PUBLIC BOARD MEETING

Thu 03 April 2025, 13:00 - 14:30

MS TEAMS

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Information *Frances Martin*

Glen Burley, Russell Hardy and Andy Parker.

13:01 - 13:02
1 min

2. Declarations of Interest

Information *Frances Martin*

13:02 - 13:04
2 min

3. Minutes of the Meeting held on the 6 March 2025

Decision *Frances Martin*

3. PUBLIC BOARD MINS - MARCH LF.pdf (9 pages)

13:04 - 13:05
1 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

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

13:05 - 13:25
20 min

5. Items for Review and Assurance

5.1. Managing Directors Report

Discussion *Jane Ives*

5.1 APRIL 2025 - WVT MD Report - BOD.pdf (6 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT IPR Month 11 February 2025.pdf (29 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Sarah Assinder*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:25 - 13:50
25 min

6. Items For Approval

6.1. Trust Objectives 2025/26

Decision *Alan Dawson*

- 6.1 20250327 Trust Objectives Board Cov Paper.pdf (1 pages)
- 6.1a 20250326 Trust Objectives DRAFT.pdf (5 pages)

6.2. Standing Orders and Standing Financial Instructions

Decision *Gwenny Scott / Katie Osmond*

- 6.2 - Standing Orders and SFIs review covering report March 25.pdf (1 pages)
- 6.2a - Joint FG Standing Orders & SFIs 2024-25 - V7 clean.pdf (82 pages)

6.3. Quality Committee Terms of Reference and Forward Planner 2025-26

Decision *Lucy Flanagan*

- 6.3 Quality Committee Terms of Reference April 2025 BOARD VERSION FINAL.pdf (7 pages)
- 6.3a QC FWD plan 25 26 only.pdf (2 pages)

13:50 - 14:20
30 min

7. Items for Noting and Information

7.1. Education Centre Capital Project Update

Discussion *Alan Dawson*

- 7.1 Ed Cen Update Board.pdf (2 pages)

7.2. NHS Staff Survey 2024

Discussion *Geoffrey Etule*

- 7.2 - Board Covering Report - NHS Staff Survey 2024.pdf (1 pages)
- 7.2a - WVT Staff Survey report 2024 GE.pdf (10 pages)
- 7.2b - RLQ-benchmark-2024 WVT full report.pdf (146 pages)
- 7.2c - RLQ-breakdown-2024 Divisions & Groups.pdf (19 pages)

7.3. Safeguarding Annual Report

Discussion *Lucy Flanagan*

- 7.3 WVT Safeguarding Annual Reports Jan Dec 2024 Board version final.pdf (29 pages)

7.4. Perinatal Services Safety Report

Discussion *Lucy Flanagan*

- 7.4 Front sheet Perinatal Services Safety Report Board version.pdf (1 pages)
- 7.4a Perinatal Services Safety Report February 2025 - redacted for Board.pdf (11 pages)

7.5. Use of the Trust Seal

For Information *Gwenny Scott*

- 7.5 - 03-04-2025 - Use of Trust Seal~v1.pdf (1 pages)

7.6. Committee Summary Reports and Minutes

7.6.1. Audit Committee Report and Minutes 12 December 2024

Discussion *Nicola Twigg*

- 7.6.1 AC FS.pdf (1 pages)
- 7.6.1 Audit Summary April 25 (Dec submission).pdf (1 pages)
- 7.6.1a Audit Committee minutes - 12 December 2024.pdf (8 pages)

7.6.2. Quality Committee Report and Minutes 30 January 2025

Discussion *Ian James*

- 7.6.2 Quality Committee Summary Report January 2025 Public.pdf (3 pages)
- 7.6.2a Quality Committee Minutes January 2025.pdf (16 pages)

7.6.3. Charity Trustee Report and Minutes 12 December 2024

Discussion *Grace Quantock*

- 7.6.3 Charity Trustee FS.pdf (1 pages)
- 7.6.3a CT Report.pdf (1 pages)
- 7.6.3b Charity Trustee minutes December 2024.pdf (4 pages)

7.6.4. Integrated Care Executive Report

Discussion *Frances Martin*

- 7.6.4 ICE Escalation & Assurance Report February-March 2025.pdf (2 pages)

14:20 - 14:25
5 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

Frances Martin

14:30 - 14:30
0 min

10. Acronyms

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

14:30 - 14:30
0 min

11. Date of Next Meeting

The next meeting will be held on 5 June 2025 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Board of Directors Meeting
Held 6 March 2025 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)
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)
Louise Robinson	LR	Deputy Company Secretary
Jo Rouse	JR	Associate Non-Executive Director (ANED)

BOD01/03.25 **GEM Awards**

Team of the Quarter – Quarter 2 – Head, Neck and Orthopaedic Team – The Chairman read out the reasons why the Head, Neck and Orthopaedic Team had been nominated for this award.

Employee of the Quarter – Quarter 2 – Jessica Rippard – The Chairman read out the reasons why Jessica had been nominated for this award.

Team of the Quarter – Quarter 3 – Microbiology Team – Goran Pinjuh and Nicola Edmunds – The Chairman read out the reasons why Goran and Nicola had been nominated for this award.

Employee of the Quarter – Quarter 3 – Katie Bayliss – The Chairman read out the reasons why Katie had been nominated for this award.

BOD02/03.25 **Apologies for Absence**

Apologies were received from Sharon Hill, Non-Executive Director and Frances Martin, Non-Executive Director.

BO003/03.25 **Quorum**

The meeting was quorate.

BOD004/03.25 **Declarations of Interest**

There were no declarations noted.

BOD05/03.25 **Minutes of the meeting held 5 December 2024**

Resolved – that the minutes of the meeting held on 5 December 2024 be confirmed as an accurate record and signed by the Chairman.

BOD06/03.25 **Matters Arising and Action Log**

Resolved – that the Action Log be received and noted.

BOD07/03.25 **Chief Executives Report**

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

(a) NHS 10 Year Plan and Social Care Reform – We are expecting this to be published in the spring. A Royal Commission on Social Care has been announced. It is hoped that this will get cross party commitment to the Policy changes in Social Care. This could take some time to get to this point and we could face some challenging winters before then.
(b) Annual Planning Guidance – This was received later than ever this year, with some of the main elements included in the Report. This is a thinned down set of guidance this year, which concentrates on financial balance, elective recovery and safe elective care. We are in the process of working with Urgent Care colleagues to finalise an agreement for the coming year. A cap around elective activity is the main area of concern. Until now, we have been able to undertake as much capacity as we can and have built accordingly to enable this. The Planning Guidance pledge talks about all type 1 Accident and Emergency Departments having a co-located Urgent Treatment Centre and that capital will be associated with this.
(c) UEC Reform Plan – This is not yet published but components of this are within the Report. Productivity Improvement Tool – There is a lot of data to help us within this on our productivity journey. We need to keep the KPIs and productivity indicators simple. We are working on some local productivity improvement packs which the Financial Group Strategy Financial Advisor is working on to further improve activity.
(d) Productivity Improvement Tool – We need to ensure that we are delivering this to the most appropriate patients. We are working with our Primary Care colleagues to see if they are able to assist in caring for some patients rather than them coming into Secondary Care.
(e) National Staff Survey 2024 – This will be published on 13 March and the contents shared at the next meeting.
(f) Recognition of the Higher Cost of Delivering Care in an Extremely Rural Setting – There is an extra £10m allocated in this year's planning round to cover this issue. A lot of work has gone into achieving and securing this funding.
(g) More From Our Great Teams – Update from the Clinical Support Division – There are many areas covered in this section including the positive news on Consultant recruitment.

(h) JI noted around the Advice and Guidance, that locally this involves a lot of time from our staff. Where this is used well it is effective but we are working with local GPs to review the volume which can take up too much Consultant time to try filter this to another area. GB agreed noting that locally there is good communication between Primary and Secondary Care Consultants and there is a need to incentivise using advice and guidance appropriately.

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

BOD08/03.25 **Integrated Performance Report**

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

a) The high numbers show the difficult times for the Trust, particularly in January, when we had to call a Critical Incident. Given the pressures, the way the organisation and the teams maintained elective activity during this time has been very impressive. Our morality figures also remain under 100 despite these pressures which is due to the hard, diligent work by all the teams on the front line.
b) A Motion is being presented to the Herefordshire Council tomorrow calling for the opening of the 2 Minor Injury Units in Herefordshire which were closed due to pressures a number of years ago. A lot of work has been undertaken to understand our flow – the number of patients attending the main Emergency Department (ED) since these services ceased has been maintained and has not increased due to this fact. Minors remain very flat, there has only been an increase in all major patients along with congestion in ED for these patients waiting for a bed.
c) The number of estates failures and roof leaks across our Urgent Care floor over the winter has been very difficult for our staff to deal with. This is due to a failure of planned preventative maintenance by our PFI Partners. We pay Sodexo to ensure that our estates are in a good and safe state. We are looking how to escalate this further. JI apologised to staff and patients for what has occurred over the last couple of months.
d) Cancer performance is still benchmarking well but we want to improve further. Stroke patients continue to receive a very good service. There is also a reduction on the number of patients waiting over 52 weeks.
e) Finance – We delivered a £14m CPIP this year but unfortunately we were aiming for £20m. We are starting off in a better place for next year with a number of plans to achieve the £20m CPIP already in place. Our financial outlook remains incredibly challenging into next year.

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

BOD09/03.25 **Quality (including Mortality)**

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

(a) Two National Patient Surveys have been published since the last meeting – The Urgent and Emergency Care Survey and the Maternity Survey. Both have been discussed in detail and the action plans have been presented to the Quality Committee.

(b) In highlight, our ED needs to focus on waiting times and information giving in relation to this, our discharge processes and privacy, dignity and communication in the context of an overcrowded department. Some of these are quite challenging to fix in an overcrowded ED but will be fixed as part of our overarching Urgent and Emergency Care Strategy.

(c) Included in the pack are the 3 areas that have been through our Peer Review process, which is part of our work towards ward accreditation. We agreed to test our methodology on a medical ward, a surgical ward and at one of our Community Hospitals. Two areas achieved a good in this process and 1 marginally missed the standard on some elements of the framework. Ward Accreditation creates a platform for continuous improvement and the Peer Review element enables an opportunity to identify strengths, areas for improvement, to learn from one another and to share best practice. All 3 teams who went through this process found it very beneficial. We plan throughout 2025 to undertake a baseline assessment of all of our ward areas against this framework.

(d) One of our Quality Priorities is around patients receiving their Parkinson's medication on time (within 30 minutes of the prescribed time) as this is classed as a critical medication. National research shows that over 50% of patients with Parkinsons who are in hospital do not receive their medications on time. As can be seen from the data our baseline performance was already very strong, but since we have been focusing on this area it has improved again and in December 89% of all medications were given on time. We particularly focused on medications not given between 30 and 60 minutes after being due and a deep dive on missed doses. We actually observed that medications were given on time but a delay in being electronically recorded. This is an area we need to work on. In other instances missed doses were not actually missed but the patient had been discharged or switched from oral to patches and the electronic system had not caught up with this. Due to the large variety of medication used for Parkinson we have done a lot of work around stock control particularly in high use areas such as frailty which has had a positive impact. We plan to continue to focus on Parkinson's medication in 2025 but broaden this Quality Priority to other time critical medications.

(e) CA advised that our mortality indices up until October 2024 remain very good with our SHMI at 99.5 which shows that we have less expected deaths than predicted.

(f) Fractured Neck of Femur – There has been a significant reduction but this is still higher than expected and we continue to implement and embed our fast track pathways.

(g) Heart failure and COPD remain less than 100 and Stroke and COPD figures remain very good.

(h) Perinatal Mortality – We have seen an increase in mortality indices to 6.7 per 1000 live births. All these deaths are subject to rigorous internal and external review. The majority of these cases have been classed as A and B which suggests that the care they received made no difference to the outcome. However, we have identified some areas for improvement around pre term prediction, growth monitoring and dealing with issues around health inequalities. All these are subject to quality improvements.

(i) IJ, Chair of the Quality Committee noted that there is nothing more important than patient experience feedback and commended the staff in the way that they picked up the challenges from the feedback and action plan raised from the Urgent and Emergency Care Survey.

(j) He also pointed out the positive feedback received around having confidence and trust in the doctors and nurses assessing and treating you and while you were waiting, were you able to get help with your condition.

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

BOD10/03.25 **Activity Performance**

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

(a) We had a positive month regarding our cancer performance in December despite our workforce challenges and the challenges with our Emergency Care Pathway.
(b) Our Breast Team challenges in the first 3 months of the year should be resolved but these have had an impact on our performance.
(c) Our Endoscopy improvements now enable us to offer almost every patient an appointment within 7 days of referral.
(d) The Cancer and Diagnostics Imaging Team undertook a deep dive into addressing some of the improvements across accessing reporting in some of our modalities particularly in CT and MRI prostate. Key to resolving some of these issues is the pathway redesign and increased capacity our Community Diagnostic Centre will provide once this is open in the late summer.
(e) Diagnostics – There have been some real challenges with our 6 weeks to access deteriorating slightly over the winter. This was driven by an increase in referrals and some significant workforce challenges. We are starting to see improvement and we are now seeing 83% of patients within 6 weeks but areas of concern still remain – Echocardiogram, non-obstetric ultrasound and neurophysiology.
(f) The management of referrals is an issue and in February there was revised guidance from GIRFT regarding the management of echocardiograms in the pathway management. This guidance is being reviewed to look at some of the efficiency schemes but our internal management referral is a particular issue that we need to address as we go into the new financial year.
(g) Urgent and Emergency Care – We are undertaking a Test For Change month in March. We tested and trialled a number of schemes the previous year which have had a positive impact on patients and staff that formed the basis for our Urgent and Emergency Care schemes in 2024/25 which had been embedded in a number of Business Cases and are now business as usual. This March we are doing the same and we are undertaking 9 Test Of Change schemes as well as ensuring that our embedded schemes for 2024/25 are working as expected. The Test For Change is being adapted and plans have all been suggested by our Clinical Teams and supported by our Transformation Team and will form the basis of our plans for 2025/26. Unlike last year, none of these schemes have any additional financial support and are all being undertaken within the cost envelopes of the Divisions looking at new ways of working. AP gave examples of some of the schemes being tested and trialled during the month.
(h) EB applauded the 9 Test For Change Schemes and is looking forward to hearing the outcomes.

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

BOD11/03.25 **Workforce**

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

(a) Sickness Absence – Over the last few months we have seen a significant increase NHS wide and in the Trust, but are now seeing a reduction. We are putting in place high impact actions, reviewing our Sickness Policy and supporting our staff to maintain a reduction in sickness absence over the coming months.
(b) We have had recruitment and retention challenges with our Health Care Support Workers. We have developed a detailed action plan working with our Divisional Leads and Matrons. GE was confident that over the next 3 months we will see a reduction in turnover and vacancies.
(c) EDI and general staff Health and Wellbeing – We continue to support national Health Programmes, GE gave examples. We are also encouraging staff to look after their health and wellbeing.
(d) E-Rostering in Inpatient nursing areas will be rolled out to all clinical areas. This is a key area to enhance workforce productivity and generate efficiency savings for the Trust.
(e) The Staff Survey results will be presented to the next Board meeting.

Resolved – that the Workforce Report be received and noted.

BOD12/03.25 **Finance Performance**

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

(a) Month 10 – Year to date we are have a £11.3m deficit, £8.4m adverse to our plan despite implementing mitigations.
(b) Drivers of Financial Positon – 1 new driver is the Welsh Parity income. We are working with the National Team to seek resolution with NHSE and NHSW.
(c) Strong elective performance has enabled us to partly mitigate some of these financial challenges.
(d) We have formally reflected an exit £4.1m deficit, which is £1m adrift from the planned level. This is part of an overall System position and we are working collaboratively with partners to deliver an overall System position for the year, which may result in some slight variances within individual organisations. Within that, there remains just under a £13m risk which includes the Welsh income described and do require mitigation by year-end. As part of the working System solutions, the element of this that is specifically a stretch target for the Trust, is to deliver a further £1.5m of mitigation over the remaining 2 months to allow us to deliver our part of the overall System outturn forecast. We are overseeing this through the Financial Recovery Board and is assessed as high risk for delivery. We have growing confidence that we will be able to deliver a significant part of this.
(e) Capital and Cash – We have spent £14.6m to date. We had confirmation finally of national funding around our Digital Programme in January, hence the delivery of this is being taken at pace to ensure that we maximise the benefit of this funding during the current financial year. We are expecting a step up in spend in January to March which is largely linked to the Community Diagnostic Centre.
(f) Cash – Balances continue to reduce which is expected. For the 13th month in a row, we have maintained prompt payment performance.

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

ITEMS FOR NOTING AND INFORMATION

BOD13/03.25 **Perinatal Safety Report**

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

(a) There is nothing in month to escalate to Board.
(b) The CQC Maternity Survey was published in November 2024 which related to births and deliveries that took place in February 2024. In the previous year, we performed in the Top 5 Trusts in the Region and for some of the questions, top Nationally. We were disappointed not to have maintained that position but there was still really strong performance. The areas that we deteriorated was around our service users feeling listened to and in particular how we communicate, engage and involve them in decision making. This does triangulate as a theme when we meet with our Maternity Neonatal Voices Partnership (MNVP), some of their feedback is around communication, engagement and information giving. We do receive very few complaints, yet when we do communication is often a theme. The team have been very proactive in wanting to make changes and improvements in this area. A number of meetings and engagement sessions have been held. We have also asked the MNVP for further engagement and support and changed the way in which we elicit feedback from our Services Users in real time. We are also further developing our suite of information that we provide through Badgernet, leaflets and mini video clips for our Service Users. We were really pleased to note that the Maternity Triage Unit (MTU) that opened at the beginning of 2024 scored very positively in the Survey. The MTU also featured in a patient perspective national publication earlier this week.
(c) LF is the Board Level Safety Champion for Maternity and Neonatal Services supported by SH and FM as NEDs in their roles. LF and FM undertook an unannounced Safety Walkabout in the service in January. We were able to observe Triage, the Neonatal Unit, Delivery Suite and the Maternity Ward. We were able to observe Maternity handover, the Safety Huddle amongst Neonates and Maternity and the full MDT handover. It was clear that patients and their safety are at the heart of everything we do. We observed good team working and positive interaction, teams talking about the priorities for the day and the team taking the opportunity to educate one another.
(d) We have been able to submit our declaration to NHSR for our compliance with the 10 Safety Standards for Maternity and Neonatal Services. Our submission is a self-assessment but supported by a peer review by the LMNS who endorsed our assessment and supported our submission to NHSR.
(e) RH noted that it is a priority to allow people to leave the world with dignity and asked that we think about how the NEDs can be more involved in end of life care across the Foundation Group.

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

BOD14/03.25 **Patient Experience Report**

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

(a) A more detailed report has been presented to the Quality Committee.
(b) We continue to send text messages to patients as part of our Friends and Family feedback. Responses have dropped down from 20% to 13% that said the vast majority of the responses we receive are positive. The team are working on real time feedback and we are launching QR Codes and other methology in April to improve feedback sources.
(c) We have made good progress in responding to patient's complaints yet there is still more to do. We are still receiving too many formal complaints and despite improvements taking too long to respond. We need to improve responding to concerns in real time to prevent them becoming more formal.
(d) We are launching a new Interpreting Service building on experiences from other parts of the Foundation Group and following a pilot in 3 services areas in the Trust.
(e) IJ, Chair of the Quality Committee agreed that the issue around complaint responses is the biggest area of challenge. Not being able to respond in a timely way then compounds the issue.

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

BOD15/03.25 **Board Assurance Framework and High Risk Report**

GS presented the Board Assurance Framework and High Risk Report and the following key points were noted:

(a) This is an interim Report with a more detailed Report being presented next month with the new format, which is being presented to Audit Committee.
(b) We are revising the content of the Board Assurance Framework to align with our Strategy for the coming year.
(c) GB advised that the CQC reviewed the new format for George Eliot and liked how this was presented, noting that it may be worth checking with them on their content.

Resolved – that the Board Assurance Framework and High Risk Report be received and noted.

BOD16/03.25 **Use of Trust Seal**

Resolved – That the use of the Trust Seal for the Joint Appointment Contract for the Provision of an Asset Condition Survey at Hereford County Hospital be received and noted.

COMMITTEE SUMMARY REPORTS AND MINUTES

BOD17/03.25 **Audit Committee Report and Minutes 21 October 2024**

Resolved - that the Audit Committee Report and Minutes 21 October 2024 be received and noted.

BOD18/03.25	**Foundation Group Board Minutes and Action Log 5 February 2025** **Resolved that the Foundation Group Minutes and Action Log 5 February 2025 be received and noted.**
BOD19/03.25	**Charity Trustee Report and Minutes 19 September 2024** **Resolved – that the Charity Trustee Report and Minutes 19 September 2024 be received and noted.**
BOD20/03.25	**Integrated Care Executive Report 14 January 2025** JI presented the Integrated Care Executive Report 14 January 2025 and the following key points were noted: (a) We are looking at the format at how we provide Assurance Reports. We have lifted the key areas from the ICB – alerting, assuring and advising. (b) Under the Alert Section, the Better Care Fund looked like they were heading for a £0.5m overspend. Further work has been carried out and it now looks as they we will achieve around a £100k underspend. **Resolved – that the Integrated Care Executive Report 14 January 2025 be received and noted.**
BOD21/03.25	**Quality Committee Report and Minutes 31 October 2024, 28 November 2024 and 19 December 2024** **Resolved that the Quality Committee Report and Minutes 31 October 2024, 28 November 2024 and 19 December 2024 be received and noted.**
BOD22/03.25	**Any Other Business** There was no further business to discuss.
BOD23/03.25	**Questions from Members of the Public** There were no questions received from Members of the Public.
BOD24/03.25	**Date of next meeting** The next meeting was due to be held on 3 April 2025 at 1.00 pm via MS Teams.

WYE VALLEY NHS TRUST
ACTIONS UPDATE: BOARD OF DIRECTORS, 3 APRIL 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETED			
N/A	N/A	N/A	N/A
ACTIONS IN PROGRESS			
N/A	N/A	N/A	N/A

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Managing Director Update Report
Lead Executive Director:	Choose an item.
Author:	Jane Ives, Managing Director
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
To update the Board on the reflections of the Managing Director on current operational and strategic issues.	
Recommended Actions required by Board or Committee	
For information.	
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.	

[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.

1.0 NHS Reset

They say a week is a long time in politics. When the new government came into power last year, its stated mandate was to deliver change. The parlous state of the economy, the war in Europe and recent seismic geo-political shifts create an environment where the status quo cannot stand and has led to the recent set of announcements and a more radical change programme.

NHS England (NHSE - the central administrative arm of the NHS) will be abolished in two years' time when it is to be subsumed into the Department of Health and Social Care (DHSC).

Our local commissioners, the Integrated Care Boards, are to shrink by 50 per cent by the end of this year. This will almost inevitably pre-empt ICB's merging across current boundaries to cover a larger geographical footprint. In time I would expect these to match the new local government boundaries based on Mayoral authorities which will be being implemented over the next 3 -4 years.

This NHS reset is being led centrally by Health Secretary Wes Streeting and Jim Mackey the new transitional NHSE CEO. Alongside Jim is our Chief executive Glen Burley, who has been announced as the national financial reset and accountability director in the transition team. Glen will continue as our Chief Executive (and that of the other Foundation Group Trusts).

The new team are determined to remove bureaucracy and revert back to a financial regime which incentivises productivity. In simple terms the more productive we are, the more resources we will have to invest in the things we want to do.

For the current year it is clear that the NHS and its constituent parts will be required to live within its means.

We have spent many years arguing that it costs more to deliver health services in a rural county like Herefordshire. This has borne fruit and we will now receive nearly £14 million a year in recognition of this and we hope a further £7m from Welsh commissioners yet be agreed. This is directly to our bottom line.

As well as significant workforce reduction in the national, regional and ICB teams there is a national requirement to review and reduce our corporate workforce increases since Covid by 50% this along with other aspects of our CPIP programme will mean a net reduction of around 130 WTE in staff posts at the trust. The plans for this are being worked through by corporate and divisional teams. We will need to do work differently and take advantage of technological change.

We will also need to reduce our spend on Bank staff by around 15 per cent and reduce our agency spend by 40 per cent to meet national requirements and our CPIP targets.

As a Trust we will adopt three key principles underpinning our priorities which are protecting patient outcomes, staff experience and improving value for tax payer's money

- We must live within our means – recognise that safety is a continuum, but we will not endanger patients.
- Clinical staffing – we will live within our establishments, balancing risk across services and departments
- We will not let processes and bureaucracy become barriers to delivery

2.0 25/26 Activity, workforce and financial plan

We have committed to meet the national elective and cancer targets, and the 78% four-hour ED target for next year. (The ED improvement is subject to a capital bid to provide an on-site UTC that will release capacity in the main ED).

We have submitted a breakeven plan after taking account of the deficit support we have and a further stretched financial risk. This represents a 6% CPIP (we delivered just under 4% last year), including assumptions about income and baseline that means that the plan is considered high risk. We are not alone in having a financial plan that has significant risk to delivery.

3.0 Staff survey

I am delighted that we have once again improved our results in the national staff survey. It is so important that our staff enjoy working in their teams, want to come to work and feel that they are able to contribute to improving care for patients.

We had particularly strong scores in the section on 'a voice that counts' with the top scores in the country for being able to make suggestions for improvement in my team, and involvement in any changes that affect my work. Feedback about leaders and managers was also very positive.

We were above average in all categories once again.

4.0 One Herefordshire review

Last week we held our annual meeting with One Herefordshire partners to review our progress over the last year and develop our plans for the coming year.

Of particular note was the progress we have made on delivering better value from the better care fund and integrated out of hospital urgent care. Both showing demonstrable change and effective joint working.

However, despite this we have continued to see growth in emergency adult admissions, particularly in people aged over 65. The over capacity of the urgent and emergency care system is the highest priority for the Partnership to focus on next year. Continuing to drive improvement from the BCF and out of hospital urgent care on the strong foundations we have is a key element of this. We also need to develop our neighbourhood health teams to support more people staying well and being cared for at home. We are well placed to deliver the national neighbourhood health guidelines that have recently been published and are set out below. We are also developing a 'gain-share' agreement with Herefordshire General Practice as part of our saving plan based on delivery of reduced emergency demand.

4.1 Neighbourhood Health Guidelines

We have worked well with our partners in Herefordshire under the One Herefordshire banner for a number of years and so are really well placed to deliver the new national guidance as follows;

- Consistent, system wide population health management approach
- Design and deliver most appropriate care for each population cohort
- Embed, standardise and scale the 6 core components of neighbourhood health
    - Population Health Management (person-level, longitudinal, linked data set)
    - Modern General Practice (move from reactive to proactive)
    - Standardising community health services
    - Neighbourhood multi-disciplinary teams
    - Integrated intermediate care with a 'Home First' approach
    - Urgent neighbourhood services

5.0 More from our Great Teams - Update from the Medical Division

Urgent and Emergency Care

We continue to have high numbers of patient in our Emergency Department, reaching record highs during March 2025. This coupled with high levels of acuity and an ongoing increase in attendances, has made the efficiency and safety of the department extremely challenged. The resilience demonstrated by our staff across acute and emergency is something we continue to be proud of. Our departmental efforts are ongoing in light of our CQC visit in December 2023 and positive developments have been implemented despite ongoing operational pressures. This includes:

- Year on year improvement of 4 hour performance
- Implemented a minor illness service in ED
- Front door streaming: Nurse navigator
- Phased implementation of ED Medical Staffing business case and ongoing recruitment

4-hour performance has improved from 54.7% in February 2024 to 65.9% in February 2025. We have also seen our time to triage decrease. Our nurse navigator is working well and navigates patients to our in house GP during the week and we have increased our usage of slots provided by our Primary Care partners during the week and weekends.

We are embarking on the recruitment plan for the medical staffing business case and the ED nursing workforce have implemented permanent changes from both the CQC report and business case improvement work including the new rota ensuring overnight senior ED sister cover.

Throughout March 2025, the test of change month across WVT, our department has provided a middle grade doctor in Medical SDEC, a REACT team to prevent admission and return patients home with support and dedicated pharmacy support in ED; all in encouragement of improving hospital flow.

Plans for further improvement:

- Reduction in ambulance handover times
- Continued focus on the above work streams with an additional focus on frequent flyers and reducing their attendances to ED.
- Nurse navigator role to be expanded
- Medical SDEC optimisation
- ED/GP direct referral pathway
- QI Project: SAMBA Audit and opportunities to improve specialty reviews.

Ambulatory & Frailty

Medical workforce plans have been developed for Geriatrics and Stroke Medicine which has been fed into the medical model for the division; after a successful away day for Geriatrics there are a number of test of change initiatives the team would like to test with one being more geriatric presence at the front door and looking at a frailty take.

Across Stroke services the team are working with TASC2 to look at thrombolysis rates and door to needle time with an internal review being undertaken of patients who could have been treated to increase our thrombolysis rates, medical model for front door Stroke has been provided for the Model C plan along with a briefing paper detailing what rehab beds would be needed to support model C, this is being worked through with the ICB.

Dermatology have identified areas in which productivity can be increased with additional patients seen in clinics and on MOPs lists, this has started to take effect as of March with a continuing focus on how the service can be improved with our current resource; business case being presented to TMB to increase substantive workforce by 1 consultant to support deliver of trust 61% RTT – currently Dermatology are not reliant on locum consultants and establishment is substantive staff only.

Rheumatology have adopted the use of AI dictation and we have seen a significant drop in letter typing backlog and turnaround time with an opportunity to use admin and clerical staff differently to support the service (clinic booking of vacant slots, data quality clean up, clinic utilisation), a key challenge across all services is the use of PIFU due to a maxims upgrade that has impacted on the work lists for PIFU (this has been escalated and being looked into) but would like to see an increased use in PIFU across A&F directorate.

Diabetes and Endocrine are performing well as a service delivery stable RTT, some challenges with Hybrid Closed Loop funding from Powys but again conversations are being had and seeking a resolution with the health board in wales. Positive meeting with Worcester colleagues to discuss the future of Renal services at Herefordshire and how that service will be delivered when the Consultant at WVT retires in August 2026 – good cross organisational working and a can do attitude to make sure the patients of Herefordshire receive good care.

Medical Specialties

A 5 year medical workforce plan has been developed for Respiratory and bridging plans to support the service during this transition period. These plans have already been progressed in recent months with the recruitment of 2wte Speciality Doctor CESR posts appointed in November 24 and commencing in post April 25. Within the Medical Model business case being presented March 25, we intend to expand this Speciality Doctor workforce further taking the establishment up to 3 Speciality Doctors. The 5 year workforce plan will continue to feed into divisional plans annually. Robust CESR training plans have been developed to support a fast track approach for Speciality Doctors to submit their CESR. Alongside this piece of work, we have reviewed our locum use and proposed a more effective locum plan which supports to address gaps in consultant ward cover, and will reduce MTS spend for 25/26.

Successful job plan reviews delivered across Cardiology CNS team which has improved productivity and utilisation of the CNS workforce across Cardiology. Productivity gains has included increasing direct clinical care time delivered in each job plan, with more clinics being delivered weekly and increase of New and Follow up capacity delivered by the CNS team. Whilst undertaking these reviews we have also delivered a consultant led OP model moving CNS and junior grade clinics to run alongside consultants to improve supervision and support and to enable standardised clinic templates. The standardisation of clinic templates has also contributed to an increased capacity for the service. In addition to this, a pilot has been agreed with the outpatient department to flex operating times enabling earlier starts for outpatient clinics to accommodate in line with different job plans and contracts. This has also supported to increase the outpatient capacity of the service.

Waiting times reduced and backlog cleared for Echocardiography. Recruitment plans progressing with 3x international trainees appointed and have started in post January 25 supporting a ‘grow your own’ approach for a hard to recruit to service. Training lead for the service was also successfully appointed in October 24 and has developed clear training programme which focuses on maximising the capacity of the workforce whilst delivering training programmes within 18 months.

Gastro Speciality Doctor CESR appointed and started in post November 24, supporting succession planning for the consultant workforce and improved middle grade support for the service enabling improved ward cover and elective delivery across middle grade workforce.

NHS
Wye Valley
NHS Trust

Integrated Performance Report

February 2025

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

Whilst we are reporting our month 11 performance in this report, we have now started the new financial year and our agenda today is facing toward 2025/26 with our Trust objectives and quality priorities presented for the boards approval. Our operational and financial plan has also been finalised in the last few days of the old year and will come to the next board meeting.

Over capacity of our urgent and emergency system remains our biggest risk and as we enter the new year from a quality, performance and financial perspective. This is despite an increased proportion of emergency patients treated on the day, increased demand and activity in our out of hospital pathways and maintaining improved discharge pathways. The increase in demand for acute beds from admission of patients aged over 65 primarily, has outstripped the improvements we have made. Renewed focus on improvement across the whole pathway from out of hospital, in hospital and back to the community is our most important improvement priority for clinical and operational leaders. This revised programme of work will commence in the next few weeks.

Theatre utilisation has been steadily improving over the last six months and reached 83% utilisation in February. There is more improvement required but there is momentum across the surgical division that I am confident will sustain and improve our productivity. The outlier specialty is Ophthalmology who are under utilising their theatre capacity and a second specialty review is being organised to ensure there is a plan for improvement that is clinically led.

Whilst reduced staff turnover is a positive, it is very disappointing to see that the turnover for our health care support workers has increased again after such positive progress last year. This is a focus for our nursing and people teams to improve this again, aligned with taking action on very high levels of sickness/absence amongst this group of staff.

As part of our financial plan for next year a headcount reduction of around 130 posts will be required to met our productivity and financial plans. These plans are being developed in our corporate and divisional teams and will require us to work in a different way and will focus primarily on our non clinical workforce. There is no doubt that at scale adoption of AI tools will be required to make the necessary change.

Whilst financial and urgent care pressures have been a feature of the last year, we can also look back with some satisfaction on falling waiting times, improved cancer performance, reducing mortality and a staff survey that remains very positive. This is the result of the hard work of our committed teams.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Infection Prevention Quality Assurance Visit- Ross Community Hospital

Infection Prevention colleagues from NHS England and the Integrated Care Board undertook a quality assurance visit at Ross Community Hospital on 6th March 2025. The visit was prompted by the ongoing CPE outbreak reported at RCH last year. The feedback from the visit was positive and notable improvements were noted by the visiting team on the day. The outbreak has been stepped down to a monitoring phase which is really positive. Whilst the formal feedback is still awaited it is pleasing to note that the team recognised outstanding leadership from matron for that area.

Ofsted Monitoring - Children's Services

Ofsted has published their latest findings for Herefordshire Children's Services. The sixth monitoring visit took place in February 2025 and is part of a series of visits put in place following the service being judged inadequate in July 2022. The focus of this visit centred around the quality and timeliness of social work assessments.

Headlines included many positive messages and acknowledged that the implementation of the Herefordshire Children's services and partnership improvement plan is making progress. The move to locality-based working has been successfully initiated and this is showing early signs of benefit and improved partnership working across health, social care and partner agencies.

The Leeds Partnership are working with health and social care colleagues and supporting teams in developing new ways of working by offering restorative practice training.

SEND inspection

Herefordshire's SEND partnership have been given the middle rating of three possible outcomes by inspectors from Ofsted and the CQC following an inspection of services during December 2024. Many areas of good practice were noted and the partnership have been asked to focus on 4 areas of improvement including:

- Reduce waiting times across health services particularly for therapeutic and diagnostic services
- Information provision for access to support services while waiting for assessment and diagnosis of neurodevelopmental conditions
- The partnership to ensure sufficient capacity and stability across all health services to improve service consistency and delivery
- The partnership needs to provide high quality information regarding the range of services available to children and young people with SEND

Prevention of Future Deaths Notice (Worcestershire Coroner)

The Trust received a Prevention of Future Deaths notice from the Worcestershire Coroner. The issues highlighted relate to pressure ulcer care, staff training in relation to wound care, lack of assurance of agency staff competency checks and lack of assurance that improvement actions were making the impact required to mitigate a case like this occurring in the future. An action plan and response to the concerns raised will be developed and submitted within the 56 day deadline.

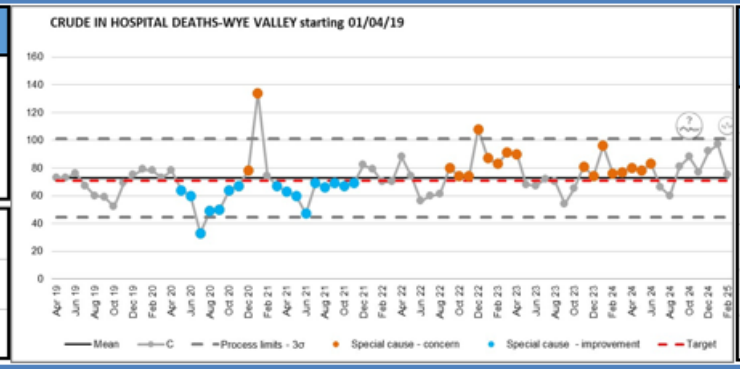
Quality & Safety Performance – Mortality

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)*	**Sep-24**	100.2	*0.7*
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Nov-24**	101.3	*1.3*
SHMI (in hospital)			98.3	*0.5*
SHMI (out-of-hospital SHMI)			108.2	*3.15*



CCS Group/Origin of Alert	Data month	SHMI	SHMI Change	Actual Deaths	Expected Deaths
Chronic Obstructive Pulmonary Disease	Nov-24	87.2	2.0	24	28
Congestive Heart Failure		103.1	5.9	64	62
Fractured Neck of Femur		115.4	-1.1	38	33
Pneumonia		106.6	1.7	206	193
Septicemia		109.2	-5.8	113	104
Stroke (*Acute Cerebrovascular Disease*)		97.7	-4.7	81	83

Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from December 2023 to November 2024 shows Wye Valley NHS Trust at **101.3**. The NHS England SHMI, which is for the period of October 2023 to September 2024, is reporting at 100.2.

- Latest **crude mortality** rate for February 2025 was **1.27%** for all admissions, which equates to 75 deaths including ED and CH's. This has reported a significant reduction since last month with 22 less observed deaths.

- Our key mortality outlier groups, with the latest figures (*December 2023 – November 2024*):
  - **Heart Failure** – Over the past few months, we have observed small increases in the mortality rates for HF patients with the latest rate reporting at slightly higher than the national average.
  - **#NOF** – Another consecutive reduction for our #NOF mortality rates, which now reports at 115.4. Improvement work to the pathway continues with the recent introduction of a #NOF bleep system, which provides earlier flagging of potential patients in the ED and allows other key teams to prepare.
  - **Pneumonia & COPD** – Both groups have reported small rises this month to 106 and 87 respectively. An update on these groups, including the most recent mortality reviews and learning, will be provided by the Respiratory Mortality Lead this month at the Learning from Deaths Committee (LfD).
  - **Sepsis –** A notable reduction in the latest mortality rates for Sepsis deaths, which is now reporting at 109.2. This is the lowest reported rate for around 2 years and is the third consecutive reduction. A presentation of the latest audit findings were reported at this months LfD Committee.
  - **Stroke –** A significant reduction reported this month with the latest rates below the national average at 97.7. This equates to 81 observed deaths against an expected 83.

- **Perinatal Mortality** – The latest 12-month rolling (*March 2024 to February 2025*) Extended Perinatal mortality remains high at **6.80** per 1000 live births. However, the latest stillbirth rate has reduced slightly to **4.95** per 1000 live births for the same 12 month period.

Quality & Safety Performance – PLACE Audit Results

We are driving this measure because:

Data

The Patient Led Assessments of the Care Environment (PLACE) results were published in February and the headline results are provided below.

Wye Valley NHS Trust 2024 PLACE results

Individual sites	Cleanliness Score %	Food Score %	Organisational Food Score %	Ward Food %	Privacy, dignity & wellbeing Score %	Condition, appearance & maintenance Score %	Dementia Score %	Disability Score %	Average score %
COUNTY HOSPITAL	98.23% ↑	90.75% ↑	94.62% ↑	89.13%↑	81.20% ↑	98.20% ↑	71.52% ↓	73.39% ↓	87.1%
BROMYARD HOSPITAL	100.00% ↑	91.39% ↑	88.02% ↑	95.24%↑	83.93% ↑	97.85% ↑	75.00% ↑	77.81% ↑	88.7%
ROSS HOSPITAL	95.96% ↓	93.45% ↓	92.01% ↑	95.12%↓	75.34% ↓	93.64% ↓	65.63% ↓	65.42% ↓	84.6%
LEOMINSTER HOSPITAL	98.81% ↓	87.98% ↓	93.06% ↑	81.58% ↓	77.05% ↓	90.91% ↓	81.87% ↑	76.62% ↓	86.0%
Weighted Organisation average	**98.16% ↓**	**90.82%↑**	**93.95% ↑**	**89.42% ↑**	**80.52% ↓**	**97.26% ↑**	**71.92% ↓**	**73.14% ↓**	**86.9%**
National Average	**98.10%**	**91.32%**	**92.17%**	**91.38%**	**88.22%**	**96.36%**	**83.66%**	**85.20%**	**90.8%**

Key
On or Greater than National Average
Under national Average – within 5%
Under national Average – greater than 6% below national average
↑ Increase in score from previous year
↓ Decrease in score from previous year

Headlines

Trust overall score is below the national average in 3 domains; Privacy dignity and wellbeing (PDW), dementia and disability. This is the second consecutive year the Trust compliance scores have fallen in these 3 domains.

Ross and Leominster have seen a deterioration in comparison to the previous year's audit.

The detailed analysis of the results is underway and will be formulated into actions. The action plan is centrally monitored by the Lead Nurse for Infection Prevention and assigned to the appropriate department/ governance forum to be implemented effectively.

The Patient Experience Committee will have oversight of the areas of concern where scores continue to deteriorate and provide support to initiate change.

Estates issues in terms of backlog maintenance and the constraints of our estate more generally make it difficult to make significant improvements in the scoring for PDW, dementia and disability domains.

Quality & Safety Performance – Quality Priorities 2025/26

We are driving this measure because:

The Trust has proposed the following priorities to focus improvement efforts in the quality of services for 2025-26. The Priorities were approved by the Quality Committee and the Executive team, and are presented for board oversight and agreement.

Safe	
Priority	**Lead**
Ensure patients receive a timely VTE risk assessment in line with NICE guidance	Deputy Chief Medical Officer
Diabetes Safety Improvement Project- establish governance arrangements, improve culture, panel etc.	Nurse Consultant - Diabetes
Improvement in food safety and quality- support delivery of Trust objective	Associate Chief Nursing Officer (Corporate)
Nutritional risk and MUST	Associate Chief Nursing Officer (Corporate)

Effective	
Priority	**Lead**
Implement Quality Improvement project to target high-risk time critical medication as locally defined	Medicines Safety Officer
Transition of care	Clinical lead for Transitional Care

Experience	
Priority	**Current Lead**
Improve responsiveness to patient experience data	Associate Director of Quality Governance
Increase the number of opportunities to grow our volunteer workforce, in numbers and reach	Associate Director of Quality Governance

The safety priorities are not due for review until the Trust Patient Safety incident response plan is reviewed and refreshed later in the year. To note these priorities include a focus on:

- Pressure damage
- Falls
- Delays in assessment, diagnosis or treatment
- Medication incidents

Quality & Safety Performance – Staffing

We are driving this measure because:

Fill Rate & CHPPD Data

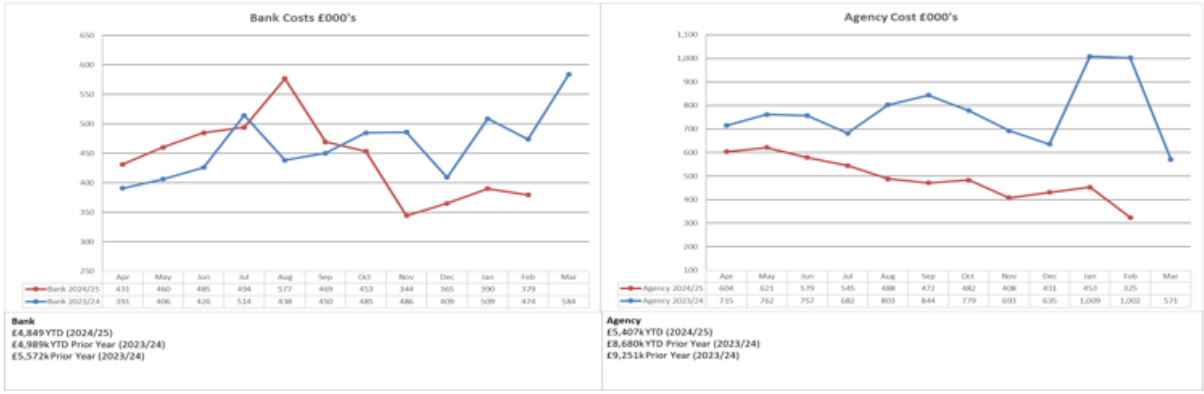
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPP
Primrose Unit	96%	82%	100%	102%	11.4
Maternity Ward	93%	93%	98%	86%	4.9
Children's Ward	110%	157%	133%	97%	17.7
Lugg Ward	113%	99%	102%	121%	6.8
Wye Ward	120%	81%	116%	84%	6.5
Cardiac Care Unit	100%	96%	100%	100%	12.0
Leominster Community Hospital	157%	76%	121%	108%	7.2
Bromyard Community Hospital	127%	94%	100%	94%	7.7
Ross Community Hospital	95%	110%	149%	110%	6.7
Teme Ward	130%	60%	89%	66%	11.4
Redbrook Ward	101%	121%	125%	150%	7.8
Special Baby Care Unit	96%	-	96%	-	23.8
Intensive Care Unit	110%	-	94%	-	27.1
Gilwern Ward	103%	131%	100%	98%	6.7
Acute Medical Unit	117%	83%	99%	121%	7.8
Ashgrove Ward	127%	92%	131%	122%	7.6
Dinmore Ward	133%	78%	100%	105%	7.0
Garway Ward	139%	91%	132%	120%	7.4
Frome Ward	121%	80%	104%	128%	6.9
Arrow Ward	147%	78%	145%	88%	7.7
Women's Health	135%	82%	100%	-	11.2

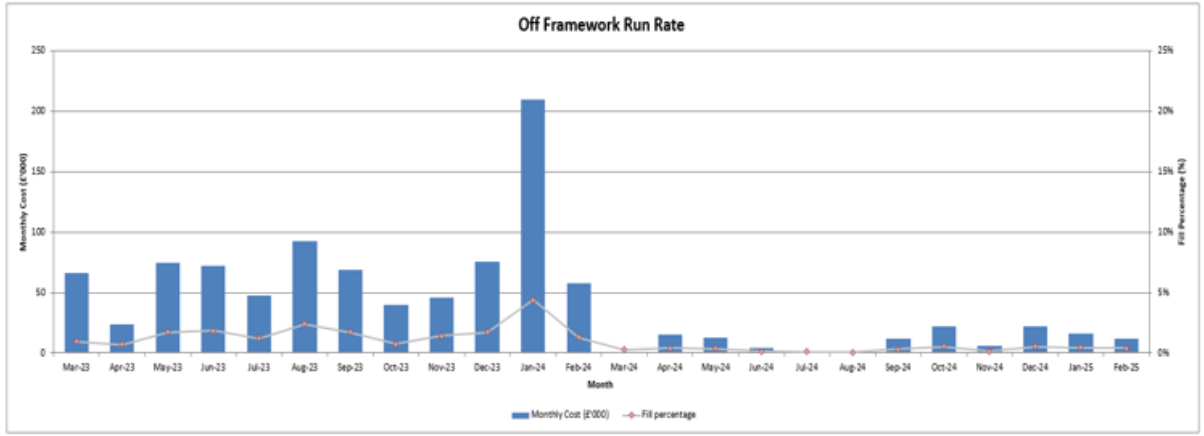
The NHS England staffing return is detailed above and includes the minimum expectations in terms of national quality board reporting requirements.

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 report agency spend has remained fairly sable and the bank position has returned to more usual levels. We continue to use a small number of off framework shifts and are a regional outlier in this respect, a plan is in place to eliminate off framework agencies from April.

In line with the regional collaborative expectations our band 5 general and band 2 rates are NHSE price cap compliant, further reductions for escalated rates (April through to July) have been agreed with our agency provider. We have introduced NHSE price cap compliance for specialist shifts from April 2025. The fill rates at capped rate are monitored via the contract performance meetings and will be shared in future reports through finance recovery board.

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Since our Community Referral Hub [CRH] opened at its new location at Nelson House in Hereford last year we are seeing significant improvements on the management of patients closer to home.

This facility provides a single point of access from a range of community services to support people leave hospital earlier, or to keep them well at home for longer. We now have a team embedded with Taurus GP Federation colleagues in the CRH which can provide access to a range of services. Including Virtual Wards, Hospital@Home, District Nursing, Urgent Community Response, along with 7 days / 12 hours access to a General Practitioner [GP] and from mid-November GP Out of Hours [OoH] services. Along with strengthen a "Call before Convey" priority phone line service to Ambulance Service colleagues to reduce acute admissions to the Emergency Department [ED] and treat patients in their own homes.

We are starting to see an increase in the number of calls from Paramedics on scene at 999 calls across Herefordshire into our CRH. Over February we had over 300 referrals from West Midlands Ambulance Service [WMAS] of which almost, almost 100 went on to be admitted to Hospital, but 200 were non-admitted. 150 of thee referrals were clinical conversations with our team in the CR, which is significantly more that the single number conversation we had per month this time last year.

Virtual Ward [VW] has seen increased occupancy over the last few weeks particularly in Frailty, Surgical Division patients and Primary Care Step-Up Admission Avoidance beds. The focus on increasing our General Surgery beds in February and March has seen very few patients being suitable for VW due to the cohort of patients. Therefore a wider review of the Surgical Divisions opportunity to utilise these beds was undertaken by the VW team and the Surgical Division. Orthopaedic patients were deemed more suitable for these beds and in recent weeks our occupancy of these surgical VW beds has increased to 80% whilst work is underway with other cohorts of suitable patients including increasing the suitability of more medical patients.

However, through our work with surgery and via the Intravenous Outpatient Parenteral Antimicrobial Therapy [IVOPAT] task and finish group which was established to review pathways, Governance and evaluate opportunities, we have seen IVOPAT occupancy increase from 30% on average per month to over 80% in recent weeks.

Valuing Patients Time Programme 2025/26

Integrated Care Division • Rapid Emergency Assessment Care Team (REACT) implementation • Support wards to maximise the SAFER Patient Care Bundle & Internal Professional Standards • Support discharge processes (linked to D2A improvements reported via One Herefordshire)	**Medical Division** • Ambulatory Care Improvements incl. UEC Bid & SDEC flow improvements • Criteria to Admit implementation • Internal Professional Standards and Length of Stay improvements
Surgical Division • Internal Professional Standards and Length of Stay improvements • Surgical SDEC optimisation	Clinical Support Division • Optimise Clinical Support Division contribution to opportunities for pre-hospital & acute floor pathways e.g CDC & Front Door Pharmacy • Support the Length of Stay improvement pathways
The Valuing Patients Time 2025/26 plan has be designed by both clinical and operational leads, cross referenced against the UEC GIRFT checklist, aligned to the 2025/26 WVT UEC planning submission and the ICS Sustainable Future Programme around Frailty (Including EOL management). The Length of Stay schemes support the NHSE Regional Improvement Learning Network (ILN) programme.	

The latest Valuing Patients Time Board discussed our schemes to improve Urgent and Emergency Care [UEC] priorities for 25/26 that have been developed in conjunction with our clinical and Divisional teams. These will alongside the priorities for our One Herefordshire Programme for developing Neighbourhood health teams and how we reduce the increasing admissions for our older population we have seen in recent years.

Our plans for next year will focus on how we increase our acute Ambulatory care offering at the front door, focus on reducing our Length of Stay across acute and community sites, along with getting our basic rights in terms of early patients flow, to ensure congestion does not occur in our ED going into the afternoon / evening

The use of Temporary Escalation Spaces [TES] has remained high all year despite our improvements in our CRH and implementation of revised pathways and focus on acute floor processes.

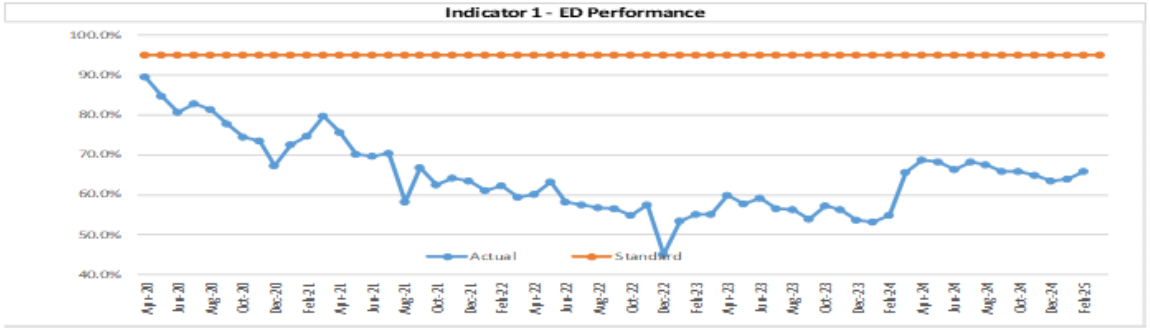
Elective productivity has improved in month with continued increases in Theatre utilisation, in particular the those specialities that need to see a reduction in their early finishes within Theatres in order to maximise their lists to treat additional patients. Looking ahead to next year we have plans to increase our weekend working with additional job planned sessions across General Surgery, Gynaecology and Urology.

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

We are driving this measure because:

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

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

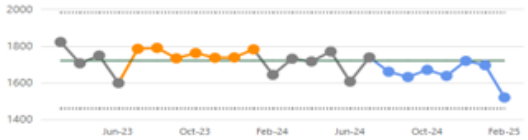


% Patients Spending More Than 12 Hours In ED

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. February`s 4 hour Emergency Access Standard [EAS] Performance was 65.9%

Performance & actions

- 5,368 Type 1 patients attended ED in February which was the lowest volume since April-24. The range of all attendances varied from 147 to 237 with 191 being the average daily attendances.
- 1,521 ambulances conveyed to the Trust in month which was the fewest since February-23. The range in month was 43 to 67. This includes 10.7% from Powys [163].
- Ambulance handover delays over 1hr were 21.4% [293] of all conveyances and 60% [826] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,117 of all admissions [46.7% of all admissions] via a Same Day pathway within no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard ranks 73/122 Type 1 Trust in England for February.
- 12.9% [802] of patients spent 12 or more hours in ED which was 1.7% fewer than last month.
- Our Valuing Patients Time Programme Board [VPTB] has oversight of the current UEC improvement schemes:

➢ SDEC has increased admissions in February this year, almost 70 more patients. The focus for next year is how we reduce the volume of follow up patients, either face to face or convert to virtual, in order to Navigate and stream more patients to our SDECs. For March we have increased the senior decision making in Medical SDEC in order to improve discharge and reduce the requirements for follow up appointments.

➢ Rapid Emergency Assessment Care Team (REACT) with Pharmacy support in ED shows early signs of success as part of March`s Test of Change schemes. This team in ED in ensuring that patients who need therapy sup[port and medications to go home receive these quickly and those that are admitted have their therapy plans and medicines checked and optimised before being transferred to the wards. The aim is to increase discharges from ED or reduce length of stay for patients.

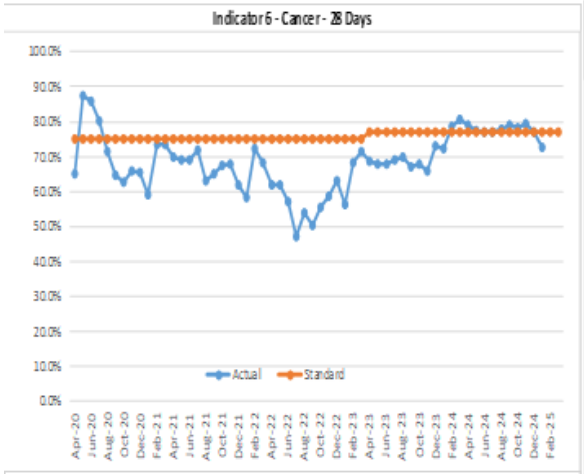
➢ Improvements in our Community Referral Hub / Urgent Community Response team / Virtual wards are covered in my Executive Summary

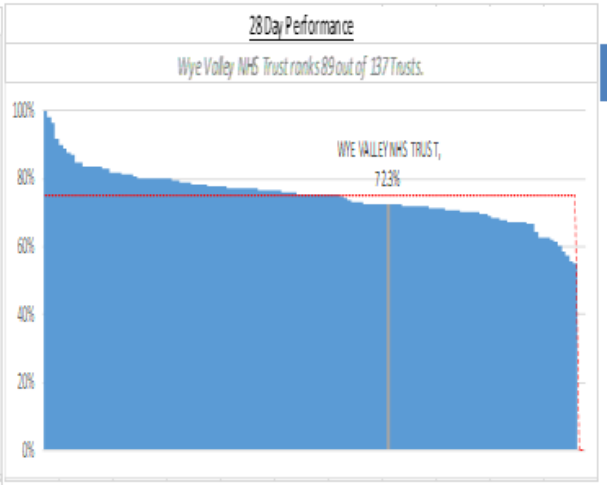
Operational Performance – Cancer Performance [January 24]

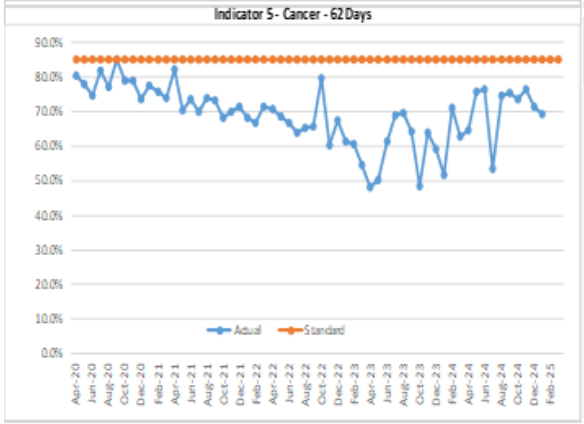
We are driving this measure because:

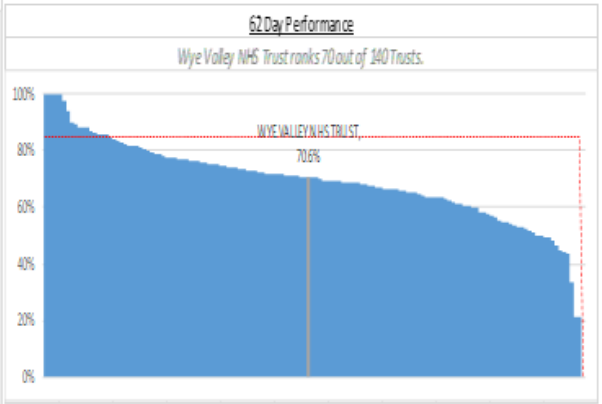
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 77% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer, known as the Faster Diagnosis Strandard [FDS], 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 15.5 % as of the end of January compared to 3 years previous. Urology are currently 46% higher when compared to referrals received 3 years ago. Referrals are currently being audited to identify themes and trends to ensure compliance to the guidance from primary care.

28 FDS:

For the first time in 12 months, WVT did not meet the faster diagnosis target of 77%, with a performance of 73%. This was largely attributed to by the known pressures within the Breast service with a decreased workforce. This position is expected to recover in February with additional Consultants joining the Breast team.

Following the deep dive discussion into Radiology cancer performance, actions have been identified to address the delays with short and long term plans, It is recognized that the Community Diagnostic Centre (CDC) will support our cancer pathways.

Breast capacity issues continue to be 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 has joined the team with a second starting in March.

Developments updates

- Text messaging is now live in Gynaecology to reassure patients of benign results. Cancer navigators have supported its implementation and will review its use of the coming weeks and months
- Breast multidisciplinary team (MDT) improvement meetings continue with a conclusion expected in March to identify actions required to address current issues and support in streamlining the pathway and MDT.
- Endoscopy SOP to reassure patients at the point of endoscopy has now been clinically agreed following an internal audit. This is expected to go live April 2025.

What the charts tell us

28 Day faster diagnosis: Performance against this target was 72.7% below the target of 77% and below our trajectory for the month. 62 Days start of treatment target was 70.6% just above the target of 70%.

Risks

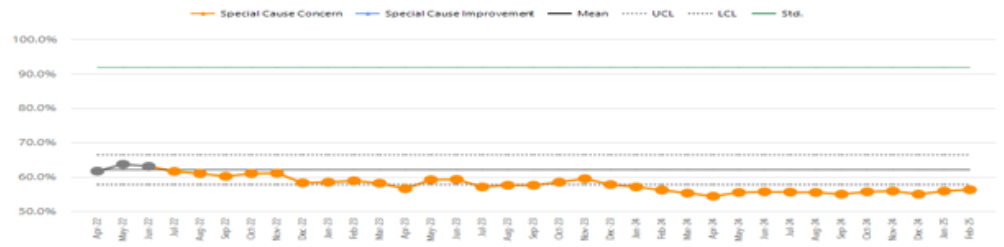
Cancer referrals continuing to remain above 19/20 levels/Histology Endoscopy Radiology and Breast capacity were an issue within month. Along with the impact of high absence levels in December and January of key medical and non-medical staff.

Operational Performance – Elective Activity / Referral To Treatment Performance

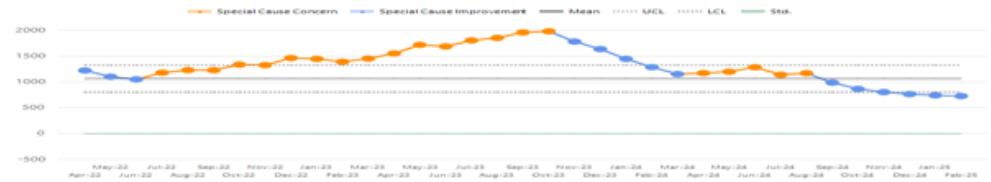
We are driving this measure because:

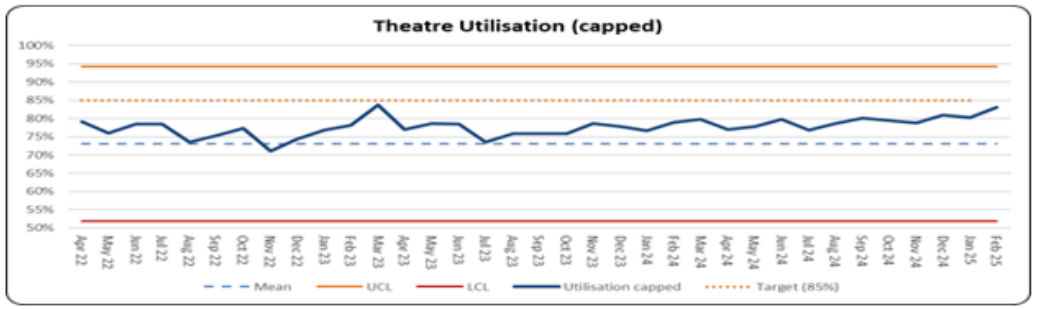
Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments 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

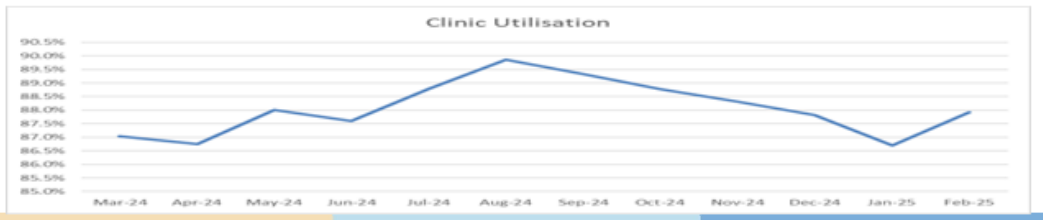
Referral To Treatment – Open Pathways (English)



Patients over 52 weeks on Incomplete Pathways Waiting List







Performance & actions

Long Waiting Patients

- 1 English and 4 Welsh patients waited over 78 weeks at the end of February which was 3 more than last month.
- 65 week position at the end of February was 39 which was 5 more than last month. This is broken down into 25 English and 14 Welsh patients.
- English patients waiting over 52 weeks shows an ongoing significant reduction since July 23. Almost 490 less patients are now waiting over 52 weeks, from almost 1,050 in the summer last year.

Activity

- Activity for the year , at the end of M11, has overall Outpatients 3% ahead of plan. Overall our percentage of New`s And Follow up appointments with a procedure is 48.5% an almost 6% improvement from April 24.
- Elective inpatients and Elective Day cases just 0.5% behind plan year to date.
- Overall our delivery of our activity plan is delivering significantly more Value Weighted Activity [VWA] over 120% than 19/20`s baseline

Productivity

- While theatre utilisation remains below the 85% target, last month attained 83.1%. This continues the improving trend seen over the last 6 months since the operational implementation of our Day Case Surgical Unit.
- On the day cancellations for non clinical reasons continues to fall. Last month 20 patients were cancelled on the day compared to the 6 month average of 49 per month.
- Clinic Utilisation also improved in month to 88% of outpatient slots being utilised along with a reduced percentage of patients who Did Not Attend. Although there is further work to undertake here is coming months.

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

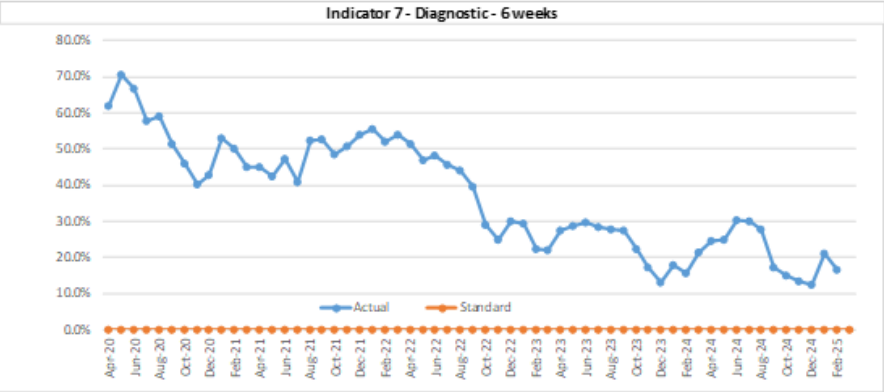
Performance against English RTT standard in February was 56.4%%. Performance against the Welsh RTT standard in October was 70.3%.

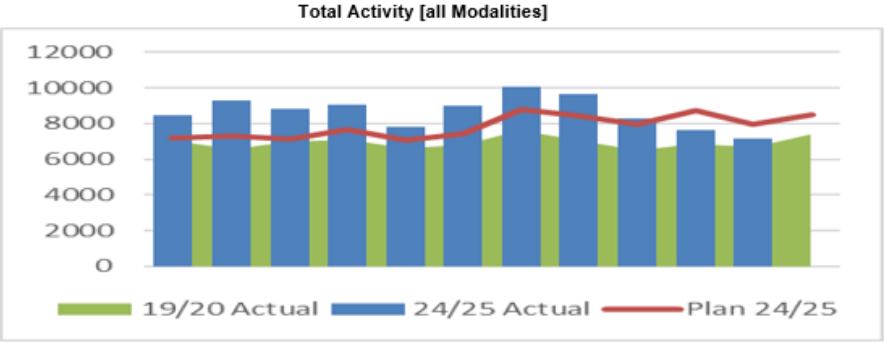
Operational Performance – Diagnostic Performance

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 has delivered 125% of 24/25`s activity plan which is 111% more than 19/20` activity

Imaging:

- 6 week wait positon at the end of M11 was 88%
- Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 9 days and 19 days respectively. CTC is a significant improvement from last month.
- One of the main causes of delays is CTC bloods/prescription delays, for which a support tool is to be implemented by the end of March 25. MRI Prostate is being looked at as a priority CDC pathway.

Audiology

- Audiology 6 week wait position is 77% overall
- An ongoing improvement in patients waiting >13weeks has continued, with 7 currently waiting, reduced from 36 in M8
- Agreed insourcing solution is in place. Together with a recruitment plan to improve the sustainability of the service this will aim is to eliminate the 13 week backlog to zero and provide a sustainable plan into the new financial year.

Neurophysiology

- <6weeks waiting is 84% for M11
- Number waiting >13wks has reduced to 4 undated
- Fragility of Consultant led clinics due to bank weekend working only is driving the long waits over 13 weeks. A service review is currently being instigated in order to develop more sustainable plans.

Echocardiography [Echos]

- 332 over 6 weeks which has more than doubled since beginning of February driven by workforce shortfalls
- Requested additional insourcing dates from provider to address waiting times for the second half of 25/26 whilst recruitment ongoing.
- Demand and capacity plan submitted for 25/26 including insourcing and bank locum capacity required to meet demand and sustain waiting times.

Risks

Increased inpatient / acute floor referring impacting on capacity of service.
Audiology, Non-Obstetric ultrasound, Cardiac Physiology and Neurophysiology capacity / workforce challenges

What the charts tell us

End of February 83.4% of patients waiting less than 6 weeks for a diagnostic test. The position at the start of year April was 75%. An almost 9% improvement and a reduction of almost 500 patients waiting beyond 6 weeks.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

Sickness absence has reduced to 5.2% with Long Term Sickness at 2.62%.and Short Term sickness at 2.57%. The main reasons for sickness absence are colds/flu, mental health conditions, gastro and msk. In our determination to reduce sickness absence to below 4%, we have revised our absence policy and are implementing high impact actions which will be reviewed at FPE meetings. We will continue to ensure appropriate management actions and support for staff are in place to reduce sickness. This remains a priority area for HR over the coming year.

Staff turnover has dropped to 9.2% and 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 6.54% but turnover for band 2/3 hcsw staff now stands at 18.73%. We have restarted the centralised recruitment process with fortnightly interviews planned over the next 3 months. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments

Working with ICS EDI colleagues, we supported neurodiversity celebration week, international women's day and we will be launching the ICS Active Bystander programme in June. With April being stress awareness month. We will be promoting and raising awareness on the schemes in place for staff to use and support their own wellbeing. We are also relaunching the connecting staff with nature programme in April.

Through our workforce opportunities programme, we are implementing schemes to enhance workforce productivity. E-job plans for consultants and e-rostering for ward based nursing areas are in place. E-expenses has been implemented and e-rostering for community nursing will be implemented by July. E-rostering will be rolled out to all clinical areas including medical staff in 2025/26 as this is seen as a key measure to enhance workforce productivity.

In line with the NHSE Operational Planning Guidance for 2025/2026, we are taking appropriate steps to reduce our agency staff (40%), bank staff (15%) and substantive workforce (circa 150wte) over the coming financial year.

To-date we have supported 534 apprentices at WVT in view of our ambition to grow and develop our employees. We now have our first apprentices in podiatry, midwifery and medical engineering.

The 2024 NHS Staff Survey results for WVT shows good progress with above average scores in all 9 areas of the survey (compassionate & inclusive, recognised & rewarded, voice that counts, safe & healthy, always learning, work flexibly, we are a team, staff engagement, morale). This is attributable to a number of leadership, staff wellbeing, workforce & OD initiatives that have been implemented and are still in place at the Trust. The full Staff Survey report is included with the papers for the Board.

Working with ICS colleagues we are supporting the NHSE sponsored Care Leaver pilot programme which aims to find employment opportunities for Care Leavers in Herefordshire & Worcestershire over the next few months.

With the NHS Charities Workforce Wellbeing Grant Fund now open for applications, we will be submitting applications to support and extend the range of wellbeing programmes that we offer to our employees.

Performance appraisals have dropped to 77.6 % but mandatory training remains strong at 89.3%. This will continue to be monitored at FPE meetings.

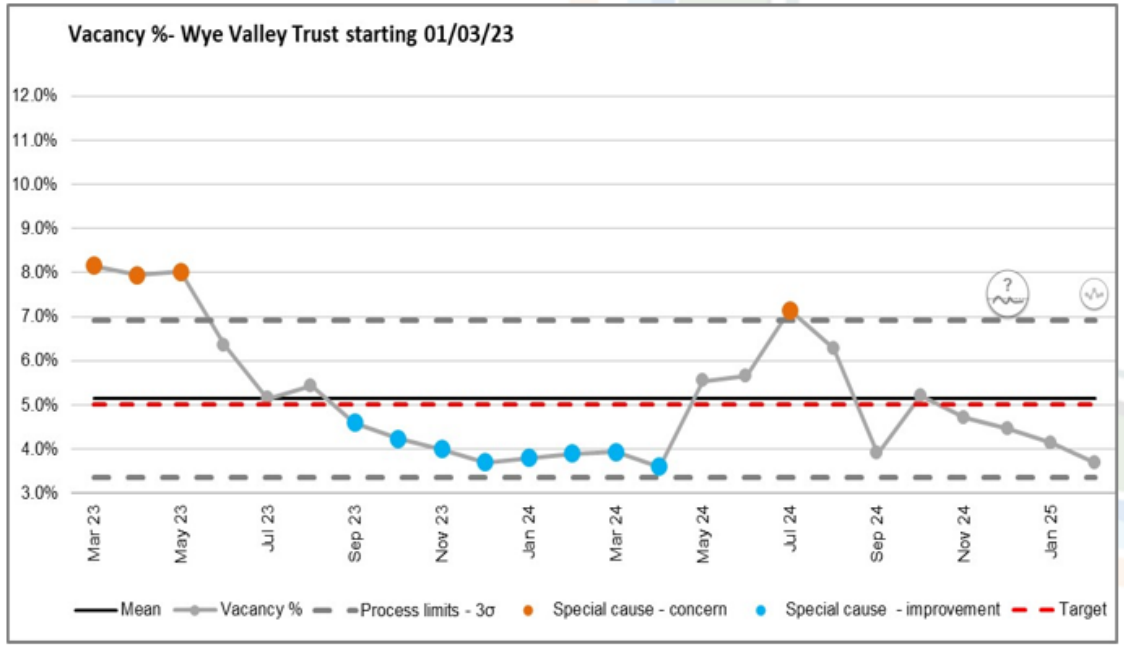
Workforce Performance – Vacancy

We are driving this measure because:

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

Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
3.9%	3.9%	3.6%	5.5%	5.7%	7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	3.7%

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 25.50 fte vacancies we have re-introduced the centralised recruitment process and working with the DWP, the recruitment team are holding weekly drop in sessions to pre screen candidates for line managers. Fortnightly interviews are in place over the next 3 months to ensure we can fill all vacancies.

N&M - we have paused international recruitment as we are starting to see a significant increase in applications from UK based applicants. 9 offers were made following a successful WVT open day and we now have 11.50fte vacancies.

CDC – 35.49 wte appointments have been made and we are on track to fill all clinical vacancies with 53.45fte to be recruited by the end of the year.

M&D - we are now working with a number of UK based and international recruitment agencies and taking active steps to fill our vacancies. Regular meetings with CMD, Medical Staffing Manager to review progress with vacancies and cases of concern. Overseas recruitment of medics to continue over the coming year. We currently have 46.43wte vacancies.

Working with 52 WVT Ambassadors, we are extending our recruitment events and promoting our vacancies Herefordshire wide with a series of events. We are extending WVT presence at regional and national fairs to promote our job opportunities. The Hereford Youth Hub is now live and situated next to the Franklin Barnes building. HR continues to work closely with DWP officers in finding suitable 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 4 months.

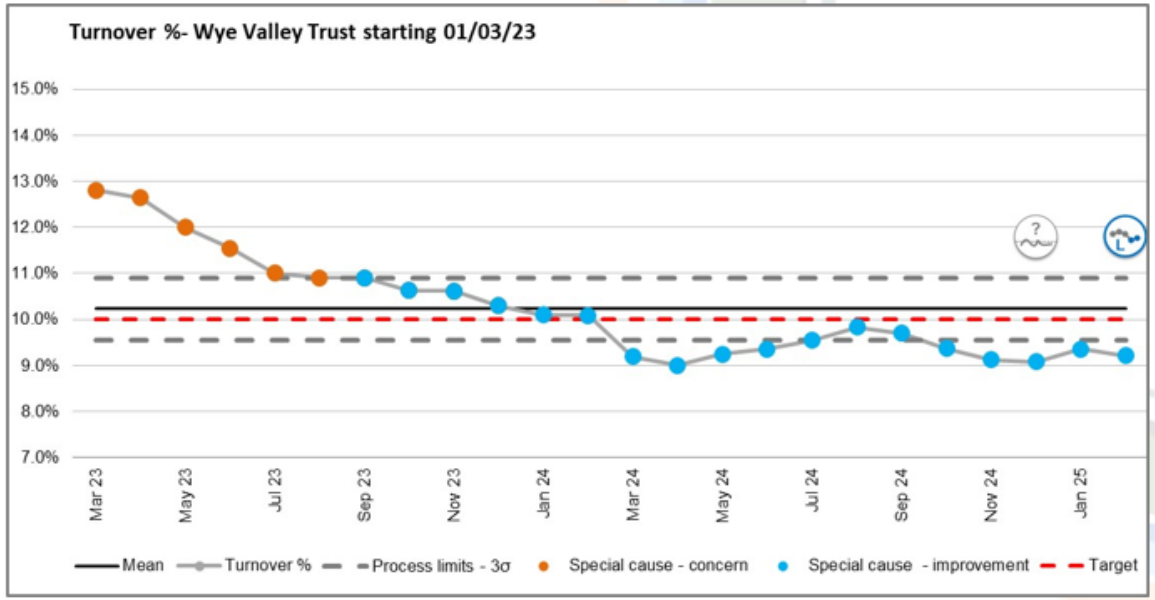
Workforce Performance – Turnover

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.

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

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



Performance & actions

The overall rolling 12 month turnover at Trust level is at 9.2% 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 (18.73%) and this is still the case across the NHS. 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 low at 6.54% 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 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 and decreased last month.

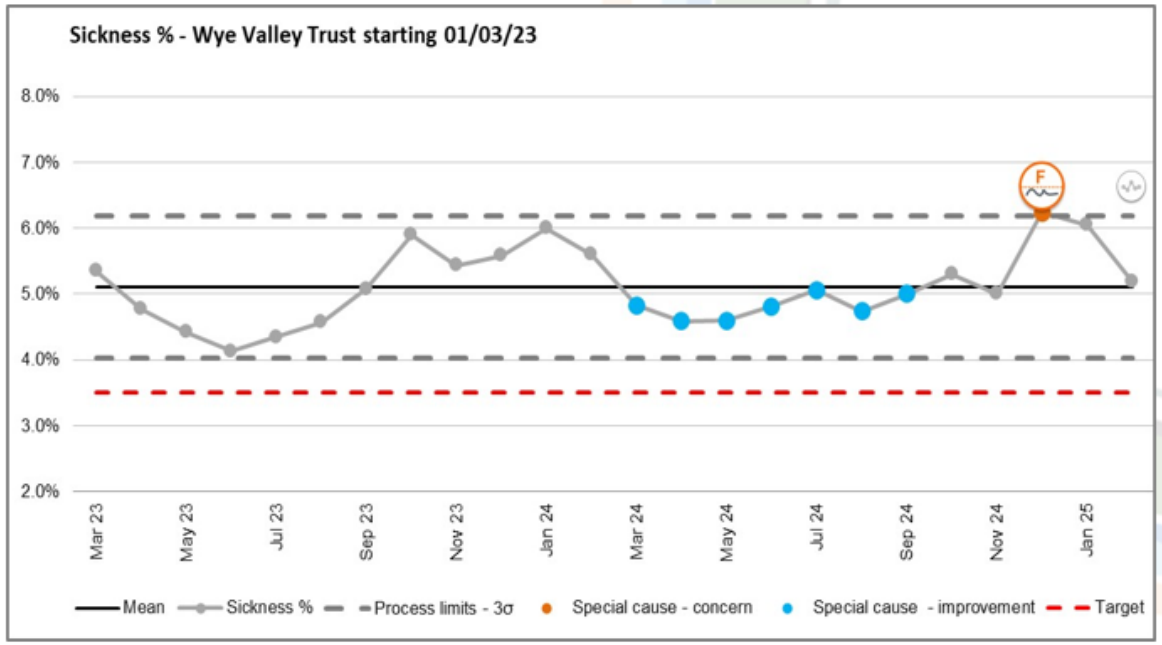
Workforce Performance – Sickness

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.

Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
5.6%	4.8%	4.6%	4.6%	4.8%	5.1%	4.7%	5.0%	5.3%	5.0%	6.2%	6.0%	5.2%

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



Performance & actions

During this month, overall sickness at Trust level has reduced to 5.2%. The main reasons for absence are colds/winter ailments, mental health issues, msk and long term conditions. 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 wide range of health & wellbeing initiatives (mental health support, employee assistance programme, NHS apps and support lines, face to face counselling, clinical psychology) are still in place for staff.

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

Risks

What the chart tells us

The rolling 12 month position shows 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 and in February reduced to pre winter pressure levels.

Our Finance– Executive Summary

Katie Osmond
Chief Finance Officer

Month 11 Income and Expenditure position

Overall month 11 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 11 position resulted in an overall YTD deficit of £11.4m. 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 11 YTD, planned pay costs are unfavourable to budget by £6.8m, (a deterioration of £0.7m in month), non-pay £5.9m (an improvement of £0.1m in month). These are partially offset by additional income of £6.5m, 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 (£5.6m YTD), which are partly mitigated. Although progress is being made, the majority of the CPIP variance relates to unidentified savings 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 £1.7m 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 whilst accepting timing changes, the month 11 position was 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 we are pursuing a further £1.5m stretch mitigation target over the final months of the year.

Capital & Cash

The outturn has increased by £0.2m since last month due to the receipt of additional funding for national schemes . Whereas significant expenditure went through in February (£7m) there remains a significant value to go through in March. 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.

Cash remains a risk which continues to be closely managed. Although manageable for the end of this year, it presents a real risk heading into 2025/26 which will continue to be closely managed.

2025/26 Financial Plan

At the time of writing, the Trust continues to work closely with system partners to complete the 2025/26 planning round. A significant level of financial risk remains to be mitigated in order for the system to deliver a break even 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 11 - 28th February 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	311,530	285,622	288,299	2,676	833
Excluded Drugs	10,484	9,610	10,139	529	(46)
Excluded Drugs	12,801	11,735	13,681	1,946	(101)
Non Contracted Activity (NCA's)	1,768	1,620	1,782	162	9
Other Income for Patient Care	11,185	10,300	10,726	425	60
Donations For Non Current Assets	4,168	3,074	3,074	(0)	(0)
Other Non Patient Income	8,280	7,617	7,493	(123)	(201)
ERF	6,925	6,275	7,187	912	156
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**367,140**	**335,853**	**342,380**	**6,527**	**710**
Pay Expenditure	225,503	206,980	213,810	(6,830)	(718)
Non Pay Expenditure	90,426	82,958	88,647	(5,689)	(131)
Excluded Drugs	23,934	21,939	23,934	(1,995)	(157)
Total Operating Expenditure	**339,862**	**311,877**	**326,391**	**(14,514)**	**(1,006)**
EBITDA	**27,277**	**23,977**	**15,989**	**(7,987)**	**(297)**
Depreciation	14,104	12,936	12,589	347	98
Impairment	5,141	5,141	4,842	299	0
Interest Receivable	1,765	1,707	1,707	(0)	0
Interest Payable on Loans	261	240	164	76	9
Interest Payable on PFI	4,482	4,316	4,099	217	0
Dividends on PDC	4,244	3,875	2,988	887	296
Operating Surplus/ (Deficit)	**813**	**(824)**	**(6,985)**	**(6,161)**	**106**
Technical Adjustments					
Donated Assets Adjustment	3,335	2,312	2,316	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)	1,741	143
Impact of IFRS16 Implementation of PFI Contract	8,214	7,500	9,240	0	0
Adj. financial performance retained Surplus/ (Deficit)	(3,104)	(3,005)	(11,427)	(8,423)	(39)

Performance & actions

The position at the end of Month 11 (February) was a deficit of £11.4m YTD. This was behind the current plan with an overall adverse variance of £8.4m YTD.

- Income shows a positive variance of £6.5m. We continue to se 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 in other areas of contract income. Nationally the ERF funding envelope is capped based on a month 8 assessment which poses a significant risk to the system and Trust (£1.5m forecast over performance).
- 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, unfilled vacancies and additional ERF income. The net position in month includes agency — 4.04% of total pay costs in month which is a decrease from 5.27% in M10, reflecting the critical incident impact last month. Medical bank use at premium rates further increases the temporary staff proportion to 7.87% of overall pay.
- Total Non Pay (incl. dep'n & interest) is adverse by £5.9m 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. There is also a PFI £1.7m 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

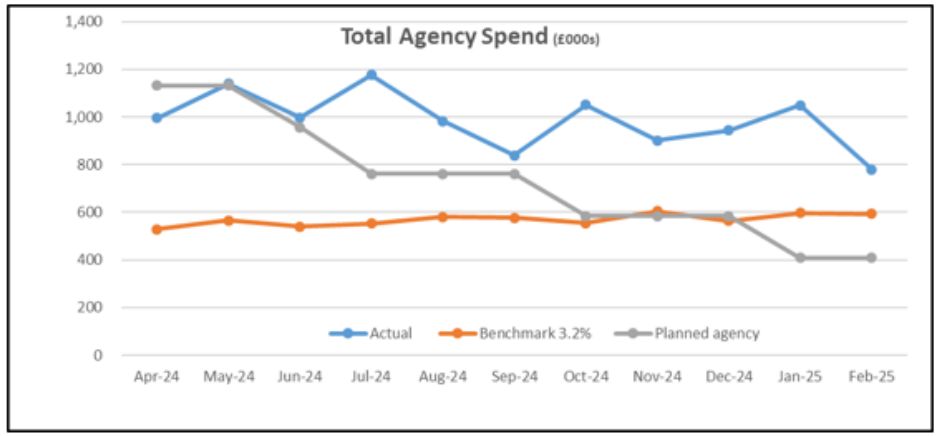
What the chart tells us

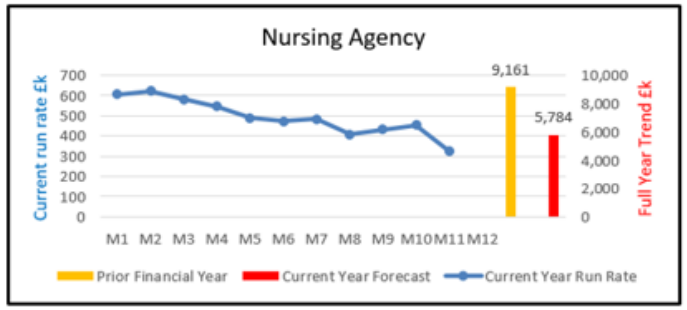
Known financial risks are putting greater pressure on delivery of our planned financial position.

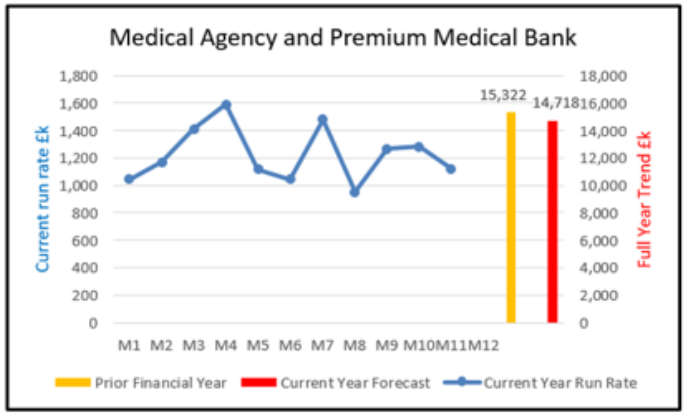
Finance Performance – Agency Spend

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 5.08% of total pay costs year to date, 1.9% 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 £10.9m. 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 £5.9m, with the actual consolidated forecast at £5.7m. 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 a slight decrease in off framework use in month with 13 shifts booked in February, a total of 124 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:** M11 has seen a small reduction in month. The Trust spent £14.2m 2223 and £15.3m in 2324, with 2425 target spend being £11m. The current forecast for 2425 has reduced from £14.9m in month 10 to £14.7m in month 11, 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

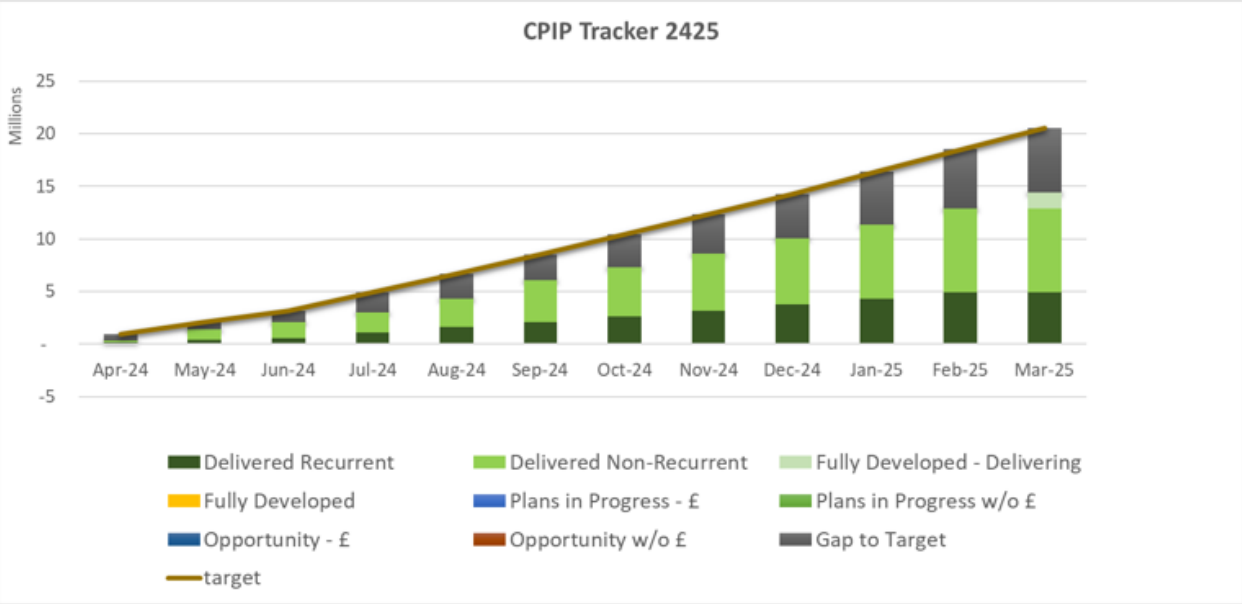
What the charts tell us

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

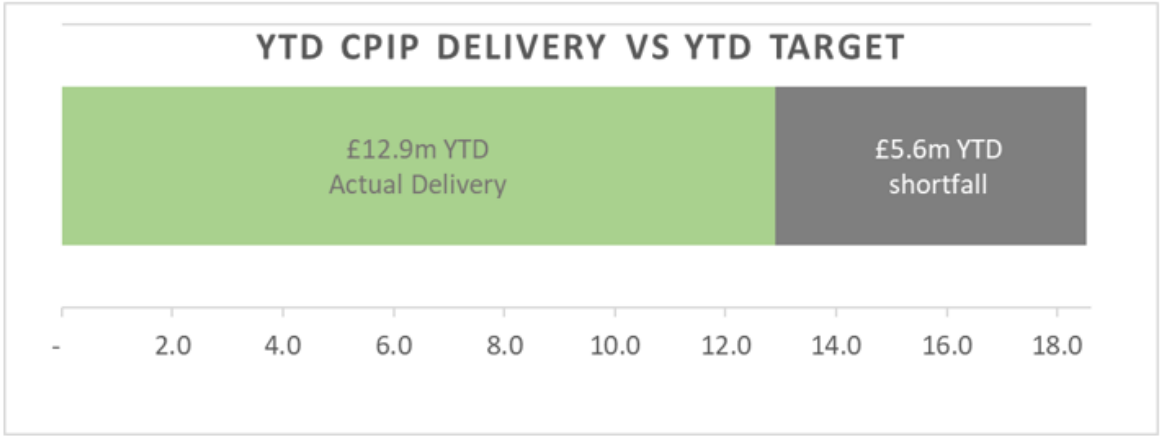
The £20.6m target breaks down into two areas: £19.4m cost out efficiency (of which £4.4m relates to 2324 NR items, of which we are targeting a £8.0m agency reduction); and a further £1.2m stretch target accepted by the Trust as part of concluding the financial plan.

The current position on CPIP delivery YTD reflects a plan of £18.5m with a Trust delivery of £12.9m resulting in a £5.6m 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 – these will be further reviewed to take forward into 2025/26 if not developed in 2024/25.

As at Month 11, the forecast total of developed schemes (including MARP & NARP) amount to £14.4m, plus a further stretch of £0.2m asked of the divisions representing their individual plans apportioned to the remaining month of the financial year.

The FRB continues to focus on furthering identification and delivery of CPIP in readiness for 2025/26. 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

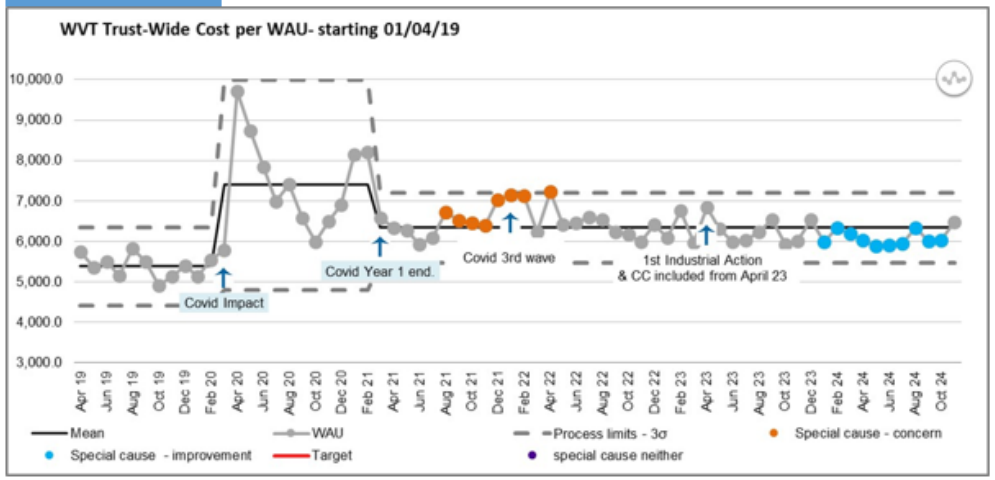
There remains a shortfall in plans to deliver the planned level of CPIP. Focus is on identifying schemes, and converting opportunities into deliverable schemes, in order to deliver a challenging CPIP target in year and ensure a sustainable start to 2526.

Finance Performance – Productivity Improvement

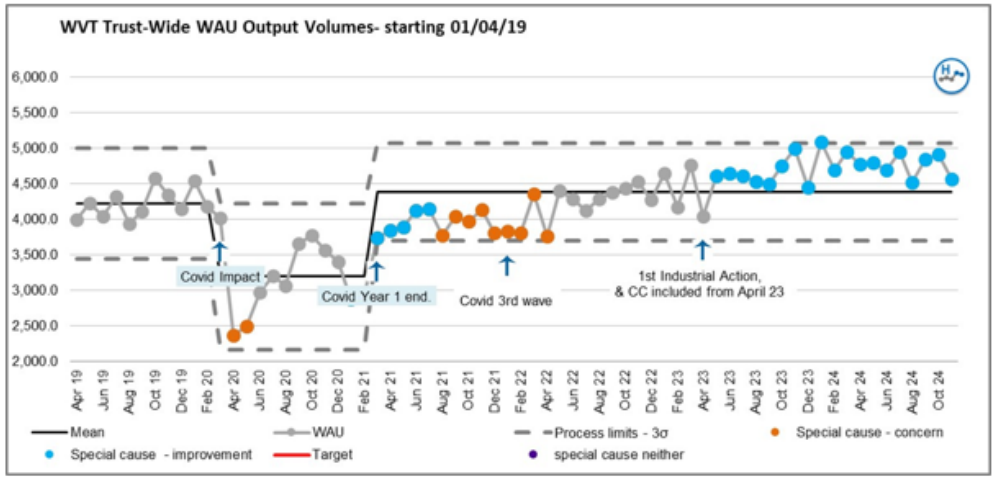
We are driving this measure because:

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 11			Full Year	
			Budget	Actual	Variance	Forecast	Variance
Local Schemes							
ICT - Clinical Systems	Owned	427	421	101	320	447	(20)
ICT - Hardware	Owned	782	676	375	301	775	7
ICT - Software	Owned	52	45	0	45	0	52
Estates Works	Owned	965	729	513	216	1,410	(445)
ESH 2324 Underspend	Owned	615	615	615	0	615	0
CDC 2324 Underspend	Owned	1,408	1,280	911	369	1,408	0
Clinical Equipment	Owned	343	266	282	(16)	498	(155)
ESH - Local Funding	Owned	2,924	2,000	58	1,942	327	2,597
CDC - Phase 2 initial funding	Owned	0	0	0	0	0	0
23/24 Cfwd	Owned	225	0	383	(383)	452	(227)
ESH - Local Funding risk element	*Owned*	*(924)*	*0*	*0*	*0*	*0*	*(924)*
System Capital Contingency	*Owned*	*(977)*	*0*	*0*	*0*	*0*	*(977)*
Total - Local CDEL funded		**5,840**	**6,032**	**3,237**	**2,795**	**5,932**	**(92)**
Grant funded and donated							
Integrated Energy Scheme	Owned	10,972	9,970	4,491	5,479	5,840	5,132
Donated assets	Owned	240	237	0	237	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**	**10,207**	**4,491**	**5,716**	**6,106**	**5,139**
National funding							
Clinical Diagnostics Centre	Owned	11,460	10,326	8,809	1,517	10,761	699
Imaging - PDC	Owned	0	0	378	(378)	378	(378)
ESH - PDC Funding	Owned	2,161	2,161	1,438	723	2,129	32
ICT - FLD	Owned	1,750	672	279	393	1,749	1
ICT - Cyber	Owned	0	0	25	(25)	75	(75)
H&W ICB and Wye Valley Future	Owned	0	0	0	0	133	(133)
Total - National PDC schemes		**15,371**	**13,159**	**10,930**	**2,229**	**15,225**	**146**
Leases							
Vehicle	Lease	0	8	0	8	0	0
IFRS16 Clinical Equipment	Lease	410	347	308	39	318	92
IFRS16 Equip Over-commitment	Lease	0	0	0	0	0	0
Total - IFRS16 Leases		**410**	**355**	**308**	**47**	**318**	**92**
Total Capital Programme		**32,866**	**29,753**	**18,966**	**10,787**	**27,580**	**5,286**

Performance & actions

Actions in Month 11 have been geared towards finalising expenditure plans for local schemes and managing the nationally funded schemes to deliver expenditure in accordance with plans. Additional resources have been secured to enable improvements to future connectivity and have been added to the forecast.

Month 11 expenditure was £4,325k. The overall programme is behind the budget but significant expenditure was delivered in Month 11 and plans are in place to meet the forecast through expenditure in the last month 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 are being utilised to fund the Virtual Desktop Interface programme plus ongoing ESR and EPR development. Expenditure on CDC continues to project £700k lower than plan and this is with a number of mitigations being included in the forecast.

Risks and mitigations

There remains a significant amount of expenditure (£8.6m) to go through in March. The main risks relate to the delivery of major items of equipment for CDC. Actions have been taken to mitigate these risks. Further work has been undertaken 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 replacement ICT is also being used to mitigate further underspend. All Scheme Managers have been asked to confirm spending plans to the end of the year and where these have changed, actions have been put in place to address the shortfall.

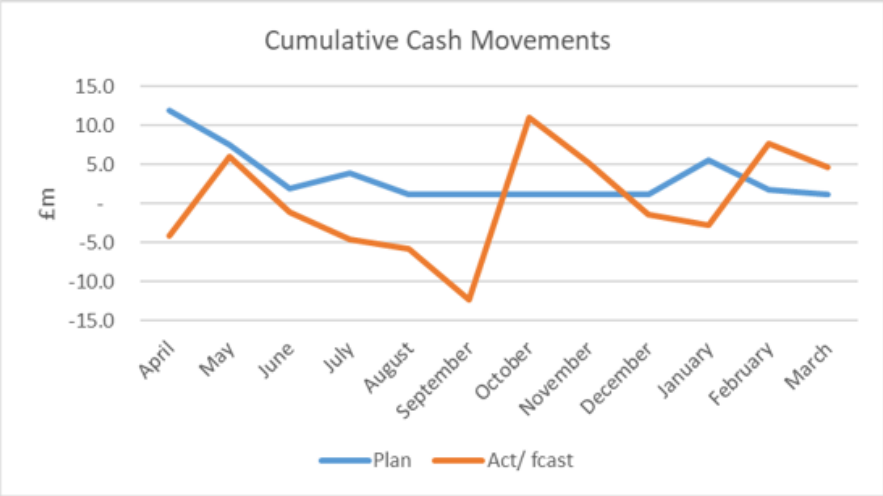
What the table tells us

The main variances to plan are the shortfall on expenditure on IES plus and 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
December	24.8	27.4		
January	21.0	31.8		
February	31.4	28.0		

Cash balances are £3.4m higher than plan, due to phasing of capital draws and deficit support

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
December	99.2%	95.0%		
January	98.9%	95.0%		
February	99.3%	95.0%		

In February, the Trust paid 99.3% of invoices within 30 days. This equates to 97% by invoice value. This is the Fourteenth 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 increased, due to the timings of final 2025/26 capital draws in February.

The Trust remains above the 95% target for Better Payment Practice.

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

February 2024	2023/24	2024/25			2024/25 Full Year		
	Accounts £000s	M11 Plan £000s	M11 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	151,182	165,485	157,578	7,907	167,117	164,557	(2,560)
Intangible Assets	14,359	11,174	9,499	1,675	10,920	10,920	0
Trade and Other Receivables	408	408	422	(14)	408	408	0
TOTAL Non Current Assets	**165,949**	**177,067**	**167,499**	**9,568**	**178,445**	**175,885**	**(2,560)**
CURRENT ASSETS:							
Inventories	4,878	4,878	5,226	(348)	4,878	5,020	142
Trade and Other Receivables	35,635	25,156	32,384	(7,228)	28,856	42,526	13,670
Cash and Cash Equivalents	26,228	27,950	31,394	(3,444)	27,447	13,281	(14,166)
TOTAL Current Assets	**66,741**	**57,984**	**69,004**	**(11,020)**	**61,181**	**60,827**	**(354)**
TOTAL ASSETS	**232,690**	**235,051**	**236,503**	**(1,452)**	**239,626**	**236,712**	**(2,914)**
CURRENT LIABILITIES							
Trade and other payables	(37,101)	(39,047)	(38,149)	(898)	(37,275)	(34,007)	3,268
Borrowings - Loans, PFI and Finance Leases	(12,697)	(12,693)	(16,207)	3,514	(12,693)	(16,295)	(3,602)
Provisions	(192)	(192)	(46)	(146)	(192)	(192)	0
Total Current Liabilities	**(49,990)**	**(51,932)**	**(54,402)**	**2,470**	**(50,160)**	**(50,494)**	**(334)**
NET CURRENT ASSETS/(LIABILITIES)	**16,751**	**6,052**	**14,602**	**(8,550)**	**11,021**	**10,333**	**(688)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**182,700**	**183,119**	**182,101**	**1,018**	**189,466**	**186,218**	**(3,248)**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(53,916)	(40,566)	(40,962)	396	(42,935)	(40,348)	2,587
Provisions	(1,619)	(1,619)	(1,721)	102	(1,619)	(1,575)	44
Total Non-Current Liabilities	**(55,535)**	**(42,185)**	**(42,683)**	**498**	**(44,554)**	**(41,923)**	**2,631**
ASSETS LESS LIABILITIES	**127,165**	**140,934**	**139,418**	**1,516**	**144,912**	**144,295**	**(617)**
TAXPAYERS EQUITY							
Public dividend capital	306,421	344,976	325,658	19,318	351,694	326,010	(25,684)
Revaluation reserve	22,047	22,047	18,072	3,975	22,047	18,072	(3,975)
Income and expenditure reserve	(201,303)	(226,089)	(204,312)	(21,777)	(228,829)	(199,787)	29,042
TOTAL	**127,165**	**140,934**	**139,418**	**1,516**	**144,912**	**144,295**	**(617)**

Performance & actions

General

The table identifies the statement of financial position as at 28 February against the plan.

Non-Current Assets

Non-Current assets are £9.5m 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 £3.4 m higher than plan, due to phasing of final Capital PDC draws of non-recurrent deficit support funding vs planned PDC drawdowns and partly offset by and the capital underspend. 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 £4m, 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 increased in month due to the timing of capital PDC draws, but are forecast to reduce during March.

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 77.0%	Variable	Improvement - High		77.1%	77.0%	77.8%	79.2%	78.1%	79.3%	77.1%	72.7%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low	Yes	88.4%	87.8%	88.5%	92.1%	91.3%	86.4%	84.3%	85.9%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		20.0%	48.4%	43.8%	39.1%	21.4%	7.7%	20.0%	15.4%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		90.7%	88.2%	89.3%	89.8%	89.0%	91.9%	96.5%	90.2%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		10	12	3	7	5	8	7		
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause	Yes	76.6%	53.5%	74.8%	75.4%	73.5%	76.4%	71.3%	69.5%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause	Yes	100.0%	83.3%	77.8%	100.0%	33.3%	66.7%	100.0%	88.9%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		65.5%	68.1%	65.7%	90.5%	56.8%	65.9%	87.9%	77.1%	
	Cancer: number of urgent cancer patients waiting over 62 days	Cancer		No Target	Common Cause	Yes	85	93	88	61	50	38	54	52	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		100.8%	114.5%	111.5%	108.9%	124.2%	108.6%	118.2%	126.1%	110.4%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		85.7%	86.8%	86.9%	87.4%	86.3%	87.3%	85.9%	85.2%	86.6%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Common Cause	Yes	99.6%	100.0%	102.2%	103.4%	101.2%	105.2%	104.0%	100.3%	96.3%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Concern - Low		66.4%	65.8%	75.9%	62.9%	51.1%	55.2%	49.4%	54.3%	60.3%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Variable	Concern - High		15.4%	18.7%	14.5%	18.8%	29.1%	25.1%	30.9%	29.7%	21.4%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		112.2%	113.5%	114.6%	120.2%	118.9%	128.9%	124.1%	121.1%	122.1%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		47.4%	46.1%	42.3%	44.4%	48.0%	48.3%	46.5%	47.2%	46.7%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause		66.4%	68.3%	67.6%	65.8%	65.8%	64.8%	63.4%	64.1%	65.9%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause		12.3%	12.4%	10.8%	12.5%	12.4%	12.2%	13.3%	14.6%	13.0%
	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		2.0%	1.9%	1.9%	1.8%	1.7%	1.9%	2.0%	1.8%	1.5%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High	Yes	291	330	312	284	270	256	232	322	219
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 92.0%	Fail	Concern - Low		55.8%	55.7%	55.6%	55.1%	55.8%	56.0%	55.1%	56.0%	56.4%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Concern - Low		70.0%	70.3%	69.4%	69.5%	70.0%	70.0%	68.4%	69.2%	70.3%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		29179	28848	28708	28783	28761	28246	27766	27410	27488
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		1285	1140	1169	987	865	804	764	740	727
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		15	14	14	9	4	1	3	2	5
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		3	1	3	2	1	0	0	0	0
	GP Referrals	Elective care		No Target	Common Cause	Yes	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		110.3%	113.7%	114.1%	111.4%	116.6%	109.1%	108.3%	112.6%	113.7%
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Common Cause	Yes	84.8%	114.7%	98.4%	83.1%	111.4%	78.0%	101.3%	104.4%	93.9%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		114.0%	119.3%	115.1%	110.8%	113.3%	107.9%	109.4%	109.1%	109.4%
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Common Cause	Yes	88.1%	123.0%	106.8%	90.8%	115.7%	83.2%	111.2%	113.2%	97.6%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		99.2%	102.3%	105.0%	110.1%	107.9%	100.5%	100.8%	104.4%	103.7%
	Total Elective Activity (volume v plan)	Elective care		No Target	Common Cause	Yes	86.2%	100.9%	91.3%	87.8%	104.9%	78.3%	90.4%	97.9%	90.7%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Improvement - High		79.7%	76.9%	78.7%	80.2%	79.5%	78.8%	80.9%	80.3%	83.1%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		39	42	40	32	26	31	39	34	20
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Concern - Low	Yes	129.5%	104.0%	100.7%	118.0%	104.4%	107.9%	103.5%	86.8%	86.6%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Common Cause		76.6%	156.2%	126.9%	93.3%	91.4%	71.8%	83.3%	80.1%	89.1%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Concern - Low	Yes	119.2%	115.1%	111.1%	116.2%	113.6%	127.4%	109.7%	93.4%	88.3%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Improvement - Low		30.2%	30.0%	27.8%	17.2%	15.1%	13.3%	12.5%	21.1%	16.6%

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-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		90.6%	95.5%	95.1%	88.9%	94.6%	94.0%	93.7%	97.1%	97.7%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Concern - High	Yes	16.3%	14.2%	16.3%	15.6%	16.2%	18.4%	17.8%	20.4%	22.5%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High	Yes	54.7%	54.8%	55.7%	55.3%	55.6%	61.8%	65.1%	64.6%	61.5%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High	Yes	86.3%	88.5%	88.1%	85.9%	87.8%	88.2%	90.2%	89.7%	89.2%
	Maternity Activity (Deliveries)	Elective care		No Target	Common Cause	Yes	113.8%	93.4%	85.6%	108.4%	92.9%	95.4%	94.9%	101.4%	93.8%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause	Yes	6.6%	6.5%	7.8%	6.5%	5.9%	6.3%	6.5%	6.1%	5.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High	Yes	87.6%	88.8%	89.9%	89.3%	88.8%	88.3%	87.8%	86.7%	87.9%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		115.8%	122.0%	115.6%	110.5%	111.8%	107.3%	109.9%	107.6%	107.5%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Common Cause	Yes	89.7%	127.2%	110.9%	94.8%	117.7%	85.7%	116.4%	117.6%	99.4%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		19.5%	19.1%	19.7%	20.1%	19.8%	20.2%	19.9%	21.3%	21.0%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term		No Target	Improvement - Low		10.1%	6.5%	4.1%	6.7%	7.5%	8.7%	7.9%	8.3%	9.0%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		100.0%	99.4%	98.6%	99.8%	99.9%	99.4%	98.8%	99.9%	99.7%
	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		84	70	134	204	348	150	69	129	81
	Patient ward moves emergency admissions (acute)	Safe, high quality care		No Target	Concern - Low		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	7	6	7	6	6	7	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause	Yes	3	3	3	3	2	2	2	2	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Concern - Low		14.1%	15.6%	17.1%	13.8%	15.5%	16.6%	15.1%	17.2%	19.3%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low	Yes	47.4%	48.9%	50.1%	47.5%	53.1%	49.0%	38.8%	38.5%	36.6%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Safe, high quality care	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Improvement - Low		100	100	99	100	102				
	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		4	2	1	0	0	2	0	2	1
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care	44	Fail	Common Cause	Yes	5	9	10	6	2	5	6	0	2
	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		2	1	2	1	2	3	1	3	1
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Common Cause	Yes	93.0%	93.0%	92.0%	92.0%	92.0%	91.0%	89.0%	91.0%	91.0%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Common Cause	Yes	98.0%			98.7%			99.4%		
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Common Cause	Yes	63.2%	74.4%	73.9%	65.8%	64.4%	67.6%	63.0%	51.5%	65.5%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause		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		78.7%	89.2%	87.5%	76.5%	75.0%	86.0%	80.9%	73.9%	80.4%
	Number of complaints	Safe, high quality care		No Target	Common Cause		30	28	18	32	44	26	27	34	26
	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		50.0%	53.8%	51.6%	50.0%	51.7%	67.9%	50.0%	60.0%	45.5%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		78.7%	79.3%	79.1%	74.5%	79.0%	76.8%	73.7%	80.0%	80.6%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Concern - Low		84.5%	80.7%	84.2%	83.2%	87.9%	82.5%	83.6%	86.7%	86.8%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		96.6%	94.4%	85.7%	90.2%	97.0%	87.9%	92.3%	93.3%	94.1%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause	Yes	20.0%	18.0%	20.0%	18.0%	18.0%	18.7%	17.0%	18.0%	19.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		18.0%	15.0%	17.3%	15.0%	15.0%	15.6%	15.0%	15.0%	16.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		24.0%	31.0%	32.0%	30.0%	28.0%	31.7%	21.0%	23.0%	31.0%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		5.5%	5.9%	5.8%	4.5%	4.1%	4.6%	4.8%	5.3%	4.0%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	80.3%	80.2%	80.3%	79.8%	80.1%	79.5%	79.8%	79.7%	77.6%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.7%	89.7%	89.5%	88.0%	88.3%	88.6%	88.8%	89.3%	89.3%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause	Yes	4.8%	5.1%	4.7%	5.0%	5.3%	5.0%	6.2%	6.0%	5.2%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.4%	9.5%	9.8%	9.7%	9.4%	9.1%	9.1%	9.4%	9.2%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		5.7%	7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	6.9%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause	Yes	(£3387k)	(£4957k)	(£3686k)	£12576k	(£602k)	(£202k)	(£1260k)	(£3002k)	(£133k)
	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		(£524k)	(£1793k)	(£606k)	(£645k)	(£178k)	£106k	(£953k)	(£2908k)	(£39k)
	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	(£566k)	(£844k)	(£811k)	£539k	(£498k)	(£598k)	(£489k)	(£798k)	(£487k)
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low	Yes	£1048k	£953k	£725k	£573k	£755k	£634k	£582k	£2848k	£804k
	Agency - expenditure as % of total pay	Finance		No Target	Improvement - Low	Yes	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance		No Target	Common Cause		(£522k)	£785k	(£284k)	(£242k)	(£697k)	(£345k)	(£431k)	£175k	(£873k)
	Cash - Balance at end of month (£m)	Finance		No Target	Common Cause	Yes	£23k	£22k	£18k	£14k	£37k	£29k	£25k	£21k	£31k
	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:	**03/04/2025**
Title of Report:	Trust Objectives 2025/26
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Executive Team
Reporting Route:	Operational Planning Group, Trust Management Board
Appendices included with this report:	Trust Objectives 2025/26
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

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

Once approved, the objectives will be communicated across the Trust, used to shape the individual objectives of executive directors and of teams. Divisional objectives will be developed to support the delivery of the Trust objectives and these will be approved at Trust Management Board.

Recommended Actions required by Board or Committee

That members approve the proposed objectives for 2025/26.

Executive Director Opinion[1]

The attached objectives have been developed in an iterative fashion with the input of executives and non executives, the Trust Management Board and divisional colleagues. These objectives reflect the priorities in the Trust Strategy and the known planning guidance at the time of development.

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

[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.

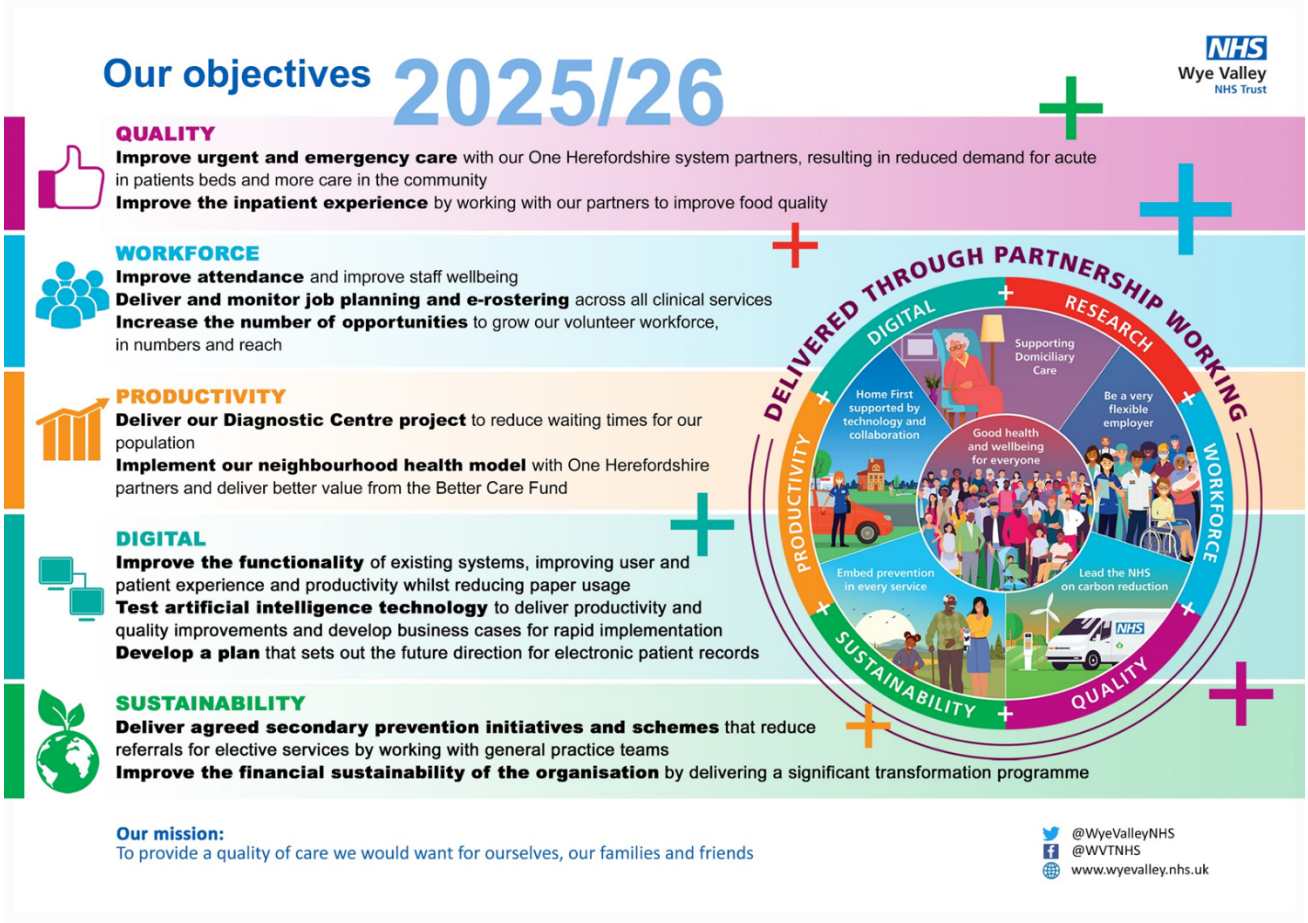
Trust Objectives 2025-26

Introduction

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

Once approved, the objectives will be communicated across the Trust, used to shape the individual objectives of executive directors and of teams. Divisional objectives will be developed to support the delivery of the Trust objectives and these will be approved at Trust Management Board.

The communications teams across the Group will also create a consistent approach for communicating them to all stakeholders to maintain the shared themes, whilst reflecting the local essence of them. The objectives are presented under headings taken from the Trust Strategy.



Quality

Improve urgent and emergency care with our One Herefordshire system partners, resulting in reduced demand for acute in patients beds and more care in the community

Lead: Chief Operating Officer

Narrative: The Trust will build on existing work with One Herefordshire (1H) partners to maximise the two hour Urgent Community Response, Virtual Ward services and increase the number of patients that are pulled from the ambulance service 999 list. The Trust will also review and implement changes to the Criteria to Admit and Criteria to Reside Pathways.

Key Performance Indicators: UEC constitutional standards

Improve the inpatient experience by working with our partners to improve food quality

Lead: Chief Nursing Officer

Narrative: The Trust will achieve this objective through:

- Developing a culture that supports a "food as medicine" ethos and ensuring the importance of holistic care is seen as the responsibility of the whole MDT
- Improve practices around screening for malnutrition to ensure staff identify the correct patients and putting in steps to address and prevent further decline
- Ensure standards are met for monitoring of food and drink intake and providing assistance to those at risk of malnutrition and dehydration.
- Ensure menus continue to meet the needs of the population including religious, cultural, nutritional needs and at various stages of life.
- Develop menus to support patients at highest risk of malnutrition such as high calorie, small volume menu; finger foods; nutritious drinks rounds.
- Improve snack provision between meals and for those who are unable to eat full meals or meet their nutrition needs from meals alone. Demonstrating to patients how they can meet their nutritional needs through food and reducing reliance on prescribed supplement drinks.
- All patients to have access to menus in an accessible format and a Food Service Dietitian to provide full analysis of our menus.
- Good practices around food safety including ensuring robust channels for communication and traceability between wards staff and catering staff for issues around texture of food/drink and reporting of food allergies.
- Robust reporting of incidents related to patient food and drink, ensuring greater visibility of issues across the Trust, identify causal factors and implement learning

Key Performance Indicators: We will measure our success by triangulating a number of data sources relating to patient experience of our meal service. This includes analysis of the national patient survey data, meal service audits from our partners and annual PLACE (Patient-Led Assessments of the Care Environment) audits.

Digital

Improve the functionality of existing systems, improving user and patient experience and productivity whilst reducing paper usage

Lead: Chief Finance Officer

Narrative: Continuing to build on our digital maturity journey, we will focus on delivery of agreed optimisation projects, including a focus on Digital First, supporting teams to move away from paper processes to end to end digital workflows. We will reinvigorate user engagement and continuously seek to maximise the benefit from our digital tools. We will champion uptake of the use of the Patient Portal and NHS App to support patients in receiving and changing their appointments and accessing correspondence digitally, reducing paper and postage and improving patient experience.

Key Performance Indicators: A further reduction in movement of paper notes by at least 65% by March 2026. Reduction in postage costs. Proportion of patients signed up to the Patient Portal.

Test artificial intelligence technology to deliver productivity and quality improvements and develop business cases for rapid implementation

Lead: Chief Finance Officer

Narrative: Support piloting of artificial intelligence (AI) technology in a widespread, well governed and agile approach. Build on initial small scale piloting and secure wider clinical engagement whilst building confidence within the Trust to use this technology and safely embed into clinical practice. Work with partners across Group and beyond to learn from best practice. Ensure measurement of benefits realised to enable development of the case for change, procurement approach and implementation.

Key Performance Indicators: Measurable benefits realisation model for ambient AI technology to support business case for investment. Proportion of clinicians utilising the tools by March 2026. Improved productivity through elective pathways. Cost improvement in the pilot projects.

Develop a plan that sets out the future direction for electronic patient records

Lead: Chief Finance Officer

Narrative: To complete the commissioned review of current electronic patient records position, and make a recommendation to Board as to future direction, timescales and funding requirements. To develop and approve the forward plan for the EPR programme.

Key Performance Indicators: Board to receive outcome of review by end June 2025. Agreed forward plan for EPR programme by end Sept 2025.

Sustainability

Deliver agreed secondary prevention initiatives and schemes that reduce referrals for elective services by working with general practice teams

Lead: Chief Medical Officer

Narrative: There has been a 14.8% increase (compared to 2019/20) in elective referrals in the last year. The increase has been in both internal referrals and referrals from primary care and includes increase in routine, urgent and 2 week wait referrals. This is leading to long waiting lists for some specialties and is affecting our ability to meet referral to treatment targets. We will work with general practice teams as well as our clinical leads to understand the drivers for the increase and deliver agreed secondary preventive initiatives to reduce referrals.

Key Performance Indicators: 5% reduction in GP referrals for routine and urgent on 2024/25 outturn. 30% reduction in internal referrals on 2024/25 outturn (Forecast for 24/25 = 13,300)

Improve the financial sustainability of the organisation by delivering a significant transformation programme

Lead: Chief Operating Officer

Narrative: Through working across our divisions we will build on improvements in Urgent and Emergency Care, Cancer and Elective we have seen in 24/25 by working on Getting It Right First Time (GIRFT) principles and benchmarking to continue improve our journey to recovering NHS Constitutional standards.

Oversight on progress through our Productivity Programme Board and Valuing Patients Time Board will ensure we are delivering the transformational changes we have collaboratively agreed with clinical, operational and Herefordshire/Powys partners throughout the year.

Delivering these improvements will ensure more elective activity is undertaken within core delivery time and reduce the requirement on escalation beds and temporary workforce.

Key Performance Indicators: NHS Constitution Standards, elective income, productivity metrics

Workforce

Improve attendance and improve staff well being

Lead: Chief People Officer

Narrative: A healthy motivated workforce is integral to achieving better care for our patients. Promoting and supporting employee health and wellbeing is at the heart of our purpose to champion better work and working lives because effective workplace wellbeing programmes can deliver mutual benefit to our employees and the communities we serve. To ensure we have a healthy workplace, we will be revising our managing attendance policy and implementing high impact actions to improve attendance and staff wellbeing. This will ensure all staff can thrive in a compassionate environment that actively encourages all employees to look after their wellbeing.

Key Performance Indicators: To maintain sickness absence at 4%

Deliver and monitor job planning and e-rostering across all clinical services

Lead: Chief People Officer

Narrative: By documenting and digitalising professional activity in e-job plans, WVT can better understand its clinical workforce capacity and better match planned capacity to expected demand. E-job planning is essential for achieving productivity gains as it enables the effective and efficient use of resources in a way that brings mutual benefits to patients and clinical staff in planning and delivering high quality care. It allows for smoother and more efficient operation of the trust, ensuring staff are utilised to their full potential, and patients receive the high level of care they deserve.

Our staff are our biggest asset and we have an obligation to strike the right balance between patient safety, cost and efficiency. Used the right way, e-rostering can influence culture change and give staff the evidence they need to make changes at the front line. It gives an overview across the organisation, not only monthly but daily, highlighting hotspots requiring intervention to ensure appropriate staffing levels and efficient deployment of staff. Having an effective e-roster empowers senior clinical staff to make informed decisions which aids intelligent planning and deployment of available resources to meet patient needs. It also facilitates the effective management of budgeted establishments to drive efficiencies in the workforce and reduce reliance on temporary and agency staff.

Key Performance Indicators: Attain 100% compliance with e-job plans and implement e-rostering across key clinical areas by March 2026.

Increase the number of opportunities to grow our volunteer workforce, in numbers and reach

Lead: Chief Nursing Officer

Narrative: The Trust is committed to improving patient experience through the contribution made by volunteers that adds value to our services. The Trust aspires to increase the contributions that volunteers can make through innovation of volunteer roles and working with the voluntary sector to provide a diverse range of experiences for volunteers across Herefordshire within a healthcare setting.

Key Performance Indicators: Numbers of: volunteer hours contributing to WVT services; volunteers recruited; areas supported by volunteers

Productivity

Deliver our Diagnostic Centre project to reduce waiting times for our population

Lead: Chief Strategy and Planning Officer

Narrative: The Wye Valley Diagnostic Centre is expected to open its doors to patients in September 2025 and offer a range of diagnostic tests that includes CT, MRI, plain film x-ray, echocardiography and ultrasound. The off-site facility will provide an innovative rapid-turnaround service for our patients and will create capacity for faster access to acute diagnostics at the County Hospital.

Key Performance Indicators: Diagnostic waiting times

Implement our neighbourhood health model with One Herefordshire partners and deliver better value from the Better Care Fund

Lead: Managing Director

Narrative: Implement the six core components of neighbourhood health and deliver the Better Care Fund plan with our 1H partners. The core components of neighbourhood health pertinent to WVT are:

- Population health managements
- Standardising community health services
- Neighbourhood multidisciplinary teams
- Integrated intermediate care with a 'Home First' approach
- Urgent neighbourhood services

Key Performance Indicators: Acute admissions of patients aged over 65/ 100,000 population, Reduce time from discharge ready date to discharge date, reduce admission to long terms residential care

Report to	**Public Board**
Date of Meeting	**03/04/2025**
Title of Report	Review of Standing Orders and Standing Financial Instructions
Lead Executive Director	**Chief Finance Officer**
Author	Gwenny Scott, Company Secretary
Appendices included with this report	Standing Orders and Standing Financial Instructions – tracked and 'clean'
Purpose of report	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The purpose of this paper is to provide the Board with the updated Standing Orders (SO) and Standing Financial Instructions (SFI) for approval following annual review. The Audit Committee agreed the amended document to go forward for Trust Board approval on 13th March 2025.

The current SOs and SFIs are published on the Trust intranet and were circulated to all relevant staff including budget holders and budget managers in 2024.

Standing Orders

No material changes are recommended. Minor changes have been made as follows:

- Updates to current terminology throughout.
- Pages 16 & 17 (8.4 and 8.10): removal of duplications
- Page 36: addition of the option to use an electronic register for Trust sealings.
- Page 59: added reference to the Code of Governance and updated reference to the Audit Committee Handbook
- Page 78: Updated reference to Records Management Code of Practice.
- Page 82: Removed reference to audit of quality account (no longer a requirement)

Standing Financial Instructions

Minor changes are proposed, highlighted in red:

- Minor reference updates
- Addition of a requirement for a contract adjudication report for all contracts valued >£100,000.

Recommendation or action requested

The Committee is asked to consider the proposed changes and recommend Trust Board approval.

Executive Director Opinion[1]

The Chief Finance Officer supports these recommendations.

[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.

George Eliot Hospital NHS Trust

Worcestershire Acute Hospitals NHS Trust

Wye Valley NHS Trust

Wye Valley NHS Trust
STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Table of Contents

Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS Trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with SOs made under Regulation 19(2).

These SOs and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The SOs, Standing Financial Instructions (SFIs), procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" SOs are:

- SFIs, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Schedule of Decisions Reserved to the Board of the Trust
- Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

These extended SOs set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

All executive and non-executive directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

INTRODUCTION

1. The George Eliot NHS Trust (GEH) is a statutory body which was established on 1st July 2009 under The NHS Trust (Establishment) Order 1993 under The George Eliot Hospital NHS Trust (Establishment) Order No 1510.
2. The principal place of business of GEH is George Eliot Hospital, College Street, Nuneaton, CV10 7DJ.
3. The Worcestershire Acute Hospitals NHS Trust (WAHT) is a statutory body established on 1st January 2000 under the NHS Trust (Establishment) Order 1990 under Order No 3473.
4. The principal place of business of WAHT is Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD.
5. The Wye Valley NHS Trust (WVT) is a body corporate which was established on 1st April 2011 under The NHS Trust (Establishment) Order 1993 (the Establishment Order).
6. The principal place of business of WVT is Trust Headquarters, Hereford County Hospital, Stonebow Road, Hereford, HR1 2ER.
7. NHS Trusts are governed by statute, mainly the National Health Service Act 2006 and the Health and Social Care Act 2012.
8. The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and Schedule 4) and in the Establishment Order.
9. As a body corporate, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role, it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee for property held by the Trust on behalf of patients.
10. The Department of Health and Social Care (DHSC) requires that Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior managers. The Code of Conduct and Code of Accountability makes various requirements concerning possible conflicts of interest of Board directors. The NHS Trusts (Membership and Procedure) Regulations 1990 requires the establishment of audit and remuneration committees with formally agreed terms of reference.
11. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.
12. Through these SOs, the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of the SOs; or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State for Health and Social Care may direct.
13. These documents, together with SFIs, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trusts' interests by ensuring, for example, that all transactions maximise the benefit to the Trust and protecting staff from possible accusations that they have acted less than properly.
14. The SOs, Scheme of Delegation document and SFIs provide a comprehensive business framework. All directors and all staff should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions to the extent required for the proper conduct of their duties.
15. **The failure to comply with SOs and SFIs can be regarded as a disciplinary matter that could result in dismissal.**

SECTION A - INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

Save as otherwise permitted by law, at any meeting the **Chair** of the Trust shall be the final authority on the interpretation of Standing Orders (SOs) on which the **Chief Executive**, guided by the **Company Secretary**, shall advise them.

GEH, WAHT and WVT are part of a Foundation Group of hospitals along with the South Warwickshire University NHS Foundation Trust (SWFT) who share a **Chief Executive**.

The **Chief Executive** works with the **Chair** to ensure that the Board maintains its capacity and is continually developed in order to remain 'fit for purpose' in the context of a changing NHS and wider healthcare environment. In support of these responsibilities a key part of the **Chief Executive** role is a focus on the integration agenda, system leadership and partnership working.

To this end, this role involves robust engagement with stakeholders, commissioners, other health and social care providers, public, private and third sector partners, children and families, to maximise the opportunities for improved service delivery at every opportunity.

The **Managing Director** is responsible for the day to day management of the Trust on behalf of the **Chief Executive** leading the Executive Team and Chairing the Trust Management Board. This role encompasses internally and externally the development and implementation of the Trust strategy, the management of relationships, engagement with staff and stakeholders and embedding partnerships with key stakeholders to the organisation, overseeing all communications activity across the Trust, both internally and externally, and the delivery of the Board Assurance Framework.

The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act 2006
- the **2012 Act** is the Health and Social Care Act 2012
- **Membership and Procedure Regulations** are the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990)2024), as amended.

Other definitions:

- **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, it shall be the **Chief Executive**.
- **Board** means the Chair, Officer (Executive Directors) and Non-Officer (Non-Executive Director) members of the Trust collectively as a body.
- **Budget** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- **Budget holder** means a director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
- **Chair of the Board (or Trust)** is the person appointed by the Secretary of State for Health and Social Care and Social Care (delegated to NHS England (NHSE) to lead

the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

- **Chief Executive** means the Chief Officer of the Trust. The **Chief Executive** is also the Accountable Officer.
- **Chief Finance Officer** means the Chief Financial Officer of the Trust.
  Clinical Directors are specialty leads reporting to and accountable to the **Chief Executive**, with professional oversight from the Chief Medical Officer. They are ***excluded*** from the term "director" for the purposes of this document, unless specifically stated otherwise.
- **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- **Committee** means a committee or sub-committee created and appointed by the Trust.
- **Committee members** means persons formally appointed by the Board to sit on or to chair specific committees.
- **Contracting and procuring** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- **Executive Director** is an officer of the Trust. Up to five will be voting members of the Trust Board, appointed in accordance with the Membership and Procedure Regulations, 1990. The remainder will not be eligible to vote on the Trust Board.
- **Funds Held on Trust** are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
- **Managing Director** means the Managing Director of the Trust and the person responsible for the day to day management of the Trust.
- **Member** means Executive Director (officer) or Non-Executive Director (non-officer) member of the Board as the context permits. Member in relation to the Board does not include its Chair.
- **Associate Member** means a person appointed to perform specific statutory and non-statutory duties, which have been delegated by the Trust Board for them to perform, and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
- **Membership, Procedure and Administration Arrangements Regulations** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
- **Motion** is a formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
- **NHS England (NHSE)** is responsible for the oversight of NHS Trusts and has delegated authority from the Secretary of State for Health and Social Care and Social Care for the appointment of the Non-Executive Directors, including the Chair of the Trust.
- **Nominated officer** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
  Non-Executive Director also is a member of the Trust Board who is not an Executive Director of the Trust and is not to be treated as an Executive Director by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

- **Officer** (or **staff**) means an employee of the Trust or any other person holding a paid appointment or office with the Trust. (This includes all employees or agents of the Trust, including medical and nursing staff and consultants practising upon the Trust's premises and shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust).
  Officer member means a member of the Trust Board who is either an Executive Director of the Trust or is to be treated as an Executive Director by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).
- **Senior Independent Director (SID)** means an independent non-officer member appointed by the Board to provide a sounding board for the Chair and serve as an intermediary for the other directors when necessary.
- **SFIs** means Standing Financial Instructions.
- **SOs** means Standing Orders.
- **Trust** means the George Eliot Hospital NHS Trust/Worcestershire Acute Hospitals NHS Trust/Wye Valley NHS Trust.
- **Company Secretary** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.
- **Vice-Chairperson/Deputy Chairperson** means the non-officer member appointed by the Board to take on the Chairperson's duties if the Chairperson is absent for any reason.
- **Working day** means any day, other than a Saturday, Sunday or legal holiday
  Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.
  All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

Policy statements: general principles

These SOs and SFIs must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- Bribery Act 2010

The Trust Board will from time to time agree and approve policy statements and procedures which will apply to all, or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's SOs and SFIs.

SECTION B – STANDING ORDERS FOR THE REGULATION OF THE PROCEEDINGS OF GEH/WAHT/WVT

Part 1 – Membership

1 Name and business of the Trust

1.1. All business shall be conducted in the name of George Eliot Hospital NHS Trust/Worcestershire Acute Hospitals NHS Trust/Wye Valley NHS Trust ("the Trust").

1.2. All funds received in trust shall be in the name of the Trust as corporate trustee. The powers exercised by the Trust as corporate trustee, in relation to funds held on trust, shall be exercised separately and distinctly from those powers exercised as a Trust.

1.3. The Trust has the functions conferred on it by Schedule 4 of the 2006 Act.

1.4. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health and Social Care. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health and Social Care.

1.5. The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, which may include members participating by video or telephone. These powers and decisions are set out in the Schedule of Decisions Reserved and Standing Financial Instructions (SFIs) which are a separate document and have effect as if incorporated into the SOs.

2 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

2.1 The Chair of the Trust (Appointed by NHSE);

2.2 The voting membership of the Trust Board shall comprise the Chair and five non-executive directors (appointed by NHSE), together with up to five executive directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent non-executive directors.

2.3 In addition to the Chair, the non-executive directors shall normally include:

a. one appointee nominated to be the Vice-Chair
b. one appointee nominated to be the Senior Independent Director
c. one or more appointees who have recent relevant financial experience

Appointees can fulfil more than one of the roles identified.

2.4 Up to five executive directors (but not exceeding the number of non-executive directors) including:

- **Chief Executive**
- Chief Finance Officer
- Medical Practitioner (Chief Medical Officer)
- Registered Nurse/Midwife (Chief Nursing Officer)
- **Managing Director**

2.5 The Board may appoint additional executive directors, in crucial roles in the Trust, and also additional non-executive directors and Associate non-executive directors to be non-voting members of the Trust Board.

2.6 The Trust shall have not more than 11 and not less than eight members (unless otherwise determined by the Secretary of State for Health and Social Care and Social Care and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

3 Appointment of Chair and Members of the Trust Board

3.1 The Chair and non-executive directors of the Trust are appointed by the NHSE, on behalf of the Secretary of State for Health and Social Care.

3.2 The **Chief Executive** shall be appointed by the Chair and the non-executive directors.

3.3 Executive directors shall be appointed by a committee comprising the Chair, the non-executive directors and the **Chief Executive**.

3.4 Where more than one person is appointed jointly to an executive director post in the Trust, those persons shall become appointed as an executive director, jointly.

4 Appointment and Powers of Deputy Chair & Senior Independent Director

4.1 Subject to SO 4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not an executive director, to be Deputy Chair & Senior Independent Director (SID), for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

4.2 Any member so appointed may at any time resign from the office of Deputy Chair and SID, by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Deputy Chair and SID, in accordance with the provisions of SO 4.1.

4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair & SID shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair & SID.

5 Tenure of office

5.1 The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements Regulations.

6 Code of Conduct and Accountability and the Trust's commitment to openness

All directors shall subscribe and adhere at all times to the principles contained in the Code of Conduct and Code of Accountability in the NHS and in the Trust's Code of Conduct (HR.93) and Managing Conflicts of Interest Policy (MF.36).

7 Functions and roles of Chair and directors

The function and role of the Chair and members of the Trust Board is described within these SOs and within those documents that are incorporated into these SO.

Part 2 – Meetings

8 Ordinary meetings of the Trust Board

8.1. All ordinary meetings of the Trust Board shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended, and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

8.2. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may from time to time determine. A minimum of six meetings shall be held each year.

8.3. The Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the Trust Board's business may be conducted without interruption and disruption.

8.4. The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Trust Board resolving as follows:

"***That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public***"

8.5. Business proposed to be transacted when the press and public have been excluded from a meeting as provided in SO 8.4, shall be confidential to members of the Board.

8.6. Members and officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Trust Board meetings without the express permission of the Trust Board.

8.7. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

8.8 The Chair may invite any member of staff of the Trust, any other NHS organisation, an officer of the local council(s) or any other individual acting in an advisory capacity to attend meetings. These invitees shall not count as part of the quorum or have any right to vote at the meeting.

8.9 An annual public meeting shall be held on or before 30 September in each year for the purpose of presenting audited accounts, annual reports and any report on the accounts.

8.10

8.11 The provisions of these SOs relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to seminars or workshops or other meetings attended by members of the Trust Board.

9 Extraordinary meetings of the Trust Board

9.1 The Chair may call a meeting of the Trust Board at any time. Directors may ask the Chair to call a meeting of the Trust Board at any time.

9.2 A meeting may be called forthwith, by the directors who are eligible to vote, if the Chair refuses to call a meeting after such a request has been presented to them, signed by at least one third of the whole number of directors who are eligible to vote (including at least one executive and one non-executive director); and has been presented to them at the Trust's principal place of business. The directors who are eligible to vote may also call a meeting forthwith if, without refusing, the Chair does not call a meeting within seven days after receipt of such request.

10 Notice of meetings

10.1 The Trust shall set dates and times of regular Trust Board meetings for the forthcoming financial year by the end of December of each year.

10.2 One third or more members of the Trust Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting. In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

10.3 A notice of the meeting shall be delivered to every director by the most effective route, at least three working days before the meeting. Notice shall be presumed to have been served two days after posting and one day after being sent out via email.

10.4 Lack of service of such notice on any individual director shall not affect the validity of a meeting. However, failure to serve such a notice on at least three directors who are eligible to vote will invalidate the meeting.

10.5 Where a part or the whole of a meeting is to be open to the public, official notice of the time, place and agenda of the meeting shall be announced in public. As required by the Public Bodies (Admission to Meetings) Act 1960 Section 1(4)(a)), notice will be given by one or more of the following announcements:

a. in the local press,
b. on the Trust's internet website,
c. displaying the notice in a conspicuous place in the Trust's hospitals or other facilities
d. displaying the notice in other "central and conspicuous places".

10.6 The Trust Board may decide to limit publication to details of the items on the meeting agenda that will be considered in the part of the meeting to be held in public. A copy of the notice including the agenda may also be sent to local organisations that will have an interest in the decisions of the Trust Board. These organisations include bodies responsible for commissioning acute and community NHS services locally, patient and public representative groups and local councils.

10.6 Notice will be given at least three working days before the meeting. Failure to do so will render the meeting invalid.

11 Agenda and Supporting Papers

11.1 The Trust Board may determine that certain matters will appear on every agenda for an ordinary meeting of the Trust Board and that these will be addressed prior to any other business being conducted at the discretion of the Chair. On agreement by the Trust Board, these matters may change from time to time.

11.2 A director may request that a matter is included on an agenda. This request should be made in writing, including by electronic means, to the Chair, **Chief Executive**, or the Company Secretary at least seven working days before the meeting, subject to SO10. Requests made less than seven working days before the meeting may be included on the agenda at the discretion of the Chair, or to the extent that this discretion is delegated to the **Chief Executive** and the **Company Secretary.**

11.3 Notwithstanding SO 11.2, a director may with the consent of the Chair of the meeting, add to the agenda of any meetings any item of business relevant to the responsibilities of the Trust under "Any Other Business".

11.4 The agenda will be sent to directors five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda but will certainly be despatched no later than three clear working days before the meeting, save in an emergency.

12 Chair of meetings

12.1 The **Chair** shall preside at any meeting of the Trust Board, if present. In his absence, the Deputy Chair shall preside.

12.2 If the Chair and Deputy Chair are absent, the directors present, who are eligible to vote, shall choose a non-executive director who shall preside. An executive director may not take the chair.

12.3 The decision of the **Chair** of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the SOs shall be final. In this interpretation he shall be advised by the **Chief Executive** and the Company Secretary and in the case of SFIs he shall be advised by the Chief Finance Officer.

13 Voting

13.1 It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

13.2 Save as provided in SO27 Suspension of Standing Orders and SO28 Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding i.e. the Chair of the meeting, shall have a second, and casting vote.

13.3 At the discretion of the **Chair**, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the **Chair** directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot. Unless specifically agreed beforehand, the voting record of each individual director in a paper ballot will not be made public or recorded.

13.4 The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

13.5 If a Board member so requests, their vote shall be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded.

13.6 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

13.7 An officer who has been formally appointed by the Trust to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy shall be entitled to exercise the voting rights of the executive director. An officer attending the Trust Board meeting to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not

exercise the voting rights of the executive director. An executive director's status when attending a meeting shall be recorded in the minutes.

13.8 Where the post has voting rights attached, joint appointees will have the power of one vote; and shall count for the purpose of SO 2 as one person:

a. either or both of those persons may attend or take part in meetings of the Board;
b. if both are present at a meeting they should cast one vote if they agree;
c. in the case of disagreements no vote should be cast;
d. the presence of either or both of those persons should count as the presence of one person for the purposes of SO14 Quorum.

13.9 For the voting rules relating to joint members see SO 3.4.

13.10 Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

14 Quorum

14.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the **Chair** and members, including at least one executive director and one non-executive director is present.

14.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

14.3 If the **Chair** or executive director or non-executive director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution because of a declaration of a conflict of interest (see **Part 3 – Standards of Business Conduct**) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting shall then proceed to the next business.

15. Record of attendance

15.1 The names of the directors and others invited by the **Chair**, in accordance with Standing Order 8, present at the meeting, shall be recorded in the minutes.

15.2. If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

16. Minutes

16.1. The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

16.2. There should be no discussion on the minutes, other than as regards their accuracy, unless the **Chair** considers discussion appropriate.

16.3. Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

17 Petitions

Where a petition has been received by the Trust, the **Chair** shall include the petition as an item for the agenda of the next meeting.

18 Notice of Motion

Subject to the provision of SO20, a director of the Trust desiring to move a motion shall give notice of this, to the **Chair**, at least seven working days before the meeting. The **Chair** shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

19 Emergency Motions

Subject to the agreement of the **Chair**, and subject also to the provision of SO20, a member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The **Chair**'s decision to include the item shall be final.

20 Motions: Procedure at and during a meeting

20.1 A motion may be proposed by the **Chair** of the meeting or any member present, it must also be seconded by another member.

20.2 The **Chair** may exclude from the debate, at their discretion, any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Trust Board proceed to next business;
- that the Trust Board adjourns;
- that the question be now put.

21 Amendments to motions

21.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

21.2 Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

21.3 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

22 Rights of reply to motions

22.1 Amendments. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

22.2 Substantive/original motion. The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

23 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

24 Motions once under debate

24.1 When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceeds to the next business
- that the question should be now put
- the appointment of an 'ad hoc' committee to deal with a specific item of business
- that a member/director be not further heard
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see SO 29).

24.2 In those cases where the motion is either that the meeting proceeds to the “next business” or “that the question be now put” in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

24.3 If a motion to proceed to the next business or that the question be now put, is carried, the **Chair** should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

25 Motion to rescind a decision of the Trust Board

25.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been

given, the Trust Board may refer the matter to any appropriate Committee or the **Chief Executive** for recommendation.

25.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the **Chair** to propose a motion to the same effect within six months. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee or the **Chief Executive**.

25.3 When the Trust Board has debated any such motion, it shall not be permissible for any director, other than the **Chair** to propose a motion to the same effect within a further period of six calendar months.

26 Chair's ruling

The decision of the **Chair** of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the SO and SFIs, at the meeting, shall be final.

27 Suspension of Standing Orders

27.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 14), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Trust Board are present (including at least one executive director and one non-executive director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

27.2 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the **Chair** and members of the Trust.

27.3 No formal business may be transacted while SO are suspended.

27.4 The Audit Committee shall review every decision to suspend SO.

28 Variation and amendment of Standing Orders

These SOs shall not be varied except in the following circumstances:

- upon a notice of motion under SO 18
- upon a recommendation of the **Chair** or **Chief Executive** included on the agenda for the meeting
- that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's non-executive members vote in favour of the amendment
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

29 Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board as follows:

> "***that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest***", Section 1 (2), Public Bodies (Admission to Meetings) Act l960.

30 General disturbances

The **Chair** (or Deputy Chair) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption. Section 1(8) of the Public Bodies (Admissions to Meetings) Act 1960 provides the Trust Board power of exclusion to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The public will be required to withdraw upon the Trust Board resolving:

> "***That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public***".

31 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

32 Observers at Trust meetings

The Trust will decide what arrangements and terms, conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms, and conditions as it deems fit.

Part 3 – Standards of business conduct

33 Declarations of interest

33.1 In addition to the statutory requirements relating to pecuniary interests dealt with in SO 34, the Trust's Management of Conflicts Policy (MF.38) requires directors to declare interests which are relevant and material to the Trust Board. All existing directors and decision-making staff as set out in the Policy should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and decision-making staff appointed subsequently should declare these interests on appointment.

33.2 Interests are:

- **Financial interests**, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- **Non-financial professional interests**, where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests**, where an individual may benefit personally in ways which are not linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests**, where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

33.3. Subject to the requirements stated in Standing Order 22, the interests of directors' spouses, partners, or other family members must be disclosed where these maybe in conflict with the Trust.

33.4 If directors have any doubts about the relevance of an interest, this should be discussed with the **Chair** of the Trust or with the Company Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

33.5 Declarations of interests should be considered by the Trust Board and retained as part of the record of each Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

33.6 If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

33.7 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports. Register of Interests

33.8 The Company Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors and other decision-making staff. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive directors.

33.9 These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

33.10 The Register of Interests will be available to the public on the Trust's web page and at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

33.11 With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or subcommittee or group of the Trust Board; and to any member of such committee or subcommittee or group (whether or not they are a director).

34 Disability of directors in proceedings on account of pecuniary interest

34.1. Subject to SO33 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

34.2. The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to them to be in the interests of the NHS that the disability should be removed.

34.3 The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

34.4 Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

34.5 For the purpose of this SO a director shall be treated, subject to SO2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

- they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or,
- they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this SO to be also an interest of the other.

34.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;
- of an interest in any company, body or person with which they are connected as mentioned in SO 34.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

34.7 This SO shall not prohibit a director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

- They have an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
- the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one hundredth of the total issued share capital of the class. This does not affect their duty to disclose the interest

34.8 This SO also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

35 Standards of Business Conduct

35.1 The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

35.2 The NHS Constitution (updated January 2021) identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

- to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies;
- to act in accordance with the terms of contract of employment;
- not to act in a discriminatory manner;
- to protect confidentiality;
- to be honest and truthful in their work;
- to aim to maintain the highest standards of care and service;

- to maintain training and personal development to contribute to improving services;
- to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity;
- to involve patients in decisions about their care and to be open and honest with them and;
- to contribute to a climate where the truth can be heard and learning from errors is encouraged.

35.3 The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

- **Selflessness**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity**: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity**: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability**: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness**: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty**: Holders of public office should be truthful.
- **Leadership**: Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

35.4 All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

- act in the best interests of the Trust and adhere to its values and this code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions;
- recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and;
- accept responsibility for their performance, learning and development.

35.5 All Directors must act in accordance with the Professional Standards Authority's 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' 2012.

35.6 All staff shall declare any relevant and material interest, such as those described in SO 33 and in the Trust's Management of Conflicts Policy (MF.38). The declaration should be made on appointment to the executive director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Management of Conflicts Policy (MF.38). The system will then add the interest to the Trust's Register of Interests.

35.7 Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the expenditure of taxpayer monies, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

35.8 If an officer becomes aware of a potential or actual contract in which they have an interest of the nature described in SO 33 and SO 34, they shall immediately advise the **Chief Finance Officer** formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed or awarded contract to which they have an interest.

35.9 Gifts and hospitality shall only be accepted in accordance with the Trust's Management of Conflicts Policy (MF.38). Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

35.10 All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy), should be declared via the Trust's online declarations of interest system. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act 2006 and the Bribery Act 2010.

35.11 In addition to SO 33, SO 34 and this Standing Order, an officer must also declare to the Chief Executive or Company Secretary any other employment, business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part 4 – Arrangements for the exercise of functions by delegation and committees

36 Exercise of functions

Subject to SO 40 and such directions as may be given by the Secretary of State for Health and Social Care and Social Care, the Trust Board may delegate any of its functions to a committee or sub-committee or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

37 Emergency powers and urgent decisions

The powers which the Trust Board has retained to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the **Chief Executive** and the **Chair** acting jointly and, if possible, after having consulted with at least two non-executive directors. The exercise of such powers by the **Chief Executive** and the **Chair** shall be reported to the next formal meeting of the Trust Board for formal ratification.

38 Delegation to committees

The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

39 Delegation to officers

Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the **Chief Executive**. The **Chief Executive** shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

40 Schedule of decisions reserved for the Trust Board

40.1 The Trust Board shall adopt a 'Schedule of Decisions Reserved for the Trust Board' setting out the matters for which approval is required by the Trust Board. The Schedule of Reservation, Delegation of Powers and Financial Delegation Limits (Standing Financial Instructions) are a separate document and shall be regarded as forming part of these SOs.

40.2 The Trust Board shall review such Schedule at such times as it considers appropriate; and shall update the Schedule of Reservation, Delegation of Powers and Financial Delegation Limits (Standing Financial Instructions) after each review.

40.3 The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub- committee shall be subject to and qualified by the reserved matters contained in that Schedule.

41 Scheme of Delegated Authorities

41.1 The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them. The Schedule that is current at the date of adoption of these SOs is contained in Appendices 1 and 2 and shall be regarded as forming part of these SOs.

41.2 The Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendices 1 and 2 after each review.

41.3 The direct accountability, to the Trust Board, of the Director of Finance and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

42 Appointment of committees

42.1 Subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care, the Trust may, and if directed by them, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

42.2 An appointed committee may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

42.3 The SOs of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.

42.4 The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

42.5 Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

42.6 The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the Secretary of State for Health and Social Care, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

42.7 Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this SO are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

42.8 The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

43 Statutory and mandatory committees

Role of Audit Committee

43.1 In line with the requirements of the Code of Governance for NHS Provider Trusts, NHS Audit Committee Handbook (fourth edition), NHS Codes of Conduct and Accountability, and the Higgs report, the Trust Board will establish an Audit Committee, constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

43.2 The terms of reference of the Audit Committee shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board. The Terms of Reference will be approved by the Trust Board and reviewed on an annual basis.

43.3 The Code of Governance for NHS Provider Trusts, and Higgs report recommends a minimum of three non-executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

Role of Auditor Panel

43.4 The Trust Board shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

43.5 The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

43.6 The terms of reference of the Auditor Panel shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Remuneration Committee

43.7 In line with the requirements of the Code of Governance for NHS Provider Trusts, NHS Codes of Conduct and Accountability, and the Higgs report, the Trust Board shall appoint a committee to undertake the role of a remuneration and terms of service committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the **Chief Executive** and other executive directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

43.8 The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the **Chief Executive** and executive directors, including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions;
- arrangements for termination of employment and other contractual terms.

43.9 The terms of reference of the Remuneration and Nominations Committee shall have effect as if incorporated into these SOs and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

43.10 The Code of Governance for NHS Provider Trusts and Higgs report recommends the committee be comprised exclusively of non-executive directors, a minimum of three, who are independent of management.

Role of the Charity Committee

43.11 The Trust Board, acting as Corporate Trustee, shall appoint a committee to be known as the Charity Trustee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

43.12 The terms of reference of the Charity Trustee shall have effect as if incorporated into these SOs and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

44 Non mandatory committees

44.1 The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

44.2 The terms of reference of these committees shall have effect as if incorporated into these SOs. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

44.3 The membership of these committees may comprise non-executive directors or executive directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

44.4 The current non-mandatory committees in place are (March 2023):

- **Quality Committee/Quality Assurance Committee**. The purpose of the Quality Committee/Quality Assurance Committee is to provide the Board with an independent and objective review of all aspects of quality and safety relating to the provision of care and services in support of ensuring the best clinical outcomes and experience for all patients; and, to assure the Board that the

Trust is aligned to the statutory quality and safety demands of existing legislation relating to all areas of the Trust.

- **Risk Management Executive/Executive Risk Management Committee.** The purpose of the Risk Management Executive/Executive Risk Committee is to ensure the effective implementation of the Risk Management Strategy and there are core processes in place to manage risks across the organisation. The Risk Management Executive/Executive Risk Management Committee reports on any issues where the Trust Board may require additional assurance or where a Trust Board decision is required.
- **Finance and Performance Executive.** The purpose of the Finance and Performance Executive is to ensure the Executive Team holds all divisions and/or directorates (as appropriate) to account for their delivery of key quality, performance, workforce and financial objectives and as required by the Trust Board and/or regulators. The overall objective is to provide assurance and support at all levels that appropriate management action (by managers and clinicians) is being exercised and that the organisation can demonstrate it is well led from "ward to board".
- **Foundation Group Strategy Committee.** The purpose of the Foundation Group Strategy Committee is to advise the Boards of South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust, Worcestershire Acute Hospitals NHS Trust and Wye Valley NHS Trust on all matters relevant to identifying and sharing best practice at pace.

These are subject to change at the discretion of the Trust Board.

45 Joint Committees

45.1 Joint committees may be appointed by the Trust by joining one or other Trusts consisting of, wholly or partly of the **Chair** and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

45.2 Any committee or joint committee appointed under this SO may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

46 Proceedings in committee to be confidential

46.1 There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

46.2 Committee members should normally regard matters dealt with or brought before the committee as being subject to disclosure, unless stated otherwise by the **Chair** of the committee. The **Chair** shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

46.3 A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

46.4 Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services

47 Applicability of Standing Orders and Standing Financial Instructions to Committees

The SO and SFIs of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "**Chair**" is to be read as a reference to the **Chair** of other committees as the context permits, and the term "member" is to be read as a reference to a member of other committees also as the context permits.

48 Duty to report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SOs to the **Chief Executive** as soon as possible.

49 Terms of reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the SOs.

50 Delegation of powers by committees to sub-committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

51 Approval of appointments to committees

The Board shall approve the appointments to each of the committees, which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

52 Appointments for statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

53 Proceedings in committee to be confidential

53.1 There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act 2000 and there is no legal justification for non-disclosure.

53.2 Committee members should normally regard matters dealt with, or brought before the committee as being subject to disclosure, unless stated otherwise by the **Chair** of the committee. The **Chair** shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

53.3 A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

53.4 Regardless of this SO, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

54 Election of Chair of committee

54.1 Each committee shall appoint a **Chair**; and may appoint a Deputy Chair from its membership. The terms of reference of the committee shall describe any specific rules regarding who the Chair should be. Meetings of the committee will not be recognised as quorate if the Chair, or Deputy Chair, or other suitably qualified, nominated member of the committee is not present to undertake the role.

54.2 Each committee shall review the appointment of its Chair, as part of the annual review of the committee's role and effectiveness.

55 Special meetings of committee

The **Chief Executive** shall require any committee to hold a special meeting, on the request of the **Chair**, or on the request, in writing of any two members of that committee.

Part 5 – Custody of seal and sealing of documents

56 Custody of seal

The common seal of the Trust shall be kept by the **Company Secretary** in a secure place.

57 Sealing of documents

57.1 The Seal of the Trust shall only be attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has first been approved in accordance with these Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authorities.

57.2 The seal shall be affixed in the presence of the signatories in accordance with Paragraph 33 of Schedule 4 of the 2006 Act:

> ***"33 Instruments etc. (1) The fixing of the seal of an NHS trust must be authenticated by the signature (a) of the chairperson or of some other person authorised (whether generally or specifically) by the NHS trust for that purpose, and (b) of one other director."*** 31. Bearing witness to the affixing of the Seal

57.3 A recommended wording for the witnessing of the use of the Seal is "The Common Seal of the George Eliot Hospital National Health Service/Worcestershire Acute Hospitals National Health Service/Wye Valley National Health Service Trust was hereunto affixed in the presence of…."

57.3 The seal shall be affixed in the presence of two executive directors, and not from the originating department, and shall be attested by them.

58 Bearing witness to the affixing of the Seal

A recommended wording for the witnessing of the use of the Seal is "*The Common Seal of the George Eliot Hospital National Health Service/Worcestershire Acute Hospitals National Health Service/Wye Valley National Health Service Trust was hereunto affixed in the presence of….*"

59 Register of sealing

The **Company Secretary** shall keep a register in which they will make an entry of every sealing, numbered consecutively in a book or electronic register provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

60 Signature of documents

60.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the **Chief Executive** or any executive director, unless any enactment requires or authorises otherwise.

60.2 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Delegation. This will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

Part 6 – Waiver of Standing Orders made by the Secretary of State for Health and Social Care

61 Power of the Secretary of State to make waivers

Under regulation NHS (Membership and Procedure) Regulations, there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

62 Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of SO 80 (below), the "relevant Chair" is:

a. at a meeting of the Trust, the Chair of that Trust
b. at a meeting of a Committee:
   - in a case where the member in question is the Chair of that committee, the Chair of the Trust;
   - in the case of any other member, the Chair of that committee.

63 Application of waiver

63.1 A waiver will apply in relation to the disability to participate in the proceedings of the Trust because of a pecuniary interest. It will apply to a member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

- services under the National Health Service Act 1977; or
- services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

63.2 Where the 'pecuniary interest' of the member in the matter, which is the subject of consideration at a meeting at which, they are present:

a. arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
b. has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

   - are members of the same profession as the member in question,
   - are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

64 Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

a. the member must disclose their interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;
b. the relevant **Chair** must consult the **Chief Executive** before making a declaration in relation to the member in question pursuant to SO 80.2b, except where that member is the **Chief Executive**;
c. in the case of a meeting of the Trust:
   - the member may take part in the consideration or discussion of the matter, which must be subjected to a vote, and the outcome recorded;
   - may not vote on any question with respect to it.
d. in the case of a meeting of the Committee:
   - the member may take part in the consideration or discussion of the matter, which must be subjected to a vote, and the outcome recorded;
   - may vote on any question with respect to it; but the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board

SECTION C – STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS FOR THE REGULATION OF TENDERING AND CONTRACTING (CONTRACT PROCEDURE RULES)

1 Duty to comply with Standing Orders and Standing Financial Instructions

1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where SO 26 Suspension of Standing Orders is applied), supplemented by such operational procedures as deemed necessary by the **Chief Executive Officer** or **Managing Director** and the **Chief Finance Officer**. These operational procedures shall have effect as if incorporated in SOs and SFIs

1.2 The **Chief Finance Officer** shall be responsible for ensuring that the operation of contracts with any external procurement partner adhere to the SFIs.

2 General

2.1 The Trust will develop a longer-term procurement strategy in conjunction with the Foundation Group.

2.2 Every contract made by or on behalf of the Trust shall comply with the procedures and requirements of:

a. these SOs
b. the Trust's SFIs
c. any direction by the Trust Board

2.3 Wherever possible, and provided it protects the Trust's position adequately, contracts made will reflect the most up to date and relevant model Standard Conditions that are provided by the Department of Health and Social Care. These models may be amended to develop bespoke contracts.

2.4 Directives of the Council of the European Union (EU) for awarding all forms of contracts shall take precedence over all other procedural requirements and guidance and shall have effect as if incorporated in these SOs. The EU Procurement Rules apply to public authorities under the Public Contracts Regulations 2015. The regulations cover fully regulated procurements and 'light touch regime'. The rules set out detailed procedures for contracts where the value equals or exceeds specific thresholds. These thresholds are exclusive of VAT and relate to the full life of the contract.

2.5 All projects and commitments of expenditure will be subject to these SFIs and should be treated as 'total value' expenditure and not disaggregated unless specifically referenced otherwise. All those in a position to commit expenditure should consider, before committing the expenditure or entering into any quotation or tender procedure, whether the expenditure is part of a larger overall sum of money to which different SFI conditions would apply. If this is deemed to be the case then the larger 'total value' sum should be used and the appropriate SFIs applied accordingly.

2.6 The **Chief Executive Officer** shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Trust Board may also determine from time to time those in-house services should be market tested by competitive tendering.

2.7 Contract procedures shall take account of the Trust's Code of Conduct (HR.93) and Managing Conflicts of Interest Policy (MF.36) and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

2.8 The application of the provisions of this part of the SOs and SFIs to contracts and purchases may be varied by resolution of the Trust Board from time to time.

3 Delegated authority to enter into contracts

3.1 The Trust Board shall have power to accept tenders and to authorise the conclusion of contracts. It may delegate such authority subject to financial limits set in accordance with Appendix 2.

a. a committee appointed under Part 4 – Arrangements for the exercise of functions by delegation and committees of these SOs

b. the **Chief Executive Officer**
c. to the **Chief Executive Officer** jointly with the **Chair**
d. the directors or nominated officers
e. officers of the Trust's procurement service supplier, in accordance with that organisation's standard operating procedures.

3.2 The financial limits determining whether quotations (competitive or otherwise) or sealed bid tenders must be obtained shall be set in accordance with the procedure in the SFIs; the current thresholds being set out in Appendix 2.

4 Competition in purchasing or disposals – procedures

The Trust Board shall from time to time adopt procedures which shall be regarded as being incorporated into these SO and which shall take account of SFIs, the Trust's Procurement rules and regulations including implementing EC Directives on Public Procurement and which shall deal with:

a. Tender process selection
b. methods for inviting tenders
c. the manner in which tenders are to be submitted
d. the receipt and safe custody of tenders
e. the opening of tenders
f. evaluation
g. re-tendering
h. such other matters in connection with tendering as the Board considers appropriate

5 Disposals of land and buildings

Land and buildings that are owned by the Trust, or are otherwise recorded as being part of the estate of the Trust, shall be disposed of in accordance with the most recent rules and guidance issued by the Department of Health. Disposal will require the approval of the Trust Board.

6 Interest of officers in contracts

6.1 Any **staff** of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any pecuniary interest, direct or indirect, the officer shall declare their interest by giving notice in writing of such fact to the **Chief Executive Officer** or the **Company Secretary** as soon as practicable in accordance with Section B, Part 3 of SOs.

6.2 **All staff** should also declare to the **Chief Executive Officer** any other employment or business or other relationship, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

6.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7 Joint Finance Arrangements

7.1 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under section 28A of the NHS Act 1977.

7.2 The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

8 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions.

9 Capital investment manual and other Department of Health guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

10 General applicability

Where the value of a contract over the life of the contract is £20,000 or more (excluding VAT), the Trust shall ensure that, unless national contracts or ProCure 21+ National Framework or similar procedures are followed, competitive tenders are invited for:

a. the supply of goods, materials and manufactured articles;
b. the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
c. For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

11 Health care services

Where the Trust elects to invite tenders for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure.

Part 1 – Use of approved firms and exemptions to contract procedure rules

12 Exceptions and instances where formal tendering need not be applied

12.1 Value for money should always be sought, though formal tendering procedures **need not be applied** where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed **£10,000** (excluding VAT) over the life of the contract;
b. the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

c. disposals are required;
d. under the contract terms of the PFI scheme in operation at Wye Valley NHS Trust, goods and services can only be supplied by the Trust's PFI partner.

12.2 Exemptions from these SOs and SFIs Contract Procedure Rules are only allowed in exceptional circumstances such as there being insufficient suppliers for the goods, works or services being procured. Permission must be obtained for any exemption using the form at Appendix 4. Major contracts may be subject to the European Procurement Rules and the Trust cannot provide an exemption from those requirements.

12.3 A written application for an exemption from the Trust's SOs and SFIs (Contract Procedure Rules) must be made to the **Chief Finance Officer** setting out the reasons for the application using the form at Appendix 3. The **Chief Finance Officer** must respond within 21 days. A register of all approved exemptions will be maintained and reported to the Audit Committee.

12.4 Reasons for exemption are, but not limited to:

a. in very exceptional circumstances where the **Chief Executive Officer** decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
b. where the requirement is covered by an existing contract;
c. where framework agreements are in place and have been approved by the Board;
d. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
e. where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
f. where specialist expertise is required and is available from only one source;
g. when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
h. there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
i. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.
j. The **Chief Finance Officer** will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work, where allowed and provided for in the Capital Investment Manual.

12.5 Tenders need not be invited in accordance with the provisions of the Trust's SOs and SFIs (Contract Procedure Rules) if an urgent decision is required, for example for the protection of life or property or to maintain the functioning of a service. Wherever possible though, at least two quotations must be obtained and any decision made or contract awarded shall be reported to the relevant director and **Chief Finance Officer**. Such emergency contracts should be let for as short a period as possible to allow their replacement with a contract that is fully compliant with the Contract Procedure Rules at the earliest practical opportunity.

12.6 **The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.**

12.7 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in the agreed Single Tender Waiver document (Appendix 3), managed by the Procurement service and reported to the Audit Committee.

12.8 The authorisation of a Single Tender Waiver does not mean that competitive tendering will remain not applicable for future periods. Wherever possible the Procurement service will work with departments to support a competitive tendering process in readiness for the contract end date.

12.9 The Audit Committee will have an explicit role in the oversight of the use of waivers. A register of waivers will be maintained and reported to the Audit Committee on an agreed schedule, as a minimum 6 monthly. This will include oversight of use of Single Tender Waivers over extended periods.

13 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the **Managing Director**, and be recorded in an appropriate Trust record.

14 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

15 Fair and adequate competition

Where the exceptions set out in section 13 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

16 List of approved firms

16.1 The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists (where relevant). Where in the opinion of the **Chief Finance Officer** it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the **Chief Executive Officer**.

16.2 **Responsibility for maintaining list.** A manager nominated by the **Managing Director** shall on behalf of the Trust maintain lists of approved firms (where considered appropriate) from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

17 Building and Engineering Construction Works

17.1 Invitations to tender shall be made only to firms included on the approved list of tenderers (where appropriate) compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

17.2 Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equality Act 2010, and any amending and/or related legislation.

17.3 Firms shall conform at least with the requirements of the Health and Safety at Work etc. Act 1974 and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

18 Financial Standing and Technical Competence of Contractors.

The **Chief Finance Officer** may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

19 Exceptions to using Approved Contractors

If, in the opinion of the **Managing Director** and the **Chief Finance Officer** or the **director** with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the **Managing Director** should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote. An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

Part 2 – Contracting and tendering procedure

20 Invitation to Tender

20.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

20.2 All invitations to tender shall state that no tender will be accepted unless:

a. submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the **Chief Executive Officer** or nominated Manager;
b. that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

20.3 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

20.4 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed):

a. shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment Standard forms of contract general conditions and major works (GC/Wks): or,
b. when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A); or,
c. in the case of civil engineering work, the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors.

These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

21 Receipt and safe custody of tenders

The **Company Secretary** or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

22 Opening tenders and register of tenders

23.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the **Managing Director** and not from the originating department.

23.2 A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £1,000,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Financial Delegation Limits at Appendix 2.

23.3 The originating department will be taken to mean the department sponsoring or commissioning the tender.

23.4 The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the **Chief Finance Officer** or any approved senior manager from the Finance Department from serving as one of the two senior managers to open tenders.

23.5 All executive directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

23.6 The **Company Secretary** will count as a director for the purposes of opening tenders.

23.7 Every tender received shall be marked with the date of opening and initialed by those present at the opening.

23.8 A register shall be maintained by the **Managing Director**, or a person authorised by him/her, to show for each set of competitive tender invitations dispatched:

- the name of all firms/individuals invited;
- the names of firms/individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

23.9 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

24 Admissibility

24.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or

any are amended, incomplete or qualified) no contract shall be awarded without the approval of the **Managing Director**.

24.2 Where only one tender is sought and/or received, the **Managing Director** and **Chief Finance Officer** shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

25 Late tenders

25.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the **Managing Director** or his or her nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

25.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the **Chief Executive Officer** or **Managing Director** or his or her nominated officer or if the process of evaluation and adjudication has not started.

25.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the **Managing Director** or his or her nominated officer.

26 Acceptance of Formal Tenders

26.1 Any discussions with a tenderer, which are deemed necessary to clarify technical aspects of their tender before the award of a contract, will not disqualify the tender.

26.2 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- experience and qualifications of team members;
- understanding of client's needs;
- feasibility and credibility of proposed approach;
- ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

26.3 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the **Managing Director**.

26.4 The use of these procedures must demonstrate that the award of the contract was:

a. not in excess of the going market rate/price current at the time the contract was awarded;
b. that best value for money was achieved.

26.5 All tenders should be treated as confidential and should be retained for inspection.

27 Tender Reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

Part 3 – Competitive and non-competitive quotations

28 General position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000 but not exceed £20,000. In both cases, the amount excludes VAT and is the cost over the life of the contract.

29 Competitive Quotations (contract value of between £10,000 and £49,999.99 excluding VAT over the contract life)

29.1 Quotations should be sought from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

29.2 For estimated expenditure with a value in excess of £10,000 and less than £50,000 (excluding VAT over the contract life), quotations should be in writing unless **Managing Director** or his or her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record. Estimated expenditure below this level but in excess of £5,000 (excluding VAT over the contract life) can be collected informally i.e. from written or telephone quotations or an approved price list.

29.3 All quotations should be treated as confidential and should be retained for inspection.

29.4 The **Managing Director** or his or her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

30 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

a. the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

b. the supply of goods or manufactured articles of any kind, which are required quickly, and are not obtainable under existing contracts;
c. miscellaneous services, supplies and disposals;
d. where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

31 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the **Managing Director or Chief Finance Officer.**

32 Authorisation of Tenders and Competitive Quotations

32.1 Providing all the conditions and circumstances set out in these SO and SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided to the value of the contract as per the Authorised Signatory List, to the whole life value of the contract (excluding VAT).

32.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation. Formal authorisation must be put in writing. In the case of authorisation by the Trust Board, this shall be recorded in their minutes.

33 Instances where Formal Competitive Tendering or Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a. the Trust shall use the NHS Supply Chain for procurement of all goods and services, unless the **Chief Executive Officer** or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.
b. If the Trust does not use the NHS Supply Chain, where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the **Chief Finance Officer**.

34 Compliance requirements for all contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a. The Trust's SOs and SFIs;
b. EU Directives and other statutory provisions;
c. Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;
d. Such of the NHS Standard Contract Conditions as are applicable.

e. Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
f. Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
g. In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The **Chief Executive Officer** shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

35 Personnel and Agency or Temporary Staff Contracts

The **Managing Director** shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

36 Healthcare Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. The **Managing Director** shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

37 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the **Managing Director** or his nominated officer;
b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
c. items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;
d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
e. land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

38 In-House Services

38.1 The **Managing Director** shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

38.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a. Specification group, comprising the **Managing Director** or nominated officer/s and specialist.

b. In-house tender group, comprising a nominee of the Managing Director and technical support.
c. Evaluation team, comprising normally: a specialist officer; a supplies officer; and, a Chief Finance Officer representative. For services having a likely expenditure exceeding £500,000, a non-executive director should be a member of the evaluation team.

38.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

38.4 The evaluation team shall make recommendations to the Board.

38.5 The **Managing Director** shall nominate an officer to oversee and manage the contract on behalf of the Trust.

39 Applicability of SFIs on Tendering and Contracting to funds held in trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

SECTION D – STANDING FINANCIAL INSTRUCTIONS

1 Interpretation

1.1. The **Chair** of the Trust is the final authority in the interpretation of SO on which the **Chief Executive Officer** shall advise him. In the case of the SFIs, he will be advised by the **Chief Finance Officer**.

1.2 The definitions applied to the SO apply also for these SFIs. The following additional definitions apply:

Legislation definitions:

No additional legislation

Other definitions:

- **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.
- **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- **Assistant Chief Operating Officers** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.

1.3. Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

2 Introduction

2.1. These SFIs are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.

2.2. The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.3. They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board (Appendix 1) and the Scheme of Delegated Authorities (Appendix 3) which both also form part of the Trust's SOs.

2.4. Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

2.5 These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the **Chief Finance Officer**, prior to action.

2.6 The SFIs apply to all staff, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs could lead to disciplinary action, up to and including dismissal.

3 Compliance with these SFIs

3.1 These SFIs prevail over any division and service guidance or procedural documents. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. All staff should notify the **Chief Finance Officer** of any conflicts between the local guidance and instruction and the SFIs, if the conflict cannot be resolved satisfactorily locally.

3.2 **All staff** have a duty to disclose, as soon as possible, to the **Chief Finance Officer** or the **Company Secretary**, any failure to comply with these SFIs. Full details of the non-compliance including an assessment of the potential impact; and any mitigating factors shall be reported by the **Chief Finance Officer** to the next formal meeting of the Audit Committee for referring action or ratification.

3.3 Changes to or variations from these SFIs will be subject to a specific resolution of the Trust Board or be consequent upon further directions from the Secretary of State.

3.4 There shall be a periodic review, normally annually, but no more than every two years of all financial limits contained in these SFIs.

4 Responsibilities and delegations

4.1 These SFIs have been compiled under the authority of the Trust Board. They are reviewed by the **Audit Committee** and approved by the Trust Board.

4.2 **The Trust Board** exercises financial supervision and control by:

a. approving the financial strategy
b. requiring the submission and approval of budgets that deliver the financial targets set for the Trust within approved allocations and overall income
c. approving specific responsibilities placed on directors and employees as indicated in the Scheme of Delegated Authorities
d. approving the method of providing financial services.

4.3 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions Reserved to the Trust Board (Appendix 1). All other powers have been delegated to the Board's appointed committees; and the directors and officers of the Trust.

4.4 **The Chief Executive Officer** is the Accountable Officer of the Trust and:

a. is legally accountable to Parliament for all of the actions of the Trust

b. is accountable to the Trust Board for ensuring that the Board of Directors meets its obligation to perform the Trust's functions within the available financial resources
c. holds overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met
d. is responsible overall for the maintenance of the Trust's systems of internal control
e. is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs

4.5 Save for the decisions and actions reserved to the Trust Board, the **Chief Executive Officer** has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The **Chief Executive Officer** will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegated Authorities (appendices 1 and 2).

4.6 The **Chief Finance Officer** is responsible for:

a. maintaining and implementing the Trust's financial policies
b. maintaining an effective system of internal financial control including ensuring that adequate and effective financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained
c. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

4.7 **All staff**, including Board members, severally and collectively, are responsible for:

a. the security of the property of the Trust;
b. avoiding loss;
c. exercising economy and efficiency in the use of resources;
d. conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.
e. considering the legality of all transactions

4.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

4.9 All officers shall make available any relevant records or information to the Chief Finance Officer in connection with the carrying out of their duties of supervision regarding the implementation of the Trust's financial policies and systems of financial control whether by internal audit or otherwise.

4.10 Contractors and their employees, who are empowered by the Trust to commit the Trust to expenditure or who are authorised to obtain income shall be covered by these instructions. It is the responsibility of the **Managing Director** to ensure that such persons are made aware of this.

Part 1 – Allocation, planning, budgets, budgetary control and monitoring

5 Financial and budget plans

5.1 The **Chief Executive Officer** shall submit to the Board and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board. These plans will include an annual financial plan, which takes into account financial targets and forecast limits of available resources. The plans will include:

a. description of the significant assumptions on which planning is based
b. details of major changes in workload, delivery of services or resources required to achieve the plans.

5.2 Prior to the start of each financial year, the **Chief Finance Officer** shall prepare and submit budgets for approval by the Board. Such budgets will:

a. be in accordance with and reconcilable, at a summary level, to the aims and objectives set out in the annual Business Plan
b. reconcile the financial plans to be provided to relevant external regulators, such as NHSE
c. reflect resource plans, including workload and workforce plans
d. be prepared within the limits of available funds
e. show how the plans will deliver against the financial targets and obligations set externally by the Secretary of State and relevant regulatory bodies; and set internally by the Trust
f. provide a forecast of the Trust's performance over the year against key financial indicators, as determined by the Trust and by relevant regulatory bodies
g. include summary financial projections for the longer term
h. identify and assess significant financial risks.

5.3 **All staff** who have been given delegated authority to manage and administer budgets shall be expected to contribute to the preparation of the annual budget.

5.4 All **Associate Chief Operating Officers** will sign up to their allocated budgets at the commencement of each financial year.

5.5 The **Chief Finance Officer** has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

6 Management of the financial resource

6.1 The **Chief Executive Officer** shall require directors and authorised budget managers to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

6.2 The **Chief Executive Officer** may change the financial outturn targets of any divisions, or services.

6.3 **Directors** and **authorised budget holders** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them.

Financial and other resources shall only be used for the purposes for which they are provided, as approved by the **Chief Executive Officer** and the Board.

7 Setting the annual financial plan

7.1 The **Chief Executive Officer** shall be responsible for providing the Trust Board with the annual financial plan, taking into account financial targets and forecast income and service developments. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health.

7.2 The **Chief Finance Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

7.3 All **Executive Directors** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

7.4 **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the **Chief Finance Officer** to enable budgets to be compiled.

7.5 All **budget managers** should sign up to their allocated budgets at the start of each financial year.

8 Managing and reporting the financial position during the year

8.1 The **Chief Finance Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

a. identifying the level of earned income directly attributable to each budget area
b. identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target
c. updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.
d. monitoring and reporting financial performance against plans and forecasts
e. delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and Performance Executive and the Trust Board in a form approved by the Board.

8.2 All **Executive Directors** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.

8.3 **All staff** to whom responsibility is delegated to incur expenditure, or generate income shall comply with the requirements of those systems.

8.4 Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

8.5 Designated **budget holders** shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:

a. progress towards delivering the required financial position for the budget area
b. the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans
c. trends and projections
d. where relevant, plans and proposals to recover adverse performance

8.6 The **Chief Finance Officer** shall ensure that **budget holders** are provided with advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

8.7 The **Chief Finance Officer** shall be required to compile and submit to the Trust Board such financial estimates and forecasts, on both revenue and capital account, as may be required from time to time.

8.8 The **Chief Finance Officer** shall keep the Trust Board informed of:

a. significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance
b. financial consequences of changes in Trust policy
c. financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services

8.9 The **Chief Finance Officer** shall:

a. ensure that **budget managers** receive adequate training on an on-going basis to help them comply with expectations and to manage successfully
b. issue timely, accurate and comprehensible advice and financial reports to each **budget manager**, covering the areas for which they are responsible

9 Annual accounts, reports and returns

9.1 The **Chief Finance Officer** shall:

a. prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DH) and the Treasury, the Trust's accounting policies, and accounting practice as determined by the accounting bodies in the UK.
b. prepare and submit annual financial reports to NHS England (NHSE) certified in accordance with current guidelines
c. submit financial returns to the DH for each financial year in accordance with the timetable prescribed by the DH
d. submit periodic monitoring and financial returns to external organisations, such as NHSE, in accordance with the timetables set by those organisations

9.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DH.

9.3 The **Chief Executive Officer** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DH requirements and guidance.

10 Budgetary Delegation

10.1 The **Chief Executive Officer** may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a. the amount of the budget;
b. the purpose(s) of each budget heading;
c. individual and group responsibilities;
d. authority to exercise virement;
e. achievement of planned levels of service;
f. the provision of regular reports.

10.2 The **Chief Executive Officer** and delegated **budget holders** must not exceed the budgetary total or virement (administrative transfer of funds from one part of a budget to another) limits set by the Trust Board.

10.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the **Chief Executive Officer**, subject to any authorised use of virement.

10.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the **Chief Executive Officer**, as advised by the **Chief Finance Officer.**

11 Budgetary Control and Reporting

11.1 The **Chief Finance Officer** will devise and maintain systems of budgetary control. These will include:

a. monthly financial reports to the Board in a form approved by the Board containing:
   - income and expenditure to date showing trends and forecast year-end position;
   - movements in working capital;
   - movements in cash and capital;
   - capital project spend and projected outturn against plan;
   - explanations of any material variances from plan;
   - details of any corrective action where necessary and the **Chief Executive Officer's** and/or **Chief Finance Officer's** view of whether such actions are sufficient to correct the situation.

b. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
c. investigation and reporting of variances from financial, workload and manpower budgets;
d. monitoring of management action to correct variances; and
e. arrangements for the authorisation of budget transfers.

11.2 Each **budget holder** is responsible for ensuring that:

a. any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Board;
b. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
c. no permanent employees are appointed without the approval of the **Managing Director** other than those provided for within the available resources and manpower establishment as approved by the Board.

11.3 The **Managing Director** is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Financial Plan and a balanced budget.

12 Capital expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure.

13 Monitoring returns

The **Chief Executive Officer** is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

Part 2 – Audit

14 Audit Committee

14.1 In accordance with SO, the Board shall formally establish an Audit Committee, with clearly defined terms of reference in line with the Code of Governance for NHS Providers (2022) and following guidance from the most recent NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

a. overseeing Internal and External Audit services;
b. reviewing financial, information systems, monitoring the integrity of the financial statements, and reviewing significant financial reporting judgments;
c. review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
d. monitoring compliance with SOs and SFIs;
e. reviewing schedules of losses and compensations and making recommendations to the Board;
f. reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans;
g. Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

14.2 Where the Audit Committee considers there is evidence of ultra vires (beyond authority) transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the NHSE. (To the Chief Finance Officer in the first instance.)

14.3 It is the responsibility of the **Chief Finance Officer** to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

15 Chief Finance Officer

15.1 The **Chief Finance Officer** is responsible for:

a. ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
b. ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;
c. deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
d. ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
- major internal financial control weaknesses discovered;
- progress on the implementation of internal audit recommendations;
- progress against plan over the previous year;
- strategic audit plan covering the coming three years;
- a detailed plan for the coming year.

15.2 The **Chief Finance Officer** or designated auditors are entitled without necessarily giving prior notice to require and receive:

a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
b. access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
c. the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
d. explanations concerning any matter under investigation.

16 Role of Internal Audit

16.1 Internal Audit will review, appraise and report upon:

a. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
b. the adequacy and application of financial and other related management controls;
c. the suitability of financial and other related management data;
d. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
   - fraud and other offences;
   - waste, extravagance, inefficient administration;
   - poor value for money or other causes.

e. Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the National Audit Office.

16.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the **Chief Finance Officer** must be notified immediately.

16.3 The **Chief Internal Auditor** will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the **Chair** and **Chief Executive Officer** of the Trust.

16.4 The **Chief Internal Auditor** shall be accountable to the **Chief Finance Officer**. The reporting system for internal audit shall be agreed between the **Chief Finance Officer**, the Audit Committee and the **Chief Internal Auditor**. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

16.5 Designated executive directors and non-executive directors must carry out audit recommendations within the timescale agreed for action. Failure to do so will be reported to the Audit Committee.

17 External Audit

Under the Local Audit and Accountability Act 2014, NHS Trusts must select and appoint their own auditors and directly manage their contracts for the audits for the financial year. Local appointment increases local accountability and moves NHS Trusts into line with NHS Foundation Trusts.

18 Fraud and corruption

18.1 In line with their responsibilities, the **Chief Executive Officer** and **Chief Finance Officer** shall monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on fraud and corruption.

18.2 The Trust shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

18.3 The Local Counter Fraud Specialist shall report to the **Chief Finance Officer** and shall work with staff in NHS Protect and the Regional Anti-Fraud Specialist in accordance with the NHS Counter Fraud Standards 2018.

18.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

19 Security Management

19.1 In line with their responsibilities, the **Managing Director** will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

19.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

19.3 The **Managing Director** has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

Part 3 – Bank and Government Banking Service (GBS) Accounts

20 General

20.1 The **Chief Finance Officer** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using the GBS accounts, or any successor organisations, for all banking services.

20.2 The Board shall approve the banking arrangements.

21 Bank and GBS Accounts

The **Chief Finance Officer** is responsible for:

a. bank accounts and the accounts of the GBS or any successor organisations;
b. establishing separate bank accounts for the Trust's non-exchequer funds;
c. ensuring payments made from bank or GBS (or successor) accounts do not exceed the amount credited to the account except where arrangements have been made;
d. reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
e. monitoring compliance with DH guidance on the level of cleared funds.

22 Banking Procedures

22.1 The **Chief Finance Officer** will prepare detailed instructions on the operation of bank and GBS (or successor) accounts, which must include:

a. the conditions under which each bank and GBS (or successor) account is to be operated;
b. those authorised to sign cheques or other orders drawn on the Trust's accounts.
c. those authorised to undertake electronic banking transactions.

22.2 The **Chief Finance Officer** must advise the Trust's bankers in writing of the conditions under which each account will be operated.

23 Tendering and Review

23.1 The **Chief Finance Officer** will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

23.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS (or successor) accounts.

Part 4 – Income, fees and charges and security of cash, cheques and other negotiable instruments

24 Income Systems

24.1 The **Chief Finance Officer** is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

24.2 The **Chief Finance Officer** is also responsible for the prompt banking of all monies received.

25 Fees and charges

25.1 The Trust shall follow the Department of Health's Payment by Results guidance in charging commissioners for healthcare services, based on the national tariff. Where prices outside of the national tariff are used, they should be calculated in accordance with the "Costing" Manual.

25.2 The **Chief Finance Officer** is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

25.3 All employees must inform the **Chief Finance Officer** promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

26 Debt recovery

26.1 The **Chief Finance Officer** is responsible for the appropriate recovery action on all outstanding debts.

26.2 Income not received should be dealt with in accordance with losses procedures.

26.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

27 Security of cash, cheques and other negotiable instruments

27.1 The **Chief Finance Officer** is responsible for:

a. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
b. ordering and securely controlling any such stationery;

c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

27.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

27.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the **Chief Finance Officer.**

27.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

Part 5 – NHS Agreement for provision of services (see also Section C, Paragraph 37)

28 Service Level Agreements

The **Chief Executive Officer**, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services. All SLAs should aim to implement the agreed priorities contained within the Financial Plan) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the **Chief Executive Officer** should take into account:

a. the standards of service quality expected;
b. the relevant national service framework (if any);
c. the provision of reliable information on cost and volume of services;
d. the NHS Commissioning and contracting guidelines;
e. that SLAs are based on integrated care pathways.

29 Involving partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the **Chief Executive Officer** to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way, the Trust can jointly manage risk with all interested parties.

30 Reports to Board on SLAs

The **Chief Executive Officer**, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

31 Commissioning

The Trust's main activity is to provide healthcare services. Guidance should be sought from the **Chief Finance Officer** where commissioning activities are necessary.

Part 6 – Terms of service, allowances and payment of employees

32 Funded Establishment

32.1 The manpower plans incorporated within the annual budget will form the funded establishment.

32.2 The funded establishment of any department may only be varied in accordance with delegated limits.

33 Staff Appointments

33.1 No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, on a permanent or temporary nature, hire agency staff, or agree to changes in any aspect of remuneration:

a. unless authorised to do so by the **Managing Director**;
b. within the limit of their approved budget and funded establishment.
c. in accordance with Trust approved human resource policies and agreements

33.2 The Board will approve procedures presented by the **Managing Director** for the determination of commencing pay rates, condition of service etc, for employees.

34 Processing Payroll

34.1 The **Chief Finance Officer** will be responsible for liaison with the Trust's payroll and **Chief People Officer** in order to:

a. specify timetables for submission of properly authorised time records and other notifications;
b. determine final pay and allowances;
c. make payment on agreed dates;
d. agree methods of payment.

34.2 The **Chief Finance Officer** will liaise with the Trust's payroll and **Chief People Officer** to issue instructions regarding:

a. verification and documentation of data;
b. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
d. security and confidentiality of payroll information;
e. checks to be applied to completed payroll before and after payment;
f. authority to release payroll data under the provisions of the Data Protection Act;
g. methods of payment available to various categories of employee and officers;

h. procedures for payment by cheque, bank credit, or cash to employees and officers;
i. procedures for the recall of cheques and bank credits;
j. pay advances and their recovery;
k. maintenance of regular and independent reconciliation of pay control accounts;
l. separation of duties of preparing records and handling cash;
m. a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

34.3 Appropriately nominated **managers** have delegated responsibility for:

a. submitting time records, and other notifications in accordance with agreed timetables;
b. completing time records and other notifications within 3 months of the date of the claim in accordance with the **Chief Finance Officer's** instructions and in the form prescribed by the **Chief People Officer**;
c. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the **Chief Finance Officer** must be informed immediately.

34.4 Regardless of the arrangements for providing the payroll service, the **Chief Finance Officer** shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

35 Contracts of Employment

The Board shall delegate responsibility to authorised **managers** for:

a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
b. dealing with variations to, or termination of, contracts of employment.

Part 7 – Non-pay expenditure

36 Delegation of Authority

36.1 The Board will approve the level of non-pay expenditure on an annual basis and the **Chief Executive Officer** will determine the level of delegation to budget managers.

36.2 The **Chief Executive Officer** will set out:

a. the list of managers who are authorised to place requisitions for the supply of goods and services;
b. the maximum level of each requisition and the system for authorisation above that level.

36.3 The **Managing Director** shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Part 8 – Choice, requisitioning, ordering, receipt and payment for goods and services

37 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the **Chief Finance Officer** and/or the **Chief Executive Officer** shall be consulted.

38 System of Payment and Payment Verification

38.1 The **Chief Finance Officer** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

38.2 The **Chief Finance Officer** will:

a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed;
b. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;
c. be responsible for the prompt payment of all properly authorised accounts and claims;
d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.
(ii) Certification that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 40 below.

39 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to net present value (NPV) using the National Loans Fund (NLF) rate plus 2%).
b. The appropriate executive director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
c. The **Chief Finance Officer** will need to be satisfied with the proposed arrangements before approving the contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
d. The **budget holder** is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate **director** or **Chief Executive Officer** if problems are encountered.

40 Official orders

Official Orders must:

a. be consecutively numbered;
b. be in a form approved by the **Chief Finance Officer**;
c. state the Trust's terms and conditions of trade;
d. only be issued to, and used by, those duly authorised by the **Chief Executive Officer**.

41 Duties of managers and officers

41.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the **Chief Finance Officer** and that:

a. all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements, letters of intent and other commitments which may result in a liability are notified to the **Chief Finance Officer** in advance of any commitment being made;
b. contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;
c. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
d. no order shall be issued for any item or items to any firm, which has made an offer of gifts, reward or benefit to directors or employees, other than:
   - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
   - conventional hospitality, such as lunches in the course of working visits;

   This provision needs to be read in conjunction with Section B, Part 3 Standards of Business Conduct;

e. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the **Chief Finance Officer** on behalf of the **Managing Director**;
f. all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
g. verbal orders must only be issued very exceptionally - by an employee designated by the **Managing Director** and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
h. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
i. goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
j. changes to the list of employees and officers authorised to certify invoices are notified to the **Chief Finance Officer**;
k. purchases from petty cash and procurement card are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance and Information;
l. petty cash and procurement card records are maintained in a form as determined by the **Chief Finance Officer**.

41.2 The **Managing Director** and **Chief Finance Officer** shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant guidance. The technical audit of these contracts shall be the responsibility of the relevant director.

42 Joint Finance Arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under the powers of Section 75 of the NHS Act 2006 **shall** comply with procedures laid down by the **Chief Finance Officer**, which shall be in accordance with these Acts.

43 External borrowing

43.1 The **Chief Finance Officer** will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The **Chief Finance Officer** is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

43.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the **Chief Executive Officer** and the **Chief Finance Officer**.

43.3 The **Chief Finance Officer** must prepare detailed procedural instructions concerning applications for loans and overdrafts.

43.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

43.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the **Chief Executive Officer** or the **Chief Finance**

Officer. The Board must be made aware of all short term borrowings at the next Board meeting. All long-term borrowing must be consistent with the plans outlined in the current Financial Plan and be approved by the Trust Board.

44 Investment

44.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

44.2 The **Chief Finance Officer** is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

44.3 The **Chief Finance Officer** will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

45 Financial framework

The **Chief Finance Officer** should ensure that members of the Board are aware of the Financial Framework. This document contains directions, which the Trust must follow. It also contains directions to Clinical Commissioning Groups regarding resource and capital allocation and funding to Trusts. The **Chief Finance Officer** should also ensure that the direction and guidance in the framework is followed by the Trust.

Part 9 – Capital investment, private financing, fixed asset registers and security of assets

46 Capital Investment

46.1 The **Chief Executive Officer**:

a. shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
b. is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
c. shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

46.2 For every capital expenditure proposal the **Managing Director** shall ensure:

a. that a business case (in line with the guidance contained within the “Capital Investment Manual”) is produced setting out:

- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
- the involvement of appropriate Trust personnel and external agencies;
- appropriate project management and control arrangements;

b. that the **Chief Finance Officer** certified professionally to the costs and revenue consequences detailed in the business case.

46.3 For capital schemes where the contracts stipulate stage payments, the **Chief Executive Officer** or **Managing Director** will issue procedures for their management.

46.4 The **Chief Finance Officer** shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

46.5 The **Chief Finance Officer** shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

46.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

46.7 The **Managing Director** shall issue to the manager responsible for any scheme:

a. specific authority to commit expenditure;
b. authority to proceed to tender;
c. approval to accept a successful tender.

46.8 The **Chief Executive Officer** will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

46.9 The **Chief Finance Officer** shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as notified to the Trust by the Department of Health/NHSE.

46.10 The **Chief Finance Officer** shall issue procedures for the rare occasions where there may be a requirement to commence work in advance of contracts being signed based on a Letter of Intent. Authorisation should be sought from the CFO and/or **Managing Director** in accordance with the scheme of delegation.

47 Asset registers

47.1 The **Managing Director** is responsible for the maintenance of registers of assets, taking account of the advice of the **Chief Finance Officer** concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis.

47.2 The Trust shall maintain an asset register recording fixed assets with sufficient detail to enable the asset's identification, valuation, type of asset, location and relevant manager.

47.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b. stores, requisitions and wages records for own materials and labour including appropriate overheads;
c. lease agreements in respect of assets held under a finance lease and capitalised.

47.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

47.5 The **Chief Finance Officer** shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

47.6 The value of each asset shall be held at fair value as determined by the Trust's accounting policies.

47.7 The value of each asset shall be depreciated using methods and rates as specified within the Trust's accounting policies.

47.8 The **Chief Finance Officer** shall calculate and pay capital charges as specified in the NHS Finance Manual issued by the Department of Health.

48 Security of Assets

48.1 The overall control of fixed assets is the responsibility of the **Chief Executive Officer**.

48.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the **Chief Finance Officer**. This procedure shall make provision for:

a. recording managerial responsibility for each asset;
b. identification of additions and disposals;
c. identification of all repairs and maintenance expenses;
d. physical security of assets;
e. periodic verification of the existence of, condition of, and title to, assets recorded;
f. identification and reporting of all costs associated with the retention of an asset;
g. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

48.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the **Chief Finance Officer**.

48.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

48.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

48.6 Where practical, assets should be marked as Trust property.

Part 10 – Stores and receipt of goods

49 General position

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a. kept to a minimum;
b. subjected to annual stock take;
c. valued at the lower of cost and net realisable value.

50 Control of stores, stocktaking, condemnations and disposal

50.1 Subject to the responsibility of the **Chief Finance Officer** for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the **Chief Executive Officer**. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the **Chief Finance Officer**. The control of any pharmaceutical stocks shall be the responsibility of a designated **pharmaceutical officer**; the control of any fuel oil and coal of a designated **estates manager**.

50.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the **designated manager/ pharmaceutical officer.** Wherever practicable, stocks should be marked as health service property.

50.3 The **Chief Finance Officer** shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

50.4 Stocktaking arrangements shall be agreed with the **Chief Finance Officer** and there shall be a physical check covering all items in store at least once a year.

50.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the **Chief Finance Officer**.

50.6 The designated **manager/pharmaceutical officer** shall be responsible for a system approved by the **Chief Finance Officer** for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the **Chief Finance Officer** any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

51 Goods supplied by NHS Supply Chain

For goods supplied via the NHS Supply Chain, the **Chief Executive Officer** shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the **Chief Finance Officer** who shall satisfy himself that the goods have been received before accepting the recharge.

Part 11 – Disposals and condemnations, losses and specials payments

52 Disposals and condemnation procedures

52.1 The **Chief Finance Officer** must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

52.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the **Chief Finance Officer** of the estimated market value of the item, taking account of professional advice where appropriate.

52.3 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the **Chief Finance Officer**;
b. recorded by the Condemning Officer in a form approved by the **Chief Finance Officer**, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the **Chief Finance Officer**.

52.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the **Chief Finance Officer** who will take the appropriate action.

53 Losses and special payments

53.1 The **Chief Finance Officer** must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

53.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform **Managing Director** and the **Chief Finance Officer** or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the **Chief Finance Officer** and/or **Managing Director**. Where a criminal offence is suspected, the **Chief Finance Officer** must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies, which may indicate fraud or corruption, the **Chief Finance Officer** must inform the relevant LCFS and NHS Protect regional team in accordance with Secretary of State for Health and Social Care's Directions. The **Chief Finance Officer** must notify NHS Protect and the External Auditor of all suspected frauds.

53.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the **Chief Finance Officer** must immediately notify:

a. the Board (via the Audit Committee),
b. the External Auditor.

53.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

53.5 The **Chief Finance Officer** shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

53.6 For any loss, the **Chief Finance Officer** should consider whether any insurance claim can be made.

53.7 The **Chief Finance Officer** shall maintain a Losses and Special Payments Register in which write-off action is recorded.

53.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

53.9 All losses and special payments must be reported to the Audit Committee at every meeting.

Part 12 – Information Technology

54 Responsibilities and duties of the Chief Finance Officer

54.1 The **Chief Finance Officer**, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
d. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as they may consider necessary are being carried out.

54.2 The **Chief Finance Officer** shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

54.3 The **Chief Finance Officer** shall publish and maintain a Freedom of Information Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority and describes the classes or types of information about our Trust that we make publicly available.

55 Responsibilities and duties of other directors and officers in relation to computer systems of a general application

In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the **Chief Finance Officer**:

a. details of the outline design of the system;
b. in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

56 Contracts for computer services with other health bodies or outside agencies

56.1 The **Chief Finance Officer** shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

56.2 Where another health organisation or any other agency provides a computer service for financial applications, the **Chief Finance Officer** shall periodically seek assurances that adequate controls are in operation.

57 IT risk assessments

The **Chief Finance Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

58 Requirements for computer systems, which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems, the **Chief Finance Officer** shall need to be satisfied that:

a. systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
b. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
c. **Chief Finance Officer** staff have access to such data;
d. such computer audit reviews as are considered necessary are being carried out.

Part 13 – Patient Property

59 Patient property

59.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

59.2 The **Chief Operating Officer** and **Chief Finance Officer**, on behalf of the **Chief Executive Officer** are responsible for ensuring that patients or their guardians, as appropriate, are given information and advice on patient property which includes two key messages:

a. Patients should keep as little property as possible on Trust premises, and this particularly applies to valuables. They should hand any item they do not need to a relative/carer to take home

b. The Trust will not accept liability for loss of or damage to the patient's property unless it is handed over for safekeeping and a copy of the Patient Property Record is obtained as a receipt.

This information and the process for handing in property will be provided in writing, by notices and other written information material including admission documentation and property records, and orally through the advice of staff responsible for admission.

59.3 The **Chief Finance Officer** must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

59.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the **Chief Finance Officer**.

59.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

59.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

59.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

Part 14 – Funds Held on Trust

60 Corporate Trustee

60.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

60.2 The **Chief Finance Officer** shall ensure that each trust fund, which the Trust is responsible for managing, is managed appropriately with regard to its purpose and to its requirements.

61 Accountability to Charity Commission and Secretary of State for Health and Social Care

61.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

61.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

62 Applicability of SFIs to funds held on Trust

62.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held in trust.

62.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

Part 15 – Retention of Records

63.1 The **Managing Director** shall be responsible for maintaining archives for all records required to be retained in accordance with the Records Management Code of Practice for Health and Social Care 2021 (updated 2023).

63.2 The records held in archives shall be capable of retrieval by authorised persons.

63.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the **Managing Director**. Detail shall be maintained of records so destroyed.

Part 16 – Risk Management and Insurance

64 Programme of risk management

64.1 The **Managing Director** shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board. The programme of risk management shall include:

a. a process for identifying and quantifying risks and potential liabilities;
b. engendering among all levels of staff a positive attitude towards the control of risk;
c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d. contingency plans to offset the impact of adverse events;
e. audit arrangements including; Internal Audit, clinical audit, health and safety review;
f. a clear indication of which risks shall be insured;
g. arrangements to review the Risk Management programme.

64.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

65 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme, this decision shall be reviewed annually.

66 Insurance arrangements with commercial insurers

There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

a. Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
b. where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
c. where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the **Chief Finance Officer** should consult the Department of Health.

67 Arrangements to be followed by the Board in agreeing insurance cover

67.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution, the **Chief Finance Officer** shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The **Chief Finance Officer** shall ensure that documented procedures cover these arrangements.

67.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the **Chief Finance Officer** shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The **Chief Finance Officer** will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses, which will not be reimbursed.

67.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The **Chief Finance Officer** should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendices 1 and 2 – Schedule of Reservation, Delegation of Powers and Financial Delegation Limits

Introduction
Standing Order 1 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session." These powers and decisions are set out in this Schedule.

1 Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1 Approve, including variations to:

- Standing Orders for the regulation of its proceedings and business (Section B, Part 4).
- this Schedule of matters reserved to the Trust Board (Section B, Part 4, SO 40).
- Standing Financial Instructions (SO 43, SO 44, SFI 2)
- Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (Section B, Part 4).
- suspension of Standing Orders (SO 27)

1.2 Determine the frequency and function of Trust Board meetings (SO 8), including:
- administration of public and private agendas of Board meetings (SO 8)
- calling extra-ordinary meetings of the Board (SO 9)

1.3 Ratify the exercise of emergency powers by the Chair and **Chief Executive Officer** (SO 37)

1.4 Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation (Section B, Part 4); and:

- delegate functions from the Board to the committees
- delegate functions from the Board to a director or officer of the Trust
- approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies
- receive reports from Board committees and take appropriate action in response to those reports
- confirm the recommendations of the committees which do not have executive decision-making powers

1.4.1. approve terms of reference and reporting arrangements of committees (SO 42).
1.4.2. approve delegation of powers from Board committees to sub-committees (SO 42)

1.5 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and modifications thereto.

- Appoint the **Chief Executive Officer** (SO 3)

- Appoint the Executive Directors (SO 3)

1.6 Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests (Section B, Part 3).

1.7 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8 Approve the disciplinary procedure for officers of the Trust.

1.9 Approve arrangements for dealing with and responding to complaints.

1.10 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust

1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2 Determination of strategy and policy

2.1 Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2 Approve the Trust's strategic direction:

2.2.1 annual budget, strategy and business plans
2.2.2 definition of the strategic aims and objectives of the Trust.
2.2.3 clinical and service development strategy
2.2.4 overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3 Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3 Direct operational decisions

3.1 Approve capital investment plans:

3.2.1 the annual capital programme
3.2.2 all variations to approved capital plans in accordance with authorization levels.
3.2.3 to acquire, dispose of, or change of use of land and/or buildings
3.2.4 capital investment in accordance with authorization levels, supported by a business case and in line with the approval guidance issued by NHS England & Improvement.

3.1 Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in accordance with the financial delegations.

3.2 Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £500K:

3.2.1 Tenders and quotations over the lifetime of the contract
3.2.2 Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement
3.2.3 Orders processed through approved supply arrangements
3.2.4 Orders processed through non-approved supply arrangements
3.2.5 Receipt of loans and trials equipment and materials
3.2.6 Prepayment agreements for services received

3.3 Decide the need to subject services to market testing (Section C, Part 1)

4 Quality, financial and performance reporting

4.1 Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2 Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

4.2.1 The Care Quality Commission
4.2.2 NHS England

4.3 Consider and approve of the Trust's Annual Report including the annual accounts.

4.4 Approve the Annual report(s) and accounts for funds held on trust.

4.5 Approve the Quality Account.

5 Audit arrangements

5.1 Approve audit arrangements recommended by the Audit Committee (including arrangements for the separate audit of funds held on trust).

5.2 Receive reports of the Audit Committee meetings and take appropriate action.

5.3 Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts.

5.4 Receive the annual management letter from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

5.5 Endorse the Annual Governance Statement for inclusion in the Annual Report

6 Management of revenue budgets and authorization levels

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Quality Committee Terms of Reference and Forward Planner 2025-26
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	
Appendices included with this report:	TOR (inc committee structure) and forward planner 2025-26
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The paper presents the revised terms of reference for the Quality committee after annual review with an updated committee structure.

In addition the forward working plan for the committee for 2025-26 is presented.

Recommended Actions required by Board or Committee

The Board is asked to approve the terms of reference and forward planner for 2025-26.

Executive Director Opinion[1]

This is the routine annual review of the Quality Committee Terms of reference.

The subcommittee structure has been reviewed and amended mainly with the addition of the diabetes safety group and medical devices committee.

The forward plan includes the entirety of work covered by Quality Committee and may be subject to minor adjustments throughout the year.

Quality Committee recommended submission to Board for final approval.

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

Wye Valley NHS Trust

Quality Committee

Terms of Reference

1. Purpose

1.1 The purpose of the Quality Committee is to provide assurance to the Board that the services provided by the Trust are being delivered in a high quality and safe manner, and provide a quality of care we would want for ourselves, our families and friends'.

1.2 The Quality Committee has delegated responsibility to ensure that the Trust is fulfilling its statutory duties, complying with national standards and achieving its own strategic objectives in respect of the provision of high quality clinical care

1.3 As a Sub-Committee of the Board, the Quality Committee will fulfil this purpose through; receiving reports that cover the breadth of the quality agenda and from those committees that report into the Quality Committee*.

1.4 Reports will be provided for assurance and provide the opportunity for scrutiny and challenge with regard to all aspects of quality, clinical safety and patient experience and ensure that where necessary lessons are learnt and implemented throughout the organisation.

1.5 The Committee will promote an organisational culture, aligned with the Trust values; **Compassion**, **Accountability**, **Respect** and **Excellence**, that strives for continuous improvement through oversight of the Trust quality priorities.

*The Committee sub structure and the functions associated with the quality agenda are referenced at the end of this document.

2. Membership

2.1 Members of the Committee are:

- Three Non-Executive Directors (designated Quality Committee link NEDS)
- Chief Nursing Officer
- Chief Medical Officer
- Managing Director
- Deputy Chief Medical Officer
- Deputy Chief Nursing Officer
- Associate Director of Quality Governance

2.2 In attendance:

- Herefordshire and Worcestershire ICB representative
- Non-executive directors

- Associate Chief Nursing Officers*
- Associate Chief Medical Officers for each division (when divisional reports are due)*
- Professional clinical leads for each division (when divisional reports are due)*
- Maternity and neonatal service representatives including either Director of Midwifery/ Deputy Director of Midwifery, Clinical Leads, neonatal matron
- Associate Chief Operating Officers will be expected to attend when their divisional report is due
- Clinical Director, Pharmacy
- Quality and Safety Matron (Corporate)
- Chair of the Clinical Effectiveness and Audit Committee
- Chair of the Patient Safety Committee
- Chair of the Patient Experience Committee
- Chair of the Learning from Deaths Committee

*Divisional management representatives are invited but not mandated to attend all meetings

2.3 Other officers of the Trust will be invited to attend for appropriate agenda items where they are the lead.

2.4 Where a member is unable to attend by exception, an appropriate deputy should be nominated and notified to the Chair. Deputies should be prepared to present reports on behalf of the member they are representing and able to answer questions in relation to assurance.

3. Duties of the Committee

3.1 In order to support the wider objectives of the Trust, the Quality Committee will focus on the following priorities for the year ahead as published in the Trust Quality Account and Patient Safety Incident Response Plan.

Quality Priorities 2025- 2026

- Ensure patients receive a timely VTE risk assessment in line with NICE guidance
- Diabetes Safety Improvement
- Food Quality and Nutritional Risk
- Implement Quality Improvement project to target high-risk time critical medication as locally defined
- Transition of care
- Improve responsiveness to patient experience data
- Increase the number of opportunities to grow our volunteer workforce, in numbers and reach

Patient Safety Priorities*

- Tissue Viability- Deterioration of MASD to G3/4 or unstageable pressure damage
- Falls- Inpatient falls in patients with dementia, delirium or a known high risk of falls
- Delay in assessment, diagnosis or treatment- Responding well to clinically changing conditions

- Admissions and discharges- incidents relating to the movement of patients, particularly delays to follow up
- Medication incidents- Incidents relating to the failure of administration of critical medications

*Patient Safety Priorities may change mid-year on evaluation of the Patient Safety Incident Response Plan.

3.2 In furtherance of achievement of its purpose, particular duties of the Committee are to:

- Oversee the development and implementation of the Trust's Quality Priorities
- Receive, review and sign off the annual Quality Account (given timings of data and audit requirements, sign off may well be virtual)
- Receive data and trends relating to quality priorities, patient safety priorities and patient experience metrics, provide assurance to the Board on performance and undertake 'deep dives' as appropriate at the discretion of the committee
- Receive reports demonstrating compliance with relevant national standards and regulatory requirements
- Receive reports in line with the Trust External review process and any associated actions pertaining to any national enquiry, regulatory review or relevant external inspection undertaken
- Receive assurance that the process for completion of Quality Impact Assessments related to, clinical service developments or transformation through assurance reporting of the Clinical Effectiveness and Audit Committee
- Agree the terms of reference and work plans for each of the sub committees it is responsible for
- Receive reports related to the workforce safeguards and establishment reviews
- The Committee will receive a quarterly update from each division. These reports will include quality improvements and remedial action being taken to address any quality, outcome, safety or patient experience concerns.
- The Committee will receive a monthly perinatal safety report in line with national expectations and a quarterly deeper dive into perinatal safety including wider quality, outcome, safety and experience metrics

3.3 In addition the committee will:

- Delegate authority to the sub committees of the committee for the approval and ratification of relevant policies
- Ratify any significant policy/ procedure, identified by the Chief Nursing Officer/Chief Medical Officer/ Associate Director of Quality Governance that the Board may need to be sighted on
- Receive reports on any Internal Audit of a clinical nature following a referral via the Audit Committee.

4. Chair

The Board shall appoint one of the Non-Executive members to be Chair of the Committee

5. Agenda setting and work plan

The Chief Nursing Officer shall have:

- Corporate oversight of agenda preparation
- Corporate oversight of an annual programme of work for the Committee to approve
- Ensure that the annual programme aligns to the commissioner quality contractual requirements

6. Quorum

A quorum shall be two Non-Executive Directors (one of which could be the Committee Chair), two Executive Directors (one of which must be the Chief Nursing Officer or the Chief Medical Officer or delegated deputy) and the Associate Director of Quality Governance or a delegated deputy.

7. Frequency of Meetings

The Committee shall normally meet monthly. The Chair may call an additional or special purposes meeting if they consider one is necessary.

8. Notice of Meetings

Unless otherwise agreed, notice of each meeting, including venue, time, date agenda and supporting papers, shall be provided with members no later than five working days prior to the date of the meeting.

9. Minutes of Meetings

The Committee shall be supported by the Executive Assistant who is appointed to oversee the Quality Committee, whose duties in this respect will include:

- Ensuring the collation & distribution of the Committee papers at least 5 working days in advance of the meeting.
- Ensuring the minutes accurately reflect the business of the meeting & keeping an accurate record of matters arising and issues to be carried forward are maintained.
- Ensuring that minutes and actions are circulated to the Chair for comments within 5 working days of the meeting and to the other members for comments within 10 working days.
- Ensure any potential quoracy issues are noted to the Chair prior to the meeting where apologies from members are received.

10. Accountability

10.1 The Committee is accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference, seek the relevant information from employees and all employees are directed to cooperate with any request made by the Quality Committee

10.2 In line with NHS England publication 'Enhancing board oversight A new approach to Non-executive director champion roles' the Committee has Non-Executive representatives as members to provide oversight to the Board on Quality and Safety priorities.

10.3 The Board of Directors has delegated responsibility to the Quality Committee for oversight of the Workforce Safeguards, establishment reviews and staffing reports.

11. Reporting Responsibilities

11.1 The minutes of the Quality Committee will be formally recorded and submitted to the Board. Any confidential matters will be identified as such in the minutes and separately recorded. The Chair will provide a brief written report to the Board (a month in arrears) meeting drawing attention to significant developments, highlighting areas where further assurance is required and matters requiring Board decisions.

11.2 The Chief Nursing Officer will highlight key information relating to workforce safeguards, establishment reviews and staffing through the monthly Quality report to board.

11.2 The Committee will review its work annually to highlight key issues in the development of the Trust's clinical activities and their management, as well as the effectiveness of the Committee.

12. Review

These Terms of Reference will be reviewed annually and recommendations made to Board of Directors for approval.

13. Approval

Date of approval: Approving Body: Board of Directors


Quality Committee
Patient Safety Committee
Clinical Effectiveness and Audit Committee
Patient Experience Committee
Overarching Safeguarding Committee
Infection Prevention Committee
Learning from Deaths Committee
Divisional Quality Governance Boards
Patient Safety Panel
External Reviews


Patient Safety Committee
Patient Safety Panel
Pressure Ulcer Panel
Falls Panel
Medicines Safety Committee
Hospital Thrombosis Committee
Deteriorating Patient Committee
End of Life Forum
Management of CAS Alerts
Diabetes Safety Group
Medical Devices Group
Medical Gases Committee


Clinical Effectiveness and Audit Committee
Nutritional Steering Group
NATSIPS2 Working Group
Clinical Audit Programme
Best practice compliance
Policy management
New Interventional Procedures and Medical Devices Implementation


Trust Infection Prevention Committee
Decontamination Committee
Cleanliness Committee
HCAI Panel
Water Group
Ventilation Group
Antimicrobial stewardship
Food Safety


Patient Experience Committee
Patient Engagement Group
Volunteer Steering Group
Patient Surveys and Feedback
Vulnerable Adults Group
Patient Information Group
Learning from Deaths Committee
Mortality Review Panel

	Reporter/ Author (Lead)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Divisional reports													
Surgery	Emma Smith	x			x			x			x		
Maternity	Amie Symes		x			x			x			x	
Medicine	Sarah Holliehead		x			x			x			x	
Integrated Care	Sarah Assinder/ Sue Moody			x			x			x			x
Clinical Support	Claire Carlsen			x			x			x			x
Perinatal Safety Report	Service leads	x	x	x	x	x	x	x	x	x	x	x	x
Sub- committee reports													
Clinical Effectiveness and Audit Committee (CEAC)	Hamza Katali/ Natasha Owen		x		x		x		x		x		x
Patient Safety Committee (PSC)	Tom Morgan-Jones/ Natasha Owen	x		x		x		x		x		x	
Patient Experience Committee (PEC)	Natasha Owen	x	x	x	x	x	x	x	x	x	x	x	x
Infection Prevention and Control Committee (IPC)	Lucy Flanagan/ Laura Weston	x	x	x	x	x	x	x	x	x	x	x	x
Learning from deaths Committee	Chizo Agwu	Update will be included in the monthly mortality paper as required.											
Quality Priority deep dives/ Patient Safety Priority Updates													
Ensure patients receive a timely VTE risk assessment in line with NICE guidance	TBC	x			x			x			x		
Diabetes Safety Improvement	TBC	x			x			x			x		
Food Quality and Nutritional Risk	TBC	x			x			x			x		
Implement Quality Improvement project to target high-risk time critical medication as locally defined	TBC		x			x			x			x	
Transition of care	TBC		x			x			x			x	
Improve responsiveness to patient experience data	TBC		x			x			x			x	
Increase the number of opportunities to grow our volunteer workforce, in numbers and reach	TBC			x			x			x			x
PSP Quarterly Overview Report	Natasha Owen		x			x			x			x	
PSP Evaluation Report	Natasha Owen				x								
Revised PSIRP	Natasha Owen						x						
Annual reports/ Board Oversight reports													
Committee TOR and forward planner	Natasha Owen												x TOR and planner 2026-27
Quality Priorty proposal 2025-26	Lucy Flanagan/ Natasha Owen											x Draft	x Final
Quality Account	Lucy Flanagan/ Natasha Owen		x										
IPC annual report	Lucy Flanagan/ Laura Weston												

Safeguarding annual report	Lucy Flanagan/ Rachael Hebbert												x
Research and Developemnt annual report	Chizo Agwu/Ingrid Du Rand												
PLACE Audit results	Laura Weston	x											
Additional routine reports													
Infection Prevention Quarterly Report	Laura Weston		x			x			x			x	
Patient Experience Report Quarterly	Natasha Owen		x			x			x			x	
Safeguarding Quarterly reports	Rachael Hebbert	x			x			x			x		
PSIRF report	Natasha Owen	x		x		x		x		x		x	
Staffing Reports	Emma Smith	x	x	x	x	x	x	x	x	x	x	x	x
Mortality monthly report- *will include LFD committee update as appendix*	Chizo Agwu	x	x	x	x	x	x	x	x	x	x	x	x
Research	Ingrid Du Rand			x			x			x			
Patient Flow Report	Lucy Flanagan	x	x	x	x	x	x	x	x	x	x	x	x
Colposcopy	Hannah Duggan					x						x	
QIA process assurance report	Natasha Owen						x						x
Safety walkabout report	Natasha Owen				x			x			x		
External review reports													
National Surveys (exception report)													
Inpatient survey	Emma Smith/ Sarah Holliehead												
Cancer Patient Experience Survey	Natalie Simcock												
UEC patient survey	Lou Weaver												
Maternity patient survey	TBC												
Sub committee TOR/ forward planners													
Patient Safety Committee	Natasha Owen	x											
IPC	Lucy Flanagan		x										
CEAC	Natasha Owen		x										
PEC	Natasha Owen	x											
Adhoc papers added during the year													

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Education Centre Capital Project Update
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Alan Dawson, Chief Strategy and Planning Officer
Reporting Route:	Education Centre Project Team
Appendices included with this report:	N/A
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide an update on the Education Centre Capital Project and set out the next steps.

Recommended Actions required by Board or Committee

That members note the update.

Executive Director Opinion[1]

It is unfortunate that the Trust is not able to take forward this scheme in the timescale that it had hoped. Circumstances mean that the scheme is not financially viable in the current climate but the Trust does have a completed design, a developed business case and planning permission should follow. This will mean that the scheme can be delivered at pace should financial conditions allow.

It is crucial that the Trust communicates the status of the scheme to stakeholders, not least the various charities and trusts that were so supportive of the planned fundraising activities associated with this proposal. I would like to take this opportunity to thank all those that have been so supportive of this scheme to date.

The Trust will continue to seek funding for the scheme and in the meantime work with the Education Team to provide additional facilities within existing buildings to best manage the increasing number of trainees planned in future years.

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

Introduction

In November 2024 the Trust finalised the full business case (FBC) for a new Education Centre. The case set out a scheme that delivered this aim and vision in a specially constructed building on the County Hospital site in Hereford. The construction was to be delivered by a selected partner at a cost of £17.5m by August 2026. The building was expected to be funded by a loan from Herefordshire Council (subject to approval of the business case) and charitable fundraising. The revenue affordability of the scheme relied on educational income and a reduction in costs by using vacated space to terminate two leases.

Update

In finalising the FBC for publication the Trust ascertained that unfortunately circumstances had changed significantly as increases in interest rates meant that the loan from the Council was unaffordable and the payback was unlikely to pass the NHS England value for money test. The Trust therefore withdrew the FBC from the December Board meeting.

At this point the Trust stopped the process of finalising the actual construction costs of the building as this was incurring cost and the likely delays meant that the work would need to be repeated in the future if another source of funding could be found.

The charitable fundraising programme associated with the scheme was also paused as there was no realistic way to utilise any charitable funding without the main funding source.

The Trust did decide to continue the planning application process so that permission was available for when a funding source for the scheme was found. Determination on the application is expected by the end of April 2025.

Next Steps

- Continue to explore funding opportunities for the scheme
- Await the outcome of the planning application process
- Communicate the pausing of the scheme to stakeholders, including the charities, trusts and individuals that pledged their support through the fundraising process

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	NHS Staff Survey 2024
Lead Executive Director:	**Chief People Officer**
Author:	Geoffrey Etule, Chief People Officer
Reporting Route:	
Appendices included with this report:	NHS Staff Survey 2024 reports
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. Each year, the survey is conducted between October and November, with the results being published by March. It asks NHS staff in England about their experiences of working for their respective NHS organisations and the survey provides essential information to employers and national stakeholders about staff experience across the NHS in England. Participation is mandatory for trusts and voluntary for non-trust organisations.

Over 1.5 million staff across NHS organisations were invited to take part in the 2024 survey and the median response rate was 50%. The WVT response rate was 34% which is reasonable considering severe operational pressures faced by the Trust over the past year.

The 2024 results for WVT shows good progress with above average scores in all areas of the survey (compassionate & inclusive, recognised & rewarded, voice that counts, safe & healthy, always learning, work flexibly, we are a team, staff engagement, morale). This is attributable to a number of leadership, staff wellbeing, workforce & OD initiatives that have been implemented and are still in place at the Trust

The overall Staff Survey results for the Group are positive with SWFT staying in the top performing group. WVT is now very close to SWFT in a number of areas and is amongst the top performing Trusts in the Midlands.

This paper provides a summary of key developments in the 2024 Staff Survey and the full report for WVT is enclosed for the Board.

Recommended Actions required by Board or Committee

The Board is asked to consider the Staff Survey report and note the actions being taken to ensure that WVT continues to thrive in the annual staff survey and is recognised as a good model employer of choice. Updates on progress being made in addressing the areas of concern highlighted in the survey will be presented to the Board over the coming months.

Executive Director Opinion[1]

The Trust continues to make positive progress in the annual Staff Survey and this is due to the leadership and workforce interventions that have been introduced at WVT over the past few years.

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

WVT NHS STAFF SURVEY – 2024

1.0 Overview

1.1 The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. Each year, the survey is conducted between October and November, with the results being published by March.

1.2 Over 1.5 million staff across NHS organisations were invited to take part in the 2024 survey and the median response rate was 50%. The WVT response rate was 34% which is reasonable considering severe operational pressures faced by the Trust over the past year.

1.3 This paper provides a summary of key developments in the 2024 Staff Survey and the full report for WVT is enclosed for the Board.

2.0 NHS Context & People Promise

2.1 The 2024 results have shown no change in the nine theme scores. All of the NHS People Promise scores remained broadly similar in 2024 as compared to 2023.

2.2 While it is positive that the improved theme scores achieved in 2023 were sustained, further improvement was not seen this year. This has meant there is no overall change in the theme indicators on key areas of health and wellbeing, staff engagement or flexible working (all of which improved in 2023).

2.3 Most of the NHS Staff Survey themes are now back to pre-COVID-19 pandemic levels, and seven are at the highest level ever. These are:

- compassionate leadership
- health and safety climate
- burnout
- appraisals
- support for work-life balance
- flexible working
- line management.

2.4 It should be noted that satisfaction with pay did improve, but this was from 31 per cent to 32 per cent and largely due to an improvement in medical staff opinion following the pay deal.

2.5 There were few shifts in some individual areas and these included improvements in views regarding appraisal, staff satisfaction with pay, and staff who often think of leaving declined. The generally good scores the NHS has on line managers and team working were broadly stable, though one indicator on respect dipped.

2.6 Willingness to recommend the NHS as place to work and as a place to be cared for were broadly stable compared to 2023 (which was an improvement on 2022). However, both scores were still lower than pre-pandemic levels.

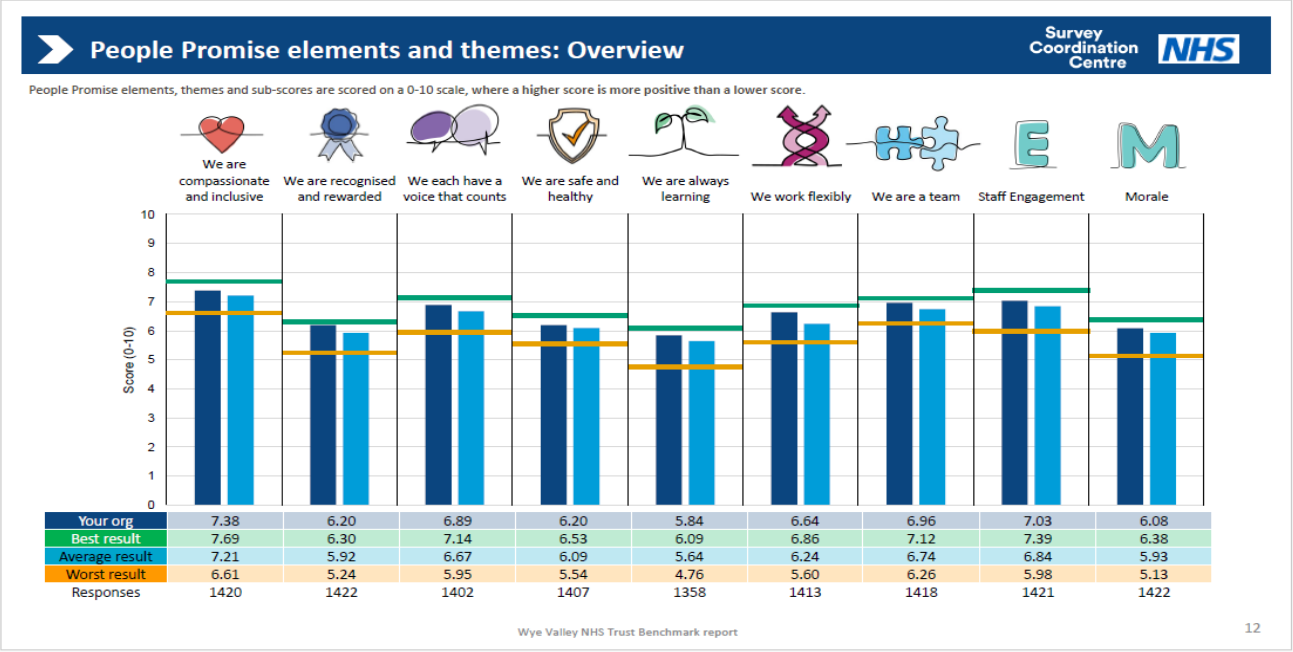
2.7 Despite the results being similar to those of the previous year, there are some areas where concerns exist. **The overall level of violence worsened** with staff experiencing violence from the public rising from 13.88 per cent to 14.38 per cent, while bullying and harassment level by the public remained at 25 per cent. However, there were small improvements in levels of reporting in both areas.

2.8 **Levels of unwanted sexual behaviour from public rose from 8.79 per cent to 8.82 per cent**, while the metric regarding unwanted sexual behaviour from other staff fell slightly. **A number of equality and diversity indicators worsened**, in particular staff experience of discrimination from public rose from 8.58 per cent to 9.25 per cent. The inequalities in staff experience measured by the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) largely did not move.

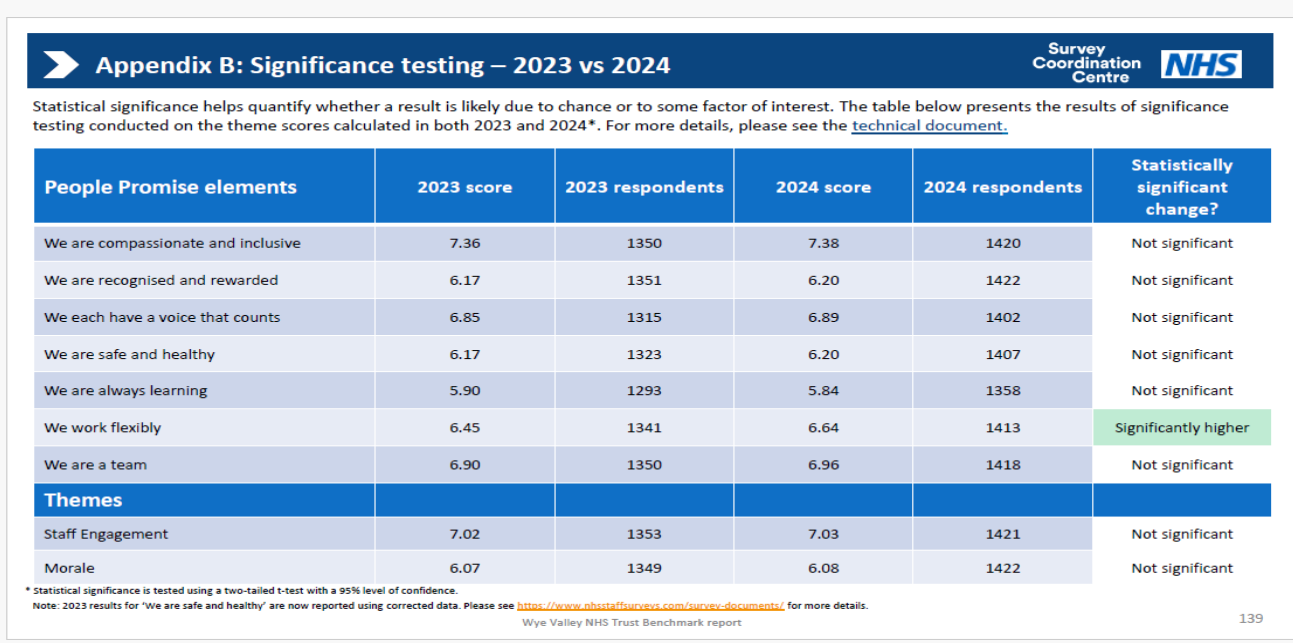
2.9 With the 2024 NHS Staff Survey scores remaining stable and consolidating on the progress made in 2023, it perhaps demonstrates the need for the NHS to keep on improving. Undoubtably, this is a positive achievement in a challenging context, but there remains plenty of scope for increasing engagement and implementing initiatives to support staff morale, staff development and health & wellbeing at work.

3.0 WVT Overview

3.1 A summary of the 2024 results for WVT shows good progress with **above average scores in all areas of the survey** (*compassionate & inclusive, recognised & rewarded, voice that counts, safe & healthy, always learning, work flexibly, we are a team, staff engagement, morale*). This is attributable to a number of leadership, staff wellbeing, workforce & OD initiatives that have been implemented and are still in place at the Trust over the past few years.



3.2 The 2024 data for WVT shows a **statistically significant higher change in one area** highlighted below i.e. *we work flexibly* which is a strategic objective of the Trust and is reflective of the concerted efforts and investments we have made in order to improve the staff experience.



Appendix B: Significance testing – 2023 vs 2024

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Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.36	1350	7.38	1420	Not significant
We are recognised and rewarded	6.17	1351	6.20	1422	Not significant
We each have a voice that counts	6.85	1315	6.89	1402	Not significant
We are safe and healthy	6.17	1323	6.20	1407	Not significant
We are always learning	5.90	1293	5.84	1358	Not significant
We work flexibly	6.45	1341	6.64	1413	Significantly higher
We are a team	6.90	1350	6.96	1418	Not significant
Themes					
Staff Engagement	7.02	1353	7.03	1421	Not significant
Morale	6.07	1349	6.08	1422	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.
Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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3.3 The table below provides a high level summary on the key People Promise questions of the survey. The main areas of some concern where WVT is slightly below average scores for NHS organisations are in Q25a, Q25b and Q25d. WVT has seen improvements in these areas in the 2024 survey and no area is rated as being amongst the worst NHS organisations in the survey. In terms of violence & aggression which was a major area of concern in previous surveys, actions implemented at WVT since 2021 continue to have a positive impact.

3.4 It should be noted that the scores for WVT in the table below are close to the average NHS scores and the overall staff survey scores for WVT are largely positive. Dissatisfaction with levels of pay remains across the NHS and many staff remain dissatisfied with their pay considering the cost of living crisis.

PEOPLE PROMISE ELEMENTS /THEMES - 2024	WVT	Average	Best	Worst
1. We are compassionate and inclusive				
Q25a – Care of patients / service users is my organisation's top priority	**<71.79% (72.32%)**	**74.42%**	**87.81%**	**50.48.%**
Q25b – My organisation acts on concerns raised by patients / service users	**>68.81%**	**70.89%**	**84.00%**	**49.55%**
Q25d – If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**<56.54% (58.07%)**	**61.54%**	**89.59%**	**39.72%**
Q25c– I would recommend my organisation as a place to work	**>61.98% (60.50%)**	**60.90%**	**79.38%**	**35.43%**
2. We are recognised and rewarded				
Q4a – The recognition I get for good work	**>58.82%**	**53.02%**	**60.37%**	**42.37%**
Q4b – The extent to which my organisation values my work	**>47.42%**	**43.88%**	**53.22%**	**28.35%**
Q4c – My level of pay	**<33.47%**	**31.14%**	**37.76%**	**22.92%**
Q9e – My immediate manager values my work	**>75.99%**	**71.30%**	**78.38%**	**64.68%**
3. We have a voice that counts				
Q20a – I would feel secure raising concerns about unsafe clinical practice	>72.80%	70.44%	79.71%	60.03%
Q20b – I am confident that my organisation would address my concern	>56.62%	55.91%	68.85%	40.42%
Q25e – I feel safe to speak up about anything that concerns me in this organisation	>62.98%	60.29%	72.15%	43.56%
4. We are safe & healthy				
Q3g – I am able to meet all the conflicting demands on my time at work	**<47.68%**	**47.51%**	**55.01%**	**36.68%**
Q5a – I have unrealistic time pressures	**<24.21%**	**25.71%**	**31.37%**	**21.01%**
Q11a – My organisation takes positive action on health & wellbeing	**>58.47%**	**55.99%**	**70.84%**	**38.51%**
Q11c – During the last 12 months have you felt unwell as a result of work related stress?	**>40.53%**	**41.45%**	**33.18%**	**48.54%**
Q13a – In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public	**<10.69%**	**14.37%**	**6.38%**	**19.61%**
Q17a – In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public	**>8.06%**	**7.98%**	**0.76%**	**13.39%**
Q17b – In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues	**>4.59%**	**3.53%**	**1.52%**	**5.85%**
5. We are always learning – above average scores for WVT in key questions posed				

6. We work flexibly – above average scores for WVT in all questions posed and close to best scores				
7. We are a team – above average scores for WVT in key areas and good feedback for support from immediate managers				
8. Engagement – maintaining above NHS average results				
9. Morale – maintaining above NHS average results				

** *< = lower score from 2023. > = higher score from 2023*

4.0 WVT Directorates

4.1 The data below indicates that the Surgical Division is the most improved and the Medical & Clinical Support Divisions are the most challenged with below average scores in all 9 areas of the survey. Working groups led by the Associate Chief Operations Officers will address the main issues of concern highlighted by staff and develop local actions.

Directorates	
Clinical Support	*Below WVT scores in all 9 areas*
Corporate Division	*Above WVT scores in all 9 areas*
Integrated Care Division	*Above WVT scores in 4 out of 9 areas*
Medical Division	*Below WVT scores in all 9 areas*
Surgical Division	*Above WVT average scores in 3 areas & close to average scores in all areas – remains the most improved Division*

4.2 WVT wide staff engagement listening events (*InTouch campaign*) are being planned to run again from May to August. This will provide an avenue for staff to identify local actions to be implemented in order to address areas of concern highlighted in the survey.

5.0 WVT Staff Groups

5.1 The data below and further analysis of the survey indicates that additional prof scientific & technical staff, healthcare scientists and the medical & dental staff group continue to have the lowest positive scores in the staff survey. As part of growing our own staff strategy, the WVT apprenticeship framework for support staff will be actively promoted to all staff. The WVT leadership development programme now includes a specific day for consultants and the Chief Medical Officer is leading more specific interventions for medical staff with Associate Medical Directors. Medical staff will also be invited to staff engagement listening events over the coming months to help identify local solutions to areas of concern. Targeted interventions will also be developed working with healthcare scientists.

Red rated in most areas	
➢ Additional Prof Scientific & Technical	
➢ Healthcare Scientists	
➢ Medical & Dental	
Amber / Green rated mainly with some red areas	
➢ Nursing & Midwifery	
➢ Allied Health Professionals	
➢ Additional Clinical Services	
Green rated mainly	
➢ Admin & Clerical ➢ Estates & Ancillary	

5.2 Workforce Race Equality Standard (WRES) 2024

5.2.1 Information from the 2024 staff survey still indicates that Black, Asian & Minority Ethnic staff are still reporting a poorer experience compared to white colleagues in terms of harassment, bullying or abuse and equal opportunities. Data from NHS Employers indicates that unfortunately this is still the case across many organisations in the NHS.

5.2.2 The Trust has 3 staff networks in place. The Black, Asian & Minority Ethnic (BAME) network, the LGBTQ+ network and the Disability network for WVT employees. These staff networks are maturing and over time will be able to drive forward and support strategic equality & diversity issues affecting staff at the Trust. WVT will also continue to work closely with ICS and group colleagues in this area.

5.3 Workforce Disability Equality Standard (WDES) 2024

5.3.1 The staff survey also indicates that staff with a long term condition or illness, are still reporting a less favourable experience in terms of harassment, bullying or abuse at work. This is also the case in many NHS organisations and the WVT Disability network and Health & Wellbeing group are implementing initiatives to support disabled staff at the Trust. The WVT managing attendance policy is being reviewed and more provisions will be made to offer additional support for disabled staff. The Trust is also working closely with the Access to Work Officers from the DWP in supporting disabled staff at work.

6.0 Notable Highlights – People Promise 2024 Survey

6.1 Information from the staff survey shows a pattern of consistent good performance in notable areas of the survey. **It is worth noting that WVT has not been rated as being amongst the worst NHS organisations in any area of the survey.**

6.2 WVT employees have provided very positive scores for support received from **their immediate line managers** as indicated in the charts below. This provides a good platform for the Trust to build on and work with line managers in getting them to take more ownership in enhancing the working experience of staff in key areas of the staff survey.

	2020	2021	2022	2023	2024
Your org	71.07%	70.63%	74.38%	75.35%	75.81%
Best result	77.39%	77.71%	79.19%	79.11%	78.63%
Average result	69.49%	69.19%	69.81%	71.50%	71.38%
Worst result	60.73%	62.13%	62.79%	65.30%	66.06%
Responses	537	1279	1244	1347	1418

	2020	2021	2022	2023	2024
Your org	61.04%	62.76%	64.11%	66.45%	66.77%
Best result	70.38%	70.55%	71.44%	73.80%	71.93%
Average result	60.86%	61.06%	62.20%	64.95%	65.31%
Worst result	51.58%	53.40%	54.10%	57.39%	57.64%
Responses	537	1276	1243	1349	1417

	2020	2021	2022	2023	2024
Your org	56.96%	61.28%	59.70%	63.24%	63.50%
Best result	63.45%	65.11%	65.23%	66.16%	65.47%
Average result	54.73%	55.75%	56.93%	58.97%	58.84%
Worst result	44.85%	48.47%	48.62%	51.84%	50.94%
Responses	535	1275	1245	1347	1419

6.2 Severe operational pressure at WVT continues to impact on progress in key questions about patient care in the 2024 survey as captured below.

Q25a – Care of patients / service users is my organisation's top priority

2018	2019	2020	2021	2022	2023	2024
72.0%	*75.7%*	*77.2%*	*73.3%*	*70.9%*	*72.32%*	*71.79%*

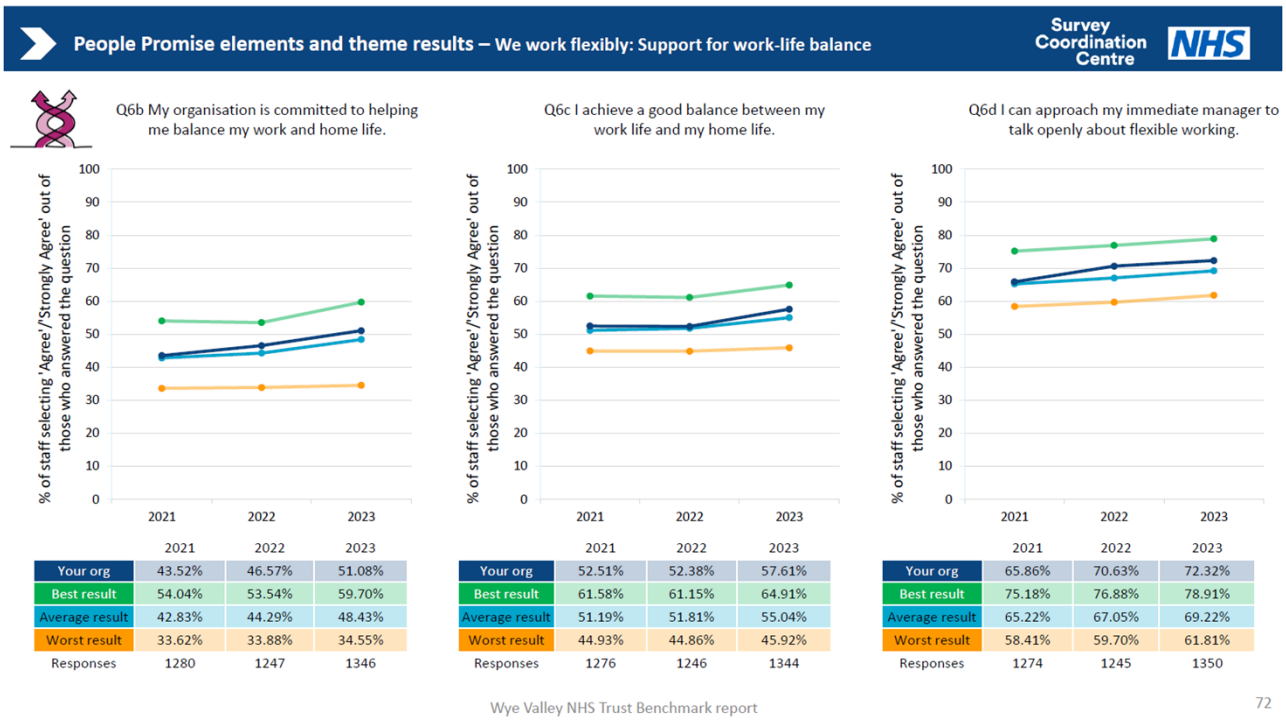
Q25c – I would recommend my organisation as a place to work

2018	2019	2020	2021	2022	2023	2024
60.2%	*64.6%*	*69.5%*	*61.0%*	*59.5%*	*60.52%*	*61.98%*

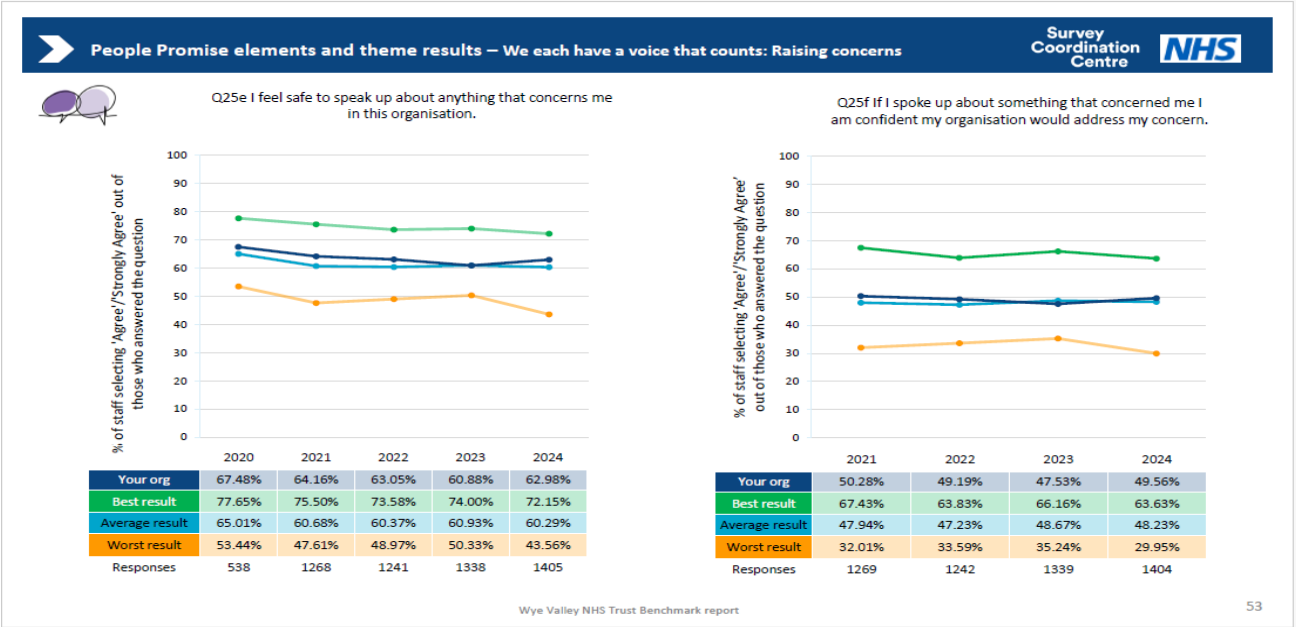
Q25d – If a friend of relative needed treatment I would be happy with the standard of care provided

2018	2019	2020	2021	2022	2023	2024
62.7%	*66.7%*	*70.6%*	*62.7%*	*57.1%*	*58.10%*	*56.54%*

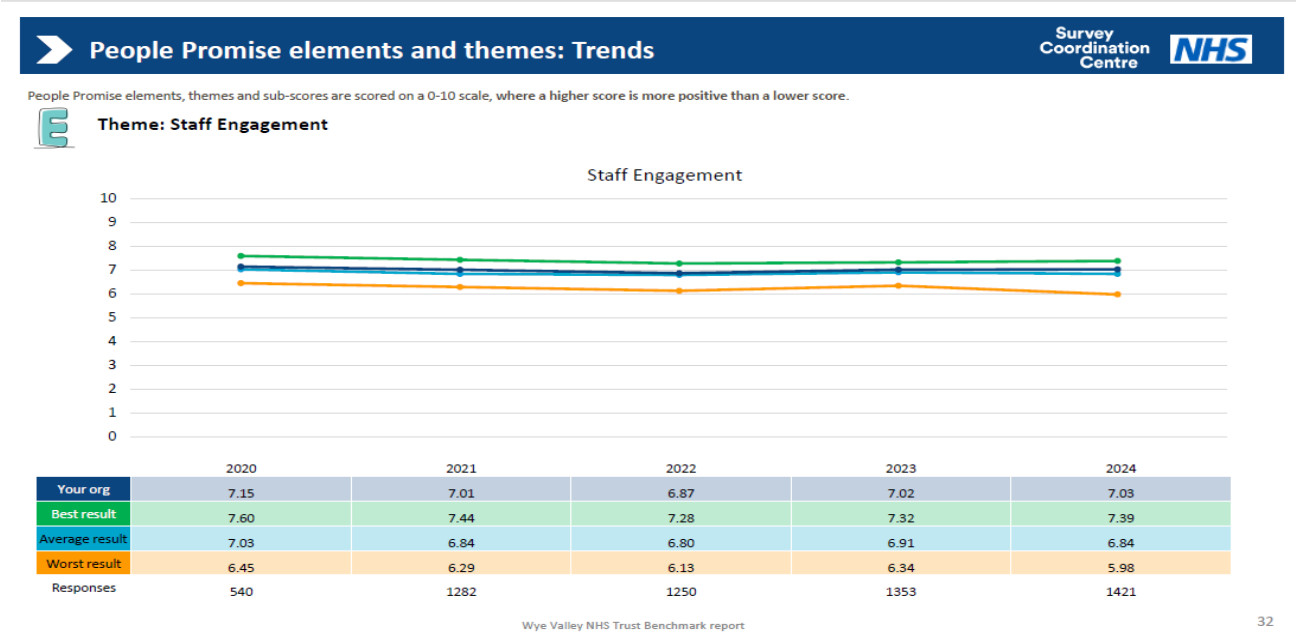
Flexible Working – significant improvements in flexible working following the *Yes To Flex* strategic objective.



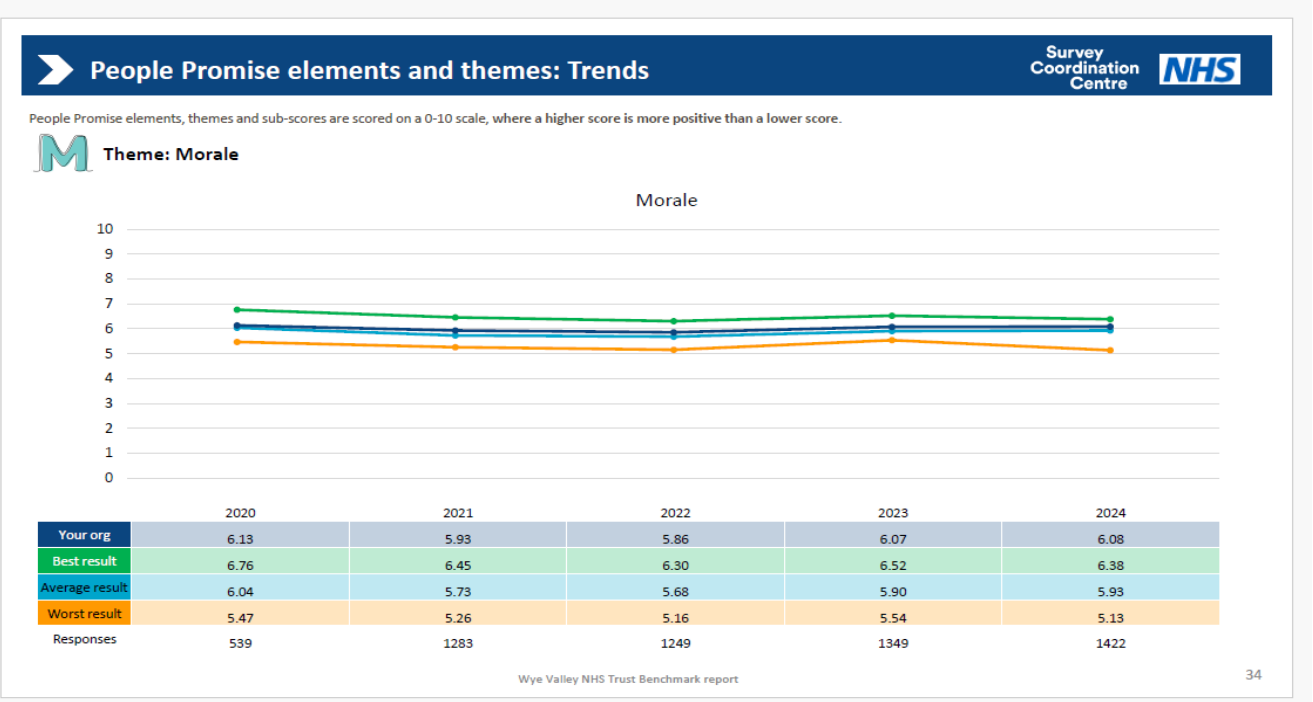
Voice that counts – WVT has maintained above NHS average scores and is making good progress in this area.



Staff Engagement – *InTouch* campaign contributed to significant improvement in staff engagement.



Morale – leadership and workforce initiatives contributed to significant improvement in morale.



People Promise elements and themes: Trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

Theme: Morale

Morale

	2020	2021	2022	2023	2024
Your org	6.13	5.93	5.86	6.07	6.08
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	539	1283	1249	1349	1422

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7.0 Group results

7.1 The overall staff survey results for the Group has SWFT staying in the top performing Group. WVT is very close to SWFT in a number of areas and GEH has seen substantial improvements. Worcester hospital have the most improved scores within the Group. The results continue to show positive progress at WVT over the past few years and WVT is still amongst the top 5 high performing Trusts in the Midlands.

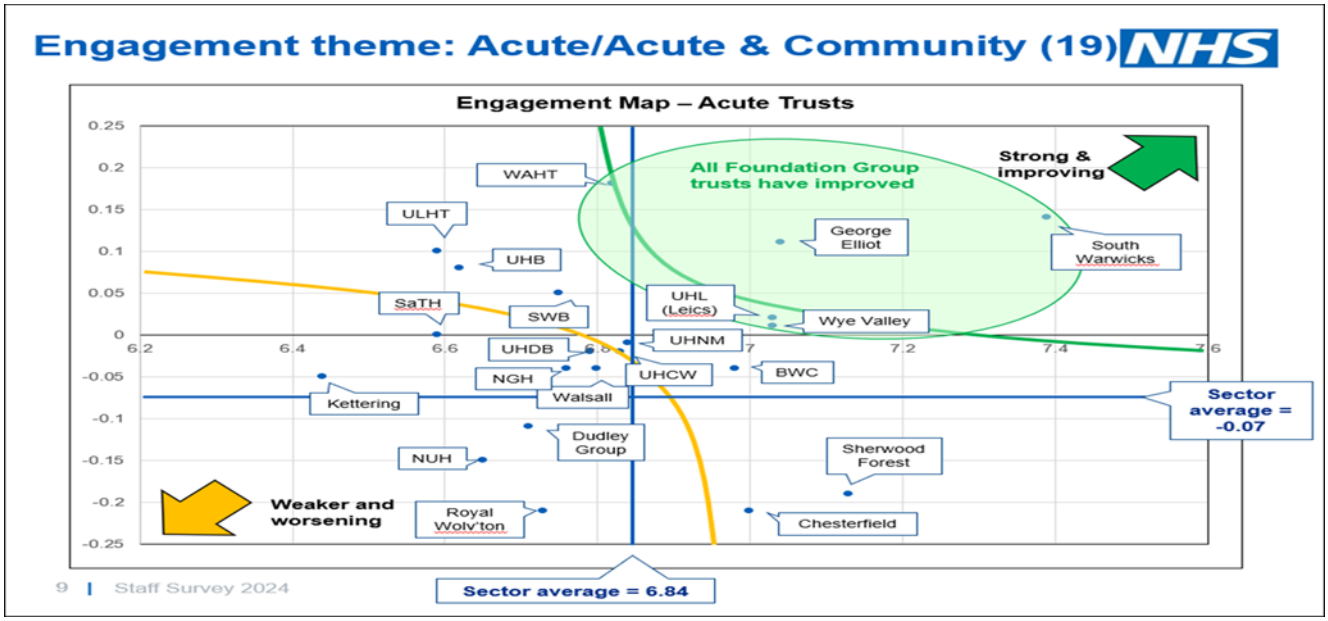
Foundation Group Staff Survey - 2023 v 2024

	Sector 24	Sector 23	GEH (24)	GEH (23)	SWFT (24)	SWFT (23)	WVT (24)	WVT (23)	WAH (24)	WAH (23)
People Promise										
1. Compassion & Inclusion	7.22	7.24	7.30 ^	7.22 ^	7.69 ^	7.67 ^	7.39 ^	7.36 ^	7.30 ^	7.10 =
2. Recognition & Reward	5.90	5.91	5.99 ^	5.95 ^	6.32 ^	6.26 ^	6.23 ^	6.18 ^	5.90 ^	5.80 ^
3. A Voice that Counts	6.68	6.69	6.79 ^	6.72 ^	7.16 ^	7.04 ^	6.87 ^	6.82 ^	6.70 ^	6.50 ^
4. Safe and Healthy	6.09	6.07	6.31 ^	6.10 ^	6.39 ^	6.26 ^	6.21 =	6.21 ^	6.10 ^	5.90 ^
5. Always learning	5.69	5.63	5.95 ^	5.74 ^	6.11 ^	6.08 ^	5.80 v	5.86 ^	5.60 ^	5.30 ^
6. We work Flexibly	6.22	6.17	6.47 ^	6.29 ^	6.90 ^	6.66 ^	6.65 ^	6.45 ^	6.40 ^	6.20 ^
7. We are a Team	6.62	6.73	6.86 ^	6.71 ^	7.09 ^	7.04 ^	6.97 ^	6.91 ^	6.70 ^	6.50 ^
Overall	Sector 24	Sector 23	GEH (24)	GEH (23)	SWFT (24)	SWFT (23)	WVT (22)	WVT (23)	WAH (22)	WAH (23)
Overall Engagement Score	6.85	6.88	7.03 ^	5.95 v	7.40 ^	7.31 ^	7.01 ^	7.00 ^	6.80 ^	6.60 =
Overall Morale Score	5.94	5.92	6.21 ^	6.00 ^	6.40 ^	6.28 ^	6.08 ^	6.08 ^	6.00 ^	5.70 ^

Key: Green shaded better than Sector, pink worse than sector, arrows indicate comparison with last year.

Group Rankings	GEH	SWFT	WVT	WAH
1. Compassion & Inclusion	3	1	2	3
2. Recognition & Reward	3	1	2	4
3. A Voice that Counts	3	1	2	4
4. Safe and Healthy	2	1	3	4
5. Always learning	2	1	3	4
6. We work Flexibly	3	1	2	4
7. We are a Team	3	1	2	4
Overall Engagement Score	2	1	3	4
Overall Morale Score	2	1	3	4

Analysis on the Engagement scores from the 2024 Staff Survey results for Midlands (ICBs and Acutes) from John Drew shows a good story for the Foundation Group in the pattern as demonstrated in the chart below. Although Engagement scores have dropped NHS wide, all 4 trusts in the Group have improved in this area which is a significant achievement.



8.0 WVT Workforce & OD initiatives

8.1 WVT has maintained a number of workforce initiatives over the past few years in order to be recognised as a good model employer of choice, and also to address the areas covered by the staff survey. Our workforce & organisational development strategy and health & wellbeing strategy with key themes & enablers supports our position as a model workplace for all employees.

8.2 The table below provides information on workforce initiatives at WVT aligned to the People Promise elements & themes of the staff survey. These initiatives are ongoing and will continue over the next year as they are designed to enhance the working culture and working environment for all employees. HR business partners have Divisional plans aligned to the People Promise and are involved in driving local staff engagement programmes.

Compassionate & inclusive	Recognised & rewarded	Voice that counts	Safe & healthy	Always learning	Work flexibly	We are a team	Staff engagement	Morale
• Staff networks – BAME, Disability, LGBTQ+ • FTSU process • Cultural ambassadors • Civility saves lives sessions • WVT strategic EDI group • ICS EDI projects • NHS EDI programmes • Mental health first aiders • Menopause passport • Disability/health passport	• GEM awards • HCSW B2/3 pay & career dev't framework • B5/6 nursing review • WVT rec & ret group • Divisional rec & ret group • WVT staff benefits • Quarterly HR road shows	• Trade union forums – JNCC, LNC • Staff networks • FTSU Guardian • FTSU champions • Exec director open door sessions • Rumour mill • HR policies & procedures • New starter surveys • Rumour mill	• Halo leisure programmes • Schwartz rounds • Mental health training • West Mids Thrive at work actions • NHS wellbeing framework actions • Menopause Charter & group • University projects (MHFA, connecting staff with nature • NHS charities bids	• Growing our own staff • Apprentices hips • CPD funds • Variety of staff devt programmes • Leadership & mgt development • T&D prospectus	• Call to action retention plan • Expanding flexi working options – term time, annualised hrs, hybrid • E-rostering option for self rostering • Advertising all jobs as open to flexi working • HR policies & procedures	• Team events • Team building sessions • Insights discovery sessions • Staff & team dev't sessions	• Exec director open door sessions • Informal drop in sessions • Walking the floor events • Regular meetings with trade union reps • WVT hapi app • Trust Talk • Regular staff comms • Wide use of screen savers	• Regular staff comms on WVT, ICS dev'ts • Dept meetings • FTSU feedback sessions

Actions for the Clinical Support, Medical Division, Medical Staff & Healthcare Scientists

The results of the 2024 staff survey highlights the need for further interventions in the Clinical Support, Medical Division and also for medical & dental staff and healthcare scientists employed at WVT. The HR team will work closely with corporate and divisional leaders to implement targeted actions to address the issues affecting staff in these areas.

9.0. Way forward

9.1 The Board is asked to consider the staff survey report and note the actions being taken to ensure that WVT continues to thrive in the annual staff survey and is recognised as good model employer of choice.

9.2 HR teams and divisional leaders will lead staff engagement sessions (*InTouch 2025*) over the next few months and a comprehensive action plan will be developed to ensure key areas of concern at WVT and NHS wide (violence at work, unwanted sexual behaviour, equality & diversity) are being addressed appropriately.

9.2 Updates on progress being made in addressing the areas of concern highlighted in the survey will be presented to the Board over the coming months.

Survey Coordination Centre

NHS

Wye Valley NHS Trust

NHS Staff Survey Benchmark report 2024

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Introduction

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this report

This benchmark report for Wye Valley NHS Trust contains results for the 2024 NHS Staff Survey, and historical results back to 2020 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations.

Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34a-b and Q35 are not weighted or benchmarked because these questions ask for demographic or factual information.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two themes (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and sub scores are related and mapped to individual survey questions.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q24f, Q26d, Q31b		

Report structure

Survey Coordination Centre

NHS

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, the themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, with the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note: where there are fewer than 10 responses for a question, this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes.
Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2023 vs 2024.
- Guidance on data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

Using the report

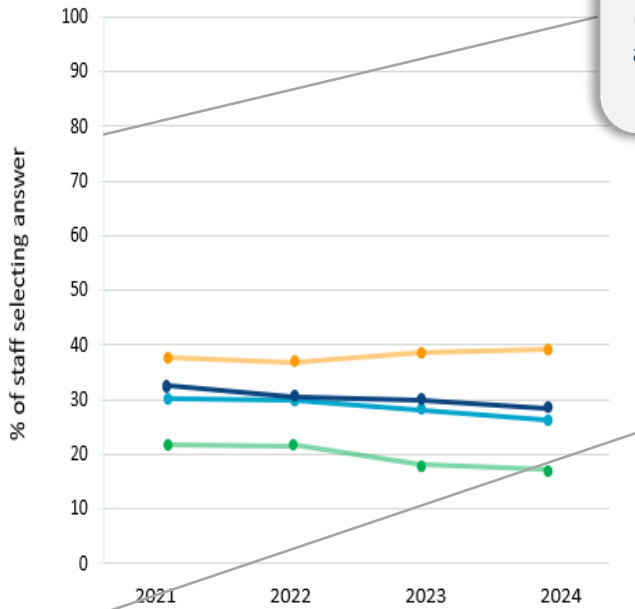
Survey Coordination Centre NHS

Note this is example data

Key features

Question number and text (or summary measure) specified at the top of each slide.

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.



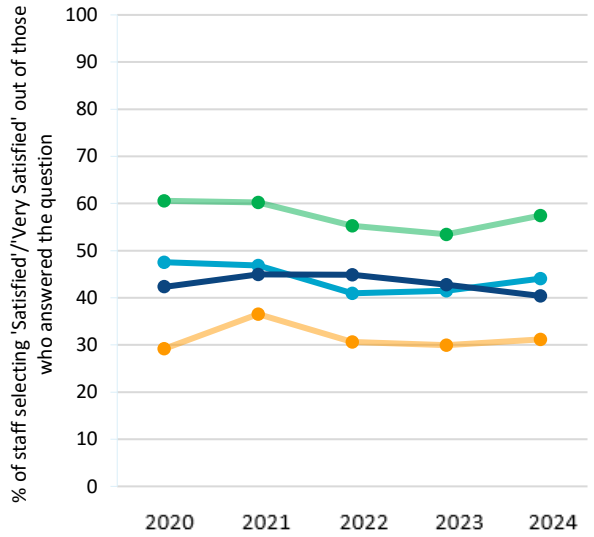
	2021	2022	2023	2024
Your org	32.6%	30.6%	30.0%	28.5%
Best result	21.8%	21.7%	18.0%	17.1%
Average result	30.2%	29.8%	28.1%	26.4%
Worst result	37.6%	36.9%	38.5%	39.2%
Responses	480	500	515	520

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

'Best result', 'Average result', and 'Worst result' refer to the **benchmarking group's** best, average and worst **results.**

Tips on how to read, interpret and use the data are included in the Appendices

Q4b How satisfied are you with each of the following aspects of your job?



	2020	2021	2022	2023	2024
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	55.3%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Note: Charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2022, 2023 and 2024 portions of the chart and table.

Survey Coordination Centre

NHS

Organisation details

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Organisation details

Survey Coordination Centre NHS

Wye Valley NHS Trust

2024 NHS Staff Survey

Organisation details

Completed questionnaires	1426
2024 response rate	34%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Acute and Acute & Community Trusts

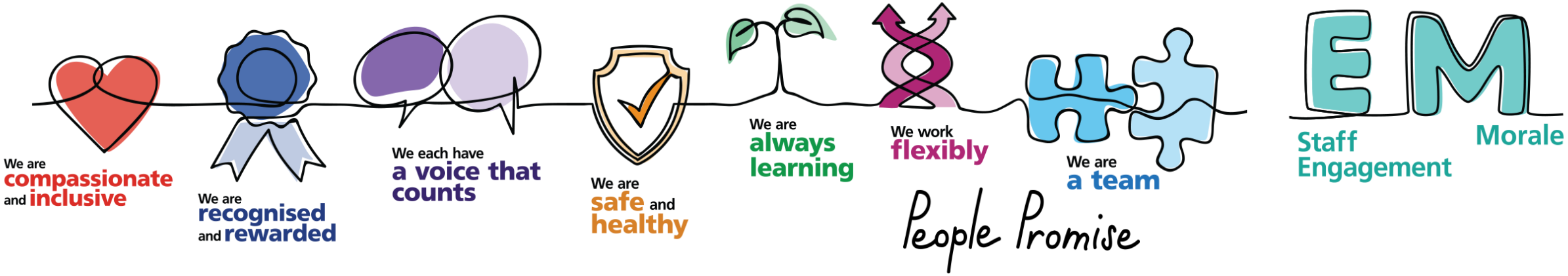
2024 benchmarking group details

Organisations in group: 122

Median response rate: 49%

No. of completed questionnaires: 532587

For more information on benchmarking group definitions please see the Technical document.



People Promise elements, themes and sub-score results

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

NHS

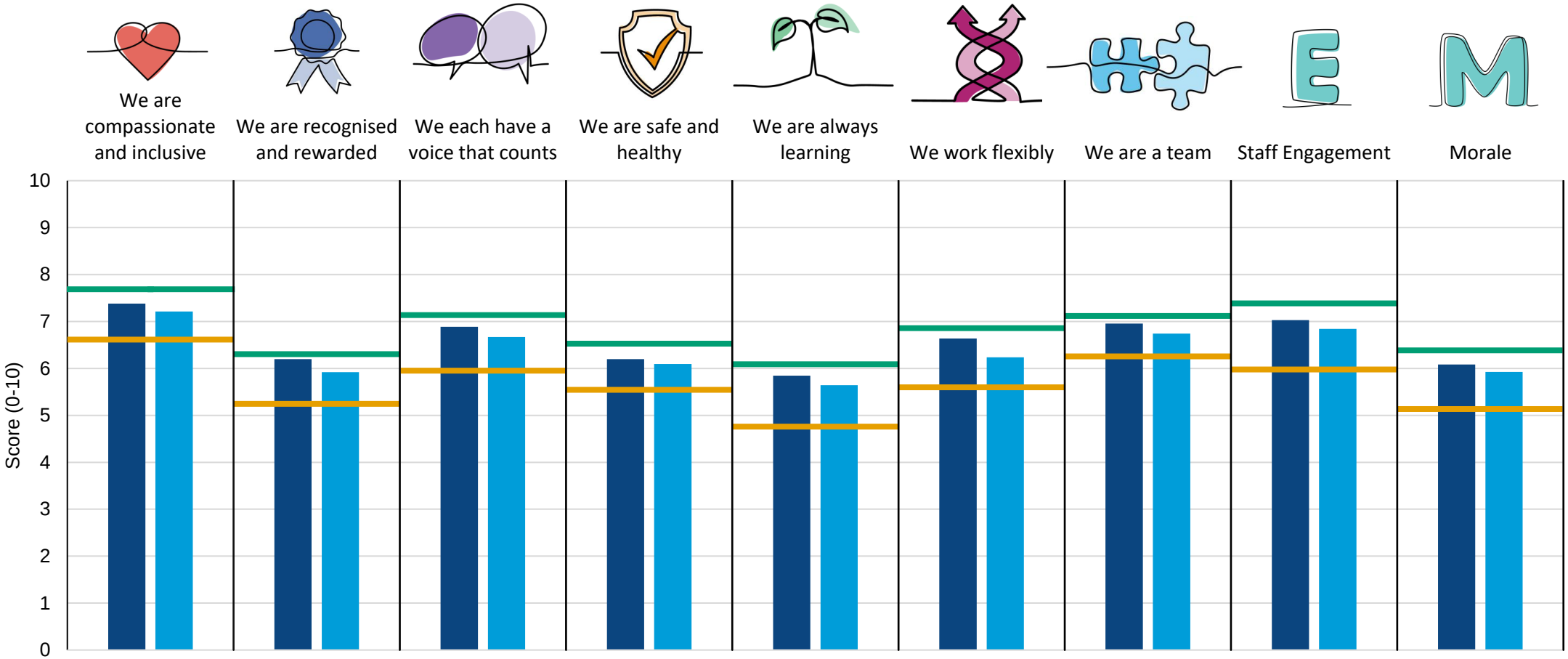
People Promise elements, themes and sub-scores: Overview

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



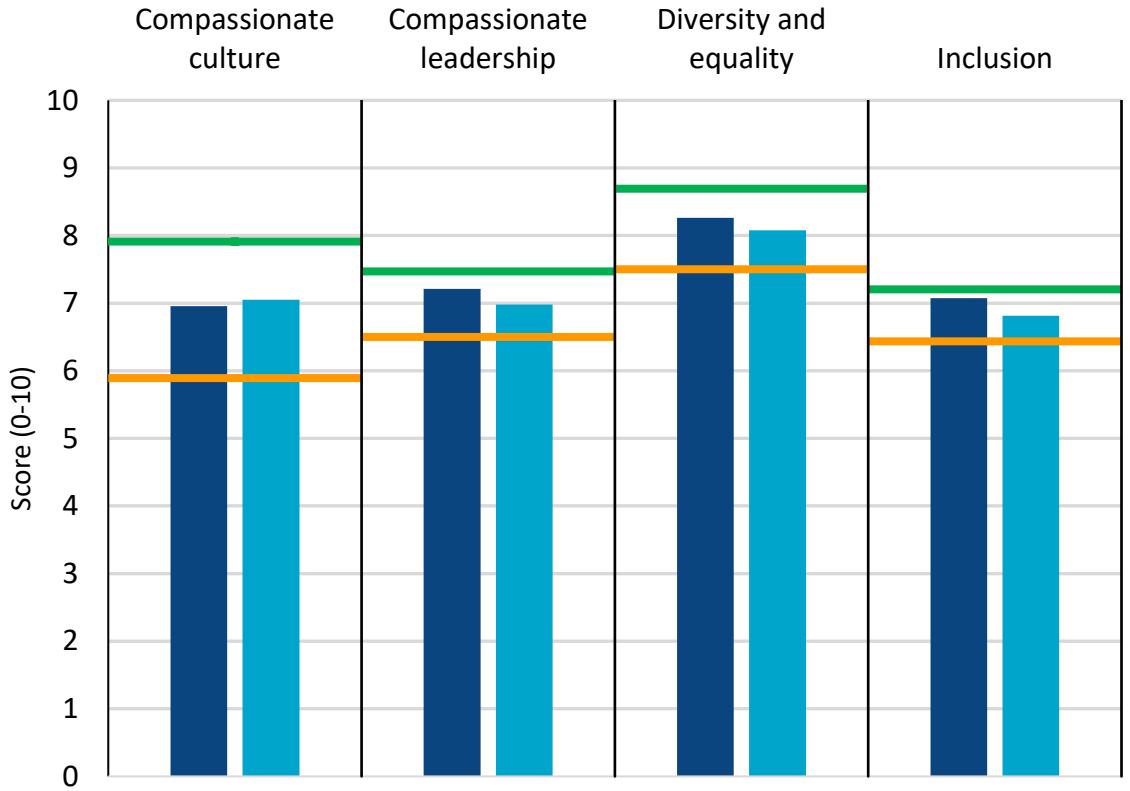
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.38	6.20	6.89	6.20	5.84	6.64	6.96	7.03	6.08
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	1420	1422	1402	1407	1358	1413	1418	1421	1422

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

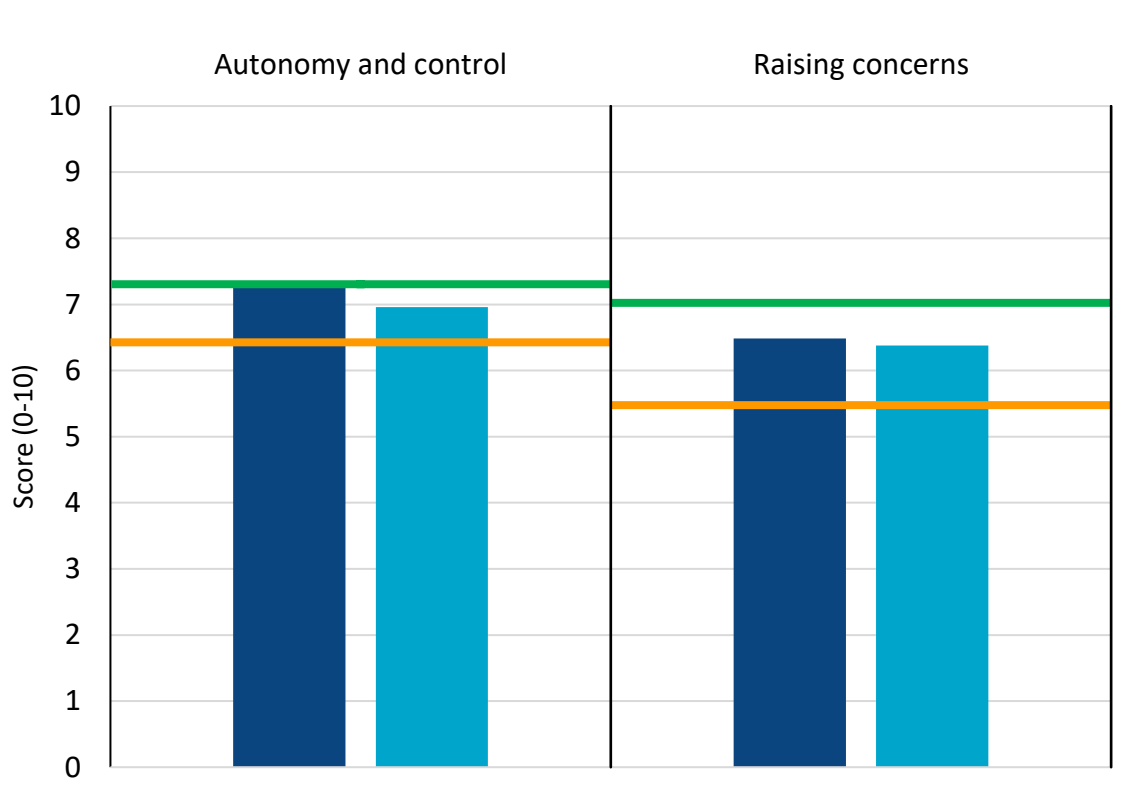
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.96	7.21	8.26	7.08
Best result	7.91	7.47	8.69	7.20
Average result	7.05	6.98	8.08	6.81
Worst result	5.89	6.50	7.50	6.44
Responses	1411	1421	1413	1412

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.29	6.49
Best result	7.31	7.02
Average result	6.96	6.38
Worst result	6.43	5.48
Responses	1422	1404

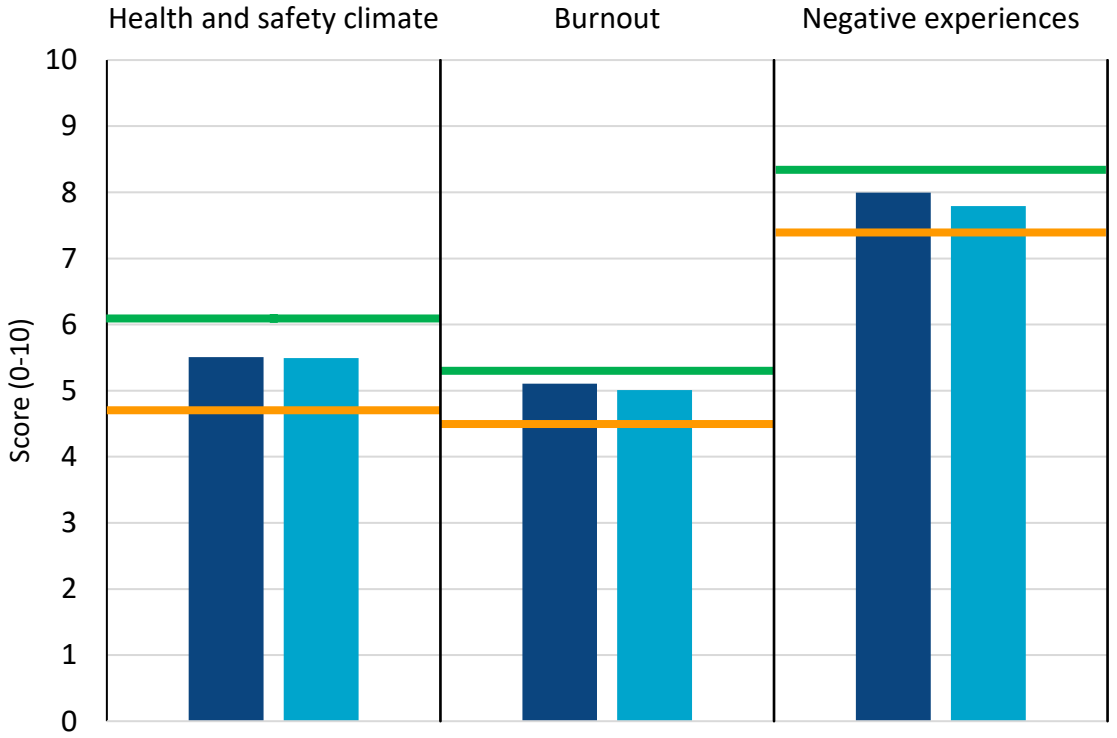
Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

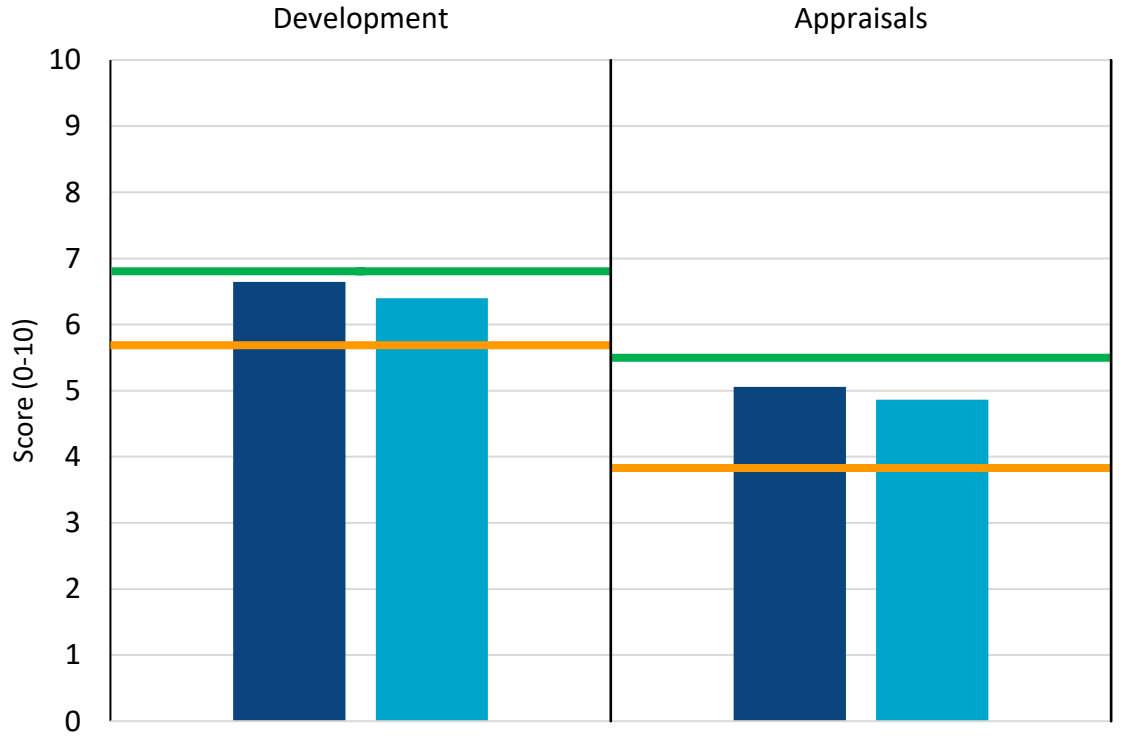
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.51	5.11	7.99
Best result	6.09	5.30	8.34
Average result	5.49	5.01	7.79
Worst result	4.70	4.50	7.39
Responses	1422	1414	1414

Promise element 5: We are always learning



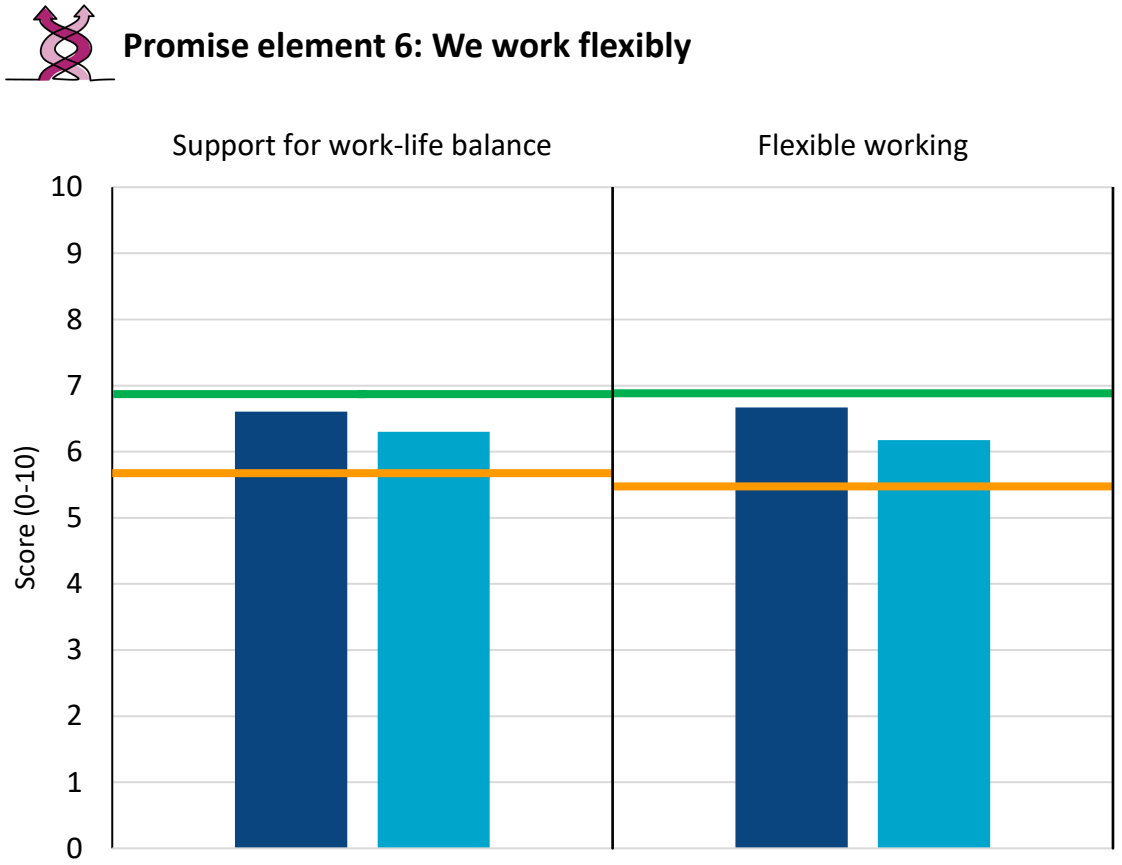
	Development	Appraisals
Your org	6.64	5.06
Best result	6.80	5.50
Average result	6.40	4.86
Worst result	5.69	3.83
Responses	1410	1361

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

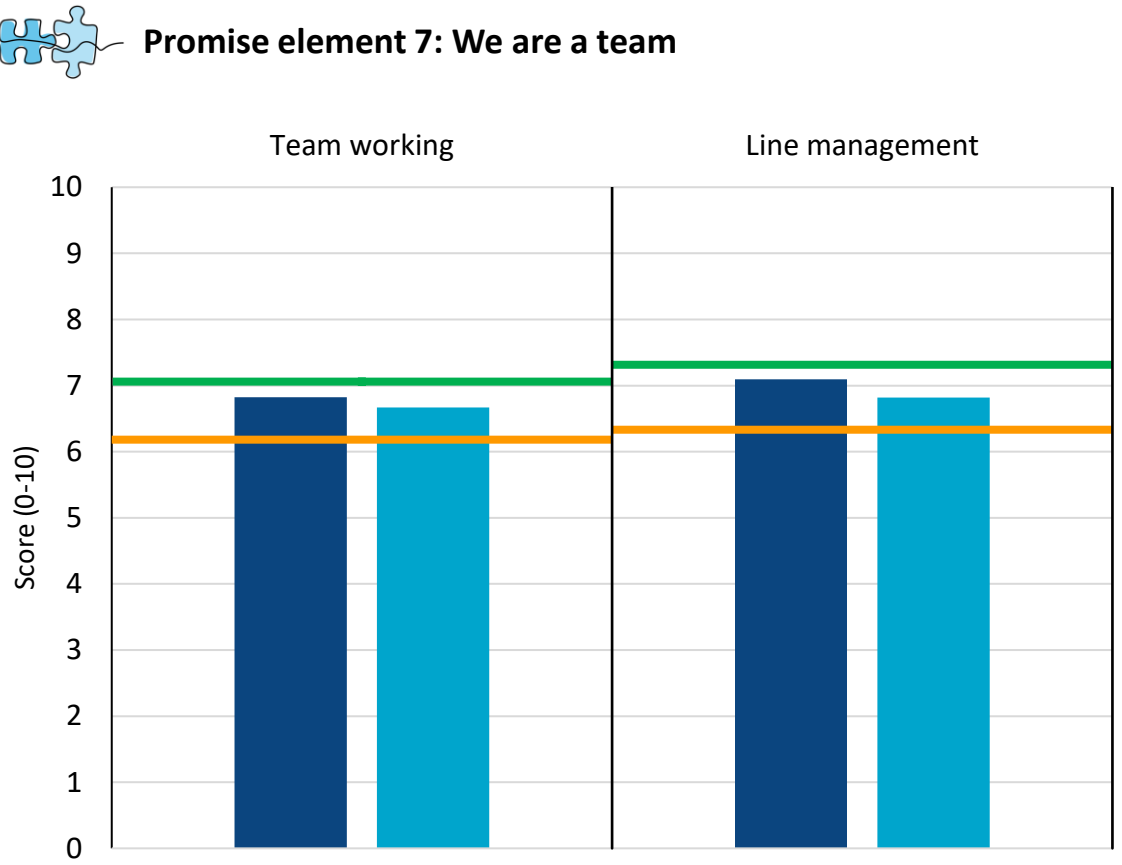
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.60	6.67
Best result	6.87	6.88
Average result	6.30	6.17
Worst result	5.67	5.47
Responses	1417	1418

Promise element 7: We are a team



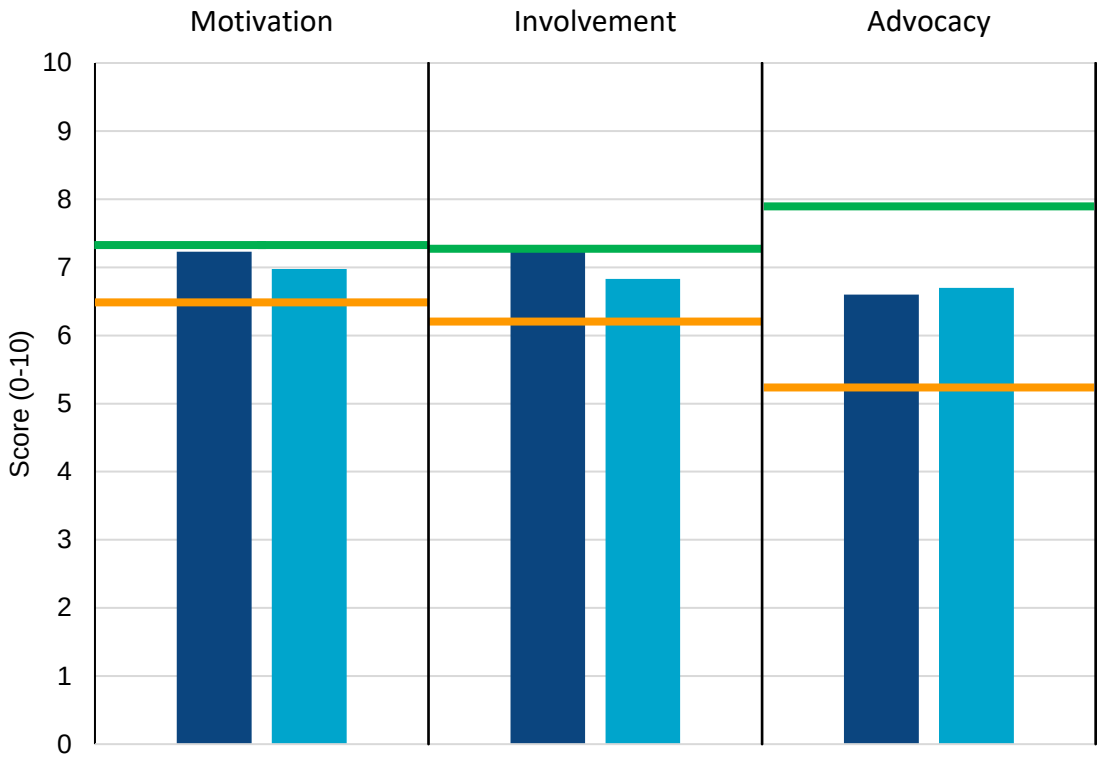
	Team working	Line management
Your org	6.82	7.09
Best result	7.06	7.31
Average result	6.67	6.82
Worst result	6.18	6.33
Responses	1421	1419

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

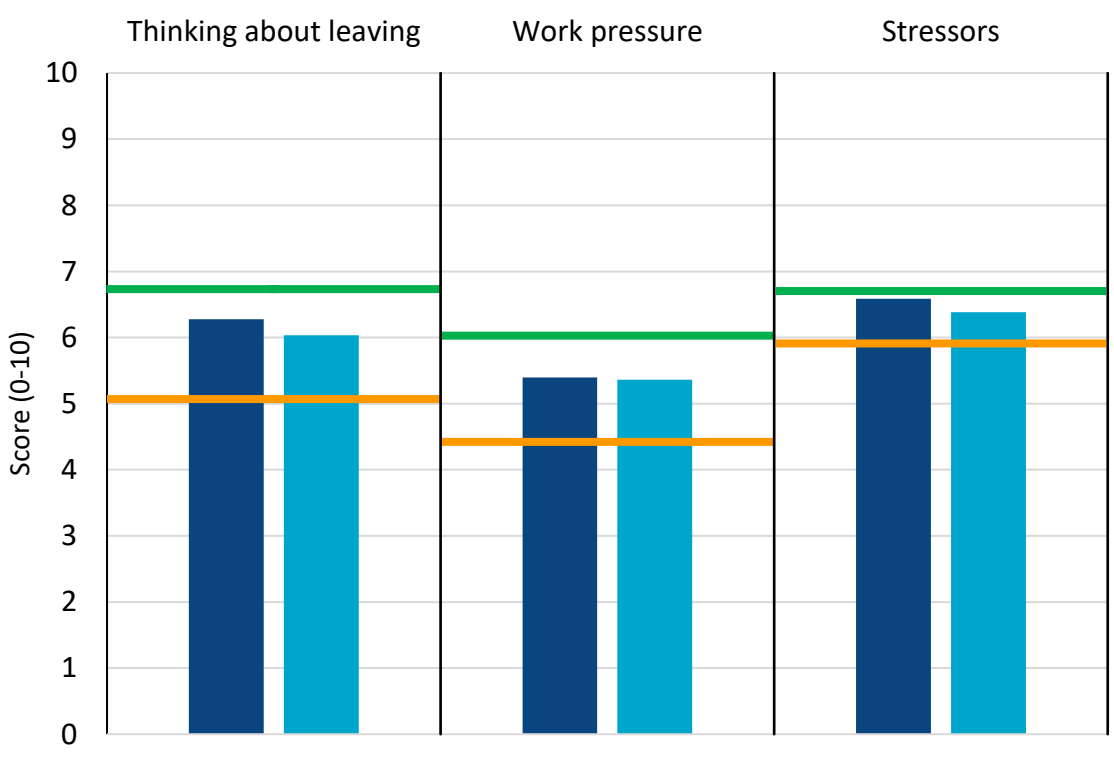
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.23	7.27	6.60
Best result	7.33	7.27	7.90
Average result	6.98	6.83	6.70
Worst result	6.49	6.20	5.24
Responses	1410	1422	1411

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.28	5.40	6.59
Best result	6.73	6.03	6.70
Average result	6.04	5.36	6.38
Worst result	5.07	4.42	5.91
Responses	1411	1422	1421

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores: Trends

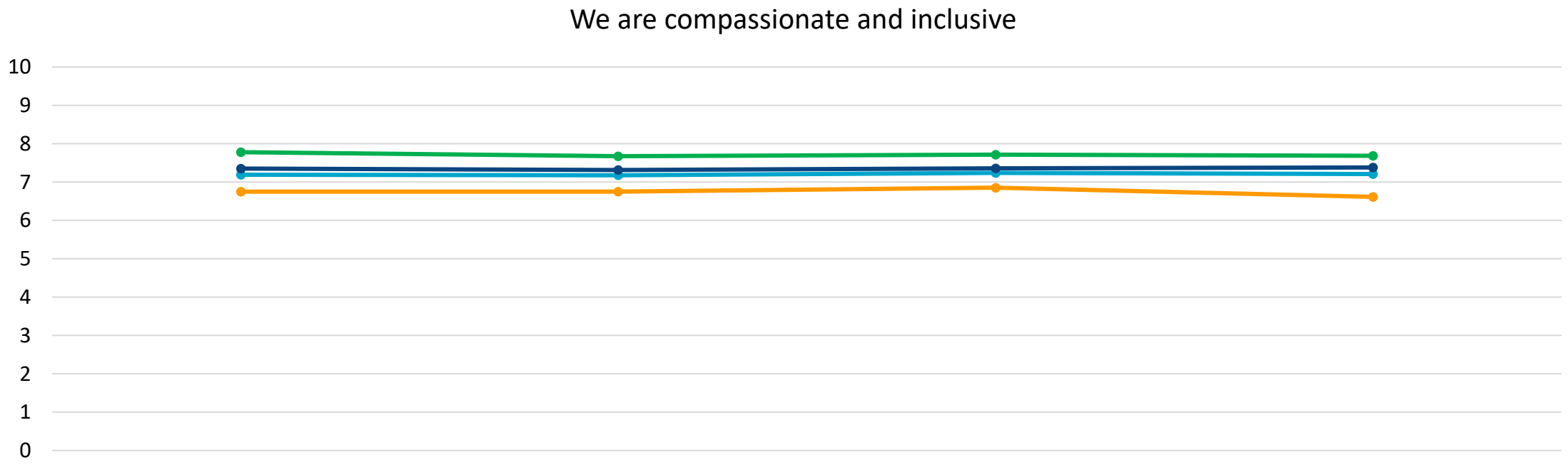
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022	2023	2024
Your org	7.35	7.31	7.36	7.38
Best result	7.78	7.67	7.72	7.69
Average result	7.19	7.18	7.24	7.21
Worst result	6.75	6.75	6.85	6.61
Responses	1282	1247	1350	1420

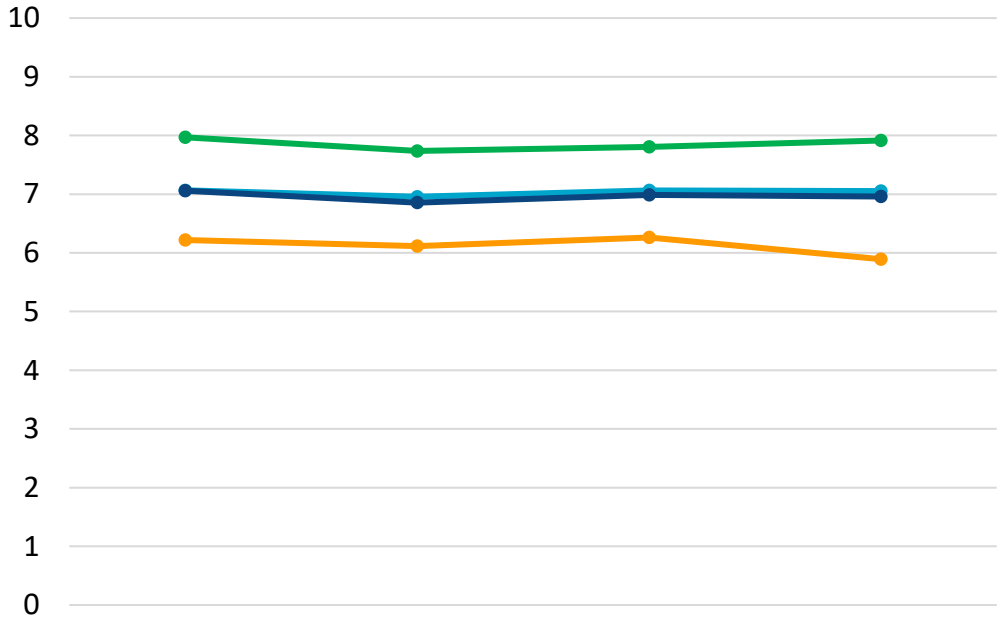
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

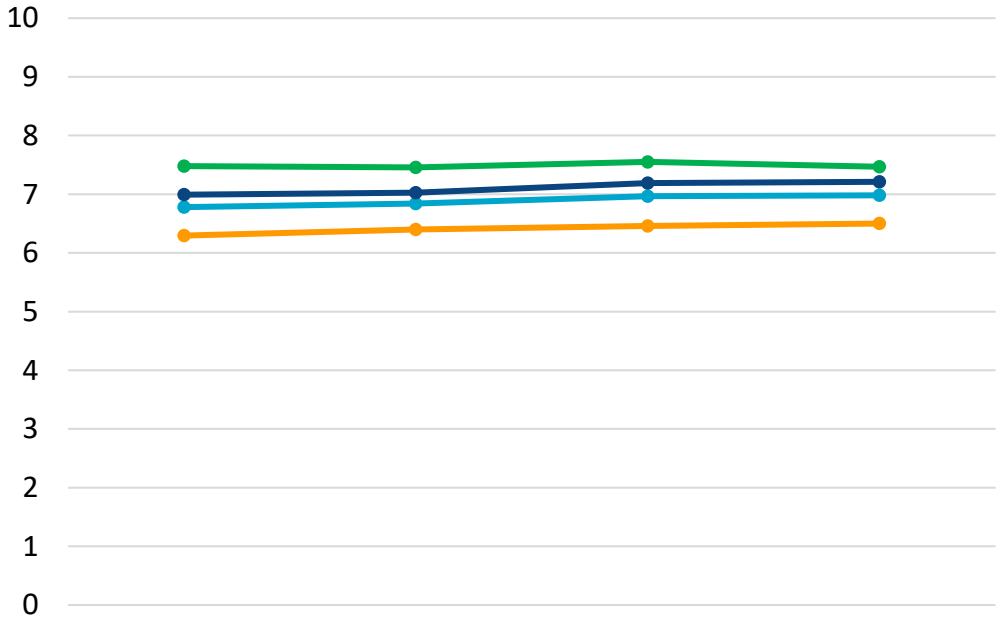
Promise element 1: We are compassionate and inclusive (1)

Compassionate culture



	2021	2022	2023	2024
Your org	7.06	6.86	6.99	6.96
Best result	7.97	7.74	7.81	7.91
Average result	7.07	6.96	7.06	7.05
Worst result	6.22	6.12	6.26	5.89
Responses	1272	1245	1342	1411

Compassionate leadership



	2021	2022	2023	2024
Your org	6.99	7.03	7.19	7.21
Best result	7.48	7.46	7.55	7.47
Average result	6.78	6.84	6.96	6.98
Worst result	6.30	6.40	6.46	6.50
Responses	1278	1246	1349	1421

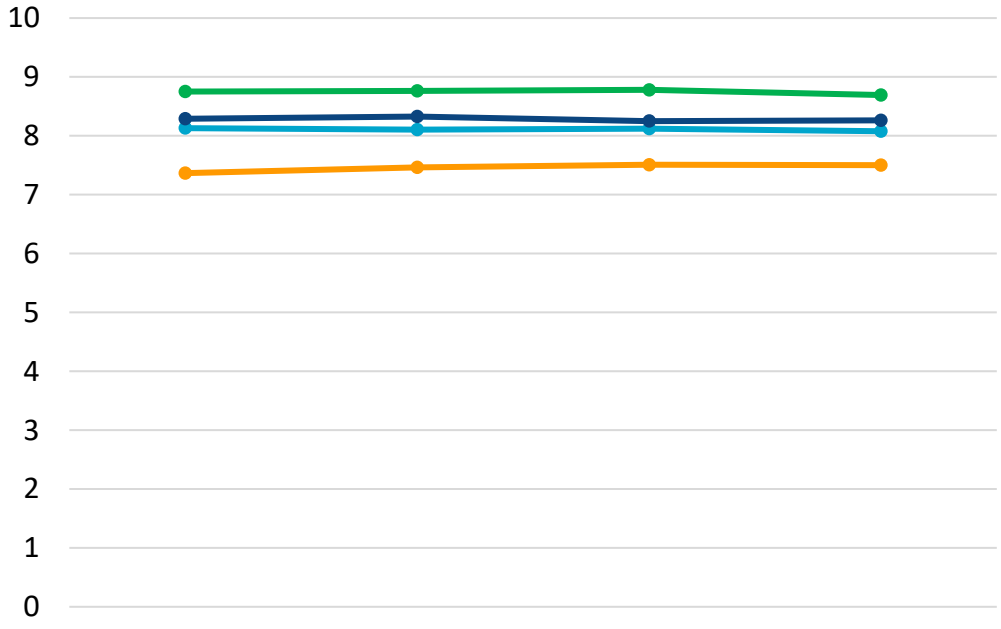
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

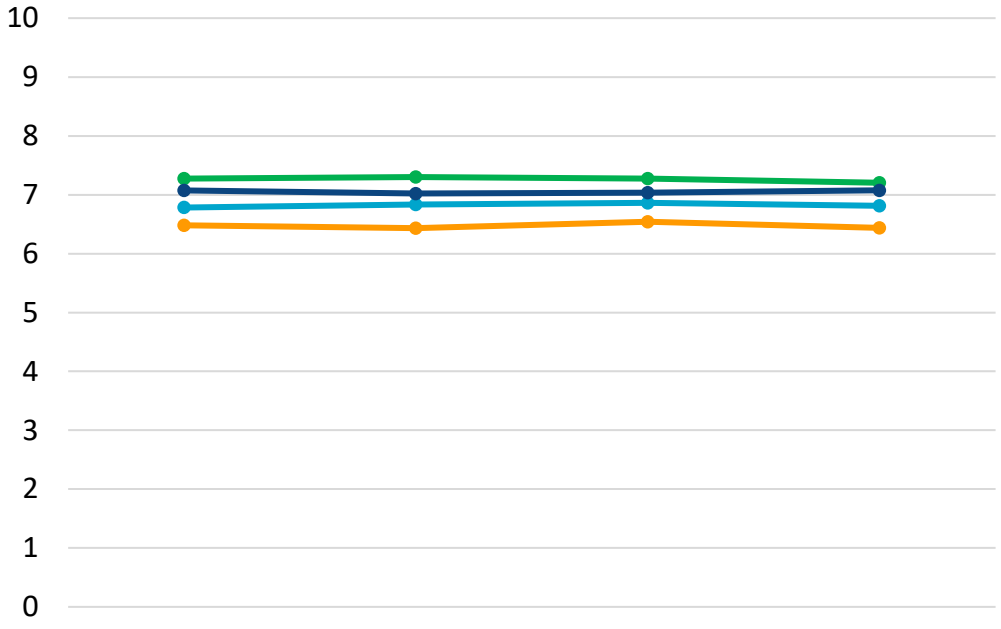
Promise element 1: We are compassionate and inclusive (2)

Diversity and equality



	2021	2022	2023	2024
Your org	8.29	8.33	8.25	8.26
Best result	8.75	8.76	8.78	8.69
Average result	8.13	8.10	8.12	8.08
Worst result	7.37	7.46	7.51	7.50
Responses	1281	1248	1341	1413

Inclusion



	2021	2022	2023	2024
Your org	7.07	7.02	7.03	7.08
Best result	7.28	7.30	7.27	7.20
Average result	6.78	6.84	6.86	6.81
Worst result	6.48	6.43	6.54	6.44
Responses	1274	1243	1346	1412

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded

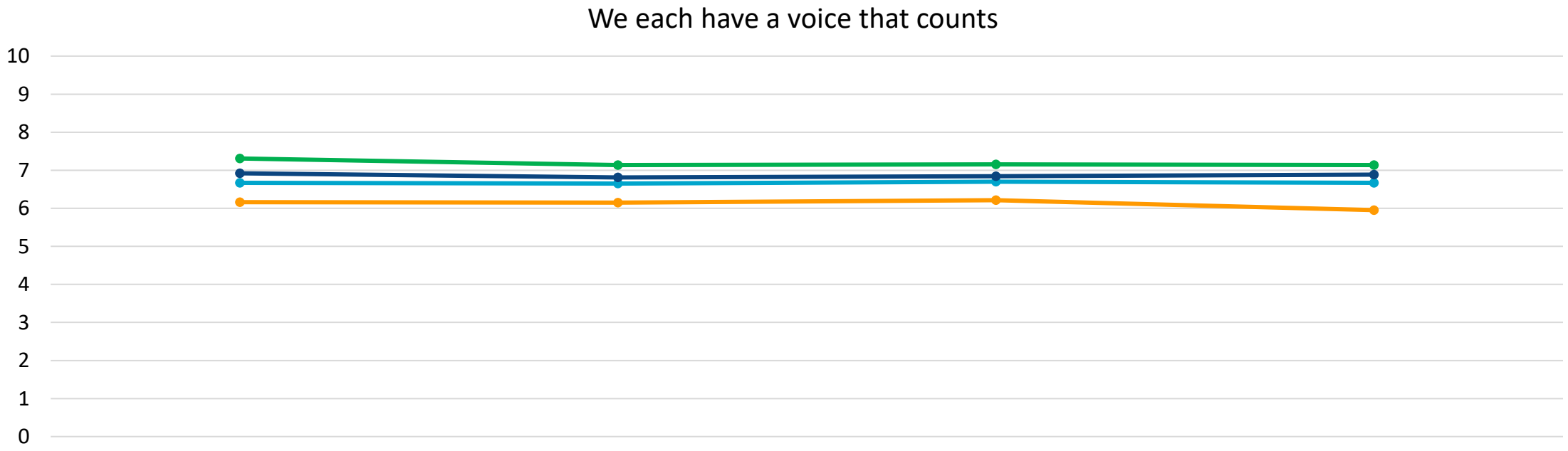
	2021	2022	2023	2024
Your org	6.10	5.94	6.17	6.20
Best result	6.47	6.36	6.37	6.30
Average result	5.81	5.72	5.94	5.92
Worst result	5.33	5.24	5.49	5.24
Responses	1277	1246	1351	1422

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022	2023	2024
Your org	6.92	6.81	6.85	6.89
Best result	7.31	7.14	7.16	7.14
Average result	6.67	6.65	6.70	6.67
Worst result	6.16	6.15	6.21	5.95
Responses	1260	1229	1315	1402

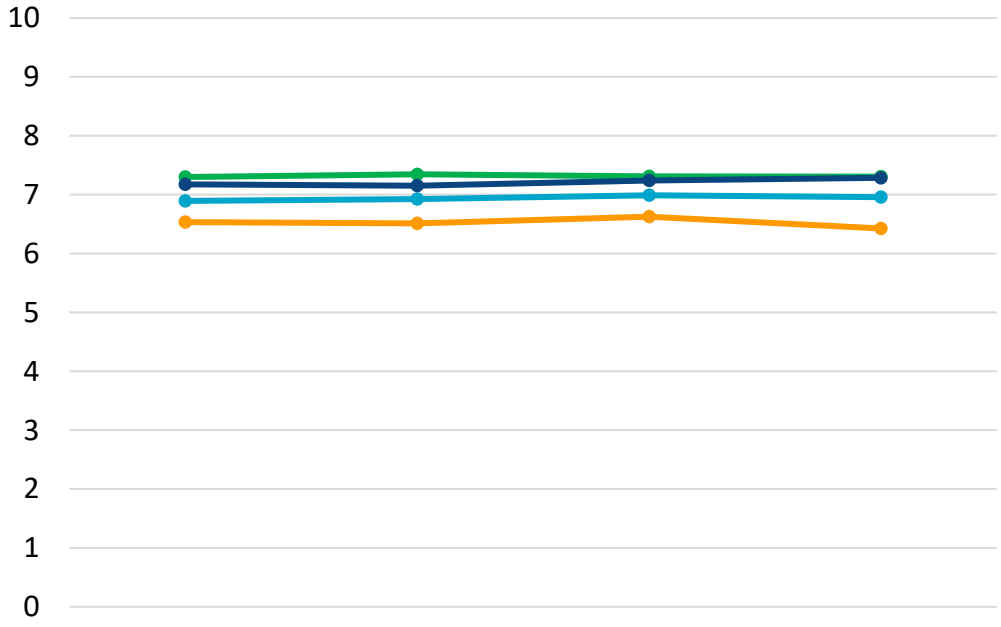
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

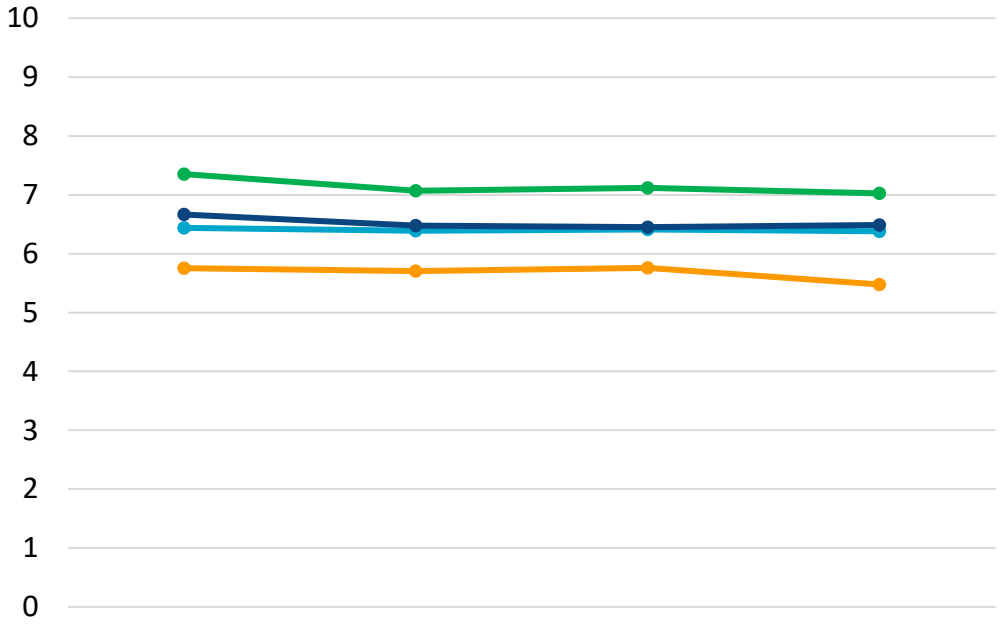
Promise element 3: We each have a voice that counts

Autonomy and control



	2021	2022	2023	2024
Your org	7.18	7.15	7.24	7.29
Best result	7.30	7.35	7.31	7.31
Average result	6.89	6.93	6.99	6.96
Worst result	6.53	6.51	6.63	6.43
Responses	1281	1246	1349	1422

Raising concerns



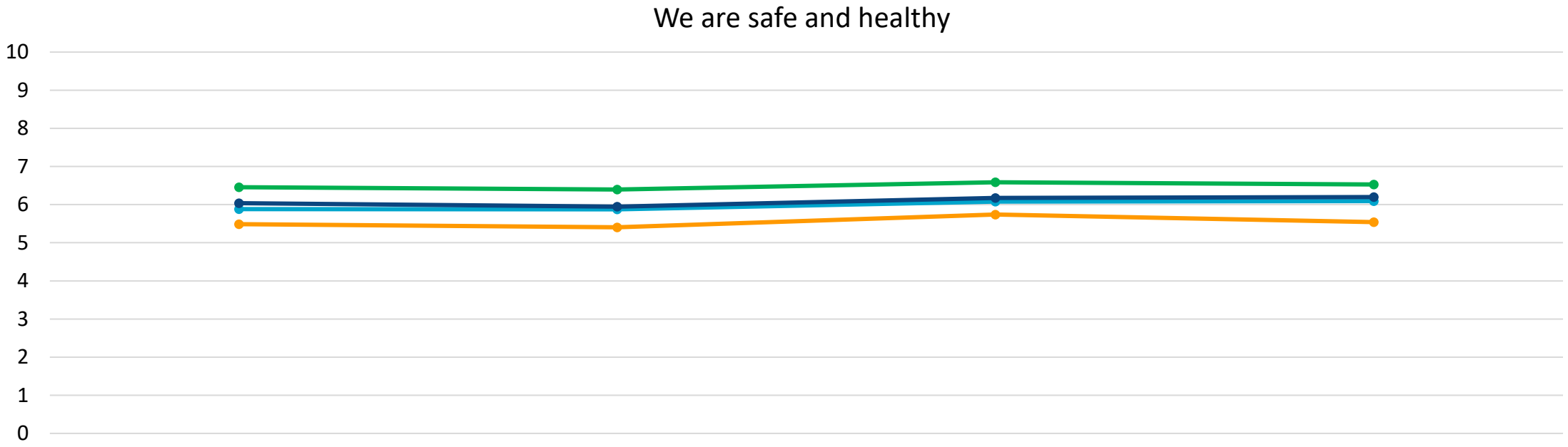
	2021	2022	2023	2024
Your org	6.66	6.48	6.45	6.49
Best result	7.35	7.07	7.12	7.02
Average result	6.44	6.39	6.41	6.38
Worst result	5.75	5.70	5.76	5.48
Responses	1262	1237	1320	1404

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	2021	2022	2023	2024
Your org	6.04	5.95	6.17	6.20
Best result	6.46	6.40	6.59	6.53
Average result	5.88	5.88	6.08	6.09
Worst result	5.49	5.41	5.74	5.54
Responses	1271	1231	1323	1407

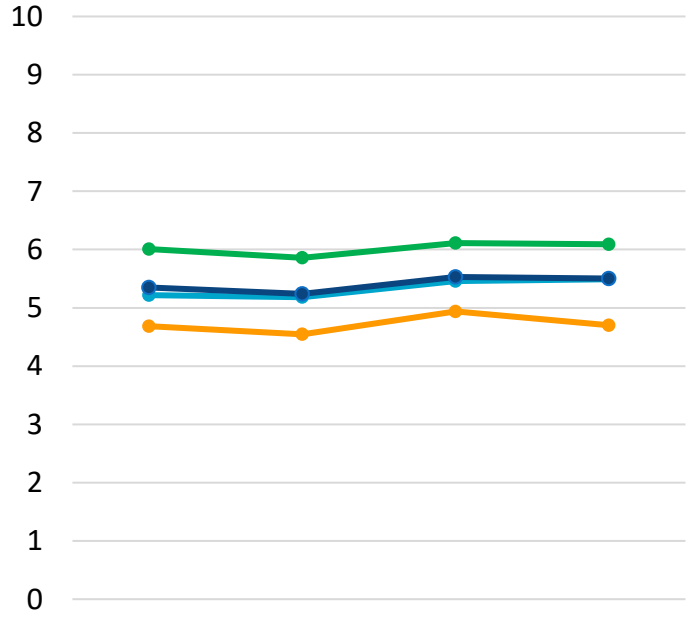
Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

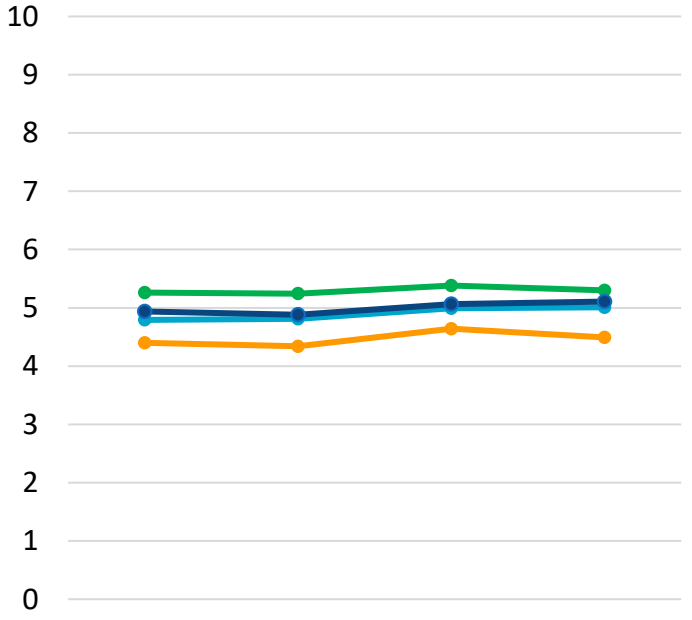
Promise element 4: We are safe and healthy

Health and safety climate



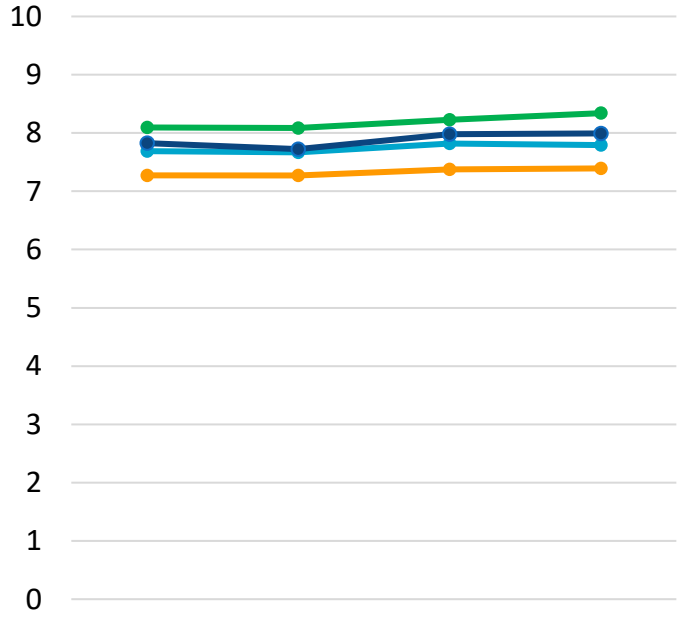
	2021	2022	2023	2024
Your org	5.35	5.24	5.53	5.51
Best result	6.01	5.86	6.11	6.09
Average result	5.21	5.18	5.46	5.49
Worst result	4.68	4.55	4.94	4.70
Responses	1283	1245	1348	1422

Burnout



	2021	2022	2023	2024
Your org	4.94	4.88	5.06	5.11
Best result	5.26	5.24	5.38	5.30
Average result	4.79	4.81	4.99	5.01
Worst result	4.40	4.34	4.64	4.50
Responses	1280	1244	1339	1414

Negative experiences



	2021	2022	2023	2024
Your org	7.82	7.72	7.98	7.99
Best result	8.10	8.09	8.23	8.34
Average result	7.69	7.67	7.82	7.79
Worst result	7.27	7.27	7.38	7.39
Responses	1274	1245	1334	1414

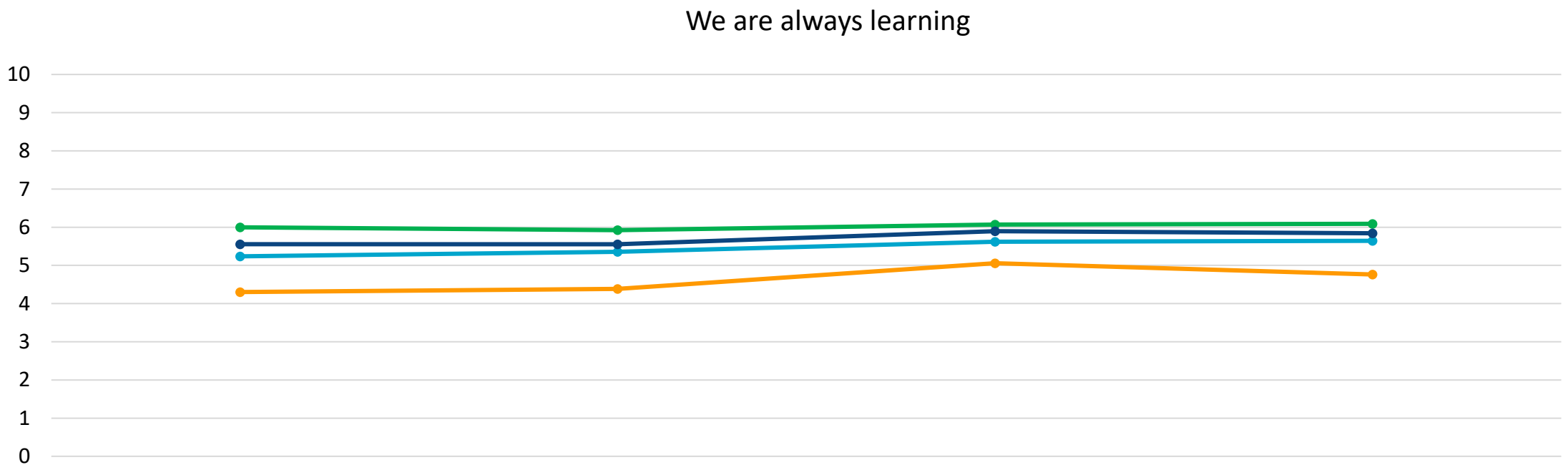
Note: 2023 results for 'Health and safety climate' and 'Negative experiences' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning



	2021	2022	2023	2024
Your org	5.55	5.56	5.90	5.84
Best result	6.00	5.92	6.07	6.09
Average result	5.24	5.35	5.62	5.64
Worst result	4.30	4.39	5.06	4.76
Responses	1182	1203	1293	1358

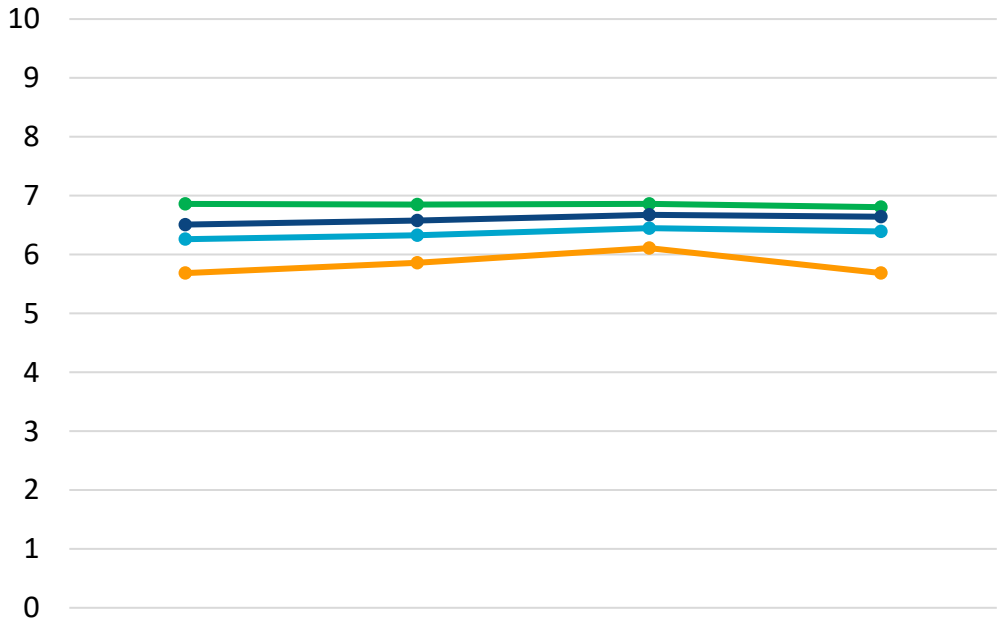
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

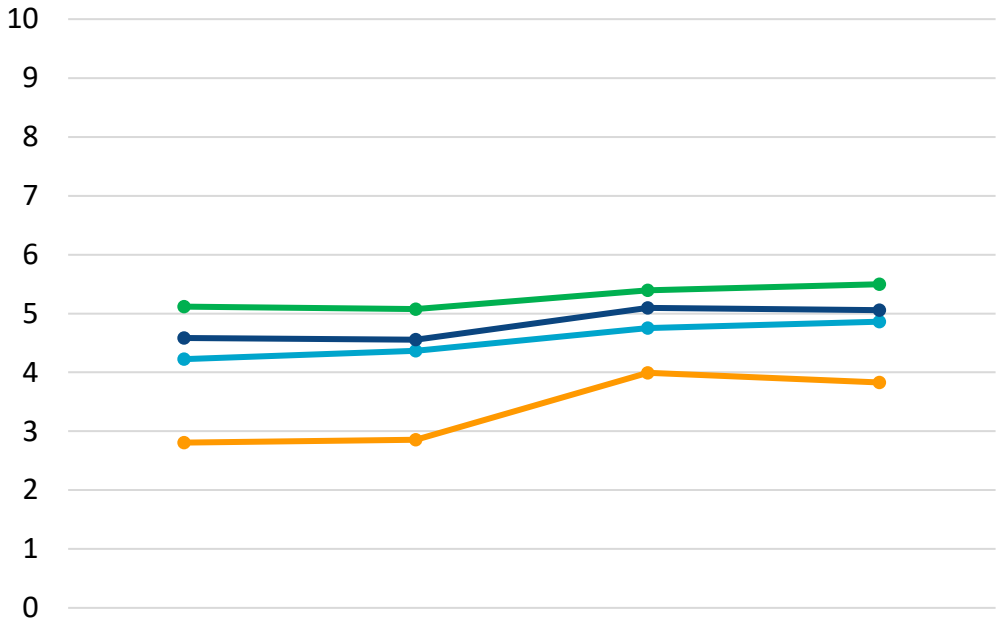
Promise element 5: We are always learning

Development



	2021	2022	2023	2024
Your org	6.51	6.58	6.67	6.64
Best result	6.86	6.85	6.86	6.80
Average result	6.26	6.33	6.45	6.40
Worst result	5.68	5.86	6.11	5.69
Responses	1271	1249	1343	1410

Appraisals



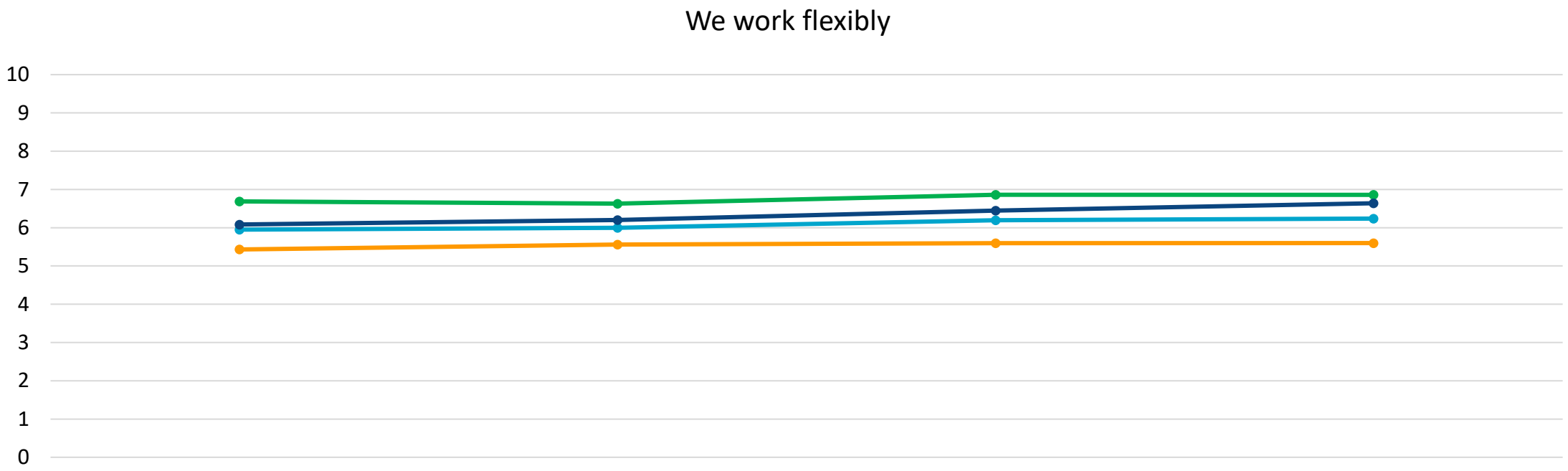
	2021	2022	2023	2024
Your org	4.58	4.55	5.10	5.06
Best result	5.12	5.08	5.40	5.50
Average result	4.23	4.37	4.75	4.86
Worst result	2.81	2.85	3.99	3.83
Responses	1188	1208	1297	1361

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	2021	2022	2023	2024
Your org	6.08	6.20	6.45	6.64
Best result	6.69	6.63	6.86	6.86
Average result	5.95	6.00	6.20	6.24
Worst result	5.43	5.56	5.60	5.60
Responses	1271	1241	1341	1413

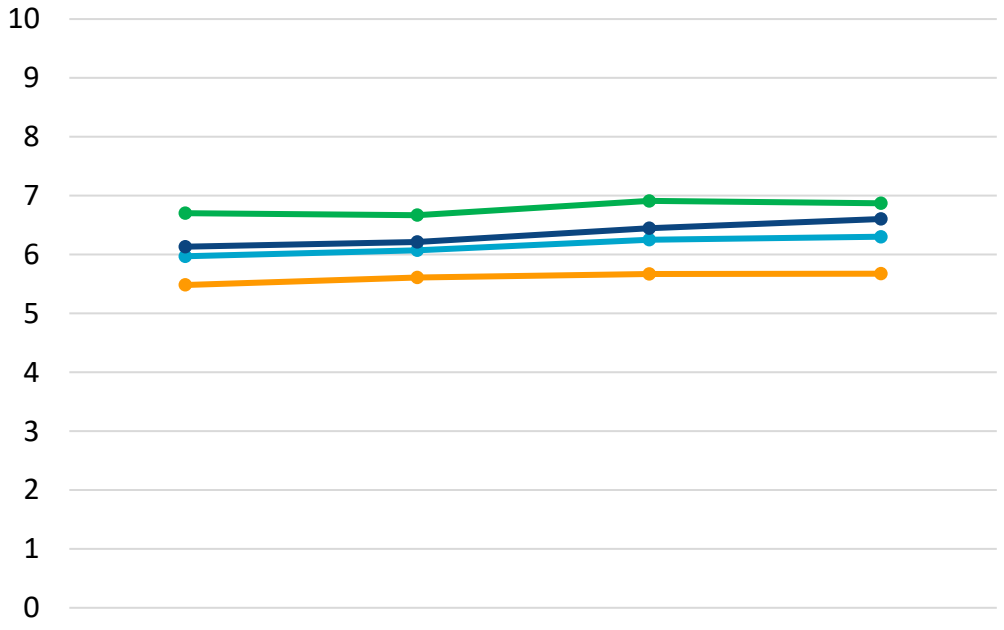
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

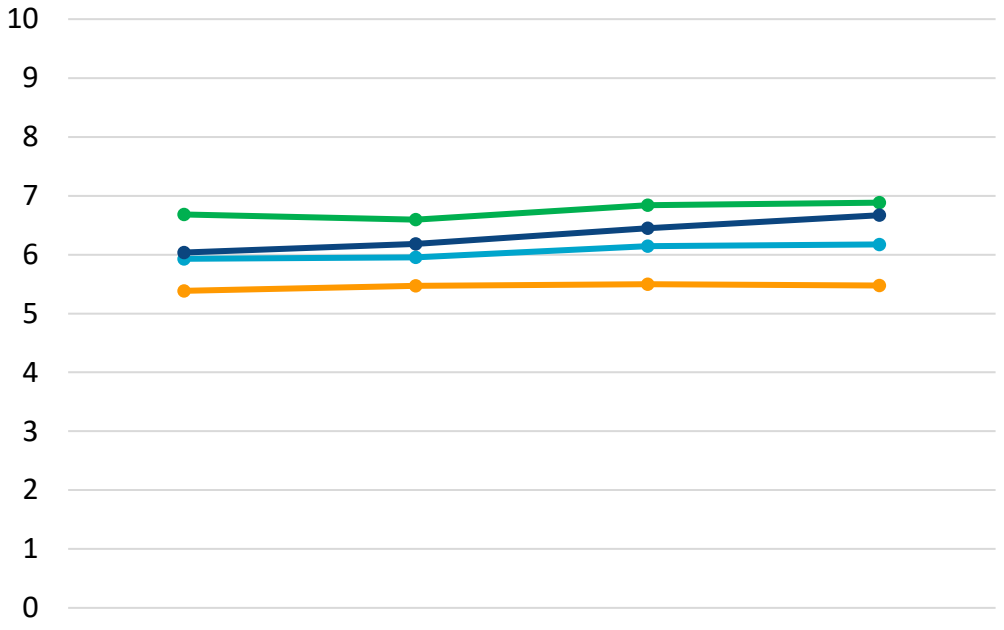
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022	2023	2024
Your org	6.13	6.21	6.44	6.60
Best result	6.70	6.67	6.91	6.87
Average result	5.97	6.07	6.25	6.30
Worst result	5.48	5.61	5.67	5.67
Responses	1281	1246	1350	1417

Flexible working



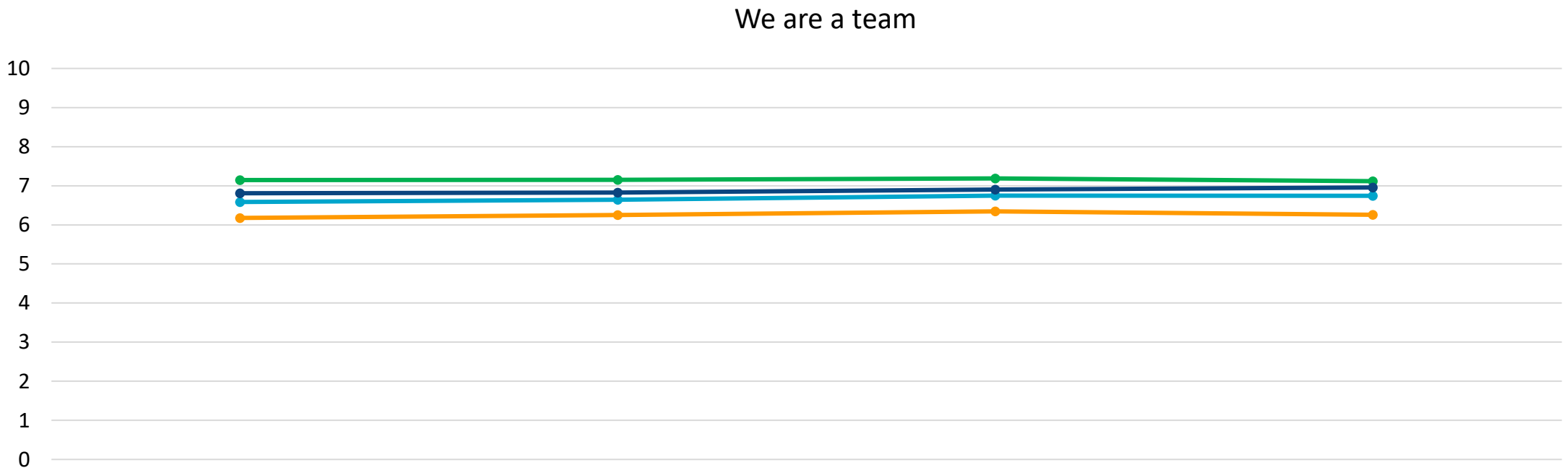
	2021	2022	2023	2024
Your org	6.04	6.18	6.45	6.67
Best result	6.68	6.59	6.84	6.88
Average result	5.93	5.95	6.15	6.17
Worst result	5.39	5.47	5.50	5.47
Responses	1273	1244	1343	1418

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



	2021	2022	2023	2024
Your org	6.81	6.82	6.90	6.96
Best result	7.15	7.15	7.19	7.12
Average result	6.58	6.64	6.75	6.74
Worst result	6.18	6.25	6.34	6.26
Responses	1275	1244	1350	1418

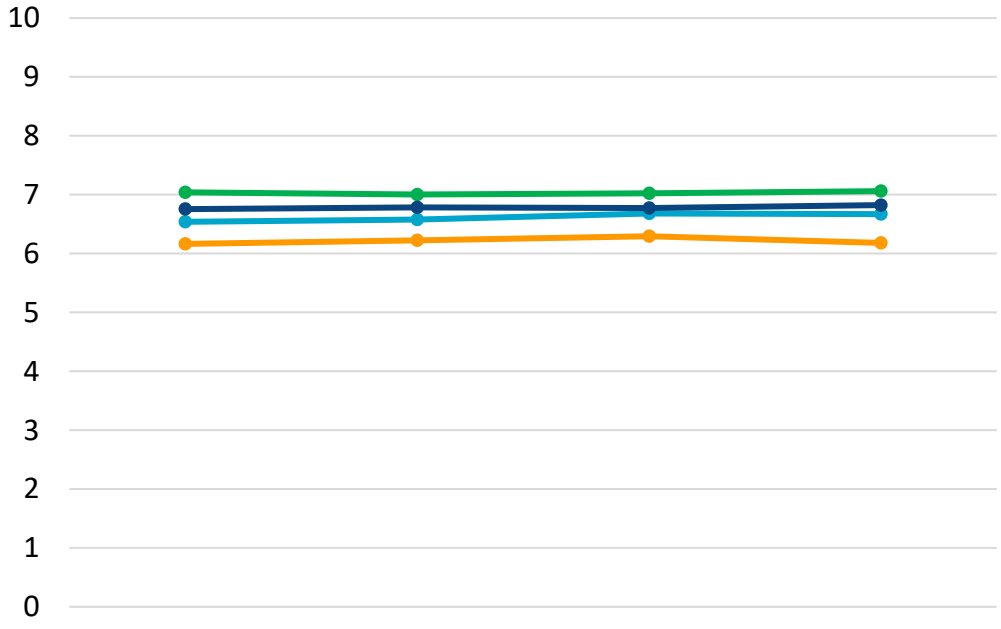
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

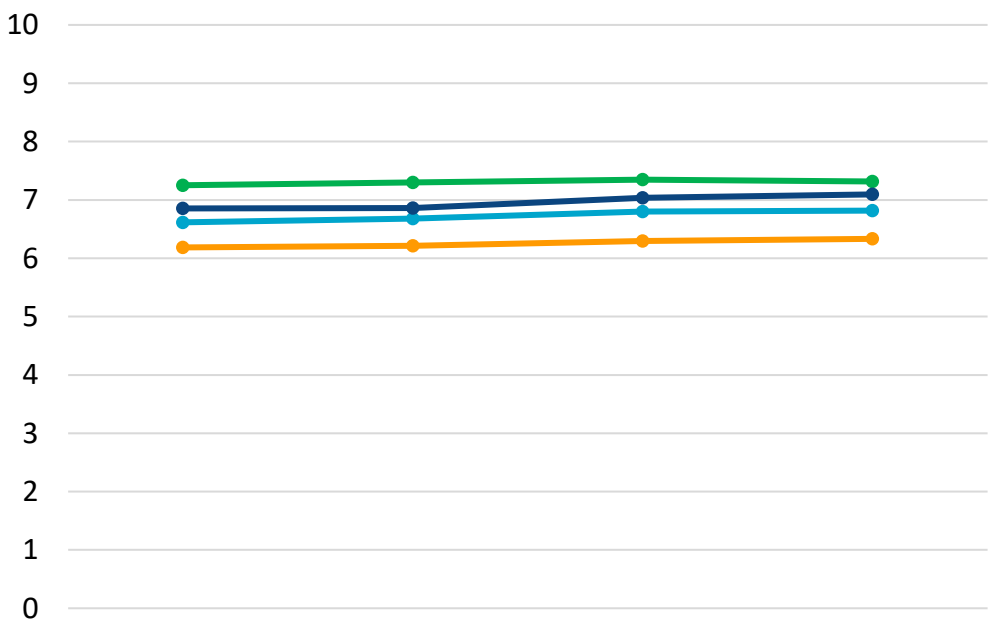
Promise element 7: We are a team

Team working



	2021	2022	2023	2024
Your org	6.75	6.78	6.77	6.82
Best result	7.04	7.00	7.02	7.06
Average result	6.54	6.58	6.68	6.67
Worst result	6.16	6.22	6.29	6.18
Responses	1280	1246	1351	1421

Line management



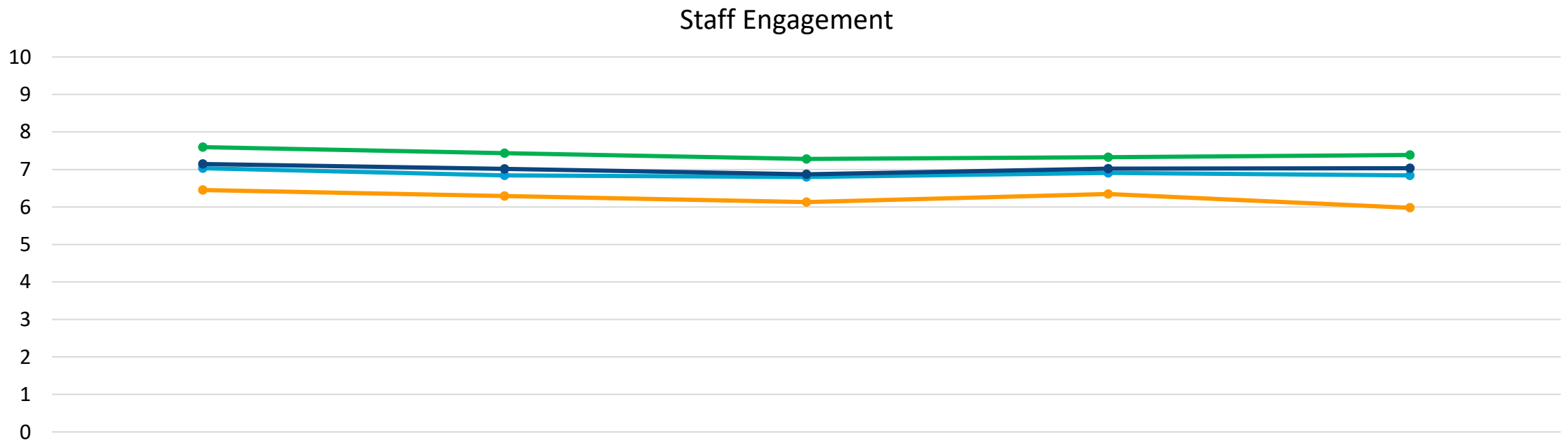
	2021	2022	2023	2024
Your org	6.85	6.86	7.03	7.09
Best result	7.25	7.30	7.35	7.31
Average result	6.62	6.68	6.80	6.82
Worst result	6.19	6.21	6.30	6.33
Responses	1278	1246	1350	1419

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



	2020	2021	2022	2023	2024
Your org	7.15	7.01	6.87	7.02	7.03
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	540	1282	1250	1353	1421

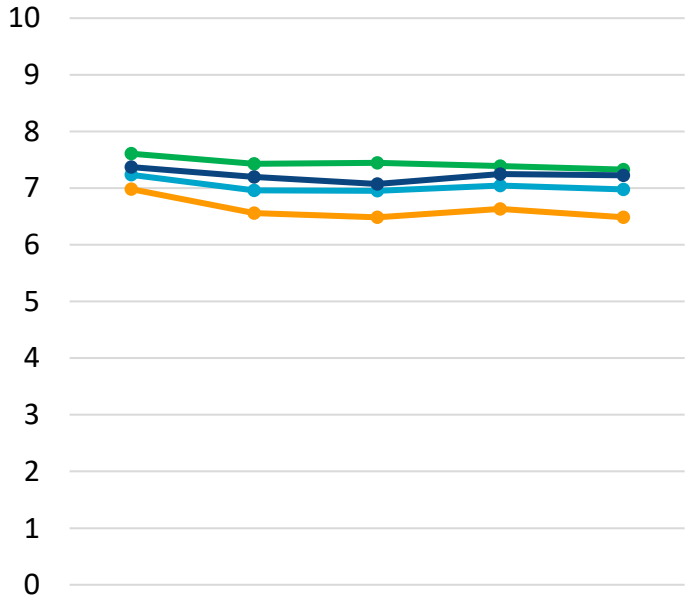
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

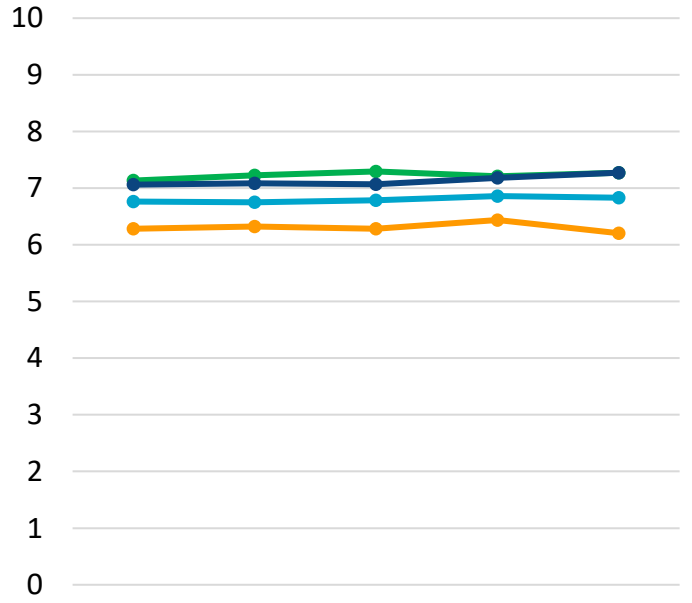
Theme: Staff Engagement

Motivation



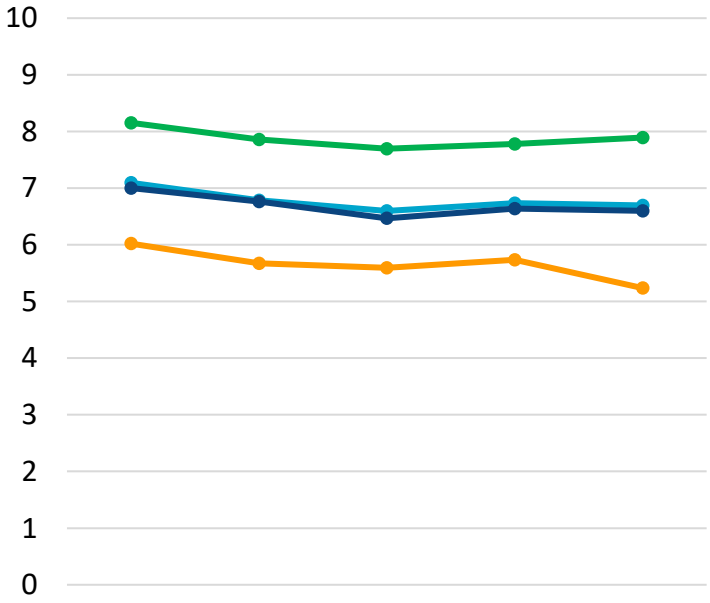
	2020	2021	2022	2023	2024
Your org	7.37	7.20	7.07	7.25	7.23
Best result	7.61	7.43	7.45	7.39	7.33
Average result	7.24	6.96	6.95	7.05	6.98
Worst result	6.98	6.56	6.49	6.63	6.49
Responses	538	1269	1236	1341	1410

Involvement



	2020	2021	2022	2023	2024
Your org	7.06	7.09	7.07	7.18	7.27
Best result	7.13	7.23	7.29	7.21	7.27
Average result	6.76	6.75	6.78	6.86	6.83
Worst result	6.28	6.32	6.28	6.44	6.20
Responses	540	1280	1246	1349	1422

Advocacy



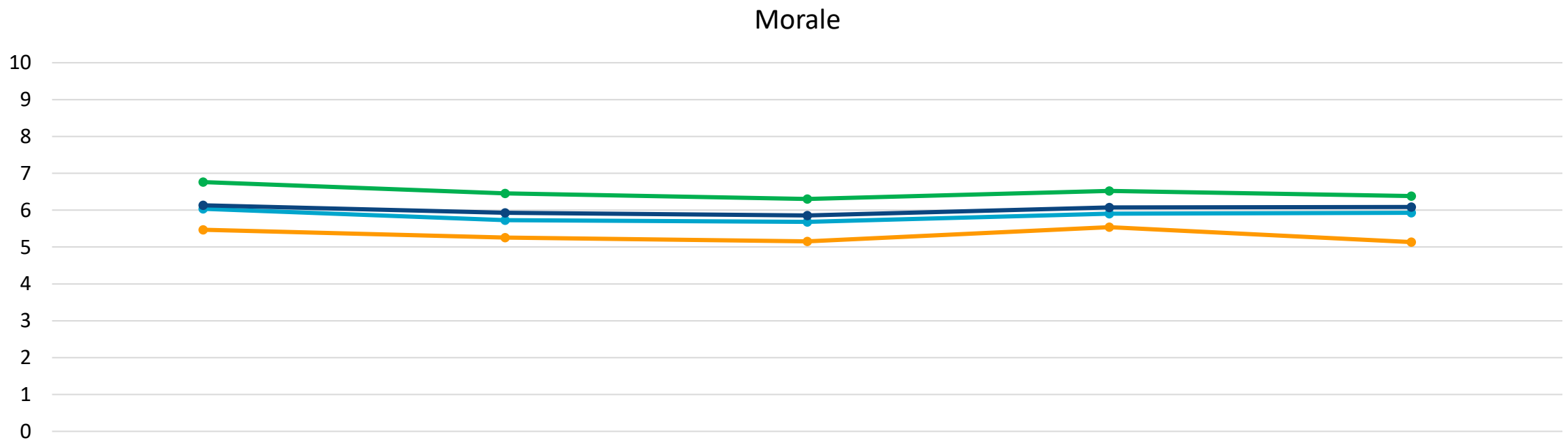
	2020	2021	2022	2023	2024
Your org	7.00	6.76	6.47	6.64	6.60
Best result	8.15	7.86	7.70	7.78	7.90
Average result	7.09	6.78	6.60	6.74	6.70
Worst result	6.02	5.68	5.60	5.73	5.24
Responses	538	1271	1245	1342	1411

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



	2020	2021	2022	2023	2024
Your org	6.13	5.93	5.86	6.07	6.08
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	539	1283	1249	1349	1422

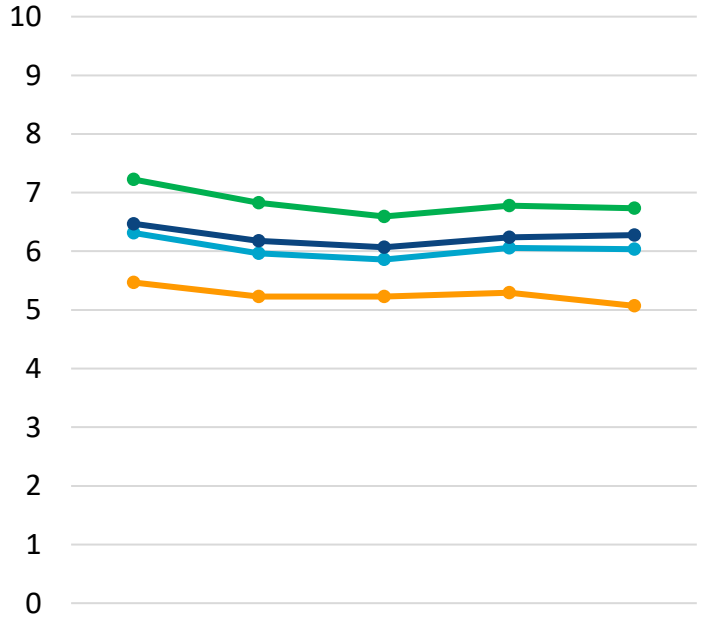
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

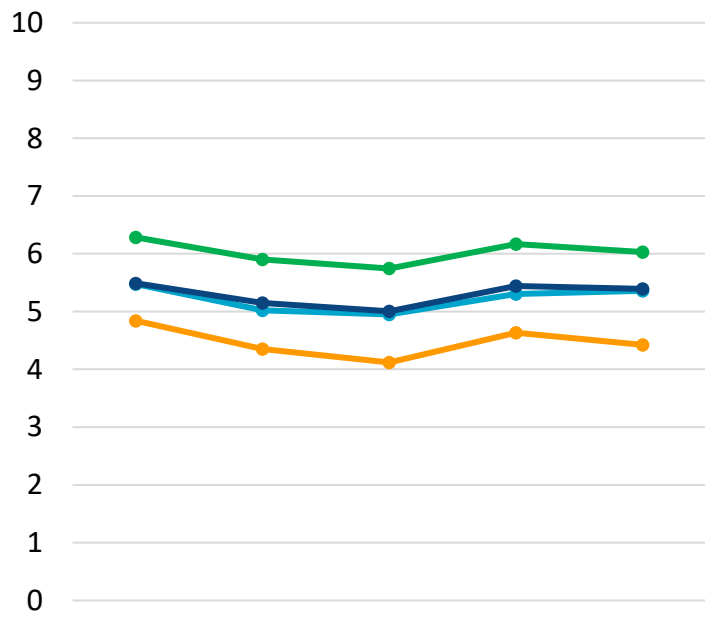
Theme: Morale

Thinking about leaving



	2020	2021	2022	2023	2024
Your org	6.47	6.18	6.07	6.24	6.28
Best result	7.22	6.83	6.59	6.78	6.73
Average result	6.31	5.97	5.86	6.06	6.04
Worst result	5.47	5.23	5.23	5.29	5.07
Responses	537	1268	1248	1340	1411

Work pressure



	2020	2021	2022	2023	2024
Your org	5.49	5.15	5.01	5.44	5.40
Best result	6.28	5.90	5.75	6.17	6.03
Average result	5.48	5.02	4.95	5.30	5.36
Worst result	4.84	4.35	4.12	4.63	4.42
Responses	538	1282	1244	1349	1422

Stressors

	2020	2021	2022	2023	2024
Your org	6.44	6.48	6.47	6.56	6.59
Best result	6.81	6.73	6.71	6.71	6.70
Average result	6.37	6.25	6.29	6.38	6.38
Worst result	5.91	5.90	5.91	6.10	5.91
Responses	536	1280	1246	1347	1421

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive

Questions included:

Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

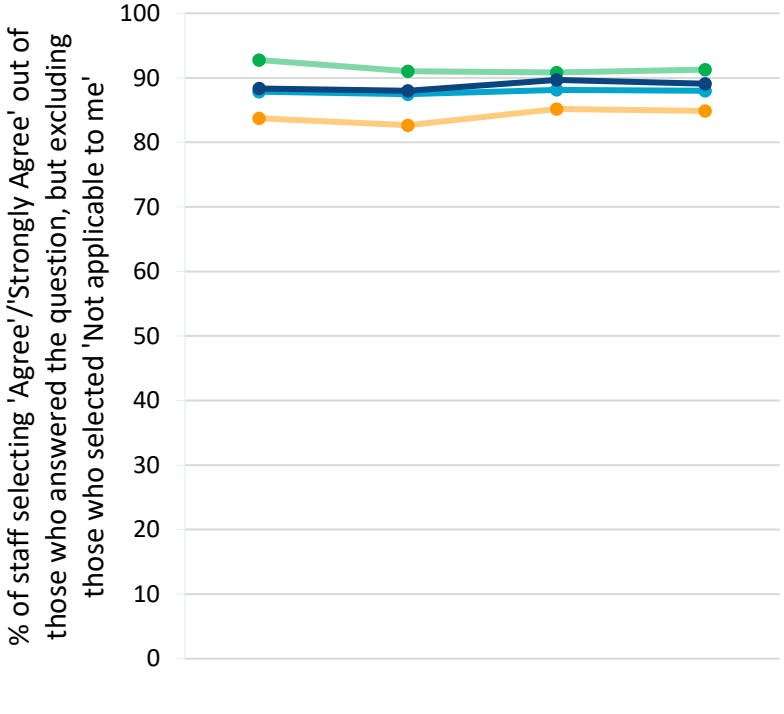
Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

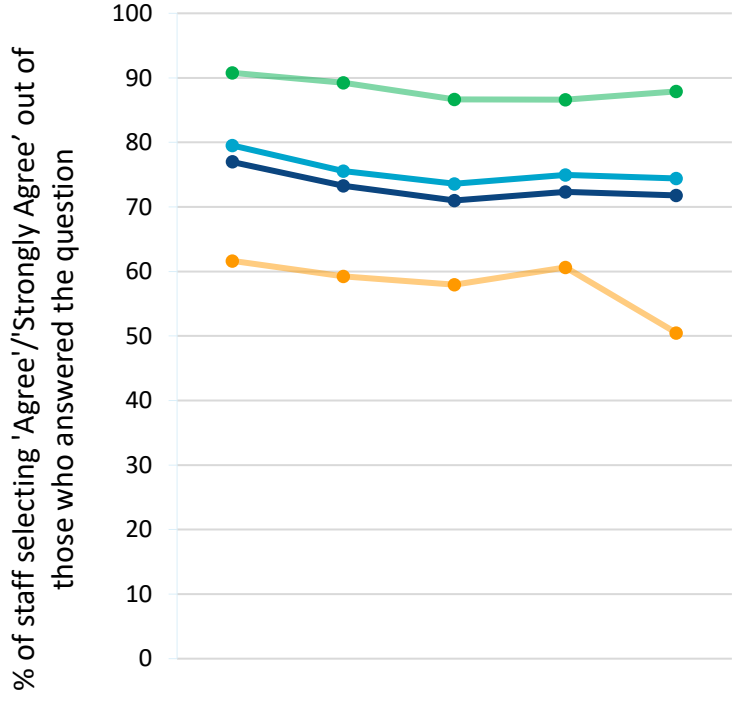
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6a I feel that my role makes a difference to patients / service users.



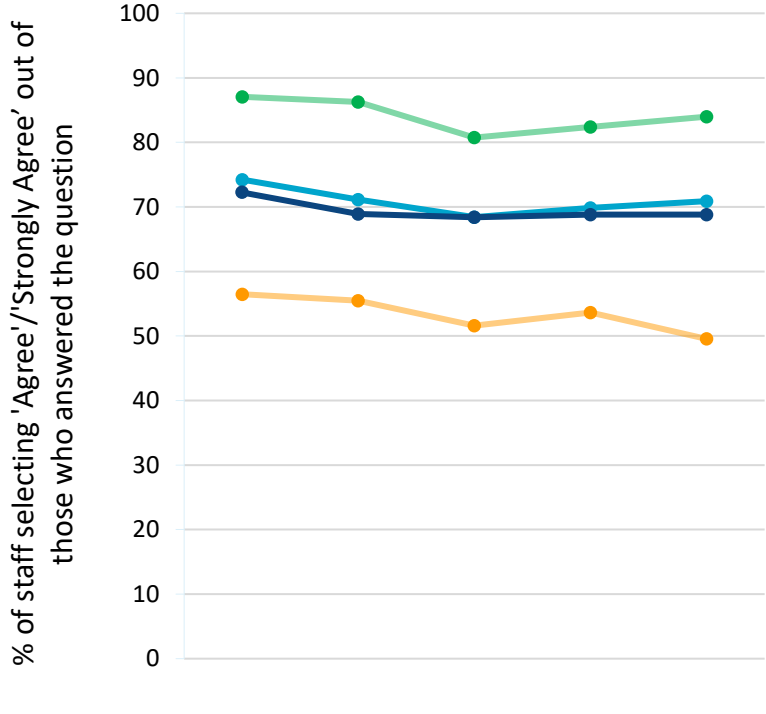
	2021	2022	2023	2024
Your org	88.34%	88.00%	89.68%	89.11%
Best result	92.76%	91.05%	90.84%	91.30%
Average result	87.85%	87.48%	88.13%	88.00%
Worst result	83.73%	82.67%	85.17%	84.88%
Responses	1234	1214	1283	1366

Q25a Care of patients / service users is my organisation's top priority.



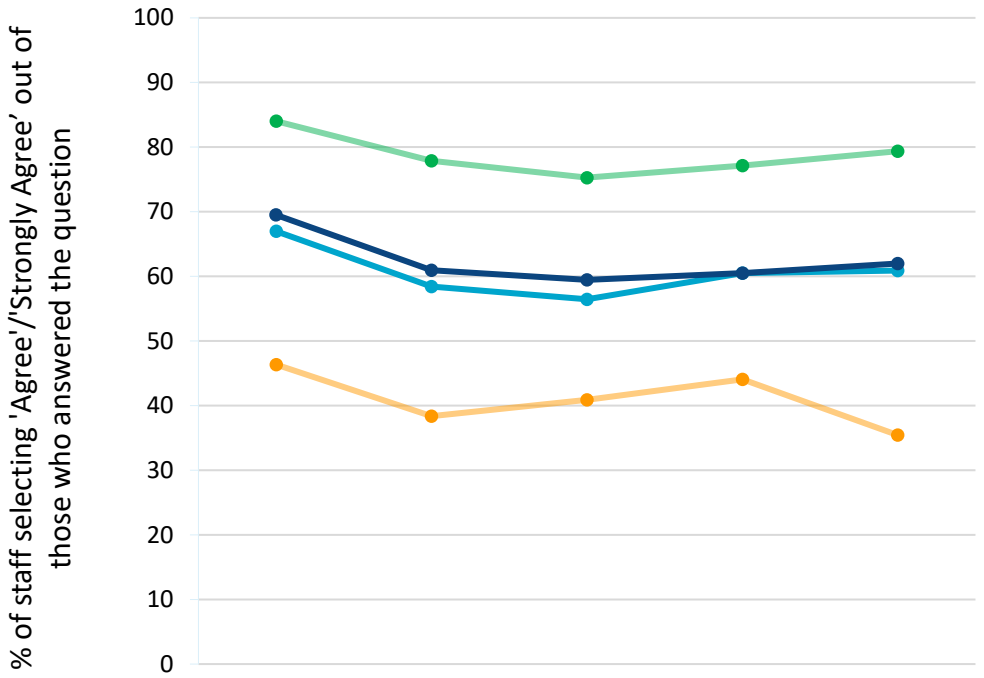
	2020	2021	2022	2023	2024
Your org	76.95%	73.27%	71.00%	72.35%	71.79%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	538	1272	1244	1341	1411

Q25b My organisation acts on concerns raised by patients / service users.



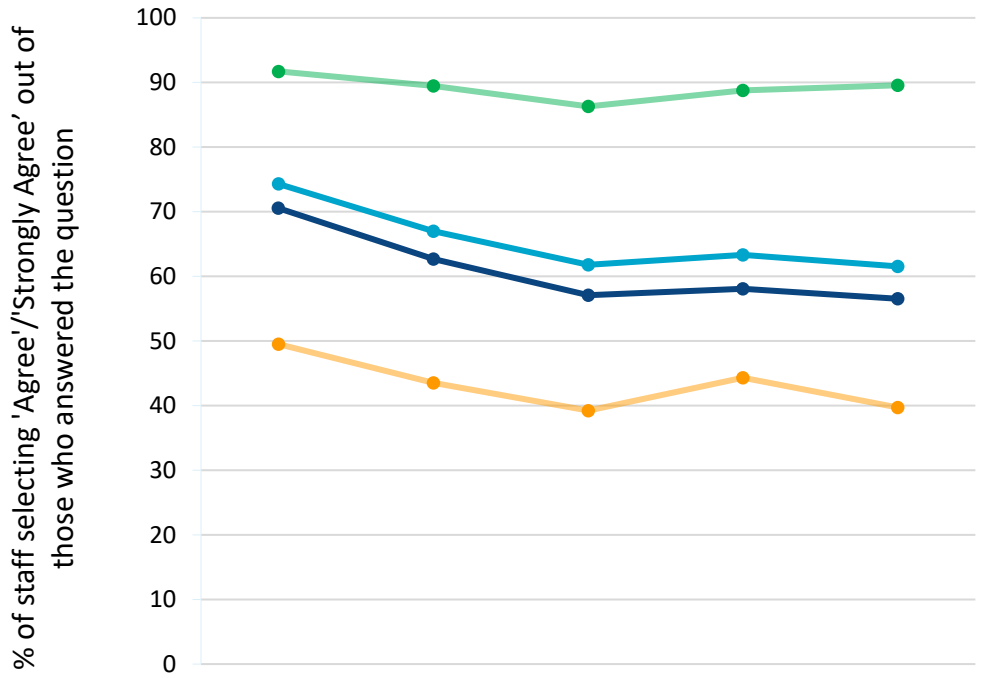
	2020	2021	2022	2023	2024
Your org	72.24%	68.89%	68.40%	68.82%	68.81%
Best result	87.06%	86.29%	80.75%	82.38%	84.00%
Average result	74.23%	71.15%	68.42%	69.86%	70.89%
Worst result	56.47%	55.47%	51.58%	53.65%	49.55%
Responses	538	1268	1243	1335	1407

Q25c I would recommend my organisation as a place to work.



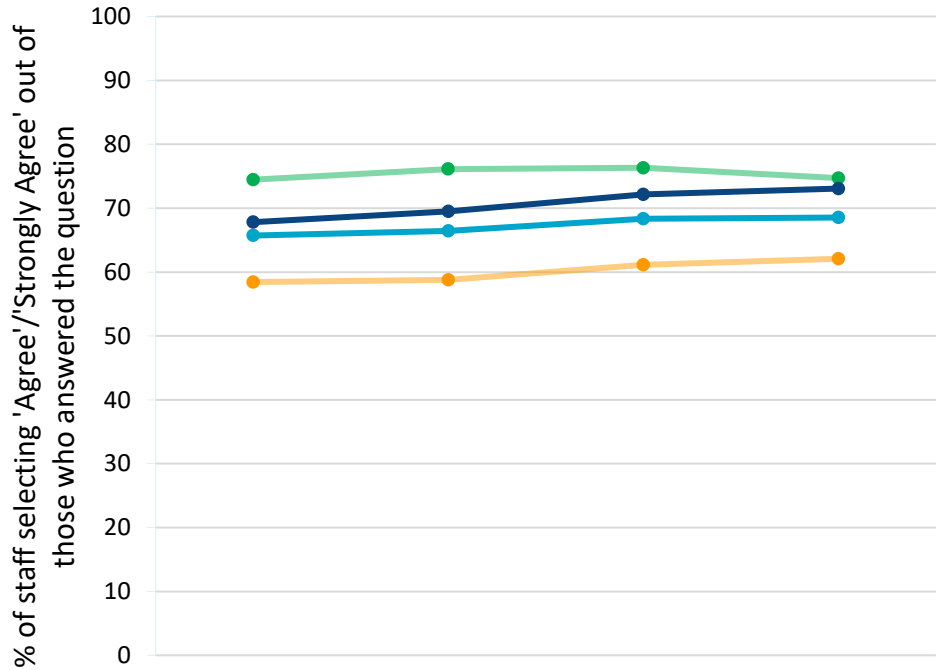
	2020	2021	2022	2023	2024
Your org	69.50%	60.94%	59.46%	60.50%	61.98%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	538	1269	1242	1341	1406

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



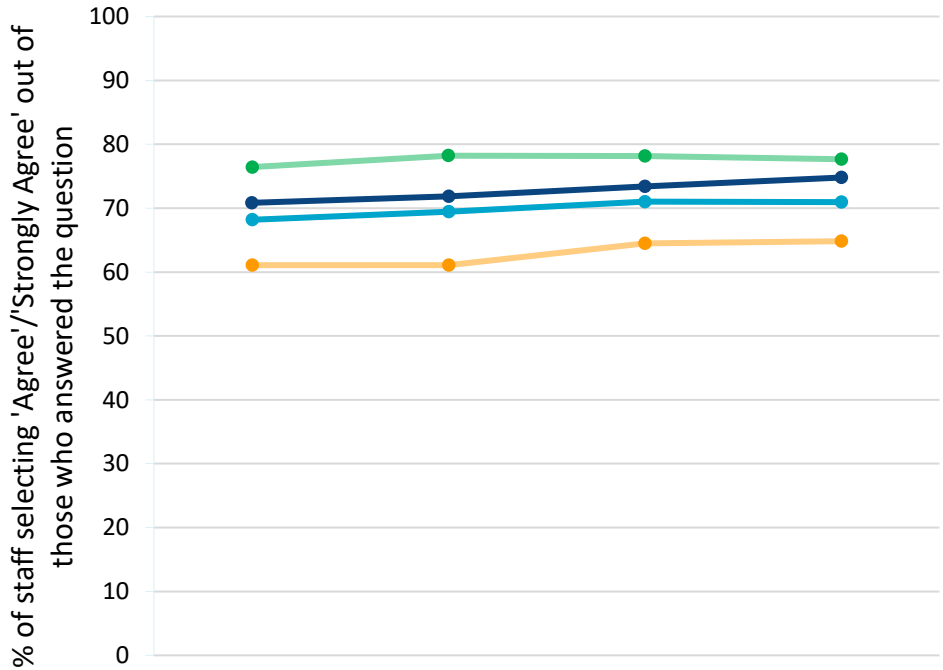
	2020	2021	2022	2023	2024
Your org	70.55%	62.68%	57.09%	58.07%	56.54%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	538	1264	1242	1337	1406

Q9f My immediate manager works together with me to come to an understanding of problems.



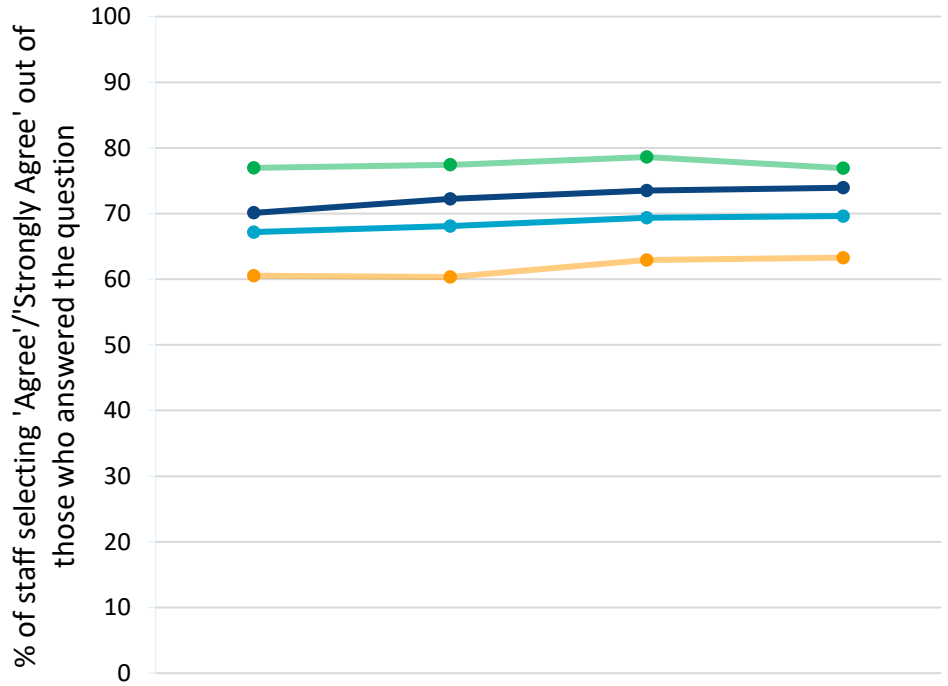
	2021	2022	2023	2024
Your org	67.81%	69.49%	72.15%	73.07%
Best result	74.46%	76.11%	76.33%	74.72%
Average result	65.72%	66.44%	68.34%	68.53%
Worst result	58.44%	58.76%	61.14%	62.08%
Responses	1279	1242	1346	1419

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



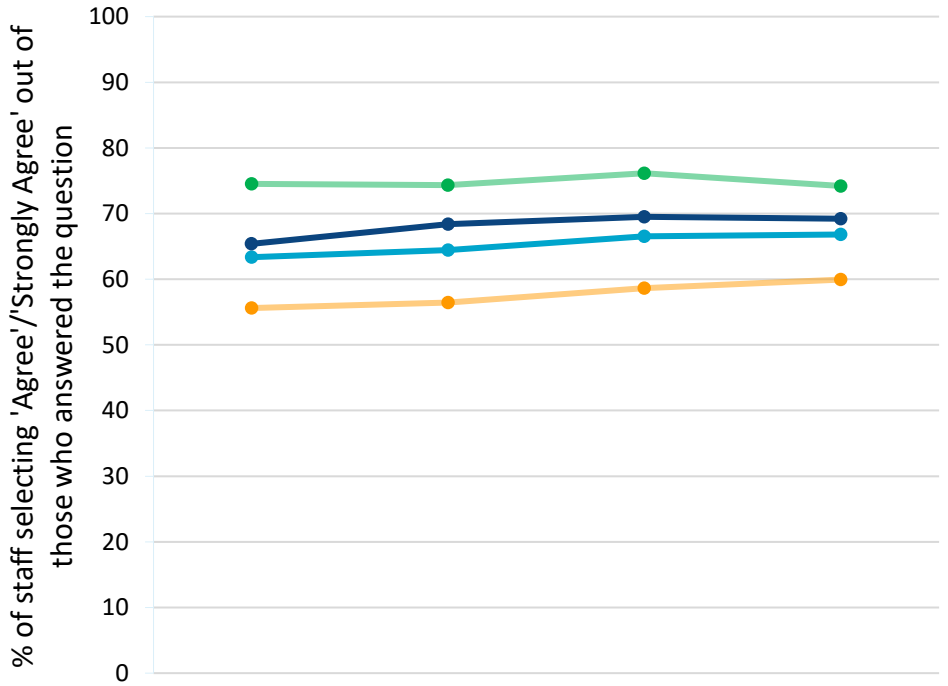
	2021	2022	2023	2024
Your org	70.84%	71.87%	73.41%	74.80%
Best result	76.43%	78.21%	78.15%	77.66%
Average result	68.18%	69.46%	71.02%	70.95%
Worst result	61.07%	61.09%	64.47%	64.83%
Responses	1277	1245	1349	1421

Q9h My immediate manager cares about my concerns.



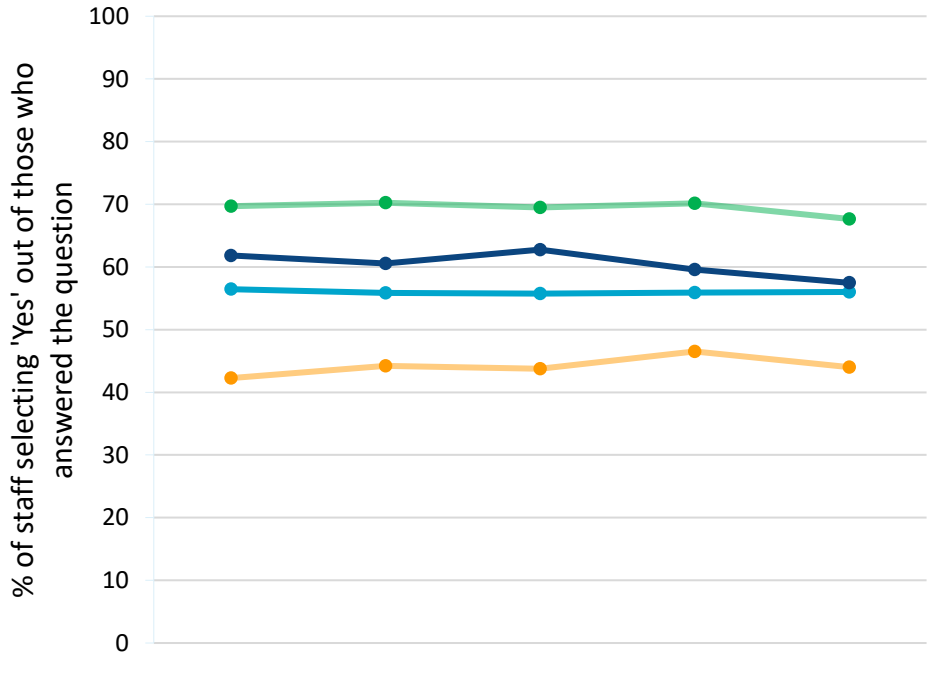
	2021	2022	2023	2024
Your org	70.10%	72.23%	73.53%	73.93%
Best result	76.96%	77.43%	78.61%	76.91%
Average result	67.18%	68.07%	69.37%	69.63%
Worst result	60.55%	60.33%	62.93%	63.29%
Responses	1275	1243	1347	1419

Q9i My immediate manager takes effective action to help me with any problems I face.



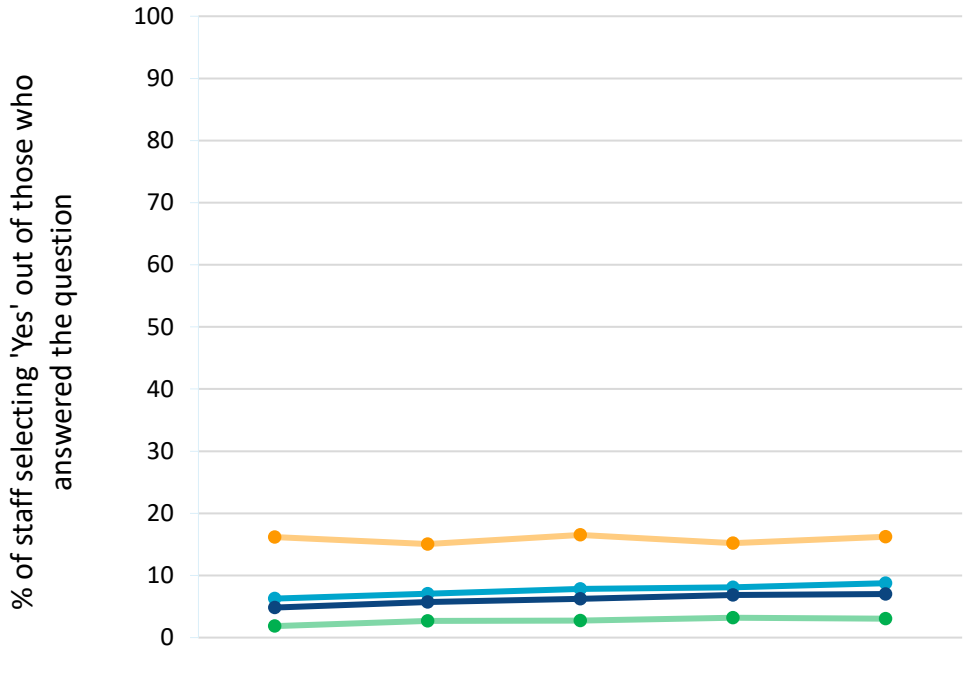
	2021	2022	2023	2024
Your org	65.39%	68.38%	69.51%	69.20%
Best result	74.52%	74.33%	76.14%	74.21%
Average result	63.36%	64.45%	66.52%	66.81%
Worst result	55.61%	56.43%	58.64%	59.94%
Responses	1274	1243	1348	1417

Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



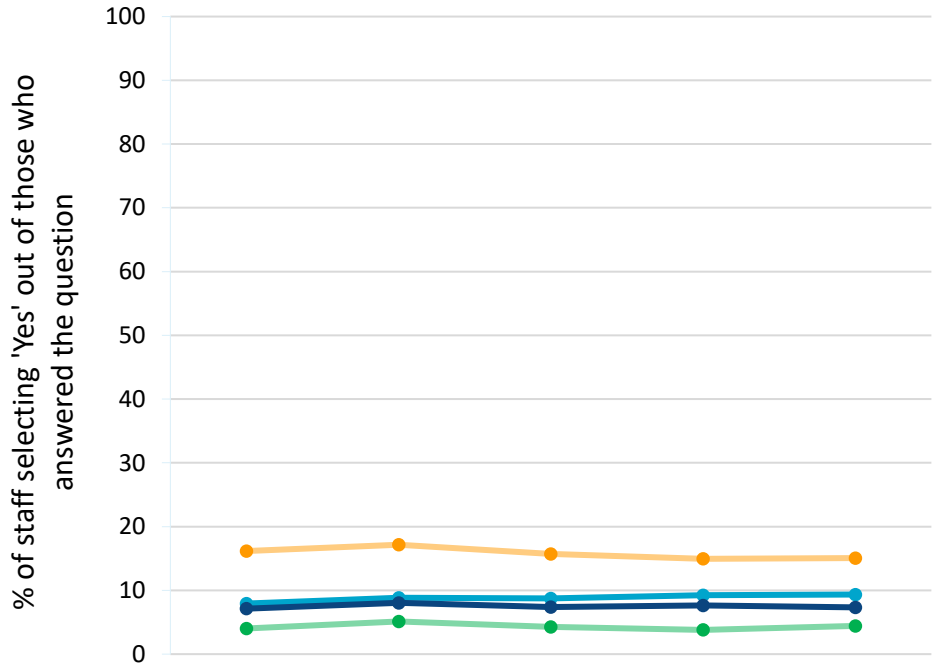
	2020	2021	2022	2023	2024
Your org	61.81%	60.56%	62.77%	59.61%	57.47%
Best result	69.72%	70.24%	69.47%	70.15%	67.66%
Average result	56.45%	55.88%	55.75%	55.91%	56.02%
Worst result	42.27%	44.21%	43.77%	46.52%	43.99%
Responses	536	1257	1233	1325	1396

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



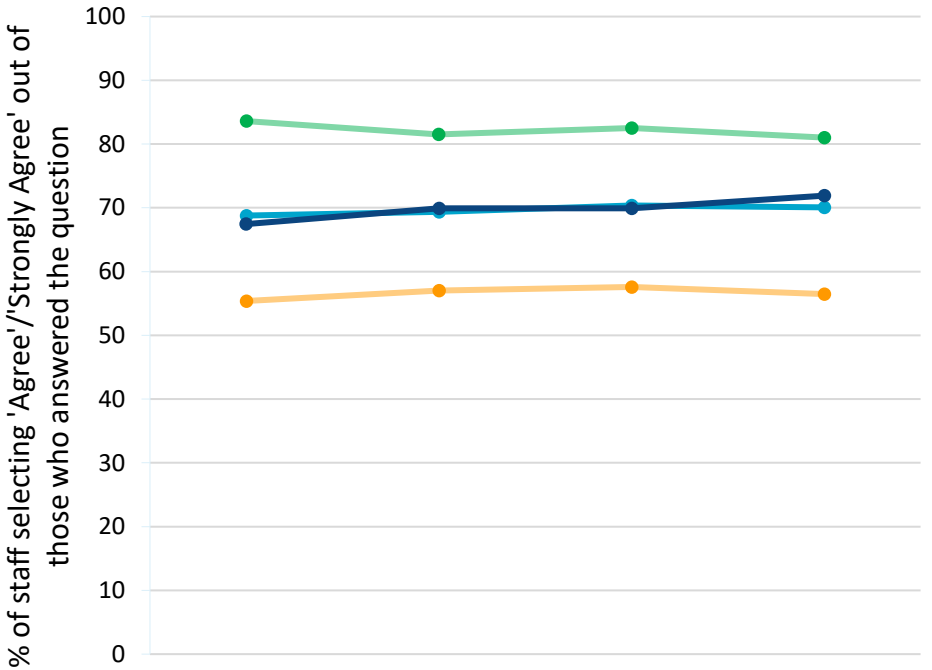
	2020	2021	2022	2023	2024
Your org	4.83%	5.72%	6.24%	6.83%	7.01%
Best result	1.84%	2.66%	2.71%	3.19%	3.03%
Average result	6.27%	7.07%	7.81%	8.09%	8.75%
Worst result	16.18%	15.05%	16.52%	15.20%	16.23%
Responses	534	1277	1248	1339	1411

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2020	2021	2022	2023	2024
Your org	7.13%	8.05%	7.41%	7.61%	7.32%
Best result	4.04%	5.12%	4.25%	3.80%	4.44%
Average result	7.93%	8.82%	8.73%	9.24%	9.35%
Worst result	16.19%	17.16%	15.69%	14.95%	15.08%
Responses	532	1272	1245	1335	1402

Q21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

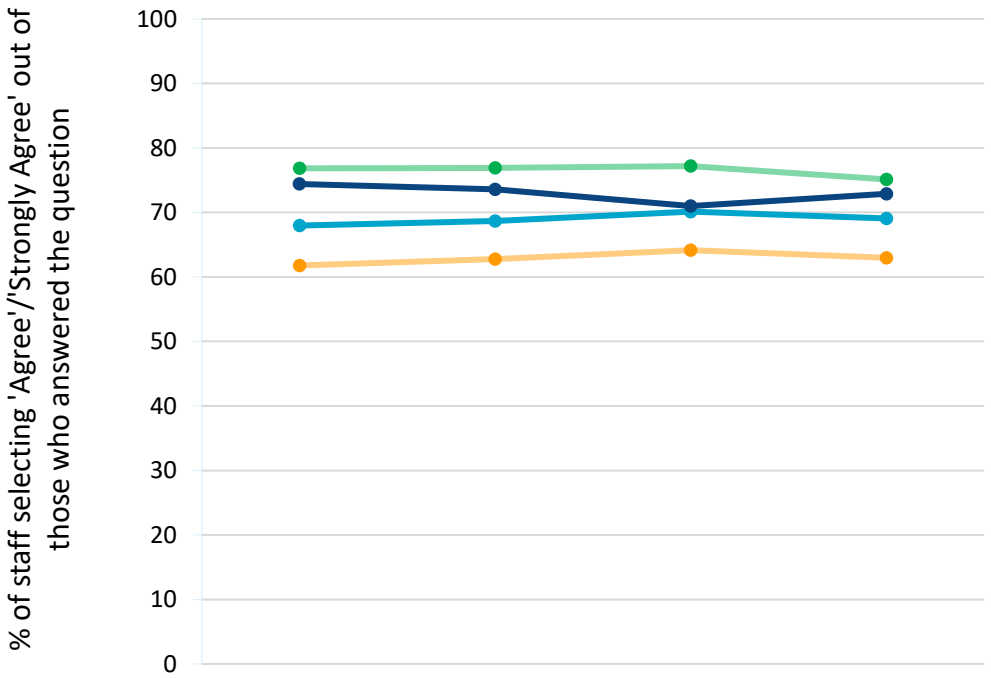


	2021	2022	2023	2024
Your org	67.45%	69.94%	69.93%	71.91%
Best result	83.61%	81.51%	82.55%	81.02%
Average result	68.79%	69.37%	70.37%	70.07%
Worst result	55.39%	57.03%	57.59%	56.47%
Responses	1272	1247	1333	1414

Survey Coordination Centre

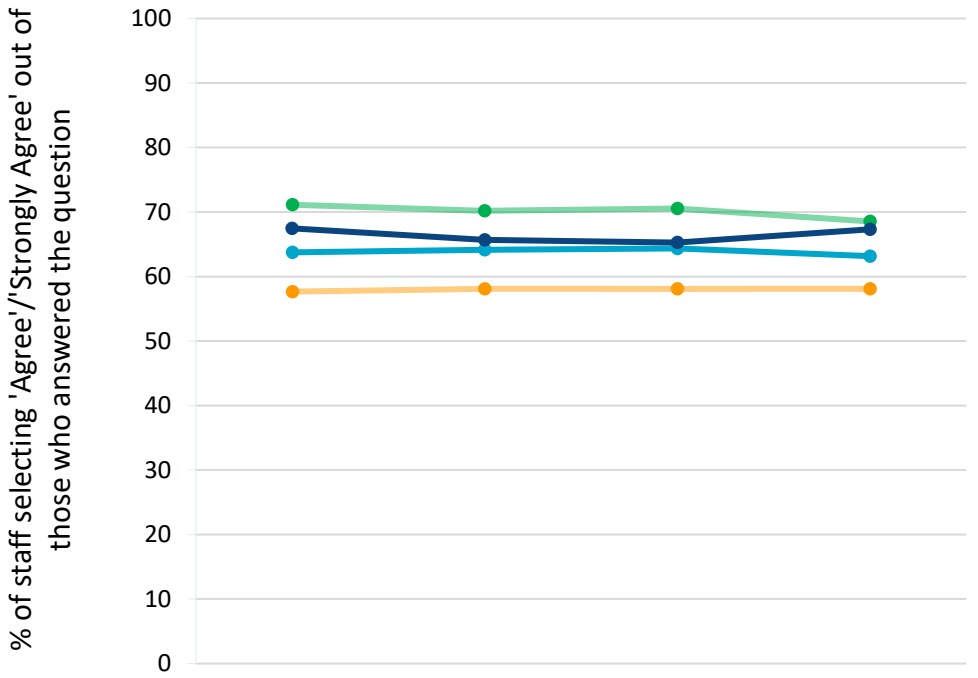
NHS

Q7h I feel valued by my team.



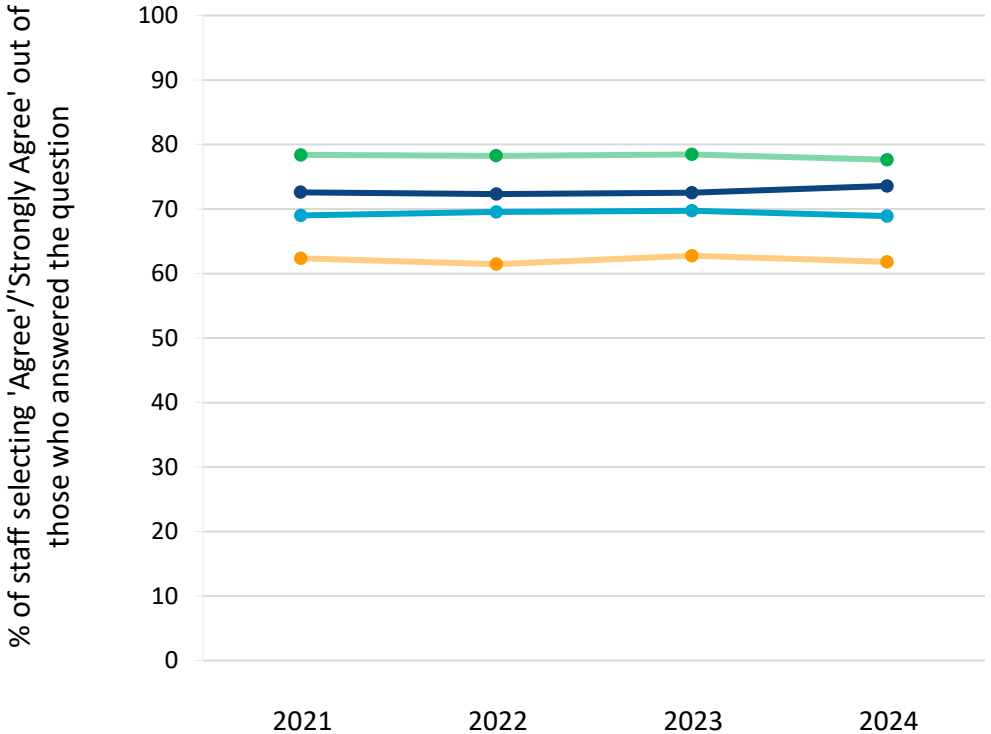
	2021	2022	2023	2024
Your org	74.41%	73.59%	70.99%	72.90%
Best result	76.84%	76.89%	77.18%	75.12%
Average result	67.97%	68.69%	70.13%	69.09%
Worst result	61.78%	62.75%	64.15%	62.98%
Responses	1270	1243	1347	1417

Q7i I feel a strong personal attachment to my team.



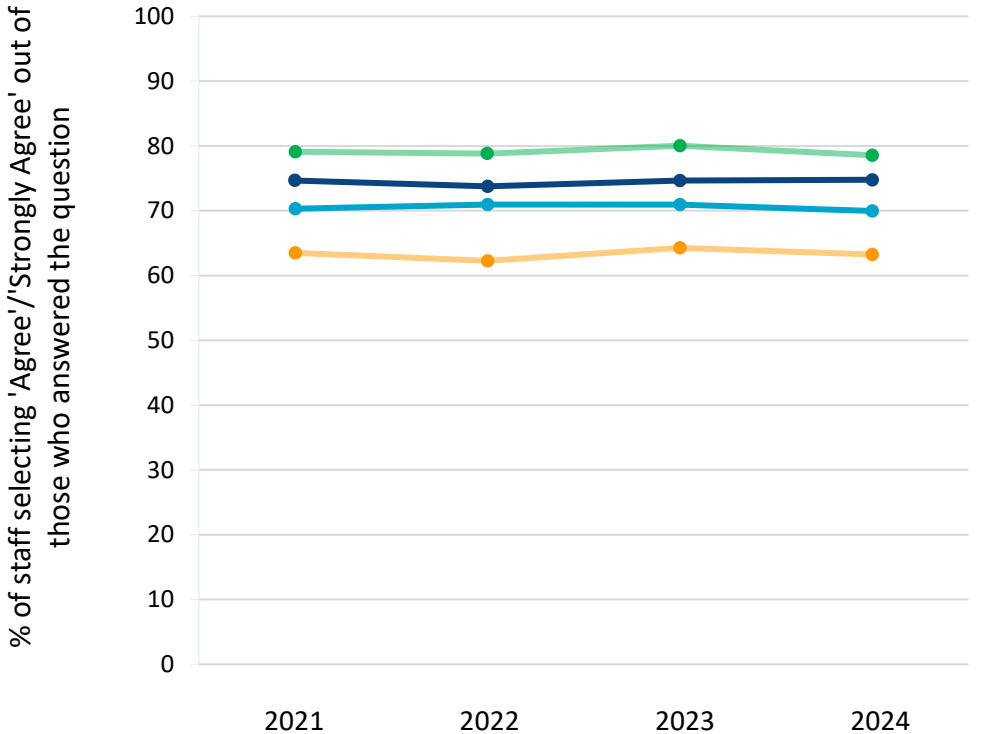
	2021	2022	2023	2024
Your org	67.47%	65.71%	65.27%	67.30%
Best result	71.13%	70.18%	70.53%	68.54%
Average result	63.74%	64.17%	64.36%	63.16%
Worst result	57.66%	58.07%	58.09%	58.08%
Responses	1271	1241	1344	1412

Q8b The people I work with are understanding and kind to one another.



	2021	2022	2023	2024
Your org	72.59%	72.32%	72.53%	73.59%
Best result	78.40%	78.25%	78.46%	77.64%
Average result	69.03%	69.56%	69.73%	68.91%
Worst result	62.36%	61.45%	62.76%	61.80%
Responses	1273	1243	1342	1411

Q8c The people I work with are polite and treat each other with respect.



	2021	2022	2023	2024
Your org	74.66%	73.76%	74.65%	74.78%
Best result	79.10%	78.82%	80.03%	78.56%
Average result	70.29%	70.94%	70.94%	69.96%
Worst result	63.49%	62.26%	64.26%	63.26%
Responses	1274	1244	1343	1413

Survey Coordination Centre

NHS

People Promise element – We are recognised and rewarded

Questions included:

Q4a, Q4b, Q4c, Q8d, Q9e

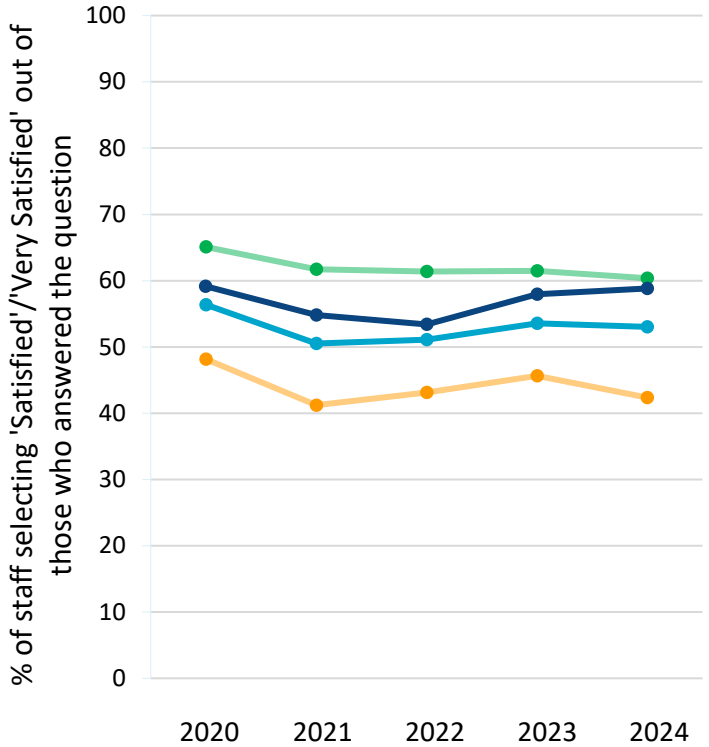
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are recognised and rewarded

Survey Coordination Centre

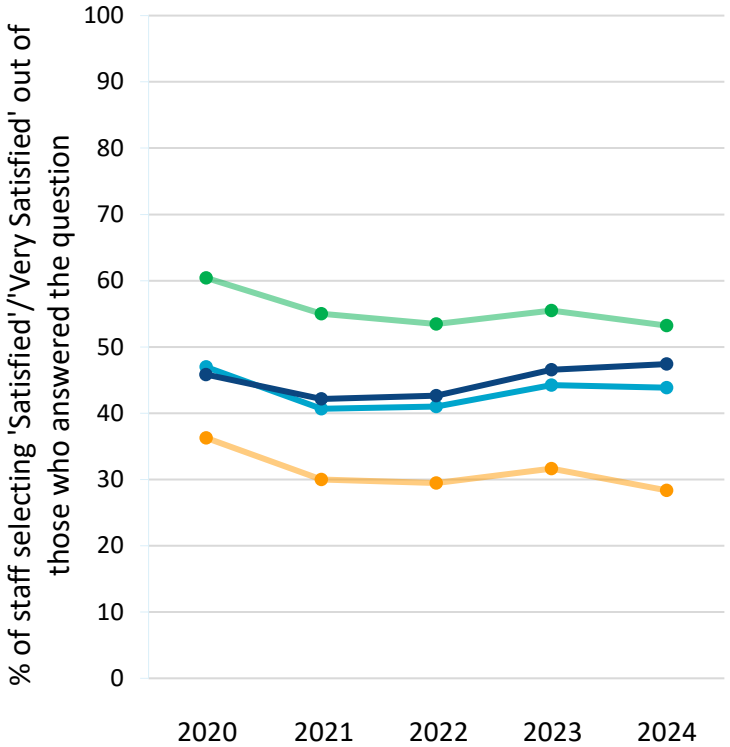
NHS

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



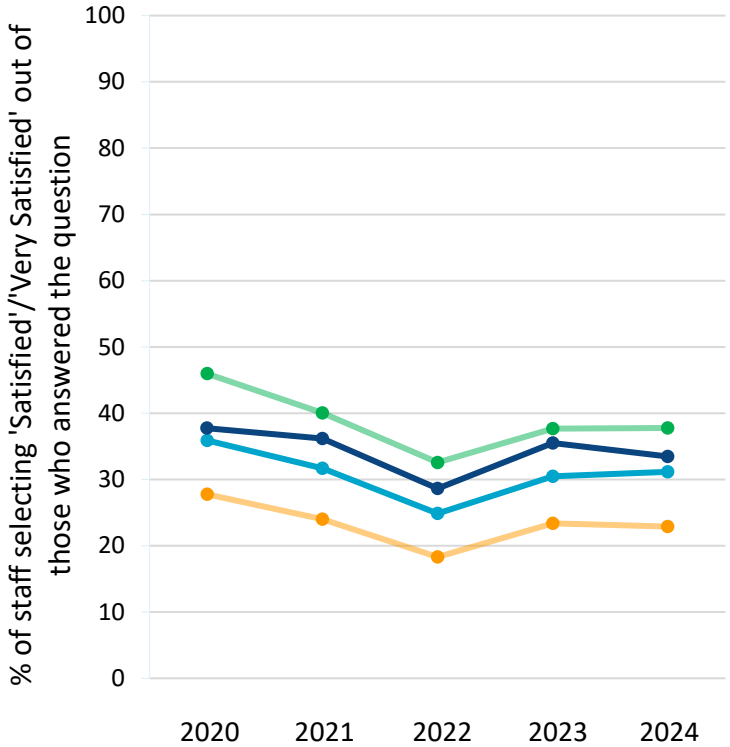
	2020	2021	2022	2023	2024
Your org	59.15%	54.82%	53.40%	57.95%	58.82%
Best result	65.08%	61.71%	61.38%	61.48%	60.37%
Average result	56.37%	50.52%	51.09%	53.56%	53.02%
Worst result	48.16%	41.22%	43.12%	45.65%	42.37%
Responses	539	1276	1246	1350	1420

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



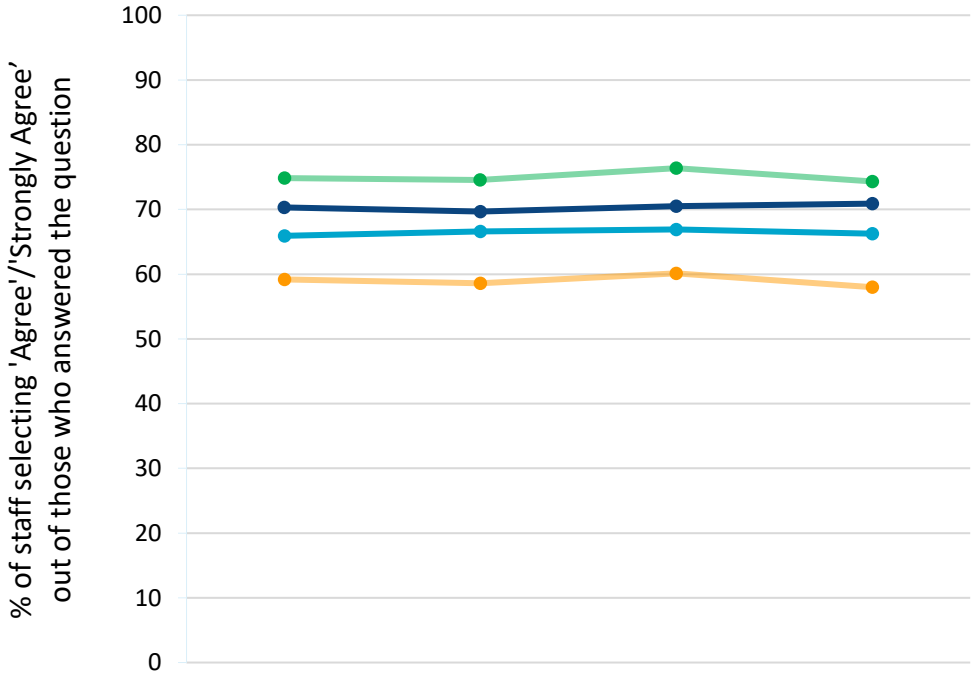
	2020	2021	2022	2023	2024
Your org	45.83%	42.15%	42.63%	46.55%	47.42%
Best result	60.42%	55.03%	53.46%	55.50%	53.22%
Average result	46.97%	40.67%	41.03%	44.23%	43.88%
Worst result	36.28%	29.99%	29.44%	31.65%	28.35%
Responses	537	1274	1244	1348	1419

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



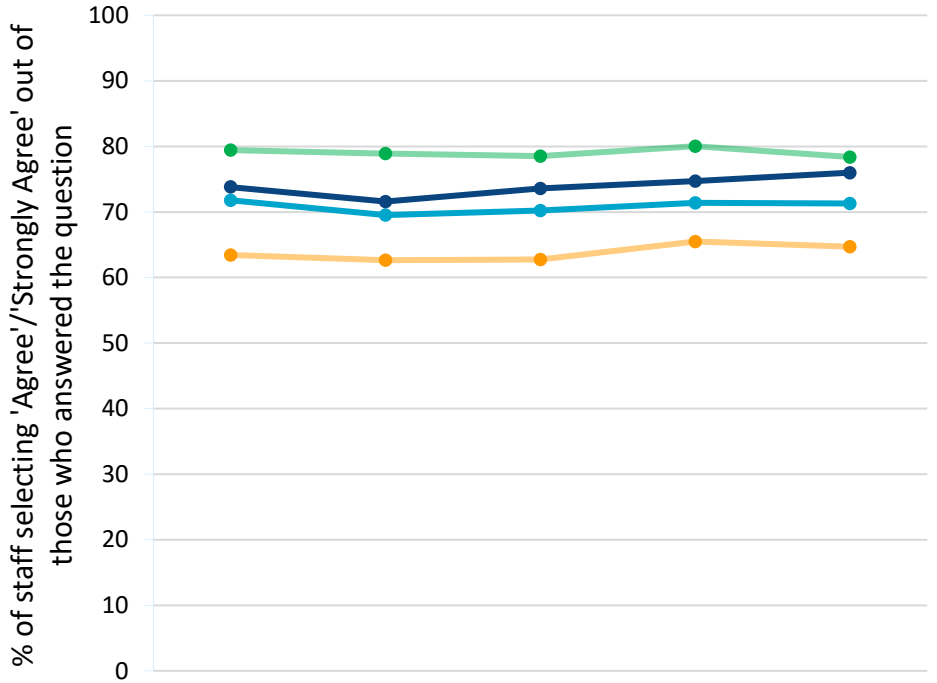
	2020	2021	2022	2023	2024
Your org	37.73%	36.17%	28.64%	35.49%	33.47%
Best result	45.96%	40.04%	32.58%	37.69%	37.76%
Average result	35.89%	31.69%	24.87%	30.49%	31.14%
Worst result	27.76%	23.99%	18.31%	23.36%	22.92%
Responses	537	1276	1243	1349	1416

Q8d The people I work with show appreciation to one another.



	2021	2022	2023	2024
Your org	70.30%	69.68%	70.53%	70.89%
Best result	74.84%	74.55%	76.37%	74.33%
Average result	65.92%	66.61%	66.91%	66.25%
Worst result	59.18%	58.59%	60.13%	57.98%
Responses	1276	1242	1343	1408

Q9e My immediate manager values my work.



	2020	2021	2022	2023	2024
Your org	73.80%	71.59%	73.58%	74.73%	75.99%
Best result	79.43%	78.89%	78.50%	80.03%	78.38%
Average result	71.78%	69.52%	70.22%	71.39%	71.30%
Worst result	63.46%	62.64%	62.76%	65.49%	64.68%
Responses	536	1275	1246	1347	1421

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

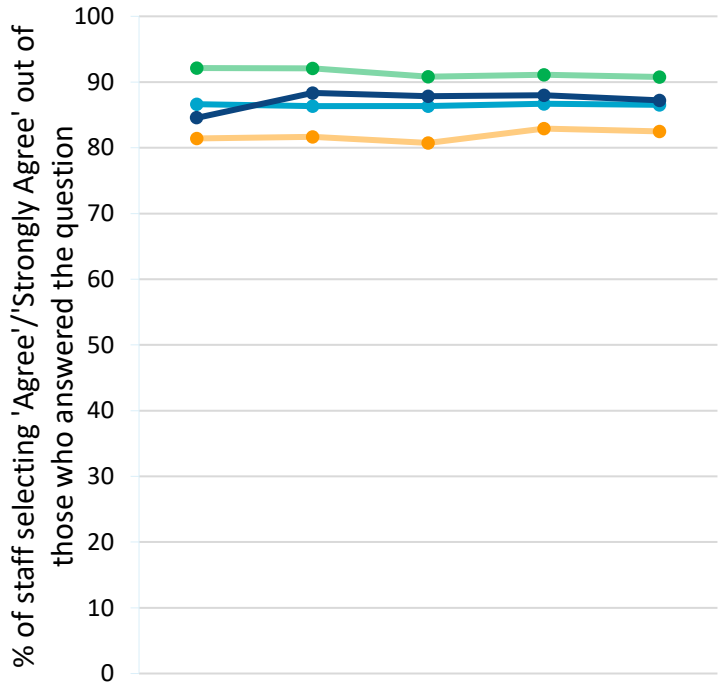
Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

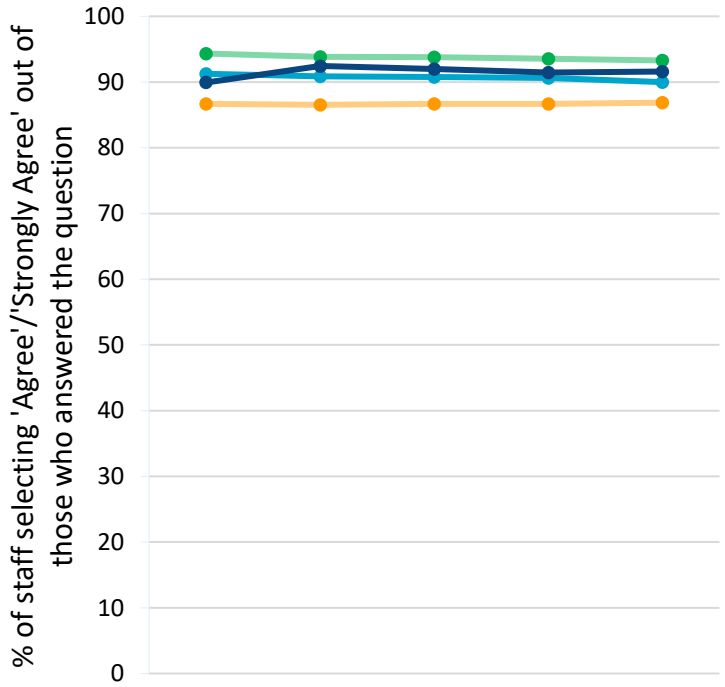
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3a I always know what my work responsibilities are.



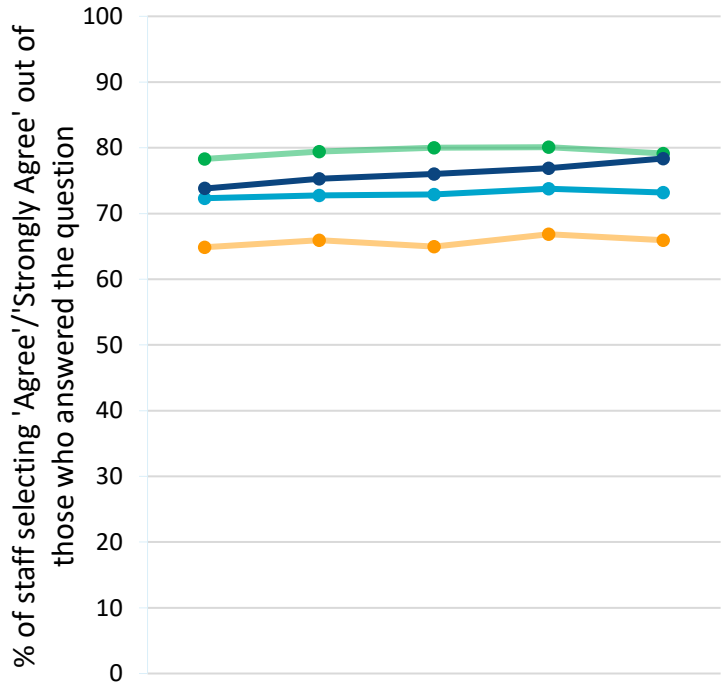
	2020	2021	2022	2023	2024
Your org	84.55%	88.35%	87.85%	87.97%	87.24%
Best result	92.13%	92.08%	90.80%	91.12%	90.77%
Average result	86.62%	86.35%	86.35%	86.70%	86.55%
Worst result	81.40%	81.65%	80.73%	82.92%	82.51%
Responses	536	1278	1248	1353	1422

Q3b I am trusted to do my job.



	2020	2021	2022	2023	2024
Your org	89.92%	92.45%	91.98%	91.44%	91.60%
Best result	94.34%	93.85%	93.81%	93.56%	93.28%
Average result	91.25%	90.85%	90.76%	90.62%	89.99%
Worst result	86.67%	86.54%	86.66%	86.67%	86.86%
Responses	533	1276	1247	1351	1420

Q3c There are frequent opportunities for me to show initiative in my role.

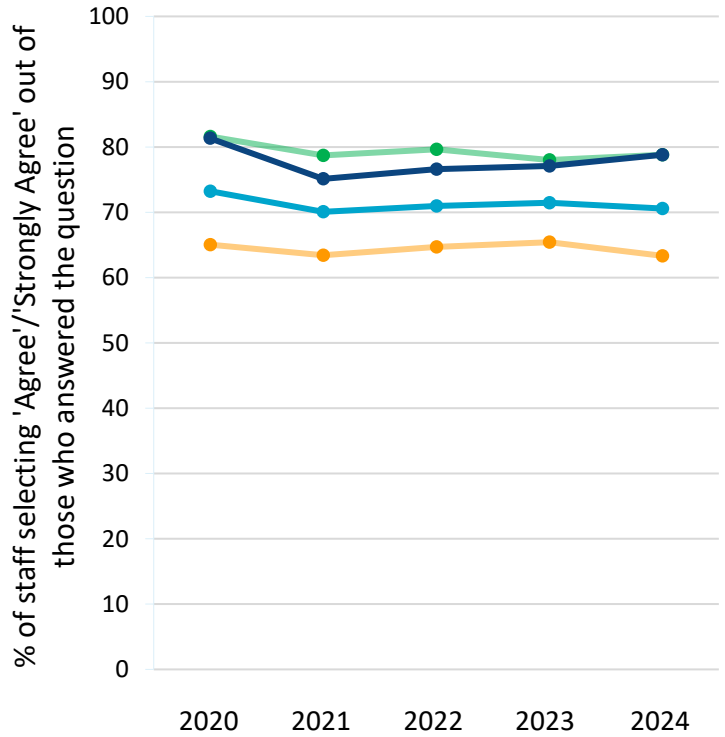


	2020	2021	2022	2023	2024
Your org	73.80%	75.31%	76.02%	76.91%	78.37%
Best result	78.30%	79.42%	80.00%	80.09%	79.13%
Average result	72.32%	72.74%	72.89%	73.76%	73.20%
Worst result	64.86%	65.95%	64.98%	66.84%	65.96%
Responses	539	1273	1239	1348	1421

Survey Coordination Centre

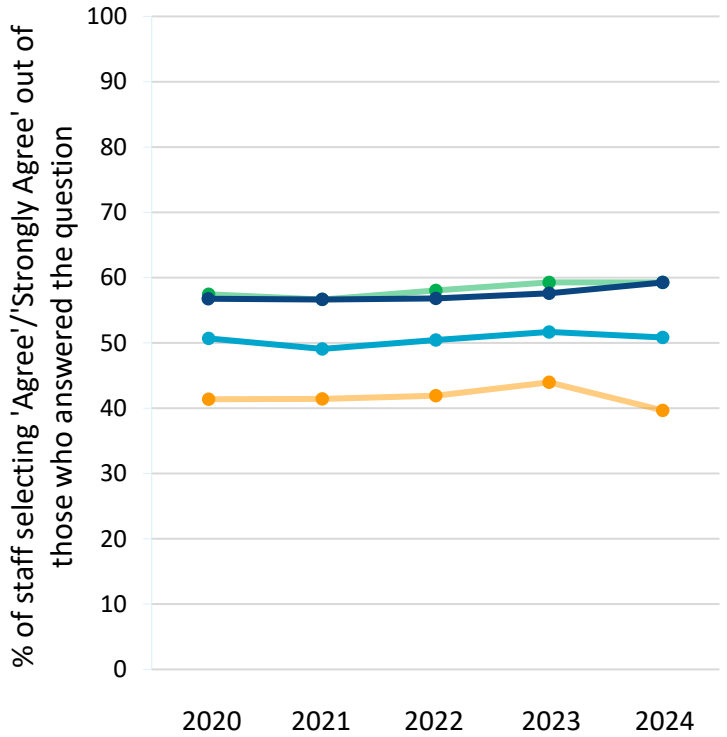
NHS

Q3d I am able to make suggestions to improve the work of my team / department.



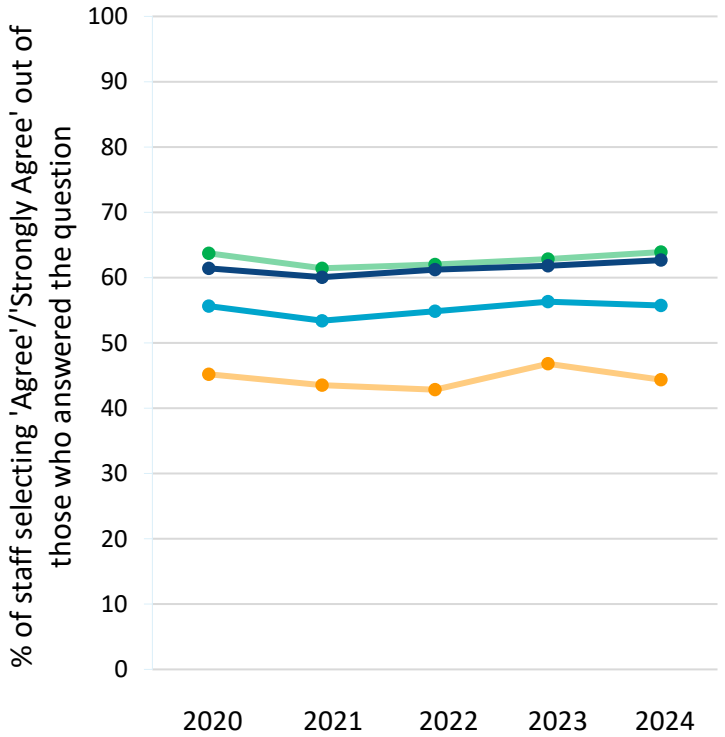
	2020	2021	2022	2023	2024
Your org	81.32%	75.12%	76.59%	77.08%	78.83%
Best result	81.61%	78.70%	79.64%	78.01%	78.83%
Average result	73.23%	70.08%	70.96%	71.46%	70.60%
Worst result	65.06%	63.41%	64.71%	65.42%	63.34%
Responses	536	1275	1242	1341	1416

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2020	2021	2022	2023	2024
Your org	56.74%	56.64%	56.82%	57.57%	59.25%
Best result	57.43%	56.64%	58.05%	59.27%	59.25%
Average result	50.68%	49.08%	50.44%	51.68%	50.81%
Worst result	41.35%	41.40%	41.91%	43.96%	39.67%
Responses	539	1279	1245	1347	1418

Q3f I am able to make improvements happen in my area of work.



	2020	2021	2022	2023	2024
Your org	61.41%	60.06%	61.22%	61.82%	62.67%
Best result	63.70%	61.43%	61.98%	62.83%	63.91%
Average result	55.64%	53.40%	54.86%	56.31%	55.73%
Worst result	45.19%	43.51%	42.83%	46.80%	44.36%
Responses	539	1276	1243	1343	1415

Survey Coordination Centre

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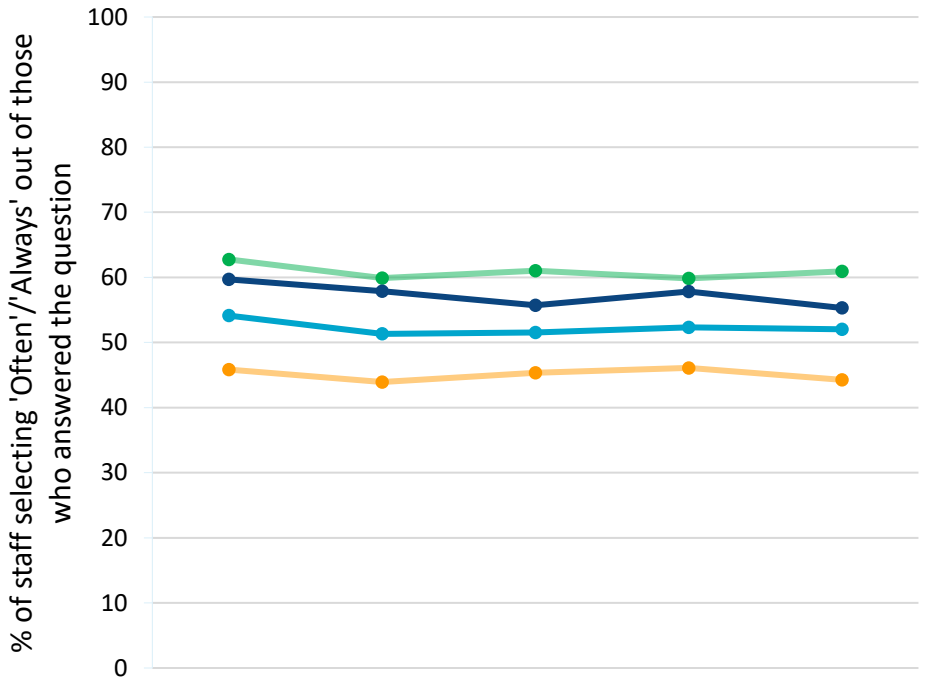
Q5b I have a choice in deciding how to do my work.

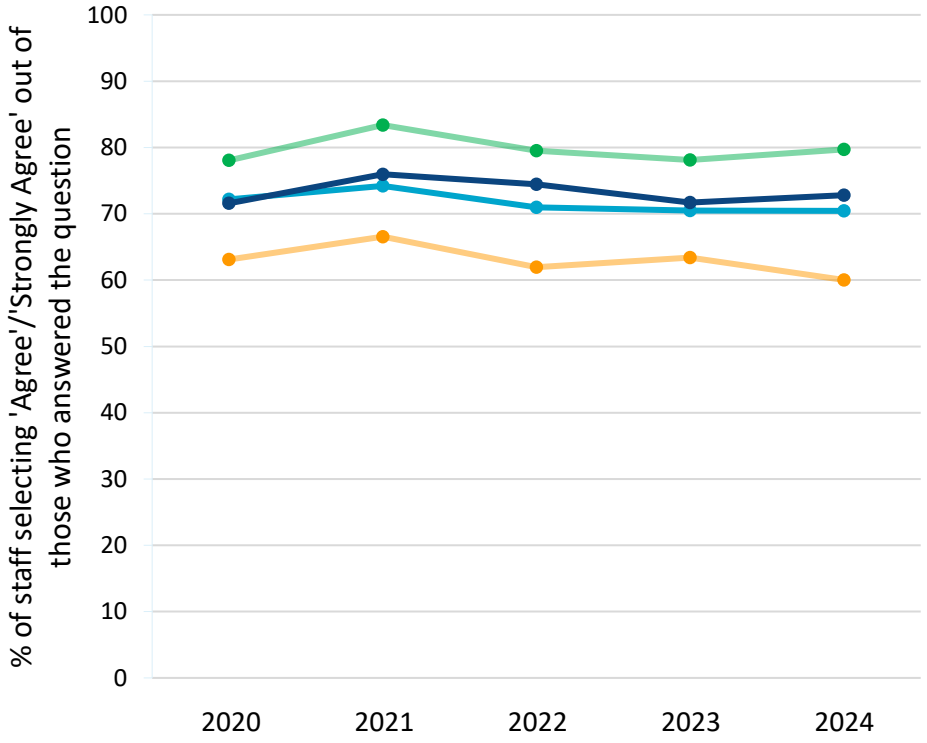


	2020	2021	2022	2023	2024
Your org	59.69%	57.89%	55.72%	57.82%	55.31%
Best result	62.76%	59.87%	61.04%	59.85%	60.94%
Average result	54.13%	51.32%	51.55%	52.31%	52.02%
Worst result	45.86%	43.93%	45.33%	46.10%	44.26%
Responses	535	1276	1243	1340	1415

Survey Coordination Centre

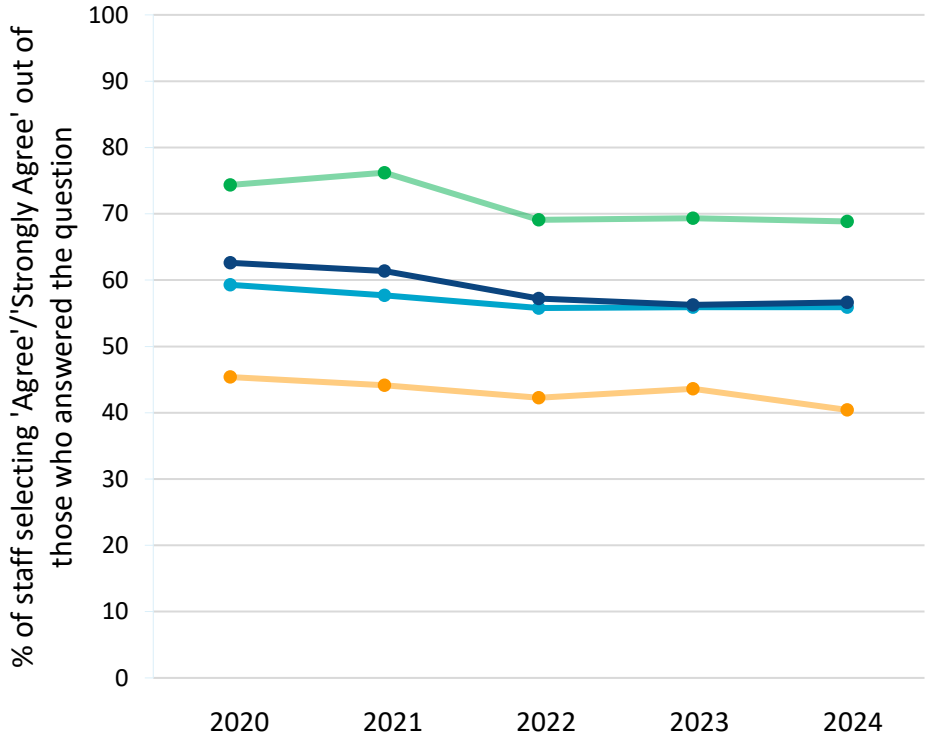
NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2020	2021	2022	2023	2024
Your org	71.58%	75.97%	74.43%	71.72%	72.80%
Best result	78.06%	83.39%	79.51%	78.11%	79.71%
Average result	72.16%	74.20%	70.96%	70.47%	70.44%
Worst result	63.08%	66.55%	61.96%	63.38%	60.03%
Responses	535	1269	1246	1332	1413

Q20b I am confident that my organisation would address my concern.

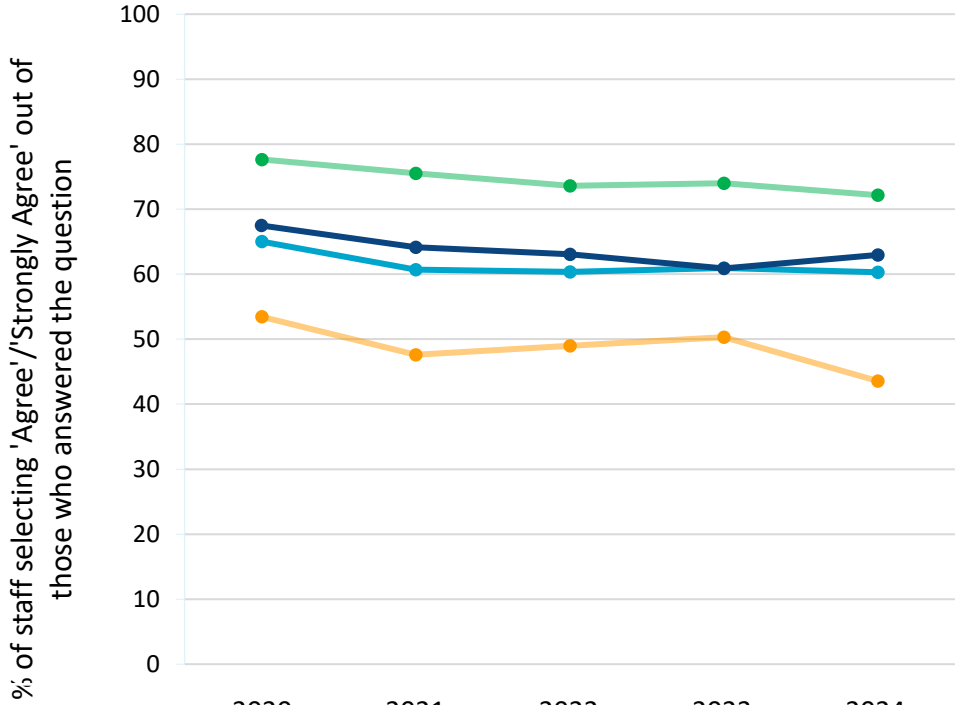


	2020	2021	2022	2023	2024
Your org	62.60%	61.36%	57.24%	56.26%	56.62%
Best result	74.37%	76.20%	69.10%	69.35%	68.85%
Average result	59.29%	57.68%	55.79%	55.93%	55.91%
Worst result	45.38%	44.13%	42.28%	43.61%	40.42%
Responses	535	1266	1245	1327	1413

Survey Coordination Centre

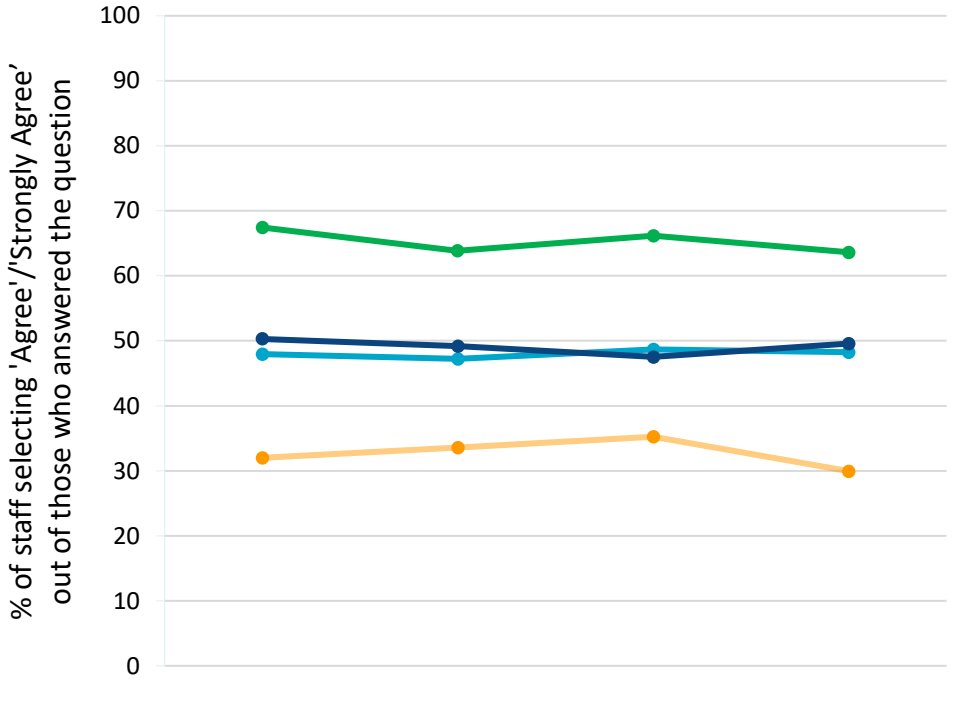
NHS

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023	2024
Your org	67.48%	64.16%	63.05%	60.88%	62.98%
Best result	77.65%	75.50%	73.58%	74.00%	72.15%
Average result	65.01%	60.68%	60.37%	60.93%	60.29%
Worst result	53.44%	47.61%	48.97%	50.33%	43.56%
Responses	538	1268	1241	1338	1405

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024
Your org	50.28%	49.19%	47.53%	49.56%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	1269	1242	1339	1404

Survey Coordination Centre

NHS

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

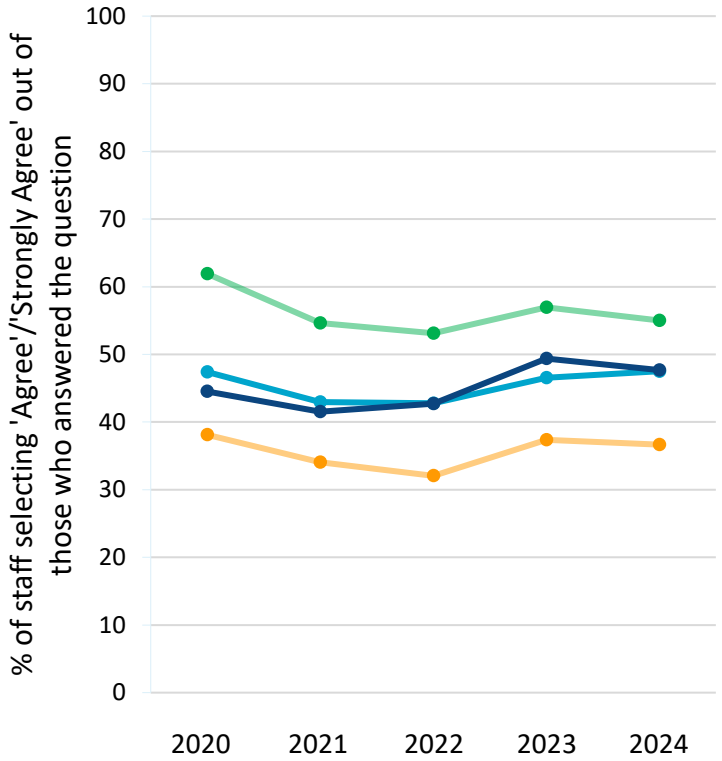
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Other questions:* Q17a, Q17b, Q22

*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

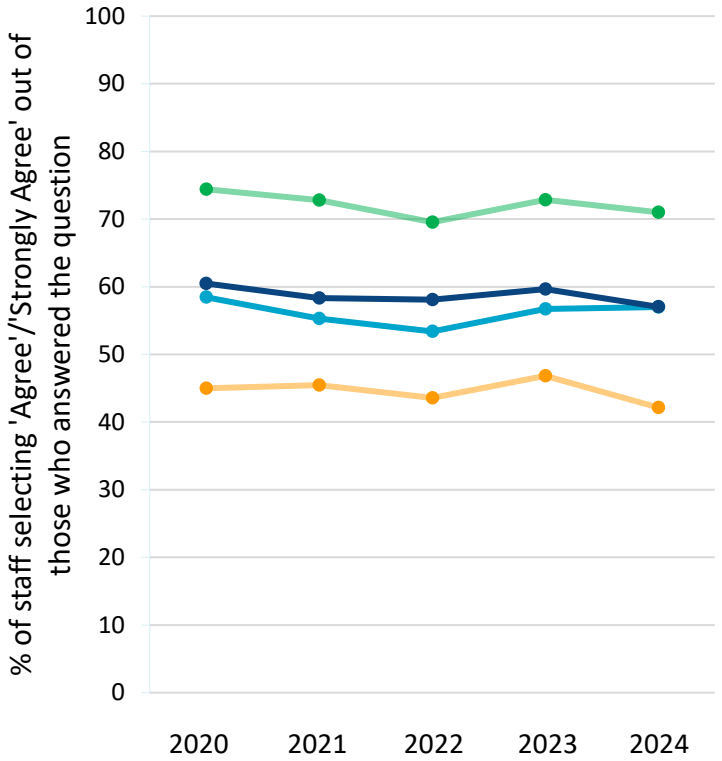
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3g I am able to meet all the conflicting demands on my time at work.



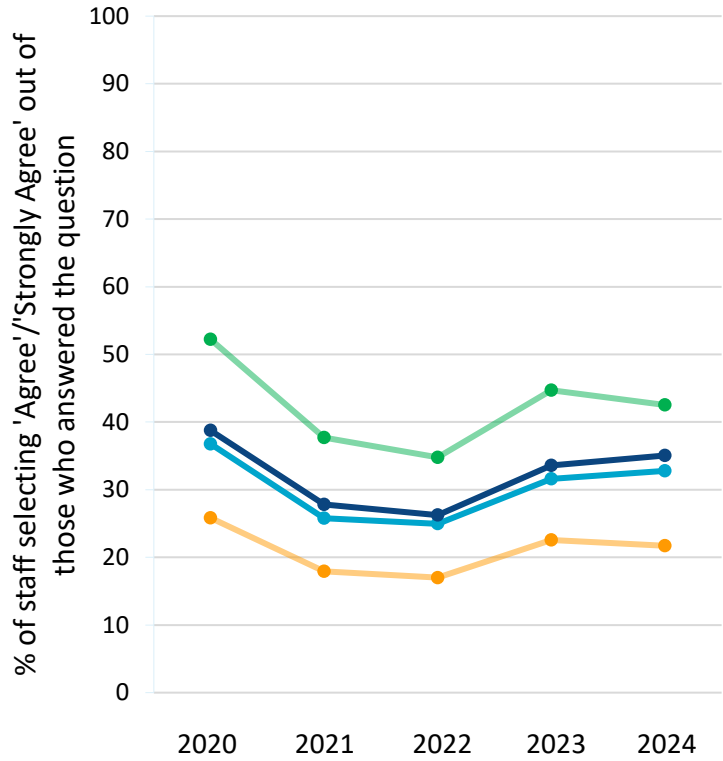
	2020	2021	2022	2023	2024
Your org	44.53%	41.53%	42.71%	49.38%	47.68%
Best result	61.92%	54.62%	53.13%	56.95%	55.01%
Average result	47.39%	42.96%	42.78%	46.56%	47.51%
Worst result	38.11%	34.06%	32.05%	37.35%	36.68%
Responses	536	1270	1242	1338	1418

Q3h I have adequate materials, supplies and equipment to do my work.



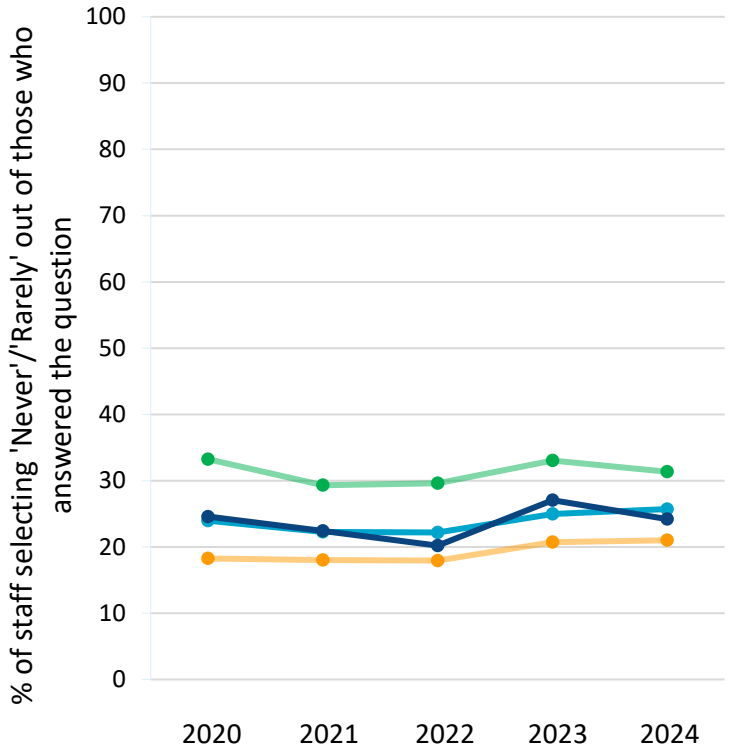
	2020	2021	2022	2023	2024
Your org	60.47%	58.33%	58.07%	59.67%	57.03%
Best result	74.41%	72.78%	69.54%	72.83%	70.99%
Average result	58.44%	55.30%	53.39%	56.69%	57.00%
Worst result	44.99%	45.47%	43.54%	46.82%	42.14%
Responses	536	1275	1239	1338	1413

Q3i There are enough staff at this organisation for me to do my job properly.



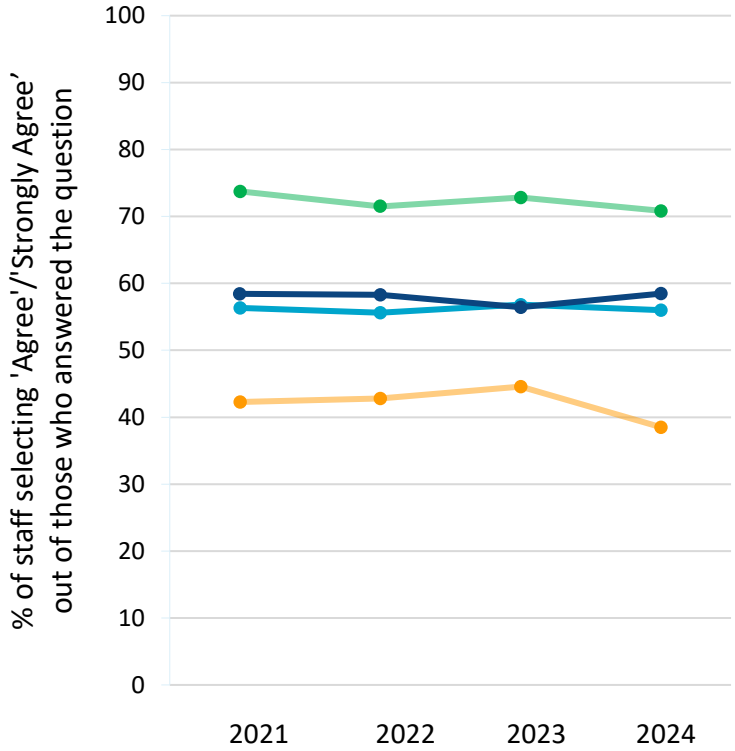
	2020	2021	2022	2023	2024
Your org	38.74%	27.84%	26.24%	33.60%	35.04%
Best result	52.21%	37.72%	34.78%	44.71%	42.52%
Average result	36.76%	25.80%	24.95%	31.62%	32.77%
Worst result	25.83%	17.92%	17.00%	22.55%	21.73%
Responses	535	1279	1242	1347	1419

Q5a I have unrealistic time pressures.



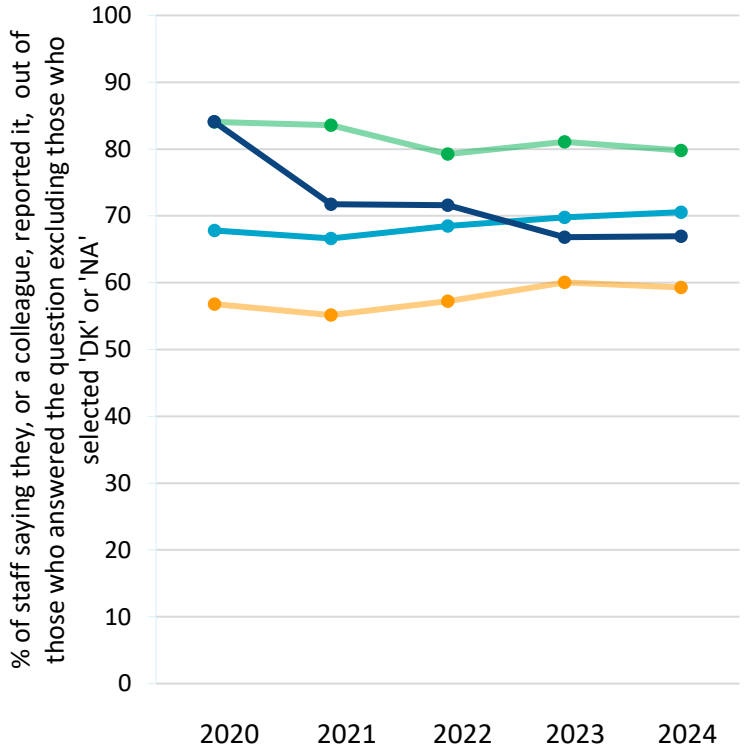
	2020	2021	2022	2023	2024
Your org	24.58%	22.41%	20.20%	27.05%	24.22%
Best result	33.24%	29.31%	29.61%	33.04%	31.37%
Average result	23.97%	22.27%	22.18%	24.95%	25.71%
Worst result	18.24%	18.00%	17.94%	20.72%	21.01%
Responses	536	1276	1245	1347	1420

Q11a My organisation takes positive action on health and well-being.



	2021	2022	2023	2024
Your org	58.43%	58.30%	56.44%	58.47%
Best result	73.75%	71.50%	72.81%	70.84%
Average result	56.34%	55.62%	56.82%	55.99%
Worst result	42.28%	42.82%	44.58%	38.51%
Responses	1277	1245	1326	1401

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



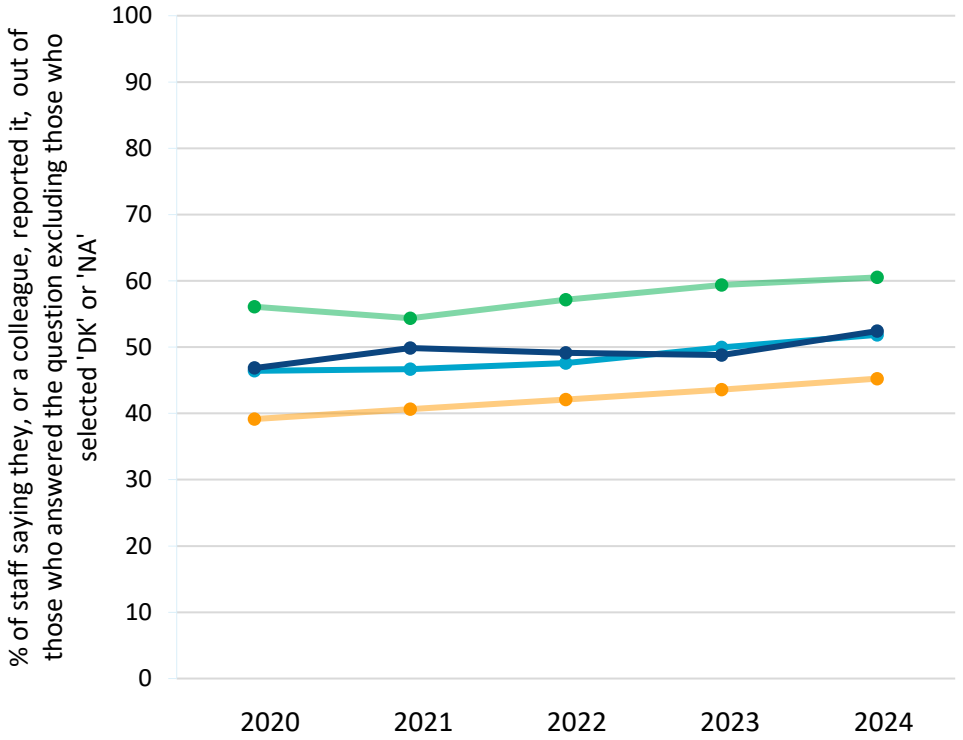
	2020	2021	2022	2023	2024
Your org	84.05%	71.73%	71.57%	66.81%	66.97%
Best result	84.05%	83.58%	79.24%	81.08%	79.79%
Average result	67.83%	66.62%	68.47%	69.78%	70.55%
Worst result	56.80%	55.15%	57.22%	60.04%	59.28%
Responses	46	139	107	115	110

Note: 2023 results for Q13d are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Survey Coordination Centre

NHS

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

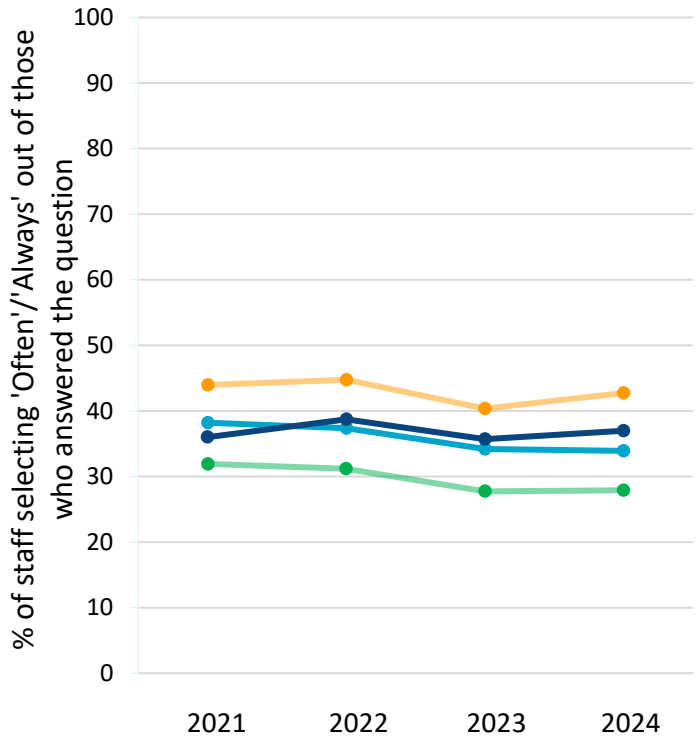


	2020	2021	2022	2023	2024
Your org	46.85%	49.87%	49.14%	48.81%	52.42%
Best result	56.07%	54.35%	57.16%	59.40%	60.52%
Average result	46.43%	46.67%	47.59%	49.96%	51.86%
Worst result	39.15%	40.63%	42.10%	43.57%	45.25%
Responses	198	419	452	404	435

Note: 2023 results for Q14d are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

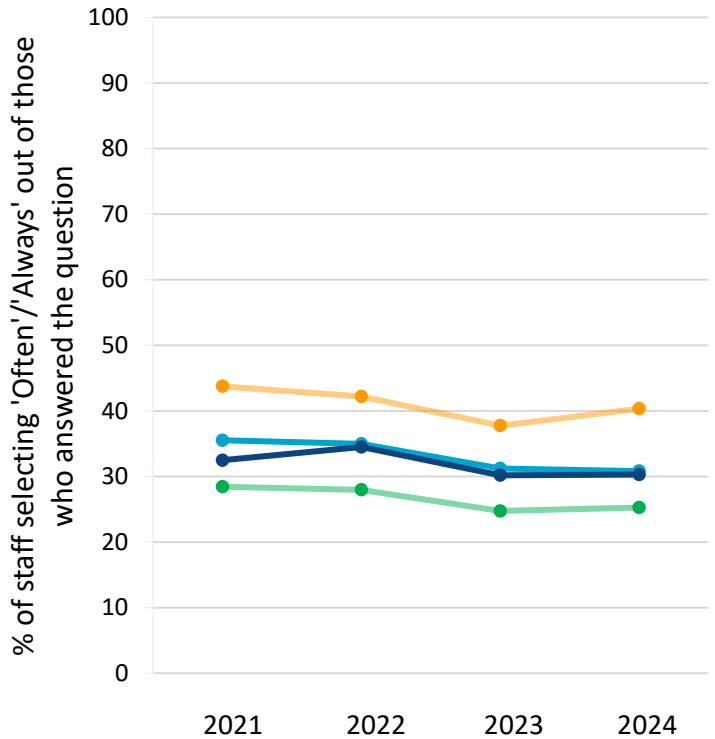
Survey Coordination Centre NHS

Q12a How often, if at all, do you find your work emotionally exhausting?



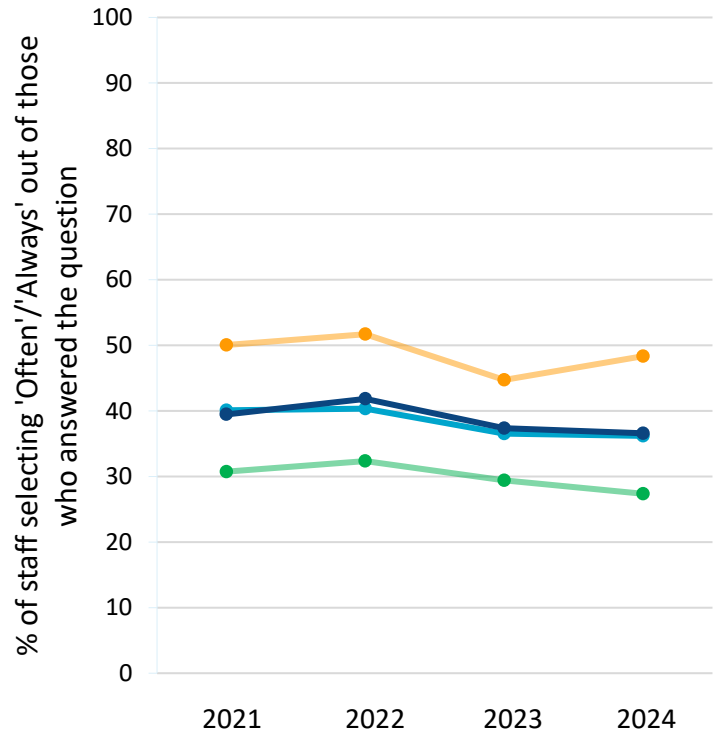
	2021	2022	2023	2024
Your org	36.01%	38.71%	35.69%	36.97%
Best result	31.92%	31.18%	27.73%	27.88%
Average result	38.20%	37.36%	34.20%	33.91%
Worst result	43.97%	44.75%	40.35%	42.73%
Responses	1280	1243	1340	1414

Q12b How often, if at all, do you feel burnt out because of your work?



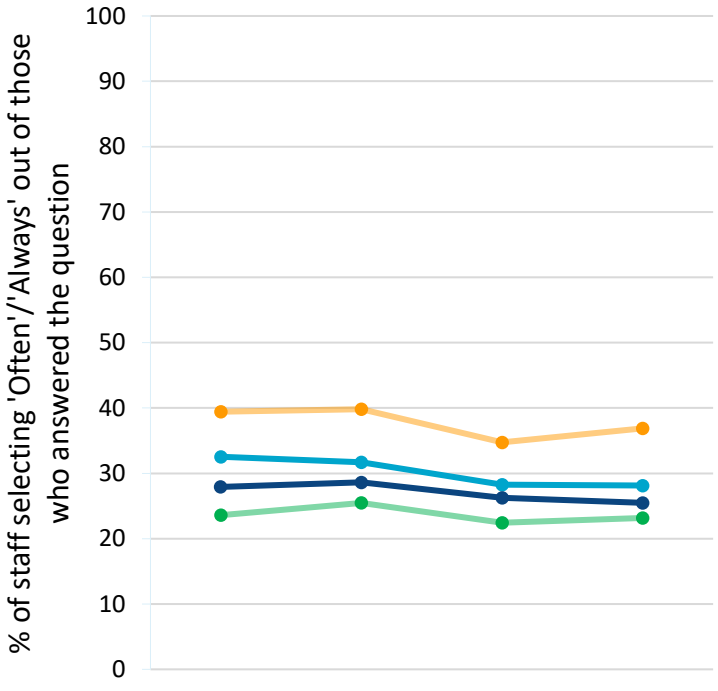
	2021	2022	2023	2024
Your org	32.47%	34.50%	30.18%	30.28%
Best result	28.44%	27.95%	24.74%	25.24%
Average result	35.52%	34.98%	31.20%	30.82%
Worst result	43.74%	42.19%	37.74%	40.36%
Responses	1279	1243	1336	1410

Q12c How often, if at all, does your work frustrate you?



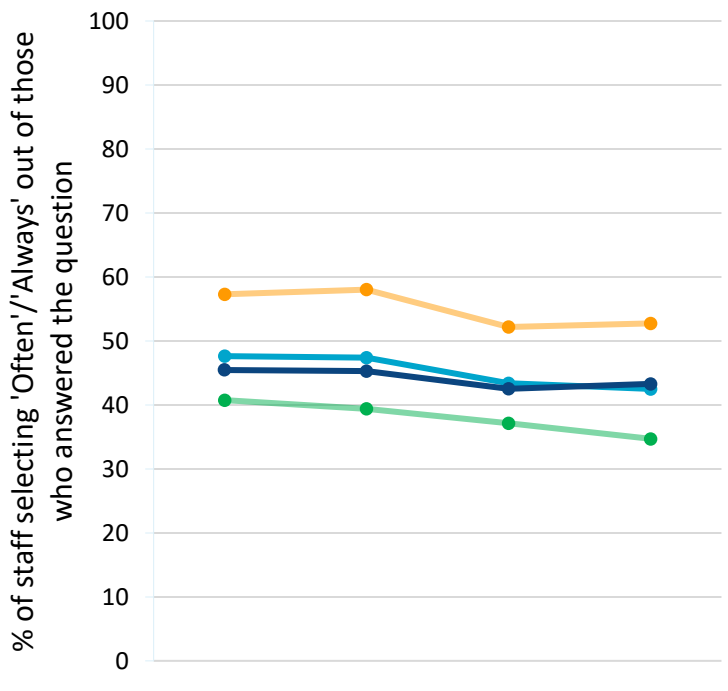
	2021	2022	2023	2024
Your org	39.48%	41.83%	37.37%	36.59%
Best result	30.74%	32.35%	29.40%	27.37%
Average result	40.11%	40.35%	36.52%	36.19%
Worst result	50.04%	51.70%	44.72%	48.33%
Responses	1281	1242	1335	1414

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



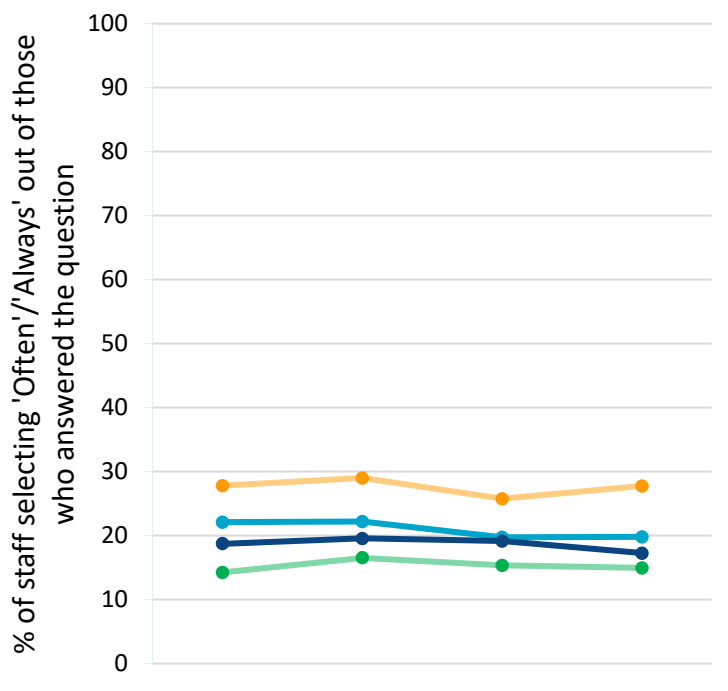
	2021	2022	2023	2024
Your org	27.90%	28.62%	26.28%	25.48%
Best result	23.59%	25.47%	22.44%	23.17%
Average result	32.54%	31.71%	28.26%	28.13%
Worst result	39.44%	39.81%	34.74%	36.90%
Responses	1279	1237	1336	1413

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



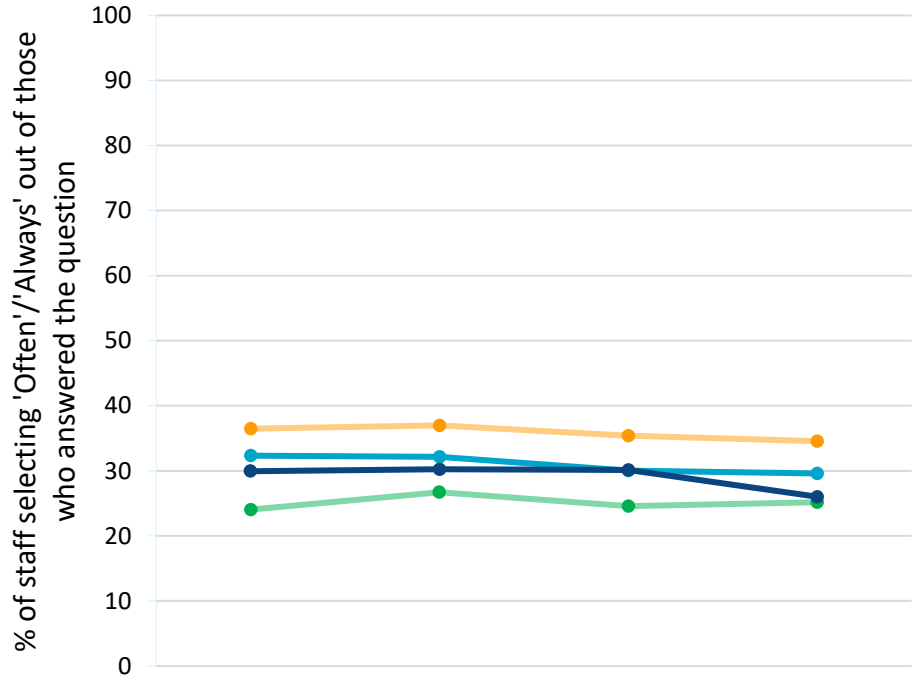
	2021	2022	2023	2024
Your org	45.45%	45.30%	42.52%	43.29%
Best result	40.75%	39.38%	37.14%	34.71%
Average result	47.62%	47.37%	43.37%	42.50%
Worst result	57.28%	58.02%	52.18%	52.73%
Responses	1276	1243	1339	1409

Q12f How often, if at all, do you feel that every working hour is tiring for you?



	2021	2022	2023	2024
Your org	18.71%	19.57%	19.14%	17.27%
Best result	14.24%	16.50%	15.36%	14.94%
Average result	22.12%	22.19%	19.73%	19.80%
Worst result	27.81%	29.01%	25.76%	27.74%
Responses	1276	1238	1334	1411

Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?

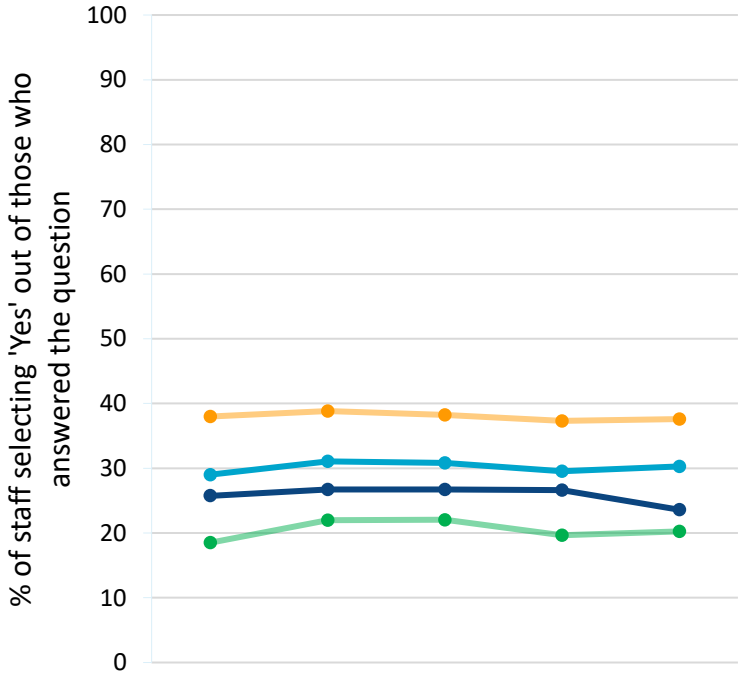


	2021	2022	2023	2024
Your org	29.94%	30.24%	30.14%	26.02%
Best result	24.04%	26.70%	24.55%	25.16%
Average result	32.33%	32.13%	30.02%	29.59%
Worst result	36.47%	36.98%	35.41%	34.56%
Responses	1278	1242	1335	1410

Survey Coordination Centre

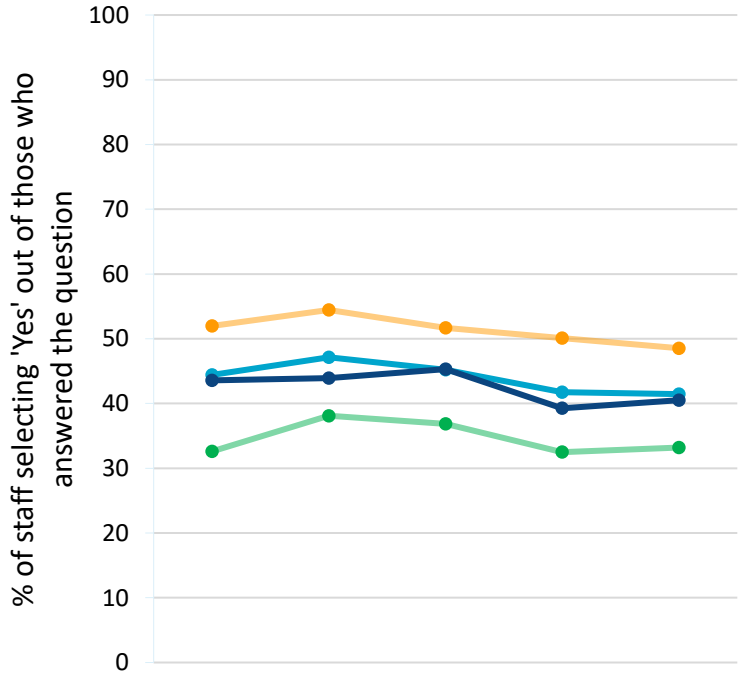
NHS

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



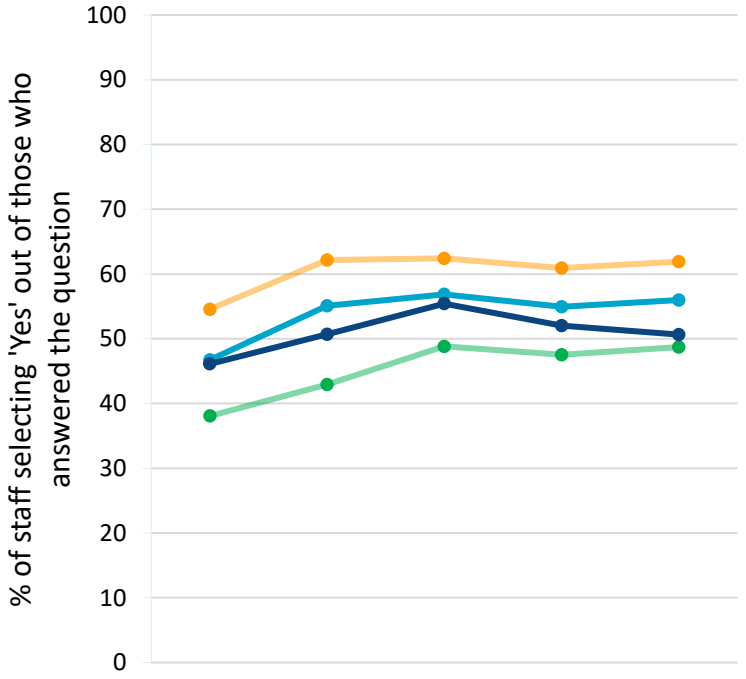
	2020	2021	2022	2023	2024
Your org	25.75%	26.71%	26.73%	26.61%	23.60%
Best result	18.50%	21.97%	22.05%	19.64%	20.23%
Average result	29.01%	31.06%	30.82%	29.54%	30.28%
Worst result	38.02%	38.84%	38.24%	37.32%	37.62%
Responses	535	1276	1243	1336	1416

Q11c During the last 12 months have you felt unwell as a result of work related stress?



	2020	2021	2022	2023	2024
Your org	43.57%	43.92%	45.31%	39.26%	40.53%
Best result	32.61%	38.12%	36.86%	32.49%	33.18%
Average result	44.41%	47.14%	45.21%	41.73%	41.45%
Worst result	51.96%	54.45%	51.71%	50.11%	48.54%
Responses	536	1278	1244	1331	1413

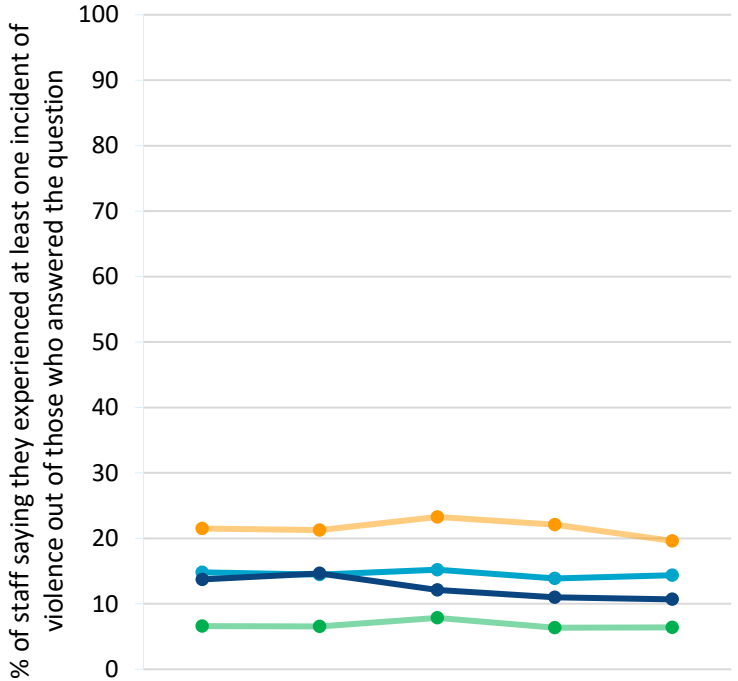
Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2020	2021	2022	2023	2024
Your org	46.11%	50.67%	55.42%	52.01%	50.64%
Best result	38.07%	42.94%	48.83%	47.53%	48.72%
Average result	46.74%	55.10%	56.85%	54.96%	55.96%
Worst result	54.57%	62.18%	62.42%	60.91%	61.92%
Responses	532	1272	1240	1324	1402

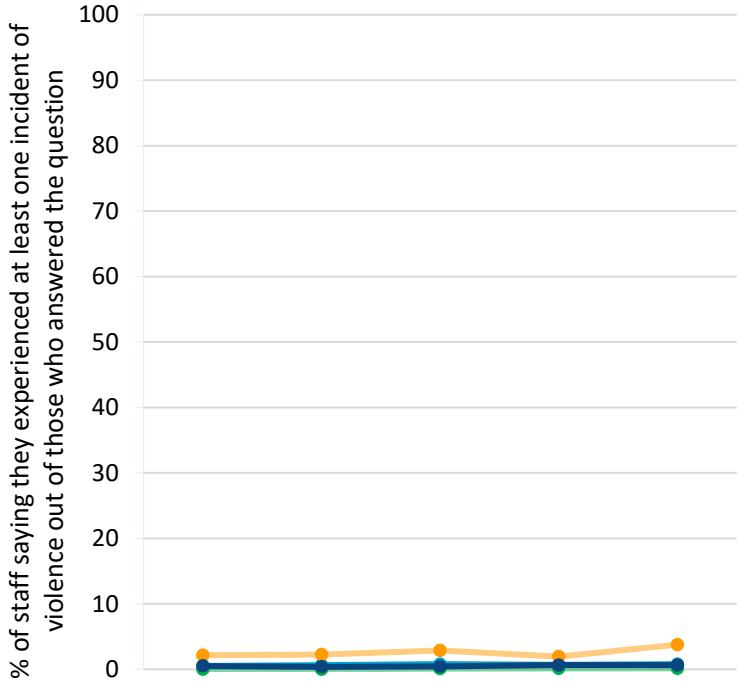
Survey Coordination Centre NHS

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



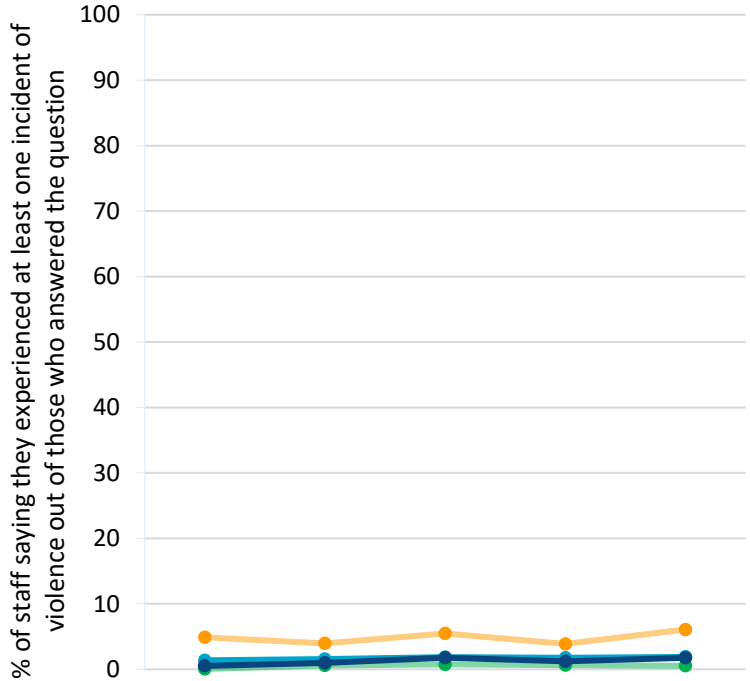
	2020	2021	2022	2023	2024
Your org	13.74%	14.64%	12.11%	10.99%	10.69%
Best result	6.62%	6.53%	7.85%	6.35%	6.38%
Average result	14.79%	14.47%	15.22%	13.88%	14.37%
Worst result	21.49%	21.27%	23.28%	22.09%	19.61%
Responses	535	1280	1246	1333	1413

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2020	2021	2022	2023	2024
Your org	0.51%	0.37%	0.43%	0.65%	0.63%
Best result	0.00%	0.00%	0.10%	0.14%	0.14%
Average result	0.51%	0.63%	0.79%	0.68%	0.76%
Worst result	2.13%	2.23%	2.90%	1.94%	3.76%
Responses	535	1261	1241	1331	1410

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



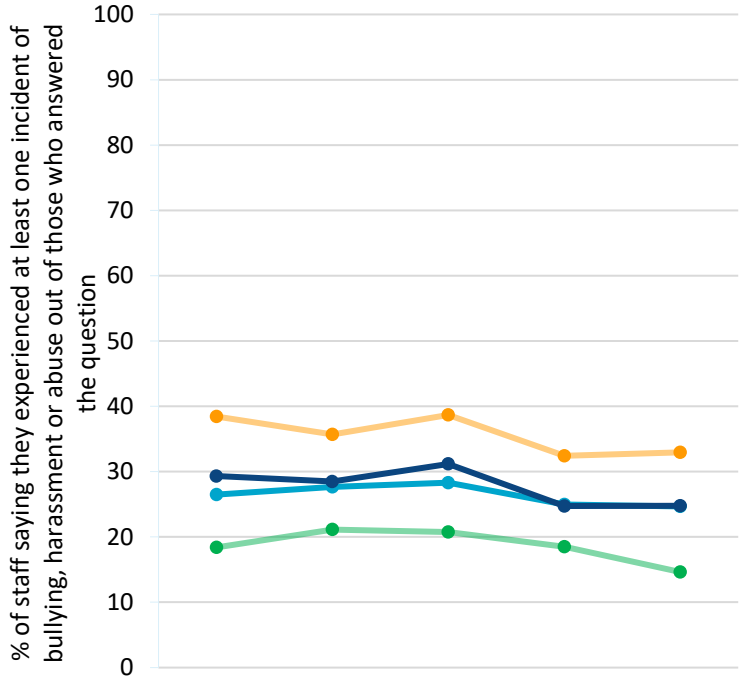
	2020	2021	2022	2023	2024
Your org	0.51%	0.99%	1.77%	1.20%	1.74%
Best result	0.06%	0.57%	0.75%	0.65%	0.53%
Average result	1.37%	1.59%	1.84%	1.78%	1.88%
Worst result	4.88%	3.98%	5.45%	3.88%	6.08%
Responses	536	1261	1236	1327	1406

Note: 2023 results for Q13a-c are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Survey Coordination Centre

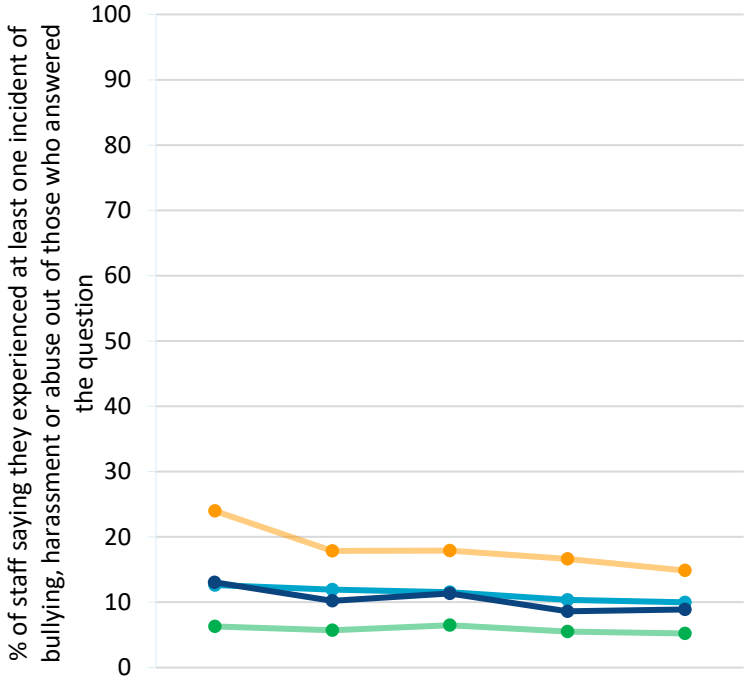
NHS

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



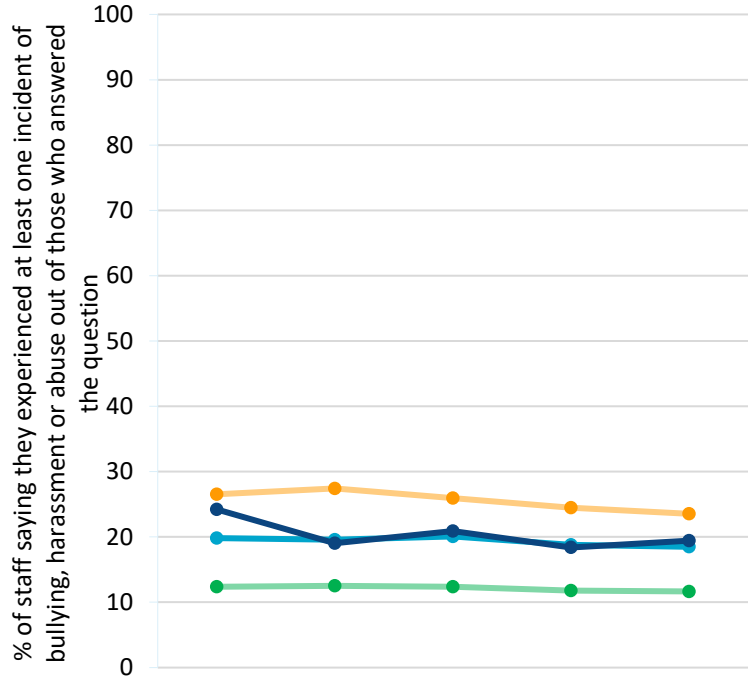
	2020	2021	2022	2023	2024
Your org	29.32%	28.49%	31.17%	24.74%	24.78%
Best result	18.42%	21.13%	20.77%	18.48%	14.63%
Average result	26.49%	27.65%	28.31%	24.99%	24.68%
Worst result	38.45%	35.69%	38.68%	32.43%	32.94%
Responses	531	1273	1242	1333	1411

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2020	2021	2022	2023	2024
Your org	13.05%	10.21%	11.32%	8.62%	8.91%
Best result	6.32%	5.72%	6.48%	5.52%	5.22%
Average result	12.64%	11.95%	11.55%	10.35%	10.00%
Worst result	23.98%	17.86%	17.89%	16.64%	14.86%
Responses	532	1261	1234	1329	1406

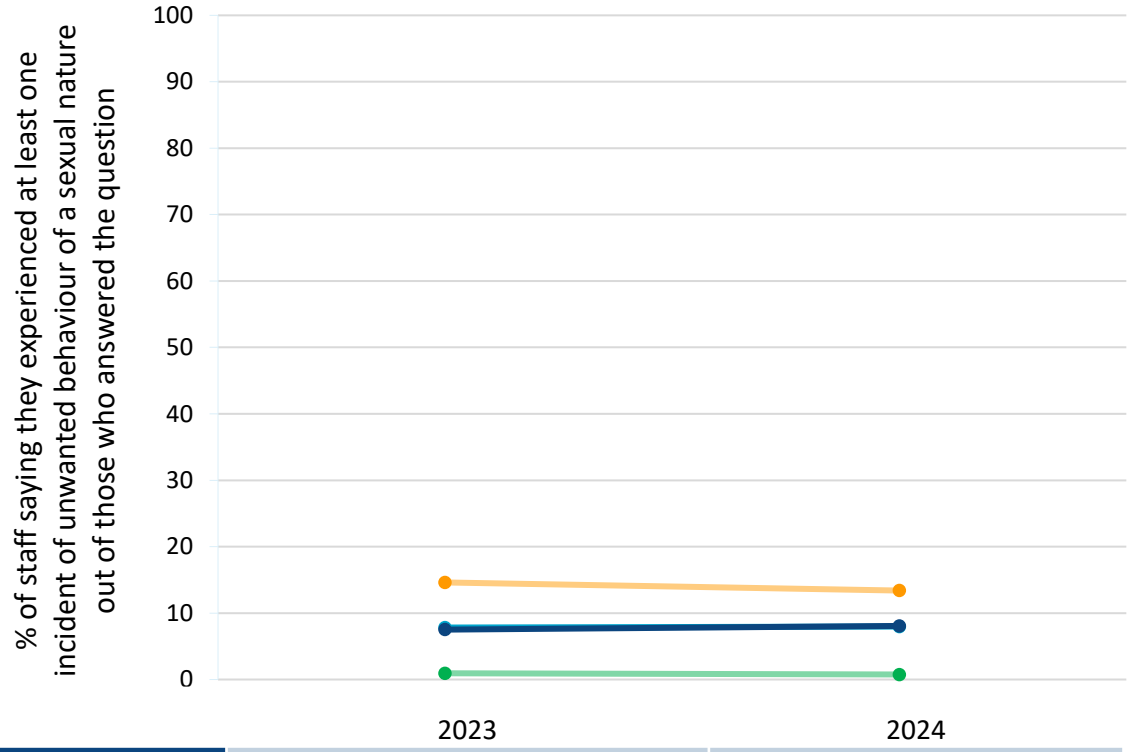
Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



	2020	2021	2022	2023	2024
Your org	24.22%	19.03%	20.91%	18.38%	19.45%
Best result	12.40%	12.51%	12.37%	11.80%	11.66%
Average result	19.80%	19.56%	20.08%	18.78%	18.49%
Worst result	26.52%	27.43%	25.97%	24.45%	23.55%
Responses	529	1261	1233	1331	1404

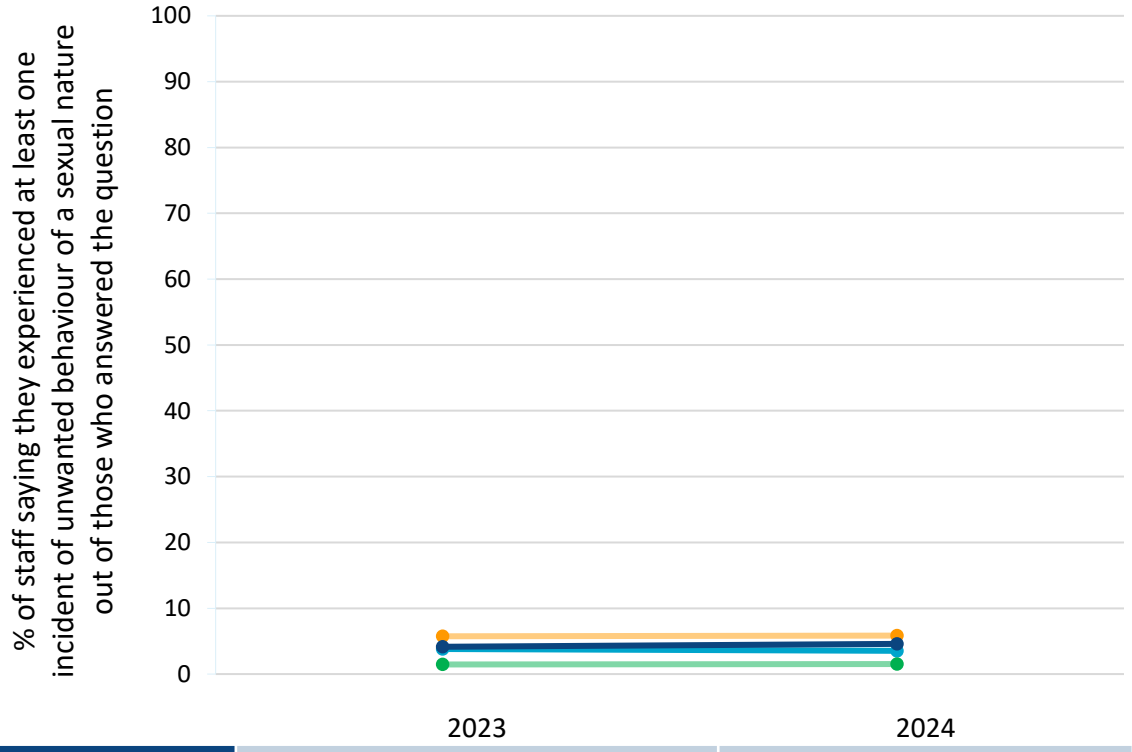
Note: 2023 results for Q14a-c are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public



	2023	2024
Your org	7.51%	8.06%
Best result	0.94%	0.76%
Average result	7.82%	7.98%
Worst result	14.61%	13.39%
Responses	1341	1415

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues



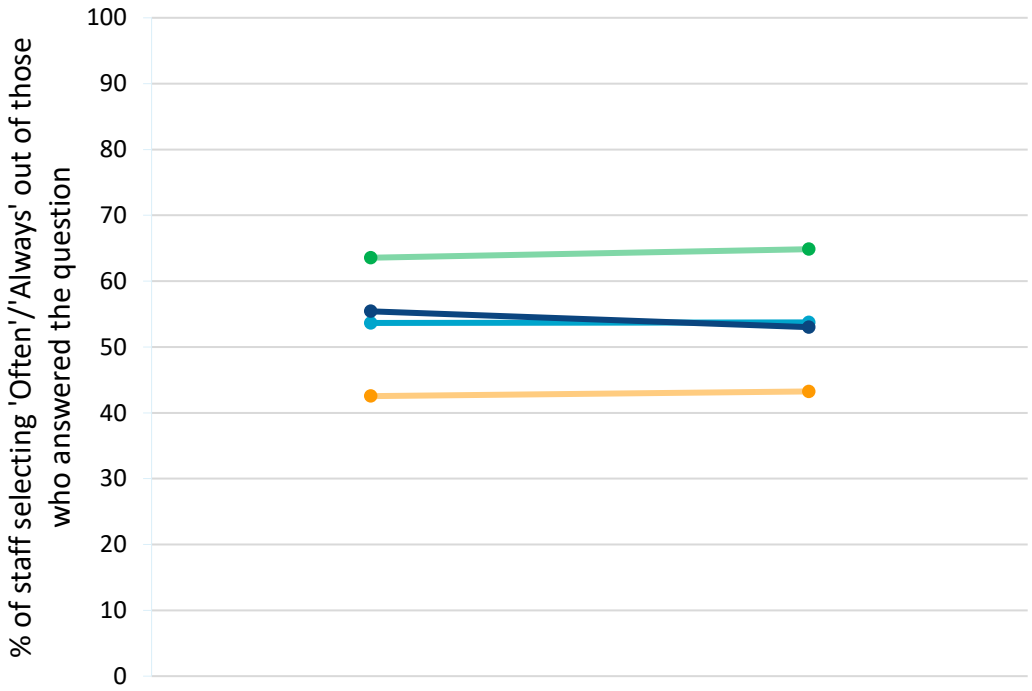
	2023	2024
Your org	4.15%	4.59%
Best result	1.46%	1.52%
Average result	3.81%	3.53%
Worst result	5.74%	5.85%
Responses	1337	1409

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

NHS

Q22 I can eat nutritious and affordable food while I am working



	2023	2024
Your org	55.41%	53.01%
Best result	63.56%	64.85%
Average result	53.65%	53.73%
Worst result	42.53%	43.25%
Responses	1336	1415

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:

Development – Q24a, Q24b, Q24c, Q24d, Q24e

Appraisals – Q23a*, Q23b, Q23c, Q23d

Other questions** - Q24f

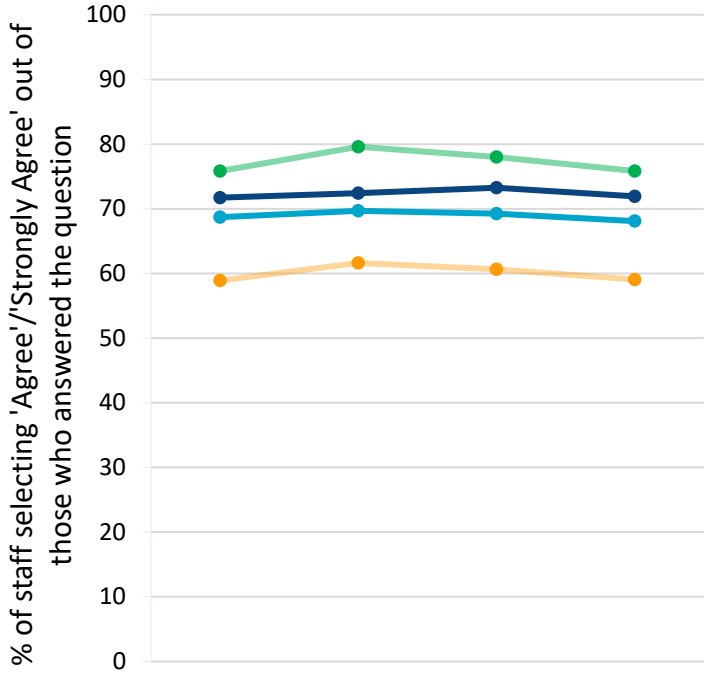
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

**Q24f does not contribute to the calculation of any scores or sub-scores.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

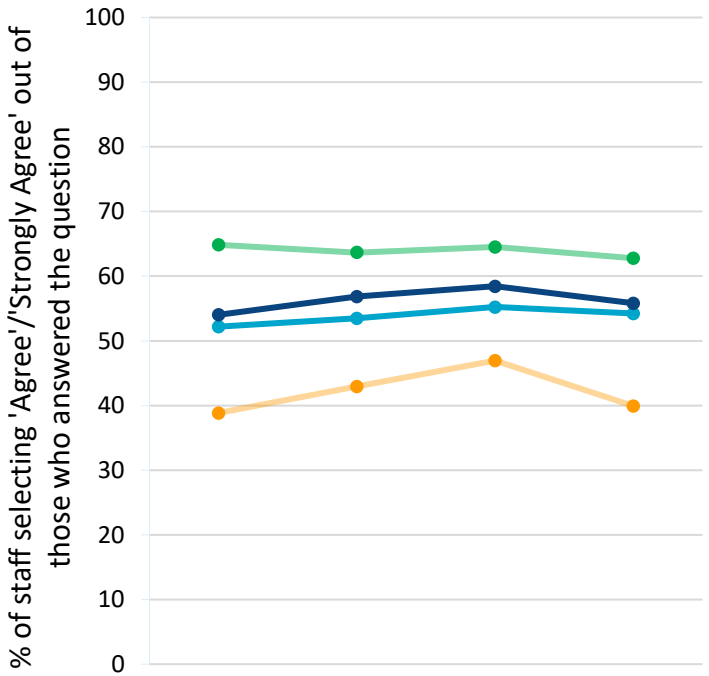
Survey Coordination Centre NHS

Q24a This organisation offers me challenging work.



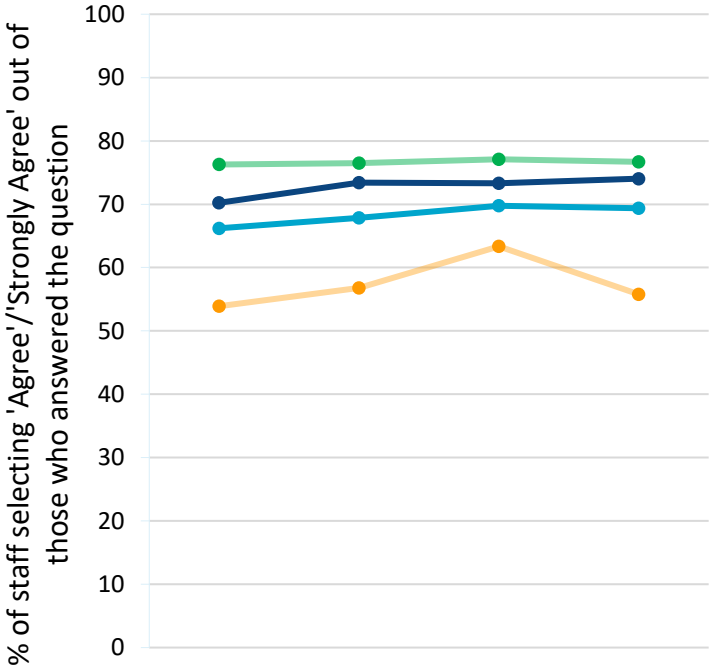
	2021	2022	2023	2024
Your org	71.72%	72.39%	73.25%	71.90%
Best result	75.83%	79.59%	78.00%	75.84%
Average result	68.68%	69.68%	69.23%	68.08%
Worst result	58.89%	61.62%	60.63%	59.05%
Responses	1268	1248	1340	1408

Q24b There are opportunities for me to develop my career in this organisation.



	2021	2022	2023	2024
Your org	54.03%	56.86%	58.45%	55.83%
Best result	64.85%	63.63%	64.50%	62.77%
Average result	52.19%	53.47%	55.24%	54.25%
Worst result	38.85%	42.97%	46.95%	39.91%
Responses	1268	1249	1340	1407

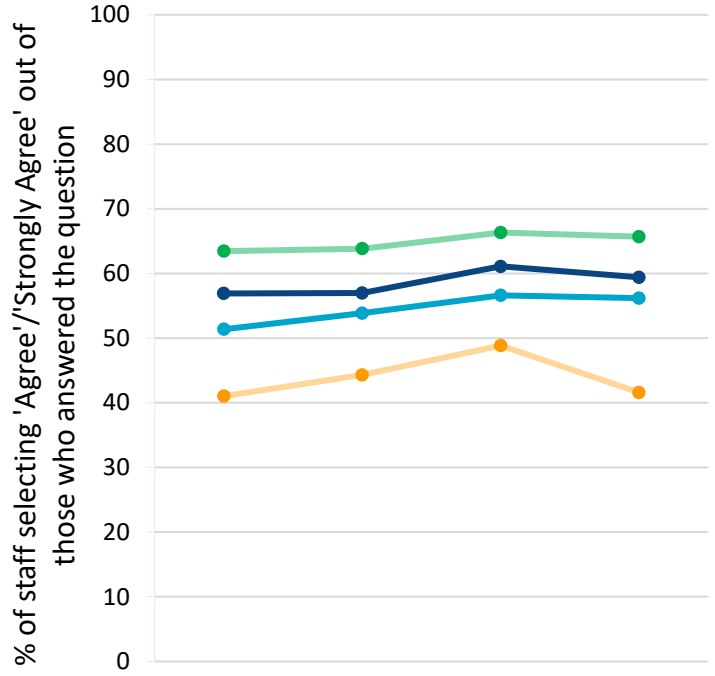
Q24c I have opportunities to improve my knowledge and skills.



	2021	2022	2023	2024
Your org	70.23%	73.41%	73.32%	74.04%
Best result	76.28%	76.49%	77.10%	76.67%
Average result	66.20%	67.87%	69.76%	69.39%
Worst result	53.90%	56.77%	63.34%	55.79%
Responses	1271	1248	1342	1407

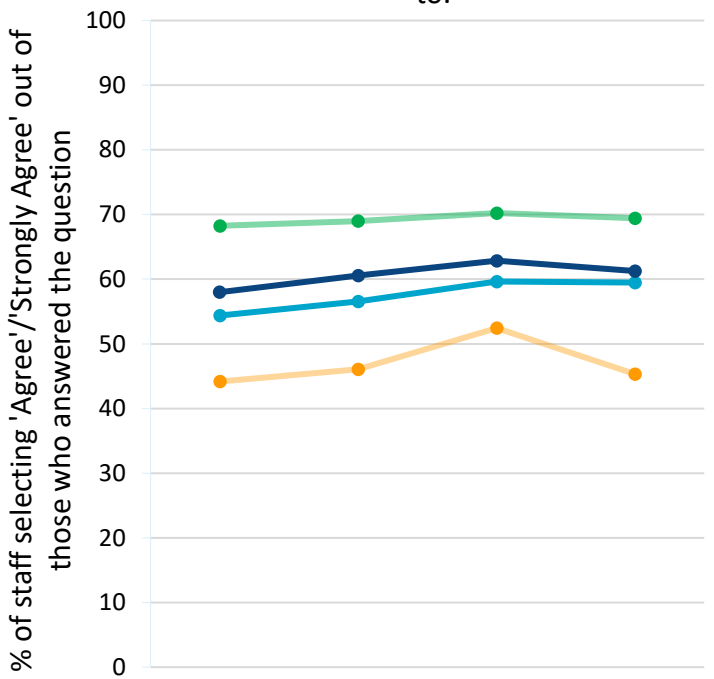
Survey Coordination Centre NHS

Q24d I feel supported to develop my potential.



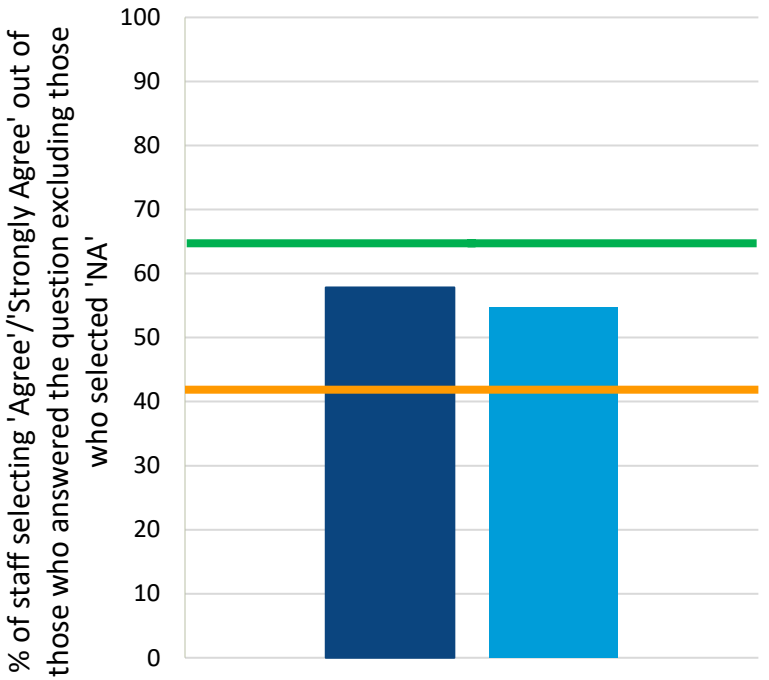
	2021	2022	2023	2024
Your org	56.90%	57.00%	61.10%	59.41%
Best result	63.45%	63.83%	66.33%	65.69%
Average result	51.37%	53.85%	56.61%	56.17%
Worst result	41.03%	44.31%	48.84%	41.60%
Responses	1262	1249	1338	1405

Q24e I am able to access the right learning and development opportunities when I need to.



	2021	2022	2023	2024
Your org	57.99%	60.54%	62.86%	61.24%
Best result	68.26%	68.98%	70.23%	69.44%
Average result	54.38%	56.55%	59.64%	59.45%
Worst result	44.17%	46.06%	52.43%	45.31%
Responses	1264	1242	1336	1391

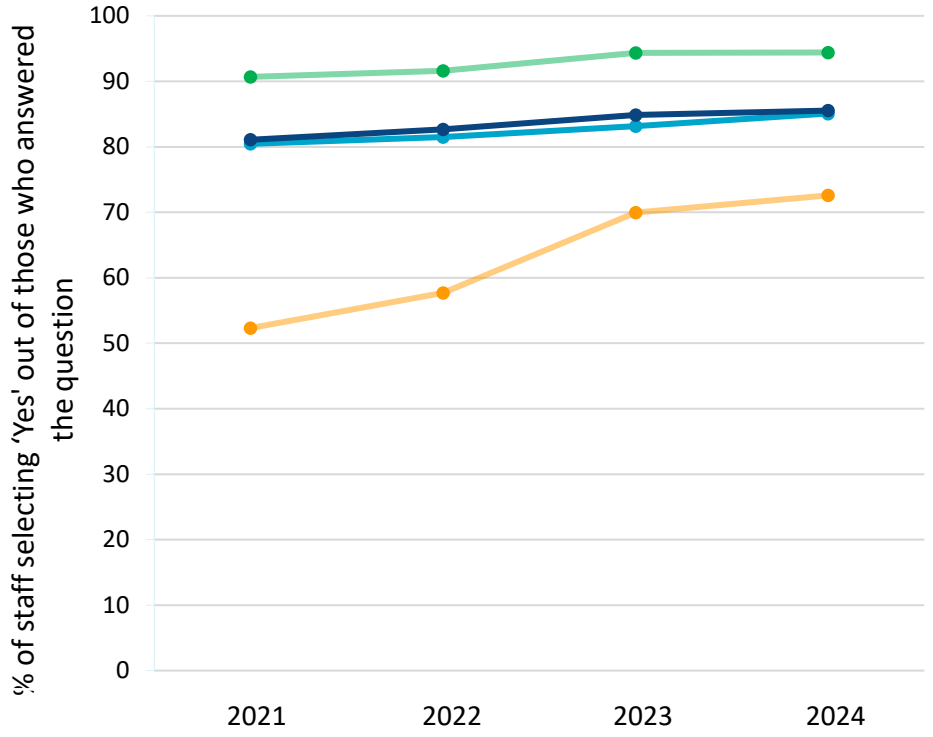
Q24f* I am able to access clinical supervision opportunities when I need to.



	2024
Your org	57.83%
Best result	64.73%
Average result	54.75%
Worst result	41.87%
Responses	1030

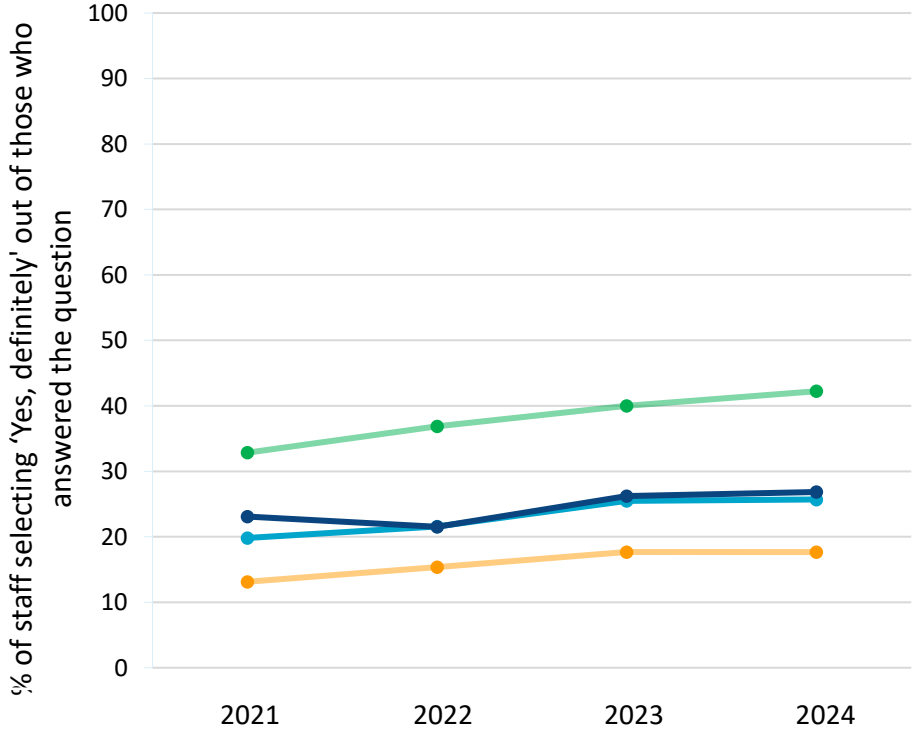
*Q24f was introduced in 2024 and does not currently contribute towards any People Promise element score, theme score or sub-score to protect trend data over five years.

Q23a* In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2021	2022	2023	2024
Your org	81.08%	82.64%	84.87%	85.53%
Best result	90.68%	91.61%	94.36%	94.41%
Average result	80.45%	81.50%	83.17%	85.08%
Worst result	52.32%	57.70%	69.95%	72.58%
Responses	1250	1241	1339	1397

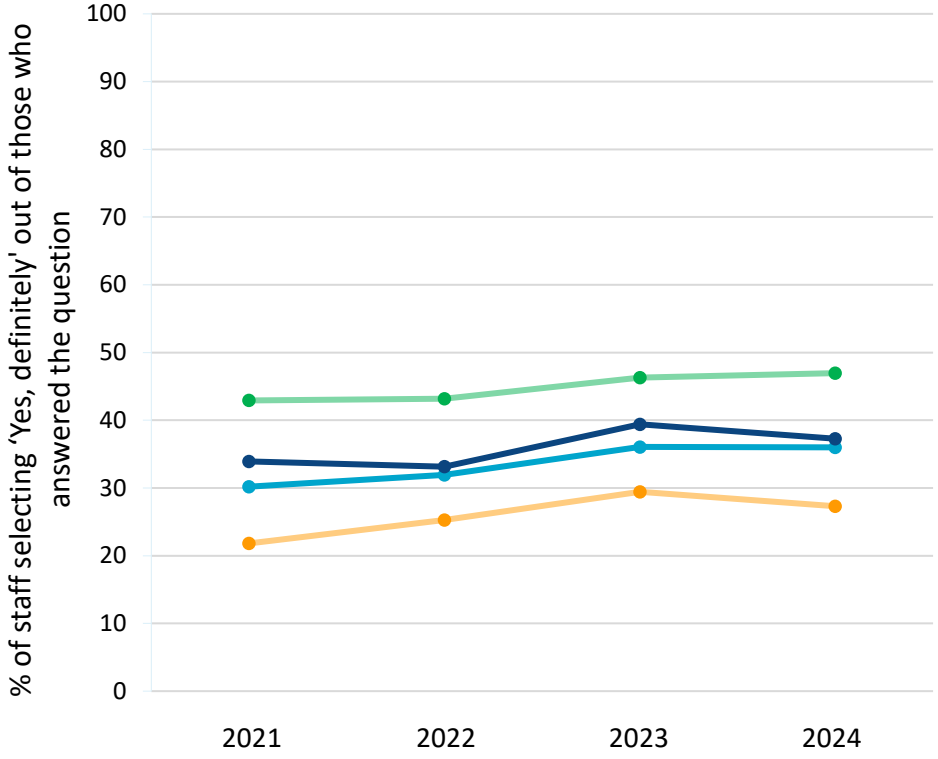
Q23b It helped me to improve how I do my job.



	2021	2022	2023	2024
Your org	23.09%	21.53%	26.23%	26.84%
Best result	32.85%	36.88%	39.99%	42.23%
Average result	19.82%	21.59%	25.50%	25.70%
Worst result	13.13%	15.35%	17.68%	17.65%
Responses	1000	1026	1132	1186

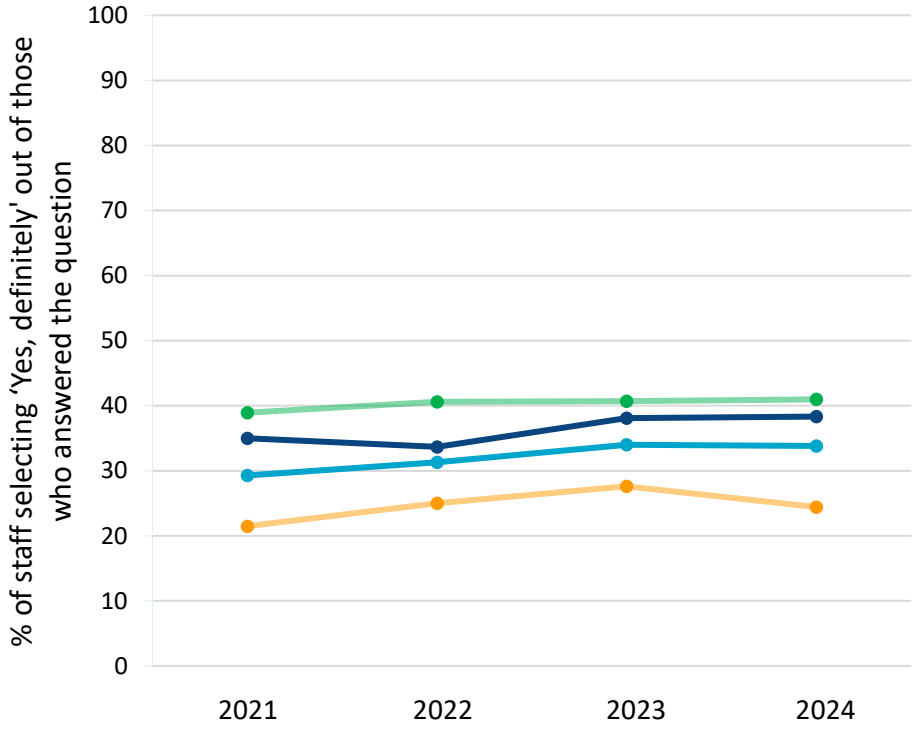
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

Q23c It helped me agree clear objectives for my work.



	2021	2022	2023	2024
Your org	33.93%	33.14%	39.40%	37.25%
Best result	42.92%	43.18%	46.31%	46.95%
Average result	30.19%	31.93%	36.06%	36.01%
Worst result	21.81%	25.28%	29.43%	27.28%
Responses	997	1023	1125	1185

Q23d It left me feeling that my work is valued by my organisation.



	2021	2022	2023	2024
Your org	35.00%	33.67%	38.10%	38.33%
Best result	38.93%	40.59%	40.69%	40.97%
Average result	29.27%	31.30%	33.99%	33.79%
Worst result	21.48%	25.03%	27.61%	24.42%
Responses	1003	1025	1129	1186

Survey Coordination Centre

NHS

People Promise element – We work flexibly

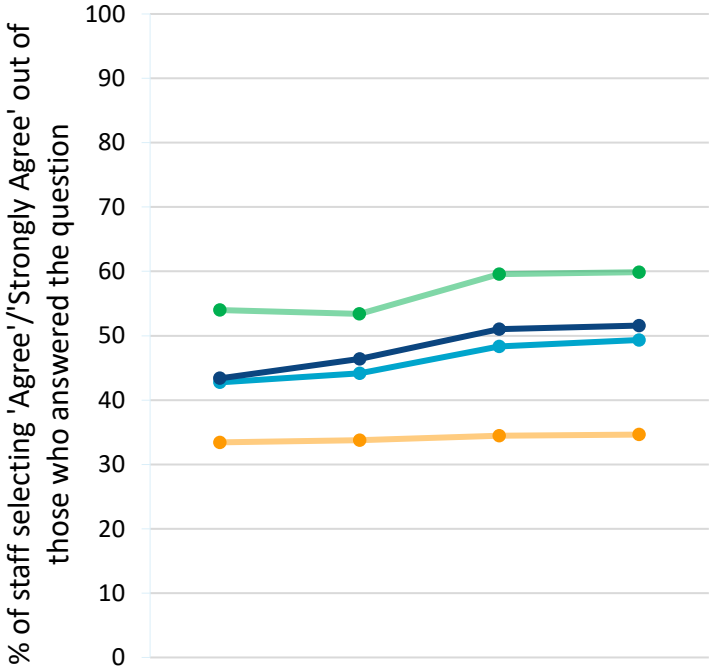
Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

Flexible working – Q4d

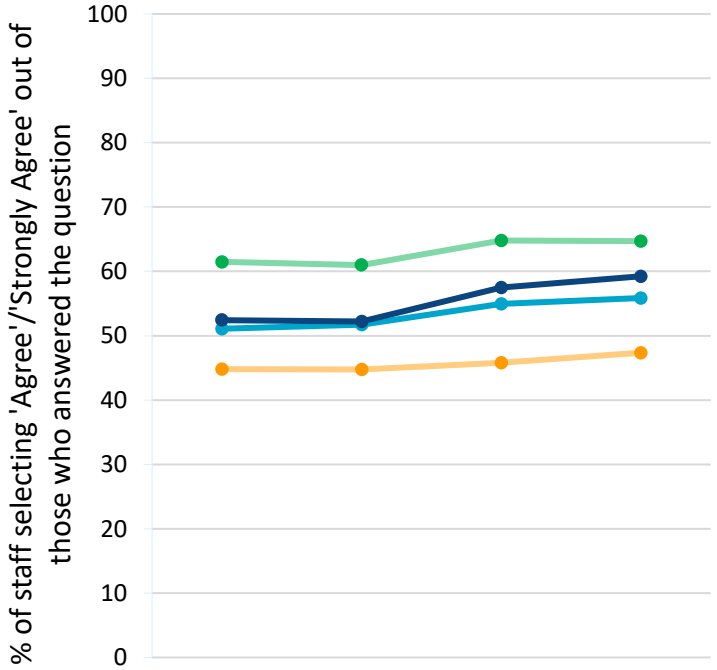
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6b My organisation is committed to helping me balance my work and home life.



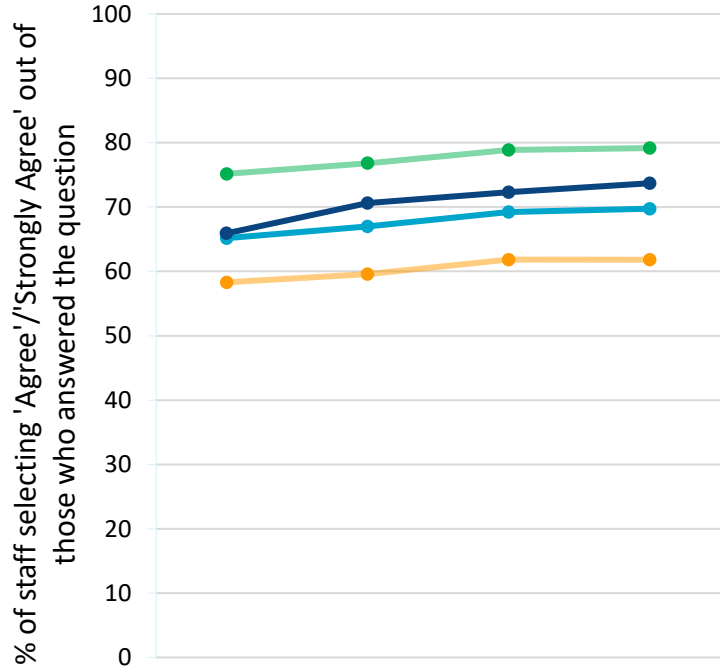
	2021	2022	2023	2024
Your org	43.37%	46.41%	51.00%	51.58%
Best result	53.99%	53.39%	59.57%	59.88%
Average result	42.75%	44.14%	48.33%	49.34%
Worst result	33.43%	33.74%	34.44%	34.64%
Responses	1280	1247	1346	1418

Q6c I achieve a good balance between my work life and my home life.



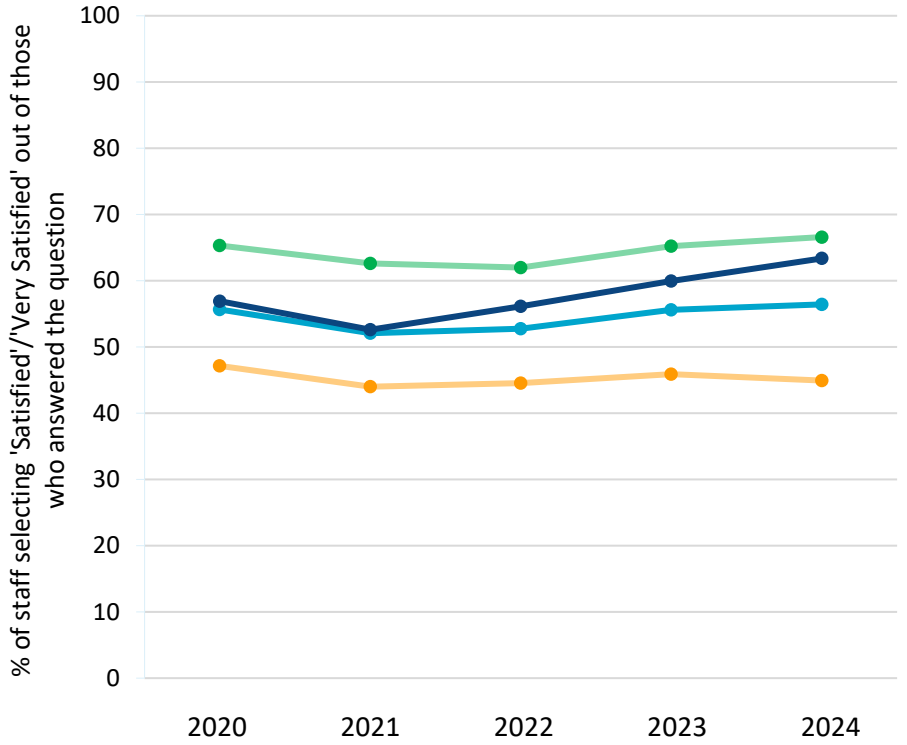
	2021	2022	2023	2024
Your org	52.43%	52.21%	57.51%	59.24%
Best result	61.48%	60.97%	64.79%	64.71%
Average result	51.09%	51.73%	54.93%	55.86%
Worst result	44.80%	44.75%	45.81%	47.36%
Responses	1276	1246	1344	1416

Q6d I can approach my immediate manager to talk openly about flexible working.



	2021	2022	2023	2024
Your org	65.92%	70.59%	72.31%	73.69%
Best result	75.16%	76.80%	78.85%	79.16%
Average result	65.17%	66.99%	69.24%	69.74%
Worst result	58.30%	59.57%	61.83%	61.80%
Responses	1274	1245	1350	1415

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.

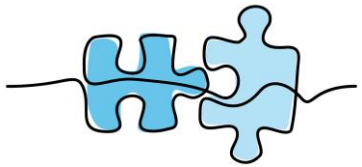


	2020	2021	2022	2023	2024
Your org	56.89%	52.61%	56.13%	59.96%	63.36%
Best result	65.32%	62.59%	61.99%	65.24%	66.60%
Average result	55.64%	52.08%	52.73%	55.59%	56.43%
Worst result	47.14%	44.00%	44.56%	45.90%	44.91%
Responses	538	1273	1244	1343	1418

Survey Coordination Centre

NHS

People Promise element – We are a team



Questions included:

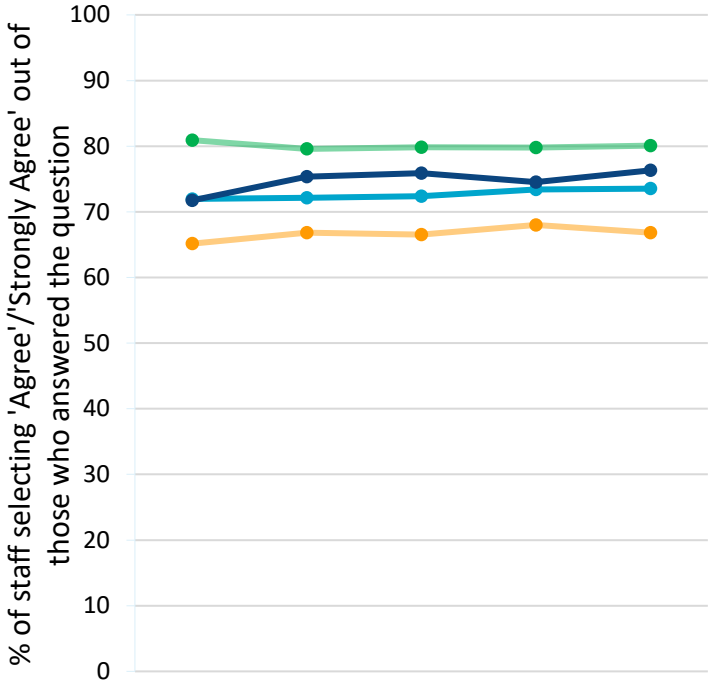
Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

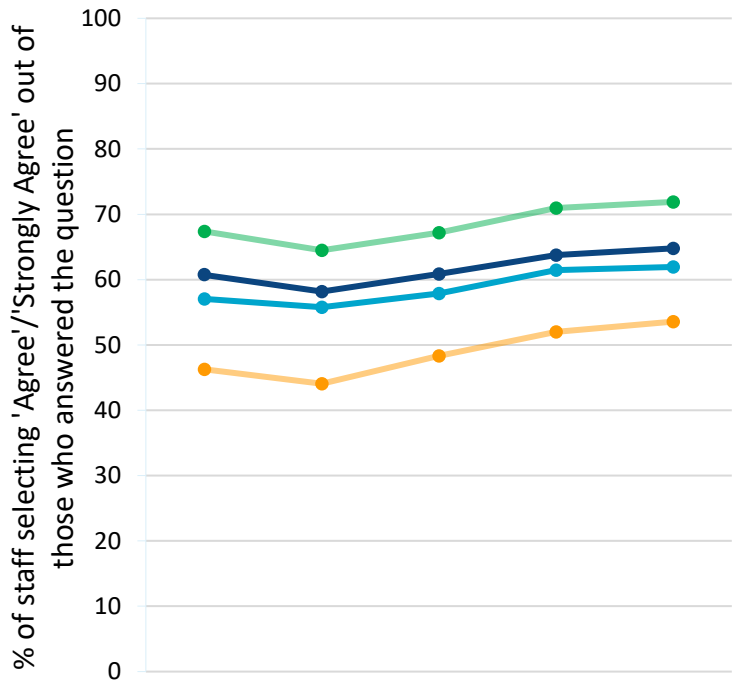
Survey Coordination Centre NHS

Q7a The team I work in has a set of shared objectives.



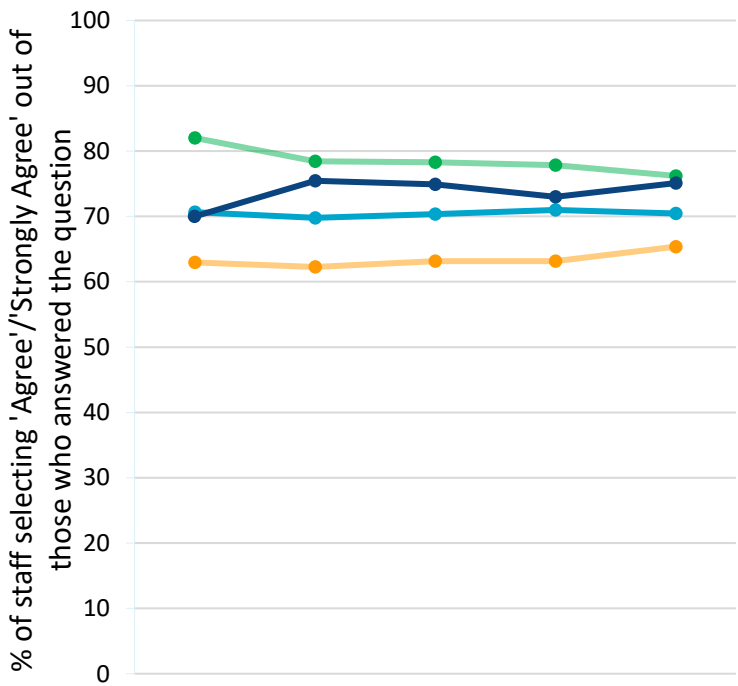
	2020	2021	2022	2023	2024
Your org	71.74%	75.36%	75.91%	74.51%	76.32%
Best result	80.92%	79.58%	79.84%	79.80%	80.07%
Average result	71.97%	72.15%	72.38%	73.42%	73.53%
Worst result	65.15%	66.83%	66.52%	68.00%	66.82%
Responses	534	1275	1245	1347	1421

Q7b The team I work in often meets to discuss the team's effectiveness.



	2020	2021	2022	2023	2024
Your org	60.73%	58.17%	60.87%	63.74%	64.79%
Best result	67.38%	64.49%	67.16%	70.97%	71.90%
Average result	57.06%	55.78%	57.87%	61.46%	61.94%
Worst result	46.26%	44.06%	48.33%	52.00%	53.58%
Responses	538	1274	1243	1347	1418

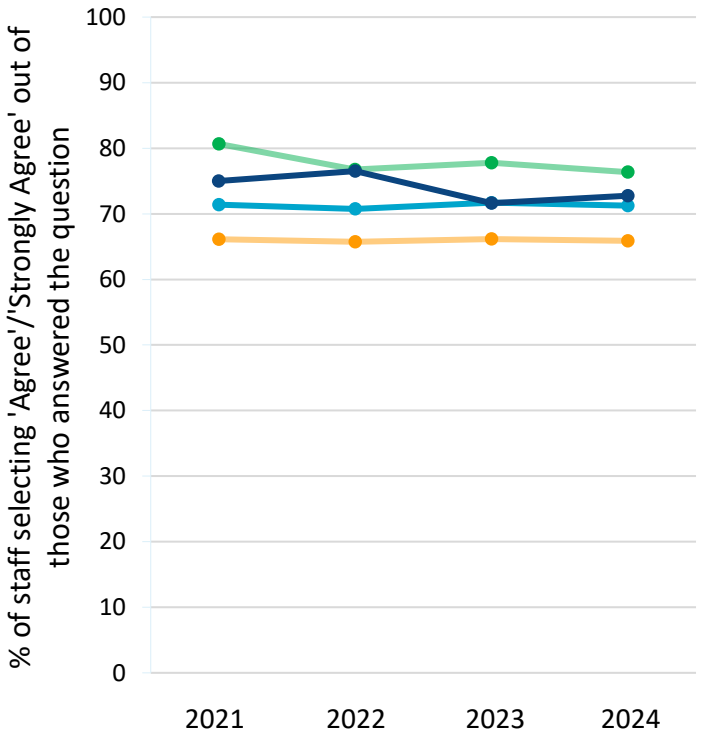
Q7c I receive the respect I deserve from my colleagues at work.



	2020	2021	2022	2023	2024
Your org	70.01%	75.45%	74.90%	73.01%	75.11%
Best result	82.02%	78.45%	78.29%	77.84%	76.21%
Average result	70.63%	69.79%	70.36%	70.99%	70.44%
Worst result	62.98%	62.27%	63.14%	63.16%	65.37%
Responses	537	1277	1245	1349	1419

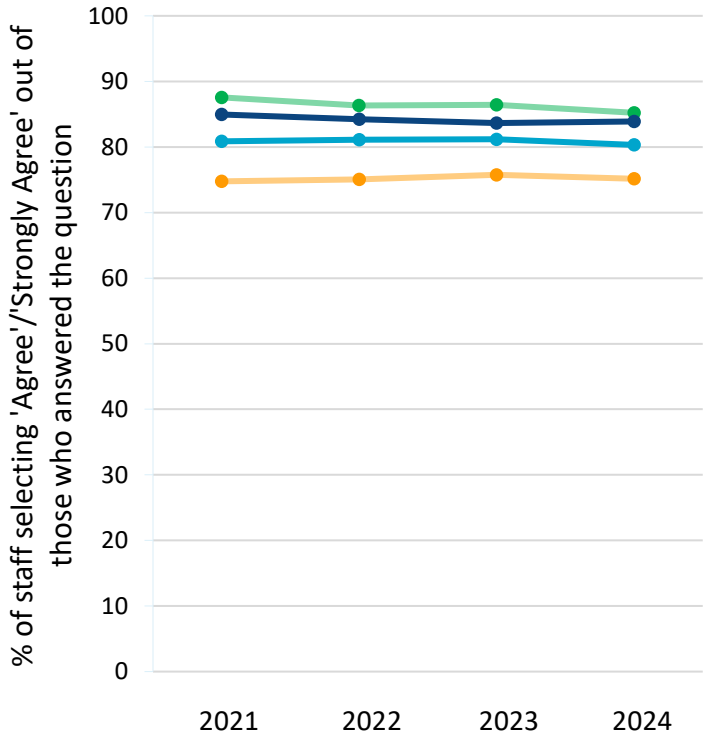
Survey Coordination Centre NHS

Q7d Team members understand each other's roles.



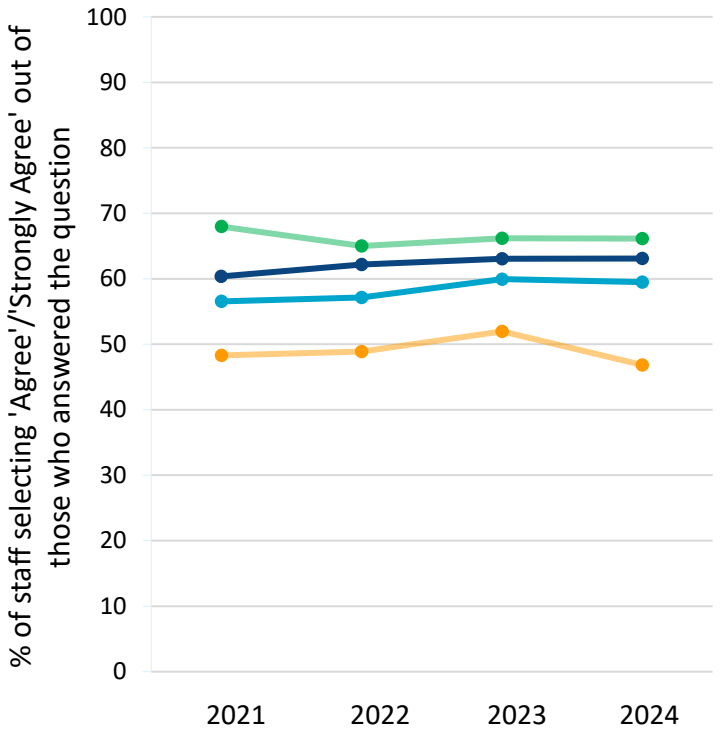
	2021	2022	2023	2024
Your org	75.00%	76.52%	71.63%	72.76%
Best result	80.65%	76.75%	77.80%	76.36%
Average result	71.41%	70.75%	71.71%	71.27%
Worst result	66.14%	65.74%	66.15%	65.89%
Responses	1273	1245	1346	1419

Q7e I enjoy working with the colleagues in my team.



	2021	2022	2023	2024
Your org	84.95%	84.25%	83.65%	83.92%
Best result	87.56%	86.32%	86.45%	85.22%
Average result	80.88%	81.11%	81.18%	80.32%
Worst result	74.76%	75.06%	75.76%	75.15%
Responses	1271	1244	1350	1416

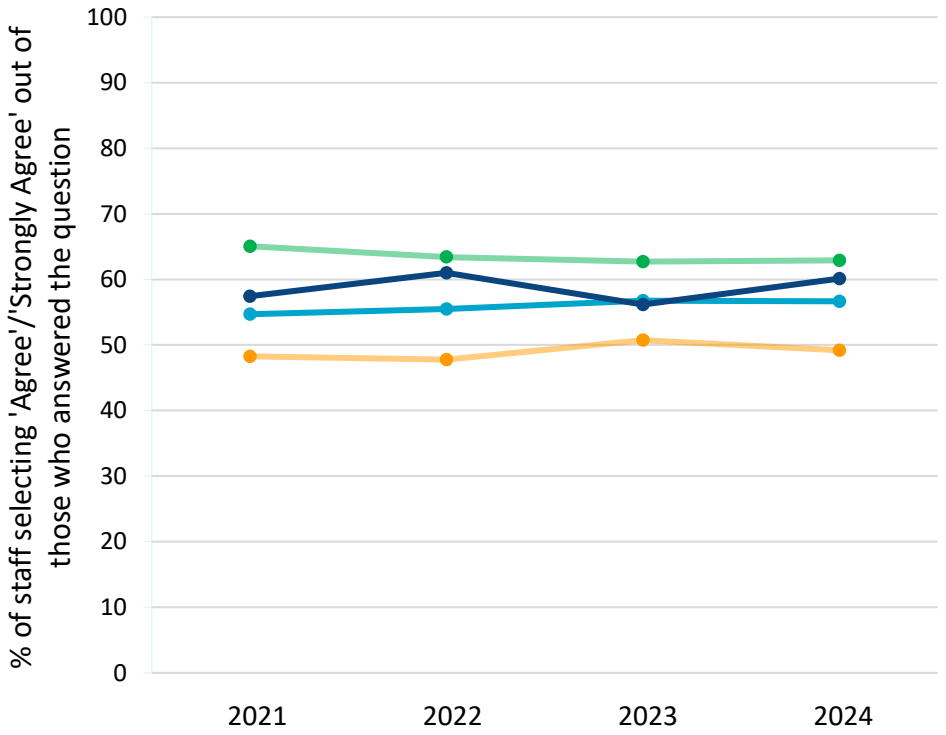
Q7f My team has enough freedom in how to do its work.



	2021	2022	2023	2024
Your org	60.36%	62.19%	63.04%	63.09%
Best result	67.97%	65.01%	66.20%	66.16%
Average result	56.55%	57.13%	59.95%	59.47%
Worst result	48.31%	48.90%	51.97%	46.83%
Responses	1272	1241	1344	1417

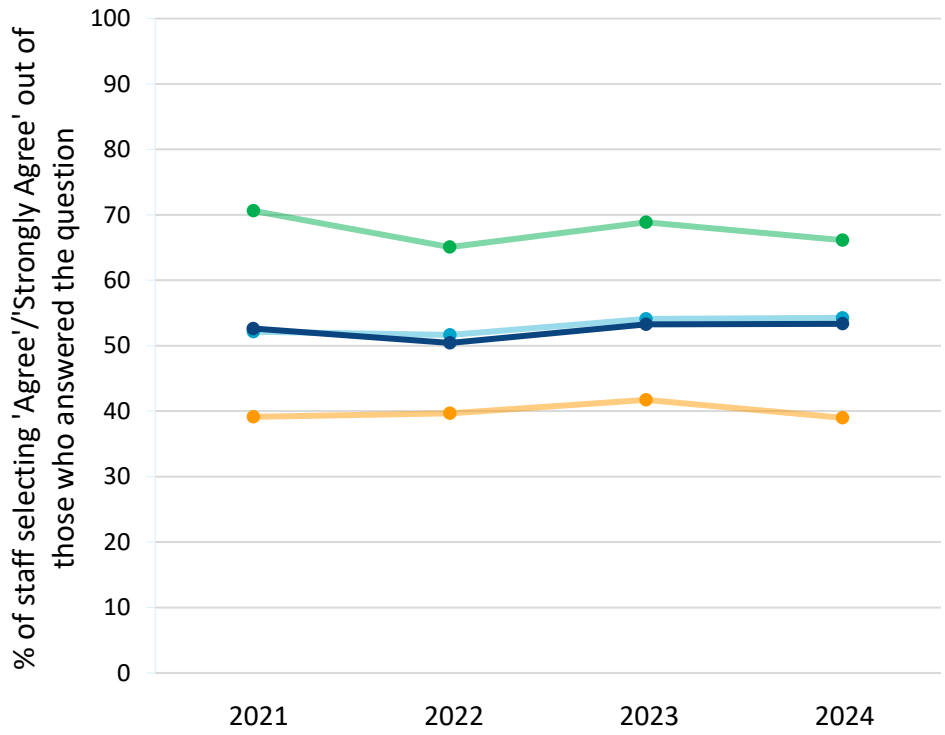
Survey Coordination Centre NHS

Q7g In my team disagreements are dealt with constructively.



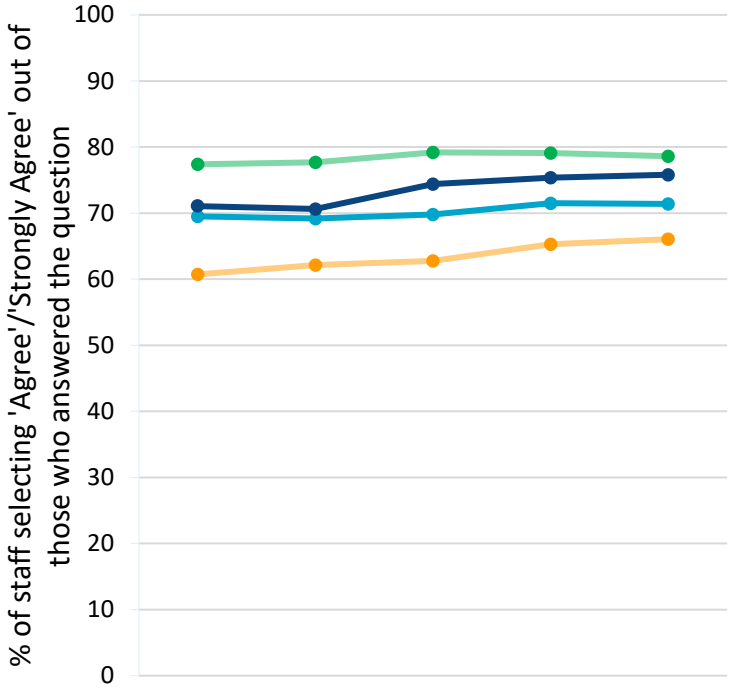
	2021	2022	2023	2024
Your org	57.42%	61.00%	56.17%	60.11%
Best result	65.06%	63.41%	62.71%	62.90%
Average result	54.69%	55.50%	56.75%	56.65%
Worst result	48.27%	47.77%	50.73%	49.19%
Responses	1271	1241	1347	1415

Q8a Teams within this organisation work well together to achieve their objectives.



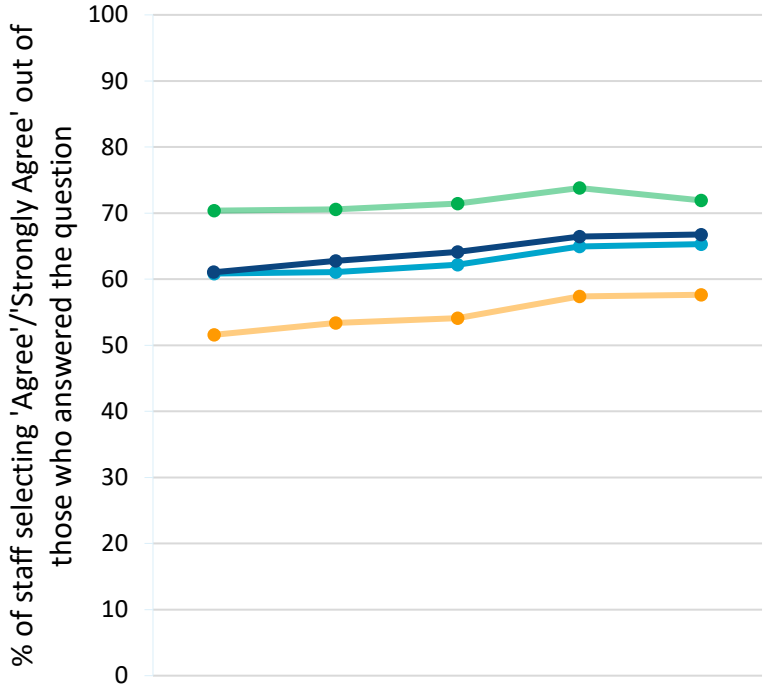
	2021	2022	2023	2024
Your org	52.61%	50.43%	53.26%	53.35%
Best result	70.62%	65.08%	68.88%	66.13%
Average result	52.14%	51.65%	54.11%	54.27%
Worst result	39.14%	39.66%	41.73%	38.98%
Responses	1272	1245	1343	1414

Q9a My immediate manager encourages me at work.



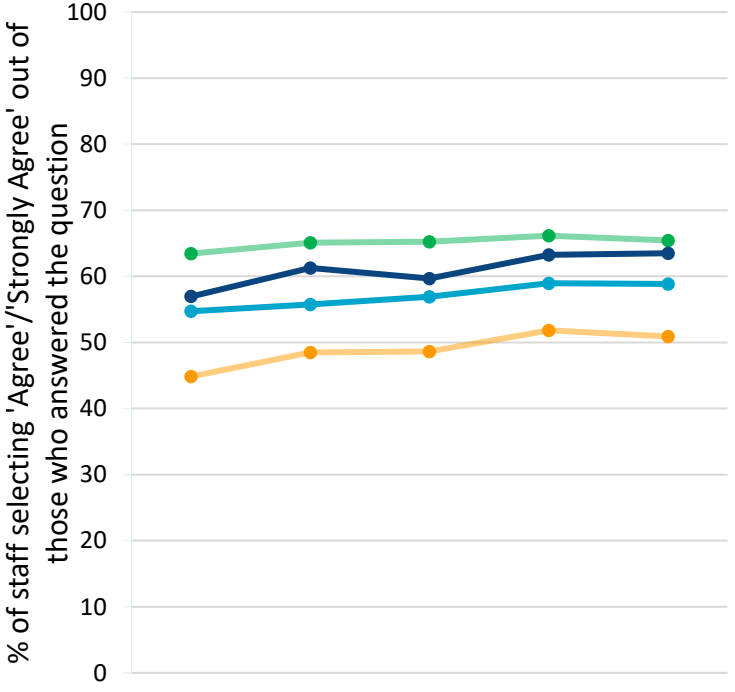
	2020	2021	2022	2023	2024
Your org	71.07%	70.63%	74.38%	75.35%	75.81%
Best result	77.39%	77.71%	79.19%	79.11%	78.63%
Average result	69.49%	69.19%	69.81%	71.50%	71.38%
Worst result	60.73%	62.13%	62.79%	65.30%	66.06%
Responses	537	1279	1244	1347	1418

Q9b My immediate manager gives me clear feedback on my work.



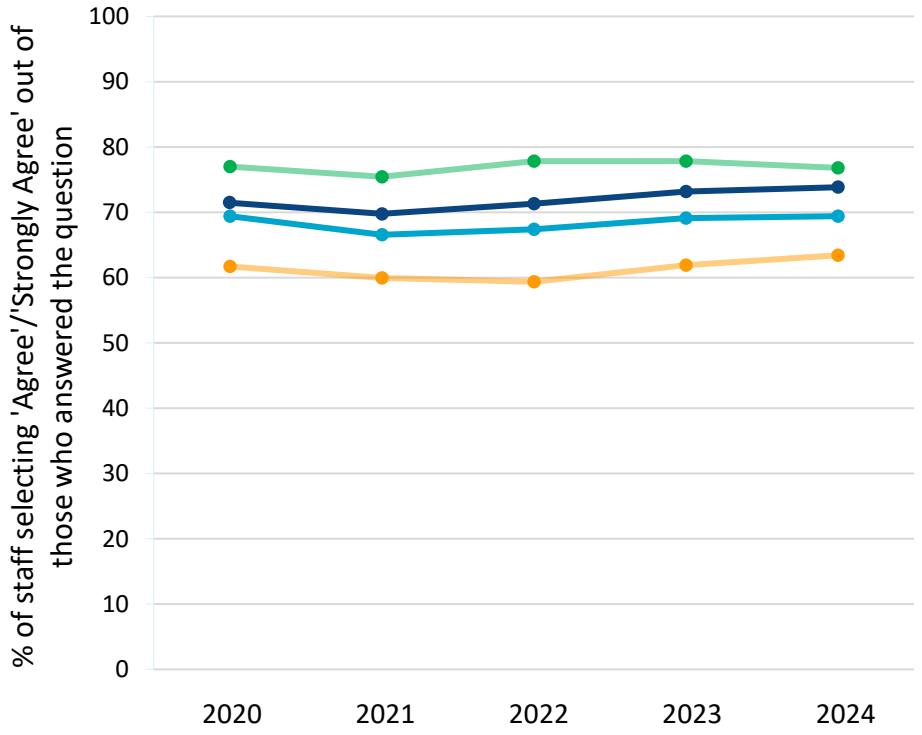
	2020	2021	2022	2023	2024
Your org	61.04%	62.76%	64.11%	66.45%	66.77%
Best result	70.38%	70.55%	71.44%	73.80%	71.93%
Average result	60.86%	61.06%	62.20%	64.95%	65.31%
Worst result	51.58%	53.40%	54.10%	57.39%	57.64%
Responses	537	1276	1243	1349	1417

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2020	2021	2022	2023	2024
Your org	56.96%	61.28%	59.70%	63.24%	63.50%
Best result	63.45%	65.11%	65.23%	66.16%	65.47%
Average result	54.73%	55.75%	56.93%	58.97%	58.84%
Worst result	44.85%	48.47%	48.62%	51.84%	50.94%
Responses	535	1275	1245	1347	1419

Q9d My immediate manager takes a positive interest in my health and well-being.



	2020	2021	2022	2023	2024
Your org	71.48%	69.77%	71.34%	73.15%	73.84%
Best result	76.99%	75.45%	77.82%	77.84%	76.82%
Average result	69.41%	66.56%	67.41%	69.10%	69.39%
Worst result	61.71%	59.97%	59.36%	61.90%	63.42%
Responses	537	1277	1244	1349	1420

Survey Coordination Centre

NHS

Theme – Staff engagement

Questions included:

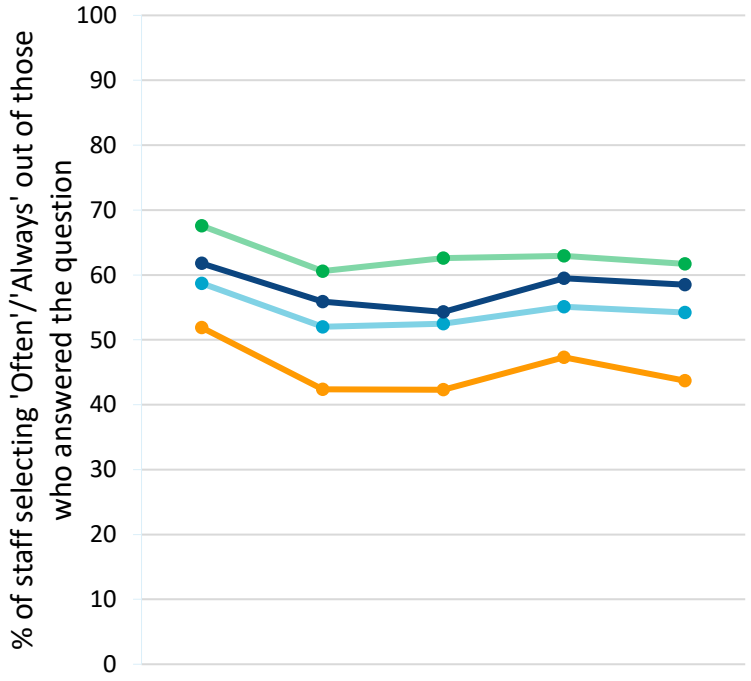
Motivation – Q2a, Q2b, Q2c

Involvement – Q3c, Q3d, Q3f

Advocacy – Q25a, Q25c, Q25d

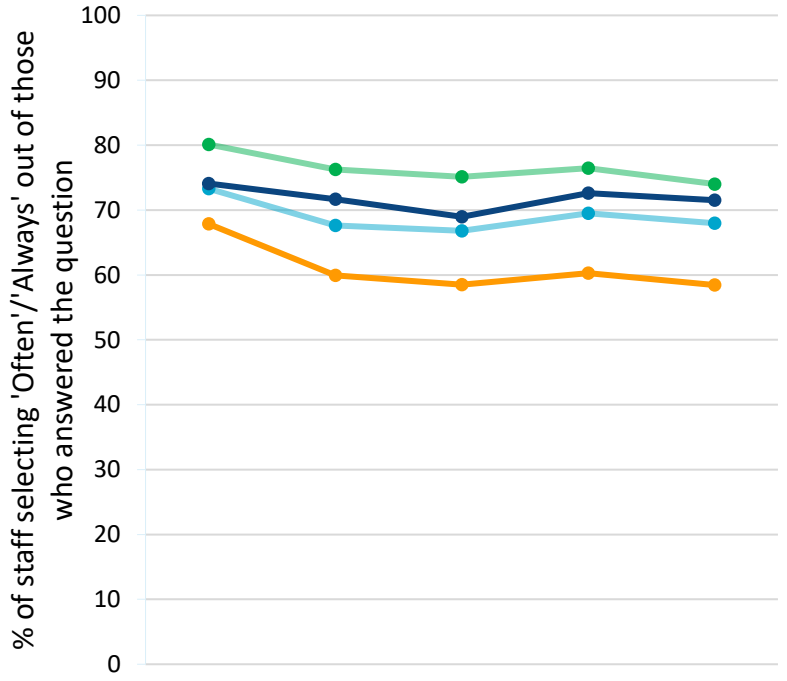
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q2a I look forward to going to work.



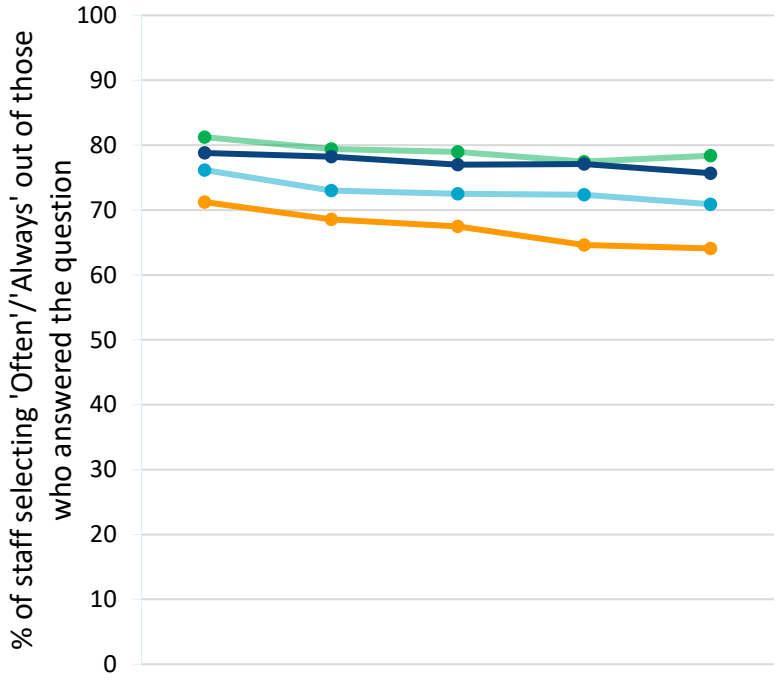
	2020	2021	2022	2023	2024
Your org	61.76%	55.87%	54.29%	59.49%	58.47%
Best result	67.56%	60.59%	62.57%	62.91%	61.70%
Average result	58.70%	52.01%	52.47%	55.07%	54.19%
Worst result	51.87%	42.39%	42.30%	47.30%	43.71%
Responses	540	1272	1240	1343	1416

Q2b I am enthusiastic about my job.



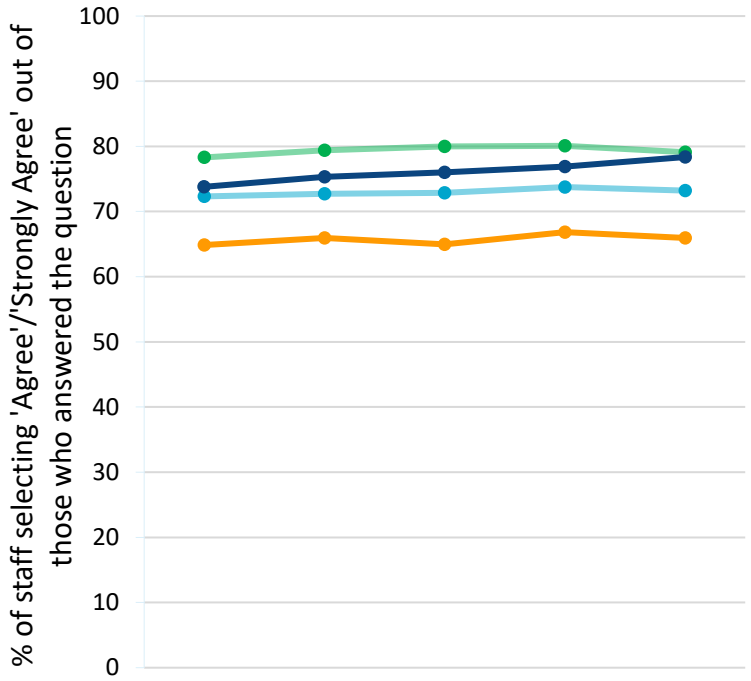
	2020	2021	2022	2023	2024
Your org	74.08%	71.66%	68.96%	72.59%	71.54%
Best result	80.10%	76.24%	75.13%	76.42%	74.01%
Average result	73.28%	67.60%	66.80%	69.49%	67.95%
Worst result	67.85%	59.92%	58.48%	60.25%	58.44%
Responses	536	1268	1237	1343	1408

Q2c Time passes quickly when I am working.



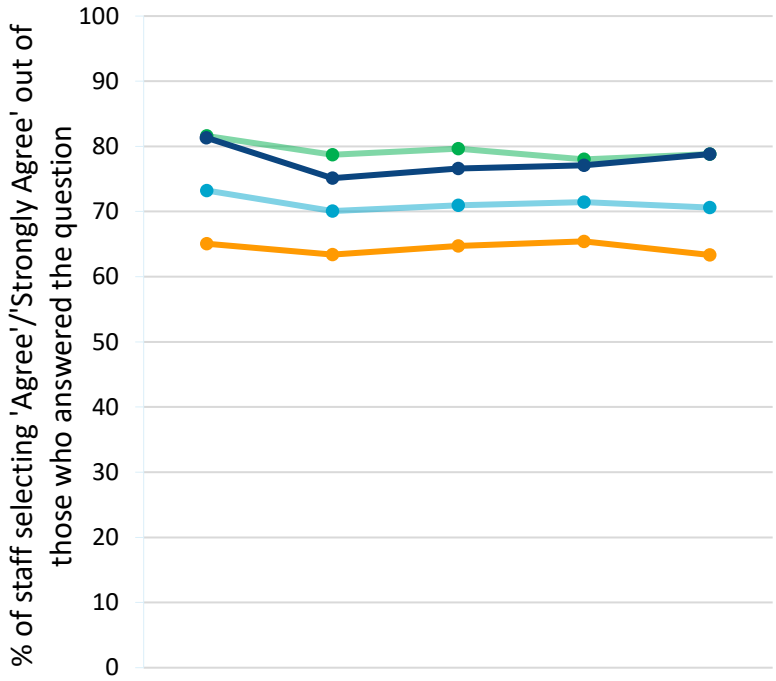
	2020	2021	2022	2023	2024
Your org	78.79%	78.22%	76.97%	77.10%	75.67%
Best result	81.23%	79.39%	78.98%	77.45%	78.37%
Average result	76.16%	72.99%	72.52%	72.36%	70.90%
Worst result	71.22%	68.54%	67.46%	64.61%	64.08%
Responses	534	1269	1237	1342	1409

Q3c There are frequent opportunities for me to show initiative in my role.



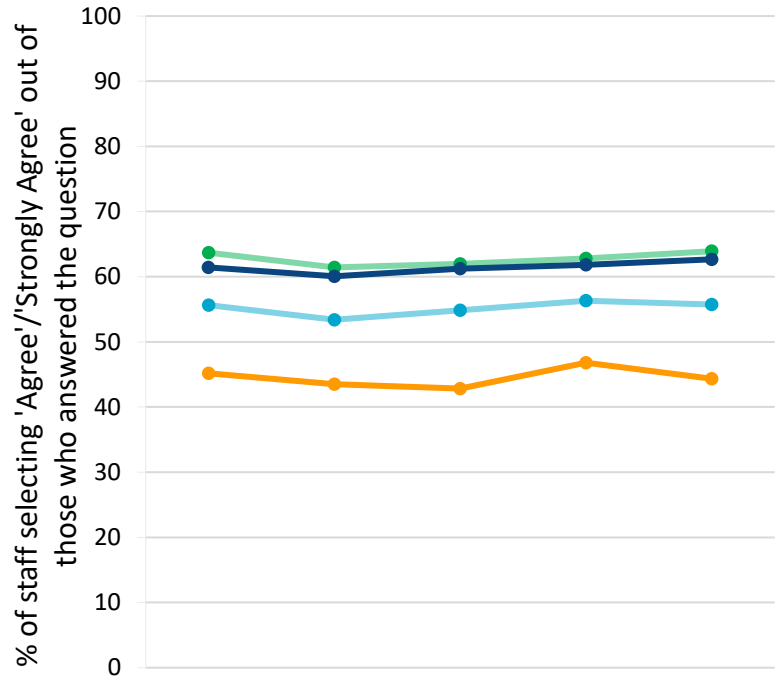
	2020	2021	2022	2023	2024
Your org	73.80%	75.31%	76.02%	76.91%	78.37%
Best result	78.30%	79.42%	80.00%	80.09%	79.13%
Average result	72.32%	72.74%	72.89%	73.76%	73.20%
Worst result	64.86%	65.95%	64.98%	66.84%	65.96%
Responses	539	1273	1239	1348	1421

Q3d I am able to make suggestions to improve the work of my team / department.



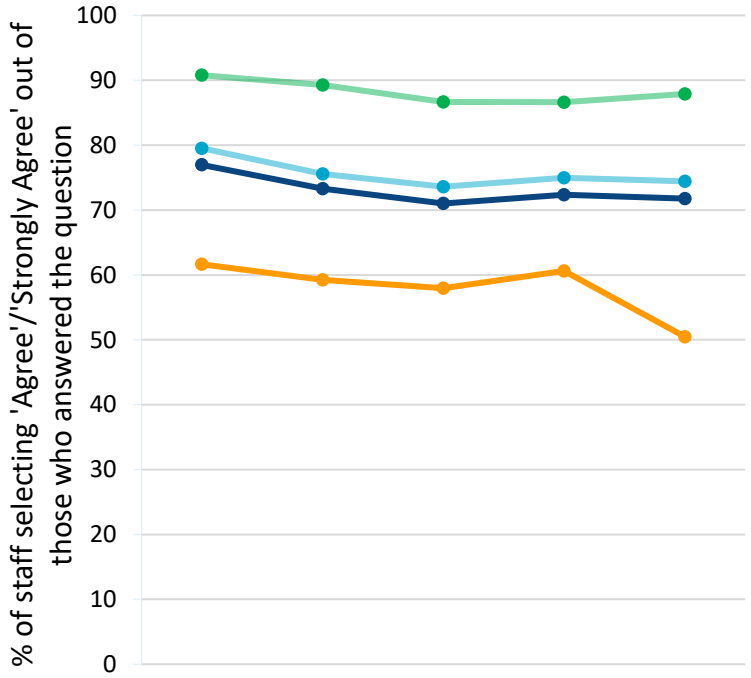
	2020	2021	2022	2023	2024
Your org	81.32%	75.12%	76.59%	77.08%	78.83%
Best result	81.61%	78.70%	79.64%	78.01%	78.83%
Average result	73.23%	70.08%	70.96%	71.46%	70.60%
Worst result	65.06%	63.41%	64.71%	65.42%	63.34%
Responses	536	1275	1242	1341	1416

Q3f I am able to make improvements happen in my area of work.



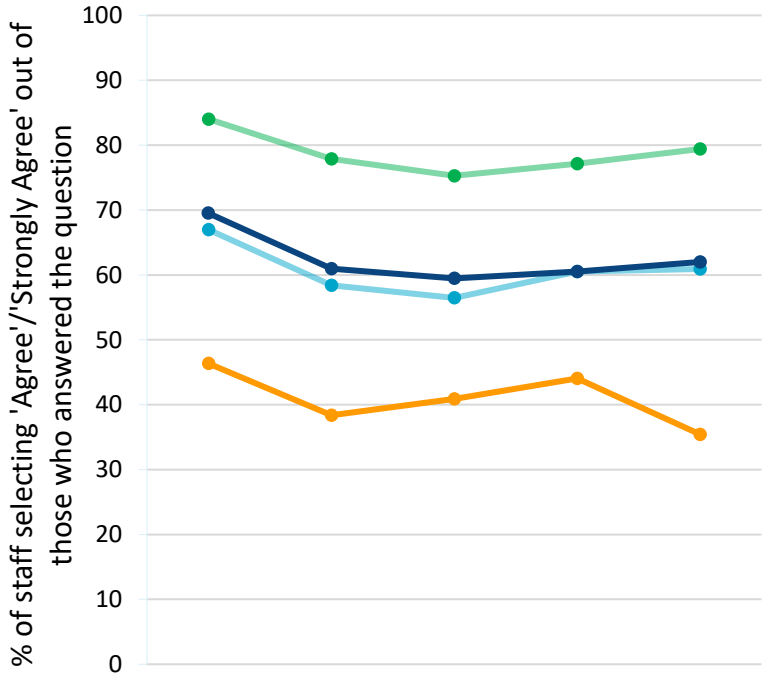
	2020	2021	2022	2023	2024
Your org	61.41%	60.06%	61.22%	61.82%	62.67%
Best result	63.70%	61.43%	61.98%	62.83%	63.91%
Average result	55.64%	53.40%	54.86%	56.31%	55.73%
Worst result	45.19%	43.51%	42.83%	46.80%	44.36%
Responses	539	1276	1243	1343	1415

Q25a Care of patients / service users is my organisation's top priority.



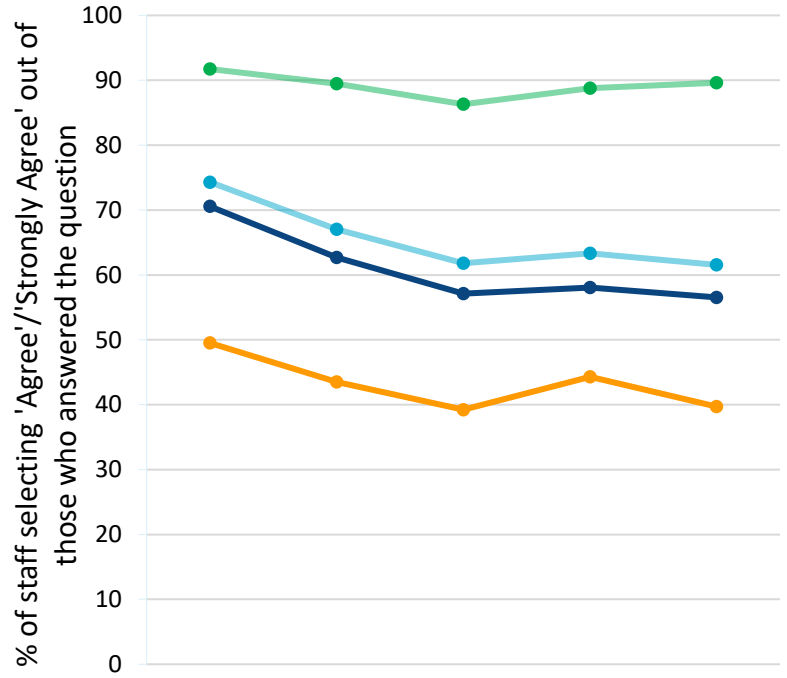
	2020	2021	2022	2023	2024
Your org	76.95%	73.27%	71.00%	72.35%	71.79%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	538	1272	1244	1341	1411

Q25c I would recommend my organisation as a place to work.



	2020	2021	2022	2023	2024
Your org	69.50%	60.94%	59.46%	60.50%	61.98%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	538	1269	1242	1341	1406

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2020	2021	2022	2023	2024
Your org	70.55%	62.68%	57.09%	58.07%	56.54%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	538	1264	1242	1337	1406

Survey Coordination Centre

NHS

Theme - Morale

Questions included:

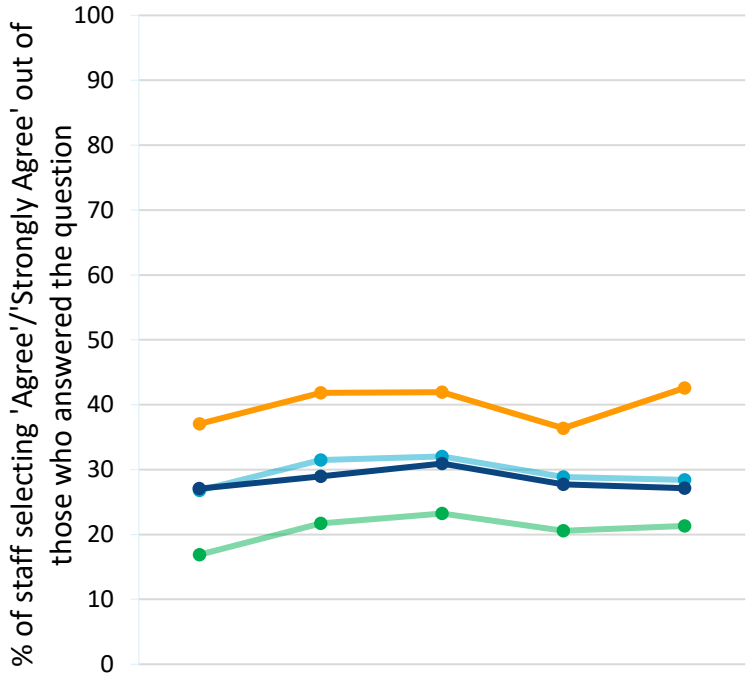
Thinking about leaving – Q26a, Q26b, Q26c

Work pressure – Q3g, Q3h, Q3i

Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

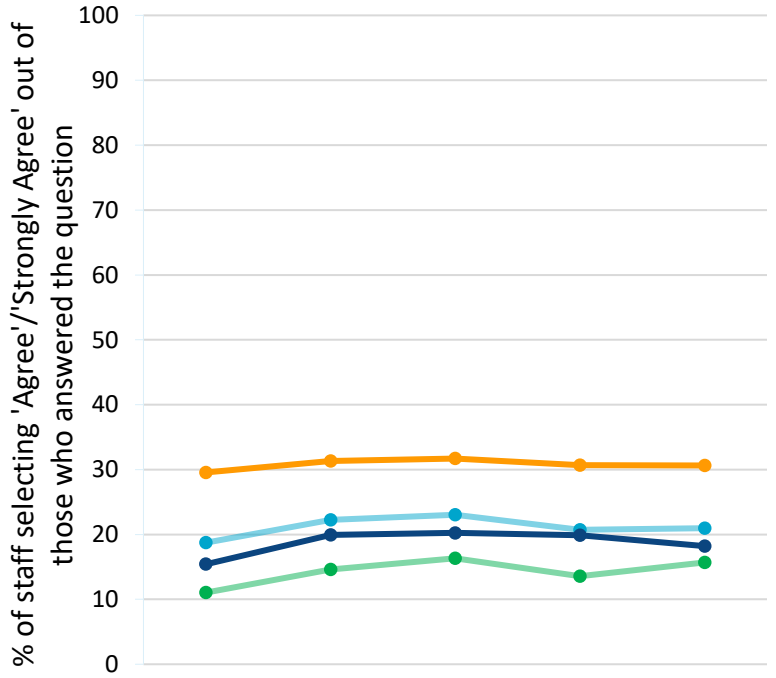
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q26a I often think about leaving this organisation.



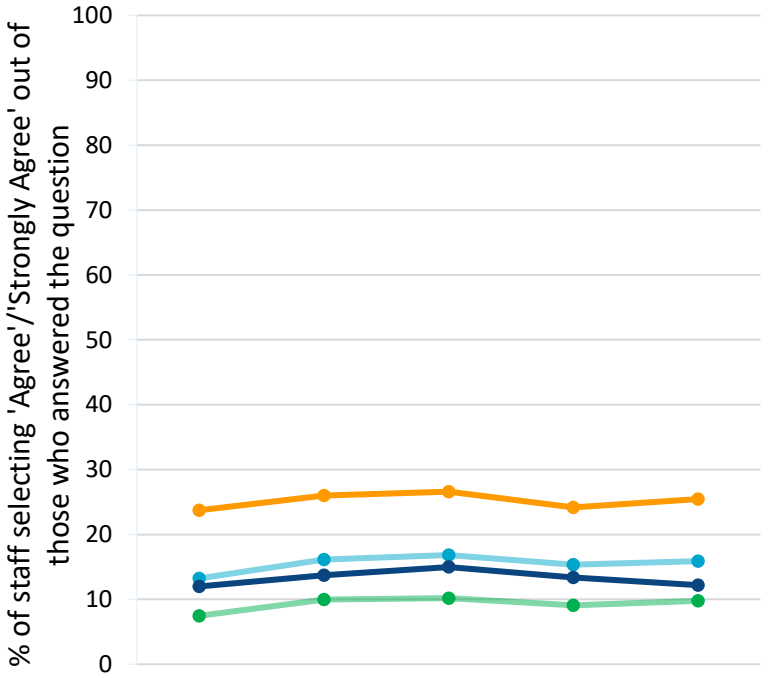
	2020	2021	2022	2023	2024
Your org	27.06%	28.94%	30.92%	27.74%	27.13%
Best result	16.88%	21.69%	23.23%	20.56%	21.30%
Average result	26.80%	31.47%	32.02%	28.87%	28.43%
Worst result	37.07%	41.84%	41.90%	36.37%	42.58%
Responses	536	1270	1249	1340	1411

Q26b I will probably look for a job at a new organisation in the next 12 months.



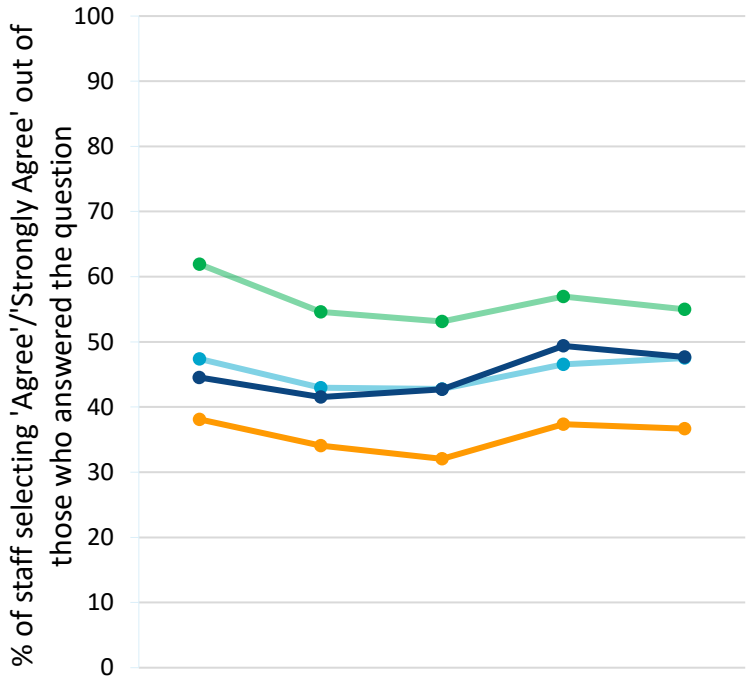
	2020	2021	2022	2023	2024
Your org	15.41%	19.93%	20.25%	19.88%	18.22%
Best result	11.04%	14.62%	16.33%	13.58%	15.68%
Average result	18.73%	22.25%	23.04%	20.73%	20.98%
Worst result	29.56%	31.32%	31.70%	30.70%	30.62%
Responses	537	1266	1245	1337	1411

Q26c As soon as I can find another job, I will leave this organisation.



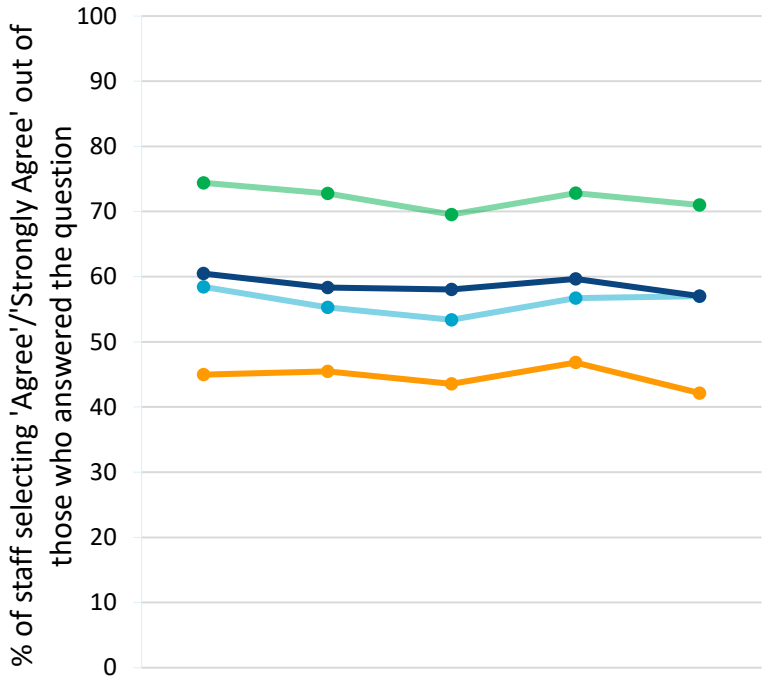
	2020	2021	2022	2023	2024
Your org	11.99%	13.74%	14.98%	13.37%	12.21%
Best result	7.47%	9.95%	10.19%	9.10%	9.76%
Average result	13.23%	16.15%	16.83%	15.32%	15.87%
Worst result	23.73%	25.99%	26.60%	24.17%	25.47%
Responses	535	1262	1247	1331	1404

Q3g I am able to meet all the conflicting demands on my time at work.



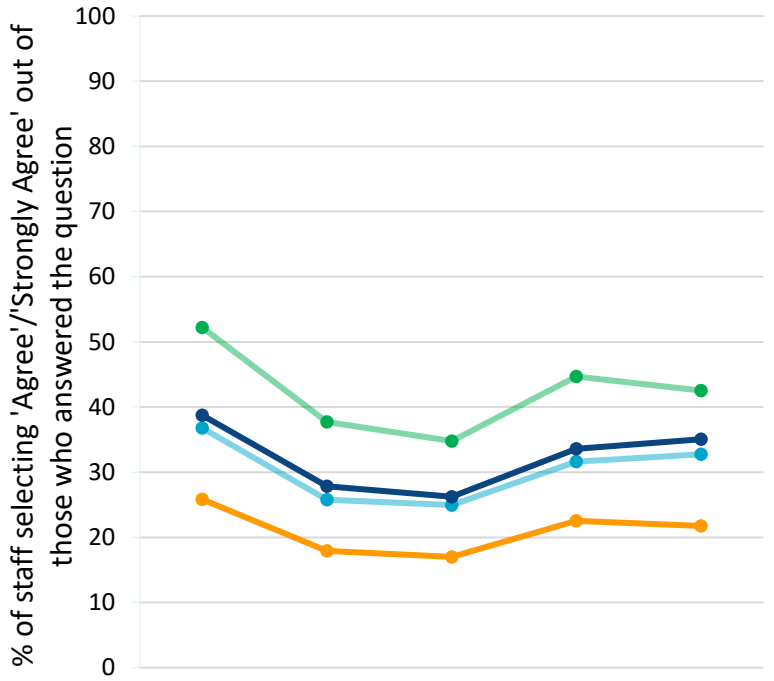
	2020	2021	2022	2023	2024
Your org	44.53%	41.53%	42.71%	49.38%	47.68%
Best result	61.92%	54.62%	53.13%	56.95%	55.01%
Average result	47.39%	42.96%	42.78%	46.56%	47.51%
Worst result	38.11%	34.06%	32.05%	37.35%	36.68%
Responses	536	1270	1242	1338	1418

Q3h I have adequate materials, supplies and equipment to do my work.



	2020	2021	2022	2023	2024
Your org	60.47%	58.33%	58.07%	59.67%	57.03%
Best result	74.41%	72.78%	69.54%	72.83%	70.99%
Average result	58.44%	55.30%	53.39%	56.69%	57.00%
Worst result	44.99%	45.47%	43.54%	46.82%	42.14%
Responses	536	1275	1239	1338	1413

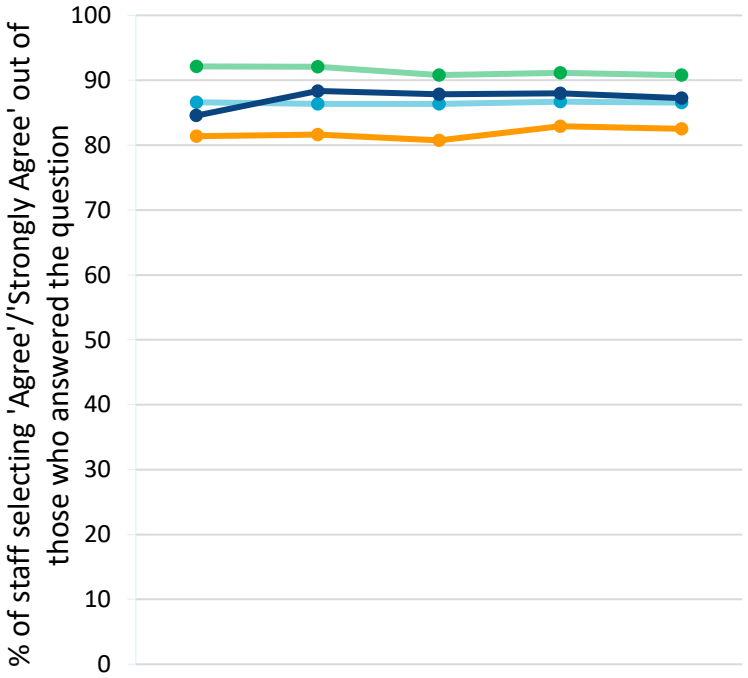
Q3i There are enough staff at this organisation for me to do my job properly.



	2020	2021	2022	2023	2024
Your org	38.74%	27.84%	26.24%	33.60%	35.04%
Best result	52.21%	37.72%	34.78%	44.71%	42.52%
Average result	36.76%	25.80%	24.95%	31.62%	32.77%
Worst result	25.83%	17.92%	17.00%	22.55%	21.73%
Responses	535	1279	1242	1347	1419

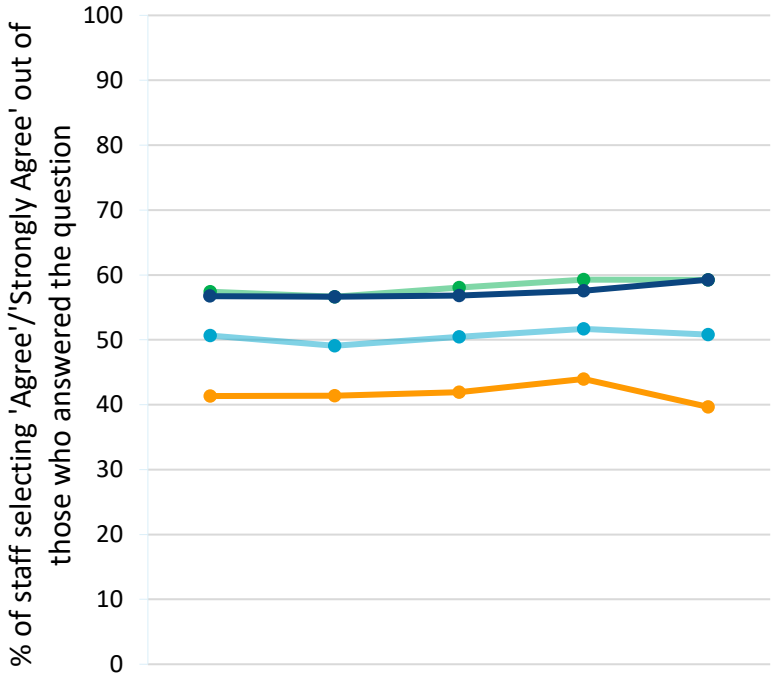
Survey Coordination Centre NHS

Q3a I always know what my work responsibilities are.



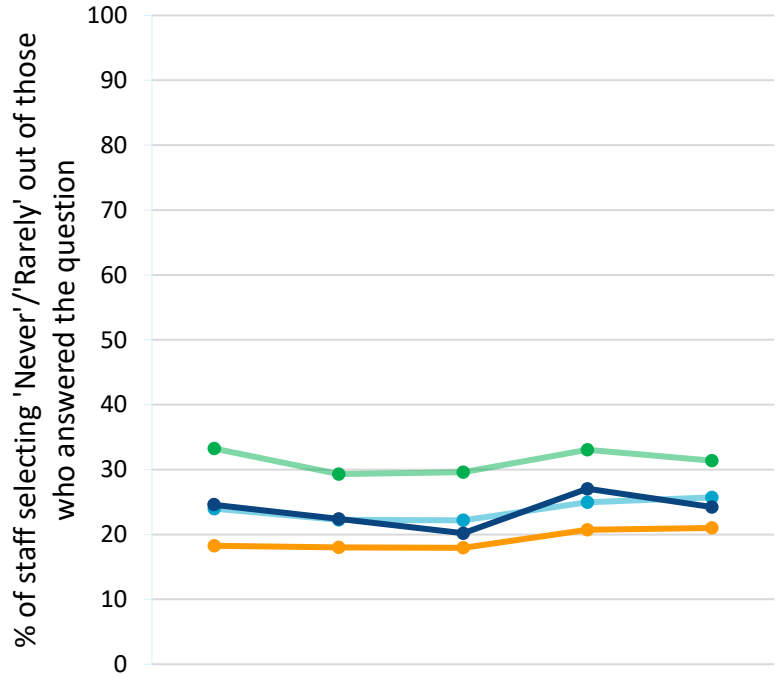
	2020	2021	2022	2023	2024
Your org	84.55%	88.35%	87.85%	87.97%	87.24%
Best result	92.13%	92.08%	90.80%	91.12%	90.77%
Average result	86.62%	86.35%	86.35%	86.70%	86.55%
Worst result	81.40%	81.65%	80.73%	82.92%	82.51%
Responses	536	1278	1248	1353	1422

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



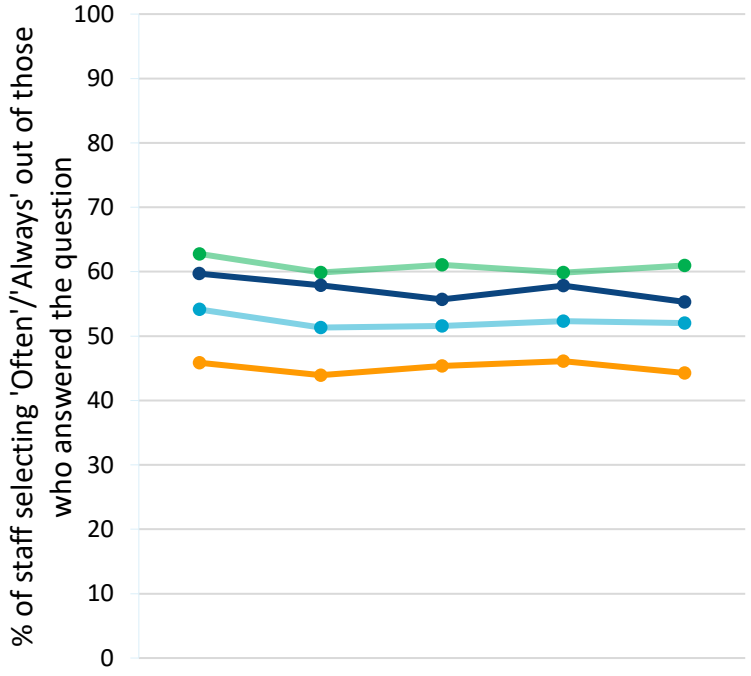
	2020	2021	2022	2023	2024
Your org	56.74%	56.64%	56.82%	57.57%	59.25%
Best result	57.43%	56.64%	58.05%	59.27%	59.25%
Average result	50.68%	49.08%	50.44%	51.68%	50.81%
Worst result	41.35%	41.40%	41.91%	43.96%	39.67%
Responses	539	1279	1245	1347	1418

Q5a I have unrealistic time pressures.



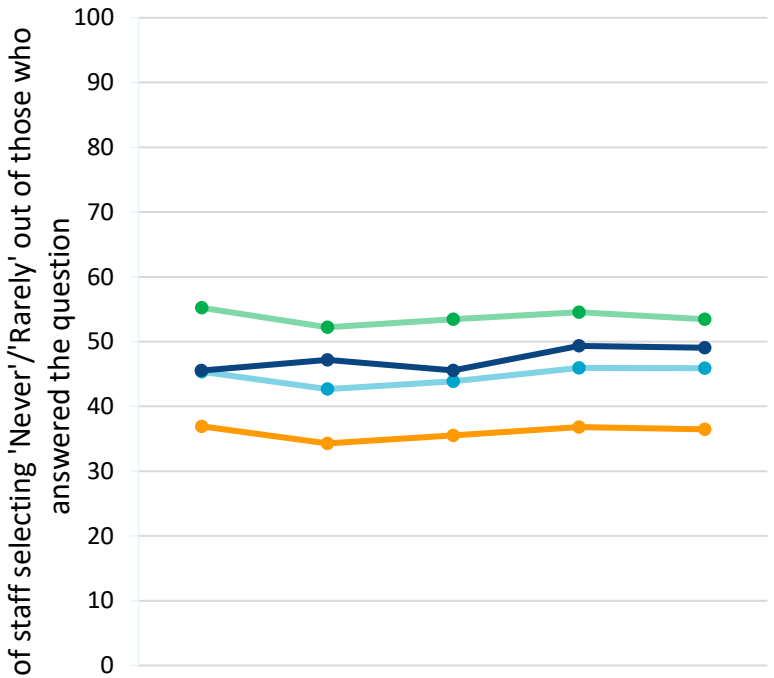
	2020	2021	2022	2023	2024
Your org	24.58%	22.41%	20.20%	27.05%	24.22%
Best result	33.24%	29.31%	29.61%	33.04%	31.37%
Average result	23.97%	22.27%	22.18%	24.95%	25.71%
Worst result	18.24%	18.00%	17.94%	20.72%	21.01%
Responses	536	1276	1245	1347	1420

Q5b I have a choice in deciding how to do my work.



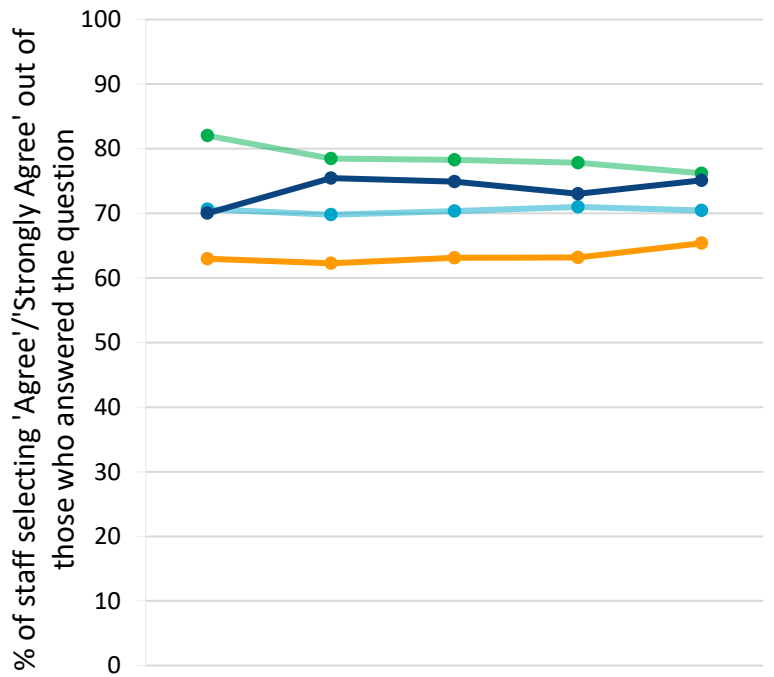
	2020	2021	2022	2023	2024
Your org	59.69%	57.89%	55.72%	57.82%	55.31%
Best result	62.76%	59.87%	61.04%	59.85%	60.94%
Average result	54.13%	51.32%	51.55%	52.31%	52.02%
Worst result	45.86%	43.93%	45.33%	46.10%	44.26%
Responses	535	1276	1243	1340	1415

Q5c Relationships at work are strained.



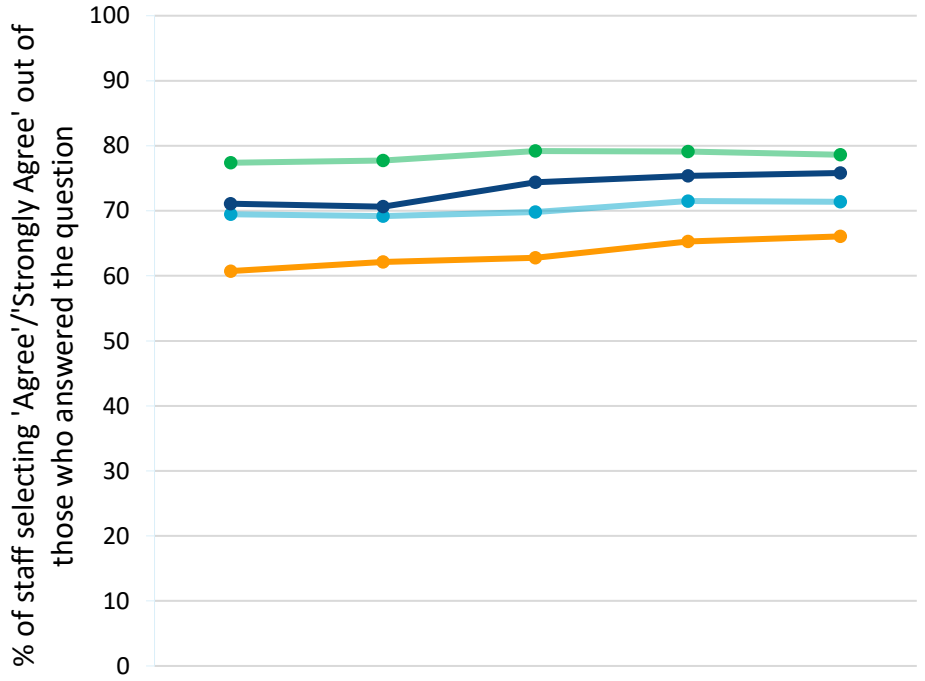
	2020	2021	2022	2023	2024
Your org	45.53%	47.17%	45.54%	49.34%	49.06%
Best result	55.23%	52.22%	53.46%	54.56%	53.48%
Average result	45.35%	42.67%	43.89%	45.94%	45.91%
Worst result	36.93%	34.28%	35.52%	36.80%	36.48%
Responses	533	1274	1240	1344	1414

Q7c I receive the respect I deserve from my colleagues at work.



	2020	2021	2022	2023	2024
Your org	70.01%	75.45%	74.90%	73.01%	75.11%
Best result	82.02%	78.45%	78.29%	77.84%	76.21%
Average result	70.63%	69.79%	70.36%	70.99%	70.44%
Worst result	62.98%	62.27%	63.14%	63.16%	65.37%
Responses	537	1277	1245	1349	1419

Q9a My immediate manager encourages me at work.



	2020	2021	2022	2023	2024
Your org	71.07%	70.63%	74.38%	75.35%	75.81%
Best result	77.39%	77.71%	79.19%	79.11%	78.63%
Average result	69.49%	69.19%	69.81%	71.50%	71.38%
Worst result	60.73%	62.13%	62.79%	65.30%	66.06%
Responses	537	1279	1244	1347	1418

Questions not linked to People Promise elements or themes

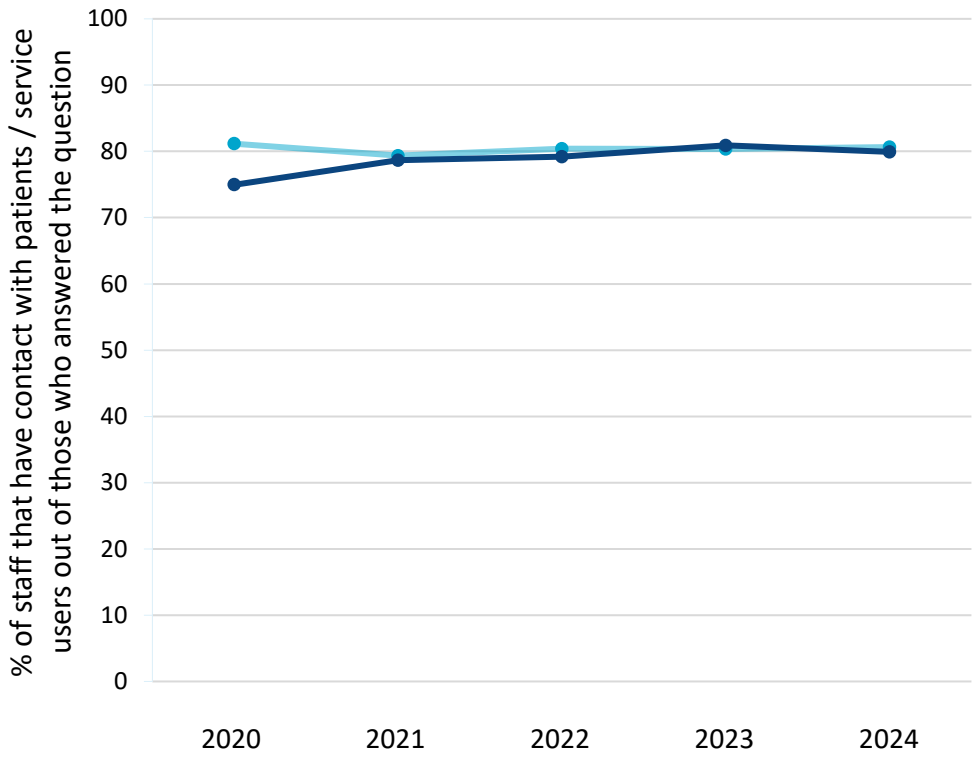
Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. The results for Q24f are reported in the section for People Promise element 5: We are always learning. These questions do not contribute to any score or sub-score calculations.

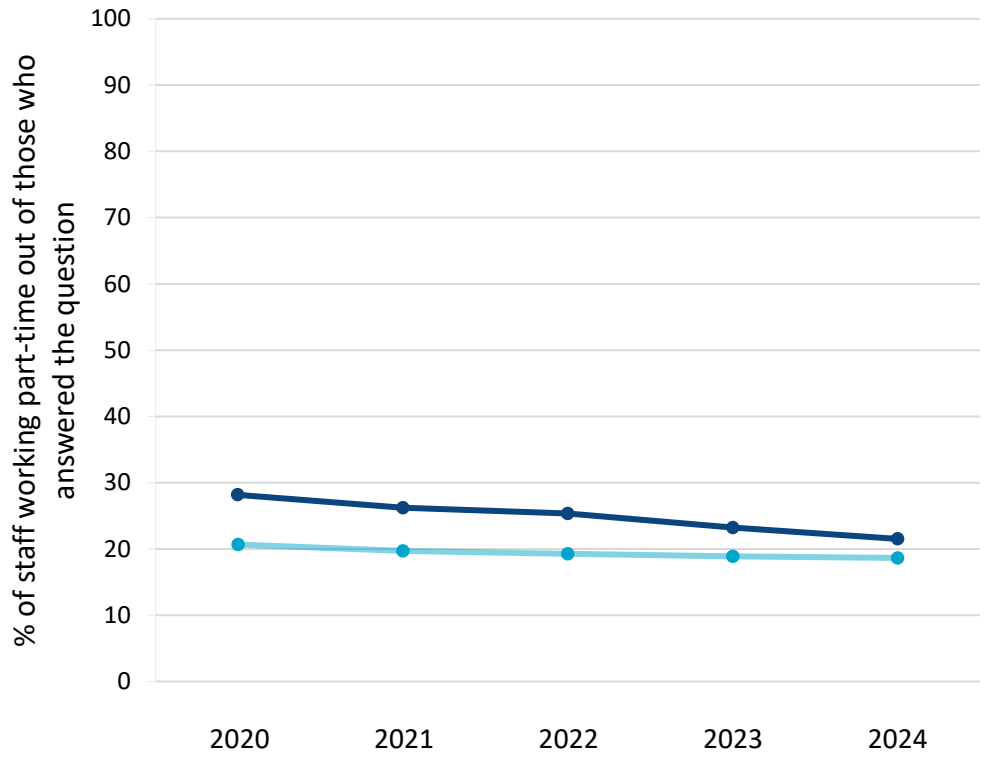
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



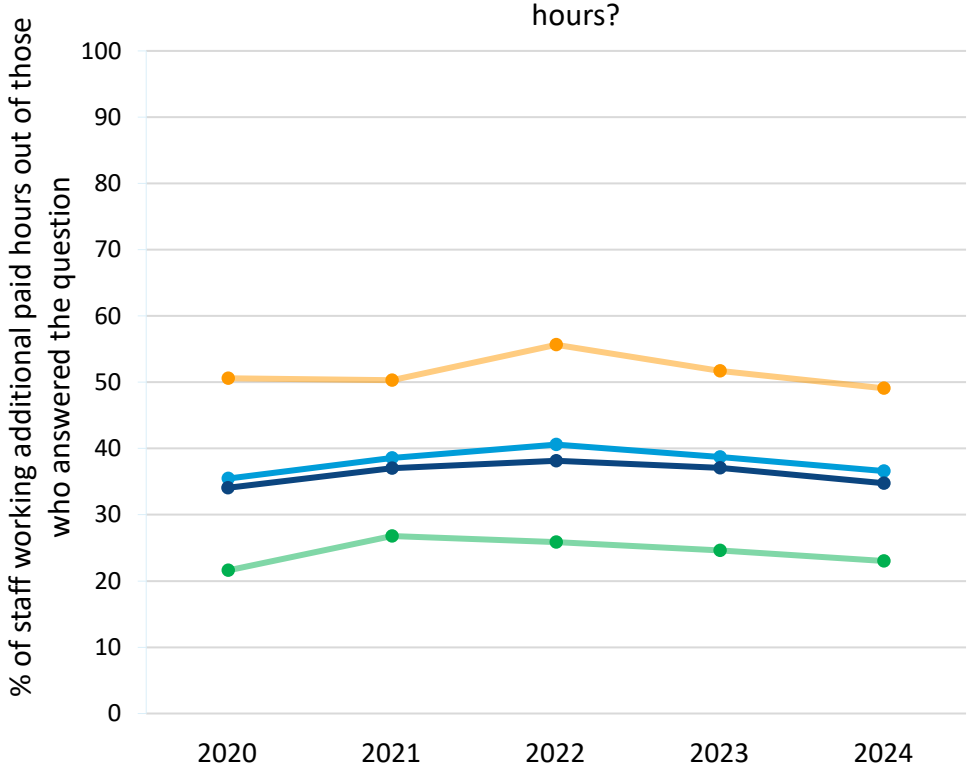
	2020	2021	2022	2023	2024
Your org	74.95%	78.67%	79.18%	80.91%	79.93%
Average	81.16%	79.36%	80.42%	80.37%	80.65%
Responses	539	1275	1244	1341	1415

Q10a How many hours a week are you contracted to work?



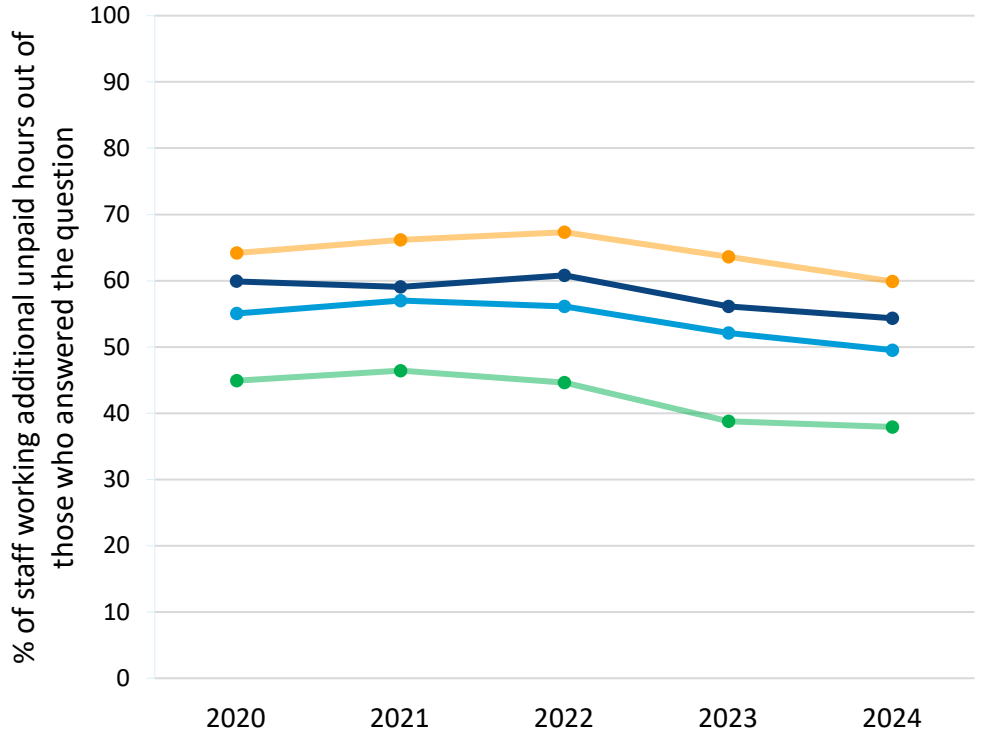
	2020	2021	2022	2023	2024
Your org	28.16%	26.20%	25.35%	23.21%	21.51%
Average	20.66%	19.69%	19.24%	18.88%	18.64%
Responses	515	1233	1199	1271	1348

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



	2020	2021	2022	2023	2024
Your org	34.07%	37.04%	38.14%	37.09%	34.75%
Lowest	21.60%	26.78%	25.87%	24.60%	23.01%
Average	35.46%	38.56%	40.59%	38.71%	36.58%
Highest	50.60%	50.31%	55.65%	51.72%	49.08%
Responses	524	1218	1177	1287	1356

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?

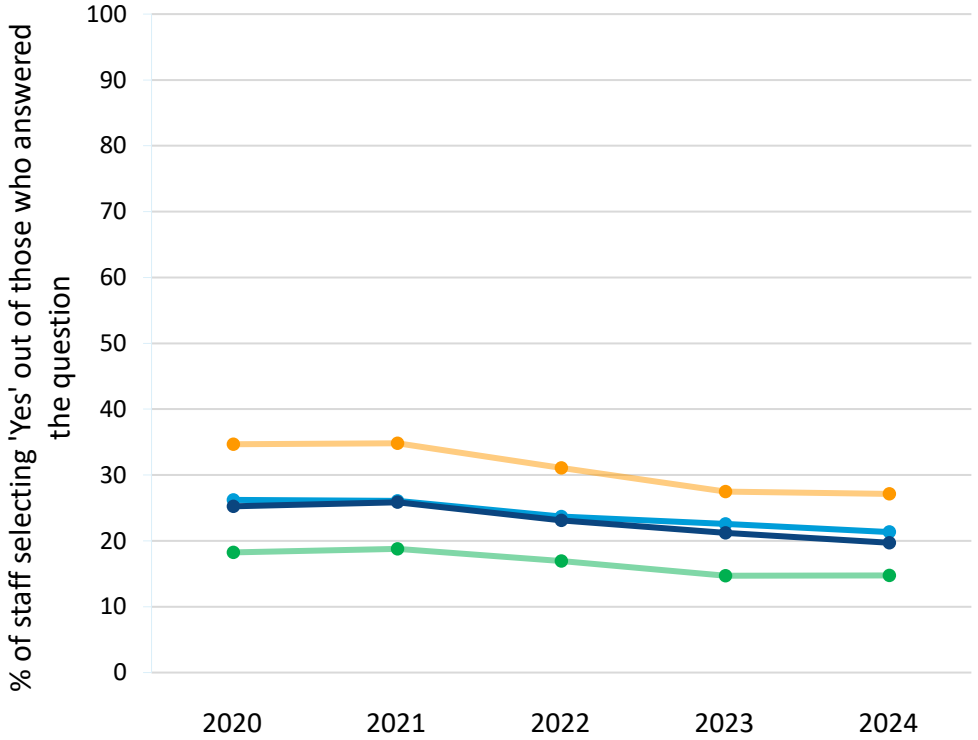


	2020	2021	2022	2023	2024
Your org	59.89%	59.05%	60.81%	56.13%	54.33%
Lowest	44.93%	46.43%	44.60%	38.79%	37.93%
Average	55.06%	57.00%	56.10%	52.10%	49.52%
Highest	64.17%	66.15%	67.31%	63.60%	59.88%
Responses	526	1231	1192	1295	1356

Survey Coordination Centre

NHS

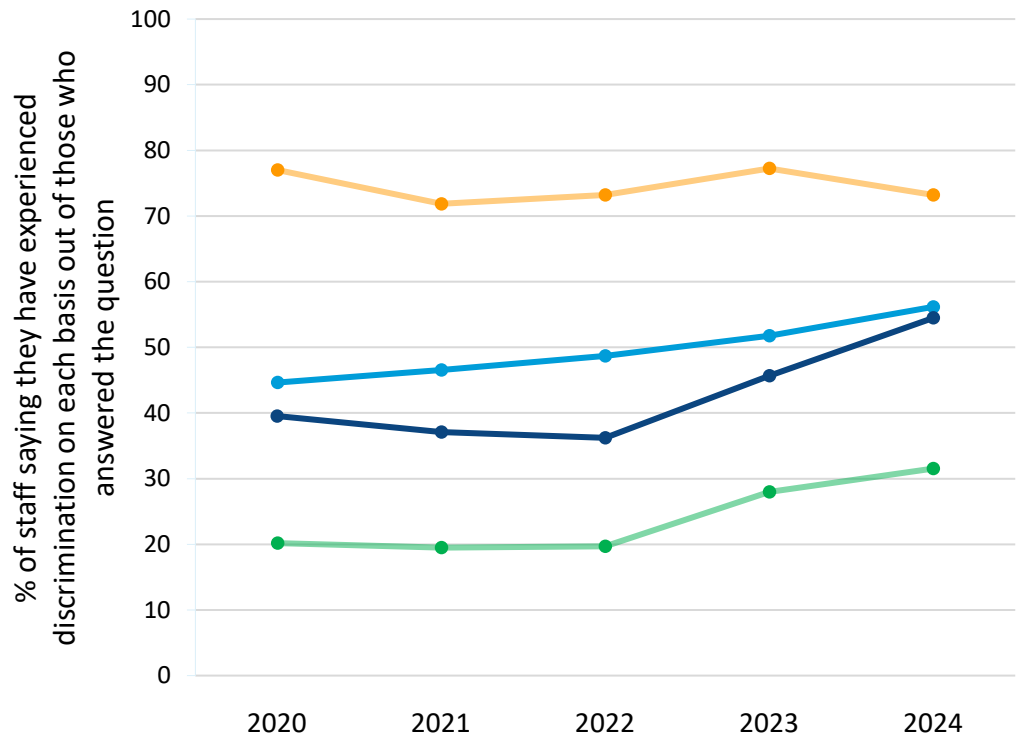
Q11e* Have you felt pressure from your manager to come to work?



	2020	2021	2022	2023	2024
Your org	25.23%	25.86%	23.10%	21.24%	19.71%
Best result	18.25%	18.78%	16.95%	14.70%	14.77%
Average result	26.22%	26.06%	23.71%	22.59%	21.34%
Worst result	34.69%	34.82%	31.07%	27.49%	27.13%
Responses	242	574	658	635	695

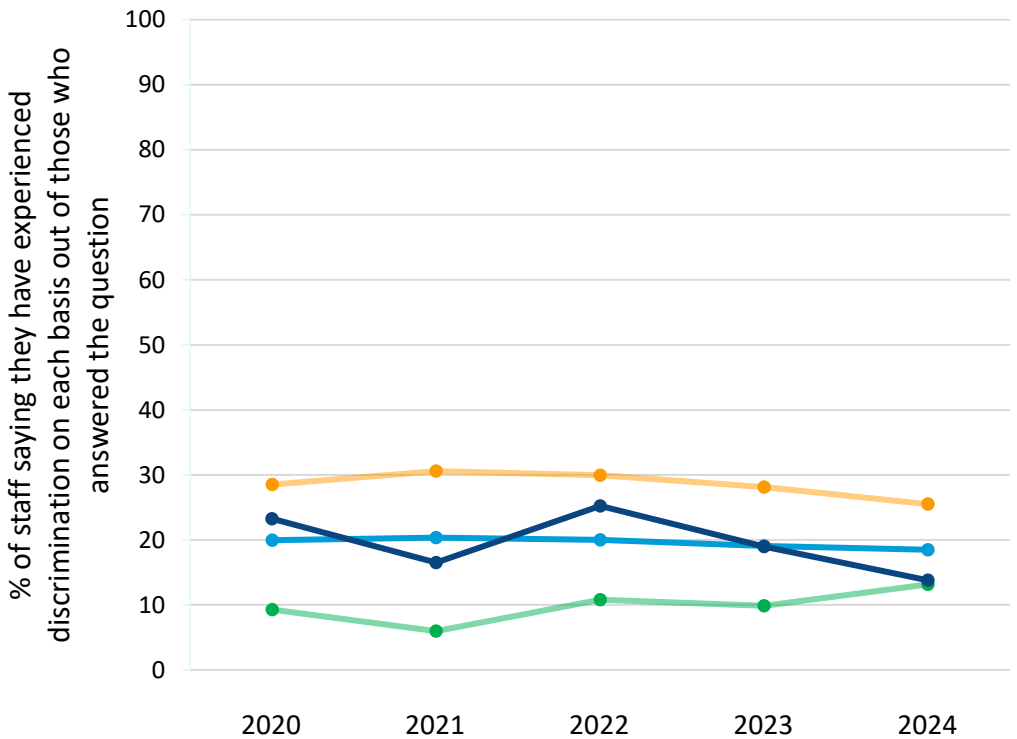
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Q16c.1 On what grounds have you experienced discrimination? - Ethnic background.



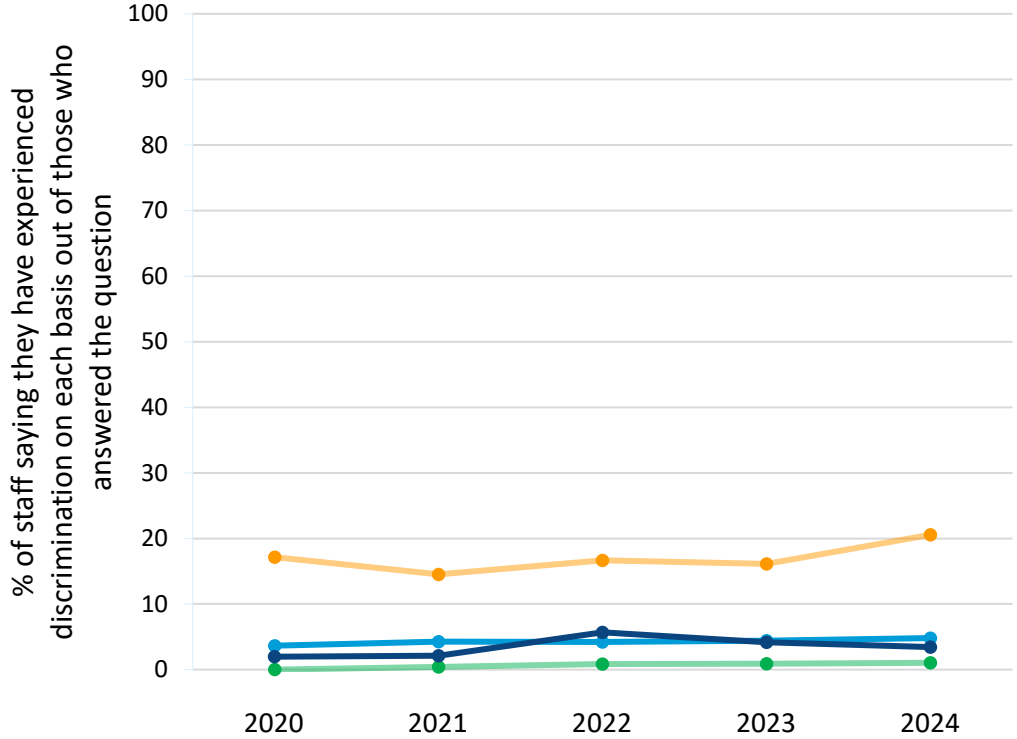
	2020	2021	2022	2023	2024
Your org	39.53%	37.09%	36.21%	45.65%	54.47%
Best result	20.18%	19.49%	19.69%	28.00%	31.53%
Average result	44.63%	46.54%	48.69%	51.77%	56.16%
Worst result	76.99%	71.86%	73.19%	77.24%	73.22%
Responses	49	138	141	151	148

Q16c.2 On what grounds have you experienced discrimination? – Gender.



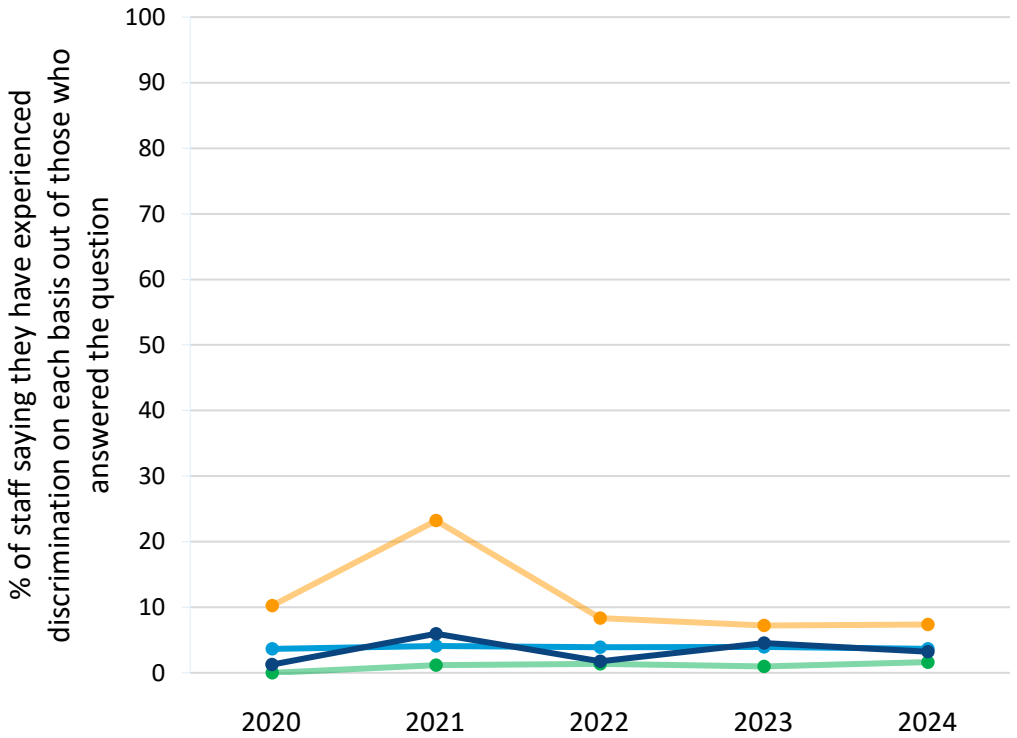
	2020	2021	2022	2023	2024
Your org	23.24%	16.50%	25.23%	18.97%	13.78%
Best result	9.30%	5.97%	10.82%	9.86%	13.16%
Average result	19.96%	20.35%	20.00%	19.07%	18.49%
Worst result	28.50%	30.58%	29.96%	28.11%	25.50%
Responses	49	138	141	151	148

Q16c.3 On what grounds have you experienced discrimination? – Religion.



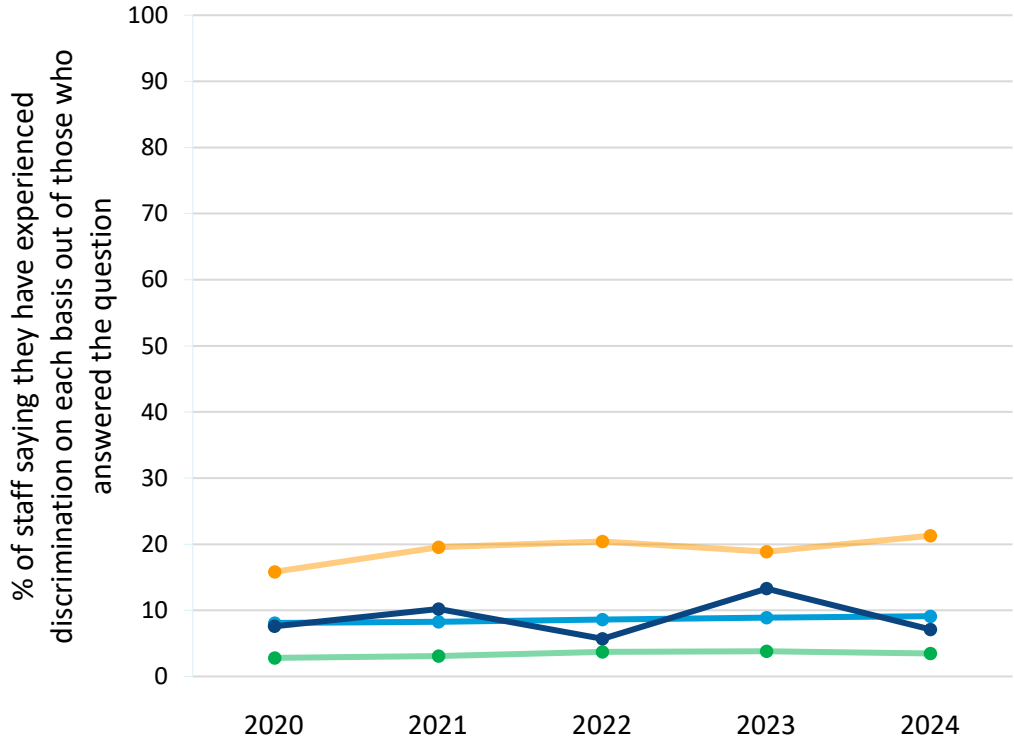
	2020	2021	2022	2023	2024
Your org	1.97%	2.10%	5.68%	4.16%	3.44%
Best result	0.00%	0.42%	0.84%	0.92%	1.04%
Average result	3.64%	4.24%	4.21%	4.43%	4.81%
Worst result	17.17%	14.52%	16.64%	16.12%	20.56%
Responses	49	138	141	151	148

Q16c.4 On what grounds have you experienced discrimination? – Sexual orientation.



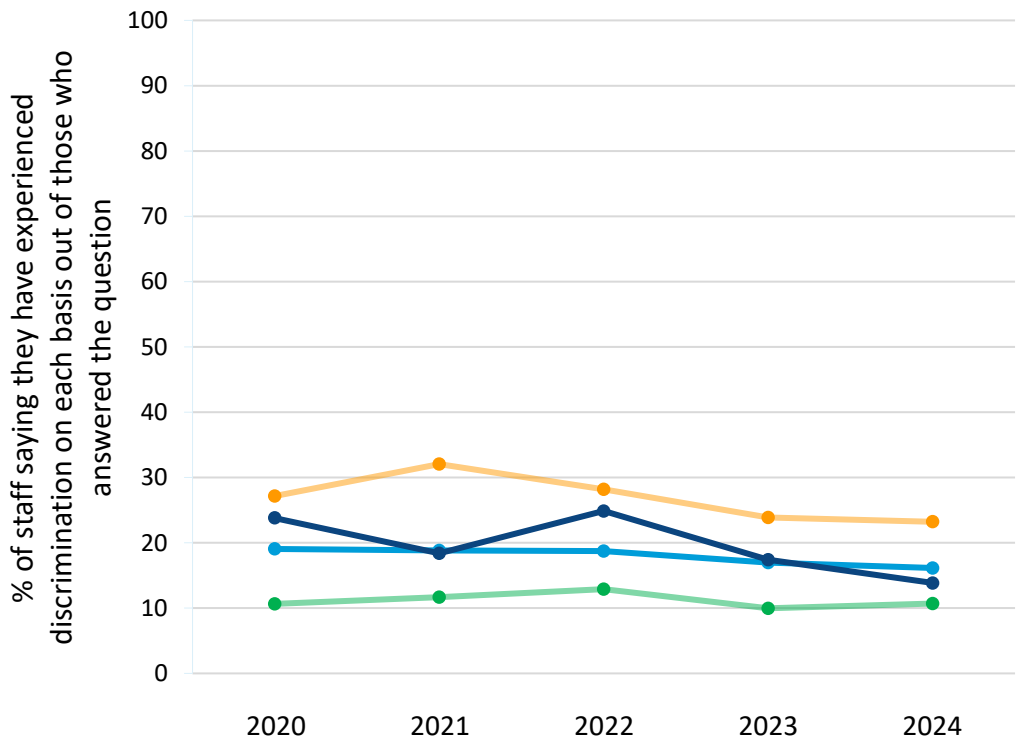
	2020	2021	2022	2023	2024
Your org	1.26%	5.96%	1.74%	4.52%	3.23%
Best result	0.00%	1.16%	1.36%	0.96%	1.63%
Average result	3.65%	4.09%	3.89%	3.96%	3.67%
Worst result	10.25%	23.21%	8.35%	7.22%	7.36%
Responses	49	138	141	151	148

Q16c.5 On what grounds have you experienced discrimination? – Disability.



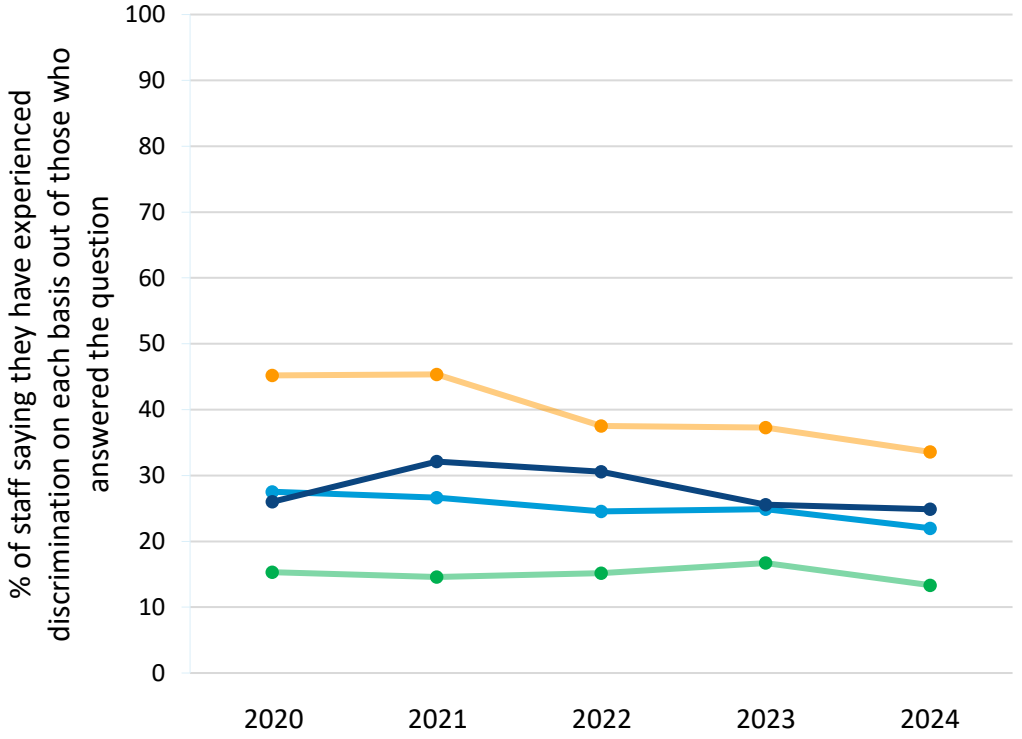
	2020	2021	2022	2023	2024
Your org	7.59%	10.22%	5.70%	13.28%	7.13%
Best result	2.81%	3.10%	3.74%	3.81%	3.48%
Average result	8.10%	8.28%	8.59%	8.91%	9.12%
Worst result	15.84%	19.54%	20.43%	18.85%	21.30%
Responses	49	138	141	151	148

Q16c.6 On what grounds have you experienced discrimination? – Age.



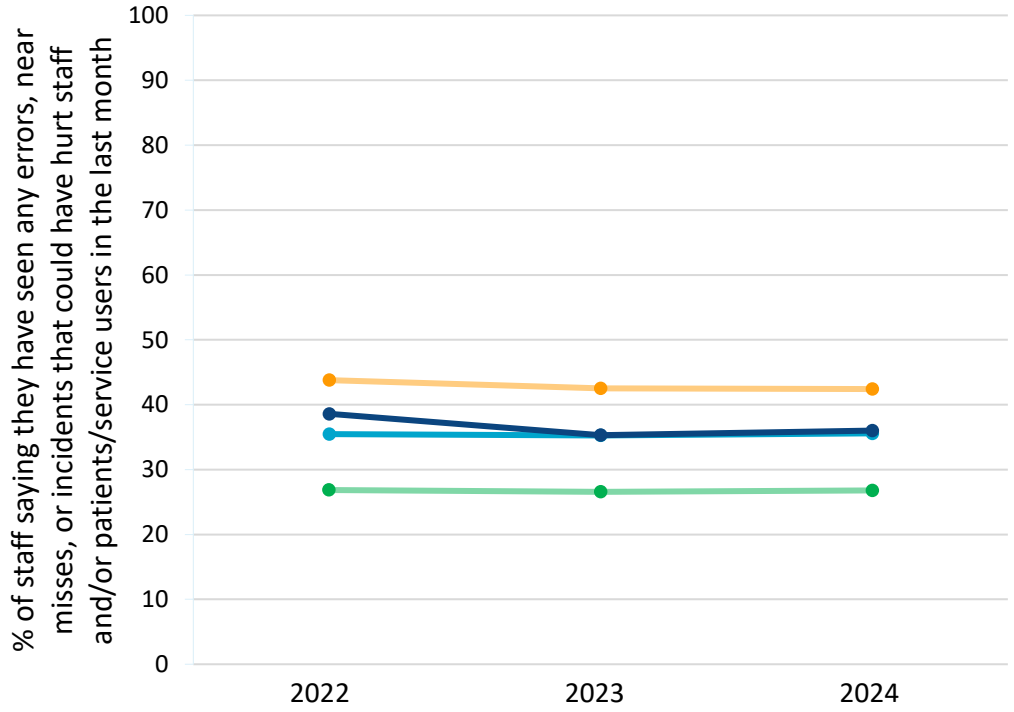
	2020	2021	2022	2023	2024
Your org	23.81%	18.41%	24.88%	17.43%	13.85%
Best result	10.65%	11.70%	12.90%	9.97%	10.71%
Average result	19.06%	18.83%	18.73%	16.99%	16.15%
Worst result	27.17%	32.05%	28.20%	23.87%	23.22%
Responses	49	138	141	151	148

Q16c.7 On what grounds have you experienced discrimination? – Other.



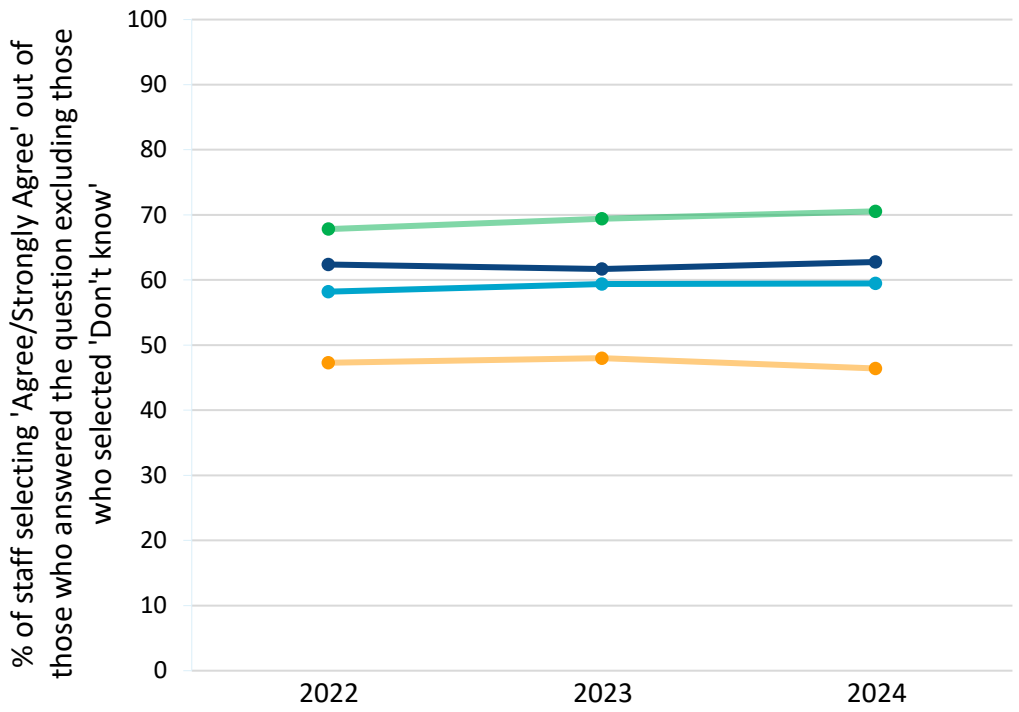
	2020	2021	2022	2023	2024
Your org	26.00%	32.11%	30.58%	25.57%	24.87%
Best result	15.33%	14.60%	15.16%	16.70%	13.34%
Average result	27.53%	26.62%	24.54%	24.88%	21.99%
Worst result	45.22%	45.35%	37.52%	37.27%	33.58%
Responses	49	138	141	151	148

Q18 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



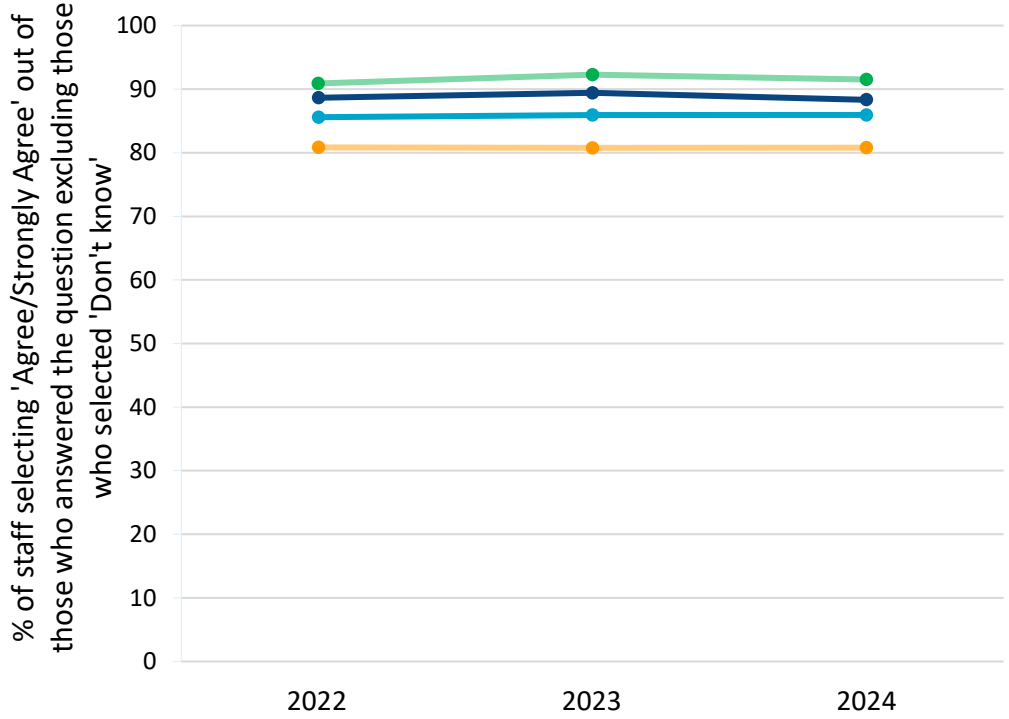
	2022	2023	2024
Your org	38.60%	35.30%	36.02%
Best result	26.85%	26.57%	26.76%
Average result	35.44%	35.26%	35.58%
Worst result	43.78%	42.54%	42.41%
Responses	1239	1323	1402

Q19a My organisation treats staff who are involved in an error, near miss or incident fairly.



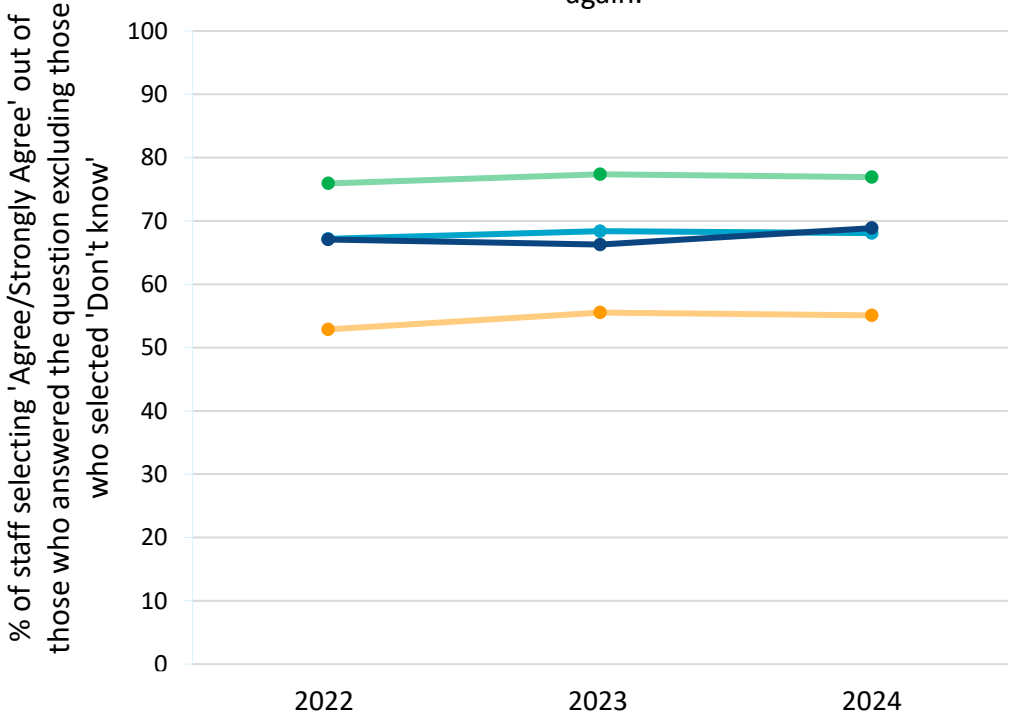
	2022	2023	2024
Your org	62.38%	61.69%	62.76%
Best result	67.82%	69.42%	70.55%
Average result	58.21%	59.40%	59.47%
Worst result	47.27%	48.00%	46.41%
Responses	959	1013	1107

Q19b My organisation encourages us to report errors, near misses or incidents.



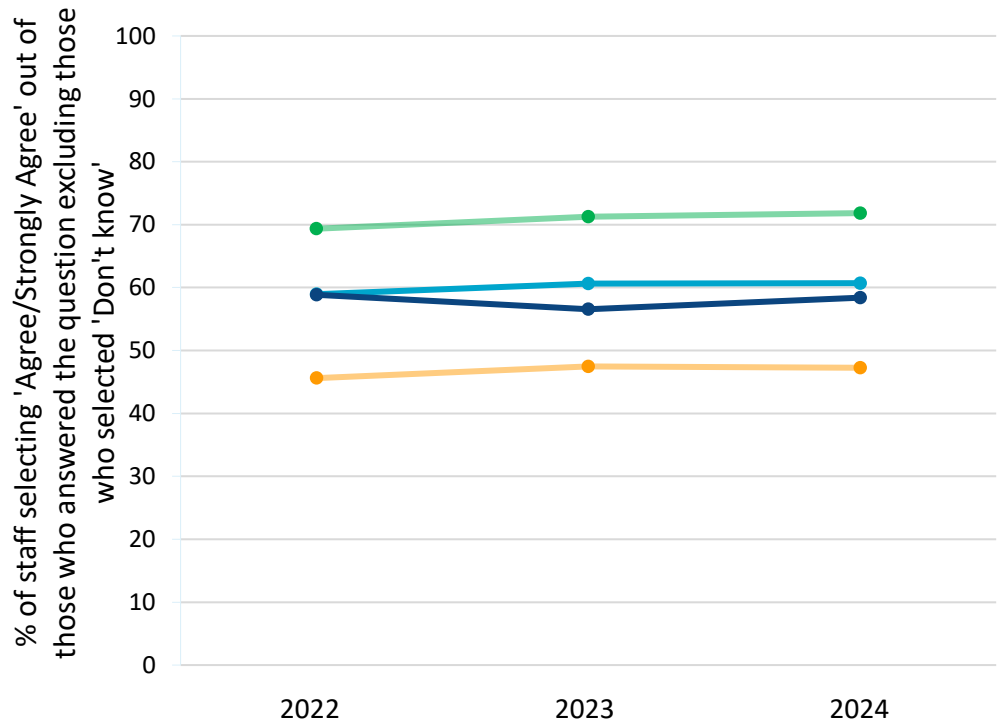
	2022	2023	2024
Your org	88.67%	89.43%	88.32%
Best result	90.90%	92.28%	91.52%
Average result	85.59%	85.95%	85.95%
Worst result	80.84%	80.77%	80.79%
Responses	1203	1285	1354

Q19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



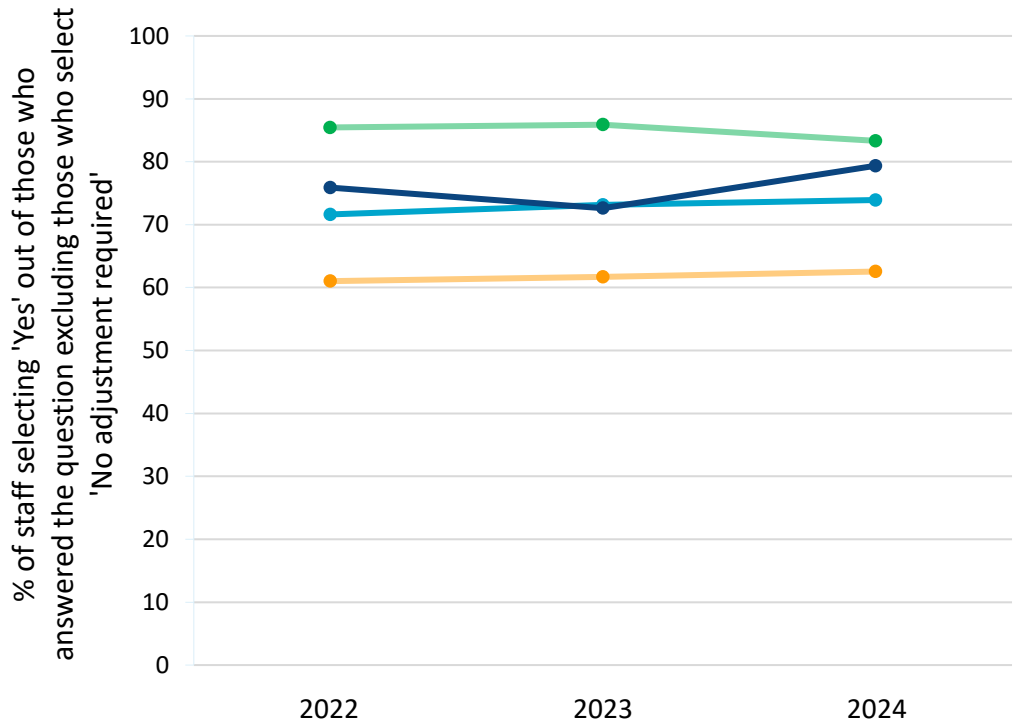
	2022	2023	2024
Your org	67.05%	66.27%	68.86%
Best result	75.92%	77.37%	76.90%
Average result	67.18%	68.39%	68.08%
Worst result	52.87%	55.52%	55.11%
Responses	1097	1161	1242

Q19d We are given feedback about changes made in response to reported errors, near misses and incidents.



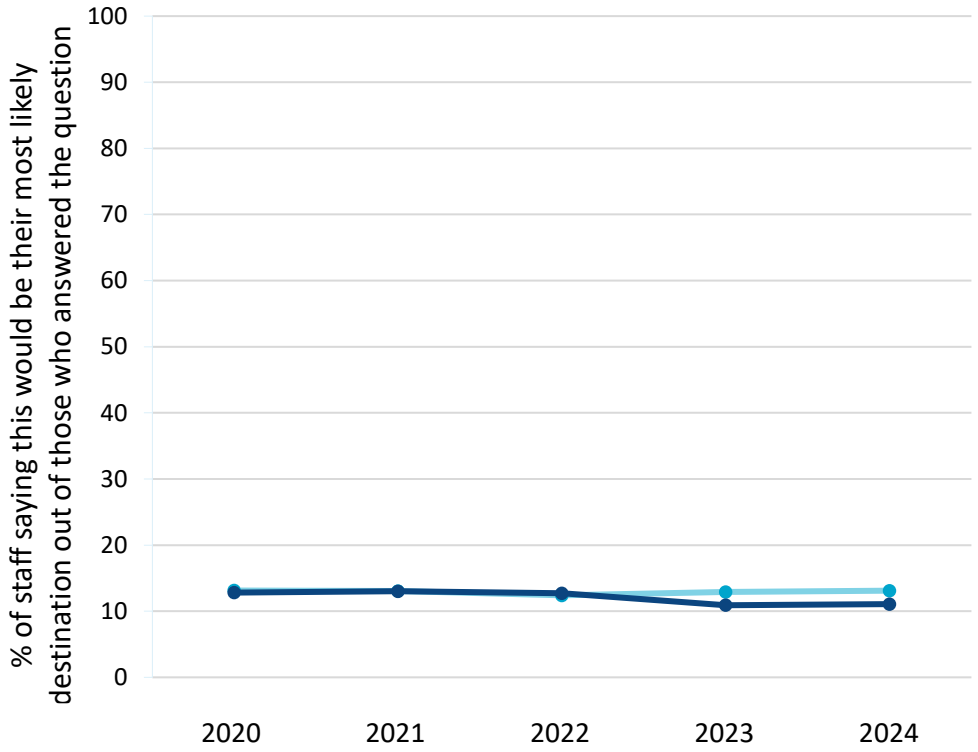
	2022	2023	2024
Your org	58.85%	56.56%	58.40%
Best result	69.36%	71.25%	71.84%
Average result	58.95%	60.66%	60.70%
Worst result	45.61%	47.47%	47.26%
Responses	1109	1173	1243

Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work?



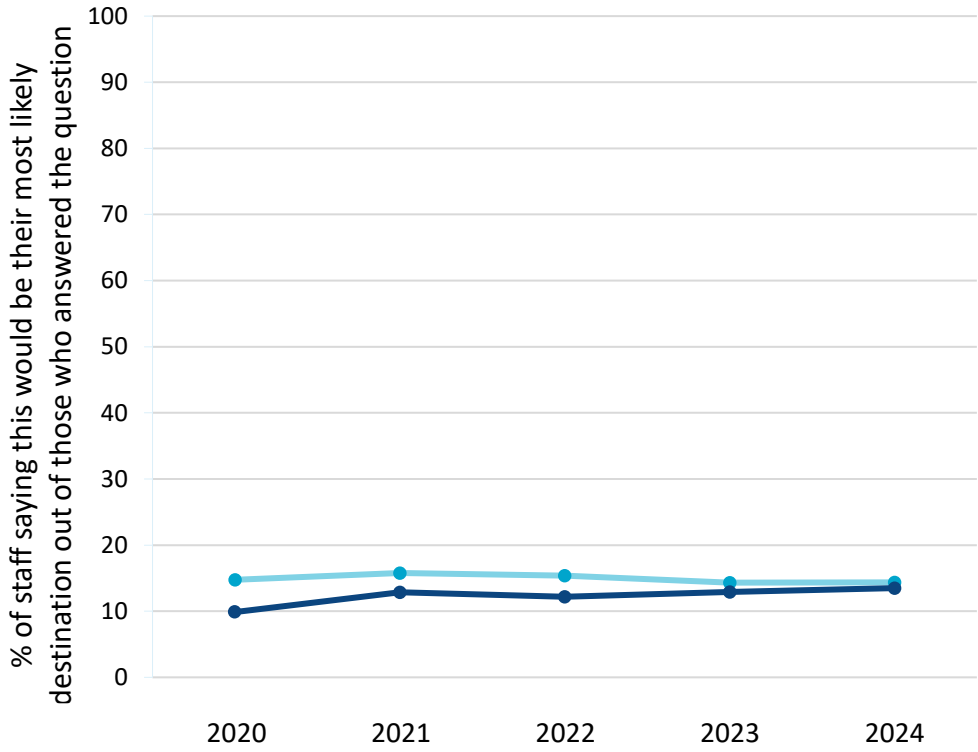
	2022	2023	2024
Your org	75.90%	72.62%	79.36%
Best result	85.45%	85.89%	83.33%
Average result	71.63%	73.13%	73.92%
Worst result	61.02%	61.72%	62.55%
Responses	155	187	201

Q26d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



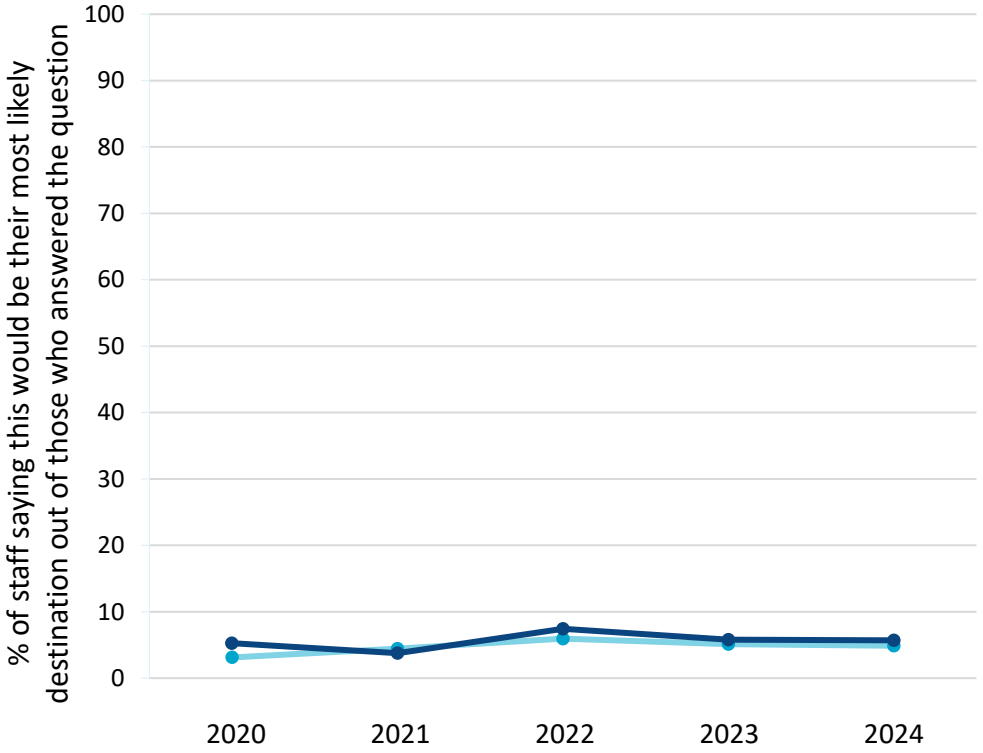
	2020	2021	2022	2023	2024
Your org	12.82%	13.03%	12.73%	10.91%	11.09%
Average	13.13%	13.04%	12.40%	12.94%	13.10%
Responses	476	1090	1076	1137	1208

Q26d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.



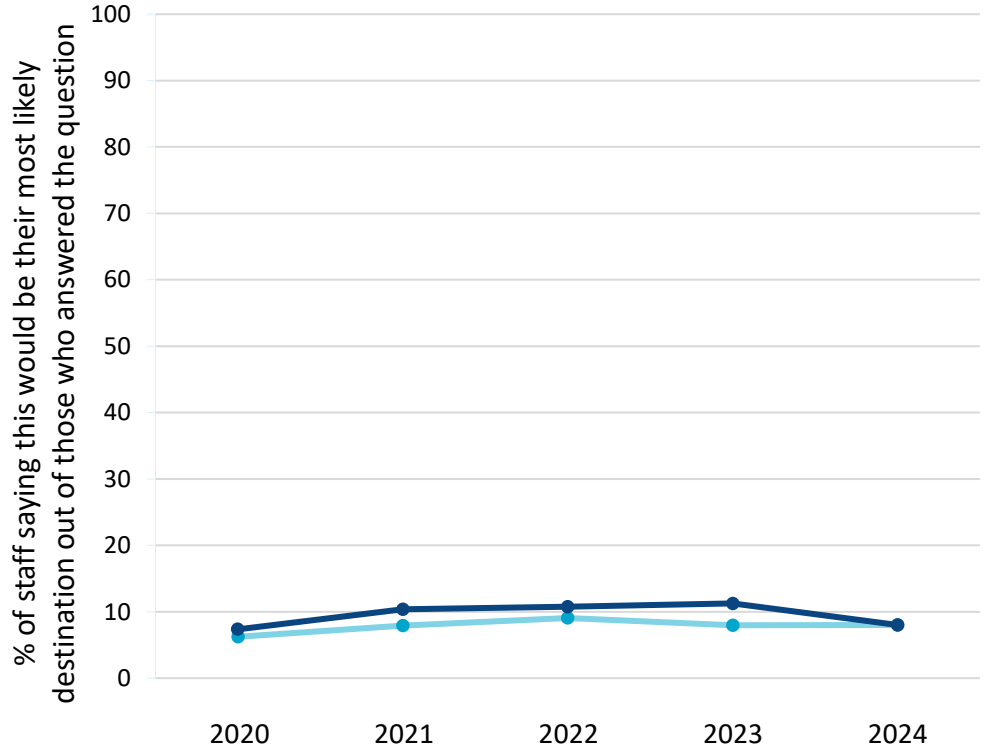
	2020	2021	2022	2023	2024
Your org	9.87%	12.84%	12.17%	12.93%	13.49%
Average	14.76%	15.78%	15.37%	14.32%	14.36%
Responses	476	1090	1076	1137	1208

Q26d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



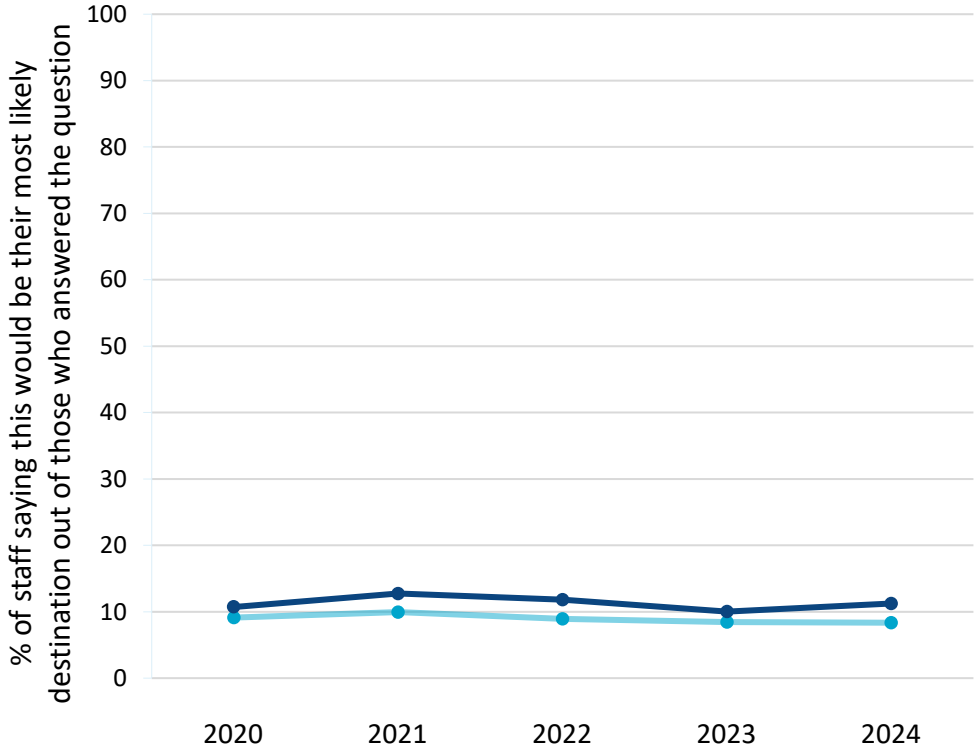
	2020	2021	2022	2023	2024
Your org	5.25%	3.76%	7.43%	5.80%	5.71%
Average	3.12%	4.47%	5.95%	5.12%	4.90%
Responses	476	1090	1076	1137	1208

Q26d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.



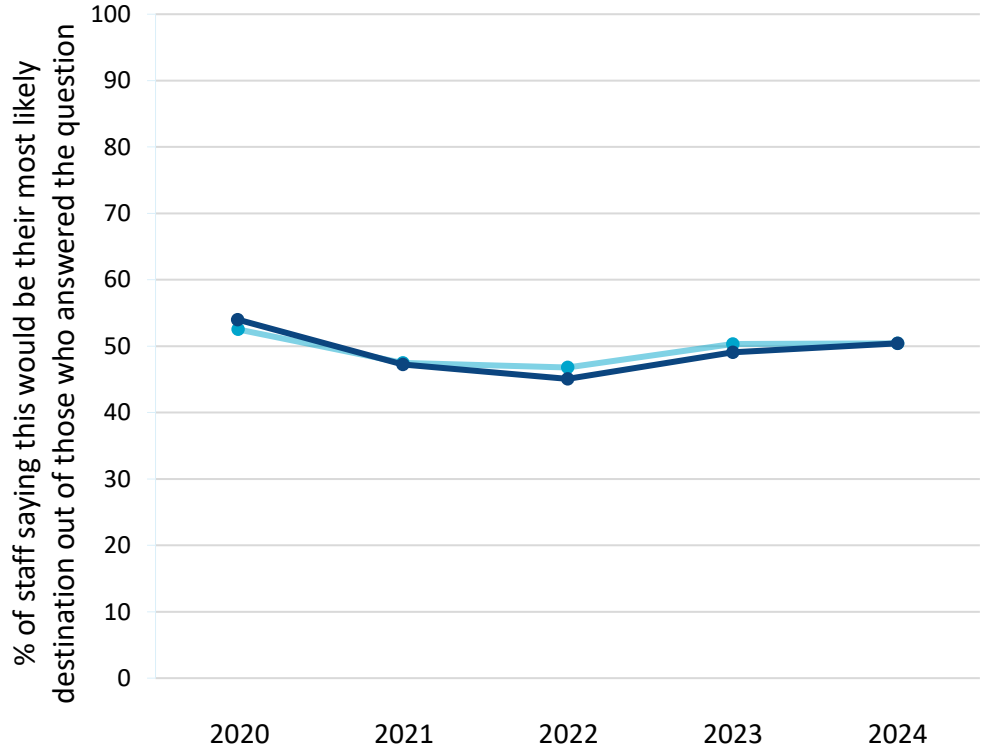
	2020	2021	2022	2023	2024
Your org	7.35%	10.37%	10.78%	11.26%	8.03%
Average	6.23%	7.91%	9.06%	7.96%	8.00%
Responses	476	1090	1076	1137	1208

Q26d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2020	2021	2022	2023	2024
Your org	10.71%	12.75%	11.80%	10.03%	11.26%
Average	9.13%	9.95%	8.94%	8.46%	8.35%
Responses	476	1090	1076	1137	1208

Q26d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2020	2021	2022	2023	2024
Your org	53.99%	47.25%	45.07%	49.08%	50.41%
Average	52.53%	47.46%	46.79%	50.34%	50.41%
Responses	476	1090	1076	1137	1208

Survey Coordination Centre

NHS

Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Equality Standards

Survey Coordination Centre NHS

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2020-2024 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey metrics used in the Workforce Disability Equality Standard (WDES). It includes the 2020-2024 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was changed to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Metric	Qu No	Workforce Disability Equality Standard
		For each of the following metrics, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

NHS

Workforce Race Equality Standards (WRES)

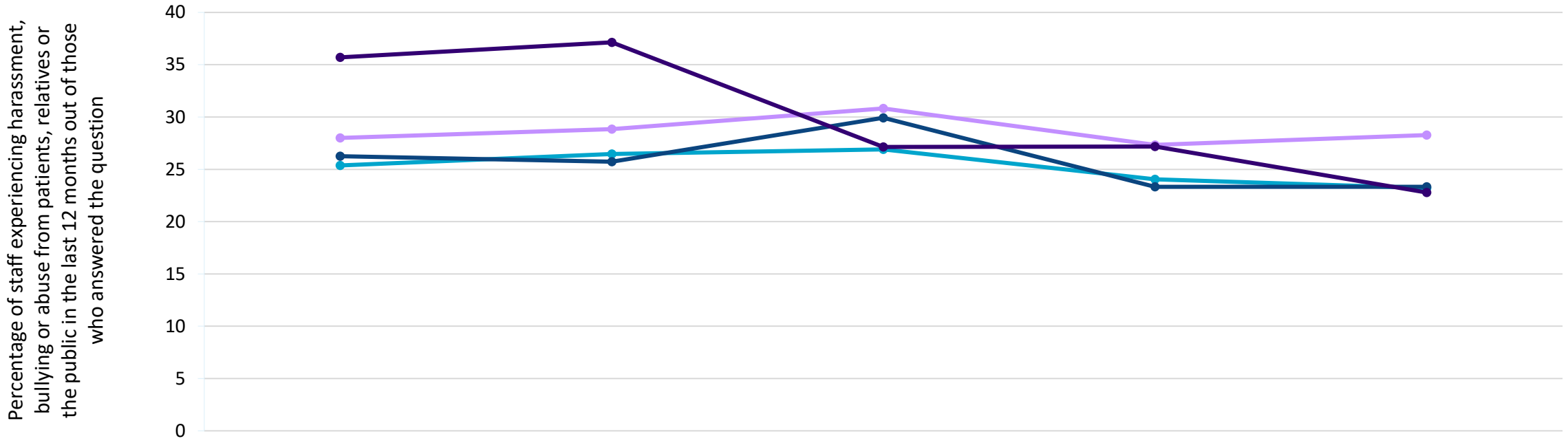
Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	26.26%	25.72%	29.93%	23.33%	23.33%
All other ethnic groups*: Your org	35.71%	37.14%	27.13%	27.18%	22.78%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	476	1147	1096	1106	1153
All other ethnic groups*: Responses	42	105	129	206	237

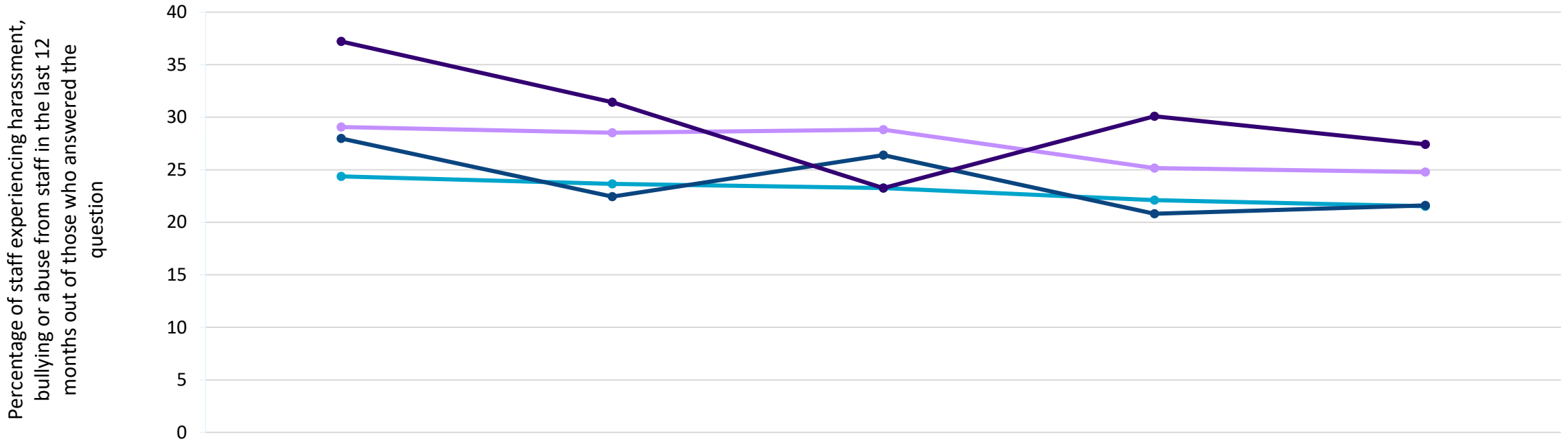
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 5 (Q14a) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	27.97%	22.45%	26.39%	20.81%	21.61%
All other ethnic groups*: Your org	37.21%	31.43%	23.26%	30.10%	27.43%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	479	1145	1095	1105	1157
All other ethnic groups*: Responses	43	105	129	206	237

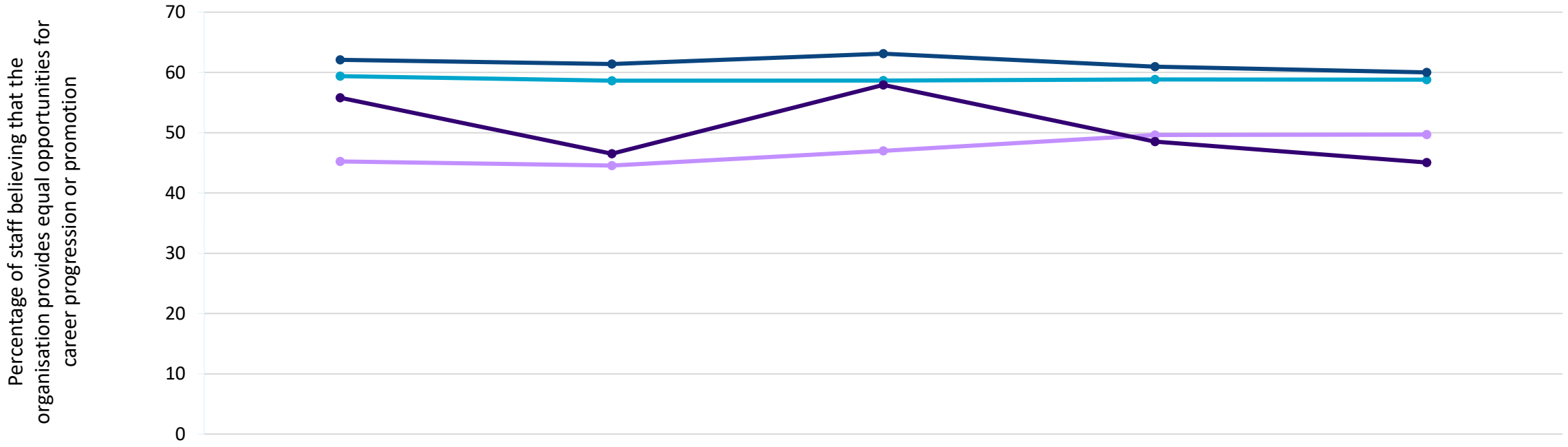
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 6 (Q14b & Q14c) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



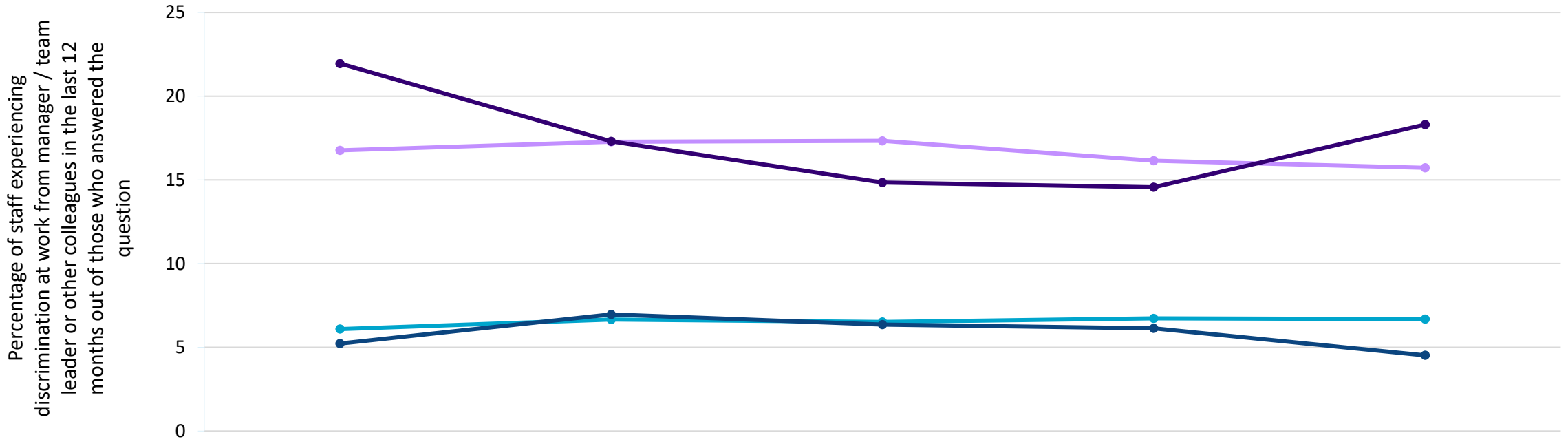
	2020	2021	2022	2023	2024
White staff: Your org	62.08%	61.41%	63.12%	60.96%	60.02%
All other ethnic groups*: Your org	55.81%	46.53%	57.94%	48.53%	45.06%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	480	1135	1090	1099	1143
All other ethnic groups*: Responses	43	101	126	204	233

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2020	2021	2022	2023	2024
White staff: Your org	5.23%	6.97%	6.36%	6.14%	4.53%
All other ethnic groups*: Your org	21.95%	17.31%	14.84%	14.56%	18.30%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	478	1148	1100	1108	1149
All other ethnic groups*: Responses	41	104	128	206	235

*Staff from all other ethnic groups combined

Survey Coordination Centre

NHS

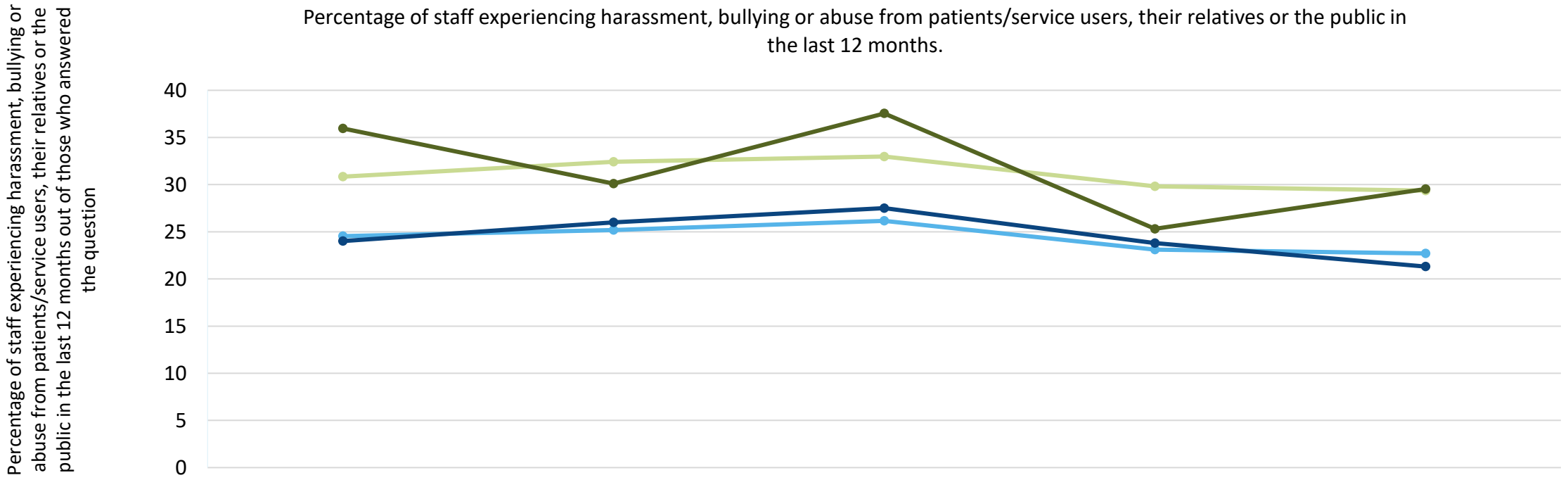
Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

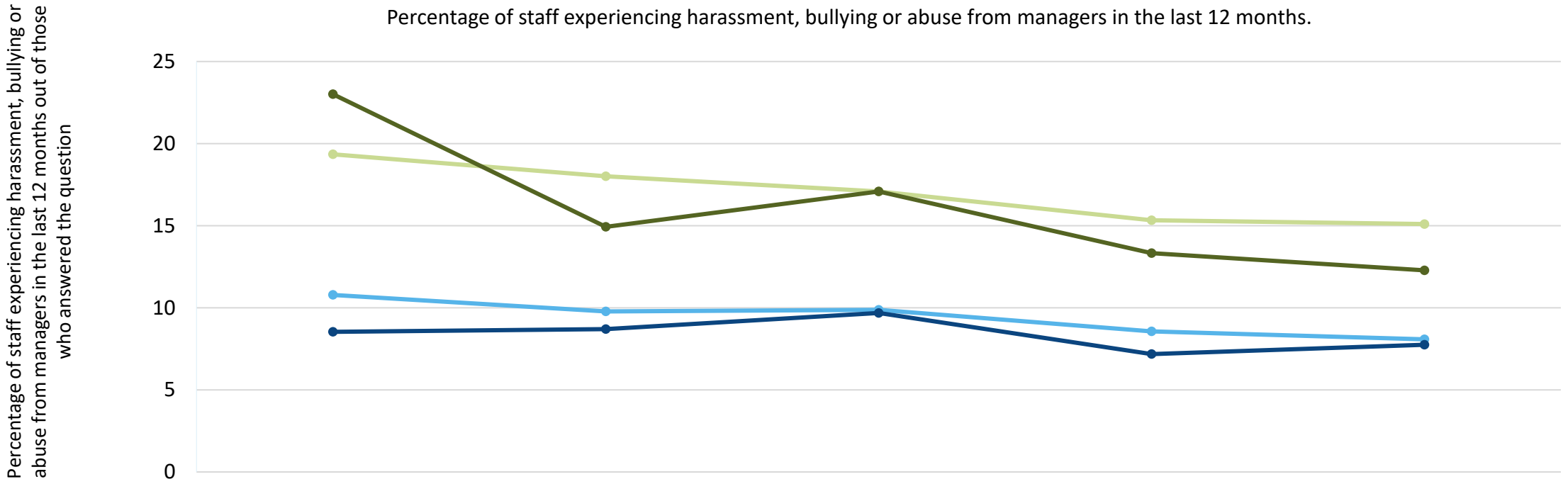


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	35.96%	30.10%	37.55%	25.32%	29.53%
Staff without a LTC or illness: Your org	24.02%	26.01%	27.51%	23.81%	21.31%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
Staff with a LTC or illness: Responses	114	289	277	316	342
Staff without a LTC or illness: Responses	408	965	956	991	1051

Note: 2023 results for WDES metric 4a (Q14a) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

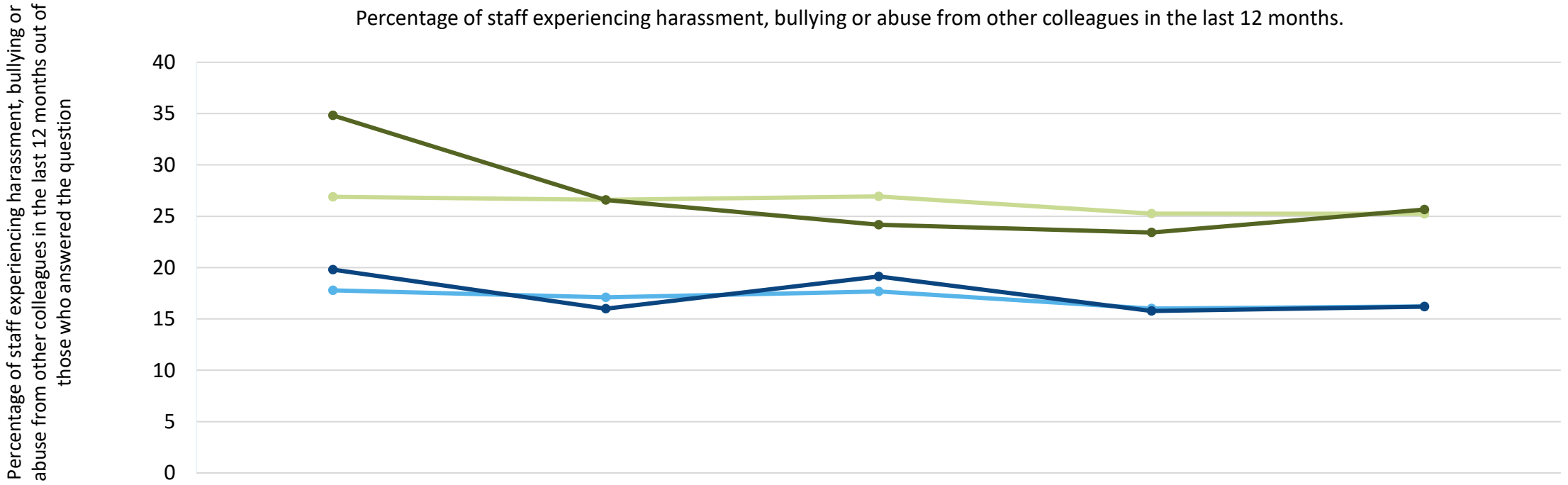


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	23.01%	14.93%	17.09%	13.33%	12.28%
Staff without a LTC or illness: Your org	8.54%	8.70%	9.68%	7.18%	7.74%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	113	288	275	315	342
Staff without a LTC or illness: Responses	410	954	950	989	1046

Note: 2023 results for WDES metric 4b (Q14b) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

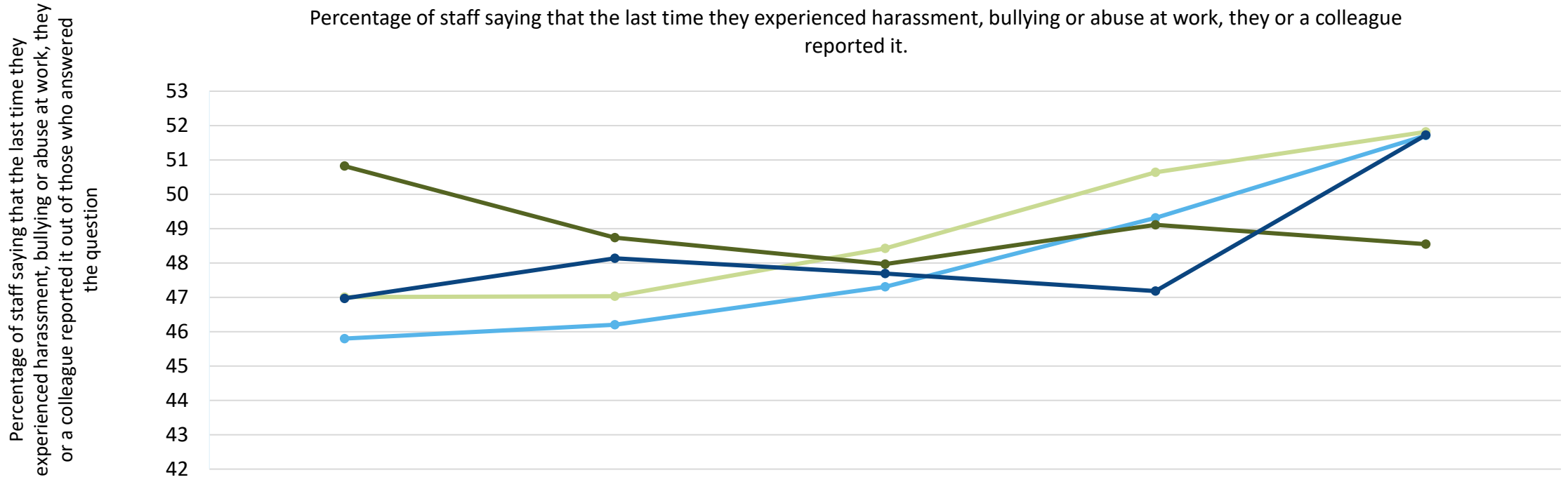


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	34.82%	26.57%	24.18%	23.42%	25.66%
Staff without a LTC or illness: Your org	19.80%	16.00%	19.14%	15.77%	16.20%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	112	286	273	316	343
Staff without a LTC or illness: Responses	409	956	951	989	1043

Note: 2023 results for WDES metric 4c (Q14c) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

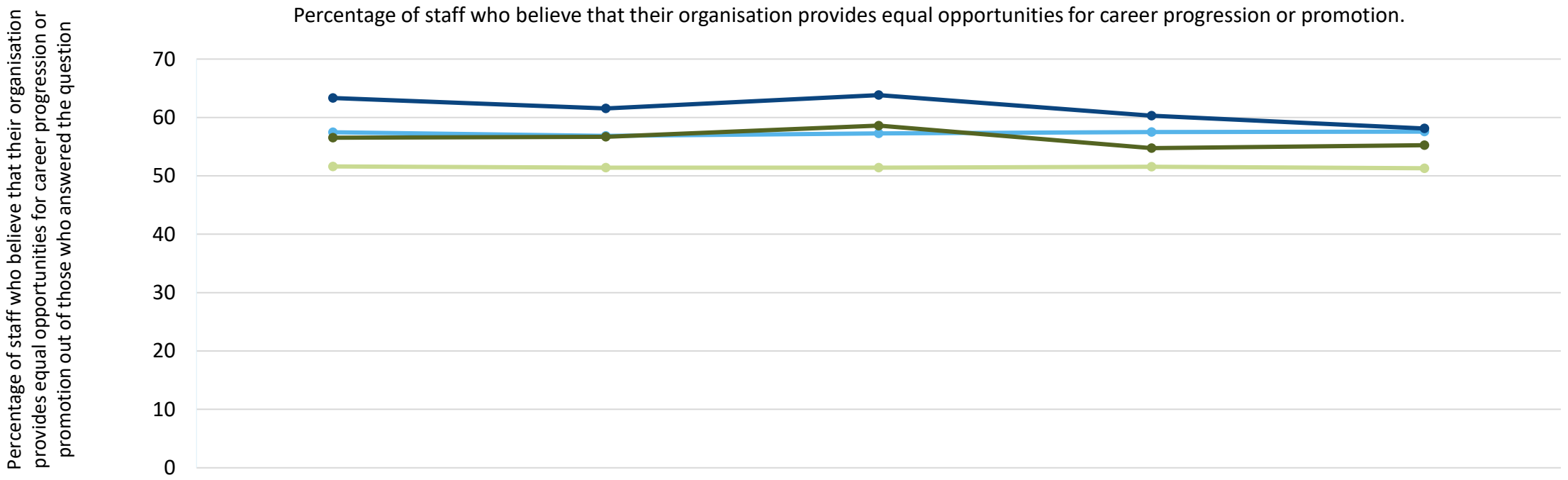


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	50.82%	48.74%	47.97%	49.11%	48.55%
Staff without a LTC or illness: Your org	46.97%	48.14%	47.69%	47.18%	51.72%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%
Staff with a LTC or illness: Responses	61	119	123	112	138
Staff without a LTC or illness: Responses	132	295	325	284	290

Note: 2023 results for WDES metric 4d (Q14d) are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

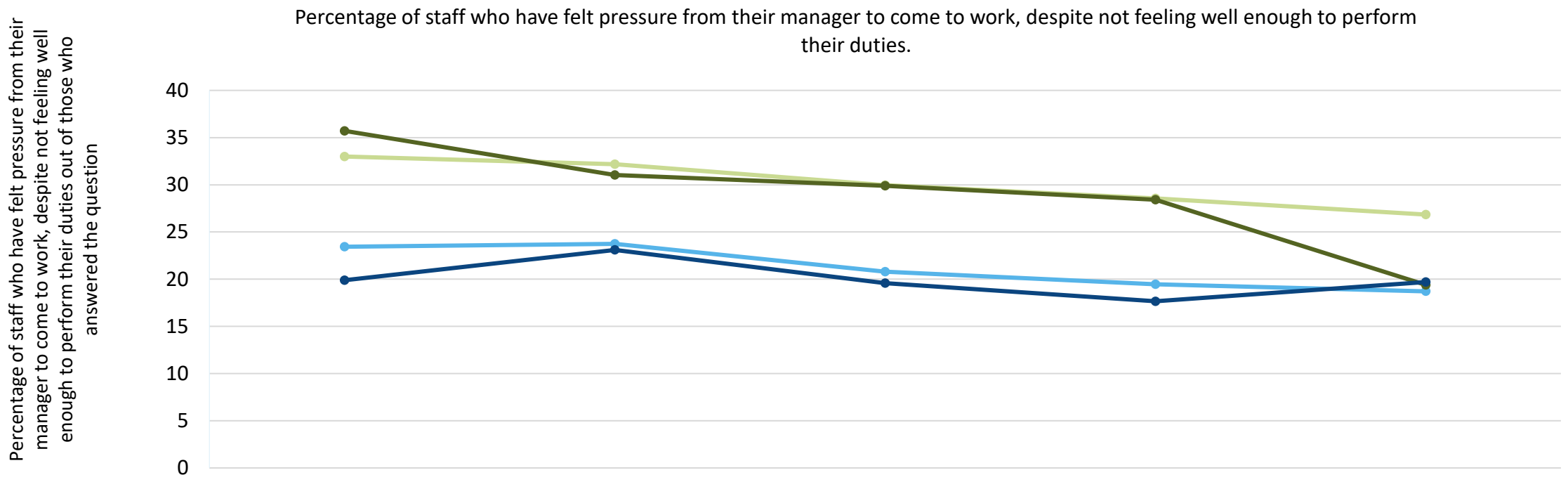
Survey Coordination Centre NHS



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	56.52%	56.69%	58.61%	54.75%	55.26%
Staff without a LTC or illness: Your org	63.35%	61.53%	63.83%	60.29%	58.11%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	115	284	273	316	342
Staff without a LTC or illness: Responses	412	954	951	982	1036

Workforce Disability Equality Standards

Survey Coordination Centre NHS



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	35.71%	31.03%	29.89%	28.43%	19.40%
Staff without a LTC or illness: Your org	19.88%	23.10%	19.57%	17.66%	19.69%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%
Staff with a LTC or illness: Responses	70	174	184	197	232
Staff without a LTC or illness: Responses	166	394	470	419	457

Workforce Disability Equality Standards

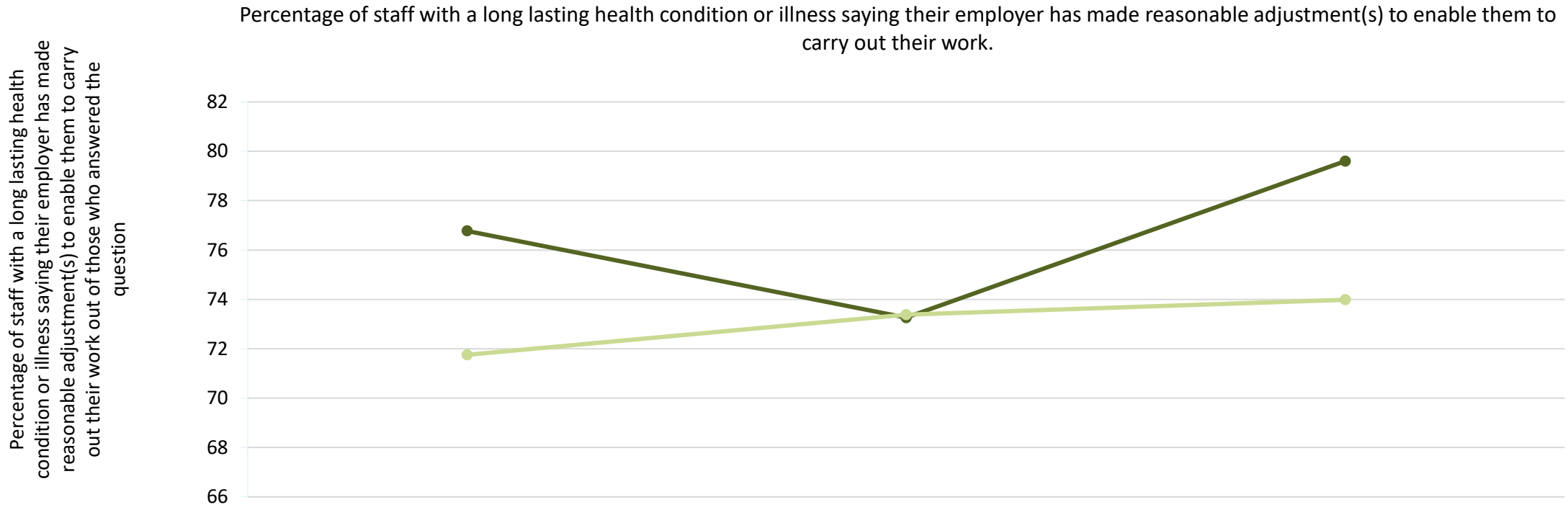
Survey Coordination Centre NHS

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	37.39%	33.91%	33.09%	39.75%	39.88%
Staff without a LTC or illness: Your org	49.15%	44.31%	45.51%	48.95%	50.33%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%
Staff with a LTC or illness: Responses	115	289	275	322	346
Staff without a LTC or illness: Responses	413	966	958	999	1055

Workforce Disability Equality Standards

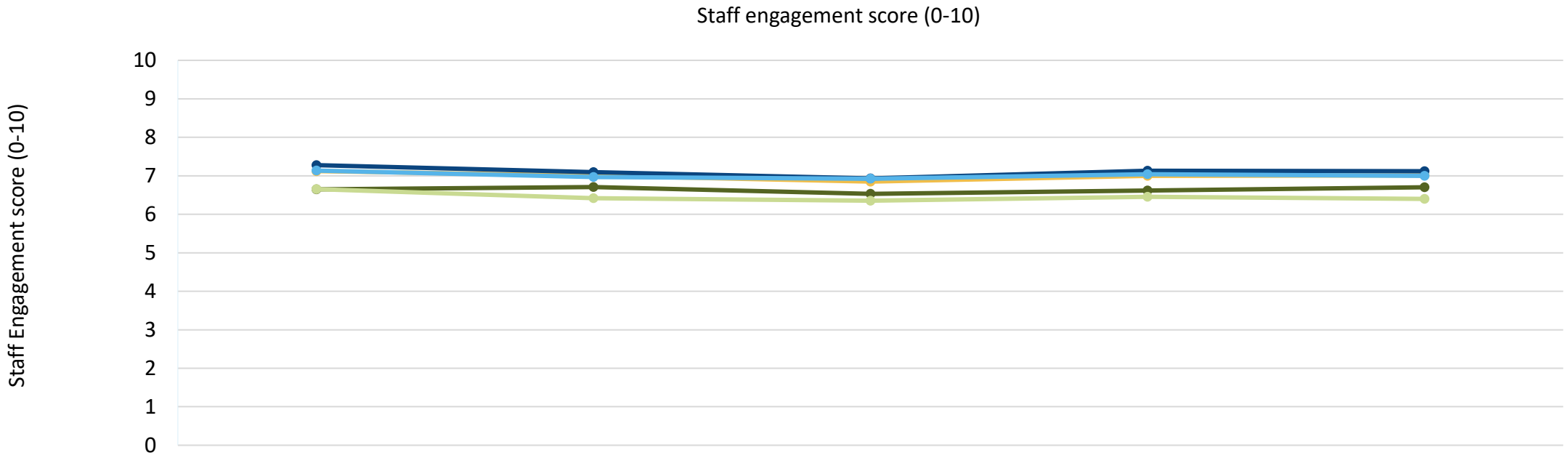
Survey Coordination Centre NHS

Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.



	2022	2023	2024
Staff with a LTC or illness: Your org	76.77%	73.26%	79.60%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%
Staff with a LTC or illness: Responses	155	187	201

Workforce Disability Equality Standards



	2020	2021	2022	2023	2024
Organisation average	7.12	7.01	6.85	7.00	7.01
Staff with a LTC or illness: Your org	6.65	6.71	6.53	6.62	6.70
Staff without a LTC or illness: Your org	7.28	7.10	6.93	7.13	7.12
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	115	290	275	322	347
Staff without a LTC or illness: Responses	415	973	964	1003	1056

Note: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Survey Coordination Centre

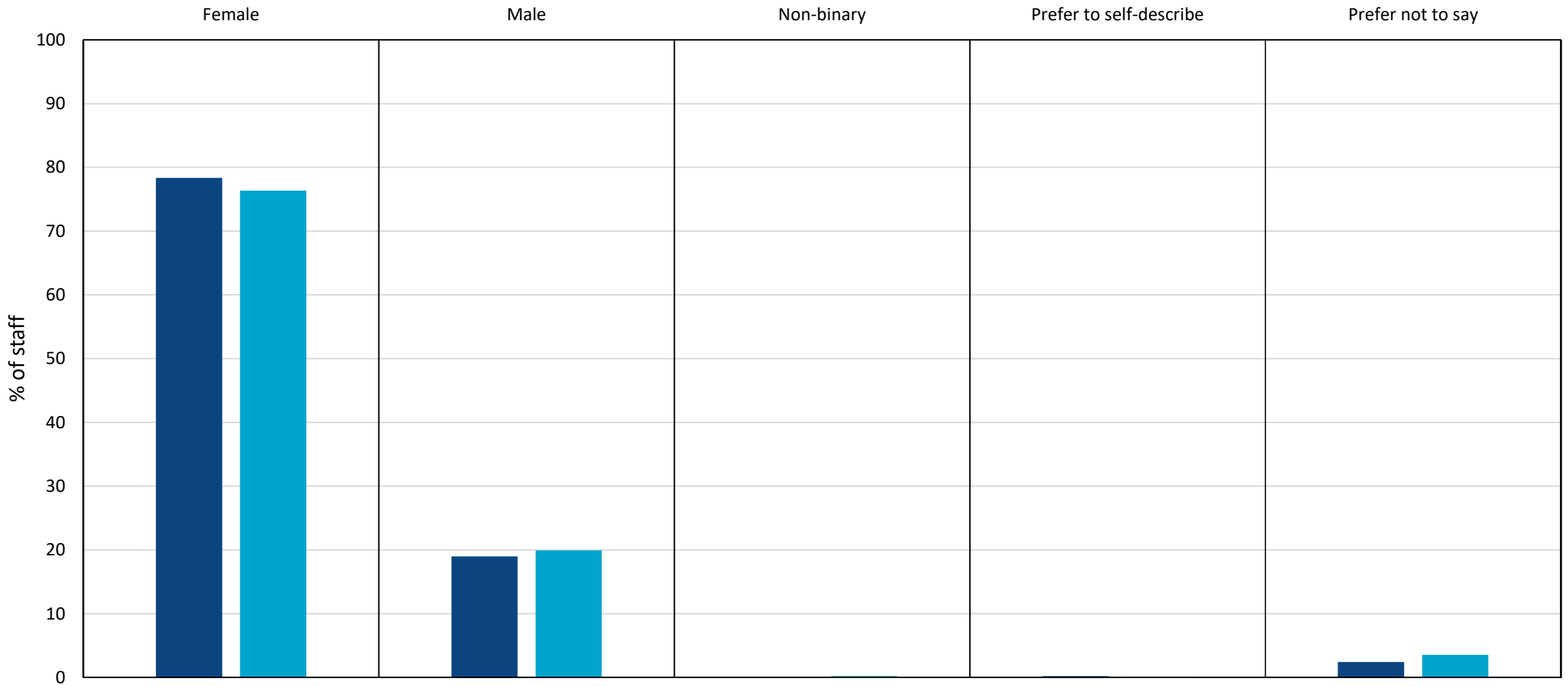
NHS

About your respondents

This section shows demographic and other background information for 2024.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

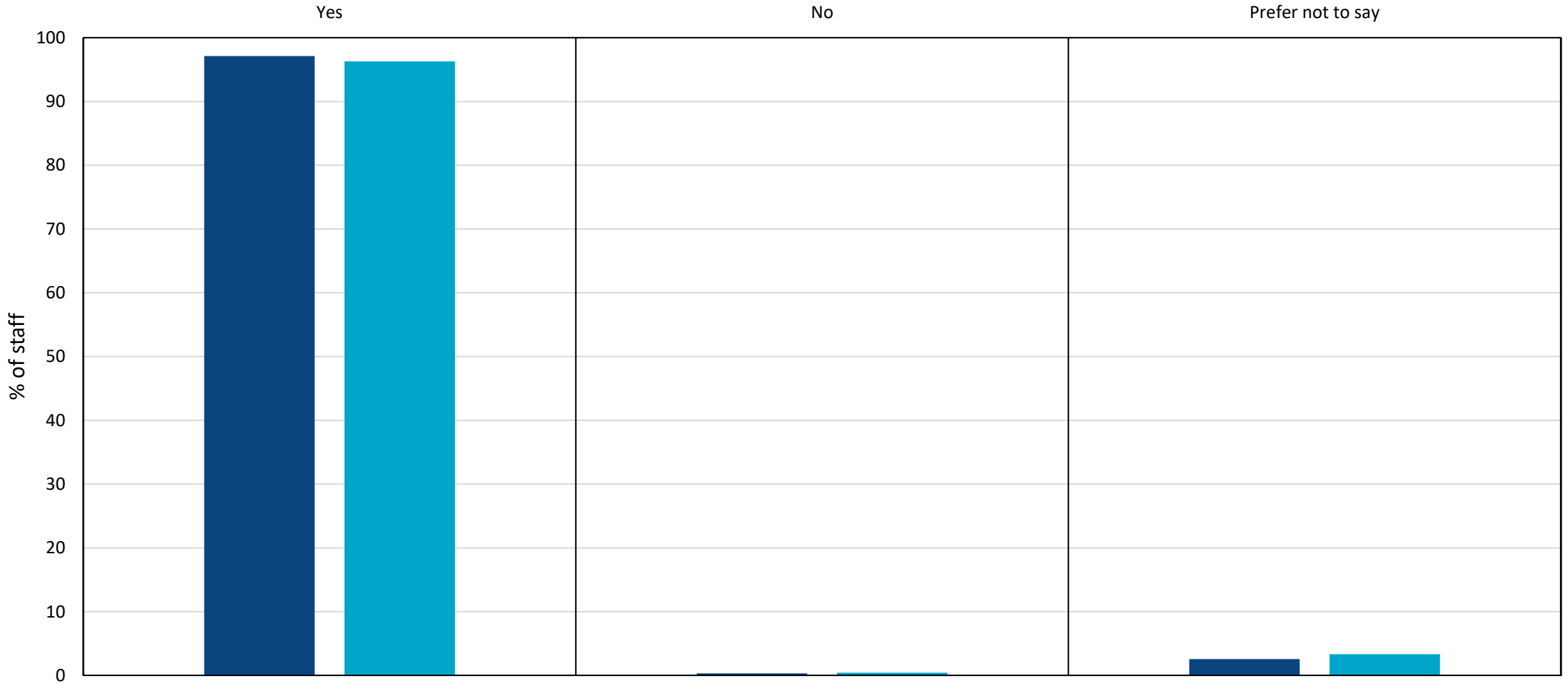
Background details - Gender



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	78.34%	18.97%	0.07%	0.21%	2.41%
Average	76.34%	19.91%	0.21%	0.13%	3.54%
Responses	1413	1413	1413	1413	1413

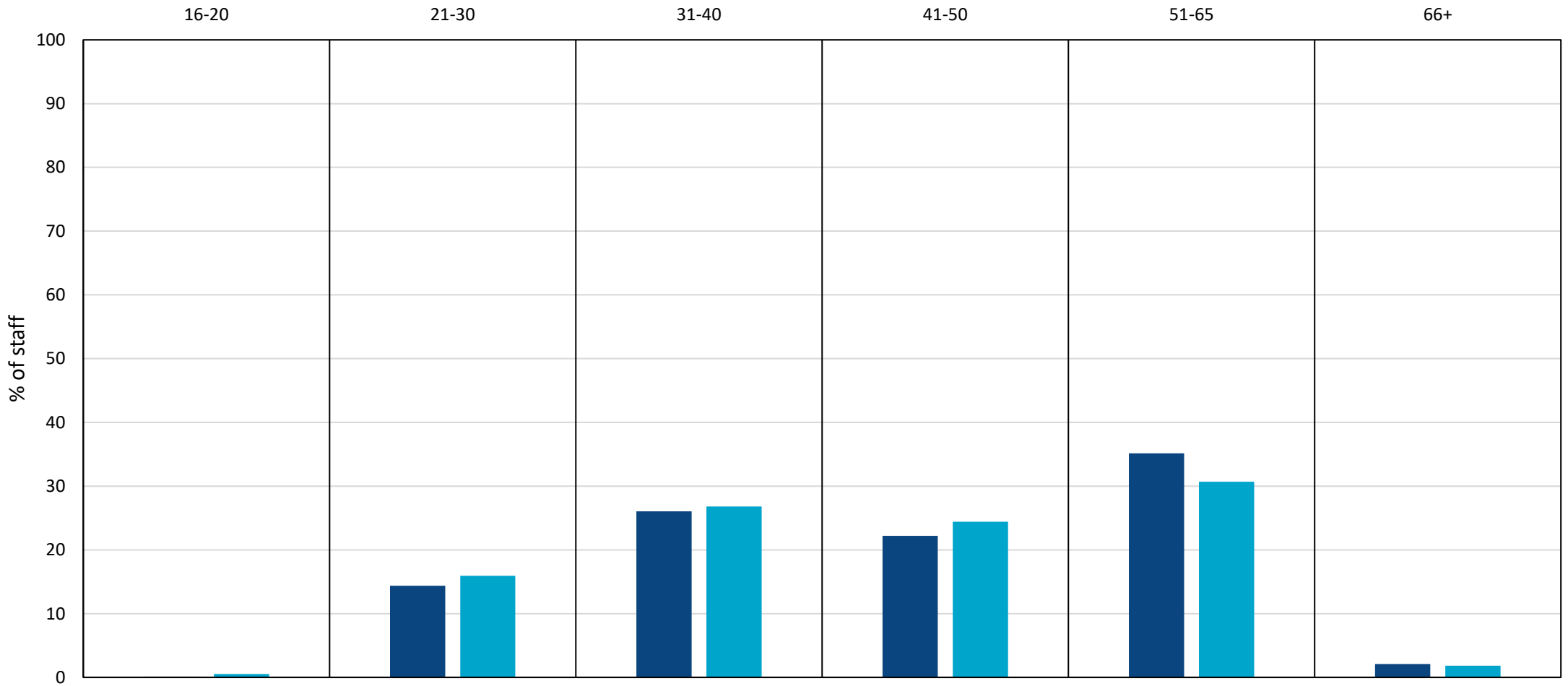
Background details – Is your gender identity the same as the sex you were registered at birth?

Survey Coordination Centre



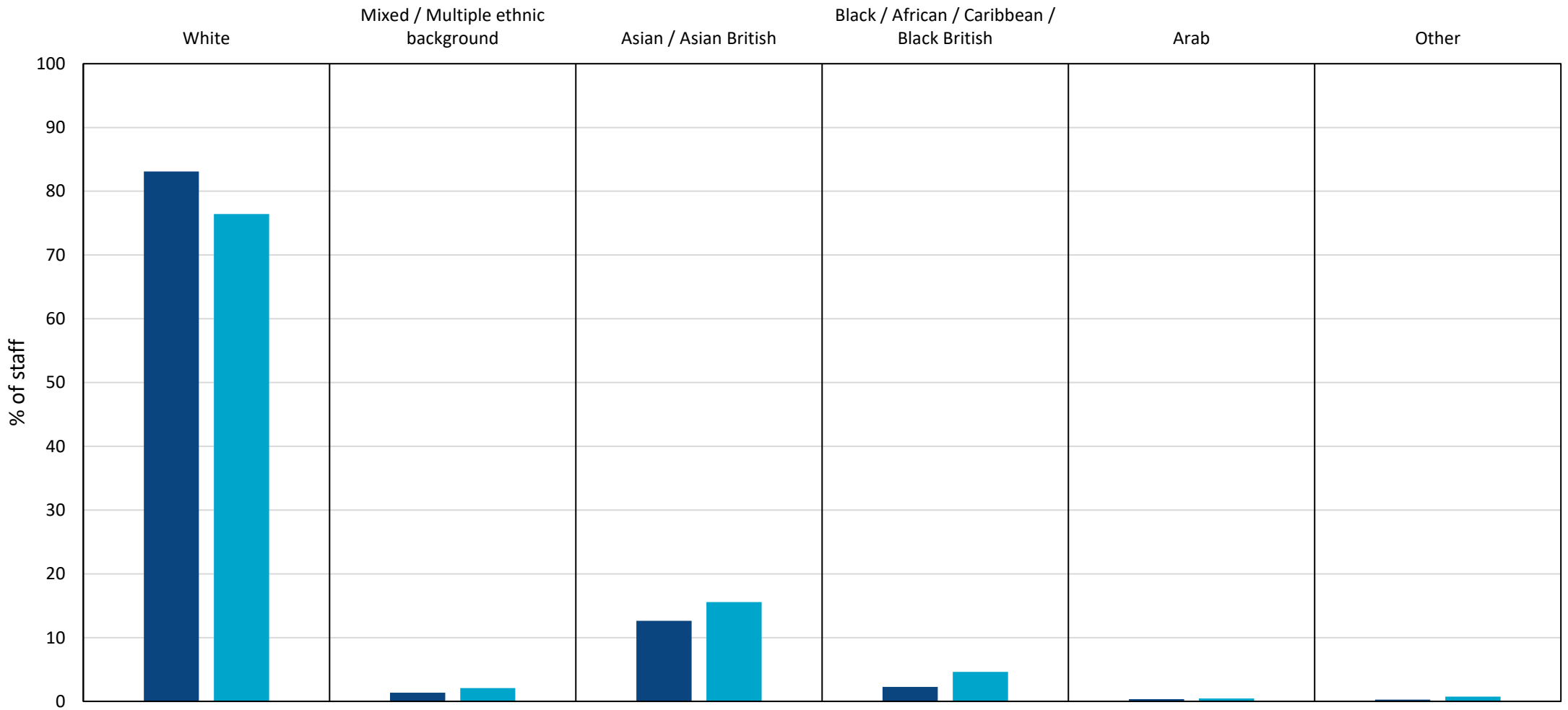
	Yes	No	Prefer not to say
Your org	97.14%	0.32%	2.54%
Average	96.28%	0.41%	3.34%
Responses	1258	1258	1258

Background details - Age



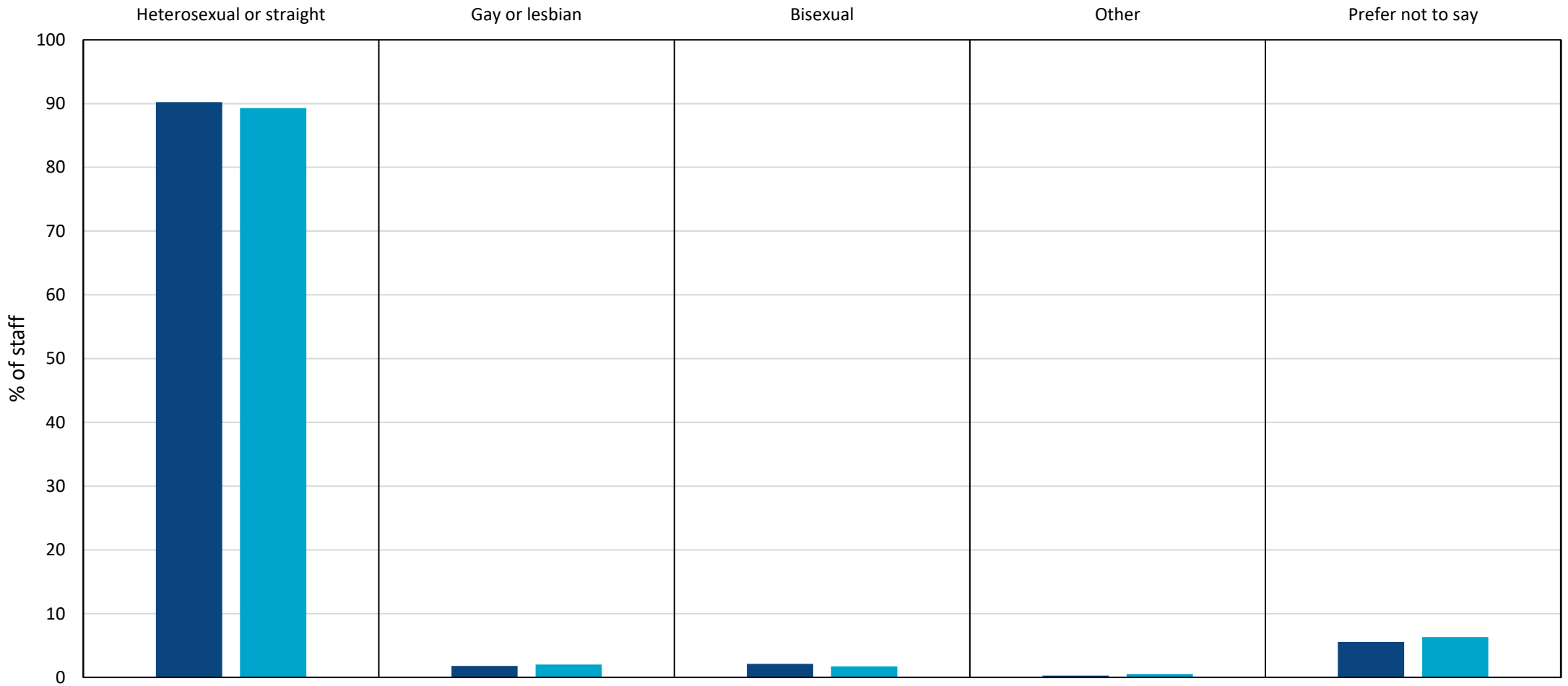
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.14%	14.39%	26.06%	22.19%	35.15%	2.08%
Average	0.52%	15.92%	26.82%	24.42%	30.69%	1.83%
Responses	1397	1397	1397	1397	1397	1397

Background details - Ethnicity



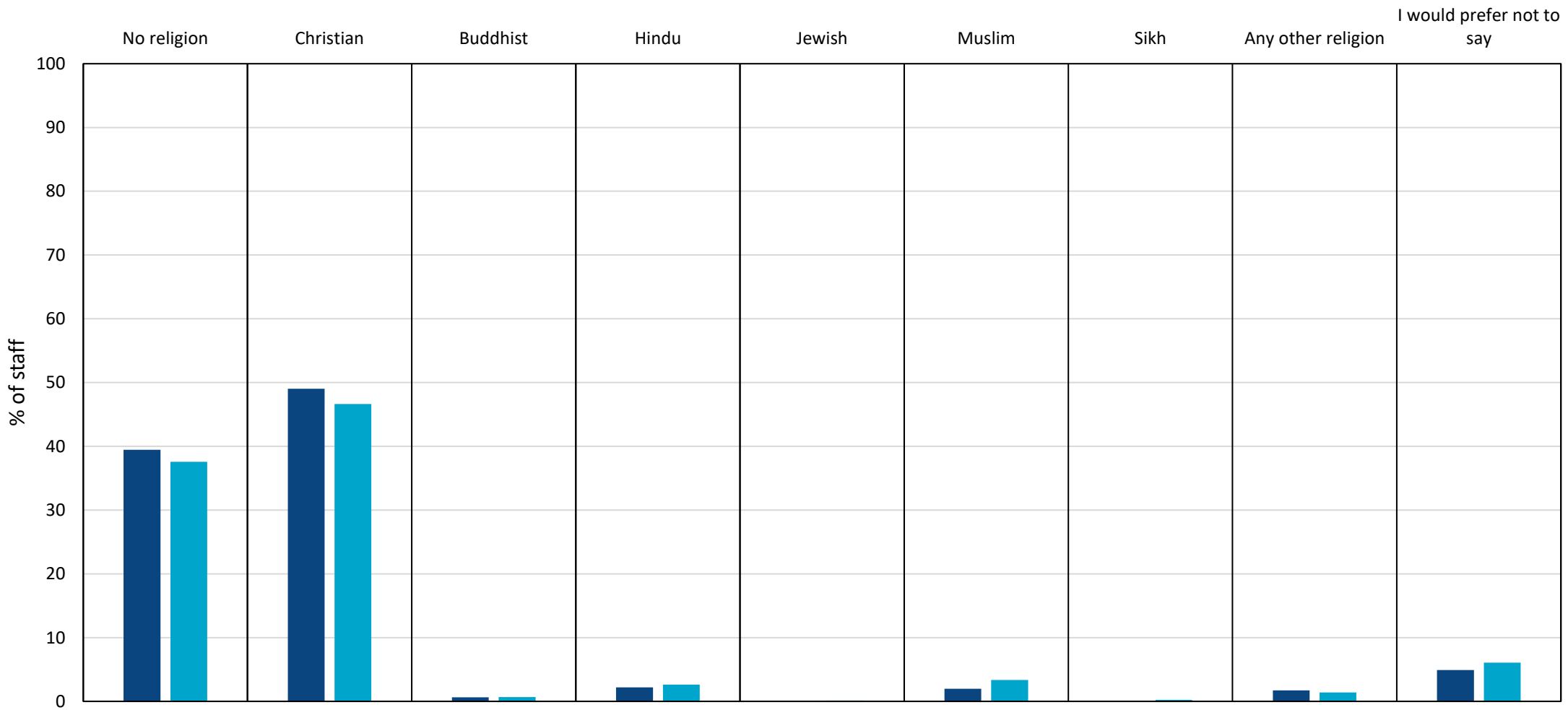
	White	Mixed / Multiple ethnic background	Asian / Asian British	Black / African / Caribbean / Black British	Arab	Other
Your org	83.10%	1.36%	12.62%	2.28%	0.36%	0.29%
Average	76.43%	2.08%	15.55%	4.62%	0.46%	0.73%
Responses	1402	1402	1402	1402	1402	1402

Background details – Sexual orientation



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	90.24%	1.78%	2.14%	0.28%	5.56%
Average	89.28%	2.03%	1.74%	0.53%	6.32%
Responses	1404	1404	1404	1404	1404

Background details - Religion



	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	39.45%	49.04%	0.64%	2.20%	0.07%	1.99%	0.00%	1.71%	4.90%
Average	37.56%	46.64%	0.66%	2.62%	0.13%	3.34%	0.25%	1.41%	6.08%
Responses	1407	1407	1407	1407	1407	1407	1407	1407	1407

Background details – Long lasting health condition or illness

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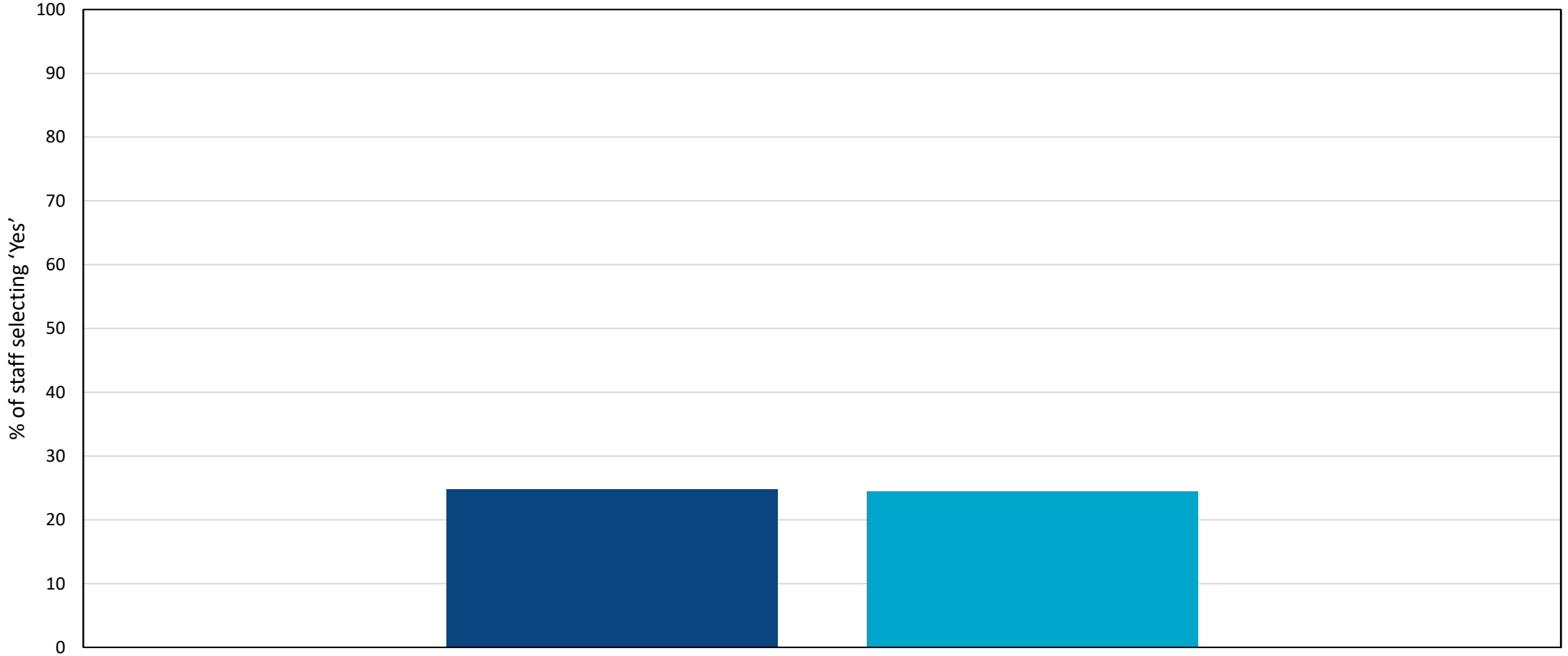
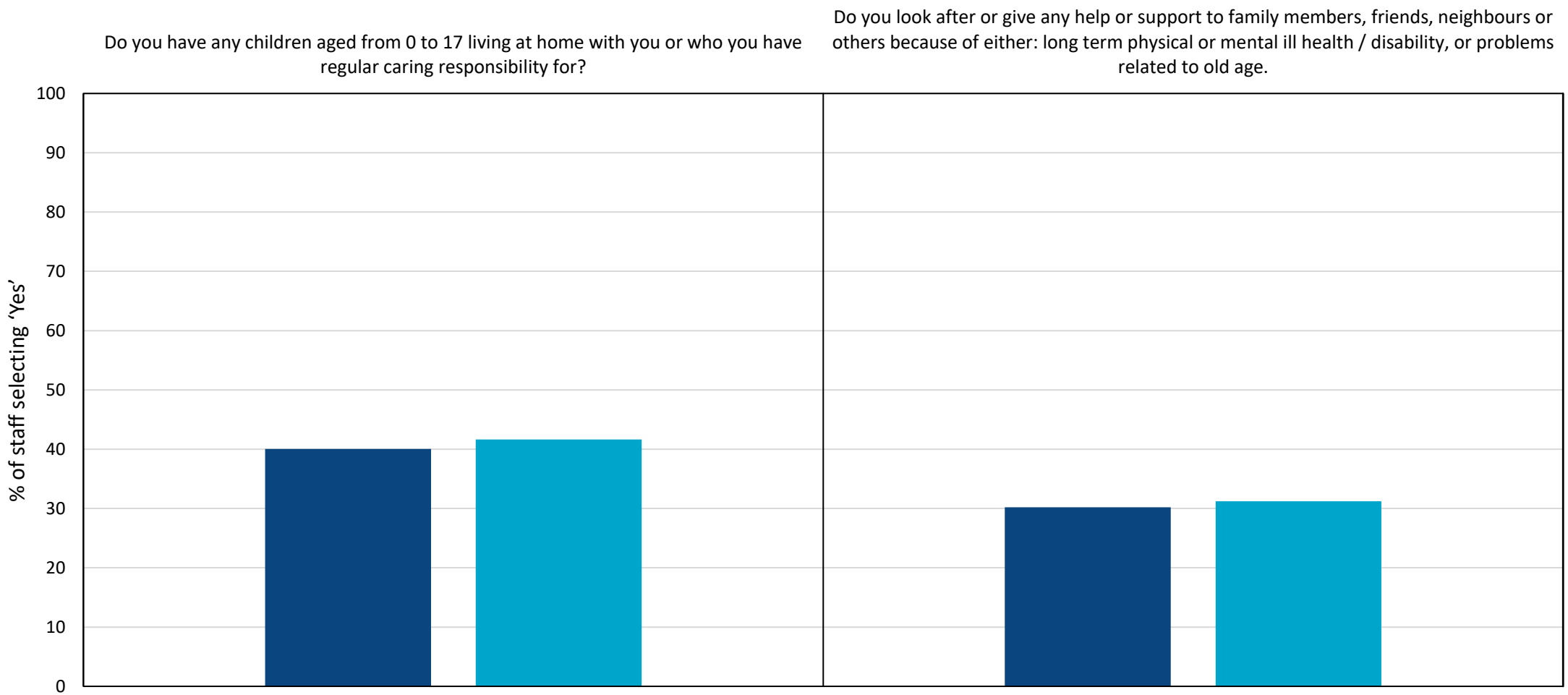
NHS

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



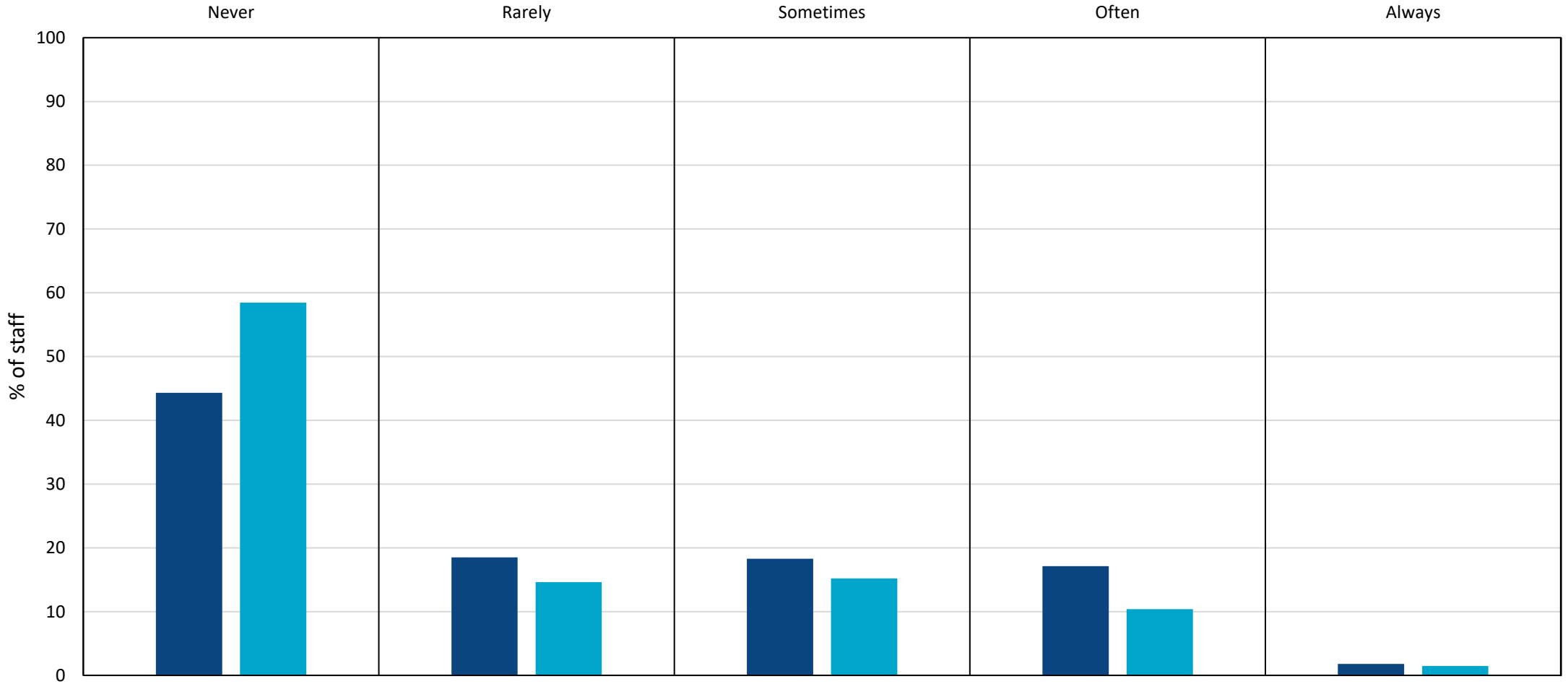
Your org	24.77%
Average	24.45%
Responses	1405

Background details – Parental / caring responsibilities



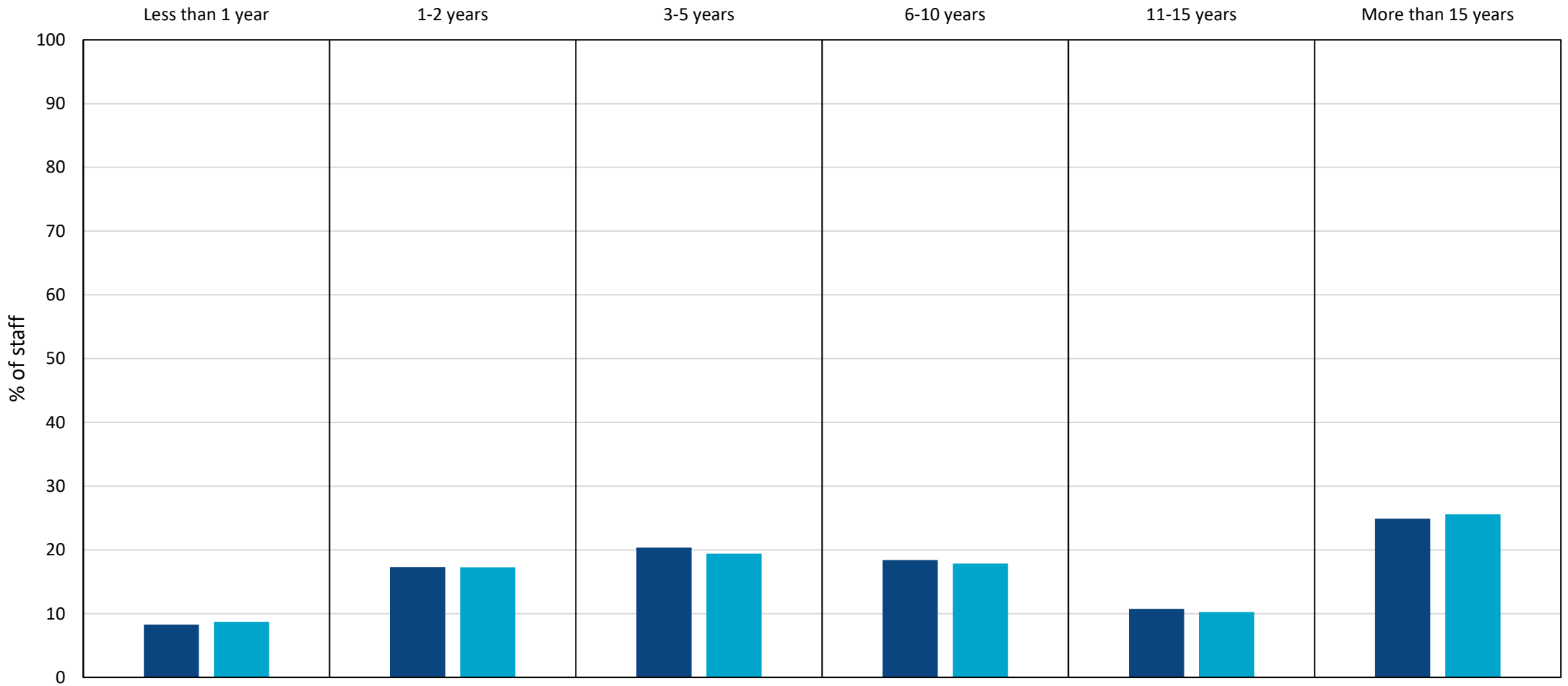
Your org	40.04%	30.21%
Average	41.64%	31.24%
Responses	1401	1397

Background details – How often do you work at/from home?



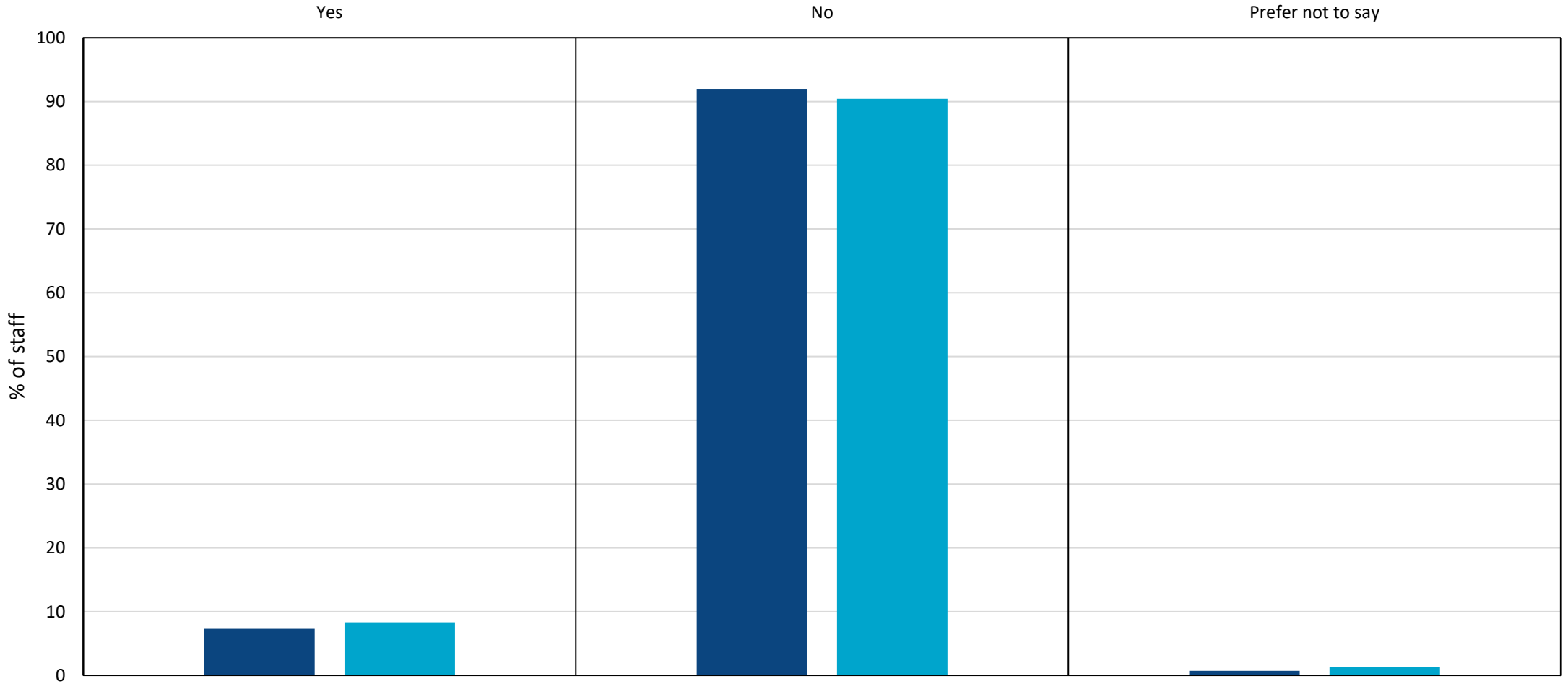
	Never	Rarely	Sometimes	Often	Always
Your org	44.31%	18.49%	18.28%	17.14%	1.78%
Average	58.46%	14.62%	15.19%	10.39%	1.47%
Responses	1406	1406	1406	1406	1406

Background details – Length of service



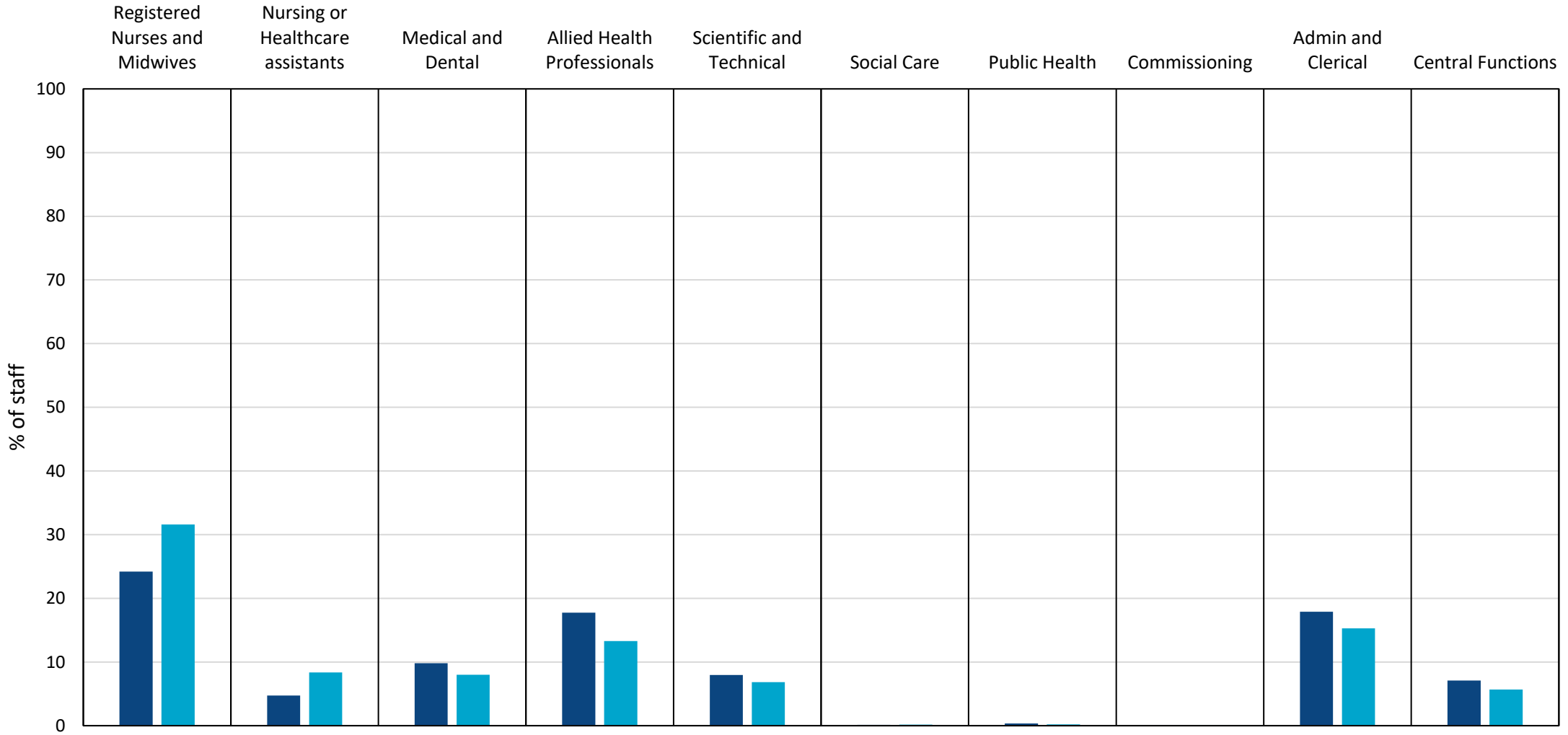
	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	8.27%	17.33%	20.37%	18.39%	10.75%	24.89%
Average	8.72%	17.29%	19.43%	17.86%	10.24%	25.58%
Responses	1414	1414	1414	1414	1414	1414

Background details – When you joined this organisation, were you recruited from outside of the UK?



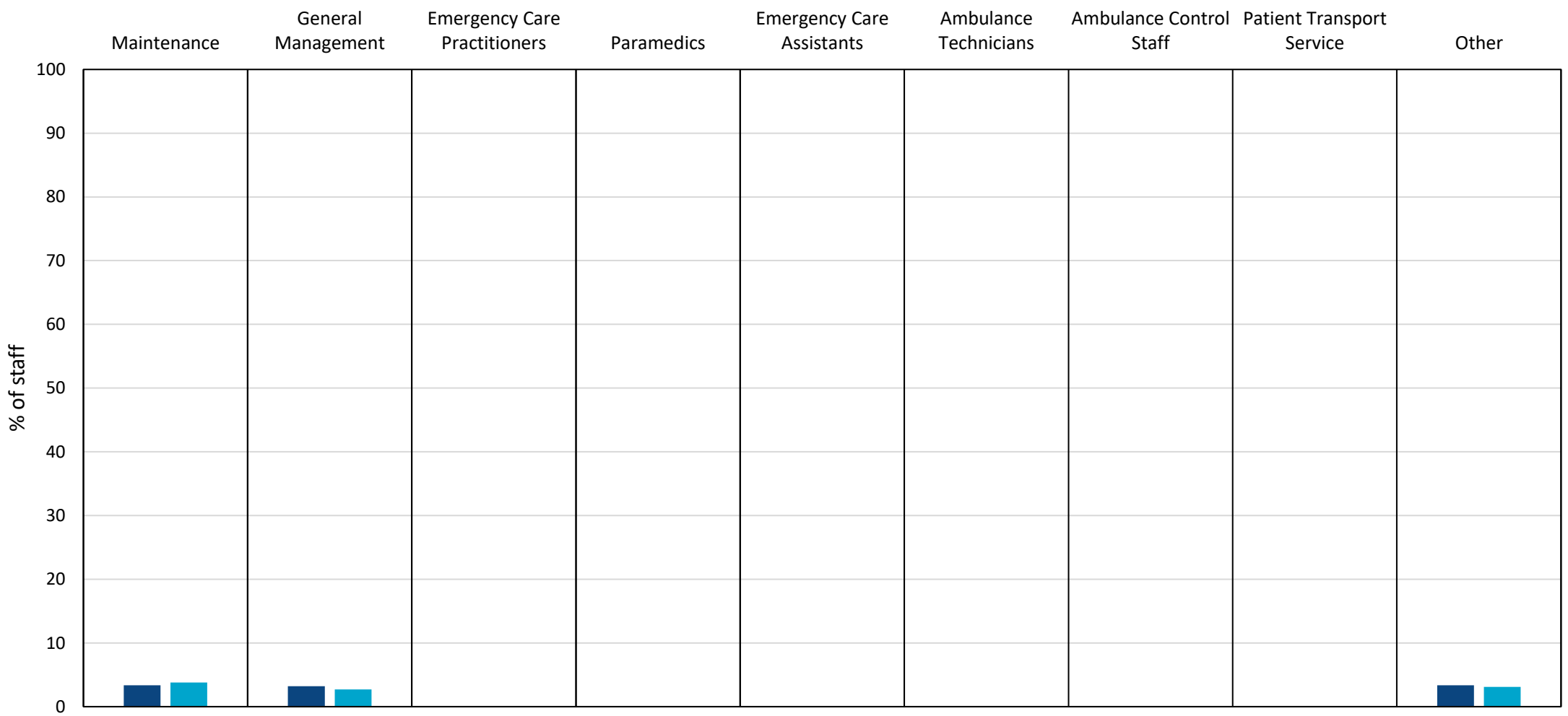
	Yes	No	Prefer not to say
Your org	7.32%	91.98%	0.70%
Average	8.30%	90.40%	1.24%
Responses	1285	1285	1285

Background details – Occupational group



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	24.19%	4.72%	9.81%	17.75%	7.95%	0.14%	0.36%	0.07%	17.90%	7.09%
Average	31.58%	8.38%	7.99%	13.29%	6.85%	0.17%	0.21%	0.07%	15.29%	5.69%
Responses	1397	1397	1397	1397	1397	1397	1397	1397	1397	1397

Background details – Occupational group



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	3.36%	3.22%	0.00%	0.07%	0.00%	0.00%	0.00%	0.00%	3.36%
Average	3.80%	2.70%	0.02%	0.02%	0.04%	0.00%	0.00%	0.00%	3.09%
Responses	1397	1397	1397	1397	1397	1397	1397	1397	1397

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Appendices

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Appendix A: Response rate

Appendix A: Response rate

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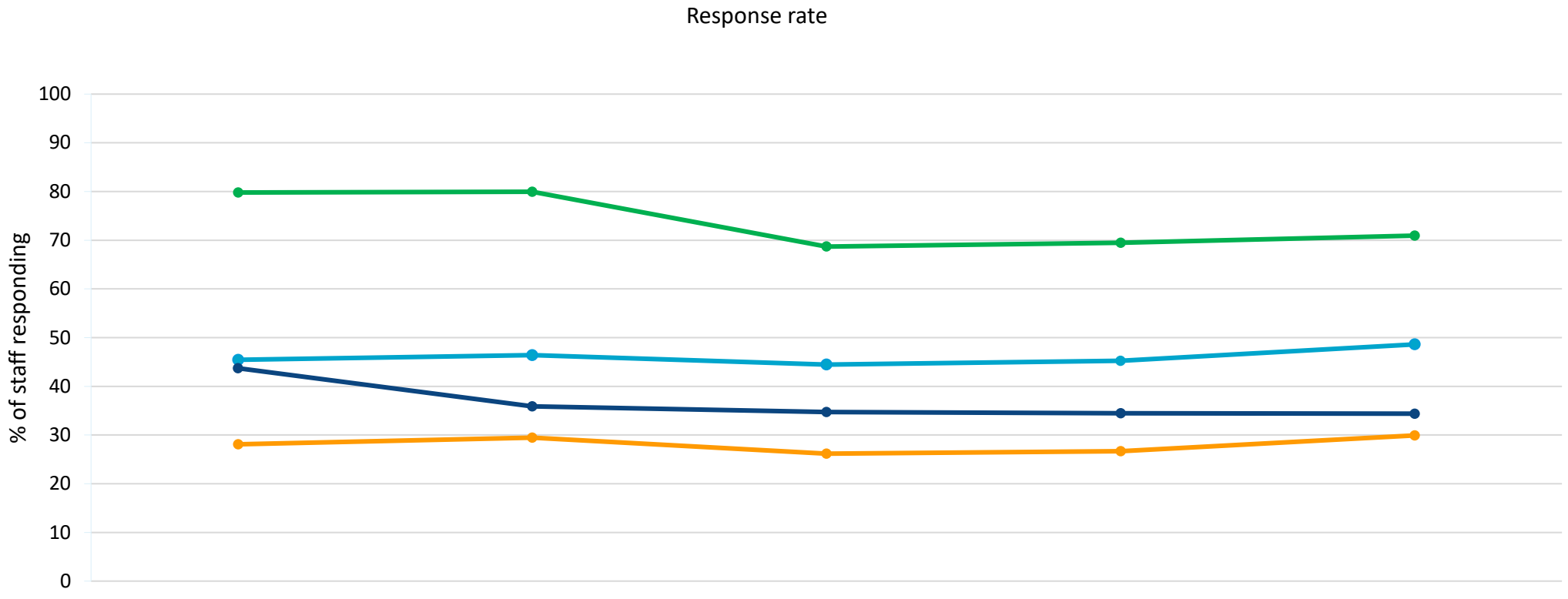

	2020	2021	2022	2023	2024
Your org	43.71%	35.90%	34.71%	34.45%	34.38%
Highest	79.77%	79.95%	68.69%	69.45%	70.92%
Average	45.43%	46.38%	44.46%	45.23%	48.61%
Lowest	28.09%	29.47%	26.17%	26.65%	29.91%
Responses	542	1284	1255	1356	1426

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Appendix B: Significance testing 2023 vs 2024

Appendix B: Significance testing – 2023 vs 2024

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Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.36	1350	7.38	1420	Not significant
We are recognised and rewarded	6.17	1351	6.20	1422	Not significant
We each have a voice that counts	6.85	1315	6.89	1402	Not significant
We are safe and healthy	6.17	1323	6.20	1407	Not significant
We are always learning	5.90	1293	5.84	1358	Not significant
We work flexibly	6.45	1341	6.64	1413	Significantly higher
We are a team	6.90	1350	6.96	1418	Not significant
Themes					
Staff Engagement	7.02	1353	7.03	1421	Not significant
Morale	6.07	1349	6.08	1422	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

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The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data but have been included to aid users.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. The People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the technical document available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer-term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Appendix C: 1. Reviewing People Promise and theme results

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another point of reference.

Areas to improve

- By checking where, the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

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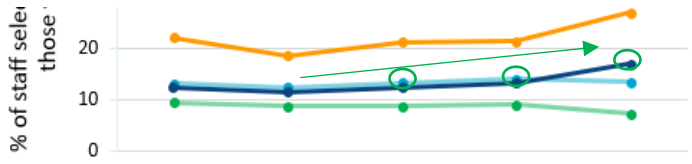
Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



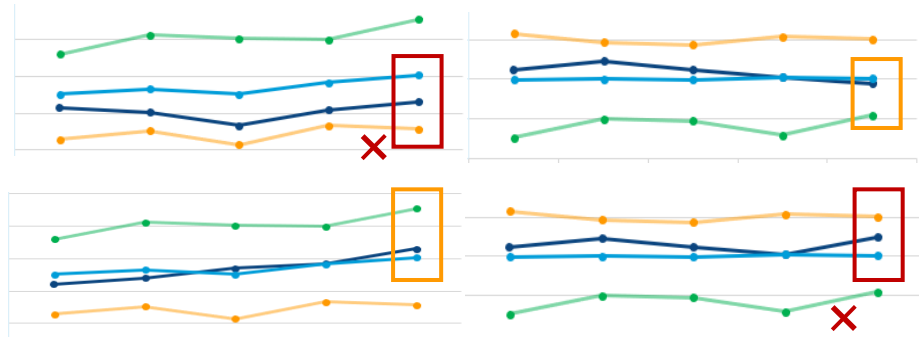
	2020	2021	2022	2023	2024
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	595

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average and worst benchmarking group result for question

Appendix C: 3. Reviewing question results

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This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

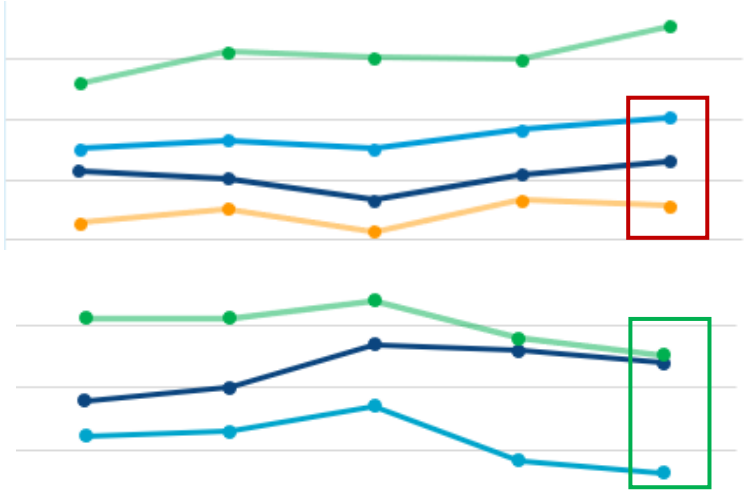
Identifying questions of interest

- **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

- **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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Appendix D: Additional reporting outputs

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

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Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Guide: Contains technical details about the NHS Staff Survey data, including data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for Wye Valley NHS Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

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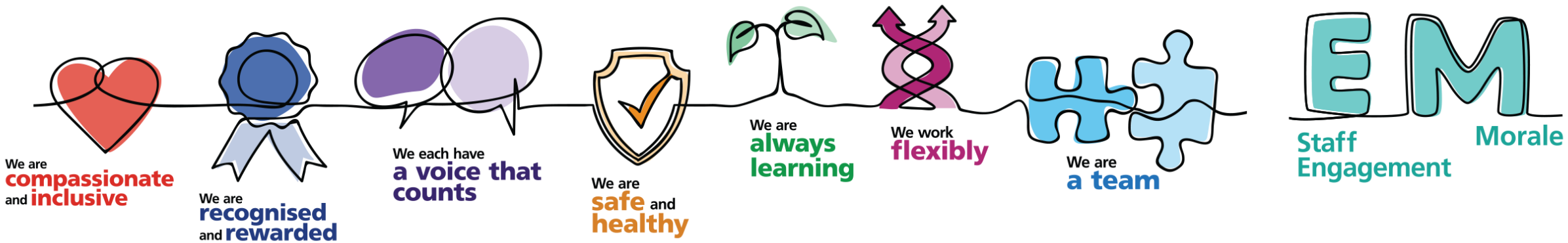


Wye Valley NHS Trust

2024 NHS Staff Survey

Breakdown report

Contents (1)

Contents (2)

This breakdown report for Wye Valley NHS Trust contains results by breakdown area for the People Promise element and theme results from the 2024 NHS Staff Survey. These results are compared to the unweighted average for your organisation.

Please note: It is possible that there are differences between the 'Your org' scores reported in this breakdown report and those in the benchmark report. This is because the results in the benchmark report are weighted to allow for fair comparisons between organisations of a similar type. However, in this report comparisons are made within your organisation, so the unweighted organisation result is a more appropriate point of comparison.

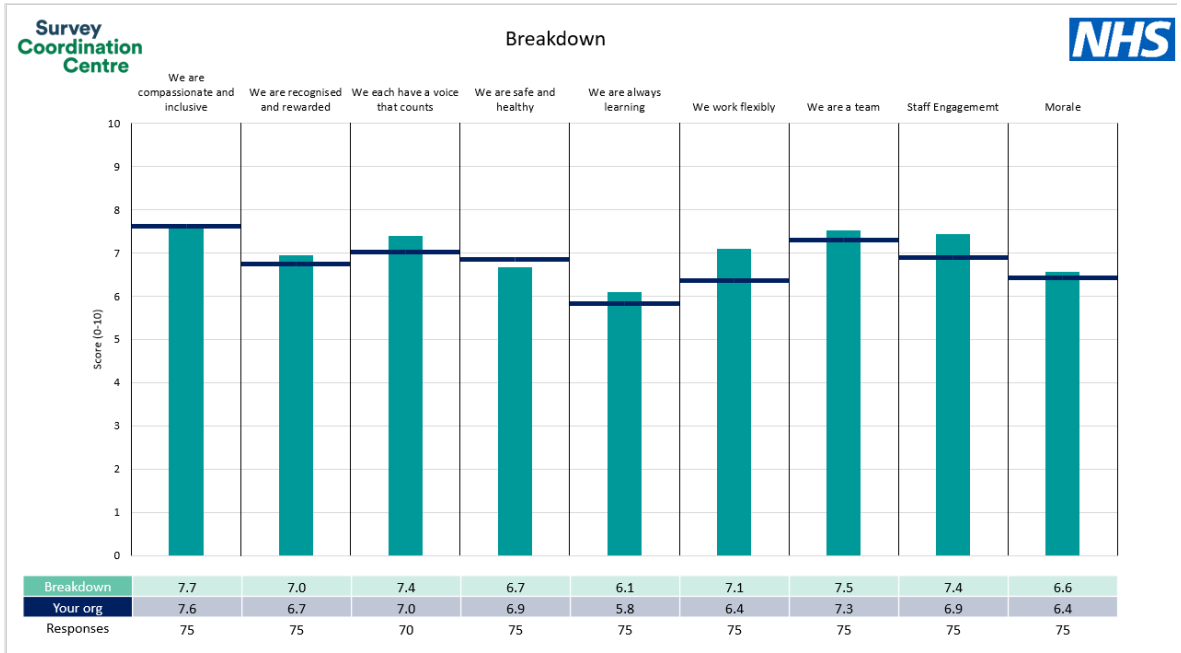
The breakdowns used in this report were provided and defined by Wye Valley NHS Trust. Details of how the People Promise element and theme scores were calculated are included in the Technical Document, available to download from our results website.

Key features

Breakdown type and **breakdown name** are specified in the header.

Breakdown results are presented in the context of the (unweighted) **organisation average ('Your org')**, so it is easy to tell if a breakdown area is performing better or worse than the organisation average. For all People Promise element and theme results, a higher score is a better result than a lower score.

The **number of responses** feeding into each measure and sub-scores for the **given breakdown** are specified below the table containing the breakdown and trust scores.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Breakdown	7.7	7.0	7.4	6.7	6.1	7.1	7.5	7.4	6.6
Your org	7.6	6.7	7.0	6.9	5.8	6.4	7.3	6.9	6.4
Responses	75	75	70	75	75	75	75	75	75

! Note: When there are fewer than 10 responses in a group, results are suppressed to protect staff confidentiality. For some organisations this could mean that all breakdown results are suppressed.

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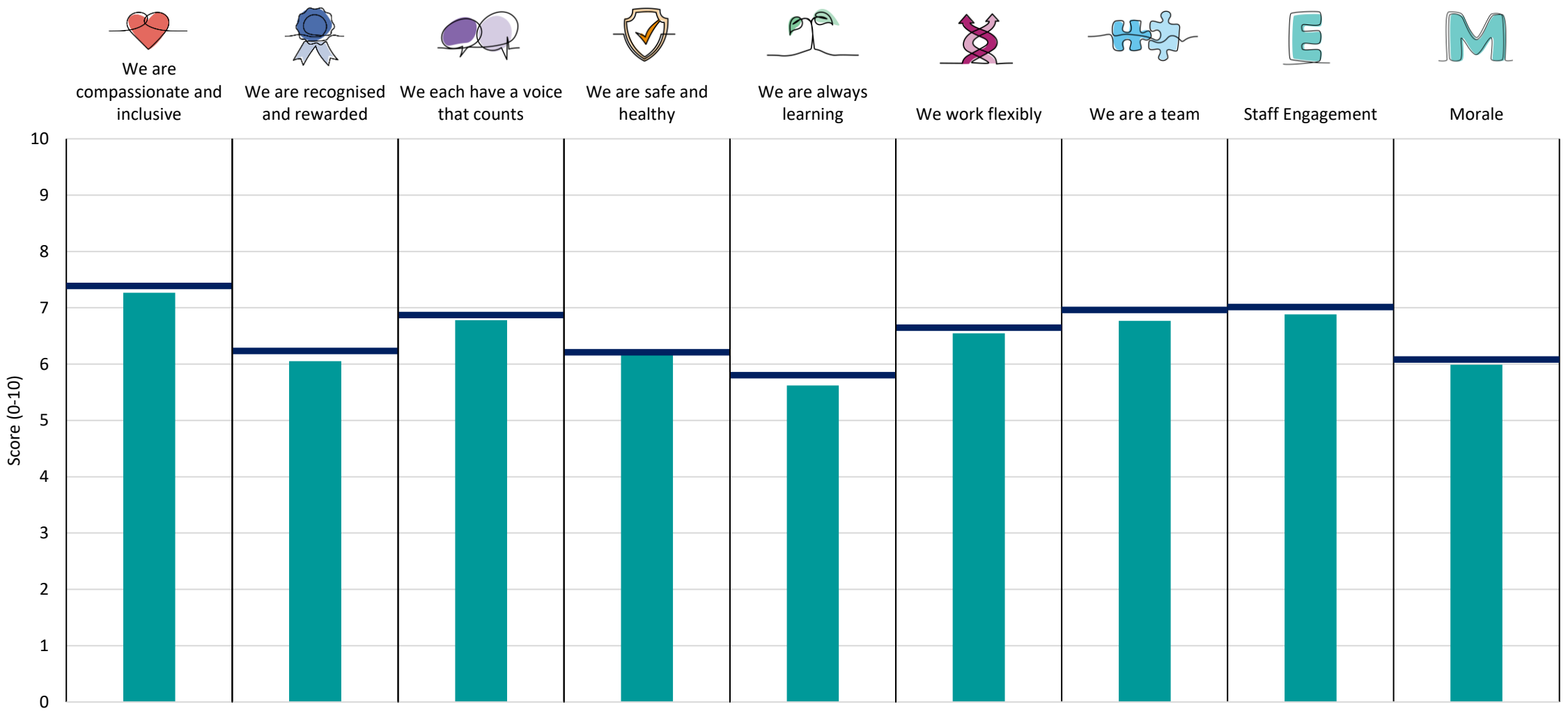
Breakdowns 1

Wye Valley NHS Trust

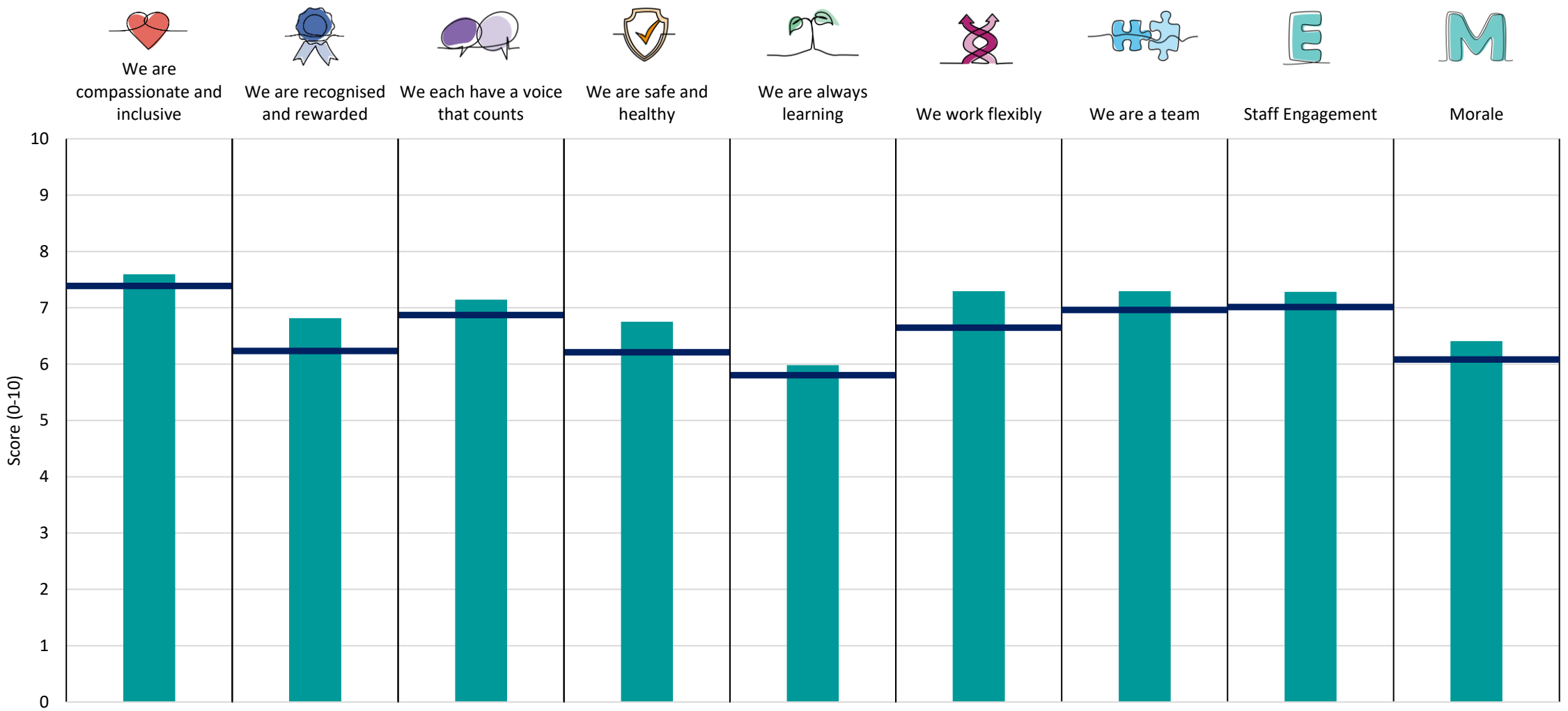
2024 NHS Staff Survey

Clinical Support



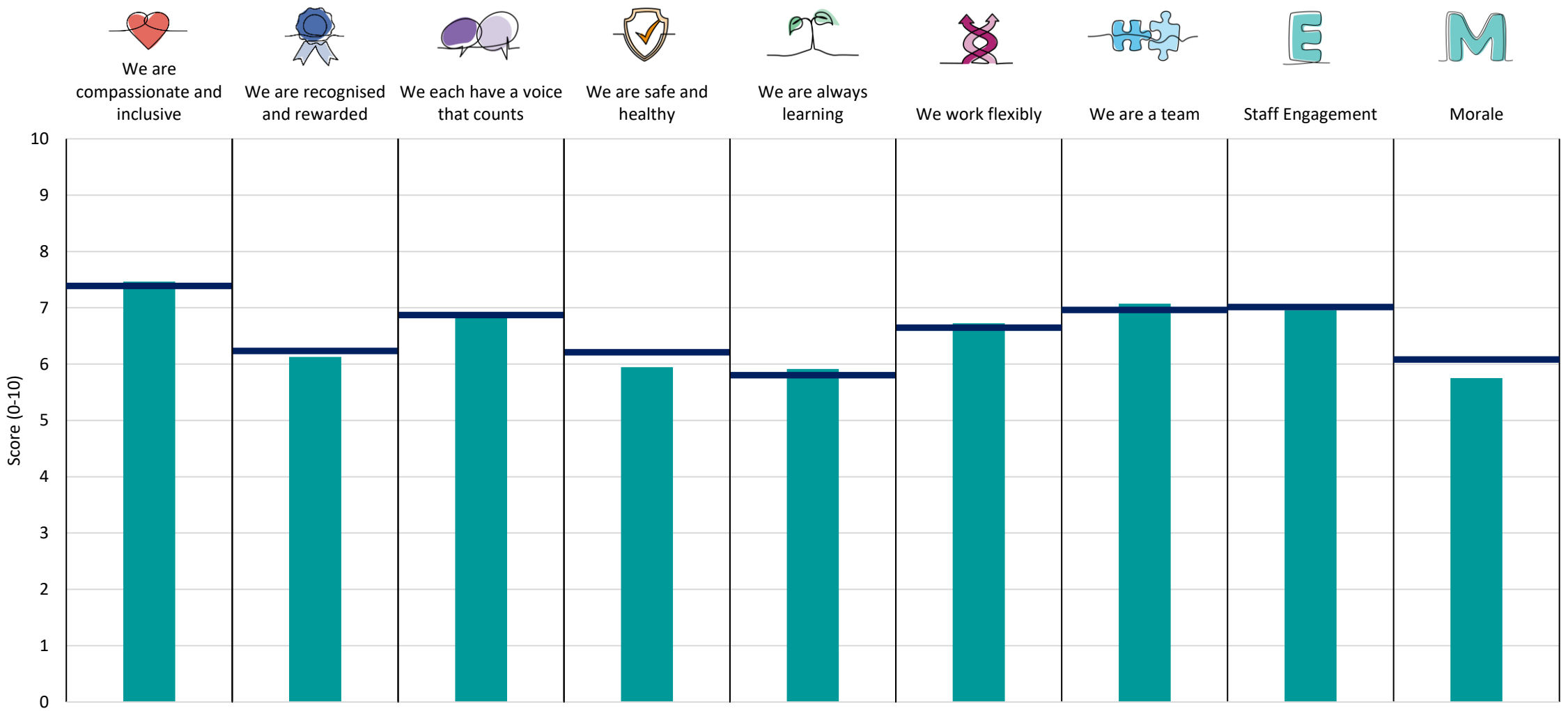
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.27	6.05	6.78	6.18	5.62	6.55	6.77	6.88	5.99
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	296	297	289	294	271	297	296	297	297

Corporate



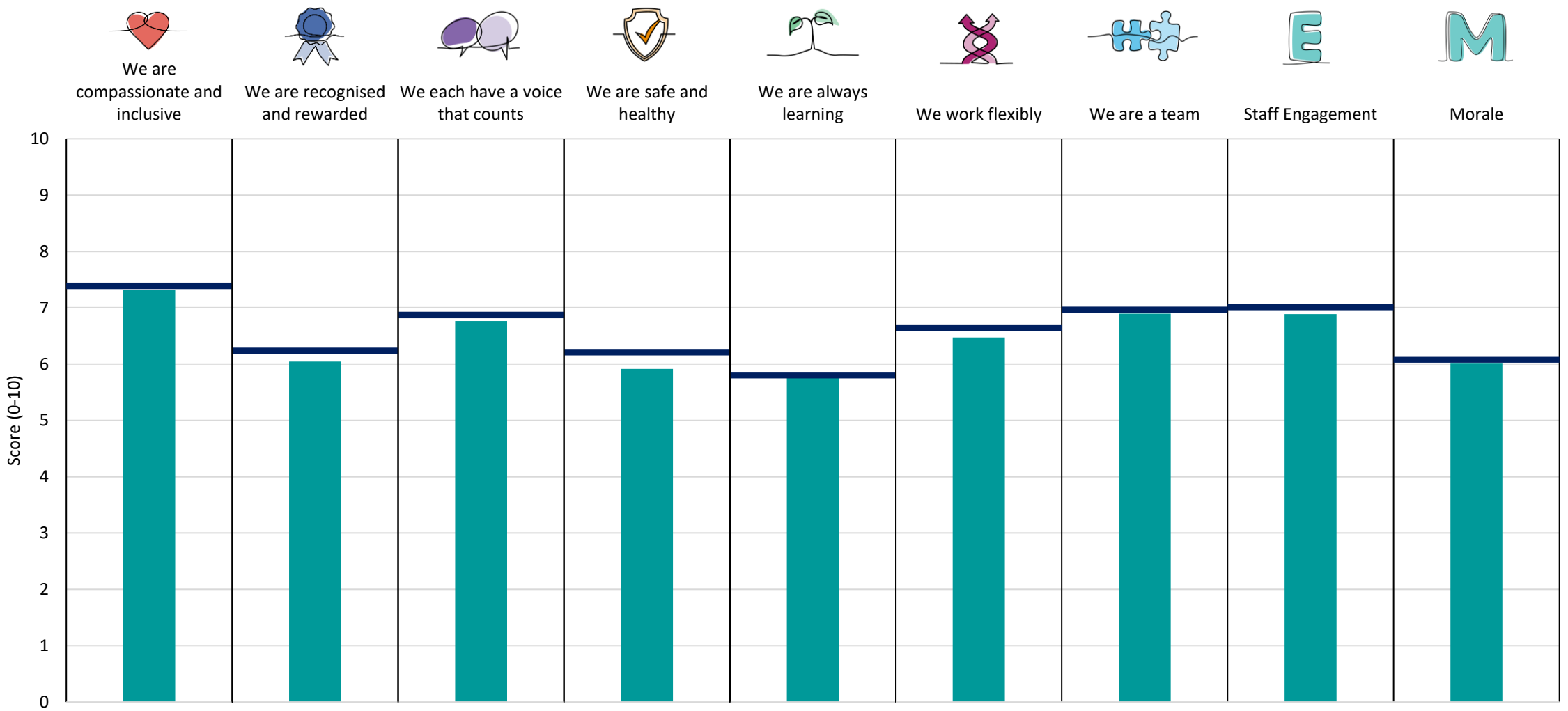
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.60	6.82	7.15	6.75	5.98	7.29	7.29	7.28	6.41
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	265	265	262	263	254	263	262	265	265

Integrated Care



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.47	6.13	6.87	5.95	5.91	6.72	7.07	6.96	5.75
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	241	241	240	238	235	240	241	241	241

Medical



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.32	6.04	6.76	5.91	5.79	6.47	6.90	6.89	6.02
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	271	272	269	269	261	269	272	272	272

Surgical

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.33	6.17	6.82	6.24	5.75	6.32	6.85	7.06	6.19
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	347	347	342	343	337	344	347	346	347

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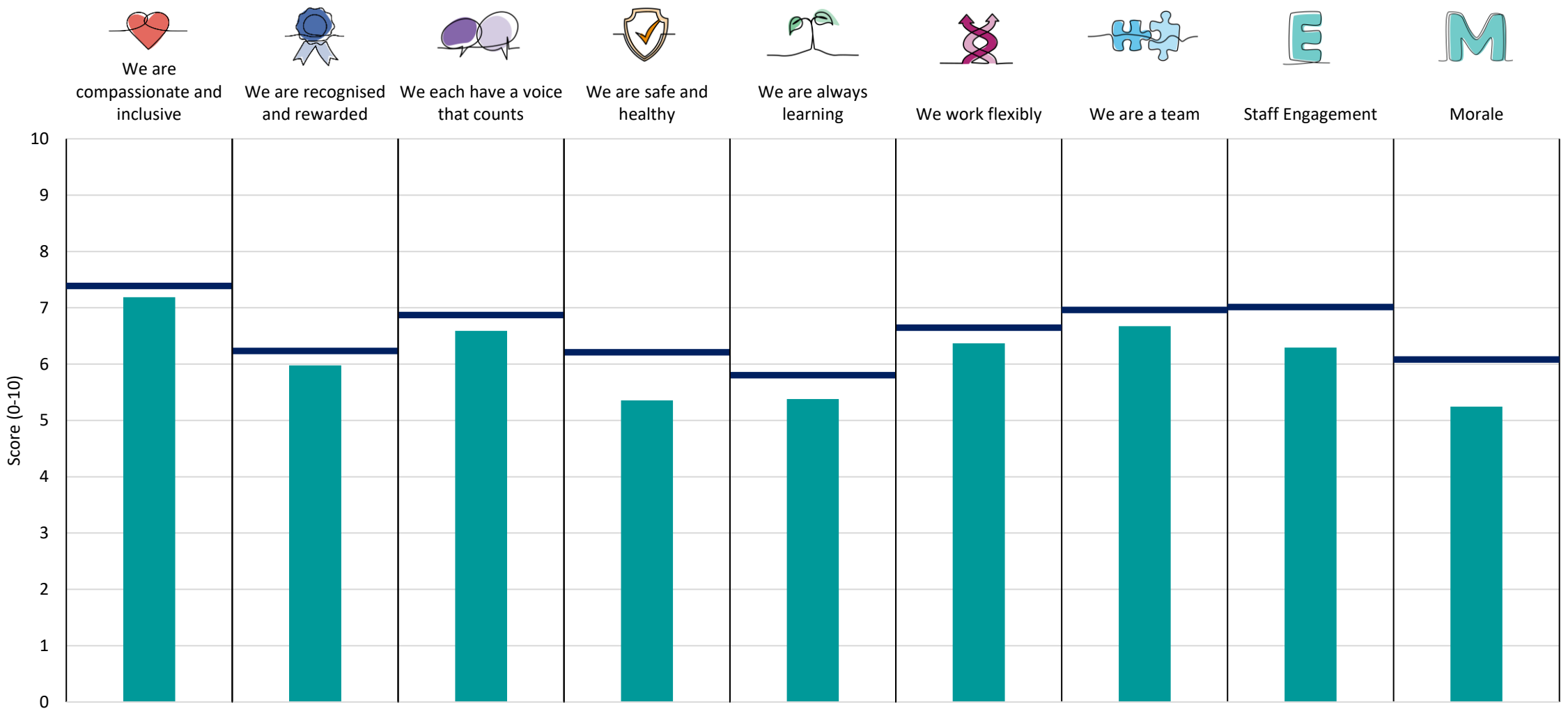
NHS

Breakdowns 2

Wye Valley NHS Trust

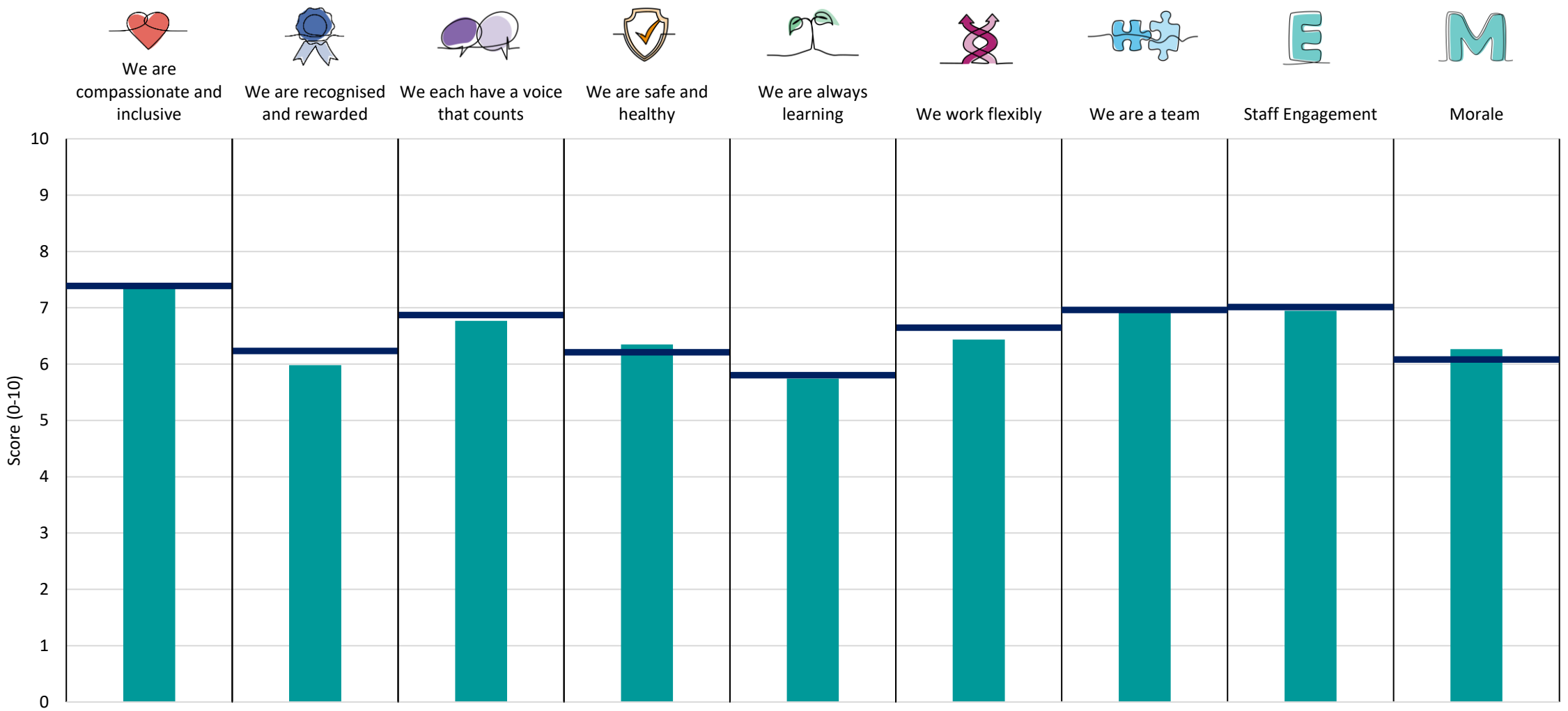
2024 NHS Staff Survey

Add Prof Scientific and Technic



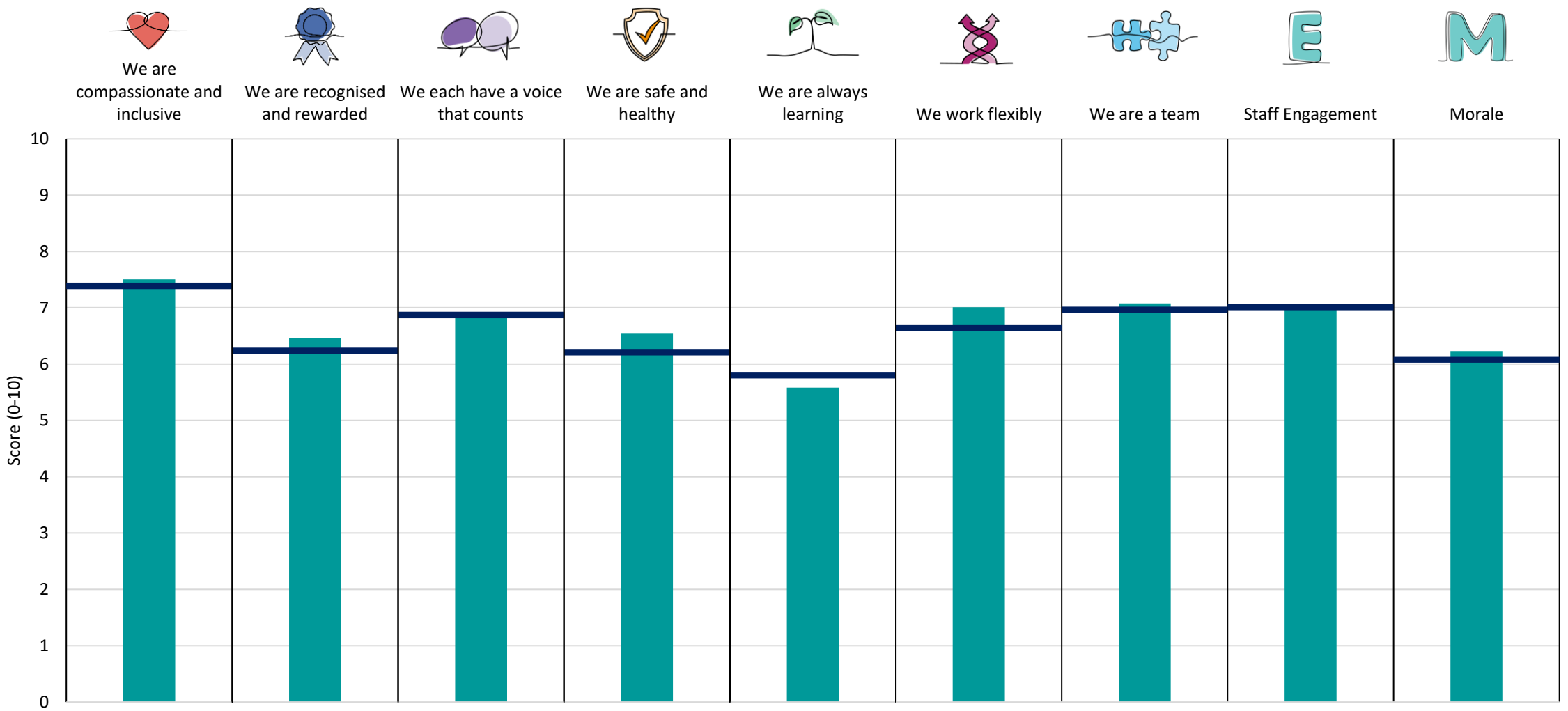
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.19	5.98	6.59	5.36	5.38	6.37	6.67	6.29	5.24
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	69	69	69	69	66	69	69	69	69

Additional Clinical Services



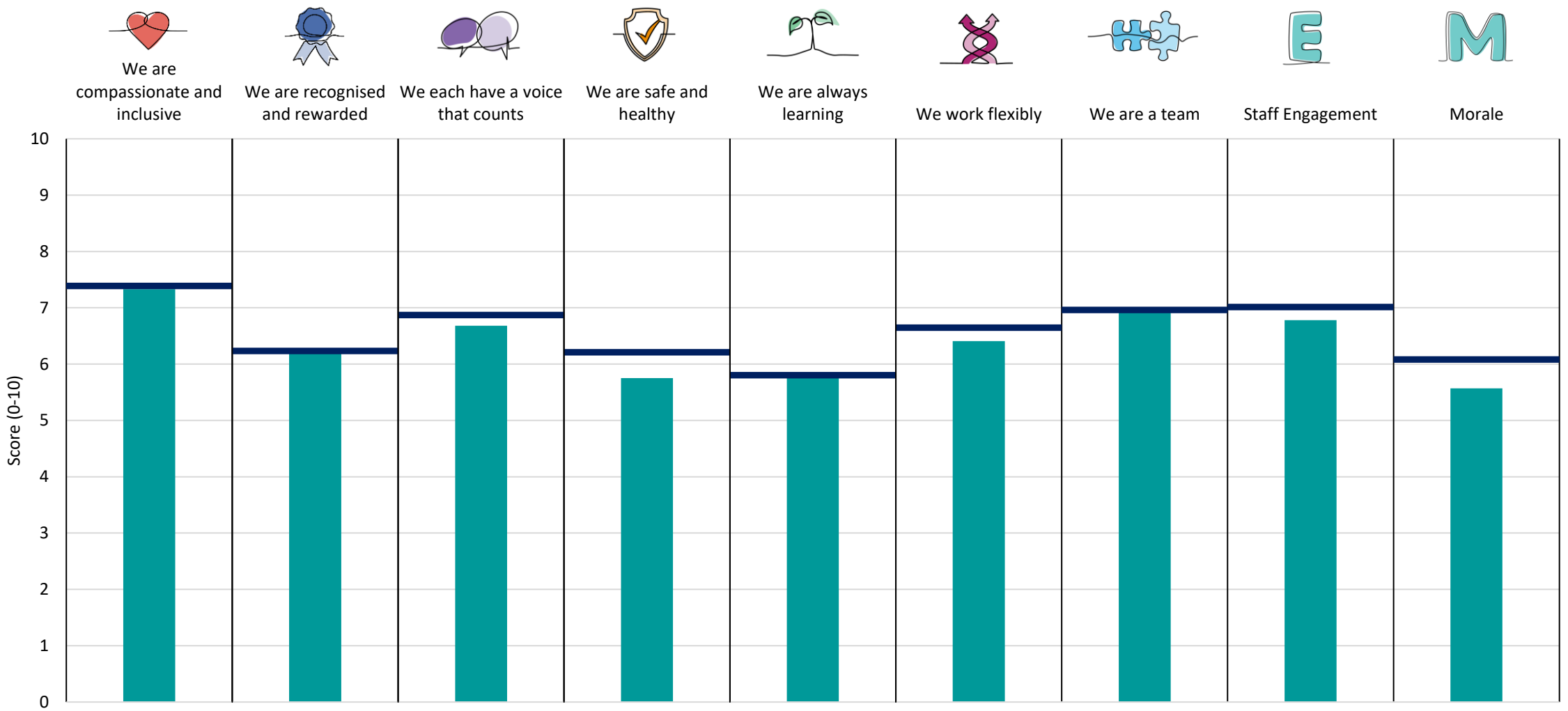
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.37	5.98	6.77	6.35	5.74	6.44	6.96	6.95	6.26
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	193	193	192	187	180	190	193	193	193

Administrative and Clerical



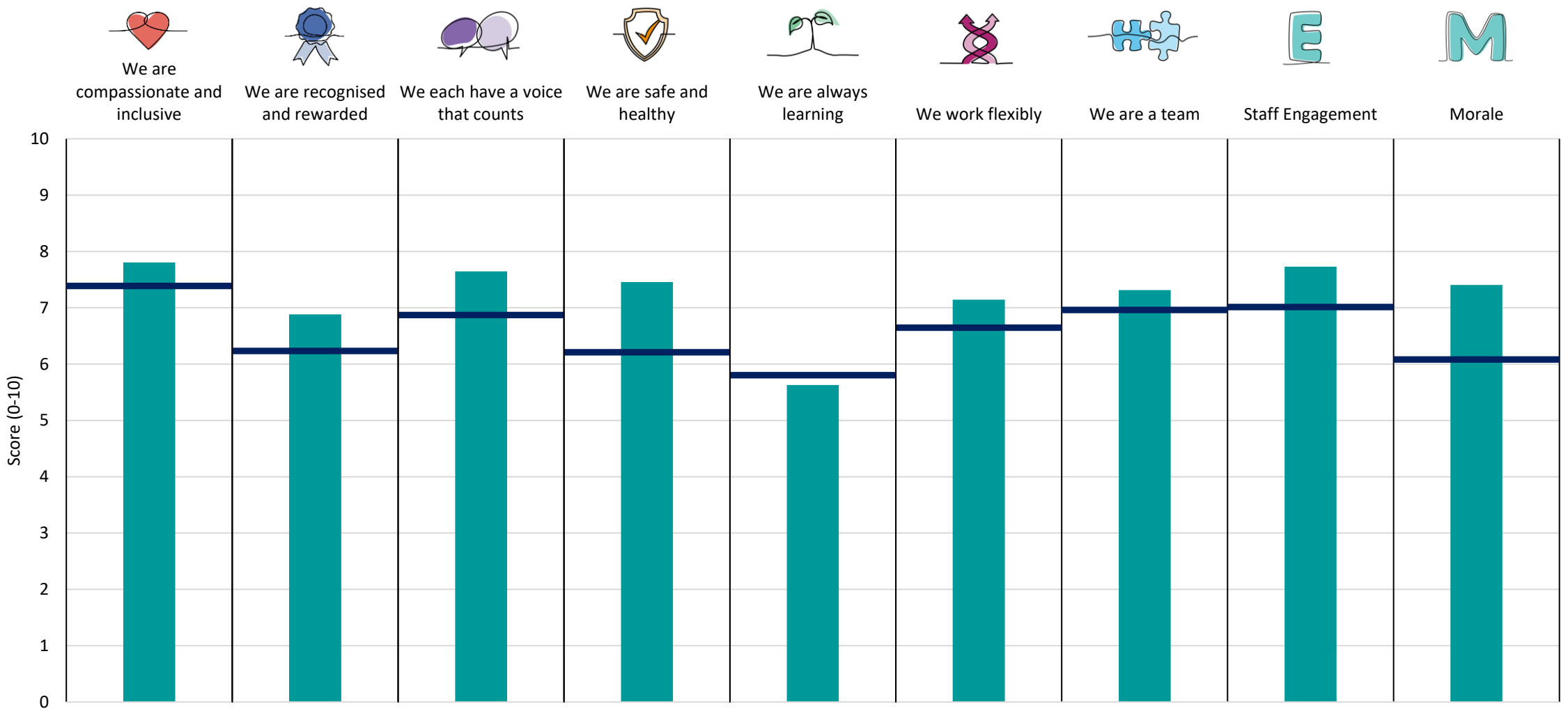
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.50	6.47	6.91	6.55	5.58	7.01	7.08	7.07	6.23
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	456	456	449	453	447	455	455	456	456

Allied Health Professionals



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.33	6.24	6.68	5.75	5.84	6.41	6.98	6.78	5.57
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	167	167	167	167	162	167	167	167	167

Estates and Ancillary

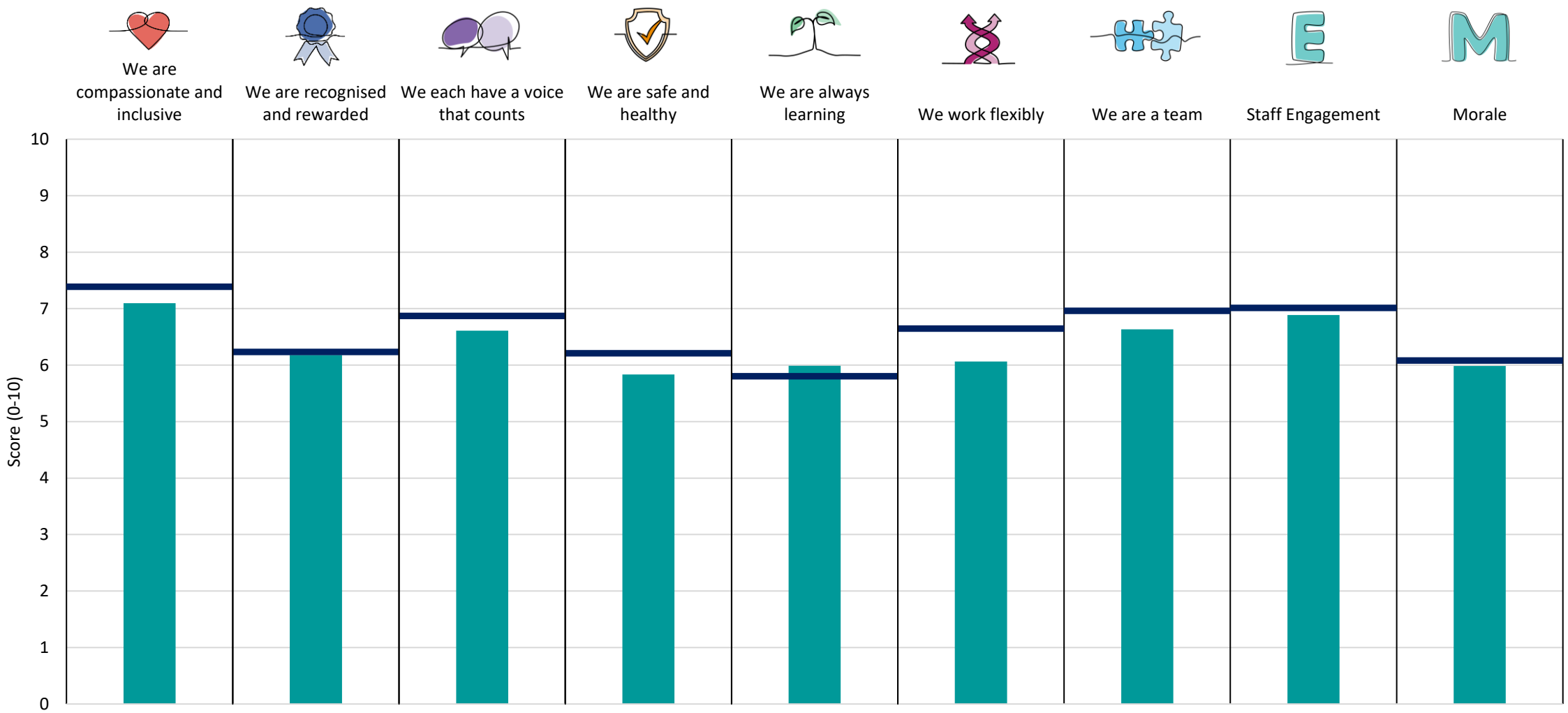


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.80	6.88	7.65	7.46	5.63	7.15	7.32	7.73	7.41
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	42	42	39	40	35	40	41	42	42

Healthcare Scientists

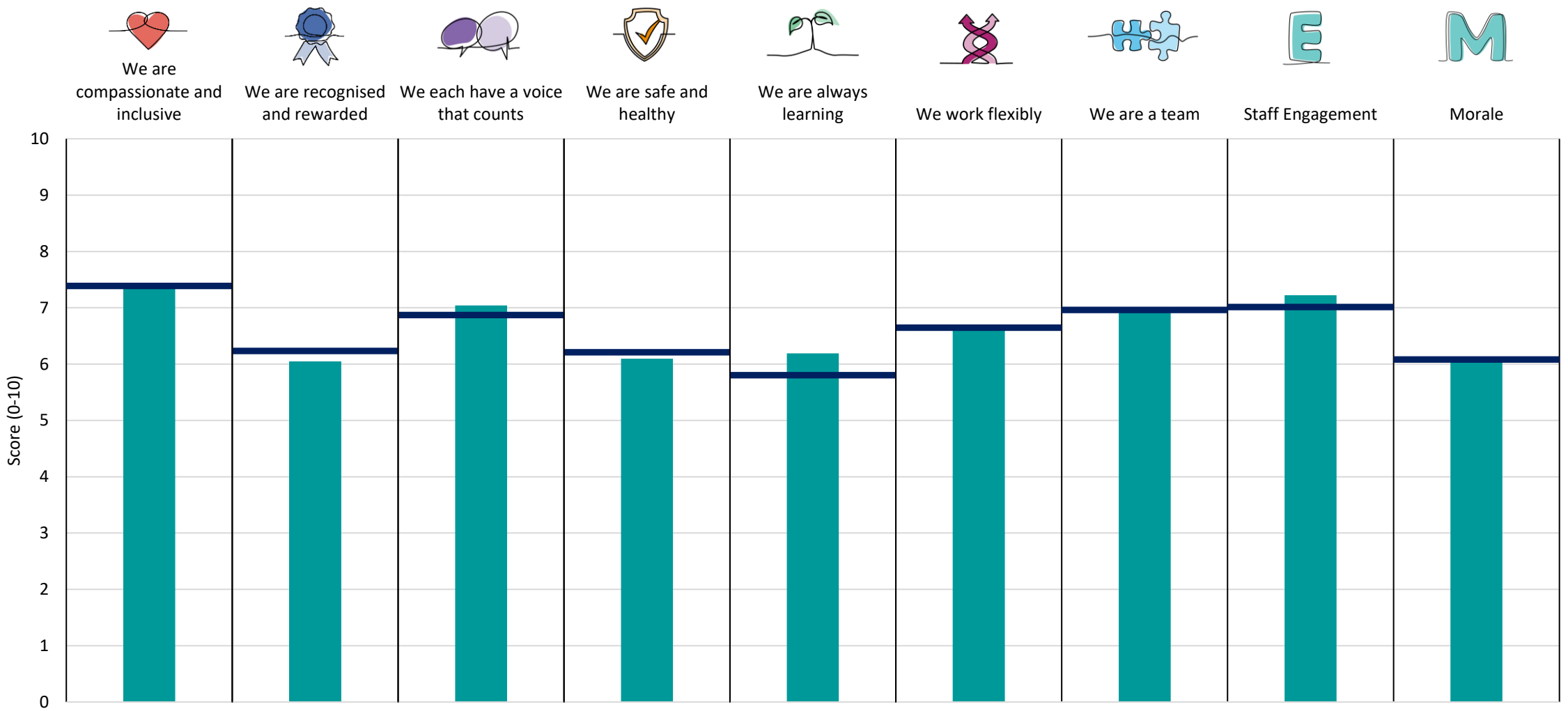
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.44	6.20	6.95	6.00	5.73	6.52	6.82	6.91	5.95
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	40	40	40	40	38	40	40	40	40

Medical and Dental



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.10	6.18	6.61	5.83	5.99	6.07	6.63	6.89	5.98
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	131	131	131	131	127	129	131	131	131

Nursing and Midwifery Registered



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.37	6.05	7.04	6.10	6.19	6.63	6.95	7.22	6.09
Your org	7.39	6.23	6.87	6.21	5.80	6.65	6.96	7.01	6.08
Responses	322	324	315	320	303	323	322	323	324

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Annual Safeguarding Reports Jan – Dec 2024
Lead Executive Director:	**Chief Nursing Officer**
Author:	Emma Lunn - Lead Nurse Adult Safeguarding Caron Shelley/Hazel French - Lead Nurses Children's Safeguarding Kirstie Gardner - Lead Nurse Children Looked After
Reporting Route:	Quality Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The purpose of this paper is to provide the Board with an annual report of the activities and progress made in relation to safeguarding adults, safeguarding children and children looked after during the period Jan – Dec 2024.

Recommended Actions required by Board or Committee

These reports provides a high degree of assurance that the work of the Safeguarding teams ensures that the organisation is meeting its statutory duties in relation to safeguarding vulnerable children, young people and adults.

The following points should be noted:

- All teams are fully recruited to establishment, including an expanded health offer in the multiagency safeguarding hub (MASH)
- Expansion of WVT health offer in MASH
- Extensive and varied training offer
- Establishment of the domestic abuse service
- Large volume of safeguarding adult reviews and domestic homicide reviews over the past year
- Increase in numbers of Initial Health Assessments completed within statutory timescales but improvement still required
- Increasing numbers of children in care placed in Herefordshire but originating out of county
- Evidence of good multiagency working
- Liberty protection safeguards postponed indefinitely

Executive Director Opinion[1]

These reports provide insight to the depth and breadth of work undertaken by the safeguarding teams.

[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.

Adult Safeguarding – Annual Report

Introduction

This Adult Safeguarding annual report outlines the activity and work undertaken by Wye Valley NHS Trust (WVT) for the period 1st January 2024 – 31st December 2024. The report demonstrates the organisation's commitment to protecting adults at risk across all services and highlights how the Trust manages allegations of abuse and neglect and ensures that safeguarding is integral to everyday practice.

Adult Safeguarding

There is a requirement that all commissioned services should have staff with the expertise and capacity to fulfil a leadership role for safeguarding adults and demonstrate they have capacity to provide leadership, guidance and supervision across the workforce.

The Adult Safeguarding Team have had a challenging year. However, they have continued to provide a high standard of guidance and support to both acute and community staff.

Visibility on the wards continues to be a challenge due to the considerable amount of daily calls the team receive from staff that require advice. Advice not confined to safeguarding but also information related to the Mental Capacity Act (MCA) application, Deprivation of Liberty Safeguards (DoLS) and Domestic Abuse (DA). Whilst it is positive that staff are reaching out to the team for advice, this has also increased pressure on the team due to the increased amount of work it generates.

The safeguarding team received a total of 714 referrals during the period between 1st January and 31st December 2024. Safeguarding referrals have continued to see a year on year increase. As in previous years, the common themes are in relation to self-neglect, domestic abuse, and omissions in care. Cases continue to be more complex, and requiring a lot of input from the WVT Adult Safeguarding Team, with commonly an overlap with learning disabilities, mental capacity, mental health and domestic abuse.

Position of Trust Concerns

Out of the total of 714 safeguarding referrals received in 2024, there were 25 position of trust concerns reported. The HR Safeguarding Allegation against Staff policy (HR.95) was followed, with input from the Associate Chief Nursing Officer and Lead Nurse for Adult Safeguarding, with oversight by the Chief Nursing Officer as Executive Lead for safeguarding.

Care at WVT

Out of the total of 714 safeguarding referrals received in 2024, 46 of these referrals were about concerns in regards to care at WVT. Most of these concerns were reviewed by the Local Authority (LA) and shared with WVT to apply the most appropriate pathway, some through a Patient Safety Incident Response Framework (PSIRF) response, and some by individual ward managers. In all instances the Local Authority are updated regarding the progress or outcomes from WVT.

Pressure Damage

Between 2023 and 2024, the way in which pressure damage is reported through Adult Safeguarding has changed. Previously, grade 3 and 4, unstageable, or multiple areas of pressure damage were automatically raised as an adult safeguarding concern. However the LA Adult Safeguarding Team were closing these referrals and signposting them back to WVT for investigation. This was creating a lot of unnecessary additional work for both teams. The ASP

(Adult Safeguarding Practitioner) continues to attend the weekly Pressure Ulcer Expert Panel (PUEP), and if there is a concern around care, neglect, omission etc. (both WVT or externally) then a recommendation is made that a safeguarding concern is raised. All other reports of pressure damage are reviewed and rapid reviews and learning are discussed at PUEP. The ASP liaises with the senior practitioner at the LA Safeguarding Team weekly for the purposes of transparency. This continues to have a significant impact on workload, and this will be further reviewed and discussed between the LA and WVT Adult Safeguarding Teams in 2025.

Training

Level 2 training has remained above the minimum requirement of 85% for each quarter in 2024.

Level 3 training dropped below the minimum requirement of 85% for the last two quarters. However, this is due to maternity leave and is scheduled to be imminently completed by the end of April 2025, therefore this will be reflected in following reports.

The Children and Adult Safeguarding Team will provide joint training in April 2025 to the Trust Board.

The Children and Adult Safeguarding Team are currently working together to also provide 'Think Family' training at the quarterly forums for 2025 as a result of a number of SARs and DHR's. Feedback from this joint training will be provided in 2025 reports.

The ASP was unable to provide additional safeguarding training due to capacity issues within the team during this reporting period, however, since the Lead Nurses return, supplementary training has re-commenced and the ASP plans to deliver training to a number of cohorts across the Trust.

Intercollegiate Guidance has recommended that all patient facing staff groups should be Level 3 trained, and this is currently under review by the Trust. Currently there is no training provision for this within the Trust. The Adult Safeguarding Team receive this training from external providers at present.

Current Domestic Homicide Reviews (DHR), Safeguarding Adult Reviews (SAR) and scoping open to WVT Adult Safeguarding Team

The SAR process is used where there has been multi-agency input into the care of an individual person that has not gone according to plan. The aim is to (a) learn from past experience, improve practice and multi-agency working (b) engage frontline practitioners and first line managers in conjunction with designated staff and safeguarding leads. The involvement of the front and first line managers gives a greater degree of ownership and, therefore, a much greater commitment to learning and dissemination of lessons (c) to involve practitioners, their managers and safeguarding leads at a learning event which will be independently chaired to facilitate discussion and debate.

Each agency completes a chronology and/or an Individual Management Review (IMR) and action plan which feeds into one main action plan monitored by the Herefordshire Safeguarding Adults Board (HSAB) Executive Committee who in turn feeds progress to the HSAB Strategic Board.

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force on 13th April 2011. The act requires a local multi-agency review of care provision and services provided to both the victim and the alleged perpetrator when a domestic homicide occurs and is carried out alongside legal/criminal proceedings. The purpose of a DHR is not to assign blame or responsibility but to learn lessons and to improve policies and practice at a local and national level.

Both DHRs and SARs are complex and often lengthy; partner agencies are required to attend numerous meetings throughout the process.

A summary of reviews is contained in the table below:-

Quarter	Identifier	Current status
Q1 23-24	HDHR10	DHR completed, awaiting sign off
Q1 24-25	HDHR12	Rapid review conducted, threshold met for DHR. Independent author commissioned
Q1 24-25	SAR LH/TH	IMR complete Await IMR Panel meeting
Q1 24-25	SAR RW	IMR complete Await IMR Panel meeting
Q1 24-25	RR DS	Discretionary SAR – no IMR required
Q1 24-25	RR AH	IMR complete Await IMR Panel meeting
Q2 24-25	RR LW	Did not meet criteria for a SAR
Q2 24-25	RR DS	Did not meet criteria for a SAR
Q2 24-25	RR JB	Did not meet criteria for a SAR
Q3 24-25	RR PH	RR completed, agreed meets criteria for full DHR
Q3 24-25	DHR14 AM	Did not meet criteria for a DHR

Action plans from previously completed SARs and DHRs are monitored regularly and reviewed at the Joint Case Review meeting. Summary oversight and review of action plans is also now included in the monthly WVT Overarching Safeguarding Committee.

Deprivation of Liberty Safeguards (DoLS) & Mental Capacity Act (MCA)

As reported in the previous two annual reports and following a period of review, the law underpinning MCA practice was set to change. The final parliamentary stage of Liberty Protection Safeguards (LPS) was completed on 24th April 2019, following this, the Liberty Protection Safeguards received royal assent on 16th May 2019 and became Law, however due to change of government, LPS has been postponed indefinitely.

Under the current DoLS legislation, staff are required to complete a mental capacity assessment to assess if the patient has capacity to consent to being accommodated in hospital for the purpose of receiving care and treatment. If the person lacks capacity in relation to this specific decision then a DoLS application is made. DoLS does not authorise the care and treatment for a patient and decisions in relation to this must be subject to separate mental capacity assessments which are always time and decision specific.

The LA is currently the responsible body for the authorisation of DoLS applications, however, there has continued to be a significant national back log of applications and outcomes for a number of years where the LA do not have the resources to undertake assessments within the required timeframes. This was one of the factors in the review of DoLS which resulted in the creation of LPS, however without LPS coming into force, this continues to be a challenge. The WVT MCA and DoLS Lead reviews hospital applications and then liaises with the LA DoLS Team to prioritise assessments.

In 2024, a total of 673 urgent DoLS applications were received, the outcomes of these applications are highlighted below:

Area Monitored	Number of Patients
DOLS approved (Standard Authorisation)	8
DOLS not approved	1
Discharged prior to being assessed by Local Authority	520
Regained capacity prior to being assessed	1
Died prior to being assessed	45
Other	98
	Total = 673

Under the DoLS process, it is recommended that if a patient remains in hospital for more than 7 days, an extension of the urgent application is requested to enable a continuation of the authorisation for up to a maximum of 14 days. This provides the hospital with the authority to continue to lawfully detain the patient in their best interests whilst awaiting an assessment by the LA for a standard DoLS authorisation. Due to current work pressures it is very difficult to ensure that extension requests for patients under an urgent DoLS are submitted by the safeguarding team to the local authority. The MCA and DoLS Lead will continue to work with the LA to resolve this.

Training

MCA training has remained over the minimum target of 85% in all quarters in 2024. DoLS Training has fallen slightly under the minimum target of 85% in two of the four quarters in 2024, however the MCA and DoLS Lead continues to provide supplementary training to all staff groups , whilst there continue to be challenges around the application of MCA in clinical practice, the overall standard in DoLS application has improved greatly in 2024. The MCA and DoLS Lead will continue providing bespoke training for 2025/2026 and it will remain one of the priorities for the team.

Mental Health Act

Herefordshire and Worcestershire Health and Care Trust continue to provide WVT with a mental health service.

The full MHA Report for April 2024 – March 2025 will be provided to WVT by the MHA Manager for Herefordshire and Worcestershire Health and Care Trust in April 2025, and this will be shared.

In 2024, there were a total of 29 patients detained to WVT.

Of these, 15 patients were detained on section 2 of the MHA, 6 were detained under section 3 of the MHA, and 8 were detained under Section 5(2) of the MHA.

All cases were appropriately transferred to specialist mental health inpatient units, both in and out of county.

Domestic Abuse

2024 was a busy and challenging year for the newly established DA Lead for WVT.

A new DA Policy and Flowchart was launched, along with a new MARAC SOP. Alerts are now put on all adult victim and perpetrator MAXIMs and Symphony electronic patient records. Alerts are also put onto children's records, if appropriate e.g. if they have contact with the victim/perpetrator.

Special urine specimen packs containing instructions on how to alert staff have been introduced for use in A&E. These are issued to patients if there is concern that they are possibly experiencing DA but there is no privacy at assessment to ask the pertinent questions.

During 2019, the West Midlands Police and Crime Commissioner allocated funding to West Mercia Women's Aid (WMWA) for an initial 2 year period to provide a full time Hospital Independent Domestic Violence Advisor (HIDVA) based in each acute trust within the region. In the summer of 2019, the WVT HIDVA commenced an honorary contract, initially based with adult safeguarding and then in the emergency department, until the Covid-19 lockdown when they worked from home. The HIDVA now divides their time between hospital and working from home. The role of the HIDVA in the hospital setting is to provide independent advice and advocacy to all victims of domestic abuse. The HIDVA now also works closely with the WVT DA Lead to provide information and advice about domestic abuse to WVT staff, which includes information awareness and training so that staff feel able and confident to ask patients about domestic abuse. They have completed numerous joint training sessions which has received positive feedback.

HIDVA referrals

WVT staff have made a total of 64 DA referrals to the HIDVA in 2024.

Training

In 2024, 146 staff attended the half-day session on DA. 165 staff attended 30-60min awareness-raising session

The DA Lead continues to provide bespoke training to all staff groups and this will continue for 2025/2026.

Learning Disability Team

WVT has a Learning Disability Liaison Service for our most vulnerable patients as part of a Service Level Agreement (SLA) with Herefordshire and Worcestershire Health and Care NHS Trust. The service promotes the rights and quality of care for people living with a learning disability including making reasonable adjustments. The team endeavour to identify people with a LD via an alert on the electronic patient record, developing pathways and reinforcing the need for good communication via the LD passport.

The Learning Disability Liaison Nurse (LDLN) service is fully embedded within the Trust and their links with the community LD team further strengthens the holistic service offered to patients, their families and carers. The links between primary and secondary care further ensure equality of access to the same healthcare as the general population to achieve the same health outcomes.

The LDLN are highly visible in clinical areas offering practical advice and support to staff especially supporting with mental capacity assessments and the best interests process.

The LDLN are involved in mortality/LeDer review process. It is important that learning extracted from these reviews forms part of the training and development for staff and also links to the LD standards.

Increasing demand for the service has been challenging for the team. There are 2 registered LD nurses who share the role for WVT and provide the liaison service five days per week. The SLA does not include cover for the service due to study leave, annual leave or sickness absence.

Supervision

Specialist safeguarding practitioners within the team receive regular supervision. Monthly group/peer supervision have been implemented within the team to discuss complex cases. Team members are advised to reflect on these sessions to inform their revalidation.

Conclusion

Safeguarding and the protection of adults at risk from abuse and harm is everyone's business. Practice around safeguarding, MHA, MCA and DOLS can be complex and challenging and the safeguarding agenda is constantly changing and advancing both nationally and locally. As the approach to safeguarding evolves, the complexity of decision making increases and therefore structures and processes must continue to develop in response, in order to safeguard the most vulnerable patients.

This Annual Report demonstrates that safeguarding adults remains a significant priority for the Trust and offers assurance that the Trust continues to meet its statutory duties as well as constantly adapting, changing and exploring ways in which we can improve how we work together to ensure the best outcomes for all those who use or come into contact with WVT services.

The Trust has continued to effectively contribute to the safeguarding of adults in Herefordshire during the past year, despite a very challenging period for everyone. The Trust has demonstrated there are effective mechanisms in place to safeguard adults at risk and to investigate and learn from concerns raised about the Trust through safeguarding processes.

WVT will maintain their commitment to be active partners in raising the profile and supporting the work of the Herefordshire Safeguarding Adults Board.

WVT will equally maintain their commitment to work collaboratively with out of county Safeguarding Boards.

Adult Safeguarding – Dataset

Adult Safeguarding Wye Valley NHS Trust					
Indicator	Target	Quarter 1 2024 Jan, Feb, Mar	Quarter 2 2024 Apr, May, June	Quarter 2 2024 July, Aug, Sept	Quarter 3 2024 Oct, Nov, Dec
WVT Board lead for adult safeguarding	Y/N	Chief Nursing Officer	Chief Nursing Officer	Chief Nursing Officer	Chief Nursing Officer
WVT Board (or sub committee) received a report on adult safeguarding	Y/N	Yes	Yes	Yes	Yes
WVT attendance at HSAB	Y/N	Yes	yes	Yes	Yes
Adult Safeguarding L2 training	85%	90.67%	90.66%	89.96%	89.74%
Adult Safeguarding L3 training	85%	100.00%	100.00%	55.55%	83.33%
Adult Safeguarding Board Level	85%	82.14%	81.25%	31.62%	23.08%
Mental Capacity Training	85%	85.98%	87.23%	86.80%	86.94
DOLS Training	85%	84.37%	85.99%	86.04%	84.87%
Prevent Level 1 & 2	85%	91.32%	91.73%	90.66%	90.59%
Prevent Level 3	85%	92.54%	92.51%	91.09%	88.85%
Position of Trust Concerns	Numbers	2	8	7	8
Concerns raised regarding care at WVT	Numbers	10	10	11	15
Number of DOLS applications made	Numbers	132	174	183	184
DOLS approved DOLS not approved Awaiting Assessment Discharged prior to being assessed Regained capacity Died prior to being assessed Other	Numbers	1 0 8 113 0 10 7 (MHA)	0 0 40 123 0 7 6 (MHA)	3 0 11 154 1 14 11 (MHA)	4 1 35 130 0 14 6 (MHA)
Numbers of new SAR/RR	Numbers	0	0	5	1
Number of SAR/RR open	Numbers	1	2	3	3
Number of DHR open	Numbers	1	1	1	1

Children & Young People Safeguarding Annual Report

1. Introduction

This report covers the period Jan 1st 2024 until 31st December 2024 and details how Wye Valley NHS Trust (WVT) is fulfilling its statutory duties to safeguard the welfare of children and young people. It sets out a summary of all activity and progress with safeguarding children. We have continued to be busy with both increasing activity and also changes in the safeguarding children agenda. This report highlights the drive for quality practice which is effective, efficient and continually improving. It also provides;

- An overview of the national and local context including influences on safeguarding children
- Assurance that WVT is compliant with its safeguarding responsibilities
- An outline of priorities for 2025-2026

All NHS trusts are required to have effective arrangements in place to safeguard vulnerable children and to assure themselves, regulators and their commissioners that these are working. All health providers must be registered with the Care Quality Commission (CQC) and are expected to be compliant with the fundamental standards of quality and safety. Two of these standards have particular relevance in safeguarding – regulation 11 (consent to care and treatment) and regulation 13 (safeguarding vulnerable people from abuse). Additionally, all NHS Trusts have statutory responsibilities under Section 11 of the Children Act of 2004 to make arrangements that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of Children. Section 11 responsibilities are detailed in the Working Together statutory guidance, the latest version was published in July 2023. These arrangements include;

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Herefordshire Safeguarding Children Partnership named safeguarding children professionals – nurse, doctor and midwife
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check
- appropriate supervision and support for staff

- employers being responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role
- provision of safeguarding training for all staff including a mandatory induction, which familiarises staff with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare
- clear policies in line with those from the HSCP for dealing with allegations against people who work with children

In summary this means that WVT has a robust safeguarding children response to:

- Ensure that all children and young people are protected from significant harm
- Ensure the welfare of the child is paramount and the voice of the child is central to all interventions
- Ensure compliance with the West Midlands Child Protection Procedures
- Implement national and local guidance in relation to safeguarding
- Play an integral part in Herefordshire Safeguarding Children Partnership and various sub and task groups
- Promote best practice throughout the trust
- To ensure that families and children who require early help interventions are identified and supported through multi agency partnerships

The message that 'safeguarding is everyone's responsibility' has been at the forefront of all our work and will remain a central focus as we also look forward to the year ahead.

2. Safeguarding Children Team

2.1. Structure

The Chief Nursing Officer is the Executive Lead for Safeguarding Children and is supported by the Associate Chief Nursing Officer who oversees the management of and the work undertaken by the team.

Role	Whole Time Equivalent
Named Nurse	1 W.T.E
Named Doctor	1.5 P.A.s
Named Midwife	1 W.T.E
Specialist Nurse Advisors (1 x Specialist Multi Agency Safeguarding Hub MASH Practitioner)	3 WTE
Safeguarding Practitioner (MASH)	1 WTE
Safeguarding Team Administrator	1 WTE

*WVT also employs the Sudden Unexpected Death in Infancy Consultant role (working 1 PA per week) for the NHS Herefordshire and Worcestershire under a contractual arrangement.

2.2. Roles

The work of the WVT Safeguarding Children Team is multi-faceted and relies heavily on partnership working, both internally and externally. We strive to deliver a seamless integrated service to safeguard children from abuse and neglect. The WVT Safeguarding Children team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective. The core functions of the team are to;

- Provide clinical leadership in respect of safeguarding to support high quality safeguarding practice
- Offer support for practice development through,
    - A robust training and development strategy utilising child safeguarding education forums, light bite sessions, quarterly newsletters as well as formal training.
    - Supervision
    - Coaching
- Support and advice on case management, attendance at complex meetings
- Provide oversight and assurance regarding how the Trust is meeting its obligations in respect of Safeguarding Children
- To provide oversight and development of policy and procedures

- To provide challenge and scrutiny of safeguarding practice internally and externally
- To support staff to provide high quality statements for family and criminal court, (police) and if attendance at court is required
- To undertake internal management reviews and contribute to multi-agency practice learning / Child Safeguarding Practice Reviews (CSPR) and ensure the shared learning is disseminated to practitioners
- To support all NHS providers in relation to child safeguarding in respect of the role of the MASH Health Practitioner and the Specialist Nurse Advisor
- Support the business of the multi-agency partnership (see Section 3.2)

3. Contribution to the work of Herefordshire Safeguarding Children Partnership (HSCP)

3.1.1. The Herefordshire Safeguarding Children Partnership (HSCP) is a statutory body established under arrangements within Working Together to Safeguard Children 2018 and is made up of the three statutory safeguarding partner organisations:

- West Mercia Police,
- NHS Herefordshire and Worcestershire
- Herefordshire Council

The broader Safeguarding Partnership consists of Relevant Agencies that cooperate to safeguard children and promote their welfare. These agencies are engaged in the activity of the Partnership's subgroups, review and audit activity, Leadership Summits and Practitioner Forums. Wye Valley NHS Trust is a key agency.

3.1.2. HSCP Strategic Priorities 2024-2025.

Safeguarding children is a multi-agency process and the Trust works closely with colleagues across Herefordshire to support the work of the HSCP ensuring that the Trust is represented at all its strategic and operational groups and contributes consistently to the work streams for the partnership's priorities. The Safeguarding Children Team also represent WVT within other multi-agency groups such as Prevent and Deter (for Child Exploitation), Multi-Agency Risk Assessment Conferences (MARAC) for high risk domestic abuse cases; and on task and finish groups as required.

During this period HSCP had four strategic priories.

Priority	Aim
Leadership and Partnership Effectiveness	Embed a culture of collective responsibility, accountability, and professional challenge built on guiding principles of respect and openness to forge an effective safeguarding children's partnership.

Neglect	Prevent and reduce neglect to improve the safety and wellbeing of children and young people in Herefordshire.
Right Help Right Time	A coordinated multi-agency approach to provide children and families with the right help and support at the right time (RHRT)
Child Exploitation	Prevent and reduce child exploitation to improve the safety and wellbeing of children and young people in Herefordshire.

The Trust ensures work plans are aligned with the Partnership's priorities and has contributed to them during 2024-2025 in a number of ways including;

Leadership

- WVT has a robust governance structure and process as detailed in Section 4 below.
- WVT NHS Trust Safeguarding Children provides appropriate representation and contribution to: Quality & Effectiveness Group, Development & Practice Group, Child Exploitation & Missing Group, and Joint Case Review Group. Additionally the trust has supported the partnership at various task and finish and other groups such as: Performance Data and a variety of Multi-agency Audit working groups, Pre-birth planning group,
- The Trust disseminates key messages from the HSCP effectively and in a timely way to all our staff through the Trust briefing system and also in a more targeted specific way via safeguarding children education forums, briefings training and newsletters.

Neglect

- Safeguarding team members contribute to the delivery of HSCP neglect /Graded Care Profile 2 (GCP2) training
- Provision of single agency GCP2 training within WVT for key staff groups and provision of refresher training
- Facilitating the embedding of GCP2 is ongoing through child safeguarding supervision and regular up-dates to staff
- Worked with partners to develop a revised Child Neglect multi-agency course, together with new tools and resources to support practitioners to identify and respond to child neglect.

Right Help Right Time

- A member of the safeguarding children team attends all the key groups that support this priority which include; Quality and Effectiveness, Development and Practice, MASH operational group, and the Joint Case Review group

- The internal Level 3 training offer includes specific training on Right Help Right Time to ensure; staff understand and can apply the Right Help Right Time levels of need guidance; can make appropriate and high quality referrals to the appropriate safeguarding services and understand and adhere to the Partnership's Resolution of Professional Disagreement Policy
- The team supports the development and delivery of training packages to a multi-agency audience on behalf of the HSCP

Exploitation / Contextual Safeguarding

- During this period the HSCP adopted the " Get Safe " Strategy
- From autumn 2024, a Specialist Nurse Advisor has the specific responsibility for leading the Trust's response to HSCP's Get Safe; child exploitation/contextual safeguarding strategy. This includes attendance at Multi agency Get Safe Operational meetings and also at HSCP Child Exploitation group. Work is underway to develop policy and guidance including alert systems for individuals at risk of or identified being exploited
- Delivery of training on Contextual aspects of safeguarding. Exploitation awareness is included in all levels of mandatory training and bespoke sessions have been delivered to individual teams and at the safeguarding education forum

3.1.3. In addition to the strategic priorities discussed above, the development of a business plan aligned to the Children's Services Improvement Plan enabled improved working between HSCP and the Improvement Board. Below are additional key priorities for 2024 and the Trust response to them:

- Review and implement a Neglect Strategy

WVT Safeguarding Children Team support for this included; membership of working groups, delivery of multi-agency training on behalf of the partnership, revision and delivery of internal Level 3 Neglect Training.

- Continue to Improve the Multi Agency Safeguarding Hub (MASH)

The last year has seen some changes within the health contribution to MASH as a new Specialist Nurse Advisor (Band 7) post was commissioned and recruited to, in addition to the existing MASH health practitioner (Band 6.) This new post has a wider remit, spanning the health economy and working across children's social care, as well as providing support to the MASH Health Practitioner in managing the growing workload. This has enabled;

- Consistent WVT representation at the MASH Group, MASH team and MASH audit meetings

- Further development of Performance Databases to monitor and report on ongoing workload and trends in the type of information that is shared for safeguarding purposes including MASH health contacts, MASH check data and Immediate Strategy meeting attendance
- Development, sourcing and delivery of training for social workers on health based topics
- Working across the health economy to improve NHS response to the 4 hour deadline to return information for MASH checks

During 2024 the effectiveness of the MASH was validated through both internal and external reviews.

- Implement a trauma informed approach across the partnership

WVT Safeguarding Children Team support for this includes attendance at training and delivery of in house training within our safeguarding education forums and internal training and utilising within child safeguarding supervision.

4. Quality Assurance and Governance

4.1. Safeguarding is central to quality of care and patient safety. The Trust has a clear governance structure in place. The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms.

Wye Valley NHS Trust has an established safeguarding children quality framework which includes a safeguarding children performance dashboard (Appendix 1) and an annual audit plan. The dashboard and report are submitted on a quarterly basis through the governance structure to the Quality Committee and NHS Herefordshire and Worcestershire Parts of the performance data is so used to inform the Herefordshire Safeguarding Children Partnership's multi-agency data set. It has been recognised by HSCP Independent Scrutineer that the addition of data from WVT NHS Trust has helped to improve the robustness of the HSCP performance data set.

4.2. Learning, Development and Training

The provision and delivery of safeguarding children training remains a key priority for the team. Significant focus has been placed upon improving the trust's compliance to ensure that the staff have the required level of competency as set down for their role.

During 2024 the safeguarding children team continued to provide updated training packages taking into consideration; learning from case reviews, HSCP priorities, Working Together 2023 and current gaps in the training provided by HSCP (Neglect, Perplexing Presentations, Children with Disabilities, Get Safe and Right Help Right Time). Training during this reporting period continued to be delivered using a virtual platform. There had been a plan to offer some training in a classroom setting but due to challenges that the team have faced in booking rooms for this all training was delivered virtually. In November a survey was completed with WVT staff asking for feedback around safeguarding training and requesting suggestions of any changes going forward. The feedback was very positive about the quality of the training and how this was impacting and enhancing staff's confidence and practice. Many responses discussed the challenges of engaging in meaningful group work and discussions virtually and were asking for future training to be delivered in a classroom setting. From 2025 the majority of safeguarding training will be in classroom settings as alternative venues have now been identified.

Additional opportunities for learning have been provided by the quarterly virtually delivered Safeguarding Forum open to all staff who work with children. These have been well attended and evaluated during the last year and provide a platform for staff to share and receive knowledge, ask questions and request future topics. Attendance is monitored as the forum hours contribute to the Level 3 passport. There is a built in evaluation process which allows for any future topics/themes to be included. There is a multi-agency element to the forums with the inclusion of external speakers which adds an additional element to the learning. Following the launch of the HSCP 'Think Family' strategy in 2024, the adult safeguarding team have been invited to collaborate with the children's safeguarding team in the planning and delivery of future quarterly safeguarding fora which have been re-branded for 2025 as 'Think Family Safeguarding Forum'.

Additional bespoke training has been provided to individual teams within WVT as requested alongside the team providing bite sized teaching, updates on teams' social media pages and contributions to team newsletters.

The safeguarding team also contribute to the community paediatric monthly teaching, as well as providing safeguarding teaching sessions for the ED doctors and also medical students.

The Training Log / Passport is being used to allow all staff a greater flexibility in order to complete their Level Three refresher requirements. This has been promoted by the team throughout this reporting period and is now much more widely used.

The safeguarding children team updates the intranet page with links to e-learning for all levels of training, as well as updating all safeguarding information on a regular basis.

Safeguarding Children Training	December 2022	December 2023	December 2024
% staff trained at level 1	88%	90%	89%
% staff trained at level 2	87%	88%	87%
% staff trained at level 3	80%	84%	85%
% Staff trained to level 4	50%	100%	100%
% Trust Board trained	88%	86%	100%

4.3. Audit

The Trust's safeguarding children team, together with key services, plan an annual audit programme which is monitored through the Trust's governance committees. Additionally an overview of audit activity is provided within the Annual Safeguarding Children Report to Trust Board. Additional audits may be undertaken, which have not been included in the plan, if a particular area is identified as needing further exploration.

4.3.1 Some key audits completed and the findings from those are included below;

Audit of Safeguarding Responses when a child presents with dog bite(s)

Children attending WVT services with dog bites may suggest concerns with neglectful care so this should always be considered. Deaths and injuries from dog attacks are increasing each year. This audit assessed professional curiosity, voice of the child and safeguarding actions by the WVT ED paediatric team / community staff when providing care and overseeing accident and emergency attendances/discharges.

There was some evidence of very good practice but increased professional curiosity and the capturing of the voice of the child consistently would greatly benefit safeguarding processes including children being spoken to directly if age/development allows. Consideration of safeguarding referrals / police referrals was not always evident.

<u>Actions</u>

Electronic patient record systems used at WVT to be adapted to include dog bite prompt questions.

Information within this review to be cascaded to appropriate teams; operational group, children's safeguarding forum, Wisdom Wednesday to ED and also a Dog safety page on Intranet.

A dog safety section on the Children's safeguarding page will be developed to include useful resources, Forum presentation and policies/guidance that are developed.

A task and finish group to be set up across Hereford and Worcester NHS safeguarding teams with input from the wider HSCP/WSCP partners to develop 'Keep me safe' around dogs guidance and also a risk assessment tool that can be utilised by multi-agency practitioners when there are concerns regarding a dog living within a family.

Re-audit when actions embedded.

Maternity safeguarding - ICON discussion compliance, reducing the risk of abusive head trauma

From the sample of postnatal cases reviewed it is apparent that ICON is discussed consistently at discharge from hospital to community midwife and by community midwife at the point of discharge to health visitor.

The sample has identified that there is no evidence of ICON being discussed during the first 10 days when the community midwife goes out to see the mother at home with a light touch reminder. This is a reduction from the previous audit.

Actions
Feedback to maternity staff audit findings in particular highlighting that a light touch reminder should be discussed on day 5 which is a standard visit for all families. Re-audit to take place in 2025.

School Nurse – Provision of reports to Child Protection Conferences

The reports audited were for Review Child Protection Conferences to evaluate the effectiveness, quality and quantity of information provided to the conference.

The majority of the reports were appropriate and completed as expected and well written. In terms of learning outcomes, as a team we need to understand why some practitioners do not write a report. This may be due to operational pressures and lack of time. The two staff who had not completed a report tended to be those that had a larger case load.

Actions

We revisited policy and best practice of report writing and shared some gold standard reports to assist with active learning. Training will be revisited in 2025, especially as there are newer members of staff that are not familiar with report writing.

Midwifery to Health Visitor Handover

A re-audit took place examining babies born in March 2024. 20 cases were audited and 100% had handovers /transfers of care completed by the midwife but these were still not being received by the health visiting service. Out of 20 cases audited, the health visiting service received a handover in 75% of the cases and these has been uploaded onto the child Community Emis record. It was identified that community midwives were completing the transfer of care on Badgernet but in 25% of cases a further handover was not completed to the health visiting SPOA to ensure that this information was shared. It was identified that the risk was mitigated to an extent as the health visiting service had been granted access to Badgernet which will allow health visitors to access safeguarding information

Actions

The IT issue to be further escalated within WVT by Digital Midwife. Community Midwives to be instructed again about the need to either verbally, via email or via electronic referral, handover maternity cases until the IT issue with the discharge of care is resolved. The maternity Standard Operating Procedure for postnatal care and discharge to be updated to include the details of digital handover as well as the need for verbal or via email. Repeat audits to be undertaken.

Paediatric Dietetics – No access Audit

Families may fail to access paediatric dietetic services through not opting in or by not being brought to appointments. It is important to ensure children have their health needs met through appropriate care, and that non-access is not due to lack of communication or safeguarding concerns. Understanding how we manage the care of children who were not brought (WNB) or don't opt in for appointments can help us to do better in the future.

Conclusion

There was evidence of clinical consideration of all children who WNB or weren't opted in to dietetic input. This was not consistently documented on clinical noting but letters were consistently present. A no access form was only used on one occasion. These forms could be used more proactively to communicate with the MDT. Our 'opt in' process requires administrative staff to document when families are not engaging, rather than an automatic discharge as used in adult dietetics. It is important that this process is communicated with staffing changes and monitored in a timely fashion to maintain a safe service.

4.3.2. The audit findings have been disseminated to practitioners through the safeguarding children education forum and within training, team meetings and briefings. Actions are monitored through the Safeguarding Children Operational Group and by exception to the Overarching Safeguarding Committee.

4.4. Policy

4.4.1. The Trust's Safeguarding and Promoting Children's Health and Welfare Policy (MF35) was revised and approved in June 2024 to reflect the changes within Working Together Guidance 2023. *This guidance supports the HSCP multi - agency procedures http://westmidlands.procedures.org.uk/page/contents

4.4.2. The Trust's Safeguarding Children Supervision Policy was revised and updated in September 2024 to reflect; Working Together Guidance 2023; HSCP Think Family Guidance 2023; NHSE Safeguarding Supervision Guide 2022.

5. Focus upon Child Safeguarding in Maternity Services

In 2024 there has been improvement in obstetric doctors safeguarding children level 3 compliance to 73%, this is an improvement of 12% from the previous year.

Midwifery staff level 3 compliance has remained at 99% this year. Safeguarding midwifery update training has been updated to reflect staff requirements following a survey, staff have requested that the update training includes levels of needs, MARF's and discharge planning meeting processes. Feedback has been positive.

Community midwives safeguarding supervision has been consistent all year at 100% with new midwives booking in for initial supervision and orientation to safeguarding in the community within their supernumerary time.

Routine enquiry in relation to Domestic Abuse (DA) has improved to 99% and there has been significant work which is ongoing educating and supporting staff with asking the routine enquiry for domestic abuse and responding to positive disclosures. In January, the maternity theme of the month was Domestic Abuse and the routine enquiry which provided staff information and guidance to empower them to improve their skills, knowledge and confidence around this area. There has

been a new urine sample routine enquiry initiative commenced in triage which aims to target women who midwives are concerned about. This offers patients a safe opportunity to disclose or discuss concerns with a midwife. This is to be audited to consider its effectiveness.

Pre-birth panel was discontinued in August 2024 following a decision from the Local Authority. Following escalation of concerns, a multi-agency audit was completed in October 2024. The audit concluded that pre-birth panel should recommence. During the time that pre-birth panel was ceased we saw a significant increase in the amount of escalations to children's services due to a number of concerns including communication, exceeding timescales, threshold decisions and case closures. Pre-birth panel recommenced in January 2025 and regular multi-agency audits will be completed to assess the effectiveness of the panel.

6. WVT 2025-2026 Priorities

Training	**Audit**	**Policy**	**Other**
Introduction of 'lunchtime learning' safeguarding children sessions	Monitor the annual safeguarding children audit plan and resultant actions	Review safeguarding supervision template to align itself with 'family formulation ' process	Set up planned 'group safeguarding supervision' for dermatology team.
Dissemination of 'family formulation' information/process to wider WVT teams. Identify members of teams to become 'family formulation' champions	Continue to play a key role in multi-agency audit group for the HSCP	Develop SOP for Get Safe processes including developing alerts for children at risk of exploitation	Amend quarterly data set collection to share with safeguarding partnership across Paediatrics, Public health nursing, ED & CLA teams
Think family training for ED teams delivered jointly by Adult and Child safeguarding teams. Introduce Think Family Safeguarding Education Forums in conjunction with Adult Safeguarding Team		Introduce CP-IS Phase 2 into Community Paediatrics, Dental Access and Public Health Nursing. Develop SOP for processes and educate teams as required	Amend Peer Review processes for Paediatricians in line with new RCPCH guidance.
Level 3 training to be offered face to face in classroom settings		Lead the development of the multi-agency Keep Me Safe When I am With	Development of Safeguarding Children Template on Clinical Noting for team to use when providing staff with

following feedback from staff teams		Dogs strategy with support from the ICB.	safeguarding information and advice around an inpatient

7. Conclusion

This annual report has provided an insight into local issues, developments and initiatives pertaining to safeguarding children and young people that have taken place during the last twelve months. In doing so it aims to provide a high level of assurance that the organisation is fulfilling its statutory duties and responsibilities in relation to safeguarding children and young people.

The Trust's Children's safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective. Ongoing monitoring of the capacity of the Trust's various services will be required during the next year to ensure that the Trust continues to meet its Section 11 responsibilities.

8. References/Links

1. Safeguarding children and young people: roles and competences for healthcare staff (2019) RCPCH.
2. HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working to help, protect and promote the welfare of children https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf
3. Children and Social Work Act (2017) http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted
4. HSCP Regional Child Protection Procedures.(Multi –agency) https://westmidlands.procedures.org.uk/page/content

Appendix 1 – PERFORMANCE DASHBOARD

Early Intervention	Jan to March	April to June	July to Sept	Oct to Dec
No of Early Help Assessment (EHA) initiated by School Nurse(SN) /Health Visitor(HV)	12	9	7	6
No of EHA SN/HV involved in	125	100	109	117
School Nurse/Health Visitor acting as lead professional	10	10	11	10
ED Alert & Cwilting Checks Completed (Target 100%)	99.80%	98.00%	99.50%	100%
Child Protection				
HV attendance at Initial and Review Child Protection Conferences (Target 100%)	100.0%	100.0%	100%	100%
Reports presented to CP conferences- HV (Target 100%)	97.5%	100.0%	100.0%	100%
SN Attendance at ICPC conferences (Target 100%)	100.0%	100.0%	100.0%	100%
Domestic Abuse (DA) notifications- numbers children	770	979	808	876
Midwifery routine question re DA	100%	99%	99%	99%
Domestic abuse disclosure (Midwifery)	0.7%	1.1%	1.3%	1.10%
Multi-Agency Risk Assessment Conference attendance	100%	100%	100.0%	100%
Number of children with a child protection plan	204	193	164	146
No of CP medicals / health assessments	21	20	16	12
Case Management Escalations resolved at Stage 1	14	12	17	16
Case Management Escalations resolved at Stage 2 and above	3	4	2	2
Number of Child Safeguarding Practice Reviews	0	0	0	0
Identified cases FGM -Women / Children	0	3	1	1
Training - Target 90%				
% staff trained at level 1	88%	89%	88%	89%
% staff trained at level 2	89%	89%	87%	87%
% staff trained at level 3	85%	84%	86%	85%
% ED staff trained at Level 3	80%	85%	84%	69%
% staff trained at Level 4	100%	50%	50%	100%
% Board members training	100%	100%	100%	100%
Supervision - Target 80%				

% HV staff who have received supervision	53%	67%	50%	82%
% SN staff who have received supervision	82%	55%	80%	63%
% Community Midwives who have received supervision	100%	100%	100%	100%
Human Resources				
Staff Referrals To Local Authority Designated Officer	3	7	1	7
Health Visitor vacancies (wte)	0.87	3	1.84	1.84
School Nurse vacancies (wte)	0.87	0	0	0.2
Birth to midwife ratio	01:23	01:25	01:21	01:23
Complaints - Safeguarding Specific				
Tier 4 beds - number waiting during quarter and outcome	1	0	0	0
Number of complaints regarding the care of a child.	1	1	0	0
Serious Incidents - Child Safeguarding specific				
Number of SIRIs	0	0	0	0

Introduction

The Children in Care Health Team (previously referred to as the Children Looked After Team) have a statutory responsibility to ensure that all Herefordshire children in care between the ages of 0-18 years, living both in and out of Herefordshire, have their health needs identified and met. These health needs are met through statutory health assessments, both initial ant at review, and at any point when a physical, social or emotional health need arises. We work with both Herefordshire Children in Care and with Children in Care placed in Herefordshire by other Local Authorities.

Structure of Children in Care Health Team

There has been no change to the nursing establishment of the Children in Care Health Team since 2019. However, the administrative posts within the team have been reviewed and re-structured this year. Job planning for the medical workforce (paediatricians) is subject to change.

- Medical Advisor for Fostering and Adoption
- Registrar/Consultant support for one Initial IHA clinic fortnightly
- 1 wte Band 8a Named Nurse for Children in Care
- 2.73 wte Band 6 Nurses for Children in Care
- 0.8 wte Band 4 Administrator to Medical Advisor for Fostering and Adoption.
- 0.76 wte Band 3 Administrator – providing administrative support for RHA's.
- 0.35 wte Band 2 Administrator

The following annual report will provide data on how WVT has met its statutory responsibilities and when this has not been achieved narrative as to why and actions taken to resolve this.

Appendices 1-5 indicate our statutory health requirements for Children in Care and process used to ensure these requirements are met by the team.

Number of Herefordshire Looked After Children

Herefordshire continues to have higher than normal numbers of children in care at 105 looked after children per 10,000 under age 18 years population. This contrasts with the rest of England which averages 71 children in care per 10,000 and our neighbours Worcester with 89 children in care per 10,00o under age 18 years population. The total number of Herefordshire children in care as at 31st December 2024 is 358 children. This is a reduction in numbers of new children in care from 408 on 31st December 2023. Herefordshire Children's Services are buddied with Leeds Children's Social Care as part of their improvement journey and some of the changes in practice may have contributed to the reducing number of new children and young people into care.

The number of Herefordshire children in care living out of area is 112. This is a reduction of 22 children in care living out of area as of 31/12/2024. These Children and Young People were living across 38 counties outside of Herefordshire.

The number of children in care living in Herefordshire continues to increase. Nationally, high numbers of children and young people from other local areas are relocated to Herefordshire the rurality of Herefordshire and the number of private residential care homes contribute to this. (29.38% %) of all statutory health assessments completed in Herefordshire were for children living in Herefordshire placed by other Local Authorities. This group of children and young people are not included in the under 18 population of children but are likely to have a health footprint across WVT.

Number of new children in to care in 2024

There were 72 new children in care in 2024. This is a reduction of 20 new children in comparison to the previous year.

The table below indicates demographic details of new children in care during this annual report year.

There were 8 new unaccompanied asylum seeking young people in 2024 and 16 new children into care living outside Herefordshire.

Number of children and young people who stopped being children in care

There were 110 children who stopped being in care during this time frame. The reasons for this are varied and include; 24 (21.8%) children who returned home to their parents; 53 (48.18%)

Gender assigned at birth for new children into care	Female	33 (45.8%)
	Male	39 (54.2%)
Age of new children into care	0-5years	25 (34.72%)
	6-9 years	4 (5.55%)
	10-15 years	27 (37.5%)
	16 Plus	5 (22.2%)

young people who turned 18; 13 (11.81%) children who had adoption orders granted; 18 (16.36%) children who had Special Guardianship Orders granted.

During this time period, one unaccompanied young person was age assessed as being over 18. Sadly, one child in care died during 2024.

Initial Health Assessments (IHA)

There is a statutory requirement to carry out an Initial Health Assessment for all new children in care within 20 working days. Significant progress has been made by them team to improve performance against this statutory timescale. In 2024, 23 (46%) new children into care had an IHA within timescales. There is still room to improve this performance but this has increased from 11% of children in 2023. This improvement can be attributed to the commitment and determination of the team and an increase in the effectiveness of multiagency working. Performance figures for completion of an IHA within statutory timescale's is multi-faceted and dependent on a number of factors including notification of a child coming into care, medical consent being obtained, capacity of the paediatrician and CIC health team.

In order to carry out an IHA, the CIC team must be informed of the child's details in a timely manner and medical consent must be obtained and received. When medical consent had been received, 45 (90%) children were offered an IHA by WVT within 20 working days.

To note, no Herefordshire children in care living outside Herefordshire had an IHA within statutory timescales.

Review Health Assessments (RHA)

Performance relating to RHAs is positive with 206 (79.23%) children in care living in Herefordshire having a Review Health Assessment (RHA) within statutory timescales including all children over the age of 5 years being offered an RHA in statutory timescales. 37% of children not seen for an RHA within statutory timescales was due to delays within the Health Visiting service. This has been raised as a concern to the Lead Professional for Health Visiting and additional processes

Have been put in place to support health visitors to complete RHA in timescales.

Key Performance Indicators at IHA for Herefordshire children in care living in Herefordshire		
Children registered with a local GP	45 (95.4%)	Data available for 47 Children
Children who have seen a dentist in the last six months	14 (29.78 %%)	It is a universal action for every new child in care to access a dental examination if they have not seen a dentist within the last six months.
Children immunised in line with National Immunisation Programme	27 (57.44%)	It is a universal action in every new child in care for children to access overdue immunisations either via the GP or vaccinations UK for school age children and young people.

Key Performance Data at RHA	KPI Data available for 260 Children seen for RHA
Children registered with a local GP	258 (99.23%)
Children who have seen a dentist in the last six months	173 (66.53%)
Children immunised in line with National Immunisation Programme	236 (90.76%)

The majority of children in Care had seen a dentist since coming into care but not always every six months. When requests for dental examination were made to the Dental Access Centre all children in care were offered an appointment. Treatment if required was provided so children and young people were dental fit. These children were then advised by the Dental Access Centre to seek an NHS Dentist. Currently there are two dental practices in Hereford that are accepting NHS Patients but once registered there is a wait for an appointment. Once registered with an NHS dentist, children are not guaranteed a dental check every six months. In September 2024 it was identified that nationally 44.6% of UK children have not seen an NHS dentist for over 12 months.

Annual Clinical Activity for Statutory Health Assessments

Annual Clinical activity 2024	Total Statutory Assessments completed	Comment
Total statutory assessments completed	439 139 (29.38%) of all statutory health assessments completed in 2024 were requests for statutory Health Assessments completed by WVT Children in Care	Requests for Health Assessments for Children in Care are increasing as Herefordshire is a big net importer of children in care from other Local Authorities. This is in part due to the rural profile of Herefordshire and also the number of private residential care homes situated within

	Health Team for children placed in Herefordshire by other Local Authorities.	Herefordshire. This is a group of Children and Young People who are not included in the numbers of under 18 population but who will have a health footprint across WVT.
Total number of IHA's completed for Children and young people living in Herefordshire	**73**	
IHA's for Herefordshire Children	50 (68.4%)	
IHA's completed for other local authorities	23 (31.5%)	
Total Number of RHA'S completed for Children and Young People Living in Herefordshire	**366**	
RHA's for Herefordshire Children Living in Herefordshire	260 (71.03%)	
RHA's completed for Children placed in Herefordshire by other local authorities	106 (29%)	

Safeguarding Meetings attended by Children in Care nurses for Children in Care living in Herefordshire and Herefordshire Children Living out of area 2024

For Children in Care contextual safeguarding and exploitation pose the greatest but not exclusive safeguarding risks to children in care. The Children in Care Nurses attend all statutory and non-statutory safeguarding meetings for children in care.

Safeguarding Meetings attended for Children in Care	
Strategy Meetings	140
Risk Management Meetings	79
Complex Strategy Meetings	4
Network Meetings	41
Placement Planning Meeting	3
Trauma informed Network Meeting (TIMAP)/CAMHS	3
Professionals Meeting/placement stability meeting	6

Corporate Parenting Board

The Named Nurse Children in Care is an active member of the Herefordshire Council Corporate parenting Board and attends bi-monthly meetings. The Named Nurse provides regular written Health Update reports to the Board including details of initiatives such as the Health Passport for Children in Care supporting children and young people to understand and develop independence skills to manage their own health.

Conclusion

The Children in Care Health Team have continued to fulfil their function and commitment to identifying the health needs of children within statutory timescales. Great progress and improvements have been made in achieving KPIs in 2024 and this will continue in 2025. The administration component of the team have been re-structured during the last year in order to provide a more streamlined and effective support for the nursing activity. The administrators are vitally important to the functioning of the team providing time critical and sensitive information to meet court timescales.

Appendix 1

Health Performance Indicators for Children in Care

Time frames for statutory health reviews

Initial Health Assessment (IHA) – All children new into care should have a Health Review with a Consultant Paediatrician within 20 working days.

Review Health Assessment (RHA): -

All children age 0-4 years should have a review every six months. Children aged 4 -18 years should have an RHA every 12 months.

Key Performance Indicators (KPI)

- All children and Young people should be registered with a local GP
- All children should have a dental check every six months.
- All children should have immunisations in line with the National Immunisation Program.

Appendix 2.

Process for when a young person refuses an RHA's

When a young person refuses a full statutory health assessment, a Child in Care Nurse will contact the young person and their foster carer and provide support and advice about any individual health concerns they may have based on a health risk assessment. General public health advice is also given this will include information on access to dental care, information about individual overdue or pending immunisations and where relevant information and points of access for emotional wellbeing and mental health support services, sexual health and drugs and alcohol services.

Appendix 3.

Herefordshire Children in Care living out of Herefordshire.

Process for requesting statutory health reviews for Herefordshire Children Looked After.

Initial Health Assessments are requested to host health teams once we have received notification that a child or young person has become a Child Looked After and consent for medical treatment and assessment.

Review Health Assessments are requested to host health teams 12 weeks in advance of when they are due and updates are requested about health reviews status 28 days after the date the review was due if we have and received them back.

All returned health reviews are quality assured to ensure the health needs of Herefordshire children and young people not living in Herefordshire have been identified. Health action plans are reviewed to ensure health needs have been identified and that action plans are SMART and reflective of the child's needs and relevant to improving the health outcomes for our children and young people. Health reviews that don't meet our quality assurance process are returned and amendments are requested. Any concerns in relation to health reviews for our children living out of Herefordshire are escalated to the Deputy Designated Nurse for Children in Care at the ICB.

Appendix 4.

Quality Assurance Process for health reviews for children who are living out of County.

All returned statutory health assessments are scrutinised for quality assurance and checked to ensure that there is a health action plan that identifies and addresses all of the child or young person's health needs and this will include an expected health plan for all key performance indicators. Health assessments that do not meet quality assurance are returned for amendment. If unmet health needs are identified concerns are escalated to the child or young person's social worker and local host health team and a request made for additional support to ensure that all of the health needs of our children and young people are met when they are living out of county

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Perinatal Services Safety Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery Elaine Evans, Neonatal Sister
Reporting Route:	Quality Committee
Appendices included with this report:	Perinatal Dashboard – Appendix 1 Neonatal Dashboard – Appendix 2
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
To provide oversight and assurance of the safety and efficiency of the perinatal service: providing detail to meet local and national reporting standards.	
Recommended Actions required by Board or Committee	
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 March.	
Executive Director Opinion[1]	
There are no matters for escalation to Board from this month's report. The safety walkabouts are well embedded and received well by staff working across maternity and neonatal care.	

[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.

Perinatal Services Safety Report – March 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 February 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 122 births in February 2025, which is a decrease from 144 in the previous month. The ratio is stable.

Midwife to birth ratio (<1:24)	1:21

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 February 2025 are recorded as:

Delay in Induction >2hrs	4
Delay in Catagory 1 C-Section >30mins	0
Delay in administering medication	0
Delay in starting syntocinon/ARM >30mins	3
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	2
Any movement of midwifery staff from any area to provide midwifery cover	27
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 February, there were four inductions of labour delayed by more than two hours, three of which involved delays in carrying out ARM (Artificial Rupture of Membranes). These delays were due to acuity levels, and the multidisciplinary team continuously reviewed the management plans for these women throughout the shift. Safety measures were provided while waiting for the induction of labour. Due to the high acuity, two community midwives were asked to support the maternity department. This request was part of the escalation process, where the manager on call was informed and had oversight of the situation.

It is positive to note that there were again no delays in Category 1 caesarean sections in February, which demonstrates effective MDT collaboration to ensure that babies were born within the recommended time.

Whilst the red flag incidents demonstrate a sharp rise in movement of staff, the data source has been changed from Inphase to BirthRate+ as this has been found to be a more accurate, and has a good complaince record of over 86%.

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 February 2025 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	1	100%	

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
February	0	0	4	0	0	0	0

3.2 **Concerns and Complaints**

Minimum Data Set Incident summary:

	Concerns	Complaints
February	1	2

Complaints/Concerns - SCBU

1 Complaint – part of wider complaint across Maternity and Neonatal Services

1 Concern – staff attitude and breakdown of communication – dealt with internally, staff provided reflection, looking at wider training need around advanced communication skills

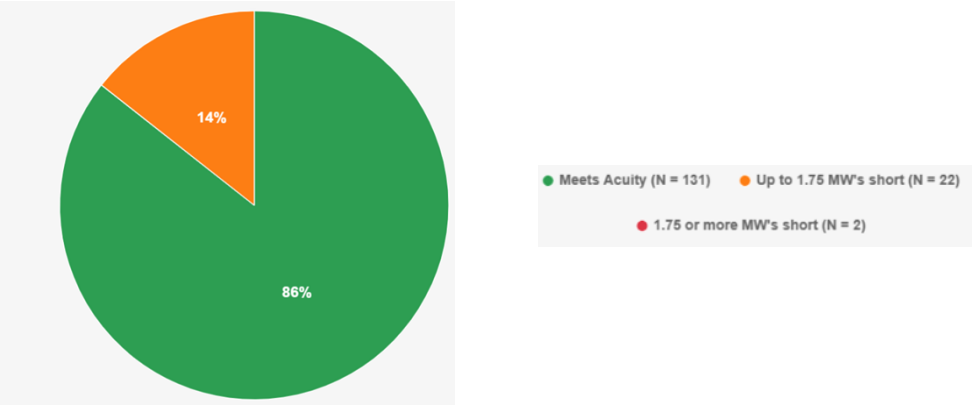
4. WORKFORCE

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 86.9% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 86% of the time. For 14% of the time the service was short by up to 1.75 midwives and for 0% 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 27 instances of staff being redeployed internally to cover acuity which is a decrease from last month's data of 51 times. There were 3 occasions where community were redeployed to support Delivery Suite acuity again a decrease from last month's data where 9 were redeployed. There were 0 occasions where specialist midwives supported clinical. There were 8 occasions where acuity was

MA1	Redeploy staff internally	27	66%
MA2	Redeploy from community	3	7%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	2%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	2	5%
MA10	Escalate to manager on call	8	20%
MA11	Maternity Unit on Divert	0	0%
TOTAL		41	

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.

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.

4.2 **Obstetric workforce**

4.2.1 The obstetric rotas have been covered throughout February 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.

FEBRUARY '25	Substantive Fill			Substantive Extra fill			Locum Fill			Totals:
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	
Consultant: Hot Week	210	210	100.00	0	210	0.00	0	210	0.00	100.00
Consultant: On Call	440	465	94.62	25	465	5.38	0	465	0.00	100.00
Consultant: Cold Week	96	96	100.00	0	96	0.00	0	96	0.00	100.00
Consultant: Antenatal Clinic	63.75	63.75	100.00	0	63.75	0.00	0	63.75	0.00	100.00
Middle Grade: delivery suite	162	180	90.00	18	180	10.00	0	180	0.00	100.00
Middle Grade: Antenatal Clinic	89.25	144.5	61.76	55.25	144.5	38.24	0	144.5	0.00	100.00

4.3 **Neonatal Medical Workforce**

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that the Neonatal Medical Workforce does not use locum support as they are fully funded and recruited to BAPM standards.

4.4 **Anaesthetic workforce**

4.4.1 The anaesthetic rotas have been covered throughout February 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	26	93%	22	78%
Anaesthetist extra days	2	7%	6	22%

The directorate team advise that the increase in extra shifts is due to leave and sickness which is expected to resolve in coming weeks.

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	93%	93%
Obstetric Consultant	100%	100%
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.

	January 25	February 25
Total QIS % (expected standard 70% of registered workforce)	43.50%	47.21%
% of shifts staffed to BAPM recommendations	96.77%	100%
% QIS against Neonatal Toolkit standards.	100%	100%
% of shifts with Supernumerary Shift Co-ordinator	19.35%	14.29%
Additional Nurse shifts to make all shifts BAPM compliant	0.4	0

It is important to note whilst the number of qualified in specialty (QIS) is below the BAPM recommended, with on-going nurse recruitment the percentage of compliance will fluctuate. In a small special care baby unit it can take between 12-18 months for a nurse to complete their neonatal foundation course before individuals can be considered for the Neonatal Critical Care Course dependent on their level of knowledge and experience. Once enrolled on the critical care course it can take up to 12 months to complete including a minimum of 150hrs placement experience.

There is a minimum of one member of staff with QIS experience on every shift with escalation plans in place during times of high activity and acuity.

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 required establishment budget to achieve a supernumerary shift leader on all shifts, so 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 **Sickness - Neonatal**

Sickness 5.13% above trust target but slight decrease from January when sickness was 5.53%. One staff member on Long term sickness, rest short-term seasonal sickness all managed within Trust Sickness and Absence Management Policy.

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.

February 2025:

Training compliance in PROMPT: Midwives	93%
Training compliance in PROMPT: Obstetric Consultants	100%
Training compliance in PROMPT: Obstetric Middle Grades	100%
Training compliance in PROMPT: Anaesthetic Consultants	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	85%
Training compliance PROMPT: Maternity Support Workers	90%
Annual NLS update compliance: Paediatric Consultants	90%
Annual NLS update compliance: Paediatric Middle Grades	60%
Annual NLS update compliance: Paediatric Juniors	88%
Annual NLS update compliance: Midwives	96%
Annual NLS update compliance: Neonatal Nurses	95%
Fetal Wellbeing update day: Obstetrics	89%
Fetal Wellbeing update day: Midwives	91%
Midwifery update day (Core Competency): Midwives	91%
Midwifery update day (Core Competency): Support Staff	97%

5.2 Mandatory Training - Neonates

The maternity and neonatal teams have individualised role-specific training but there is some MDT cross over training, in particular in regard to neonatal resuscitation and breast feeding training and updates. Where compliance is low plans are in place to address this.

Course	Staff Group	Compliance	Comments
Newborn Life Support	Nursing	95%	
Newborn Life Support	Consultants	90%	
Newborn Life Support	Registrars	60%	
Newborn Life Support	Resident Drs.	88%	
Maternity Breast Feeding (1yr update)		86.36%	

Core & Essential Mandatory Training – Neonatal

Mandatory Training	Staff Group	Compliance	Comments
Core	Nursing	95.83%	
Essential	Nursing	90.02%	Challenges getting staff booked onto some courses – including IV Therapy, and PA/PS training.

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.

A walkabout took place on 6th February, with visits to the Delivery Suite, Maternity Ward, and SCBU. The maternity department was well-staffed that day, with no women in active labour. One inpatient on the maternity ward was uncertain about her birth options; the Consultant Midwife was called to assist with decision-making, ensuring the woman felt listened to and supported in making an informed choice. This approach supports personalised care planning, which the team is prioritising this year with the relaunch of the BRAIN mnemonic alongside the MNVP.

The burst pipe that affected the outpatient department was discussed, particularly the potential risk posed by ventilation in the theatre. The champions recommended debriefing after such events to ensure continuity of service and suggested contacting the estates team to help develop a business continuity plan. This has been arranged and is scheduled to take place in April. The maternity ward successfully accommodated the patients booked for assessments, ensuring that every patient was seen as planned. The collaboration between the estates and wider teams was acknowledged for their effective and timely efforts in safely reopening the department before the end of the day.

An update was provided on the organisation of the Theme of the Month, with each theme now assigned to a specialty midwife for coordination. The initiative includes walkabouts, videos on the closed Maternity Facebook page, a dedicated staff room board, articles in Friday Feedback, Check-In bulletins, and a presentation during the Over to You session, open to all staff. Each theme is also allocated a slot in Education and Audit to engage a broader audience, including doctors and other

staff members. It was suggested that the Hot Week consultant and registrar be involved where possible, with an emphasis on a multidisciplinary and professional approach. This is being taken forward.

In SCBU, the team is preparing for the launch of neonatal BadgerNet. Laptops on wheels have been delivered, and staff training is set to begin soon. The SCBU team is also exploring the Worcester Hospital paper-light process, with plans to implement a similar approach in the near future. The central monitoring screen was discussed, and progress is being made, with the electrical review currently underway.

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. We are awaiting the final confirmation from NSHR.

5.5 **CNST MIS Year 7**

MIS Year 7 was published in February. We have 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	Januar	Februar
Total bookings	154	122	135	147	150	127	137	131
Women who were booked before 12 + 6 weeks	147	116	120	139	141	119	133	128
% Women who were booked before 12 + 6 weeks (target 90%)	95.5%	95.1%	88.9%	94.6%	94.0%	93.7%	97.1%	97.7%
Women who were booked after 12 + 6 weeks	7	6	15	8	9	8	4	3
% Women who were booked after 12 + 6 weeks	4.5%	4.9%	11.1%	5.4%	6.0%	6.3%	2.9%	2.3%
Midwife led care at booking	27	24	18	27	27	16	27	22
% Midwife led care at booking	17.5%	19.7%	13.3%	18.4%	18.0%	12.6%	19.7%	16.8%
Women with BMI of 30 and over at booking	40	40	38	43	37	43	42	42
% Women with BMI of 30 and over at booking	26.0%	32.8%	28.1%	29.3%	24.7%	33.9%	30.7%	32.1%
% Antenatal Personalised Care Plan completed	97.1%	100.0%	98.4%	98.40%	99.00%	98.50%	99.3%	100.0%
% Intrapartum Personalised Care Plan completed	61.0%	68.5%	63.1%	63.1%	65.5%	64.0%	55.3%	65.4%
% Portal Access Consent	100.0%	98.4%	99.3%	99.3%	98.7%	99.2%	98.5%	100.0%
% Portal Access - Women who registered and logged in	82.5%	80.8%	79.9%	79.5%	85.8%	80.2%	80.7%	76.3%
% Contacts were place of birth suitability was recorded	65.4%	65.3%	69.5%	69.5%	65.5%	74.1%	69.8%	69.9%
% High risk women assigned a named Consultant - within 7 days	62.7%	58.40%	59.00%	59.00%	62.80%	71.00%	70.4%	71.3%
% High risk women assigned a named Consultant - at any time	86.0%	88.5%	84.2%	84.2%	83.6%	89.7%	81.8%	85.3%
% Antenatal contacts with a reviewed / authorised risk assessment	77.1%	72.9%	84.2%	84.2%	81.0%	82.8%	85.2%	83.6%
% Antenatal contacts with a risk assessment form completed	91.1%	91.7%	96.8%	96.8%	95.8%	95.5%	92.9%	94.9%
Recorded Smoking Status at Booking - Yes	10	5	9	11	13	10	11	11
Recorded Smoking Status at Booking - No	144	117	126	136	137	117	126	120
Recorded Smoking Status at Booking - Unknown	0	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%	100.0%
Women who were current smokers at booking	10	5	9	11	13	10	11	11
% Women who were current smokers at booking	6.5%	4.1%	6.7%	7.5%	8.7%	7.9%	8.0%	8.4%
Smokers who were referred to smoking cessation services	9	5	9	11	13	8	10	9
% Smokers who were referred to smoking cessation services	90.0%	100.0%	100.0%	100.0%	100.0%	90.0%	90.9%	81.8%
Smokers who accepted CO screening at booking	10	5	9	11	12	10	10	11
% Smokers who accepted CO screening at booking	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	90.9%	100.0%
Women who were screened for CO at booking	149	113	130	136	140	121	130	122
% 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%	93.1%
Women with CO reading of 4 ppm or more at booking	6	5	10	7	8	13	13	11
% 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%	8.4%
Total births (deliveries)	128	125	142	130	124	129	144	122
Home Births	0	1	3	2	2	1	0	0
BBA's	0	1	1	1	0	2	1	1
Vaginal births (deliveries)	47	43	58	57	40	50	60	47
% Vaginal births (deliveries)	36.7%	34.4%	40.8%	43.8%	32.3%	38.8%	41.7%	38.5%
Ventouse & forceps births (deliveries)	17	13	21	19	19	7	15	12
% Ventouse & forceps births (deliveries)	13.3%	10.4%	14.8%	14.6%	15.3%	5.4%	10.4%	9.8%
RG*1 having a caesarean section with no previous births	2	2	3	3	5	3	6	4
RG*1 Deliveries	17	15	16	16	23	15	23	13
RG*1 % C-section deliveries	11.8%	13.3%	18.8%	18.75%	21.74%	20.00%	26.1%	30.8%
RG*2 having a caesarean section with no previous births	20	25	14	14	24	21	19	23
RG*2 Deliveries	36	31	31	31	31	28	36	37
RG*2 % C-section deliveries	55.6%	80.6%	45.2%	45.16%	77.42%	75.00%	52.8%	62.2%
RG*5 having a caesarean section with at least one previous birth	18	21	21	21	16	23	20	15
RG*5 Deliveries	19	23	27	27	16	25	22	17
RG*5 % C-section deliveries	94.7%	91.3%	77.8%	77.78%	100.00%	92.00%	90.9%	88.2%
Total Elective C-Sections	27	22	28	21	30	27	35	30
Total Emergency C-Sections	36	46	34	33	34	44	33	32
Total Caesarean births (deliveries)	63	68	62	54	64	71	68	62
% Total Caesarean births (deliveries)	49.2%	54.4%	43.7%	41.5%	51.6%	55.0%	47.2%	50.8%
% Grade 1 C-Sections within 30 minutes	75.0%	75.0%	87.5%	87.5%	87.5%	77.8%	60.0%	100.0%
% Grade 2 C-Sections within 75 minutes	84.6%	100.0%	90.9%	90.9%	90.5%	90.3%	91.7%	87.5%
Midwife led (low risk care) births	29	29	26	30	12	16	27	17
% Midwife led (low risk care) births	22.7%	23.2%	18.3%	22.9%	9.7%	12.4%	18.6%	13.9%
Home births (deliveries) - midwife led only	0	0	1	1	0	0	0	0
% Home births (deliveries)	0.0%	0.0%	0.7%	0.8%	0.0%	0.0%	0.0%	0.0%
Total number of babies born	131	128	144	132	124	129	144	122
Babies born preterm (singletons born 36+6 or less)	17	11	16	13	8	11	8	4
% Babies born preterm (singletons born 36+6 or less)	13.0%	8.6%	11.1%	9.8%	6.5%	8.5%	5.52%	3.28%
Singleton babies born 26+6 or less	0	1	0	1	0	0	0	0
% Singleton babies born 26+6 or less	0.00%	0.83%	0.00%	0.77%	0.00%	0.00%	0%	0.0%
Babies (multiples) born 27+6 or less	0	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%		
Stillbirths	2	2	0	0	2	0	0	0
% Stillbirths	1.5%	1.6%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%
Live births where breastfeeding initiated (first feed = breastmilk)	102	105	108	107	100	105	0.00	0.00
% Live births where breastfeeding initiated (first feed = breastmilk)	81.0%	86.1%	76.6%	82.3%	82.0%	81.4%	116	101
Women who were current smokers at booking (delivered mothers)	7	11	8	8	10	9	81.1%	82.8%
% Women who were current smokers at booking (delivered mothers)	5.5%	8.8%	5.6%	6.1%	8.1%	7.0%	12	11
Women who were current smokers at birth (delivery)	8	12	9	6	8	8	8.3%	9.0%
% Women who were current smokers at birth (delivery)	6.4%	9.6%	6.3%	4.6%	6.5%	6.2%	9	8
% Women with CO measured at 36 weeks	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	6.2%	6.6%
% CO >= 4ppm at booking and below 4 ppm at 36 weeks	2.7%	7.2%	4.8%	3.5%	6.3%	5.4%	100.0%	99.1%
Late pregnancy loss (singletons 16+0 - 23+6)	0	1	0	0	0	0	9.1%	4.3%
% (as a % of all singleton births)				0.00%	0.00%	0.00%	1	0
% Detection rate for FGR (below 3rd centile)	10%	20.0%	22.2%	0.0%	12.5%	40.0%	0.69%	0.00%
							0%	0%

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Women who had a PPH of 1,500ml or more	6	5	9	4	3	6	9	5
% Women who had a PPH of 1,500ml or more	4.7%	4.0%	5.0%	3.1%	2.4%	4.7%	6.3%	4.1%
Women who sustained a 3rd or 4th degree tear	1	0	0	0	0	0	2	1
% 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%	1.7%
% Induction of labour rate (of all births)	34.4%	39.2%	34.5%	32.3%	30.6%	40.3%	32.6%	43.4%
Routine Enquiry Domestic Violence - Asked	84	78	100	80	87	86	86	66
Routine Enquiry Domestic Violence - Unable to ask	43	47	41	51	35	42	53	52
Routine Enquiry Domestic Violence - Unknown	1	0	1	0	2	1	6	4
% routine enquiry domestic violence	99.2%	100.0%	99.3%	100.0%	98.4%	99.2%	95.9%	96.7%
Midwife to birth ratio	1:22	1:21	1:27	1:23	1:23	1:24	1:24	1:21
Delay in Induction >2hrs	0	0	2	0	0	1	1	4
Delay in Catagory 1 C-Section >30mins	0	2	0	1	1	2	0	0
Delay in administering medication	0	1	0	0	0	1	1	0
Delay in starting syntocinon/ARM >30mins	0	0	0	1	0	0	1	3
Delay in Suturing >60mins	0	0	0	0	0	0	0	0
Unable to provide 1:1 care in labour	0	0	0	0	0	0	0	0
Delay in Triage >30mins	0	0	1	0	0	0	0	0
Community midwives on call covering maternity unit	0	3	2	1	0	1	0	2
Any movement of midwifery staff from any area to provide midwifery cover	1	0	2	0	2	1	3	27
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0	0
DSC lost - supernumerary status	0	0	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0	0	0	0	0	0
Number of women presenting to service with reduced fetal movements	220	199	203	211	204	228	207	205
Number of women presenting with RFM who are recorded as having a CTG	218	197	200	211	203	225	206	204
% of women presenting with RFM who received CTG	99.1%	99.0%	98.5%	100.0%	99.5%	98.7%	99.52%	99.51%
Total admissions to neonatal care	12	6	15	17	13	13	14	8
Unexpected admissions of full-term babies to neonatal care	3	2	4	7	9	4	6	4
% Unexpected admissions of full-term babies to neonatal care	2.7%	1.7%	3.1%	5.9%	7.8%	3.4%	4.4%	3.4%
Eligible Babies	1	0	2	3	2	2	0	1
% taken within hour	100.0%	n/a	100.0%	66.6%	100.0%	100.0%	0.0%	100.0%
Adm temp <36.5 degrees	0	0	0	0	0	0	0	0
Eligible Babies	22	12	19	16	21	16	20	17
% taken within hour	86.3%	75.0%	94.0%	87.5%	100.0%	100.0%	95.0%	100.0%
Adm temp <36.5 degrees	3	1	0	1	0	2	1	3
Babies born with an APGAR score between 0 and 6 (at 5 minutes)	3	3	6	5	0	1	1	3
Neonatal deaths	0	0	1	1	0	0	2	0
% Neonatal deaths	0.0%	0.8%	0.7%	0.8%	0.0%	0.0%	1.4%	0.0%
Neonatal mortality per 1,000 births	0.00	0.00	6.94	7.58	0.00	0.00	13.89	0.00
Neonatal transfers for therapeutic hypothermia	0	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	n/a
Neonatal brain injuries	0	0	0	0	0	0	0	0
% Neonatal brain injuries	n/a	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	1
Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	2	2	2	2	3	2	0	1
% 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%		100.0%
Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	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	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	n/a

Obstetrics admissions to ITU	1	0	0	0	0	0	0	0
Maternal deaths	0	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%	96.8%
Postnatal readmissions within 28 days (mothers)	10	13	2	8	8	11	8	12
Postnatal readmissions within 28 days (babies)	5	7	7	4	8	4	4	2
Number of times Maternity Services Suspended per month	0	1	0	0	0	0	0	0
Number of hrs Maternity Services suspended	0	9	0	0	0	0	0	0
Number of times Home Birth services suspended per month	0	0	1	0	0	0	0	0
Number of hrs Home Birth services suspended	0	0	12	0	0	0	0	0
Number of times SCBU suspended per month	0	0	1	0	0	0	0	0
Number of hrs SCBU suspended per month	0	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	4
New MNSI SI referrals accepted	0	0	0	1	1	0	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	0
Coroner Reg 28 made directly to Trust	0	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	0
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	0	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	0
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	3	2	2	0	0		TBC	TBC
establishment	0.06wte	2.4wte	2.4wte	4wte	4wte		2.07wte	2.07wte
Inphase related to workforce (service provision/staffing)	0	3	4	1	2	2	2	27
MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	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				2
Service User feedback: Number of Complaints (formal)	1	0	1	4	1	0	4	2
Staff feedback from frontline champions and walk-abouts (number of themes)	0	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	10	10
Training compliance in PROMPT: Midwives	93%	93%	96%	96%	98%	98%	96%	93%
Training compliance in PROMPT: Obstetric Consultants	100%	100%	100%	90%	100%	100%	90%	100%
Training compliance in PROMPT: Obstetric Middle Grades	93%	93%	92%	92%	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	100%	100%	100%	100%	100%
Training compliance in PROMPT: Anaesthetic Middle Grades	100%	100%	100%	100%	92%	92%	83%	85%
Training compliance PROMPT: Maternity Support Workers	65%	62%	73%	81%	100%	100%	94%	90%
Annual NLS update compliance: Paediatric Consultants	100%	100%	100%	100%	100%	100%	89%	90%
Annual NLS update compliance: Paediatric Middle Grades	100%	80%	100%	100%	100%	100%	80%	60%
Annual NLS update compliance: Paediatric Juniors	91%	90%	100%	100%	100%	100%	100%	88%
Annual NLS update compliance: Midwives	93%	93%	96%	96%	98%	98%	99%	96%
Annual NLS update compliance: Neonatal Nurses	100%	100%	100%	84%	100%	100%	86%	95%
Fetal Wellbeing update day: Obstetrics	89%	95%	84%	85%	100%	90%	90%	89%
Fetal Wellbeing update day: Midwives	94%	95%	92%	91%	98%	92%	93%	91%
Midwifery update day (Core Competency): Midwives	98%	98%	94%	94%	98%	98%	99%	91%
Midwifery update day (Core Competency): Support Staff	79%	77%	81%	85%	94%	94%	94%	97%

Appendix 2 – neonatal 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	0		
Band 6 Vacancy Gap (5.2wte)	0	0	0	0	0	0	0	0	0	0.33	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	2.14		
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	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	0		
Attrition Rate (WTE)	0	0.92	0	0.61	0	0	0	0.62	0	0	1.53		
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%	5.13%		
Safe Staffing													
% Shifts staffed to BAPM Standards	96%	100%	100%	98.39%	98.31%	96.67%	71.67%	81.36%	82.26	**96.77**	100%		
QIS % (standard = 70% of registered workforce)	48%	46%	46%	49.80%	49.80%	44%	44%	44%	45.80%	**43.50%**	47.21%		
% of shifts QIS to toolkit				91.94%	100%	100%	95.74%	93.22%	96.77	**100%**	100%		
% Shifts with supernumerary shift co-ordinator	18%	59%	16%	22.57%	10.17%	11.67%	6.67%	11.86%	1.61%	**19.35%**	14.29%		
Appraisal Rate	71%	92%	79.00%	84.3%	68.75%	77%	73.7%	88.00%	94.50%	94.40%	92.00%		
Mandatory Training Core	91.43%	99%	98.1%	98.09%	98.26%	97.60%	91.85%	93.70%	93.08%	96.54%	95.83%		
Mandatory Training Essential	83.5%	92%	93%	92.79%	92.94%	88.66%	85.61%	87.40%	89.90%	90.33%	90.02%		
Basic Life Support	80%	80%	80.00%	80.00%	81%	78%	64%	61.54%	59.08%	56.00%	56.52%		
Newborn Life Support >90%	86%	94%	90%	100%	100%	100%	84%	100%	100%	86.00%	95%		
Maternity Breastfeeding update.	70%	75%	95%	98.95%	80%	73%	95.83%	95.83%	95.65%	87.50%	86.30%		
Safeguarding Level 3	90.00%	100%	100%	100%	90%	100%	92.59%	87.50%	78.26%	91.67%	100.00%		
Compliments/Complaints/Concerns													
Complaints/Concerns	0	0	1	0	0	0	0	0	0	1	1		
Infection Prevention													
Overall - Star rating.	5	5	4	5	5	5	5	5	5	4	4		
Ward Assurance Audit		98%		85.50%		96%	91%	91.60%		100%		96.50%	
Hand Hygiene	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%		100%	
Bare Below the Elbow	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		67%	
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	2	8	1	2		5	8	4	6	3		
Medication Errors	0	0	0	0	0	0	0	0	0	0	0		
Staffing	0	0	0	0	0	0	0	1	1	0	0		
Service Escalation (OPEL RED/BLACK)	0	0	0	0	0	0	0	OPEL 3 x 1	Opel 3 x 5	0	0		
Exception reports - ex-utero outside of care pathwa	1	0	0	1	0	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	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%	3.44%	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%	40%		
Number of babies born between 34-36 wks gestation and admitted to SCBU	4	2	2	5	1	3	6	2	5	0	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	0		
Neonatal Outreach Team													
Total Patients	12	12	8	7	12	11	14	21	13	14	10		
NewReferrals	6	9	5	5	6	5	8	11	2	3	3		
Existing Patients continuing care	4	3	3	2	6	6	6	10	11	11	7		
No. NGT Feeding in the community	4	5	7	3	3	3	3	7	2	11	9		
Receiving EBM on discharge from SCBU	6	7	5	6	8	7	7	12	2	11	10		
Receiving EBM on discharge from O/R	1	3	0	0	2	1	1	5	1	1	5		
Numbers Discharged from outreach	4	9	6	0	3	5	5	9	4	7	7		
Number of Incidents (Inphase)	0	1	1	0	0	0	0	0	0	1	0		
Prolonged Jaundice Screening Referrals	24	28	26	19	28	26	18	26	29	18	20		
Prolonged Jaundice Screening - Total Number of Refferals meeting criteria	19	26	22	13	21	22	15	23	29	17	17		
Prolonged Jaundice Screens - Outreach	15	19	20	10	18	20	11	18	13	11	13		
Prolonged Jaundice Screens - RAC	4	7	10	10	11	9	4	5	16	4	4		

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Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
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 10th March 2025, the Licence to Install Service Media between Wirrall Borough Council and Wye Valley NHS Trust (part of the CDC programme of works) 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:	**03/04/2025**
Title of Report:	Audit Committee Summary Report 12 December 2024
Lead Executive Director:	Choose an item.
Author:	Nicola Twigg, Chair of Audit Committee/NED
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To brief the Board on the main issues arising from the Audit Committees held on 12 December 2024.

Recommended Actions required by Board or Committee

To receive the report.

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.

Wye Valley NHS Trust
Trust Board Meeting – 3 April 2025
Summary of Audit Committee (AC) meeting held on 12 Dec 2024

MATTERS FOR PARTICULAR ATTENTION

Internal Audit – No reports received however it was agreed that the CMO would be asked to provide an ongoing update on Job Planning progress. 2025 planning has started and Internal Audits to be agreed in due course following consultation with Execs and Non-Execs.

Financial Update – Audit planning report received for following year, received and noted with no further issues for escalation at this stage

Terms of Reference – Updated to allow alignment with National Model and Foundation Group standards.

Pharmacy Update – Clinical Director of Pharmacy, presented a full update on current position and initiatives to reduced expired drugs losses

OTHER MATTERS

Report	Discussion / Recommendation
Financial Reporting Risks	Received and noted
Contract Management	Joint Workshop with Foundation Group partners agreed for next AC meeting
Losses & Compensations	Received and agreed that patient property losses would also be picked up at Quality Committee as part of Patient Experience
ICS	Reports received and noted for information purposes only

No items for further escalation

Prepared by:-
Nicola Twigg, Chair of Audit Committee

WYE VALLEY NHS TRUST
Minutes of the Audit Committee
Held on 12 December 2024
Via MS Teams

Present:		
Nicola Twigg	NT	Audit Committee Chair & Non-Executive Director (NED)
Sharon Hill	SH	Non-Executive Director (NED)
Ian James	IJ	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Gwenny Scott	SC	Associate Director of Corporate Governance/Company Secretary
In attendance:		
Jessica Connelly	JC	Assistant Manager, Deloittes LLP
Mark Coton	MC	Assistant Manager, RSM Risk Assurance Services LLP
Ian Howse	IH	Partner, Risk Advisory Team, Deloittes LLP (joined at 10:00 a.m.)
Mike Gennard	MG	Partner, RSM Risk Assurance Services LLP
Asam Hussain	AH	Risk Assurance Director, RSM Risk Assurance Services LLP
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Tony McConkey	TMC	Clinical Director of Pharmacy (For agenda item 7.2.1.)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Wendy Twigg	WT	Executive Assistant (for the Minutes)
Shona Wilcox	SW	Audit Manager, Deloittes LLP

Minute		**Action**
AC001/12.24	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Heather Moreton, Associate Chief Finance Officer.	
AC002/12.24	**QUORUM & DECLARATIONS OF INTEREST**	
	The meeting was quorate. There were no Declarations of Interest.	
AC003/12.24	**MINUTES OF THE MEETING HELD ON THE 21 OCTOBER 2024**	
	The minutes were approved as an accurate record of the meeting. The confidential minutes were approved.	
	The minutes and confidential minutes be confirmed as an accurate record of the meeting and signed off by the Committee Chair.	
AC004/12.24	**MATTERS ARISING AND ACTIONS**	
	The complete actions were noted as completed on the action log. AC05.5/09.23 – Contract Management – A joint workshop with the Board to be arranged in the new year with the Foundation Group on 'Contract Management & Atamis'. Atamis has now been rolled out as the single solution to the NHS. Gaynor McGarry, Head of Procurement to be invited to provide a presentation on Contract Management together with an update on Procurement regulations and compliance and Atamis at the March Audit Committee. **ACTION** AC004/06.24 – Matters Arising and Actions – A discussion with Foundation Group colleagues to take place to ascertain if a Financial Reporting Risk	**KO**

	Report is in place for Wye Valley Trust (WVT) to benchmark ourselves against. It was noted that WVT is further ahead with Financial Reporting Risk Reporting and work is progressing with colleagues across Group. Agreed to **CLOSE ACTION** AC005.3/10.24 – Finance Governance (Financial Recovery Board) - 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. Agreed to carry forward for Company Secretary to review as part of Governance. **ACTION** AC005.3/10.24 – Finance Governance (Financial Recovery Board) - Worcestershire Acute Hospital Trust to be contacted with regard to their reporting mechanism for the FRB plan. Reports have been reviewed. Agreed to **CLOSE ACTION** AC006.1/10.24 – Single Tender Waivers - Payments under multi-year contracts e.g. PFI contracts to be more visible through Audit Committee. The Head of Procurement will extract the most material high value contracts and produce a stocktake to obtain clarity on all payment requests and any variations for more visibility. Agreed to pick up in the Contract Management presentation in March. **ACTION** AC006.2/10.24 – Losses and Compensations - Update on the process and controls for sign off for patient claims for loss of personal effects. An update was presented at the December meeting in response to the action within agenda item 7.2. **ACTION CLOSED.** AC006.2/10.24 – Losses and Compensations - Update by HM provided within action log. The Clinical Director of Pharmacy attended the meeting to update on initiatives to reduce expired drugs losses under agenda item 7.2.1. 'Initiatives to reduce expired drugs losses'. **ACTION CLOSED** AC006.3/10.24 – Update on cash position - A review of the cash slide within the IPR to be completed. Cash position will be built into IPR for Month 9 reporting. **ACTION COMPLETED** AC007.2/10.24 – Data Quality – Venous Thromboembolism - The Chief Medical Officer or deputy to be invited to the next meeting to provide update on the improvement plan. **ACTION CLOSED.**	**GS** **KO**
	The action update be received and noted.	
AC005/12.24	**GOVERNANCE**	
AC005.1/12.24	**REVIEW OF AUDIT COMMITTEE TERMS OF REFERENCE**	
	GS provided an update on the Audit Committee Terms of Reference (TOR) and the following points were noted:- • The TOR's align with national NHS model, the Code of Governance and the Foundation Group. South Warwickshire Foundation Trust	

	(SWFT) have reviewed the TOR and no material changes have been made; • At the end of the financial year GS will produce a report on the Audit Committee's activities and effectiveness to include compliance against the TOR. It is expected that as it is the Foundation Group model the TOR is unlikely to change; • GS to check that within the TOR at least one Non-Executive Director holds a financial or equivalent qualification under 'Membership Attendance' as a requirement. **ACTION**	**GS**
	(A) The Audit Committee Terms of Reference update was received and noted. **(B) The text to be checked in relation to the membership attendance of the TOR to ensure that at least one Non-Executive Director holds a financial qualification or equivalent.**	
AC006/12.24	**INTERNAL AUDIT**	
AC006.1/12.24	**IA PROGRESS REPORT**	
	IA presented the IA progress report update and the following points were noted:- • No reports were presented at the meeting. Confirmation received that the IA are on track for the delivery of the Audit Plan. Confirmation received that the Key Financial Controls work is almost complete; • Four further reviews have been scheduled for the next quarter; • Medical Job Planning – following a meeting with the Chief Medical Officer (CA) it was requested that the audit be deferred to 2025/26 to ensure that job plans are in a better position. Agreed that the job planning audit take place no later than Quarter 2 2025/26. **ACTION** • Digital Nurse Noting – the system was implemented later than planned and a further upgrade to reduce the number of observation sheets requires completion, which will delay the review until March. IA will endeavour to finalise the report at a later Audit Committee and will share the report with Audit Committee members before the meeting; • It was agreed that the surgical job plans would be completed by the end of November. NT requested that the report is added to follow up to ensure that the surgical job plans have been completed or if delayed, the reason for the delay. Confirmation was received that the job-planning round for 24/25 is now closed with the vast majority of job plans between 70% to 80% signed off. The job plans for 25/26 have been scheduled between January and March/April to align to operational planning. It was suggested that the Chief Medical Officer and the Job Planning team extract a summary of the 24/25 close off period to provide assurance to the Audit Committee. The summary to include specialties that were completed and the level of completion. The IA can support the deferral and identify any further improvements. It was agreed that a management assurance report on job planning 2024/25 be presented by the Chief Medical Officer (CA) at the March Audit Committee to include the process,	**IA**

	completion rates (including Surgical Division) and reason for the deferral. **ACTION** • The Board Workshop in January will discuss operational planning, which will include job planning and should provide members with oversight.	**CA**
	(A) The IA progress report update was received and noted. **(B) Plan the job planning audit no later than Quarter 2 2025/26.** **(C) The CMO to present a management assurance report on job planning 2024/25, including Surgical Division at the March Audit Committee.**	
AC006.2/12.24	**RECOMMENDATION TRACKER**	
	IA presented the Recommendation Tracker update and the following points were noted:- • It was reported that of the 57 actions in the tracker, 22 were closed as implemented, 25 the date had not yet been reached and 10 were still in progress with extensions requested. The details of the 10 actions were presented in the report and taken as read; • It was agreed that qualitative comments for outstanding actions and any concerns would be added to the Head of Internal Audit Comments. The narrative for rescheduled and overdue implementation dates and the management delays in the KPI's to be reintroduced into the IA report. **ACTION** • When the Audit Plan for 25/26 is being developed and reviewed at Trust Management Board, there is an opportunity to reinforce the KPI's and charter between IA and WVT regarding roles and responsibilities. It was noted that the IA will strive to meet the 10 day deadline for reports; • The Junior Doctor pay award was highlighted and the payment of arrears to Doctors that have left the Trust, which would impact on pensions. The IA confirmed that the payment would be paid to the individual as part of the Department of Work and Pensions as it would become a liability on the NHS Provider; • The IA confirmed that the Discharge Planning report would be completed by the end of December.	**IA**
	(A) The Recommendation Tracker update was received and noted. **(B) RSM to add narrative on performance against the Internal Audit KPI's.**	
AC006.3/12.24	**INTERNAL AUDIT PLAN 25/26**	
	IA provided a verbal update on the Internal Audit Plan 25/26 and the following points were noted:- • Schedules will be shared with Executive Management to provide an opportunity to review the Internal Audit Plan 25/26 with meetings to be arranged in January. Feedback and input will be collated from Executive Directors, Non-Executive Directors and the Audit Committee, which will be shared at the Trust Management Board to shortlist. Non-Executive Directors will have the opportunity to provide	

	suggestions to NT on any priorities for inclusion in the Audit Plan for approval in the March Audit Committee.	
	The verbal update on the Internal Audit Plan 25/26 be received and noted.	
AC007/12.24	**FINANCIAL FOCUS**	
AC007.2/12.24	**LOSSES & COMPENSATION**	
	KO presented the Losses & Compensation update and the following points were noted:- • The purpose of the report is to provide a summary of the Losses and Special Payments made during Quarter 2 2024/25 and to confirm the current process undertaken to check claims; • A response to the action from the October Audit Committee relating to the process of signing off claims for patients missing items and whether the patient's own insurance had been considered. Evidence of the item and value to be submitted by patient or relative, the Ward Sister/General Manager would review and sign off. The patient is not asked if the item is covered by insurance to enable the patient to claim for the item. HM is following up with the Patient Experience team and legal advisors to understand if a process can be implemented. A review by HM of the approval level from General Manager to Divisional level to validate more expensive items to consider strengthening the process to be undertaken; • The largest value within the period relates to bloods and drugs write offs and any bad debts, which are relatively small in value; • The Audit Committee were assured that there is a robust audit trail in place for paying out claims to patients; • From a Quality Committee perspective the Patient Experience team is reviewing the purchasing of bags to collect patient's items to avoid missing items. Agreed that IJ as Chair of Quality Committee will review processes relating to lost patient property as part of Quality Committee. **ACTION**	**IJ**
	(A) The Losses & Compensation update was received and noted. **(B) The Chair of Quality Committee to schedule a review of the processes relating to lost patient property.**	
AC007.2.1/12.24	**INITIATIVES TO REDUCE EXPIRED DRUGS LOSSES**	
	The Clinical Director of Pharmacy (TMC) updated the initiatives to reduce expired drugs losses and the following points were noted:- • The reasons for medicines waste was outlined and included expired drugs, destroyed (dropped, badly stored, broken or patient declined medication and wasted) and failed (in process of making product, wasted, patient is ill and cannot take medication); • To minimise wastage drugs are made up in Pharmacy when chemotherapy patients are on the ward to reduce waste; • Quarter 1 expired stock was reported at £71k and £84k for Quarter 2; • Medicines has a turnover of £30 million, with waste reported as 1% of that turnover. The national target is benchmarked at 1%, however the Trust target is 0.5%;	

	• For Quarter 1 400 products expired, the top 25 accounted for 80% of the cost and the top four lines accounted for 45% of the waste; • The next steps for Pharmacy include addressing staffing issues, which will be removed from the risk register from January as staffing will be at full establishment; • Pharmacy is trialling a bank member of staff to review high cost lines and check on the auto and manual re-order status of products. The team are working with Foundation Group colleagues on risk sharing with expiring stock. A wholesale licence is required to move expiring stock in each organisations; • A robotics business case for Pharmacy to address the space issue is being developed, which would improve stock rotation and tracking of expiring stock; • Pharmacy will liaise with Finance regarding the completion of a stocktake towards the end of the financial year.	
	The Initiatives to reduce expired drugs losses was received and noted.	
AC007.1./12.24	**ICS FINANCIAL REPORTING/GOVERNANCE UPDATE**	
	KO provided a verbal update on the ICS financial reporting/governance and the following point was noted:- • This standing agenda item to provide a read across back to the ICS to consider the relationship from a Provider perspective and the arrangements around system risk and link back into ICS and ICB.	
	The ICS financial reporting/Governance update was received and noted.	
AC007.1.1/12.24	**ICS MONITORING REPORT**	
	KO presented the ICS monitoring report and the following points were noted:- • It is proposed that due to the size of the ICS Monitoring dashboard that a front page dashboard summary is presented at future Audit Committees for information to sign post areas of risk that WVT are sighted on rather than sharing the whole report; • The members discussed the importance of the report and where the report should be presented. It was agreed that the ICS report is submitted to the Financial Recovery Board for consideration. **ACTION** • From a risk perspective the Audit Committee require the information to ensure that the Committee are on track and making the right decision, however the role of the Audit Committee is not to scrutinize the financial information. The Committee agreed to present the ICS dashboard only to future Audit Committee meetings. **ACTION** • An on-line reading room facility to be considered for Non-Executive Directors. **ACTION**	**KO** **KO** **GS**
	(A) The ICS monitoring report was received and noted. **(B) Submit the ICS report to the Financial Recovery Board for consideration.** **(C) Present the ICS dashboard only to Audit Committee at future meetings.**	

	(D) Consider establishing an on-line reading room for Non-Executive Directors.	
AC007.3/12.24	**FINANCIAL REPORTING RISKS**	
	KO presented the financial reporting risks update and the following point was noted:- • One of the actions from the Audit process was clarity on financial reporting risks and the improvements from a team perspective. Progress is being shown on the financial reporting risk areas and the actions and mitigations undertaken.	
	The financial reporting risks were received and noted and assurance provided that the action is being progressed.	
AC007.4/12.24	**SINGLE TENDER WAIVERS**	
	KO provided an update on Single Tender Waivers and the following point was noted:- • No report was presented this month. The Single Tender Waivers process has moved from paper forms and embedded into Integra. When a requisition is input on to the Integra system to order it prompts the team to go through the waiver check process and if a waiver is required it will be completed online and the auto approval process. This process will enable more comprehensive reporting. It was agreed that a six month catch up Single Tender Waiver report will be presented at the March Audit Committee. **ACTION**	**KO**
	(A) The Single Tender Waivers be received and noted. **(B) Six month update on Single Tender Waivers to be reported at the March Audit Committee.**	
AC008/12.24	**EXTERNAL AUDIT**	
AC008.1/12.24	**NHS SECTOR DEVELOPMENTS**	
	EA provided an update on NHS Sector Developments and the following points were noted:- • It was reported by the EA that there was no evidence within WVT on ethical points for Accountants. The paper advises that clarity is required around the correct way to operate and to be aware of rationalisation around behaviours; • In terms of disclosures on the environment, the EA advised WVT to start thinking about the systems for collecting data for providing disclosures; • The Value for Money (VFM) report which includes ethical standards and IFRS standards to be included on the Audit Committee agenda under Financial Focus. **ACTION**	**KO**
	(A) The NHS sector developments update was received and noted. **(B) A report on the Trust's response to the areas identified for improvement in the VFM report 2023/24 to be presented in March.**	
AC008.2/12.24	**EXTERNAL AUDIT PLANNING REPORT 2024/25**	
	EA provided an update on the External Audit Planning Report 2024/25 and the following points were noted:-	

	• The EA have been in discussion with the Trust regarding planning and the significant risks the Trust face. No new risks were reported. Contracting and understanding and movement of payment by results arrangements moving forward is critical, further work to be undertaken to ascertain if revenue recognition is a significant risk. The next EA visit will determine the detail of the various contracts in place and the results EA will be presented in the interim report; • The EA reported that the Accounts timetable will be to complete in June and the draft return by the Finance team on the 25 April 2025. The EA have recommended to NHSE they undertake a two phase approach, to split to end of June and to the end of September as provider accounts will not be signed off until late November; • Progress on timetables was noted; • The biggest improvements this year can be made on quality indicators, the Remuneration report and the Annual report. EA offered support on the completion of the reports if required; • Planning work has commenced on the timeline. The interim phase, February to April will focus in on key judgemental areas and to finalise Value for Money work before commencing Year End work in May and June. During quarter 4 EA will issue the Audit Plan and provide a verbal update after the interim work on key findings; • With regard to Materiality, forecast revenues as the basis for materiality with £7.3 million for planning, which will be revisited when final revenue figures are received. The reporting threshold is £300k which is in line with prior years; • With regard to Value for Money, the ongoing issue is the challenge around financial sustainability, the CQC action plans and addressing any issues. There is a possibility that there may be a referral to the Secretary of State, with no response expected; • Two significant risks were raised for capital expenditure and management override.	
	The External Audit planning report 2024/25 was received and noted.	
AC009/12.24	**<u>ANY OTHER BUSINESS</u>**	
	• It was reported that Mike Gennard, Partner, RSM Risk Assurance Services LLP will be retiring at the end of the financial year. MG's attendance at the March Audit Committee noted as his final meeting. • The Audit Committee thanked MG for all his support.	
AC011/12.24	**<u>DATE OF THE NEXT MEETING</u>** **Thursday 13 March 2025 – 9:30 a.m. – 12:00 p.m. via TEAMS**	

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Quality Committee 30 January 2025 Minutes and Escalation Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Ian James Non-Executive Director and Chair
Reporting Route:	Chair of Quality Committee
Appendices included with this report:	Quality Committee Minutes January 2025
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

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.

Recommended Actions required by Board or Committee

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

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.

Matters for Noting

1. **Perinatal Safety Report –** Committee discussed the increase in PMRT cases and received assurance that the majority of cases were graded A or B ie there were no care issues judged to have affected the outcome. A number of steps have been taken to further strengthen our processes including sharing learning with Worcester. Further assurance was received on the response to obstetric haemorrhages, where we are an outlier, and the ongoing work to improve our pre-term pathway.

2. **CNST 10 Compliance** – Following delegation to Quality Committee from Board, Committee was pleased to sign off the CNST submission and congratulated the teams for achieving compliance in all 10 standards.

3. **Maternity Survey Report** – Further to concern at the December Committee about the survey results indicating questions about how well doctors and midwifes are working together as well as patient concerns about being listened to, Committee received an update on the work underway to address these issues. This was presented jointly by the Safety Matron and the lead Obstetrician who stressed the level of engagement across the team and the renewed focus on MDT working.

4. **Quality Priority – Timely medications** – The focus on timely medication for Parkinson's patients throughout the year has resulted in a downward trend for missed and late doses. Committee expressed its appreciation of the work done by the project lead and welcomed the widening of focus into other conditions as well as more support for self-medication.

5. **Quality Priority – Timely VTE Risk Assessments** – Performance has improved but we still do not meet the 95% target, though Committee noted that national performance sits at 89% and the tightening of the timeframe to 14 hours rather than 24 hours presents new challenges. That said we do have variability of performance across the medical and surgical divisions and opportunities to move closer to the 95% target and these will remain our focus.

6. **Divisional Report - Surgical Division** – The Division reported on a number of positive developments including complaint response times, the establishment of the 24 hour outreach team following the ITU peer review in 2024 and the leadership of paediatric ED through the paediatric team. Of concern was the challenges in dentistry services which are being addressed and the demands on Frome ward following ward reconfiguration which resulted in increased numbers and complexity of patients being looked after. A number of steps have been take to improve the situation.

7. **Quarterly Safeguarding Reports –** For Adults, Committee was pleased to receive the deep dive into MCA /DoLS following comments in both Safeguarding Adults and Domestic Abuse Deaths Reviews. The deep dive highlights problems with documentation and recording of decision making which mirrors concerns from our own audit. A number of steps are being taken to further heighten awareness and to support better recording and documentation.

Committee noted with concern the number of children in care placed in Herefordshire by other councils – 431 at the end of December. These children are not “visible” as part of the under 18’s population but put a huge burden on services particularly Community Paediatrics.

8. **Urgent and Emergency Care Survey Results** – The survey had a good response rate (highest in the Foundation Group) and showed positive results in particular for the staff in ED. A plan is in place to address areas where feedback was disappointing and links are being made with South Warwickshire Trust where results show most improvement. Overall Committee felt the results should be viewed positively given the pressures on the Urgent and Emergency Care Department.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 30 January 2025 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)
Nicola Twigg	NT	Non-Executive Director (NED)
In attendance:		
Kirstie Gardner	KG	Named Nurse Children in Care (for item 14.1)
Dan Harding	DH	Associate Chief Operating Officer, Medical Division
Ehab Hafiz	EH	Consultant Obstetrics and Gynaecology (for items 6-8)
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Leah Hughes	LH	Operational Clinical Lead Radiography
Hamza Katali	HK	Associate Chief Medical Officer Clinical Support
Candice Lewis	CL	Perinatal Quality and Safety Matron (PQSM) (for items 6-8)
Emma Lunn	EL	Lead Nurse Adult Safeguarding (for item 14.3)
Tom Morgan-Jones	TM-J	Deputy Chief Medical Officer (DCMO)
Sue Moody	SM	Associate Chief AHP, Integrated Care Division (ACAHP)
Rachel Murray	RM	Clinical Quality Improvement and CQUIN Manager
Vicky Roberts	VR	Executive Assistant (for the minutes)
Gwenny Scott	GS	Company Secretary
Emma Smith	ES	Deputy Chief Nursing Officer
Amy Tootell	ET	Specialist Nurse Advisor Safeguarding Children (for item 14.4)
Caroline Waite	CW	Relief Approved Mental Health Professional, Community Wellbeing (for item 14.3)
Louise Weaver	LW	Acute and Emergency Matron (for item 15)
Raechel Wordsworth	RW	Medicines Safety Officer (for item 9)

QC01/01.25	**APOLOGIES FOR ABSENCE**	
	Rachael Hebbert, Associate Director Nursing, Jo Rouse, Associate Non-Executive Director, Amie Symes, Associate Director Midwifery and Emma Wales, Associate Chief Medical Officer, Medical Division	
QC02/01.25	**QUORUM**	
	The meeting was quorate.	
QC03/01.25	**DECLARATIONS OF INTEREST**	
	Grace Quantock asked for it to be noted that she had been appointed to the Judicial Appointments Committee.	

QC04/01.25	**MINUTES OF THE MEETING HELD ON 20 December 2024**	
	Page 5, Research Report required an amendment 'invested hospital to be replaced with 'research active trust'.	
	Resolved – that the minutes of the meeting held on 20 December 2024 be received and approved with the amendment noted.	
QC05/01.25	**ACTION LOG AND MATTERS ARISING**	
	The actions were updated: QC09/12.24 – ACAHP to look further into the demography of the case load in the City team – Update will be included in the next quarterly report March 2025. CQ09/12.24 – ACAHP to assess any change noted in skin damage associated with the change to the new continence product – The change will take place in February and an updated will be given in future reports. ACTION COMPLETE CQ13/12.24 – CNO to circulate the infographic around antimicrobial stewardship and the change of antibiotics from IV to oral administration – The infographic was circulated and positive comments received. ACTION COMPLETE	
QC06/01.25	**PERINATAL SAFETY REPORT**	
	The PQSM presented the Perinatal Safety Report. The report was taken as read and the following points were highlighted. There had been an increase in PMRT cases. To provide assurance, the majority of cases were graded A/B and actions for all cases were monitored and tracked and all data scrutinised. Meetings had also taken place with Worcester and as an MDT team tracking emerging themes. A review of the PMRT process had taken place which includes introduction of a new newsletter and themes. Birth outside of guidance is widely recognised as a National issue, and work is ongoing on both a regional and national level. Our local work is being led by our Consultant Midwife, Sarah Morris. In response to case reviews a number of actions have been commenced. Prevention of pre-term birth action plan is fully underway and overseen through QI Forum. Out of area grow chart change has now been fully implemented and embedded and is also auditing through Perinatal QI Forum. The Trust remains an outlier for obstetric haemorrhage. This is an ongoing quality improvement project which is embedding across the perinatal team and good feedback has been received from the team.	

	Training compliance remains above 90% in line with CNST standards. Saving babies lives version 3 is also on track to achieve full compliance. The CNO added that part of the obstetric haemorrhage quality improvement project relates to accurate measurement of blood loss and maybe why we are seeing more cases. However, a further cluster has been seen recently and need to make sure that cases are reviewed to ensure there is not a practice issue. It was confirmed that an increase had been seen as a result of the introduction of the new measures and more were being identified. There had not been a problem in management of haemorrhages but there had sometimes been a delay in recognition. Teams had been educated, and there has been an increase in the number of staff present when bleeding is ongoing. The use of measuring drapes has also been implemented to give a measure of the level of blood loss. The project is ongoing and will be closely monitored. The CNO also noted that the quality improvement work on pre-term pathway has been going on for some time and asked what the outcomes are from this work. Pre-term pathway improvement is a joint approach between midwives and doctors and ways of referral to the pathway have improved with better triaging and early referral and will be monitored closely. There is also collaboration with Worcester and meeting has been scheduled with the wider team. Grace Quantock (NED) asked if the development of a system wide strategy to address health inequalities had shown an impact and was it also possible to cross reference patient's experience and feeling unheard with health inequalities. Areas of deprivation and ethnicity are being looked at and that information would be brought back in a future report. The number of minutes by which the 30 minute standard was missed for Category 1 C-Sections would also be added to future reports. The CMO asked how the effectiveness of PROMPT and CTG training is monitored and what processes were in place to upskill and give confidence where issues in practice are identified. For PROMPT all scenarios have been Re-written for 2025 using real life scenarios. A 'So What' PROMPT team is also now in place. A gold standard run through of what good should look like also takes place with feedback each month. Also have shared training agendas with LMNS. It was noted that the main aim of PROMPT training is to improve teamwork but when staff are under pressure can have different reactions and, therefore had increased the number of emergency drills with follow up discussion to identify any weaknesses. The success of these hot de-briefs is creating psychological safety and enabling people to talk about how it felt for them and prevents escalations. Hot debriefs take place when	

	possible and the Patient Safety Midwife monitors and invites the group to a debrief. This also links in with the ongoing cultural work. CTG wellbeing study day is done annually and all the team are compliant. NICE criteria are followed but there are differing opinions. A clear skills drill has been set up and delivery suite co-ordinators have a theme for the week and carry out drills. The Governance team will review weekly. The ACMO for clinical support (consultant obstetrician) expressed his thanks for the presentation and wanted to reassure the Committee that he had participated in the new format of the PROMPT and it had been well received. The faculty is a multi-disciplinary team including Anaesthetists, Obstetricians, Midwifes and Theatre teams. There had been 2 main scenarios of massive haemorrhage.	
	<u>Resolved</u> – that **A. The perinatal safety update was received and noted.** **B. Information on areas of deprivation and ethnicity would added to future reports.** **C. The number of minutes by which the 30 minute standard was missed for Category 1 C-Sections would also be added to future reports.**	**CL/AS** **CL/AS**
QC07/12.24	**<u>CNST 10 COMPLIANCE SUBMISSION</u>**	
	The CNO gave an update on the CNST 10 compliance. The Board had delegated this to Quality Committee for sign off due to the timing of the submission to the incentive scheme. 10/10 standards of compliance have been achieved for which the Maternity and Neonatal teams should be congratulated. The LMNS have peer reviewed the evidence and assessment status. The CNO asked the Committee to recommend that the CEO sign the declaration that the trust is compliant and confirm LMNS review processes. The submission will also go to the LMNS Board which is scheduled to take place in the next few weeks. The committee recommend sign off for full compliance to NHSR	
	<u>Resolved</u> – that the Quality Committee agreed to recommend sign off full compliance to NHSR.	

QC08/01.25	**MATERNITY SURVEY REPORT**	
	The PQSM provided an overview of the CQC Maternity survey results: Following discussion at Quality Committee in December the results were shared amongst the maternity and obstetrics teams. The results were also shared in staff training. A Maternity Safety Summit has been arranged for the next quarter to address underlying cultural issues and to work as a team to find solutions and facilitate improvements. An action plan has been drafted in response to the survey: • Bring back MDT meetings • 'Walk in one another's shoes' – A life in the day of. • Re-launch communication tools that are tried and tested nationally also re-launch of SBARS. • A compliments and complaints newsletter to be produced every 6 months and will pull themes from debriefs. A number of women have given their consent to publish patient stories. All staff are engaged and need to have clear direction, the right culture and have a goal as a team. Have linked with the MMVP lead who is analysing and will link in with the team. Some cultural issues had been identified between teams and also midwives to patients and some cultural NHS training has been undertaken. The Consultant Obs & Gynae (clinical lead) added that the survey had been of women delivering in January and February 2024 and it had been disappointing to see the feedback that communication between doctors and midwives had been poor and this forms part of the planned cultural changes and will be addressed at the maternity summit. It is very important to avoid conflict in front of patients and civility is of greatest importance. To think about solutions and a plan to monitor progress over the next few months. Progress will be monitored by the CMO and CNO. This will become a quality improvement project and will sit with QI forum on a monthly basis. The Chair noted that this was an important area for consideration at Quality Committee and thanked both for their perspectives.	
	Resolved – that the Update on the Maternity Services Survey was received and noted.	

QC09/12.24	**QUALITY PRIORITY UPDATE – GET IT ON TIME CAMPAIGN FOR PARKINSON'S MEDICATIONS / HIGH RISK TME CRITICAL MEDS**	
	Raechel Wordsworth shared the data and gave an update on progress of the quality priority regarding critical medications. The reason for the data collection was a quality priority for the trust but is also in line with a National drive by Parkinson's UK. The data presented was from July-December 2024 and highlighted the large volumes of Parkinson's medications that had been administered over that timeframe with a very low number of missed doses and on a deeper dive of these very few true missed doses. A deep dive took place into those missed doses and through December showed there had been 8 missed doses affecting 5 patients on 4 wards. The percentage of medications on time every time showed improvement throughout 2024, with a particularly high increase in June. This was based on some education being delivered. Ward visits had helped the MSO to understand some of the issues in practice which showed that the majority of patients had received their medication on time but the nurse had not updated EPMA quickly enough. In December 2024 a deep dive into other critical medications took place, concentrating on diabetes and long acting insulin. Of a total 463 there were 5 missed doses. It was noted that self-administration is not being used on wards as much as it should be therefore questionnaires were given to staff asking why they do not use this. Nurses were not promoting this as they found it difficult as a function on EPMA and thought it to be time consuming. The action plan going forward is to have a focus group to support self-administration, not just for Parkinson's, but also for diabetes. It is planned to give more support to frailty wards and community hospitals to improve timing of critical medications and also work with the EPMA team to share education with nurses to help with deferred doses. There is also NMP focus and doctor's training to ensure that prescriptions are stopped correctly. Plans to continue links with Parkinson's Nurses and Parkinson's UK and continue to promote all critical medications using the medicines related guidelines which are available online. Will continue to do a deep dive into other critical medications as well as continuation of the Parkinson's data.	

	There had been some frustration previously regarding impact around change. Following visits to wards and community hospitals to try to understand the barriers there had been much more engagement and support from nursing staff. The committee were supportive of the new focus on other critical medications and going forward a focus on common themes such as self-administration was fully supported. It was felt that the issues with insulin were very different and the approach would depend on where they are arising, whether at the front door or after being on wards for a period of time either acute or at Community Hospitals. There was a question whether it would be possible to have a diabetes specialist nurse at the front door and also to improve culture and staff understanding of diabetes treatments and patients' own level of expertise and knowledge of their treatments. There had been positive progress and the Committee were appreciative of the hard work which had gone into achieving these improvements and there is an opportunity to refresh the quality priority for next year.	
	Resolved – that the Quality Priority update was received and noted.	
QC10/01.25	**QUALITY PRIORITY – ENSURE PATIENTS RECEIVE TIMELY VTE RISK ASSESSMENT IN LINE WITH NICE GUIDANCE**	
	The DCMO gave an update on progress of this quality priority. The quality priority for 2024-25 improvement plan for VTE assessment compliances which focussed on education and awareness. Supporting divisions to meet the target of 95%. The standard NHSE contract has been adjusted to a timeline of 14 hours from 24 hours. Achieving this will require further refinement of reporting mechanisms. The cohorts for inclusion have been reviewed and following revision of the data logic the Medical Division had showed some improvement in performance, this related to SDEC areas in hospital having been taken out of the logic, as agreed with NHSE. The Surgical Division had also showed great improvement and had been brought in line with medical performance. Education continues. Looking towards Maxims upgrade, though a date for this is yet to be confirmed. There is further work to do on Power BI dashboard and also on location and clinician reports.	

	National figures have been released – NHSE performance for Q1 and Q2 down to 89% nationally, noting that no region in the UK has hit 95%. Many places are having difficulty moving to 14 hours and there are also some issues due to paper reporting vs electronic. WVT does remain behind that national target but continues to improve. Further information from Power BI dashboard and Maxims support will help with further improvement. There was a lag to reporting of preventable thrombosis and information on that would be provided in the next report. Elective surgery was looked at to see if forms can be completed pre-op and signed off on admission. However, rules state this cannot be commenced before admission of patient. This has been raised with the MAXIMs team whether a work around is possible and are awaiting response. It was noted that this has been a problem in the surgical division for a considerable amount of time. There are some areas where compliance variable, particularly ENT and were hoping for a solution through pre-Op. On speaking to clinicians, compliance was better when there was a paper VTE form to complete. The problem with this is the time it takes to complete on the electronic system. Looking to see if this can be part of WHO checklist and are working through division to try to achieve those improvements. It was appreciated that the surgical division are trying very hard but that a sustainable solution is needed and support to get things enacted with Maxims team. There had been some progress although this was slower than would have liked.	
	Resolved – that the Quality Priority update be received and noted	
QC11/01.25	**DIVISIONAL QUARTERLY REPORT – SURGICAL DIVISION**	
	The DCN presented the quarterly report for the Surgical Division. There had been one new PSII for this period, the death of a patient on the ENT pathway. The Medical Examiner raised two concerns • Whether cancer could have been diagnosed earlier. • The patient had been lost to follow up and whether this was of significance. Rapid reviews have taken place and this is being investigated further. There are three open PSIs, one never event in Ophthalmology which is nearing conclusion.	

	There is focus to improve compliance in responding to complaints in a timely way and saw a 79% improvement in year. There are a total of 30 open complaints in the division. ITU peer review was undertaken in 2024 with some clear actions for improved practice which have progressed. 24 hour outreach is now well established and has reported to Deteriorating Patient Committee. Now seeing lower levels of admission to ITU and will continue to monitor the data to see if there is any correlation. The Neonatal Safety report was recently presented to LMNS board. Previously Quality Committee reporting had included some neonatal information but mainly focussed on maternity. To ensure the board have good understanding of all neonatal concerns, future reporting will include more neonatal information. The trusts response to the ED CQC report from 2023 was to aim to provide a 24 hour Paediatric Nurse within ED (12 hours previously) and since November 2024 Paediatric ED services has been the responsibility of the paediatric team. There had been a robust implementation plan, with senior nurses on the ward on call overnight to support ED and is now well embedded in practice. Acuity dependency piece of work in paediatric ED, continued to see high volumes of patients in that area and want to ensure the staffing model is correct. The trust is moving forward to adopt the National initiative, Martha's Law (also referred to as cause for concern) and are hoping to be in the second co-hort to commence. Having 24 hour outreach has been integral to ensuring this can be taken forward. It was important to recognise that ward colleagues will need to ask series of questions to patients every day in relation to their care and hope this will also support deteriorating patient work. The approach is that this will become part of 'business as usual' and will evidence that people have been asked about their care. It was noted that the first findings of early adopters show that it is making a difference for patients and treatment plans. There will be a national data set and a data return will be expected. There had been a number of Going the Extra Mile Awards in the Division. The Surgical Day Case hub has received excellent feedback from patients. There is some concern about dental services and there are a number of risks on the register. In particular, there are concerns around ageing and deteriorating equipment. There are no maintenance packages in place due to age and is becoming costly to repair which is impacting activity. This will be taken through business planning as concern.	

	Retention and recruitment of staff, particularly dentists, is difficult and there remain two vacancies for dentists in the community and a number for nursing staff. This is partly due to pay grade. Funding has been made available and, is going through a banding re-process to support recruitment and retention into the service. Of greatest concern is care of patients on Frome ward. There have always been good patient outcomes on the ward, and low sickness and agency rates. Following bed re-configuration in July the bed base increased to 35. And the ward takes all complex elective and emergency surgery and has a high level of boarding. Also complex medical patients which can be up to 12 but average of 4-8. The ward also house chest trauma and all medical and surgical patients who require central lines. This has had an impact on staff morale, sickness has increased 13% and levels of agency staffing has also increased due to sickness and additional boarding patients. The data set in report showed that this is also affecting patient care outcomes. A round table has taken place, Executive colleagues have been alerted and will be meeting with them. There are also some measures in place to support and improve patient outcomes. We have provided some restorative supervision for staff on the ward. Supporting with staffing levels with a Practice Educator often in numbers to be able to provide more support. There is also agreement to reduce boarding number to 5 and looking to re-evaluate bed re-configuration with query a transfer of beds to Redbrook. There is concern regarding compliance to the National Laparotomy audit. With just under half of cases being on the system. From April 2025 there will be a requirement to also add patients undergoing non-laparoscopic surgery. An appraisal will be undertaken and working through options but without additional resource to support it is unlikely that the trust will achieve the best practice tariff. The CNO noted that Frome ward accreditation/ peer review took place in November 2024 and was rated as ‘good’. She suggested a reflection on whether Frome had experienced an acute and rapid deterioration since that time or whether the peer review methodology need revision. It was noted that a there was a lot going well in the Division, the CMO asked for incidents and complaints themes and trends for future reports.	
	<u>Resolved</u> - that the quarterly report for Surgical Division be received and noted.	

QC12/01.25	**STAFFING REPORT**	
	The DCN presented the staffing report and highlighted the following areas. There continued to be high levels of attendance at ED and an increase in boarding patients. A new policy for escalation has been agreed including extreme boarding levels. More escalation areas have been used in month, including Medical Day Case. There is also an increase in beds in the community setting. There has been a slight increase in incidents related to staffing levels rather than skill mix. There has been an improvement in HCA staffing levels although turnover rate remains high. The Education Team are doing some work to improve the HCA induction programme and support in clinical practice. There was an increase in sickness in month with high incidences of colds and flu and also pregnancy related sickness. Agency spend had decreased in November and continues to do so although there was a slight increase in December by 3 wte. The main areas utilising agency staff being ED, community, frailty, Redbrook and Frome wards. There is ongoing work with the Regional agency reduction collaborative. Working with 46 trusts across the Midlands to get to NHSI cap rates for agency nurse usage. HCA and band 5 general nursing will be at capped rate by Monday 3rd February and specialist nurses due by end of March.	
	Resolved – that the staffing report be received and noted.	
QC13/01.25	**MORTALITY REPORT**	
	The Mortality report was taken as read.	
	Resolved – that the Mortality report was received and noted.	
QC14/01.25	**SAFEGUARDING QUARTERLY REPORTS**	
	The Named Nurse Children in Care, The Relief Approved Mental Health Professional for Community Wellbeing, Lead Nurse Adult Safeguarding and Specialist Nurse Advisor Safeguarding Children, presented the safeguarding updates. The reports were taken as read and the following points were highlighted: 14.1 Children in care The number of children placed into Herefordshire from other Local Authorities at end December 2024 there were 431 from other areas who are not visible within the recognised population of under 18s in	

	Herefordshire. This has impacted on all services, particularly Community Paediatrics due to the children's difficulties with trauma, and increased presentation for autism and ADHD and other neuro-diverse behaviours. There have been 106 health assessments between September and January for Herefordshire children, also 38 for children from other areas. There is a statutory requirement that initial health assessments should be done within 20 working days of a child becoming looked after. Work continues from WVT perspective to improve performance, once we receive notification of a CLA we push for medical consent from Local Authority as are unable to complete health assessments without that consent. A multi-agency task and finish group has been set up to improve the health journey and get initial health assessments completed. On the corporate parenting agenda is a robust chasing process for social workers which is well supported. Once medical consent is granted we are seeing children quickly and do see all children. Due to capacity issues across the country there are 112 children living out of area requiring initial health assessments. There is a lot outsourcing to GP practices for this. This will not be problem in terms of arranging assessments but are requesting payment before completion. We are working closely with ICB to get finance in place. 14.2 <u>Adult Safeguarding – Deep Dive Mental Capacity Act</u> A deep dive had taken place into MCA/DoLs related to SARs and DARDRs as requested by Quality Committee. The MCA Lead has reviewed 5 SARS and 2 DARDRs. There is awareness in staff to following the Principles for Mental Capacity Act but that it is not always documented well. This is an important aspect of the process and a lot of work is to be done promoting recording best interest decision making. Supplementary training has been revised and takes place on a monthly basis. This is now a session on mental capacity and best interest decision making, Incorporating learning around capacity and consent, what to do when patient is refusing and their capacity is in doubt, how to make lawful decisions and best practice in assessing capacity. A mental capacity assessment template and best interest check list have also been developed and looking to revise those templates and produce a guide/checklist for staff to go along side to help with completion of forms. Alongside this have also undertaken an audit of the Mental Capacity Act which is now coming to an end. It has shown similar findings to the SAR deep dive and is also in line with national findings. There will be continued education and feedback provided to staff and also looking at e-learning to see if there may be scope to add extra modules. Going forward there will be monthly audits which can be fed back to staff.	

	The Chair, having read the report, noted that it was reassuring that there were no new issues of note and that there had been a long standing issue with the audit process and it was noted that having a monthly audit feeding into an annual summary had been well received by staff and was a positive step for the future. The CNO added that that at the Safety in Synch meeting it had been discussed that many agencies are struggling with the application of the Mental Capacity Act in practice and there was an appetite to bring together teams to increase training capacity. The CNO wanted to reassure colleagues in relation to the reference around the mental capacity template not being in line with the law and confirmed that this is 'new' case law and therefore not a risk and will be revised now the case law has passed. It was noted that there had been a case recently where there had been an example of good practice in the diabetes team regarding a gentleman lacking capacity managing diabetes. Several meetings had taken place, making best interest decisions for him. Keeping his wishes at the centre of our decision making, worked towards decision which was least restrictive for the patient. 14.3 Adult Safeguarding Continue to see high levels of safeguarding referrals and DoLs applications. A deep dive was done into inconsistencies in applications for the standard of DoLs , following this we have seen significant improvement. The Domestic Abuse Lead is progressing with new ideas and referrals are high, however there still room for improvement. More training is planned for ED to provide front door practitioners advice on what to do when patients present to ED. Adult policy is in place and the team continue to have very good relationships with partner agencies. There have been difficulties to provide training to District Nurses which has been escalated. From Domestic homicide reviews it is identified that District Nurses would benefit from additional training. There has been some feedback that staff are having difficulties contacting the Safeguarding Team and it was noted that staff do have contacts for the local authority adult safeguarding team and a new professionals line in hours and also an out of hours on call duty team. Level 3 and Board level Adult Safeguarding training is planned to take place in April. There is an area of concern to look at with the local authority regarding urgent DoLs extensions. When a person comes to hospital and is deemed to lack capacity there is a 7 day DoLs authorisation which can be extended	

for further 7 days if necessary. There have been instances when we have not been notified that a patient is going to be in hospital for longer than 7 days and we do not always apply for extensions. This is common for all hospitals and Shropshire, Worcestershire and Powys Local Authorities are requesting to do the DoLs extension at the same time as an urgent request is put in. There are ongoing discussions with the LA and safeguarding teams and this may be considered in the future for Herefordshire.

There had been high levels of rapid reviews SARs and DHRs. For quarter three there had been one rapid review. There is ongoing review of how these are reported and investigated.

14.4 Children's Safeguarding

Health Visitors and school nurses have attended 100% of initial child protection conferences.

There was some concern that Health Visitor supervision rates had reduced in the last quarter to 50%. However, in this quarter it had risen to 82% and would have been higher but some sessions had cancelled due to ill health.

Community midwifery supervision rate remains high at 100%

Training compliance remains above WVT minimum. A training satisfaction survey provided positive feedback regarding training provided but had identified the need for face to face sessions.

A member of the Safeguarding team has been leading on the new 'Keep me safe strategy' increasing multi agency responsibility to 'Keep me safe when sleeping' and 'Keep me safe when crying' and 'Keep me safe around dogs' which will launch next quarter and includes all mutli-agency partners in Herefordshire.

There has been a positive impact in MASH since the increase of B7 Specialist Practitioner alongside B6 MASH Practitioner has allowed greater input into multi agency audit case reviews and learning from referrals. This is disseminated through Child Safeguarding forums.

There has been an increase in quality of referrals into Children's Services from ED since November from Paediatric Assessment Unit in ED which is now 24 hours.

Implementation of domestic abuse alerts for children has enabled identification of children at risk of domestic abuse as well as adults.

The number of children with protection plans had continued to decrease to 146 and had been 164. This does fit with the improvement plan for Children's Services to identify support needed by children to be put on to child protection plans but should also be viewed with caution to ensure children and young people receive the right support.

	There had been a decrease in attendance of School Nurses at supervision which had dropped to 50%. This has been raised with service leads and will be implementing quarterly group supervisions for school nurses to attend alongside individual supervision if they wish. Compliance ED L3 training had decreased to 68% but this risk is mitigated by paediatric assessment run by paediatric staff and compliance was at 94%. The action from the Section 11 audit regarding safer recruitment had not been progressed although do have safer recruitment policy and training is offered. Had been given reassurance by the paediatric department that they are following the policy and staff are attending training which ensures that at least one member of each interview panel has received training. However, we do not have data to provide that assurance. A meeting is to take place between Safeguarding and HR to address this. There had been an increase in the number of escalations from maternity safeguarding leads which correlated with the Local Authority having stopped the Pre-birth Panel. After recent escalations made by WVT the LA have agreed to re-start the panel, and this multi-agency work will reduce the number of escalations.	
	Resolved – that the Safeguarding Quarterly Reports be received and noted.	
QC15/01.25	**URGENT AND EMERGENCY CARE SURVEY RESULTS**	
	The ED Matron gave the key highlights from the Urgent and Emergency Care survey. WVT had the highest number of participants in Foundation Group and response rate of 33%. Results were better than expected regarding information staff are giving to patients while waiting. Results were worse than expected regarding discharge process. Also worse than expected was privacy. There is a challenge in the department due to giving care in corridors and having clinical conversations in chairs. Thematic analysis was really useful and overall there were positive comments about staff and all staff are doing their best in difficult circumstances. A robust action plan is place which highlights 5 areas to be addressed. Internally there are some processes in need of review. Privacy is difficult but need to review the use of spaces and also to highlight the impact of overcrowding on staff as well as patients.	

	Within the Foundation Group SWFT had improved most overall and will liaise within them to see what can be done to show improvement at WVT. The MD noted that a hugely congested ED is very difficult for both staff and patients but that there were things not due to environment that are within our gift and that kindness, civility and communication were particularly important. The CNO had also had the opportunity to talk to number of staff recently who have accessed ED either as patient or family member and will provide thematic feedback to the team.	
	Resolved – that the Urgent and Emergency Care Survey Results were received and noted.	
QC16/01.25	**QUALITY PRIORITY – REDUCTION OPF GRADE II PRESSURE ULCERS**	
	The ACAHP gave an update on the progress of the quality priority. A slight improvement in category II pressure ulcers is being recorded around the trust but it is felt to be important to keep this as a quality priority for next year. The report provided details of incidence of category 2 pressure ulcers in frailty, community hospitals, district nursing and divisions. There is most concern about incidents reported in District Nursing however, a new Matron is in place in District Nursing. A review of reported incidents showed that on 55% of cases had been categorised correctly. Which has led to staff training to understand how to categorise skin damage. Information on improvement will be brought to Quality Committee quarterly and will also be included in the Divisional report. The improvement plans will also be presented to Pressure Ulcer Panel in February. Integrated Care and Medical Divisions are giving most focus to pressure ulcers as less prevalent in Surgical areas.	
	Resolved – that the Quality Priority update be received and noted.	
	INFECTION PREVENTION COMMITTEE SUMMARY REPORT	
	The Infection Prevention Committee summary report was taken as read	
QC17/01.25	**ANY OTHER BUSINESS**	
	The boarding and PSIRF reports would be taken as read and reported at the next meeting.	
QC18/01.25	**DATE OF NEXT MEETING** The next meeting is due to be held on 27 February 2025 at 1.00 - 4.00 pm via MS Teams.	

Report to:	**Public Board**
Date of Meeting:	**03/04/2025**
Title of Report:	Charity Trustee Summary Report 12 December 2024
Lead Executive Director:	Choose an item.
Author:	Grace Quantock, Chair of Charity Trustee/NED
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To brief the Board on the main issues arising from the Charity Trustee held on 12 December 2024.

Recommended Actions required by Board or Committee

To receive the report.

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.

Charitable Funds Committee Report
December 12, 2024

Matters for Noting

1. **2023/24 Audited Accounts**: The Committee reviewed and approved the audited accounts for the financial year 2023/24. The independent examination has been completed with no changes to the previously discussed accounts. The Management Representation Letter was endorsed for submission to the Charity Commission ahead of the deadline. An action was noted to review meeting attendance on page 6 of the accounts, specifically to correct Nicola Twigg being listed twice.

2. **Appointment of Independent Examiner/External Audit**: The level of audit required for 2024/25 will depend on whether income exceeds the £1m threshold, which remains uncertain pending receipt of education fundraising income. Quotes have been requested for both an independent examination and a full audit. A detailed proposal will be prepared, and offline approval may be required depending on timing.

3. **Quarter 2 Financial Position 2024/25**: Income for the first half of the year totalled £153k, with expenditure outweighing income at £240k. Overall funds have reduced by £86k. The majority of funds are held as restricted, with unrestricted funds of £0.2m. The £550k agreed for the Education Centre is not yet reflected in these figures.

4. **Fundraising Updates:**
- Maternity Bereavement Garden: The project is nearly complete with only a small amount of work outstanding. There are remaining funds from the project that will be directed towards the PETALS counselling service. An offer has been received to host a Charity Ball in February with a free venue.

- Contactless Giving Machine: The machine has been relocated within the Trust but is not performing as well as anticipated, except during Baby Loss Awareness Week. Plans are in place to make it more eye-catching and involve volunteers to direct the public to it. Compensation has been secured due to inactivity caused by connectivity issues.

- Education Centre: Focus is on Charitable Trusts which will be the main stay of the fundraising. Potential donations amount to approximately £1.1m to £1.2m towards the £1.5m target. The Strategic Fundraising Meeting has agreed to end the Fundraising Campaign Director secondment, with thanks given to Alison Bolton for her work. Alternative approaches are being reviewed to advance the fundraising efforts.

- Staff Lottery: The staff lottery continues to be extremely popular, with the monthly prize draw reaching £750 tax-free.

5. **VAT Relief:** It was confirmed that VAT relief applies when charitable funds are used to purchase medical equipment, making this the preferred approach to maximise the value of charitable funds.

6. **Other Business:** An update was requested on Education Centre discussion with the council. It was noted that promised information had not been received as it was still being worked on. A meeting has taken place with David Moon who is meeting with NHS England about the scheme.

Matters for Escalation

None.

WYE VALLEY NHS TRUST

Minutes of the Charity Trustee
Held on 12th December 2024
Via MS Teams

Present:

Grace Quantock	GQ	Non-Executive Director and Chair (NED)
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Glen Burley	GB	Chief Executive
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director
Kieran Lappin	LK	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
Gwenny Scott	GS	Company Secretary, Associate Director of Corporate Governance

In attendance:

Katie Farmer	KF	Charity Fundraiser
Heather Moreton	HM	Associate Chief Finance Officer
Vicky Brownbridge	VB	Executive Assistant – For the minutes

Minute		Action
CT01/12.24	**Apologies for Absence**	
	Apologies were received from: Chizo Agwu, Chief Medical Officer, Sharon Hill, Non-Executive Director, Andrew Parker, Chief Operating Officer, Jo Rouse, Associate Non-Executive Director, Russell Hardy, Trust Chairman, Nicola Twigg, Non-Executive Director.	
CT02/12.24	**Quorum**	
	The meeting was quorate.	
CT03/12.24	**Declarations of Interest**	
	There were no new declarations of interest.	
CT04/12.24	**Minutes of the meeting held on 19th September 2024**	
	The minutes of the meeting held on 19th September 2024 were agreed as an accurate record of the meeting and signed by the Chair	
	Resolved – that the minutes of the meeting held on 19th September 2024 be received and approved.	

CT05/12.24	**Matters Arising and Action Log**	
	All actions were reviewed and updated.	
	Resolved – that the action log updates be received and noted	
CT06/12.24	**ITEMS FOR REVIEW AND ASSURANCE**	
	6.1 2023/24 Audited Accounts for approval and 2023/24 Management Representation Letter for approval The Associate Chief Finance Officer, Heather Moreton (HM), took the paper as read and advised that the independent examination of the accounts had taken place and there were no changes to the previous accounts discussed. It was proposed to approve the sign off of the management representation letter and submit to the Charity Commission a month early. This proposal was endorsed by the Trustees. The Non-Executive Director, Kieran Lappin, (KL) pointed out a necessary change to be made in the report. Page 6 lists Nicola Twigg twice. This will be looked into and amended. **ACTION** **5.2 Quarter 2 Charitable Funds Finance Report** Heather Moreton (HM) presented the Quarter 2 Charitable Funds Finance Report. The report was taken as read and the following points were highlighted: Income remains lower for the first half of the year at £153k. Expenditure outweighed income at £240k for the first six months but overall funds have reduced by £86k. The £550k agreed for the Education Centre isn't reflected in reports yet. The majority of funds are held in restricted, with unrestricted funds of £0.2 m. The Chief Executive, Glen Burley (GB), queried the level of audit required and the threshold of £1m and whether there are clear plans on utilisation of funds going forward. The importance to encourage expenditure in those areas was stressed. There was agreement active work is ongoing to use Charitable Trust funds, however the meeting does not currently have sight of these. The Charity Fundraiser, Katie Farmer (KF) raised the Oncology Trust Fund meet quarterly so, moving forward, it might be a plan to report back to Heather so this meeting has sight of expenditure plans. The Chief Finance Officer, Katie Osmond (KO), clarified the level of audit depends on funds received in the year rather than accumulated balances.	**HM**

Kieran Lappin (KL) asked if VAT relief applied if charitable funds were used to buy medical equipment. It was confirmed that this is the case and this would therefore be the preferred way to maximise charitable funds monies.

5.3 Appointment of Independent Examination / External Audit

Heather Moreton (HM) provided a verbal update that currently funds are under £1m and the income in the year dictates whether a full audit or just an independent examination is required. It is not sure whether that threshold will be reached as yet, depending on when the education fundraising comes in, and it is therefore uncertain which type of audit will be required. Quotes have been asked for both and a paper is being put together, offline approval may be required depending on timing.

5.4 Fundraising Update

The Charity Fundraiser, Katie Farmer (KF) gave an update on fundraising. The pre-circulated report was taken as read and the following key points were noted:

The Maternity Bereavement Garden is nearly finished with a small amount of work outstanding. There is money left over from the project for Petals. It was noted that there has been an offer to host a Charity Ball in February with a free venue.

There has been discussion between WVT, SWFT, GEH and WAHT around the contactless giving machines and everyone is in agreement the machines are not doing as well as anticipated. The contactless giving machine at WVT has been moved to a different location where it proved more successful during Baby Loss Awareness Week but not so since. There is a plan to make it more eye catching and to link in with volunteers in the foyer to signpost the public to the machine.

Katie Farmer (KF) advised there has been negotiation for reimbursement due to inactivity caused by connectivity issues with the contactless giving machine. It has been agreed that the Charity will receive compensation.

The Chief Strategy and Planning Officer, Alan Dawson (AD) took the report as read and provided further update.

Following on from the Chairman's Lunch focus is on Charitable Trusts which will be the main stay of the fundraising. Donations potentially amount to around £1.1 to £1.2m of the £1.5m target.

Alan Dawson (AD) advised that it had been agreed at the Strategic Fundraising Meeting to end the Fundraising Campaign Director secondment. Thanks were given to Alison Bolton for the work that has been undertaken to get to this point.

	Alternative approaches are now being reviewed to take fundraising to the next level. The staff lottery continues to prove to be incredibly popular with the monthly prize draw this month being £750 tax free.	
	<u>Resolved</u> – that: **(A) The finance and fundraising updates be received and noted.** **(B) The proposal for approval to sign off the Representation Letter was ENDORSED.** **(C) To review meeting attendance on page 6 of the 2023/24 Audited Accounts to ensure correct meeting attendance.**	
CT07/12.24	**<u>Any Other Business</u>**	
	The Non-Executive Director and Chair, Grace Quantock (GQ) asked whether there was an update on issues with the Council. Alan Dawson (AD) advised that the promised information had not been received as it was still being worked on. There has been a meeting with David Moon who is meeting with NHS England about the scheme. Thanks were expressed by the Committee to Alison Bolton for the work undertaken in her role as Fundraising Campaign Director.	
CT08/12.24	**<u>Date of next meeting</u>**	
	The next meeting is due to be held on 13th March 2025, 1300, via MS Teams	

Escalation and Assurance Report

Report from: Integrated Care Executive
Date of meeting: 11 February and 11 March 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 (BCF)**
Rating rationale	The month 9 position had been revised following reconciliation of social care pay costs, resulting in an overall underspend of £0.92m. This was driven by an underspend in social work and social care workforce which offset a considerable overspend on hospital discharge. The overspend issues were therefore mitigated but remained a concern given low occupancy rates. Additional occupancy data from LICU and HS would enable further analysis. At month 10 the forecast was an overspend of £0.121m, a deterioration of £0.007m compared to the month 9 forecast. **Planning for 2025/26** Planning guidance, policy framework and allocations for the BCF had been published. The total allocation had increased very little, which caused a potential cost pressure of c£1.1m. There were potential mitigations to reduce this, which would require further discussion. A One Herefordshire Strategy session at the end of March would consider the 10 year plan.
Outcome	Data on cost per care day/hour would be provided alongside outcomes data to aid an understanding of where best value for money could be gained.
Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Urgent Community Response (UCR)**
Rating rationale	Referrals had increased and the number of admissions avoided as a result continued on an upward trajectory. 88.5% were seen within target time. Analysis of data about referrals that met exclusion criteria and rejected referrals was helping inform the development of plans for referrals to the new diagnostic centre. Engagement with the Welsh ambulance service continued and barriers to improvement would be part of planned summit.
Outcome	The Committee was assured by progress
Item/Topic	**Discharge to Assess (D2A)**
Rating rationale	An independent review had provided focus and a recovery plan had been agreed following a summit with system partners in February. There had been sustained improvement in pathway one with very few delays. The summit would consider how this was being achieved and the value for money. Occupancy in Hillside beds had increased but LICU remained an issue; proposals regarding capacity and the staffing model were under review. A demand and capacity review had been undertaken to inform a business case for additional therapists. Cost savings elsewhere would be identified to provide the funding needed. In February the lowest number of bed days lost due to Herefordshire delays since August 2023 was achieved but Powys delays remained an issue. A summit had been arranged with Powys system leaders to develop an understanding of discharge delays. D2A continued to have a significant impact on reducing ED attendances and ambulance numbers. There were learning opportunities with Worcester on a single point of access, which would be considered.
Outcome	The Committee was assured by progress and plans to improve processes and cost.

Escalation and Assurance Report

Report from: Integrated Care Executive
Date of meeting: 11 February and 11 March 2025
Report to: Wye Valley NHS Trust Board and One Herefordshire Partnership

Item/Topic	Virtual Ward
Rating rationale	The team was engaging with surgical and medical teams to agree criteria to increase their virtual ward occupancy. An audit of hospital ward occupancy identified only one patient appropriate for virtual ward. A review of length of stay on virtual wars was positive overall. The final five surgical beds of the expansion would open shortly and were likely to be used by gastroenterology. Readmission data had been reviewed against benchmark data from other virtual wards, which indicated reasonable Trust performance but a potential need to reconfigure the number of beds per speciality.
Outcome	The Committee was assured regarding progress and the creative approaches being taken.

Advise: Items received for information or approval	
Item/Topic	**Falls Service**
Summary	The service would be taken on by WVT on as an interim solution while the ICB led a procurement process. The revised MOU describing the arrangement would be presented at the next meeting for approval.
Outcome	Noted

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