin could be sent out with updates** **(C) Alison Bolton, Campaign Director, would be invited to the next meeting to give an outline of the education centre programme and fundraising plan** **(D) A plan for investment of charitable funds will be brought to next fundraising group meeting** **(E) Due to concern regarding a further delay to making a decision on investment of funds until the next committee meeting, it was agreed for The Chief Finance Officer would make a recommendation for the shorter term prior to the next committee** **(F) A review of communication to trust staff to encourage more awareness of charitable funds among trust staff and how to apply for them is to take place**	**KF** **AD** **KO/HM** **KO** **KF**
CT08/06.23	**Any Other Business**	
	The Charity Fundraiser (KF) recently went to Bromyard Community Hospital to meet with the League of Friends. The league has only 2 remaining members and are wrapping up at end of 2023. Any funds remaining with the League of Friends will come in to charitable funds. However, there are some regular donations which the League want to ring fence. A meeting will therefore take place between Heather Moreton, Cathy Attwell, and the Communications Team to make sure that all are in agreement. KF also noted that Bromyard are having a sensory garden built which is due to open in Spring 2024 and would very much like it if Charity Trustees could send a representative to officially open the garden.	**KF/HM**

	Mr Myers (ANED and Chair) agreed that he would be very happy to open the garden. The Trust Chairman (RH) is also happy to attend if dates could be provided and the diary allows. Frances Martin (NED) is also very happy to volunteer as Non-Executive Director linked to Bromyard. The Managing Director (JI) noted that better links should be developed with League of Friends to help raise their profile. It was added that there should be a note of caution regarding connection with Ross League of Friends. It is perceived as a very sensitive area. The Trust Chairman (RH) noted that this would be Mr Myers' last meeting as Chair and thanked him for the way he had chaired meetings over the last years with a level passion and commitment to try and make a difference. Always 'keeping us on our toes' with what are we doing with the money raised, and always thinking of different ways of raising money. He felt incredibly lucky to have had Mr Myers as Chair of our trustees and passed on thanks on behalf of all of the Trustees. Mr Myers noted that he would be in attendance at the meeting in December, which would be his last one, but had really enjoyed his time as Chair of the Committee and will do all he can to assist in the future.	**KF**
	Resolved that: **(A) A meeting to take place between Heather Moreton, Cathy Attwell, Katie Farmer and the Communications Team to ensure that all were in agreement to the plan for funds following the disbanding of the Bromyard Community Hospital League of Friends.** **(B) Mr Myers, The Trust Chairman (RH) and Mrs Martin (NED) have agreed to attend the opening of the sensory garden at Bromyard Community Hospital, diary permitting. The Charity Fundraiser (KF) to inform when a date for the opening is identified.**	**KF/HM** **KF**
CT09/10.23	**<u>Date of next meeting</u>**	
	The next meeting is due to be held on 14th December 2023 1400, via MS Teams	

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 26 October 2023 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Chizo Agwu	CA	Chief Medical Officer – (Incoming) Observing
Ellie Bulmer	EB	Associate Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	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
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Jonathan Boulter	JB	Associate Chief Operating Officer – Surgical Division
Robbie Dedi	RD	Deputy Chief Medical Officer
Hazel French	HF	Named Nurse Safeguarding Children – For Item 4
Kirstie Gardner	KG	Named Nurse Children in Care – For Item 4
Rachael Hebbert	RH	Associate Chief Nursing Officer
Sarah Holliehead	SH	Associate Chief Nurse, Medical Division
Leah Hughes	LH	Operational Clinical Lead Radiographer – Left after Item 4.1
Val Jones	VJ	Executive Assistant (for the minutes)
Alex Maclaine	AM	General Manager, Diagnostic Services
Tony McConkey	TM	Clinical Director, Pharmacy & Medicines Optimisation
Sue Moody	SM	General Manager - Acute and Countywide Services
Sarah Sharp	SS	Matron, Head, Neck and Orthopaedics – Left after Item 11
Rachael Skinner	RS	Integrated Care Boards Representative – Left after Item 4.1
Amie Symes	AS	Associate Director of Midwifery – Left after Item 11
Emma Wales	EW	Associate Chief Medical Officer, Medical Division

QC001/10.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Amanda James, Matron, Surgical Specialties and Emma Smith, Divisional Nurse Director, Surgery.	
QC002/10.23	**QUORUM**	
	The meeting was quorate.	
QC003/10.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/10.23	**MINUTES OF THE MEETING HELD ON 28 SEPTEMBER 2023**	
	Resolved – that the minutes of the meeting held on 28 September 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/10.23	**ACTION LOG**	
	(a) QC015/09.22 – (B) – An update will be provided to the next Mortality Report on the background to the Trust being an outlier on a number of measures and our high admission rates. Report delayed until November. (b) QC007/09.23 – (B) – The Cancer Professional Lead will confirm whether the Consultant needs to lead on care planning or whether this could be another member of staff – The Clinical Cancer Lead will oversee the care planning work based on CPES results. The Cancer Professional Lead will project manage the specialities highlighted within the survey report.	**CB**
	Resolved – that: **(A) The Action Log be received and noted.** **(B) An update will be provided in the November Mortality Report on the background to the Trust being an outlier on a number of measures and our high admission rates.**	**CB**
	BUSINESS SECTION	
QC006/10.23	**QUARTER 2 2023/24 SAFEGUARDING REPORTS**	
	The Associate Chief Nursing Officer (ACNO), Named Nurse Safeguarding Children and the Named Nurse Children in Care presented the Quarter 2 2023/24 Safeguarding Reports and the following key points were noted: Adults • There have been a number of alterations in the team due to workforce changes. The MCA DOLS Lead is now in post (also a registered Social Worker and Mental Health Practitioner) along with the Domestic Abuse Lead. The new hospital Independent Domestic Violence Advisor is now on site and supporting patients and staff. • We have not managed to appoint to the Band 5 for maternity leave cover. The ICB are supporting us with a Deputy Designated Safeguarding Nurse and additional admin support. • The Deputy Designated Nurse has recognised that the Trust do not have a specific Adult Safeguarding Nurse and an Abuse Policy in place. NHSE recommend one should be in place. • The standard of referrals coming to the team are very variable. Some of the QIP work recognised the need to work on these and the education around this. The ongoing concerns around the practical application of MCA and DOLS in practice have been highlighted.	

	• There are an increasing number of referrals to Adult Safeguarding regarding care delivered at the Trust. When reviewed, not all meet safeguarding criteria and are closed down but the Local Authority, we are monitoring these and analysing them in more detail. • The Chief Nursing Officer (CNO) noted that is acceptable practice to adopt and follow the multiagency safeguarding procedures and checked if it was absolutely necessary to have a local policy in addition to these. The Integrated Care Boards Representative was not aware of any changes, noting that it seemed unusual to make a change to local procedures when no other changes have been made. The ACNO will check the background to this. • The CNO noted that we had agreed to engage with Care Homes around using the safeguarding process inappropriately in some instances and queried if there was an update on this. The ACNO advised that the Lead Nurse Adult Safeguarding did have an initial meeting, with a meeting with the Adult Safeguarding Lead from the Local Authority and the Adult Safeguarding Practitioner around several areas around more integrated working, taking place. An update on this will be provided in the next quarterly report. • The Chief Medical Officer (CMO) was concerned around poor quality referrals, noting that any referral received should be welcomed as this is a safeguarding issue regardless of the format this is presented in. Secondly, he was concerned around the availability of IMCA's regarding mental capacity. It appears to be inconsistent in their supply and the decision around whether one is needed or not appears to be inconsistent as well. He questioned whether the team are happy with our availability and application and use of IMCA's. The ACNO advised that any referral received is reviewed, this is around unpicking the referral as to whether it is appropriate for the Trust. Some of these are sent directly to the Local Authority and then require our Adult Safeguarding team to go back to the ward for more detail. We are acting as an intermediary on occasions. This is causing difficulties due to the lack of capacity within the team currently. We are looking at what is lacking in the referrals and whether we need to educate those sending the referrals. Regarding the IMCA's, these are outsourced. We have to refer to Onside to get an IMCA. We have asked for an IMCA in the past, but when the patient's next of kin is available, on occasion, they have refused due to this. The ACNO will review the detail around the sourcing of IMCA's. • Ms Quantock (NED) queried if the Trust are co-developing with adults with learning difficulties Policies concerning their care, or whether this is something that could be considered in the future. The ACNO advised that with our own Policies we do consider this and involve them where possible.	**RH** **RH** **RH**

	• The Associate Chief Medical Officer, Medical Division advised that a couple of referrals were around discharge issues but on review, this was not the case. Better clarification/communication was all that was required. The safeguarding route for these referrals was not appropriate. <u>Children's Safeguarding</u> • In general, training levels are compliant. An area of concern remains with the Emergency Department (ED). Senior staff in the department are all trained at high levels. The difficult is with registered nurses who are only 37% compliant. ED have identified a new ED Champion with regular briefing sessions held. • Supervision levels are good. Health Visiting has increased to 81% from 68% and School Nursing to 87% from 67%. Midwifery supervision rates for Community Midwives are at 100%. • A multi-agency Policy for children needing a medical and how we access the health of children on Protection Plans has been developed. This was approved yesterday. • We are not receiving timely notifications in relation to children coming onto Child Protection Plans and coming off them, from the Local Authority due to IT issues. Work is being carried out with their IT team looking at putting in solutions. This should be resolved by November. • We are still awaiting approval from the ICB for the MASH Practitioner post regarding funding. This has been through Wye Valley Trust due process and signed off. There were 256 checks in 2021. By June 2023, there have been 450 so far which is a significant increase. • Child Protection numbers remain high and have increased again this quarter. They had been on a downward projection. We are being supported by Leeds Teaching Hospitals NHS Trust, who are an outstanding Trust in this area, with dedicated workshops for our improvement journey. • There are 2 Child Safeguarding Practice Reviews, still in draft. There will be some learning for the Trust and multi-agency learning from these. We will be able to report more specifics in the next report. Some of the early findings have been acted upon already. • Mr James (Chair of the Quality Committee and NED) advised that the new format of the reports worked well. There is a lot of detail with these reports, and this helps to focus our attention on particular areas.	

	• The CNO advised that the strategic view is that we might do something different regarding MASH in the future but this is some time off and therefore she will pursue with the Herefordshire and Worcestershire ICB CNO the quickest route to getting the MASH post approved. • The CNO advised that some new members of the Board require Safeguarding training and asked that the Named Nurse Safeguarding Children put on a bespoke session for this training to enable 100% compliance for the Board members. • The Managing Director questioned regarding training for ED staff, whether the concern was around them not being trained or practical issues as they are not trained. The Named Nurse Safeguarding Children advised that the worry is around their release for training. There have been no significant issues identified. • The Managing Director noted that it has been mentioned that we are in a better place now with the new Health Visitor contract as there is a different skill mix. There are concerns from a safeguarding perspective of the new commissioning arrangements for Health Visitors. The Managing Director confirmed that the tender process had been completed. The Named Nurse Safeguarding Children advised that further discussions were needed with the Matron for Women and Children around this. We looked at new ways of managing safeguarding when this was being produced. More work is needed around this for Health Visitors roles to ensure how they identify children most at risk and how we inform our partners of these changes. The CNO advised that the outcome of the tender had not yet been communicated to our teams and that we should be sensitive to this. • The CMO raised concern around children being seen quickly enough for their Early Health Assessments. The Named Nurse Safeguarding Children advised that improving this will form part of our improvement work and support from Leeds Teaching Hospitals NHS around changing the way that we work with families and children across the partnership. • Mr James (Chair and NED) noted that the Child Protection alert system is not working properly. Is there a workaround for this? The Named Nurse Safeguarding Children advised that there are 2 systems related to this. CPIS is automatically updated through the spine. As long as the Social Care system is updated, the spine will be updated. The issue is national notifications from the Local Authority system processes. This is partly human error and partly system processes which we are working on. The process is working better than previously and is being monitored on a daily basis. Mitigations are in place and if a child comes through ED or the Paediatric Unit, they directly use the national system as this is more likely to be up to date.	**HF**

	Children Looked After • We continue to be able to offer all of our Statutory Review Assessments on time. The process for out of area children is working well and we are seeing a higher number of children within the timeframe. • We are gradually developing a group of Looked After Children sessions with them around service development. A number of good ideas are coming from these discussions. These will be built into our service delivery. • Staff are attending all Safeguarding meetings despite our staffing numbers. • Mosaic – There are some problems regarding medical consent forms not being uploaded onto this system. There are ongoing discussions, but a plan has been agreed. This is uploaded onto the Social Workers' system with hard copies available. There are a high number of agency Social Workers which is not ideal. • A new team is being formed around unaccompanied asylum seekers to ensure that their assessments are being undertaken. • Medical consents are still an issue but this is being worked on. • There are consistently over 400 children in care – this number is not reducing. A delay in consent is causing a backlog of Initial Health Assessments which puts pressure on the teams. There have also been 20 out of area Initial Health Assessment requests as well which is unusual. This is an unpredictable service to plan for. • The planned retirement of our Administrator will put pressure on the service until they are replaced. Mitigations are in place but this may mean a delay in requesting Initial Health Assessments. We are unable to use Bank Staff due to the confidentiality issues and systems used. • The Managing Director noted that we missed the 20 working days target for Initial Health Assessments and questioned by what margin we are missing these. The Named Nurse Children in Care advised that this was variable. Some months we do well achieving the target and others not so well due to leave etc. A chart of the days by which we are missing the target for the Initial Health Assessments for Children in Care will be included in the next report. • The Managing Director was concerned around the lack of Administrative support and did not feel that with discussion with the Local Authority to provide access, using a member of Bank staff with the required skills would be an issue. If temporary staff are needed, this should be used and escalated if there are barriers to this. The ACNO advised that the plan was to have an overlap of	**KG**

	the permanent member of staff leaving and the new person starting. • The CNO provided a brief update on the Children and Young Persons services. The report just discussed only covers the activities of the teams that sit within the CNO's management remit. For those services sitting in other parts of the Trust an internal review has been commissioned and is being led by Jo Clutterbuck; this will look at how teams are engaged with one another, governance arrangements and oversight of waiting lists. The plan was to share the findings and some options and recommendations to the CNO and the Chief Transformation and Delivery Officer, One Herefordshire in the next few weeks. The Trust also commissioned an external review by the Region against the "Covering all Bases" national publication which will include a review of all the services that we offer to young people. Originally Region advised that they would complete this review by October and December at the latest. Unfortunately, they mistakenly thought that the review being undertaken by the Trust was duplication and therefore paused their review. We have advised Region of the difference and asked for their review to be completed by December. The review will include a workforce review and given Community Paediatrician national shortages they have been asked to look at alternative workforce models in the Child Development Centre. This was discussed at the Finance & Performance Committee and other forums. We know that we have significant waiting times for Community Paediatrics for new and follow up appointments. At the Trust Management Board meeting last week, it was agreed for a Locum post to support the service along with some insourcing. There may be a problem with the Locum availability which is being reviewed. The first revised meeting of the Community Children's Finance & Performance Executive improvement meeting was held after pausing over the summer. The Chief Transformation and Delivery Officer, One Herefordshire is the Chair. There is scaled down attendance at the meeting to key individuals to develop and oversee a performance dashboard and overarching Improvement Plan. This will be reported back through the Safeguarding Reports to the Quality Committee.	
	<u>Resolved</u> – that: **(A) The Quarter 2 2023/24 Safeguarding Reports be received and noted.** **(B) The Associate Chief Nursing Officer will check the background to the change to the Trust following multi-agency procedures rather than having our own Policy.** **(C) An update on the meeting with the Adult Safeguarding Lead, Local Authority and the Adult Safeguarding Practitioner around more integrated working regarding appropriate safeguarding referrals will be included in the next Safeguarding Report.**	**RH** **RH** **RH**

	(D) The Associate Chief Nursing Officer will review the detail around the outsourcing of IMCA's.	**HF**
	(E) The Named Nurse Safeguarding Children will arrange a bespoke session for safeguarding training to enable 100% compliance for the Board members.	**KG**
	(F) A chart of the days by which we are missing the target for the Initial Health Assessments for Children in Care will be included in the next Safeguarding Report.	
QC007/10.23	**QUALITY PRIORITY – ENSURING PATIENTS RECEIVE TIMELY CRITICAL MEDICATIONS**	
	The Clinical Director, Pharmacy & Medicines Optimisation (CD) presented the Quality Priority – Ensuring Patients Receive Timely Critical Medications and the following key points were noted: • **Aims** – To reduce missed and delayed doses of critical medications. To work with Foundation Group colleagues to improve the care of Parkinson's patients by ensuring their medications are received on time every time. • **Progress Since May** – Data is available for May, August and September – data for June and July is unavailable from EPMA. This information relates to Parkinson's treatment only. Highlights comparing May to September 2023 - Missed doses of Parkinson's treatment medicines improved from 1.35% to 0.84%. Doses delayed beyond 30 minutes improved from 20.9% to 19.5%, although still of concern as high. Omitted doses for specific reason (eg nil by mouth, patient refused) improved from 3.8% to 1.86% in September. There is still insufficient data to indicate a trend. • **Activities Undertaken so far** – Presentation on initiative at AHP celebration event. Trust Talk and communications via Medicines Champions at ward level. Screen Savers. Direct ward visits by Medicines Safety Officer to raise awareness. Shared awareness with Parkinson's Specialist Nurse to promote. Raised awareness at FY1 training sessions. Manned display boards in Spires to raises awareness. • **Next Steps** – Expand data set to wider critical medicines list. Continue with monthly data monitoring. Feedback findings to wards/departments and agree improvement actions. Review Self Administration of Medicines Procedure to ensure opportunities are maximised to deliver timely medicines administration and promote patients independence. Continue reporting of progress via Medicines Safety Committee, Patient Safety Committee and Quality Committee. Link to Foundation Group partners.	

	• Mr James (Chair and NED) questioned how this works on a practical level, ie how does the nurse in charge know when a patient on the ward needs their medication. The CD advised that this is flagged through the EPMA system. The Associate Chief Medical Officer, Medical Division noted that EPMA has raised awareness of this issue and made medication timings more visible. Evidence from recent audits undertaken by the Parkinson's team has shown that EPMA is making a huge difference along with the Parkinson's Nurses now involved which is positive. Work commenced on this since we started the Getting It Right First Time initiative. • The incoming CMO questioned if there are some wards doing significantly better than others and is there some good practice we can share. Now we have a reporting tool we will be able to report in detail back to specific ward areas. The CD confirmed that we have this level of detail which can be provided for future reports. • The General Manager - Acute and Countywide Services advised that the local Parkinson's Group is very proactive and a possible resource. We need to find ways of giving more empowerment to our patients to ensure that they receive their medication on time. The CD advised that if is sometimes difficult at ward level for staff to know what they can enable patients to do. A Risk Assessment needs to be undertaken to enable more patients to have access to their medication – this needs more promotion. • Mrs Twigg (NED) found the data very useful and the ability to understand what information can be provided. She was interested to know what the repeat patient numbers are in this data, ie would 4 doses missed for 1 patient be highlighted each time. The CD advised that there is so much data that can be provided, with EPMA being very visible. At each shift there is the ability to prompt staff if there are any doses that have been missed. • The CMO asked if we know why nurses find it difficult to enable patients to self-administer medications. The CNO advised that this is around the application of our Policy and which patients we deem safe to self-administer. This is wider than just nursing. The CD advised that the Self-Medical Policy and the Self-Administration Policy are available for specific drugs which simplify the process. There needs to be more around education than changing Policies. • Ms Quantock (NED) questioned if there is a Policy on timely doses of medications with withdrawal effects. For example, some psychiatric medications can cause huge side effects if missed which can continue for some take after the drug is restarted. The CD advised that there is nothing specific around this but something that we can consider. The CNO advised that in the Quality Priority context, we have a defined scope on the drugs that we are focusing on.	**TM**

	<u>Resolved</u> – that: **(A) The Quality Priority – Ensuring Patients Receive Timely Critical Medications be received and noted.** **(B) Future Ensuring Patients Receive Timely Critical Medications Reports will report down to ward level detail.**	**TM**
QC008/10.23	**<u>QUALITY PRIORITY – PRESSURE ULCER QUARTERLY REPORT</u>**	
	The Associate Director of Quality Governance (ADQG) and the General Manager - Acute and Countywide Services presented the Quality Priority – Pressure Ulcer Quarterly Report and the following key points were noted: • There are a wide range of issues challenging us. We need a cultural change around this. 60% of pressure damage is occurring before patients come into hospital. Therefore, we need to seek a system wide approach to improvement which is key to providing a better quality of care for Herefordshire patients. • The qualitative data indicates the reasons for this level of harm which are expansive and not focused on 1 or 2 key issues which suggest a cultural change is required. • Accountability and central oversight needs to improve to determine that improvement plans are generating the required results. • The aim is to try to simplify the data and any harm caused to patients whilst in the Trust. It was felt that the previous report was too simplified, hence this report is more comprehensive. • We have also changed the numbers to rates per 1000 bed days as we report for falls. • The numbers remain high with an upward trend in Frailty but a downward trend in Community Hospitals, medical and District Nursing. The total incident rate is also being reported. • Acquired pressure ulcers – Category 2 pressure ulcers are still the highest proportion of pressure ulcers being reported. There has been an increase in harm over the last year, with only medical having a lower number. We are seeing a downtrend for the District Nursing team over the last 12 months. Frailty, surgical and Community Hospitals are not showing an improvement and may be where we need to focus on. • The General Manager - Acute and Countywide Services Chairs the Pressure Ulcer Panel with good reporting but we need to be reporting pressure damage earlier in the patient's pathway. ED are better now at reporting skin issue which enables us to be clear	

	where the pressure ulcer damage has started, ie in our organisation, at home etc which is positive. • Themes from investigations (included in the report) are now discussed at the Pressure Ulcer Panel. These are broken down into 5 areas – Assessments, Categorisation, Documentation, Care and Treatment and Communication and Escalation. Patients are not always correctly engaged around managing their care and we need to be clearer around this, which we are working on. • The General Manager - Acute and Countywide Services is concerned around how skin damage is being categorised. A lot of work is being carried out around this to ensure staff are aware of how to do this. We also need to ensure that patients have the correct dressings and equipment. Communication between teams is very important in and out of county. We know what our issues are and are trialling the new Patient Safety Incident Response Framework (PSIRF). • Mr James (Chair and NED) noted that there are a large number of issues with things that need to change across the Trust and with the wider system. • The CNO advised that we are hoping to have a dashboard available on Maxims (delayed due to upgrade issues) for each nurse in charge to see how many patients in their care have had a Risk Assessment completed and how many have not. • The CNO highlighted that we have a small Tissue Viability Nursing Team and pressure ulcers are everyone's business. • The CNO advised that improvements will be seen if we focus on training and education. The vast majority of staff are internationally trained and their home country training is very different. This training does not provide the same underpinning training that UK trained nurses will receive. We therefore need bespoke education for all staff, but particularly for our internationally trained nurses. • Mrs Twigg (NED) felt this was the easiest data to read and understand in terms of where we are. A couple of charts had standard averages whereas a trended rolling average would have been ideal. • Mrs Twigg (NED) questioned what is happening next – Divisional Improvements plans are being developed but we are not always seeing where these are being reviewed and understand the governance process. The report notes that we are not always getting buy in and accountability to follow plans through. We need a cultural change as mentioned. The ADQG advised that the understanding and learning is being captured at the Pressure Ulcer Panel. . Bespoke improvement plans will be produced if agreed. We are transitioning to the PSIRF and some of this process has been lost during this phase. PSIRF will release time to enable the Pressure Panel remit to change regarding learning and oversight.	**RH**

	• The Managing Director advised that the 60% of pressure damage occurring outside of the hospital is a Herefordshire issue and discussion is needed at Safety in Sync. The 40% occurring in the Trust is an issue and has doubled in 4 years and she queried whether these were avoidable or unavoidable. Secondly, complaints are being received around a relative refusing care – there has to be a level of informed consent for these patients. The General Manager - Acute and Countywide Services agreed that there is a local issue that needs to be dealt with. The Practice Educator in Integrated Care is working hard to improve tissue viability awareness. Bespoke training for Community Hospitals is being undertaken by a new member of staff in post. The main concern is around consent and whether we really know that patients are making an informed decision. More work is need around this. There is good engagement with Divisions at the Pressure Ulcer Panel. • Mr James (Chair and NED) agreed that information needs to be reported back through Divisional Reports for triangulation. • The ADQG advised that the avoidable pressure ulcer damage data was taken out of the report this time as this was linked to Serious Incidents. We need to agree at the Pressure Ulcer Panel how we determine this and identify for future reports.	
	<u>Resolved</u> – that: **(A) The Quality Priority – Pressure Ulcer Quarterly Report be received and noted.** **(B) The Associate Chief Nursing Officer will review having bespoke education for all staff, but particularly for our internationally trained nurses around pressure ulcers.**	**RH**
QC009/10.23	**<u>QUALITY PRIORITORY – TO REDUCE CDI RATES AND DELIVER OUR CLEANLINESS STRATEGY</u>**	
	The Lead Infection Prevention Nurse (LIPN) presented the Quality Priority – To Reduce CDI Rates and Deliver Our Cleanliness Strategy and the following key points were noted: • We are below trajectory for month end. However, we had 20 cases until September which is the threshold for the entire year. • There were 3 C-Diff cases reported during this quarter. These were a mixture of Community and hospital onset cases. All 3 had areas for improvement which may have contributed to the infection. The themes remain the same – beds and commode cleaning issues. One case was linked back to another patient.	

- A lot of work is being carried out with clinical staff regarding cleaning to reduce numbers. Issues were picked up around international nurses understanding of their role in cleanliness as well. A lot of work at ward level is being undertaken to address this.

- Discussion is being held with the Education and Development Centre around setting up face to face training.

- It has been added onto the Risk Register that we are an outlier for our C-Diff rates.

- We continue to work with our ICS colleagues and they are helping to review our system data.

- Joint Cleanliness Strategy – This has been developed from the beginning of this financial year. We are meeting fortnightly with key staff to deliver actions. An Action Plan has been developed with 16 actions. The key thing we need to address is around joint monitoring as there are different systems being used which records data differently. We are holding a meeting to address this to agree to using just one system.

- Graphs within the report on the whole demonstrate compliance with the Cleaning Standards 2021. We are above or just about where we want to be with all of the elements. There are some clinical areas that have not achieved 3 stars which are ED and Delivery Suite. This is mainly due to capacity in these areas and access into spaces to undertake the cleaning. We are working with the teams to support with this and to look at how to support improvement.

- Internal Audit Compliance with National Cleaning Standards – We are compliant with all actions bar 2 elements. We are behind deadline for getting assurance from Division that they are receiving the Improvement Plans from their local areas. We have met with them to see how we can progress this. A meeting with the Governance Leads is taking place to discuss. The other issue is due to the contract with Sodexo. The actions suggested that we need to ensure that the National Cleaning Standards are included in our current Trust contract. We have assurance and monitor against these standards, but due to ongoing discussions regarding the contract, this is not yet included.

- At the beginning of the financial year, 46 actions were set for the Infection Prevention Improvement Plan with a further 17 additional actions added to the original document. We are progressing well overall. We have had to change some of the deadlines previously set to enable them to be more achievable. We are just slightly below the target for compliance of Trust staff completing the Cleanliness Cleaning Standards. We are promoting this to achieve compliance.

	• NHSE Support - We have received lots of support from NHSE with regular meetings with the Lead Infection Prevention Nurse discussing the plan. We also have regular visit from the ICS who come on site to support. NHSE and ICS attended for a supportive visit and visited ED, Redbrook and Lugg Wards and visited public areas. There is some learning from this visit for the Trust. • The CNO advised that a formal visit to get us out of intensive support was due at the beginning of September, but after the informal visit, it was not felt that we were ready and so this had been moved to 12 December. The CNO expressed her disappointment and emphasised that we need to change what we are currently doing as this is obviously not working. This is more around local ownership. Discussion was held at the Finance & Performance Executive Committee around who is responsible for clinical areas for monitoring and oversight. We are bringing together a group of individuals to look at a number of areas. We need to consider whether we need different management arrangements for SSA's, internal cleaning staff and housekeepers. There is variability within these roles and responsibilities are not clear. Joint monitoring has to be on one system for monitoring as well. We need more robust oversight for areas that we have responsibility for. The CNO has committed with the Business Director, Sodexo to ensure clinical prioritisation of all jobs to keep the estate clean. We need one single Standard Operational Procedure we all follow whether working for the Trust of Sodexo. • Mr James (Chair and NED) welcomed the urgency that the CNO is bringing to this issue. • Mr James (Chair and NED) questioned whether the improvements required will be achievable by 12 December. The CNO advised that we have no choice but to be. Key to this is local ownership and who is responsible for each of our clinical areas. • The Incoming CMO queried if antimicrobial stewardship is contributing to this issue. The LIPN advised that all hospital infections are reviewed and no themes have been found regards this. Most infections are not linked to this. We know that we have not had a robust delivery of antimicrobial stewardship. However, a senior Pharmacist is retiring and returning into the role as an Antimicrobial Stewardship Pharmacist. • The CNO advised that the Trust reviewed the antimicrobial stewardship formulary about a year ago and reviewed what should and should not be used. Ordersets were also developed on the system as well. We now just need oversight of this. • Mrs Martin (NED) questioned whether we provide an environment fit for our users. All the NEDs take this very seriously and offered any support to the frontline team that was required to improve cleanliness	

	<u>Resolved</u> – that the Quality Priority – To Reduce CDI Rates and Deliver Our Cleanliness Strategy be received and noted.	
QC010/10.23	**<u>MORTALITY REPORT</u>**	
	The CMO presented the Mortality Report and the following key points were noted: • Our SHIMI is down to 100.1. • Our depth of coding is improving quite dramatically. We still have issues with our Palliative Care coding. • A Business Case for a mortality section in InPhase is being added. • Cardiac Failure Audit – 12 patients were reviewed. Of these, 6 died of heart failure and the expert who reviewed the cases deemed that good care was provided. There were some learning points identified. A Coding Cardiology Ward Round type event would be useful to improve this. • Mr James (Chair and NED) noted that the appendix to the report refers to retrospective reviews of the cause of death and questioned how practical this is. The CMO advised that we are keen to have an EDS for deaths. InPhase are reviewing whether this is possible to add.	
	<u>Resolved</u> – that the Mortality Report be received and noted.	
QC011/10.23	**<u>EMERGENCY READMISSION AUDIT</u>**	
	Report delayed due to illness.	
QC012/10.23	**<u>DIVISION QUARTERLY REPORT – SURGICAL DIVISION</u>**	
	The Associate Chief Operating Officer – Surgical Division presented the Division Quarterly Report – Surgical Division and the following key points were noted: • Serious Incident numbers remains static. There have been a number of new Serious Incidents (5) with 16 closed. Two more have been closed since the report was written. There are 9 outstanding Serious Incidents with the ICB for final review. • No Never Events occurred during this period. • VTE – This is a slightly deteriorating picture. This has reduced from 86% to 83.7% during this quarter. A deep dive has taken place into a couple of areas to find out what is driving this. Upper GI were at 63.6% - this was due to a Locum not submitting the assessment. This has been addressed with training.	

	• The second area was Gynaecology. A deep dive and audit were undertaken. The audit results differed from the reported systems. A couple of areas were identified that do not meet the criteria for patients to have a VTE assessment. Informatics are supporting a fix for this. With this in place, their result would have been 95%. • Complaints – There has been a rise in the number received. We had 21 in July down to 6 in September (which is average). • A review of complaints has been undertaken to ensure a swift resolution is found. We now work weekly with the Directorates, sending out complaints that need addressing with key actions rather than monthly. • Orthodontics is one of the key areas for complaints. A deep dive was undertaken on the Gynaecology complaints with 9 reviewed. Communication was the key theme found relating to prior to appointments, long waiters and on the day communication. The team are meeting fortnightly to discuss key learning points to address for an action plan. • Compliments - 90 were received during this quarter. There was a 90.79% positive feedback. • Maternity Well Led and Safe Care Quality Commission Inspection – The rating for the Well Led Domain has moved to good. There are still improvements to be undertaken. • There are significant waiting times for a first new appointment in Gynaecology. The new Outpatient Waiting List has been validated down to 42 weeks from 65 weeks at the start of the review. The Gynaecology Team are reviewing how they can work differently to continue to reduce and sustain waiting times. Virtual reviews are being undertaken along with desk top reviews. The desktop review was on 200 patients with 40% not needing a face to face meeting. There is more work to do to ensure that our triage process is more robust. Last week, 29% of patients were seen virtually which is very positive. • Endoscopy – Our Joint Advisory Group (JAG) Accreditation is due. We submitted our annual review to the JAG in March 2023. Following this, JAG advised the Trust that the award of accreditation had been deferred by 5 months for further documentation to be sent and to achieve some actions (detail within the report). We submitted all evidence required last week ahead of the deadline of 1 December. • There is concern around the Community Paediatric Service around staffing and performance. We should have a workforce of 4.2WTE but were down to 1.8WTE at one point in the quarter. There are plans in place to provide insourcing for 8 weeks to see 92 patients by a Locum. There are a number of patients awaiting follow up and diagnosis. A meeting was held to discuss to agree on how to highlight the urgent cases that need to be seen.	

	• Maxillo Facial and Orthodontics are fragile services due to workforce issues. We are now arranging for joint clinics with Worcester and have an Insourcing company to provide some elements of this service. Longer term arrangements are being discussed with the ICB. • The CMO questioned whether all Consultant Gynaecologists were involved in the Table Top Review. The Associate Chief Operating Officer – Surgical Division advised that 2 Consultants were key to this along with learning across all specialities. The CMO advised that we need a good learning process for Junior Consultants in the Trust to prevent patients being brought back unnecessarily. The Associate Chief Operating Officer – Surgical Division advised that this needs to be formalised with the Division. We contact the patient twice and then virtually but need a process to deal with the outcome after this.	
	Resolved – that the Division Quarterly Report – Surgical Division be received and noted.	
QC013/10.23	**PQSM REPORT - MATERNITY**	
	The Associate Director of Midwifery (ADM) presented the PQSM Report – Maternity, which was taken as read, and the following key points were noted: • This was an average month in terms of the number of births. Induction of labour rate dropped slightly and the Robson groups are stable. • There was 1 late foetal loss with no care issues. There were no incidents graded as moderate or above and there were no HSIB referrals. • Recruitment is very positive. When all the Midwives who have joined the Trust have completed their supernumerary cover by November, staff may be allowed annual leave over Christmas which does not usually occur. • We have 6WTE Community vacancies and 7 applicants so we are hoping to fill all our vacancies. • Friends and Family Test – We had only 1 response during September. We need to support teams to increase engagement around this. • There were no complaints received during this month. • CNST results are fairly promising. There are tight deadlines to meet and changes are still being made to the standards. • There are training issues around CNST, particularly with anaesthetic colleagues.	

	• Saving Babies Lives is much more complex along with a new element around diabetes. A Task and Finish Group has been set up for this. There is some support in terms of addressing issues with guidance. • Mrs Martin (NED) referred to an incident in the report where the Obstetric Consultant was not called and queried if there was any harm caused due to this. The ADM confirmed that there was no harm to the patient caused. There is work needed around when to use the call system. • Mrs Martin (NED) noted that there were two mothers with a BMI over 50 which is a theme we are now seeing. There is obviously a risk of complications associated with this and the wider Public Health issues that we need to acknowledge. The ADM advised that often these women are also diabetic and may live in more deprived areas. The Continuing of Carer Plan will set out some of our plans to address these issues and to support these women in early pregnancy onwards. • The CNO advised that the CNST 10 Standards require sign off by the Board of Directors and nationally by February 2024. Due to Board arrangements, there will not be a Board of Directors meeting until March next year. It has therefore been agreed for a significant maternity focus at the end of November in order to get some of these documents signed off and to provide an overview of where we are. The plan is to take the Standards to the Board meeting in December for final sign off to named individuals or Quality Committee. • The CNO advised that the new Midlands Escalation Framework gives us the ability to divert patients as discussed. Before the Policy was developed, the CNO was not aware of any diverts. Now that the Policy is in place, this has been used on a number of occasions. We need to consider what has changed, whether we now have a lower threshold or it is our acuity of patients. If there is a significant safety issue then it is right to divert but if not our threshold is too low. Mr James (Chair and NED) agreed this needs to be considered with possibly an audit carried out in the future. • The CMO agreed with these concerns. Region felt that this was the right thing to do but in Birmingham, factors to consider are very different than in Herefordshire. • The ADM advised that before the Policy was in place, she was aware of diversions locally taking place that have not been highlighted. • In response to a question raised by the Incoming CMO, the ADM advised that post-operative haematology simulations skill drills are part of CNST with 90% of staff having undertaken these.	
	<u>Resolved</u> – that the PQSM Report - Maternity be received and noted.	

QC014/10.23	**STAFFING REPORT**	
	The CNO presented the Staffing Report, which was taken as read, and the following key points were noted: • We are trying to make the NHSE Fill Rate return more meaningful. This is a mandated report but we need to understand this at a more granular level. We do not articulate in our reports details around under and over staffing. • Workforce Information – Sickness levels are improving significantly. Vacancy factors are also improving but agency usage has increase significantly. We are having to open unfunded beds along with cover for ED. The Matrons agreed to undertake a piece of work in the Finance and Performance Executive meeting to review this.	
	Resolved – that the Staffing Report be received and noted.	
QC015/10.23	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The Deputy CMO presented the Patient Safety Committee Summary Report and the following key points were noted: • Thrombosis Committee – There have been concerns discussed at the last meetings in terms of First Clinician Reviews slipping since the change from Datix to InPhase. A monthly reminder is being sent to Divisions of the names of the Clinicians who are behind on their completion rates. • Agreement needs to be reached around the VTE assessment rules with the Information Team before the Deputy CMO leaves. • More clinical input is needed for the Thrombosis Committee. • Mrs Martin (NED) questioned if there is anything that we can do to support regarding VTE. The Deputy CMO advised that this did become business as usual with a lot of ground work around the new processes at the start. Learning from Root Cause Analyses is showing the same issues but this is not leading to significant harm. We need to keep communicating this out to staff and to keep the impetus up to prevent numbers slipping. We have struggled with VTE assessment for a number of reasons. We need to understand the algorithm and the update on Maxims is still awaited. • The CD advised that this has been a standing agenda item on the EPMA/EPR Boards and escalated up to the Digital Programme Board. The integration of the 2 systems has been challenging.	

	• Mrs Martin (NED) questioned whether, as noted in the report, we have 4500 Community patients using equipment that will require review. The ADQG confirmed that this was correct. The Managing Director was interested to know the actual risk level and what is the definition of equipment. The ADQG advised that she had inquired with the National Team in regards to this and the response was to proceed. She will clarify what equipment is included. • The Incoming CMO queried if the screening was more of a data quality issue or whether it was more than this. If so, what are the biggest barriers to achieving 95%? The Deputy CMO advised that a complicated algorithm is put in to form our VTE compliance. Compliance across wards is around 80 – 85% but they are not completing the assessment but are prescribing Heparin when required. When we can link Maxims to EPMA we can also link prescribing to the assessment rather than as 2 separate stages.	**NO**
	<u>Resolved</u> – that: **(A) The Patient Safety Committee Summary Report be received and noted.** **(B) The Associate Director of Quality Governance will inquire as to what the equipment for Community patients is that requires review.**	**NO**
QC016/10.23	**<u>DETERIORATING PATIENT TERMS OF REFERENCE AND WORKPLAN</u>**	
	The Deputy CMO presented the Deteriorating Patient Terms Of Reference (TOR) and Workplan, which was taken as read, and the following key points were noted: • These have been agreed at the Committee and reflects what is needed. This is a large piece of work with multiple streams coming out of this, as described in the report. Continued engagement with clinical teams is required for this. • The Incoming CMO noted that there is a lot of work focusing on adults and highlighted the need to cover children as well. The TOR and membership need to include a Paediatric representative and an Obstetric representative and this needs including in the dashboard. The Deputy CMO advised that there was an explicit decision made not to do this as they have their own group to cover this. This could be added on if needed. The Incoming CMO was happy for this not to be included as these groups are covered elsewhere. • Mrs Martin (NED) queried who is the Chair of this group. The Deputy CMO advised that he is currently the Chair and a successor needs to be appointed but this has not yet be decided as only 2 meetings have been held.	
	<u>Resolved</u> – that the Deteriorating Patient Terms Of Reference and Workplan be received and approved.	

QC017/10.23	**LOCSSIP UPDATE**	
	The Deputy CMO presented the LocSSIP Update and the following key points were noted: • NatSSIPs 2 is trying to simplify NatSSIPs as well as ensuring better oversight, monitoring and auditing of our LocSSIPs. • We now understand our interventional procedures but we need underpinning Standard Operating Procedures and monitoring of the use of LocSSIPs for assurance. • This is a monitoring paper of our position and what we have done and what we can do, especially electronically. • The CNO, ADQG and the Deputy CMO are meeting next week to discuss the handover of some of these issues. • The ADQG advised that focus for the future is around NatSSIPs 2. There is concern across the Foundation Group of the implementation of these new standards.	
	Resolved – that the LocSSIP Update be received and noted.	
	CONFIDENTIAL SECTION	
QC018/10.23	**SERIOUS INCIDENT REPORT**	
QC019/10.23	**ANY OTHER BUSINESS**	
	• The CNO advised that is nearly a year ago that we introduced our Boarding Policy. We were in a position where we had to sign up to the least worst option to deal with pressures within the Trust and suggested that a report be presented to the Quality Committee on staff and patient experience around this. Any suggestions around who is best placed to produce this and the content of the report were welcomed. The Managing Director noted that pressures continue within the Trust. The report therefore needs to include how many boarders there are, where they are, how many staff are needed to look after these patients and the financial impact and the impact it is having on both staff and patients. The CMO agreed, noting that mortality data also needs to be included to triangulate this information. • Mr James (Chair and NED) acknowledged that this is the last Quality Committee meeting for the CMO and Deputy CMO. They have exemplified the ability across a range of complex areas to bring this Committee back to our core assurance role in ensuring the quality of care that we provide to our patients is what we want for ourselves, our families and our friends. He thanked them both for all their support.	**NO/DA**

	<u>Resolved</u> - that: **(A) The Any Other Business be received and noted.** **(B) The Associate Director of Quality Governance and the Associate Chief Operating Officer Medicine will present a report to the next Quality Committee on the Boarding Policy one year on from introduction.**	**NO/DA**
QC020/10.23	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 30 November 2023 at 1.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Quality Committee November 2023 Minutes and Escalation 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 present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

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

3. Executive Director Opinion[1]

NA

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

Matters for Noting

1. **Boarding Report** - Quality Committee has started to receive monthly reports on the quality and safety aspects of our Boarding Policy use and welcomed the opportunity to scrutinise the impact of the need to boarded patients.

2. **Medical Division Quarterly Report** – Board will note the positive reflections in the report on work to improve harm from pressure ulcers, the opening of the Frailty SDEC and the use of care through Virtual Wards. Of concern is highlighted the work we need to do to improve care for patients with dementia as a result of losing our clinical lead and our Admiral Nurses. Following a review of infection prevention practices in ED a number of changes have been made including a new "Hit Squad" to do quick turn-round cleans in between patients using cubicles.

3. **Maternity Quarterly Report** - Planned building alterations to improve maternity triage environment have commenced.

- Reductions in midwife vacancies means we anticipate no reliance on agency staff for next few months.
- Saving Babies Lives Care Bundle – work is continuing supported by LMNS with the intention of confirming compliance with this year's requirements.
- Work also on track to achieve wider CNST standards subject to LMNS peer review.

4. **Maternity Services – Monthly PQSM Report**

- QC was informed of 1 late foetal loss, 1 neo-natal death and 1 maternity death reportable to MBRRACE. In none of these cases were any issues with care identified.

5. **Patient Experience Committee Summary Report**

- Committee noted the ongoing work to ensure security of patient property. Audit Committee has also asked for a report on this issue due to claims and financial loss to the Trust.

Matters for Escalation

1. **Maternity Services Monthly PQSM Report**

- Committee was informed of a moderate incident following discovery of an issue with EPMA discharge summaries not being sent to GP's. This came to light in Maternity but is wider across the Trust and is being addressed to review patients affected. In Maternity the period at issue is August to November as prior to that paper copies were also sent to GP's.

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 30 November 2023 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director – Left during Item 7.1
Natasha Owen	NO	Associate Director of Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In attendance:		
Helen Harris	HH	Integrated Care Boards Representative
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)
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division – Left during Item 7.2
Sue Moody	SM	General Manager - Acute and Countywide Services
Emma Smith	ES	Associate Chief Nursing Officer – Surgery Division
Amie Symes	AS	Associate Director of Midwifery – Left after Item 7.2
Emma Wales	EW	Associate Chief Medical Officer, Medical Division

QC001/11.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from David Allison, Associate Chief Operational Officer, Medical Division, Ellie Bulmer, Associate Non-Executive Director, Jane Ives, Managing Director, Tony McConkey, Clinical Director, Pharmacy & Medicines Optimisation and Rachael Skinner, Integrated Care Boards Representative.	
QC002/11.23	**QUORUM**	
	The meeting was quorate.	
QC003/11.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/11.23	**MINUTES OF THE MEETING HELD ON 26 OCTOBER 2023**	
	Resolved – that the minutes of the meeting held on 26 October 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/11.23	**ACTION LOG**	
	(a) QC019/10.22 – (B) – Quarter 2 2023/34 Safeguarding Reports - The Chief Nursing Officer (CNO) confirmed that the safeguarding training booked for the January Board Workshop was for the new ANEDs/NEDs to undertake their Board level training and as a refresher for the remaining Board members. (b) QC006/10.23 – (D) – Quarter 2 2023/24 Safeguarding Reports - The Associate Chief Nursing Officer advised that the current contract for outsourcing IMCA's runs from 1 August 2021 to 31 July 2026. There is specific criteria that the person has to meet. The contract is monitored on a quarterly basis and the Trust are able to feed any concerns into these meetings by sharing these with the DoLS Lead for Herefordshire Council. (c) QC015/10.23 – (B) – Patient Safety Committee Summary Report – The Associate Director of Quality Governance (ADQG) advised the meeting of the list of the equipment for Community patients that requires review. There is not a defined timeframe to review this. A Working Group has been set up to work on this. Mrs Frances (NED) noted that it would be useful to know how other Trusts were managing this process.	
	Resolved – that the Action Log be received and noted.	
	BUSINESS SECTION	
QC006/11.23	**MORTALITY REPORT**	
	The Chief Medical Officer (CMO) presented the Mortality Report, which was taken as read, and the following key points were noted: • Our SHMI has risen by 0.35. This increase is due to our pneumonia deaths, which have increased from previous months. • We are an outlier for heart failure but this is improving. An audit has shown that this is mostly due to coding quality issues rather than issues in care. • There has been a slight increase in stroke deaths, but we still have one of the beset SHMI in the country. • Our perinatal mortality figures are good. We have had 4 consecutive months of being below the national ambition of 2.6 deaths per 1000 live births. • We are reviewing pneumonia deaths and having a focused review to assure ourselves around any potential issues in care.	

	• Mrs Martin (NED) noted that we need to ensure that for our perinatal mortality, we are comparing like for like. We are a small unit and do not have high risk patients. The Associate Director of Midwifery (ADM) advised that comparison with similar units is shown in the EMBRACE Reports. We always have a delay in this reporting but we are still performing well. The CNO advised that we do get compared to other small units but we differ in that we take small babies where other units do not. • Mr James (Chair of the Quality Committee and NED) noted that our figures are good and improving which implies that the Mortality Strategy is working. He asked the new CMO if there was anything further the Trust should be doing. The CMO confirmed that the Strategy is definitely working. A lot of this improvement has coincided with Digital EPR and improvement in coding of co-morbidities. We will be discussing a mechanism for sharing learning across the Trust as we re-establish the Learning From Deaths Committee.	
	Resolved – that the Mortality Report be received and noted.	
QC007/11.23	**BOARDING REPORT**	
	The Associate Chief Medical Officer (ACMO), Medical Division presented the Boarding Report and the following key points were noted: • The ACMO, Medical Division explained the difference between a Reverse Boarder – additional patients on a ward against a confirmed discharge for that day and Multiple Boarders - an additional patient on a ward, not in a bed space and not against a planned discharge. • The Boarding Policy was implemented into the Trust in 2022. We have had an increasing number of Boarders over the last few months which is a particular issue for the Medical Division as medical wards have the highest number of Boarders. Frailty Wards can have an additional 3 or 4 patients boarding. • Complaints and concerns – There have not been a large number of formal complaints raised but there have been a large number of verbal concerns received including from staff who are concerned around the difficulties of getting a patient out of an additional bed due to lack of space. These patients often do not have a chair or table available and may have already spent a long time in the Emergency 'Department (ED) waiting for a bed. There have also been some significant incidents relating to patients being in a boarding space. There is also concern around privacy and dignity. Last winter, there was evidence that there was an increase in falls and pressure ulcers due to Boarding patients. Additional nursing staff were therefore put into these wards to improve this situation. • Boarding patients was put into place to spread the risk across the Trust rather than just in ED. Medical wards are less suitable for these patients than Frailty wards due to their geographical design.	

	• This year there has been a massive emphasis on discharging well patients from hospital. A lot of work has been put into this from the Medical Division where we have control, ie who is sent to the Discharge Lounge to support staff. We do not have control over patients waiting for a package of care, discharge to assess and being discharged to Care Homes. • Mr James (Chair and NED) welcomed the report and having a discussion around Boarding patients. There is a lot of information in the report, which is open and transparent around the patient and staff experience. • The CNO agreed this is having an impact on our patients and staff and welcomed feedback on the report. It was agreed that this will be presented to the Quality Committee on a monthly basis. • The CNO confirmed that some of these Boarders are in a non designated bed space with no call bed, oxygen suction or curtains. The Managing Director advised that discussion had been held at the last Senior Leaders meeting on the number of patients being admitted above our funded bed base in hospital wards and in Community Hospitals. • The Boarding Policy was not intended for patients to board overnight, but we know that this had occurred in the last few weeks due to pressures. Lugg Ward has 3 Boarders today, with patients being remarkably understanding in a not ideal environment. It is obvious the impact that this is having on the care we are able to provide our patients and the impact that this is having on our staff. • Mrs Hill (NED) questioned to what degree Powys and Out Of County patients are bed blocking whilst awaiting Social Care packages of care. The ACMO, Medical Division advised that last week the majority of delays were Herefordshire patients (70%). It may be useful to have the number of medically stable patients fit for discharge included in the report. If these patients were discharged, we would not need to board patients. The General Manager - Acute and Countywide Services confirmed that Out Of County numbers are low with a Powys Co-ordinator in the Trust who manages these patients. They have limited resources but actively seek to move patients. They rarely have over 10 patients waiting to be moved. The main block is the lack of paid carers in the community. A lot of work is being undertaken to prevent unnecessary admissions with the use of the Urgent Response Hub, Frailty Same Day Emergency Care (SDEC), Virtual Wards and working with the West Midlands Ambulance Service to prevent patients unnecessarily being brought into the hospital.	**DA**

	• Mrs Twigg (NED) queried if we understand what the barriers and the blocks are and if there is an alternative option. The ACMO, Medical Division advised that the biggest risk is having a patient waiting at home for an ambulance as the ambulance is unable to leave ED as their patient is waiting for a bed. We need to ensure that pathways are working smoothly and efficiently out of the hospital. • The CNO advised that the Trust Management Board recently agreed to the expansion of the footprint of the Discharge Lounge within the Medical Day Case. This is not an ideal patient experience and a decision that was taken reluctantly but what is needed prior to winter. Staff need to understand the process of moving a patient to the Discharge Lounge (which is not an ideal environment for their patients) to reduce the risk of a patient waiting at home by allowing a Boarder to be admitted onto their ward to free up ED for patients waiting. • The CMO noted that the risk is all around flow. An appendix in the report on utilisation of the Discharge lounge, the number of patients fit for discharge still on the ward and what we are doing to prevent unnecessary admissions and bed blockers would be useful to provide the entire picture and enable us to see where we need to work with our partners for a solution. • The ACMO, Medical Division advised that Worcester go onto divert to us which means that we have more Boarders, with the rest of the Foundation Group not having Boarders. This requires a change of mind set for our Clinicians to discharge more patients and utilised the facilities available. • Mr James (Chair and NED) noted that Boarding patients are not receiving the care that we would wish to provide and questioned whether there was anything more we could do to improve the patient experience. The ACMO, Medical Division advised that the difficulty is that we are working in a financially strapped environment. Any improvements we could make are costly and we do not want to spend money on something that we do not want to last. This is more around discharging patients from hospital. • Mr James (Chair and NED) queried whether information is given to patients / relatives around managing expectations. The ACMO, Medical Division confirmed that patients understand and see the pressures in ED as well as a lot of news reporting on EDs being pressured and overwhelmed with numbers of patients. • The Associate Chief Nurse, Medical Division advised that communication is key. We advise a patient before they leave AMU or ED. Patients on the wards also look out for Boarding patients who do not have a call bell (have to use a hand bell). We are also mindful going into the winter months around infection prevention with norovirus a real challenge around this. The CNO confirmed that a couple of Boarding spaces have been closed due to infections. Overcrowding in clinical areas leads to more infections.	

	• The CNO advised that we have asked our NED colleagues when they are undertaking their Patient Safety Walkabouts to take a "fresh eyes" approach see if they can see anything that can be improved. • In response to a question raised by Ms Quantock (NED), the ACMO, Medical Division advised that we are trying to empower nurses on the wards to determine who is in a bed space and who is a Boarder. • The CMO questioned whether it was acceptable to move someone fit to discharge to a Boarder space to free up a bed. The ACMO, Medical Division advised that the difficulty with this option is that most of the patients are old and frail and not suitable to be moved, especially if they have dementia. • The CNO noted the comments made and will ensure that these are added to future reports.	**LF**
	<u>Resolved</u> – that: **(A) The Boarding Report be received and noted.** **(B) The Board Report will be presented to the Quality Committee on a monthly basis.** **(C) The Chief Nursing Officer will ensure that the comments made no the Boarding Report are included in future reports.**	**DA** **LF**
QC008/11.23	**<u>DIVISION QUARTERLY REPORT – MEDICAL DIVISION</u>**	
	The Associate Chief Nurse (ACN), Medical Division presented the Division Quarterly Report – Medical Division and the following key points were noted: • The report covers the period from August to October. • All Serious Incidents have been either closed, or if outstanding, all investigations have been carried out by the Trust. • In the report there are several examples of Quality Improvements initiated due to incidents and complaints in line with our new Patient Safety Incident Response Framework (PSIRF). • The ACN, Medical Division gave the background to some of the key examples of Quality Improvements initiated within the Division post incident including a new Eating Disorder Pathway and Guidance and a poster being developed by a Ward Sister for her ward relating to diabetes management after 3 incidents relating to diabetes ketosis not being correctly escalated.	

	• The Chief Operating Officer and the ACN, Medical Division attending a complaint meeting to address clinical concerns raised by staff around patients not having wristbands. Immediate action was taken and an audit tool implemented with the sister conducting further audits in the future. This is being led by the Phlebotomy team. There is concern around reliance on agency staff and we need to ensure that we can clearly identify these patients. • Friends and Family feedback is positive. We are ensuring that any actions are addressed. • We are performing well with our Pressure Ulcer CQUIN at 89% in Quarter 2 and 80% for our Frailty CQUIN. • We are proud that our Frailty SDEC opened on 12 September. This will prevent older people having to wait for longer to be assessed in ED by a specialist, often associated with a longer length of stay. Identification of these patients at the front door will help trigger a geriatric assessment and discharge where possible on the same day. A summary of this service is included in the report. The Frailty SDEC at the Trust has been highlighted as good practice in the recent British Geriatric Society publication "Front Door Frailty: Advice on setting up services". The ACN, Medical Division thanked all the clinical and non-clinical staff for their help in setting up the Frailty SDEC. • Real progress is being made with the use of the Virtual Ward. Increased patient numbers has enabled a maximum capacity of up to 20 patients with various strategies for increasing the awareness and capabilities of the Virtual Ward. • We are very proud of our staff member winning the Health and Social Care Awards Adolescent and Child category. • We are above the national average for the number of patients seeing a Geriatrician. This is due to the commitment and dedication of our nurses and multi-disciplinary team across the Division which is evidenced with the variety of compliments received. • As a Trust, we need to ensure systems are in place to support continuous improvement of quality of care for people with dementia and their carers whilst in hospital. The expected standard is that there is a Senior Dementia Lead within the Trust who guides and monitors delivery of the Local Dementia Strategy. There should also be an assigned Board member with responsibility for dementia care and Clinical Dementia Specialist Leads who have access to Champions to support the delivery of dementia care. We previously had Admiral Nurses at the Trust and the Dementia Lead role was assigned to the ACN, Medical Division who was supported by our Frailty Lead. The Frailty Lead has since left the Trust and the volunteer who supported this area. Also, due to challenges within the role of the ACN, Medical Division, the Dementia Lead role has been unfulfilled.	

	• The complaints and concerns received evidence that despite our best efforts, we are not improving our Dementia Care Standards and advocating person centred care, and as a consequence, our patients are staying in hospital longer than they should be. There are a number of concerns raised based on data recorded in the Dementia Annual Statement for the National Audit of Dementia Round 6 (details included in the report). There is currently no resource to undertake this audit. There are a number of actions being taken to address this issue and the ACN, Medical Division has arranged 2 training dates in December and January for the Virtual Dementia Tour at the Trust. This gives attendees an experience of what dementia might be like using specialist equipment and creating a simulated environment. • Operational Pressures and Cleanliness in the ED – Breaches in infection prevention practices were observed during previous reviews by NHSE and Herefordshire and Worcestershire ICB in October 2021 and March 2022 and concerns were raised relating to a number of C-Diff cases. We are receiving intensive support to help up improve in these areas. • Due to the concerns highlighted, a Project Team was formed to address actions identified with support from Sodexo and Estates. During this time, a complete overview of cleanliness was undertaken in the department and all areas were deep cleaned and many estates jobs addressed along with the development of an action plan. One of the key concerns was the cleaning of cubicles and equipment in-between patients being transferred out of the department to the wards and other patients being moved into the vacant cubicle in an expedited fashion. • During the latest pre-inspection in ED with observing and monitoring infection prevention practices and cleanliness processes took place, notable improvements were seen. • To facilitate further improvements, a request has been made for winter monies to fund a “Hit Squad” consisting of 2 cleaners who could support 24 / 7 to address the rapid turnover and intensive cleaning required as a consequence and provide assurance that cleanliness standards are being met. • Patient Flow and Congestion in ED – This remains a concern across the Trust, resulting in increasing numbers of medical outliers, Boarders on the wards and patients remaining for long periods of time in ED. • The Associate Chief Operating Officer, Medical Division is leading on different projects to maximise productivity from the wards to address flow and congestion (details within the report). Volunteers in ED are also reporting issues with lack of privacy and dignity for patients, with breaches in confidentiality occurring for some patients when being informed of their diagnosis due to lack of appropriate space.	

	• Violence and Aggression – The increased lack of police attendance across ED is a concern for the Division and the Managing Director is addressing this issue at Executive level. The Matron and Security Officer are regularly meeting to discuss this concern. • Complaints – There have been 68 complaints received during this reporting period in comparison to 51 being received during the previous quarter. Staff are phoning complainants where possible to try to resolve issues and staff are being encouraged to discuss issues with complainants at the time of the issue to prevent this progressing. • The ACN, Medical Division read out the email received from a Band 7 Sister working in ED around the exceptional care provided by staff and in particular one member of staff during a very emotional and difficult situation. This shows that despite the extreme conditions that ED staff are working in on a daily basis, they are still able to work across Divisions to ensure exceptional care is provided. • Mr James (Chair and NED) liked that the report was focused and comprehensive and addresses the quality issues in the Division. • Mrs Martin (NED) noted the importance of getting the balance right, a lot of what we do is very good with good care provided by our staff. • Mrs Martin (NED) noted that there was a lack of leadership on the Frailty Wards which was now been resolved with posts recruited to and questioned whether there were any themes with these changes. The ACN, Medical Division advised that there were no themes and the changes were due to sickness (not stress related). One Band 7 is now back in post and one Band 6 has been backfill and one temporary backfill for sickness. • Mrs Martin (NED) questioned whether discussions are being held as a System with One Herefordshire regarding the Dementia challenges around different ways of approaching this. Money is obviously an issue but we need the correct skills as well. The ACN, Medical Division advised that the ICB are supporting with this along with a Consultant and raising the profile of this issue as well as a meeting with the CNO to discuss this. A Business Justification is being presented to the Trust Management Board to enable us to move forward in this area. It is recognised as a gap but we will be working in an integrated way. • Mr James (Chair and NED) queried if there were Dementia Friends to support in this area. The ACN, Medical Division advised that we used to have this support. The Dementia Group in the Trust had patient representatives and were very engaging. We have lost traction on this due to conflicting priorities. We lost a valuable resource with the 2 members of staff leaving.	

	• The ACMO, Medical Division advised that we have staff in the Division who support as much as they are able with the National Audit for Dementia. Despite this, we were in the bottom quartile for most areas. We need a member of staff whose job role is to improve the care for our dementia patients. A patient with dementia is more likely to stay in hospital for longer and more likely to come to harm as well due to this length of stay. • The CNO was fully supportive of the Business Justification being presented to the Trust Management Board. We previously had 4 Admiral Nurses who were externally funded and she questioned what happened to this funding. The General Manager, Acute and Countywide Services advised these posts had to be filled with Mental Health Nurses with the funding pulled. This was Better Care Funding and was very restrictive in how it could be used. The CNO noted that other Trusts in the Foundation Group must have sustainably funded these posts as they are still current. We need a dedicated resource for this. The ACN, Medical Division agreed noting that we need the right staff in these posts who do not need to be Mental Health Nurses. • The Associate Chief Nursing Officer advised that we need a Dementia Lead to empower our nurses to have more knowledge of dementia care. • Ms Quantock (NED) noted the increase in aggression in ED due to lack of police presence and asked if this is evidence based as there is a lot of interesting evidence that we can learn from. The ACN, Medical Division advised that de-escalation training is an area that we are lacking in. This is predominately around patients being brought into ED as this is considered a safe place for them but they do not need to be in hospital. It is around how we keep these individuals safe but in a more appropriate environment. Ms Quantock (NED) queried if the team have considered having discussions with the senior team in the police to agree a way forward. The CNO confirmed that the Managing Director is having these discussions at the right level. We are pursuing this in general terms in particular around adults and having a suite as a place of safety which is not in ED. There is a particular problem with children and young people with the perception that the room in ED is not suitable for them. The CNO is arranging a meeting with key staff in the police, Local Authority, Mental Health services and ourselves to discuss how we ensure that the right action is taken for each child and young person to ensure that when they present to the hospital, they are cared for in the right place.	

	• Mr James (Chair and NED) noted there were a lot of responses to the Friends and Family questionnaires with tables included in the report, and asked what we do with this information and what details can we glean from this. The ACN, Medical Division advised that meetings are being held to understand this new process and dive further into the detail and put actions in to address any concerns raised. The CNO advised that once all the training has been completed, an Excel spreadsheet will contain all the information obtained. We are then able to drill down into a rich source of information of where we are doing well and where we can improve. The ADQG noted that a lot of work has gone into obtaining this information which is discussed at the Patient Safety Committee and will filter through to the Quality Committee via their minutes.	
	Resolved – that the Division Quarterly Report – Medical Division be received and noted.	
	MATERNITY REPORTING	
QC009/11.23	**MATERNITY SERVICES QUARTERLY REPORT**	
	The ADM presented the Maternity Services Quarterly Report and the following key points were noted: • The Executive Summary of the Report describes some of the changes in terms of reporting. • It has been agreed locally to present the PQSM Report to the Quality Committee and Public Board of Directors on a monthly basis, the latter with the minimum data set as the data around maternity loses could be identifiable. This information will be presented to the Private Board of Directors meetings. • Maternity Triage – The planned estate improvements are now underway. We have recruited to the core team and training for the BSOTS programme has been planned. Currently this is scoring as a 20 on the Risk Register which we expect to reduce by February once the BSOTS is fully implemented. • Workforce / Staffing – The service has a vacancy rate of 2.84WTE. Newly qualified staff will be taking up these vacancies which has meant that there will not be any agency staff from now until the end of February as the new recruits join the Trust during this period. • Following a grant fund from the LMNS to invest in the Trust's Maternity Website, this has enabled a midwife to focus on this work. We are now in a position to launch the website in the near future. • Service User Involvement – The Maternity Voices Partnership Chair has resigned from this post due to other commitments. Our Maternity Safety Champions continue to meet regularly along with meetings with the Perinatal Quad. We have Executive support to raise any concerns to the Board of Directors if required.	

	• We have signed up to the RCM Caring for You Charter in May which outlines the commitment to care for our midwives and support staff to facilitate them to care for women and their families. • Saving Babies Lives Care Bundle V3 – There are 6 elements within this year's Bundle. The LMNS are required to review the evidence we provide and confirm compliance over 2 quarters. The LMNS are also supporting us in achieving this compliance. The first check has been undertaken and the team will continue to progress the work with the second review due in January. Following the LMNS feedback, the Trust Board will be asked to delegate sign off to the Executive Safety Champion and the Chair of the Quality Committee. • CNST – The LMNS will peer review and sign off our compliance with the CNST in January. Due to the timings of our Board of Directors meetings, the Board of Directors will be asked to delegate sign off to the Quality Committee at the end of January. • Training – The trajectory for compliance is positive and we are expecting to achieve 90% across all groups (except Anaesthetic Registrars which is at 81%) by the beginning of December. Should this not be met, the CNST standards will accept 80% compliance with the submission of an Action Plan to the Board of Directors. • Mr James (Chair and NED) noted the CNST issue around obstetric rest times for staff which is not possible for us to achieve due to our small size. Are we hoping to reconcile this and have a justifiable position to enable us to comply with these standards? The ADM confirmed that a meeting is being held with the Regional Obstetricians to discuss this and we are able to be compliant with an Action Plan in place. The Royal College Of Obstetricians released guidance around on call and rest periods but we only have a Consultant on call. This will mean significant changes to how we have been working out our on calls. Having on call prior to a SPA session is one option being explored. There are challenges around how we manage job plans to enable this and it was acknowledged in the Royal College Of Obstetricians paper around how challenging this is to achieve with a small team. • The CNO advised, regarding the CNST 10 Standards, that we rely heavily on the LMNS to review all of our Standards rather than just some to provide more assurance and reassurance. Due to timings of the meetings, we will require the Board of Directors to delegate a lot of the responsibility to Mr James (NED) as Chair of the Quality Committee, Mrs Martin (NED) as Non-Executive Safety Champion and the CNO as the Executive Safety Champion. Most of the scrutiny will be around the Saving Babies Lives Care Bundle V3 as this is significantly different from the previous set of Standards. • Mr James (Chair and NED) advised that we need to understand more around the issues and challenges raised in the Report and asked for each report to pick up on one of these areas for a deep dive each month.	**AS**

	<u>Resolved</u> – that: **(A) The Maternity Services Quarterly Report be received and noted.** **(B) Future Reports will contain a deep dive on one of the issues and challenges in the Department.**	**AS**
QC010/11.23	**<u>PQSM REPORT</u>**	
	The ADM presented the PQSM Report, which was taken as read, and the following key points were noted: • The ADM advised of a late foetal loss, which was unavoidable, with the family being supported by the Bereavement Midwife. There was also one neonatal death, again with no issues around care found, with the family also being supported. • There was one case reportable as a maternal death to MBRRACE. The background of this case was provided but there were no concerns around the care provided. • There was one case reported as a moderate incident. This highlighted an issue across the Trust with EPMA discharges to GP practices. An Action Plan is being developed on how we manage maternity cases. A further meeting is being held with the Lead in Primary Care Services to discuss this further. • It was agreed to review all discharges from August to November as prior to this date, GPs would have received a paper notification of a discharge so there would not have been a significant delay in this information being received if not also sent out electronically. After August, no paper copies of discharges were sent to GPs. • During October, there were no cases referable to HSIB. • There are workforce gaps in the Medical Services. These were all covered without the use of Locums during October. There are robust processes in place to employ Locums in line with CNST Standards. • All midwives completed their training despite the pressures. • There has been an increase in the multidisciplinary team ward rounds to 96% in October. • There was one new claim received which relates to a case which was referred to HSIB in 2021. The learning was addressed from this case. The background to this case was provided to the meeting.	

	• The CNO advised that an issue was picked up with Discharge Summaries across a number of specialities, The Discharge summaries were either being partially or not completed for Primary Care. Maternity were largely effected by this. Discussion was held around this issue at the Safety In Sync meeting held this morning. There is a risk that women may develop gestational diabetes if Primary Care are not informed of this and therefore have not been able to take appropriate action. The ADM advised that there are 1400 incomplete Discharge Summaries going back to 2021. We are reviewing the most recent to try to reduce the risk for this newest number of patients. Once this has been completed and communicated to Primary Care, we will review the older cohort of patients. The EPMA Team have advised that if a Discharge Summary was created with no essential information to the GP (paper birth notes were sent to the GP until August), we can delete this entry and close this down as there was no relevant information to send to the GP. This issue will be presented to the multidisciplinary group to review and agree a process. It will not be until the GPs receive these Discharge Summaries that we will be aware of whether the appropriate follow up was undertaken for these patients or if any action has been missed. We will then be able to review if any harm has been caused. • Mr James (Chair and NED) questioned how this issue occurred. The ADQG advised that this is due to a tick not being put in the TTO completed box. This is required to be ticked in EPMA even if the patient is not being issued with a prescription. A huge amount of work has been undertaken to communicate this out to staff and the EPMA are reviewing if a more robust system can be put into place. This is the primary source of this issue. • The ADM advised that this streamlined system is now the second part of the process. Doctors will normally have access to the Discharge Summary as many women are under the care of a midwife who is able to complete this. Midwives have started many drafts for the Discharge Summary but require the doctor to complete them which they are not always doing. We are now asking for routine Discharge Summaries to be completed by the doctor. The SHO who joins the ward rounds is in agreement with this process.	
	<u>Resolved</u> – that the PQSM Report be received and noted.	
QC011/11.23	**<u>STAFFING REPORT</u>**	
	The Associate Chief Nursing Officer, Surgery Division presented the Staffing Report and the following key points were noted: • This was another busy month with high volumes of patients coming into ED and admissions onto the wards. Boarding has also increased in month, especially overnight. Escalation areas are being utilised and Day Case is being opened more frequency overnight, along with the corridor in ED being opened for additional patients.	

	• The Biannual Staffing Review will be presented to the December Quality Committee meeting. This shows an increase in acuity and dependency in our patients. This is also being seen nationally. These issues have a big impact on the number of staff needed to care for these patients. • Many fill rates are over 100% due to these issues. • Frailty has been particularly effected, with an uplift in the Frailty Block. WTE staff are not yet showing on the fill rate data. • Positively, we are not seeing an increase in incidents in relation to staffing. Meetings are held 3 times a day to ensure we are deploying the right staff to the right areas and managing additional staffing. • There has been an increase in sickness in month. There is a stable picture regarding vacancy and turnover rates. • Temporary staffing usage has increased in month but there was a reduction in agency usage and an increase in Bank levels. • Overall, we saw 177WTE additional nursing staff required during the month. A breakdown with more detail will be included in next month's report with the reasons for these additional staff. 30WTE staff were required due to Boarding patients, 16WTE due to additional beds and 19WTE due to areas being open with no funded establishment. • We are continuing to see a decrease in the use of high level agency spend which is positive. • The CNO noted that we need to find a way to describe what the Associate Chief Nursing Officer, Surgery Division is starting to analyse regarding temporary staffing that we will continue to use that is not funded establishment. She was concerned around the financial effect this is having. There were 180WTE over establishment which we need to explain which is beyond our control. We need a different way to measure this. The CNO was also concerned around sickness levels. We had done really well with our Health Care Support Workers, getting this down to around 5%, but this is now back up to 10%. The central recruitment process was paused during the summer months which means that there was an increase in vacancies. One of our objectives was to stop Health Care Support Worker agency usage but we have not been able to achieve this due to these factors. • Mr James (Chair and NED) was supportive of finding a way to present this information which means that we can draw the background and reasons for this.	

	• The CNO advised that a national letter was sent out recently, with one of the requests for the ICS CNO to review provider CNO clinical areas that were not being staffed at gold standard. There is no definition of what gold standard is. We undertake an acuity review at least twice a year which we base our staffing on. This often does not meet the level planned and is below this recommendation. We have therefore pushed back on this advising that we use the evidence based tools recommended by NICE and staff to this level or where we feel appropriate with our professional judgement. The ICB CNO is fully supportive of this approach.	
	Resolved – that the Staffing Report be received and noted.	
QC012/11.23	**SAFETY WALKABOUTS PROPOSAL**	
	The CNO presented the Safety Walkabouts Proposal and the following key points were noted: • Various options have been tried to support NEDs with these walkabouts. We now have NED direct links with clinical areas to establish stronger relationships and understand the services provided. This will enable any issues to be raised at Board of Directors meetings as well as good news stories. • Patient Safety Walkabouts have previously included an Executive Director, member of the Quality and Satiety Team and a NED in attendance. The Quality and Safety Team coordinate these visits. This entails a lot of work to achieve. • The proposal is for the Divisions and the NEDs to agree between themselves where the visits take place and when. Some Walkabouts could be informal and may not require feedback but there is a process to provide feedback to ensure central oversight. • This proposal has been sent to the Executive Directors for their feedback. The CNO welcomed views from the Committee on the proposal in the report. • Mrs Twigg (NED) welcomed this proposal noting that from a NED perspective, it was an enjoyable experience and useful to have a framework to work with. The CNO advised that the plan was not to have a structure that limits how these Walkabouts are carried out with a more flexible approach required. Mrs Twigg (NED) noted that the onus is on the NEDs to pick out the appropriate data on the form to complete. • The Integrated Care Boards Representative advised that this is exactly what PSIRF is working towards and links in with these quality and oversight visits. • Mr James (Chair and NED) noted that staff and teams need to understand the purpose of this visit as well. He also suggested including in the Divisional Reports the feedback from the visits undertaken as another piece of triangulation.	

	<u>Resolved</u> – that the Safety Walkabouts Proposal be received and approved.	
QC013/11.23	**<u>CLINICAL EFFECTIVENESS AND AUDIT SUMMARY REPORT</u>**	
	The ADQG presented the Clinical Effectiveness and Audit Summary Report and the following key points were noted: • The minutes from the meeting are now being used to form the framework for this report rather than having a summary report. • The 4 key questions are being use to highlight any key areas – "What is going well? (Good Practice)", "What is off track? (Risks)", Area of concern (On track but risk of going off)" and "Escalations (Issues raised by Directorates)". • The Trust Audit Programme is largely on track with only 4 audits delayed. • The Trust is unable to participate in the National Ophthalmology Audit due to the lack of an electronic system to enable data extraction required for the audit. • Discussion was held around the lack of progress with LocSSIPs. NatSSIPs 2 has been released and we need to be following this. Therefore a refresh around this and focus on the new standards is being undertaken rather than trying to meet the old standards. • The Chest Drain Audit was discussed again and agreed that we need a Trustwide Policy now which was an agreed action to take forward.	
	<u>Resolved</u> – that the Clinical Effectiveness and Audit Summary Report be received and noted.	
QC014/11.23	**<u>PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT</u>**	
	The ADQG presented the Patient Experience Committee Summary Report and the following key points were noted: • The minutes from the meeting are now being used to form the framework for this report rather than having a summary report, as for the Clinical Effectiveness and Audit Committee. • The Committee was re-established in April. There is good engagement across the Divisions and rich conversations held. • There is ongoing concern around responses to complaints and time to respond. We are starting to see improvements with response times but further work is still required.	

	• Patient Property and Loss – This has been discussed previously and one Ombudsman complaint was partially upheld relating to this issue. A lot of discussions have been held and a Working Group set up around improvement processes. During 2023, £22k was paid out for loss of property. The focus on this area continues and work is occurring to improve disclaimers and encouraging patients to send valuables home. One of the issues around documenting property was the change from using paper to an electronic system. We are reviewing how we can improve this process. • Mr James (Chair and NED) noted that there appeared to be a lack of engagement around this issue in the report. The ADQG agreed that enthusiasm has declined but this is not slowing down the work that we are doing. This is not a Policy issue but a practice issue which we are progressing. • Mrs Twigg (NED and Chair of the Audit Committee) advised that this has discussed at Audit Committee. There are a number of good initiatives which are being trialled but we are seeing an increase in the number of losses. She asked that an update on patient property and loss be fed into the Audit Committee. • The CMO advised that a lot of information is captured from the Medical Examiner Service around feedback from Next of Kin which does not appear to be reported anywhere. She felt that it would be useful to feed a report into the patient experience committee around the learning and what we need to celebrate and what we need to improve.	**NO**
	<u>Resolved</u> – that: **(A) The Patient Experience Committee Summary Report be received and noted.** **(B) An update on patient property and loss to be fed into the Audit Committee.**	**NO**
	CONFIDENTIAL SECTION	
QC015/11.23	**<u>SERIOUS INCIDENT SHUTDOWN PROCESS</u>**	
QC016/11.23	**<u>ANY OTHER BUSINESS</u>**	
	There was no further business to discuss.	
QC017/11.23	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 21 December 2023 at 1.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**07/03/2024**
Title of Report:	Quality Committee December 2023 Minutes and Escalation 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 present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

2. Recommendation(s)

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

3. Executive Director Opinion[1]

NA

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

Quality Improvement

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

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

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

Digital

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

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

Productivity

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

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

Sustainability

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

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

Workforce

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

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

Research

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

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

Matters for Noting

1. **Boarding** – Quality Committee received an update on the impact of boarding patients which increased between October and November. Committee noted the impact on patient care and experience including the impact on mixed-sex breaches and the focus on better use of reverse boarding and use of the Discharge Lounge to ease pressures together with the "challenge event" aimed at increasing the rate of discharge.

2. **CQC Unannounced Inspection of ED**

   Committee received a report on the feedback following the CQC inspection on 6 and 7 December and the follow-up visit on 20 December. The formal report will not be received until the end of January but committee noted the concerns including around triage, routine observations, management of Sepsis and medications management for patients who spend an extended period in ED. Committee was assured about the prompt follow to the concerns raised and the demonstration of this to inspectors at the follow-up visit. Committee also noted the extreme pressures on ED staff given the ongoing level of service pressures. Frailty SDEC is now open and has been highlighted as good practice by the British Geriatric Society.

- Action had been taken led by the phlebotomy team following staff concerns about patients not having wristbands.
- We are falling short in our systems to ensure best quality of care for our dementia patients, with a vacant dementia lead role, withdrawal of funding for Admiral Nurses and complaints and concerns indicating that we need to improve patient-centred care. Actions are in hand and QC will continue to review as part of the quarterly divisional report.
- Pressures in ED have led to concerns about routine cleanliness, particularly cleaning of cubicles between patients. As a result we have established a dedicated "hit squad" to provide 24/7 rapid cleaning.

3. **Integrated Care Division Report**

- Good work highlighted reducing falls in our community hospitals and a number of projects working more closely with GP's in East Locality. Tissue Viability (pressure ulcers) remains the main area of concern and we discussed how the new patient safety framework is assisting in co-ordinating and focussing improvement work across the Divisions.

4. **Maternity Services – Monthly PQSM Report**

- Obstetric consultant vacancies have put pressure on rotas, though all covered by existing team and vacancy out to advert. Success in filing midwifery posts meant no rota gaps leading into the New Year.

5. **Maternity Services – CNST sign-off.**

- Work continues to establish our position with regard to the 10 standards and we expect, subject to LMNS review, to be able to meet all 10.

6. **Patient Safety Incident Response Framework (PSIRF) Policy**

- Committee approved the new Policy to support implementation of the national framework.

Matters for Escalation

None.

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 21 December 2023 at 1.00 – 4.00 pm
Via MS Teams

Present:		
Ian James	IJ	Committee Chair and Non-Executive Director
Ellie Bulmer	EB	Associate Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director – Arrived during Item 9 and left after Item 8.2
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Grace Quantock	GQ	Non-Executive Director – Joined during Item 3.1
In attendance:		
David Allison	DA	Associate Chief Operating Officer, Medical Division
Lynn Carpenter	LC	Quality and Safety Matron
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)
Hamza Katali	HK	Associate Chief Medical Officer, Clinical Support Division – Arrived during Item 9
Sue Moody	SM	General Manager - Acute and Countywide Services – Left after Item 8.2
Emma Smith	ES	Associate Chief Nursing Officer – Surgery Division
Rachael Skinner	RS	Integrated Care Boards Representative
Aime Symes		Associate Director of Midwifery – For Items 8.1 and 8.2

QC001/12.23	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Chizo Agwu, Chief Medical Officer, Tony McConkey, Clinical Director, Pharmacy & Medicines Optimisation, Natasha Owen, Associate Director of Quality Governance and Nicola Twigg, Non-Executive Director.	
QC002/12.23	**QUORUM**	
	Mr James (Chair of the Quality Committee and NED) noted that the meeting was not quorate when the Managing Director was not present.	
QC003/12.23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest received.	
QC004/12.23	**MINUTES OF THE MEETING HELD ON 30 NOVEMBER 2023**	
	Resolved – that the minutes of the meeting held on 30 November 2023 be confirmed as an accurate record of the meeting and signed by the Committee Chair.	

QC005/12.23	**ACTION LOG**	
	(a) QC007/11.23 – (C) – Boarding Reports - The Chief Nursing Officer (CNO) advised that due to the short turnaround for papers, the Care Quality Committee Inspection and the Junior Doctors strike, the comments made at the November meeting on the Boarding Report will now be included in the January report.	**LF**
	(b) QC007/09.23 – (C) – Cancer Patient Experience Survey Results – The Cancer Professional Lead and the Associate Director of Quality Governance (ADQG) 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. To discuss with the ADQG on a date for this.	**NO**
	(c) 006/10.23 – (B) – Quarter 2 2023/24 Safeguarding Reports – An update on the background to the change to the Trust following multi-agency procedures rather than having our own Policy will be provided in the next Safeguarding Quarterly Report.	**RH**
	(d) QC008/10.23 – (B) – Quality Priority – Pressure Ulcer Quarterly Report – The Associate Chief Nursing Officer will review having bespoke education for all staff, but particularly for our internationally trained nurses around pressure ulcers. An update will be provided in the next Quarterly Pressure Ulcer Report.	**RH**
	(e) The CNO advised that we have failed to progress with the recruitment of the Band 7 MASH role in the multidisciplinary Safeguarding Hub as we have been unable to confirm finances with the ICB Board. The Chief Transformation and Delivery Officer is pursuing this as the Chief Finance Officer is currently off work.	
	Resolved – that: **(A) The Action Log be received and noted.**	
	(B) Boarding Reports - The Chief Nursing Officer advised that the comments made at the November meeting on the Boarding Report will now be included in the January report.	**LF**
	(C) Cancer Patient Experience Survey Results – 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. To discuss with the Associate Director of Quality Governance on a date for this.	**NO**
	(D) Quarter 2 2023/24 Safeguarding Reports – An update on the background to the change to the Trust following multi-agency procedures rather than having our own Policy will be provided in the next Safeguarding Quarterly Report.	**RH**

	(E) Quality Priority – Pressure Ulcer Quarterly Report – The Associate Chief Nursing Officer will review having bespoke education for all staff, but particularly for our internationally trained nurses around pressure ulcers. An update will be provided in the next Quarterly Pressure Ulcer Report.	**RH**
	BUSINESS SECTION	
QC006/12.23	**<u>BOARDING / OPERATIONAL REPORT</u>**	
	The Associate Chief Operating Officer (ACOO), Medicine presented the Boarding / Operational Report and the following key points were noted: • **Introduction** - The introduction sets the context of what boarding is and the approach taken by the Trust. • **October / November Comparison** – Different data is being presented in this report due to the Care Quality Commission inspection and time restrictions. Any number in red is higher than the previous month. We boarded more patients in November with the lowest number boarded at 6 and the highest in the mid 30's. Many days we are at least 20 or over. • **KPI Overview** – The average number of boarders was 17.5, with 526 in month. This peaked at 27. These are considerable numbers given our bed base. Boarding time data is not available as Maxims does not store historic bed moves. Operationally we board roughly 80% of patients during the daytime (ie before 7.00 pm). • **Quality and Safety- Complaints and Concerns** – There are some ongoing concerns. An example of one compliant was given. There has not been a significant increase in the numbers received. • **Quality and Safety – Incidents** – There were 4 incidents in November, with less reported in October. There is a concern that staff are not reporting incidents as we could be building a tolerance but this is not proven. The themes are included on the slide. • **Quality and Safety Overview** – We are not consistently applying the Standard Operating Procedure, particularly around reverse boarding. We have expanded the Discharge Lounge hence less patients to reverse board. It is difficult to board on AMU as this is a poor patient experience. • **Conclusion** – There are ongoing discharge delays which are reducing our inpatient bed capacity and are increasing our bed capacity. We are struggling to fill the Discharge Lounge – there are usually patients to move. We need to review the process to fully utilise this. The live Discharge Lounge dashboard refreshes every 15 minutes. The Frailty Wards have been subject to excess boarding and have the highest numbers of discharge delays. Boarding numbers on Arrow and Lugg Wards show the need for specialised acute beds.	

	• **Next Steps** - We continue to collect available data with monthly reporting to the Quality Committee. Further work is needed to reduce the number of discharge delays, particularly frailty. The 20 Patient challenge event is occurring during November and December with the aim to discharge an additional 20 complex discharges over a 4 week period. Quality and Safety data to be presented monthly going forward to align to other KPI's (excluding time of boarding data – unable to provide). Continue to optimise Discharge Lounge occupancy every day against new criteria and additional spaces. Zero tolerance for discharge delays on Lugg and Arrow Wards through winter. Re-emphasise that wards choose who to board and where, and that site team only facilitate/monitor. Refocus reverse boarding as the priority when patients not suitable for Discharge Lounge. Monitor impact of new ward-based Flow and Discharge Co-ordinator role on the method and extent of boarding (and use of Discharge Lounge). Ensure boarding/use of Discharge Lounge is part of ward huddles. • The Integrated Care Boards Representative noted that teams and wards are in a difficult position. NHSE are concerned around the impact of boarding on mixed sex breaches as the Trust are flagging in the top 7 nationally. This has been discussed previously at Quality Committee. Safety is the driving factor and is often what contributes to mixed sex breaches. Wards are keen to get patients into a bed space and we appreciate any information around reverse boarding where possible. Any additional detail around how mixed sex breaches are being best managed within this context would be appreciated. • The CNO advised that if boarding numbers were lower we would have more choice but these are not driving our mixed sex breaches. The aim is for these not to occur. When we have higher numbers it is more difficult to manage with a higher potential for an increase in our mixed sex breaches. We are concerned that staff will not have time to report mixed sex breaches with current pressures. • The CNO questioned whether we have set some evaluation criteria for our new Discharge Co-ordinators. The ACOO, Medicine advised that this needs to be agreed. • The CNO noted that we drafted a letter in October 2022 when we first introduced boarding to give to patients to explain why we are doing this. Are we still giving this letter out? The Associate Chief Nurse, Medical Division advised that this is requested but will review and ensure that this is occurring. The Associate Chief Nursing Officer, Surgery Division advised that the Sisters go around to discuss with patients the situation. • The ACOO, Medical Division queried whether correlating boarding activity with Discharge Lounge utilisation would be useful to include in the report. The CNO advised that this was one of the measures agreed at the last meeting and will be included in future reports.	**DA** **SH**

	• Mr James (Chair and NED) advised that the minutes from the last meeting will include the details of what was agreed. We need to focus on flow and discharge and around whether we can do more around quality and safety for patients. We need to push back that we do not want to normalise this as this is a temporary measures but we need to challenge the issues around dignity and privacy. • Mr James (Chair and NED) quoted a report from the Nuffield Trust that 80% of discharges are with the Community and was concerned that we do not entrench our view that most issues are around delays that sit outside of our ability to do anything about them.	
	<u>Resolved</u> – that: **(A) The Boarding / Operational Report Report be received and noted.** **(B) The Associate Chief Operating Officer, Medicine will review whether we have set some evaluation criteria for our new Discharge Co-ordinators.** **(C) The Associate Chief Nurse, Medical Division will review and ensure that patients are being given the letter explaining the background and reason for boarding.**	**DA** **SH**
QC007/12.23	**<u>CQC UNANNOUNCED INSPECTION FEEDBACK</u>**	
	The CNO presented the CQC Unannounced Inspection Feedback and the following key points were noted: • The Inspection took place from 7.00 pm on Tuesday 5th December until 4.00 pm on Thursday 7 December. The rationale for this Inspection followed on from a Whistle Blowing incident in April this year. This arose following an opportunity to move the Emergency Department (ED) back into a single footprint rather than an Ambulatory ED as well. We responded to the whistleblowing and at the time the Care Quality Commission were satisfied with our response and the associated ED Summit was planned around improvements to be made around ED and the associated pathways. • Since that time, the Care Quality Commission have received a number of routine enquiries relating to ED including the Regulation 28 related to triage. The Care Quality Commission also access the national system around complaints and incidents. Given the various sources of intelligence they had ongoing concerns and arranged the unannounced inspection.	

	• There were a number of safety concerns raised and these are summarised in the letters attached and circulated to Quality Committee members. If these are not sufficiently dealt with, this could lead to an inadequate rating for the Safety Domain. The Care Quality Commission visited again yesterday to check that the changes we advised we have made in our communication with them during the inspection and subsequent letters had been implemented. • In summary, the main concerns were the management of sepsis in ED in terms of compliance with the Sepsis 6 Bundle and prescribing of antibiotics in a timely way, which was poor across the board. They were concerned around our routine observations of patients and escalation of deteriorating patients. They were also concerned around triage – when ED made service improvements and changes were made, the team were keen to introduce the Pitt Stop. Pit Stop enables rapid senior clinical review and is gold standard treatment. However given that the ED is overwhelmed with patients, this meant that some high risk patients were potentially waiting for a long period of time for triage and review. The Care Quality Commission could see that we are still aspiring to deliver this, although we are not yet introducing nurse led triage of patients within 15 minutes so that we are aware of our highest risk patients. • There were also concerns around multiple systems in use in the department. Symphony (computer system used in ED) is not designed for long stay patients or a prescribing system. There are a number of patients waiting in ED for a long time and if admitted into our care, are entered onto Maxims with EPMA used to prescribed their medications. They were not concerned around the patients who are not admitted and either seen and discharged or those or are seen and referred to a speciality team. They were concerned around the patients who are due to be admitted but not seen and therefore not on EPMA. This relies on a nurse or doctor to remember to prescribe routine medications when they are due given symphony is not a prescribing system. The Care Quality Commission are concerned around our oversight of patients in the Waiting room and on the internal corridor. We can have 3 – 4 patients on a trolley with a “corridor nurse” to care for them but they are sometimes called away for other urgent duties. In response to the findings, we responded immediately to anything that was escalated to the ED team or the CNO. A Safety Summit was held with the Division and ED colleagues on the Friday after the Inspection. A further Safety Summit was held on the following Monday around medications in particular. A weekly governance meeting with ED colleagues, Divisional colleagues, the Chief Operating Officer, CNO and Chief Medical Officer has been set up for a regular catch up regarding the actions agreed to ensure these are progressing in a timely manner. We will continue with these meetings until we are satisfied that all the changes are in place.	

	• The Care Quality Commission visited again on 20 December – the Inspector who attended both visits could see the changes put in place since the original Inspection and the work in progress to further improve. We are hopeful that they have seen sufficient actions taken and this will avoid any regulatory sanctions but we will not be advised of this until their report which is due at the end of January. We have also put in additional staffing (nurses and Health Care Support Workers (HCSW)) in the Waiting Room who oversee this and undertake observations and intentional rounding. We also have an additional triage nurse if needed and additional HCSW to ensure there are always staff if there are patients in the corridor. Staff feel safer with less risk with these changes put in place. A number of staff have been upset by this Inspection findings despite their best efforts – we cannot underestimate the pressures this is placing on them. The CNO is concerned around the team, but is amazed that they continue to be so positive. . There is a draft Action Plan which will be presented to the next Quality Committee meeting. • Mr James (Chair and NED) noted the pressure on staff anyway even without this additional stress. We need to ensure that our focus remains on patient safety and care. • The Associate Chief Nurse, Medical Division advised that staff have embraced the concerns raised and turned this into a positive. Some of these were not a surprise and areas that we are already aware of and are working on to improve. Having a fresh pair of eyes in the Paediatric Department was useful as they picked up on some areas we were not aware of. We are pursuing update training for those nurses on night shifts to ensure they have the appropriate skills and competence to care for paediatric patients as training has been difficult to access and not all staff were up to date. • Mrs Martin (NED) thanked the team and the CNO for the helpful description and background. It is incredible how staff keep going under all of this pressure. They have the full support of the Board of Directors and offered any support that they needed. The CNO advised that staff are upset and have been offered debriefing sessions where appropriate. • Mr James (Chair and NED) advised that we need to consider how we support staff to transform how we work in the future. • The CNO advised of the next steps – the Care Quality Commission have 56 days to produce a draft report. This is due at the end of January. We have a 2 week opportunity to provide any additional evidence that they will consider in the context of this report (3 January). ED have a couple of audits and 4 Standard Operating Procedures that we can share with colleagues at the Care Quality Commission. Between now and the end of January, the Care Quality Commission could issue a regulatory breach notification and sanction. We will then receive the report for factual accuracy – we have up to 14 days to respond to this. This was a focused Inspection and therefore all 5 Domains will be reviewed.	

	<u>Resolved</u> – that the CQC Unannounced Inspection Feedback be received and noted.	
QC008/12.23	**<u>MORTALITY REPORT</u>**	
	The Mortality Report was taken as read and the following comments were noted: • Mrs Hill (NED) noted that there has been an increase in numbers, particularly in heart failure, and questioned at what level we would be concerned. Is there an underlying theme? The Managing Director agreed there is concern around this with work starting on reviewing this as resource has been found to support this. The CNO advised that we are also focusing on sepsis as this is an outlier too.	
	<u>Resolved</u> – that the Mortality Report be received and noted.	
QC009/12.23	**<u>DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE DIVISION</u>**	
	The General Manager - Acute and Countywide Services (GM) presented the Divisional Quarterly Report – Integrated Care Division and the following key points were noted: • The number of falls in Community Hospitals are reducing which we are very proud of. • There have only been a few complaints but these have been complicated and the Ombudsman have been involved. There is 1 outstanding complaint which is being signed off by the end of the week. • The top 10 themes from Friends and Family are included in the report. • Tissue viability is the main concern – an Action Plan is included in the report. • We now have 3 Care Home Clinical Practitioners in post that include tissue viability. There has been good feedback from this and good engagement with staff in the Community. • The East Locality are working well with the GPs on a number of projects. • Following additional funding from the ICB, additional therapy posts have been recruited to which has meant a reduction in waiting lists across all 3 professions. This has enabled the team to transform their services and provide more training consistently into schools. The detail around the transformation work is included in the report.	

	• Stroke Community Project – The achievements to date are included in the report. This is around providing support to paid or unpaid careers looking after stroke patients who require complicated manual handling. • Community Urgent Response Work – A graph is included in the report which shows the success of this work. This is around providing urgent response to long term condition patients. This shows the work we are doing and where referrals are received from, which is very board and expanding all of the time. The plan is to try to keep these patients out of hospital unnecessarily. • There are ongoing concerns around recruitment across the whole Division. The Divisional Development Plan is included for detail. • There have been issues at Leominster Community Hospital with the team well supported by Board colleagues. There is a new Ward Manager now in post. • Mrs Bulmer (ANED) noted that the falls data for Ross Community Hospital stood out. The GM advised that these numbers are very variable. We had between 20 to 30 falls a few years ago, so 7 is still very low compared to previous figures. We are talking to staff using the Afloat tool and how much observation a patient at risk of falls should have. HCSW are now on the ward to observe these patients. • Mr James (Chair and NED) noted that we need to work out how we cross reference our tissue viability work within our new Patient Safety Incident Response Framework (PSIRF) approach. The GM advised that she is also the Chair of the Pressure Ulcer Panel and pressure ulcers were one of the first areas to move to PSIRF. This is working well with each Division having their own Action Plan and learning from each incident presented. There is a clear plan for the same issues arising. Mr James (Chair and NED) questioned whether there is an expectation that the new approach will enable us to focus on improvement and the need to understand how best we use this new process. The GM confirmed that this is the case with figures remaining consistent since changing over to the new process. The issue arises if a skin check is not carried out in ED as we do not know then when the damage occurred. This has really improved. The other big concern is our vulnerable patients in the community that we do not regularly see. How we manage this group of patients is a Divisional concern and an area that they are working on. • Mr James (Chair and NED) queried whether the integrated work being carried out in the East Locality is planned to be replicated across the whole county or whether each Locality works individually. The GM advised that both ways of working will be put into place – we are trying to work broadly across the Localities.	

	<u>Resolved</u> – that the Division Quarterly Report – Integrated Care Division be received and noted.	
QC010/12.23	**<u>DIVISION QUARTERLY REPORT – CLINICAL SUPPORT DIVISION</u>**	
	The Operational Clinical Lead Radiographer presented the Division Quarterly Report – Clinical Support Division and the following key points were noted: • The number of incidents has reduced slightly. This is due to staff getting used to InPhase and partly due to a training issue. • There were no Serious Incidents or PSIRF this quarter. There is only one remaining Serious Incident remaining, detail in the report. • There were 8 complaints – 3 of which are now fully resolved. • Audiology – Due to the issues highlighted, we are taking part in the Bronze meetings. We are also undertaking a look back exercise over the last 5 years. This will be completed by the end of the month – there have been no issues found so far. • Radiology – Rapid AI technology for CT head has been implemented which will support speedier decision making for patient treatment with our tertiary centre as part of the Stroke Network for the Thrombectomy Pathway. A Consultant Breast Mammographer is now in post from November, which is increasing our 2WW clinic capacity. The CDC Business Case has been approved. MRI and CT reports are under the 28 day turnaround in line with expected national standards. 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 (96%), CT (97%), USS (99%) and DEXA (92%) within 6 weeks. Of concern is the radiopharmaceutical contract which was due to go live in October saving £6k per month. However the new service provider, Cardiff University Hospitals, was told to cease activity by the MHRA. Service supply for our Nuclear Medicine Service is being upheld again from within the Midlands. New contract discussions are taking place with New Cross. • Pathology – A new Blood Sciences Manager has been appointed to cover a secondment. The CESR group has now started as part of the Midlands wide initiative. Our local CESR candidate is now reporting some cases. There is concern around the lack of Histopathology and Microbiology Consultants. Turnaround times for Histopathology is of concern which is a national issue. We are working within the SMP to take forward a 6 point Transformation Plan.	

	• Pharmacy – The new Deputy Chief Pharmacist has commenced in post. We have also appointed a Lead Pharmacist for Education and Training who is starting on 8 January. Relocation of some Pharmacy staff off site to St Owen's Chambers to expand operational footprint at the Trust has occurred. A CCN has been approved to convert existing office space in the Trust into a Dispensary annex to provide additional operational dispensing area. Approximate. timeframe – mid-January. We continue to have recruitment issues but this has plateaued currently. • Patient Access – The RMC have now absorbed the Administration Validation Trustwide with automated processes now in place and robust processes in place for closure of referrals. Super Saturdays are taking place in the Oxford Suite for General Surgery with over 5 Consultant in attendance and a mini pre-op available. We have achieved 4½ out of 5 stars for our Friends and Family scores on Outpatients. RMC staff are working closely to support all the cancellations due to the strikes and rebooking clinics at short notice. A cleanliness 5* rating through Clinical Support Outpatient areas has been achieved. Short notice clinic set up and cancellations are still a challenge. Forward planning meetings are being arranged and the Outpatient room allocation project should help reduce these numbers. • Cancer Services – Cancer alliance navigations now sit under the line management of Cancer Services. We are also recruiting to a new role of Cancer Transformation Manager. We are especially proud of the number of compliments received across Cancer Services, resilience in the teams in what has been operationally challenging times and increased long term sickness and a quarterly cancer deep dive which has developed more actions to improve cancer performance across the Trust. We are worried about our Haematology Service. There is no agreement from other Trusts in relation to transferring patients if we lose any of our current locums. We are not achieving our cancer performance targets or trajectory for patients above 63 days, now going into Tier 2. We are also experiencing patient complaints due to the corridor closure – these are being updated to the Estates Team. • Mr James (Chair and NED) noted that Pharmacy vacancies having plateaued is very positive, with all the recruitment put in showing an impact. • The Managing Director noted that a number of staff moved to Primary Care for better hours, which happened nationally, which appears to have halted now. A lot of effort has been put in by the Clinical Director, Pharmacy & Medicines Optimisation and his team to recruit staff and improve retention. • The Managing Director was informed this morning that we are probably not going to be escalated for our cancer performance. This will need to be approved by the National Team.	

	• Mrs Hill (NED) highlighted that the in depth lookback exercise of a Locum Histopathologist's reporting remains ongoing, with 3 patients identified who had a delay to treatment or an unnecessary surveillance procedure due to the original histology report. Who have had a Duty Of Candour, and queried if there are any further issues. The CNO advised that a full briefing on the Histopathology service is being presented to the next Quality Committee meeting which should cover this question. • Mr James (Chair and NED) noted regarding the Haematology risks, there is no fall back if we lose our Locums and asked what the plan is. The Managing Director confirmed that this is the issue. Last time this occurred we had to get Region involved to get a plan in place if we were unable to offer a service. We are looking for a backup plan should this occur again. There is no agreement to this as yet although we do intend to have this in place. This is around all our fragile services and what we can do about them.	
	Resolved – that the Division Quarterly Report – Clinical Support Division be received and noted.	
	MATERNITY REPORTING	
QC011/12.23	**PQSM REPORT**	
	The Associate Director of Midwifery (ADM) presented the PQSM Report, which was taken as read, and the following key points were noted: • During October there was 1 moderate incident reported regarding Insights and EPMA discharges. There were no HSIB cases. • Workforce – There was a noted increase in Obstetric Consultant rota gaps. This is due to some vacancies and sickness and was all covered by the existing team. A job has gone out to advert with interviews in the New Year. • The number of midwifery gaps has decreased from September. The Band 5 Midwives are finishing their supernumerary time and are now all included in the numbers with no rota gaps in the New Year. • Our current true Midwifery vacancy rate is 2.84WTE. Maternity leave currently leaves the service with an actual vacancy rate of 7.94WTE with 6WTE staff having been recruited and joining the Trust between December and February. • Compliments – 15 were received in October. Friends and Family Test – We are looking at how to extract and use this data. Community Midwives are promoting this. • There was 1 complaint in October – detail within the report.	

	• There were no concerns raised by the Safety Champion Walkabout which occurs each month. This is taking place at different times of the day and in different areas. • There was 1 new claim relating to a HSIB case – details within the report. • The Managing Director questioned the progress on Continuity Of Carer. The ADM advised that she is working on a draft papers with costings being worked out. Once this is received, a presentation will be given to the Quality Committee.	
	Resolved – that the PQSM Report be received and noted.	
QC012/12.23	**CNST 10 – SUBMISSION FOR SIGN OFF**	
	The ADM presented the CNST 10 – Submission for sign off and the following key points were noted: • We expect to achieve all 10 Standards again this year. The Trust Board were asked to sign off on much of the work but due to the timings of the Board meetings, they have delegated responsibility to the Quality Committee. • Safety Action 1 – We are compliant, with no deaths meeting the criteria in this time period. We are working with Worcester colleagues and the LMNS to review any cases. • Safety Action 2 – We have already declared compliance. This has been verified and confirmed as passed. • Safety Action 3 – The audit needs to be signed off and the action plan confirmed (Appendix 1 of the report). There are a series of actions in the template. The CNO advised that we are at risk of not complying if we do not have an Action Plan in place. We also need to ensure that we are making progress against this. The CNO also felt that this should be amber and will ask the team to update this with monthly updates. • Safety Action 4 – We are compliant with Section B and C. We are compliant with Section A in terms of the number of Obstetricians employed. The more challenging aspect, which a number of Trusts are challenged with, is around the RCOG compensatory rest. Mrs Ibrahim and Mrs Tahir met with the Regional Obstetric Lead around how we can achieve this. The guidance is outside of the practice we use for any other medical workforce model. There are suggestions around setting up on call to fall on the day before a day off or before SPA time but neither are really suitable. The document also specifies that small Trusts will find this more difficult to achieve as they do not have the breadth of staff. The Action Plan on how to achieve this (Appendix 2) should enable us to be complaint.	

	• Mrs Martin (NED) noted that there must be a solution for a small Trust, as we are, or this is not going to be achievable. • The Managing Director noted that this is guidance and not a standard but is being used by the CNST as a standard. No other specialties have this in place. How do we currently manage compensatory rest if the Consultant comes into the Trust? The ADM advised that if a member of the team comes in, then cover is found. We have always left it to the doctors professional judgement to determine how they feel as they know their limitations. • The Associate Chief Medical Officer, Clinical Support Division advised that currently we take our own initiative on what we able to work and what we need covered. It is rare that cover is needed. • Mr James (Chair and NED) noted that this is a weak plan at the moment. The ADM advised that this is the minimum expectation and that it is envisaged that this will be removed from Year 6 of the scheme. We should have the guidance by the end of the spring and will know what it might look like then if we need to put this into place. Mr James (Chair and NED) was in agreement to endorsing a plan that we put in place if and when we need to. • Section D – Neonatal Workforce – An action plan was developed last year (Appendix 3) and we need to show progress against this. The CNO advised that this is a refresh from last year. We do not quite meet the standards due to our small size but we mitigate this with plans for more training. We were deemed compliant last year for our submission and have no concerns over compliance this year. • Safety Action 5 – Appendix 4 is for information. • Safety Action 6 – We believe that we will be compliant, we are just awaiting confirmation from the LMNS. 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. Following the LMNS feedback, the Trust Board has delegated sign off to the Executive and Non-Executive Safety Champion and Chair of Quality Committee. • Safety Action 7 – This is progressing well – we consider ourselves compliant. • Safety Action 8 – We consider ourselves compliant. We have achieved 90% training across all areas. There was a last minute addendum that if 80% was achieved with a plan to achieve 90% within the timeframe this was acceptable. The action plan is included in the appendix. Both Appendix 5 and 6 require approval. The CNO was happy to support this and the LMNS have also reviewed this. Mr James (Chair and NED) was happy for the LMNS to provide the assurance around this.	

	• Safety Action 9 – Awaiting LMNS review. • Safety Action 10 – Compliant.	
	<u>Resolved</u> – that the CNST 10 – Submission for sign off be received and the Appendices 1 – 6 be approved.	
QC013/12.23	**<u>BOARDING / OPERATIONAL REPORT</u>**	
	This was covered earlier in the meeting.	
QC014/12.23	**<u>PSIRF POLICY</u>**	
	The Quality and Safety Matron (QSM) presented the PSIRF Policy, which was taken as read, and the following key points were noted: • The Policy has been written on the national template and approved in draft by the ICB and the Patient Safety Committee. It has now been moved to the Trust template. • This is for approval at the Quality Committee prior to being sent to the Policy Review Group. • The process is around an important set of behaviours, culture and feeling safe to talk about concerns. A NED is asked to observe at the Patient Safety Panel. The richness of discussion and learning with clinical colleagues is very positive. All the NEDs were offered an open invitation to attend. • Mrs Martin (NED) asked from a One Herefordshire view, how much work is being done together with primary care. The QSM advised that we are currently not in the same place but we do work closely together on safety concerns and incidents. There is not a national requirement for Primary care to implement this at this time. • The CNO noted that relationships and partnership working is key. We are not as integrated as we could be now that we have moved away from using Datix to embrace PSIRF which means that we are now on a different system to Primary Care who are still signed up to Datix. That said the QSM advised that none of the systems interconnect anyway and are often set up differently and therefore this is not a major concern. • Mr James (Chair and NED) advised of an ICB meeting with NED colleagues around how the ICB quality perspective may be able to be focused in a different way. Another meeting was around system issues across Primary and Secondary and Community Care. A further meeting is planned in February.	
	<u>Resolved</u> – that the PSIRF Policy be received and noted.	
	CONFIDENTIAL SECTION	
QC015/12.23	**<u>PATIENT SAFETY INCIDENTS SUMMARY REPORT</u>**	

QC016/12.23	**ANY OTHER BUSINESS**	
	There was no further business to discuss.	
QC017/12.23	**DATE OF NEXT MEETING** The next meeting is due to be held on 25 January 2024 at 1.00 pm via MS Teams.	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 February 2024 at 1.30pm via Microsoft Teams

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

Present:

Russell Hardy	(RH)	Group Chairman
Chizo Agwu	(CA)	Chief Medical Officer WVT
Charles Ashton	(CAs)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(AC)	Managing Director SWFT
Stephen Collman	(SC)	Managing Director WAHT
Richard Colley	(RC)	NED SWFT
Neil Cook	(NC)	Chief Finance Officer WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Catherine Free	(CF)	Managing Director GEH
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Paramjit Gill	(PG)	Nominated NED SWFT
Natalie Green	(NG)	Chief Nursing Officer GEH
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WHAT (present from minute 24.013)
Julie Houlder	(JH)	NED and Vice Chair GEH
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Helen Lancaster	(HL)	Chief Operating Officer WAHT
Vikki Lewis	(VL)	Chief Digital Information Officer WAHT
Kim Li	(KL)	Chief Finance Officer SWFT
Michelle Lynch	(ML)	Associate NED (ANED) WAHT
Anil Majithia	(AM)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Dame Julie Moore	(JM)	NED WAHT
Richard Oosterom	(RO)	ANED WAHT
Simon Page	(SP)	NED and Vice Chair SWFT (present from minute 24.009)
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED GEH
Naj Rashid	(NR)	Chief Medical Officer GEH
Jo Rouse	(JR)	NED WVT
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
Nicola Twigg	(NT)	NED WVT
Sue Whelan Tracy	(SWT)	NED SWFT
Umar Zamman	(UZ)	NED GEH

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 February 2024 at 1.30pm via Microsoft Teams

In attendance:

Jon Barnes	(JB)	Chief Transformation and Delivery Officer WVT
Julian Berlet	(JBe)	Deputy Chief Medical Officer WAHT (present from minute 24.012)
Ellie Bulmer	(EB)	ANED WVT
Paul Capener	(PC)	ANED GEH
Oliver Cofler	(OC)	ANED SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Phil Gilbert	(PGi)	NED (Non-Voting) SWFT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Richard Haynes	(Rha)	Director of Communications WAHT
Mark Hetherington	(MH)	ANED GEH
Erica Hermon	(EH)	Associate Director of Corporate Governance WVT and Company Secretary WVT/WAHT
Oli Hiscoe	(OH)	ANED SWFT
Suzi Joberns	(SJ)	Deputy Chief Finance Officer WVT (deputising for the Chief Finance Officer)
Rosie Kneafsey	(RK)	ANED GEH
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KL)	Communications Officer WAHT
Jo Newton	(JN)	Director of Strategy and Planning WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Gertie Nic Philib	(GP)	Chief People Officer GEH/SWFT
Peter Orton	(PO)	Communications Officer WAHT
Jackie Richards	(JR)	ANED GEH
Tina Ricketts	(TR)	Director of People and Culture WAHT
Sue Sinclair	(SSi)	ANED WAHT
Robin Snead	(RS	Chief Operating Officer GEH
Leigh Tranter	(LT)	Communications Manager SWFT
Jules Walton	(JW)	Deputy Chief Medical Officer WAHT

There were six SWFT Governors, and two guest observers in attendance. There were no members of the pubic in attendance.

MINUTE		ACTION
24.001	**APOLOGIES FOR ABSENCE** Apologies for absence were received from: Sarah Collett, Trust Secretary GEH/SWFT; Simone Jordan, NED GEH; Zoe Mayhew, Chief Commissioning Officer (Health and Care) SWFT; David Moon, Group Strategic Financial Advisor; Katie Osmond, Chief Finance Officer WVT; Bharti Patel, ANED SWFT; and, David Spraggett, NED SWFT. **Resolved – that the position be noted.**	
24.002	**DECLARATIONS OF INTEREST** The Chief Finance Officer for GEH declared that he had been made the appointed NED for Innovate Healthcare Services Ltd.	

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 February 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	Dame Julie Moore (NED WAHT) declared that she had been appointed as Chair of Health Data Research UK. **Resolved – that the position be noted.**	
24.003	**GEH PUBLIC MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023** Mrs Martin (NED WAHT) noted that she was marked as in attendance at the 1 November 2023 meeting rather than in the apologies section. She requested that this be amended to the minutes. **Resolved – that the GEH public Minutes of the meeting held on 1 November 2023 be confirmed as an accurate record of the meeting subject to the amendments above and signed by the Group Chairman.**	
24.004	**SWFT PUBLIC MINUTES OF THE MEETNG HELD ON 1 NOVEMBER 2023** Mrs Martin (NED WAHT) noted that she was marked as in attendance at the 1 November 2023 meeting rather than in the apologies section. She requested that this be amended to the minutes. **Resolved – that the SWFT public Minutes of the meeting held on 1 November 2023 be confirmed as an accurate record of the meeting subject to the amendments above and signed by the Group Chairman.**	
24.005	**WAHT PUBLIC MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023** Mrs Martin (NED WAHT) noted that she was marked as in attendance at the 1 November 2023 meeting rather than in the apologies section. She requested that this be amended to the minutes. **Resolved – that the WAHT public Minutes of the meeting held on 1 November 2023 be confirmed as an accurate record of the meeting subject to the amendments above and signed by the Group Chairman.**	
24.006	**WVT PUBLIC MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023** Mrs Martin (NED WAHT) noted that she was marked as in attendance at the 1 November 2023 meeting rather than in the apologies section. She requested that this be amended to the minutes. **Resolved – that the WVT public Minutes of the meeting held on 1 November 2023 be confirmed as an accurate record of the meeting subject to the amendments above and signed by the Group Chairman.**	
24.007	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.007.01	Chairman's Remarks	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 February 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	The Group Chairman started the meeting by informing the Foundation Group Boards of the sad passing of Winston Crasto, Consultant and Clinical Director of Medicine for GEH. He explained how Winston was a loved colleague and would be greatly missed by all who worked with him. The Group Chairman passed on his sincere condolences to Winston's family. **Resolved – that the position be noted.**	
24.007.02	Foundation Group Performance Report (minutes 23.058 and 23.080.01 refers) The Managing Director for WVT confirmed that the cancer diagnosis following ED attendance data had been received. This would be included in the next Foundation Group Performance Report at the May 2024 meeting. **Resolved – that the cancer diagnosis from ED attendance be included in the May 2024 performance report.**	**MDs**
24.007.03	Deep Dive into Additional Performance Measures – Theatre Productivity (minute 23.060 refers) The Chief Operating Officer for WVT confirmed that work was ongoing to record theatre utilisation data by cost per minute rather than by a percentage. He confirmed that this should be available in time for the May 2024 meeting. **Resolved – that the Chief Operating Officers look into recording theatre utilisation data by cost per minute rather than by a percentage.**	**COOs**
24.007.04	Gender Pay Gap Annual Report (minute 23.084 refers) The Chief Operating Officer for SWFT/GEH confirmed that a detailed breakdown as to the female to male pay gap by professional group and from across each of the nine protected characteristics had been shared with the individual organisations. **Resolved – that the position be noted.**	
24.008	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chairman provided an overview of the Foundation Group Boards Workshop and Cyber Security Training that had taken place in the morning prior to Foundation Group Boards. He explained that there had been a session on productivity from Lord Patrick Carter of Coles, and an important progress update on South Midlands Pathology which would improve pathology services for patients. The Group Chairman took the time to urge the public and members of the Foundation Group Boards to protect themselves online by updating their	

MINUTE		ACTION
	passwords, using a password manager where possible and not using the same or easily guessed passwords. **Resolved – that the position be noted.**	
24.009	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director for WVT presented the WVT update on performance to the Boards. She explained that the Emergency Department (ED) continued to be an area of concern, however performance was average compared nationally. With that said there had been an unannounced Care Quality Commission (CQC) visit in December that raised serious concerns about safety and reinforced that a congested ED was not a safe ED. The Managing Director for WVT explained that WVT's ED had been the subject of continuous redesign since Covid-19 but that the CQC had identified that the pathway didn't work effectively and consistently when faced with a congested department. She assured the Boards that WVT had responded to the initial safety concerns, partly by increasing the staffing level, but also by implementing operational digital dashboards. The Managing Director for WVT continued that the main cause of the congestion through ED was due to what was going on outside ED. She explained that a summit with the senior clinical teams and managers in the Trust had taken place to investigate why the department had become so busy since Covid-19, going from a 20 bed deficit to nearer a 60 bed deficit on a daily basis. The Managing Director informed the Boards that there were three main drivers: a growth in demand; a growth in length of stay; and, the medically fit for discharge (MFFD) cohort changing. She added that the prioritisation moving forward to address these issues would be industrialising Virtual Wards and implementing simplifying access into the community services, maximising Same Day Emergency Care (SDEC) and working with colleagues around Discharge to Assess (D2A) pathways. Added to this was the need to look at the broader demand and capacity analysis against the acute bed capacity. The Managing Director for WVT also highlighted that WVT's faster diagnosis standard had improved further since the figure in the Boards report and was now at 73 per cent in December and WVT had maintained that for January 2024. She went on to explain that this was nearing national average and would also start to improve the 62 day referral to treatment target for cancers. The Managing Director concluded by expressing that she was proud that despite the congestion in the hospital and ED, the Trust had managed to maintain their mortality statistics and were best in the Foundation Group in this area. She did provide the Boards with a warning that WVT's mortality indicators would be affected over the next 6-12 months once the SDEC coding was changed in April 2024. The Group Chairman invited questions and perspectives, and of particular note were the following points.	

MINUTE		ACTION
	Mr Oosterom (NED WAHT) queried about what it would take to scale up Virtual Wards. The Managing Director for WVT explained that it was about implementing it across all of the Trust's specialties but also aligning it more effectively to the community urgent response team and the right clinical advice at the right point of a patient's pathway. The Group Chief Executive added that following conversations with one of the National Urgent and Emergency Care Leads, there was recent analysis in the Health Service Journal (HSJ) that virtual wards were not that cost effective, however this was due to the scaling issue. One of the suggestions was to use Virtual Wards as a way of getting all patients home first more rapidly, and all specialties or wards have a cohort of patients that they are caring for in the community. He explained that this would help facilitate the earlier discharge and in turn improve outcomes. The Group Chief Executive felt that Virtual Wards was a big opportunity and something that the Foundation Group should be using to avoid admission as much as possible. The Managing Director for SWFT presented the SWFT update on performance to the Boards. He highlighted that ED had been a challenge for SWFT following a difficult winter, which had resulted in a drop in ED performance especially ambulance hand over time and 4hr performance. However, SWFT remained well within national average for ED performance and the drop had been due to a number of factors. The Managing Director for SWFT went on to explain that these factors included an increase in attendances to ED, around 20 per cent of ambulance activity being from out of area, occupancy had remained high in the hospital which had also impacted flow through ED. He highlighted that despite these challenges the Trust remained in a better place compared to previous winters which demonstrated the learning that had taken place. The Managing Director for SWFT took the time to thank community teams for their support in diverting patients away from ED and supporting with some of the urgent care needed within the community. He explained that this was reflected through the intention to award the Trust with the new Lead Provider for Community Integrator Services in Warwickshire. The Managing Director for SWFT highlighted the work that had taken place to sustain the 28 Day Faster Diagnosis Standard in Cancer Services, which had been sustained despite a large increase in two week wait (2ww) referrals. He explained that work was ongoing in the system regarding the Referral to Treatment (RTT) standards and remained a focus area. The Managing Director for SWFT thanked the work of the Trust's Theatre's, Endoscopy and ENT teams for sustained and increased theatre utilisation. The Group Chairman invited questions and perspectives, and of particular note were the following points. Mrs Whelan Tracy (NED SWFT) informed the Managing Director for SWFT that she was continuing to be made aware of information suggesting that there were safety concerns from patients in a South Warwickshire area still waiting their first Oncology appointment. She queried whether there was any assurance around this matter that could be given and whether it had been raised with the CQC. The Managing Director for SWFT explained that this did remain an area	

MINUTE		ACTION

of concern and focus for SWFT, however the concerns were not being seen through complaints but that didn't mean it was not being picked up or focused on. He assured the Boards that the Trust always have and continue to maintain dialog with the CQC over cancer and cancer issues. The Chief Nursing Officer for SWFT added that she met with the CQC on a monthly basis informally and shared the Trust's concerns about oncology during these meetings. She added that there was a monthly System Quality Review Meeting which was a formal meeting where she had also repeatedly raised her concerns over Oncology for the Trust and the system, and the CQC were supporting the Trust with those conversations.

The Managing Director for GEH presented the GEH update on performance to the Boards. She started by informing the Boards that GEH's ED performance remained challenged, and performance was expected to drop following a particularly challenging few weeks. The Managing Director for GEH expressed her apologies to GEH patients for the pressures faced and thanked the teams at GEH for ensuring safe care in such challenging circumstances. The Managing Director for GEH went on to discuss the mortality indicators for GEH and the Standard Hospital Mortality Indicators (SHMI) between August and July 2023 which were higher than expected, however this had returned back into normal range. She explained that previously staff sickness levels had been a challenge and whilst this was still an area of focus, absence was starting to reduce across the Trust. The Managing Director for GEH informed the Boards that Cancer performance was the Trust's biggest challenge despite the ED challenges, and the faster diagnosis standard had been affected significantly in December 2023. She explained that this was due to the fragility in the Urology workforce but also the high number of 2ww referrals into Breast Cancer. The Managing Director for GEH took the time to thank both SWFT and University Hospitals Coventry and Warwickshire (UHCW) who had supported GEH with this work. She assured the Boards that these had now improved and that the Trust was aiming to get to 75 per cent by March 2024 which was the national standard.

The Managing Director for GEH added that Elective work continued to improve and despite the challenges Elective work had maintained throughout January and into February 2024. She noted that RTT had slipped however work was underway to determine what could be done in house and what they needed to link in with partners on.

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

Mr Zamman (NED GEH) queried whether mortality rates were being monitored by deprivation considering that the Foundation Group were focusing on health inequalities and prevention. The Managing Director for GEH assured Mr Zamman that mortality was measured in two different ways, and they do take into account deprivation as part of that measure.

MINUTE		ACTION
	The Managing Director for WAHT presented the WAHT performance update to the Boards. He started with ED and explained that the Trust were working with community partners to develop their single point of access which was part one of the Trust's strategy to grow SDEC areas. The Managing Director for WAHT explained that ambulance handover delays continued to be a problem, especially at weekends and a large focus continued to be on improving this. The Managing Director for WAHT highlighted that flow continued to be an issue for WAHT and was the main issue driving metrics down, however the underlying reason of the issues relating to flow stemmed from the Frailty Model and General Medicine. A significant amount of work was taking place to restructure these areas in the short and medium term. The Managing Director for WAHT added that Cancer performance remained a key area to improve for WAHT with concerns specifically around Urology and Dermatology. He continued that WAHT had commissioned an external review into Urology to look at a pathway design and the report following this review had just been received back. WVT had been supporting WAHT with Dermatology and the Managing Director for WAHT expressed his thanks to those teams and highlighted the benefit of the Foundation Group, especially around improving fragile services. He concluded by informing the Boards that Elective work continued to be challenged however the Trust was looking into mutual aid options and internal capacity. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chief Executive highlighted that one of the challenges at the moment is ensuring we are delivering on the 76 per cent performance during March and there is a lot of effort from all Trust in the group on that. But this report has a lot of informative information to highlight variation across the trust. Variation is quite stark in the theatres utilisation across the group so he encouraged the COOs to make connections with the teams that are leading on this to ensure each trust was getting value out of that capacity as it will not only help financially but improve performance. The Group Chairman took the time to apologies to WAHT employees for the current staff car parking set up. He offered assurance that discussions and work were taking place behind the scenes to try and resolve staff parking issues as priority and that in the meantime WAHT staff would not be being charged for car parking. The Group Chairman also thanked all of the Foundation Group's front line teams for their continued efforts to provide safe, effective care. **Resolved – that** **A) The Chief Operating Officers' look at the variations in the Foundation Group Performance Report, particularly around theatre utilisation, and look at where improvements on productivity could be made across the Group based on best practice, and** **B) the Foundation Group Performance report be received and noted.**	**COOs**

MINUTE		ACTION
24.010	**GROUP ANALYTICS UPDATE** The Chief Finance Officer for GEH informed the Boards that progress continued to be made with Group Analytics Programme, however this had slowed down due to the pressures faced across the Foundation Group. He highlighted that the Group Analytics Board had been developing the capacity and capability of the informatics function, and the key element had been developing the Group Informatics Forum which enabled Informatics colleagues to share best practice between themselves. The Chief Finance Officer for GEH explained that Power BI had also been implemented as part of the Foundation Group's reporting tools to give access to the latest reporting technology. Each Trust were at different stages of developing reporting dashboards through Power BI, however developing them had been more challenging than envisioned and work was taking place to try and streamline the process. The Chief Finance Officer for GEH informed the Boards that work continued regarding making sharing data across the Foundation Group easier, which in turn would help the Informatics teams with their workload. The Chief Finance Officer for GEH highlighted was the adding of kite marks to the metrics, the deadline to complete this work had been pushed back slightly from March 2024 to June 2024. Finally he took the time to thank colleagues for attending the Informatics Workshops and thanked WAHT Informatics colleagues for joining the Group Analytics Board and Informatics team so seamlessly, and expressed what a welcomed member of the Group they were. Moving forward the Group Analytics Board would start to focus on developing an information led culture across the Foundation Group, which would start with developing teams and using informatics to drive decision making. The Group Chairman invited questions and perspectives, and of particular note were the following points. Mr Oosterom (NED WAHT) thanked the Chief Finance Officer for GEH for a comprehensive overview and expressed how important the Informatics work was to ensure operational excellence. He explained that there seemed to be an issue with lack of resources to support each Trust's change programmes across the Foundation Group and was there a way to draw on everyone's skills across the Group to solve this. The Chef Finance Officer for GEH expressed that there had been discussions regarding how to utilise collective expertise across the Foundation Group in terms of analytics. The Group Chief Executive offered additional assurance that the Chief Digital Transformation Officer for WAHT would be supporting that work moving forward following a discussion at Foundation Group Strategy Committee which was detailed in the Foundation Group Strategy Committee report in the meeting papers. Mr Murphy (NED WAHT) queried whether AI and Robot automation not being a priority in regard to upcoming work would have an impact. The Chief Finance Officer for GEH explained that AI hadn't been a priority for the last couple of years, however moving forward it does need to be picked up again and is something we are looking into regarding how that links in with the digital	

MINUTE		ACTION
	agenda. The Chief Digital Transformation Officer for WAHT explained that AI was broader than analytics and would be being picked up through the innovation work that was on the upcoming digital agenda. **Resolved – that the position be noted.**	
24.011	**MUTUAL AID FOR ELECTIVE PATIENTS DEEP DIVE** The Chief Operating Officer for SWFT explained that, post Covid-19, waiting lists had increased substantially and recovering this had been a challenge. As a way of resolving the recovery challenge there had been a national push to look into mutual aid across systems and regions to bring down backlogs. Working as a Foundation Group had been beneficial and had been easier to facilitate and progress patients. The Chief Operating Officer for SWFT explained that a monthly Foundation Group Operational Group had been set up to discuss any operational issues, but it also meant that each Trust could understand each other's priorities and upcoming work. She continued, that further to this there was a fortnightly mutual aid meeting where specialties that needed support would be discussed and appropriate processes but in place. However, in addition to this, the meetings had also enabled the operational teams across the Foundation Group get to know each other and build working relationships. This had resulted in solutions being put in place in a timelier manner, and therefore supported the reduction of waiting times for patients which had been key. The Chief Operating Officer for WAHT shared a patient success story from ITV News with the Boards. The success story shared how a patients surgery waiting time had reduced from 3 years to 2 weeks, and the Chief Operating Officer for WAHT explained that it highlighted why using resources across the Foundation Group better was the right way forward for patients. She went on to explain that putting the process in place to enable mutual aid across the Foundation Group wasn't easy and there were challenges that still needed to be resolved, these included being able to provide consistent pre-operative care for patients transferred mid-pathway, asking patients to travel or attend virtual appointments due to being unable to dispatch staff to patient areas following the increase in services demand, claiming income from the Welsh NHS system for patients who reside in Wales, and a lot of patients were not wanting to travel for treatment especially for major surgery due to the distance home, being away from friends and family and the post-op follow up visits. The Chief Operating Officer for WAHT informed the Boards that processes were also proving challenging, such as agreeing a standardised clinical criteria for listing for surgery, clearance of the 65ww and 78ww, contacting patients and administrative challenges, and managing patient expectations if the mutual aid offer was unsuccessful or the patient was unable to travel. The Chief Operating Officer for WAHT highlighted that harmonisation of waiting lists at a Group level was the focus moving forward. She explained that waiting lists continued to rise and harmonising these across the Foundation Group would enable these to be managed more effectively and get patients seen	

MINUTE		ACTION
	quicker. The Chief Operating Officer for WAHT added that the Foundation Group Operational meetings would continue to take place for improving performance opportunities, and to explore whether post-operative care could be carried out closer to the patient's home if their treatment/operation took place out of area. The Group Chairman invited questions and perspectives, and of particular note were the following points. The Group Chairman thanked all the Chief Operating Officers, Chief Medical Officers and Chief Nursing Officer's from across the Foundation Group for the time and effort being put into make this work for patients. The Group Chief Executive expressed that it was interesting to see the reciprocation between the organisation to address the back logs. However, he highlighted that eventually the goal should be that each organisation was optimising their capacity and meeting local catchment area volumes, so patients weren't being asked to travel. Mrs Martin (NED WVT) emphasised the importance of working with community colleagues to support patient transport needs which could help with uptake when mutual aid was out of area for the patient. **Resolved – that the Mutual Aid for Elective patients deep dive be received and noted.**	
24.012	**SAFE STAFFING OVERVIEW (TO INCLUDE NURSE PER BED RATIO)** The Chief Nursing Officer for WAHT presented the safe staffing overview to the Boards. She explained that over recent months the Chief Nursing Officers from across the Foundation Group had been working together to standardise the Key Performance Indicators (KPIs) around safe staffing and standardise how these were reported. The Chief Nursing Officer for SWFT explained that Nurse staffing at SWFT had been a challenge for the last three months, with on average 20 extra beds requiring staffing. On top of this she explained that SWFT were seeing higher acuity patients requiring additional staff. There had also been more mental health patients needed to be cared for in an acute setting would require additional staff due to the lack of tier 3 mental health provisions, SWFT were in contact with the Coventry and Warwickshire system colleagues to resolve these pathway issues. The Chief Nursing Officer for SWFT continued that the Trust had seen a higher than usual vacancy rate in paediatric nursing, and work was taking place to find a solution. Despite this SWFT agency spend had reduced and this was due to the focus around recruitment and retention that had taken place and challenging the use of agency Nurses which came at premium cost. The Chief Nursing Officer for SWFT assured the Boards that	

MINUTE		ACTION

there had been no correlation in the harm related to unsafe staffing which was reassuring to the Trust but also the public.

The Chief Nursing Officer for WVT provided an overview for WVT, explaining that staffing levels were safe however this was not being achieved at the best value for money or quality of care due to having to rely heavily on agency and temporary workforce. She added that this was due to budgets not aligning with the establishments, despite vacancy's being low. Due to this there was a need for 20 whole time equivalents (wte) on top of current staffing levels to ensure patient safety was met. This was a continuous issue and had been for around two years due to the bed occupancy remaining high. Therefore a paper had been submitted to the Trust's Management Board to align budgets with the establishment needs and recruit substantive nurses, and in turn improve value for money and quality of care.

The Chief Nursing Officer for GEH explained that GEH along with the other Trust's in the Foundation Group, had extra patients being bedded above planned figures. This was averaging around 32 extra a day, and required 28wte Nurses and 14 Health Care Support Workers (HSWs) to ensure patient safety was met. Despite these challenges she was pleased to report that the Trust's agency spends had reduced and they hadn't had to use off framework agencies since July 2023. The Chief Nursing Officer for GEH explained that the Trust's specialist area's used the most agency staff, however this was still higher than ideal and moving forward there would be a focus on staff retention. She informed the Boards that staffing levels were considered daily and as part of all incidents reported, and she was pleased to report that despite staffing challenges and bed occupancy, harm levels had not been affected. Finally, the Chief Nursing Officer for GEH explained that the dashboard in the report showed GEH's care hours per patient as the lowest in the group and offered assurance that she was working with her teams to improve those levels.

The Chief Nursing Officer for WAHT echoed the other Chief Nursing Officer's challenges with bed occupancy and staffing challenges. However, she was pleased to report that there had been a reduction month on month in regard to agency spend and she had been linking in with WVT on how to improve WAHT's vacancy rates. The Chief Nursing Officer for WAHT highlighted that WAHT had not had any falls with harm and was proud of the Trust's harm indicators in general at the moment. Moving forward over the next four to eight weeks there would be a focus on nurse to bed ratios and how to improve that figure, as well as looking at the opportunities with Registered Nurse Associates (RNAs) and skill mix revies.

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

The Group Chief Executive thanked the Chief Nursing Officers for an interesting report and explained how fascinating he had found the comparison across the Foundation Group on Nurse Staffing. He explained that going forward it would be good to see Bank Staff and Agency Staff separated in terms of temporary

MINUTE		ACTION
	workforce. This was due to Bank Staff being essential to managing rotas in a good way, whereas Agency were wanting to be avoided. The Group Chief Executive expressed that the Safer Staffing toolkit was also something to be mindful of, as this didn't consider the experience of staff but just the number of staff. He also noted that it was interesting to see areas that had a low vacancy rate but were still requiring additional staff, which would indicate that the staffing budget for that area was too low. The Managing Director for GEH queried with the Chief Nursing Officer for GEH whether the incident figure was correct in the dashboard. She queried this due to the Trust having the highest vacancy rate and lowest care hours per patient. The Chief Nursing Officer for GEH agreed that the figures seem incredibly low for November and December 2023. She felt this was due to several factors, one being improving the vacancy rate around that time, but also it was likely that there had been under reporting of incidents on Datix. **Resolved – that the safe staffing overview including nurse per bed ratio be received and noted.**	
24.013	**EQAULITY UPDATE – NHS EQUALITY DELIVERY SCHEME (EDS 2022)** The Group Chairman took the time at the start of the EDS update to say thank you to the Director of People and Culture at WAHT as this would be her last Foundation Group Boards before leaving WAHT. He thanked the Director of People and Culture at WAHT for the phenomenal efforts that she had put in for several years at WAHT and wished her well in her future endeavours. The Chief People Officer for GEH/SWFT presented the EDS update to the Boards. She explained the EDS is well known in the NHS since 2011. It was updated most recently in 2022 and was essentially an improvement framework to improve services for patients but also staff to create and open and inclusive culture, meeting obligations under The Equality Act 2010 and the Public Sector Equality Duty. She explained that there were 11 outcomes across three domains that were required to be reviewed and published from March 2024. The three domains were Commissioned or Provisioned Services, Workforce Health and Wellbeing and Inclusive Leadership. The Chief People Officer for GEH/SWFT informed the Foundation Group Boards that it was set out in the basis of the guidance that key stakeholder groups should be included, with a wide frame variety of people inputting including the public, patients, staff, trade unions, HR professionals and staff networks. She assured the Boards that the work had been undertaken in each Trust and was pleased to report that there were no areas across the Foundation Group with underdeveloped activity against the EDS. The Chief People Officer for GEH/SWFT added that there was plenty of opportunity from the review to share and learn across the Foundation Group to improve equality system. The Group Chairman invited questions and perspectives, and of particular note were the following points.	

MINUTE		ACTION
	Mrs Whelan Tracy sought assurance that the three services reviewed in the EDS report captured citizens from identity groups which were harder to reach. The Chief People Officer for GEH/SWFT confirmed that she would look into this further, however assured the Boards that the review would continue to expand each year capturing both community and acute services as part of the review. The Managing Director for WVT queried whether the thresholds and criteria were being applied in the same way across the Group, and it was agreed that this would be picked up outside of the meeting. The Managing Director for WAHT recommended that a peer network be set up as part of the EDS review as it would be very easy to have a biased view against your own service and organisation. **Resolved – that** **A) the Chief People Officers ensure that the EDS review thresholds and criteria were being applied the same way across the Foundation Group, and** **B) the Chief People Officers look at setting up a peer network as part of the EDS review process due to the risk of unconscious biased, and** **C) the Chief People Officers ensure that the three services in the EDS report captured citizens from groups which were harder to reach, and** **D) the Equality update be received and noted.**	**CPOs** **CPOs** **CPOs**
24.014	**FOUNDATION GROUP BOARDS SCHEDULE OF BUSINESS 2024/25 FOR APPROVAL** The Foundation Group Boards approved the 2024/25 Foundation Group Boards Schedule of Business and noted that it would continue to mature as the meeting developed. **Resolved – that Foundation Group Boards Schedule of Business for 2024/25 be approved and ratified.**	
24.015	**FOUNDATION GROUP STRATEGY COMMITTEE ANNUAL REPORT 2022/23** The Foundation Group Boards received and noted the Foundation Group Strategy Committee Annual Report for 2022/23. **Resolved – that the Foundation Group Strategy Committee Annual Report for 2022/23 be received and noted.**	
24.016	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING ON THE 16 JANUARY 2024**	

MINUTE		ACTION
	The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting on the 16 January 2024. The Group Chairman highlighted in particular the Group Job Planning discussion and how to move forward with job plans focused on demand and capacity. The Group Chairman also drew attention to the Group Digital Scope Proposal that would see the Chief Digital Transformation Officer for WAHT take on a Group leadership position in digital transformation moving forward. **Resolved – that the Foundation Group Strategy Committee report from the meeting held on the 16 January 2024 be received and noted.**	
24.017	**ANY OTHER BUSINESS** There was no further business discussed. **Resolved – that the position be noted.**	
24.018	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
24.018.01	Question from a SWFT Public Governor (West Stratford and Borders) The following question was submitted by the Public Governor in advance of the meeting: *'Is it considered appropriate for there to be more Executives appointed jointly to different Trusts to develop more Group actions, or is the appointment of executives to single Trusts the best way to deliver improvements in each of the Group Trusts?'* The Group Chief Executive explained that the Foundation Group model worked across the four Trusts because accountability sat with the individual Chief Officer's of each Trust. He continued that whilst there were Group level roles, these were advisory, and accountability still sat with the individual Chief Officer's the same way it does when an individual Chief Officer leads on something on behalf of the Foundation Group. **Resolved – that the position be noted.**	
24.019	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
24.020	**APOLOGIES FOR ABSENCE**	
24.021	**DECLARATIONS OF INTEREST**	
24.022	**GEH CONFIDENTIAL MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023**	
24.023	**SWFT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023**	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 February 2024 at 1.30pm via Microsoft Teams

MINUTE		ACTION
24.024	**WAHT CONFIDENTIAL MINUTES OF THE MEETING HELD ON 1 NOVEMBER 2023**	
24.025	**WVT CONFIDENTIAL MINUTES OF THE MEETING HELD ON THE 1 NOVEMBER 2023**	
24.026	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
24.027	**STAFF SURVEY**	
24.028	**FOUNDATION GROUP OBJECTIVES**	
24.029	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 18 OCTOBER 2023**	
24.030	**ANY OTHER BUSINESS**	
24.031	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on 1 May 2024 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chairman) Date: 1 May 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 REPORT: 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) and 24.007.02 (07.02.2024) 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 / S Collman	Update from Foundation Group Boards on the 7 February 2024 – that the data had been received and would be included in the May 2024 meeting report.
23.060 (02.08.2023) and 24.007.03 (07.02.2024) 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 / H Lancaster	Chief Operating Officers are in the process of recalculating theatre productivity to include an indication of the resource cost per unit.
24.009 (07.02.2024) Foundation Group Performance Report	The Chief Operating Officers' look at the variations in the Foundation Group Performance Report, particularly around theatre utilisation, and look at where improvements on productivity could be made across the Group based on best practice.	H Heran / R Snead / A Parker / H Lancaster	
24.013 (07.02.2024) Equality Update – NHS Equality Delivery Scheme (EDS 2022)	The Chief People Officers ensure that the EDS review thresholds and criteria were being applied the same way across the Foundation Group	G Nic Philip / G Etule / T Ricketts	

	The Chief People Officers look at setting up a peer network as part of the EDS review process due to the risk of unconscious biased. The Chief People Officers ensure that the three services in the EDS report captured citizens from groups which were harder to reach.		
REPORTS SCHEDULED FOR FUTURE MEETINGS			

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