PUBLIC BOARD MEETING

Thu 06 March 2025, 13:00 - 14:30

MS TEAMS

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Russell Hardy

13:01 - 13:02
1 min

2. Declarations of Interest

Russell Hardy

13:02 - 13:03
1 min

3. Minutes of the Meeting held on the 5 December 2024

Decision *Russell Hardy*

3. PUBLIC BOARD MINS - DECEMBER LF.pdf (12 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

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*

5.1 MARCH 2025 - WVT CEO Report - BOD.pdf (9 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

WVT IPR Month 10 January 2025.pdf (32 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:35 - 14:20
45 min

6. Items for Noting and Information

6.1. Perinatal Safety Report

Discussion *Lucy Flanagan*

- Perinatal Services Safety Report January 2025 final version Board.pdf (14 pages)

6.2. Patient Experience Report

Discussion *Lucy Flanagan*

- Patient experience report Feb 25 V1 board version.pdf (11 pages)

6.3. Board Assurance Framework and High Risk Report

Discussion *Gwenny Scott*

- BAF covering report TB March 2025 - WVT.pdf (1 pages)
- Board Assurance Framework_High Risk Report to TB March 2025 - WVT.pdf (3 pages)

6.4. Use of Trust Seal

Information *Gwenny Scott*

- 04-02-2025 - Use of Trust Seal~v1.pdf (1 pages)

6.5. Committee Summary Reports and Minutes

6.5.1. Audit Committee Report and Minutes 21 October 2024

Discussion *Nicola Twigg*

- 7.5.1 AC Front Sheet.pdf (1 pages)
- 7.5.1 Audit Summary March 25 (Oct submission).pdf (1 pages)

6.5.2. Foundation Group Board Minutes and Action Log 5 February 2025

Discussion *Russell Hardy*

- 1. Draft Public FGB Minutes - 5 February 2025.pdf (14 pages)
- 3. Draft Public FGB Matters Arising and Actions Update Report.pdf (1 pages)

6.5.3. Charity Trustee Report and Minutes 19 September 2024

Discussion *Grace Quantock*

- CT FS and Report.pdf (3 pages)

6.5.4. Integrated Care Executive 14 January 2025

Discussion *Frances Martin*

- 7.5.4 ICS FS.pdf (1 pages)
- ICE Escalation & Assurance Report January 2025.pdf (1 pages)

6.5.5. Quality Committee Report and Minutes 31 October 2024, 28 November 2024 and 19 December 2024

Discussion *Ian James*

- QC Summary October 24 Public.pdf (4 pages)
- Quality Committee Minutes October final.pdf (16 pages)
- QC Summary November 24 Public.pdf (3 pages)

- Quality Committee Minutes November 2024 final.pdf (18 pages)
- QC Summary Public December 24.pdf (2 pages)
- 7.5.5b Quality Committee Minutes December final.pdf (10 pages)

14:20 - 14:25
5 min

7. Any Other Business

14:25 - 14:30
5 min

8. Questions from Members of the Public

Russell Hardy

14:30 - 14:30
0 min

9. Acronyms

- Z Acronyms - updated 07.06.24.pdf (3 pages)

14:30 - 14:30
0 min

10. Date of Next Meeting

The next meeting will be held on 3 April 2025 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 5 December 2024 at 1.00 pm
Via MS Teams

Present:

Russell Hardy	RH	Chairman
Chizo Agwu	CA	Chief Medical Officer
Glen Burley	GB	Chief Executive
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director (NED)
Frances Martin	FM	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Andy Parker	AP	Chief Operating Officer
Grace Quantock	GQ	Non-Executive Director (NED)
Gwenny Scott	GS	(Incoming) Associate Director of Corporate Governance
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:

Ellie Bulmer	EB	Associate Non-Executive Director (ANED)
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Val Jones	VJ	Executive Assistant (For the minutes)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Amie Symes	AS	Associate Director of Midwifery – For Items 6.1 and 7.1

BOD01/12.24 **Apologies for Absence**

Apologies were received from Sharon Hill, Non-Executive Director and Jo Rouse, Associate Non-Executive Director.

BOD02/12.24 **Quorum**

The meeting was quorate.

BOD03/12.24 **Declarations of Interest**

The Chairman advised that he has retired from the Charity – You're Cherished.

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

BOD04/12.24 **Minutes of the meeting held 3 October 2024**

Resolved – that the minutes of the meeting held on 3 October 2024 be confirmed as an accurate record and signed by the Chairman.

BOD05/12.24 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD06/12.24 **Chief Executives Report**

GB presented his Report and the following key points were noted:

(a) Revisions to the Single Operating Framework (SOF) – This includes all of the measures that make up the SOF. The new Secretary of State has indicated that more freedoms and potentially more flexible capital arrangements will be available to organisations who are higher up the segmentation process. We see in the analysis that Wye Valley Trust has 7 indicators in blue (best performance in the quartile) 14 in amber (inter quartile range) and 4 in red (worst performance) which is an improving position. We are actually doing better in Segment 3 than colleagues in Segment 2. Two other things have a bearing on this – the financial position of the organisation and CQC rating of the organisation. Due to our overall financial position we are held down a little on this. We have made the case that a large element of this is due to our rurality and are hoping that this will be acknowledged formally at some point regarding how we are funded.

(b) Updated Framework – This is an important time for the NHS as the long term plan is being consulted on. More detail will be provided on this as it becomes available. The redefinition of the role of the Integrated Care Systems versus the role of organisations such as our Trust is helpful. We need to be held accountable for the delivery of performance standards and managing our money and quality opposed to holding that at System level. At System level there is a great opportunity for Integrated Care Systems to focus more on demand management, wider determinants of health and ensuring that our all of our partnerships are working effectively. A large element of the Framework relates to the Staff Survey and we have seen an improving position on this for the Trust.

(c) Insightful Board – This has been updated recently and GS has been reviewing these changes. Positively the drafting of the document included the use of our Integrated Performance Report that we have across the Foundation Group as an example of best practice. One of the main changes to the previous version is more focus on productivity.

(d) Update from our Surgical Division – Huge changes have been taking place, most notably the Surgical Day Unit and the Surgical Elective Hub. Key milestones are treating over a thousand patients in the first month. Our Theatre productivity has also improved and due to this and the wider productivity improvements, we are seeing continuing reduction in our long waiters. The other important milestone from a quality perspective is the Critical Care Outreach Centre has expanded to a 24/7 service.

(e) RH noted that next year is going to be a tough year for the NHS from a financial perspective. GB agreed noting that the NHS is under pressure this year and Trusts achieving their financial plan for this year, some of which we will have to carry over into next year along with the inflation changes and the increases to National Insurance and the increase in demand we are continuing to manage.

(f) IJ welcomed the reframing of the Integrated Care Boards (ICB) and the refocus on the population health and health inequalities which will enable us to deliver our services if we can get these right. He welcomed the discussions with the ICB, noting that we need to foster these conversations in a way that works well for all of us. GB agreed and that we need to ensure that this is the focus of the ICB. The NHS needs to get to grips with the increase in demand that we can manage.

Resolved – that the Chief Executives Report be received and noted.

BOD07/12.24 **Integrated Performance Report**

JI presented the review of the Integrated Performance Report and the following key points were noted:

a) RH formally recognised the phenomenal level of demand coming into A&E and across our services that the front line teams are having to deal with. He thanked them for their commitment every day as they do the best they possibly can for our patients. He recognised the level of waits some patients are experiencing in accessing our services, which are below what we would expect, due to the level of demand we are experiencing. He apologised on behalf of the Board of Directors for any delays patients are experiencing.
b) JI agreed with these sentiments noting that staff are going the extra mile to support our patients and thanked all the teams, in particular the clinical teams.
c) We are responsible for the quality of what we do, activity and our financial position and we need to keep all these things in balance. In the Board Workshop we covered in detail around these things including the transformation of Community Services and how we work with our integrated neighbourhood teams. To contextualise this huge demand on our acute services, on Monday morning we had to care for 75 patients above our bed base, boarding some patients in areas such as Endoscopy where patients should be recovering from their procedure and not having Inpatients in there and the Emergency Department (ED) waiting for admission. This is extremely difficult to manage on a daily basis.
d) SSNAP Data – We have once again achieved a Level A for this which measures the quality of our stroke services, which is a huge achievement that many do not achieve.
e) Mortality – Numbers remain stable for this. To help reduce our mortality figures further, we need to ensure for our Fractured Neck of Femur Pathway that patients are able to have fast track access to a ward which is hindered by our overcapacity in our urgent care pathways.
f) We are doing a number of things to improve how we are dealing with demand, one of which is reducing the number of patients coming into the hospital and providing more care at home. Also ensuring that we are reducing our number of medically fit for discharge patients, especially for Pathway 2 and 3 patients. Finally more work is required around prevention and we are working with our GPs and Community Teams around care plans and ensuring that patients with long terms conditions know what to do if they have a flare up. There is a lot of work going on around this but more is still needed. We also need operational excellence in things that we do in the hospital to ensure that the Acute hospital is as sleek and high quality as possible but we are still seeing a number of patients at a level above our bed base.
g) Elective Activity - This is around how many patients we can realistically treat though our elective pathway. There is improvement but there are still lists that are not full, which we are focussing on. We are also concentrating on getting paid for what we do. We are making changes around cataract recording to ensure that we are being correctly paid for the work that we are doing. All this needs to come together to ensure that we are in a better place by the end of the financial year to achieve a run rate that is nearer what we should be achieving to also improve our financial position.

h) RH clarified that in the NHS if you undertake 2 individual cataract operations with a gap between each you get paid twice. However, we do 2 at once for efficiency and patient recovery and need to get paid correctly.
i) GB has spoken with the National Lead for Elective Recovery on the Elective Recovery Plan and he is supportive of what we are doing.

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

BOD08/12.24 **Quality (including Mortality)**

LF and CA presented the Quality Report (including Mortality) and the following key points were noted:

(a) As noted in the report, we had the National Peer Review of Neonatal Services in November and are awaiting the full report. There were no immediate or serious concerns that we were required to address in a timely way. There were some areas to improve, which we have already addressed. This was a largely positive visit that saw strong MDT working and positive feedback from families that were using the service.
(b) LF attended the launch of the first Volunteers Strategy Steering Group in November. A new Volunteer Coordinator has started in post and the plan is to expand our volunteer workforce which has reduced significantly since Covid. In particular we need to expand to support our wards given our pressures on the wards. We also need to recruit volunteers for a Contact Centre that we are setting up. This is aimed at reducing DNAs for Outpatient appointments and we plan to pilot our Contact Centre in Ophthalmology shortly.
(c) Included in the pack is information relating to mixed sex accommodation breaches. We are an outlier nationally but a small number of decisions to accommodate a mixed sex breach can lead to a large volume of breaches due to how the counting rules work. We have seen recently an increase, some of which is due to the bed reconfiguration that we introduced in the late summer but this is also driven by boarding, operational pressures and the limited options we have with our estates. We will always prioritise safety over a mixed sex breach but recognise that this is not ideal for our patients.
(d) C-Diff – We are above the threshold for our numbers, with national rates also increasing, although our own Local System (Herefordshire and Worcestershire) are in the bottom quartile in the region. Included in the pack are the quality improvement initiatives that we are focusing on to target this issue, particularly looking at high risk patients, understanding antibiotic history prior to hospital admission and antibiotic stewardship. We are increasing our Antibiotic Ward Rounds to provide specialist advice to clinical teams around antibiotic use.
(e) Agency – We are still on a positive trajectory. We received our Regional Visit in November. We are doing all of the right things, they felt that we were in a strong position to achieve the capped rate for General Nursing shifts by the end of January.

(f) CA advised that the mortality indices for the 12 month period from July 2023 to June 2024 remains good at 100. This is the level of mortality that we expect due to the demographic of our patients. Regarding diagnostic codes, it is pleasing to see less than expected numbers for pneumonia and COPD. Heart failure and stroke mortality are both now at expected levels. Sepsis also continues to improve. Fractured neck of femur is higher than expected and we are undertaking a trust wide quality improvement. We need to improve on the timeliness of admitting patients to the ward, the target is within 4 hours and getting patients to surgery, which is 36 hours. We are introducing a new fast track protocol to improve these figures. We are also reviewing the quality of care patients are receiving in ED.

(g) The Medical Examiner service is doing very well. In September, this was rolled out fully in the Community. Due to a change in legislation with improvements in death certification, we have seen improvement in this area and a reduction in referrals to the Coroner. CA met with the Coroner and he is pleased with our improvements.

(h) FM highlighted the volunteering opportunities in the Trust in all areas which is beneficial to the individual as well as to the community.

(i) RH reiterated the DNA reference, noting that 1 in 20 patients DNA their appointment. This is costing the Trust millions in terms of lost income. If you are unable to attend an appointment, please advise us as soon as possible.

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

BOD09/12.24 **Activity Performance**

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

(a) AP commended our Surgical Division whilst we are under extreme pressures. They have only cancelled a small number of patients despite these pressures.

(b) We have set an extremely ambitious Elective Activity Plan for this year which was reviewed again at the end of the summer to stretch this even further for the second half of the year. We are delivering this and we have seen an increase in our Theatre utilisation, an increase in the number of patients that we are treating in our Theatres and an increase in our Outpatient utilisation. The key focus for Quarter 4 is focussing on the 3 or 4 specialties where we know that we can improve Theatre utilisation. Reducing DNAs and cancellations are also key to this. As previously mentioned we are using volunteers and using 2 way texting for our Theatre patients to ensure that patients are arriving with volunteers phoning patients to ensure that they are attending for dates in the next few weeks.

(c) We have a reduction in our long waiters and are almost at zero for our 65WW. This will definitely be zero in the New Year. Regarding 52WW, we had over 1300 but are now down to 800 from the summer.

(d) Diagnostic pathways have seen a significant improvement and AP thanked the teams for this achievement. We have 85% of our patients waiting less than 6 weeks. For imaging, 90% of patient are waiting less than 6 weeks for a diagnostic procedure. There has also been a huge reduction in our patients waiting in the acute audiology service and echocardiograms. Our main concern now is our Paediatric audiology but we have a Locum in post whilst we review our Audiology workforce to maintain a good level of access for patients.

(e) Our Urgent and Emergency Care Pathway is under extreme pressure at the Front Door and also to maintain safety and flow, we are using temporary escalation spaces across our wards. Some of the initiatives are – navigation at the Front Door by a senior experienced nurse is continuing and we are seeing an increased number of patients streamed to Primary Care in Out of Hours Services and also expanding our Medical Day Case and Discharge Lounge will allow us to stream more patients away from SDEC which will enable them to see more patients from ED.

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

BOD10/12.24 **Workforce**

GE presented the Workforce Report and the following key points were noted:

(a) Following new legislation regarding sexual safety at work, we have adopted NHS Policy on this and are raising awareness around our zero tolerance approach to any sexual harassment, untoward behaviours or discrimination in the workplace.
(b) The majority of our KPIs are heading in the right direction, with improvements in appraisals and staff turnover overall below 10%. We are supporting employees with health checks and vaccinations in our drive to maintain low sickness absence over the winter months.
(c) Through our Workforce Opportunities Group we are looking at schemes that enhance workforce productivity and throughout 2025 we are introducing E-Rostering for all of our clinical staff groups within the Trust.
(d) We are supporting the NHS Pilot Programme for care leavers. We are offering job opportunities for care leavers working with our ICS colleagues over the next few months.
(e) RH noted that there is a lot in the press around some people thinking that banter in the workplace is acceptable. Banter that makes colleagues feel uncomfortable is not acceptable and staff need to speak up.
(f) GQ questioned regarding this whether there is any work in the Trust around being an active bystander and speaking up about this. GE advised that we are currently developing the programme across the ICS with training programmes for Freedom To Speak Up Champions taking place. From January onwards we will be promoting the full publicity campaign.

Resolved – that the Workforce Report be received and noted.

BOD11/12.24 **Finance Performance**

KO presented the Finance Performance Report and the following key points were noted:

(a) This report covers the period until the end of October. Year to date we have a £6.8m deficit and are £4.6m behind plan. However this does show a small increase in our run rate and a slowing in the adverse variant. We should not underestimate how challenging how finances remain.
(b) The Financial Recovery Board is well established and we continue to focus on a range of mitigations to improve the run rate and ensure delivery of those mitigations. Divisional engagement in these meetings is good and we oversee this at the Finance and Performance Executive and Check and Challenge meetings.

(c) The risk around the pay award settlement in included in the pack. The funding that we received for this is less than the costs of implementing this for our staff.
(d) We continue to maintain strong elective performance particularly in September and October which provides support to the overall financial position.
(e) The forecast position remains in line with the plan but there are a number of risks and mitigations. We continue to look at the extent to which we can mitigate some of these risks. Across the System, there will be reforecasting exercise at Month 9 with a view to approaching the year end.
(f) The pack includes a refreshed set of charts around our cost per weighted activity unit. This is one measure of our productivity in terms of delivery of our services and we have done some work across the Foundation Group to ensure that these measures are broadly comparable and are approached in the same way. They reflect an improving trend in the volume of activity that we are delivering and there are some early signs of improvement in the cost per activity unit.
(g) Capital and Cash – We have invested £9.5m year to date and we are confident in delivering the full spend across the year by year end. There is a detailed reforecasting exercise across the NHS this month to ensure that everyone is really clear on the capital outturn position. In terms of cash, with careful management we have been doing around balances, we have been able to maintain our prompt payment performance to date although we do have concerns around the overall availability of cash as we move towards the end of the year given our current deficit to plan.
(h) GB noted regarding the issue of the pay awards and whether we have received adequate funding for it as this is a feature for all the Trusts across the Foundation Group financially. GB has been reassured by the National Chief Finance Officer that we will receive full funding.
(i) KL noted that we are a large part of the local economy and have obligations not only to patients but to all of our suppliers. The table in the report shows that we are paying 95% of payments within 30 days which matches the best of any organisation.
(j) RH thanked the Executives for their leadership during this challenging period.

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

ITEMS FOR APPROVAL

BOD12/12.24 **CNST Compliance**

AS presented the CNST Compliance which was taken as read, and the following key points were noted:

(a) We are coming towards the end of Year 6 and have now passed the final inclusion date for many of the actions. The paper outlines anticipated compliance of 8 out of the 10 Safety Actions, but since the submission of the report we have undertaken the external LMNS Review and now have full compliance for Safety Action 6 also.
(b) We are anticipating full compliance with all 10 of the Safety Actions, which will be our third year of full compliance against the CNST Standards. This improves the outcome of patients using our service.

(c) We will now submit the evidence to the LMNS for external review. Once we have received their compliance view, we will bring the report back to the Board of Directors for final approval to enable the Board Declaration to be submitted.
(d) Due to the timing of the Wye Valley Trust Board meetings, we are seeking delegation of full sign off to Quality Committee on 30 January.
(e) FM thanked AS and the team for all their hard work in achieving this.

Resolved – that the CNST Compliance be received and final approval delegated to the Quality Committee on 30 January 2025.

BOD13/12.24 **Trust Seal – Elective Surgical Hub**

Resolved – that the Trust Seal – Elective Surgical Hub be received and approved.

ITEMS FOR NOTING AND INFORMATION

BOD15/12.24 **Perinatal Safety Report**

AS presented the Perinatal Safety Report, which was taken as read, and the following key points were noted:

(a) Activity remains stable and consistent with no escalations required.
(b) One moderate incident was submitted in October.
(c) There has been an increase in complaints – 4 in October. On review, these do relate to care over a wider period of time with some being retrospective complaints. Communication and clinical treatment are the main themes.
(d) PMRT – There has been an increase in perinatal mortality cases – key themes are included in the report. Assurance can be taken on the quality improvement measures in addressing our main thematic issues.
(e) Maternity and Obstetrics Workforce – Midwifery workforce is largely stable with no concerns. However there is some impact due to pregnancy and sickness in the Anaesthetic Team which has required additional shifts being covered by the existing workforce. All shifts are covered and patient safety is not being compromised.
(f) LMNS Insight Visit – The initial feedback is included in the report. This was largely positive feedback with areas of concern raised that we were already sighted on with much work already established and underway.
(g) IJ noted the concern in the increase in perinatal deaths and was happy from a Quality Committee perspective that we have taken all the actions required and the thematic learning from these. He went on to note the comment about health inequalities and the number of patients not having English as their first language. AS advised that this was a recent review we undertook as part of the Insight Visit along with the work we were doing to respond to the themes that we had identified. They were assured by the work that we had achieved. Regarding health inequalities, there is some work ongoing around translation services and we opted to be an early implementer of the Trust's wider translation services review and we will feedback on our findings. We have put a paper forward for Continuity Of Carer which has been approved in principle subject to identifying funding in the future to assist with the health inequalities issues. AS is looking outside the organisation for research funding as we believe this would be of significant benefit to this cohort of patients.

(h) RH questioned on the Birthrate Plus tool, how many midwives that says we should have compared to how many we have. AS advised that we do meet all the required standards. We have recently undergone another Birthrate Plus review, detail of which was only received this week, which shows that we need a slight increase in numbers.

Resolved – that the Perinatal Safety Report be received and noted.

BOD16/12.24 **Patient Experience Quarterly Report**

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

(a) The National Inpatient Survey was recently published and an in-depth review of this took place at Quality Committee in October.
(b) The challenges that we face around feedback from our Inpatients are particularly around communication and waiting times, food, and information relating to discharge and support available after discharge. Feedback was wholly positive around kindness and compassion and treating our patients with dignity and respect.
(c) The Inpatient Survey this time included focussed questions around the experience of patients on the Virtual Ward, with scores for this very positive.
(d) The improvement work that we have undertaken focussed around Inpatients will help to improve results going forward. Sodexo updated us recently on work that they are doing with us to improve the food offered to patients. The Volunteer Contract Centre will also help us improve the patient experience overall. We can also learn from the South Warwickshire Foundation Trust as they performed really well in the Survey.
(e) We are worried about the number of complaints overall and we benchmarked high compared to our Foundation Group colleagues, with a spike in October. We are seeing a rise in the number of comebacks with complaint responses – we need to get this right first time when concerns are raised. Response times have improved, particularly in the Medical Division, but there is still more work to do.
(f) As agreed, we have undertaken a comparison around the Ombudsman and we are not an outlier and we compare well with the rest of the Foundation Group.
(g) A deep dive was conducted due to the rise of complaints in October and a thematic analysis undertaken which is broken down in the table. Predominately this is around how we communicate, how we engage and interact with our patients.
(h) Included in the report is our performance against our objectives that we set ourselves at the beginning of 2024 and overall we are performing well or improving against these objectives with the exception of the number of complaints we are receiving.
(i) The Urgent and Emergency Department CQC Survey and the Maternity Survey were published last week. The findings and the action plan will be presented to the December Quality Committee.
(j) JI had met with the UK Chief Executive of Sodexo and discussed food provision. When the survey was undertaken, they had just changed their food provider. The provider now used is used across the country with a Devon Trust in the top 5, we are virtually at the bottom. This is about the whole process and Sodexo are learning lessons. He was clear that they must improve patient food and experience and food catering offered to staff.

(k) NT noted that this was discussed at the Quality Committee at great length with the data received very in-depth. She was not concerned around the numbers received – we need to learn what we are doing wrong and improve on getting it right first time.

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

BOD17/12.24 **EPRR Core Standards Report 2024/25**

AP presented the EPRR Core Standards Report 2024/25, which was taken as read, and the following key points were noted:

(a) Compliance has improved from 78 to 82% this year. The main area of focus for 2025/26 is in our Business Continuity Planning around exercising all the team and testing plans as well as working with suppliers and providers of services to the Trust on their Business Continuity Plans.
(b) Across the Integrated Care System in Herefordshire and Worcestershire every NHS Provider has improved compliance. Key for us next year is how our Emergency Planning Teams function and continue to strengthen and learn from each other and also pool our Emergency Planning resource to ensure that training and education and testing is there to support one another.
(c) The Action Plan is included to show the actions that we need to take in 2025/26 to achieve full compliance for submission in 2026.

Resolved – That the EPRR Core Standards Report 2024/25 be received and noted.

BOD18/12.24 **Board Assurance Framework**

GS presented the Board Assurance Framework (BAF) and the following key points were noted:

(a) There are no new risks. One risk will be closed – Fragility to the Haematology Service. The Risk to Productivity and Capacity Plans has gone down along with the risk around the Academic Programme. No other significant changes.
(b) There is no High Risk Report due to technical difficulties. Discussion has been held with the Executive Team around improving reporting around risk and making this a more user friendly and visible document.
(c) RH wanted to ensure that across the Foundation Group we are identifying the impact on Social Care providers who we depend on for flow and discharge given the increase in National Insurance. If the settlements to the Care Homes and Domiciliary Care providers from Local Councils matches this increase, this is a low risk. If it does not, then it is of concern. GS to incorporate this risk into the Risk Register. **GS**

Resolved – that:

(A) The Board Assurance Framework be received and noted.

(B) To incorporate the risk around settlements to Care Homes and Domiciliary Care providers possibly not matching the increase in National Insurance and the impact this will have on our flow and discharge. **GS**

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD19/12.24 **Audit Committee Report and Minutes 19 September 2024**

Resolved - that the Audit Committee Report and Minutes 19 September 2024 be received and noted.

BOD20/12.24 **Foundation Group Board Minutes and Action Log 6 November 2024**

Resolved that the Foundation Group Minutes and Action Log 6 November 2024 be received and noted.

BOD21/12.24 **Quality Committee Report and Minutes 29 August 2024 and 26 September 20024**

Resolved that the Quality Committee Report and Minutes 29 August 2024 and 26 September 2024 be received and noted.

BOD22/12.24 **Any Other Business**

There was no further business to discuss.

BOD23/12.24 **Questions from Members of the Public**

Q1. In Hereford County Hospital, as well as many other hospitals, there is concern about long trolley waits for admission in A&E departments. In the interests of transparency and accuracy, (to avoid speculation), it is necessary for details to be publicly available. I note that on page 28/231 of the Board papers is a graph titled % of patients spending more than 12 hours in ED, congratulations. However this graph is extremely difficult to interpret and would be much better if this axis were fixed such as “number of patients” waiting more than 12 hours in ED. This would be much more meaningful to anyone looking at the graph, everybody could see the actual number waiting. Hence would the Board request that the vertical axis is changed as suggested or that a second graph is included in subsequent Board reports?

A1. AP advised that for October, those patients totalled 903. This is not just trolley waits but also the percentage of patients that are waiting in ED greater than 12 hours. We are measured by NHSE against the percentage of patients waiting over 12 hours and not just the number of patients. AP was happy to put in a narrative each month around the number of patients as well as the percentage. **AP**

RH noted that the level of waits are unacceptable for patients, their family and teams for patient outcomes. This experience is not seen in other European Healthcare Systems.

Q2. At present the Public Board meetings are online only for members of the public in Herefordshire and the surrounding areas. This excludes a significant part of the population that are not online, many of whom are elderly and are thus frequent uses of hospital services.

	In order to be more inclusive of the public would the Board consider moving to a hybrid system where the Board meets face to face and members of the Public who wish to attend in person could do so yet it could also be broadcast online for those who prefer that method of viewing.. This hybrid system would offer public participation to a much wider audience without excluding those who are not online? **A2.** RH agreed for digital meetings that if you do not have access to technology it makes it difficult but equally what we do find across the Foundation Group is for a number of citizens who are infirm, less mobile or have transport issues, the digital format does allow them to attend public meetings that they otherwise would not be able to attend. We are looking at more physical meetings next year but hybrid meetings are not very effective. FM advised that we had 245 views of the Annual General Meeting which are very high numbers. Digital solutions are available in Libraries and other Community Services, but we want to be as inclusive as we can. **<u>Resolved</u> – that:** **(A) The Questions from the Members of Public be received and noted.** **(B) Future Activity Performance Reports will include a narrative round the number of patients as well as the percentage waiting longer than 12 hours in the Emergency Department.**	**AP**
BOD24/12.24	**<u>Date of next meeting</u>** The next meeting was due to be held on 6 March 2025 at 1.00 pm via MS Teams.	

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 6 MARCH 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
BOD18/12.24 Board Assurance Framework 05.12.24	(B) To incorporate the risk around settlements to Care Homes and Domiciliary Care providers possibly not matching the increase in National Insurance and the impact this will have on our flow and discharge.	GS	'Completed - To incorporate in the BAF review for 2025/26.
BOD23/12.24 Questions from Members of the Public 05.12.24	(B) Future Activity Performance Reports will include a narrative round the number of patients as well as the percentage waiting longer than 12 hours in the Emergency Department.	AP	Update SPC chart and narrative included in the IPR under Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance.
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
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 2024/25 Objectives the report relates to:

Quality Improvement

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

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

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

Digital

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

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

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

Productivity

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

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

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

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*

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

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

Workforce

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

☐ *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*

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

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*

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

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1. NHS 10 Year Plan and Social Care Reform

The various 'vision' groups have now concluded their work which has been passed on to the 'enabler' groups. The enabler groups are due to finish their work by the end of February 2025 with the intention that The Long Term Plan is published in the spring. It has also recently been announced that Tom Kibasi, an NHS Chair, has been asked to write the report. Tom assisted Lord Darzi in his investigation report last year. The national equivalents of our Foundation Group 'Big Moves' have already been articulated. These 'mission shifts' are from analogue to digital, from treatment to prevention and from hospital to home. The work of the vision groups reinforces these principles and focusses heavily on localisation and digitisation of healthcare. Initial guidance on the development of a neighbourhood health focus has also been released alongside the annual Planning Guidance.

Social Care reform is not within the brief of the NHS Plan, but a Royal Commission on social care has also been announced. Whilst the aim to achieve cross-party consensus on Social Care Policy is welcome, the timeline for completion of the Commission is likely to be two or three winters away. It is therefore anticipated that there will be some policy changes ahead of this. One already announced in this year's Planning Guidance is a change to the Better Care Fund oversight arrangements. This follows the general move to delegate decisions to a more local level and to reduce ring fencing funding based on national priorities.

2. Annual Planning Guidance

After a longer than normal delay, 2025/26 NHS Planning Guidance and supporting material was finally published on 28th January 2025. The delay appears to have been driven by the need to adjust ambitions for improvement in the context of a very challenging financial settlement. One of the reasons why the financial position looks worse than it otherwise might have, is the fact that many parts of the NHS are behind their 2024/25 recovery plans. Inflationary, including pay award pressures, have also contrived to reduce the potential for growth funding. Consequently, many items previously subject to national ring-fencing have been removed. We have also seen a move away from a nationally funded Elective Recovery Fund (ERF) pot to something which is capped at System level.

We will also soon see the publication of a more detailed Urgent and Emergency Care (UEC) Reform Plan. This will include further details on the Planning Guidance pledge that all type 1 Accident and Emergency (A&E) Departments will need to have a co-located Urgent Treatment Centre (UTC), and that capital will be available to facilitate this move. In the case of the Foundation Group, only George Eliot Hospital (GEH) currently has an on-site UTC. I have mixed views about the benefits of UTCs. Whilst any increase in acute capacity will help with A&E demand, UTCs can potentially drive more patients onto an acute site from Primary Care. This may not be the best model for patients and will add cost to those sites that run one.

The Planning Guidance included the following key objectives for acute providers:

- Re-statement of the aim to return to the 18-week Referral to Treatment (RTT) elective waiting times target through a 5% improvement in all Trusts in year with an overall NHS position of 65% required.
- All providers expected to get to at least 60% RTT, and 67% for non-admitted pathways.
- No more than 1% of the waiting list to be over 52-weeks.
- 62-day cancer standard - 75% by March 2026.
- 28-day Faster Diagnostics Standard (FDS) - 80% by March 2026.
- 4hr Emergency Access Standard (EAS) - 78% by March 2026.
- Also 'a higher proportion' year-on-year of patients treated in Emergency Departments (ED) within 12hrs.
- Category 2 Ambulance response times not worse than 30 minutes average over the year.

- Each Trust to reduce agency spend by at least 30% year-on-year, and bank spend to reduce by 10%.
- Reduce the Whole time Equivalent (WTE) productivity gap compared to pre-Covid-19 position (i.e. improving the workforce productivity tool measure).

3. UEC Reform Plan

The national update of the UEC Reform Plan is expected to be published very soon. The Planning Guidance indicated that the following top ten areas of focus will remain. This includes the retention of the 78% EAS standard in 2025/26.

- Improving vaccination rates and targeted preventative winter virus care.
- Reducing 111 calls put through to 999 or directed to ED.
- Improve Hear & Treat, See & Treat, and Reduce Avoidable Conveyances.
- Reducing ambulance handover delays.
- Rapid triage at the front door to navigate patients quickly to the right care and avoid admission wherever possible.
- Getting into a hospital bed more quickly for those who need one.
- Improving access to specialist out-of-hospital provision.
- Shorter Length of Stay.
- Reduce discharge delays.
- Standardising and scaling the six core components of neighbourhood health.

4. Productivity Improvement Tool

A further addition to the national suite of productivity improvement tools has also been published. Since publication, David Moon, Group Strategic Financial Advisor, and I have had the chance to talk to the national team about the methodology. It builds on some of the Model Hospital analysis and hopefully complements the national reference cost data. Like most national tools though, the methodology needs to be fully understood to get the maximum benefit from the data. The rankings section on clinical productivity opportunities is perhaps the hardest section to follow. This is not helped by the footnote being wrong in that it suggests that the ranking is in the wrong order. The 'opportunity' calculation also includes a base 2% (i.e. the national efficiency requirement for 2025/26) for all Trusts even if you are ranked as the most efficient on current cost. The opportunity only increases for the lowest performing two thirds of Trusts and then not by much. It is therefore quite misleading.

There is then a corporate services opportunity which seem to allow some Trusts to count corporate costs differently and which doesn't seem to handle the PFI issues well. As set out in the planning guidance it identifies savings opportunities for temporary staffing including agency and bank expenditure. Whilst some bank expenditure is not cost effective, for many Trusts Banks are uses as a mechanism to pay part time staff to do additional shifts - which is good flexible working.

Whilst we have taken the time to understand the peculiarities of the tool, I fear that many will not. This will lead to some missed opportunities and potentially the wrong conclusions will be drawn. But we will explore them further internally.

5. Elective Recovery Plan Refresh

In addition to the move away from a nationally funded Elective Recovery Fund (ERF), the other big change in this updated plan is the move back to the constitutional standards performance measure of Referral to Treatment Time (RTT). The plan requires all providers to improve their headline RTT performance by 5% although it strongly hints towards waiting list validation being one of the significant contributors. It doesn't specifically mention a long waiting time maximum, although

indications are that 52-weeks will be a backstop measure quite soon. Other significant elements of the plan are:

- Expanded use of the NHS App for consultation, booking and choice.
- Outpatient Productivity/Transformation including 'did not attend' (DNA) reduction, booking productivity, increasing Patient Initiated Follow-Ups (PIFU), more use of Advice and Guidance (A&G) to primary care, and incentivisation of Best Practice Pathways.
- Diagnostics pathway improvement, use of Community Diagnostic Centres (CDCs) and opening times and direct access for General Practitioners (GPs).
- Financial Framework - Confirmation of the cap on ERF, some tariff changes, A&G split with GPs (which will incentivise GPs to use this more), payment for validation.
- Use of the Independent Sector including through easier NHS App Choice

6. National Staff Survey 2024

The Staff Survey remains my most important lead indicator of quality, safety and operational performance. This was strongly reinforced by John Drew, the guest speaker at our February 2025 Foundation Group Boards Workshop. John is currently regional Director of Workforce, Training and Education but previously led on the Staff Survey for NHS England (NHSE). He demonstrated the very close correlation between the results of the survey and all aspects of organisational performance. By the time that we next meet as a Board this year's survey will probably have been published. The results are currently under embargo, but I am anticipating farther improvements in all Trusts within the Group. The actual results will be shared as soon as they are published.

7. Recognition of the Higher Cost of Delivering Care in an Extremely Rural Setting

For several years, we have been arguing that WVT incurs a unique set of additional costs associated with scale and extreme rurality. This work has been led by David Moon, Group Strategic Financial Advisor. I was very pleased to see that, buried away in the Planning Guidance for system allocation there was an additional £10m allocation specifically to address this issue. We will now also be seeking funding from the Welsh Government to fund the equivalent costs associated with our healthcare support to the population of Powys. I would like to thank David for his work on this.

8. More From Our Great Teams – Update From the Clinical Support Division

Patient Access

In Outpatients there have been a number of developments which support the specialties to deliver improved services. A Virtual Fracture service is commencing at the end of February 2025 which will reduce the need for patient attendance in the busy fracture clinics. This service has also provided career progression within the Plaster Team to support recruitment and retention. Plaster room trainee's "grow you own" model continues to grow with 2 further band 3 in post to replace vacancies to continue to support the service.

To support the continuation of elective and emergency surgery following the cessation of primary care wound services (as a result of collective action), a wound clinic for adult Herefordshire patients has been set up using Oxford Suite nursing staff and RMC/reception administration staff. These clinics also help ease congestion in ED and SDECS with patients needing follow up wound care able to be sent directly to the clinic. The development of this service has demonstrated effective team work across divisions, and has received excellent patient feedback and experience.

Building works will be completed by end of February to provide additional Outpatient Capacity. Revised clinic template will be implemented for the 3rd March 2025, allowing patients to be seen in the right place at the right time, Outpatient room utilisation improved to 79% in January.

Further specialities are now back to being directly bookable (14 in total) through the national e-Referral Service which gives patients certainty of a date for their first Outpatient appointment, further specialties are underway with waiting lists being booked out and Directory Of Services reviewed.

Mortuary/Bereavement

Significant improvements have been made in the Mortuary and Bereavement Department over the past 12 months. These changes have enhanced efficiency, patient care, and stakeholder collaboration, while also ensuring compliance with best practices and regulation guidelines.

Implementation of Bespoke Mortuary Database 'EDEN'
The 'EDEN' system is now fully embedded, replacing paper-based processes and significantly reducing the risk of errors in patient record management. This software enables real-time tracking of patient movements, improves data accuracy, and facilitates audits, ensuring full traceability and compliance with regulatory requirements.

Introduction of iPassport as Our Quality Management System
We have successfully implemented iPassport to oversee Standard Operating Procedures (SOPs), staff training and competencies, and audits. This has strengthened our governance processes, making it easier to track and implement improvements. As a result, we have enhanced compliance, streamlined staff training, and improved the efficiency of internal audits and procedural updates.

Significant Improvement in Post-Mortem Turnaround Times
Our efforts to streamline processes and improve coordination have resulted in a marked reduction in post-mortem turnaround times. In 2023, the average time from the admission of the deceased to the post-mortem was 6.4 days; this has now been reduced to just 3.2 days. This improvement ensures a more responsive service, reduces delays for families, and allows for more efficient resource management.

Investment in Staff Development – Trainee Anatomical Pathology Technologist (APT)
We have introduced our first Trainee APT role in over 20 years as part of a "grow your own" initiative. The trainee is on track to qualify by summer 2025, strengthening our workforce sustainability and ensuring that we develop skilled professionals within our own department. This initiative not only addresses workforce challenges but also provides career progression opportunities within the organisation.

Improved Stakeholder Relationships
We have received positive feedback from the; Coroner's Office, Funeral Directors and the Crematorium, reflecting the significant improvements in our working relationships. Enhanced communication and collaboration have led to a more seamless service, ultimately benefiting bereaved families during a difficult time.

Collaboration with the Medical Examiner's Office (MEO) to Reduce Paper Usage and Improve Turnaround Times
Our ongoing work with the MEO service has allowed us to transition towards a more digital, paper-light system. This has improved efficiency and reduced the average turnaround time within the Mortuary from 8.8 days to 7.4 days, ensuring a timelier and compassionate service for families.

Cancer Services

Since February 2024, the Trust has hit the 28 day Faster Diagnosis Target of 75% each month. Despite the national target not being increased to 77% until March 2025, WVT has set a local target to meet 77% from April 2024 and have successfully met this to date. WVT has now recruited four Cancer pathway navigators into substantive posts to support continued development of Cancer pathways.

Cancer Outcomes and Services Dataset (COSD) performance has continued to improve with Wye Valley now ranking 9th out of 136 eligible Trusts which is a marked improvement from ranking 55th in April 2024.

The Haematology service has maintained open and safe access with Locum recruitment. Wye Valley has now successfully recruited an NHS Locum Consultant with the view of the post holder becoming substantive within 12 months once CESR has been obtained. The Consultant is due to start with WVT in July 2025.

Our Acute Palliative Care Consultant is due to retire this month. The team has successfully recruited a replacement with the post holder starting in May 2025. An interim plan has been agreed to cover the service until the post holder is in place.

Diagnostic Services

The Radiology team have continued to deliver significantly increased capacity across main modalities including; MRI (Magnetic Resonance Imaging), CT (Computed Tomography), NOUSS (Non-Obstetric Ultrasound Scan) and DEXA (Dual Energy X-ray Absorptiometry/bone density scan) achieving; 160%; 141%; 109% and 101% of 2019 activity in January 2025. All modalities are delivering above plan year to date.

The Wye Valley Community Diagnostic Centre build work is moving according to timescales with handover expected during the beginning of August 2025. In terms of additional workforce for the new centre, the project is currently 48% recruited to plan. Work is underway to explore expansion opportunities.

Following a successful NHSE bid, the department proceeded with additional 3D mammography machines, which has increased scanning capacity for both symptomatic and screening patients, MRI AI Acceleration software was installed on the 2 MRI scanners on the acute county site during Q3 2024, to not only speed up image acquisition improving productivity but also improve image quality.

Digital transformation continues with I-Refer due to be rolled out imminently. I-Refer is an AI enabled clinical decisions support software, with the aim to facilitate improved appropriateness of image requesting. Meanwhile both Order Comms and I-Refer software for General Practice is progressing.

Meanwhile, Audiology waiting times see an ongoing improvement with the under 6 week wait position improving from 48% in April 2024 to 32% in January 2025. The services face difficulty with the Head of Service position vacant since the previous post holder retired in December 2024. Other local Audiology services are facing a similar challenge, with Gloucester, Worcester and Brecon looking to recruit permanent Head of Service. Insourcing support to Paediatric Audiology continues, currently there are plans being enacted to remove the reliance on insourcing.

Pharmacy

Pharmacy recruitment has seen a vast improvement compared to the position last year. Our substantive Pharmacist establishment is now fully recruited to and we will welcome our final two qualified Pharmacists in August 2025. We have continued to see vacancies within our Pharmacy Technician pool, however, we are confident that through our Pharmacy Technician Pre-Registration Trainee programme, these vacancies will be filled by our current cohort by the end of the calendar year.

In 24/25, we have internally recruited four Pharmacist's and five Pharmacy Technicians. This demonstrates the benefits of having a proactive and supportive Education & Training team – the ability to create and maintain a sustainable workforce has been (and will continue to be) essential to improving our workforce establishment.

The improved establishment position has allowed the clinical Pharmacists/Pharmacy Technicians to return to ward-based working. The collaborative effort across speciality areas within the department to release ward-based staff is shown through our productivity gains: 47% improvement in TTO turnaround times from January 2024 – January 2025. Outpatient Prescription turnaround times have also improved by 10% during the same time period.

Pathology

Histopathology – Since the last report, our two new Histopathologists have integrated seamlessly into the department. As anticipated, their addition has further improved Histology turnaround times (TATs), with WVT achieving the highest TATs in the region for both 7-day and 10-day reporting specimens in December and January.

Additional funding from the ICB has been secured to support Digital Pathology, with an ambitious target of 50% reporting by the end of March. However, progress has been hindered by technical issues with the system host and delays in receiving the additional funding at the Trust level. Our colleagues at WAHT are facing similar challenges, making the target equally demanding for them. Despite these setbacks, every effort will be made to ensure WVT progresses as close to the 50% target as possible.

Blood Sciences – The tender process for the new Managed Laboratory Services (MLS) has now completed and a business case went to TMB and was approved on the 7th February. The implementation plan is over a 9-month period and once fully implemented it is expected that there will be efficiency gains within Blood Sciences but also much improved TAT's for ED one-hour standard patients.

Endoscopy

Endoscopy was moved from Surgery to CSD in September 2024. Since then there have been positive changes made including updating of the Endoscopy template for further productivity gains and job planning our Clinical Nurse Endoscopist for 5 scoping lists per week (including some flexible sessions). WVT alongside our colleagues at WAHT will shortly start the FIT @80 pilot for bowel screening.

9. GEMs Board September 2024 - Winners from Quarter 2 and Quarter 3

Team of the Quarter – Quarter 2 – Head, Neck and Orthopaedic Teams

The Administration Teams within Head, Neck & Orthopaedics, led by their DGM & Admin

Managers have gone above and beyond in supporting the Directorate to reduce the number of

Patients waiting >65 weeks.

There have been multiple challenges along the way with cancellations, excess Trauma, bed pressures, ever-changing locum schedules, insourcing and outsourcing to name a few! Throughout, the teams have maintained professionalism, often working over their core hours to fill a short notice cancellation or amending the lists according to the pressures of the day and validate waiting lists.

Employee of the Quarter – Quarter 2 – Jessica Rippard

Jess demonstrates all of the Trusts core values working as a HCA. Her communication and compassion for the patients in her care is fantastic and she is always looking at how to improve the patients experience and the service the department provides.

Jess regularly designs patient centred displays around the department, normally funded by herself, as well as buying patient's distraction toys and fidgets to gift the children after blood tests.

She is extremely attentive and has helped identify that a child has diabetes when listening to the parents' concerns around a child that had been unwell, and escalated these suspicions to the consultant. With this, Jess has helped the child avoid being treated for DKA and instead getting a speedy treatment on the Childrens Ward.

Jess has also shown great compassion towards a colleague after hearing that her colleague's anniversary of her stillborn child was the following day. After realising her colleague was anxious and upset that she wasn't able to leave work the next day in time to get a balloon and ornaments for her child's grave, Jess fundraised with other colleagues and bought a balloon, grave ornaments and gifts for the family. She did this out of the kindness of her heart, and we really think it shows her consideration and true character.

She truly goes above and beyond, in both her professional role and support of her colleagues outside of work.

Team of the Quarter – Quarter 3 – Goran Pinjuh and Nicola Edmunds

Pathology is very short staffed especially the Microbiology Department which is on the risk register. Goran was recently upgraded to a Snr BMS and has made an incredible improvement in Microbiology. He has taken on the main responsibility of Quality and as such took it upon himself to lead on the UKAS inspection findings. Nikki is employed part time as the overall Pathology Quality Manager and has had to be more hands on with Microbiology to enable us to get through our UKAS inspections. They have both worked late into the night, weekends and during their annual leave to get the work done to meet the short deadlines set by UKAS. They both show their commitment to the team by ensuring that the whole of pathology remains accredited.

Employee of the Quarter – Quarter 3 – Katie Bayliss

Katie is relatively new to the paediatric respiratory team but brings a wealth of experience to the team. Katie received concerning photographic evidence of a young child with asthma living in accommodation severely infested with mould. Despite efforts from the family to raise their concerns with housing department they had received no real help so Katie has conducted a home visit to assess the home environment, when the team don't usually see patients outside the hospital environment, and escalate the serious concerns with social housing and our ICB programme manager using her position as a respiratory specialist within the Trust. Despite having a busy workload Katie continued to prioritise the case throughout her working day. Without Katie going the extra mile the outcomes for the child could have been very different and we may have been contributing to a different type of review.

Glen Burley
Chief Executive Officer

NHS
Wye Valley
NHS Trust

Integrated Performance Report

January 2025

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

Across the NHS, this winter period has been extremely challenging. The pressure that an increasing number of admissions to hospital places on the wider bed base is an ongoing cause for concern, in particular the number of patients being cared for in Temporary escalation spaces (Boarders), despite a range of strategies in place to reduce this. Demand pressure on our services, particularly in our urgent care pathways intensified into January, and despite our collective efforts we, like many other Trusts, declared a critical incident on Wednesday 8th January. Thanks to the combined effort of our teams and partners we were in a sufficiently improved positon to stand this down on Monday 13th January.

Staff sickness improved marginally in January but remains high following the increase seen in December, alongside the increased prevalence of winter illness in our community. As a result of these challenges, we have continued reliance on temporary workforce to maintain safe staffing levels. Use of Off Framework agency shifts marginally increased through the winter period though remains at comparatively low levels.

Capacity was disappointingly impacted by water leaks on the Hereford County site during adverse weather. Through our established contractual arrangements with the PFI partner we are seeking assurance that these have been fully mitigated.

Despite these pressures our Operational and Clinical teams maintained protection of our elective pathways, delivering the elective activity plan, and with only a very small number of postponed procedures.

Our thanks to each of our teams and system partners who responded flexibly and professionally during this challenging period.

Whilst turnover rates remain overall stable and below the 10% target, we do see a significantly higher turnover in our Health Care Support Workers (HCSW) with around 30 vacancies currently in this staff group. This not only has a quality impact on our wards and also drives premium cost. Targeted actions are ongoing to improve recruitment, on boarding and retention.

Overall we remain behind our agreed financial plan for the year, partly driven by the significant impact of winter. Through our Financial Recovery Board and work with System partners and NHSE we are pursuing mitigations to improve financial performance by year end, including seeking national support to resolve a funding misalignment with Welsh Commissioners.

Operational planning for 2025/26 is well underway and has been complemented by publication of the national guidance. As expected, though there is a welcome smaller set of national objectives, the financial settlement is extremely challenging and represents a real terms reduction in funding year on year. Development of our cost and productivity improvement schemes is a key focus for the divisions. Teams are focused on improvements in our elective pathways, and in urgent care where we have a number of test of change projects planned for March. Once fully triangulated, the final plan will come to Board for adoption in April.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Urgent and Emergency Care (UEC) Patient Survey Results

The national UEC survey was published in November 2024 and related to treatment received by patients in February 2024.

A high level overview was provided to the Trust Quality Committee in January and an action plan was presented in February. The Thematic analysis of those areas requiring improvement included; access, arrival and reception, waiting and being informed of waiting times, discharge process, privacy, dignity and communication. Comfort and facilities were also noted.

Maternity Patient Survey results

The national maternity survey results were published in November 2024. When we compare our results to last years survey the Trust has performed significantly worse in 11 questions. Areas of concern raised in the survey triangulate with other sources of intelligence from the LMNS, MNVP and patient complaints. The department have taken a proactive approach to addressing cultural issues including team working and communication which were a feature in all data sources. In addition, a focused action plan responding to the survey results has been developed.

	Monthly ED Attendance	Monthly Admissions
April	7635	1783
May	7630	1831
June	7328	1820
July	7540	1838
Aug	7238	1681
Sept	7367	1724
Oct	7568	1891
Nov	7399	1956
Dec	7406	2021
Jan	6921	1852

	Total		Boarders		Escalation	
Date	Average	Range	Average	Range	Average	Range
Jan	37	29-47	23	17-29	14	8-18
Feb	39	28-48	24	15-30	15	7-19
Mar	34	17-47	23	15-33	11	2-18
Apr	35	19-47	21	12-32	14	6-20
May	40	25-65	25	16-34	16	9-25
June	38	17-56	23	13-29	15	4-27
July	33	16-45	24	7-32	10	2-16
Aug	22	6-43	16	3-28	6	0-15
Sept	25	10-36	21	10-30	4	0-11
Oct	31	18-46	23	14-29	8	1-17
Nov	26	7-44	20	7-32	6	0-13
Dec	30	14-48	22	6-35	8	5-14
Jan	34	21-46	25	14-33	10	4-16

Operational pressures

The increasing number of admissions to hospital as can be seen in the table on the left and the pressure this places on the wider bed base is an ongoing cause for concern with the number of escalation beds open and in particular the number of patients being cared for in Temporary escalation spaces (Boarders)

There are a number of strategies in place to reduce this pressure including;

- Expansion of virtual ward capacity
- Focus on community response hub providing urgent and emergency care closer to home
- Acute bedded capacity/ demand analysis and future modelling
- Focus on discharge pathways and discharge delays
- ED streaming/navigation and best practice utilisation of Same Day Emergency Care Capacity

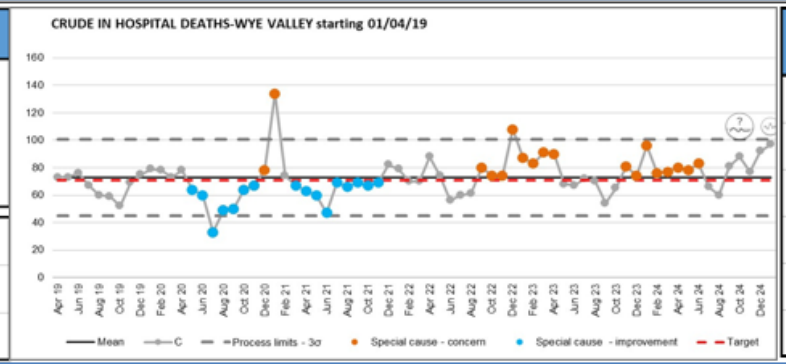
Quality & Safety Performance – Mortality

We are driving this measure because:

. The past few months have shown significant continued reductions in our SHMI, and has since returned to an 'as expected' level of mortality for our demographic.

Data

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Aug-24**	99.5	-0.6
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Oct-24**	99.9	1.4
SHMI (in hospital)			*97.7*	*2.6*
SHMI (out-of-hospital SHMI)			*105.0*	*-1.22*



CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	Oct-24	**84.9**	27	23	-13.9
Congestive Heart Failure		**97.4**	63	61	1.9
Fractured Neck of Femur		**115.3**	34	39	-6.9
Pneumonia		**104.9**	197	207	2.8
Septicemia		**114.9**	104	120	-1.2
Stroke (*Acute Cerebrovascular Disease*)		**102.2**	83	85	-0.2

Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from November 2023 to October 2024 shows Wye Valley NHS Trust at 99.9. The NHS England SHMI, which is for the period of September 2023 to August 2024, is reporting at 99.5. Both measures are now reporting on or under the national average for expected levels of mortality.
- Latest **crude mortality** rate for January 2025 was 1.48% for all admissions, which equates to 97 deaths. In addition, there were 21 deaths in our Emergency Department during January, which is significantly higher than our average. An initial data deep dive has begun to better understand the cohort of patients, along with a review of the Medical Examiner scrutiny's for these cases.
- Another overall positive month for our key mortality outlier groups, with the latest figures (*November 2023 to October 2024*) showing the majority of outlier groups are now reporting at or below expected levels of mortality.
    - **#NOF –** Another further significant reduction of 6 points in the latest 12 month SHMI, which now sits at 115.3. On-going work continues with implementing a revised fast track pathway, actions and improvements are being managed through the monthly stakeholder steering group.
    - **Heart Failure** – Has reported a small increase in the latest SHMI to 97.4, but remaining firmly under the expected levels of mortality for our population
    - **Sepsis –** A small decrease in the 12 month rolling SHMI to 114.9, equating to 120 actual deaths against 104 expected deaths.
    - **Pneumonia –** Another small increase reported in the latest 12 month SHMI, which now reports at 104.9. Initial deep dive has begun to better understand the recent reduction in the number of provider spells for Pneumonia, which has conversely lead to a reduction in the number of expected deaths significantly. Findings will be feedback through the LfD committee.
    - **Stroke –** A minor reduction in the latest 12 month rolling SHMI, which currently sits just above the National average at 102.2.
- **Medical Examiner Service** – The service had its busiest month to date, supporting 258 deaths from across Herefordshire during January 2025. All of the bereaved families had the opportunity to discuss the Cause of Death and the care provided with a Medical Examiner.
- **Perinatal Mortality** – The latest 12-month rolling (*February 2024 – January 2025*) Extended Perinatal mortality has risen to **6.77** per 1000 live births. The latest stillbirth rate is **4.92** per 1000 live births for the same 12 month period.

Quality & Safety Performance – Ward Accreditation

We are driving this measure because:

Trust aim to implement peer review visits across wards and clinical areas as part of a wider Ward Accreditation Programme

Data

Bromyard Community Hospital
Peer review Visit
Standard: GOOD

Section	Overall Result
1. 15 Steps Assessment	Good
2. Professional presentation	Good
3. Cleanliness and IPC	Good
4. Care needs adequately met	Good
5. Individualised care	Good
6. Safe medication management	Good
7. Patient experience	Good
8. Positive safety climate and culture	Good
9. Deteriorating patient and managing clinical risk	Good
10. Training and development	Good
11. Leadership and management	Good

Acute Medical Unit
Peer review Visit
Standard: NOT MET*

Section	Overall Result
1. 15 Steps Assessment	Standard not met
2. Professional presentation	Standard not met
3. Cleanliness and IPC	Good
4. Care needs adequately met	Standard not met
5. Individualised care	Standard not met
6. Safe medication management	Good
7. Patient experience	Standard not met
8. Positive safety climate and culture	Standard not met
9. Deteriorating patient and managing clinical risk	Standard not met
10. Training and development	Good
11. Leadership and management	Good

Frome Ward
Peer review Visit
Standard: GOOD

Section	Overall Result
1. 15 Steps Assessment	Good
2. Professional presentation	Good
3. Cleanliness and IPC	Good
4. Care needs adequately met	Good
5. Individualised care	Good
6. Safe medication management	Good
7. Patient experience	Good
8. Positive safety climate and culture	Good
9. Deteriorating patient and managing clinical risk	Good
10. Training and development	Good
11. Leadership and management	Good

** The bar for achievement at standard levels in ward accreditation is set high. Not all wards will achieve accreditation the first time, this can take some years to achieve. Achievement will be part of a continuous improvement journey, rather than a pass or fail. The focus is on success and improvement over time and knowing where to focus.*

Headlines

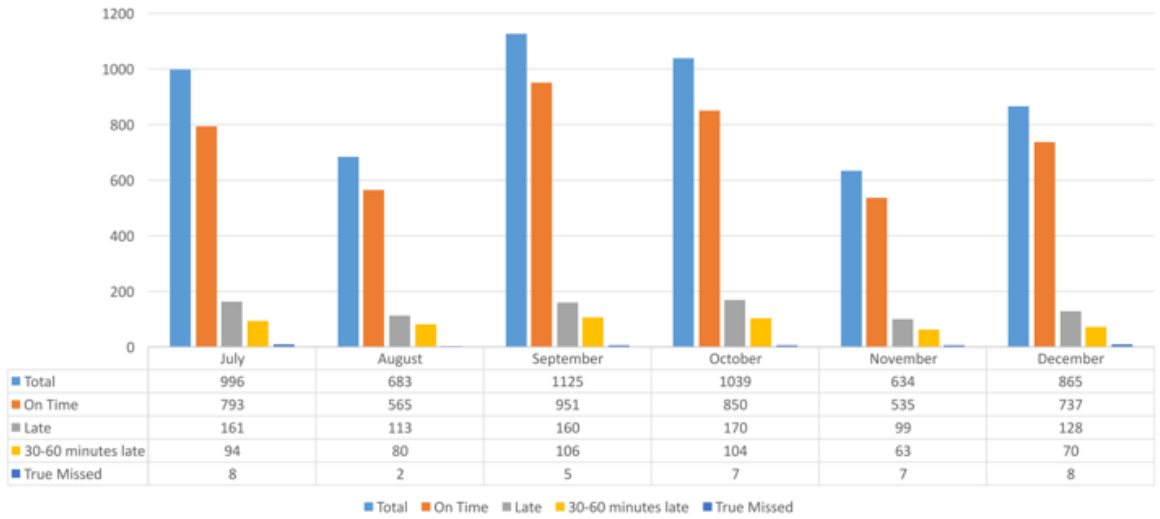
The Trust Ward Accreditation programme is supported by a Steering Group
Pilot peer review visits across medical, surgical and community hospital now completed
Feedback from all pilots areas that the visit was a positive experience
Feedback from the visits to be reviewed by Steering Group
Next steps are to review the visit methodology and resource required to fully implement the programme
Plan to be developed for baseline assessment of remaining ward areas throughout 2025
Dashboard being developed to digitally enable wards to collate evidence and wider support to deliver the programme

Quality & Safety Performance – 'Get it on Time' campaign for Parkinson's medications

We are driving this measure because:

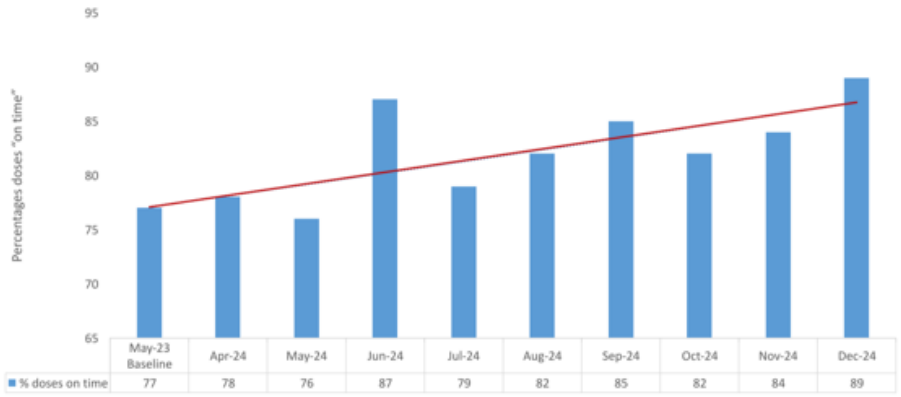
The Trust signed up to a group quality priority in 2024-25 to deliver the 'Get it on Time' campaign to ensure patients with Parkinson's are safe in our care and continue to receive their Parkinson's medications during an inpatient stay.

Data



	July	August	September	October	November	December
Total	996	683	1125	1039	634	865
On Time	793	565	951	850	535	737
Late	161	113	160	170	99	128
30-60 minutes late	94	80	106	104	63	70
True Missed	8	2	5	7	7	8

% of medications "on time every time"



	May-23 Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
% doses on time	77	78	76	87	79	82	85	82	84	89

Headlines

Chart ones shows the break down of missed doses month on month based on the time delay or actual missed dose. Month on month since September 2024 overall number of delayed/ missed doses is reducing.
Chart two shows the % of medication prescribed on time every time and an upward trend is emerging.

An area of particular concern was doses 30-60 minutes late. Observational work highlighted that patients were indeed getting their medication on time but staff were delayed in updating the electronic medicines system, therefore noted as late. In addition, availability of drugs in ward areas was an issue. Stock lists for highest areas of administration have been updated to ensure levels reflect this.

A deep dive of December true missed doses identified other issues that show doses are not actually missed but our administrative practices are affecting the data. For example; a patient was changed to patches, oral meds not stopped on EPMA yet patient received correct medication. A patient was discharged home but the discharge on EPMA delayed so this registered as a missed dose.

Work and learning from this campaign is to be expanded to other critical medications as part of the focus for 2026

Summary: Plan of Action

- Support given to frailty wards and community hospitals to improve timings of critical meds.
- Working with EPMA team to help share education about EPMA and using the deferred doses correctly.
- Liaise with prescribers through NMP forums and Drs training to encourage prescriptions to be stopped correctly and timely.
- Continue links with Parkinson Nurses and Parkinson's UK as well as continuing to promote all critical meds MRG (medicines related guideline) Trustwide available on the intranet and continue to be part of the Parkinson's Excellence Network that is National.
- Continue the deep dive into other critical meds as well as continuation of the Parkinson's data.

Quality & Safety Performance – Staffing

Fill Rate & CHPPD Data

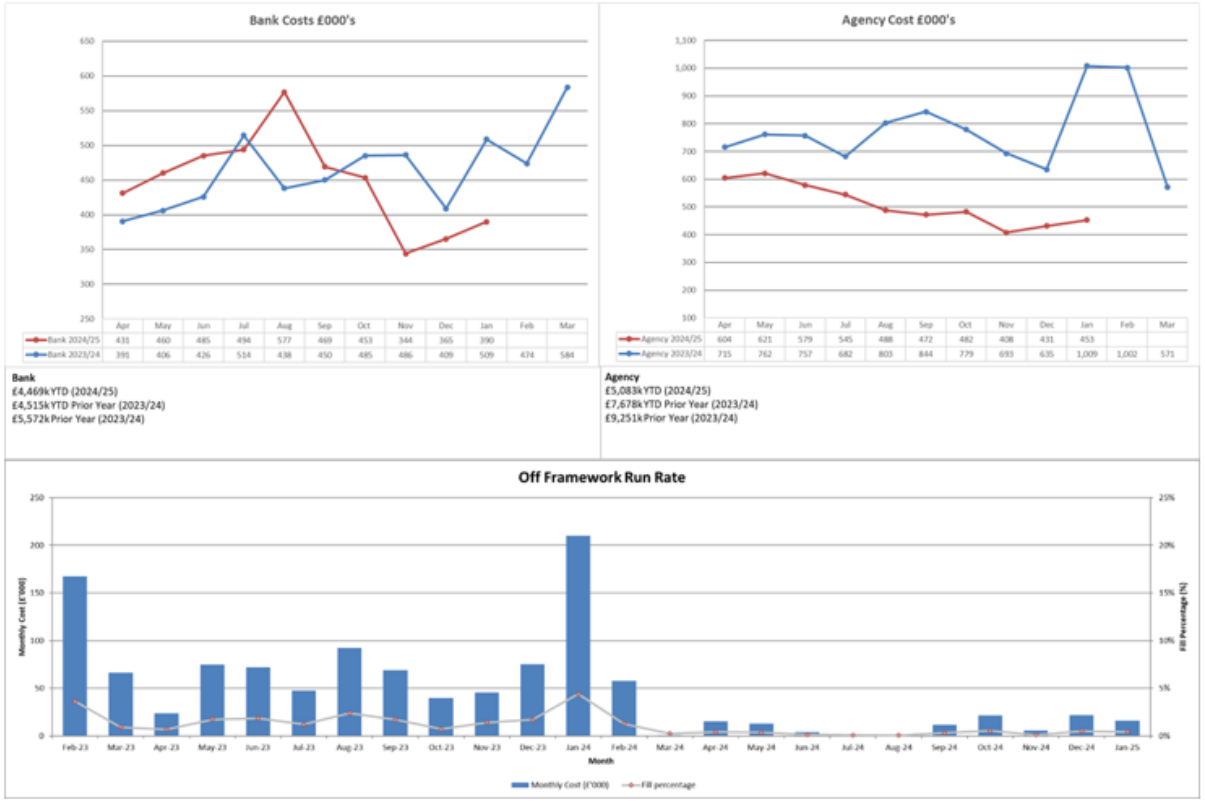
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	92%	76%	104%	110%	9.6
Maternity Ward	86%	92%	92%	97%	5.9
Children's Ward	104%	145%	126%	84%	19.1
Lugg Ward	125%	76%	116%	113%	7.0
Wye Ward	116%	84%	125%	79%	6.8
Cardiac Care Unit	99%	100%	100%	100%	11.8
Leominster Community Hospital	221%	80%	169%	120%	8.0
Bromyard Community Hospital	118%	92%	100%	97%	7.1
Ross Community Hospital	100%	114%	113%	123%	6.4
Teme Ward	141%	56%	91%	69%	10.9
Redbrook Ward	112%	111%	130%	133%	7.6
Special Baby Care Unit	106%	-	97%	-	19.4
Intensive Care Unit	121%	-	102%	-	27.9
Gilwern Ward	104%	136%	100%	108%	6.9
Acute Medical Unit	126%	82%	102%	141%	8.2
Ashgrove Ward	137%	89%	127%	115%	7.4
Dinmore Ward	121%	79%	98%	103%	6.9
Garway Ward	155%	89%	130%	126%	7.7
Frome Ward	120%	81%	101%	127%	6.7
Arrow Ward	157%	77%	172%	82%	8.2
Women's Health	128%	83%	100%	-	10.9

The NHS England staffing return is detailed above and includes the minimum expectations in terms of national quality board reporting requirements.

Board should note that figures are based on base levels for funded establishment (core beds) where over fill is seen this is either due to:

- High level of patient acuity and dependency
- Additional beds (community hospitals) and individual patients with specific needs
- Higher levels of acuity and/or dependency and patients being cared for in Temporary Escalation Spaces (TES)

Bank & Agency



Since the last Board Report, agency spend has remained fairly sable and the bank position has returned to more usual levels. There has been a marginal increase in off framework shifts, although these do remain small in number. The majority were last minute shifts required to cover short term sickness.

In line with the regional collaborative expectations our band 5 general and band 2 rates are NHSE price cap compliant and fill at this rate is being monitored via the contract performance meetings. A single escalated rate for band 5 general has been introduced and an alternative for off framework has been introduced; both of these are subject to enhanced controls (break glass process). Work is ongoing to ensure NHSE price cap compliance for specialist shifts from March 2025.

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Declaring a Critical Incident in January to help support and manage our patient flow, protect our elective capacity and support staff, who have continually been faced with ongoing challenges throughout the year, was an unfortunate but necessary first for Wye Valley NHS Trust.

The position leading up to the festive period already saw high levels of the "quad-demic" of Flu A and B, increased Covdi-19 and Respiratory syncytial virus (RSV) in our patient groups which continued into January.

ED patient flow was hindered by the increased requirement for isolation in the department, along with higher acuity, challenges with higher >0 length of stay admissions and our ability to isolate and cohort on the wards. In order to support flow we introduced Lateral Flow Testing for both types of Flu and Covid in order to make quicker decision making about, treatment plans, isolation and cohorting.

However, a range of extreme and unprecedented demands during the first days of January saw severe pressure including excessive Emergency Department (ED) waiting times, ambulance offloading delays and the need to provide care in settings not typically used for ED services, along with extreme Ambulance handover delays, acute estates issues impacting on the ED due to water leaks across multiple areas and pressure to create extra capacity. Increased Temporary Escalation Spaces (TES) at the acute and community sites

Therefore a Critical Incident was necessary due to the extraordinary pressures our staff were faced with and in order to gain Trustwide and wider Herefordshire and Powys Health and Social care systems to enact support and their own escalation plans to support their local District General Hospital

Our Critical Incident was in place from Wednesday 8th January to Monday 13th January where we saw our staff respond to the challenge, in way that is typical for our Trust when faced with these pressures, with flexibility, commitment and professionalism along with System partners providing additional action and resource, particularly across Herefordshire, to expiate discharges.

Thank you to all WVT staff and wider partners for their continued support and additional efforts over January.

Despite these pressures our Operational and Clinical teams maintained protection of our elective pathways, and despite a very small number of postponed procedures, we managed to maintain our activity plans during January and Year to Date we broadly remain on plan. Although we have seen some pressures in some specialties and within some modalities within our Diagnostics pathways as detailed further on in my section of the Integrated Performance Report.

Although Winter Pressures are still prevalent, as move towards March, we are already looking at our Urgent and Emergency Care and Elective Care operational and productivity schemes for 2025/26. Getting It Right First Time (GIRFT) remains the cornerstone of our operational performance improvement plans and WVT remains one of the highest performance across a range of measures within the Elective Faster Further Programme giving ourselves a firm foundation for further improvements and opportunities to deliver more in the year ahead.

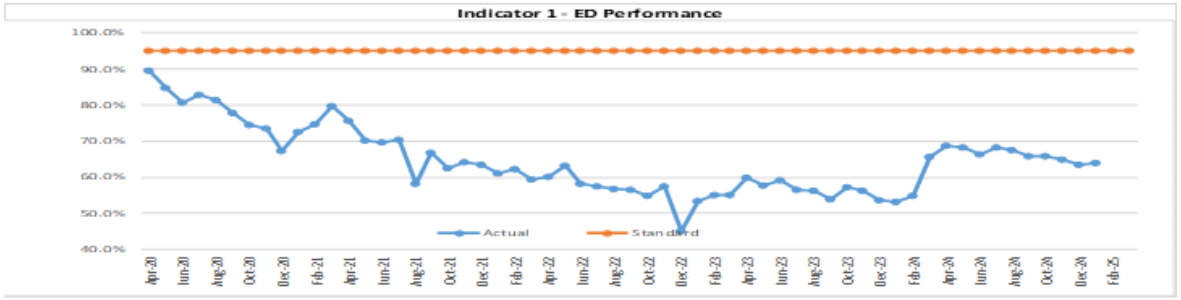
For March we are focusing the opportunity, as part of the National drive to improve Emergency Access Standards (EAS) during the month, to test new ways of working to improve patient experience in ED and on our wards which will also help us to design our improvements. During the month each Division will undertake 2-3 different ways of working which test and inform our Valuing Patient Time agenda for 2025/26

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

We are driving this measure because:

The National 4 Hour Emergency Access Standard (EAS) 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

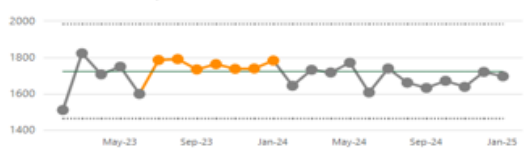


% Patients Spending More Than 12 Hours In ED

Type 1 Minors Attendances

% Admissions on Same Day Emergency Care (SDEC) Pathway

Ambulance Conveyances



Risks

- Sustained pressure in Type 1 ED attendances and continued challenges with demand and high acuity with fluctuating high levels of attendances and Ambulance conveyances.
- System patient flow constraints.

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. Januarys 4 hour Emergency Access Standard [EAS] Performance was 64.1%

Performance & actions

- 5,660 Type 1 patients attended ED in January which was the lowest volume since April-24. The range of all attendances varied from 137 to 228 with 202 being the average daily attendances.
- 1,697 ambulances conveyed to the Trust in month which was 24 fewer than last month. The range in month was 37 to 65. This includes 9.1% from Powys [155].
- Ambulance handover delays over 1hr were 29.7% [444] of all conveyances and 54% [813] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,268 of all admissions [47.2% of all admissions] via a Same Day pathway within no overnight admissions. This is a 0.7% increase over last month.
- Our Type 1 ED attendances 4 hour Emergency Access Standard ranks 73/122 Type 1 Trust in England for January.
- 14.6% [1,012] of patients spent 12 or more hours in ED which was 1.3% more than last month and the highest position since February 2024 [16.9%].
- In January our Minors 4hr EAS was 95% and our Paediatric 4hr EAS as 98.5%
- Our Valuing Patients Time Programme Board [VPTB] has oversight of the current UEC improvement schemes:

➢ Virtual Ward [VW] expansion of Surgical beds has occurred and an increase in Medical beds is planned for the March. Including VW increased "in-reach" into the acute ward Board Rounds to maximism opportunities to increase capacity utilsiation

➢ Resolving the Governance and implementation of increased Outpatient Parenteral Antibiotic Therapy [OPAT]

➢ Increased flow to our revised estate for our Discharge Lounge and profile increased SDEC / acute medicine follow up patients through this revised area.

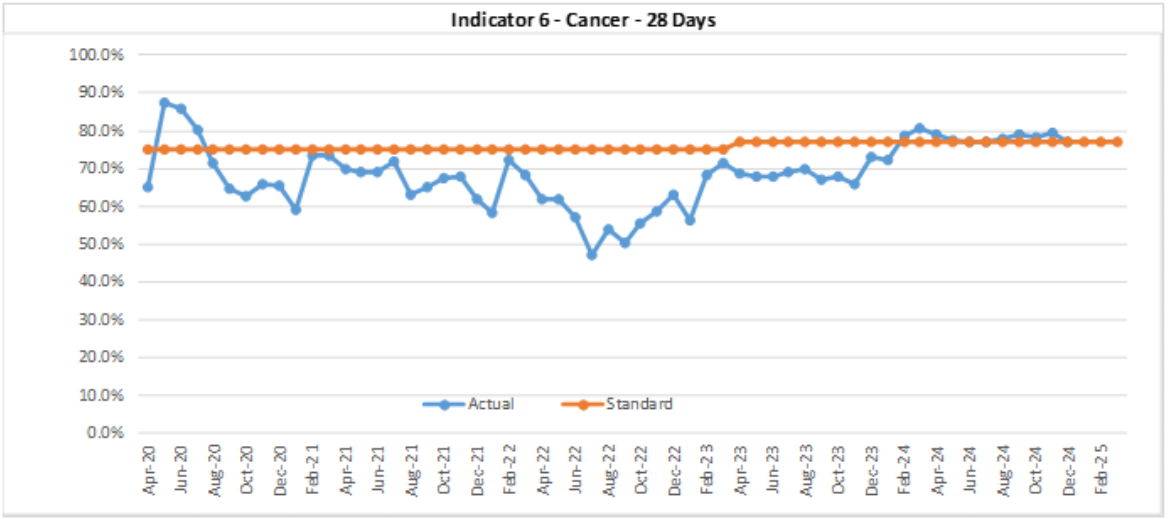
➢ Revised Escalation and Patient flow policy launched in January along with a "Test of Change" week , in February, for patient flow roles and responsibilities at ward and Divisional levels to ensure patient flow is clinical led and Accountability is clear

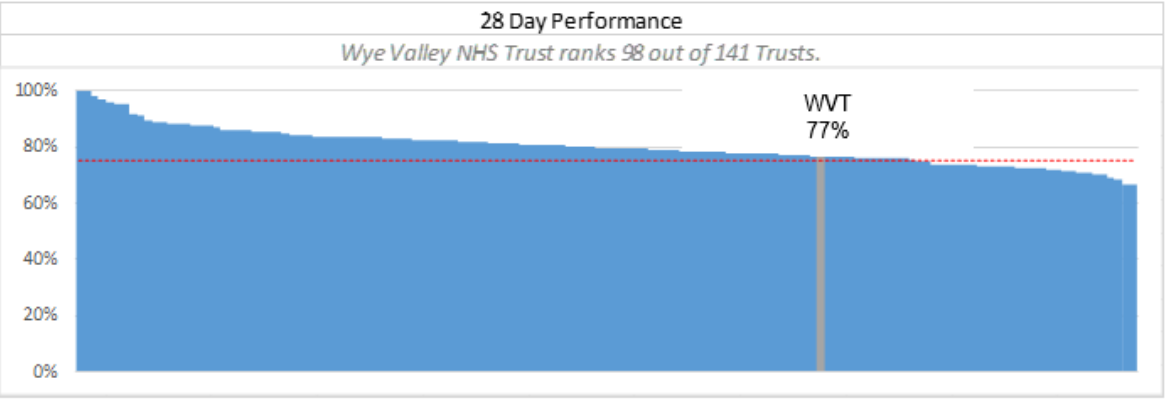
Operational Performance – Cancer Performance 28 Days Fast Diagnosis Standard [FDS] [December 24]

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 77% 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 & actions

Referrals:

Overall referrals up 15.8% as of the end of December compared to 3 years previous. Gynaecology in particular is showing 39% increase in the same comparison. Once the Post-menopausal bleeding (PMB) pathway is agreed, referral numbers into Gynaecology is expected to decrease which in turn should have a positive impact on performance.

28 FDS:

The Trust has met the 77% target despite significant pressures in the Breast service which reported a 32% reduction in FDS performance when compared to November. The target remains under threat in January however Breast do have plans to recover activity in February and therefore an improvement is anticipated.

During the last period we have undertaken a "deep dive" into improving our Radiology performance for cancer. This had representation across the multidisciplinary team and further meetings are scheduled in March to review the finding and develop into a short and long term plan for 2025/26.

Endoscopy cancer access:
During January, all patients referred on a cancer pathway for OesophagoGastro Duodenoscopy (OGD), Colonoscopies and Flexible Sigmoidoscopy were offered an appointment within 7 days, however for transnasal endoscopy patients there was an 11 day wait, however to reduce this patients were instead offered an OGD appointment at 7 days (if appropriate).

Our Cancer teams are working across Divisions to develop plans for 2025/26 to improve our FDS performance to 80% before March 2026.

What the charts tell us

28 Day faster diagnosis: Performance against this target was 77%. This target has been consistently maintained since February 2024.

Risks

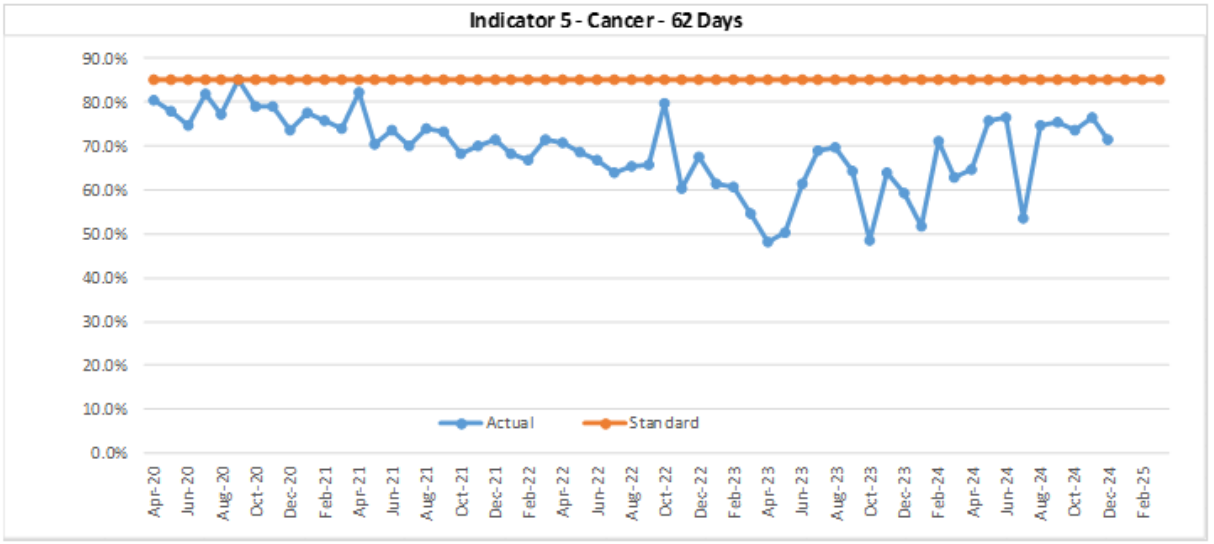
Cancer referrals continuing to remain above 19/20 levels/Histology Endoscopy and Radiology capacity still remain a challenge to maintain 28FDS. Issues related to Breast workforce over December 24 to February 25 are an issue but plans in place to recover.

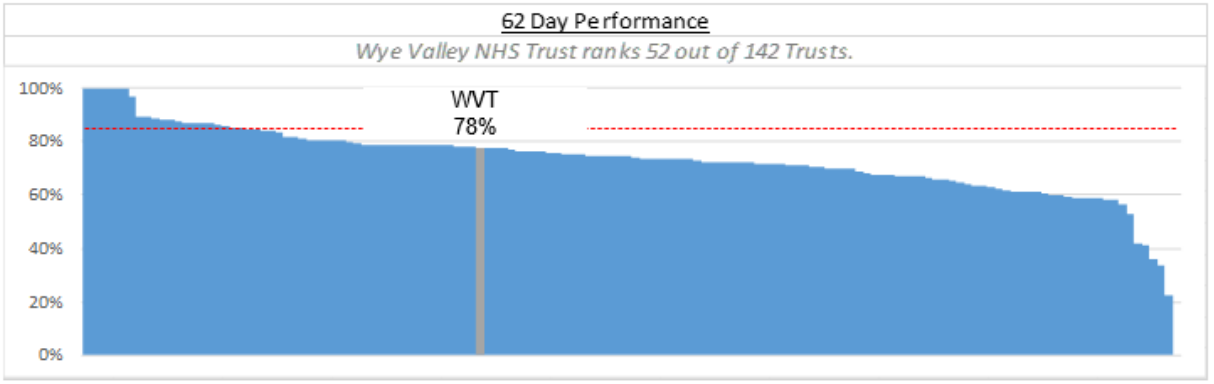
Operational Performance – Cancer Performance 62 days Start of Treatment Standard [December 24]

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





What the charts tell us

62 day Treatment Standard: The Trust's performance was 78% against a target of 85%.

Performance & actions

62 Days:

Trust reported a position of 78% for 62 days. Recorded activity was lower than previous months with 76 recorded treatments as opposed to an average count of around 100.

We have seen improved utilisation of daily ring fenced pre-operative assessment slots is supporting improvements seen in 62 day performance. First week of December reported 70% utilisation against 33% utilisation during the 2nd week of November. Work continues to promote the use of the these daily slots with cancer specialties via the weekly Cancer Patient Tracking list meeting and through Divisional communications.

Breast capacity issues has been a concern and as a result has seen a delay in patients receiving their first appointment within the specialty. This has been driven by sickness, annual leave and a vacant post. A locum was appointed in December and two further NHS fixed term locums are due to join in February. The specialty has been working hard to prioritise patients and maximise use of clinics, which to date has ensured Breast continue maintain their service, however these challenges of capacity issues have impacted had some impact on December but further impacts on January performance.

Developments updates

- Text messaging to go live in Gynaecology in February to reassure patients of benign results. Along with one of our cancer pathway navigator has been ring fenced to support the specialty progress actions for the Workshop held in December last year.
- The hepatocellular carcinoma surveillance nurse post is out to advert to help support in the earlier detection of Hepatocellular cancer to enable timely curative treatment and increase survival rates.
- Breast multidisciplinary team (MDT) improvement meetings are to be understand current issues and develop required actions to support streamlining the current processes across the week to improve pathway progression.

Risks

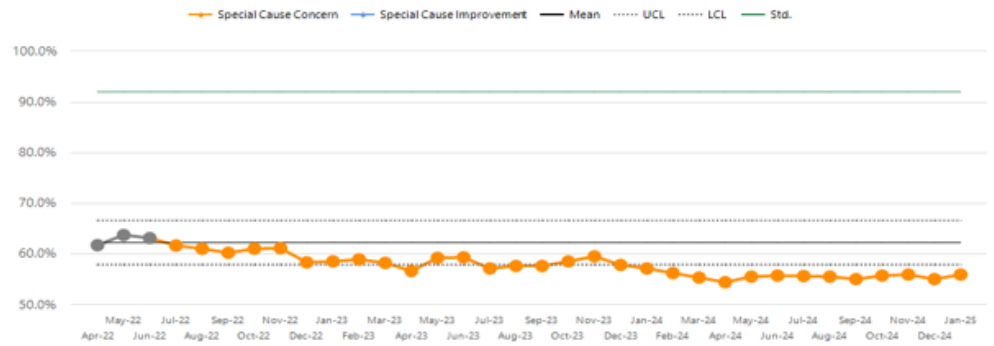
Workforce capacity and shortfalls in some specialities along with the impact of tertiary referrals.

Operational Performance – Referral To Treatment Performance

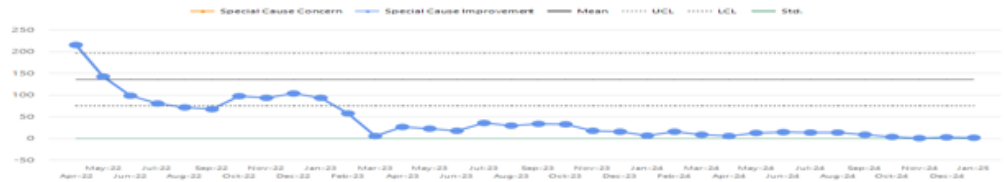
We are driving this measure because:

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 Trust's agreed plans as part of the annual Business Planning process with commissioners

Referral To Treatment – Open Pathways (English)

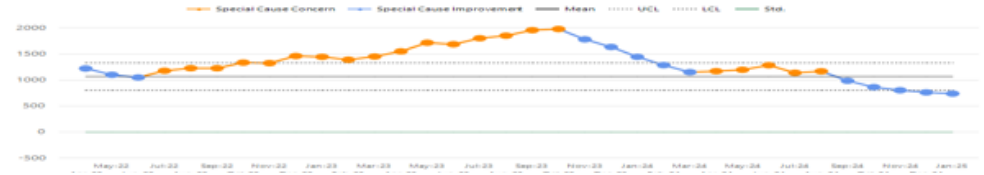


Patients over 78 weeks on Incomplete Pathways Waiting List



Weekly tracking of patients over 65 weeks on Incomplete Pathways Waiting List

Patients over 52 weeks on Incomplete Pathways Waiting List



Performance & actions

Long Waiting Patients

- 2 Welsh and zero English patients waited over 78 weeks at the end of January.
- 65 week position at the end of January was 21 English and 11 Welsh patients.
- This is a reduction of from over 220 patient during mid-June
- February's forecast for 65 week wait patients are:

➢ 26 English and 16 Welsh patients. All these patients are tracked weekly in regards to progress and all breaches are escalated and progressed. We still have issues regarding cornea tissue for a volume of patients, along with issues with complex patients and tertiary support to progress pathways. Are prediction for March is currently12 patients but, again, each patient is being tracked for resolution before then.

The Trust is has seen a significant reduction in 52 week waits over the last few months. Our combined Welsh and English position at the start of April was over 1200, of which 100 patient waiting for their treatment, at the end of January this has reduced to 766 patients, of which 616 are English patients. This equates to 2.9% of the Waiting List for English patients.

We continue to manage our Theatre capacity dynamically to increase capacity for high risk specialties, mutual aid across the Region and Foundation Group and use of the Integrated Care Boards [ICB] contracts with Independent Sector Providers in order to reduce the number of long waiting patients further. The use of the ISP is now targeted to ensure capacity across the ICS across both providers in work through first.

Risks

Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued high level of referrals and the impact of high cancer referrals.

Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

What the charts tell us

Performance against English RTT standard in January was 56%. Performance against the Welsh RTT standard in January was 69.2%.

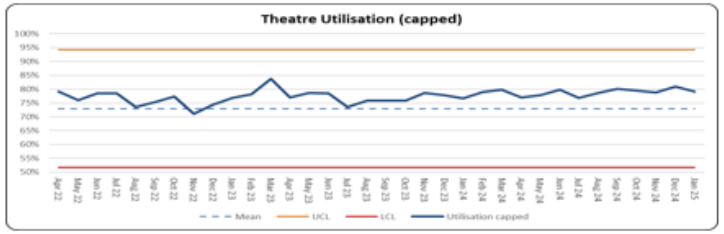
Operational Performance – Activity / Productivity

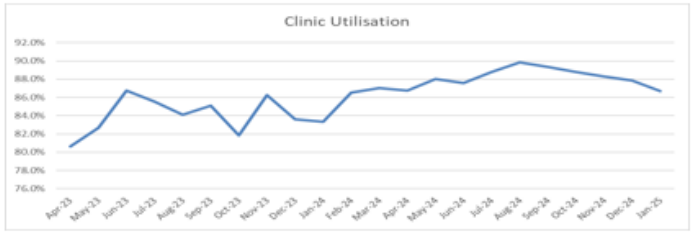
We are driving this measure because:

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 Trust's agreed plans as part of the annual Business Planning process with commissioners

Outpatient Activity		Year To Date	Charts
New	2019/20	51204	
	Plan This Year	58731	
	This Year	57481	
	Diff vs 19/20	6277	
	Variance	12%	
	Diff vs Plan	-1250	
	Variance	-2%	
	Total New	57481	
Follow Up	2019/20	111617	
	Plan This Year	117817	
	This Year	126638	
	Diff vs 19/20	15021	
	Variance	13%	
	Diff vs Plan	8821	
	Variance	7%	
	Total	126638	

Admissions		Year To Date	Charts
Elective Inpatient	2019/20	2351	
	Plan This Year	2559	
	This Year	2465	
	Diff vs 19/20	114	
	Variance	5%	
	Diff vs Plan	-94	
	Variance	-4%	
Elective Daycase	2019/20	17344	
	Plan This Year	19052	
	This Year	19185	
	Diff vs 19/20	1841	
	Variance	11%	
	Diff vs Plan	133	
	Variance	1%	





Performance & actions

Activity Summary

- New Outpatients [OP] Year to Date [YTD] activity is 2% behind plan but 12% above 19/20. This plan was readjusted to include more activity for the second half of the year.
- 47.8% of OP were either new or a follow-up patients with a procedure.
- Elective inpatient was 4% below plan, but 13% above 19/20 and Elective Daycases was 1% above plan and 11% above 19/20 for January

Theatre Productivity

- Theatre utilisation was 80.3% for January 2025. There are key specialties that are not yet delivering 80%+ Theatre utilisation that are the focus for the next few month; Ophthalmology, Gynaecology, General Surgery and Ear, Nose and Throat.
- Both December and January had multiple challenges with workforce absence and the impact of acute estates and UEC flow issues.

Outpatient Productivity

- Our Did not Arrive (DNA) rate was 6.1% in January, a slight decrease from 6.5% in December, and the second lowest rate this year.
- DNAs are still higher than we would like and we are looking at some of the work undertake across the Foundation Group around how various specialties and patients demographics were targeted for reminder phone calls in order to reduce cohorts of patients DNAing.

Risks

Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued high level of referrals and the impact of high cancer referrals.

What the charts tell us

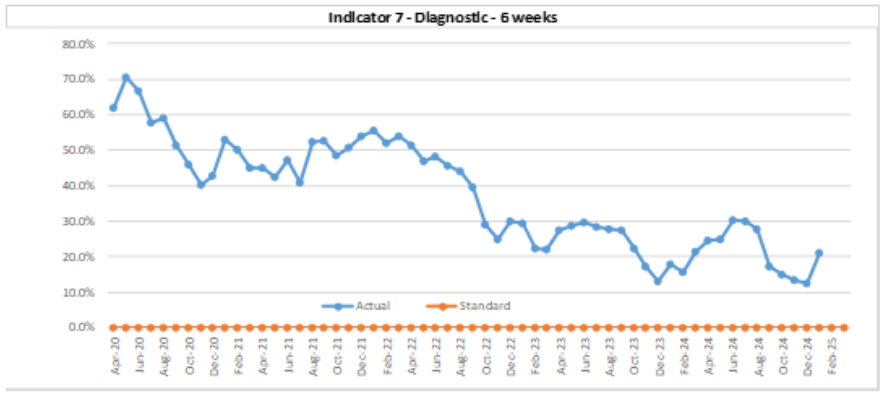
Theatre utilisation – two months above 80% target focus on key specialties to get above 85%
Clinic utilisation remains strong. January was challenged with pressures on UEC and the impact to maintain c90% slot utilisation performance

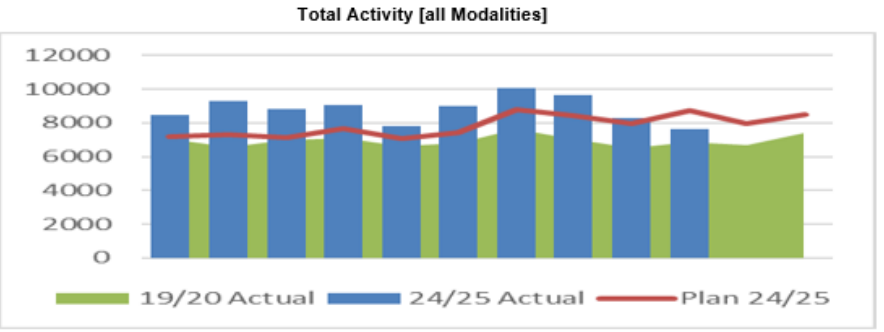
Operational Performance – Diagnostic Performance

We are driving this measure because:

Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] 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 weeks. Less than 1% of patients should wait 6 weeks or more for a diagnostic test. For 2024/25 the Trust aims to achieve 95% of patients waiting less than 6 weeks for a diagnostic test by March 2025.

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 & actions

Overall, Diagnostics delivered 88% of 2024/25 activity plan and 111% of the same month 2019/20. This months reduction in activity was driven by workforce challenges with increased absence

Imaging:
Overall Imaging`s 6 week wait position at end of month 10 was 80% compared to 82% month prior. Currently zero Computed Tomography (CT) waiting >13 weeks. 7 Magnetic Resonance Imaging (MRI) >13 weeks and 6 Non Obstetric Ultrasound (NOUS) >13 weeks.

- Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 7 and 20 days respectively. CTC has reduced from 28 days.
- The main drivers for longer waits are patient cancellations and patient delays, mainly due to floods, increased patient illness and the festive period. Incomplete referrals have caused delays whilst trying to retrieve this information (Frailty scores). Delays in bloods and prescriptions will occur until MAXIMS enables prescription at point of referral (order comms enhancement)
- Average report turnaround times for MRI prostate and CTC was 9 days and 1 day respectively.
- NOUS has been a concerning picture with a worsening position due to workforce shortage. A plan is now in place to stabilize and improve the 6 week position.

Audiology:

- Audiology 6 week wait position in month 10 70% for both adult and paediatric services, compared to 71% month prior.
- Audiology patients waiting >13 weeks (driven by paeds) reduced to 5 compared to 30 the month prior. Agreed insourcing solution continues using vacant budget, Together with a recruitment plan to improve the sustainability of the service this will aim is to eliminate the 13 week backlog to zero by the end of March and provide a sustainable plan into the new year.

Echocardiograms (Echos):

- Waiting times pushed out slightly but capacity improving from next month with our new capacity plan being implemented maximising trainee scanning time and new templates being implemented for Echocardiographers. This will sustain waiting times demand dependent but will monitor closely.

Risks

Increased inpatient / acute floor referring impacting on capacity of service.
Audiology, Non-Obstetric ultrasound and Neurophysiology capacity / workforce challenges. MRI pacemaker capacity severely limited with waiting patients not visible to internal/external reporting . A task and finish group has been established to review processes and ensure these patients are now treated and that no harm has occurred.

What the charts tell us

End of January 79% of patients waiting less than 6 weeks for a diagnostic test. The position was 59% at the end of July 2024, a 11% improvement and a reduction of almost 1150 patients waiting beyond 6 weeks.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

The Trust participated in the national programme to reform and streamline Mandatory and Statutory Training as set out within the 25/26 NHS Operating Plan. We are also involved in engagement events for the future NHS workforce solution that is being procured by NHS England to replace ESR and have submitted our Organisational Readiness Assessment.

NHS England are consulting on a new management and leadership framework and the Department of Health & Social Care are consulting on regulation of NHS managers. Through the ICS and NHS Chief People Officer forums, we have responded to the consultation and emphasized the need for robust standards to support professional development, just & restorative cultures underpinned by principles of fairness, equality and trust.

Sickness absence has reduced to 6.0% from 6.2% with Long Term Sickness at 3.08%.and Short Term sickness at 2.97%. The main reasons for sickness absence are winter ailments mental health conditions, gastrointestinal problems and pregnancy related illness. We are determined to reduce sickness absence in 2025/26 and we will be putting in place more high level impact actions including a comprehensive review of the absence policy, deep dives at FPE meetings and highlighting days lost with the costs of sickness absence to all departments on a regular basis. We will continue to take appropriate management actions to support our employees whilst reducing sickness absence over the coming year.

Staff turnover now stands at 9.4%. HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at to 6.75% but turnover for band 2 hcsw staff has increased to 18.48%. We have identified all areas with high staff turnover where staff leave within the first year of employment and are working with matrons and divisional leads on a WVT action plan to reduce staff turnover.

We supported Holocaust Memorial Day and LGBTQ+ History Month as part of our EDI programme of events. We now have a WVT Women's Staff Network in place and we are supporting the NHS breast screening campaign *(Help Us, Help You*) encouraging women living in England to attend breast screening appointments.

To enhance workforce productivity and attain cost savings, e-expenses has been introduced and the e-community scheduling system to improve operational / financial efficiency for the integrated care division will be implemented over the next 18 weeks. Following the successful roll out of e-rostering to nursing areas, plans are being finalised to roll e-rostering to other clinical areas in 2025/26 as this is recognised as a key area to enhance workforce productivity.

The 2024 NHS National Staff Survey will be published on 13 March 2025 and the reports will be presented at the next Board meeting

Following a visit to the County Hospital, 13 final year business students from the University of Derby will be undertaking their management projects at WVT working on schemes including health & wellbeing, staff engagement, gender pay gap, sustainability and recruitment & retention. We intend to extend this programme to business students from Worcester University too as they are our workforce of the future.

WVT continues to perform well with mandatory training which now stands at 88.3%. Performance appraisals has dropped to 79.7% due to significant operational pressures over the past 3 months. This is being addressed through FPE meetings.

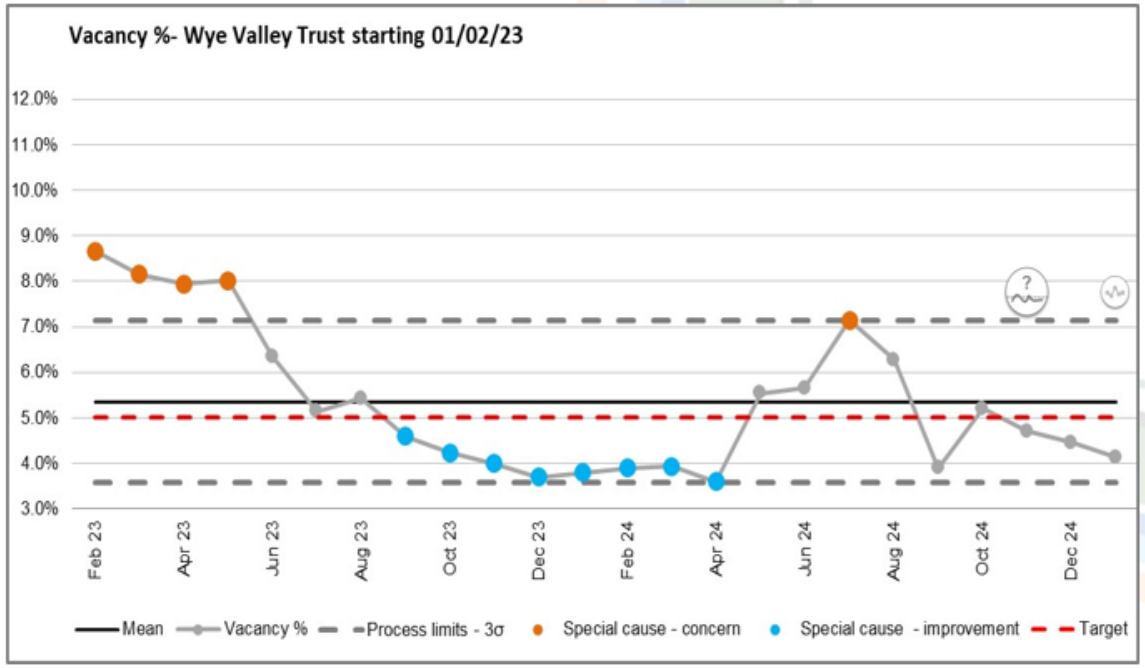
Workforce Performance – Vacancy

We are driving this measure because:

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

Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
3.8%	3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%

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 & actions

HCSW – with 31.30 wte vacancies, we have identified all areas with high vacancies and are working with matrons and ward managers to actively recruit to vacant posts. Weekly HR screening drop in interviews are now in place in addition to regular planned interviews with ward managers.

N&M - we successfully recruited 58 international nurses last year. We have now paused our international recruitment as we are starting to see a significant increase in applications from UK based applicants.

CDC – 35.49 wte appointments made including 2 international echo cardiographers in January. We are sense checking the workforce model with service leads to ensure all ongoing appointments are appropriate & affordable.

M&D - regular meetings with CMD & HR to review progress with vacancies and cases of concern. Overseas recruitment of medics to continue over the coming year as we are working with many agencies. We currently have 55.37wte vacancies. Consultants appointed in microbiology, haematology and palliative medicine.

In 2025/26, we will continue to extend our recruitment events and promote our vacancies Herefordshire wide with a series of events. We will also be extending WVT presence at regional and national fairs to promote our job opportunities using our 52 WVT ambassadors. With the Hereford Youth Hub now situated next to the Franklin Barnes building, HR will continue to work closely with DWP officers in finding suitable shadowing & job opportunities for young people as this reflects our aim to support 'young people' within the county.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

The rolling 12 month position remains fairly consistent, with a large improvement at the beginning of the 23/24 financial year down to a decrease in substantive budget along with an increase in staff in post which has continued for the first 10 months of the year, with a slight increase in the last 2 months of 23/24. There was a decrease April 24, before an increase in the next 3 months, large increase in July 24 due to the Elective Surgical hub business case before a decrease in August, followed by a large decrease in September due to a realignment of budgets for OSCE Nurses and the Education contract. An Increase in October due to realignment of OSCE nurse budget and the education contract as well as the additional of approved business cases. With a decrease in the last 3 months.

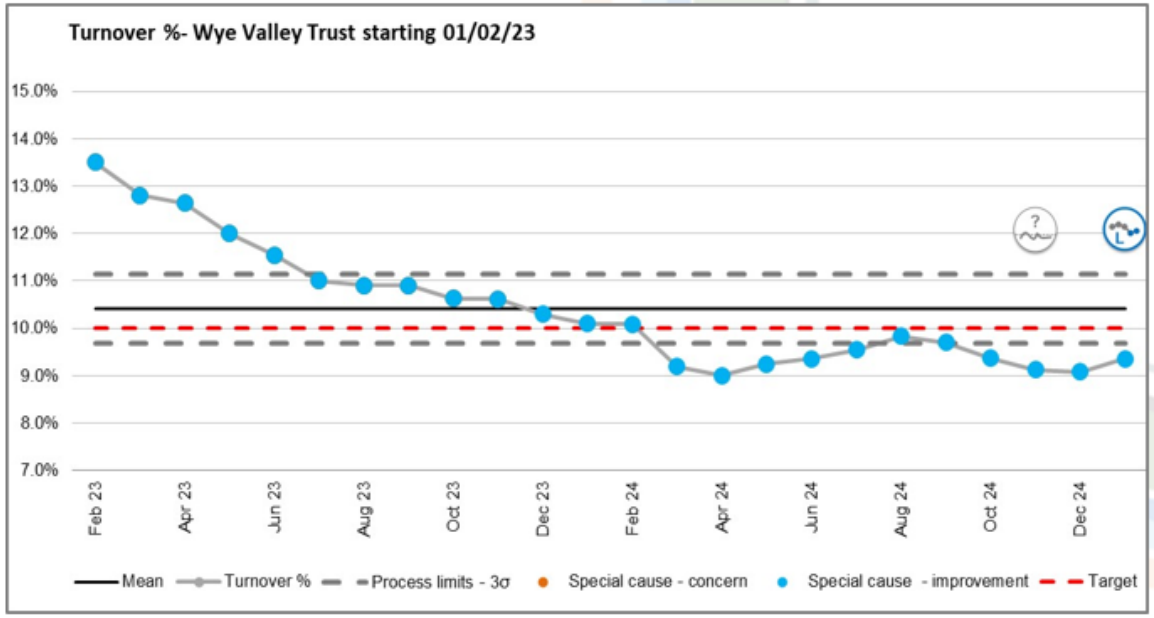
Workforce Performance – Turnover

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-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
10.1%	10.1%	9.2%	9.0%	9.2%	9.4%	9.5%	9.8%	9.7%	9.4%	9.1%	9.1%	9.4%

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



Performance & actions

The overall rolling 12 month turnover at Trust level is at 9.4% and we are taking steps to ensure this stays below 10.0%. Clinical support workers at band 2 level have the highest turnover rate at the Trust (18.48%). We have identified all areas with high staff turnover (dinmore, garway, mru, amu, ashgrove, frome) where staff leave within the first year of employment and are working with matrons and divisional leads on a WVT action plan to reduce staff turnover

We have reintroduced the centralised recruitment process and are strengthening the pastoral care support and training being provided. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships.

Turnover rates for qualified nurses remains steady at 6.75% and divisional teams are using a variety of flexible working options and development opportunities to retain staff.

Through divisional recruitment & retention working groups, HR and line managers review and analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group continues to oversee exit interview surveys and recruitment & retention areas of concern to ensure actions are being progressed in a timely manner to aid recruitment & retention of staff across the Trust.

Risks

Growing staff turnover for band 2 clinical support workers

What the chart tells us

The rolling 12 month position shows a decreasing trend in the last 12 months. An improved position present in March and April 24 due to now removing retire and returnees, with an increase in the last part of the first half of the year, which has decreased in the second half of the year, although increased in January.

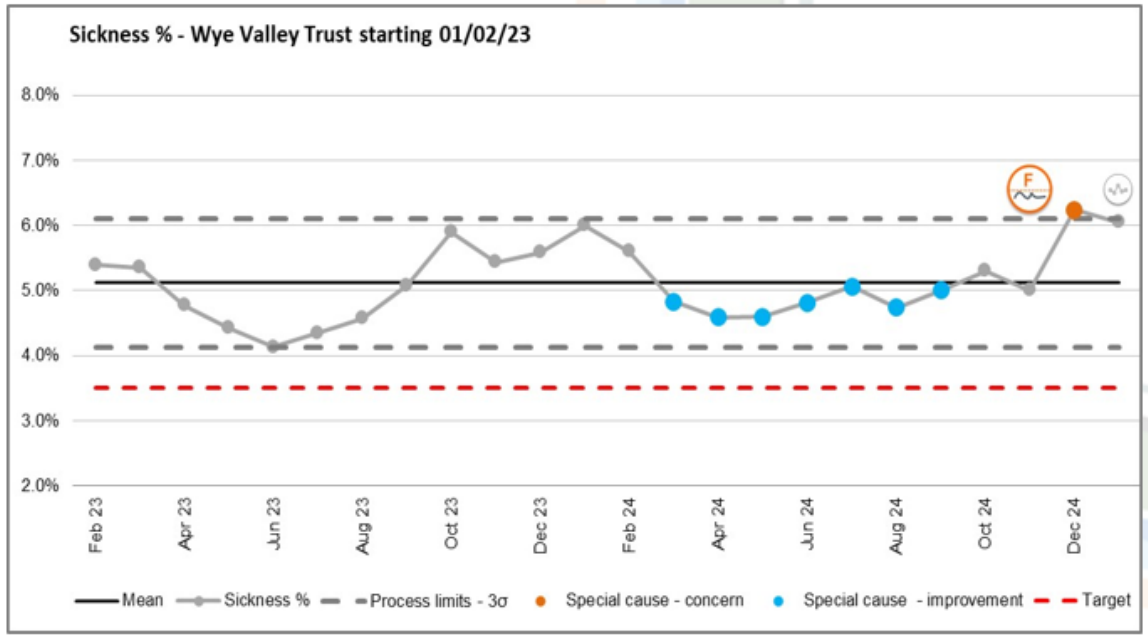
Workforce Performance – Sickness

We are driving this measure because:

We aim to reduce absence so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staff.

Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
6.0%	5.6%	4.8%	4.6%	4.6%	4.8%	5.1%	4.7%	5.0%	5.3%	5.0%	6.2%	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



Performance & actions

During this month, overall sickness at Trust level has reduced to 6.0% and the main reasons for absence are colds/winter ailments, gastro conditions, mental health issues and pregnancy related illness.
We will be putting in place more high level impact actions including a comprehensive review of the absence policy, deep dives at FPE meetings and highlighting days lost with the costs of sickness absence to all departments on a regular basis.
At F&PE meetings, divisions will continue to present comprehensive data on sickness absence which includes heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.
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 management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for all long term sickness absence and short term absence cases of concern to ensure the absence process is being managed appropriately. The HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence.

Risks

What the chart tells us

The rolling 12 month position shows an increase in the first 6 months of the period, with a fluctuating pattern following due winter pressures and an increase of Covid and flu cases. The was a reduction in the last quarter of the financial year, which has remained consistent for the first 2 months of this year, increasing in the next 2 months before decreasing again in August then increasing again last two months, dropping off in November but showing an increase in December to reflect winter pressures, which have reduced slightly in January.

Our Finance– Executive Summary

Katie Osmond
Chief Finance Officer

Month 10 Income and Expenditure position

Overall month 10 has resulted in a YTD adverse variance of £8.4m against the revised deficit plan, largely driven by an anticipated income risk, unplanned expenditure pressures and slippage on the CPIP programme.

The Month 10 position resulted in an overall YTD deficit of £11.3m. This was behind the current planned deficit, with an overall adverse variance of £8.4m. The previously established Financial Recovery Board (FRB) continues to focus on the identification and delivery of CPIP as well as driving improved financial performance using existing programmes and projects. The Trust also provides significant focus on the financial position through monthly Finance and Performance Executives meetings targeting delivery of existing plans and identification of mitigations. At Month 10 YTD, planned pay costs are unfavourable to budget by £6.1m, (a deterioration of £1.4m in month), non-pay £6.0m (a deterioration of £0.9m in month). These are partially offset by additional income of £5.8m, largely achieved through an over performance in Elective Recovery Funding (ERF), contractual gains and excluded drugs income.

The primary reason for expenditure overspend relates to unplanned cost pressures and the under delivery of CPIP (£5.1m YTD), which are partly mitigated. Although progress is being made, the majority of the CPIP variance relates to planned CPIP schemes that remain in the unidentified phase, requiring further action to result in deliverable schemes — these are examined in Check and Challenge meetings with Divisions as part of the FRB. Unplanned emergency demand pressures and medical workforce sickness have continued to adversely impact the financial position and the level of CPIP achievement. Outside of CPIP, there is also a £1.6m adverse variance YTD driven by a technical adjustment to the control total for historical accounting changes on PFI.

Forecast Outturn

Through FRB there has been a rolling assessment of risks in the forecast position. The Trust has identified a range of mitigations to offset unplanned cost pressures and pleasingly, the month 10 position was marginally better than the projected outturn for the month. Updated System assumptions have allowed the Trust to officially reflect a forecast exit 2024/25 position of £4.1m deficit, £1m adrift from plan, whilst acknowledging this remains high risk. Though a range of mitigations have been deployed, there remains £12.9m of known risk requiring mitigation in order to secure delivery of this forecast exit positon. In order to mitigate this level of risk we require: a national resolution to the out of system income risk in relation to Welsh Commissioning; mitigation for the impact of UEC demand on the cost base; and system support to mitigate the PFI technical adjustment. In addition the Trust has agreed to pursue a further £1.5m stretch mitigation target over the final months of the year, though this is assessed as high risk for delivery.

Capital

Following the detailed review of expenditure forecast at month 8 and 9, the forecast outturn has remained unchanged. This includes a £0.7m reduction in expenditure on the nationally funded element of CDC. Significant expenditure is due to take place in the last 2 months of the year. Delivering the forecast is still dependent on Radiology equipment for the CDC being delivered into storage, which provides the security of having the equipment ready to transfer to the new building. Locally funded capital is forecast to be fully utilised with close oversight to manage potential underspends by bringing forward schemes from 2025/26 with options to spend resource at short notice being considered.

Cash

Cash remains a risk which continues to be closely managed. Although £28.3m of revenue funding has now been agreed (and paid year-to date) through additional non-recurrent income, if the adverse variance isn't rectified this will become a real risk to the Trusts ability to pay suppliers on time. It remains difficult to access additional cash support where the requirement is driven by us being off-plan.

Finance Performance – 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 2025 - 2024/25

	2024-25 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	311,363	259,633	261,476	1,843	(1,587)
Excluded Drugs	10,484	8,737	9,312	575	296
Excluded Drugs	12,801	10,668	12,715	2,047	383
Non Contracted Activity (NCA's)	1,768	1,473	1,626	153	29
Other Income for Patient Care	11,185	9,415	9,780	365	63
Donations For Non Current Assets	4,168	3,074	3,074	0	(0)
Other Non Patient Income	8,127	6,829	6,907	78	41
ERF	6,925	5,624	6,381	757	463
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**366,825**	**305,453**	**311,270**	**5,817**	**(311)**
Pay Expenditure	225,378	188,358	194,470	(6,112)	(1,392)
Non Pay Expenditure	90,153	75,295	80,853	(5,558)	(637)
Excluded Drugs	23,934	19,945	21,783	(1,838)	(827)
Total Operating Expenditure	**339,465**	**283,598**	**297,106**	**(13,508)**	**(2,855)**
EBITDA	**27,360**	**21,855**	**14,164**	**(7,691)**	**(3,166)**
Depreciation	14,104	11,767	11,518	249	97
Impairment	5,141	5,141	4,842	299	0
Interest Receivable	1,682	1,566	1,566	(0)	(0)
Interest Payable on Loans	261	218	151	67	6
Interest Payable on PFI	4,482	4,150	3,933	217	217
Dividends on PDC	4,244	3,505	2,914	591	296
Operating Surplus/ (Deficit)	**813**	**(1,361)**	**(7,627)**	**(6,267)**	**(2,551)**
Technical Adjustments					
Donated Assets Adjustment	3,335	2,381	2,385	4	1
Net impact of asset impairments	(5,141)	(5,141)	(4,842)	299	0
IFRS16 2425 PFI re-measurement adjustment	(2,490)	(2,490)	(2,272)	1,598	1,598
Impact of IFRS16 Implementation of PFI Contract	8,214	6,801	8,399	0	(1,458)
Adj. financial performance retained Surplus/ (Deficit)	(3,104)	(2,914)	(11,297)	(8,385)	(2,691)

Performance & actions

The position at the end of Month 10 (January) was a deficit of £11.3m YTD. This was behind the current plan with an overall adverse variance of £8.4m YTD.

- Income shows a positive variance of £5.8m. This is the first month we have seen the impact of the non receipt of the Welsh stretch in the position, as it was budgeted in the last quarter of the year. This has been offset by further over performance on drugs and ERF.
- Pay is adverse YTD due to under-delivered CPIP, medical workforce pressures. escalation areas and UEC related pressures; this has been partially mitigated by slippage on recruitment linked to capacity, unfilled vacancies and the additional ERF income. The net position in month includes agency — 5.27% of total pay costs in month which is an increase from 4.84% in M9, reflecting the critical incident impact. Medical bank use at premium rates further increases the temporary staff proportion to 9.13% of overall pay.
- Total Non Pay (incl. dep'n & interest) is adverse by £6.0m YTD largely due to under-delivered CPIP, the cost of delivering activity, continued high MSSE spends, Clinical Services contracts, excluded Drugs and phasing of Private Sector usage. Some of this overspend is directly offset by the additional ERF income and excluded drugs income.

PFI £1.6m adverse variance driven by a technical adjustment to the control total for historical accounting changes on PFI

Risks

Key Financial risks

- Stretch target (£1.2m CPIP not delivered)
- CPIP Cost Efficiency delivery recurrently
- Level of Agency (as % of pay)
- Income includes over-performance on ERF that may be capped
- Change in performance adjustment regarding PFI accounting
- Winter and Critical Incident impact on financial performance
- Marginal Cost of delivering activity

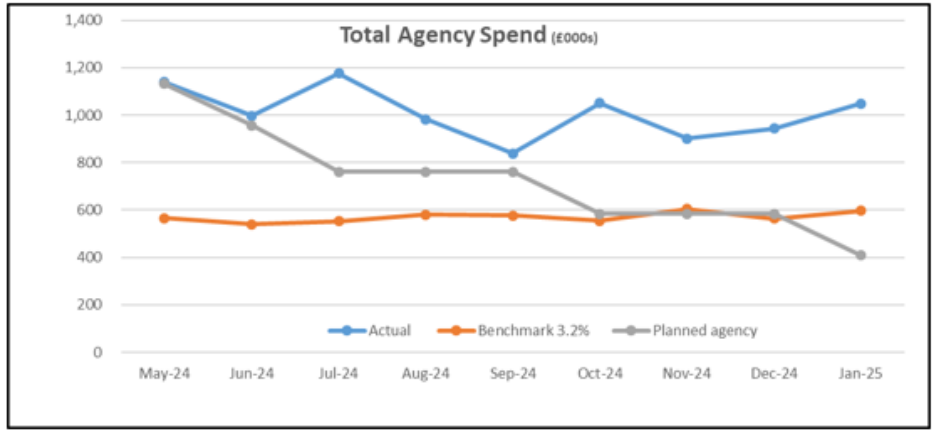
What the chart tells us

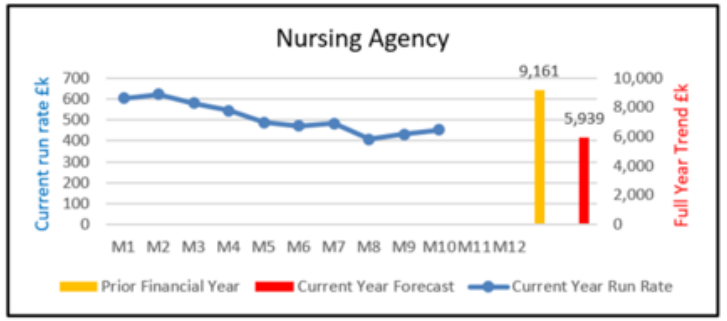
Known financial risks are putting greater pressure on delivery of our planned financial position.

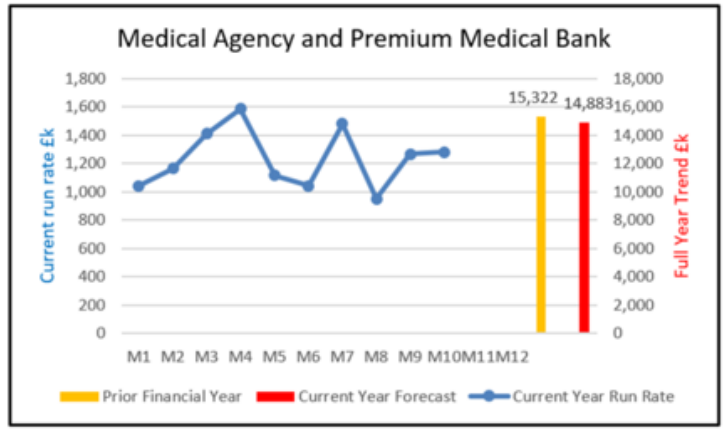
Finance Performance – Agency Spend

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 & actions

Agency represents 5.2% of total pay costs year to date, 2.0% above the national target of 3.2%. There is still a considerable way to achieve a sustainable baseline trend. Total agency spend year to date (excluding premium cost medical bank) is £10.1m. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** The trend shows an in year reduction in spend, with increased control actions delivered. Target spend for 2425 is £5.2m, a £4m reduction in spend from 2324 (totalling £9.2m). YTD spend extrapolated to full year would result in a projected full year spend of £6.1m, while the actual forecast is £5.9m. Approved rate changes initiated from July 24, (latest rate card update in Jan 25) should further reduce nursing agency spend, other plans are also in place to further improve the trend. Bank and Substantive performance will also need monitoring to ensure a bottom line reduction in spend.
- **Off framework Nurse Agency:** there has been an increase in off framework use in month with 15 shifts booked in January, a total of 111 shifts YTD. This is a significant reduction on the 2324 levels, but had been holding at around 3 shifts up to September, increasing to 18 on average since October.
- **Medical staffing agency and premium cost bank:** M10 has seen a continued increase, reflecting the critical incident in month. The Trust spent £14.2m 2223 and £15.3m in 2324, with 2425 target spend being £11m. The current forecast for 2425 is £14.9m demonstrating more work is required to continue to address the sustained use of bank and agency.

Risks

Level of Agency (% of pay)

Increased workforce gaps (e.g. sickness) resulting in greater requirement for temporary workforce.

Supply and Demand price pressures

Impact of winter / UEC pressures driving demand

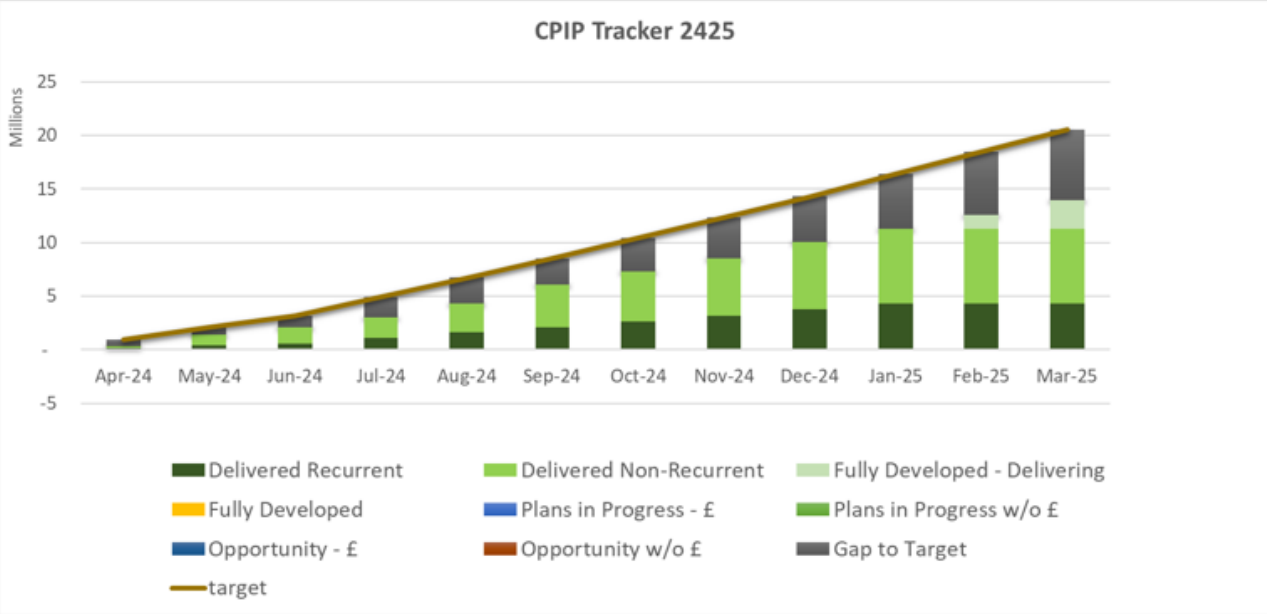
What the charts tell us

Although there is good progress in targeted areas, agency (and premium medical bank) use remains at an unsustainable level and poses a threat to achievement of the plan.

Finance Performance – 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 & actions

The £20.6m target breaks down into two areas: £19.4m cost out efficiency (of which £4.4m relates to 2324 NR items, of which we are targeting a £8.0m agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

The current position on CPIP delivery YTD reflects a plan of £16.4m with a Trust delivery of £11.3m resulting in a £5.1m variance to plan.

The majority of the variance relates to planned schemes that are still in the opportunity and unidentified phase, requiring further action to result in deliverable schemes.

As at Month 10, the forecast total of developed schemes (including MARP & NARP) amount to £13.9m, phased to deliver more as the year develops, plus a further stretch of £0.6m asked of the divisions representing their individual plans apportioned to remaining months of the financial year.

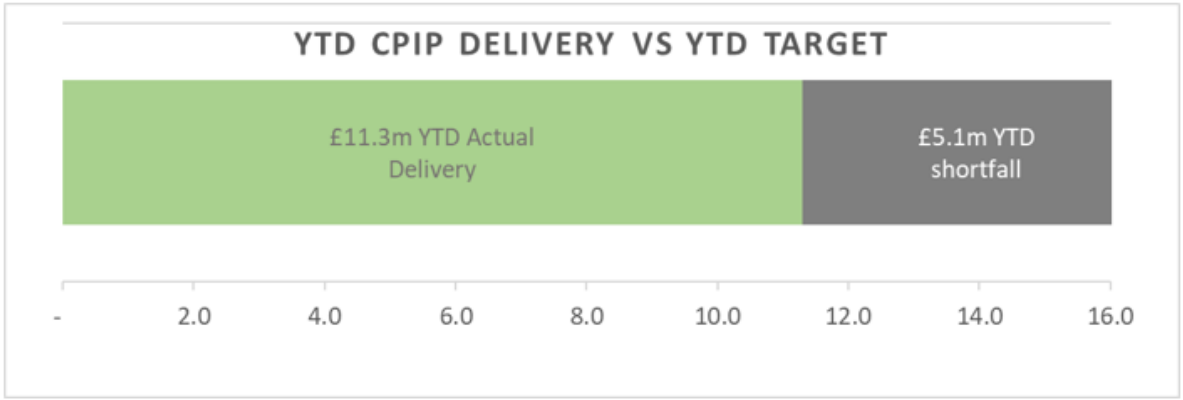
The FRB continues to focus on furthering identification and delivery of CPIP. As part of the FRB, monthly Check and Challenge meetings with Divisions are taking place to specifically focus on identification and delivery of savings schemes.

Risks

Under achievement of Cost Improvement (CPIP)
Achievements relying on non recurrent delivery.
Unidentified and Opportunity schemes not developing at pace needed for full delivery

What the charts tell us

There remains a shortfall in plans to deliver the planned level of CPIP. Focus is on identifying schemes, and converting opportunities into deliverable schemes, in order to deliver a challenging CPIP target in year and ensure a sustainable start to 2526.



Finance Performance – Elective Recovery

We are driving this measure because:

Capitalising on the elective recovery funding mechanism is key to successfully delivering the financial plan. Maximising the activity we undertake within the resources available will ensure best use of system resources and support financial sustainability

Performance & actions

2024/25 Plan & months 1-9

For 24/25 there has been a continuation to the way we are paid for our English Commissioned elective activity

- **Baseline:** we have been given a price in the contract for our elective income which is based on activity x price in 19/20
- **Target:** uplifted for 24/25 tariff's (Value weighted activity - VWA). For H&W this is 106% and we have been given a set amount of £7m to achieve that target. The value is based on a 'fair share' of the income given for this purpose to the ICB. Our plan was to achieve greater than that
- **Financial:** We included £6.3m of additional income for over performing against our ERF target
- **Estimate in month** is based on a detailed calculation for H&W activity (92% of our activity) For Gloucestershire, Shropshire and Specialised Commissioning we used national data.
- During M7 a new national VWA baseline was confirmed, there were new national tariffs issued. This led to a change to our performance with our YTD being slightly behind the ERF over performance target.
- At month 9 we were issued with an indicative cap for our activity which would see us achieve the additional £6.3m but risks non payment of assumed over-performance of £1.5m above that.

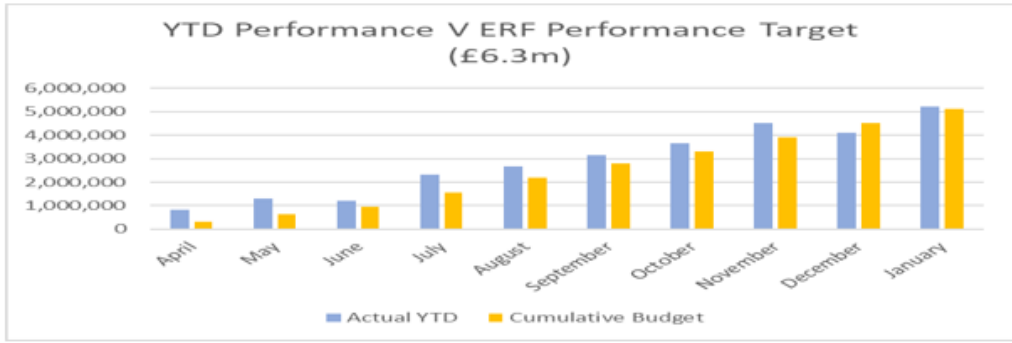
Month 10 Update

- Performance of H&W ICB VWA in month 10 was 134% of 19/20 activity, with a cumulative position of 120.6% YTD.
- National data was made available covering month 1-7 and shows improved cumulative performance, largely due to a change in the dataset which provided a further £0.4m on months 1-6.
- However due to phasing of the activity and resulting income in the plan we are showing a performance YTD of £0.1m above plan.
- We have historically seen strong elective performance in the last quarter and anticipate this being the case; we need to maintain this level of performance to achieve the forecast elective income.
- Nationally the ERF funding envelope is capped based on a month 8 assessment which poses a significant risk to the system and Trust. From a Trust perspective our most likely forecast elective position is £1.5m above the capped level. The ICB have escalated this risk with NHSE.

Table 1: H&W ICB Baseline V Actual

HEREFORD ICB ONLY 19/20 baseline V 24/25 actual	April	May	June	July	August	September	October	November	December	January
1920 BASELINE	£4,142,948	£3,954,684	£3,877,435	£4,427,044	£3,695,154	£3,897,051	£4,096,656	£3,905,778	£3,424,566	£3,915,364
24/25 plan	£4,462,368	£4,274,103	£4,196,940	£5,039,344	£4,307,453	£4,509,465	£4,624,767	£4,513,958.91	£4,024,894	£4,515,637
2045/25 Actuals	£4,295,014	£4,457,918	£4,402,226	£4,721,209	£4,410,234	£4,827,363	5,229,894	4,839,614	4,305,407	£5,246,313.14
24/25 Plan as % of 19/20	107.7%	108.1%	108.2%	113.8%	116.6%	115.7%	112.9%	115.6%	117.5%	115.3%
In month actual % of 19/20	122.9%	119.4%	104.2%	117.2%	127.8%	113.2%	117.8%	123.9%	125.7%	134.0%
YTD actual % of 19/20	122.9%	108.1%	109.9%	109.0%	88.9%	92.9%	96.5%	116.2%	117.1%	120.6%

Chart 1: ERF over performance(YTD position)



Risks

Deterioration in the operational performance resulting in underachievement of ERF plans. . Non budgeted spend to achieve the elective activity

Nationally applied cap on the ERF: System challenging the assumed value with NHSE

What the charts tell us

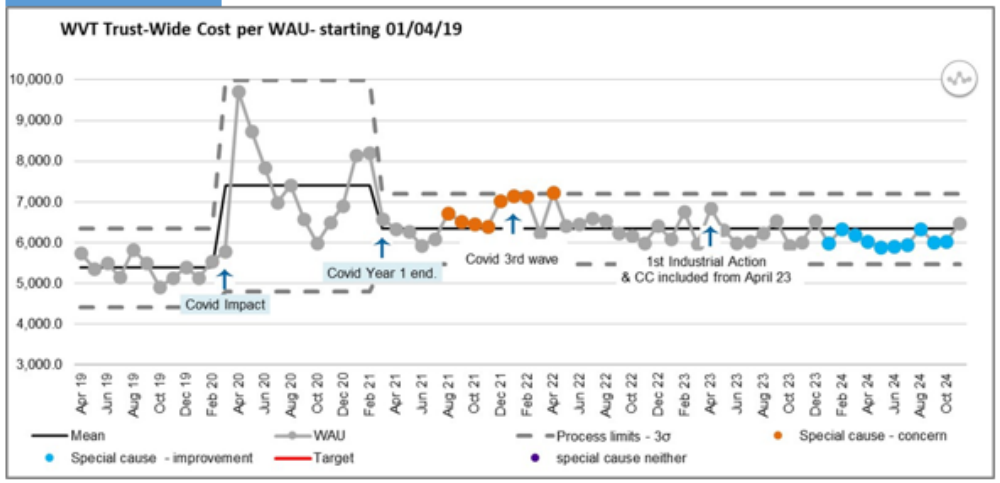
Despite the significant operational challenges activity levels of elective are recovering and in line with target and planned level.

Finance Performance – Productivity Improvement

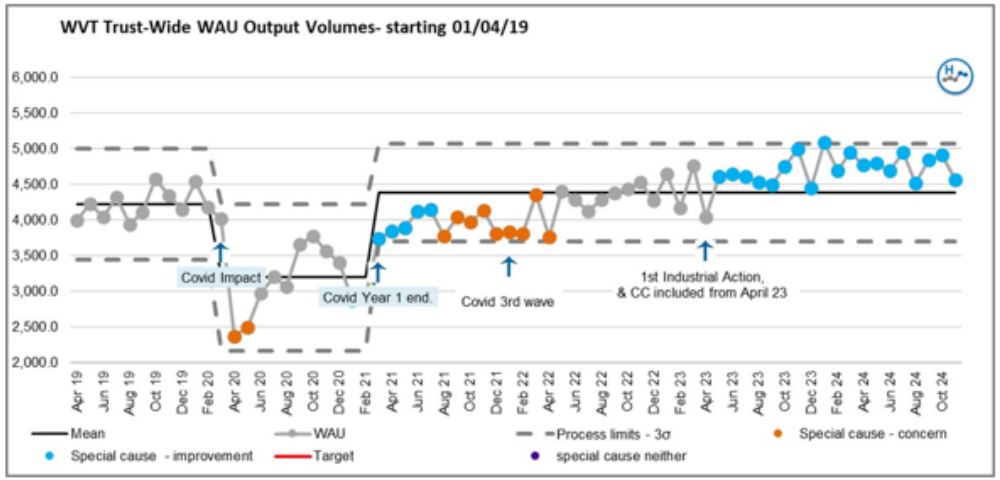
We are driving this measure because:

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

Cost per WAU



WAU Output Volumes



Cost per WAU - Alignment in methodology across the Foundation Group

Work has been undertaken across the Foundation Group to agree and establish a methodology which could be adopted by each Trust when calculating the Cost per Weighted Activity Unit (WAU). This has resulted in an alignment of the base data, financials and inflationary adjustments used within the calculation and provides a more meaningful trend comparison across the Foundation Group.

The cost per WAU is reported two months in arrears. This is due to dependency on capturing fully coded data to achieve a more robust result.

Care must be taken when comparing WAU's reported in different places, e.g. model hospital, as data sources will vary and will not be directly comparable to the group methodology.

This WAU is a long term trend measure, and as productivity improves you would expect to see a reduction in the cost per WAU over time

What the charts tell us

The upper and lower control limits within the SPC Charts have been set based on three date ranges as follows:

- 11 months April 2019 to Feb 2020 (Pre Covid Impact)
- 12 months March 2020 to March 2021 (Main impact of Covid pandemic)
- April 2021 onwards (recovery)

Based on the above parameters the graphs show that despite the significant operational challenges overall activity levels are recovering. WAU output volumes have moved to be above the average and have remained so over the last 12 month period.

From Jan 2024 the cost per WAU is showing an improving position, indicating improved efficiency in delivering activity. Whilst productivity initiatives have started to deliver, we are not yet seeing the overall level of productivity required to improve the cost per WAU to the 2019/20 levels.

Finance Performance – Capital

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.

Capital Scheme	Type of Capital	Full Year Plan	Year to Date - Month 10			Full Year	
			Budget	Actual	Variance	Forecast	Variance
Local Schemes							
ICT - Clinical Systems	Owned	427	366	90	276	447	(20)
ICT - Hardware	Owned	782	570	348	222	671	111
ICT - Software	Owned	52	38	0	38	0	52
Estates Works	Owned	621	651	283	368	1,186	(565)
ESH 2324 Underspend	Owned	615	615	615	0	615	0
CDC 2324 Underspend	Owned	1,408	1,152	911	241	1,408	0
Clinical Equipment	Owned	343	224	442	(218)	532	(189)
ESH - Local Funding	Owned	2,924	2,000	58	1,942	278	2,646
CDC - Phase 2 initial funding	Owned	0	0	0	0	0	0
23/24 Cfwd	Owned	225	0	531	(531)	600	(375)
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*0*	*(924)*
System Capital Contingency	*Owned*	*(633)*	*(477)*	*0*	*(477)*	*0*	*(633)*
Total - Local CDEL funded		**5,840**	**5,139**	**3,278**	**1,861**	**5,736**	**104**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	8,973	4,333	4,640	5,840	5,132
Donated assets	Owned	240	201	0	201	233	7
Education Centre	Owned	0	0	0	(0)	0	(0)
Donated Clinical Equpt	Owned	33	0	0	0	33	0
Total - Grant funded and Donated		**11,245**	**9,174**	**4,333**	**4,841**	**6,106**	**5,139**
National funding							
Clinical Diagnostics Centre	Owned	11,460	9,295	4,880	4,415	10,760	700
Imaging - PDC	Owned	0	0	378	(378)	415	(415)
ESH - PDC Funding	Owned	2,161	2,161	1,421	740	2,130	31
ICT - FLD	Owned	1,750	572	43	529	1,750	0
Total - National PDC schemes		**15,371**	**12,028**	**6,722**	**5,306**	**15,054**	**317**
Leases							
Vehicle	Lease	0	8	0	8	0	0
IFRS16 Clinical Equipment	Lease	410	294	308	(14)	514	(104)
IFRS16 Equip Over-commitment	Lease	0	0	0	0	0	0
Total - IFRS16 Leases		**410**	**302**	**308**	**(6)**	**514**	**(104)**
Total Capital Programme		**32,866**	**26,643**	**14,640**	**12,003**	**27,411**	**5,455**

Performance & actions

Actions in Month 10 included agreeing the FLD monies and identifying expenditure to go against the award. Further work has been undertaken to maximise expenditure against CDC funding as far as possible. Further estates schemes and equipment procurement has been approved in order to maximise 2024/25 resources.

Month 10 expenditure was £1,819k. The overall programme is behind the budget but plans are in place to meet the forecast through expenditure in the last two months of the financial year. Expenditure on CDC is projected to rise with the procurement of MRI, CT and X ray equipment alongside ongoing development expenditure. FLD monies have been agreed with NHSE and a plan is in place to utilise the funding through the Virtual Desktop Interface programme. Expenditure on CDC continues to project £700k lower than plan after mitigation.

Risks and mitigations

There remains a significant amount of expenditure (£12.8m) to go through in the final 2 months of the year. The main risks relate to the delivery of major items of equipment for CDC. All actions have been taken to mitigate these risks. Further work is ongoing with the main contractor to bring forward activities as far as possible in the current financial year. Estates schemes including the replacement of Gilwern roof and boilers have been brought forward. Expenditure on IT replacement remains an option to mitigate further underspend.

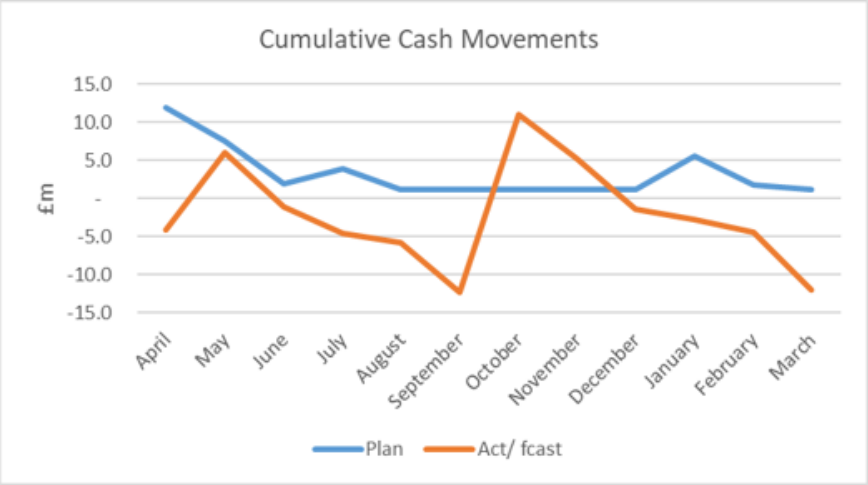
What the table tells us

The main variances to plan are the shortfall on expenditure on IES plus an underspend against plan for CDC . The remainder of the programme remains on target subject to the risks identified above.

Finance Performance – Cash

We are driving this measure because:

The financial performance of the Trust, both in I&E and revenue have a direct impact on the Trust's cash position. Sufficient cash balances are required in order for the Trust to undertake its day to day operations.



Cash Balance				
Month	Performance	Target	Direction	Rating
November	29.3	27.4	↓	
December	24.8	27.4		
January	21.0	31.8		
Cash balances are £10.8 m lower than plan, due to less PDC being drawn than planned, partly offset by phased receipts of non-recurrent deficit support funding.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
November	98.6%	95.0%	↓	
December	99.2%	95.0%		
January	98.9%	95.0%		
In January, the Trust paid 98.9% of invoices within 30 days. This equates to 97% by invoice value. This is the thirteenth month, in a row, that we have achieved the 95% (by volume) target.				

Performance & actions

Cash balances are £10.8m lower than plan, due to less PDC being drawn than planned, partly offset by phased receipts of non-recurrent deficit support funding. This leads to a forecast reduction in cash over the final months of the year.

	Phasing of non recurrent income to support deficit							
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
£k	0	20,129	2,816	2,807	860	861	866	**28,339**

Risks

Unavailability of cash (in a timely manner) to meet the needs of the Trust whilst we continue with an adverse variance to plan. This would impact on the Trust's ability to pay suppliers and staff in a timely manner. The mitigations are:

- I&E and capital plans to be met
- Continued close management of cash and escalation to system and region if Trust continues to be off-plan.
- Liaison with the ICB and NHSE to confirm the payment mechanism for ERF over-performance to continue as limited cash has been received so far for 24/25.

What the chart tells us

The month end cash balance has decreased, as expected given the favorable timing of deficit and pay award funding in previous months in addition to the Trust continuing to be off-plan in terms of I&E.

The Trust remains above the 95% target for Better Payment Practice although the continued deficit trajectory may require the Trust to reduce creditor payment runs for Q4.

Finance Performance – Statement of Financial Position

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.

Statement of Financial Position

January 2024	2023/24	2024/25			2024/25 Full Year		
	Accounts £000s	M10 Plan £000s	M10 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	151,182	163,876	154,069	9,807	167,117	163,482	(3,635)
Intangible Assets	14,359	11,405	9,753	1,652	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	408	408	0
TOTAL Non Current Assets	**165,949**	**175,689**	**164,244**	**11,445**	**178,445**	**174,810**	**(3,635)**
CURRENT ASSETS:							
Inventories	4,878	4,878	4,966	(88)	4,878	5,020	142
Trade and Other Receivables	35,635	21,456	32,773	(11,317)	28,856	43,327	14,471
Cash and Cash Equivalents	26,228	31,752	20,962	10,790	27,447	14,281	(13,166)
TOTAL Current Assets	**66,741**	**58,086**	**58,701**	**(615)**	**61,181**	**62,628**	**1,447**
TOTAL ASSETS	**232,690**	**233,775**	**222,945**	**10,830**	**239,626**	**237,438**	**(2,188)**
CURRENT LIABILITIES							
Trade and other payables	(37,101)	(38,693)	(36,800)	(1,893)	(37,275)	(33,800)	3,475
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(16,295)	3,602	(12,693)	(16,295)	(3,602)
Provisions	(192)	(192)	(46)	(146)	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(51,578)**	**(53,141)**	**1,563**	**(50,160)**	**(50,287)**	**(127)**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**6,508**	**5,560**	**948**	**11,021**	**12,341**	**1,320**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**182,197**	**169,804**	**12,393**	**189,466**	**187,151**	**(2,315)**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(53,916)	(40,691)	(42,031)	1,340	(42,935)	(40,348)	2,587
Provisions	(1,619)	(1,619)	(1,729)	110	(1,619)	(1,609)	10
Total Non-Current Liabilities	**(55,535)**	**(42,310)**	**(43,760)**	**1,450**	**(44,554)**	**(41,957)**	**2,597**
ASSETS LESS LIABILITIES	**127,165**	**139,887**	**126,044**	**13,843**	**144,912**	**145,194**	**282**
TAXPAYERS EQUITY							
Public dividend capital	306,421	343,677	312,926	30,751	351,694	324,752	(26,942)
Revaluation reserve	22,047	22,047	18,107	3,940	22,047	18,072	(3,975)
Income and expenditure reserve	(201,303)	(225,837)	(204,989)	(20,848)	(228,829)	(197,630)	31,199
TOTAL	**127,165**	**139,887**	**126,044**	**13,843**	**144,912**	**145,194**	**282**

Performance & actions

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

Non-Current Assets
Non-Current assets are £11m lower than plan due to slippage in the capital programme (see capital section, above). The forecast is lower than planned due to the forecast underspend on capital and in addition to a reduction in depreciation and impairments.

Working balances
Net working balances - receivables less payables - have strengthened compared to plan, mainly due to expected receipt of elective and Welsh overperformance. Cash balances are £10.8 m lower than plan and are forecast to reduce further if the adverse I&E trend continues. The forecast shows a large increase in debtors representing the risk of a continued adverse I&E position and the timing uncertainty of receiving cash for over-performance.

Borrowings
The total movements in borrowings, across current and long-term balances (plan versus actual) differ, by £5m, due to accounting of the phasing of the PFI liability repayments between plan and actual.

Taxpayers Equity
PDC is lower than plan as less additional PDC has been drawn because of slippage in our capital programme and the non-recurrent deficit funding negating the need to draw revenue PDC.
The revaluation reserve has reduced, compared to the plan, reflecting a correction between the revaluation reserve and the I&E reserve identified during the year end audit.
The income and expenditure reserve reflects the deficit for the year to date along with the historical correction relating to the revaluation reserve. The forecast Income and expenditure reserve is based on an I&E variance of £1m against plan by 31st March 2025.

Risks

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

What the chart tells us

Current assets outweigh current liabilities. Cash balances have started to reduce, as expected, and are forecast to reduce further by the end of March.

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High		77.3%	77.1%	77.0%	77.8%	79.2%	78.1%	79.3%	77.1%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Common Cause		93.4%	88.4%	87.8%	88.5%	92.1%	91.3%	86.4%	84.3%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		32.1%	20.0%	48.4%	43.8%	39.1%	21.4%	7.7%	20.0%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		85.5%	90.7%	88.2%	89.3%	89.8%	89.0%	91.9%	96.5%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		11	10	12	3	7	5	8	7	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	75.7%	76.6%	53.5%	74.8%	75.4%	73.5%	76.4%	71.3%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause	Yes	100.0%	100.0%	83.3%	77.8%	100.0%	33.3%	66.7%	100.0%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		63.3%	65.5%	68.1%	65.7%	90.5%	56.8%	65.9%	87.9%	
	Cancer: number of urgent cancer patients waiting over 62 days	Cancer		No Target	Common Cause	Yes	93	85	93	88	61	50	38	54	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		113.9%	101.1%	115.2%	111.9%	109.3%	124.4%	108.9%	118.4%	126.3%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		84.7%	85.7%	86.8%	86.9%	87.4%	86.3%	87.3%	85.9%	85.3%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Improvement - High		107.4%	99.6%	100.0%	102.2%	103.4%	101.2%	105.2%	104.0%	100.3%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Concern - Low	Yes	72.7%	66.4%	65.8%	75.9%	62.9%	51.1%	55.2%	49.4%	54.3%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Variable	Concern - High		10.5%	15.4%	18.7%	14.5%	18.8%	29.1%	25.1%	30.9%	29.7%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		111.5%	112.2%	113.5%	114.6%	120.2%	118.9%	129.0%	124.1%	121.5%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		46.9%	47.4%	46.1%	42.3%	44.4%	48.0%	48.3%	46.5%	47.2%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause		68.1%	66.4%	68.3%	67.6%	65.8%	65.8%	64.8%	63.4%	64.1%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause		11.7%	12.3%	12.4%	10.8%	12.5%	12.4%	12.2%	13.3%	14.6%
	A&E - Time to treatment	Urgent and emergency care		No Target	Common Cause	Yes	0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care		No Target	Improvement - Low		1.8%	2.0%	1.9%	1.9%	1.8%	1.7%	1.9%	2.0%	1.8%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High	Yes	318	291	330	312	284	270	256	232	322
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		7.8%	8.0%	9.1%	8.3%	7.7%	8.9%	9.2%		

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		55.6%	55.8%	55.7%	55.6%	55.1%	55.8%	56.0%	55.1%	56.0%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		68.2%	70.0%	70.3%	69.4%	69.5%	70.0%	70.0%	68.4%	69.2%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		28574	29179	28848	28708	28783	28761	28246	27766	27410
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low	Yes	1198	1285	1140	1169	987	865	804	764	740
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		13	15	14	14	9	4	1	3	2
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		2	3	1	3	2	1	0	0	0
	GP Referrals	Elective care		No Target	Common Cause	Yes	103.2%	91.2%	102.9%	87.0%	94.6%	103.2%	90.8%	104.7%	97.1%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		113.3%	110.3%	113.7%	114.1%	111.4%	116.6%	109.1%	108.3%	112.5%
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Improvement - High	Yes	105.7%	84.8%	114.7%	98.4%	83.1%	111.4%	77.9%	101.4%	104.3%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		117.9%	113.9%	119.3%	115.1%	110.7%	113.2%	107.9%	109.2%	108.7%
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	111.9%	88.0%	123.0%	106.8%	90.8%	115.5%	83.1%	111.0%	112.8%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		110.5%	99.2%	102.3%	105.0%	110.1%	107.9%	100.4%	100.2%	104.4%
	Total Elective Activity (volume v plan)	Elective care		No Target	Common Cause	Yes	112.8%	86.2%	100.9%	91.3%	87.8%	104.9%	78.3%	89.9%	97.9%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Common Cause		77.9%	79.7%	76.9%	78.7%	80.2%	79.5%	78.8%	80.9%	79.2%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		24	39	42	40	32	26	31	39	34
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Concern - Low	Yes	126.5%	129.5%	104.0%	100.7%	118.0%	104.4%	107.9%	103.5%	86.8%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Common Cause	Yes	98.1%	76.6%	156.2%	126.9%	93.3%	91.4%	71.8%	83.3%	80.1%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Concern - Low	Yes	130.6%	119.2%	115.1%	111.1%	116.2%	113.6%	127.4%	109.7%	93.4%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Improvement - Low		24.8%	30.2%	30.0%	27.8%	17.2%	15.1%	13.3%	12.5%	21.1%

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Elective care	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Common Cause		93.9%	90.6%	95.5%	95.1%	88.9%	94.6%	94.0%	93.7%	97.1%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause		16.0%	16.3%	14.2%	16.3%	15.6%	16.2%	18.4%	17.8%	
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High	Yes	55.5%	54.7%	54.8%	55.7%	55.3%	55.6%	61.8%	65.1%	
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High	Yes	87.3%	86.3%	88.5%	88.1%	85.9%	87.8%	88.2%	90.2%	
	Maternity Activity (Deliveries)	Elective care		No Target	Common Cause	Yes	83.9%	113.8%	93.4%	85.6%	108.4%	92.9%	95.4%	94.9%	
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.3%	6.6%	6.5%	7.8%	6.5%	5.9%	6.3%	6.5%	6.1%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Concern - Low	Yes	88.0%	87.6%	88.8%	89.9%	89.3%	88.8%	88.3%	87.8%	86.7%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		120.2%	115.7%	122.0%	115.6%	110.4%	111.6%	107.3%	109.6%	107.1%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Improvement - High	Yes	115.0%	89.6%	127.1%	110.9%	94.8%	117.5%	85.7%	116.1%	117.1%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		20.5%	19.5%	19.1%	19.7%	20.0%	19.8%	20.2%	19.7%	21.1%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term		No Target	Improvement - Low		5.3%	10.1%	6.5%	4.1%	6.7%	7.5%	8.7%	7.9%	8.0%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		100.0%	100.0%	99.4%	98.6%	99.8%	99.9%	99.4%	98.8%	99.9%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<= 0	Variable	Common Cause	Yes	99	84	70	134	204	348	150	69	129
	Patient ward moves emergency admissions (acute)	Safe, high quality care		No Target	Concern - Low		9.5%	8.9%	8.2%	7.4%	7.1%	8.7%	7.4%	6.7%	
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		6	6	6	7	6	7	6	6	7
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause	Yes	2	3	3	3	3	2	2	3	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Concern - Low		15.3%	14.1%	15.6%	17.1%	13.8%	15.5%	16.6%	15.1%	17.2%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low	Yes	42.6%	47.4%	48.9%	50.1%	47.5%	53.1%	49.0%	38.8%	38.5%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		4.6%	4.8%	4.3%	4.5%	4.8%	4.3%			

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Safe, high quality care	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Improvement - Low		100	100	100	99	100				
	Never Events	Safe, high quality care	0	Variable	Concern - Low		0	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	0
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause		0	4	2	1	0	0	2	0	2
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care	44	Fail	Common Cause	Yes	6	5	9	10	6	2	5	6	0
	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		4	2	1	2	1	2	3	1	4
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Common Cause	Yes	92.0%	93.0%	93.0%	92.0%	92.0%	92.0%	91.0%	89.0%	91.0%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Concern - Low	Yes		98.0%			98.7%				
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Common Cause	Yes	50.9%	63.2%	74.4%	73.9%	65.8%	64.4%	67.6%	63.0%	51.9%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause		66.7%	20.0%	33.3%	0.0%	66.7%	100.0%	80.0%	71.4%	55.6%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause		75.0%	78.7%	89.2%	87.5%	76.5%	75.0%	86.0%	80.9%	73.9%
	Number of complaints	Safe, high quality care		No Target	Common Cause		31	30	28	18	32	44	27	27	33
	Number of complaints referred to Ombudsman	Safe, high quality care	<= 0	Variable	Improvement - Low		0	0	0	0	0	0	0	0	0
	Complaints resolved within policy timeframe	Safe, high quality care	>= 90.0%	Fail	Common Cause		39.4%	50.0%	53.8%	51.6%	50.0%	51.7%	67.9%	50.0%	60.0%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		81.1%	78.7%	79.3%	79.1%	74.5%	79.0%	76.8%	73.7%	80.0%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Concern - Low		82.7%	84.5%	80.7%	84.2%	83.2%	87.9%	82.5%	83.6%	86.7%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		85.7%	96.6%	94.4%	85.7%	90.2%	97.0%	87.9%	92.3%	93.3%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause	Yes	19.0%	20.0%	18.0%	20.0%	18.0%	18.0%	18.7%	17.0%	18.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		16.0%	18.0%	15.0%	17.3%	15.0%	15.0%	15.6%	15.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		25.0%	24.0%	31.0%	32.0%	30.0%	28.0%	31.7%	21.0%	23.0%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		6.3%	5.5%	5.9%	5.8%	4.5%	4.1%	4.6%	4.8%	5.3%
	Appraisals	Looking after our people	>= 85.0%	Fail	Improvement - High		79.2%	80.3%	80.2%	80.3%	79.8%	80.1%	79.5%	79.8%	79.7%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.8%	89.7%	89.7%	89.5%	88.0%	88.3%	88.6%	88.8%	89.3%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause	Yes	4.6%	4.8%	5.1%	4.7%	5.0%	5.3%	5.0%	6.2%	6.0%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.2%	9.4%	9.5%	9.8%	9.7%	9.4%	9.1%	9.1%	9.4%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		5.5%	5.7%	7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause	Yes	(£3387k)	(£3387k)	(£4957k)	(£3686k)	£12576k	(£602k)	(£202k)	(£1260k)	(£3001k)
	I&E - Margin (%)	Finance		No Target	Common Cause	Yes	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)	(£0k)
	I&E - Variance from plan (£k)	Finance		No Target	Common Cause		(£469k)	(£524k)	(£1793k)	(£606k)	(£645k)	(£178k)	£106k	(£953k)	(£2907k)
	I&E - Variance from Plan (%)	Finance		No Target	Common Cause		(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)
	CPIP - Variance from plan (£k)	Finance		No Target	Common Cause	Yes	(£580k)	(£566k)	(£844k)	(£811k)	£539k	(£498k)	(£598k)	(£489k)	(£798k)
	Agency - expenditure (£k)	Finance		No Target	Concern - High	Yes	£1027k	£1048k	£953k	£725k	£573k	£755k	£634k	£582k	£2848k
	Agency - expenditure as % of total pay	Finance		No Target	Concern - High	Yes	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance		No Target	Common Cause		£178k	(£522k)	£785k	(£284k)	(£242k)	(£697k)	(£345k)	(£431k)	£175k
	Cash - Balance at end of month (£m)	Finance		No Target	Common Cause	Yes	£30k	£23k	£22k	£18k	£14k	£37k	£29k	£25k	£21k
	BPPC - Invoices paid <30 days (% value £k)	Finance		No Target	Common Cause		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance		No Target	Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

Report to:	**Public Board**
Date of Meeting:	**6th March 2025**
Title of Report:	Perinatal Safety 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:	Attached as appendices; • Perinatal Dashboard – Appendix 1 • SCBU Dashboard – Appendix 2

1. Purpose of the report

To provide oversight and assurance of the safety and efficiency of the Perinatal service; providing detail to meet local and national reporting standards.

2. Recommendation(s)

Board is asked to note the contents of the exception report and pursue any key lines of enquiry. Quality committee provided due scrutiny at the meeting in February.

3. Executive Director Opinion[1]

This report and the further confidential detail has been provided to Quality Committee, the following key points are to be noted:

- Achievement of 10/10 CNST standards and submission to NHS resolution has been made in line with the required deadline
- Since the last board meeting the Insights report following a visit by the Local Maternity and Neonatal system and maternity survey results have been published. These have been reviewed and shared in full with quality committee. This triangulated information highlights that there are communication and engagement concerns that have been raised by our service users that the MDT must address. The teams have taken a proactive approach and have held a series of feedback summits to enable the teams to fully address these matters moving forward.
- The unannounced safety champion visit was positively received; the champions were able to observe handovers and team briefs (scuddles) which clearly demonstrated a focus on patient safety and major obstetric haemorrhage.

[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 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***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*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***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*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***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*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

Perinatal Services Safety Report – January 2025

1. INTRODUCTION

1.1 Since 2016 the spotlight has been on maternity services to work towards achieving a national target of reducing stillbirths, neonatal deaths and intrapartum brain injuries by 50% by 2025. The Perinatal Safety Report considers and meets the requirements set out within the NHS Resolution Maternity Incentive Scheme (CNST) Year 6, the Maternity Self-assessment Tool, and embeds the NHSEI Perinatal Quality Surveillance Model (PQSM). The information in this report provides an update on key maternity and neonatal safety initiatives against locally and nationally agreed measures, to support WVT to achieve the national ambition.

1.2 This report features the monthly reporting requirement data for January 2025. The report will be shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board.

2. PERFORMANCE

2.1 Activity

There were 144 births in January, which is an increase from 129 in the previous month. The ratio is stable.

Midwife to birth ratio (<1:24)	1:24

2.2 Red flags

Red flags are outlined within CNST standards and are all subject to an incident report and MDT review. The red flags in January are recorded as:

	January
Delay in Induction >2hrs	1
Delay in Catagory 1 C-Section >30mins	0
Delay in administering medication	1
Delay in starting syntocinon/ARM >30mins	1
Delay in Suturing >60mins	0
Unable to provide 1:1 care in labour	0
Delay in Triage >30mins	0
Community midwives on call covering maternity unit	0
Any movement of midwifery staff from any area to provide midwifery cover	3
Delayed recognition of and action on abnormal vital signs	0
DSC lost - supernumerary status	0
Full clinical examination not carried out when presenting in labour	0
Delay of more than 30 minutes in providing pain relief	0

In the month of January, there were no instances of Category 1 Caesarean Sections (CS) that took longer than the standard 30-minute timeframe, this is an improvement on previous months. The movement of staff has been undertaken to accommodate peaks in acuity with a rise in sickness rate over the winter months. The service was not compromised and this is acknowledged further in the BR+ acuity.

2.3 RCOG Obstetric attendance

CNST requires compliance with the RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. Our performance in January is noted below, but it should also be highlighted that the team remain fully compliant with attendance as required in all instances.

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	N/A	
Caesarean birth for women with BMI>50	0	N/A	
Caesarean birth <28/40	0	N/A	
Premature twins (<30/40)	0	N/A	
4th degree perineal tear repair	0	N/A	
Unexpected intrapartum stillbirth	0	N/A	
Eclampsia	0	N/A	
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	50%	

A review has been conducted regarding an incident involving an ongoing postpartum haemorrhage (PPH) of over 2 litres during which the full MOH protocol was not followed. The registrar conducted the delivery and was supported by 2 midwives. The volume of blood loss was not identified by the team until it was advanced in the stage. The Registrar requested the appropriate drugs whilst bleeding was ongoing but the emergency call was not activated and ongoing measuring was not undertaken. The Consultant was notified whilst bleeding was ongoing. Incident under further review and investigation.

3. SAFETY

3.1 Incidents

To provide Board oversight and assurance, this report aligns to the PQSM Minimum Data Set requirement and provides detail on incidents graded moderate or above; including incidents reported to MNSI (formerly HSIB), NHS Resolution Early Notifications/Claims. Whilst we transition to improved ways of working under PSIRF, this report also provides detail on cases determined as a PSII and any cluster reviews under the PSIRF umbrella.

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee, a forum where scrutiny and assurance are gained, and is restricted to the 'private' section of Board.

3.1.2 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
January	2	0	4	0	0	0	0

3.2 Concerns and Complaints

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is potentially patient identifiable and therefore only the numbers of concerns and complaints are covered in this section.

	Concerns	Complaints
January	2	4

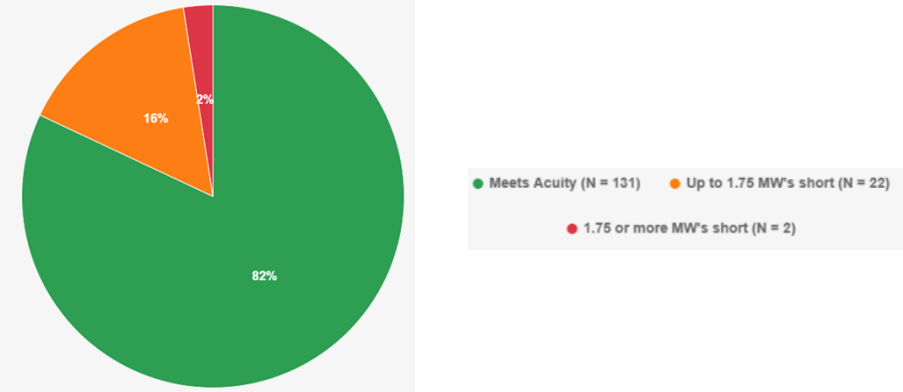
4. WORKFORCE

4.1 Safe Staffing - Midwifery

A monthly submission to Board outlining how safe staffing in maternity is monitored will provide assurance. Safe staffing is monitored by the following:

- Completion of Birthrate plus acuity tool
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags, also monitored for CNST compliance
- Shift fill data
- Daily SitRep reporting
- Sickness absence, vacancy and turnover rate

4.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 86.5% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 82% of the time. For 16% of the time the service was short by up to 1.75 midwives and for 2% of the time the service was more than 1.75 midwives short.



4.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 51 instances of staff being redeployed internally to cover acuity, for example from another clinical area to Delivery Suite, in a small service this is more excessive than would be expected but it still demonstrates flexibility within the service to meet acuity needs. There were 9 occasions where community were redeployed to support Delivery Suite acuity. There were 6 occasions where specialist midwives supported clinical acuity and this is a positive practice, they all participate in a standby rota which supports them to retain clinical skill whilst meeting the needs of the service. There were 11 occasions where acuity was escalated to the manager on call for support highlighting a culture where the team feel able to highlight issues and that the pathway in place is effective. The increased sickness rates significantly impacted this, but all standards have been met and safety maintained.

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	51	60%
MA2	Redeploy from community	9	11%
MA3	Redeploy staff from training	2	2%
MA4	Staff unable to take allocated breaks	3	4%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	6	7%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	3	4%
MA10	Escalate to manager on call	11	13%
MA11	Maternity Unit on Divert	0	0%
TOTAL		85	

*The % is rounded to nearest whole number

4.1.3 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November 2023. The data for January is currently unavailable and will be presented in the February report.

4.2 Obstetric workforce

4.2.1 The obstetric rotas have been covered throughout January as outlined below. The Obstetric workforce has remained compliant with the RCOG standards for recruitment of Locums during the CNST year as no short-term locums have been recruited over the period.

JANUARY '25	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	220	220	100.00	0	220	0.00	0	220	0.00
Consultant: On Call	467	479.5	97.39	12.5	479.5	2.61	0	479.5	0.00
Consultant: Cold Week	128	128	100.00	0	128	0.00	0	128	0.00
Consultant: Antenatal Clinic	89.25	89.25	100.00	0	89.25	0.00	0	89.25	0.00
Middle Grade: delivery suite	157.5	198	79.55	40.5	198	20.45	0	198	0.00
Middle Grade: Antenatal Clinic	93.5	170	55.00	76.5	170	45.00	0	170	0.00

4.3 Neonatal Medical Workforce

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that BAPM standards are achieved, although locum workforce may be used at times to bridge vacancy or sickness gaps.

4.4 Anaesthetic workforce

4.4.1 The anaesthetic rotas have been covered throughout January as outlined below. The rota gaps were filled by existing members of staff with cover provided 100% of the time.

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	31	100%	29	94%
Anaesthetist extra days	0	0%	2	6%

4.5 MDT ward rounds

4.5.1 MDT ward rounds take place at 08:30 and 20:30 daily. Medical staff attendance is expected 100% of the time, however due to high acuity for example, this may not always be possible.

	08:30	20:30
Anaesthetist	94%	90%
Obstetric Consultant	100%	97%
Ward round completed	100%	100%

4.6 Neonatal Nursing

4.6.1 Safe neonatal nurse staffing is monitored by:

- Completion of safe staffing on BadgerNet (twice daily)
- Monitoring nurse patient ratios as per BAPM safe staffing standards.
- Morning MDT safety huddle
- Daily escalation depending on capacity and acuity - temporary bank and agency staff.
- Monitoring sickness and absence rates
- Monitor and review recruitment/vacancies.

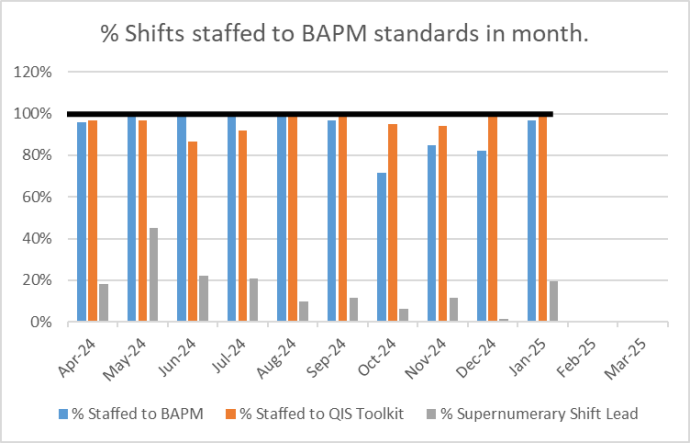
The following nurse patient ratios are expected to meet BAPM standards.

1.1 Intensive Care (IC)
1.2 High dependency (HD)
1.4 Special Care (SCBU)
Supernumerary Shift Co-ordinator.

Our Neonatal Workforce Establishment is defined by the BAPM service standards for hospitals providing Neonatal Care. The neonatal workforce is outlined as below:

Nursing Position	Budgeted WTE	Contracted WTE	Maternity leave	Long Term Sickness.
Band 7	2.0	2.0	0	0
Band 6	5.2	4.87	0	0
Band 5	10.4	10.73	0.92	1.0
Neonatal Outreach	1.26	1.26	0	0

Throughout January 2025 96.77% of the shifts on SCBU were covered to BAPM standards, 100% of the shifts were staffed to QIS to Neonatal Toolkit standards and 19.35% had a supernumerary shift leader.



There were two shifts when we did not meet BAPM Safe Staffing Standards in January and this was due to high acuity on the unit. We currently do not have the funded establishment to achieve a supernumerary shift leader on all shifts and given the size of our unit this is an accepted position; our compliance for reporting this is based on our capacity and acuity. There is at least one nurse with QIS on all shifts, and all shifts remained safe.

4.6.2 **Neonatal Staffing – Qualified in Speciality**

The Neonatal Toolkit (2009) defines that:

- A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS).
- Units have a minimum of two registered nurses/midwives on duty at all times, of which at least one is QIS
- Babies requiring high dependency care are cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under the supervision of a registered nurse/midwife (QIS). A minimum of a 1:2 staff-to-baby ratio is provided at all times (some babies may require a higher staff-to-baby ratio for a period of time.
- Babies requiring intensive care are cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under the supervision of a registered nurse/midwife (QIS). A minimum of a 1:1 staff to-baby ratio is provided at all times (some babies may require a higher staff-to-baby ratio for a period of time).

Trajectory of QIS from September 24 – March 25

	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25
Total QIS %	39%	44.2%	44.2%	48.0%	43.5%	47.21%	50.4%

Although the trajectory for the overall QIS compliance shows an improving picture in March this is because we will have 3.06wte Band 5 vacancies at the end of March. VR have been agreed and are currently out to advert on NHS job page. Once recruitment has taken place, it is likely our QIS % will return to around 40% unless we can recruit staff who have an existing Neonatal Qualification. We currently have one Band 5 undertaking the critical care course at Birmingham City University (completion June 25) and we anticipate being able to send a further two staff members on the course during 25/26 (funding permitting). We have one Band 5 completing the Neonatal Foundation Course, commencing March 25.

4.6.3 **Quality nurse Roles and AHP Provision**

There is no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7wte Practice Education Lead (B7) with 0.3wte Clinical working within role (=1.0wte) and 0.2wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2wte B7 funding has been used to support a B6 Developmental Care Lead on a fixed term contract until March 2025.

4.6.4 **Sickness and Maternity Leave**

Month	Sickness (Trust Target <3%)	Maternity Leave (WTE)
December	**8.75%**	**0.92wte**
January	**5.53%**	**0.92wte**

Sickness had increased in December and January (25) due to 2 x Long Term Sickness Episodes and an increase in short term sickness for seasonal illnesses.

5. COMPLIANCE

5.1 CNST standards (Year 6) required compliance with training to be at 90% in all staff groups by 1st December 2024. Compliance has been achieved in all staff groups. The training team have worked hard over the year to ensure all areas are above the CNST recommendation of 90%. Year 7 standards have just been launched and review identifies the same standards will be required.

Training compliance in PROMPT: Midwives	96%
Training compliance in PROMPT: Obstetric Consultants	90%
Training compliance in PROMPT: Obstetric Middle Grades	100%
Training compliance in PROMPT: Anaesthetic Consultants	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	83%
Training compliance PROMPT: Maternity Support Workers	94%
Annual NLS update compliance: Paediatric Consultants	89%
Annual NLS update compliance: Paediatric Middle Grades	80%
Annual NLS update compliance: Paediatric Juniors	100%
Annual NLS update compliance: Midwives	99%
Annual NLS update compliance: Neonatal Nurses	86%
Fetal Wellbeing update day: Obstetrics	90%
Fetal Wellbeing update day: Midwives	93%
Midwifery update day (Core Competency): Midwives	99%
Midwifery update day (Core Competency): Support Staff	94%

5.2 **ATAIN- Avoiding Term Admissions into Neonatal Unit**

The national benchmark for ATAIN is 5% with a best practice guide of 3%. Our current performance for January is 2.3%. This demonstrates the work of the team in taking learning form cases and implementing improvement. The full ATAIN quarterly report will be shared in the next quarterly report in March 2025.

5.3 **Safety Champions**

Maternity Safety Champions work at every level – trust, regional and national – and across regional and organisational boundaries. They develop strong partnerships, can promote the professional cultures needed to deliver better care, and play a key role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice. CNST Safety Action 9 requires all Trusts to have visible Maternity and Neonatal Board Safety Champions who are able to support the perinatal leadership team in their work to better understand and craft local cultures.

December and January planned walkabouts had to be cancelled due to acuity across the Trust however one of the Non-Executive champions carried out an informal walk round and commented that there was good morale, positive approach to the culture work, continued focus on the preterm pathway, Health care support workers had good morale although sickness in the team could present some challenges. SCBU confirmed that stock and procurement issues had been resolved. There was also an unannounced visit early morning 06.00 hrs to 09.00 hrs on the 23rd January, the safety champions visited SCBU, triage, delivery suite and the ward. Handovers and scuddles were observed. A focus on major obstetric haemorrhage was a feature in the MDT handover with a demonstration of the new drapes. The next planned safety walkabout is planned for early February 2025.

5.4 **CNST MIS Year 6**

Full compliance has been declared and submitted, supported by the Trust Board and ICB Board. This has enabled 3 consecutive years of full compliance.

5.5 **CNST MIS Year 7**

MIS Year 7 was published in February. We are reviewed this and identified the new guidance has undergone minimal change since year 6. We are currently setting out our trajectories to ensure we can maintain compliance in Year 7.

APPENDIX 1 – PQSM Dashboard

Indicator Description	July	August	September	October	November	December	Janua
Total bookings	154	122	135	147	150	127	137
Women who were booked before 12 + 6 weeks	147	116	120	139	141	119	133
% Women who were booked before 12 + 6 weeks (target 90%)	95.5%	95.1%	88.9%	94.6%	94.0%	93.7%	97.1%
Women who were booked after 12 + 6 weeks	7	6	15	8	9	8	4
% Women who were booked after 12 + 6 weeks	4.5%	4.9%	11.1%	5.4%	6.0%	6.3%	2.9%
Midwife led care at booking	27	24	18	27	27	16	27
% Midwife led care at booking	17.5%	19.7%	13.3%	18.4%	18.0%	12.6%	19.7%
Women with BMI of 30 and over at booking	40	40	38	43	37	43	42
% Women with BMI of 30 and over at booking	26.0%	32.8%	28.1%	29.3%	24.7%	33.9%	30.7%
% Antenatal Personalised Care Plan completed	97.1%	100.0%	98.4%	98.40%	99.00%	98.50%	99.3%
% Intrapartum Personalised Care Plan completed	61.0%	68.5%	63.1%	63.1%	65.5%	64.0%	55.3%
% Portal Access Consent	100.0%	98.4%	99.3%	99.3%	98.7%	99.2%	98.5%
% Portal Access - Women who registered and logged in	82.5%	80.8%	79.9%	79.5%	85.8%	80.2%	80.7%
% Contacts were place of birth suitability was recorded	65.4%	65.3%	69.5%	69.5%	65.5%	74.1%	69.8%
% High risk women assigned a named Consultant - within 7 days	62.7%	58.40%	59.00%	59.00%	62.80%	71.00%	70.4%
% High risk women assigned a named Consultant - at any time	86.0%	88.5%	84.2%	84.2%	83.6%	89.7%	81.8%
% Antenatal contacts with a reviewed / authorised risk assessment	77.1%	72.9%	84.2%	84.2%	81.0%	82.8%	85.2%
% Antenatal contacts with a risk assessment form completed	91.1%	91.7%	96.8%	96.8%	95.8%	95.5%	92.9%
Recorded Smoking Status at Booking - Yes	10	5	9	11	13	10	11
Recorded Smoking Status at Booking - No	144	117	126	136	137	117	126
Recorded Smoking Status at Booking - Unknown	0	0	0	0	0	0	0
% of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Women who were current smokers at booking	10	5	9	11	13	10	11
% Women who were current smokers at booking	6.5%	4.1%	6.7%	7.5%	8.7%	7.9%	8.0%
Smokers who were referred to smoking cessation services	9	5	9	11	13	8	10
% Smokers who were referred to smoking cessation services	90.0%	100.0%	100.0%	100.0%	100.0%	90.0%	90.9%
Smokers who accepted CO screening at booking	10	5	9	11	12	10	10
% Smokers who accepted CO screening at booking	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	90.9%
Women who were screened for CO at booking	149	113	130	136	140	121	130
% Women who were screened for CO at booking (of total bookings)	91.4%	92.6%	96.3%	92.5%	93.3%	95.3%	94.9%
Women with CO reading of 4 ppm or more at booking	6	5	10	7	8	13	13
% Women with CO reading of 4 ppm or more at booking (of total bookings)	3.9%	4.1%	7.4%	4.8%	5.3%	10.2%	9.5%
Total births (deliveries)	128	125	142	130	124	129	144
Home Births	0	1	3	2	2	1	0
BBA's	0	1	1	1	0	2	1
Vaginal births (deliveries)	47	43	58	57	40	50	60
% Vaginal births (deliveries)	36.7%	34.4%	40.8%	43.8%	32.3%	38.8%	41.7%
Ventouse & forceps births (deliveries)	17	13	21	19	19	7	15
% Ventouse & forceps births (deliveries)	13.3%	10.4%	14.8%	14.6%	15.3%	5.4%	10.4%
RG*1 having a caesarean section with no previous births	2	2	3	3	5	3	6
RG*1 Deliveries	17	15	16	16	23	15	23
RG*1 % C-section deliveries	11.8%	13.3%	18.8%	18.75%	21.74%	20.00%	26.1%
RG*2 having a caesarean section with no previous births	20	25	14	14	24	21	19
RG*2 Deliveries	36	31	31	31	31	28	36
RG*2 % C-section deliveries	55.6%	80.6%	45.2%	45.16%	77.42%	75.00%	52.8%
RG*5 having a caesarean section with at least one previous birth	18	21	21	21	16	23	20
RG*5 Deliveries	19	23	27	27	16	25	22
RG*5 % C-section deliveries	94.7%	91.3%	77.8%	77.78%	100.00%	92.00%	90.9%
Total Elective C-Sections	27	22	28	21	30	27	35
Total Emergency C-Sections	36	46	34	33	34	44	33
Total Caesarean births (deliveries)	63	68	62	54	64	71	68
% Total Caesarean births (deliveries)	49.2%	54.4%	43.7%	41.5%	51.6%	55.0%	47.2%
% Grade 1 C-Sections within 30 minutes	75.0%	75.0%	87.5%	87.5%	87.5%	77.8%	60.0%
% Grade 2 C-Sections within 75 minutes	84.6%	100.0%	90.9%	90.9%	90.5%	90.3%	91.7%
Midwife led (low risk care) births	29	29	26	30	12	16	27
% Midwife led (low risk care) births	22.7%	23.2%	18.3%	22.9%	9.7%	12.4%	18.6%
Home births (deliveries) - midwife led only	0	0	1	1	0	0	0
% Home births (deliveries)	0.0%	0.0%	0.7%	0.8%	0.0%	0.0%	0.0%
Total number of babies born	131	128	144	132	124	129	144
Babies born preterm (singletons born 36+6 or less)	17	11	16	13	8	11	8
% Babies born preterm (singletons born 36+6 or less)	13.0%	8.6%	11.1%	9.8%	6.5%	8.5%	5.52%
Singleton babies born 26+6 or less	0	1	0	1	0	0	0
% Singleton babies born 26+6 or less	0.00%	0.83%	0.00%	0.77%	0.00%	0.00%	0%
Babies (multiples) born 27+6 or less	0	0	0	0	0	0	0
% Babies (multiples) born 27+6 or less	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0%
Stillbirths	2	2	0	0	2	0	0
% Stillbirths	1.5%	1.6%	0.0%	0.0%	1.6%	0.0%	0.0%
Live births where breastfeeding initiated (first feed = breastmilk)	102	105	108	107	100	105	116
% Live births where breastfeeding initiated (first feed = breastmilk)	81.0%	86.1%	76.6%	82.3%	82.0%	81.4%	81.1%
Women who were current smokers at booking (delivered mothers)	7	11	8	8	10	9	12
% Women who were current smokers at booking (delivered mothers)	5.5%	8.8%	5.6%	6.1%	8.1%	7.0%	8.3%
Women who were current smokers at birth (delivery)	8	12	9	6	8	8	9
% Women who were current smokers at birth (delivery)	6.4%	9.6%	6.3%	4.6%	6.5%	6.2%	6.2%
% Women with CO measured at 36 weeks	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%
% CO >= 4ppm at booking and below 4 ppm at 36 weeks	2.7%	7.2%	4.8%	3.5%	6.3%	5.4%	9.1%
Late pregnancy loss (singletons 16+0 - 23+6)	0	1	0	0	0	0	1
% (as a % of all singleton births)				0.00%	0.00%	0.00%	0.69%
% Detection rate for FGR (below 3rd centile)	10%	20.0%	22.2%	0.0%	12.5%	40.0%	0%

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Women who had a PPH of 1,500ml or more	6	5	9	4	3	6	9
% Women who had a PPH of 1,500ml or more	4.7%	4.0%	5.0%	3.1%	2.4%	4.7%	6.3%
Women who sustained a 3rd or 4th degree tear	1	0	0	0	0	0	2
% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.5%	0.00%	0.00%	0.00%	0.00%	0.00%	2.6%
% Induction of labour rate (of all births)	34.4%	39.2%	34.5%	32.3%	30.6%	40.3%	32.6%
Routine Enquiry Domestic Violence - Asked	84	78	100	80	87	86	86
Routine Enquiry Domestic Violence - Unable to ask	43	47	41	51	35	42	53
Routine Enquiry Domestic Violence - Unknown	1	0	1	0	2	1	6
% routine enquiry domestic violence	99.2%	100.0%	99.3%	100.0%	98.4%	99.2%	95.9%
Midwife to birth ratio	1:22	1:21	1:27	1:23	1:23	1:24	01:24
Delay in Induction >2hrs	0	0	2	0	0	1	1
Delay in Catagory 1 C-Section >30mins	0	2	0	1	1	2	0
Delay in administering medication	0	1	0	0	0	1	1
Delay in starting syntocinon/ARM >30mins	0	0	0	1	0	0	1
Delay in Suturing >60mins	0	0	0	0	0	0	0
Unable to provide 1:1 care in labour	0	0	0	0	0	0	0
Delay in Triage >30mins	0	0	1	0	0	0	0
Community midwives on call covering maternity unit	0	3	2	1	0	1	0
Any movement of midwifery staff from any area to provide midwifery cover	1	0	2	0	2	1	3
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
DSC lost - supernumerary status	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0	0	0	0	0
Number of women presenting to service with reduced fetal movements	220	199	203	211	204	228	207
Number of women presenting with RFM who are recorded as having a CTG	218	197	200	211	203	225	206
% of women presenting with RFM who received CTG	99.1%	99.0%	98.5%	100.0%	99.5%	98.7%	99.52%
Total admissions to neonatal care	12	6	15	17	13	13	14
Unexpected admissions of full-term babies to neonatal care	3	2	4	7	9	4	6
% Unexpected admissions of full-term babies to neonatal care	2.7%	1.7%	3.1%	5.9%	7.8%	3.4%	4.4%
Eligible Babies	1	0	2	3	2	2	0
% taken within hour	100.0%	n/a	100.0%	66.6%	100.0%	100.0%	0.0%
Adm temp <36.5 degrees	0	0	0	0	0	0	0
Eligible Babies	22	12	19	16	21	16	20
% taken within hour	86.3%	75.0%	94.0%	87.5%	100.0%	100.0%	95.0%
Adm temp <36.5 degrees	3	1	0	1	0	2	1
Babies born with an APGAR score between 0 and 6 (at 5 minutes)	3	3	6	5	0	1	1
Neonatal deaths	0	0	1	1	0	0	2
% Neonatal deaths	0.0%	0.8%	0.7%	0.8%	0.0%	0.0%	1.4%
Neonatal mortality per 1,000 births	0.00	0.00	6.94	7.58	0.00	0.00	13.89
Neonatal transfers for therapeutic hypothermia	0	0	0	0	0	0	0
% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Neonatal brain injuries	0	0	0	0	0	0	0
% Neonatal brain injuries	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	1	1	2	2	2	2	0
Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	2	2	2	2	3	2	0
% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	50.0%	50.0%	100.0%	100.0%	66.7%	100.0%	
Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0	0	0	0
Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0	0	0	0	0
% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Obstetrics admissions to ITU	1	0	0	0	0	0	0
Maternal deaths	0	0	0	0	0	0	0
% Postnatal Personalised Care Plan completed	98.4%	97.7%	97.5%	97.5%	98.3%	97.8%	96.6%
Postnatal readmissions within 28 days (mothers)	10	13	2	8	8	11	8
Postnatal readmissions within 28 days (babies)	5	7	7	4	8	4	4
Number of times Maternity Services Suspended per month	0	1	0	0	0	0	0
Number of hrs Maternity Services suspended	0	9	0	0	0	0	0
Number of times Home Birth services suspended per month	0	0	1	0	0	0	0
Number of hrs Home Birth services suspended	0	0	12	0	0	0	0
Number of times SCBU suspended per month	0	0	1	0	0	0	0
Number of hrs SCBU suspended per month	0	0	0	0	0	0	0
Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0	0	1	2	0	1
New MNSI SI referrals accepted	0	0	0	1	1	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0	0	0	0	0	0
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	0	0	0	0	0	0	0
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0	0	0	0	0
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	3	2	2	0	0		TBC
establishment	0.06wte	2.4wte	2.4wte	4wte	4wte		1wte
Inphase related to workforce (service provision/staffing)	0	3	4	1	2	2	2
MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Service User feedback: Number of Compliments (formal)	7	5	6	4			
Service User feedback: Number of Complaints (formal)	1	0	1	4	1	0	4
Staff feedback from frontline champions and walk-abouts (number of themes)	0	0	0	0	0	0	0

Progress in achievement of CNST /10	On Track	On Track	On track	On track	On track	On track	TBC
Training compliance in PROMPT: Midwives	93%	93%	96%	96%	98%	98%	96%
Training compliance in PROMPT: Obstetric Consultants	100%	100%	100%	90%	100%	100%	90%
Training compliance in PROMPT: Obstetric Middle Grades	93%	93%	92%	92%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%	100%	100%	92%	92%	83%
Training compliance PROMPT: Maternity Support Workers	65%	62%	73%	81%	100%	100%	94%
Annual NLS update compliance: Paediatric Consultants	100%	100%	100%	100%	100%	100%	89%
Annual NLS update compliance: Paediatric Middle Grades	100%	80%	100%	100%	100%	100%	80%
Annual NLS update compliance: Paediatric Juniors	91%	90%	100%	100%	100%	100%	100%
Annual NLS update compliance: Midwives	93%	93%	96%	96%	98%	98%	99%
Annual NLS update compliance: Neonatal Nurses	100%	100%	100%	84%	100%	100%	86%
Fetal Wellbeing update day: Obstetrics	89%	95%	84%	85%	100%	90%	90%
Fetal Wellbeing update day: Midwives	94%	95%	92%	91%	98%	92%	93%
Midwifery update day (Core Competency): Midwives	98%	98%	94%	94%	98%	98%	99%
Midwifery update day (Core Competency): Support Staff	79%	77%	81%	85%	94%	94%	94%

APPENDIX 2 – SCBU DASHBOARD

SCBU DASHBOARD 2023-2024													
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Comments
Staffing: Vacancy Gaps, Attrition Rate, Sickness													
Band 7 Vacancy Gap (2.0wte)	1	1	1	0	0	0	0	0	0	0			
Band 6 Vacancy Gap (5.2wte)	0	0	0	0	0	0	0	0	0	0.33			
Band 5 Vacancy Gap (10.5)	0.63	0.75	0.75	2.36	2.36	0	0	0	0.61	0.61			
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	0	0	0	0	0	0	0	0	0			
Band 2 Vacancy Gap (1.0wte)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0.32	0.32	0.32	0.32	0.32	0	0	0	0	0			
Attrition Rate (WTE)	0	0.92	0	0.61	0	0	0	0.62	0	0			
Maternity Leave (WTE)	0	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	
Sickness (<3.5%)	10.46%	7.49%	11.18%	7.10%	5.63%	3.66%	1.87%	5.20%	8.75%	5.53%			
Safe Staffing													
% Shifts staffed to BAPM Standards	96%	100%	100%	98.39%	98.31%	96.67%	71.67%	81.36%	82.26	**96.77**			
QIS % (standard = 70% of registered workforce)	48%	46%	46%	49.80%	49.80%	44%	44%	44%	45.80%	**43.50%**			
% of shifts QIS to toolkit				91.94%	100%	100%	95.74%	93.22%	96.77	**100%**			
% Shifts with supernumerary shift co-ordinator	18%	59%	16%	22.57%	10.17%	11.67%	6.67%	11.86%	1.61%	**19.35%**			
Appraisal Rate	71%	92%	79.00%	84.3%	68.75%	77%	73.7%	88.00%	94.50%	94.40%			
Mandatory Training Core	91.43%	99%	98.1%	98.09%	98.26%	97.60%	91.85%	93.70%	93.08%	96.54%			
Mandatory Training Essential	83.5%	92%	93%	92.79%	92.94%	88.66%	85.61%	87.40%	89.90%	90.33%			
Basic Life Support	80%	80%	80.00%	80.00%	81%	78%	64%	61.54%	59.08%	56.00%			
Newborn Life Support >90%	86%	94%	90%	100%	100%	100%	84%	100%	100%	86.00%			
Maternity Breastfeeding update.	70%	75%	95%	98.95%	80%	73%	95.83%	95.83%	95.65%	87.50%			
Safeguarding Level 3	90.00%	100%	100%	100%	90%	100%	92.59%	87.50%	78.26%	91.67%			
Compliments/Complaints/Concerns													
Complaints/Concerns	0	0	1	0	0	0	0	0	0	1			
Infection Prevention													
Overall - Star rating.	5	5	4	5	5	5	5	5	5	4			
Ward Assurance Audit		98%		85.50%		96%	91%	91.60%		100%			
Hand Hygiene	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%			
Bare Below the Elbow	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	2	8	1	2		5	8	4	6			
Medication Errors	0	0	0	0	0	0	0	0	0	0			
Staffing	0	0	0	0	0	0	0	1	1	0			
Service Escalation (OPEL RED/BLACK)	0	0	0	0	0	0	0	OPEL 3 x 1	Opel 3 x 5	0			
Exception reports - ex-utero outside of care pathwa	1	0	0	1	0	0	0	0	0	0			
Exception reports - in utero transfers outside of pathway/network	0	1	0	1	0	0	0	0	0	0			
Audits													
Quaterly CD Audit	90.90%					100%							
Safe storage of Medicines	75%			81.80%									
IV Fluid Prescription - Target 90% Compliance	87%		92%			91%			97%				
Clinical Notes Audit - Correct Completion target 90%	94%		95%			96%			94%				
Cannula Care Plan (Peripheral Cannula) Target 90%	80%		89%			92%			98%				
Gentamicin Clinical Audit	82%		96%			96%			89%				
NGT Misplacement NPSA Safety Alert 2016 Target 90%	91%		100%			100%			94%				
Pain Audit Tool Completed Correctly Target 80%	70%		77%			80%			63%				
Growth parameters Audit	86%		80%			87%			77%				

Transitional Care and Term Admissions													
% Unexpected admissions of full-term babies to neonatal care (of all live term births) m(National Average 5% Best Practice <3%)	5.6%	1.5%	4%	2.3%	*2.3%	*2.08%	*3.78%	*4.9%	2.30%	tbc			* To be verified at ATAIN review meeting
TC Bed occupancy rate on SCBU % including parent bedroom	51%	26.80%	77%	87%	72%	75%	96%	95%	74%	57%			
Number of babies born between 34-36 wks gestation and admitted to SCBU	4	2	2	5	1	3	6	2	5	0			
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	0	2* twins	0	4	2	11	1	0	3	2			
Neonatal Outreach Team													
Total Patients	12	12	8	7	12	11	14	21	13	14			
NewReferrals	6	9	5	5	6	5	8	11	2	3			
Existing Patients continuing care	4	3	3	2	6	6	6	10	11	11			
No. NGT Feeding in the community	4	5	7	3	3	3	3	7	2	11			
Receiving EBM on discharge from SCBU	6	7	5	6	8	7	7	12	2	11			
Receiving EBM on discharge from O/R	1	3	0	0	2	1	1	5	1	1			
Numbers Discharged from outreach	4	9	6	0	3	5	5	9	4	7			
Number of Incidents (Inphase)	0	1	1	0	0	0	0	0	0	1			
Prolonged Jaundice Screening Referrals	24	28	26	19	28	26	18	26	29	18			
Prolonged Jaundice Screening - Total Number of Refferals meeting criteria	19	26	22	13	21	22	15	23	29	17			
Prolonged Jaundice Screens - Outreach	15	19	20	10	18	20	11	18	13	11			
Prolonged Jaundice Screens - RAC	4	7	10	10	11	9	4	5	16	4			

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
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:	Lynn Carpenter, Quality & Safety Matron
Documents covered by this report:	Main report

1. Purpose of the report

To update the Committee on the progress in key areas for improving patient experience, supporting the delivery of the updated Trust quality priority for 2024-25; *Improve responsiveness to patient experience data*.

2. Recommendation(s)

Board is asked to note the content of the report.

3. Executive Director Opinion[1]

A comprehensive report and scrutiny was given at Quality Committee in February.

The number of complaints received and the time we are taking to respond is a cause for concern.

Increasing feedback relating to waiting times is likely due to operational winter pressures, it would be helpful to understand through the deep dive the extent to which this is urgent and emergency care or our planned care pathways.

The implementation of Word360 for interpreting will save the trust a significant amount of money and has already been proven through the pilot areas and the wider foundation group that it will significantly improve patient and clinician experience.

[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 2024/25 Objectives the report relates to:	
Quality Improvement ☐ ***Develop a business case and implement our blueprint for integrated urgent and emergency care with our One Herefordshire partners*** ☐ ***Work with partners to ensure that patients can move to their chosen destination rapidly, reducing discharge delays*** ☐ ***Work with partners to deliver the improvement plan for Children's services*** ***Digital*** ☐ ***Implement an electronic record into our Emergency Department that integrates with other systems*** ☐ ***Deliver the final elements of our paperless patient record plans in order to improve efficiency and reduce duplication*** ☐ ***Maximise the functionality of EMIS with 1H partners and the shared care record*** ***Productivity*** ☐ ***Deliver our Elective Surgical Hub project and associated productivity improvements in order to increase elective activity and reduce waiting times*** ☐ ***Continue our Community Diagnostic Centre project in order to improve access to diagnostics for our population*** ☐ ***Create system productivity indicators to understand the value of public sector spending in health and care***	***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*** ☐ ***Redesign selected services to focus more on prevention in order to reduce secondary care activity*** ☐ ***Build our Integrated Energy Solution on the County Hospital site to reduce carbon emissions*** ***Workforce*** ☐ ***Deliver plans for 'grow our own' career pathways that provide attractive roles for applicants*** ☐ ***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*** ☐ ***Embed EDI objectives in our performance appraisals in order to make a demonstrable improvement in EDI indicators for patients and staff*** ***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*** ☐ ***Continue to progress our plans for an Education Centre in order to develop our workforce and attract and retain staff***

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 for patient experience.

Headlines

- 91.13% of feedback received using FFT text messaging is positive
- Some technical issues in November with FFT data – now resolved
- Project underway with Healthcare Communication to improve FFT response rates
- Negative feedback now outweighs the positive with 'waiting times' for inpatient FFT
- Marginal increase in complaint response times in Q3 but remains much improved from 22/23
- 'Wait for operation/procedure' has replaced 'patient not being listened to' in the top 10 concern categories
- PALS service remains fragile but well supported by clinical teams

Quality Priority 2024-25- Improve responsiveness to patient experience data

The priority was to focus on the following areas;

- Evidence use of FFT feedback to generate improvement (projects/ case studies)
- Improvement in national patient survey results
- Evidence use of survey feedback to generate improvement (projects/ case studies)
- Reduction in complaints and concerns
- Improved response times to complaints and concerns
- Reduction in overdue responses to complaints and concerns
- Reduction in comebacks or re-opened cases
- Increased patient engagement and collaboration on improvement projects

Friends and Family Test (FFT)

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

FFT Results

Below is the FFT results data from October 2024 - January 2025.

Headlines

Between October 2024 – January 2025;

- The Trust has sent 101349 messages for feedback.
- 17469 responses were received (13% response rate overall)
- 91.13% of these responses are positive feedback.
- 10.62% of patients gave further comments in regards to how they scored their experience.

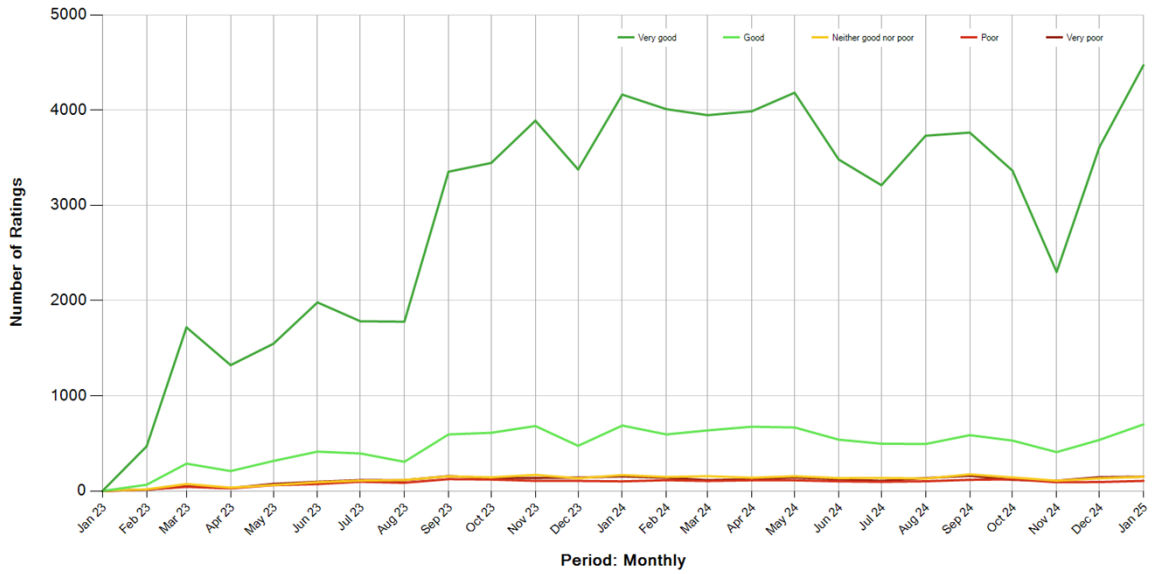
Quantitative Data

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

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Trust	91.74%	91.66%	91.99%	92.1%	91.91%	91.49%	91.35%	91.63%	90.19%	90.83%	89.05%	91.40%	92.27%
Inpt	85.65%	81.67%	88.63%	85.97%	82.79%	84.54%	80.65%	84.24%	82.68%	87.91%	82.49%	83.61%	86.67%
OP	94.32%	94.13%	93.91%	94.48%	94.11%	94.21%	94.46%	94.78%	93.03%	92.93%	92.32%	94.75%	93.87%

Overall, we continue to see the highest satisfaction ratings in outpatients, at a consistent level each month, inpatients show a fluctuating picture in comparison.

The chart below shows the actual response received by patients and overwhelmingly the most popular response continues to be ‘very good’ month on month. During November 2024 we experienced a technical issue that resulted in a reduction in data sent from Information services, service resumed as normal in December. January 2025 has witnessed a further increase towards 5000.



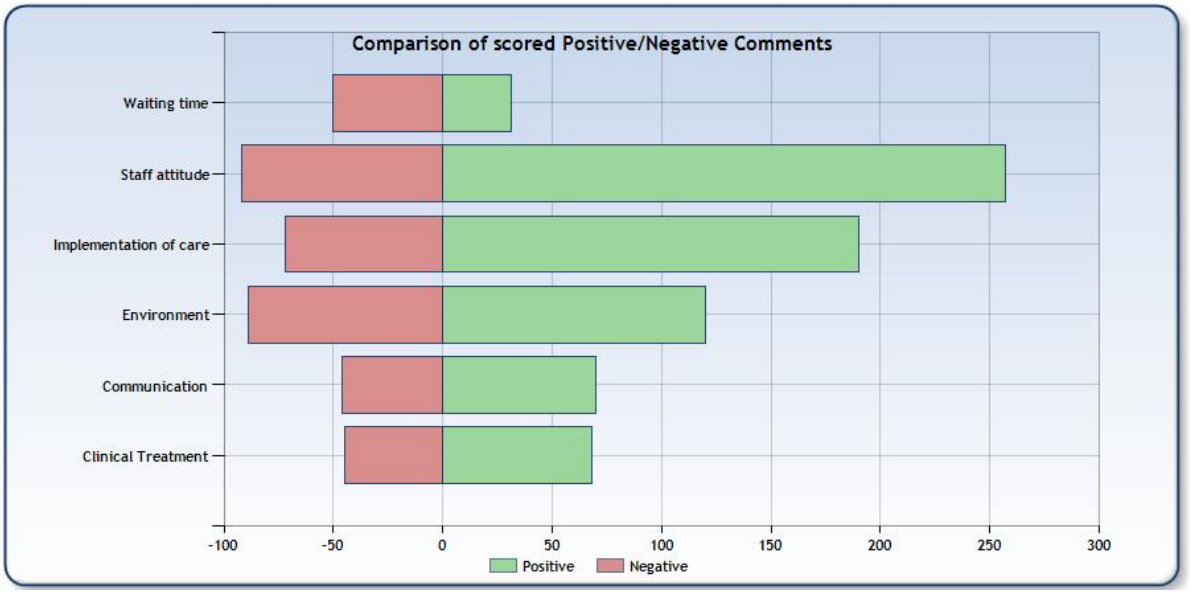
The Trust's average response rate when introducing the text messaging service was 20% and a breakdown month on month can be seen in the table below. To try to improve our response rate we are currently working with Healthcare Communication to introduce the additional ability for patients to leave feedback at any time through the Envoy system, in addition to text messages. This facility is due to go live in early April. In addition, we are currently reviewing how we communicate and promote FFT with the development of new communication aids in the form of a new poster, pop-up banners and use of social media. A promotional campaign is timed for early April to promote the new facility and at regular intervals throughout the year to encourage feedback.

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Trust	21%	21%	21%	20%	20%	19%	18%	18%	18%	19%	18%	17%	17%	17%	17%	17%	16%	9%	12%	13%
Inpatient	19%	17%	15%	16%	15%	15%	15%	18%	16%	17%	18%	16%	18%	15%	17%	15%	15%	7%	15%	15%
Outpatient	20%	22%	21%	20%	20%	18%	18%	17%	18%	19%	17%	17%	16%	16%	16%	16%	15%	16%	11%	12%
Day case	24%	24%	26%	24%	23%	24%	22%	24%	23%	25%	23%	23%	23%	23%	22%	21%	21%	23%	20%	20%

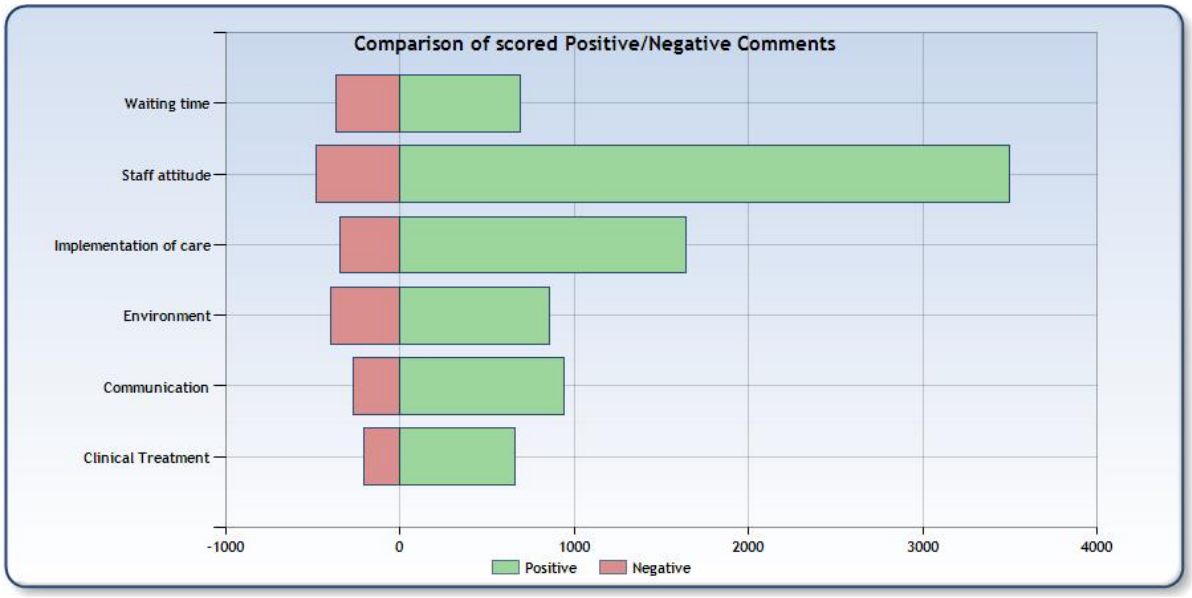
Qualitative Feedback

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

Inpatient responses



Outpatient responses



For the first time since reporting we can see that negative feedback outweighs the positive with waiting times and is likely to relate to operational pressures and waiting lists.

Complaints

This section of the report provides;

- Performance data
- Comebacks
- PHSO cases update
- Feedback from the Medical Examiner Service

Complaints position

(New complaints only)

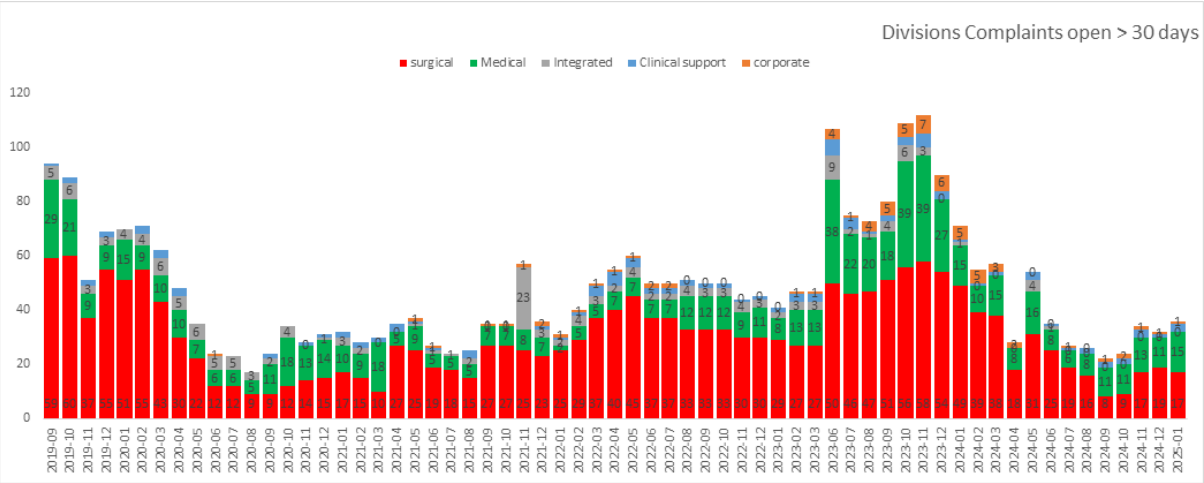
KPI	Jul	Aug	Sept	Oct	Nov	Dec	Total Q2	Total Q3	Total Apr-Dec (inc)
Number of complaints **2023**	40	22	32	36	33	25	94	94	283
Number of complaints **2024**	29 ↓27%	21 ↓4%	32	46 ↑28%	27 ↓18%	27 ↑8%	82 ↓13%	100 ↑6%	289 ↑2%

A comparison of data between Q2-3 in 2023 and 2024 shows an overall increase of 2% in complaints received. There was a noticeable spike in October. This trend can be seen over time with similar increases, though further analysis shows that some of these complaints were related to historic clinical treatment.

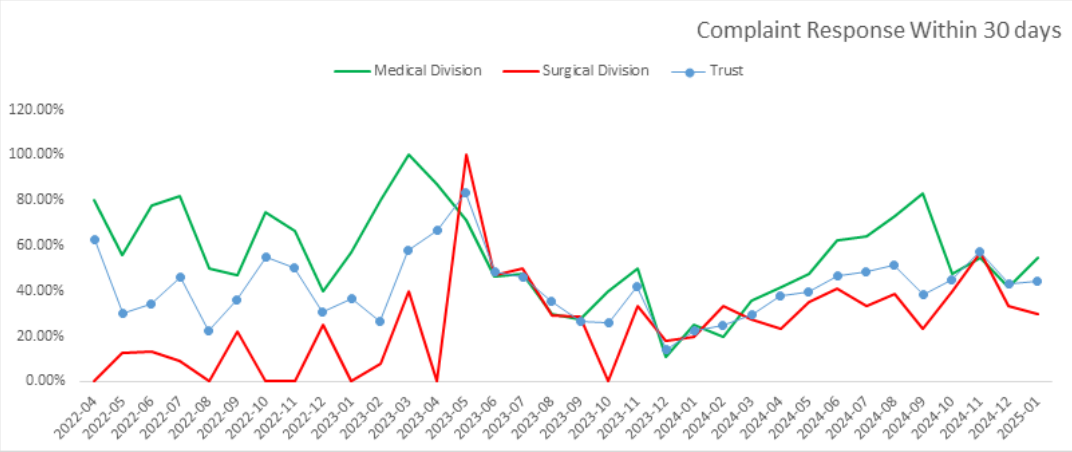
There has been an overall slight increasing trend in the total number of new complaints received since April 2022.

Complaint response times

The chart below highlights the current number of complaints open over 30 days by division. These figures will include any complaints where an agreed timeframe has been applied. Despite a marginal increase in Q3, the overdue complaints position has improved significantly since 2022/23.

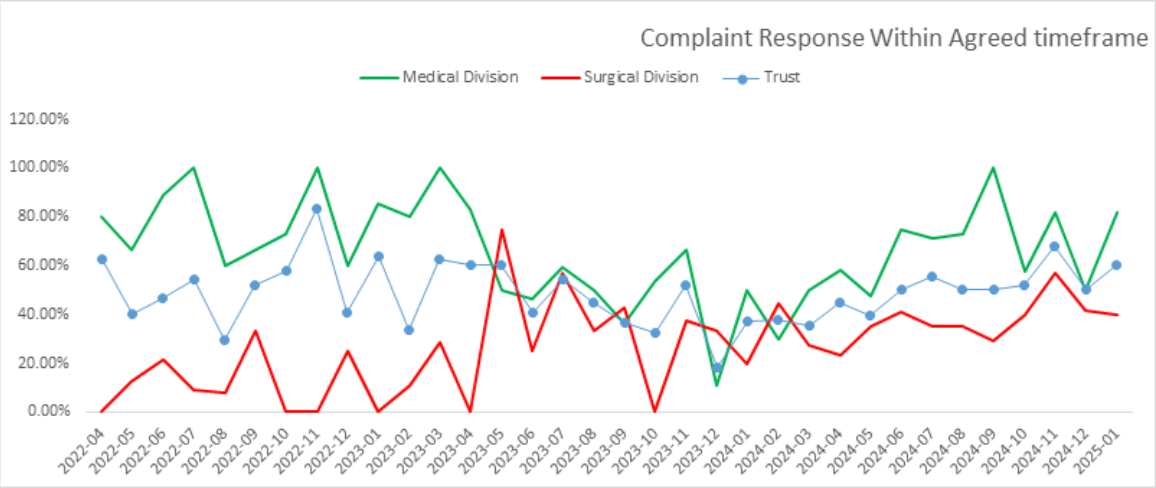


The chart below shows the percentage of complaints being resolved within the 30 day timeframe (rolling 3 month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers.



Version 2 25/03/2024

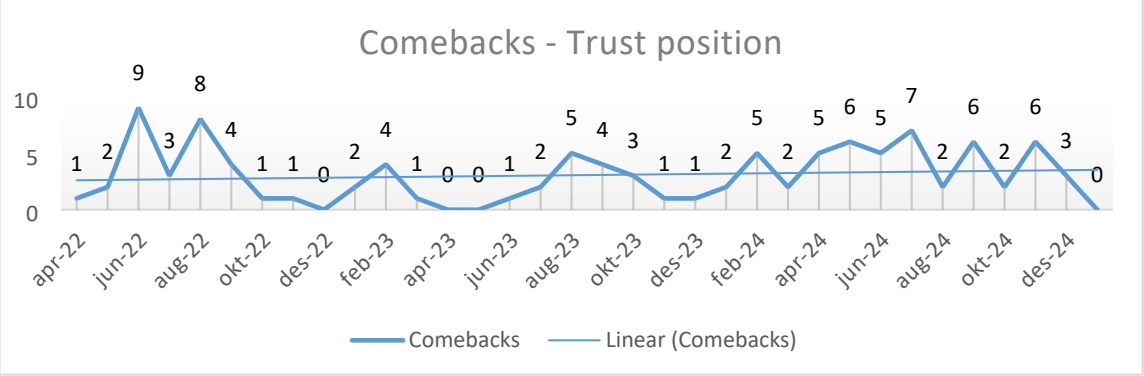
Often complaints are complex in nature and require multiple services to input to the investigation and response. Where this is the case, early engagement with the complainant should be undertaken to agree a timeframe for the response to be provided. The chart below highlights performance for these cases where a timeframe is agreed that is greater than our specified 30 day target.



These charts demonstrate that whilst there is almost a 20% improvement when agreeing the timescale to respond with complainants, we are still only meeting any individually agreed deadlines 60% of the time.

Comebacks

When also considering the number of complaints that are reopened ('comebacks') that Divisions also need to respond to, this increases the total number of complaint responses required.



Number of comebacks 2022	36
Number of comebacks 2023	25
Number of comebacks 2024 (Apr-Jan inc)	42

The previous deep dive of comebacks received suggested the following issues:

- Initial complaint responses either did not answer all of the questions raised in their original complaint, or the response had factual inaccuracies.
- Investigating officers engaging with complainants where verbal questions were raised but not included in the response. When responses are approved and signed off by Divisions and Executives, they would be unaware that this additional information was agreed.
- Closing letters that confirm the issue has been resolved following a conversation/meeting but does not summarise the discussion (sometimes despite the complainant agreeing to this approach).
- New information provided in the complaint response that the complainant was unaware of.
- Factual inaccuracies in dates/times/names.

Version 2 25/03/2024

A subsequent review of the 9 comebacks revived in November and December shows the following themes:

- 1 x factual inaccuracy
- 1 x unanswered questions from original complaint
- 2 x requests for amended wording
- 4 x conflicting information given at clinic appointments following the complaint response
- 2 x unhappy with complaint response/outcome. One of these has since referred their complaint to the PHSO

Parliamentary and Health Service Ombudsman (PHSO) update

There was a sharp increase in cases referred to the PHSO in 2024. Analysis across the group shows that WVT is not an outlier for referral.

Calendar Year	PHSO cases
2021	5
2022	1
2023	2
2024	6
2025 (to date)	1

Status of the PHSO cases in 2024/5 is summarised in the below table:

Year	Division/s	Issues	Resolution method	Outcome
Jan 2024	Surgical	Delay in referral to tertiary centre	Detailed investigation	Ongoing
Feb 2024	Surgical	Care and treatment in maternity, poor communication, poor aftercare	Financial remedy	£500 paid - closed
May 2024	Medical	EOL care, communication with family	PHSO mediated meeting	Resolved with meeting – no further action
June 2024	Surgical	Delay in surgery, post op recovery concerns	Preliminary investigation	No further action - closed
July 2024	Welsh Ombudsman enquiry for PTHB investigation	Post op neurological care and rehabilitation delays	Detailed investigation PTHB as commissioner of WVT service to pay financial remedy	£500 from PTHB WVT to share final report findings
Aug 2024	Medical	Delay in cancer diagnosis	Preliminary enquiry	Ongoing
Feb 2025	Surgical	Delay in surgery, post op recovery concerns (same complainant as June 24, further questions escalated to PHSO)	Preliminary investigation	Ongoing

Feedback from the Medical Examiner Service

The Committee requested an update regarding any actions and evidence from learning from the discussions the Medical Examiners have with next of kin.

The Medical Examiner Service aims to:

- Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths that occur in Herefordshire;
- Provide an independent level of scrutiny to the causes of death;

- Provide a better service for the bereaved, allowing an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased;

During January 2025, there were 258 deaths that occurred across Herefordshire, which were reviewed and managed through the local Medical Examiner Service.

- 121 deaths in the **Acute** hospital setting (*including ED and CH's*).
- 137 deaths in the **Community** setting.

In total, there were 34 coronial referrals, of which included 25 cases from the hospital setting.

ALL of the bereaved families and carers had the opportunity to speak with a Medical Examiner to discuss the cause of death and any concerns or queries they may have had about the care their loved one received.

From the Medical Examiner review of the 121 acute hospital deaths:

- 95% identified investigations ordered and acted on in a timely manner
- 82% had a ReSPECT form in place
- 79% had clear communication with the family about End of Life care

Sample of a selection of NOK feedback:

- Granddaughter was upset that she was not updated on her grandfather's clinical situation the day prior to his death
- There was a 'lack of communication with the family on the reality of the situation'
- Mental health of a patient was not managed well and communication with the family was poor
- Difficulty obtaining information from the ward
- In a positive light, there was feedback to outline the strong continuity of leadership and communication even following multiple admissions

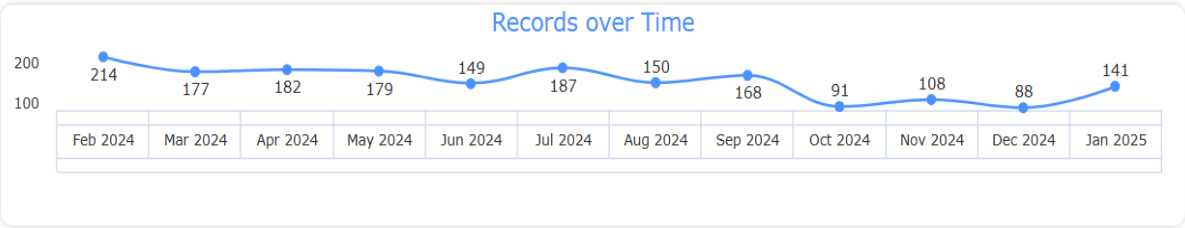
In addition to the above, there is a large amount of positive feedback that families were happy with the care their loved ones received.

Families are signposted to PALS or Complaints should they wish to raise a concern or make a complaint and the next print of bereavement booklets will have more detailed information regarding the options available. Quality & Safety have offered to support a development session for ME's and bereavement colleagues to outline what these services do so this can be communicated effectively to families.

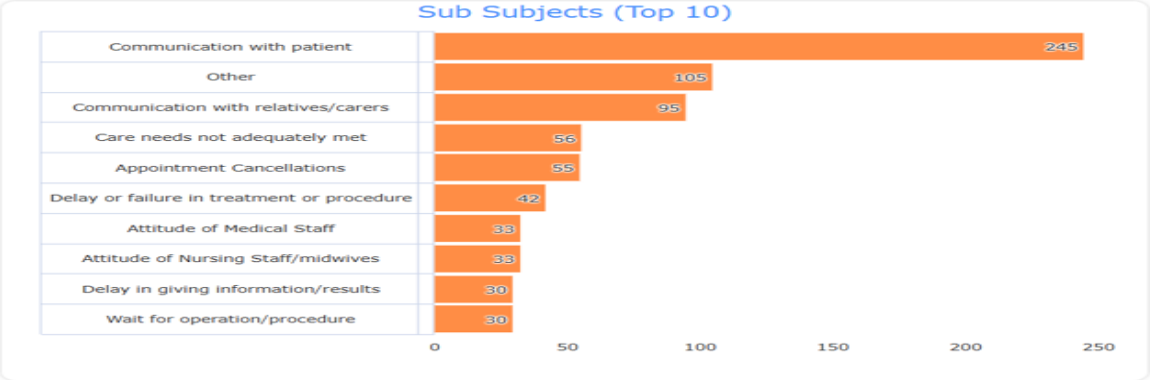
The Mortality app within InPhase has been further developed, and there are now more specific questions within the ME review that will support more detailed analysis and triangulation of family feedback.

Concerns

The number of concerns reported over time is detailed below



There has been little change in the top 10 themes for this reporting period. Communication with patient, relatives and carers remain in the top three highest reported themes for concerns although patient not being listened to has moved out of the top 10 to be replaced with wait for operation/procedure.



PALS service

The PALS service remained in a fragile position during this reporting period as the team restructure was undertaken with the new team structure implementation due to commence from 1st January 2025.

A business justification for a new interpreting provider and process has been approved to reduce admin burden and to improve access to high quality, accessible and cost effective interpreting provision. This is currently being rolled out.

During this time period the temporary process agreed for managing concerns to ensure provision of a minimum level of service provision continued. This included signposting of patients and carers directly to services to raise their concerns for early resolution. This has meant that not all contacts with PALS have been logged as concerns, since this is a core team function and not done by clinical teams.

The situation is being constantly monitored and engagement has been ongoing with clinical teams to try to mitigate the impact on service users.

Patient Experience Committee

The committee has two core sub-groups now established and embedding to support the quality priority and wider Trust objectives; Patient Engagement Group and Volunteer Steering Group.

Patient Engagement Forum

The patient engagement forum continues to meet monthly with many staff bringing projects to the group for input and support. The group have supported with initiatives such as PLACE audits, script development for the contact centre, frailty improvement initiatives and development of FFT posters.

Members have supported planning for health information week in January and will be supporting with a promotional stand across the week. As well as the main health information week themes this was used to promote the dementia roadmap and patient portal and an update will be provided in the next patient experience report.

Volunteer Steering Group

The Group approved to pilot of the volunteer contact centre aiming to reduce DNA's after receiving a presentation on the model being used at GEH. The WVT pilot commenced with Ophthalmology. The contact centre pilot for ophthalmology demonstrated a positive outcome. The learning from this pilot is being used to expand the reach of the contact centre into other specialities to support the continued drive to reduce DNA rates. A number of new volunteers have been recruited to support this.

Progress continues to support the use of volunteers in gardening roles at community sites and discussions are underway to establish how this might be replicated at the acute site.

Engagement is underway to implement the use of WRVS NHS responders to support a pick up and deliver service. Initially this will be used to deliver medications to patients and community hospitals. Future options to expand this further are being explored.

Conclusion

When reviewing the data against our quality priority measures we are seeing progress and improvement in a number of areas, however recognise there is more work to do to deliver the quality priority.

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Board Assurance Framework and High Risk Report
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	Executive Risk Management Committee
Appendices included with this report:	Board Assurance Framework and High Risk Report
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Board Assurance Framework (BAF) in its current form is held on InPhase, the Trust's Risk Management system, alongside the Trust's risk register. The BAF represents a report from the system, which is presented monthly to the Executive Risk Management Committee (ERMC) for review together with all the Trust's high-scored risks.
A revised BAF format is in development and the attached interim report is presented to the Trust Board to provide assurance as to the regular oversight of the individual risks within the Trust's governance structure.

Recommended Actions required by Board or Committee

The Trust Board is asked to:

- Note the interim BAF report and summary high risk report.
- Take assurance from the report as to the oversight of individual risks within the Trust's governance framework.
- Note the plans to develop the BAF format and to present this to the Board in April 2025.

Executive Director Opinion[1]

The Managing Director is reviewing ERMC to enhance its focus on assurance and strengthen oversight and reporting to the Board.

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

NHS
Wye Valley
NHS Trust

Board Assurance Framework Report March 2025

The Board Assurance Framework is currently undergoing a revision with a view to providing a more digestible format, incorporating additional information and increasing the focus on assurance and actions to reduce risks in line with the target scores.

The Board Assurance Framework will also be refreshed in the new financial year to align with the updated Trust strategic objectives.

The attached interim report sets out a summary of the current Board Assurance Framework risks. The new format will be presented to the Board in April.

The report also includes the Trust's highest scored risks (scored 15+).

Each risk is allocated to a specific committee for oversight.

The clinical divisions oversee divisional risks within their respective governance arrangements and provide regular updates to the Executive Risk Management Committee.

Corporate committees within the governance framework review risks relevant to their respective agendas.

All risks scored 15+ are reviewed regularly by the Executive Risk Management Committee, with scheduled deep-dive reviews of risks within each division scored 12+.

NHS
Wye Valley
NHS Trust

Board Assurance Framework Risks

Ref	Title/summary	Current score	Target score	Committee Oversight
0002	Difficulties in delivering on the Equality, Diversity and Inclusion agenda	9	6	Culture and Inclusion Group
0054	Ability of system to manage flow across the urgent and emergency care pathway	16	8	Finance & Performance Executive
0056	Availability of Capital Funds to meet Trust's Strategic Objectives	12	9	Capital Planning Committee
0058	Clinical and support staff recruitment and retention	12	8	Education and Workforce Committee
0059	Delivery of the Digital Strategy	12	8	Digital Programme Board
0066	Risks to productivity and operational capacity plans and delivery	10	10	Productivity Programme Board
0423	Fragility of the Haematology service at Wye Valley	10	5	Finance & Performance Executive
0756	Fragility of Histopathology Service	8	8	Finance & Performance Executive
0857	Fragility of Medical cover for Stroke pathway	9	3	Finance & Performance Executive
1687	One Herefordshire delivery of responsibilities contained within the MOU	6	6	One Herefordshire Partnership
1688	Delivery of Academic Programme to improve our Research Profile	6	4	Academic Programme Steering Group
1931	Failure to gain system support for agreed Herefordshire Integrated Care Model	9	3	One Herefordshire Partnership
1932	Inability to fund the required resource to achieve maximum functionality of EMIS	9	3	Digital Programme Board
1933	Inability to identify resource to 'left shift' and/or maintain financial flow into Herefordshire	12	3	One Herefordshire Partnership
1934	Risk of reputational damage to Wye Valley NHS Trust in relation to the strength of partnership working arrangements	12	8	Children and Young People's Partnership
1945	Cyber Security	15	10	Digital, Data and Technology (DDAT) Programme Board

High Risks (15+)

Ref	Risk Description	Current score
789	Risk of adverse patient events due to long stay within ED and overcrowding	20
1704	Delivery of Financial Plan and improving underlying position	20
1927	Consultant Respiratory Vacancies	20
1937	Inability to admit patients with a fractured neck of femur to Dinmore ward within the recommended 4 hours	20
255	Decline in function of APEX (including data storage)	16
687	Lack of health psychology for children	16
1762	Replacement of 4 Aseptic Isolators	16
1781	Lack of appropriate Mental health assessment room	16
1873	Inappropriate use of Endoscopy Recovery for inpatients	16
1905	Compliance with NICE Guidance – Sepsis Standards	16
1954	Paediatric Audiology Staffing	16
1992	Risk of harm to patients awaiting discharge to Powys	16
2020	Ongoing CPE outbreak at RCH	16
2025	Delays to Pacemaker patients requiring MRI scans	16
2066	Gilwern Assessment Unit roof leak	16
33	Potential impact on the Quality of Patient Care when placing patients in Temporary Escalation accommodation within Ward Areas	15
1907	Delay in Specialty Reviews	15
1936	Inappropriate use of Gynaecology SDEC	15
2006	Inadequate Governance workforce within Pathology	15
2027	Risk of loss of Joint Advisory Group (JAG) accreditation within endoscopy	15
2091	Loss of continuity in Endoscopy due to ventilation failure	15

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Use of the Trust Seal
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Associate Director of Corporate Governance & Company Secretary
Reporting Route:	N/A
Appendices included with this report:	N/A
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authorities.

The Board is asked to note the use of the Trust Seal.

On 4th February 2025, the Joint Appointment Contract for the Provision of an Asset Condition Survey at Hereford County Hospital between Wye Valley NHS Trust, Mercia Healthcare Limited and Oxhey Hall Consulting Limited was sealed.

In line with the NHS ProCure23 process and the NEC4 Contract the use of the Trust Seal was required.

Recommended Actions required by Board or Committee

The Board is asked to note the use of the Trust Seal as described above.

Executive Director Opinion[1]

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

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Audit Committee Summary Report 21 October 2024
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 Committees held on 21 October 2024.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

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

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

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

Digital

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

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

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

Productivity

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

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

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

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***

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

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

Workforce

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

☒ ***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***

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

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***

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

[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 – 6 March 2025
Summary of Audit Committee (AC) meeting held on 21 Oct 2024

MATTERS FOR PARTICULAR ATTENTION

Internal Audit –

RSM shared three final Internal Audit reports.

Medical/Surgical Junior Doctor's Rota Management resulted in a partial assurance opinion and the actions have been agreed. A working group has been implemented to ensure there is traction behind the actions with oversight by the Chief Medical Officer and Chief People Officer.

Data Quality VTE also resulted in a Partial Assurance opinion and an improvement plan is currently being undertaken however as the CMO was unable to the October meeting it was agreed that a further report would be provided to the next Audit Committee meeting.

Pre-Operative Assessments resulted in a Reasonable Assurance opinion which was a pleasing outcome and an external review had also been undertaken with recommendations linking into productivity improvement, the Finance Recovery Board check and challenge actions and job planning relating to Pre-Op.

Financial Update –

The Associate Chief Finance officer updated the committee on the cash position. The report set out the YTD cash position and forecast for the remainder of the year, if the run rate continues. It also set out the governance process in place to monitor the risk of a deteriorating cash position. It was agreed that a further review of the cash slide within the IPR is undertaken

External Audit provided a brief verbal update on the current position and reported that a de-brief had taken place with both teams identifying areas for focus with more detailed planning in progress.

The Chief Financial Officer presented an update on External Audit Re Procurement as a confidential item to the Non-Executive members of Audit Committee outlining the group wide tender process, timescales and considerations.

Cyber Security & Risk

The Board workshop in February 2024 focused on Cyber Security & Risk with the agreement to then update routinely at Audit Committee to provide appropriate ongoing assurance. Cyber risk is placed on the Board Assurance Framework which covers a potential impact of a Cyber-attack on the Trust. A full update was presented to the committee including the stages of incident response. Feedback from the DSPT gap analysis and data from the continuing improvement report is to be presented at the March 2025 Audit Committee

OTHER MATTERS

Report	Discussion / Recommendation
The ICS Audit Plan	An update was received and noted. It was agreed that WVT AC would try and align where possible and appropriate.
ICS Finance Committee monitoring report	Received and noted
Finance Governance (Financial Recovery Board)	It was suggested that an evaluation on the progress of the FRB is presented in Quarter 4 as the ICS Finance Committee do not receive direct financial reports from the FRB. Finance Recovery Board Plan to be removed from the work plan and an evaluation of effectiveness to be presented at a future Audit Committee for consideration.

Prepared by:-
Nicola Twigg, Chair of Audit Committee

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 February 2025 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. 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.

Russell Hardy	(RH)	Group Chair
Chizo Agwu	(CAg)	Chief Medical Officer WVT
Varadarajan Baskar	(VB)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Chief Clinical Strategy Officer WAHT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Adam Carson	(AC)	Managing Director SWFT
Stephen Collman	(SC)	Managing Director WAHT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Catherine Free	(CF)	Managing Director GEH
Phil Gilbert	(PG)	NED SWFT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Paramjit Gill	(PGi)	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 WAHT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Kim Li	(KLi)	Chief Finance Officer SWFT
Anil Majithia	(AMa)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Grace Quantock	(GQ)	NED WVT
Najam Rashid	(NR)	Chief Medical Officer GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Acting Chief Medical Officer WAHT
Ellie Ward	(EW)	Acting Chief Nursing Officer SWFT
Robert White	(RW)	NED SWFT
Umar Zamman	(UZ)	NED GEH

<u>In attendance</u>:

Adrian Stokes	(AS)	Group Management Consultant
Rebecca Brown	(RBr)	Chief Information Officer WAHT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
John Burnett	(JBu)	Head of Communications WVT

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 February 2025 at 1.30pm via Microsoft Teams

Paul Capener	(PC)	ANED GEH
Oliver Cofler	(OC)	ANED SWFT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Catherine Driscoll	(CDr)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT
Jo Kirwan	(JK)	Deputy Director of Finance WAHT (deputising for Chief Finance Officer WAHT)
Rosie Kneafsey	(RK)	ANED GEH
Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Elva Jordan-Boyd	(EJB)	Interim Chief People Officer SWFT
Kieran Lappin	(KLa)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Sara MacLeod	(SMa)	Interim Chief People Officer GEH
Alex Moran	(AMo)	ANED WAHT
Laura Nelson	(LN)	Chief Integration Officer – Coventry and Warwickshire Integrated Care Board (observing)
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Bharti Patel	(BP)	ANED SWFT
Mary Powell	(MP)	Head of Strategic Communications SWFT
Jackie Richards	(JR)	ANED GEH
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Robin Snead	(RS)	Chief Operating Officer GEH
Vidhya Sumesh	(VS)	Group Business Information Specialist (observing)
James Turner	(JT)	Head of Communications GEH
Sue Whelan Tracy	(SWT)	NED SWFT (non-voting)

Apologies:

Neil Cook	(NC)	Chief Finance Officer WAHT
Julie Houlder	(JH)	NED and Vice Chair GEH
Simone Jordan	(SJ)	NED GEH
Zoe Mayhew	(ZM)	Chief Commissioning Officer (Health and Care) SWFT
Jo Newton	(JN)	Chief Strategy Officer WAHT
Simon Page	(SP)	NED and Vice Chair SWFT
Sarah Raistrick	(SR)	NED GEH
Sue Sinclair	(SSi)	ANED WAHT

There were four SWFT Governors and seven members of the public also in attendance.

MINUTE		**ACTION**
25.001	**DECLARATIONS OF INTEREST** Paul Capener, ANED GEH declared that he no longer had a consulting	

MINUTE		ACTION
	company and now operated self-employed under Paul Capener Governance Services. Grace Quantock, NED WVT declared that she had joined the Judicial Appointments Commission as a panel member. **Resolved – that the position be noted.**	
25.002	**PUBLIC MINUTES OF THE MEETING HELD ON 6 NOVEMBER 2024** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 6 November 2024 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.003	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.003.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.004	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the Foundation Group Boards Workshop, which focused around three key items. Firstly John Drew, Director of Workforce, Training and Education for NHS England (NHSE) gave a talk about the Staff Survey, the Foundation Groups results, and the improvement being seen. The Foundation Group worked heavily on the Staff Survey results to ensure all Trusts are a happy and enjoyable place to work, which in turn would deliver better care to patients. The Group Chair continued that a presentation was then provided on Clinical Safety by Rebecca Brown, Chief Digital Information Officer for WAHT. This was particularly relevant with the development of Artificial Intelligence being seen and the roll out of Electronic Patient Records (EPR) at SWFT and GEH. Finally, the Foundation Group were provided with an update from the Chief People Officers on one of the Foundation Groups 'Big Moves, Be a Very Flexible Employer'. This highlighted how essential it was to retain the most experienced and talented staff, and to do this was to ensure we were enabling a work-life balance. **Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.**	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 February 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
25.005	**FOUNDATION GROUP PERFORMANCE REPORT** The Managing Director for WVT provided an update on WVTs performance. She explained that over the winter period Urgent and Emergency Care (UEC) had been challenged nationally. Despite the challenges WVT were reporting above the national average for the Emergency Department (ED), where half of attendances were being managed on the Same Day Emergency Care (SDEC) pathway. The Managing Director for WVT continued that as at the time of the meeting, WVT had thirty patients in temporary escalation spaces, and twenty patients in ED waiting for beds. This highlighted that despite the work taking place, there was still a way to go, and reducing demand for emergency beds would be a focus for 2025/26. Despite the UEC challenges, WVTs Elective Care Metrics continued to improve, with the Trust ranking near the top regionally for productivity compared to pre-Covid-19. The Managing Director for WVT concluded with an update on Cancer performance highlighting that the 62-day performance had improved within the previous twelve months, and WVT were already on track to beat the 2025/26 targets set. The Managing Director for SWFT started by celebrating that SWFT had been awarded the prestigious Trust of the Year award, at the annual Health Service Journal (HSJ) awards in November 2024. The award highlighted the positive work taking place across the Trust including performance, culture, and improvement but most notably the staff and the hard work they continued to put in every day. The Managing Director for SWFT explained that UEC continued to be a challenge through December 2024, followed by a worse January 2025. This resulted in SWFT calling its first ever Critical Incident at the start of the month. Work had commenced to understand the lack of flow a bit further, however one of the drivers continued to be out of area activity, with SWFT being one of the biggest importers in the West Midlands. The Managing Director explained that between January 2023 and January 2025, the Trust had seen a 99% increase of attendances from Coventry postcodes, a 154% increase in Coventry admissions, a 169% increase in attendances from Rugby and 233% increase in admissions from Rugby. That sets against growth in South Warwickshire to an overall growth of 18%. This wasn't a sustainable position and would be monitored closely moving forward. The Managing Director for SWFT highlighted an improvement in the Faster Diagnosis Standard (FDS) at 84% and thanked the teams involved. There was fragility to be aware of however, especially over the next few months due to the high number of referrals being seen. He concluded by informing the Foundation Group Boards that sickness rates at SWFT had increased slightly over the winter months, but the Trust was being watchful of these and ensuring managers were offering support available. The Managing Director for GEH raised similar concerns regarding winter pressures around UEC to SWFT and WVT. She added that an increase in flu that had also arrived earlier than expected had impacted the increase in demand. The Managing Director for GEH explained that the rise in demand and resulted in the Trust's worst 4hr performance all year. This has been made	

MINUTE		ACTION

worse by bed occupancy and Medically Fit For Discharge (MFFD) sitting at 58 patients, equating to two wards' worth of patients that could be being cared for elsewhere but instead were in acute beds. MFFD patients being in acute beds meant that temporary escalation spaces were being used in the ED. The Managing Director for GEH highlighted that SDEC was at 47% which had continued to increase throughout the year and was the result of GEH heavily investing in SDEC though virtual wards and avoiding admissions where possible. She continued that GEH had managed to protect Elective work activity and the Elective Recovery Fund (ERF) delivery. Waiting lists continued to be an issue with some patients waiting over 64 weeks, however this continued to be a focus area, the Trust was working hard ensure no patients were waiting over 52 weeks. The Managing Director for GEH explained that Cancer performance continued to be a key focus area, as this had dropped mainly driven by an increase of Breast Cancer referrals. She concluded by highlighting that the FDS for GEH had improved, however did fluctuate so Cancer and Diagnostic pathways were being streamlined to remove blockages and bring wait times in line with national standards.

The Managing Director for WAHT provided an overview of 'hat's performance. In line with the other Trusts in the Foundation Group UEC continued to be a challenge, however WAHT had seen a deterioration around the Urgent and Emergency Access Standard and continued to struggle with long ambulance handover delays. He added that discussions with NHSE had taken place to address these issues however it was important to note that these had been impacted by the EPR role out, site work and the significant increase in lfu. The Managing Director for WAHT explained that WAHT had also seen a significant increase in walk-ins.,. Despite the challenges WAHT had seen rapid improvements particularly around ambulance handovers, which had been helped by an Advanced Clinical Practicitioner (ACP) doing a five/ten-minute review of patients on the Worcestershire Royal Hospital site. Patients received an ACP assessment and were pulled through one of the SDEC pathways where appropriate. Whilst improvements were being seen already through SDEC this had grown and acuity had shifted, resulting in a better patient experience. The knock-on of this had been fewer diversions being needed to the Alexandra Hospital. The Managing Director for WAHT highlighted that the Trust's discharge profile was improving with daily discharge targets being hit more regularly and most recently 70-80 discharges on a weekend whereas previously this was around 30-40. He concluded that there was still a way to go with focus shifting to the front door demand management, integration with community services, and the work on frailty and trauma.

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

The Group Chair asked each Managing Director their current MFFD figures which were as follows, WVT 34, SWFT 51, GEH 58 and WAHT 133. He explained that based on those numbers there was over 250 people MFFD in an acute bed. It cost on average £450 to stay in an acute bed, in another care

MINUTE		ACTION
	setting this was around £150, resulting in a NET saving of around £300. This meant in the Foundation Group alone there was over £27mil of NET saving if with system partners' MFFD and flow efficiency were resolved. The Group Chief Executive noted the challenges faced by UEC services and added that the challenges faced by Trusts in terms of demand added to the difficulty in discharging patients. On top of this the challenges added to safety, quality and financial challenges faced by the NHS. The Group Chief Executive therefore took the time to express how impressed he was with how all four Trusts had responded to the challenges faced over the past twelve months. He added that all four Trusts' ambulance delays had been reduced significantly. The Group Chief Executive explained that moving forward The Planning Guidance had been released at the end of January 2025, which would allow the Foundation Group to calculate activity versus price which should show clear productivity focus areas and where the highest demand was. Paul Capener, NED GEH highlighted that not much detail was discussed in relation to outpatients, however this was showing as a problem across the Foundation Group. He sought assurance that there was sufficient focus being given to Outpatients given the national agenda and the push on Referral to Treatment (RTT). The Group Chief Executive responded that it would be a good idea to do a deep dive into this for next time, especially with some of the work taking place to reduce Did Not Attend (DNA) rates and follow ups. Sarah Raistrick, NED GEH queried whether the increase in some of the pressures as a result of Flu had been triangulated with the lower uptake in Flu vaccinations. In particular, had those who had been admitted due to Flu had the vaccine. The Managing Director GEH responded that no, this had not been done, and it was likely to be something discussed at the Quality Committees. However, she encouraged members of the public and colleagues to get vaccinated as it was the best way to protect each other and patients. The Group Medical Advisor requested that perinatal deaths in comparison to national mean also be included in the Foundation Group Performance report moving forward. **Resolved – that** **A) the Foundation Group Performance Report be received and noted;** **B) the Chief Operating Officers to present a deep dive into Outpatients at the next Foundation Group Boards meeting;** **C) the Managing Directors ensure that perinatal deaths in comparison to national mean are included in the Foundation Gorup Performance Report moving forward.**	**COOs** **MDs**
25.006	**DIAGNOSTICS DEEP DIVE** The Chief Operating Officer for SWFT started by explaining that Diagnostics underpinned everything, however demand on Diagnostics services was rising.	

MINUTE		ACTION

Unfortunately, a lack of infrastructure combined with staffing shortages meant waiting lists were growing. She explained that both NICE guidance and the Elective Recovery Plan (ERP) positioned diagnostics at the cornerstone of modern healthcare delivery, and critical tools and accurate clinical decision-making. The ERP underlines diagnostics as pivotal in addressing backlogs and meeting increasing demand.

The Chief Operating Officer for SWFT explained that nationally the number of patients on a waiting list for diagnostic tests and the overall number of tests continued to grow. As a Foundation Group the number of tests carried out had grown, however the waiting lists were more stable. All Trusts had reduced the number of patients waiting over thirteen weeks for a diagnostic test, however this remained a challenge for WAHT. Diagnostics was complicated and was more than just imaging, for example Endoscopy and Physiological Measurement were both important parts of diagnostics that came with their own demands. The challenges faced by each organisation were therefore quite different. For GEH whilst they have an overall stable waiting list, DEXA Scans for over six and thirteen weeks was challenged. SWFT had struggled with Audiology and non-obstetric ultrasound. WAHT Audiology and MRI were challenges. Whilst WVT had fragilities across all diagnostics, they had an overall improvement in waiting times.

The Chief Operating Officer for WAHT continued that whilst all Trusts had managed to reduce backlogs across the Foundation Group, with more tests being carried out and sustaining the waiting list position, reporting turnaround times was a challenge. There was consistent good performance of turnaround times within 4hrs for tests in ED. However urgent inpatient reporting looked low, and cancer pathways within three days for GEH. The Chief Operating Officer for WAHT explained that reporting is a particular challenge but was linked to the increase in demand for diagnostics and there was variation across the Foundation Group in percentages but also how this was being addressed locally within the different organisations. All Trusts were looking at increasing workforce and changing practice around access to diagnostics and report turnaround times. The Chief Operating Officer for WAHT explain that looking at the broader challenges there were clear examples of where best practice could be adopted across the Foundation Group. He continued by celebrating the successes across the Foundation Group particularly around reducing the backlogs overall, and the progress of Community Diagnostic Hubs. The Chief Operating Officer for WAHT concluded by explaining that moving forward we want to look at how each Trust was using resource, and how each Trust was comparing productivity wise and looking at the elective pathways.

The Chief Medical Officer for WVT explained that the Chief Medical Officers across the Foundation Group had picked out three key areas for improving diagnostics, similarly to what had already been presented. The first area was the need to increase workforce, due to many areas having limited specialty skills. She continued that demand was another area. Demand for diagnostics across the different modalities was increasing which would be multifactorial,

MINUTE		ACTION

however it provided the opportunity to share best practice in terms of demand management and ensuring clear pathway criteria for referral. The Chief Medical Officer for WVT explained that the third area was AI and the number of opportunities this provided both in increasing diagnostic accuracy and improving productivity and efficiency. However, it was noted that this did not come without its risks. The Chief Medical Officer at SWFT added that demand was growing and whilst testing had improved and waiting lists were being reasonably managed, that was also under significant cost pressure, and it was the reporting challenges that remained the real issue. The sporadic scarcity of expertise in some locations needed to be addressed.

The Chief Medical Officer for GEH explained that GEH had been trailing AI since December 2024, which showed an improvement in productivity and some quality. The GEH Urgent Treatment Centres were on the edge of the department and clinicians were having to get right the way across the other side of the hospital to find a consultant to report on a diagnostics test. Through the use of AI GEH had managed to cut that out and had already seen that they were able to report much quicker. The reports were then reviewed by a Consultant the following day and so far, they had not found any sort of risk or anything significant missed.

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

The Group Medical Advisor advised that there was a lot of work taking place with the West Midlands Imaging Network who could support this work and resolve some of the issues.

The Group Chair thanked the Chief Operating Officers and Chief Medical Officers for their presentation. He agreed with the Chief Medical Officers that AI seemed an incredibly exciting development, especially for fragile services and driving productivity.

The Group Chief Executive informed the Foundation Group Boards that he had asked the Group Medical Advisor to convene a forum, particularly in Radiology, with the Clinical and Operational Leads to initiate conversations around resolving these issues. That forum wouldn't necessarily be able to solve all the issues however it would provide good opportunities for leadership to emerge and move things forward. He added that one of things that needs to be looked into was a common reporting platform and that would be something that the West Midlands Imaging Network could help with. The other area to think about was Histopathology, and through digitalisation would improve productivity and provide a way to manage capacity across the Foundation Group. It would also allow individuals to sub-specialise which is a good way to recruit and retain Consultants.

Resolved – that the Diagnostics Deep Dive be received and noted.

MINUTE		ACTION
25.007	**EMERGENCY DEPARTMENT BENCHMARKING** The Chief Operating Officer for WVT presented the ED Benchmarking report to the Foundation Group Boards. He provided the initial background for the piece of work which had been requested by the Group Chief Executive around increased funding and whether that could be used for admission avoidance and increased discharging. It was important to note that this was ongoing and would continue to progress. The Chief Operating Officer for WVT explained that all EDs within the Foundation Group had faced particularly challenged winters from Flu, RSV, Covid-19, attendances and admissions. However, this was no longer something being faced just during winter months but instead had become a year-round pressure which was increasing year on year. Pressures in the ED were often an indicator of a wider issue across Trusts, systems and Health and Social Care. To address the issues various methods and work streams had been put in place to address ED congestion whether that was virtual wards, Urgent Community Response teams, empowering neighbourhood teams or working with local authorities around discharge management. On top of this internal schemes had been put in place to address flow, length of stay as well as improving ED practices. The Chief Operating Officer for WVT continued that often the additional measures put in place to support ED because of congestion and to maintain patient safety, results in additional staffing and opening surge areas inside or outside of ED. He explained that this piece of work was about understanding the current states of our EDs, productivity and where we could share learning to improve pathways. The Chief Operating Officer for WVT explained that in order to measure and compare EDs in a uniform way the Chief Operating Officers and Chief Finance Officer had looked at Model Hospital which collected data in the same way for all Trusts. This provided detail on how all EDs and UEC pathways performed and how each ED across the group was unique. The Chief Operating Officer for WVT noted that it also provided detail on productivity, but this need further reviewing but would help locate areas of inquisitive behaviour and where improvements in contrast to other EDs could be made. He concluded that all EDs were increasingly congested and struggling to get to pre-Covid-19 levels of 4hr Emergency Access Standard (EAS). Each of the EDs across the Foundation Group were different in their specific challenges, however all had differing solutions and resources to address their respective challenges. The Chief Finance Officer for WVT presented the financial analysis specifically looking at EDs and built on some of the work already standardised in review of the cost per weighted activity. She took the time to thank the Finance Teams across the Foundation Group for working closely together to align methodology to allow cross comparison. The Chief Finance Officer for WVT explained that the analysis had helped identify the resources that were utilised in ED relative to workforce levels, volumes of patients and the time that patients were spending in each department. Broadly the data did triangulate with the	

MINUTE		ACTION

performance metrics, meaning increases in demand were driving an increased use of resources, often at premium rates. The Chief Finance Officer for WVT continued that that additional costs were needed to safely manage congestion through the UEC pathways. However this was often done in a reactive way to demand pressures, which was what drives the premium in cost base. She explained that the increase in spend wasn't just seen in EDs but was seen through the pathway including how to utilise and staff temporary escalation spaces. The Chief Finance Officer for WVT concluded that moving forward it was important to use the early intelligence and benchmarking to better understand the drivers of variation throughout the UEC pathway. In particular in the EDs, and how that could be converted into opportunities to better utilise resources.

The Chief Operating Officer for WVT explained the next steps and actions. There was still a lot of work that needed doing in relation to ED productivity and efficiency including to understand the cost differences. To enable decongestion of EDs and improve cost per unit it was important to look at the workforce models across the Foundation Group and what learning could be shared. Another key factor would be managing temporary escalation spaces, developing the Urgent Community Response teams and Virtual Wards.

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

The Group Chief Executive reassured members of the public that ambulances waiting outside ED departments did not mean patients had not been seen. They would have been reviewed on arrival and usually waiting to be admitted into hospital. One of the best ways to address the issue would be to have the NHS come to them if they were in a care home, or through call before convey which would allow consultants to advise on the best possible service. Often this allowed patients to go straight to SDEC or Frailty, avoiding a long wait in ED.

Karen Martin, NED WAHT, queried why the Alexandra Hospital was an outlier in regard to age profile. The Chief Operating Officer for WAHT explained that this was partly driven by the pathway for paediatric patients, with paediatric centralised mostly through the Worcestershire Royal Hospital. The Managing Director for WAHT added that it was also in part due to pathway changes. A lot of acute pathways are managed through Worcestershire Royal Hospital, and the lower acuity patients will be diverted up to the Alexandra Hospital.

The Group Chair queried what the ambulance pit-stop model with the ACP review was indicating in terms of patients who didn't need to be in an ambulance. The Chief Nursing Officer for WAHT responded that this was looking at around 35-45%.

The Vice Chair for WVT recommended at a future Foundation Group Boards meeting the work on ED wait times be triangulated in relation to mortality and morbidity.

MINUTE		ACTION
	Resolved – that **A) the Emergency Department Benchmarking be received and noted;** **B) the Chief Operating Officers and Chief Medical Officers look into ED wait times and their relation to mortality and morbidity.**	**COOs/ CMOs**
25.008	**EQUALITY, DIVERSITY AND INCLUSION (EDI) UPDATE** The Chief People Officer for WVT started by informing the Foundation Group Boards that it was important to note when EDI was referred to it all came down to the staff experience. This was evident when you look at the performance measures for EDI, which were all geared towards enhancing the employee experience, therefore by attaining EDI goals the Foundation Group was creating a psychologically safe and compassionate working environment. The Chief People Officer for WVT continued that there were ten key areas in the NHS Constitution that addressed reducing health inequalities, these aligned with the Foundation Groups strategic priorities. He added that when compared to the NHS Constitution it was clear the Foundation Group was acting as an anchor organisation for health inequalities. The Chief People Officer for WVT informed the Foundation Group Boards that in 2024 the NHS brought into effect six High Impact Actions to show progress made to address prejudice and discrimination within the health service. These actions were as follows: 1) Chief Executive's Chairs and Board members should put EDI objectives in place that they are personally responsible for. 2) Employ and develop staff in a fair and inclusive way and target groups that are under-represented in the organisation. 3) Write and put and improvement plan in place to end pay gaps. 4) Write and put an improvement plan in place that deals with health inequality in the workforce. 5) Set up a detailed programme for NHS staff recruited countries outside the UK. 6) Create a workplace that ends bullying, discrimination, harassment, and physical violence at work. The Chief People Officer for WVT provided an overview of the Annual Staff Survey results, which showed all four organisations taking the right steps to address EDI requirements from the people promise. He continued that each Trust also had programmes in place to address the High Impact Actions and had created a dashboard to establish the position against each action, with some areas that still needed focus, particularly around action six now that the Sexual Safety Charter was in place. The Group Chair invited questions and perspectives and of particular note were the following points. Sue Whelan Tracy, NED SWFT thanked the Chief People Officers for their presentation. She highlighted that it was key with EDI to build managers' confidence to be able listen to the complex and difficult situations and to act on	

MINUTE		ACTION
	them appropriately. She queried whether training to support this had been rolled out, specifically at SWFT. The Interim Chief People Officer for SWFT offered assurance that this was being looked at, and recently a new learning management system had been developed to try and ensure the relevant packages could be accessible. **Resolved – that the Equality, Diversity and Inclusion Update be received and noted.**	
25.009	**FOUNDATION GROUP BOARDS SCHEDULE OF BUSINESS FOR APPROVAL** The Foundation Group Boards Schedule of Business for 2025/26 was approved and ratified. **Resolved – that the Foundation Group Boards Schedule of Business be approved and ratified.**	
25.010	**ANNUAL REVIEW OF BOARD COMMITTEE TERMS OF REFERENCE** The Trust Secretary for GEH/SWFT presented the Board Committee Terms of Reference to the Foundation Group Boards. This included Audit Committees, Appointments and Remuneration Committees, and the Foundation Group Strategy Committee. The report included an update on the Charity Trustees Terms of Reference which would go through individual Charity Trustees for approval. There was also an update on the Quality Committees Terms of Reference which would go through individual Quality Committees and then onto individual Trust Board meetings for approval. The Associate Director of Corporate Governance/Company Secretary for WHAT/WVT added that the Audit Committee Terms of Reference changes had been made to align more closely with the Code of Governance. **Resolved – that the Annual review of Board Committee Terms of Reference be approved and ratified.**	
25.011	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING ON THE 17 DECEMBER 2024** The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting that took place on the 17 December 2024. **Resolved – that the Foundation Group Strategy Committee Report from the meeting held on 17 December 2024 be received and noted.**	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 February 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
25.012	**ANY OTHER BUSINESS**	
25.012.01	Chair's Remarks The Group Chair advised the Foundation Group Boards that Sue Whelan Tracy, NED SWFT and Simon Page, Vice Chair SWFT would be standing down as NEDs on the 8 February 2025 as their term came to an end. He took the time to thank them for their commitment over the years and wished them well in their future endeavours. **Resolved – that the position be noted.**	
25.013	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
25.013.01	Question from a Member of the Public The following question was submitted by a member of the public in advance of the meeting: *'Do any of the hospitals in the Foundation Group allow members of staff who are trans-identifying men (i.e. biological males), to use the women's (biological females), changing rooms and toilets? If so, which hospitals in the Foundation Group allow this?'* The Group Chair advised that the Foundation Group greatly valued people of different races, different sexual orientations and different beliefs. All are treated with respect and kindness and staff were encouraged to use whichever facility best reflected their gender. He concluded that this would continue to be the Foundation Groups position, and with new builds taking place gender neutral bathrooms would start to be introduced. **Resolved – that the position be noted.**	
25.013.02	Question from a Member of the Public The following question was submitted by a member of the public in advance of the meeting: *'Will the Board engage in talks with Worcestershire Country Council to consider the possibility of the NHS purchasing the land at the County Hall estate currently used as a car park, to be used by visitors to Worcestershire Royal Hospital, thus easing parking problems at the hospital?''* The Managing Director for WAHT informed the Foundation Group Boards that there were several discussions taking place with partners to try and resolve the car parking issues faced at Worcestershire Royal Hospital. The conversations were confidential so detail could not currently be shared but the Managing Director offered assurance that he would keep the Foundation Group Boards	

MINUTE		ACTION
	and public up to date as things moved forward. The Group Chairman added that he symphonised with the public regarding car parking and assured them that it was a subject that continued to be a focus for the entire WAHT Board. **Resolved – that the position be noted.**	
25.014	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.015	**CONFIDENTIAL APOLOGIES FOR ABSENCE**	
25.016	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.017	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 6 NOVEMBER 2024**	
25.018	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.019	**APPOINTMENT OF EXTERNAL AUDITORS**	
25.020	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 16 JULY 2024**	
25.021	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.022	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chair) Date: 7 May 2025
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 MAY 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
25.005 (05.02.2025) Foundation Group Performance Report	The Chief Operating Officers present a deep dive into Outpatients at the next Foundation Group Boards meeting. The Managing Directors ensure that perinatal deaths in comparison to national mean are included in the Foundation Group Performance Report moving forward.	H Heran / A Parker / R Snead / C Douglas A Carson / J Ives / S Collman / C Free	
25.007 (05.02.2025) Emergency Department Benchmarking	The Chief Operating Officers and Chief Medical Officers look into ED wait times and their relation to mortality and morbidity.	H Heran / A Parker / R Snead / C Douglas / N Rashid / V Baskar / J Walton / C Agwu	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

Report to:	**Public Board**
Date of Meeting:	**6 March 2025**
Title of Report:	Charity Trustee Summary Report 19 September 2024
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	
Lead Executive Director:	Select Director
Author:	Grace Quantock, CT Chair
Documents covered by this report:	

1. Purpose of the report

To brief the Board on the main issues arising from the Charity Trustee held on 19 September 2024.

2. Recommendation(s)

To receive the Report.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

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

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

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

Digital

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

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

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

Productivity

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

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

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

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***

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

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

Workforce

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

☐ ***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***

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

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***

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

[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.

Charitable Funds Committee Report
September 19, 2024

Matters for Noting

1. Maternity Bereavement Fund: The Committee received an update on the Maternity Bereavement Fund. The Garden project is underway and will be completed in time for Baby Loss Awareness Week (BLAW) from October 9-15. Several internal fundraising events are planned during the week.

2. Charitable Funds Governance: The Fundraiser has worked with Finance colleagues to rewrite and produce updated charitable funds guidance and make changes to the way charitable bids are made. An updated e-form has gone live with accompanying guidance to ensure applications provide a full explanation of how expenditure meets requirements. The charity currently has low reserves and a pause on general purpose spending, necessitating lateral thinking in assisting staff with purchases and plans.

3. Community Fundraising: The charity continues to receive support through third-party events. The focus remains on maintaining third-party relationships to support events rather than managing large-scale events internally. Being a single person fundraising function, for many years it has been necessary to encourage and maintain these third-party relationships to support their events rather than organizing large-scale events internally.

4. Education Centre Fundraising: The Fundraising Campaign Director (FCD) continues to network with businesses across Herefordshire and attends monthly networking events and meetings. Invitations to the Chairman's Lunch have been distributed, with confirmed attendance from the Herefordshire Mayor and High Sheriff on October 17th. A film describing the need for a bespoke Education Centre is being redeveloped for the Chairman's Lunch.

5. Financial Report (Q1 2024/25): At the end of June 2024, the value of funds held was £2.4m, with £1.5m in restricted funds and £0.9m unrestricted. The largest unrestricted fund is the education centre at £0.6m prior to commitments. Investment income in Q1 totalled £27k, reflecting the benefits of the enacted treasury management policy.

6. Staff Wellbeing and Volunteer Expansion Funding: The Committee agreed to fund committed posts until the end of March 2025 only. This involves a 2% top slice from the Education Centre fund and a 5% top slice from all other unrestricted funds, with the remainder covered by investment income received in Q1, forecasted for Q2, and a small amount of the forecast income for October.

7. Draft Annual Accounts 2023/24: The draft accounts for the financial year ending 31st March 2024 were presented. With income for the year being £0.5m, it remains under the £1m threshold where a full external audit would be required. R&D Accounting is undertaking the external examination of the accounts, and the process remains on track for the Trustee to review the final examined accounts in November.

8. Charity Ball Proposal: The Committee discussed the proposal for holding a charity ball. While the Trust will need to commit a proportion of the total cost upfront to secure bookings, this will be recouped by ticket sales. The Committee decided to agree on amounts outside the meeting and accept the offer of support and knowledge from Associate NED Ellie Bulmer's experience in running charity galas.

9. Fundraising Strategy: The Committee reviewed the draft of the new Fundraising Strategy, which offers a broad brush approach to the charity and fundraising efforts. While feedback was generally positive, more work is needed on branding aspects.

10. Fundraising Campaign Director Role: The Committee decided to extend the Fundraising Campaign Director role, with the review date to be agreed offline, considering that Ali Bolton was seconded elsewhere in WVT for part of the year and the Education Centre fundraising is now beginning in earnest.

Matters for Escalation

None.

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Integrated Care Executive Escalation and Assurance Report
Status of report:	**☐Approval ☐Position statement ☒Information ☐Discussion**
Report Approval Route:	Click or tap here to enter text.
Lead Executive Director:	Select Director
Author:	Gwenny Scott, Associate Director of Corporate Governance
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 Integrated Care Executive held on 14 January 2025.

2. Recommendation(s)

To receive the report.

3. Executive Director Opinion[1]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

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

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Escalation and Assurance Report

Report from: Integrated Care Executive
Date of meeting: 14 January 2025
Report to: Wye Valley NHS Trust Board and One Herefordshire Partnership

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Better Care Fund**
Rating rationale	The overall year to date position at month 9 had deteriorated, with a forecast overspend of £304k. The key driver of this was discharge funding, some of which was offset by underspend in other areas, including staff vacancies. No improvements in capacity or reductions in length of stay had been seen at LICU, Hillside or Home First resulting in continued spot purchasing elsewhere. An overspend was forecast at Hillside due to use of agency staff to cover vacancies, despite under-delivery of activity. Short term care home beds were overspent against plan. Home First was forecasting an underspend due to staff vacancies. Next year there would be more pressure, particularly on discharge, following the annual financial settlement for the region, which was lower than the predicted increase in cost of care. A bold plan was required for 2025/26, taking into account financial and demand related risks.
Outcome	The financial position would be escalated to the Wye Valley Trust Board and One Herefordshire Partnership

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Urgent Community Response (UCR)**
Rating rationale	Performance had dropped in November but had increased over the last 12 months and Community Referral Hub (CRH) referrals were high in December. The role of the CRH, the UCR and Virtual Wards was being promoted with ED clinicians; more promotion was needed in care homes. Call Before Convey was growing following engagement with WMAS. The service was now better able to prioritise and monitor calls to the CRH. Changes to the Virtual Ward and GP processes were progressing well. Regarding IVOPAT, there were concerns about consultant oversight for each speciality; a task and finish group had overseen development of mitigations.
Outcome	The Committee was assured by progress.
Item/Topic	**Discharge to Assess**
Rating rationale	Overall there had been good progress, particularly in pathway 1 where there was sustained improvement but there was more to do on pathway 2. There was a slight improvement in LICU occupancy but it remained a particular concern. Medically Fit for Discharge delays deteriorated in October but then improved again. Discharge to Powys remained an issue, representing a high proportion of all discharge delays; engagement with partners in Powys continued. The number of patients still at home 91 days after discharge from Home First had improved, indicating people were receiving the right therapies Hillside and LICU occupancy levels were a concern as above, both operationally and contractually/financially; work was in progress to seek solutions with partners. Quality outcomes continued to improve but recruitment was a challenge.
Outcome	The Committee was assured by the progress demonstrated.

Advise: Items received for information or approval	
Item/Topic	**Enhanced health in care homes**
Summary	Early analysis of data (from WVT) on care home admissions to ED indicated a higher conversion rate to admission compared to total ED admissions and a greater rate of readmissions. Data from Frailty SDEC and presenting complaint data would also be added to the analysis to provide greater insight.
Outcome	While further data refinement, analysis and presentation were required, the early data analysis was promising in helping to provide a deeper understanding of issues.

Assurance Rating Key	
Red	There are significant gaps in assurance and the Committee is not assured of the adequacy of action plans.
Amber	There are gaps in assurance but the Committee is assured that appropriate plans are in place.
Green	The Committee was assured that there are no gaps in assurance.

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Quality Committee 31 October 2024 Minutes and Escalation Report
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Chair Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and QC Chair
Documents covered by this report:	Quality Committee Minutes October 2024

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]

N/A

[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 2024/25 Objectives the report relates to:

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Workforce

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

☐ ***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***

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

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***

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

Matters for Noting

1. **Safeguarding Quarterly Reports**

   Adults – Committee welcomed the good progress raising the profile of domestic abuse and widening the opportunities for people to seek help. Committee was concerned that progress embedding MCA and DoLS processes is still slow; also that related issues have been picked up in safeguarding and domestic homicide reviews. This will be scrutinised further in the next safeguarding update. Committee supported the work being done on gender identity to ensure the Trust is responding in a personalised and inclusive way

   Children - Committee focussed on supervision rates for staff and noted concerns regarding Health Visitor supervision rates and will keep this under review. Committee welcomed the focus on safer recruitment – ensuring that selection panels include at least 1 member with safer recruitment training.

   Look After Children – Following recent focus on dental care for LAC, Committee was assured that all children can access dental care when requested but do not always receive routine checks which is a concern. Committee expressed its thanks to the Named Nurse for LAC following an email from Herefordshire Council expressing their thanks for her hard work.

2. **Quality Priority – VTE Risk Assessments** – Committee expressed some frustration at the rate of progress but acknowledged the efforts being made to improve education, processes, reporting and data validation; also the work to ensure learning from best practice elsewhere.

3. **Mortality Report** – Committee noted the continued good performance of the SHMI indicator and noted that the next few months' figures will be impacted by removal of SDEC data which will take time to feed through into comparative data.

4. **Quality Priority – Timely Administration of Critical Medications** – Committee received a deep dive which allowed focus on wards and community hospitals where performance is variable. Progress is continuing but is slower than anticipated.

5. **Boarding Report** – We continue to see high numbers of boarded patients and Committee welcomed the appointment of a Flow Co-ordinator and the agreement to move the Discharge Lounge to improve accessibility and the quality of the environment.

6. **Divisional Report – Surgical Division** – Committee welcomed the focus in the divisional report on quality priorities, particularly VTE where there are opportunities to improve performance as part of pre-op, and complaints where the new "PSRF" approach has been used to address issues raised in gynaecology and in urology. There are quality issues with the environment in the new temporary Primrose Ward and work is being done to improve daylight and toilet access.

7. **Perinatal Safety Report** – Committee reviewed a number of documents covering compliance with the CNST standards and the anticipation is that we will be able to demonstrate compliance with all 10. Committee also noted the plans to ensure compliance with the national standards for our neonatal workforce.

8. **In-Patient Survey Results** – Quality Committee received a summary of the survey results which, while broadly in line with the previous year, showed notably positive scores around staffing – kindness, compassion, dignity and respect and around the Virtual Wards. Food continues to be an area where we need to improve. Actions will be worked up as the focus for the divisions.

9. **Quality Engagement Visits Update** – The joint visits to services by an Exec and a Non-Exec have been in place for 6 months and this was an opportunity for Committee to reflect on the process. Committee agreed that the initiative has been positive both for services and for Board members taking part. There is a need to ensure an effective feedback-loop to pick up and report back on issues; at the same time the whole process needs to be light-touch in terms of governance.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 31 October 2024 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 (CMO)
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Sharon Hill	SH	Non-Executive Director (NED)
Rachael Hebbert	RH	Associate Director Nursing (ADN)
Jane Ives	JI	Managing Director (MD)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Grace Quantock	GQ	Non-Executive Director (NED)
Jo Rouse	JR	Associate Non-Executive Director (ANED) – Left at 2.30pm
In attendance:		
Lynn Carpenter	LC	Quality and Safety Matron
Kirsty Gardiner	KG	Named Nurse, Children in Care
Rebecca Haywood-Tibbetts	RH-T	ICB Deputy Named Nurse, Adult Safeguarding - for item 6
Leah Hughes	LH	Operational Clinical Lead Radiography
Tony McConkey	TMcC	Clinical Director Pharmacy (CDP)
Cathy McInerney	CMcI	Patient Safety Lead, NHS Herefordshire and Worcestershire ICB
Vicky Morris	VM	ICB Non-Executive Member, Herefordshire and Worcestershire ICB
Sue Moody	SM	Associate Chief AHP, Integrated Care Division (ACAHP)
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer (DCMO) - for items 7 and 8
Vicky Roberts	VR	Executive Assistant (for the minutes)
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division (ACNO)
Amie Symes	AS	Associate Director Midwifery (ADM)
Emma Wales	EW	Associate Chief Medical Officer (ACMO), Medical Division

QC01/10.24	**APOLOGIES FOR ABSENCE**	
	Dan Harding (Associate Chief Operating Officer Medical Division), Helen Harris (Integrated Care Boards (ICB) Representative), Natasha Owen (Associate Director of Quality Governance), Nicola Twigg (Non-Executive Director).	
QC02/10.24	**QUORUM**	
	The meeting was quorate.	
QC03/10.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC04/10.24	**MINUTES OF THE MEETING HELD ON 26 September 2024**	
	Resolved – that the minutes of the meeting held on 26 September 2024 be received and approved.	

QC05/10-.24	**ACTION LOG AND MATTERS ARISING**	
	The actions were reviewed and updated: QC006 – Priority Patient Moves, capture of data on Dementia. Confirmed that diagnosis can be recorded and will be included in boarding report from November. Action closed. QC13/09.24 - Tissue viability City Team to perform a relative comparison – Will be presented in next divisional report QC17/08.24 - Data sets to be listed on EPMA – It is confirmed that have been included and a meeting has taken place including Antimicrobial pharmacist and microbiology to review antibiotic consumption and data sets. QC18/09.24 – Requirements for fixing faulty call bells. – This is confirmed as 2 hours response time for both Community and Estates. Action closed. CQ20/09.24 - Respiratory issue – The report will be submitted in due course. Carry forward There were no further matters arsing.	
	Resolved – that: the Action Log be received and updated.	
	BUSINESS SECTION	
QC06/10.24	**SAFEGUARDING REPORTS QUARTER 1 2024/25**	
	The ADN gave update on both adult and children's safeguarding including children looked after. The reports were taken as read and the following points highlighted. 6.1 Adult Safeguarding Good progress has been made with policies. Domestic abuse and adult safeguarding *are* in the approval process. Still in the process of developing the screening questions in ED for domestic abuse. However, an initiative has been launched placing Domestic Abuse notes in urine packs in ED, Gynaecology and Maternity which is working well. Renewal of level 3 training is due for a number of staff but there are no concerns around training generally. Embedding of mental capacity act in clinical practice. Have done audits and training and there are some areas of concern in some adult safeguarding and domestic homicide reviews. Work is in progress and with additional capacity in the team, will be able to look more proactively at this. This was noted at peer review visits and is on the risk register.	

	Some concerns re gender identity have been escalated through the Overarching Safeguarding Committee re caring for patients re gender identity. These are largely, but not exclusively children and young people's concerns around bathroom facilities, areas in which they are cared for and aspects of labelling. Need to ensure that all policies are mindful and may need some proactive work to be carried out around that. ICS training has been done around identity issues but need to ensure it forms part of all policies. The volume of safeguarding and domestic homicide reviews has increased and this was raised as a concern at Herefordshire Safeguarding Adult Board. Assurance has been provided that all SARS and DHRs meet the appropriate threshold but the Board made a decision to look at a way in which to approach these reviews and processes and have introduced an extra triage system. Grace Quantock (NED) referred to the point on gender identity and added that midwifery staff had received training around LGBT families and offered support with this work. It was agreed to follow this up outside the meeting. **ACTION** The Committee agreed that this needed to be dealt with sensitively, treating individuals with respect and delivering a personalised service but to also look at the practical implications and find the right way forward in line with people's needs and wishes. Sharon Hill (NED) expressed concern around embedding of the mental capacity act the slow progress. Questioned if the plan is effective and asked how it has progressed in the Foundation Group. It was confirmed that the MCA and DOLS Practitioner works in liaison with ICS colleagues. But until very recently had not capacity to work on the proposed actions. Training feedback has been good yet still not embedded. It is in progress but is a common theme. The CNO has spoken to other Chief Nurses across the region and confirmed that it is a common issue. It was also noted that in the past medical colleagues had benefitted from legal training around the correct implementation of the mental capacity act and this may want to be explored as a future opportunity. The Chair requested further detail from safeguarding and domestic homicide reviews regarding MCA DOLS and to be provided in the next report in February 2025. **ACTION** The Chair noted the positive progress which had been seen with the Lead for Domestic Abuse in post for one year and that the next thing was to look at a structured training plan for how this is going to be embedded. <u>6.2 Children's Safeguarding</u> School Nurse supervision rates have improved to 80%.	**RH/GQ** **RH**

	Training compliance remains high. However, there is some concern about the decrease in the number of children subject to a protection plan, which is being monitored. Also of concern is Health Visitor attendance at supervision which has decreased. A plan is in place to address this. The recent Section 11 audit identified some required improvements. Will need to do a self-assessment of safeguarding for NHSE and need to report about safer recruitment training. Training is available but need to be assured that at least one member of each recruitment panel has undergone safer recruitment training. <u>6.3 Looked After Children</u> The Named Nurse, Children in Care highlighted the following points: A band 4 administrator has been recruited and the vacant band 3 Administrator post is also to be recruited as part of the restructure plan. The number of children who had health assessments has remained at 77%. Initial health assessments continue to be a challenge regarding medical consents. The number of children taken into care has been variable month to month. A Task and Finish group continues to work closely to make sure the health element is embedded in children's practice. No children have been refused a dental examination when requested and now have a process in place and guidance on how often children need to be seen. There has been a rise in safeguarding attendance and continue to have a large percentage of children requiring statutory health assessments and health input. It was noted that the committee have been assured that looked after children receive dental treatment when it is needed but do not always receive routine check- ups and anything that can be done to advance this would be welcome. It was also noted that ICB are keen to focus on areas of highest need and there may be an opportunity for investment in services for looked after children. There has been a rise in safeguarding meetings attendance and continue to have large percentage of children requiring statutory visits. The Chair asked about the reason for the drop in the number of looked after children. This was due to a large number of children turned 18 and therefore were no longer looked after. Also 16 children had been granted adoption orders since August. Early help also prevents children coming into care.	

	The CNO read an email which had been received for the Local Authority expressing thanks for the hard work of the Named Nurse for Children in Care and the Committee also expressed their thanks.	
	Resolved – that: **A. The safeguarding reports were received and noted.** **B. Grace Quantock offered support with gender navigation work was agreed to follow this up outside the meeting** **C. further detail from safeguarding and domestic homicide reviews regarding MCA DOLS and to be provided in the next report in February 2025**	**RH/GQ** **RH**
QC07/10.24	**QUALITY PRIORTY – ENSURE PATIENTS RECEIVE A TIMELY VTE RISK ASSESSMENT IN LINE WITH NICE GUIDELINES**	
	The DCMO gave an update on current VTE risk assessment compliance, rates of hospital acquired VTE and improvement work. The improvement plan is continuing, There has been a lot of education and improvement of awareness amongst staff. Power BI is helping to identify areas needing improvement. There will be some further mapping of the elective and surgical pathways. Improvement is starting to be seen in medical due to changes in the clerking document. The reporting logic template has been agreed and further information on performance will be given in the next report. Internal audit report by RSM has been received and have a policy, are focussed on improvement and a plan to move forward with the Thrombosis Committee. Some gaps in documentation and how reporting lines are structured have been identified and require further work. The Chair noted that the RSM report had been to Audit Committee and, other than things already known about had pointed out some process issues and that it was helpful to have that piece of work completed. The DCMO is working on validation of data and has met with the information team to ensure that all areas included in the data are the correct ones. There was some frustration around the slow progress being made. However, It is acknowledged that progress is slow but that NICE need to provide clearer guidance over what is included in each category which is causing confusion. Conversations have taken place with colleagues at George Eliot, Sheffield and London and are satisfied that have a national view. It is also noted that we have good reporting ability through electronic records.	

	The CMO also added that there are also some cultural issues and that some clinicians thought it is more important to prescribe prophylaxis than to perform a risk assessment. Education is ongoing and work to align EPMA to the risk assessment which will be taken to Trust Board in November. Fresh data of VTE re-admission rates had not been received at this time but that this is where we want to see the difference. Improvements are being seen on power BI with what people doing at ward level and also far more regular compliance rates on key areas.	
	<u>Resolved</u> that – the update on this quality priority was received and noted.	
QC08/10.24	**<u>QUALITY PRIORTY – IMPLEMENTING NATSIPS II STANDARDS</u>**	
	The DCMO gave an update on the progress made on improvement of this quality priority. Information has been shared with other members of the Foundation Group and a national group based at Imperial Hospital regarding progress with NatSSIPS II To implement this quality priority 'stages' have been created with a proposed timeline for each stage. The NatSSIPs II working group will oversee the project and its implementation. The working group will report to the Patient Safety Committee The features drawn from national group show that we are not behind, and, in some aspects further ahead. We will continue to join with other sites to see how they are adopting NatSSIPS II. The report notes that SWFT are presenting a paper to their Quality Committee proposing not to fully implement NatSSIPS II. It was noted that there were advantages across the group of doing the same thing but that there were differing positions from site to site, some having not fully implemented the first iteration of NatSSIPS and some not having made a full move to an electronic system.	
	<u>Resolved</u> – that the update on this quality priority was received and noted.	

QC09/10.24	**MORTALITY REPORT**	
	The CMO presented the mortality report. 12 month rolling SHMI to April is at 98. Data is now available to June which shows it has increased to 100. As SDEC data has been removed there is an expectation for SHMI to continue to increase until rebasing takes place but will be looking deeper into the figures to fully understand. To note that all hospitals are required remove SDEC data by July. A positive month for key outlier groups, both #NOF and sepsis have fallen. The first NOF workshop to mark the current state has taken place, which was well attended. The second workshop is scheduled to take place on 8th November and will agree the new pathway. There has been good stakeholder involvement and are pleased with the progress being made. Need to achieve timely admission of patients with #NOF to the ward base to receive specialist care. 10 patients have recently died out of hospital from hospital acquired pneumonia. A deep dive will take place into the community to understand this further. The Learning from Deaths committee continues to go well. Individual cases of perinatal mortality have been reviewed. An audit of sepsis will be taking place and will be reported to Deteriorating Patient Committee. Medical Examiner scrutiny of community deaths has gone well and rolled out to all PCNs and GP practices. Mortality module on In-Phase won an industry award for the ability for medical examiners to be able to assure the next of kin of the process. The MD asked about the rise in the number of strokes. The first 6 months had not raised any issues in care and a meeting with Public Health showed a health issue in the community. A further meeting will take place to review the second half. Also to be noted that there had been a drop in the percentage of patients thrombolised in August.	
	Resolved – that the Mortality Report was received and noted.	
QC10/10.24	**QUALITY PRIORITY – FULLY IMPLEMENT THE GET IT ON TIME CAMPAIGN FOR PARKINSONS MEDICATIONS. IMPLEMENT QUALITY IMPROVEMENT PROJECT TO TARGET HIGH RISK TIME CRITICAL MEDICATION**	
	The CDP gave an update on this quality priority and presented the data from August.	

	This priority is focussed on the get it on time initiative for Parkinsons drugs and would also like it to extend to insulin in the future. Self-medication results from patient survey 2023. Started the initiative 2023-24 and results from 2023 improved from the 2022 position when patients bring their own medications are allowed to self-medicate. WVT are ranking second in foundation group. 80% patients received their medication on time, 12% within 30-60 minutes of due time, 5% administered within 60-120 minutes of due time, 2% administered over 120 minutes of due time and 1% were missed doses. During August there were 9 missed doses affecting 6 patients over 4 wards. Some missed doses were due to medication not being available and are reviewing the stock list to ensure available on frailty block. Continue with reminders to ward staff to prescribe Parkinson's medicines within 30 minutes of the prescribed time and are seeing more incidences reported through InPhase. We are working with staff to make sure that if there are missed or deferring doses, the reason is added. Self-administration - The upgrade to improve EPMA has been delayed and have a plan for a work around. There is specific work being done at Ross Community Hospital and Garway Ward as they have the most administration issues around Parkinsons. The Chair noted that this had been difficult and had seen some improvement, though not as much as had been wanted and it was helpful to have deep dive analysis. It was suggested that some form of visual aid, e.g. coloured wrist band, may be a prompt for staff. A lot had been done in the past for this, including pill timers. Also a lot of wards write medication times on whiteboards next to the bed. Grace Quantock (NED) noted that there have been issues with administration of insulin and it was agreed for a discussion to take place outside the meeting to discuss this. **ACTION** The ACMO added that the Impact of delayed dose varies depending on stage of Parkinson's disease and it is suspected that aspect is not looked at in the figures available.	**TMC/GQ**
	<u>Resolved</u> – that: **A. The quality priority update was received and noted** **B. A discussion would take place around issues with the administration of insulin for in-patients.**	**TMC/QC**

QC11/10.24	**BOARDING REPORT**	
	The ACMO presented the boarding report. The number of boarding patients remains high and increased in September although did use escalation areas less. The Discharge Lounge was used more per day although the overall percentage was lower. A Patient Flow Facilitator has been appointed and is responsible for line management of the Discharge Lounge. The costs are expected back for expansion and moving of Discharge Lounge. There is no planned date for work to commence but is a priority. Escalation policy rewrite and flow workshops are underway with senior leaders ahead of winter, including use of the ED external corridor which is not in the escalation policy but will be in the new policy. Incident reports remains broadly the same, 33 incidents last month, predominantly Wye, and ED AMU. Also receiving complaints from staff on Arrow and frailty wards. Increasing use of Discharge Lounge and reduced boarding are part of the winter plan and capital will be broadly prioritised to expand and re-locate the lounge. Timely discharge is also important. The CNO noted that review of escalation spaces and what order they are used in is critical. A number senior nurses have indicated that some spaces should only be used as an in-extremis option. Senior nurses doing work on numbers that can be taken by each ward considering acuity and safety issues. There is added complexity with the need to ensure there are ring fenced beds for NOF and stroke as patients need to be on ward in a timely manner. Admission avoidance initiatives are also in place. Virtual Ward via the Integrated Care Division. Also CIRH are now co-located with General Practice and working closely with the ambulance service.	
	Resolved – that the Boarding Report was received and noted.	
QC12/10.24	**DIVISIONAL QUARTERLY REPORT – SURGICAL DIVISION**	
	The ACNO presented the quarterly report for the Surgical Division. VTE - Now more information through power BI shows lowest compliance level is elective surgery. Some areas have good compliance and are improving. Surgical SDEC are included in the data and should be omitted. Work is ongoing which should show an increase in compliance. Elective pathway work in ongoing and working in pre-op to collect information pre-operatively for VTE.	

	Looking to see if there is anything that can be done to support clinicians through the admission process. Patients either admitted via Primrose, Surgical hub or via a surgical ward. A meeting is taking place to look at this across clinical nursing and operational staff. Complaints compliance. A similar number of complaints are coming in but are being answered in a more timely way – phone calls are having an impact. A higher number of compliments are also being received. The ITU action plan will continue to be monitored through the divisional report. 24 hour outreach service has been implemented and continue to work with Integrated Care colleagues to provide therapy support. Elective hub has been operational for a few months and has shown successes in the elective pathway now up to 3.8 cases per list. There have been improvements in utilisation and in September nearly 1000 patients went through the elective pathway. There have also been some challenges within hub which is meant to be provision for high volume, low intensity patients but have been some longer cases through. There are also lot of new staff into new hub and slight difference in skills for international recruits and are considering more practice educator support to support the transition. Elective pathway demand and capacity work is taking place for next year and job planning to ensure hub and main theatres are delivering. Ward re-configuration took place in July, Primrose moved to day case which provides 12 beds for elective admissions and care for patients coming in for larger surgery. There is no daylight on the ward and are currently seeking charitable funds to provide light panels and improve toileting facilities. Emergency laparoscopic cholecystectomy pathway improvements have been made. Patients are brought in to ward over night or to SDEC and go to theatre directly which has reduced length of stay and re-admission rates. Paediatric Youth Workers are supporting transition to adulthood care. 24 hour critical outreach Additional Band 6 nurses have been recruited to provide 24 hour care for critically ill patients across the trust. This will enable progress to implement Martha's rule. PSIRF work in gynaecology is coming to conclusion. There has been improvement to numbers of complaints and have received lots of compliments. However, there has been an increase in urology complaints, some themes being patient care, treatment plans and communication with medical staff. Doing the same work that was done for gynaecology using PSIRF principles.	

	There are concerns on Primrose re elective flow as it is used as an escalation area. There had been minimal cancellations but a lot of work is to be done to make sure that patients are in the right place. When the Endoscopy Unit is open staff also oversee this. There have been a number of mixed sex breaches on Gilwern. Breaches are usually with trauma patients and now seeing incidences with medical or surgical outliers. Need to ensure if patients are outliers they need to be of the same sex. Will be performing a deep dive of breaches which will form part of the next report. NELA audit showed some deterioration in year. Last year met the best practice tariff this year has not. An action plan in place to ensure can meet best practice tariff next month. On a positive note, we were able to meet all the required metrics from a surgical and anaesthetics perspective and more importantly are second out of 16 in the region for mortality for emergency laparotomies. The MD noted that Primrose had been put in as a temporary measure and was part of the estates strategy work. The flexibility of teams who moved as part of re-configuration was appreciated, especially Primrose and Lynne Kedward will be looking into options to make improvements.	
	<u>Resolved</u> – that the Quarterly Update Report for Surgical Division was received and noted.	
QC13/09.24	**<u>PERINATAL SAFETY REPORT AND CNST 10 REQUIREMENT</u>**	
	The ADM presented the Perinatal Safety Report and update on CNST 10 Requirement. The service remains stable with no pressing issues. It was noted that the report contained a number of appendices which are necessary to meet the needs of the CNST process, making sure that relevant information has been shared with relevant boards. Summary of CQC maternity survey - Successful in terms of improvement and an action plan has been co-produced (appendix 3 or the report) to give re-assurance to the Committee around target dates as working in conjunction with MNVP who have limited time to support activities. Transitional care audit information - The Neonatal unit (term SCBU has been used at WVT) comprises a number of bed spaces including SCBU, transitional care cots and high dependency cot. Moving forward will refer to neonatal transition care cots Babies have set criteria and the report outlines the number of babies who have been in over a quarterly period.	

	Sometimes Mother and baby may be sent to the neonatal unit but there are some periods of separation which are usually around feeding issues and mothers who are not ready to go to the unit if still they have ongoing obstetric care needs. Some work to be done around developing a pathway for antibiotics to be given to reduce separation. A Band 3 Support Worker role has been created, to include Naso-gastric feeding, fully supported by LMNS. The associated action plan was attached with the report. The ACNO gave an update on the Neonatal workforce standards. To comply with one the National standards for neonatal workforce is to have qualified nurses in specialty. The standard is 70% and are 40% compliant due to staff leaving or retiring. Plans are in place to make improvements, have four new starters, and two training places each year to be able to get the qualification. This is on the risk register but is a compliance risk and not a safety risk. Have utilised the governance role within ward manager role and brought in a Clinical Educator. Each unit to have super-numary nurse per shift - There are 3 super-numary nurses in SCBU and 12 cots which is a safe level of staffing. We are not complaint to standard but it is felt that the currently level of staffing does not pose any current risk. The number of staff on long term sickness now rectified and there should be improvements in the forthcoming year. SCBU peer review is to take place Monday 4th November and although workforce challenges were previously accepted by ODN as appropriately mitigated, they are likely to come up in the review	
	Resolved that: The perinatal Safety Report and CNST 10 Requirement report be received and noted.	
QC14/09.24	**STAFFING REPORT**	
	The ACNO presented the staffing report. The high number of attendances at ED and the decant to other areas impacted workforce. Community beds were open and additional staff brought in. Endoscopy was open as an escalation area and there were high levels of boarding patients on ward areas, often above 20. There is continued improvement with fill rate data.	

	Sickness levels had increased, although the number of vacancies had decreased. The highest level of vacancies remain in medical, Health Care Assistants and continue with centralised HCA recruitment. Use of agency staff has reduced. There is focus in relation to 1:1 care and additional staffing requirements, ED due to vacancies and Community Hospitals to cover additional beds. A paper went through TMB to recruit 13 whole time equivalent HCAs for Community Hospitals to support escalation beds, also frailty. An increase in off framework Thornbury usage was seen for Operating Department Practitioners due to some vacancies, recruiting internationally and training our own and sickness. There are no Registered Mental Health nurses in the trust and therefore there is reliance on agency when they are needed. Working with ID Medical colleagues to get pool of Operating Department Practitioners and RMNs. The Chair asked what was the likely timeline to fully recruit HCAs. It was confirmed that there were 40 whole time vacancies, which is likely to increase due to Community Hospitals. A fortnightly meeting is taking place with the Chief People Officer looking at centralised recruitment which is attended by the CNO and it is hoped to reduce the number of vacancies. It was also noted that turnover at 14% had not deteriorated and that turn over is due to having fewer applicants and a number wanting to progress. It was also noted that another factor is the increase in National Living Wage and its comparison to the bottom of Band 2. This is also similar regarding Imaging Assistants.	
	Resolved – that: The staffing report was received and noted.	
QC15/09.24	**IN PATIENT SURVEY RESULTS**	
	The ACNO presented the in patient survey results. There had been a good uptake with 45% of people responding. 75% were emergency patients and 25% elective admissions. 45/50 sat in the average bracket. There were three areas lower and one higher than expected and was broadly the same as the previous year. There was concern over waiting times being transferred to ward from ED. Food received the lowest score and was significantly worse in relation to quality and accessibility to food outside meal times. Discharge planning, making sure people have information they need and was low as was asking for people's views on care while an inpatient. Feedback on adequate nursing levels to meet needs was positive.	

	The information given to patients about what to expect on virtual ward was very good. Group benchmarking showed most scores were similar, particularly to George Elliot and Worcester. There are opportunities to learn from SWFT on some elements of the survey where they were in the top 5 in the region. Predominantly positive comments regarding staff scores, kindness, compassion, dignity and respect remain high. In the coming months The Patient Quality Committee will work on actions together with Divisions. The CNO noted that a task and finish session with Sodexo had taken place to discuss a new food offer and new crockery has been launched	
	Resolved: that the In Patient Safety Results were received and noted.	
QC16/10.24	**QUALITY ENGAGEMENT VISIT UPDATE**	
	The Quality and Safety Matron summarised the outcome of the first quarter Quality Engagement Visits. Executive and Non-Executives have been conducting visits to look at quality issues in clinical areas. These have been well met by clinical teams and have received positive feedback. There is one visit per week with 16 visits undertaken in quarter 2. Themes were detailed in the report and recommendations listed. Any considerations around next steps need to ensure that the process does not become burdensome. It is recommended to strengthen the feedback loop and how things can be in place to support and also to improve assurance that recommendations are being undertaken and track their impact. There is a positive theme regarding team working, flexibility and support, people working together well and is consistent across most visits. Recommend a centralised reporting mechanism to distribute feedback so it can be tracked and monitored. The Quality and Safety team take ownership of estates issues and make sure these are appropriately fed in. It was agreed that from a quality perspective a meaningful process was needed to provide feedback and governance should be light.	
	Resolved – that the Quality Engagement Visit update be received and noted.	

QC17/10.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	The CNO asked that the Infection Prevention Committee summary report be taken as read and asked for the following to be noted: Commencing first week November the Occupational Health Team will be present at entrances and exits, main corridor and canteen to improve uptake of flu vaccines. Frances Martin (NED) asked how often are we getting updates on numbers and could they be shared. It was noted that this would have to come from Occupational Health but as some staff are vaccinated elsewhere and although they are asked to let Occupational Health know if this is the case, numbers may not be accurate.	
	Resolved – that: the infection prevention summary report was received and noted.	
QC18/09.24	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The Patient Safety Committee report was taken as read and there was nothing further to be highlighted. The Chair noted that regarding medicine reconciliation the minutes said that this cannot be fixed for quite some time. The CDP said that this has been an issue for some time but is improving now that staffing levels have increased. That it would not be 100% and will have to be approximate. 50% patients will get medicines reconciled as a target and will prioritise those patients. Patient Safety Committee will keep this in view.	
	Resolved – that: the Patient Safety Committee Summary Report was received and noted.	
QC19/09.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The ADN presented the Patient Experience Committee summary report. There is currently a reduced service in PALS due to the high number of vacancies which will be going out to recruitment. The CNO noted that the first meeting of the Volunteer Steering Group had taken place. A Volunteer co-ordinator has been appointed and a volunteer contact centre plan is underway. It was also noted that since Covid volunteer numbers have reduced with the greatest gap on wards. The steering group will continue to meet and guide strategy as move forward.	
	Resolved – that the Patient Experience Committee Summary Report was received and noted.	

	CONFIDENTIAL SECTION	
QC20.1/09.24	**PATIENT SAFETY INCIDENTS REPORT**	
QC20.2/09.24	**FATALITY OF LOOKED AFTER CHILD**	
QC21/010.24	**ANY OTHER BUSINESS**	
	The ACMO referred to the Medical Division deep dive which would be presented at the next committee meeting and noted that it may differ slightly to previous reports as she and the Matrons would be writing it.	
	DATE OF NEXT MEETING The next meeting is due to be held on 28th November at 1.00-4.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Quality Committee 28 November 2024 Minutes and Escalation Report
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Chair Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and QC Chair
Documents covered by this report:	Quality Committee Minutes November 2024

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]

N/A

[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 2024/25 Objectives the report relates to:

Quality Improvement

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

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

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

Digital

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

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

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

Productivity

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

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

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

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***

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

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

Workforce

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

☐ ***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***

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

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***

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

Matters for Noting

1. **Perinatal Safety Quality Report -** Committee highlighted the overview of stillbirths and perinatal deaths where we have seen increased numbers in the current year, and sought assurance around the response process and learning from the assessment of each case and the gradings assigned to the levels of care provided.

2. **Mortality Report** – Our SHMI indicator continues to indicate good overall management of mortality risks. The main area of concern continues to be fractured neck of femur related deaths and the new fast track pathway has now been agreed. Committee also discussed sepsis where our indicator is high and discussed the improved learning that is now available for Structured Judgement Reviews.

3. **Quality Priority – Improving Care od Deteriorating Patients** – Committee focussed its discussion around the implementation of "Martha's Rule" The 2nd part of Martha's Rule is "Call for Consent" and establishes how next of kin can raise an alert if they think a loved one is deteriorating. A Task and Finish Group is working through the practicalities and implementation is aligned with the establishment of the 24/7 Critical Outreach Team which we need to establish first. The Trust is also linking with the national pilot to ensure we pick up learning.

4. **Quality Priority – Improve Responsiveness to Patient Experience** – Complaint numbers remain a concern, though down slightly on a year ago and response times have improved. Engagement with complainants is improving but we are not always following through on discussions held with complainants in our formal responses and needs to improve. The PALS service has vacancies and this may be impacting on complaint numbers.

   Committee asked for further investigation regarding complaints in Women and Children's clinics about not being listened to when experiencing pain.

5. **Divisional Report – Medical Division** – Discussion focussed on overcrowding in the ED and the developments to counter this including a GP presence. The high profile of our Cardiology consultants was commended – we are seen as national experts and providing training to specialist tertiary centres.

6. **Boarding Report** – Boarding numbers had increased and Committee noted the increase also in complaints and concerns referencing boarding.

7. **Infection Prevention Quarterly Report** – C-Diff infections increased in Q2 putting the Trust above trajectory against the annual target set by the NHSE. Recent cases are being investigated to assess possible trends though it was noted that nationally numbers have increased. The increase also puts the Trust above the benchmark mortality level. Cleanliness audits continue to show improvements in performance with 96% achieving 4 or 5 stars.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 28 November 2024 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 (CMO)
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Sharon Hill	SH	Non-Executive Director (NED)
Rachael Hebbert	RH	Associate Director Nursing (ADN)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Natasha Owen	NO	Associate Director of Quality Governance (ADQG)
Grace Quantock	GQ	Non-Executive Director (NED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Gwenny Scott	GS	Company Secretary (CS)
Nicola Twigg	NT	Non-Executive Director (NED)

In attendance:		
Felicity Archer	FA	Matron, Medical Specialties
Lucie Grisewood	LG	Infection Prevention Nurse (IPN) – For Item 15
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Leah Hughes	LH	Operational Clinical Lead Radiography
Val Jones	VJ	Executive Assistant for the minutes
Sue Moody	SM	Associate Chief AHP, Integrated Care Division (ACAHP)
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer (DCMO)
Ian O'Loughlin	IO	Estates and Engineering Manager (EEM) – For Item 4
Amie Symes	AS	Associate Director Midwifery (ADM) – For Item 9
Emma Wales	EW	Associate Chief Medical Officer (ACMO), Medical Division

QC01/11.24	**APOLOGIES FOR ABSENCE**	
	Dan Harding, Associate Chief Operating Officer Medical Division, Sarah Holliehead, Associate Chief Nurse, Medical Division, Jane Ives, Managing Director, Tony McConkey, Clinical Director, Pharmacy, Emma Smith, Associate Chief Nursing Officer, Surgery Division and Laura Weston, Infection Prevention Lead Nurse.	
QC02/11.24	**QUORUM**	
	The meeting was quorate.	
QC03/11.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC04/11.24	**MINUTES OF THE MEETING HELD ON 31 OCTOBER 2024**	
	Resolved – that the minutes of the meeting held on 31 October 2024 be received and approved.	

QC05/11.24	**ACTION LOG AND MATTERS ARISING**	
	QC06/10.24 - Safeguarding Reports - Grace Quantock offered support with gender identity work and it was agreed to follow this up outside the meeting – This has now been completed. QC10/10.24 - Quality Priority – High Risk Time Critical Medication - Grace Quantock (NED) noted that there have been issues with administration of insulin and it was agreed that a discussion would take place outside the meeting to discuss this – This is being picked up at the next Diabetes Safety Forum.	
	Resolved – that the Action Log be received and updated.	
	BUSINESS SECTION	
QC06/11.24	**PERINATAL SAFETY QUARTERLY REPORT**	
	The ADN presented the Perinatal Safety Quarterly Report, which was taken as read, and the following key points were noted: • 1 case has been reported to HSIB and PMRT. There have been 4 complaints received which is an increase. They do not have related themes and do not relate to care during the same month. • PMRT Section - This includes an overview of the stillbirths and neonatal deaths for this year along with the gradings in care which provides assurance that there is a robust process in place for scrutiny and early identification of learning. Reassurance can also be taken that in the significant majority of cases, those sad outcomes could not have been avoided. • QI Work – The ADN highlighted this section. This also includes a PowerPoint sheet which outlines how we triangulate all of the data and use that intelligence. • Mrs Martin (NED) noted that the she and Mrs Hill (NED) were aware of all the information in the report in their role as Safety Champions as well as the CNO. We will discuss this report in more detail out of the meeting and will escalate anything required back through the Quality Committee. • The ADN confirmed that we are still waiting for the Insight report following the LMNS visit in November.	
	Resolved – that the Perinatal Safety Report was received and noted.	

QC07/11.24	**<u>TERMS OF REFERENCE MEDICAL DEVICES SAFETY GROUP</u>**	
	The EEM presented the Terms Of Reference (TOR) Medical Devices Safety Group and the following key points were noted: • The Medical Safety Devices Group (MSDG) used to exist but was dissolved and we are proposing this is reinstated. The group will enable more robust governance relating to the procurement, management and repair of medical devices. • The CNO had already commented on the proposed TOR and these comments were included in the draft TOR. It was recommended that the new committee report into the Patient Safety Committee. • The CMO noted that discussion has been held around new devices and Clinicians wanting to introduce new devices and the process around this which goes to CEAC. We need to agree how we triangulate all of this so that the MSDG is sighted on this. The ADQG will send the EEM the document around the process for new devices. • Mrs Martin (NED) queried if the CS was happy with this suggestion and whether we could be in alignment with other Trusts. The CS advised that this will be part of the wider conversation being held around Sub-Committees. • Mr James (Chair and NED) felt that it was good practice to have a sentence at the beginning of the TOR around what the purpose of the group is. The EEM will discuss with colleagues to get this sentence written and included in the TOR.	**NO** **IO**
	<u>Resolved</u> that: **(A) The Terms Of Reference Medical Devices Safety Group be received and approved with the agreed comments.** **(B) The Associate Director of Quality Governance will forward the document around the process for new devices onto the Estates and Engineering Manager.** **(C) The Estates and Engineering Manager will include a sentence in the Terms Of Reference for the Medical Devices Safety Group to sum up the purpose of the group.**	**NO** **IO**
QC08/11.24	**<u>MORTALITY REPORT</u>**	
	The CMO presented the Mortality Report and the following key points were noted: • The 12 month rolling SHMI from August 2023 to July 2024 is 100. We were anticipating a rise, but this is not showing as yet. • On reviewing the diagnostic codes that we monitor there has been an improvement in most areas. Sepsis is still high but there has been some improvement and the Emergency Department (ED) are continuing to undertake regular audits. We have asked them to undertake some process mapping to try to understand why we are not consistently hitting the golden 1 hour for giving antibiotics.	

	Stroke has also improved during this period. Fractured neck of femur remains the key issue. We have held the second workshop and agreed a fast track pathway. The key aspects of this are having a pre-alert for these patients that will set things in motion that will enable patients to be admitted quickly and start specific therapies. There have also been some changes to the Theatre pathway. • Structured Judgement Reviews (SJR) – We are now able to analyse these for key areas of learning. One of key areas of learning is the need for medication reconciliation and ensuring that our clinical teams are taking a good medical history, prescribing as appropriate etc. We are also improving the quality of clerking we get from the SJR to pull out good practice. Whilst documentation is an issue, the SJR will provide evidence of good documentation and communication with families. • Pneumonia and COPD remain below 100 which means that we have less unexpected deaths in these areas. • Mr James (Chair and NED) queried when the changes following the second Fractured Neck of Femur Workshop will be put into place. The CMO advised that we are in the implementation stage. Some of the pre-alerts require West Midlands Ambulance Service to alert us that they are bringing in a patient with a fractured neck of femur. These discussions are taking place. We also want to implement a bleep process so that if a patient attends our hospital, we are able to alert the Wards and the Site Manager. Some of the "quick fixes" have already been put into place, eg the timeliness of some of the procedures in Theatre and ensuring that the fractured neck of femur patients are first on the list over the weekend. • Mr James (Chair and NED) queried if we will get to a point when we can access what percentage of patients are getting into the right bed in the right timeframe and into surgery in the target time. The CMO advised that there is more than just the timeliness to consider. Clinicians talk about a Super Six around the things that need to happen. As part of this we are going to build a dashboard so that we can pull out all of these KPIs easily. We systematically went through the journey of a patient with a fractured neck of femur, which had good stakeholder engagement, so that we can identify what we need to do differently. When this is all embedded in the New Year, we will invite a Peer Review if we are still having issues. The key improvements are getting patients on the ward and into surgery in a timely manner. • Mr James (Chair and NED) queried if there was any update on the general issue around stroke deaths in Hereford. The CMO advised that we met with Public Health and the initial feeling is that this is related to deaths in Care Homes. We need the background to these patients and whether they were discharged from the hospital with a second meeting being arranged. We have reviewed the care of our own stroke patients at the last Learning From Deaths Committee which will be presented back to the next Mortality Meeting. One of our issues is being able to thrombolyse in a timely manner. We are part of a national quality improvement. Our	

	problem appears to be out of hours when we do not have consistent stroke specialist cover.	
	Resolved – that the Mortality Report be received and noted.	
QC09/11.24	**QUALITY PRIORITY – IMPROVING CARE OF DETERIORATING PATIENTS AND IMPLEMENTING MARTHA'S RULE BY JANUARY 2025**	
	The CMO presented the Quality Priority – Improving Care of Deteriorating Patients and Implementing Martha's Rule by January 2025 and the following key points were noted: • The report contains a summary of the work of the Deteriorating Patient Committee over the last quarter. • We have now launched the 24/7 cover by the Critical Outreach Team on 14 October, which is going well. They have a live dashboard which enables an easy view of patients with a high NEWS score so that they can proactively manage these patients as required. They also have an audit platform funded for a year to help audit their work. • Martha's Rule will be renamed as Call For Concern to be in line with the rest of the country. This involves rolling out implementing the way that next of kin can alert us if they have concerns that their loved one is deteriorating. We have a Task and Finish Group working through the practicalities of implementing this. The plan is to embed the 24/7 Outreach cover for 6 months before we roll out the second part of Martha's Rule which also requires a Business Case. • We also have Divisional Reports where we invite different Divisions to provide their performance in different metrics such as measuring NEWS and escalations according to Policy, equipment checks and mandatory training. The key things found are that we need to work with Business Intelligence to try to make pulling the reports easier. • Ms Quantock (NED) noted in the report it mentions that where patients were not being flagged appropriately, the teams have moved back to paper charts at the end of beds which appears to be a retrograde step going back to paper. The CMO advised that the Division took the decision, as this is the safest option currently as the tool they have currently does not appear to be performing as well as expected in term of alerting them to deterioration. This is a temporary measure until the national tool comes in. The only assurance we can receive is with spot audit checks which is on the Forward Planner. • The CNO advised that Obstetrics returning to paper is because they use another system to the wards which meant it was difficult for them to see the patient's critical observations over time and spot a deterioration. This decision was discussed with the Safety Champions.	

	• The CMO advised that although we are not part of the national pilot regarding the implementation of Martha's Rule, the team are observing this and taking learning from this around implementation. We need to get the Business Case and Policies approved including the Communication Strategy along with agreeing the strategy for children. The West Midlands want to adopt the strategy of getting Critical Care Nurses upskilled on a 6 week course so that they can be the point of contact for the parents. We decided not to be part of this Pilot as our teams did not feel they were ready and did not feel that 6 weeks would be enough time for this training. We are therefore looking at how we can provide this in the future for Paediatrics. There is a way forward potentially with the Consultants rota which is being reviewed. • Mr James (Chair and NED) noted that previous reports contained a dashboard presenting data on the CQUINS which was helpful to provide an overall view of the Deteriorating Patient Quality Priority and queried if this will be included in future reports. The CMO advised that producing this required a lot of resource involving a spot audit. Mr James (Chair and NED) emphasised the need for an update on overall progress without having to involve a lot of work to produce.	
	<u>Resolved</u> – that the Quality Priority – Improving Care of Deteriorating Patients and Implementing Martha's Rule by January 2025 be received and noted.	
QC10/11.24	**<u>QUALITY PRIORITY – IMPROVE RESPONSIVENESS TO PATIENT EXPERIENCE DATA</u>**	
	The ADQG presented the Quality Priority – Improve Responsiveness to Patient Data and the following key points were noted: • The FFT data was not available for this report. • Complaints – Quarter 1 and 2 data is included in the report. When compared to 2023 – 2024 there has been a slight decrease in overall numbers but they are still quite high. There was also a spike in October. We have had a significant spike in complaints in Quarter 1 and also in October. We have an improvement in our overall response times. We focus mainly on Surgical and Medical Divisions as Integrated Care and Clinical Support have very small numbers. In Quarter 2 we had the lowest number of overall complaints since 2021 which was positive. A review of reasons for delays in responses showed this was usually due to arranging a meeting with a complainant and a delay in the Divisional sign off. We are getting good response times when we are agreeing the final response time with the complainant rather than the 30 working day deadline. However, that is still only 50% of the target. We think there are some issues with data accuracy and how this is being measured so we are anticipating that once this is reviewed there will be an improvement.	

	• We have undertaken a review of "comebacks" as we noticed an increase this year. The analysis of this has been interesting and we have found some quick wins with some of the causes. Some of these are basic factual accuracies. One of the positive things that we do is speak to the complainant on the telephone really early on to ensure that we fully understand their complaint. We have noticed that sometimes these verbal questions and anything that emerges from these conversations is not being documented in a way that is always captured in the final response. We can support colleagues with capturing this and ensuring that it is tracked through to the final response. Sometimes we can resolve an issue during this verbal exchange or meeting but we are not always very good at summarising this in the complaint response. • We have undertaken a deep dive into the spike in October. The deep dive from the spike last year found the key areas of concerns were Urgent and Emergency Care, Head, Neck and Orthopaedics and Womens and Childrens. This time the areas have changed slightly and the Surgical Specialties have emerged with an increase along with Womens and Childrens. The themes and issues for Womens and Childrens are different this time from the previous spike. The focused improvement work that has been carried out has made an impact on the previous issues. • PHSO Cases – There has been an increase in these cases and we were asked if we were an outlier or if this was specific to the Trust. We compared the data from 2023 across the Foundation Group which shows that we are not an outlier. We believe this is just a reflection of the PHSO catching up after Covid as they had a huge resource issue. • Concerns / PALS Service – We have a fragile service with some significant gaps in the team and therefore had to change some of our processes. The focus has been on concerns being addressed, with a decrease in the number of recorded concerns as the Clinical Teams do not log the concerns, the PALS team undertake this. Concerns are still being responded to as quickly as possible and telephoning the complainant. The team are just catching up on updating InPhase. • Patient Experience Committee – The Patient Engagement Group (Sub-Committee) is increasing its membership, taking on a lot of improvement work with Patient Engagement Representatives keen to be involved in a lot of different workstreams. • Volunteer Steering Group – Terms Of Reference are attached. The first meeting held was very positive with stakeholders attending to provide more insight and objectivity into how we should be recruiting volunteers. • The CNO advised that an abridged version of this Report will be going to the Board of Directors meeting.	

	• The CNO queried if the reduction in concerns is purely administrative or linked to the rise in complaints as some individuals have decided to pursue a formal process as a consequence of a reduced PALS service. Secondly, are we worried given that the Inpatient Survey for 2024 will be for those patients who spent 1 or more night in hospital in October, do we know how many of those October complaints relate to care that happened in October and are we worried about what our survey might show up for next year. The ADQG felt there might be a link in response to the first question. In response to the second question there has been a lot of focus on the themes that were coming out and we could undertake further analysis on this if required. The CNO did not feel this was not necessary given the limited resource and that it wouldn't change the outcome of feedback received in the survey. • Ms Quantock (NED) noted the theme in surgical around patients not being listened to when experiencing pain, and in Women and Childrens clinic examinations not being stopped when requested by a patient or treatment causing pain and further injuries, do we have a sense of what is happening, is there a wider cultural issue and of the long term impact. The ADQG advised that the deep dive was produced for this Report and is something that we can discuss with the Division to mitigate this and understand the underlying reasons. Mr James (Chair and NED) queried how we responded to these incidents and what happens when a complaint comes in regarding a concerning issue, how quickly do we deal with that issue. The ADQG advised that when complaints are being triaged and there is a suggestion of patient harm, this would trigger the Patient Safety Incident process which would ensure a more timely review of the incident. Once this has been through due process, we would check whether the complainant investigation timeframe and process is still the most appropriate method or whether we need to do something more individual and we would communicate this to the complainant along the process. If we identify any themes or trends, that would also trigger a different process which would be dealt with through the HR route if appropriate. • Mrs Twigg (NED) asked if we review the complaints data compared to the concerns to see if there is any correlation in terms of volumes and time scales. This would provide a good picture of overall feedback in terms of how we are dealing with areas. Secondly 27% of comebacks seems high with a lot of additional work associated. A number of these issues were around factual inaccuracies and she wondered if there was a correlation with the timescale these are dealt with and losing sight of what the real facts and issues are. Thirdly she noted in the report the recognition that there is more work to do to deliver the Quality Priority but was not sure what we are doing differently or going to do differently to get the result we need. The ADQG noted that there are different processes for different places and whether we can learn and streamline from this. We still need to get to a place where we can implement the PHSO Model Complaint Guidance which looks at the whole process of concerns and complaints differently to how we are currently. Mr James (Chair and NED) agreed with the issue of comebacks and noted the issue around having conversations with complainants but	**NO**

	not having quality control around the process to ensure these are captured in responses. • The CMO advised that we are moving towards the Divisions reporting their own trends and actions being taken. • The CMO advised that the Medical Examiners speak to every next of kin to understand the care that their loved one received and their views on it which is all documented. There may be actions from this and evidence of learning. This data is discussed at the Patient Experience Committee and the CMO asked for this to be included into the next report.	**NO**
	<u>Resolved</u> – that: **(A) The Quality Priority – Improve Responsiveness to Patient Data be received and noted** **(B) To discuss with the Surgical Division around the theme in surgical around patients not being listened to when experiencing pain, and in Women and Childrens clinic examinations not being stopped when requested by a patient or treatment causing pain and further injuries to mitigate this and understand the underlying reasons.** **(C) To include in the next Patient Experience Report any actions and evidence of learning from the discussions the Medical Examiners have with next of kin on the care that their loved ones received and their views on it.**	**NO** **NO**
QC11/11.24	**<u>WARD ACCREDITATION PEER REVIEW UPDATE 105.49</u>**	
	The ADN presented the Ward Accreditation Peer Review Update and the following key points were noted: • A plan was approved by Quality Committee to undertake Ward Peer Review visits starting with 3 pilot sites. Feedback included from Bromyard Community Hospital who received a Good Rating and AMU who just missed meeting the accreditation standards. The key learning points are included in the report. National evidence shows that it can take some Ward areas 2 to 3 years to achieve this accreditation standard. • Feedback was provided on the day with further opportunities for face to face and Teams meetings for more detailed feedback. Any immediate safety concerns on the day were addressed immediately. Clear guidance was provided to AMU and an opportunity to revisit. The 3rd site, Frome Ward, was visited yesterday. • The plan was to have reviewed all Ward areas by the end of March 2024 but we need to consider the current resource available and whether this is practical. Other Foundation Group colleagues suspend their visits during the winter period. We have received positive feedback from the teams that we have visited.	

	• The CNO advised of the background to the revised approach to the reviews. The original ward accreditation pilot was carried out on Dinmore Ward which led us to take a revised approach by focussing on the peer review element as the key benefit. The next step is to undertake a stocktake of the 3 reviews, tweak the SOP and approach as necessary and agree a reasonable timescale for next steps. • Mrs Martin (NED) queried the methodology in terms of how we triangulate the scores and the commentary. The ADN advised that the report only includes the highlights and a summary, not all the detail and we are still working on the data as well as what was actually found on the day of the visit. • The CMO found it useful having the information set out in the slides to provide a composite view of the Ward area. • Mrs Martin (NED) did not feel with the current pressures it was the right time to continue with this but the process and principles should be being used by all of our teams and a guide of what "good" looks like when we are undertaking our visits. • The CNO advised that the AND has reduced capacity due to providing cover arrangements in the medical division The original plan was to visit all of our Wards and Community Hospitals by the end of March, but this does not appear to be a practical option. We need to take stock of what has and has not worked and aim to continue with the programme at a slower pace. • Mr James (Chair and NED) noted that for a Peer Review to work well, it is based on trying to encourage self-improvement and self-awareness among different Wards and encouraging a quest for improvement. This could mean that different teams can visit different Wards to reduce the pressure of all reviews being done by the same people. He offered his support due to his background in Peer Reviews if this was helpful. • In light of operational and workforce capacity pressures, Mrs Martin (NED) felt it would be helpful to have a short report to QC recommending a pause in the Ward accreditation Peer Review process so that it is a positive decision to pause the programme and reflect and use our resource in a different way rather than a failure to complete a programme previously supported by the Board. • The CNO reiterated that this started with the Chief Executive setting a task to all of the Foundation Group to implement ward accreditation which is what we set out to do and is why we now have a mixed methodology. The accreditation process does require you to have the same team undertaking the review to ensure consistency in application and methodology.	**LF**

	<u>Resolved</u> – that: **(A) The Ward Accreditation Peer Review Update was received and noted.** **(B) A short report will be presented to a future Quality Committee on why we have shifted from a ward accreditation approach to a peer review process.**	**LF**
QC12/11.24	**<u>DIVISIONAL QUARTERLY REPORT – MEDICAL DIVISION</u>**	
	The ACMO, Medical Division presented the Divisional Quarterly Report - Medical Division, which was taken as read, and the following key points were noted: • There have been no Patient Safety Incidents reported during this quarter. We have performed highly in the SNAAP stroke data on a Regional basis. There have been several National Audits that show we are performing above national standards (COPD, heart failure and asthma). We have also improved our antimicrobial stewardship over the last quarter. • The ACMO, Medical Division provided the background to an incident which had occurred which was a good example of having an environment that staff feel that they can escalate concerns quickly and that they will be listened to. • We are especially proud of our new ED which has an improvement environment following the completion of the ED Lifecycle Work. Our Nurse Navigator role is proving effective. The Lead Medical Acute ACP is going to be working with the Nurse Navigator which will help support between ED and SDEC. The GP based in ED is seeing a high number of patients and discharged 80% of them straight away or back to their own GP. The Cleanliness Score has improved in ED and AMU. • Cardiology have Consultants speaking at national conferences and being national experts along with people coming from tertiary centres to Hereford to be trained by one of the Consultant Cardiologists on highly technical pacing issues. ED improved over the last quarter with their complaints response. There were also less complaints received in October. • The Medical Flow and Discharge Lounge Co-ordinator is in post to improve the flow of patients from the Ward to the Discharge Lounge. We have also appointed to various senior nursing roles with work starting on the Discharge Lounge which is due to be finished before the end of the year. • We have introduced a new process around risk to ensure that risk on the Risk Register goes from being identified to being live as quickly and accurately as possible. This included training for the Clinical Leads and Matrons.	

	• The Division are concerned around overcrowding in ED and boarders on the Wards along with nurse and medical agency spend. There is also concern around mortality for our fractured neck of femur patients which was covered in the Mortality Section. • We had a low Staff Survey response which is disappointing. The move from Gilwern Ward back to Redbrook Ward has been a challenge for staff, which has been identified through an increase in incidents, complaints and concerns which is being addressed with a round table next week. There are a number of overdue incidents which we are working to close down. • The SNAAP data set is changing and we cannot run our internal report. We are working with the Information Team to enable us to keep track. Our VTE compliance is low but we believe there is a data issue. There are still concerns around bed rails. We have been asking the Wards to audit more and more things, so the Matrons have worked together to rationalise the audits to ensure that we are getting the information that we need. From mid-December due to sickness, there will be no governance support. • Mrs Hill (NED) questioned if we are confident that we have enough grip and oversight on Locums employed and do the Division feel supported where Locums are employed to gain this confidence. The CMO felt that we have assurance that we are able to pick up issues quickly. The situation will only improve with more substantive appointments due to the process followed in the interview and induction processes. The ACMO, Medical Division felt the Division were more aware of the process to follow if concerns are raised.	
	<u>Resolved</u> – that the Divisional Quarterly Report - Medical Division was received and noted.	
QC13/11.24	**<u>BOARDING REPORT</u>**	
	The ACMO, Medical Division presented the Boarding Report and the following key points were noted: • Our boarding rates are increasing again, particularly over the last 10 days. We are also using more Escalation Areas, including the external corridor in ED. The impact of the Medical Flow Co-ordinator should be seen in next month's report. • We have had more InPhase reports relating to boarding than previously, and boarding is being mentioned more in complaints and concerns. The details around complaints and concerns will be included again in the next report. • The CMO noted that one of the objectives in the Research Group is to increase the number of primary research that we do. Following the MOU signed with the Three Counties we met with their Research Team to develop a protocol looking at the impact of the use of temporary escalation spaces on staff.	

	• Mrs Hill (NED) queried if we got our medical fit for discharge patient numbers close to zero, would we free up enough beds to prevent boarding. The ACMO, Medical Division advised that this would not alleviate this issue as our bed base is too small for the Trust. Mrs Hill (NED) queried whether we include what is being done for medically fit for discharge patients in the report as this would help with the boarding issue. The ACMO, Medical Division advised that the difficulty was that 2 Divisions are responsible for these areas. Mr James (Chair and NED) felt that the Divisional Quarterly Report should focus on these wider issues including admissions avoidance and crisis response etc. • Mr James (Chair and NED) queried progress around what we are doing around admission avoidance. The CMO advised that recently our discharge profile has improved but we are admitting more as the demand is higher. The use of the Virtual Ward has significantly improved as well. The ACMO, Medical Division advised that we do not have the staff to cover an Escalation Ward. • The CNO advised that in the weekly Regional CNO meeting discussion was held around the pressures across the NHS and in particular patients in temporary escalation spaces and overcrowded EDs and they are trying to ramp up the oversight arrangements for patients who spend a long time in ED. Some Trusts are pushing back on conducting individual reviews as this as it is similar to the old reporting regime and is an industry rather than a helpful way of eliciting learning. The CNO has been considering how we change the Boarding Report as she felt it should not just be Medical Division but a Winter Pressures Report that includes patients in temporary escalation areas, patients who spend more than 24 hours in ED, patients who spend a certain amount of time in an ambulance etc, but this needs to be worked up. We could also include our strategies for improving flow in this. • The CNO noted that the Chief Operating Officer presented a Winter Preparation presentation and the use of Temporary Escalation Spaces a few months ago and we agreed that even if all of our strategies succeeded in terms of bed days saved, we would still have a high number of DTA's in ED and a number of boarders. Therefore all of our strategies alone will not fix this, we are still going to have boarders. • The ACAHP advised that the term medically fit for discharge sometimes includes patients who may not be able to look themselves at home, with the Discharge Team key to this. This is a complex area and she will include detail around this in her next Divisional Report. The ACMO, Medical Division advised that the term Medically Stable for Discharge is now the preferred term, as this means that they are medically stable and do not need to be in an Acute Hospital.	
	<u>Resolved</u> that the Boarding Report be received and noted.	

QC14/11.24	**STAFFING REPORT**	
	The CNO presented the Staffing Report and the following key points were noted: • The vast majority of our boarders sit within the Frailty Block, and they have on average 5 additional patients each day. Therefore their planned level of staffing is for their establishment which is based on their number of beds (24 not the 29 they often have). This has to have an impact on our staff morale and sickness etc. The number of incidents reported in relation to staffing are under-reported as staff do not have the time to report incidents. • We know that using temporary workforce, in particular agency, does not provide the continuity of care for patients or the same level of quality. The CNO remains concerned around the levels of sickness, particularly seen in our Health Care Support Workers (HCSW). We have a centralised recruitment campaign with a good recruitment trajectory around HCSW but we are seeing the standard of applicants dropping in comparison to a year ago. Where we are seeing over fill rates, this is due either to having additional beds open or higher acuity and where we have under fill rates, this is because we titrate the staffing according to the number of patients in elective surgery for example where numbers drop at the weekend so staffing can too. • The ICB Representative noted that the extra patients not only effects the staff but also the medical staff which is not always captured. It would therefore be useful when reviewing boarding to look at staffing across the board. The CNO advised that the Staffing Report is to fulfil the NQB national requirement to report on nurse staffing. There is no intention on her part to not recognise the value of other members of the MDT. With the resource and data available to her team the report will continue to focus on nursing only. Mrs Martin (NED) agreed, noting that we need to remember the impact on portering, diagnostic services etc as well. • The CNO advised that the Region have set up a Regional Collaborative to make sure that all the Trusts in the Region achieve the capped rate for agency, so that we can manage the market more effectively. . The regional team visited in November and the visit was very positive with a feeling that we have a strong story to tell and focussing on all the right things. We are working towards compliance with cap for general nursing shifts by the end of January and working towards cap for critical shifts by the end of March. The Associate Chief Nursing Officer – Surgery Division is the Deputy Chair of the Regional Collaborative and helping us to take that forward. The team were impressed that we have some wards where we are trying to recruit to turnover so that we do not experience gaps that have to be filled with temporary workforce. They share our concerns over HCSW recruitment and sickness levels although recognised not dissimilar to other trusts.	
	Resolved – that the Staffing Report be received and noted.	

QC15/11.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The ADQG presented the Patient Experience Committee Summary Report, which was taken as read, and the following key points were noted: • The ADQG highlighted the work being done around the Reasonable Adjustments Policy for the Trust along with the Patient passport to support that. • Discussion was also held around the Inpatient Survey results and the working going on around this.	
	Resolved: that the Patient Experience Committee Summary Report be received and noted.	
QC16/11.24	**CINICAL EFFECTIVENESS AND AUDIT SUMMARY REPORT**	
	The ADQG presented the Clinical Effectiveness and Audit Summary Report, which was taken as read, and the following key points were noted: • The Committee discussed a number of items in detail and approved some key documents for the Trust including our Working Together document, Mortality Review Policy, Lumbar Puncture LocSSIPs and our Food and Drink Strategy. • The CNO advised that due to the meeting not being quorate for part of the meeting due to key staff attending a mandated regional meeting, the Elastomeric Policy and associated documentation were approved subsequently, which has meant that we can go live with the 4 times a day antibiotics in the community.	
	Resolved – that the Clinical Effectiveness and Audit Summary Report be received and noted.	
QC17/11.24	**INFECTION PREVENTION COMMITTEE QUARTERLY REPORT**	
	The IPN presented the Infection Prevention Committee Quarterly Report, which was taken as read, and the following key points were noted: • The NHS Standards Contract 2024/25 was published in August due to the increase in trends and more ambitious threshold for both C-Diff and gram negative bacteraemia. The new thresholds for this year are 38 hospital acquired C-Diffs, 51 hospital acquired E-colis and 2 pseudomonas bacteraemia and 11 Klebsiella bacterium. • C-Diff cases at Quarter 2 are 25 cases against the 38 threshold. This is an increase of 17 cases reported in Quarter 1 with an unusual rise in prevalence in both July (9) and August (10). We have undertaken a C-Diff Summit held on 3 September to review the Trust's current position and to identify any additional actions to reduce and prevent further infections. One of the actions was to review a sample of our C-Diff patients looking at their pre-admission antibiotic history but also to determine whether there are any other risk factors prior to them being admitted. We are continuing to liaise with Informatics to develop graphs and C-Diff data to support effective analysis of our patients. We are also reviewing current patient demographics to identify any changes	

	along with reviewing all our EIA positive patients and considering the appropriate labelling of our hospital onset hospital acquired and community onset hospital acquired, and linking them into being hospital acquired healthcare associated infections. We are also reviewing the correlation between the increase in our cases and whether there are any changes to treatment pathways. • Hereford and Worcester ICB are noted to the one of the highest ICBs per number of cases per 100,000 bed days. We will continue to work with the ICB. • Six out of the 42 EIA positive externally reported cases unfortunately died within 30 days of their C-Diff acquisition. The national benchmark for C-Diff 30 day mortality nationally is 12.9, the Trust are at 14.3. Trust cases did not have C-Diff on their death certificate so this gives us a 0% reading. We continue to have 0 MRSA bacterium. • As of the 2nd Quarter we have 7 cases of E-coli, which takes our overall number to 22. The threshold for 2024/25 is 51. With regards to Klebsiella we had 3 cases during this quarter which brings our numbers to 7 with our threshold at 11. With regards to Pseudomonas we have 2 cases during this quarter, with a total of 3 cases with our threshold set at 2. Hereford ICB was noted to have one of the lowest number of cases per 100,000 beds. • We are undertaking a full review of our healthcare linked E-coli bacterium in 2023/24 and a mortality review of all associated deaths to aid future learning. We are also undertaking a review of all bacteraemia within the Infection Prevention Team. We are also undertaking a new Blood Culture Policy and training package. This has been approved by the IPC Committee and will be rolled out Trustwide before the end of Quarter 3. These actions are to address areas that have been identified in the Infection Prevention Improvement Plan. • During Quarter 2 we had 6 Covid outbreaks with no areas closing. Two patients died with Covid on their death certificate, and these are under review. We had 1 Norovirus outbreak and the area remained open. We had 2 CPE outbreaks one ongoing in Ross Community Hospital and the other in ITU. The background to these cases was provided along with the action plan. • The WHO declared a Public Health Emergency of international concern due to the rapid spread of MPox virus in July 2024. We have had 2 patients admitted with suspected MPox but both were found to be negative. An MPox Incident Meeting was Chaired by the Assistant Director of IPC, NHSE to identify areas of learning and development. Key learning areas were early recognition and assessment of the patient to identify the correct patient pathway, better communication with external agencies for support and annual high consequence infection prevention disease training for high risk areas.	

	• Surgical site infections – The Trust participate every quarter in the UK HSA surveillance service monitoring programme. The latest report received back from UK HSA is the period January to March 2024. The details of this report were provided to the Committee. • Cleanliness – Monitoring Audits have indicated an overall improvement on performance for cleanliness over Quarter 2 with 96% of all audits undertaken achieving 4 or 5 stars. This is a similar position to Quarter 1 and therefore resulting in a decrease of Improvement Plans being required. Our Annual Priority Plans have 11 actions that were set for completion during this Quarter. All have been completed bar 4, which are in progress to achieve full compliance by the end of Quarter 3, details of which were provided. • Board Assurance Framework – To date, 4 of the 10 hygiene code criterions are fully compliant and 6 requiring some additional evidence to ensure that we are fully assured. We are 83% compliant and have met 9 of the key line enquiries. Compliance with staff being fit mask tested has dropped from compliant to partially compliant due to issues with our reporting system. The background to this service was provided. • PLACE Audits – We have completed the inspection for all 4 inpatient areas and submitted our audit findings. The PLACE Working Group will collate the audit findings and share with key stakeholders. • External Visits – July 2024 the ICS IPC Service Improvement Lead supported the IPC Team in visiting and reviewing Ross Community Hospital following the CP outbreak in July. Any areas of learning were shared with key staff at the time. • Mr James (NED) noted that C-Diff infection rates appear to have gone up amongst our peer group and nationally as well. Is there a reason for this? The IPN advised that there is an increase in many areas throughout the UK and this is being reviewed for a cause. • The CNO noted in relation to mortality related to C-Diff, we are working with the Mortality Team to check that our reviews are in line with learning from deaths and to elicit any learning. A further summit was held in November around C-Diff which included the CMO to get her view. A new Microbiologist in post noted that our testing arrangements for C-Diff in the Trust are different to what she has seen in other NHS organisations which could be why we are finding more cases. There is research evidence around our demographic (seeing more C-Diff cases in rural areas than in urban areas) and we need to focus on the antimicrobial stewardship to improve our figures. We agreed to a look back at a longer antibiotic history of patients coming into hospital and those patients who are colonized. We need a Trustwide campaign on the duration of antibiotics and ensure that we use the appropriate antibiotics and treatment and that we switch to oral from IV as soon as possible. We have also dedicated one of our Infection Prevention Nurses purely to clostridioide infections to support with this. Positively our ribotyping (which advises which type of C-Diff you are dealing with) shows no cross contamination between patients.	

	• The CNO provided the background to the fitting of masks and the reason for the issues around recording this information for assurance.	
	Resolved – that the Infection Prevention Committee Quarterly Report be received and noted.	
QC18/11.24	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	The CNO presented the Infection Prevention Committee Summary Report and the following key points were noted: • This highlighted the excellent work by the Infection Prevention and Education Teams on Blood Culture training. • It is very difficult this year to get an accurate picture of the update of flu and Covid vaccinations. During the pandemic we input onto 1 particular electronic platform which meant we could receive feedback nationally so that we could compare our performance Regionally and Nationally. This is no longer available Regionally or Nationally and some of our staff will have had access to vaccinations at community locations. • Mrs Martin (NED) felt it would be useful to see the running total of staff being vaccinated and how this compares to last year.	**LF**
	Resolved – that: **(A) The Infection Prevention Committee Summary Report be received and noted.** **(B) Future Infection Prevention Committee Summary Reports will include a running total of staff being vaccinated and how this compares to last year.**	**LF**
	CONFIDENTIAL SECTION	
QC19/11.24	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
QC20/11.24	**ANY OTHER CONFIDENTIAL BUSINESS**	
QC21/11.24	**DATE OF NEXT MEETING** The next meeting is due to be held on 19 December at 1.00 - 4.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**06/03/2025**
Title of Report:	Quality Committee 19 December 2024 Minutes and Escalation Report
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☒**Discussion**
Report Approval Route:	Chair Quality Committee
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James, NED and QC Chair
Documents covered by this report:	Quality Committee Minutes December 2024

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]

N/A

4. Please tick box for the Trust's 2024/25 Objectives the report relates to:

Quality Improvement

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

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

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

Digital

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

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

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

Productivity

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

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

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

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***

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

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

Workforce

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

☐ ***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***

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

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***

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

[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. **Mortality Report** – Our SHMI indicator is stable at 100 - representing an overall expected number of deaths. The biggest SHMI concern remains Neck of Femur related deaths. However the new fast track pathway has commenced with standards at each stage of the pathway and agreement with the Ambulance Service to provide alerts of cases being conveyed.

   Committee has concerns about the spike in perinatal deaths, currently showing 6.7 deaths per 100 live births compared to the national ambition set at 4.65. For context, this follows a long period of improving performance and overall numbers are small so a cluster of deaths over a short period can impact the rolling average significantly. Quality Committee will continue to keep this under close scrutiny

2. **Research Quarterly Report** – The Trust continues to perform well in promoting and participating in research projects and “punches above its weight” in comparison to other Trusts in the region. Committee commended the work being done, particularly collaborative work with the university and across the Foundation Group.

3. **Divisional Report – Integrated Care** – Discussion focussed on pressure ulcer concerns in District Nursing and identified the need to understand relative performance across the 3 Teams. The initiatives to reduce falls have seen a reduction in bed-rail related falls.

4. **Divisional Report – Clinical Support –** Committee received an update on the review of DEXA cases which is nearing completion. It was reported that ED pressures are consequentially impacting and increasing demand for imaging services. Committee commended the excellent performance of Pathology histology services and the improved performance in pharmacy services. The robustness of haematology services remains a concern with business continuity subject to ongoing discussions with Worcester and with the ICS.

5. **Infection Prevention Committee Quarterly Report** – Uptake of Flu and Covid vaccination rates for staff are lower than expected but are difficult to assess as we do not know how many staff have been vaccinated outside the Trust’s own programme

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 19 December 2024 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 (CMO)
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Lucy Flanagan	LF	Chief Nursing Officer (CNO)
Sharon Hill	SH	Non-Executive Director (NED)
Jane Ives	JI	Managing Director (MD)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Natasha Owen	NO	Associate Director of Quality Governance (ADQG)
Grace Quantock	GQ	Non-Executive Director (NED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Gwenny Scott	GS	Company Secretary (CS)
Nicola Twigg	NT	Non-Executive Director (NED)
In attendance:		
Sarah Assinder	SA	Associate Chief Operating Officer, Integrated Care
Ingrid Du Rand	IDuR	Associate Chief Medical Officer – Clinical Research
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Leah Hughes	LH	Operational Clinical Lead Radiography
Sue Moody	SM	Associate Chief AHP, Integrated Care Division (ACAHP)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Emma Smith	ES	Associate Chief Nursing Officer, Surgery Division

QC01/12.24	**APOLOGIES FOR ABSENCE**	
	Dan Harding, Associate Chief Operating Officer Medical Division, Rachael Hebbert, Associate Director Nursing, Sarah Holliehead, Associate Chief Nurse, Medical Division, Tom Morgan-Jones, Deputy Chief Medical Officer, Amie Symes, Associate Director Midwifery, Emma Wales, Associate Chief Medical Officer, Medical Division and Vicky Morris, ICB Non-Executive Member, Herefordshire and Worcestershire ICB	
QC02/12.24	**QUORUM**	
	The meeting was quorate.	
QC03/12.24	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
QC04/12.24	**MINUTES OF THE MEETING HELD ON 28 November 2024**	
	Resolved – that the minutes of the meeting held on 28 November 2024 be received and approved.	

QC05/12.24	**ACTION LOG AND MATTERS ARISING**	
	It was noted that as there was no representative from maternity in attendance that the CNO and CMO would give their reflections on the triangulated information from the three maternity papers on the agenda rather than present the papers individually. QC07/11.24 Medical Devices. Forward information on How CEAC adopts new equipment. Agreed would report in to Patient Safety Committee. QC10/11.24 – Discuss with surgical division patients not being listened to regarding pain and stopping examinations – Lynn Carpenter will take this forward and an update will be added to the next Patient Experience report. QC10/11.24 – Actions and evidence of learnings from discussions Medical Examiners have with next of kin on care of loved ones to be included in next report – To be included in next quarterly Patient Experience report QC11/11.24 – Report on why have shifted from a ward accreditation approach to a peer review process – to be included in the next update in March 2025.	
QC06/12.24	**MORTALITY REPORT**	
	The CMO presented the mortality report and highlighted the following points: SHMI July 2023 – June 2024 remains stable at 100. Having the expected number of deaths in respect to demographics. Heart failure had been an outlier but patients have been identified earlier, and had an MDT approach to their care which had seen a steady reduction of SHMI to 96. Stroke and sepsis were also reducing. There had been a slight increase in COPD and pneumonia but they remain within the expected range. #NOF remains an outlier but had seen no deterioration remaining at 125. A new fast track pathway has been introduced which includes clear standards and targets for each stage of the pathway. The KPIs to be monitored have also been identified. An agreement has been made with the Welsh Ambulance Service, and it is hoped to also get the same agreement from West Midlands Ambulance Service, to pre-alert any cases. Of greatest concern is perinatal mortality which has shown a significant increase to 6.7 per 1000 live births. Ambition nationally is set at 4.65. A presentation of the cases was given at Learning from Deaths Committee. In last year there had been 8 still births, of those, 6 have been extensively investigated through the LMNS process. One case scored D (could have been potentially prevented), others scored A or B (LMNS are satisfied with the quality of care). In terms of the case which scored D this was in relation to pre-term prediction, the patient had a bi-cornate uterus so could have	

	been predicted could go into pre-term labour but had not been on the pre-term pathway. The team used the opportunity to look at all pre-term births to see if they could have been prevented and are undertaking a quality improvement exercise which is focussing on a number of things including growth charts particularly for out of area cases and communication and use of interpreters given 3 cases involved the interpreting service The Medical Examiner service remains robust and well regarded and all deaths are now being scrutinised, including those in the community. The Coroner is also satisfied with the service. Learning from Deaths Committee continues and detailed reviews of stroke, cardiology and palliative care have taken place. The mortality panel continues to provide reviews of cases where there are concerns around quality of care. One key learning identified lack of medicines reconciliation which sometimes leads to harm and will be an area of focus. The Chair gave his congratulations on the Medical Examiner Service and asked about the perinatal cases at Learning from Deaths Committee. Was it the case that LDC endorsed what had already been done or was anything new found? Though in small numbers it is very difficult to pick up the nuances, but LDC had looked at what had already been done. In summary, perinatal mortality had been low previously and this could suggest an unfortunate cluster of cases over a few months rather than a worrying thematic trend, this will be monitored closely.	
	<u>Resolved</u> – that the Mortality Report be received and noted.	
QC07/12.24	**<u>RESEARCH REPORT</u>**	
	The ACMO Clinical Research highlighted the key points from the Quarter 2 Research report. 174 patients had participated in 20 studies. There were three commercial studies in oncology, renal and paediatrics. 12 specialities in the Trust are involved in research and WVT are placed 15th in the West Midlands. The main specialities involved are Anaesthetics, ITU and Oncology. New studies in respiratory and surgery are also recruiting well. Specifically the surgical study led by Oxford. The research strategy has been implemented and a Strategy Action Plan has been created. There had been some difficulties with staffing with a number of staff having left the trust. A new Research Manager will commence in January 2025 and thanks was given to the support received from colleagues at Worcester.	

	A Lead Research Nurse has been appointed but sickness has led to some gaps in admin structure. Governance and quality had been very good and there had been no serious incidents or deviations from protocol. The Clinical Research Network has undergone restructuring and became the new Research Delivery Network. The financial position is currently strong but funding infra-structure from the RDN is uncertain. There will be opportunities to apply for additional funding and will have a 5 year forecast for regional funding which will enable some succession planning. One of the biggest risks for 2025 is physical space and due to the re-organisation of the Oxford Suite, the research room is no longer available to see patients which has prevented three studies from opening. Other options for accommodation are being investigated. The main priority for 2025 to fully embed the strategy. The Chair, recognising the resource difficulty and asked if collaboration with University of Worcester had progressed. It was confirmed that there are links with the University Research Groups and had also looked within the wider Foundation Group to identify joint opportunities for primary and sponsored research. This was important in terms of wider ambitions as well as quality of research. The CMO added that the MoU with 3 Counties had been agreed to develop some primary research strategies and thought has also been given to do research on the impact of boarding on our staff. It is an ambition is to become a research active trust and will be exploring this.	
	<u>Resolved</u> – that the Research Report be received and noted	
QC08/12.24	**<u>BOARDING REPORT</u>**	
	The report was taken as read and the ADQG highlighted the following points. We continue to board a significant number of patients although numbers for November were slightly lower than those in October. Discharge Lounge use had increased and work continues to re-configure the lounge which is due to open on Monday. Increasing capacity of the Medical Day Case unit to allow movement of some Medical SDEC work. Cross-divisional work is ongoing in relation to flow. The Flow Facilitator is working with wards to improve use of Medical SDEC, flow workshops are taking place with senior leaders and there will be a 'test of change week' to assess some of the processes.	

	<u>Resolved</u> – that the Boarding Report be received and noted	
QC09/12.24	**<u>DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE</u>**	
	The ACAHP gave the highlights from the Integrated Care Division quarterly report. There was concern that pressure ulcers were not improving in District Nursing particulary in the city team although caseload numbers are larger in this team. The Divisional restructure will focus a Matron within district nursing from 6th January 2025. As actioned from the previous meeting some further details were provided from the City Team: • City locality has the largest population of 78,000 and do report in higher numbers than other localities. There is a higher incidence of MASD and work is underway around quality of referrals and to ensure the categorisation of pressure ulcers is known. • There were low numbers of medication errors although City does have higher numbers compared to other localities. This is largely insulin related incidents. Falls – There is now an Inpatient Falls Lead in the division and in Community Hospitals. There have also been positive results from the project around bed rails and reducing falls due to the inappropriate use of bed rails . The Community Referral Hub is now based at Nelson House and provides a dedicated service 8am-8pm, 7 days per week with the recent addition of a GP to support the hub Children's Therapies received positive feedback following a SEND inspection in November for new ways of working, the report is due to be received in January. Feedback gathered from parents and carers regarding children's physiotherapy drop in sessions has been overwhelmingly positive. There have been very few complaints and none remain outstanding. Stroke and SSNAP remains banded as A. The report detailed a case study from Community ACPs from a family member which summarised great work in community. There is some concern regarding infection control and the Ross CPE outbreak. A meeting has taken place with Kirsty Morgan, NHSE and we have received a lot support and work continues on this ongoing issue. Key areas are clinical cleaning and equipment.	

	The Chair commented that he and the CNO had attended the Community Response Hub on a quality engagement visit and had been very impressed. The CNO asked if any work had been done on the demographic of patients in the City Team, i.e. were there more frail/elderly patients and looking at demography between the different teams and skill mix of teams. It was confirmed that the population demographic of the city is not as old as other localities but is possibly a poorer demographic and also skill mix of teams with those in the City team being less experienced. The ACAHP will look further into this. **ACTION**. It was also agreed to assess any change in skin damage associated with the change to the new continence product. **ACTION** The CNO noted that the CPE outbreak in Worcester had continued for a considerable time and that it is known from the pattern of new positives at Ross and the periods of time between them that it is a practice issue. A further CPE outbreak meeting had taken place and the Infection Prevention Team are providing ongoing back to basics training. GQ (NED) asked about 10+ overdue incidents and asked if there were any themes around these and what support was being prioritised. This is primarily Community Hospital Sisters and the theme is generally pressure ulcers or falls, that there were no obvious themes. For reassurance the incidents are screened at the time of reporting and reviewed for immediate action, the overdue element relates to them just not having been formally closed off. The ICB Representative referring to the City team improvements and size of case load and frequency of visiting asked if it is around continuity of care as all those things would be picked up through continuity of care model. It was confirmed that here is a lot of overlap with this and pressure ulcer improvement plan this would be discussed with the Locality Manager. **ACTION** The ACMO Clinical Research pointed out that there is good evidence that vitamin D deficiency and pressure ulcers linked and there is not enough awareness, especially in the winter months and would forward a paper around this. **ACTION**	**SM** **SM** **SM** **IDuR**
	<u>Resolved</u> – that: **A. The Integrated Care Division Quarterly Report be received and noted.** **B. The ACAHP will look at the demography of the case load in the city team.** **C. The ACAHP would assess any change noted in skin damage associated with the change to the new continence product**	**SM** **SM**

	D. The ACAHP would feedback to the City Locality Manager regarding Continuity of Care and the Continuity of Care Model **E. The ACMO would circulate the paper regarding vitamin D deficiency**	**SM** **IDuR**
QC10/12.24	**DIVISIONAL QUARTERLY REPORT – CLINICAL SUPPORT**	
	Leah Hughes, Operational Clinical Lead, Radiography, gave the quarterly update for the Clinical Support Division. The number of incidents reported had been stable until November when a slight increase was seen. There was a theme around radiology incidents and patients incorrectly requested for imaging. A round table meeting took place and an action plan was developed. Radiology and Audiology Works and installation of the additional mammography machine in Fred Bulmer is underway. CT perfusion scanning has commenced and is going well. Diagnostic Centre building work continues to progress at a good rate and is planned to open in July or August 2025. There is concern over the increase in ED demand and high proportion of workload for imaging. The DEXA scanning service is also of concern. Working through the final patients as part of the review process and will be sending out letters to clinical teams to support with clinical review of patients where imaging and DEXA reports were changed following re-processing of the images. Staffing levels in Audiology is of concern due to imminent retirement of the Service Lead and also a member of staff on maternity leave in Paediatric Audiology. Pathology Exceptional histology performance 92% of cases met the 72 hours turnaround target. Advanced digital reporting is also progressing. The Histology review is coming to conclusion and some reports have been issued. Endoscopy Endoscopy transferred from the surgical division in September. A template has been developed to optimise efficiency and improve cancer performance.	

	There are still some operational challenges and are slightly behind in the plan for 2024/25 and due to sickness, this is unlikely to recover. The use of the Endoscopy area has also had some impact on lists. <u>Mortuary/Bereavement</u> The Eden IT system has been implemented, which has been positive. Quality and governance has also been enhanced in the Mortuary. <u>Pharmacy</u> Vacancy rate is at 13% and have now appointed a new Clinical Director of Pharmacy and Medicines Optimisation as Tony McConkey will be retiring from this post in March 2025. KPIs have showed significant improvement. TTOs 66% done within 2 hours and 62% of out patients within 30 minutes. There is concern about the expansion of pharmacy services and capacity with Aseptic and dispensing services. <u>Patient Access</u> Education Clinical Band 6 is now in post in Out-Patients, supporting care delivery. Proud of the high level of SPDRs and mandatory training across all patient access/mortuary which has been continually maintained. There remains some concern around room utilisation and is not always at KPI target in Oxford and Fred Bulmer but is continually monitored. <u>Cancer Services</u> Four substantive Cancer Navigator posts were approved at TMB and are now making progress with type 2 lung health check programme. Regarding Haematology, there has been no agreement from other trusts in relation to transferring patients if any locums are lost which could create considerable pressure on the service. There also remains a Consultant vacancy. Conversations are ongoing with Worcester and there has been a meeting of the two haematology groups to help relationships. An ICS paper is also being produced on the approach to business continuity plans. There is concern about representation at Cancer Board but work is ongoing to improve this. The ICB Representative asked for further detail regarding the DEXA scanning issue and was it a risk of over or under diagnosis and was there risk of harm. One patient had been diagnosed as osteoporotic and turned out to be normal and in many of the cases results were better than had been thought although there were 8 patients identified where there may have been harm caused due to delay in treatment. Clinicians are reviewing	

	all cases and a final report will be submitted by end March. This has also being raised through ICB ELT. The Chair asked if pausing of the South Midlands Pathology Network had posed a risk. It was confirmed that the network was not paused but an option appraisal was being undertaken on how the network is going to be structured so was not a risk.	
	Resolved – that the Clinical Support Divisional Quarterly Report be received and noted.	
QC11/12.24	**PERINATAL SAFETY REPORT**	
	The report was taken as read and noted.	
	Resolved that the Perinatal Safety Report be received and noted.	
QC12/12.24	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The ADQG highlighted the following points from the Patient Experience Committee summary report. There is continued progress with the patient engagement group which is meeting regularly. There are a lot of initiatives and projects ongoing and a large number of staff asking to come to speak to the engagement group. The final advert is out to post for the PALS team which will ensure the team is returned to full strength.	
	Resolved – that the Patient Experience Committee Summary Report be received and noted.	
QC13/12.24	**INFECTION PREVENTION COMMITTEE QUARTERLY REPORT**	
	The CNO presented the Infection Prevention Committee quarterly report. The report was taken as read and the following key points were noted. The High Consequence Infections Diseases policy has been completed and approved. Flu and Covid vaccinations take up amongst front line staff has been low across the NHS and locally. Cases of both flu and Covid have increased, ED had been congested and patient flow, and isolation had been a challenge. A new testing kit will be available before Christmas to be able to screen and assess patients as to likelihood of flu and covid and isolate accordingly. The infographic around antimicrobial stewardship regarding the change of delivery of antibiotics from IV to oral will be circulated separately.	

	Clinical teams returned to wearing masks last week and local evidence shows that this stops spread between staff. It was noted that although vaccination uptake had been low at the trust that it is possible to obtain vaccinations at GP practices so it is difficult to understand the total uptake. It was suggested that this could form part of a staff survey.	
	<u>Resolved</u> – that: **A. The Infection Prevention Committee Quarterly Report be received and noted.** **B. The CNO would circulate the infographic around antimicrobial stewardship and the change of antibiotics from IV to oral administration.**	**LF**
	<u>CONFIDENTIAL SECTION</u>	
QC14/12.24	**<u>MATERNITY CQC SURVEY PRESENTATION AND ACTION PLAN</u>**	
QC15/12.24	**<u>LMNS INSIGHT VISIT REPORT</u>**	
QC16/12.24	**<u>PATIENT SAFETY INCIDENTS SUMMARY REPORT</u>**	
QC17/12.24	**<u>ANY OTHER BUSINESS</u>**	
QC18/12.24	**<u>DATE OF NEXT MEETING</u>** The next meeting is due to be held on 30 January 2025 at 1.00 - 4.00 pm via MS Teams.	

Acronym	
AAU	Acute Admissions Unit
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 Fund
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
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
GEH	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
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio

HV	Health Visitor
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
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
MOU	Memorandum of Understanding
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
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
OHP	One Herefordshire Partnership
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
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
RTT	Referral to Treatment
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
SLA	Service Level Agreement
SOP	Standard Operating Procedure
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
WAHT	Worcestershire Acute Hospitals Trust
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