PUBLIC BOARD MEETING

Thu 05 June 2025, 13:00 - 15:15

MS TEAMS

Agenda

13:00 - 13:05
5 min

1. Going the Extra Mile Award Winners Quarter 4 2024/25

Russell Hardy

1.1. Team of the Quarter – Cath Lab Team

1.2. Employee of the Quarter – Dan Fearn

13:05 - 13:06
1 min

2. Apologies for Absence

Russell Hardy

13:06 - 13:07
1 min

3. Declarations of Interest

Russell Hardy

13:07 - 13:08
1 min

4. Minutes of the Meeting held on the 3 April 2025

Decision *Russell Hardy*

4. PUBLIC BOARD MINUTES - APRIL 2025 LF.pdf (7 pages)

13:08 - 13:10
2 min

5. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

5. PUBLIC BOARD ACTION LOG - JUNE 2025.pdf (1 pages)

13:10 - 13:30
20 min

6. PFI Performance Issues

Discussion *Alan Dawson*

6. 20250605 PFI Performance Paper v2.pdf (3 pages)

13:30 - 14:05
35 min

7. Items for Review and Assurance

7.1. Chief Executive's Report

Discussion *Stephen Collman*

7.1 WVT CEO Board Report June 2025.pdf (5 pages)

7.2. Integrated Performance Report

Discussion *Jane Ives*

7.2 WVT IPR 01 April 25 (004).pdf (25 pages)

7.2.1. Quality (including Mortality / Learning from Deaths)

Discussion *Lucy Flanagan/Chizo Agwu*

7.2.2. Activity Performance

Discussion *Andy Parker*

7.2.3. Workforce

Discussion *Geoffrey Etule*

7.2.4. Finance Performance

Discussion *Katie Osmond*

7.3. Use of the Trust Seal

Discussion *Gwenny Scott*

7.3 05-06-2025 - Use of Trust Seal~v1.pdf (1 pages)

14:05 - 14:20
15 min

8. Items For Approval

8.1. Board Assurance Framework and Risk Appetite Report

Decision *Gwenny Scott*

8.1. BAF and Risk Cover Report June 2025.pdf (1 pages)
8.1a. Board Assurance Framework Report to Trust Board June 2025.pdf (6 pages)
8.1b. ERMC Escalation & Assurance Report May 2025.pdf (2 pages)

8.2. Trust Annual Quality Account 2024-25

Decision *Lucy Flanagan*

8.2 Quality Accounts FS.pdf (1 pages)
8.2a QA2024-25 draft.V1.6.pdf (85 pages)

8.3. Herefordshire and Worcestershire NHS Five Year Joint Forward Plan update for 2025/26

Decision *Alan Dawson*

8.3 20250605 JFP Board Cov Paper.pdf (3 pages)
8.3a HW JFP 2025 refresh_combined FINAL.pdf (89 pages)

8.4. Emergency Preparedness, Resilience and Response (EPRR)Annual Report

Decision *Sean Smith*

8.4 EPRR ANNUAL REPORT.pdf (11 pages)

8.5. 25/26 Operational / Financial Plan and Budgets

Decision *Katie Osmond*

8.5 2526 final plan_budgets_board paper_Final (1).pdf (10 pages)

14:20 - 15:05
45 min

9. Items for Noting and Information

9.1. Powys Elective Commissioning Intentions

Information *Katie Osmond / Andy Parker*

9.1 Powys Commissioning Paper_v4.pdf (2 pages)

9.2. Freedom to Speak Up Annual Report

Discussion *Jo Sandford*

9.2 FTSU Annual Report 2024-25 (002) - FINAL.pdf (7 pages)

9.3. Patient Experience Quarterly Report

Assurance *Lucy Flanagan*

9.3 Patient Experience Report May 2025 Board version.pdf (15 pages)

9.4. Committee Summary Reports and Minutes

9.4.1. Audit Committee Report 15 May 2025

Discussion *Nicola Twigg*

9.4.1 Audit Committee Escalation & Assurance Report 15 May 2025.pdf (2 pages)

9.4.2. Foundation Group Board Minutes and Action Log 7 May 2025

Discussion *Russell Hardy*

9.4.2 Draft Public FGB Minutes - 7 May 2025 v2.pdf (13 pages)
9.4.2a Public FGB Matters Arising and Actions Update Report.pdf (1 pages)

9.4.3. Quality Committee Report and Minutes 27 February 2025

Discussion *Ian James*

9.4.3 Quality Committee Summary Report February 2025 Public.pdf (2 pages)
9.4.3a Quality Committee Minutes February 2025.pdf (17 pages)

9.4.4. Integrated Care Executive Update Report - April 2025

Discussion *Gwenny Scott*

9.4.4 ICE Escalation & Assurance Report May 2025.pdf (1 pages)

9.5. Perinatal Safety Report

Assurance *Lucy Flanagan*

9.5 Perinatal Safety Report Board version April 2025 LF 2.pdf (14 pages)

15:05 - 15:10
5 min

10. Any Other Business

15:10 - 15:15
5 min

11. Questions from Members of the Public

Russell Hardy

15:15 - 15:15

12. Acronyms

0 min

Z Acronyms - updated 07.06.24.pdf (3 pages)

15:15 - 15:15
0 min

13. Date of Next Meeting

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

WYE VALLEY NHS TRUST
Minutes of the Public Board Meeting
Held on 3 April 2025 at 1.00 pm – 2.30 pm
Live Streamed

Present (Voting):		
Frances Martin	FM	Non-Executive Director and Meeting Chair
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Ian James	IJ	Non-Executive Director
Katie Osmond	KO	Chief Finance Officer
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
Present (Non Voting):		
Ellie Bulmer	EB	Associate Non-Executive Director
Stephen Collman	SC	Acting Chief Executive
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Kieran Lappin	KL	Associate Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Gwenny Scott	GS	Associate Director of Corporate Governance
In Attendance:		
Sarah Assinder	SA	Associate Chief Operating Officer, Integrated Care Division
Val Jones	VJ	Executive Assistant for the minutes
Apologies		
Glen Burley	GB	Chief Executive (Voting)
Russell Hardy	RH	Chairman (Voting)
Sharon Hill	SH	Non-Executive Director (Voting)
Andy Parker	AP	Chief Operating Officer (Voting)

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**FM**	**Information**	**Verbal**
Noted as above. FM advised that GB has taken over the role as National Financial Reset and Accountability Director. SC will be the Acting CEO for Wye Valley Trust during this period. JI will continue as the Managing Director.				
1.1	**Quorum and Declarations of interest**	**FM**	**Information**	**Verbal**
The Board was quorate and there were no new declarations received.				
2.	**Minutes of meeting on 6 March 2025**	**FM**	**Approval**	**Enclosure 1**
To change BOD08/03.25 - Integrated Performance Report – morality to mortality. Approved.				

3.	**Matters Arising and Action Log**	**FM**	**Information**	**Enclosure 2**
All actions in the log were completed.				
4.	**Managing Directors Report**	**JI**	**Information**	**Enclosure 3**

We are currently in a rapidly changing environment. We had the NHS reset a few weeks ago with changes to the NHSE and around the top team. There is a rapid change approach to the scale of the challenge nationally and regionally. JI highlighted some of the key contents of the letter received from Jim Mackey (new transitional NHSE CEO).

The national deficit was planned at £6.6bn but with the work carried out has enabled this to be reduced to £300m. Our own forecast plan is part of this. This shows the significant scale of challenge we have along with the rest of the NHS. Last year we delivered about 4% of our CPIP, half of which was non-recurrent. This year we have set a target of 6% with around 80% of this recurrent.

The letter also talked about the intention to move the NHS away from deficit support back to a fair share approach. In Herefordshire we have an issue around rurality and we now have around £14m and are expecting more from the Welsh Commissioners to support this rurality challenge. These changes equate to our £100m our System will lose over the next time period (to be agreed).

The letter set out the changes expected from the ICB with their reduction of funding by 50% to move into a more strategic commissioning role. The issues that they currently deal with will move to NHSE and then the Department Of Health as they move into this new structure. There is a requirement to reduce any corporate cost growth over the last few years by 50%. We will be accelerating some areas we are working on across the Foundation Group.

There is also a suggestion that there will not be a cap in elective activity but this needs to be agreed with Commissioners. Our Activity Plan means that we deliver the national target within the budgets we have set out. We have been notified from our Welsh Commissioners that from Quarter 2 they are expecting Welsh patients to be treated by the Welsh standards- a maximum of 52 weeks for Outpatients and 104 weeks for routine Inpatients. This is a long way from the English standards where there is a 52 week expectation by the end of next year.

National Staff Survey – We have further improved on our strong position. The positive feedback around managers in particular shows how strong staff feel about their leadership and management team. We will continue to work on improving our experience for staff.

Working with Partners in One Herefordshire – The One Herefordshire Partnership has been going for 4 years now. Our 4th Annual Review was held last week with a positive meeting where we reviewed our position and set out our ambitions for next year. The Neighbourhood Guidelines are included in the report. Two of the shifts in the NHS Plan are around treatment to prevention and Acute to Community Services. We need to work closely with our Primary Care colleagues to be able to deliver this and this will be part of our plan for this year. Urgent and emergency are part of how we reduce this.

The Board accepted the Managing Directors Report.

5.	**INTEGRATED PERFORMANCE REPORT**	**JI**	**Assurance**	**Enclosure 4**

The Trust and Quality Objectives for this coming year are on the agenda today. Urgent Care, Emergency Medicine and over capacity continue to be our biggest problems in relation to performance and financially. We have reviewed our increase in emergency demand with our One Herefordshire partners which has increased by 15% for admissions over the last 2 years for patients aged over 65 years. The approach of work with partners and internally will be about how we reduce this number. We are supporting people to prevent them becoming ill or to provide more care at home and less in the Acute setting.

Theatre utilisation is improving with a sustained improvement for February at 82% - our target is 85%. If our Ophthalmology numbers improved, we would achieve 85%. A Speciality Review with Ophthalmology is being undertaken to review what we need to do to improve utilisation.

Health Care Support Workers – Good progress is being made to improve turnover rates with a number of interventions. We are keen to understand why this has reduced again.

Waiting times are significantly down, cancer times are improving and mortality rates are down along with a good Staff Survey but there are still a number of challenges to face over the coming year.

The Board accepted the Integrated Performance Report.

6.	QUALITY (INCLUDING MORTALITY)	LF/CA	Assurance	Enclosure 4

LF advised that Ross Community Hospital has had an ongoing outbreak of CPE since last year. As a Trust, we are under intensive support from NHSE. Last month, NHSE and the ICB undertook an assurance visit where they were able to lift the Outbreak Status. They saw good improvement in environmental cleanliness and infection prevention. They singled out the Lead Of Ross Community Hospital for her leadership to introduce these improvements. We are now in a monitoring phase and hope to be able to close this down by the end of May.

The report includes the high level results from the Patient led Environment Assessment published in February. We have included national benchmarking and where we feature in relation to this but we need a more detailed analysis. We need to understand why we have deteriorated from last year with Ross and Leominster Community Hospitals. We will be focusing on 3 domains where we need to make improvement – privacy, dignity and wellbeing and dementia and disability. Some of the issues are around our estate, eg accessible toilets, Prayer Rooms and quiet spaces for patients and relatives in each area. We are not able to address all of these issues due to the limitations of our estate but will focus on those that we can.

PLACE Results – Food scores have improved but further work is needed. We are aware and are working on improving this in partnership with Sodexo.

We have set our Quality Priorities for the forthcoming year. These were shared at Quality Committee in draft at their February meeting and again last month. Some are a refresh of last year's priorities with a change of focus and scope and some are new – the Diabetes Safety Priority is new for the Trust. Diabetes is complex and safety is vitally important. The new Diabetes Safety Forum has set its Terms Of Reference. Improvement is needed around food and we have a Quality Priority around this. Following the successful focus on Parkinson's as a time critical medication, we are now moving onto other time critical medications. We are also focussing on the transition for children to adult services. A Workshop was held this morning around volunteers and their expansion in the organisation.

CA advised that our SHMI remains stable at 100. Our observed and expected deaths are similar in our care which is positive.

Outlier Groups – We have seen an improvement in our Fractured Neck of Femur patients. Further work is required but the Quality Priority is assisting with this. There has also been improvement in our Sepsis and Stroke numbers where our SHMI is less than 100, ie less than expected deaths in our service. Our perinatal mortality remains high at 6.8. Last month we saw a reduction in our stillbirth rate. All deaths are subject to internal and external scrutiny. We are working on the Quality Priority especially around prediction of preterm and growth charts.

IJ (Chair of the Quality Committee and NED) advised that the PLACE audit results were discussed in detail at the Quality Committee meeting held last week. He went on to congratulate Bromyard Community Hospital who improved their scores in all domains.

FM noted that we have over 100 volunteers currently with opportunities in every area of the Trust. We are revising the way someone can become a volunteer with more proactive approaches through the media shortly to show members of the public how they can help and support local services.

The Board accepted the Quality (including Mortality) Report.

7.	ACTIVITY PERFORMANCE	SA	Assurance	Enclosure 4

Teams are providing services outside of the hospital site but it is important that they are part of the Trust to reduce demand in the Acute. The Community Referral Hub (CRH) was expanded last November with a GP available 12 hours a day, 365 days a year. They are co-located with CRH staff on site. West Midlands Ambulance Service Paramedics are able to directly contact the GP for clinical conversations to discuss if it is appropriate to bring a patient into the Emergency Department (ED). If it is appropriate to keep the patient at home, a suitable person is sent within 2 hours to access and either send in for diagnostics and be sent home or admit if that is required.

The Virtual Ward has been expanded with consistent occupancy. We are now able to admit surgical specialities.

We are still dealing with a congested ED and having to use temporary escalation areas. We are looking at 2025/26 plans to see what further we can do to improve and decongest. This includes looking at an ambulatory space with same day discharge, details are included in the report. Staff are also working on internal patient flow to ensure that every morning we can get everything in place to discharge patients home by lunchtime.

We are working closely with the Local Authority regarding Discharge Pathways. There have been significant improvements in patients being delayed waiting to be discharged. The focus is now on Powys patients who wait longer than Herefordshire patients.

Elective Productivity – A lot of work has been done around maximising lists on Theatre sessions to improve productivity.

The Board accepted the Activity Performance Report.

8.	**WORKFORCE**	**GS**	**Assurance**	**Enclosure 4**

We are seeing a reduction in sickness absence. We are revising the Absence Policy to ensure more impact on the actions that we are bringing in. Our plan is to support employees whilst reducing sickness absence to below 4%.

Operational Planning Guidance 2025/26 – We are ramping up efforts to roll out E-rostering to all medical groups. This is a key element to optimise our workforce.

April is Stress Awareness Month – This is about leading with care and compassion to ensure that we are looking after our employees.

There is concern over our Health Care Support Worker turnover, hence we are analysing the results. Intelligence through Exit Interviews shows that Line Managers are not offering enough pastoral care support during the first few month. Line Managers are experiencing operational pressures on their capacity but we are speaking with Divisional Leads to ensure that they make time for this key staff group. We are also actively working with our Practice Education Leads.

Staff Survey – We are very proud of our good results. This shows the efforts put in by Human Resources and Organisational Development leadership is having a positive effect.

The Board accepted the Workforce Report.

9.	**FINANCE**	**KO**	**Assurance**	**Enclosure 4**

Month 11 – The focus is working through the national Planning Guidance for 2025/26. This will be discussed in more detail in the Private Board meeting.

Year to date we have an adverse variance of £8.4m with a CPIP saving of just under £13m. February saw a reduction of high cost agency spend which is positive.

Adverse Variance to Plan – We expect to see further improvement for the end of March figures which will include the result of implementation of a range of mitigations discussed and agreed with the System including a further stretch target.

The Financial Recovery Board meetings have kept the focus on the forecast outturn and mitigating actions. We are now moving to discussions on 2025/26 in terms of CPIP delivery.

Capital and Cash – We saw a step up in capital in February due to the timing of programmes. A further large amount is expected to be concluded in March relating to the Community Diagnostic Centre and investment in frontline digitisation only secured late in the financial year. Cash has become less of a challenge. KO thanked the teams for their close management of this. This remains a concern for 2025/26 due to the challenging nature of the Financial Plan with oversight through the Board of Directors.

FM thanked KO and the team for dealing with a very difficult year, noting that 2025/26 is likely to be equally difficult.

The Board accepted the Finance Report.

	ITEMS FOR APPROVAL			
10.	**TRUST OBJECTIVES 2025/26**	**AD**	**Approval**	**Enclosure 5**

The Report was taken as read. These have been discussed extensively in the past in Board Workshops. These form the basis of the Trust Objectives for Divisions and wider teams. They contain overarching narrative and how we can demonstrate progress.

Recurring themes which are a continued focus for the organisation are Urgent and Elective Care, reducing elective referrals, financial sustainability and improving IT functionality. New areas include food quality, testing out AI in the organisation and tacking sickness and growing our own volunteer workforce.

Many of these Objectives will be delivered with our One Herefordshire partnership. A mid-year Report will be presented to the Board along with an annual round up in the Annual Report.

The Board approved the Trust Objectives 2025/26.

11.	**STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS**	**KO/GS**	**Approval**	**Enclosure 6**

The Audit Committee has reviewed these in detail with the tracked changes showing. The changes bring us more up to date with the recent changes in Standing Financial Instructions.

KO advised regarding the Standing Financial Instructions we have reinforced the requirement for the Contract Adjudication Report for contracts over £100,000 that aligns with the work that we are doing with the Procurement Service in terms of good quality contract management and links to the Procurement Act.

NT as Chair of the Audit Committee confirmed that these documents have been fully reviewed and was happy to support.

The Board approved the Standing Orders and Standing Financial Instructions.

12.	**QUALITY COMMITTEE TERMS OF REFERENCE AND FORWARD PLANNER 2025/26**	**LF**	**Approval**	**Enclosure 7**

This is the usual annual review with just a couple of minor adjustments made to the Terms Of Reference. The agreed Quality Priorities are also included.

The Subcommittee structure has been revised in light of the new Diabetes Committee and the Medical Devices Committee.

The Forward Planner was discussed at Quality Committee and agreed for final approval at Board. This may be subject to change over the coming year.

IJ as Chair of the Quality Committee advised that the Quality Priorities are particular areas of focus for the Committee, noting that there are a number of other quality areas that will continue to be scrutinised through the Subcommittees.

The Board approved the Quality Committee Terms Of Reference and Forward Planner 2025/26.

	ITEMS FOR NOTING AND INFORMATION			
13.	**EDUCATION CENTRE CAPITAL PROJECT UPDATE**	**AD**	**Information**	**Enclosure 8**

This was the major capital scheme we were expecting to take forward. Due to the change in interest rates between developing the Outline Business Case and the Full Business Case, this has made the case unaffordable at this time. We have therefore decided to pause this project but will continue to support the planning application and expect the determination from the Planning Department by the end of April. We have also paused the charitable funds relating to this project. We are in an advanced state of preparedness if we are able to find the funding.

We need to find a new source of funding which we have a number of leads and will continue to work on. We are communicating this out to our stakeholders, charitable trustees and individuals who pledged support to this scheme.

The Board accepted the Education Centre Capital Project Update.

14.	**NHS Staff Survey 2024**	**GE**	**Information**	**Enclosure 9**

This is one of the most important measures which tells us how the organisation is functioning. The results are largely back to 2023 levels, with 2024 very similar to 2023. We have seen good results from a national perspective regarding compassionate leadership with work life balance and appraisals.

There is a concern nationally regarding levels of violence against staff and unwanted sexual behaviours. Some equality and diversity and inclusion indicators are frozen and not improving. From a Wye Valley Trust perspective, GE was pleased to say that we are maintaining a strong performance in all areas of the survey. The areas of concern that we are working on are included in the report. The Trust are not rated amongst the worse in areas in the Health Service which is something to be proud of. Feedback about support from Line Managers is very positive along with good feedback around staff morale. Freedom To Speak Up is working well with a good work/life balance. Engagement scores are amongst the best in the NHS.

We are relaunching the InTouch staff campaign in the next 3 – 4 months. We are working with local leaders regarding some areas of concern.

JI noted the pleasing set of results. The staff response rate needs to improve with only 1 in 3 responding. The aim is to get above 50% this year. This will be a personal objective for the Executive Directors this year.

NT congratulated the team on the results which during a time of change and uncertainty should not be underestimated.

NT noted that violence and unwanted sexual behaviours along with racial abuse are increasing. What does this look like on the front line for staff and what does this mean? We need to understand more around how to improve this from Board level down to get behind this.

GQ questioned what we are doing to mitigate and support staff until we can take the actions required. GE will consider this as part of the reviewing of the results. We are working with colleagues and staff networks along with staff themselves for ideas they may have. At the National NHSE meeting this week, GE raised the question if any organisation was not seeing difficulties around these areas. They will come back with an answer to this as they were not able to provide a response in the meeting and GE will feedback with this.

The Board accepted the NHS Staff Survey 2024.

15.	**SAFEGUARDING ANNUAL REPORT**	**LF**	**Information**	**Enclosure 10**

FM advised that a case study and training along with Trust responsibilities was provided at the Board Workshop held this morning.

LF advised that the Trust have a responsibility to provide an Annual Report on Safeguarding. Safeguarding is a quarterly agenda item for the Quality Committee and the Annual Report is a distillation of those reports.

This is complex and sensitive work but we have 3 committed teams and are fully recruited. We have expanded the offer within the multiagency Safeguarding Team Hub and since the last Annual Report we have employed a Domestic Abuse Lead and set up the Domestic Abuse service.

The Board accepted the Safeguarding Annual Report.

16.	**PERINATAL SERVICES SAFETY REPORT**	**LF**	**Information**	**Enclosure 11**

There are no areas by exception to report. We are fully recruited to all services in maternity. There are challenges within the Neonatal Service for qualified in specialty staff but we achieve 100% of QIS on each shift on our Neonatal Ward.

CNST 10 Self-Declaration Year 6 – We are awaiting the results of this self –declaration and are hopeful that they will endorse our compliance of 10 out of 10 standards. Year 7 of the Maternity Incentive Scheme was published earlier this week and we are currently reviewing this to ensure that we can achieve a further 10 out of 10 standards this year.

The Safeguarding Safety Champions (LF, FM and SH) take part in monthly meetings and walkabouts. These walkabouts are well received by staff working on the Neonatal Unit and Maternity Unit. This is also an opportunity for staff to raise concerns and highlight positive practice too. **The Board accepted the Perinatal Services Safety Report.**				
17.	**USE OF THE TRUST SEAL**	**GS**	**Information**	**Enclosure 12**
The Board accepted the Use of the Trust Seal.				
	COMMITTEE SUMMARY REPORTS AND MINUTES			
18.	**AUDIT COMMITTEE REPORT AND MINUTES 12 DECEMBER 2024**	**NT**	**Information**	**Enclosure 13**
The Board accepted the Audit Committee Report and Minutes 12 December 2024.				
19.	**QUALITY COMMITTEE REPORT AND MINUTES 30 JANUARY 2025**	**IJ**	**Information**	**Enclosure 14**
The Board accepted the Quality Committee Report and Minutes 30 January 2025.				
20.	**CHARITY TRUSTEE REPORT AND MINUTES 12 DECEMBER 2024**	**GQ**	**Information**	**Enclosure 15**
The Board accepted the Charity Trustee Report and Minutes 12 December 2024.				
21.	**INTEGRATED CARE EXECUTIVE REPORT**	**FM**	**Information**	**Enclosure 16**
JI advised that this Report has been produced in a new format in terms of an Assurance Report and asked for feedback on using this approach for all other reports. **Action 21 – To feedback to GS and JI on the new format of the Integrated Care Executive Report in terms of using this approach for all other reports – ALL.** **The Board accepted the Integrated Care Executive Report.**				
22.	**ANY OTHER BUSINESS**			
There was no further business to discuss.				
23.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			
There were no questions received.				
DATE AND TIME OF THE NEXT MEETING - Thursday 5 June 2025 – 1.00 pm – 2.30 pm				

WYE VALLEY NHS TRUST
ACTIONS UPDATE: PUBLIC BOARD MEETING – 5 JUNE 2025

Public Board Reporting Action Log 2025/26							
Month	**Ref.**	**Item**	**Action**	**Lead**	**Due date**	**Status**	**Update**
April 2025	Action 21	INTEGRATED CARE EXECUTIVE REPORT	To feedback to GS and JI on the new format of the Integrated Care Executive Report in terms of using this approach for all other reports.	All		**Closed**	Completed.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	PFI Performance
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Alan Dawson, CSPO
Reporting Route:	N/A
Appendices included with this report:	None
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

Over the winter period 2024/25 the Trust suffered a number of estates-related failures that had a significant impact on operational performance at a period of high patient demand. These issues included a number of water leaks into the Emergency Department and have now been resolved. The number and nature of the issues were such that the Trust had concerns about the PFI partners' (Mercia Healthcare Ltd and their service provider Sodexo) capacity and capability to manage the hard facilities management element of the contract.

As per the PFI contract, the Trust levied unavailability deductions for the areas affected but these are not material sums and are not a serious incentive. After legal advice, other contractual levers were considered and explored but found not to be workable. The Trust has therefore invited Mercia and Sodexo to attend the Trust Board meeting to answer the following questions.

1. With a failure to complete lifecycle maintenance schemes according to your plans, a lack of planned preventative maintenance and a reactive maintenance backlog stretching back four years, how can the Board be assured that the hospital building is in safe hands?
2. With the PFI contract coming to a close in four years' time and the mortgage now paid, what incentive is there for you to improve performance?
3. Despite reassurances that planned maintenance was done, why have we had so many leaks into the hospital over the last winter?
4. Is it true that we have had roofing leaks in the hospital because you have failed to clear gutters and down pipes?

The Trust is still awaiting a final narrative from the PFI partners on the root causes with some of the issues and it is crucial that lessons are learned as the contract enters its final four years and the amount of lifecycle replacement work on site increases considerably.

Since this paper was written, Sodexo and Mercia declined to attend the meeting and submitted a written response yesterday (04/06/2025) which has been reproduced in full below.

Recommended Actions required by Board or Committee

- That Board members note the significant issues experienced over winter and the Trust's response to them.
- That Board members note the response from Mercia Healthcare Ltd and its service provider Sodexo

Executive Director Opinion[1]
The issues encountered over the winter were frustrating for staff and patients and the Trust needs assurance that its buildings are being maintained in a way that allows for service continuity.

On review of the questions shared, Mercia and Sodexo wish to decline your request to attend. Mercia (MHL) and Sodexo have as an alternative considered each question and respond as follows:

1. With a failure to complete lifecycle maintenance schemes according to your plans, a lack of planned preventative maintenance and a reactive maintenance backlog stretching back four years, how can the Board be assured that the hospital building is in safe hands?

   Lifecycle delivery is reported every month. Lifecycle has been delivered to maintain the Availability of the Hospital as necessary. The Trust is aware that MHL has taken the initiative and will increase funding of Lifecycle delivery project management by an additional 50% on an ex-contract basis in order to assist all parties at the Hospital.

   Planned Preventative Maintenance (PPM) is actively managed and reported through both internal Sodexo governance and monthly reporting mechanisms. Where access constraints have impacted delivery, these have been highlighted to all relevant stakeholders.

   The reactive maintenance backlog is being addressed through a structured recovery plan for both the Trust and PFI estates, with a clear plan to resolve the PFI estate within the next four months. Clearing the backlog in the Trust estate will depend upon funding being made available by the Trust.

   Sodexo operates under a robust governance framework, including regular internal and independent audits. Additionally, MHL has commissioned an independent audit by Capitec, reinforcing our shared commitment to transparency and continuous improvement.

2. With the PFI contract coming to a close in four years' time and the mortgage now paid, what incentive is there for you to improve performance?

   Performance will continue to be reported and measured monthly using the mechanics set out in the Project Agreement.

   Sodexo remains fully committed to delivering high-quality services throughout the remainder of the PFI contract and beyond. Our ongoing collaboration with the Trust on service improvement initiatives reflects this commitment.

   Sodexo's ambition is to continue a partnership with the Trust post-PFI, and we are actively investing in both people and processes to support that goal. Our recent recognition as a strategic supplier to the NHS and Department of Health & Social Care underscores our long-term dedication to the sector and to delivering value beyond contractual obligations.

3. Despite reassurances that planned maintenance was done, why have we had so many leaks into the hospital over the last winter?

   This has been the subject of detailed discussion between the parties. As noted above, the Trust is aware that MHL has commissioned Capitec to undertake a further assurance review for the benefit of all parties.

   Lifecycle replacement works of significant elements are by nature disruptive although of course we seek to minimise that. The majority of roof replacements under the Lifecycle programme were completed successfully and ahead of schedule. However, isolated issues did occur in areas such as Endoscopy and ED, due to a combination of contractor performance and previously unidentified structural issues, which needed to be and were corrected as part of the works.

   These incidents were compounded by exceptionally wet weather during the repair period. All cases have been thoroughly documented, and a Root Cause Analysis is underway to ensure lessons are captured and shared.

[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.

Additionally, Sodexo supported a Trust-led project on the GAU roof, which had experienced delays due to funding. This was delivered by a separate contractor and is also being reviewed as part of the broader analysis.

A separate, unrelated leak in Women's Health was promptly addressed through reactive maintenance, demonstrating the team's responsiveness.

4. Is it true that we have had roofing leaks in the hospital because you have failed to clear gutters and down pipes?

Access limitations to high-level gutters and downpipes did contribute to blockages above ED and Endoscopy, which in turn exacerbated leak issues. These constraints were due to safety concerns with the access systems that prevented timely maintenance. The access system is now being replaced as part of lifecycle and will re-enable access for regular gutter clearance.

Low-level gutters and downpipes were and are maintained on a six-month cycle - exceeding contractual requirements - with support from specialist subcontractors.

A comprehensive Root Cause Analysis is in progress to evaluate all contributing factors and ensure that future maintenance and lifecycle replacement strategies are both proactive and resilient.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Chief Executive Officer Update Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Stephen Collman
Reporting Route:	
Appendices included with this report:	None
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
To update the Board on the reflections of the CEO 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. Model ICB Development

NHS England, in collaboration with ICB leaders nationwide, has published the Model Integrated Care Board (ICB) Blueprint v1.0, which sets out a strategic framework for how ICBs will operate in the coming years. This blueprint is designed to support delivery of the forthcoming 10-Year Health Plan and reposition ICBs as intelligent healthcare payers and strategic commissioners. The following is a summary:

Purpose and Strategic Context: Going forward, ICBs are expected to shift focus from reactive institutional activity to proactive population health management. This includes three strategic system shifts:

1. Treatment to Prevention – Emphasising public health, prevention, and early intervention to reduce health inequalities.
2. Hospital to Community – Prioritising neighbourhood and community-based care to reduce reliance on acute settings.
3. Analogue to Digital – Embedding digital tools and data analytics to support smarter commissioning and delivery.

[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.

Core Functions of a Model ICB**:**

ICBs will focus on four principal commissioning functions:

1. Understanding Local Context – Using data, predictive modelling and public engagement to assess population health needs.
2. Developing Long-Term Strategy – Co-producing evidence-based population health strategies and care pathways.
3. Strategic Purchasing – Aligning investment with population need, managing markets, and driving outcome-focused contracting.
4. Evaluating Impact – Monitoring utilisation and outcomes to adapt commissioning in real-time and maximise value.

Additionally, governance, statutory duties, risk management and business continuity remain foundational responsibilities.

Functional Realignment and Transition

The blueprint outlines a phased approach to reconfiguring ICB functions:

- Grow: Investment in population health analytics, strategic planning, and community commissioning.
- Retain and Adapt: Streamlining corporate services, embedding quality and clinical governance in commissioning.
- Transfer: Shifting performance management, workforce strategy, safeguarding, and some operational services to regions, providers or neighbourhood teams.

Capabilities and Enablers

To perform their role effectively, ICBs must strengthen the following:

- Data and Analytics: Population-level segmentation, predictive modelling, and integration via the Federated Data Platform.
- Strategic Capacity: Enhanced capability in population health strategy, commissioning, and system leadership.
- Finance and Contracting: Development of value-based purchasing and advanced commercial skills.
- Co-design and Engagement: Systematic involvement of communities, particularly underserved populations.
- Clinical and System Leadership: Strong clinical input, risk management, and collaborative partnership working, especially with local government.

Cost Reduction and Delivery in 2025/26

All ICBs are required to reduce their running costs by Q3 2025/26. Plans are due 30 May 2025. These reductions must not result in cost-shifting to providers unless accompanied by system-wide efficiencies.

Key points include:

- Savings will largely be delivered through consolidation, automation, and clustering of functions.
- National support will include tools for voluntary redundancy and redeployment.
- Leadership structures should align with the blueprint, reducing board-level headcount where appropriate.

ICB Cluster arrangements

To deliver the plan, the six ICBs in the West Midlands have worked collectively and have reviewed the range of options for clustering and working at a larger scale. and are recommending that the six ICBs introduce three sets of clustered management arrangements, each covering two current ICB footprints and with total population ranges from 1.8 million to 3.1 million. The recommendation for Herefordshire and Worcestershire is that 'clustering' with Coventry and Warwickshire is the best solution to deliver the savings requirements and the new range of functions. The plans that are due to be submitted at the end of May will reflect that proposal and then NHSE will review the detailed plans and decide whether that can then be implemented.

ICB Update

Building a Sustainable Future (BSF) Programme

The BSF programme continues to evolve as a core part of the ICS's long-term strategy to deliver resilient, high-quality services within a sustainable financial framework. Key recent developments include:

- Elective Reform and Clinical Sustainability: Initial focus areas have been agreed for service redesign—Dermatology & Plastics, Haematology, and Ophthalmology—with work now underway to explore new delivery models.
- Service Prioritisation: A new framework for service investment and decommissioning has been developed and is being piloted. It will guide medium-term decisions from 2025/26 onwards. The Strategic Commissioning Committee will review the framework following the pilot.
- System Enablers – Population Health Management: System-wide workshops have been held to progress a new implementation plan in collaboration with local authority public health teams. This work aligns with the national shift to strategic commissioning informed by population health data and capabilities.

The BSF Delivery Board is scheduled to review overall programme progress on 27 May.

Joint Forward Plan (JFP) Refresh

The Herefordshire and Worcestershire system is currently refreshing its Five-Year Joint Forward Plan. While the forthcoming 10-Year NHS Plan (expected summer 2025) will inform future iterations, the current refresh focuses on:

- Progress on 2024/25 priorities and delivery
- Setting performance targets and priorities for 2025/26
- Introduction and alignment of the BSF programme
- Further integration of population health management and neighbourhood health models
- Key in-year updates, including the Point Prevalence Audit 2024 results and financial position

These developments will support Wye Valley NHS Trust's strategic alignment with the ICS and help prepare for the anticipated shift in national expectations around service transformation, strategic commissioning, and population health.

2. Operational Excellence Conference

Operational leaders from across the Foundation group completed their development programme and finished with a conference of presentations and speakers. Congratulations to Jane on organising

and leading this. It demonstrated the value the group brings in the sharing of improvement and skills across the four Trusts. The challenge is to now take this and meet our challenges of innovation and productivity at scale that is evident through this. A focus we can develop is adapting this approach to clinical leaders across the group.

3. Integrated Care Division – CEO Report May 2025

Quarter 4 saw the Integrated Care Division implement a management restructure. The drivers for this are ensuring the division can provide effective leadership relevant to the changes within the NHS.

In particular the focus on admission avoidance, through our integrated urgent care pathways, but also to provide skills and knowledge to support the delivery of the Neighbourhood Health programme.

In April, the Division commenced a review of Virtual Ward, following its transfer in October 2024. The full evaluation is scheduled to be completed end of May, but overall occupancy has significantly increased, and crucial posts have been recruited to.

Referrals from the ambulance service to our Urgent Community Response team via “Call before convey” continue to increase and are sustained.

Our single point of access (Community Referral Hub) has continued to integrate, both process and physically, with our primary care teams. The hub is collocated with our out of hours providers and benchmarked well during a recent regional exercise.

May saw the division take on the countywide fall response service. Previously provided by a private provider, this service has been merged into our urgent response offer. One of the intended benefits is that we will able to support opportunities to increase the activity related to this element of the service, due to the integrated support available within this pathway to keep uninjured fallers at home.

Our system continue to work together to improve discharge to assess pathways, to reduce delays for patients when they no longer meet the Criteria to Reside. We have seen sustained improvements in our Pathway 1 delay position, Home First and WVT Bridging Team work together to ensure patients are discharged the same day that they are deemed ready for discharge.

Pathways 2 and 3 have been our system focus, with significant improvements in occupancy within our Pathway 2 residential provider’s bed capacity, work continues to improve the nursing provider.

The division provide a number of community health services, a review of activity, demand and capacity and waiting times with a particular focus on productivity has seen waiting times reduce in the majority of services. 2025 will see a particular focus on community nursing, with a full review and productivity plan in progress.

4. GEM Board June 2025

Winners from Quarter 4 – 2024/25

Team of the Quarter – Quarter 4 – Cath Lab Team

There was a potential staff shortfall that would have resulted in the cancellation of eight routine patients, which had happened to the same patients previously. It would have been easy to cancel the list and send patients home who had been waiting for months, but thanks to Mandy's proactive efforts, we were able to proceed whilst ensuring comprehensive care.

Sister Heather from CCU volunteered to assist as a scrub nurse. Her willingness to help at such short notice was crucial. Lynne also deserves special recognition for taking on the role of scrub nurse.

Dickson and Alison's expertise and hard work were instrumental in helping complete the full cath list efficiently and safely.

Mandy, Tegan and Mia worked tirelessly in the patient area to ensure all pre and post-angiography care was meticulously handled. Their effort to accommodate exemplifies the spirit of teamwork and patient-centred care that characterises our team.

The importance of conducting the angiogram list was underscored by one of the patients where their angiogram revealed critical disease, necessitating an urgent PCI at Worcester Royal Hospital the following week, thereby preventing a potential heart attack.

Each member of the team played a pivotal role in the day's success. It is their enthusiasm and commitment to patient care that truly make a difference. I am not only impressed but also inspired by their collective attitude and professionalism.

Employee of the Quarter – Quarter 4 – Dan Fearn

Dan has worked with clinicians and across his division and the organisation to rapidly test ambient AI in the organisation to reduce the time taken for clinicians to make their clinical notes and write clinical letters.

He arranged a free trail of new technology and, following safety checks, rolled it out across multiple departments and clinicians – supporting other managers to start their own testing programmes.

The testing and adoption of new AI technology is one of the trust objectives this year and Dan and the clinicians who are testing have us off to a flying start to increase our productivity.

NHS
Wye Valley
NHS Trust

Integrated Performance Report

April 2025

Integrated Performance Report: Public Guidance Pack

Compassion • Accountability • Respect • Excellence

Managing Director – Executive Summary

Jane Ives
Managing Director

We are managing as always a number of competing pressures and in this months report I will concentrate initially on our financial performance linking to the other aspects of our responsibilities.

Our month one financial performance is on plan although as the year goes on the financial target gets progressively more difficult. It is good news we are off to the right start to the year particularly on our cost and productivity improvement plans (CPIP) where we have over performed, but maintaining momentum is key to delivery for the year. We still have around £6m of CPIP to identify, although finance and performance executive meeting feedback has been encouraging on further identification and I am confident we will identify schemes over the next month.

We have significant risks relating to Welsh income, both in Welsh commissioners matching English in recognising the cost of rurality, but also the commissioning of longer waiting times for Welsh patients for short term financials savings. The impact of the routine (not urgent or children's) waiting times extending to 52 weeks for out-patients and 104 weeks for elective care is significant. It will impact around 8,500 OPD and 1100 elective Welsh patients who will have to wait up to a year longer for their treatment. Whilst the waits are for non-urgent care we are unaware of a quality impact assessment being completed to identify clinical risks to patients from the commissioning decisions. The impact of the Trust's income is around £3m and so far there has been no provision for the additional administrative costs of running differential waiting times for patients. We are seeking to mitigate this loss by reducing costs but the likelihood of stranded costs is high and the impact on additional costs in later years to catch up with the delayed work is not yet able to be identified.

The target for English patients is no more than 1% of the waiting list being patients waiting over 52 weeks by the end of the financial year and achieving our operational activity plan will achieve this. In month 1 we met our activity plan despite high levels of consultant sickness.

Our diagnostics activity plan is behind plan but we anticipate that we will meet our target over the year when the additional capacity from the CDC when it open at the end of September comes on stream.

Our biggest risk to quality, performance and finance remains urgent and emergency care. In terms of quality the rise in SHMI (mortality) is concerning, however, this is mainly due to the number of expected deaths have decreased rather than actual deaths increasing which does point to a problem in coding our activity. We do have time to recode and submit our data and this is underway. The level of effort and attention being given to improving urgent care pathways both out of hospital and in hospital is commensurate with the level of risk to both performance and our finances. This is included in the COO section of the report.

A significant amount of organisational change will be required to meet our headcount and corporate spend reduction targets as part of our financial plan and this will be discussed with staff side representatives in the coming weeks as part of a formal change management process.

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Infection Prevention and Control Board Assurance Framework- Compliance update (reported in full at Trust Infection Prevention Committee in April)

The Trust's self-assessment against the updated IPC BAF version 1.0 Key Lines of Enquiry (KLOE) issued in March 2023 and the actions required to strengthen assurance have been updated.

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability.
Using this framework is not compulsory, however it is regarded as a source of internal assurance, supporting organisations to maintain quality standards by identifying any areas of risk and the corrective actions required in response. The framework is ordered by the 10 criterion of the Hygiene Code.

The Trust has assessed as partially complaint for all 10 domains. All KLOEs are reviewed and updated quarterly. In total there are 54 KLOE for self-assessment across the 10 Hygiene Code criterion. In total, 88% of the KLOEs are met. Five of the 10 Hygiene Code criterion are fully compliant; 5 require additional evidence to ensure fully assurance is achieved. The Trust has no areas of non-compliance across the KLOES or domains.

None of the areas of partial compliance represent a patient safety concern and work is in progress to achieve and evidence full compliance.

Areas of partial compliance:

2.4.1 – Ventilation systems – full compliance will be achieved when ventilation policy ratified – in process
2.7 – Waste Management – review of audit arrangements and associated action plans
3.6 – Antimicrobial Stewardship (AMS) – Limited pharmacy and microbiology resource, AMS resource focussed on priority areas – on risk register
6.5 – Fit mask testing – fully compliant with the exception of being able to easily collate reports – new recording process currently being trialled
7.1/8.5 – management of patients with known or suspected infections – audit of practice across 7 days per week to ensure consistency of practice, particularly at times when Infection prevention team not available (Sat/Sun April to September)

Criterion
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Ross Community Hospital – CPE outbreak and NHSE/ICB Assurance visit – 6th March 2025

Ross Community Hospital declared a Carbapenamase Producing Enterobacteriaceae (CPE) outbreak in July 2024. As part of the outbreak NHSE and the ICB undertook an assurance visit on **6th March 2025**. The full report has been shared with Board members.

There was significant improvement noted in the ward leadership, with the community matron being able to clearly describe the actions she has taken since commencement of post. The leadership was clear through the presentation that was delivered at the beginning of the day and was evident during the ward visit. There was an improved understanding of the responsibilities of the team and a clear acknowledgement of the work that is left to do and the plans to deliver this.

High level findings included:

- Significant improvement in ward leadership and clear understanding of individual roles and responsibilities
- Notable Quality Improvement plans developed at the beginning of the outbreak having a positive impact
- The team observed caring and compassionate patient interactions. Staff were open about challenges they had faced and positive about the improvements made so far
- Additional training and Infection prevention team support to the area had proven beneficial and supportive

Key themes for improvement included:

- Waste Management – significant improvements have been seen – further work required on waste segregation and audit of compliance
- Environmental cleanliness – the team noted the level of cleanliness in the ward areas to be high, focus required in non clinical areas in particular
- Beds, mattresses and pressure cushions – ensuring that pressure cushions are part of the bed mattress audit
- Personal Protective Equipment – some staff "over using" gloves for tasks where glove use not necessary – IPC team to provide further education
- Estates work – general backlog maintenance prioritisation to enable improved standards of cleanliness to be achieved
- Storage of equipment on the lower ground floor requires review to enable improved segregation of clean equipment, linen and equipment awaiting cleaning
- Estates work required in old mortuary area to enable more storage space

During the visit NHSE recommended a de-escalation process from outbreak status to surveillance and monitoring, this included a step down of the frequency of patient screening and changes to the flushing and cleaning regimes in line with business as usual processes.

On the **7th May 2025** we were able to step down the CPE outbreak fully and this decision was taken in conjunction with NHSE colleagues and colleagues from the UK health security agency (UKHSA). The decision was based on no new CPE infections reported since January 2025 and regular assurance gained through IPC audits and peer review visits provided by the ICB

The Trust overall remains under intensive support for cleanliness and the county hospital site will be receiving a full day inspection by Infection Prevention colleagues from NHS England and the Integrated Care Board on Friday 30th May 2025.

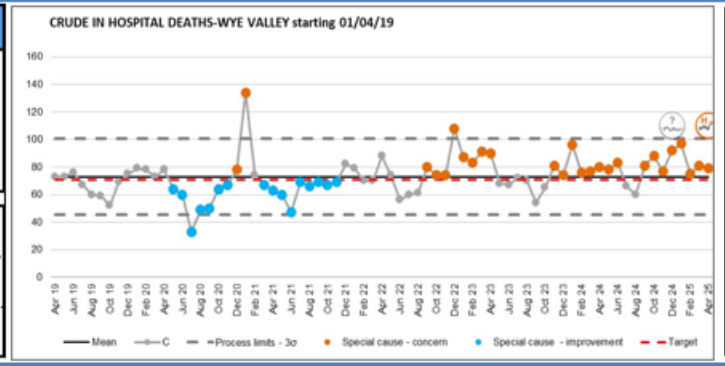
Quality & Safety Performance – Mortality

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)*	**Dec-24**	**105.0**	***2.0***
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Jan-25**	**106.9**	***3.0***
SHMI (in hospital)			**102.3**	***2.1***
SHMI (out-of-hospital SHMI)			**117.7**	***5.1***



CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	Jan-25	**104.98**	**27.62**	**29**	**19.89**
Congestive Heart Failure		**112.98**	**58.42**	**66**	**1.14**
Fractured Neck of Femur		**148.91**	**31.56**	**47**	**36.59**
Pneumonia		**104.53**	**175.06**	**183**	**-1.95**
Septicemia		**109.15**	**98.95**	**108**	**2.07**
Stroke (Acute Cerebrovascular Disease)		**103.42**	**83.16**	**86**	**5.58**

Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from February 2024 to January 2025 shows Wye Valley NHS Trust at **106.9,** which is a significant increase as we start to include the winter months within the data period.
- The NHS England SHMI, which is for the period of January 2024 to December 2024, is also reporting above the National mean at 105.
- Latest **crude mortality** rate for April 2025 was **1.34%** for all admissions, which equates to 79 deaths including ED and CH's.
- Our key mortality outlier groups, with the latest figures (*February 2024 to January 2025*):
    - **Heart Failure** – A small rise in the latest SHMI to 112.9. This is the fourth consecutive rise in heart failure mortality rates. Although, the actual number of deaths has fallen over the 12 month period, the level of expected deaths has dropped significantly faster.
    - **#NOF** – This month has reported a significant rise in the rolling 12 month SHMI of 36 points to 148.91. The main cause for the rise was the 11x deaths attributed to #NOF in January 2025. A full review of these cases is underway with the Clinical Lead and Clinical Coding Department. Based on an initial review, the majority of the patients Cause of Deaths are not related directly to the #NOF.
    - **Pneumonia –** A positive month with a significant 1.95 reduction in the rolling 12 month SHMI to 104.5. This equates to 183 observed deaths, which is 15 less deaths than last months report.
    - **Sepsis** – The latest rolling 12 month SHMI shows a small rise to 109, although the number of deaths attributed to Sepsis for this period has fallen. The reason for the rise in the SHMI is due to a much lower expected number of deaths.
    - **Stroke** – A small increase in the latest 12 month rolling SHMI to 103.4. As mentioned above, this seems to be related to a drop in the expected level of deaths as opposed to a significant rise in the observed levels of mortality.
- There were presentations from the Acute Medicine, General Medicine and Neonatal teams at the May LfD Committee. Each of the presentations outlined their latest data, mortality reviews and findings, learning and key next steps.

Quality & Safety Performance – Staffing

Fill Rate & CHPPD Data

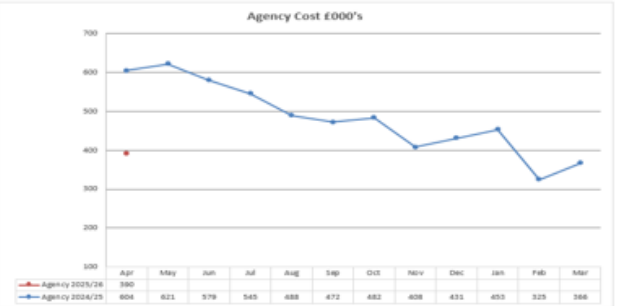
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	75%	70%	70%	67%	12.0
Maternity Ward	91%	99%	98%	97%	7.0
Children's Ward	123%	105%	128%	83%	18.4
Lugg Ward	134%	88%	122%	117%	7.2
Wye Ward	119%	81%	123%	92%	6.8
Cardiac Care Unit	100%	100%	99%	97%	11.6
Leominster Community Hospital	156%	75%	100%	98%	6.5
Bromyard Community Hospital	102%	85%	102%	89%	8.0
Ross Community Hospital	99%	105%	150%	106%	6.3
Teme Ward	128%	47%	93%	57%	13.6
Redbrook Ward	105%	152%	140%	160%	8.7
Special Baby Care Unit	86%	-	98%	-	16.2
Intensive Care Unit	108%	-	97%	-	32.6
Gilwern Ward	101%	140%	98%	107%	6.7
Acute Medical Unit	128%	92%	99%	146%	8.1
Ashgrove Ward	139%	90%	133%	111%	7.5
Dinmore Ward	129%	75%	106%	96%	7.2
Garway Ward	139%	89%	122%	129%	8.7
Frome Ward	123%	86%	107%	126%	7.0
Arrow Ward	153%	74%	148%	89%	7.7
Women's Health	130%	90%	100%	-	11.4

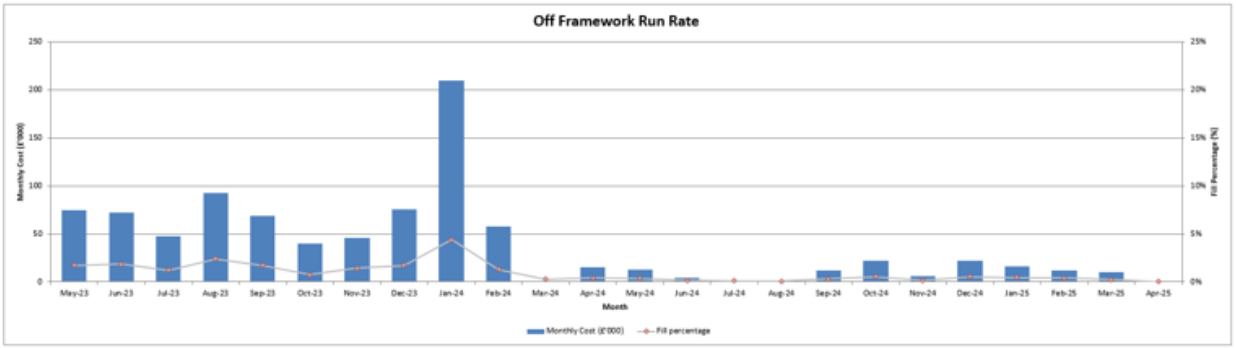
The NHS England staffing return is detailed above and includes the minimum expectations in terms of national quality board reporting requirements.

Fill rates for day time remain stable from the previous month, although we have seen an overall decrease in RN and HCA fill rates by 3% at night. The 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 stable. In March, the Trust committed to stopping all off framework agency nurses. The only exception to this, is if a RMN is needed for a patients care and our agency supplier have been unable to supply. One off framework shift was utilised in April.

The Trust continues to be part of the collaborative working with the NHSE Regional Team to reduce all agency pay rates to national cap levels. As a Trust, we achieved cap rates for general registered nurses within the regional time frame of the 31st January. All Trust's in the region had a target of being cap compliant by the end of March for specialist nurses. Although we have seen a reduction in the number of shifts being requested for specialist areas, cap compliance levels for specialist nurses are not being met, the majority of these specialist nursing shifts are for the Emergency Department. The Trust is working with the master vend to ensure they increase their compliance level, and meet their target of 80% compliance.

As part of the collaborative work the Trust will also be stopping all Health Care Assistant agency usage by the end of June. A plan has been developed to support the Trust achieve this target. The rise in bank spend is associated with these changes. During the last couple of weeks we have seen a 41% decrease in Agency HCA demand.

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Two key areas to highlight this month. As we start to head into the summer months we need to ensure our plans to improve Urgent and Emergency Care (UEC) are progressing, as we look ahead to Winter 25, and that our Productivity schemes are delivering to reduce our Elective Waiting Lists whilst ensuring we maintain grip on our Cost Improvements and Productivity Plans (CPIP) for this year.

Urgent and Emergency Care

Over April our UEC pathway has seen significant challenges with high emergency admissions along with increased pressure from the Easter period, Infection Prevention issues across a number of inpatient and Community Hospital wards, including Flu and Covid outbreaks, high level of Non-invasive ventilation (NIV) patients, levels normally seen at winter, the ongoing need to maintain high level of escalation beds, often evoking our extremist escalation plans, and high use of Temporary Escalation Spaces (TES). The impact of these challenges in April lead to the Trust declaring an internal Business Continuity incident with internal actions and responses similar to the Critical Incident declared in January of this year.

Our Emergency Department team were faced with some challenging workforce issues that we are aiming to address with some rota changes, particularly out of hours, in order to provide senior support to our teams.

Ahead of this winter we have a number of initiatives aimed to improve our 4 hour Emergency Access Standards, improved Ward base processes and reducing the increasing volume of emergency admissions.

Some of these schemes are:

- Embedding and strengthening our front door streaming to ensure our patient are managed in the right place on the right care pathway. Ongoing training and competencies for our Senior Nursing staff undertaking these roles is underway to maximise internal and external integrated services that are available to ED.
- Increasing our Ambulatory and Same Day Emergency Care (SDEC)provision at the front door. The final solution is based on a national UEC bid for Capital investment in our estates to increase our physical capacity. In the meantime we are reviewing what more can be achieved with the current estates, criteria and with the increase in our Medical Day Case capacity who we prevent our SDECs from doing yesterdays work and focus on "pulling" as many appropriate patients as we can from ED.
- Our Neighbourhood health programme. Bringing together the different core of existing practice components into an integrated service offer to improve coordination and quality of care, with a focus on people with the most complex needs and reducing emergency admissions into Secondary care
- Working with our Powys partners around Same Day pathways and improve Discharge pathways and planning to reduce our Powys patients length of stay on our Acute floor and in our Acute and community Hospital beds
- Trustwide Valuing Patients Time UEC workshops scheduled for May and June followed by a 4 week intensive Plan, Do, Study, Act quality improvement to testing our key schemes with weekly Executive lead wash-up sessions.

Productivity Schemes

Our key focus for improved productivity across our elective pathways for Q2 25/26 are:

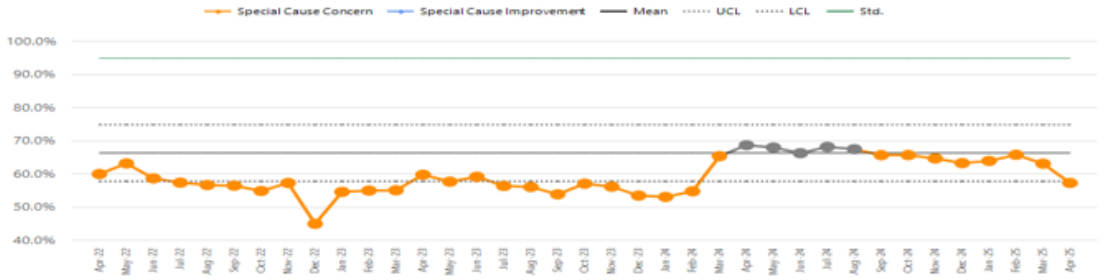
- Clinical Template Reviews across eight key specialities. The process will ensure that we have fully reviewed and updated our outpatient clinic templates to ensure that all our clinicians are working to (or towards) best practices using robust benchmarking where available. This will include sharing templates across the Foundation Group. We are using the Getting it Right First Time (GIRFT) 12 week pilot model used successfully at University Hospitals of Leicester, covering a 2 week initial review, 8 week pilot of changes, and 2 week post implementation review, assessing any further amendments or impacts. Work on this starting in June.
- Evidence Based Interventions (EBI). The list of EPIs has been developed to help make sure patients are not offered unnecessary treatment on the NHS and that unnecessary treatments can cause harm to patients. Reviewing our waiting lists and referrals has started along with benchmarking with Model Hospital resources.
- Management of elective referrals. Both internal and external. Reviewing our Patient Access Policy against national best practice, delivering education and training on its content, along with reviewing the clinical appropriateness of internal referrals and whether the appropriate pathways are being adhered too.

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

We are driving this measure because:

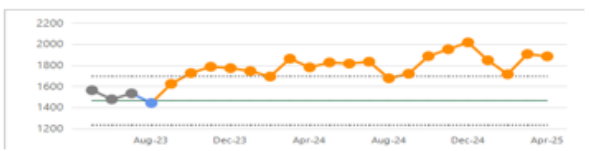
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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



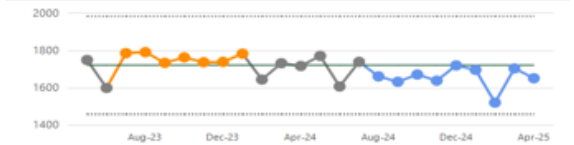
% Patients Spending More Than 12 Hours In ED

Emergency Admissions



% 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. Along with increase >0 Length of Stay emergency admissions
- System patient flow constraints.

What the chart tells us

- Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances due to the impact of the COVID19 pandemic
- April`s 4 hour Emergency Access Standard [EAS] Performance was 57.4%

Performance & actions

- 6,005 Type 1 patients attended ED in April which 303 fewer than the previous month. The range of all attendances varied from 153 to 265 with 200 being the average daily attendances.
- 1,652 ambulances conveyed to the Trust in month which was marginally less than the average through 2024/25 [1,674]. The range in month was 42 to 68. This includes 10.5% from Powys [173].
- Ambulance handover delays over 1hr were 38.5% [579] of all conveyances which was the highest position on record for the Trust. 44.3% [665] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,229 of all admissions [47.2% of all admissions] via a Same Day pathway within no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 87/120 Type 1 Trust in England for April.
- 16% [1,078] of patients spent 12 or more hours in ED which was 3% more than last month.
- Key actions being taken to recovery our 4hr EAS :

➢ Review Medical rotas and operational oversight to improve time to be seen / refer in ED particularly during the out of hours period

➢ Focus on improving our non-admitted performance for patient who do not require an inpatient bed

➢ Maximise and standardisation of Streaming at the front door to ensuring patients are treated and managed via the correct clinical pathway

➢ Reviewing our Same Day Emergency Care capacity and criteria. Both how we increase internal utilization of our SDECs and how we increasing capacity for external referrals from Primary Care , 111 and Urgent Community Response teams.

➢ Ensure we only admit patients that meet the Criteria to Admit thresholds.

➢ Increase the use of Call before Convey with Ambulance service partners

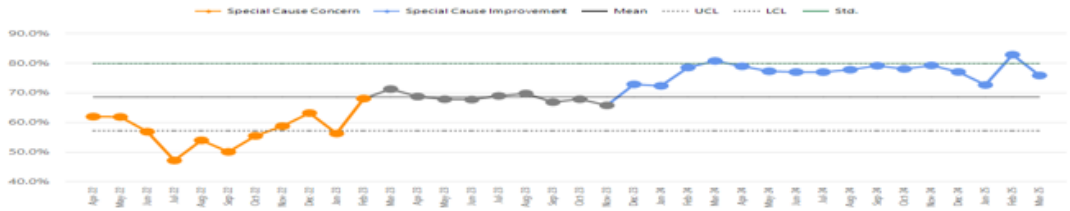
Operational Performance – Cancer Performance (March 25)

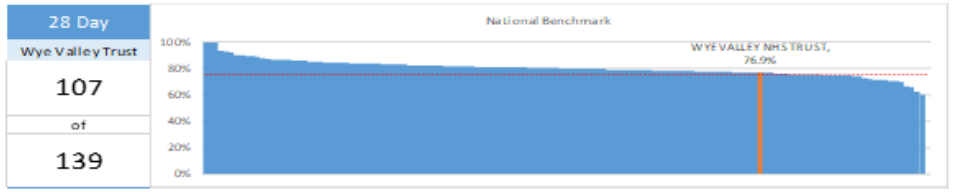
We are driving this measure because:

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 80% 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 Standard [FDS], and 75% start first treatment within 62 days to be achieved by March 2026

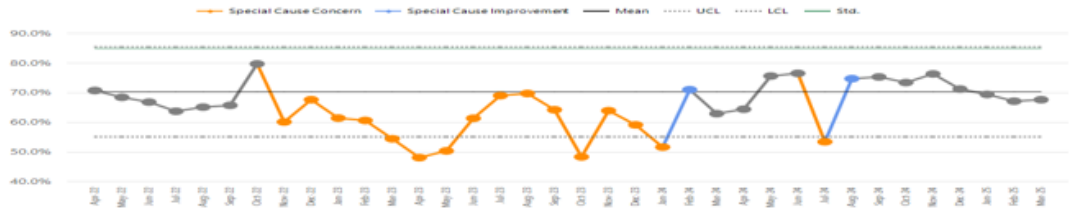
Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

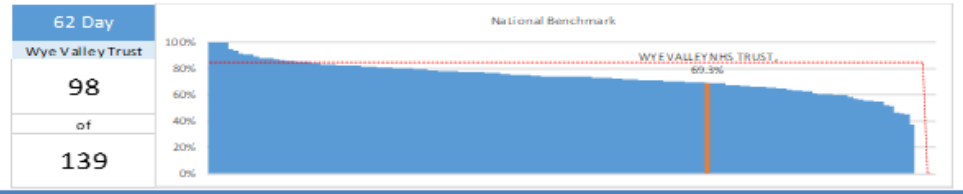
28 Days (Performance & Benchmark)





62 Days (Performance & Benchmark)





Performance & actions

Referrals:

As of March 2025, overall referrals have increased by 16% compared to three years prior. Particularly notable are the increases in Gynaecology and Urology referrals, which have risen by 36% and 43%. Referrals continue to be audited to identify themes and trends to ensure compliance to the guidance from primary care.

28 FDS:

In March 2025, the Trust met the FDS, achieving a performance of 77%. The target trajectory is to reach 82.3% by the end of March 2026, and focused efforts are ongoing to drive continued improvement. This is a stretched target greater than the National requirement.

Breast capacity remains a concern, leading to delays in patients receiving their first appointment within the specialty. This has been caused by a referral backlog, driven by staff sickness, annual leave, vacancies, and an increased volume of referrals. All vacancies have now been filled, and the specialty has a clear plan in place to reduce waiting times.

Delays in radiology, particularly in accessing scans, remain a challenge, and both short- and long-term actions are being implemented to address these issues. The Community Diagnostic Centre (CDC) is expected to play a key role in supporting and enhancing our cancer pathways.

Developments updates

- Text messaging for benign results is due to be live in all cancer specialties by the end of May. Cancer navigators will continue to review the use with results of the audit to be shared in the coming months.
- Development of Power BI cancer performance dashboards is ongoing, this will offer daily updates on the latest position. These dashboards provide specialties with clear visibility to monitor performance and conduct detailed reviews
- CTC prescription tool to go live in May 2025 and will reduce delays for prescriptions reaching Pharmacy

What the charts tell us

- 28 Day faster diagnosis performance this month was 77%.
- 62 Days start of treatment target was 73% below target of 75.3%

Risks

- Cancer referrals continuing to remain above 19/20 levels
- Radiology and breast service capacity were challenged during the month, alongside a backlog of breast referrals

Operational Performance – Elective Activity / Productivity / 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

New/First Attendances

Total vs Plan	This Year	Plan	Diff / Var
	9,499	9,167	332 / 4%
Vs 2019/20	This Year	2019/20	Diff / Var
	9,499	8,058	1441 / 18%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	10.2	3.5	65.9%

IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	3,369	3,071	298 / 10%
vs 2019/20	This Year	2019/20	Diff / Var
	3,369	2,932	437 / 15%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	14.0	7.0	50.1%

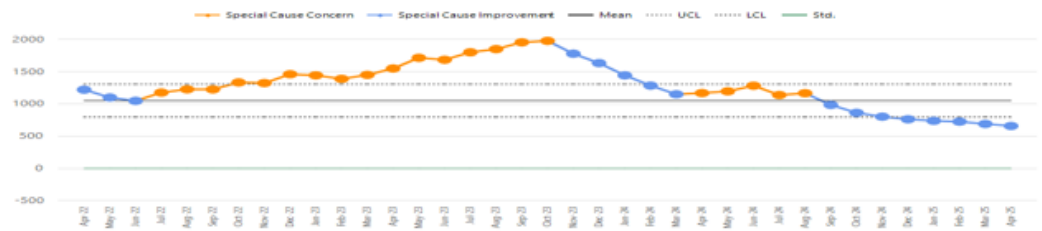
Follow Up Attendances

Total Vs Plan	This Year	Plan	Diff / Var
	21,083	18,796	2287 / 12%
Total vs 2019/20	This Year	2019/20	Diff / Var
	21,083	16,404	4679 / 29%
Waitlist Clearance (wks)	Total	> See By Date (SBD)	% Past SBD
	15.6	5.5	60.7%

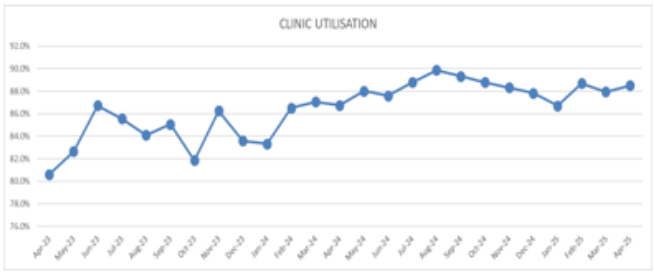
Endoscopies

Total Vs Plan	This Year	Plan	Diff / Var
	1,206	1,090	116 / 11%
vs 2019/20	This Year	2019/20	Diff / Var
	1,206	1,275	-69 / -5%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	16.4	0.7	95.5%

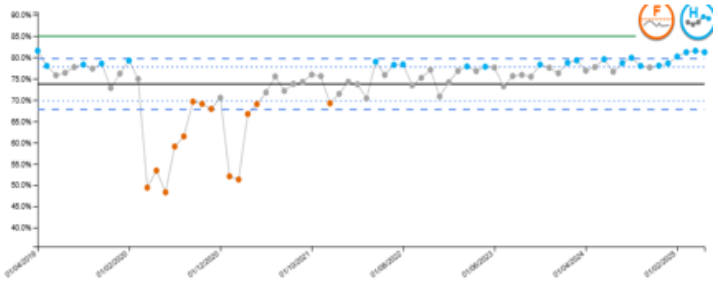
Patients over 52 weeks on Incomplete Pathways Waiting List



Clinic Utilisation



Theatres Utilisation (Uncapped)



Performance & actions

- Theatre productivity continues to improve, with further progress achieved in reducing late starts. The average late start time in April was 14 minutes (last 6 month average 34 minutes), marking 3 consecutive months of 15 minutes or less
- Despite continued UEC challenges, average cases per theatre list last month increased to 3.8, equalling the record set last autumn and reflective of further improvement projects
- Elective arthroplasty length of stay project has started to realise benefits for our elective orthopaedic ward, delivering a 1 day reduction in average length of stay with the first month of revised pathways being operational
- Plans to implement 6 day working within the Elective Surgical Hub have been developed, with a 'go live' date of 28th June confirmed. This will deliver an initial 5 full day lists per month across 3 specialities with further lists planned for later in the year
- Pre Operative Assessment optimisation work continues with utilisation increasing to 9$.6% and the number of patients requiring a second assessment reducing to just 3%, from over 10%

Long Waiting Patients

- 2 [1 English and 1 Welsh] patients waited over 78 weeks at the end of April which is 3 less than March-25.
- 65 week position at the end of April was 17 English patients.
- 526 English patients were waiting over 52 weeks for treatment at the end of April. The Trust has had continued reduction in this position since July-23. This equates to 2.3% of English patients waiting over 52weeks at the end of April.

What the charts tell us

- Performance against English RTT standard in April was 57.1%
- 2.3% of English patients on our Waiting List were waiting more than 52 weeks at the end of April.
- Performance against the Welsh RTT standard in April was 70.8%.

Risks

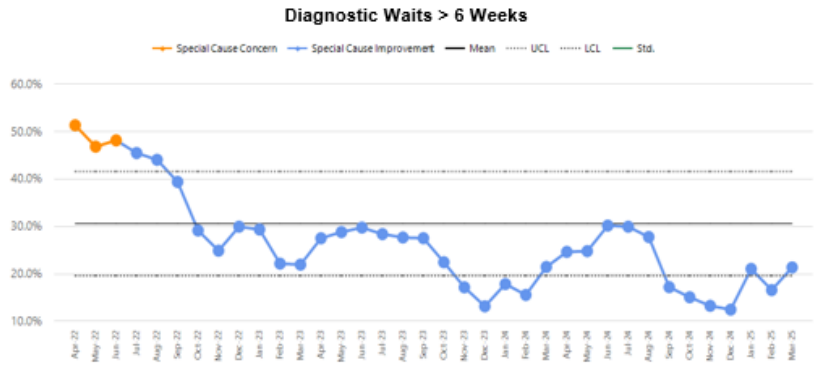
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.
- Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

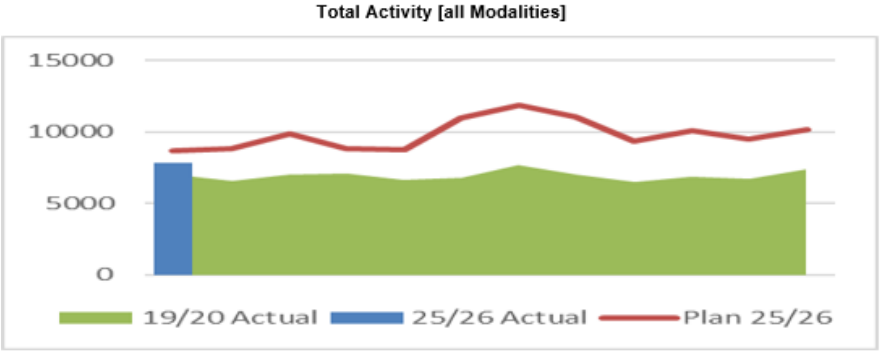
Operational Performance – Diagnostic Performance

We are driving this measure because:

Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] may include a diagnostic test; therefore, ensuring patients receive their diagnostic test within 6 weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks/26 weeks. Less than 1% of patients should wait 6 weeks or more for a diagnostic test. For 2024/25 the Trust aims to achieve 95% of patients waiting less than 6 weeks for a diagnostic test by March 2025.

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





Performance & actions

Overall Diagnostics delivered 90% of 25/26 activity plan which was 111% compared with 19/20 activity. The main areas of under delivery were in Echocardiograms, Neurophysiology and Computed Tomography (CT)

Imaging:
6 week wait positon at the end of M1 was 82%
Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 9 days and 19 days respectively.
One of the main causes of delays is CTC bloods/prescription. Implementation of the software solution has been delayed to the end of May 25. MRI Prostate MRI is being looked at as a priority to improve access via the Community Diagnostic Centre (CDC) pathway.
M1 25/26 is below plan due unplanned scanner downtime impacting on elective activity.

Audiology
Audiology 6 week wait position is 68% overall with an ongoing improvement in patients waiting >13weeks has continued, with 6 currently waiting
Agreed insourcing solution for Paediatrics is temporarily paused due to unsuitability of candidates. Bank/Locum has been advertised with no interest at either B6 or B7 level. Substantive B7 interviews take place at the end of May
Cross-working from Adults into Paediatrics has recently commenced to support mitigating risk where appropriate
Both teams are in progress of formal restructure

Neurophysiology
<6weeks waiting is 78% for M1
Number waiting >13wks has reduced to 8 with 2 undated
From July the waiting list position will be delivering at 11 weeks waiting
A service review is currently being instigated in order to develop more sustainable plans.

Echocardiograms (Echos)
The position has deteriorated over the first part of Q1 due to ongoing challenges with workforce and recruitment timeframes and operational "go live" of new staff. Whilst we look to stabilise the workforce additional out of hours working has commenced using the CDC workforce and use of interim insourcing capacity so we can get the volume of patients over 6 weeks down from >800 to <100 over the summer. a refreshed trajectory is being worked on along with ongoing work about the management of internal referrals

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 April 72.5% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

The new NHS Very Senior Managers (VSM) pay framework has been published and it is designed to deliver commitment to ensure strong and accountable leadership. The broad aim of the framework is to introduce greater alignment of approach to remuneration across all NHS organisations. Key features of the framework includes new pay bands, recruitment premia for challenged organisations, options for local bonus schemes and no annual pay awards for leaders who don't make improvements and their organisations remains in the recovery support programme i.e. are allocated the lowest NHS performance assessment framework (segment 5).

NHS pay awards for 2025/26 have been published. Agenda for Change staff including nursing will receive 3.6%, doctors are to receive 4% and VSMs have been allocated 3.25%. Resident doctors are to receive an average of 5.4% (4% plus a consolidated payment of £750) however, the BMA is balloting for potential strike action over pay.

Sickness absence stands at 5.2% with Long Term Sickness at 2.86%.and Short Term sickness at 2.34%. The main reasons for sickness absence are colds/flu. mental health conditions, gastro and pregnancy related illness. We have revised our absence policy with more stringent attendance targets especially for new staff and wellbeing support measures for employees. WVT will be participating in the delayed NHS wide absence study which is due to commence by July and we will continue to take appropriate management actions to reduce sickness in line with our revised absence policy. Reducing sickness absence remains a priority area for HR and OH over the coming year.

Staff turnover has dropped to 8.8% 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 clinical vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at to 6.42% but turnover for band 2/3 hcsw staff now stands at 18.37%. The centralised recruitment process is in place and we are working with the DWP to fill our support worker vacancies. Managers with support worker vacancies have been identified and active steps are being taken to reduce staff vacancies in these departments. We are also encouraging admin staff to apply for hcsw vacancies in our attempt to protect employment.

We supported the NHS wide Equality & Human Rights Week and the National Walking Month. We will be rolling out the Active Bystander training programme over the coming months. We now have in place the WVT Women's Network and we will be submitting our application to NHS Charities seeking funds to provide more support and awareness sessions to staff experiencing difficulties at work due to the menopause. The annual WVT staff fun day will take place on 21 June at the Halo Leisure Centre.

To enhance workforce productivity we have implemented e-expenses and e-rostering for community nursing is being implemented . In addition to nursing areas, e-rostering will be rolled out to other clinical areas in 2025/26 as this is seen as a key measure to enhance workforce productivity. The workforce tracking tool developed by the business intelligence team is being finalised and a chart showing workforce movements will be included in reports from July onwards.

Following the NHSE letter to review and reduce corporate costs, executive directors are reviewing their areas of responsibility to ensure we can reduce staffing costs in corporate areas as appropriate. We are conducting a comprehensive review of our admin structures for all pay bands and benchmarking this across the Group in view of developing a new streamlined admin operating model.

Working with ICS colleagues we continue to support the NHSE sponsored Care Leaver pilot programme which aims to find employment opportunities for Care Leavers in Herefordshire & Worcestershire. We are also developing an ICS wide recruitment database to support and retain individuals affected by management of change programmes.

Performance appraisals have fallen to 73.5% and this will be addressed through FPE meetings. WVT continues to perform well with mandatory training which now stands at 89.8%.

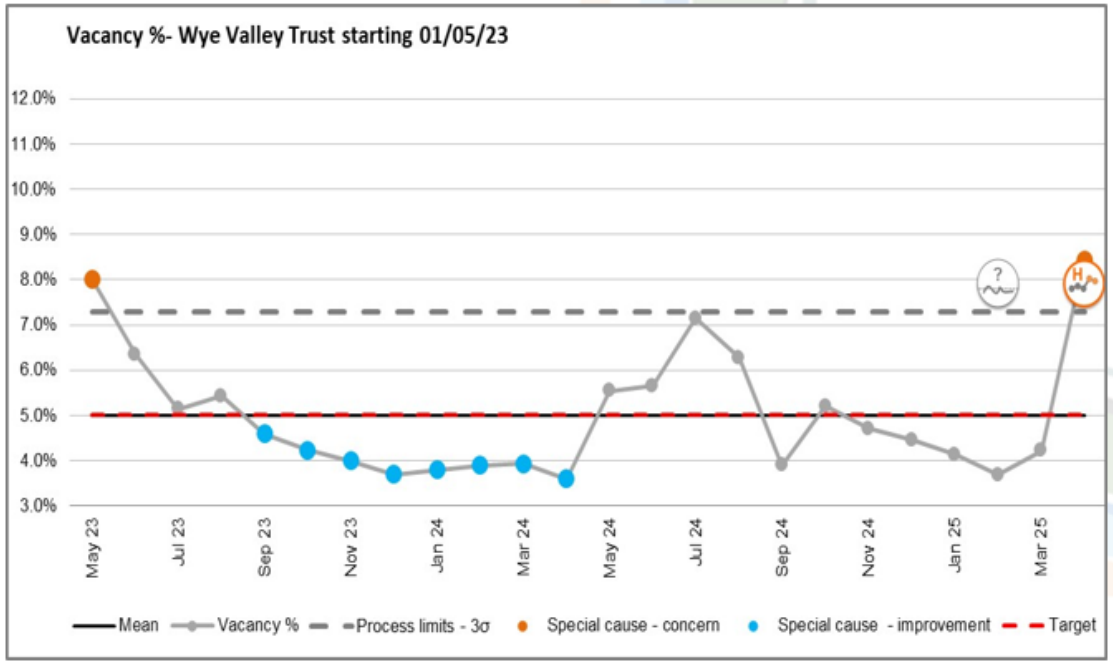
Workforce Performance – Vacancy

We are driving this measure because:

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

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
3.6%	5.5%	5.7%	7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	3.7%	4.2%	8.4%

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



Performance & actions

HCSW – with 20.96 wte vacancies largely in the medical division, we have re-introduced the centralised recruitment process and are providing more recruitment support to the division. We are also working actively with the DWP to fill our support worker vacancies. Admin staff are being encouraged to apply for hcsw vacancies.

N&M - we have paused our international recruitment as we are now seeing a significant increase in applications from UK based applicants. We currently have 37.50 wte vacancies.

CDC – 56.83.49 wte appointments have been made and 67.43% of posts have now been filled.

M&D - regular meetings with CMD, Medical Staffing Manager & Strategic Medical HR Lead to review progress with vacancies and cases of concern. Overseas recruitment of medics to continue over the coming year. We currently have 29.16wte vacancies for consultants, 9.38wte for sas drs and 7.1wte for resident drs.

Vacancy & workforce review panels - centralised and divisional panels are now in place reviewing all vacancy requests to replace posts and taking measures to reduce workforce costs.

We continue to promote our clinical vacancies Herefordshire wide with a series of events. We have also extended our WVT presence at regional and national fairs to promote our clinical job opportunities.
HR continues to work closely with DWP officers in finding suitable job opportunities for job seekers. 52 WVT Ambassadors have signed up to support career events at schools, colleges and universities and this reflects our aim to support 'young people' within the county.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

The penultimate 4 months of 24/25 showed a decreasing position, increasing in the last month mainly due to a decrease in substantive staff. There is a large increase in the first month of 25/26, mainly due to an increase of substantive budget due to realignment of reserves, together with a bottom up exercise and review of rostering areas.

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.

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
9.0%	9.2%	9.4%	9.5%	9.8%	9.7%	9.4%	9.1%	9.1%	9.4%	9.2%	8.9%	8.8%

Assurance	Variation	Data Quality Mark
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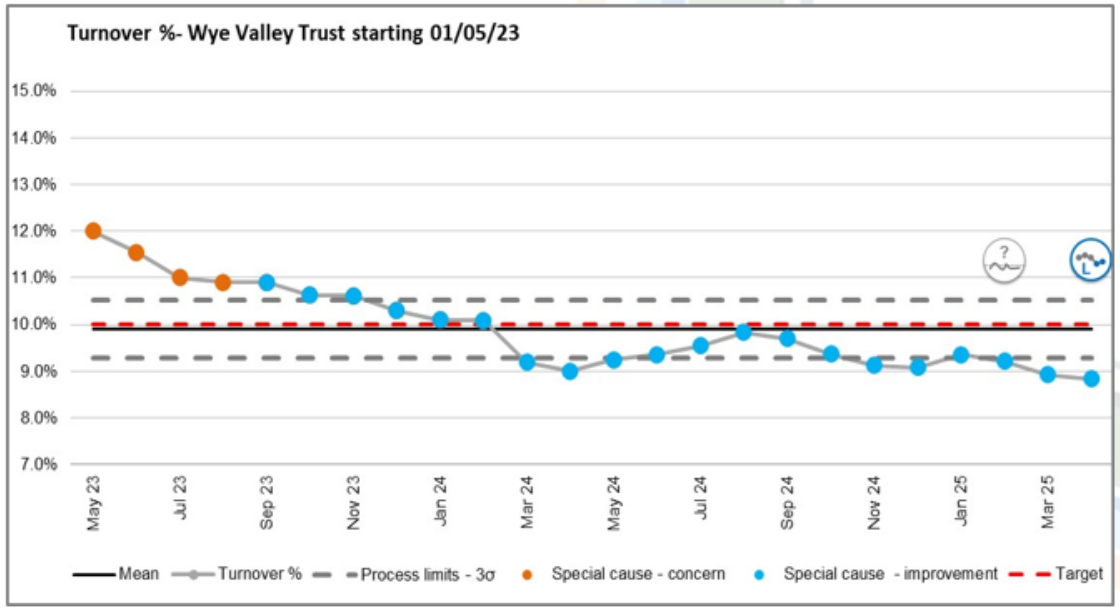

Performance & actions

The overall rolling 12 month turnover at Trust level is now at 8.8% which is the lowest % over the past year. We will continue to take appropriate steps to ensure this stays below 10.0%.
Clinical support workers at band 2 level have the highest turnover rate at the Trust (18.37%) 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 to newly recruited support workers. 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 6.42% 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

Staff turnover for support workers

What the chart tells us

The rolling 24 month position shows an overall decreasing trend in the last 12 months. An improved position present from March and April 24 due to now removing retire and returnees.

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.

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

Assurance	Variation	Data Quality Mark
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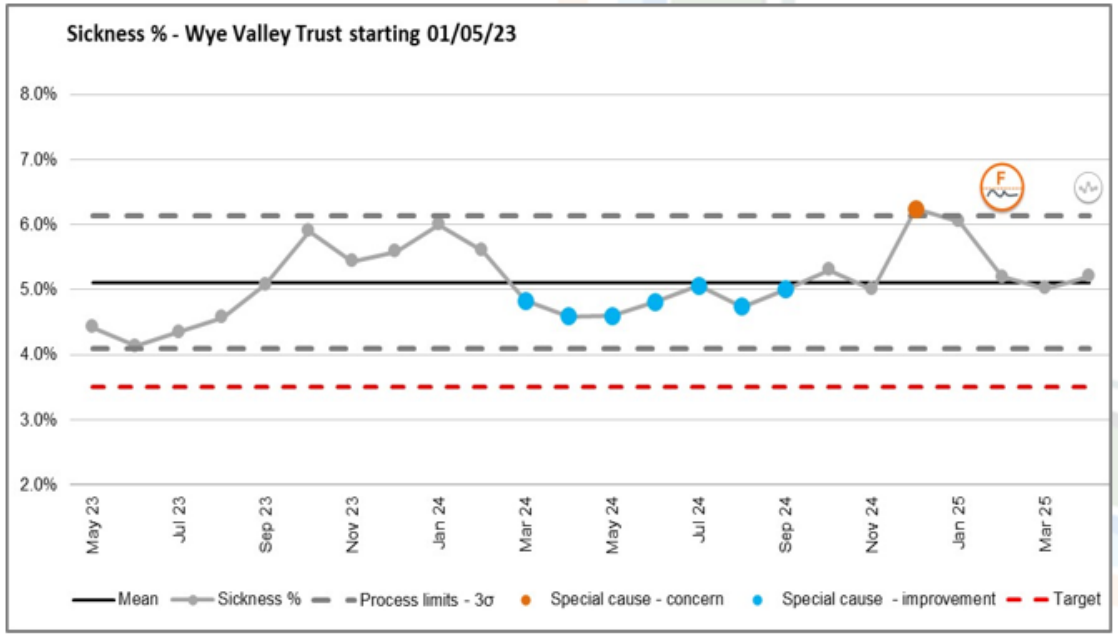


Performance & actions

During this month, overall sickness at Trust level stands at 5.2% and the main reasons for absence are colds/winter ailments, mental health issues, gatro and pregnancy related illness.
A revised absence policy with more stringent attendance targets especially for new employees has now been agreed with staff side representatives. 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 and to demonstrate formal management actions being taken.
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 a decrease position in the final 3 months of 24/25 reduced to pre winter pressure levels. This has slightly increased in the fist month of 25/26

Our Finance– Executive Summary

Katie Osmond
Chief Finance Officer

Month 1 Income and Expenditure position

Overall month 1 is largely on plan. This is a pleasing position given the critical incident that occurred at the latter end of April, estimated to cost in the region of £60k.

The Trust has set a breakeven plan for 2025/26, which includes a £25m CPIP challenge, and has been devolved to budget holders for delivery. The plan does include a high level of risk, estimated to be in the region of £16m. This includes items such as Welsh Parity income, income stretch (£2m), and CPIP opportunity and unidentified risk, including a level of assumed mitigation.

2025/26 is an opportunity for the Trust to focus on the spend reduction required year on year to reach a breakeven position, which includes a nationally prescribed 40% reduction on agency and 15% reduction on bank spending, as well as a headcount reduction on admin and clerical and support roles. The well established Financial Recovery Board (FRB) remains in place and will continue to maintain strong oversight of the risks and mitigations to support delivery of the plan, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability.

Cash

Cash balances at the end of April were £7m higher than planned and will continue to be closely monitored. The Better Payment Practice Code continues to be met.

Cash Balance				
Month	Performance	Target	Direction	Rating
February	31.4	27.4	↓	⚑
March	37.9	52.8		
April	35.3	28.1		
Cash balances are £7m higher than plan, due to reduction in debtors, driven by ICB receipts and timing of capital expenditure				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
February	99.3%	95.0%	↓	⚑
March	99.2%	95.0%		
April	98.4%	95.0%		
In April the Trust paid 98.4% of invoices within 30 days. This equates to 99.6% by invoice value. This is the sixteenth month, in a row, that we have achieved the 95% (by volume) target.				

Finance Performance – Year to Date Income and Expenditure

We are driving this measure because:

The Income and Expenditure plan reflects the Trust's breakeven plan, operations and the resources available to the Trust to achieve its activity, workforce and financial 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 1 - 30th April 2025 - 2025/26

	2024-25 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE CUMULATIVE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Contract Income	349,951	29,246	29,178	(68)	(68)
Excluded Drugs	10,484	874	776	(98)	(98)
Excluded Drugs	15,614	1,301	1,272	(29)	(29)
Non Contracted Activity (NCA's)	1,723	168	175	7	7
Other Income for Patient Care	12,612	1,051	1,068	17	17
Donations For Non Current Assets	240	0	0	0	0
Other Non Patient Income	8,093	674	577	(97)	(97)
ERF	0	0	16	16	16
6.3% Superannuation	0	0	0	0	0
Total Operating Income	**398,717**	**33,315**	**33,062**	**(253)**	**(253)**
Substantive Pay	219,132	18,420	18,244	176	176
Bank & WLI Pay	16,123	1,525	1,659	(133)	(133)
Agency pay	8,046	973	946	27	27
Non Pay Expenditure	98,785	8,483	8,603	(120)	(120)
Excluded Drugs	28,251	2,373	2,247	127	127
Total Operating Expenditure	**370,337**	**31,775**	**31,699**	**76**	**76**
EBITDA	**28,380**	**1,540**	**1,363**	**(176)**	**(176)**
Depreciation	13,414	1,118	1,057	61	61
Impairment	4,584	0	0	0	0
Interest Receivable	527	44	186	142	142
Interest Payable on Loans	180	15	13	2	2
Interest Payable on PFI	2,944	137	137	0	0
Dividends on PDC	4,296	358	358	0	0
Operating Surplus/ (Deficit)	**3,489**	**(44)**	**(16)**	**813**	**29**
Technical Adjustments					
Donated Assets - Additions	(240)	0	0	0	0
Donated Asset Depreciation	776	65	67	(2)	(2)
Donated Assets Adjustment	536	65	67	(2)	(2)
Net impact of asset impairments	4,584	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	(8,609)	(802)	(849)	47	47
Adj. financial performance retained Surplus/ (Deficit)	(0)	(781)	(798)	(16)	(16)

Performance & actions

The position at the end of Month 1 (April) was a deficit of £798k YTD. This was largely on plan with an overall adverse variance of £16k YTD. Within the month, there was a critical incident, that cost the Trust £60k that required mitigation.

- Income shows an adverse variance of £253k. This is largely offset within direct underspends in Non Pay in Excluded Drugs, Depreciation and Interest.
- Pay is favorable by £70k in month. The net position in month includes agency — 4.54% of total pay costs in month which is an increase from 2.62% in M12 (influenced by the £13.3m pension cost in M12). Bank use at premium rates further increases the total temporary staff proportion to 8.67% of overall pay.
- Total Non Pay (operating & non operating) is favourable by £254k YTD including technical adjustment benefits. The favourable variance is largely due to additional interest received due to high cash balances, and an underspend on excluded drugs (both offset by under-recovery of income).
- Within Adjustments, achieved a PFI £47k favourable variance driven by a technical adjustment to the control total for historical accounting changes on PFI

Risks

Key Financial risks

- Overall cost reduction needed to achieve breakeven by end of year
- CPIP Cost Efficiency delivery recurrently
- Level of Agency (as % of pay)
- Change in performance adjustment regarding PFI accounting
- Future cost pressures: eg. Winter and Critical Incident impact on financial performance
- Marginal Cost of delivering activity

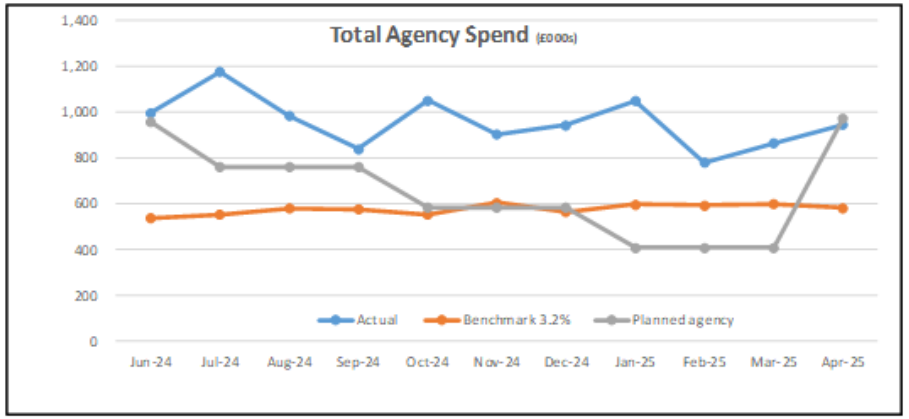
What the chart tells us

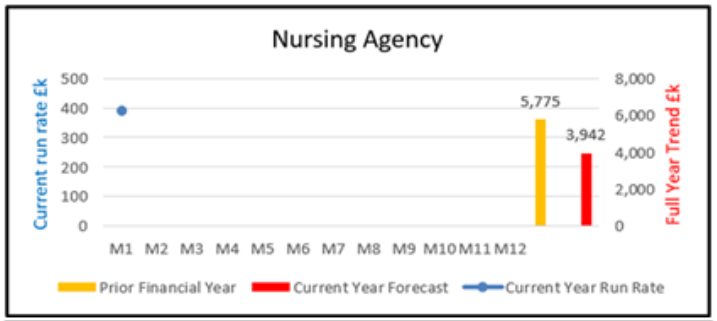
There are no material variances in this month, though the plan includes a number of known financial risks.

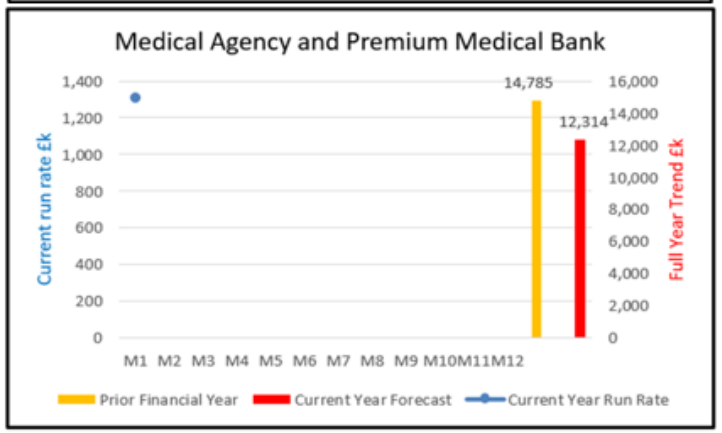
Finance Performance – Agency Spend

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 4.54% of total pay costs year to date, 1.3% 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 £946k. This represents a premium above the cost of corresponding substantive pay cost for the equivalent clinical hours.

- **Nursing agency:** Total spend in 2425 was £5.8m. Approved rate changes initiated from July 24, (latest rate card update in Jan 25) had reduced nursing agency spend in the previous year, other plans are also in place to further improve the trend. The cost for nurse agency spend in April was £390k.
- **Off framework Nurse Agency:** there has been a decrease in off framework use in month with 2 shifts booked in April compared to 11 in March. The total shifts booked in 2024/25 was 134.
- **Medical staffing agency and premium cost bank:** The Trust spent £15.3m in 2324 and £14.8m in 2425. The total spend in month 1 is £1,311k

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

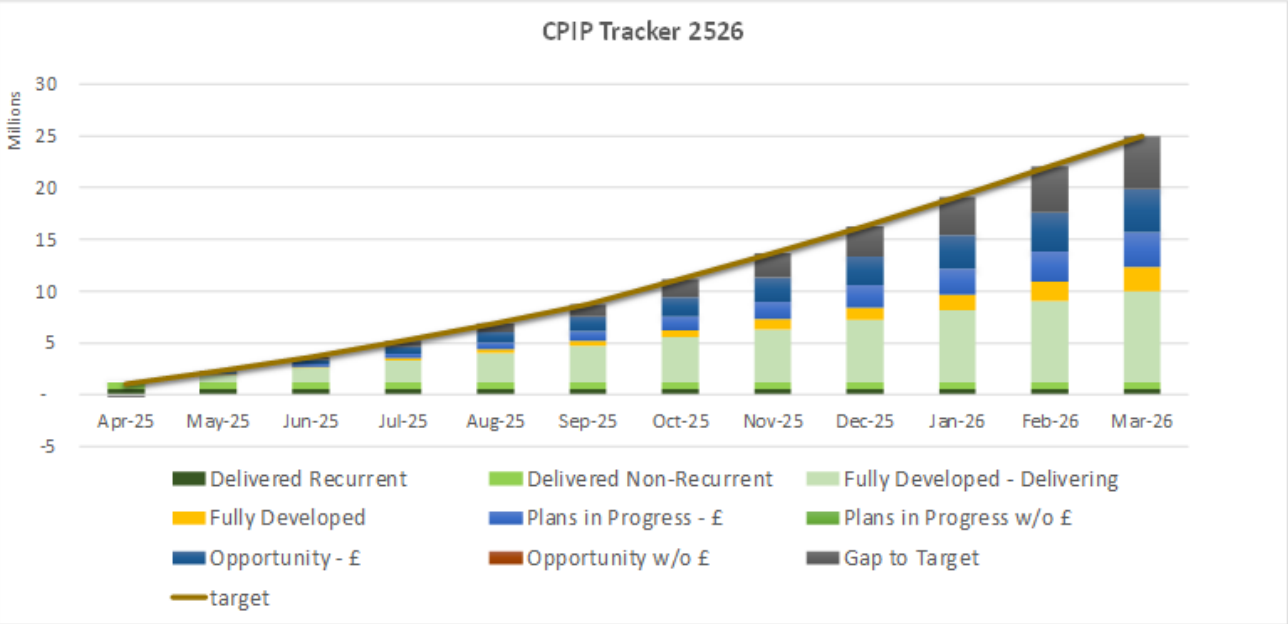
What the charts tell us

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.

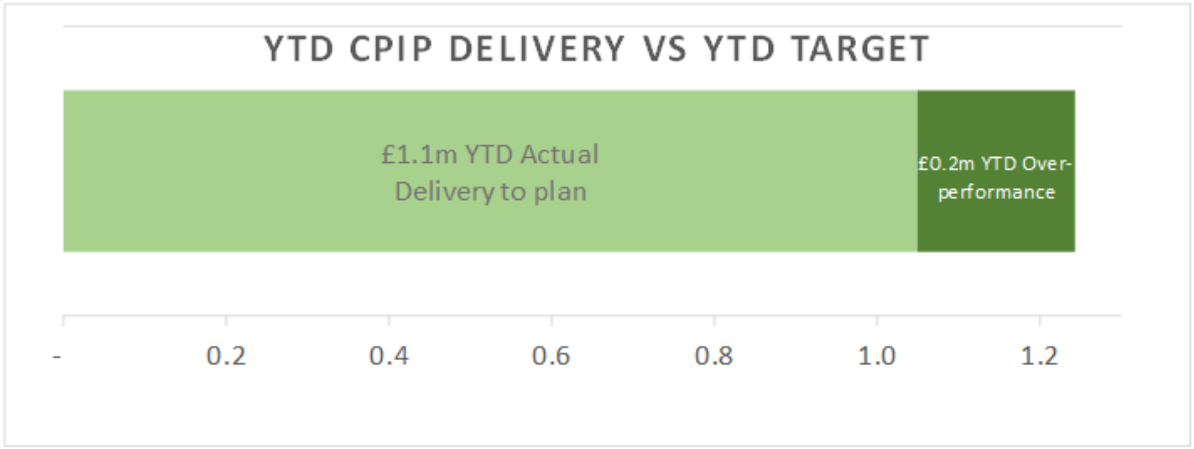


Performance & actions

The £25m target is set to be delivered through Pay £15.5m & Non Pay £9.5m, which includes a recurrent assumption of £17.35m. The £25m represents a cost reduction in 2025/26, including notable schemes of Agency reduction (40% year on year), Bank reduction (15% year on year) and a headcount reduction. The programme includes a continued focus on reducing growth from pre Covid levels.

The current position on CPIP delivery to date reflects a plan of £1.05m with a Trust delivery of £1.24m resulting in a £0.2m over-performance to plan. This does include £567k of recurrent delivery, £51k less than expected in the month. The critical incident has impacted the ability to deliver CPIP in M1 and so the overall delivery is pleasing.

The FRB continues to focus on furthering identification and delivery of CPIP in order to achieve our breakeven plan. As part of the FRB, monthly Check and Challenge meetings with Divisions continue to 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
Undelivered / non recurrent CPIP could be taken forward into 2026/27 target

What the charts tell us

There is currently a shortfall to deliver the planned level of CPIP. Focus is on identifying schemes, and converting unidentified & opportunities into deliverable schemes, in order to deliver a challenging CPIP target in year and sustainably.

Finance Performance – Elective Recovery

We are driving this measure because:

Delivering our full elective activity and income is key to successfully delivering the financial plan. Maximising the activity we undertake within the resources available will ensure best use of system resources and support financial sustainability

Performance & actions

2025/26 English Commissioners

- In 2024/25 we were able to access a national elective recovery fund (ERF) to reimburse activity over-performance.
- For 2025/26 the national pot has been delegated to the ICBs and we have to agree a notified payment limit, which is effectively the maximum income we can earn. As part of agreement of that notified payment limit, we are in the process of agreeing an Indicative Activity Plan (IAP) (activity by specialty and POD X price) that supports that. This is a complex piece of work
- In addition we have been notified that commissioners outside of H&W ICB will be reducing activity to 80% of 2024/25. These commissioners are significantly smaller that H&W ICB but will also require an IAP.

2025/25 Welsh Commissioners

- In the context of Powys Local Health Boards (PLHB) financial situation they confirmed in March 2025 an intention to adhere to the NHS Wales waiting times standards i.e. that all patients will receive treatment within 104 weeks and 52 weeks waits for outpatients by March 2026. This is different to the NHS England standards of all patients being treated within 52 weeks by March 2026. This excludes children, urgent and cancer pathways and only applies to those patients that have both a Welsh GP and reside in a Welsh postcode.
- Over the last few weeks we have been working with PLHB colleagues to understand the impact. In addition to a slow down in activity they have also included an expectation that this will significantly reduce the level of elective income we should expect through our contract. Our modelling suggests a smaller net impact on elective income, and we continue to work through this with Welsh colleagues.

Month 1: All Commissioners including Powys activity and £ by POD

	APRIL M1	APRIL M1
DC	£2,179,531	2,682
EL	£1,225,265	237
	£3,404,796	2,919
OPAFA	£1,352,599	6,708
OPROC	£1,237,238	7,185
	£2,589,837	13,893
Grand Total	£5,994,634	16,812

Risks

- Further work is required to triangulate the income plan, budget and elective activity monitoring to ensure we have correct reporting
- Agreement of the indicative plans with H&W ICB and other commissioners
- Agreement of Welsh elective activity plan

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 80.0%	Fail	Improvement - High		77.8%	79.2%	78.1%	79.3%	77.1%	72.7%	82.9%	75.9%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low	Yes	88.5%	92.1%	91.3%	86.4%	84.3%	85.9%	79.1%	83.8%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		43.8%	39.1%	21.4%	7.7%	20.0%	15.4%	0.0%	16.7%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		89.3%	89.8%	89.0%	91.9%	96.5%	90.2%	94.1%	95.4%	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		3	7	5	8	7	3	7	9	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause		74.8%	75.4%	73.5%	76.4%	71.3%	69.5%	67.2%	67.7%	
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		77.8%	100.0%	33.3%	66.7%	100.0%	88.9%	100.0%	100.0%	
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		65.7%	90.5%	56.8%	65.9%	87.9%	77.1%	74.3%	78.8%	
	Cancer: number of cancer patients waiting over 62 days	Cancer		No Target	Common Cause	Yes	88	61	50	38	54	52	60	74	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		111.5%	108.9%	124.2%	108.6%	118.3%	126.1%	110.5%	108.0%	
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		86.9%	87.4%	86.3%	87.3%	85.9%	85.2%	86.6%	86.2%	87.4%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Common Cause	Yes	102.2%	103.4%	101.2%	105.2%	104.0%	100.3%	96.3%	102.0%	99.0%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Concern - Low		75.9%	62.9%	51.1%	55.2%	49.4%	54.3%	60.3%	55.2%	44.3%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Variable	Concern - High		14.5%	18.8%	29.1%	25.1%	30.9%	29.7%	21.4%	26.6%	38.5%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		114.6%	120.2%	118.9%	128.9%	124.1%	121.1%	121.7%	127.3%	118.0%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		42.3%	44.4%	48.0%	48.2%	46.4%	47.2%	46.7%	49.1%	47.2%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Concern - Low		67.6%	65.8%	65.8%	64.8%	63.4%	64.1%	65.9%	63.2%	57.4%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Concern - High		10.8%	12.5%	12.4%	12.2%	13.3%	14.6%	13.0%	13.2%	16.4%
	A&E - Time to treatment	Urgent and emergency care		No Target	Common Cause		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care		No Target	Improvement - Low		1.9%	1.8%	1.7%	1.9%	2.0%	1.8%	1.5%	1.9%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High	Yes	312	284	270	256	232	322	219	293	277
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause		8.3%	7.7%	8.9%	9.2%					

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 61.0%	Variable	Concern - Low		55.6%	55.1%	55.8%	56.0%	55.1%	56.0%	56.4%	56.5%	57.1%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care	>= 95.0%	Fail	Common Cause	Yes	69.4%	69.5%	70.0%	70.0%	68.4%	69.2%	70.3%	70.0%	70.8%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		28708	28783	28761	28246	27766	27410	27488	27476	27943
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		1169	987	865	804	764	740	727	692	660
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		14	9	4	1	3	2	5	5	2
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		3	2	1	0	0	0	0	0	0
	GP Referrals	Elective care		No Target	Improvement - High	Yes	87.2%	94.6%	103.2%	91.1%	105.1%	98.7%	91.1%	101.7%	
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		114.1%	111.4%	116.6%	109.2%	108.3%	112.6%	113.8%	148.4%	119.3%
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Improvement - High	Yes	98.4%	83.1%	111.4%	78.0%	101.4%	104.4%	94.0%	82.0%	101.1%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		115.1%	110.8%	113.3%	107.9%	109.6%	109.2%	109.8%	140.1%	126.3%
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	106.8%	90.8%	115.7%	83.2%	111.4%	113.4%	98.0%	86.0%	108.0%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		105.0%	110.1%	107.9%	100.5%	100.8%	104.4%	104.0%	127.6%	106.5%
	Total Elective Activity (volume v plan)	Elective care		No Target	Common Cause		91.3%	87.8%	104.9%	78.3%	90.4%	97.9%	91.0%	77.2%	93.9%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Improvement - High		78.7%	80.2%	79.5%	78.8%	80.9%	80.3%	83.1%	82.0%	
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		40	32	26	31	39	35	20	26	
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Improvement - High	Yes	100.7%	118.0%	104.4%	107.9%	103.5%	86.8%	86.6%	102.7%	
	Diagnostic Activity - Endoscopy	Elective care		No Target	Concern - Low		126.9%	93.3%	91.4%	71.8%	83.3%	80.1%	89.1%	78.9%	
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Improvement - High	Yes	111.1%	116.2%	113.6%	127.4%	109.7%	93.4%	88.3%	119.2%	
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Improvement - Low		27.8%	17.2%	15.1%	13.3%	12.5%	21.1%	16.6%	21.4%	

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Elective Care	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Improvement - High		95.1%	88.9%	94.6%	94.0%	93.7%	97.1%	97.7%	97.8%	99.1%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Concern - High	Yes	16.3%	15.6%	16.2%	18.4%	17.8%	20.4%	22.5%	21.8%	19.8%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High		55.7%	55.3%	55.6%	61.8%	65.1%	64.6%	61.5%	66.5%	67.9%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High		88.1%	85.9%	87.8%	88.2%	90.2%	89.7%	89.2%	90.8%	88.7%
	Maternity Activity (Deliveries)	Elective care		No Target	Common Cause	Yes	85.6%	108.4%	92.9%	95.4%	94.9%	101.4%	93.8%	88.0%	91.1%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause		7.8%	6.5%	5.9%	6.3%	6.5%	6.2%	5.9%	5.4%	
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High	Yes	89.9%	89.3%	88.8%	88.3%	87.8%	86.7%	88.7%	88.0%	
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		115.6%	110.5%	111.8%	107.4%	110.2%	107.8%	108.0%	136.5%	129.7%
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Improvement - High	Yes	110.9%	94.8%	117.7%	85.8%	116.7%	117.9%	99.9%	88.0%	111.4%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		19.8%	20.1%	19.9%	20.2%	20.1%	21.4%	21.4%	19.9%	18.8%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term		No Target	Improvement - Low		4.1%	6.7%	7.5%	8.7%	7.9%	8.0%	8.4%	7.4%	8.1%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		98.6%	99.8%	99.9%	99.4%	98.8%	99.9%	99.7%	94.7%	
	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		134	204	348	150	69	129	81	64	117
	Patient ward moves emergency admissions (acute)	Safe, high quality care		No Target	Concern - Low		7.4%	7.1%	8.7%	7.5%	6.7%	7.0%	6.5%	6.4%	6.3%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		7	6	7	6	6	7	6	6	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause	Yes	3	3	2	2	2	2	2	2	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Concern - Low		17.1%	13.8%	15.5%	16.6%	15.1%	17.2%	19.3%	17.3%	16.7%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low		50.1%	47.5%	53.1%	49.0%	38.8%	38.5%	36.6%	24.9%	20.8%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		4.5%	4.9%	4.5%	5.0%	4.5%	4.5%			

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Safe, high quality care	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Common Cause	Yes	99	100	102	103	105				
	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	Improvement - High	Yes	0	0	0	0	0	0	0	1	1
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause		1	0	0	2	0	2	1	2	0
	Number of external reportable >AD+1 clostridium difficule cases	Safe, high quality care	44	Fail	Common Cause		10	6	2	5	6	0	3	3	1
	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		2	1	2	3	1	2	1		1
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Common Cause		92.0%	92.0%	92.0%	91.0%	89.0%	92.0%	92.0%	91.0%	91.0%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Common Cause	Yes		98.7%			99.4%			98.8%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Common Cause	Yes	73.9%	65.8%	64.4%	67.6%	63.0%	51.5%	65.5%	65.4%	
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Improvement - High		0.0%	66.7%	100.0%	80.0%	71.4%	54.5%	66.7%	66.7%	
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause		87.5%	76.5%	75.0%	86.0%	80.9%	73.9%	80.4%	75.9%	
	Number of complaints	Safe, high quality care		No Target	Common Cause		18	31	44	25	26	33	26	35	39
	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		51.6%	50.0%	51.7%	67.9%	48.1%	60.0%	45.5%	25.7%	58.3%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		79.1%	74.5%	79.0%	76.8%	73.7%	80.0%	80.6%	76.4%	72.6%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Concern - Low		84.2%	83.2%	87.9%	82.5%	83.6%	86.7%	86.8%	85.7%	81.3%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		85.7%	90.2%	97.0%	87.9%	92.3%	93.3%	94.1%	100.0%	100.0%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause	Yes	20.0%	18.0%	18.0%	18.0%	17.0%	18.0%	19.0%	19.0%	19.0%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Improvement - High		17.3%	15.0%	15.0%	16.0%	15.0%	15.0%	16.0%	15.0%	15.0%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		32.0%	30.0%	28.0%	32.0%	21.0%	23.0%	31.0%	24.0%	23.0%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		5.8%	4.5%	4.1%	4.6%	4.8%	5.3%	4.0%	2.6%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	80.3%	79.8%	80.1%	79.5%	79.8%	79.7%	77.6%	77.7%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		89.5%	88.0%	88.3%	88.6%	88.8%	89.3%	89.3%	89.4%
	Overall Sickness	Looking after our people	<= 3.5%	Fail	Common Cause	Yes	4.7%	5.0%	5.3%	5.0%	6.2%	6.0%	5.2%	5.0%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.8%	9.7%	9.4%	9.1%	9.1%	9.4%	9.2%	8.9%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Improvement - Low		6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	6.9%	4.2%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause	Yes	(£3686k)	£12576k	(£602k)	(£202k)	(£1260k)	(£3002k)	(£133k)	£5805k
	I&E - Margin (%)	Finance		No Target	Common Cause	Yes	(£0k)	£0k	(£0k)	(£0k)	(£0k)	(£0k)	(£0k)	£0k
	I&E - Variance from plan (£k)	Finance		No Target	Concern - High	Yes	(£606k)	(£645k)	(£178k)	£106k	(£953k)	(£2908k)	(£39k)	£5901k
	I&E - Variance from Plan (%)	Finance		No Target	Common Cause		(£0k)	(£0k)	(£0k)	£0k	(£0k)	(£0k)	(£0k)	£0k
	CPIP - Variance from plan (£k)	Finance		No Target	Common Cause		(£811k)	£539k	(£498k)	(£598k)	(£489k)	(£798k)	(£487k)	(£931k)
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low	Yes	£725k	£573k	£755k	£634k	£582k	£2848k	£804k	£1069k
	Agency - expenditure as % of total pay	Finance		No Target	Improvement - Low	Yes	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance		No Target	Concern - High	Yes	(£284k)	(£242k)	(£697k)	(£345k)	(£431k)	£175k	(£873k)	£2271k
	Cash - Balance at end of month (£m)	Finance		No Target	Common Cause	Yes	£18k	£14k	£37k	£29k	£25k	£21k	£31k	£26k
	BPPC - Invoices paid <30 days (% value £k)	Finance		No Target	Concern - High		£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

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
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 9th April 2025, the Licence to Install Service Media between Balfour Beatty Group Limited and WVT (part of the CDC programme of works) was sealed.
- On 14th May 2025 the Land Registry Transfer Deed - Electricity Substation site at Wye Valley Diagnostic Centre in Holmer Road 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.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Board Assurance Framework and Risk Appetite Report
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Associate Director of Governance
Reporting Route:	Executive Risk Management Committee
Appendices included with this report:	Executive Risk Management Committee Escalation and Assurance Report
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

Following approval of the Trust's strategic objectives for 2025/26 the Board Assurance Framework (BAF) risks and the Trust's Risk Appetite Statement have been reviewed and refreshed.

The new headline BAF risks are presented for Board approval prior to full assessment and description within a new BAF format.

A plan for the treatment of the 2024/25 BAF risks is presented for approval.

The refreshed Risk Appetite Statement is presented for Board approval with one proposed change to reflect a higher risk appetite relating to the people category.

A new Escalation and Assurance Report from the Executive Risk Management Committee is presented to provide assurance regarding management and oversight of corporate and operational risk and the development of the strategic risks within the BAF.

Recommended Actions required by Board or Committee

The Board is asked to:

a) Approve the BAF risks for 2025/26 for full development.
b) Approve the planned treatment of the 2024/25 BAF risks.
c) Approve the refreshed Risk Appetite Statement.
d) Receive for assurance the Escalation and Assurance Report from the Executive Risk Management Committee.

Executive Director Opinion[1]

The contents of the report have been considered by the Executive Risk Management Committee, which is chaired by the Managing Director.

[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.

Board Assurance Framework and Risk Appetite Statement Report 2025/26

1. Introduction

Following approval of the Trust's new strategic objectives, a review has been undertaken of the strategic risks for 2025/26. A set of new risks for inclusion in the Board Assurance Framework (BAF) has been presented to and agreed by the Executive Risk Management Committee.

The new risks are each aligned either to one of the new strategic objectives or to another Trust Board priority. Each will also be aligned to a Trust Board sub-committee for oversight.

Based on the new risks, the Executive Risk Management Committee also considered the Trust's Risk Appetite Statement.

The Committee's decisions were to:

a. Agree the proposed BAF risks for Board approval and further development.
b. Agree the treatment of the 2024/25 BAF risks.
c. Propose one change to the Risk Appetite Statement reflecting a higher risk tolerance relating to the workforce strategy.

Following Board approval, the new risks will be fully assessed and described in detail in a new format (endorsed by the Audit Committee), which is more closely aligned to the approach of Foundation Group partners and will enhance the Board's clarity of oversight.

The full BAF will be regularly presented to the Audit Committee as part of its role in overseeing the Trust's internal controls and risk management arrangements. The relevant Board and executive committees will regularly review the strategic risks aligned to them and the relevant sources of assurance. The Executive Risk Management Committee will regularly review the BAF prior to presentation to the Trust Board.

Going forward, Escalation and Assurance Reports from the Executive Risk Management Committee will be presented to the Board summarising its role in overseeing management of the operational and corporate risks on the Trust risk register. The first of these reports is attached at **appendix 1.**

2. Proposed new Strategic Risks

The following proposed risks will be further developed into the new BAF format with additional detail. The sources of internal assurance described are based on the KPIs attached to the new strategic risks; additional sources will be included as the risk descriptions are developed. The planned independent assurance described references the annual Internal Audit Plan; additional sources may emerge during the year and could include regulatory reviews.

The risk appetite references the proposed refreshed Risk Appetite Statement described in section 4 below.

Ref	Risk	Strategic Priority Alignment	Risk appetite	Committee oversight	Main Source of Internal Assurance	Planned independent assurance
BAF1	Risk of failure to improve patient experience in response to **patient feedback.**	Improve the inpatient experience by working with our partners to improve food quality. Increase the number of opportunities to grow our volunteer workforce, in numbers and reach.	High/ open	Quality Committee	Patient feedback	None planned
BAF2	Risk of failure to improve **urgent and emergency care.**	Improve urgent and emergency care with our One H system partners, resulting in reduced demand for acute in patients beds and more care in the community	High/ open	Valuing Patients Time Board	UEC constitutional standards performance	None planned
BAF3	Risk that we do not improve **operational capacity, productivity and patient flow.**	• Deliver agreed secondary prevention initiatives and schemes that reduce referrals for elective services by working with general practice teams. • Implement our neighbourhood health model with One Herefordshire partners and deliver better value from the Better Care Fund	High/ open	Valuing Patients Time Board	• Levels of GP referrals • Levels of internal referrals • Numbers of acute admissions of patients aged over 65 • Time from discharge ready date to discharge date • Rate of admission to long term residential care	Internal Audits: • Community services • Theatre productivity
BAF4	Risk that we do not improve **diagnostic performance.**	Deliver our Diagnostic Centre project to reduce waiting times for our population	High/ open	Valuing Patients Time Board	Diagnostic waiting times	None planned
BAF5	Risk that we do not achieve **transformation of services** to deliver the operational plan.	Improve the financial sustainability of the organisation by delivering a significant transformation programme	High/ open	Valuing Patients Time Board	Constitutional standards performance	None planned
BAF6	Risk of failure to deliver the **financial plan** and improve financial sustainability.	Improve the financial sustainability of the organisation by delivering a significant transformation programme	Moderate/ cautious	Financial Recovery Board	• Delivery of financial plan • CPIP delivery	Internal Audit: (Key Financial Controls -

						business intelligence & Contract management
BAF7	Risk of failure to maintain a sustainable, available, effective **workforce** able to meet demand and patient need and deliver the highest quality services.	• Improve attendance and improve staff well being • Deliver and monitor job planning and e-rostering across all clinical services	Significant/ seek	Trust Board	• Sickness absence • Staff turnover • Vacancies • Compliance with e-job plans • E-rostering implementation progress	Internal Audit: Medical Job Planning
BAF8	Risk of non-delivery of full **digital strategy.**	• Improve the functionality of existing systems, improving user and patient experience and productivity whilst reducing paper usage • Test artificial intelligence technology to deliver productivity and quality improvements and develop business cases for rapid implementation • Develop a plan that sets out the future direction for electronic patient records	Significant/ seek	Trust Management Board	• Reduction in movement of paper notes and associated cost savings. • Improved elective productivity and cost savings associated with AI use. • Completion of EPR Plan.	None planned
BAF9	Risk of a successful **cyber security** attack.	All	Significant/ seek	Trust Management Board	TBC	Internal Audit: Cyber Assessment Framework
BAF10	Risk that we do not deliver our **quality improvement** priorities.	Quality Priorities	High/ open	Quality Committee	Quality Priority progress reports	None planned
BAF11	Risk of failure to ensure our **hospital estate** is safe, sustainable and supports delivery of high quality care.	Capital Programme PFI Expiry Programme Carbon reduction Green Plan	High/ open	TBC	TBC	None planned
BAF12	Risk that we do not implement an effective transfer of responsibilities and a fully functioning, well maintained estate under the **Private Finance Initiative (PFI) expiry** arrangements.	PFI Expiry Programme	High/ open	PFI Expiry Committee	Programme progress	None planned

3. Treatment of Current BAF risks

The proposed plan for the current BAF risks is as follows. All risks will be closed on Inphase as the BAF will now be recorded separately.

a. Absorb into relevant new strategic risk

- Ability of system to manage flow across the urgent and emergency care pathway
- There is a risk that One Herefordshire will be unable to make improvements to 'working in a more integrated way'
- Difficulties in delivering on the Equality, Diversity and Inclusion agenda
- Clinical and support staff recruitment and retention
- Availability of Capital Funds to meet Trust's Strategic Objectives
- Delivery of the Digital Strategy
- Risks to productivity and operational capacity plans and delivery
- Inability to fund the required resource to achieve maximum functionality of EMIS
- Inability to identify resource to 'left shift' and/or maintain financial flow into Herefordshire
- Cyber Security

b. Reassess as a live operational/corporate risk

- Delivery of Academic Programme to improve our Research Profile
- One Herefordshire delivery of responsibilities contained within the MOU
- Risk of reputational damage to Wye Valley NHS Trust in relation to the strength of partnership working arrangements
- Fragility of the Haematology service at Wye Valley
- Fragility of Histopathology Service
- Fragility of Medical cover for Stroke pathway

c. Close

- Failure to gain system support for agreed Herefordshire Integrated Care Model

4. Risk Appetite Statement Review

Risk Appetite is the level of Risk that the Trust is willing to accept while pursuing its objectives before any action is determined to be necessary in order to reduce the Risk.

The Trust Board previously agreed that the Trust's Risk appetite would be reviewed using the Good Governance Institute Matrix for NHS Organisations.

The matrix has six risk levels as follows:

None	**Avoid**	Avoidance of risk and uncertainty is a key organisational objective
Low	**Minimal**	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Moderate	**Cautious**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
High	**Open**	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Significant	**Seek**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Significant	**Mature**	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

The current risk appetite statement was agreed in March 2024 and sets a risk level for each of six categories of risk as follows:

Finance	**Moderate**	**Cautious**
Regulation	**High**	**Open**
People	**High**	**Open**
Quality	**High**	**Open**
Reputation	**High**	**Open**
Innovation	**Significant**	**Seek**

The Executive Risk Committee reviewed this statement and agreed to propose to the Board a change to the risk appetite for the people category to reflect greater ambition and a more challenging strategy in this area in 2025/26. The proposed Risk Appetite Statement is overleaf. Once approved, the statement will be published on the intranet for staff reference. The proposed risk appetite level for each category has been reflected in the new BAF risk chart in section 2 above.

WYE VALLEY NHS TRUST RISK APPETITE STATEMENT

RISK APPETITE LEVEL ▶ RISK TYPES ▼	**0. NONE - Avoid** Avoidance of risk and uncertainty is a key system objective	**1. LOW- Minimal** 'As low as reasonably possible' (ALARP) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**2. MODERATE – Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**3. HIGH – Open** Willing to consider all potential delivery options and accept a degree of inherent risk while also providing an acceptable level of reward (and VfM)	**4. SIGNIFICANT – Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**5. SIGNIFICANT – Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
FINANCE ***How will we use our resources?***	Avoidance of financial loss is a key objective. We have no appetite for financial loss. We are only willing to accept the low-cost option as VfM is the primary concern. Tight controls in place with limited devolved decision taking authority.	We are only prepared to accept the possibility of very limited financial risk. VfM is the primary concern. Strong central control with limited devolved decision taking authority.	**We are prepared to accept possibility of some limited financial risk. VfM is the primary concern but willing to consider other benefits or constraints. Resources are generally restricted to existing commitments. Strong central control is the default but some devolvement of decisions is accepted.**	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not being the overarching factor. Resources are allocated in order to capitalise on opportunities. We carefully balance central control with devolvement of decisions.	We will invest for the best possible return and accept the possibility of increased financial risk. Resources allocated without firm guarantee of return. We tend to devolve decisions with lower levels of inherent risk.	We will consistently invest for the best possible return for stakeholders, recognizing that the potential for substantial gain outweighs inherent risks. Our default is to devolve decisions where possible, only keeping central control for decisions with the highest levels of inherent risk.
REGULATION ***How will we be perceived by our regulators?***	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of some limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	**We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.**	We are willing to accept decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders
PEOPLE ***How will we develop our people?***	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approached to workforce recruitment and retention are not a priority and will only be adopted if established and proved to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk as a direct result from innovation as long as there is the potential for improved recruitment and retention and developmental opportunities for staff.	**We will pursue workforce innovation. We are willing to take risks which may have impact on our people but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but is worthwhile due of long term gains.**	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
QUALITY ***How will we deliver safe services?***	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely necessary.	Our preference is for risk avoidance. However if necessary, we will take decisions on quality where there is a low degree of inherent risks and possibility of improved outcomes and appropriate controls are in place.	**We are prepared to accept the possibility of short term impact on quality outcomes with potential for longer-term rewards.**	We are willing to take decisions on quality where there may be higher inherent risks but potential for significant longer-term gains.	We seek to take high risk decisions on quality in pursuit of significant gains and mitigation to our other risks.
REPUTATION ***How will we be perceived by the public and our partners?***	We have no appetite for any decisions that could lead to additional scrutiny or attention on the organisation. External interest in the organisation viewed with concern.	Our appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	We are prepared to accept the possibility of limited reputational risk as long as appropriate controls are in place to limit the risk.	**We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.**	We are willing to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
INNOVATION ***How progressive and innovative do we want to be?***	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or established and proved to be effective in a variety of settings	Tendency to stick to the status quo, innovations in practice generally avoided unless really necessary. Systems/technology developments limited to improvements to protection of current operations & practice.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	**Innovation pursued –desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery.**	Innovation is the priority– consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery.

Appendix 1: Executive Risk Management Committee Escalation & Assurance Report

Escalation and Assurance Report

Report from: Executive Risk Management Committee
Date of meeting: 20 May 2025
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation
None

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Health and Safety Issues**
Rating rationale	The Health, Safety and Wellbeing Committee met in April and discussed emerging concerns about the management of sharps and the ability to demonstrate sustained improvement since enforcement action in 2019. The Committee Chair would discuss the issue with the Chief Nurse.
Outcome	The verbal report was noted. A formal report would be presented at the next meeting.
Item/Topic	**Risk Register Deep Dive (12+): Medical Division**
Rating rationale	The Committee considered the individual risks, the scoring, the adequacy of controls and planned mitigations and the sufficiency of information within the register. **Risks scored 15+:** • Long stays and overcrowding in ED: A recent workshop had identified improvement actions that were being developed; planned capital works were also expected to help address the situation. • Resuscitation space in ED: the planned capital plans for ED would include actions to help address this. • Mental Health Assessment room in ED: The risk was expected to be resolved imminently. • Consultant respiratory vacancies: Despite recruitment, the situation remained fragile due to continued staffing gaps combined with sickness. • Fractured Neck of Femur admissions: Additional improvements would be made to reduce the risk. • Speciality reviews in ED: the risk was expected to reduce imminently following actions. • SDEC consultant cover: A role was currently being advertised which would reduce the risk.
Outcome	The Committee was assured by the Division's improved management and oversight of risk.
Item/Topic	**Risks scored 15+: Surgical Division**
Rating rationale	The division had three live risks scored 15+. • Health psychology for children: this aged risk was also on the ICB risk register. It was agreed that following review of the risk score, the risk should be treated as 'accepted' as it could not be mitigated any further. • Medical workforce in paediatrics: An aged risk. The position remained fragile; recruitment was planned which it was hoped would reduce the risk. An aged risk of 5 years. • Theatre capacity: Funding had been received to address the issue; the risk score had been reduced to 9.
Outcome	The Committee was assured by the management and oversight of the Division's highest risks.
Item/Topic	**Risks scored 15+: Integrated Care Division**
Rating rationale	The division had only one live risk scored 15+; this related to patients waiting discharge to Powys, which was scored 16, reflecting a range of issues, including quality, such as the risk of hospital acquired functional decline. This cohort of patients was unable to benefit from Herefordshire community services or discharge initiatives and the length of stay was disproportionate compared with Herefordshire patients. Recent summits with Powys gave some confidence that the situation would be improved.
Outcome	The Committee was assured by the Divisional and Executive oversight of the risk.
Item/Topic	**Risks scored 15+: Clinical Support Division**
Rating rationale	The Division had four live risks scored 16+: • A risk related to data storage would shortly be resolved, with work about to commence • A plan to mitigate limited governance resources within Pathology had been developed; this would be described within the risk register before closure of the risk. • A funding plan was in place to reduce a ventilation risk in Endoscopy. It was agreed that the risk score was too high in any event and would be reviewed. • Options to support the clinical nurse specialist provision in Gynae-oncology were being reviewed with the Surgery Division to ensure resilience. It was agreed that the risk score would be reviewed and reduced.
Outcome	The Committee was assured by the management and oversight of the Division's highest risks.

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

Appendix 1: Executive Risk Management Committee Escalation & Assurance Report

Escalation and Assurance Report

Report from: Executive Risk Management Committee
Date of meeting: 20 May 2025
Report to: Trust Board

Item/Topic	Risks scored 15+: Corporate Departments
Rating rationale	There were 5 corporate/trust-wide risks scored 15+: The quality risk related to the use of temporary escalation spaces remained very high (20) with extreme levels continuing, A new plan was being prepared for the development of an Education Centre, with a range of mitigations already in place, which would enable the reduction of the risk score. The risk of ligature hazards in a number of areas would be overseen by the relevant clinical departments with support from Estates. The risks associated with the delivery of the Financial Plan and the PFI Expiry Programme would be closed and opened on the Board Assurance Framework.
Outcome	
Item/Topic	**Risks Awaiting Approval**
Rating rationale	The number of risks awaiting approval for all divisions had increased between March and April, with surgical having the most at 22 and ICD the least at 3.
Outcome	Divisional and department leads were encouraged to ensure regular review of new risks awaiting approval and swift deletion of any that were not approved.

Assure: Including assurance items rated green	
Item/Topic	**Board Assurance Framework (BAF) 2025/25**
Rating rationale	In line with the agreed new BAF approach, the report set out: • A plan for the 2024/25 risks • Proposed new/refreshed risks aligned to the new strategic objectives and other strategic priorities The detail for each risk on the BAF would be developed and would subsequently be overseen by the relevant committee for each risk.
Outcome	The Committee endorsed the approach and approved the proposed new risk headings for full risk assessment and inclusion in the BAF.
Item/Topic	**Closed Risks**
Rating rationale	14 risks had been closed by the divisions, demonstrating positive use of the risk register as a tool to manage risk. Some risks were closed as they had achieved target risk rating. Others had been absorbed within, combined with or superseded by other risks.
Outcome	The Committee approved the closure of all 14 risks.

To Note: Items received for information or approval	
Item/Topic	**Risk Appetite Statement**
Summary	In line with best practice, the Risk Policy required an annual review of the Risk Appetite Statement by the Trust Board. The statement was last reviewed in March 2024 and was based on a six-level matrix with six categories of risk. The statement had been reviewed alongside the proposed new BAF risks. The Committee agreed that the risk appetite statement did not require change with the exception of the people category. It was agreed that a higher risk appetite was needed this year in view of the national efficiency and productivity targets and the more ambitious strategy for the workforce this year.
Outcome	The Committee agreed to recommend to the Trust Board that no changes should be made to the current risk appetite statement with the exception of people category risks, where the appetite should be moved from 'high/open' to 'significant/seek'.

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

NHS
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WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Trust Annual Quality Account 2024-25
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	Quality Committee
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Trust Annual Quality Account details the progress against the 2024-25 quality priorities and sets out the quality priorities for 2025-26. The account includes all statutory information in relation to quality and safety of our services. The format is slightly amended this year based on feedback from the Patient Engagement Group.

Recommended Actions required by Board or Committee

The Board is asked to note the content of the quality account and approve the document for publication by 30th June 2025.

The board is asked to note the quality account has been approved virtually by Quality Committee ahead of presentation to the board.

Executive Director Opinion[1]

The Quality Account is recommended for approval, it has been prepared in line with national guidance; the account is no longer subject to an audit opinion.

The Board is asked to approved the account with the understanding that the following will be undertaken prior to full publication at end of June:

- External stakeholder comments will be included and any material comments escalated to Board for comment
- Final proof read and quality check

[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.

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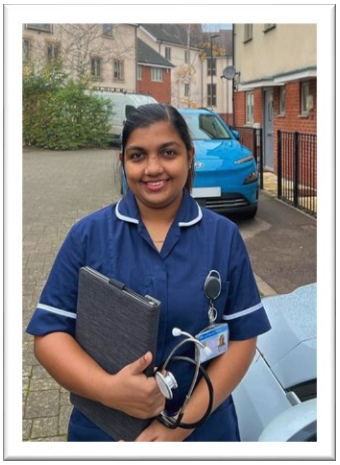


Quality Account 2024-25

Contents – to be updated once proof read

Introduction to Quality Accounts

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Quality Account for Wye Valley NHS Trust (the Trust) reflects on the achievements made in the past year against the goals set. It also looks forward to the year ahead and defines what the priorities for quality improvements will be and how the Trust expects to achieve and monitor them.

How will the Quality Account be published?

In line with legal requirements, all NHS healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30th June 2025. The Trust also makes the Quality Account available on the Trust website.

About the Trust

The Trust is an acute and community service provider, with a wide range of services provided to people of all ages living in Herefordshire and some of the population of mid-Powys. The Trust employs over 4000 staff who operate from the County Hospital, many community sites and in people's homes.

Wye Valley NHS Trust was established in 2011 and provides healthcare services at Hereford County Hospital in Hereford and at community hospitals in Ross-on-Wye, Leominster and Bromyard.

The Trust provides community and hospital care to a population of approximately 195,000 people in Herefordshire and a population of more than 40,000 people in mid-Powys, Wales.

The Trust has four clinical divisions: Surgical, Medical, Integrated Care and Clinical Support.

The Trust delivers joined up services, helping people to remain independent at home for as long as possible by providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, the Trust offer a wide range of services to keep you and your family well.

The Trust is part of a Foundation Group with South Warwickshire NHS Foundation Trust, George Eliot Hospitals NHS Trust and Worcestershire Acute Hospitals NHS Trust with a single Chief Executive Officer and Chairman. All four organisations face similar challenges and have a common strategic vision for how these can be solved. The Foundation Group model retains the identity of each individual trust whilst strengthening the opportunities available to secure a sustainable future for local health services and providing a platform to share best practice and improve whole system patient pathways.

Having been rated as 'Requires Improvement' by the Care Quality Commission the journey to 'Good' is continuing and the Quality Account illustrates what the Trust are doing to achieve this.

Wye Valley NHS Trust Mission and Values

Our Mission:
To provide a quality of care we would want for ourselves, our family and friends.

Our Values:
Compassion - We will support patients and ensure that they are cared for with compassion.

Accountability - We will act with integrity, assuming responsibility for our actions and decisions.

Respect - We will treat every individual in a non-judgemental manner, ensuring privacy, fairness and confidentiality.

Excellence - We will challenge ourselves to do better and strive for excellence

Introduction from the Chief Executive

The last year has been a positive year for Wye Valley NHS Trust with much to celebrate and I am proud to see so many good news stories from across our services for 2024-25 highlighted in the Quality Account.

Last year saw the Trust implemented the National Patient Safety Strategy, going 'live' with the Patient Safety Incident Response Framework and connecting to the new national incident reporting system within national timeframes.

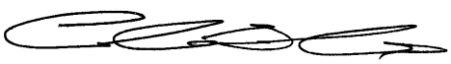
In 2024-25 the Trust has started to see the benefits of this new method for learning from patient safety incidents. In particular with our work on reducing pressure ulcers developing or worsening in our care, seeing a 30% reduction in cases (category 2 pressure ulcers).

Quality and Safety remains a top priority for the Trust and is at the forefront of our work with system partners ensuring that patients continue to access the right services at the right time, despite the pressures we face across primary care, secondary care and within our community services. A system-wide forum (Safety in Sync) where learning is shared and colleagues work together to improve the quality and safety of our services was shortlisted for a Health Service Journal Award for 'Developing a positive patient safety culture'. This reflects the way in which we work together and put patients at the heart of our service improvements.

The Quality Account details successes and external recognitions of our work and there is much to celebrate. Last year also saw the introduction of our 'We Share We Learn' competition, allowing staff to showcase projects demonstrating improvements in quality of care. You can read all about the winning project 'Rheumatology homecare' in the account.

It has been pleasing to see the re-establishment of our Patient Engagement Group and the projects they have been involved in throughout the year. Our local carer's organisations have also joined this group ensuring our focus on quality of care reaches beyond our patients but to those who support our patients in their home environment managing their health conditions. I would like to extend my thanks to the Group for their support in producing the Quality Account this year.

I welcome the Quality Priorities we have set for 2025-26 and look forward to seeing more improvements to our services over the coming year.



Glen Burley, Chief Executive

Celebrating External Recognition

Leominster Community Services receives Civic Award for all services - #AmazingWVTStaff
Leominster Community Hospital was nominated for a Civic Award. Marijke Post, Locality Manager North & West, received the award at the Town Council meeting on 8 April on behalf of all staff for all services in Leominster – inpatients, outpatients and community services.

Marijke thanked the town and its residents for the award and explained how much it meant – especially in the challenging times for the NHS at the moment. Many residents came up to share their positive experiences of receiving care from Leominster Community Hospital – either as an outpatient, on our wards or from our community teams. There was a great sense of pride from residents about their hospital.

Marijke spoke about the importance of the hospital as a community asset and gave some examples of integrated working: paramedics from the local GP surgery, Ryeland Road, sharing an office with the Leominster District Nursing Team; our partnership with the Leominster Wildlife Trust and our ambition to open a Leg Café at our community hospital.

The nomination is listed here (it was received a year ago):

"Leominster considers itself very lucky to still have a Community Hospital. For over 100 years it has served our community and the towns surrounding it. Many of us can say that at some point we have been a patient of both the old Cottage Hospital and the current Community Hospital, whether it be as an inpatient or an outpatient visiting many of the outpatient department it offers. The last 3 years have been hard on everyone, but the staff were there 24/7 caring for the most poorly of our community during the high peaks of Covid19. They strived to deliver the best care in a stressful situation. They went above and beyond the call of duty, not only to keep those in their care safe but also themselves. 3 years later they are still maintaining the high level of care. To acknowledge their service to the community couldn't be served better than this award to acknowledge their service to the community of our wonderful little town."

Marijke receiving the award at the Town Council meeting

Marijke with staff members who help provide services at Leominster Community Hospital from ward staff, kitchen and domestic staff to administrators and community nurses

#AmazingWVTStaff shortlisted for Institute of Biomedical Science Award
Well done to Kim Owens, a trainee Biomedical Scientist from Histopathology who has been shortlisted for the Rising Star award at the IBMS awards 2024 after being nominated! Kim has been at WVT for over 12 years and last year she started a degree apprenticeship with Staffordshire University and has been working incredibly hard studying whilst having a full time job and balancing life events.
We wish her the best of luck at the awards taking place on Friday 28 June.

Wye Valley NHS Trust and One Herefordshire Partnership shortlisted for an HSJ Patient Safety Award!
We are very proud that the Safety in Sync forum was shortlisted by the HSJ for a 'Developing a Positive Patient Safety Culture' award.

Safety in Sync is a forum open to all staff across Herefordshire from health and social care organisations to discuss quality and safety issues that need system collaboration to mitigate risks to patient safety.

Safety in Sync is carefully crafted to provide a psychologically safe space for colleagues to raise quality and safety issues that impact beyond a single organisation. Staff can share their patient safety concerns and these are received with a view to providing support, advice, resource, expertise and an integrated approach to mitigating risks within our system; truly putting patient needs at the heart of our decision making.

Discussions are summarised in a newsletter and shared widely with all organisations at PLACE. The aim of the forum is to use the collective knowledge, skills and expertise across the system to rapidly mitigate patient safety risks and develop sustainable improvements.

"I am absolutely thrilled that we were a finalist for this award and really proud of the team who make this happen, I want to give a massive shout out to Natasha Owen for her leadership in making this the success that it is today – Well done Natasha and the whole team.

The forum has gone from strength to strength over the last 12 months and has made tangiable differences to patient safety and experience for the populations we serve." Lucy Flanagan Chief Nursing Officer

If you would like to join Safety in Sync, to bring a topic for discussion or simply listen, we meet virtually, from 0830-0930 on the last Thursday of each month and you would be very welcome. Please contact safety@wvt.nhs.uk for more information.

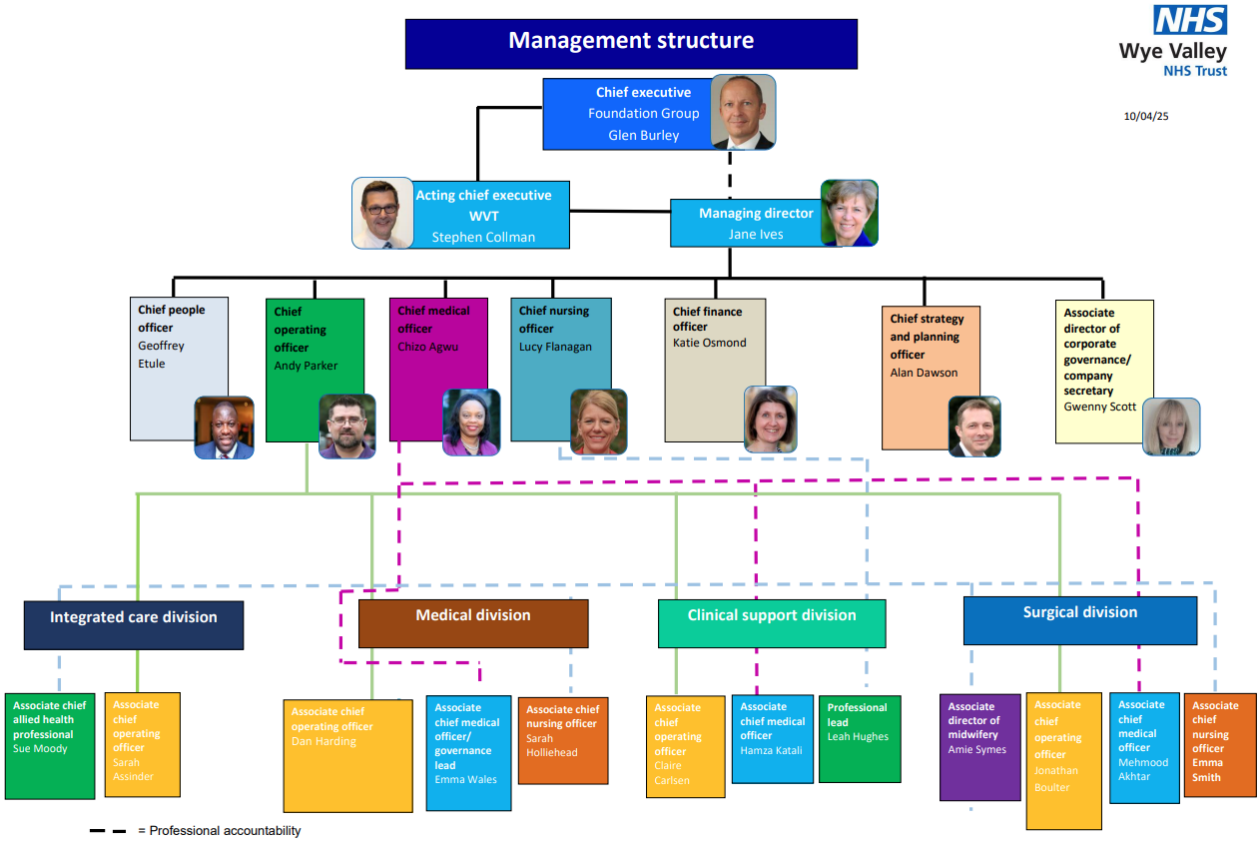
#amazingWVTstaff
Mental Health and Physiotherapy services receive 'commended' certificates
Our occupational health department entered our Mental Health service and Physiotherapy service into the National Occupational Health Awards through the NHS Health at Work Network. Both services received certificates commended them.

Organisational Change

Wye Valley NHS Trust is part of a Foundation Group that includes South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and Worcestershire Acute Hospitals NHS Trust. Each Trust retains its own Trust Board with the common link being a shared Chief Executive Officer and Trust Chairman.

The Foundation Group enables the Trust to strengthen opportunities available to help secure a sustainable future for all four organisations and allows each Trust to maintain its own governance while benefitting from scale and learning across the wider group.

In October 2024, the Trust appointed Gwenny Scott as Associate Director of Corporate Governance/Company Secretary, following the retirement of Erica Hermon.



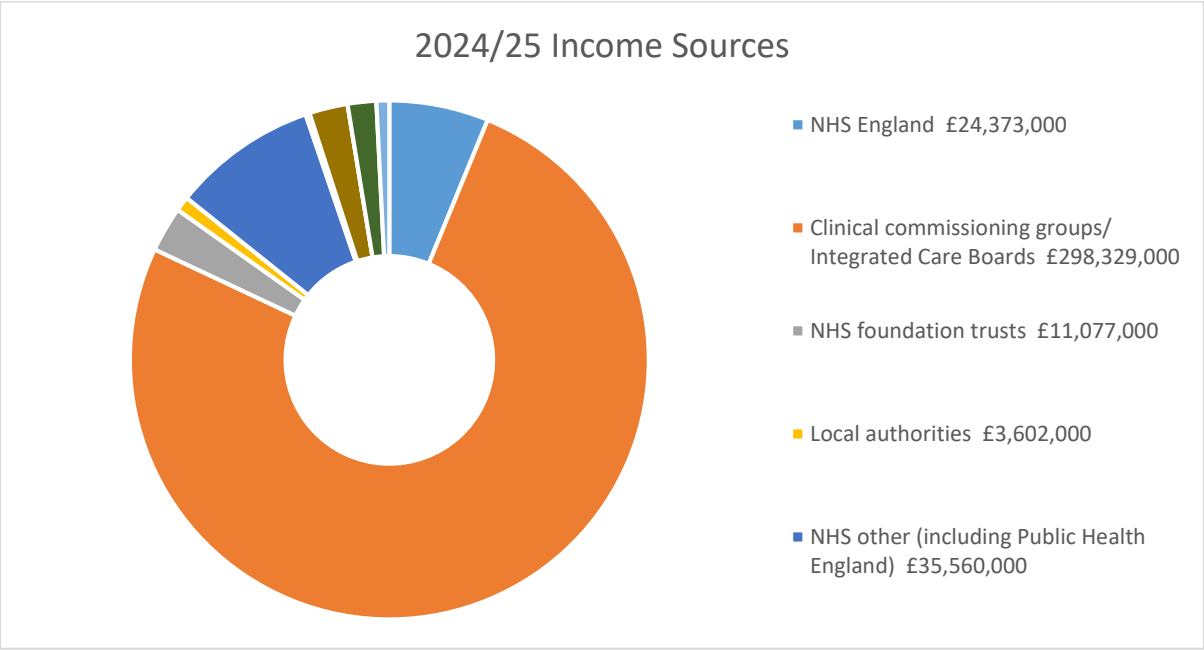
Statement of Assurance

The Trust provided and/or subcontracted 62 acute and community services for the population of Herefordshire, bordering English counties, and mid- Powys (details on these services is provided in Appendix 4). The Trust has reviewed all the data available on the quality of care in all of these services.

More detail on the income of the Trust can be found in the Annual Report 2024-25.

The income generated by Wye Valley NHS Trust for services reviewed in 2024-25 represents 100% of the total income generated from the provision of relevant health services.

A breakdown of income received from each body for 2024-25 is illustrated below.



Care Quality Commission (CQC) Overview of Progress

The Trust had no official CQC inspections.

Herefordshire welcomed Ofsted and CQC inspectors in December 2024, who undertook a local area SEND Partnership Inspection. Herefordshire's SEND partnership is jointly led by Herefordshire Council and NHS Herefordshire and Worcestershire Integrated Care Board (ICB) and commissions services for children and young people with Special Educational Needs and Disabilities (SEND) in the county.

The findings of the inspection highlights many areas of good practice across the partnership, recognising the positive impact of new ways of working, including our drop-in clinics for speech and language therapy and physiotherapy.

Co-production with children and young people with SEND and their families is strong. The development of the 'Herefordshire Helpers' has raised the profile of children and young people at the highest levels. Parent carer voice Herefordshire told inspectors that they feel heard and that their views are acted on by the partnership.

Three national survey reports were released by the CQC in 2024/25 for inpatients, maternity and urgent and emergency care further detail can be found on pg.42.

The County hospital's overall rating remains requires improvement. For the full breakdown of service ratings see Appendix 1.

The Trust is currently registered with the Care Quality Commission without any compliance conditions and is licensed to provide services.

Ratings for the whole trust

Safe	Effective	Caring
Requires improvement ➔➔ Mar 2020	Requires improvement ➔➔ Mar 2020	Good ➔➔ Mar 2020

CELEBRATING CHANGE

The first annual Poster competition held at Wye Valley Trust allowed entrants the chance to showcase their innovative ideas aimed at improving patient care and safety.

RHEUMATIC RELIEF:

Taking control of rheumatology homecare prescriptions

Erin Tew, Lead Rheumatology Pharmacist

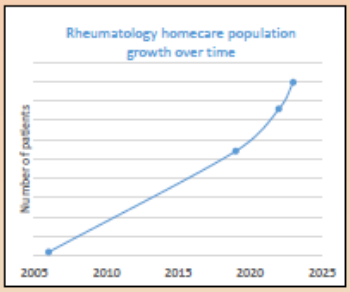
BACKGROUND

The Rheumatology Biologics team was established in 2006 to coordinate the prescribing and administration of biologic DMARDs to 40 patients. The Biologics team at WVT is acknowledged as novel due to its cost-effective use of admin staff to support the clinical team.

Today, our formulary includes 15 biologic DMARDs and 5 small molecule inhibitors with NICE approval for increasing numbers of rheumatological conditions.

By the end of 2021, NICE had expanded eligibility criteria for 5 drugs allowing patients with moderate rheumatoid arthritis to access treatment before disease progressed to severe activity.

By May 2024, the service coordinates treatment for 1,115 patients including 809 patients prescribed either biologic DMARDs or targeted synthetic DMARDs via homecare.



PROBLEM & IMPACT

Following staff turnover in key roles during Spring/Summer 23, the Biologics team had reached overwhelm by Autumn 23.

A large number of homecare prescriptions were due or overdue for renewal. It was difficult to clearly identify or define this workload: prescription renewal was driven by the homecare provider and variation exists in the prescription request processes.

Negative impact on patient care: delayed or missed doses which for some patients resulted in worry, reduced symptom control or symptom flare.

Negative impact on Rheumatology department: increasing numbers of prescription queries received by Biologics team. Increasing numbers of advice and guidance requests for support managing symptoms and flare.

Negative impact on staff morale and wellbeing: both within the Biologics team and the wider Rheumatology Department as work pressure increased.

AIM

To ensure that homecare prescriptions are renewed safely and efficiently without delay to patients

SOLUTIONS

Interventions were implemented stepwise following PDSA methodology

[1] VISUALISE THE WORKLOAD
A worklist was developed to calculate prescription renewal date and is used to identify priority tasks

[2] GOVERNANCE
Implementation of an SOP to standardise practice and underpin decision making for non-clinical staff

[3] EXTEND Rx DURATION
Established prescriptions extended to 6months/24weeks. Later extended to 56week maximum.

[4] OPTIMISE STAFFING
Pharmacist NMP facilitated rapid prescription completion
Pharmacy Technician secondment facilitated significant progress with processing overdue prescriptions and resolving outstanding prescription queries.

[5] REDUCE RENEWAL LEAD TIME
Estimated that prescription renewal required 4-6weeks ahead of due date to allow for processing time and delivery.

OUTCOMES

	October 2023: Reactive processes	May 2024: Proactive processes
Total homecare patients (exclusions: methotrexate prescriptions)	740	↑ 809
Projected number of prescriptions/year	2,591	↓ 1,292
Overdue prescriptions	247	↓ 25 (all known to be on hold)
Average length of prescription	18weeks	↑ 42weeks

Anecdotal findings: significant reduction in queries relating to late/missing prescriptions directed to Biologics team directly from patients or from clinicians responding to advice and guidance queries or following clinic appointments.

LEARNING & SHARING

Rheumatology homecare population is projected to increase further: this project demonstrates the benefit of working smarter within the existing staffing resource. Ensuring efficient and effective functioning of the Biologics team is essential to the core running of the Rheumatology department.

Opportunistic collaboration with the Pharmacy homecare team was essential to achieving early visualisation of the workload.

Safe and robust prescribing processes are necessary to ensure timely prescription renewal and prevent unintentional breaks in treatment that could impact on patient morbidity and mortality.

Robust process for stopping/suspending prescriptions provided organisational confidence to extend prescription duration.

We anticipate that the full benefit from this project will be realised in January 2025 when all suitable prescriptions have been extended to a maximum of 56 weeks.

Future opportunities for development could include centralisation of homecare prescribing processes to support service resilience for more specialties this could be at Trust or ICB level.

Rheumatology team have been updated with project developments as they have evolved. Additionally, the project outcomes have been shared with Pharmacy and Medicines Optimisation team at Herefordshire & Worcestershire ICB. We have been approached to support the Gastro Specialist Pharmacist to develop parallel processes including a prescription worklist to support the management of their homecare workload.

Solutions to the challenges associated with growing homecare populations are of interest nationally; we intend to submit abstracts to the European Alliance of Associations for Rheumatology conference and the Clinical Pharmacy Congress.

The results achieved by this project would not have been possible without the hard work of Holly-May Crawford, Lynne Owen, Michele Aflalion, Sarah Collier, Claire Tyler, Jane Kelly & Edan Weeks. We are grateful for the help provided from Pharmacy by Yvonne Coats, Shaun Jones & Huw Roberts.

Core Areas of Assurance

National Audit and National Confidential Enquiries (NCEPOD)

We participated in 57 (95%) of National Clinical Audits

Data submission ranged between 25-100% of eligible cases for individual audits

Clinical teams present reports and improvement action plans to their Specialty Audit Meetings

During 2024/25, there were 60 national clinical audits that Wye Valley NHS Trust were eligible to participate in based on the services provided. The Trust participated in 57 (95%) of national clinical audits. In addition, the Trust participated in 100% of the National Confidential Enquiries. Detailed in Appendix 2.

There were a total of 3 eligible audits that the Trust did not participate in during 2024/25:
1. National Ophthalmology Audit Database
2. National Cardiac Arrest Audit
3. Oral and Dentoalveolar Surgery Study

National Data opt-out

The national data opt-out program enables patients to decline the use of their confidential medical information for research and planning purposes.

Prior to the Trust submitting data to the appropriate national audits, it is essential to identify and exclude patients who have chosen to opt out. This process may lead to a decrease in the number of patients included in the audit, and in instances where patient numbers are low, it can affect the audit results. Such considerations will be taken into account when evaluating outcomes and implementing necessary actions.

The Trust had lower case submission rates for Myocardial Ischaemia National Audit Project (MINAP) due to staffing pressures and patient care taking precedence over data collection. Measures have now been implemented to enhance participation in the audit.

Learning from Audit

In 2024/25 the Trust Clinical Audit Programme included a total of 299 projects (national & local combined). The programme is monitored by the Trust's divisional and directorate governance groups on a monthly basis with oversight through the Clinical Effectiveness & Audit Committee. Within Wye Valley NHS Trust the results from national and local clinical audits are reviewed by the clinical teams involved in the audit at specialty level. If the review indicates that improvements are required, action plans are devised and monitored within the divisions.

Highlights from Various Published National Audit Reports during 2024/25

There were 43 national clinical audits that published reports in 2024/25 and 7 reports for the National Confidential Enquiry programme. Following review by the relevant specialty, with action plans developed where appropriate.

A selection of these reports have been included below reflecting areas of good practice and what the Trust intends to do where standards are not met.

National Emergency Laparotomy Audit

The National Emergency Laparotomy Audit (NELA) was established to describe and compare inpatient care and outcomes of patients undergoing emergency laparotomy in England and Wales in order to promote quality improvement, by collecting high quality comparative data from all NHS providers.

NELA National Emergency Laparotomy Audit

Executive Summary

Wye Valley NHS Trust

Results from 2021–2023 – the Ninth Year of the National Emergency Laparotomy Audit

1 **166 patients** who had emergency bowel surgery were included in the Year 9 audit

2 Improvements in mortality– **Hospital mortality was 7.6%** compared to the national mean of 9.3 %

3 Preoperative assessment of risk **was within target at 88%** after peaking at 90.4% in Year 8.

4 **83.5% of patients** with a high documented risk had **consultant surgeon** input before surgery.

54.1% of patients with a high documented risk had **consultant anaesthetist** input before surgery.

5 **Patients with sepsis** suspected at time of arrival in hospital waited a median of **15.5 hours from time of admission** until surgery. (This data reflects the overall duration across all hospitals)

6 **Median time to antibiotics in patients with suspected sepsis** was 3.1 hours from arrival in hospital. (This data reflects the overall duration across all hospitals)

7 **54.8% of patients** had CT reported before surgery **Compared to** 48.1% in Year 8

8 Presence of both **anaesthetic and surgical consultants** during surgery in high-risk patients was **89.4% compared to** 90% in Year 8

9 **82.6% of high-risk patients** were admitted to critical care postoperatively **compared to** 79.8% in Year 8.

10 **16% of patients** aged 80 or over, or 65+ and frail, had geriatrician input **compared to** 33% in Year 8.

11 Postoperative length of hospital stay (LOS) **in Year 9 was12 days compared to** 16 days in Year 8.

Areas reflecting good practice:

We are proud to report that we have achieved good performance in the following key areas, demonstrating our commitment to patient safety and quality care:

- Case ascertainment
- Comprehensive documentation of preoperative risk factors
- Prompt arrival in the theatre, aligning with the urgency of each case
- Pre-operative input of a consultant surgeon and anaesthetist for patients with a documented risk of death at 5% or higher
- Assurance of a consultant surgeon and anaesthetist's presence in the theatre for cases with a risk of death of 5% or more
- Admission to critical care postoperatively for patients with a risk of death of 5% or greater
- Optimised postoperative length of stay
- Our current mortality rate stands at 7.6%, positioning us as the second lowest in the region for emergency laparotomy procedures.

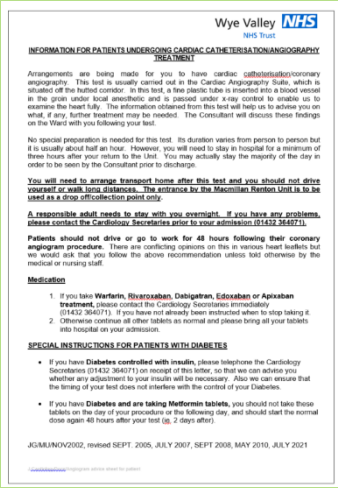
Areas requiring improvement:

- Perioperative assessment by a member of the geriatrician led multidisciplinary team for patients aged 80 plus or 65 or over with a clinical frailty score of ≥5
- Admission to Critical Care (risk of death is ≥5%)

Local actions taken:

- The Frailty team is now engaged on a daily basis through an emergency patient list to assess individuals aged 80 and above, or those aged 65 and older with a clinical frailty score of 5 or higher
- All patients with a mortality risk of 5% or greater are now admitted to Critical Care following an emergency laparotomy
- The provision of a 24hr emergency theatre (CEPOD theatre) CEPOD stands for Confidential Enquiries into Perioperative Deaths
- A dedicated Consultant Anaesthetist Lead for Emergency Surgery to drive forward best practice
- Introduction of a new Emergency Laparotomy Quality Improvement Care Bundle with NELA specific requirements in relation to fluid management, lactate measurement to identify sick patients and early antibiotics within 1 hour if sepsis, suspected peritonitis or perforation.

Key Results demonstrated from a local Quality Improvement Project
Cardiac Catheterisation and Coronary Angiography Patient Information Leaflet



Wye Valley NHS
NHS Trust

INFORMATION FOR PATIENTS UNDERGOING CARDIAC CATHETERISATION/ANGIOGRAPHY TREATMENT

Arrangements are being made for you to have cardiac catheterisation/coronary angiography. This test is usually carried out in the Cardiac Angiography Suite, which is situated off the hutted corridor. In this test, a fine plastic tube is inserted into a blood vessel in the groin under local anesthetic and is passed under x-ray control to enable us to examine the heart fully. The information obtained from this test will help us to advise you on what, if any, further treatment may be needed. The Consultant will discuss these findings on the Ward with you following your test.

No special preparation is needed for this test. Its duration varies from person to person but it is usually about half an hour. However, you will need to stay in hospital for a minimum of three hours after your return to the Unit. You may actually stay the majority of the day in order to be seen by the Consultant prior to discharge.

You will need to arrange transport home after this test and you should not drive yourself or walk long distances. The entrance by the Macmillan Ranton Unit is to be used as a drop off/collection point only.

A responsible adult needs to stay with you overnight. If you have any problems, please contact the Cardiology Secretaries prior to your admission (01432 364071).

Patients should not drive or go to work for 48 hours following their coronary angiogram procedure. There are conflicting opinions on this in various heart leaflets but we would ask that you follow the above recommendation unless told otherwise by the medical or nursing staff.

Medication

1. If you take **Warfarin, Rivaroxaban, Dabigatran, Edoxaban or Apixaban treatment,** please contact the Cardiology Secretaries immediately (01432 364071). If you have not already been instructed when to stop taking it.
2. Otherwise continue all other tablets as normal and please bring all your tablets into hospital on your admission.

SPECIAL INSTRUCTIONS FOR PATIENTS WITH DIABETES

- If you have **Diabetes controlled with insulin,** please telephone the Cardiology Secretaries (01432 364071) on receipt of this letter, so that we can advise you whether any adjustment to your insulin will be necessary. Also we can ensure that the timing of your test does not interfere with the control of your Diabetes.
- If you have **Diabetes and are taking Metformin tablets,** you should not take these tablets on the day of your procedure or the following day, and should start the normal dose again 48 hours after your test (ie. 2 days after).

JG/MU/NOV2002, revised SEPT. 2005, JULY 2007, SEPT 2008, MAY 2010, JULY 2021

Project aim

The development of a new patient information leaflet for cardiac angiograms is essential to ensure patients receive accurate, up-to-date, and comprehensive guidance about the procedure.

The existing leaflet had not been updated to reflect recent advances in angiogram techniques, leading to outdated information that may not align with current best practices.

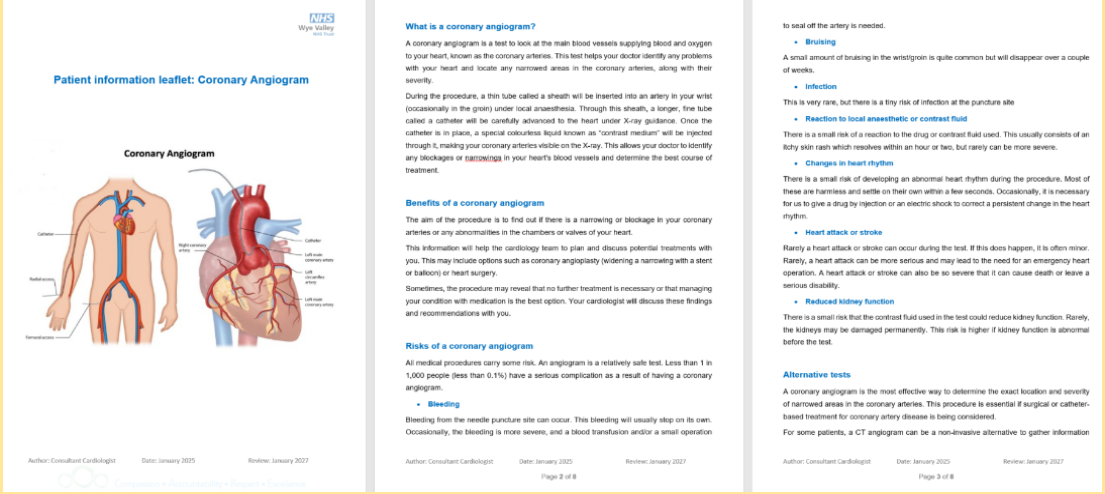
Additionally, it lacked the crucial details that should be provided to patients, such as updated procedural expectations, potential risks, and post-procedure care instructions.

A revised leaflet will enhance patient understanding, improve informed consent, and contribute to a better overall patient experience.

What we did

Revised and enhanced the patient information leaflet for cardiac catheterisation and coronary angiography in a timely manner, ensuring its accuracy, clarity, engagement, and compliance with the latest clinical guidelines.

- Ensured the updated leaflet is written in plain language, catering to patients with varying literacy levels and linguistic backgrounds.
- Clearly explained the purpose, procedure, risks, benefits, and alternatives of cardiac catheterisation and coronary angiography to empower patients in decision-making.
- Implemented further improvements to the revised patient information leaflet following feedback from the Trust's voluntary readers panel (patient representatives).



Patient information leaflet: Coronary Angiogram

Coronary Angiogram

What is a coronary angiogram?

A coronary angiogram is a test to look at the main blood vessels supplying blood and oxygen to your heart, known as the coronary arteries. This test helps your doctor identify any problems with your heart and locate any narrowed areas in the coronary arteries, along with their severity.

During the procedure, a thin tube called a sheath will be inserted into an artery in your wrist (occasionally in the groin) under local anaesthesia. Through this sheath, a longer, fine tube called a catheter will be carefully advanced to the heart under X-ray guidance. Once the catheter is in place, a special colourless liquid known as "contrast medium" will be injected through it, making your coronary arteries visible on the X-ray. This allows your doctor to identify any blockages or narrowings in your heart's blood vessels and determine the best course of treatment.

Benefits of a coronary angiogram

The aim of the procedure is to find out if there is a narrowing or blockage in your coronary arteries or any abnormalities in the chambers or valves of your heart.

This information will help the cardiology team to plan and discuss potential treatments with you. This may include options such as coronary angioplasty (widening a narrowing with a stent or balloon) or heart surgery.

Sometimes, the procedure may reveal that no further treatment is necessary or that managing your condition with medication is the best option. Your cardiologist will discuss these findings and recommendations with you.

Risks of a coronary angiogram

All medical procedures carry some risk. An angiogram is a relatively safe test. Less than 1 in 1,000 people (less than 0.1%) have a serious complication as a result of having a coronary angiogram.

- Bleeding

Bleeding from the needle puncture site can occur. This bleeding will usually stop on its own. Occasionally, the bleeding is more severe, and a blood transfusion and/or a small operation

to seal off the artery is needed.

- Bruising

A small amount of bruising in the wrist/groin is quite common but will disappear over a couple of weeks.

- Infection

This is very rare, but there is a tiny risk of infection at the puncture site

- Reaction to local anaesthetic or contrast fluid

There is a small risk of a reaction to the drug or contrast fluid used. This usually consists of an itchy skin rash which resolves within an hour or two, but rarely can be more severe.

- Changes in heart rhythm

There is a small risk of developing an abnormal heart rhythm during the procedure. Most of these are harmless and settle on their own within a few seconds. Occasionally, it is necessary for us to give a drug by injection or an electric shock to correct a persistent change in the heart rhythm.

- Heart attack or stroke

Rarely a heart attack or stroke can occur during the test. If this does happen, it is often minor. Rarely, a heart attack can be more serious and may lead to the need for an emergency heart operation. A heart attack or stroke can also be so severe that it can cause death or leave a serious disability.

- Reduced kidney function

There is a small risk that the contrast fluid used in the test could reduce kidney function. Rarely, the kidneys may be damaged permanently. This risk is higher if kidney function is abnormal before the test.

Alternative tests

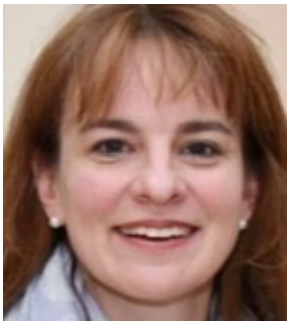
A coronary angiogram is the most effective way to determine the exact location and severity of narrowed areas in the coronary arteries. This procedure is essential if surgical or catheter-based treatment for coronary artery disease is being considered.

For some patients, a CT angiogram can be a non-invasive alternative to gather information

Outcome

Creating an improved patient information leaflet for cardiac angiograms has been important for improving patient care. By including the latest updates on angiogram procedures and all necessary details, the updated leaflet is offering patients better guidance. This assists patients to make informed choices about their treatment. It gives a clearer understanding of the procedure, its risks, and post-care process, increasing patient confidence, reducing anxiety, and encouraging better compliance of medical advice.
Ultimately, a well-structured and up-to-date leaflet is contributing to a more positive patient experience and improved clinical outcomes.

Trust Research Participation Overview 24/25



The Clinical Research and Development Strategy continues to be a cornerstone of our Trust's vision to improve the health and wellbeing of the communities we serve across Herefordshire and the surrounding areas. Guided by our Trust CARE values, this strategy underpins our commitment to enhancing patient care through research and innovation, while aligning with the NHS's broader healthcare priorities.

We are dedicated to ensuring that research participants receive the highest standard of care and experience while optimizing resources provided by the National Institute for Health and Care Research (NIHR), research funders, and charitable organizations. By fostering engagement and awareness across all levels—from the Trust Board to frontline teams—we aim to:

- ***Increase staff participation in clinical research.***
- ***Offer greater opportunities for patient involvement.***
- ***Align research with pressing local health needs.***
- ***Achieve financial sustainability in research activities.***

Achievements in 2024/25

In 2024/25, we made significant strides in advancing research excellence:

- Recruitment Highlights: A total of 280 patients participated in 22 trials across 15 specialties:
  - Anaesthesia
  - Surgery
  - Critical Care
  - Oncology
  - Diabetes
  - Respiratory
- New Studies Initiated: We opened 9 new trials in 9 specialties
- 7 New Associate Principal Investigators
- First renal commercial clinical trial opened

Introduction of the Research Manager Role

January 2025, the Trust appointed it's first-ever Research Manager, marking a pivotal step in strengthening our clinical research infrastructure. This dedicated role enhances strategic oversight, ensures efficient resource allocation, and supports research teams in navigating complex trials and funding opportunities.

The **Research Manager** will play a key role in strengthening the Trust's academic program by:

- **Integrating Research & Education:** Connecting clinical research with training initiatives to enhance learning.
- **Mentorship & Development:** Supporting clinicians, junior researchers, and students in building research skills.
- **Expanding Academic Partnerships:** Collaborating with universities and research organisations to drive joint studies and funding opportunities.

In addition to these achievements, our collaborations with partners, including the NIHR, universities, and industry sponsors, continue to grow and expand the reach and impact of research.

Challenges and Lessons Learned
While 2024/25 brought many successes, we faced challenges such as recruitment hurdles and resource constraints. These experiences have informed our approach, leading to innovative solutions and refined strategies for the coming year.

Research Priorities for 2025/26
Our focus in 2025/26 is to strengthen research impact, improve accessibility, and drive financial sustainability.
Key priorities include:

- **Expanding Commercial Research to Increase Financial Value:** We aim to increase revenue through greater participation in commercial research, collaborating with industry sponsors to attract high-value studies. By streamlining processes and enhancing engagement with commercial trial providers, we will improve efficiency and optimize funding opportunities.
- **Aligning Research with Local Health Needs & Improving Access for Rural Populations:** Research initiatives will be tailored to address pressing local health concerns, ensuring that studies reflect the needs of our communities. We will also work to **improve accessibility for rural populations**, establishing outreach programs and satellite research sites to reduce barriers to participation and ensure equitable access to clinical trials.
- **Raising Awareness & Engagement through a Trust-Wide Clinical Trials Day:** Fostering a culture of research, we will host an annual **Clinical Trials Day**, providing education, engagement activities, and public awareness campaigns. This initiative will highlight the importance of clinical trials and encourage both patients and staff to take part in research.
- **Enhancing Clinician Involvement through Training & Education** Increasing clinician engagement remains a priority, with a focus on expanding research training programs. As part of this effort, we will be present and supporting Education and Training Days, providing opportunities and signposting for clinicians and researchers to engage with leading experts, access professional development resources and explore pathways for research involvement. We will strengthen the **Associate Principal Investigator and Principal Investigator pathways**, providing mentorship, structured learning opportunities, and dedicated resources to encourage more clinicians to take active roles in research.

Acknowledgments

We would like to extend our heartfelt thanks to our dedicated staff, research participants, funding partners, and collaborators. Their contributions continue to drive the success of our research efforts and inspire innovation in healthcare.

Safety Alerts

Safety alerts are issued when there is a specific issue that without immediate actions being taken could result in serious harm or death. They set out what health or care organisations need to do to reduce the risk.

In 2024-25, the Trust continued to receive patient safety alerts through the Central Alerting System (CAS) and the Medicines & Healthcare Products Regulatory Agency (MHRA). These were managed appropriately through the established process, which includes checking for relevancy and recording completed actions.

The Trust implemented a new management system which provides centralised oversight of all the alerts. This enables the alert to be linked to any relevant incident or risk to start to provide a triangulated profile of the Trusts safety position

Field Safety Notices (FSNs) are important communications about the safety of a medical device that are sent to customers (the Trust) by a device manufacturer or their representatives.

An email address was created and communicated on the Trusts website to allow manufacturers to send their alerts to a centralised account, thus providing a coordinated response.

Best Practice Guidance

Since being first established in 1999, The National Institute for Health and Care Excellence (NICE) have been providing evidence-based recommendations for the health and social care sector; developed by independent committees of various professionals, consultants and lay members – to assist us in providing the very best care for our patients.

In the year, 2024-25, the Trust has successfully continued to oversee how NICE guidance is managed through the continued use of PR.S.21 - Implementation of NICE Guidance SOP since ratified in 2022 – a process that continues to work well across the Trust.

Within the year, we have continued to receive a high level of engagement from divisions in the allocation of a lead for each piece of guidance; which has allowed the NICE guidance team to promptly send out the guidance, arrange meetings and provide support to those leads identified with completing baseline assessments and obtaining evidence of the current practice.

The table below shows the guidance published by type within the last financial year (correct as of 24th March 2025.

Type of Guidance	Total number
NICE Guidance	22
Clinical Guidance	13
Quality Standard	4
Diagnostic Guideline	6
Technical Appraisal Guidance	93
Medical Innovation Brief	2
Interventional Procedure Guidance	18
Medical Technologies Guidance	2
Health Technology Evaluation	5
Highly-Specialised Technology Guidance	2
TOTAL =	**167**

Information Governance

Information Governance is how an organisation handles patient and staff information, which may be of a sensitive nature. This includes ensuring all information, especially personal, is held legally, securely and confidentially.

The Data Security Protection Toolkit (DSPT) was introduced in 2018-19 and replaces the Information Governance Toolkit (IGT).

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the Cyber Assessment Framework.

Last year, the Trust achieved Standards Met for meeting the requirements of the DSPT. The Trust's year-to-date position is shown in the table below:

Progress Dashboard		
Mandatory Reporting – **34/47 mandatory evidence items provided.**		**Baseline Submission provided December 2024** **Current position: Standards Met** **Final submission due – 30/06/25**
Outcomes 34/47		Confirmed
Standards Met: June 2024		

Baseline submission was provided in December 2024 with 23 of the 47 requirements provided.

At the end of February 2024, 34 of the 47 requirements have been provided. The Trust is being audited by RSM Audit in March and April 2025 for compliance with the DSPT, and any recommendations will assist the trust with the final submission of the DSPT in June 2025

Clinical Coding and Error Rate

Clinical coding is the translation of medical terminology (written by the clinicians) that describes a patient's complaint, problem, diagnosis, treatment or other reason for seeking medical attention into standard codes that can then be easily tabulated, aggregated and sorted for statistical and financial analysis, in an efficient and meaningful manner.

The figures for 2024-25 show an improvement across the board for all areas of Clinical

Coding, well exceeding Mandatory target.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip operation) so that indicators of quality can be produced to help improvement processes.

The Trust has a constant focus on data quality and the need to meet the organisation's reporting requirements against the National Data Security and Protection Toolkit.

Data Quality Standard 1. The Trust uses a variety of systems and processes to ensure poor data quality does not undermine the information being reported. Data quality (DQ) checks are performed on all main reporting domains (including quality, finance, operational performance, and workforce). The Trust makes use of internal and external benchmarks to highlight areas potentially requiring improvement to data quality.

As part of the Foundation Group, the Trust has developed some key principles for data quality and these will be adopted across all trusts within the group. Further work on developing Information strategy across the group is ongoing and projects and work streams being finalised. The Trust uses a Data Quality Kite mark within its main Trust Board KPIs as an indicator of the level of assurance of the quality of the data which supports each indicator.

	WVT results	Mandatory	Advisory
Primary diagnosis	96%	90%	95%
Secondary diagnosis	97.2%	80%	90%
Primary procedure	99.3%	90%	95%
Secondary procedure	99.2%	80%	90%

Illustration of the percentage coding accuracy at Wye Valley NHS Trust in 2024-25 of which all mandated standards were met as set by NHS Digital.

The Trust is committed to ensuring staff are aware of their responsibility for data quality and the accurate recording of data on Trust electronic systems and paper held records. The Trust have included this responsibility in all job descriptions and regular audits are undertaken. We work closely with our partner IMS Maxims who are supporting with electronic patient record development. The Trust's commitment to data quality is demonstrated by implementing the following principles:

- The aim is that all staff should be fully trained in the use and recording of data on electronic systems – where possible access should not be given until training has taken place.
- All managers are responsible for data quality within their services.
- Staff are aware of the reporting mechanisms for data quality issues and complaints.

- The Trust has a dedicated team for each electronic system that sits with the CSG, for managing data quality issues, system management, system configuration in line with national standards and advising staff on managing data quality issues. For other

systems used within specific departments there may be a single administrator providing support and advice.

- Regular reports are sent out for managers to ensure missing data and errors are actioned and regular meetings are held to discuss and report actions of the same.
- Summary data quality dashboard produced weekly and discussed at weekly Trust wide patient tracking list (PTL) meeting.
- Additional steps added to commissioning data sets processing to identify incorrectly recorded data and passed to the Electronic Patient Record Support Team to correct for the IMS MAXIMS system.

The Patient's NHS number

The patient's NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients.

The Trust submitted records during 2024-25 to the Secondary Uses Service (SUS), for inclusion in the Hospital Episodes Statistics (HES), which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number for the period April 2024 to March 2025, is detailed below.

NHS Number 24/25				
	Has NHS	No Number	Total	%
IP	66992	39	67031	99.9%
OP	461992	209	462201	100.0%
AE	87480	522	88002	99.4%

The Patient's Registered GP Practice Code

Accurate recording of the patient's GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

The Trust submitted records during 2024-25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records, which included the patients valid General Medical Practice Code, was highest at 100% for Outpatients.

GP Code 24/25				
	Gp code	No Number	Total	%
IP	66313	718	67031	98.9%
OP	462102	99	462201	100.0%
AE	87897	105	88002	99.9%

Commissioning for Quality and Innovations (CQUINs) 2024-25

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care including transformational change.

For 2024-25, NHS England paused the mandatory CQUIN scheme.

CELEBRATING CHANGE

WORKING TOGETHER AT WYE VALLEY NHS TRUST.
IMPROVING SEPSIS OUTCOMES

Sepsis is a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues - causing organ damage and failure, that affects roughly 245,000 individuals in the UK each year, of which ~11,000 cases are fatal (The UK Sepsis Trust, 2025). Sepsis is caused by organisms including bacteria, viruses, and fungi. Risk factors include being very young or old, a weakened immune system from conditions such as cancer or diabetes, major trauma, and burns. A diagnosis of sepsis requires immediate treatment with intravenous fluids and antimicrobial medications with ongoing hospital care and stabilisation.

An example of NICE guidance and clinical audit coming together to improve patient safety and care quality across the trust with the release of NICE guidance, NG51: Suspected sepsis: recognition, diagnosis and early management (NICE, 2024); and, ongoing local audits are being performed quarterly to ensure that standards are being met and kept at high standards.

Aim: Determine the Emergency Department's systems and responses for when a patient with suspected sepsis presents – including: recognition, prioritisation and escalation of suspected cases, timescales for FY2/SHO and above review and testing, antibiotic medication, IV fluids and oxygen administration, and the use of the 'Sepsis Six' care bundle within NICE recommended time scales criteria.

Aim 1: NG51 – Recommendation 1.1: When to suspect sepsis
"Think 'could this be sepsis?' if a person presents with symptoms or signs that indicate possible infection"
"*Develop a core set of protocols for all patients who present with signs of sepsis*."

Aim 2: NG51 – Recommendation 1.14, 1.15, 1.16: Antibiotic therapy, intravenous fluid and oxygen
"*Develop a protocol for treating patients with suspected sepsis with antibiotics, IV fluids and oxygen where indicated*."

How was this achieved?
Sepsis has been identified as a WVT Trust priority in a move to reduce the mortality rates published according to NHS Digital SHMI report (NHS Digital , 2023).
In response the Trust implemented and promoted the Sepsis Six care bundle. Baseline assessments and local audits took place to identify areas of improvement – this has led to the development of the Sepsis and Antibiotic posters for ED and ward display; and update of the Sepsis clinical guideline and pathways; including antibiotic stewardship, timely review within 1 hour, and appropriate blood culturing.

Further and ongoing works:
A revised and updates Sepsis Care Bundle and guideline has been developed and this is due to be approved.
A NICE Quality Standard is due to be published in August 2025 which will outline areas where there has been the most variation across the country.

Ongoing local audits for Sepsis response will be carried out against NICE standards

Who is involved?

- Emergency Department
- Medical and Surgical Teams
- Pathology
- Pharmacy

References

NHS Digital, 2023. Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, September 2021 - August 2022. [Online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2023-01/shmi-data [Accessed 17 Mrch 2025].
NICE, 2024. Suspected sepsis: recognition, diagnosis and early management. [Online] Available at: https://www.nice.org.uk/guidance/ng51 [Accessed 18 March 2025].
The UK Sepsis Trust, 2025. What is sepsis?. [Online] Available at: https://sepsistrust.org/about-sepsis/ [Accessed 17 March 2025].

Quality of Services - Key Areas

Incident Reporting

The Trust promotes a culture of safety where staff are encouraged to report actual or near miss incidents.

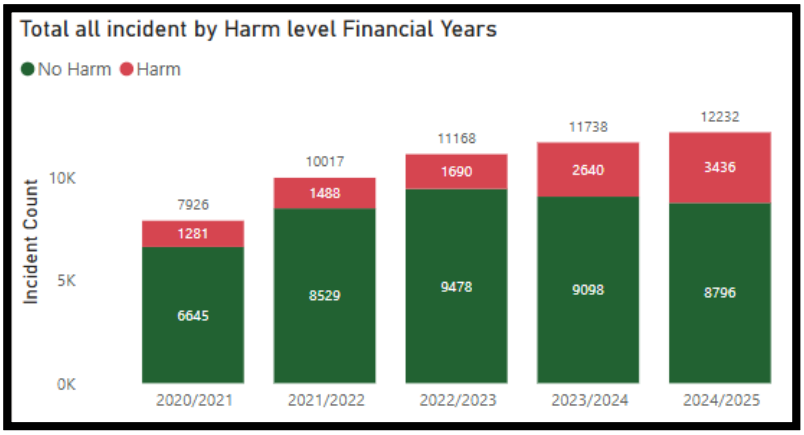
National comparison data is only available for the quarter (October, November, and December 2024) from Learning from Patient Safety Events (LFPSE).

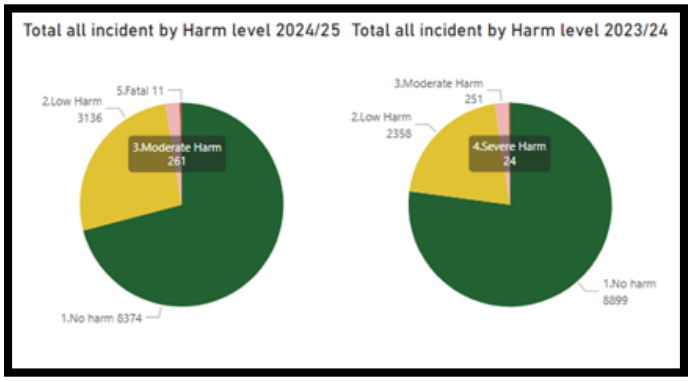
For the quarter LFPSE reports that 788,185 incidents were reported nationally. The Trust for the same quarter reported 2,976 patient safety incidents as well as 291 non patient safety incidents which are not part of the submission to LFPSE.

National current year comparisons are not available with the move to a new incident reporting framework as they are not yet available from NHS England

For patient safety incidents we now collect both physical and psychological harm but to provide a comparison with previous years the following graphs only relate to physical harm. The reason we now record psychological harm is because it is vital to understand the impact an incident has on a patient and we are able to have a more complete picture of the event. We will be able to compare psychological harm in future reports.

The chart adjacent shows all incidents reported by the Trust on the incident reporting system. The incidents reported increased during 2024-25 by 4%. This shows no harm incidents account for 72% of incidents.





The proportion of harm incidents has increased to 28% of all patient safety incidents, however of those harm 91% are low harm. The volume of moderate or greater harm is 8% (261)

The top five categories of all incidents reported in 2024-25 are shown in the next table. The top five remain the same as the previous year but the following are now greater than falls

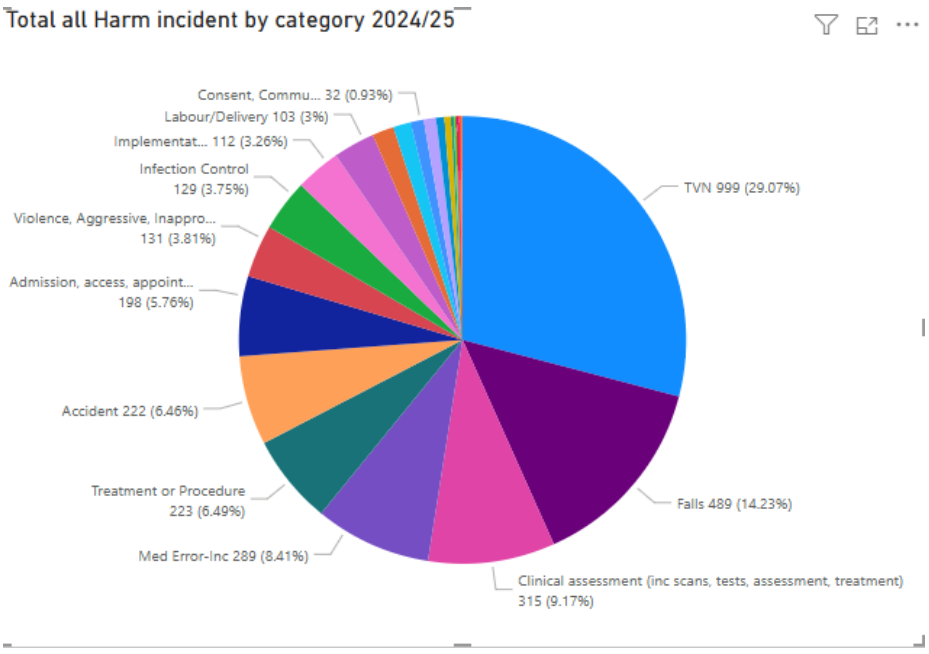
- Admission, access, appointments, transfer, discharge (up 29% from last year)
- Infrastructure (incl. staff, facilities, environment) (up 40%)
- Falls have dropped by 5%.
- Clinical assessment (incl. scans, tests, assessment, treatment) dropped by 8%.
- Tissue Viability incidents have increased by 2.5%.

Category	2023/24	2024/25	% of total	% change
Tissue Viability	2702	2770	22.68%	2.52%
Admission, access, appointments, transfer, discharge	1007	1295	10.60%	28.60%
Infrastructure (incl. staff, facilities, environment)	895	1255	10.27%	40.22%
Falls	1127	1068	8.74%	-5.24%
Clinical assessment (incl. scans, tests, assessment, treatment)	1104	1013	8.29%	-8.24%

Incidents with Harm

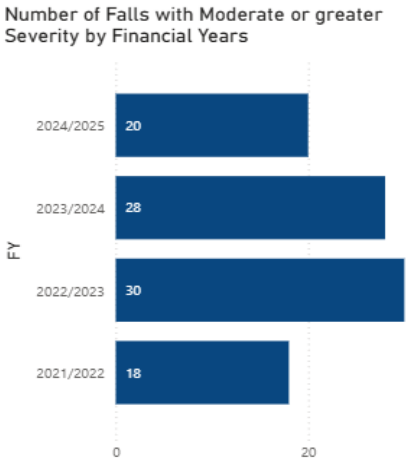
The top five incidents with harm are comparable to the total incidents, with the addition of treatment or procedure.

Category	2023/24	2024/25	Grand Total	% Change
Tissue Viability	816	999	29.07%	22.43%
Falls	407	489	14.23%	20.15%
Clinical assessment (incl. scans, tests, assessment, treatment)	225	315	9.17%	40.00%
Medication Error-Incidents	171	289	8.41%	69.01%
Treatment or Procedure	206	223	6.49%	8.25%



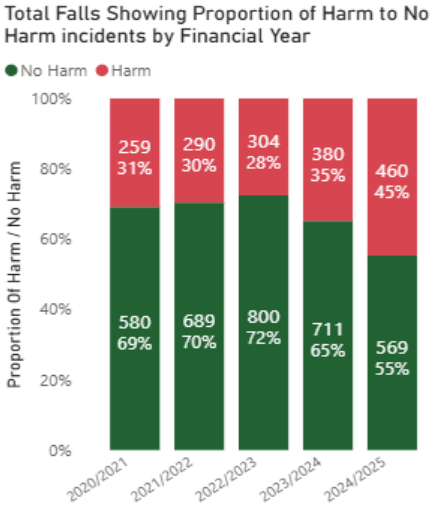
Reducing Harm to Patients

Reduce patient falls



In 2024-25, we saw the following changes:

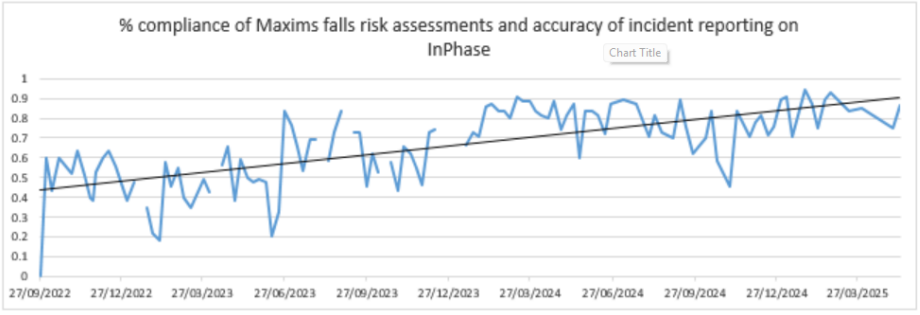
- Total falls decreased by 5.7%
- The falls rate for moderate harm and above has fallen.
- Proportion of harmful falls as a percentage of total falls has increased to 45% from 35% in 2024/25. An increase in the number of low harm falls resulted in an increase in the harm rate.



Falls are classed as low harm according to LFPSE guidance if a patient undergoes a scan/x-ray even if there is no fracture/harm. There have been a number of unwitnessed falls where a scan is requested as staff are unsure if a patient has sustained a head injury or other injury.

The Trust has undertaken a number of actions over the previous 12 months, these include:

- Patient safety priority introduced in April 2024 to monitor falls in patients with dementia, delirium or known high risk of falls.
- Increased training provided.
- Pilot bed rails process across all Community Hospital sites to improve compliance.
- Criteria introduced on the appropriate placement of patients in extremis identified bed spaces.
- Ultra low beds increased across the Trust as part of the current bed replacement plan.
- Post fall medical assessment template introduced.
- Privacy curtains/personal care grab packs near bathrooms
- Introduction of yellow socks/wristband to identify patients at high risk of falls
- Revision of clinical nurse noting Falls risk assessment/bed rails assessment
- Snapshot weekly audit of completion of nursing risk assessment for patients who have fallen. The chart below shows an improving trend.



2025/26 will see the Trust continue to build on the progress made in 2024/25, with the introduction of the following:

- Joint working with the Trusts newly appointed Dementia lead.
- Reinstate Falls/Dementia/Frailty steering group.
- Review of the recently published NICE guidelines for falls
- Falls policy due for review
- Shared learning safety huddle across Integrated Care Division learning form incidents.
- InPhase reporting support for Integrated Care Division staff regarding levels of harm/accurate completion of falls section.
- Resource pack/training 'to be rolled out by Falls lead.
- Community Hospital to develop criteria for patients being placed in low visibility/extremis bed spaces.
- New Band 6s within Integrated Care/Medical division to be provided support regarding leadership/risk management / senior oversight for patients at risk of falls.
- Post fall retrieval flat lifting device training to be provided via Moving and Handling.
- Falls SIMS training provided by Education team.
- Improvement project 'Frailty/Community Hospitals improving the amount of ward based activity for patients (out for lunch campaign)'.

Duty of Candour

This is a statutory duty of all health and social care providers to be open and transparent with people using healthcare services. The Trust engages with those affected by patient safety events and invites involvement by providing input into reviews and investigations whether that is by co-producing Terms of Reference for learning responses, face-to-face meetings or telephone calls.

For any incident that meets the statutory duty, there is a prompt and a section to complete within the incident record; however, staff are encouraged to be open and honest about any incident that occurs as part of the professional duty of candour.

Duty of candour is monitored through monthly divisional and corporate reports and as part of their reporting to the Quality Committee. In addition, patient or family engagement is undertaken when a complaint has been received relating to a patient safety incident. This provides a nominated point of contact for the patient and families and ensures they are included in the investigations if they choose to do so.

Never Events

During 2024/25, one incident met the National criteria for a 'Never Event' which occurred in Ophthalmology this was investigated under the Patient Safety Incident Response Framework (PSIRF) as a Patient Safety Incident Investigation (PSII).

Adult Safeguarding

Adult Safeguarding means protecting a person's right to live in safety and free from abuse and neglect and is everybody's business. This remains a high priority for the Trust and we continue to work with partner agencies across Herefordshire and beyond to ensure best practice.

The Trust ensure the principles of empowerment, prevention, proportionality, protection; partnership working and accountability have been applied preserving the individual's wellbeing at its core. The outcomes being that people are:

- Safe and able to protect themselves from abuse and neglect.
- Treated fairly and with dignity and respect.
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

Making Safeguarding Personal (MSP) continues to remain a high priority and the Trust have endeavoured to ensure the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible.

WVT now have a Lead for Domestic Abuse in post who works as part of the Adult Safeguarding team but also integrally with the Children's Safeguarding Team. The Lead is responsible for coordinating WVT's response to domestic abuse. The Domestic Abuse Act was passed in 2021 and puts clear responsibilities on all agencies to ensure that they are asking about domestic abuse and providing an effective response for all victim-survivors.

The Lead works very closely with the Hospital Independent Domestic Violence Advisor (HIDVA) (employed by West Mercia Women's Aid but working within WVT). The HIDVA provides independent advice and support for all patients and staff. The Lead for Domestic Abuse and HIDVA jointly deliver training across the Trust and a large focus of their roles is to raise awareness about domestic abuse and to build staff confidence so that more victims are identified and receive the support that they need.

The Trust maintains its commitment to Herefordshire Multiagency Risk Assessment Conference (MARAC) and Domestic Abuse Perpetrator Panel and is an active member of the Domestic Abuse Operational Group and MARAC Governance Group.

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests process in everyday practice. This has continued to be a quality priority for WVT. The Trust has an adult safeguarding performance dashboard, which is monitored and discussed at the Trust's Overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Quality Committee, with a report produced for the Trust Board annually.
The Trust has maintained its commitment to be an active member of the Herefordshire Safeguarding Adult Board and associated sub-groups, contributing to multi-agency audit, Safeguarding Adult Reviews and Domestic Homicide Reviews.

The Trust has equally maintained their commitment to work collaboratively with out of county safeguarding boards.

Children Safeguarding

A child and/or young person is defined as anyone who has not yet reached their 18th birthday.

Safeguarding children and young people is central to the quality of care provided to patients by the Trust. The Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people.

The Trust recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2023. 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.

The Chief Nursing Officer is the Trust's Executive Lead for Safeguarding Children and the Associate Chief Nursing Officer oversees the management of and the work undertaken by the Child Safeguarding team. The Trust has maintained a robust focus on Safeguarding Children through the governance arrangements depicted below.

The work of the safeguarding team is multi-faceted and relies heavily on partnership working, both internally and externally. The Trust strives to deliver a seamless integrated service to safeguard children from abuse and neglect. The Child 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.

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:
  - Providing a robust training and development strategy utilising education forums, light bite sessions as well as formal training.
  - Supervision.
  - Coaching.
  - Share learning from safeguarding practice reviews.
  - Support and advise on case management, including 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 court, the police and if attendance at court is required.
- To undertake internal management reviews and contribute to multi-agency practice learning / CSPRs (Child Safeguarding Practice Reviews.)
- Support the business of the multi-agency partnership.
- The Trust has an established safeguarding children quality framework, which includes a safeguarding children performance dashboard and an annual audit plan. The Trust's Overarching Safeguarding Committee monitors this framework. A report summarising activity and priorities is produced for the Trust Board annually. Learning from single and multi-agency audits, child safeguarding practice reviews and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

Ensuring staff receive the required safeguarding children training continues to be a priority and compliance rates for Levels 1, 2, 3, 4 and Board level, are shown in the table opposite

Level of training	December 2024 (actual)	WVT expected level
Level 1	89%	85%
Level 2	87%	85%
Level 3	85%	85%
Level 4	100%	100%
Board level	100%	100%

The Trust continues to support the business of the Herefordshire Safeguarding Children Partnership in a number of ways for example;

- By aligning safeguarding children priorities to those of the Partnership; contributing to the work of the various subgroups and task and finish groups and by providing trainers for various learning and educational events.
- The multi-agency work extends to contributing to the Local Authority Improvement Plan which is in response to the Ofsted inspections. To support this in response to looking to improve multi-agency working we have appointed a Specialist Safeguarding Children Practitioner within the MASH (B7) to strengthen collaborative working. The Trust already provides the health practitioner within the multi-agency safeguarding hub (MASH) which is often the first point of contact for professionals, family members or the public when they have concerns about a child's welfare or safety.
- Support the Children and Young Peoples partnership for Herefordshire (CYPP)

  Keeping children and young people safe – BE SAFE FROM HARM

  (Supporting children and young people with our public health services discussing healthy relationships and professionals being trained to recognise safeguarding thresholds – the safeguarding team contributing to wider partnership training on this) The safeguarding team are key contributors to the Get Safe programme to prevent CE (child/criminal exploitation)

  Improving children and young people's health and wellbeing – BE HEALTHY

(NHS services working on priorities of obesity, mental health support and access to dental health)
Helping ALL children and young people succeed – BE AMAZING
Ensuring that children and young people are influential in our communities – FEEL PART OF THE COMMUNITY
As a safeguarding team we will support the mission of the CYPP to improve safeguarding in children's services.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records for:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases
- certain 'dangerous occurrences' (near miss – incidents with a high potential to cause death or serious injury)

The Trust has a legal duty to report all RIDDOR reportable incidents in a timely manner. Work related accidents which lead to a member of staff unable to work, or are unable to perform their normal duties for a period of more than seven days need to be reported within 15 days of the incident. More serious incidents including deaths, fractures, need to be reported within 48hrs.

During 2024-25 there were a total of 6 RIDDOR reportable incidents, a decrease of four compared to 2023-24. Of these incidents, 2 were patient related and 4 were staff incidents. The detail below provides an outline of these incidents:

Patient incidents : Injuries included;	Staff incidents : Injuries included;
• Fatality following an unwitnessed fall, resulting in laceration to head, left forearm and right elbow • Displaced commuted intertrochanteric fracture of the left proximal femur	• Wrist injury • Release of biological hazard in labs • Fracture of right distal radius • Dislocation of the left shoulder

Patient Reported Outcome Measures (PROMS)

What do we do? Participation in the national Patient Reported Outcomes (PROMs) programme is mandatory for Trusts in England where the relevant operative procedures are undertaken. The procedures included within the programme are:

- Hip replacements
- Knee replacements

Patients are asked to complete a questionnaire pre-operatively and then at 6 months post-surgery. The questionnaires include general quality of life measures and some condition specific measures. Comparison is then made of scores pre- and post-surgery to gauge the level of health gain following the operation. Results are usually publicly available through the NHS & Social Care Information Centre website.

How are we doing?

Participation rates are determined by the completion of pre-operative and post-operative questionnaires that are assessed on a national level. It is important to note that patient involvement in these questionnaires is voluntary.

England and Provider-level participation and coverage April 2023 to March 2024 (Published 13th February 2025)

There were 747 eligible hospital episodes and 124 pre-operative questionnaires returned – a headline participation rate of 26% for Wye Valley NHS Trust (69.3% in England)

Of the 122 post-operative questionnaires sent out, 86 have been returned – a response rate of 43% (47.6% in England).

Outcomes

Results of outcomes, in terms of scores improved, unchanged or worsened were published in February 2025.

The responses from the data outlined below are the patients' view of the changes to their wellbeing following their procedure.

April 2023 to March 2024 Finalised Data (published 13th February 2025)

Score	Procedure	Scores improved		Scores unchanged		Scores worsened	
		Wye Valley Trust	England	Wye Valley Trust	England	Wye Valley Trust	England
EQ-5D Index score (a combination of five key criteria concerning general health)	Hip replacements	**95.8%**	88.8%	**0%**	5.3%	**4.2%**	5.9%
	Knee replacements	**84.6%**	80.9%	**7.7%**	9.1%	**7.7%**	10%
EQ VAS (current state of the patients general health marked on a visual analogue scale)	Hip replacements	**75%**	68.6%	**5%**	8.9%	**20%**	22.5%
	Knee replacements	**58.5%**	58.9%	**17%**	11%	**24.5%**	30.1%
Condition Specific Measures Oxford Hip/Knee Score	Hip replacements	**100%**	97.1%	**-**	0.6%	**-**	2.2%
	Knee replacements	**90.2%**	93.9%	**1.6%**	1.1%	**8.2%**	5%

Improving Patient Engagement

The Trust receives feedback on its services through a number of different sources. This includes direct engagement and survey results as well as friends and family test (FFT), compliments, concerns and complaints data.

In addition to our internal patient engagement activities, the Trust continues to work with both healthcare and voluntary sector partners, through the Maternity and Neonatal Voices Partnership (MNVP), Herefordshire Community Partnership, Herefordshire Healthwatch and as part of the wider ICS Herefordshire Engagement Network to work collaboratively to identify areas for improvement, share learning and support the embedding patient engagement in all areas of service development.

The Trust wide patient engagement forum (PEF) continues to meet monthly utilising a hybrid approach offering the option to attend either virtually or face to face, in order to maximise the opportunities for engagement.

Over this reporting period the group has expanded its membership to include representation from Credu, the Powys carers group in addition to the representation from CarerLinks, the Herefordshire equivalent. Speakeasynow, Health Checkers, who represent the views of those with learning disabilities and autism in Herefordshire, have also joined the membership.

As part of an initiative for Non-Executive Directors (NEDs) to shadow the many volunteering opportunities across the Trust, one of our NEDs has also attended the forum remotely, to gain first hand insight into the valuable contribution of the PEF.

Patent Engagement Forum Initiatives

The PEF have supported a number of initiatives and new service developments this year as well as continuing to support our regular activities such as patient led audits. One notable initiative was participation in a recent workshop to answer the question "what does excellent geriatric care look like". The group debated this question and one patient representative joined the carer group's representatives to present the forum's thoughts on this question, ensuring the patient and carer voice was central to the future planning of geriatric services. This interaction was very positively received and the geriatric team will continue to work with the PEF as they develop their service further. The patient representative who attended the workshop to represent the PEF provided the feedback below which was also submitted as a letter to the Hereford Times:

"*The Wye Valley Hospital Trust Geriatric service set up a forum to consider the best it could be. It restored my faith in consultations. I was privileged to be part of the Patient Experience half hour slot and want to share my respect for the team and the process.*

The service deserves greater understanding. Geriatrics is not about chronicle age - a school friend died of dementia before she was 60. My first experience of being termed geriatric was being pregnant at the age of 34. I came to understand that it is about facing failing abilities and complicated problems with limited resources. Something we all have to come to terms with.

At 86, I have much awareness of end of life care but only known one person meet a geriatrician. He was greatly appreciative of having the whole person approach that I now consider an essential part of well-being. This genuinely open-minded consultation was a powerful demonstration of the teamwork that brings out the best in people. It was inclusive and exploratory with concern for each other and purpose. And we could laugh together – the best medicine of all.

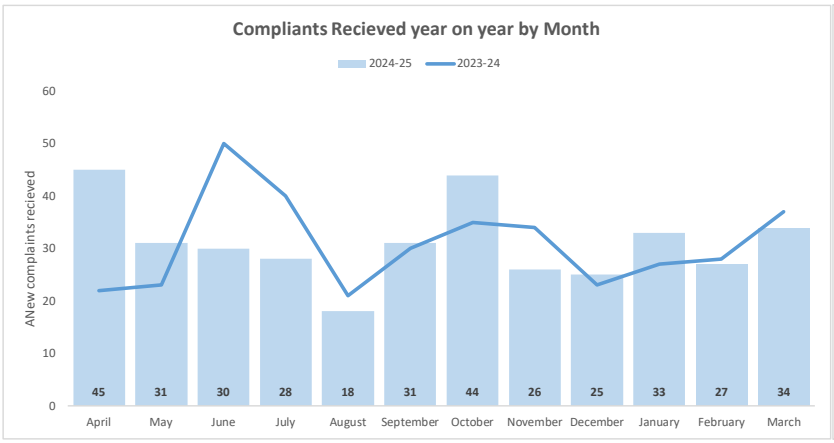
Let's all talk more about how we want to live better – whatever age we are."

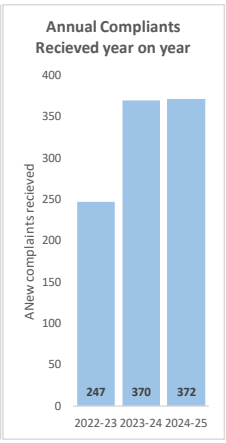
Complaints

The complaints team are structured within the patient safety work stream, rather than patient experience. This has multiple benefits including greater alignment with the patient safety strategy and has enabled effective oversight and triangulation of data, recognising that patient safety incidents are being raised by patients and families via the complaints route.

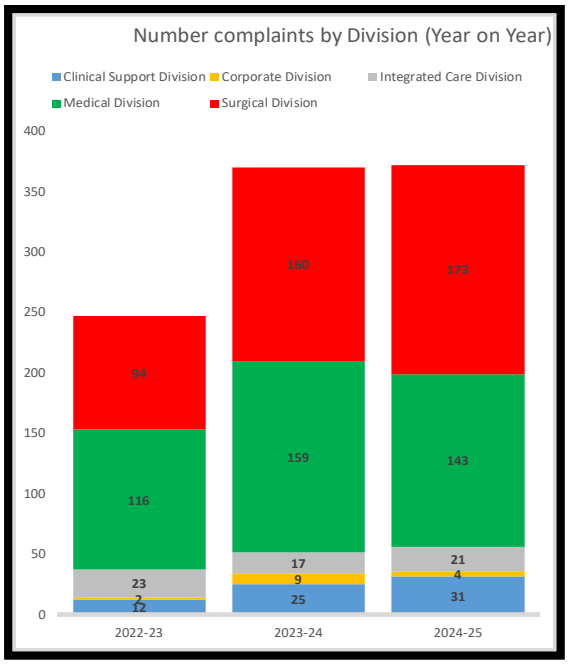
A robust triage process is embedded to analyse complaints in more depth, identify themes and triangulate with multiple sources of patient safety information which improves our understanding of safety, and our patient safety culture as well as patient experience.

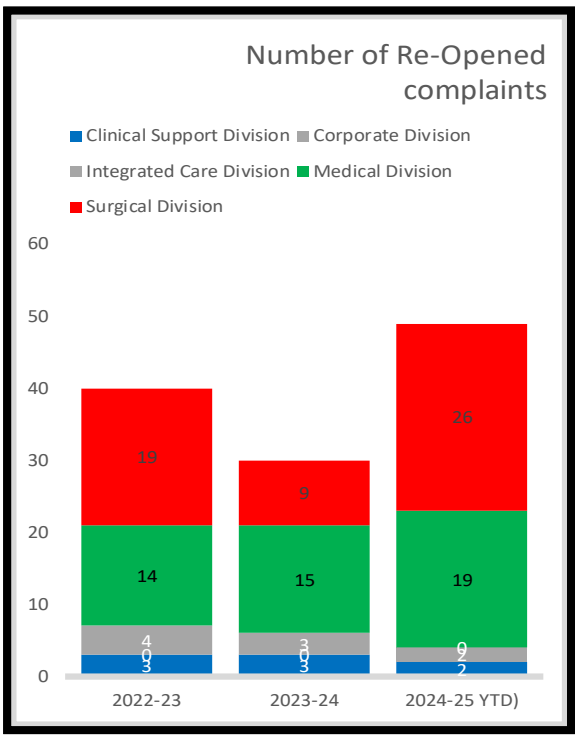
The overall number of complaints received during 2024-25 were essentially the same as last year only two more.





Surgery has 47% of Trust complaints up 13 complaints on last year with Medicine receiving 38% of complaints down 16 on last year.





There has been an increase of complaints that have been reopened, from 30 in 2023/24 to 49 in 2024/25 up 63%. Surgery has seen an increase of 17.

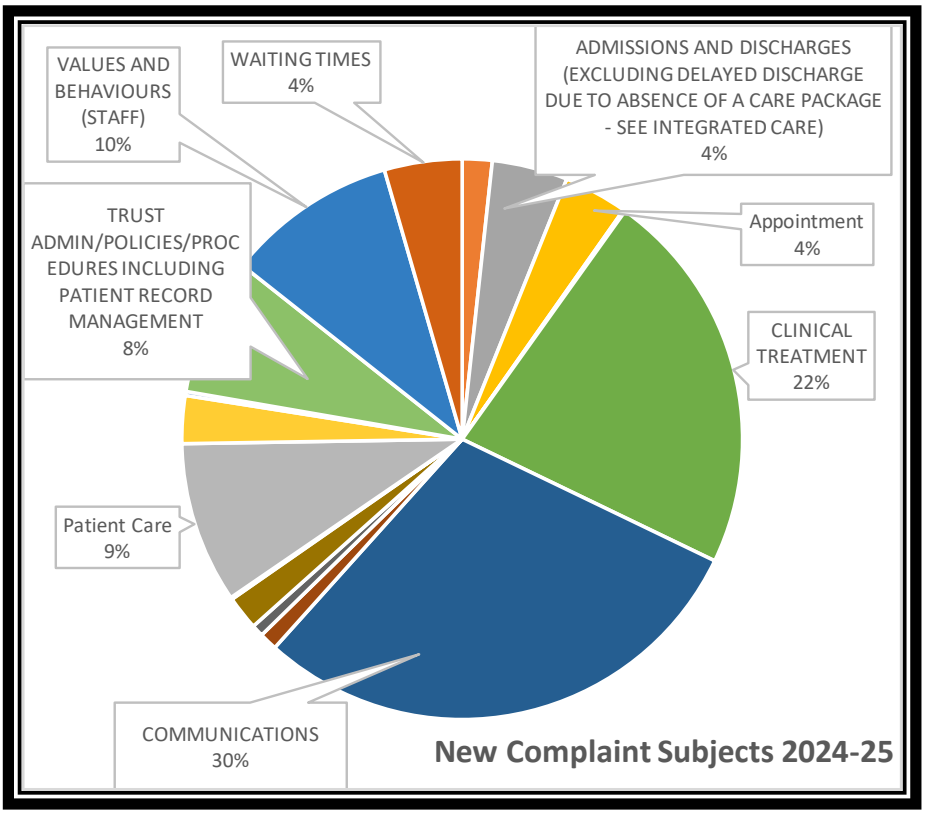
There have been 4 preliminary enquiries made by the Parliamentary and Health Service Ombudsman (PHSO) in 2024/5:

- decision for a mediated meeting which was resolved successfully with no further action
- primary investigation by the Welsh Ombudsman for PTHB, investigation partly related to care provision at WVT – closed
- decision made not to investigate further
- still awaiting outcome decision.

Complaint categories

62% of the complaints received related to perceived issues with the following categories by complainants: These are largely the same as last year.

- Communications up 2 %
- Clinical treatment up 2%
- Values and behaviour down 1%



1. Communication:

There may be more than one communication issue identified within a single complaint e.g. communication with patient or carer, between departments or with the GP. Whilst we have seen an increase in the number of communication issues identified within a complaint, the number of complaints has decreased which reflects the more detailed complaint examination process. The main sub categories identified communication concern with patients, relatives and carers and patients not feeling listened to although this has improved by 6% on last year's numbers.

2. Clinical Treatment:

A review of complaints shows the following sub categories accounted for 67% of complaints in this category. Numbers in these categories are down 19% on last year.

- Delay or failure in treatment or procedure
- Delay or failure to diagnose (inc e.g. missed fracture)
- Lack of clinical assessment
- Post-treatment complications
- Inadequate pain management

3. Values and Behaviour:

There may be more than one issue identified relating to values and behaviour within a single complaint e.g. attitude of staff, rudeness or failure to act in a professional manner. These complaints are down 9% on last year.

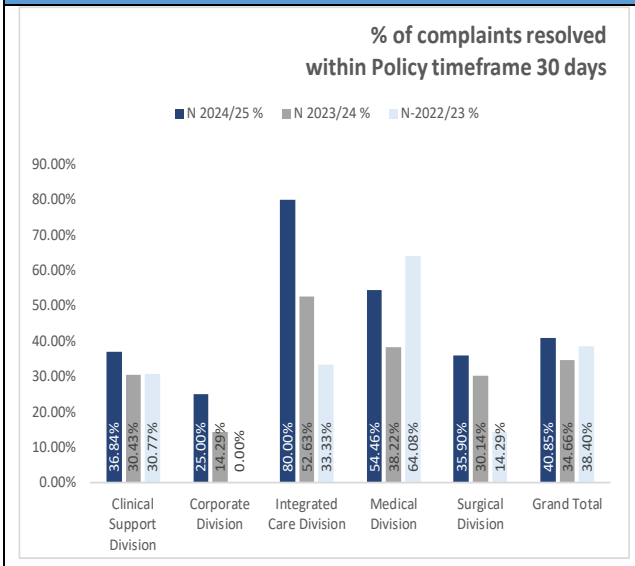
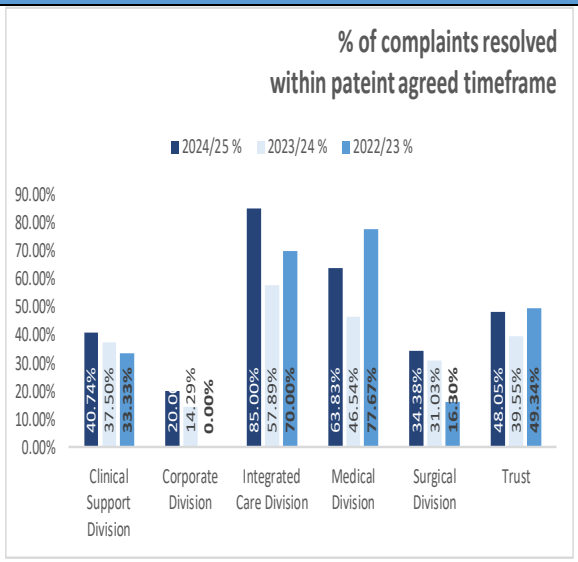
These are added to the complaint at the triage process and are based on the complainants' perception of their experience.

Complaint response times:

There are two measures:

- Agree with the complainant
- The complaints policy timescale 30 working days

The chart compares closed complaints

Agree with the complainant	The complaints policy timescale 25 working days
	

Over all, the number of complaint responses that are completed within the agreed 30 day timeframe is improved from 35% to 41%. Within complainants timeframe shows slightly improved performance 48% and is up on last year's 40%.

Inpatient and National Surveys

Three national survey reports were released by the CQC in 2024/25 for inpatients, maternity and urgent and emergency care. In addition, NHS England once again hosted the National Cancer Patient Experience Survey.

A brief overview of the survey results are outlined below. The results relate to patient experiences of care in 2023/24. All results have been shared with the relevant teams for review and development of improvement plans and this year we have chosen to focus a spotlight on the National Inpatient Survey.

National Surveys 2024/25

- Four national surveys have been commissioned by Care Quality Commission (CQC), and data collection carried out during 2024/25.
- The **annual inpatient survey, maternity survey and Adult and Emergency Care Survey** results will be received later in 2025.
- The expected publication date for the most recent **Children & Young Peoples survey** is May 2025.
- NHS England are once again hosting the National Cancer Patient Experience Survey. The results of this are expected to be published later in 2025.

Maternity Survey

Women and other pregnant people who gave birth between 1 and 29 February 2024 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey.

At WVT 264, participants were invited to complete the survey and 124 responded representing a 48% response rate.

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth**: Delays to discharge on the day of leaving hospital
- ✓ **Care after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Postnatal Care:** Care in the ward after birth: Being able to get help from staff when needed
- ✓ **Triage:** Assessment and evaluation: Felt that concerns were taken seriously
- ✓ **Care after birth:** Midwife/midwifery team being aware of service user and baby's medical history

Areas identified for continuing improvement work includes some aspects of communication, raising concerns and partners/supporters being able to stay as much as the service user wanted.

The maternity department are committed to working in partnership with the Maternity and Neonatal Voices Partnership (MNVP), co-producing an action plan to explore further service improvements.

Urgent and Emergency Care (UEC)

Patients were eligible for the survey if they were aged 16 years or older and had attended UEC services during September 2023.

1250 participants from WVT were invited to take part, with 399 responding representing a 33% response rate.

The results remained consistent to the previous year for the majority of questions, with positive scores for five questions resulting in the Trust sitting above average in national benchmarking.

Where service user experience is best

- ✓ **Waiting**: Staff providing help with patients' conditions or symptoms while waiting.
- ✓ **Arrival:** Patients told why they had to wait with the ambulance crew.
- ✓ **Communication and compassion:** Patients having confidence and trust in doctors and nurses treating them.
- ✓ **Hospital environment:** Patients feeling safe around other patients or visitors while in A&E.
- ✓ **Information:** From information provided by staff, patients feeling able to care for condition at home.

Areas identified for continuing improvement work include some aspects of communication and dignity and respect.

National Cancer Patient Experience Survey (NCPES)

The National Cancer Patient Experience Survey 2023 was sent to adult (ages 16 and over) NHS patients with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May, June 2023. 262 patients responded out of a total of 407 patients locally, resulting in a response rate of 64%.

In national benchmarking, the Trust scored above the expected range on 8 questions with no questions falling below the expected range.

Spotlight on the National Inpatient Survey

A total of 1250 patients who had an overnight stay in an acute bed in the hospital during November 2023 were given the opportunity to participate in the survey. A total of 538 responses were received, representing a 45% response rate.

In addition to the quantitative data, a coded thematic analysis of the patient comments was undertaken, the results of which were generally reflective of the quantitative data. The patient comments provide a rich source of qualitative data:

"Consultant excellent and spent time explaining things to me. Some very good nurses and lovely volunteers who helped me."

A benchmarking exercise across our partnership group also identified areas for shared learning opportunities. A summary of the key findings are outlined below:

- Overall, our position has remained relatively stable
- Food, waiting list times and discharge remain a challenge
- Patient comments in relation to staff are predominantly positive
- Scores for kindness and compassion as well as dignity and respect remain high
- Feedback section – a significant improvement on the previous year demonstrating that improvement actions are working
- Good results for the new questions relating to virtual wards with WVT falling in the highest scoring Trusts in the region

Improvement plans

1. Divisions have analysed data at local level and triangulated with FFT (Friends and Family Test) feedback, PLACE (patient led assessment of the care environment) and PLACElite data to inform divisional level improvement plans

Trust wide - 4 improvement initiatives have been identified

1. Food quality and safety- joint working group with Sodexo established
2. Working group established to improve communications regarding medicines on discharge
3. Work with care navigator teams to identify health and social care support on discharge
4. Explore opportunities for shared learning with group partner Trusts regarding communication about waiting times when on a waiting list

FFT and local survey data is being utilised for real time feedback to measure success of improvements

Friends and Family Test (FFT) – National Data Collection

The NHS Friends and Family test (FFT) was launched in 2013 and was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving NHS care or treatment. In July 2022, the Trust introduced a new system for receiving feedback from patients for the Friends and Family test sending a text message to patients to receive their feedback. Whilst Trusts are no longer monitored on response rate we know that the more feedback we receive the more opportunity we have to improve patient experience.

From 1st April 2024 – 31st March 2025, the Trust received 55,847 responses from our patients and service users, representing an overall response rate of 15%. Over 91% of ratings are positive. Prior to using the text messaging service, the Trust response rate was between 1% and 6%.

Question 1	Ratings Received	Response Rate
SMS	55847	14.81%
Totals	**55847**	**14.81%**

Question 2	Comments Received	Response Rate
SMS	46544	12.34%
Totals	**46544**	**12.34%**

A project commenced in the first quarter of 2025, which will allow individuals to leave feedback at any time, using the survey function of the electronic system we currently use. The project team made up of staff and patient/volunteer representatives have been able to design the survey and review the current process, once live it will see the system introduce improvements where needed and ensure all clinical areas across the Trust receive Friends and Family Test feedback.

The project is currently at the build stage and is anticipated to 'Go Live' in June 2025.

Freedom to Speak Up (FTSU)

The requirement for Trusts to have a FTSU Guardian, as a mandated post in NHS Trusts continues as an outcome of the public enquiry in 2016 chaired by Sir Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust. More recently, the importance of the Guardian role has been highlighted by the Lucy Letby case.

There are now over 1200 FTSU Guardians in over 500 NHS primary and secondary care, independent sector organisations and national bodies. According to the latest data from the National Guardian's Office, FTSU guardians have handled over 133,000 cases since their establishment, with the most recent year, 2024/25, seeing over 32,000 cases reported to them, representing a significant increase from previous years. In 2024-25, WVT had over 175 cases with each providing an opportunity to learn and make improvements that benefit the wellbeing of our colleagues and the care we provide to our service users. Research and data shows that an open culture in a Trust provides the safety needed for staff to speak up in the confidence that their voice will be heard.

FTSU and Civility Saves Lives

The Guardian alongside the team of FTSU Champions at the Trust continue to work together to deliver the Civility Saves Lives training.

The Guardian leads on this by promoting FTSU, Civility Saves Lives (CSL) and the need for teams to create a space of physiological safety. This has all been promoted across the Trust in a number of ways both virtually and face to face:

- Mandated eLearning for Speaking Up for all WVT staff. This is one of the KPIs for measuring staff awareness of how to raise concerns and what they can expect.
- Listen Up Training is now part of all managers appraisal after feedback that managers do not listen. Also 'Listen Up' was the theme of this year's speak up month. Highlighting that being able to listen to staff is equally as important as them speaking up.
- Delivering CSL sessions to 420 staff both Trust wide and bespoke to teams.
- Recruiting 20 more Champions taking us from 82 to 112 in the Trust. The aim is to have at least one Champion in each area and recruitment is ongoing
- Continuing to provide a new way of speaking up via a QR code and confidential Microsoft Teams online form

National Speaking Up Month

In the National Speaking up Month, October 2024, the FTSU team contributed to Staff Wellbeing week and attended the Foundation Group FTSU conference hosted by SWFT as well as promoting FTSU via Trust Talk (the global weekly newsletter for staff). There was a stand in the staff canteen each week to both promote speaking up and to recruit Champions. Several Champions were available to talk to staff considering the role. It was very successful.

Delivering awareness of FTSU and CSL at every Corporate Induction as well as other bespoke training. This includes timetabled sessions with foundation doctors, doctors in training, preceptorship, and student and OSCE nurses

FTSU Quality Indicators

Year of the Staff Survey	WVT Score	National/ Sector Score	Position Nationally
2023 Model Hospital/Staff Survey	60.84%	60.89%	Quartile 3 – Mid

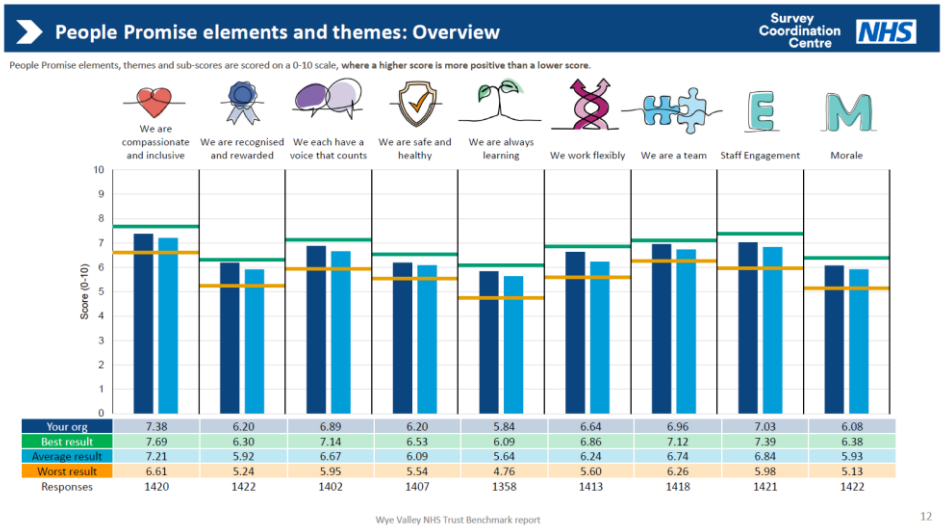
FTSU quality indicators include the response to the question, “I feel safe to speak up about what concerns me in my Trust”. This is calculated from the responses to the staff survey.

NHS Staff Survey 2024

The 2024 NHS Staff Survey was conducted between October and November 2024 with results published in March 2025.

34% of our staff (1,426) participated in the 2024 survey and the results for Wye Valley NHS Trust show further improvements with scores above the average ratings of benchmark comparators.

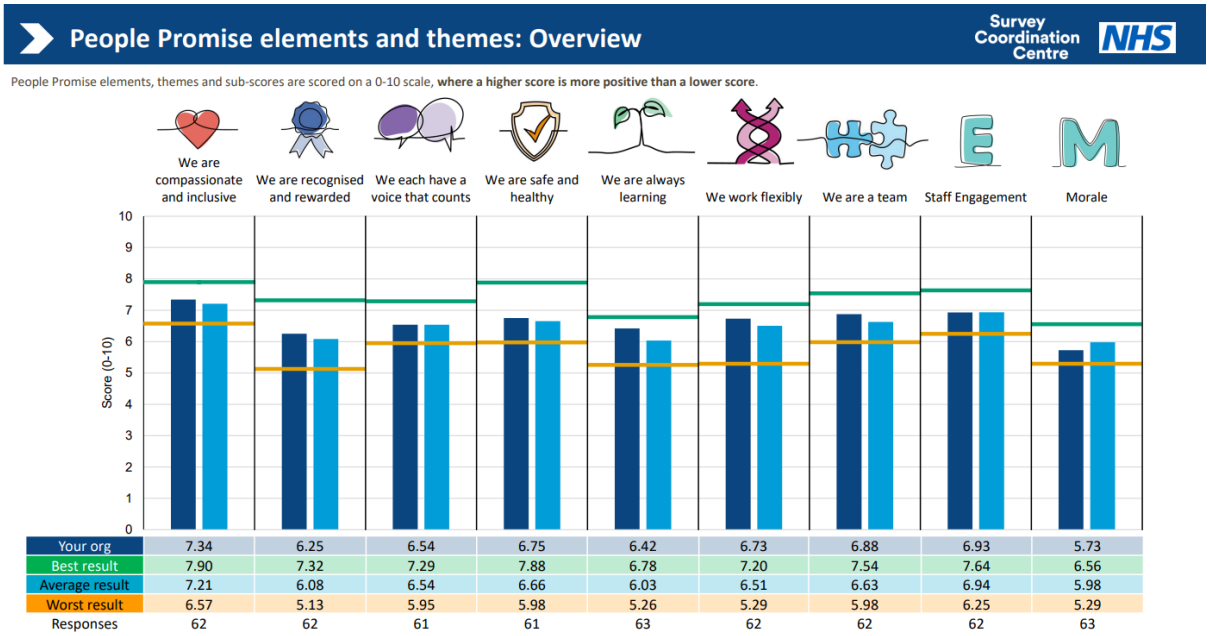
The following chart details the Trust’s performance against each of the People Promise elements:



The 2024 data for WVT particularly shows a statistically significantly higher change in the area of *We work flexibly* which is a reflection of the additional focus in this area of retention, wellbeing and engagement work. And WVT are ranked 6th nationally in the recommending the Trust as a place to work.

These further improved outcomes are as a result of the ongoing focus and number of Trust-wide leadership, workforce, education and OD initiatives that have been implemented over the past few years.

The national staff survey was also introduced for bank workers in 2023 and this year we had a response rate of 16% (compared to the national median response rate of 17%), see chart below.

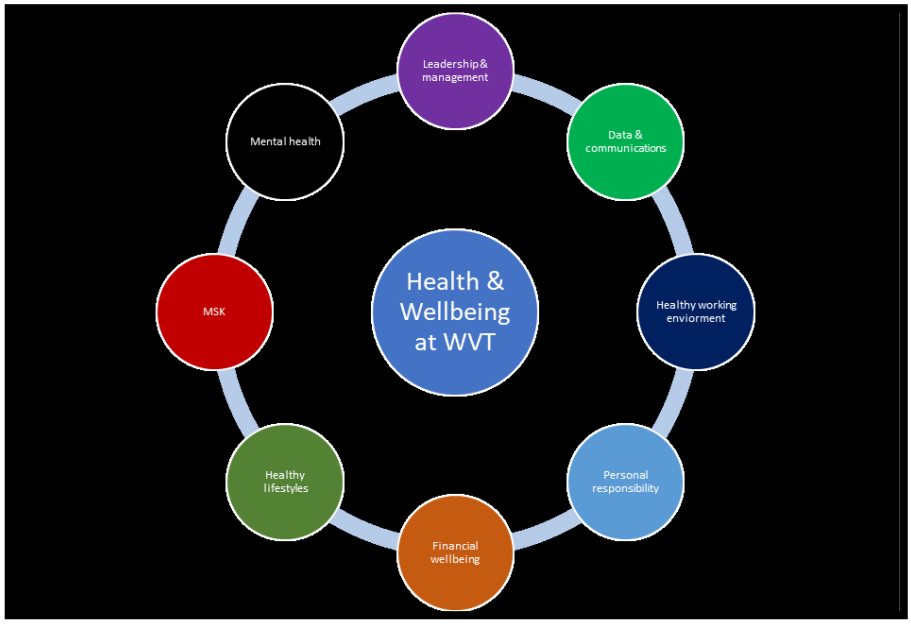


We are seeing scores above the average benchmark group of 90 organisations, across the majority of themes. 78% of WVT bank staff respondents would recommend the Trust as a place to work and WVT features as joint 4th in the top 10 of acute Trusts on this measure.

During 2025, we will continue to build on the WVT '*In Touch*' staff engagement work with a focus on local engagement and actions across directorates and with regular progress and improvement monitoring over the year. This will be facilitated through the retention work and as a key standing item on the Trust's Recruitment, Retention and Engagement Steering Group.

Health & Wellbeing

WVT Health & Wellbeing Strategy:



Optimising Your Wellbeing is our Commitment / Helping You to Help Yourself

We have seen positive outcomes and impacts on our staff through the range of Health and Wellbeing offers and initiatives provided throughout the year in supporting staff mental and physical health and wellbeing. This includes a staff physiotherapy service, access to mental health support including Employee Assistance Programme (EAP) provision and face to face counselling, participation in Schwartz Rounds which support emotional and psychological wellbeing, encouraging staff to get involved in the Connecting with Nature programme and a holistic fitness and wellbeing package provided in partnership with Halo Leisure instructors which includes Boditrax, walking groups, on site exercise and Pilates classes and staff discounts for the leisure centre.

Appraisals and Mandatory Training

The table below shows the Trust's performance against statutory and mandatory training and appraisal as at end of March 2025; we have seen improvements in both areas compared to the previous year. All areas are working to ensuring that appraisals are up to date by end of June 2025.

	Target	Actual March 2025
Core Skills (Statutory and Mandatory) Training	85%	89.4%
Appraisals	85%	77.7%

Recruitment and Retention

We have continued to make good progress throughout the year. During 2024/25, we have seen a further improvement in turnover which at March 2025 is 8.9% and below the 10% KPI target.

There have been a number of recruitment initiatives with a focus on reducing our vacancy gap, particularly in our healthcare support worker, pharmacy and allied health professions. We continue to be focussed on working with our partners across Herefordshire and Worcestershire ICS in recruitment events and promoting careers and we had Trust representatives attend 42 local and regional events in this last year. We have also seen successes and progress in filling our medical workforce vacancies throughout the year.

WVT has continued to work collaboratively with the Department for Work and Pensions (DWP) and to date 48% of applicants through this route have been offered positions within the Trust.

In addition, our focus is also on 'Grown our Own' strategies and the Trust has supported 504 apprentices to date.

CELEBRATING CHANGE -
Integrated Care Division – Patient Story

A great patient story highlighting how having a single professional to oversee a patient's condition can have positive benefits.

Wye Valley NHS Trust

GOOD NEWS

ROBERT'S POSITIVE EXPERIENCE

PAST HOSPITAL ADMISSIONS

- **2021**: Four admissions
  - General Medicine and Geriatrics
- **2022**: Four admissions
  - General Medicine, Cardiology and Urology
- **2023**: Five admissions
  - General Medicine and Geriatrics

In 2023, one period exceeding eleven weeks after contracting COVID-19

FOLLOWING LAST HOSPITAL DISCHARGE

In mid-2023 Robert was placed under proactive management when discharged from hospital, with a referral to ACP team.

Weekly blood pressure observations (including, postural drop), lung capacity, blood oxygen saturation and breathing; as well as reviewing sleep patterns and levels of swelling (oedema).

Due to regular review by a particular ACP – resulted in regular visits being reduced to fortnightly, with no admissions for lengthy period of hospitalisations in last 12 months.

From these regular reviews by our ACP, recommendations have been made to Cardiology, Respiratory, Geriatrics, Hepatology, and WVT oxygen specialists and St. Michael's Hospice for counselling.

THE BENEFITS TO ROBERT

As a result of the ACP direct contact with Robert – any concerns, deviations or worsen symptoms regarding Robert's health could be averted, by the ACP directly liaising with Robert's GP and specialist teams to seek further guidance, regarding infections, medication changes, physiotherapy and occupational therapy attendances, and home aids to combat issues as they arise.

And as a result of the ACP's overall knowledge of Robert's health issues, and the correct access to information and monitoring of his vital signs – this has prevented escalation of his current problems into a serious classification that would require hospitalisation.

Robert has been very happy with the regular contact and reassurance from our ACP and their ability to discuss information in laymen terms relevance to his various health conditions has immensely improved his overall health, demeanour and confidence.

Without our ACP's input, Robert would have been in and out of hospital for assessments, in between periods on being housebound which in turn would serious affect his overall mental health.

Quality Priorities:

Review of the Previous Twelve Months

Quality Priorities for 2024-25

The Trust identified seven quality priorities for 2024-25, which are detailed below. This section explains the progress made for each priority over the previous 12 months.

Safe	Effective	Experience
1. Implementing the NatSSIPs2 standards and improving management and oversight of safety in relation to interventional procedures. 2. Reduction in cases of Category 2 pressure ulcers. 3. Ensure patients receive a timely VTE risk assessment in line with NICE guidance. 4. Improving the care of the deteriorating patient and implementing Martha's rule by January 2025.	5. Implement a Quality Improvement project to target high-risk time-critical medication as locally defined. 6. Fully implement the 'Get it on Time' campaign for Parkinson's medications.	7. Improve responsiveness to patient experience data.

Quality Priorities - Safe

1. Implementing the NatSSIPs2 standards and improving management and oversight of safety in relation to interventional procedures

The Centre for Perioperative Care (CPOC) published their guidance, National Safety Standards for Invasive Procedure 2 (NatSSIPs 2) in January 2023.

This publication has seen NatSSIPs guidance evolve, containing less emphasis on tick boxes or rare 'Never Events', to now including cautions, priorities and a clear concept of proportionate checks based on risk with the focus being on implementation.

To allow implementation of this quality priority 'Stages' were created with a proposed timeline for each stage. Due to the size and content of the guidance, this was the sensible option available to enable manageable implementation.

Proposed timeframe for the project

Up to Nov 24

- Preparation and planning for the NatSSIPs 2 working group
- Be able to assure that all relevant documentation and practices are in line with the original NatSSIPs guidance.

Nov 24 – Feb 25

- First meeting of the NatSSIPs 2 working group to be held in November.
- NatSSIPs2working group to review and prioritise implementation of the guidance.

Feb 25-March 25

- NatSSIPs 2 working group to transition from an implementation group to a monitoring, continuous improvement working group for NatSSIPs/LocSSIPs.

Apr 25 onwards

- NatSSIPs 2 working group to embed a monitoring and continuous quality improvement approach, becoming a business-as-usual model.

The NatSSIPs2 working group has had to delay the initial meeting but has held three meetings in since the beginning of 2025, with stakeholder involvement including patient representation.

Moving forward

- The working group now needs to understand and prioritise implementation
- Review areas and registers to support improvement
- Aim to be in a position to propose a Trust Wide audit to be undertaken, taking into account the mixture of electronic and paper completion of checklists
- Commencing next year an annual board report as per NatSSIPs2 guidance will be included in the Trusts Quality Accounts.

Whilst there have been delays the Trust is pleased that there is evidence of progress being made with implementation.

2. Reduction in cases of Category 2 pressure ulcers

The Trust wanted to continue focus on pressure ulcers for 2024/25 as a Quality Priority, but focus the parameters with the aim on reducing the number of category 2 pressure damage incidents developed in our care.

The priorities aims were:

- Improve training at a local ward and team level
- Improve documentation and recording of activity
- Improve engagement of staff with Tissue Viability (TV) processes
- Better senior clinical oversight of patients.

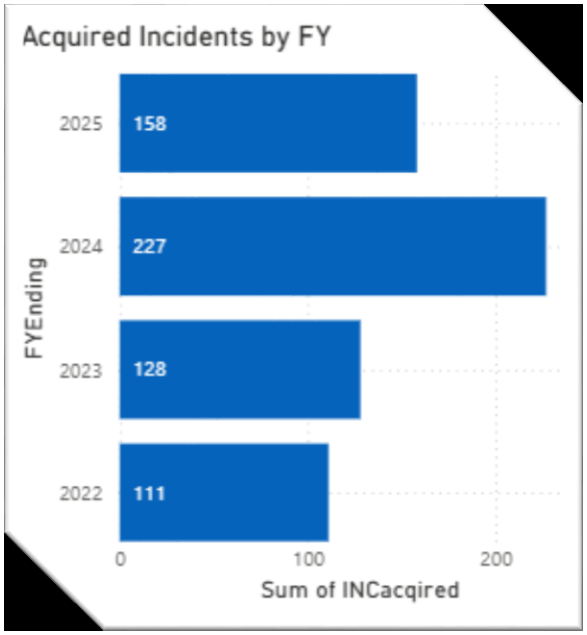
The past 12 months have focused on:

- Ensure that cases are categorised correctly, refreshed staff training was introduced to support staff how to understand how to categorise skin damage, this continues and is showing benefits.
- Improved data available for all teams.
- Divisional engagement at weekly Pressure Ulcer Panel (PUP) is good, and includes front line staff presenting rapid reviews and gaining insight from the process, along with District Nurse team members shadowing pressure ulcer panel helps the understanding of the wider issues.
- Management of vulnerable patients in the community is supported by safeguarding colleagues.
- Patient Safety Incident Response Framework (PSIRF) methodology adopted for pressure ulcers.
- Management of vulnerable patients in the community is supported by safeguarding colleagues.
- Focus on the quality of assessment and documentation
- Documentation audits.
- Integrated Care and Medical Division giving most focus to pressure ulcers as less prevalent in Surgical Division.

Continued work/Challenges

- Senior clinical oversight of caseloads remains a challenge for some District Nurse teams.
- Quality of assessment and documentation remains an issue but is improving.
- The actions from the divisional improvement plans will be drawn together into a Trust Wide improvement plan.
- Pressure Ulcer Panel – continued divisional engagement and learning from incidents.

The Trust is pleased to see a reduction of 30% or 69 incidents as a result of this Quality Priority.



3. Ensure patients receive a timely VTE risk assessment in line with NICE guidance

The Quality Priority for 2024-25 improvement plan for VTE assessment compliance focused on education and awareness, and supporting Divisions to meet the target of 95% risk assessment. Whilst commencing this Quality Priority the risk assessment target also returned to the standard NHSE contract and was also adjusted to a timeline of within 14 hours from 24 hours.

National figures released show overall NHSE performance for Q1 and Q2 was down to 89%, noting that no region in the UK has hit 95%. With many places having difficulty moving to 14 hours which is partly due to trusts experiencing issues due to paper reporting vs electronic.

Implementation of this quality priority has seen the following achievements over the past year:

- The cohorts for inclusion being reviewed and fully agreed. Following this revision the Surgical and Medical Division showed improvement
- Thrombosis Committee membership has been extended
- WVT continues to use the VTE Specialist Network buddy service to access support and guidance on improvement work
- VTE Specialists Network (VSN) membership amongst WVT is growing
- A live dashboard has VTE incorporated as one of the metrics
- World Thrombosis Day has been part of an awareness campaign in October
- Policy changed to ensure AHP's can undertake screening
- VTE teaching has been included in induction programs for new doctors
- Grand Round lecture on VTE has been delivered
- FY2 doctors have had an education session
- Dashboard has identified areas for improvement

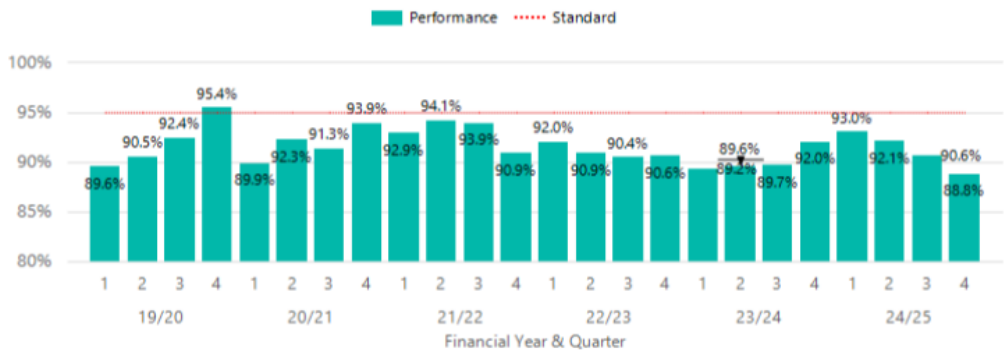
- Mapping of elective surgical pathway has started and emergency pathways will follow

The Plan Ahead:

- A link between the risk assessment tool and EPMA has progressed but awaits Maxims upgrade testing
- There is further work to do on the dashboard and also on location and clinician reports
- Aim to report missed or late administration of Thromboprophylaxis treatment in future reports potentially by partnership with EPMA supplier (epro).

Following the Trust being in the process of changing to Power BI, the SQL dataset remains the source of trust performance. The revised logic shows an improvement in recent quarters which is close to the 95% target. This reflects the impact of VTE improvement plan actions

Figure 2
Revised Logic:



Whilst WVT does remain behind the national target our results continue to improve. Further information from the dashboard and Maxims upgrade support will help with further improvement.

It is acknowledged that there has been some progress although this was slower than the Trust would have liked, as a result, it has been agreed VTE will continue as a quality priority for 2025-26.

4. Improving the care of the deteriorating patient and implementing Martha's rule by January 2025

Improving the care of 'Deteriorating Patient and implementation of Call for Concerns (Martha's Rule) was a quality priority for 2024/25. NHSE propose the PIER (Prevention, Identification, Escalation and Response) approach to improving care of deteriorating patients to ensure that it is a whole pathway, which is supported by systems rather than only advocating a single strategy for identification.

The past 12 months have seen the monitoring of compliance to key standards, reviewing progress with the improvement plan, and the review of any incidents related to the care of the deteriorating patient to ensure learning.

Martha's Rule renamed as 'Call for Concern' to be in line with the rest of the country is a major patient safety initiative providing patients and families with a way to seek an urgent

review if their or their loved one's condition deteriorates and they are concerned this is not being responded to. Martha's Rule will help improve both the quality and safety of care for patients whose condition is worsening. Better identification and management of deterioration is one of NHS England's key priorities in improvement patient safety.

What we have done

Focusing on improving detection, escalation and management as well as prevention. To that effect clinical teams have been invited to Deteriorating Patient Committee to present their compliance to essential to role resuscitation training, NEWS early warning escalation policies and any incidents leading to deterioration and equipment compliance and to identify any quality improvements to be made to further improve compliance.

The Resuscitation Committee has recently been re-arranged into a new format and frequency.

The Trust had stopped taking part in the cardiac arrest audits but has now started to take part in the national audit which will give outcome data and also the ability to benchmark against other services.

The Critical Care Outreach team expanded in September providing a 24 hour service which has been a great success (previously 12 hours per day). The number of requests has doubled over time showing 50% to be out of hours and 50% within hours. Placing the Trust to be in a position to be able to provide more consistent care for patients.

The second part of Martha's rule to implement call for concern has been paused as there will be an opportunity to take part in a funded National pilot. An expression of interest has been submitted and the Trust waits to hear whether this has been successful.

The previous 12 months have seen a lot of work done to improve the care of the deteriorating patient and critical outreach data shows more escalation. Data has been broken down for divisions so they can improve using their individual data, along with collating incidents of failed escalation to identify barriers. Mortality is stable and improving.

Quality Priorities - Effective

5. Implement the Quality Improvement project to target high-risk time-critical medication as locally defined.
6. Fully implement the 'Get it on Time' campaign for Parkinson's medications

These two Quality Priorities that are closely linked commenced in 2023-24. To enable continuation with progress made it was agreed to continue them as Quality Priorities for 2024-25, supporting the National drive by Parkinson's UK.

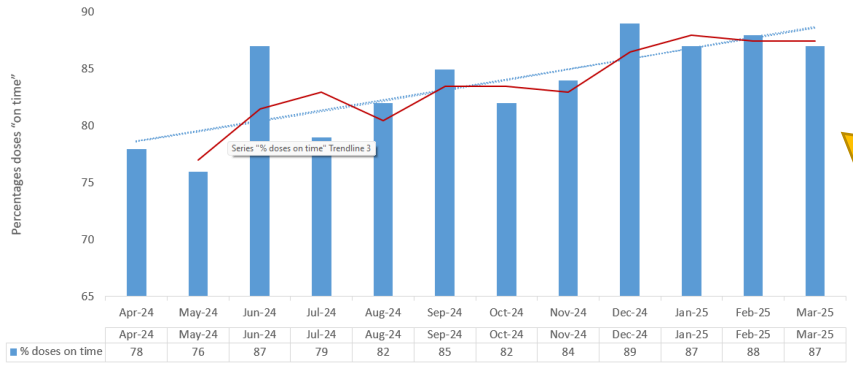
Ward visits have helped the Medicines Safety Officer (MSO) appreciate and understand issues experienced in practice. Sharing of data with Matrons and Ward sisters and engagement with wards and community hospitals to understand the barriers previously experienced regarding the impact around change, witnessed improved engagement and support from nursing staff.

A deep dive took place into missed doses to truly understand the data. The data presented for July-December 24 highlighted the large volumes of Parkinson's medication that had been administered over that timeframe, with a very low number of missed doses and on a deeper dive of these doses highlighting very few were true missed doses.

With the majority of patients receiving their medication on time but nurses' not updating EPMA quickly enough, tipped the administration into the next time category appearing as administered late, when this was not the case.

To support staff stock lists for the highest areas of administration have been updated to ensure medications are available to prevent "meds unavailable" situations.

% of medications "on time every time"



58% of people with Parkinson's admitted to hospital do not receive their medication on time every time (Parkinson's UK 2022 data)

On average 84% of patients admitted to Wye Valley NHS Trust receive their medication on time every time.

OUTSTANDING PERFORMANCE!

The percentage of medications on time every time has showed improvement

throughout 2024, following education being delivered.

In addition, a deep dive was completed in December into other critical medications, focusing on diabetes and long acting insulin. The findings showed out of a total of 463 there were 5 missed doses.

Identified on-going work:

- Self-administration is not being used on wards as much as it could be. A questionnaire completed by staff confirmed that nurses found it difficult as a function on EPMA and thought it to be time consuming, therefore they were not promoting this option.
- Provide continued support to frailty wards and community hospitals to improve timing of critical medications.
- Work with the EPMA team to share education with nurses to help with deferred doses.
- Non-Medical Prescribing (NMP) focus and doctor's training to be provided to ensure that prescriptions are stopped correctly.
- Continue links with Parkinson's Nurses and Parkinson's UK and continue to promote all critical mediations using the medicines related guidelines which are available online.
- Continue with deep dives into other critical medications as well as continuation of the Parkinson's data.
- Continue to liaise with the Foundation Group to compare data,

To allow the continuation of the positive progress made with these quality priorities, it has been agreed to continue with the focus on time critical medications identifying specific areas to pursue

Quality Priorities - Experience

7. Improve responsiveness to patient experience data –

The quality priority for 2023-24 was broad; 'Improve patient experience'. Whilst survey and FFT responses had shown improvement in some aspects of patient experience our responsiveness to feedback was inconsistent and failing to meet national and local targets. This limited our ability to generate widespread sustainable improvement.

To provide focus, the priority was updated for 2024-25 to 'Improve responsiveness to patient experience data'. The aim being to see an improvement in the following areas;

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

When reviewing the data against our quality priority measures we are seeing progress and improvement in a number of areas, however, recognise there is more work to do to deliver the quality priority. The measures will be monitored next year against our revised priority to tackle the areas where improvement has not been realised.

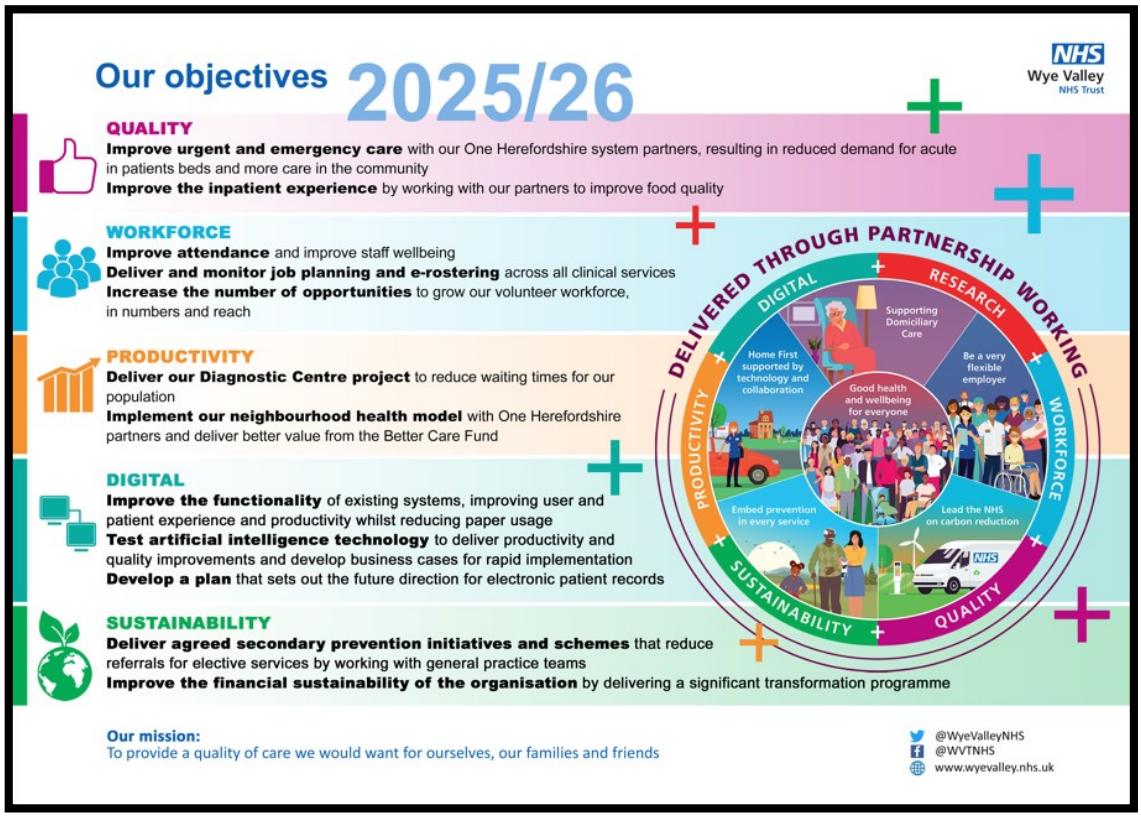
Measure	Update August 2024	Update October 2024	Update Feb 25	Update year end
Evidence use of FFT feedback to generate improvement (projects/ case studies)	Defined projects based solely on FFT in some areas. Other areas are triangulating and using data for improvement projects. This is reported to PEC by divisions.	Next update in Q4	PEC cancelled in February next update in March	Due to delays in rolling out to all services further projects stalled. Will continue to review next year with introduction of expanded system
Improvement in national patient survey results	Final data awaited.	Mixed results with some areas of improvement and good practice but other areas of deterioration.	Acute & Emergency care presented in December, Maternity presented in February	No further survey results reported.
Evidence use of survey feedback to generate improvement (projects/ case studies)	Whilst final data not verified. Initial results confirmed internal concerns in two areas; food quality and communication about medicines on discharge. Improvement work underway for both.	Improvement projects established to tackle the areas of concern noted in the survey as presented to QC in October.		Improvement projects continue and new quality priority introduction for 2025-26 for nutrition and food quality.
Reduction in complaints and concerns	Number of complaints increasing however a downward trend in recent months for concerns.	Complaints continue to increase along with comebacks and cases referred to the PHSO.	2% increase in complaints, reduced concerns reflective of reduced admin function	3% increase in complaints overall.

Improved response times to complaints and concerns	There is month on month improvement since February 2024 in response times to complaints.	Lowest number of overdue complaints since 2020	Slight increase in Q3, but remains lower than 22/23	Overall an improving trend continues. However overall the Trust only responds to a complaint within agreed timeframes for 50 of complaints.
Reduction in overdue responses to complaints and concerns.	Downward trend in number of overdue complaints with August 2024 showing the lowest number since February 2021.		Complaint response times trend improved since Dec 23	Overall improvement but not meeting board KPI of 90%.
Reduction in comebacks or re-opened cases.	There has been an increase in re-opened cases and comebacks year to date.	Reduction seen in Q2 but YTD still high. Issues known and discussion at PEC to seek support from divisions to remedy the issues.	YTD remains higher than 22/23. Analysis identified themes and feedback provided to divisions	Comebacks doubled from 2023-2024. Deep dive into underlying issues undertaken and shared with divisions.
Increased patient engagement and collaboration on improvement projects	The Patient Engagement Group is meeting regularly again with new and increased membership. The members are participating in a wide range of improvement work including; projects based on survey results. PLACE and PLACE lite, 15 steps and stakeholder engagement.	Continued and increased engagement at the Group, participating in more projects and seeking to increase membership more representative of the patient population.	Patient Engagement Group continuing to embed and collaborate with improvement projects	Group fully embedded and supporting a number of projects. Members report positive experience of being in the group and being part of service level change.

Quality Priorities:

The Year Ahead

2025-26 Trust Objectives



QUALITY PRIORITIES 2025-26

Quality Priorities 2025/26

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, the Executive team and Board.

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

SAFE

Ensure patients receive a timely VTE risk assessment in line with NICE guidance

Building on the work undertaken in 2024-25 this remains a priority due to the national barriers in achieving the risk assessment target (see information above). The focus this year will be on improving our electronic systems to make the risk assessment easier to complete reducing the risk of delayed thromboprohylaxis treatment.

Diabetes Safety Improvement Project

Management of diabetes and insulin treatment whilst an inpatient and in the community setting is an area of great importance. The priority will focus on how we improve oversight and assurance that patients are appropriately supported to manage their diabetes through learning from incidents and good practice. Focussing on how we embed good practice consistently for every patient regardless of the setting they are receiving care.

Improvement in food safety and quality.

Nutrition risk and MUST scoring.

The two priorities are closely linked and will be worked into one project overseen by the Nutrition Steering Group and Trust lead for Nutrition. The priority was prompted by the continued poor feedback we receive from patients about food quality and the importance on patients being able to make safe choices for nutrition whilst in our care.

EFFECTIVE

Implement a quality improvement initiative to ensure timely administration of critical medications.

Building on the success of our critical medications priority for 2024-25, the project will focus on embedding self administration practices across our services. This was a key element of learning from the Get It Right On Time project and an inititative that will support staff and patients to ensure safe and high quality care.

Transition of Care for Children and Young People.

Ensuring children and young people with chronic or complex medical conditions can move seamlessly from paediatric to adult services is vital to ensuring patients continue to receive safe and quality care. A recent national study found that this on happened in line with NICE guidance 50% of the time. The priority will focus on ensuring there are local standardised transition pathways for all relevant service at Wye Valley NHS Trust.

EXPERIENCE

Improve responsiveness to patient experience data

This priority continues and aims to tackle the areas that did not see improvement last year through two key projects;

- Expanding the reach of our Friends and Family Test service
- Implementation of the PHSO Model Complaint Standards

Increase the number of opporunities to increase our volunteer workforce in numbers and in reach

The contribution volunteers make to support our services adds value that improves patient experience across both the inpatient, outpatient and community settings. The Trust has over 100 volunteers working with us in a variety of roles and are seeking to continue this exemplarary work and expand our opportunities to improve patient experience across all services and settings.

External Statements of Assurance

Statement of Assurance from NHS Herefordshire and Worcestershire ICB regarding Wye Valley Trust Quality Account for 2024-25

TO BE ADDED

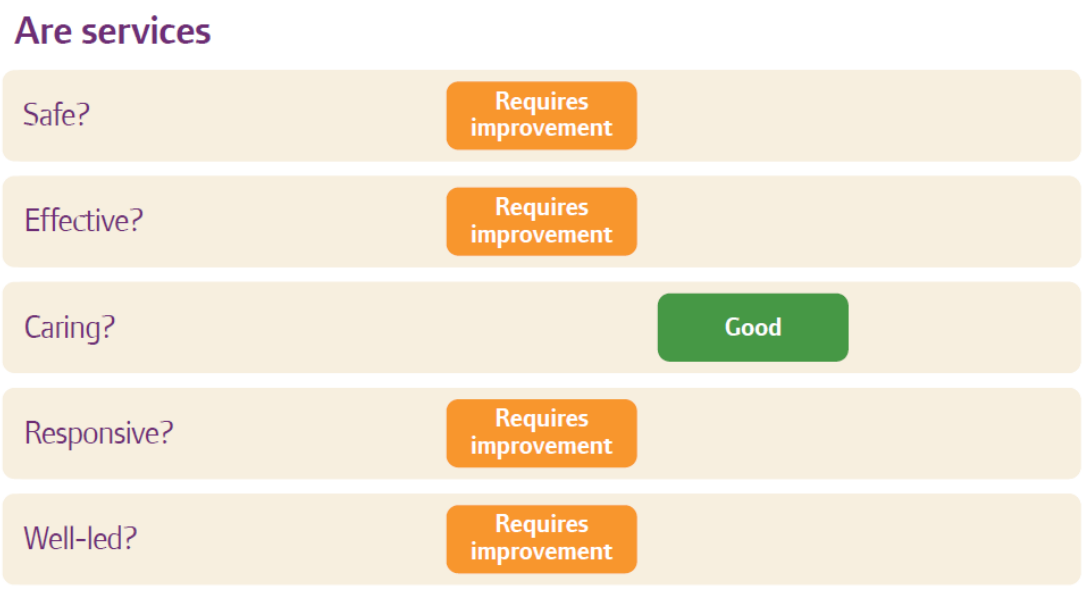
Simon Trickett
Chief Executive Officer- NHS Herefordshire and Worcestershire Integrated Care Board

Appendices

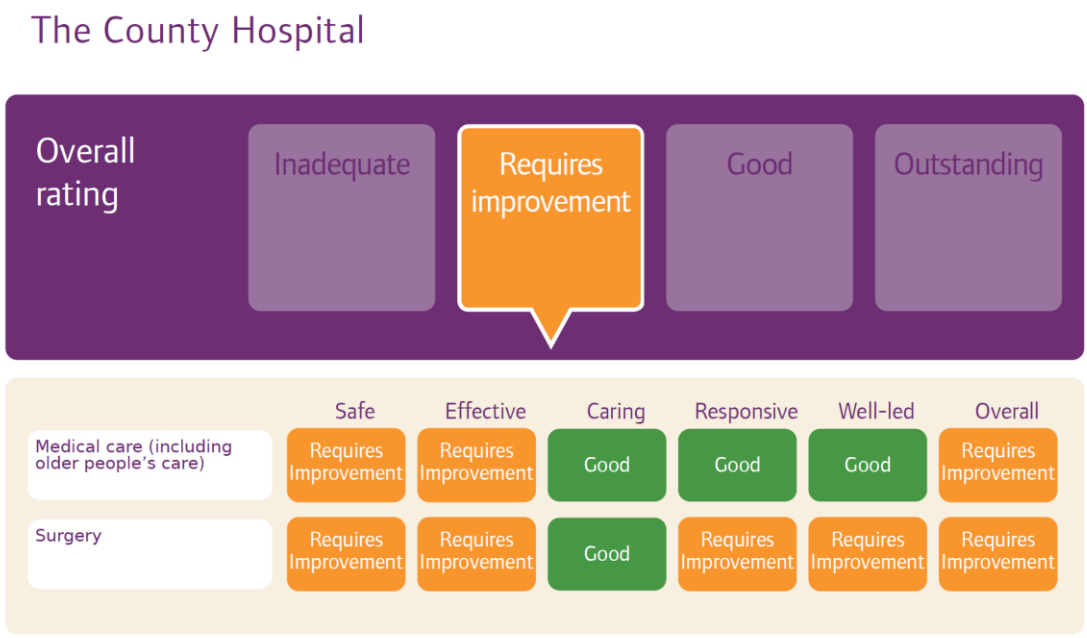
Appendix 1

CQC Ratings Tables

Acute Site ratings



Most recent inspection rating changes



Community Services

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good → ← Mar 2020	Good → ← Mar 2020	Good ↓ Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Requires improvement → ← Mar 2020	Requires improvement → ← Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Requires improvement → ← Mar 2020
Community end of life care	Good ↑ Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020
Community dental services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good ↑ Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020	Good → ← Mar 2020	Good ↑ Mar 2020

Appendix 2
National Audit & NCEPOD Compliance

Eligible National Audits	WVT participation in 2024-2025	Cases submitted (where applicable)	Comments
Royal College of Emergency Medicine (RCEM) Care of older people	✓	N/A	Report not yet due to be published
Royal College of Emergency Medicine (RCEM) Adolescent Mental Health	✓	N/A	Report not yet due to be published
Royal College of Emergency Medicine (RCEM) Time Critical Medications	✓	N/A	Report not yet due to be published
The National Major Trauma Registry (NMTR)	✓	All eligible cases submitted	Report not yet due to be published
Case Mix Programme (CMP)	✓	All eligible cases submitted	Case Mix Programme report quarterly and the Annual Public Report is not yet due to be published
National Audit of Metastatic Breast Cancer (NAoMe)	✓	All eligible cases submitted	National Audit of Metastatic Breast Cancer Report 2024 (NAoMe) State of the Nation Report published 12th September 2024
National Audit of Primary Breast Cancer (NAoPri)	✓	All eligible cases submitted	National Audit of Primary Breast Cancer Report 2024 (NAoPri) State of the Nation Report published 12th September 2024
National Bowel Cancer Audit (NBOCA)	✓	N/A	Bowel cancer report (NBOCA / NATCAN) State of the Nation Report published 9th January 2025
National Kidney Cancer Audit (NKCA)	✓	N/A	National Kidney Cancer Audit Report 2024 (NKCA) State of the Nation Report published 12th September 2024

National Lung Cancer Audit (NLCA)	✓	All eligible cases submitted	National Lung Cancer Audit (NLCA) State of the Nation Report published 10th April 2024
National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	All eligible cases submitted	National Non-Hodgkin Lymphoma Audit Report 2024 (NNHLA) State of the Nation Report published 12th September 2024
National Oesophago-Gastric Cancer Audit (NOGCA)	✓	All eligible cases submitted	Oesophago-gastric cancer report (NOGCA / NATCAN) State of the Nation Report published 9th January 2025
National Ovarian Cancer Audit (NOCA)	✓	All eligible cases submitted	National Ovarian Cancer Audit Report 2024 (NOCA) State of the Nation Report published 12th September 2024
National Pancreatic Cancer Audit (NPaCA)	✓	All eligible cases submitted	National Pancreatic Cancer Audit Report 2024 (NPaCA) State of the Nation Report published 12th September 2024
National Prostate Cancer Audit (NPCA)	✓	All eligible cases submitted	Prostate cancer report (NPCA / NATCAN) State of the Nation Report published 9th January 2025
National Audit of Cardiac Rhythm Management (CRM)	✓	All eligible cases submitted	Cardiac Rhythm Management (NICOR) Annual Report published 14th April 2024
National Audit of Cardiac Rehabilitation	✓	All eligible cases submitted	National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2024 published 11th December 2024
Myocardial Ischaemia National Audit Project (MINAP)	✓	25%	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) Annual Report published 14th April 2024
National Heart Failure Audit (NHFA)	✓	93.1%	National Heart Failure Audit (NHFA) Annual Report published 14th April 2024

National Diabetes Audit - CORE	✓	All eligible cases submitted	Annual report not yet published but quarterly reports available online
Diabetes Prevention Programme (DPP) Audit	✓	All eligible cases submitted	Report not yet due to be published
National Diabetes Foot Care Audit (NDFA)	✓	N/A	National Diabetes Foot Care Audit (NDFA) – State of the Nation Report published 9th May 2024
National Diabetes Inpatient Safety Audit (NDISA)	✓	N/A	National Diabetes Inpatient Safety Audit 2022/23 Report published 13th June 2024
National Pregnancy in Diabetes Audit (NPID)	✓	All eligible cases submitted	Report not yet due to be published
Transition (Adolescents and Young Adults) and Young Type 2 Audit	✓	N/A	Report not yet due to be published
Gestational Diabetes Audit	✓	N/A	Report not yet due to be published
National Audit of Dementia	✓	All eligible cases submitted	Dementia – Care in General Hospitals (NAD) Report published 12th December 2024 Dementia audit: Memory Assessment Services 2023/2024 (NAD) Report published 8th August 2024
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	All eligible cases submitted	2023 Annual SHOT report published July 9th 2024
National Maternity and Perinatal Audit (NMPA)	✓	All eligible cases submitted	Perinatal mental health report (NMPA) Evaluating hospital and crisis care for perinatal mental health Report published 11th July 2024
National Hip Fracture Database	✓	All eligible cases submitted	Using the national database to improve hip fracture care (NHFD) A broken hip – three steps to

			recovery Report published 12th September 2024
Fracture Liaison Database	✓	N/A	Fracture Liaison Service Database report (FFFAP) Annual Report published 9th January 2025
National Inpatient Falls Audit	✓	All eligible cases included	Inpatient falls-2024 national report on 2023 clinical data (NAIF) Report published 10th October 2024
National Joint Registry (NJR)	✓	All eligible cases included	National Joint Registry Annual Report 2024 Report published 1st October 2024
National PROMS Programme	✓	N/A	Patient Reported Outcome Measures (PROMs) in England, Final 2023/24 data Published 13th February 2025
NPDA National Paediatric Diabetes	✓	All eligible cases included	Paediatric diabetes – PREMS report 2024 (NPDA) Report published 14th November 2024 National Paediatric Diabetes Audit (NPDA) report: Care and Outcomes 2022/23 Report published 10th April 2024
National Neonatal Audit Programme (NNAP)	✓	All eligible cases included	Neonatal audit–Summary report on 2023 data (NNAP) Report published 10th October 2024
National Audit of Seizures and Epilepsies in Children and Young People	✓	All eligible cases included	Epilepsy 12 State of the Nation Report published 11th July 2024
UK Cystic Fibrosis Registry (Adults & Children)	✓	Data only collected on Children	UK Cystic Fibrosis Registry 2023 Annual Data Report published October 2024
National Child Mortality Database	✓	N/A	Child deaths due to asthma or anaphylaxis (NCMD) thematic report published 12th December 2024 Child Death Review Data Release 2024 (NCMD) Report published 14th November 2024

			Learning from deaths of children with a learning disability and autistic children (NCMD) Report published 11th July 2024
Cleft Registry and Audit NEtwork (CRANE)	✓	All eligible cases included	Cleft Registry and Audit NEtwork (CRANE) 2024 Annual Report published 12th December 2024
National Respiratory Audit Programme (NRAP) COPD Secondary Care	✓	N/A	Respiratory care – Organisational audit 2024 (NRAP) Report published 14th November 2024 Breathing Well respiratory audit report (NRAP) Report published 11th July 2024
National Respiratory Audit Programme (NRAP) Pulmonary Rehabilitation	✓	N/A	Respiratory care – Organisational audit 2024 (NRAP) Report published 14th November 2024 Breathing Well respiratory audit report (NRAP) Report published 11th July 2024
National Respiratory Audit Programme (NRAP) Adult Asthma Secondary Care	✓	N/A	Respiratory care – Organisational audit 2024 (NRAP) Report published 14th November 2024 Breathing Well respiratory audit report (NRAP) Report published 11th July 2024
National Respiratory Audit Programme (NRAP) Children and Young People's Asthma Secondary Care	✓	N/A	Respiratory care – Organisational audit 2024 (NRAP) Report published 14th November 2024 Breathing Well respiratory audit report (NRAP) Report published 11th July 2024
National Early Inflammatory Arthritis Audit (NEIAA)	✓	All eligible cases included	Early inflammatory arthritis 2024 report (NEIAA) state of the Nation Report published 10th October 2024
Sentinel Stroke National Audit programme (SSNAP)	✓	All eligible cases included	Stroke – State of the Nation report (SSNAP) Report published 14th November 2024
National Emergency Laparotomy Audit (NELA)	✓	All eligible cases included	Emergency Laparotomy-Ninth Patient Report (NELA) Report published 10th October 2024

Perioperative Quality Improvement Programme (PQIP)	✓	All eligible cases included	Perioperative Quality Improvement Programme (PQIP) Report 5 published September 2024
Breast and cosmetic implant registry	✓	All eligible cases included	Breast and Cosmetic Implant Registry - January to December 2023, Management Information Report published 24th October 2024
British Hernia Society Registry	✓	N/A	Report not yet due to be published
Society for Acute Medicines Benchmarking Audit (SAMBA)	✓	All eligible cases included	Winter SAMBA24 National Report published 11th December 2024
BAUS Urology Audits – BAUS Penile Fracture udit	✓	N/A	Report not yet due to be published
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	✓	N/A	I-DUNC National Summary Report published 13th December 2024
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	✓	N/A	Report not yet due to be published
National Audit of Care at the End of Life (NACEL)	✓	All eligible cases included	Report not yet due to be published
UK Renal Registry Chronic Kidney Disease Audit	✓		Report not yet due to be published
UK Renal Registry National Acute Kidney Injury Audit	✓	All eligible cases included	UK Renal Registry- Acute Kidney Injury (AKI) in England 2022 Report – Published 20th December 2023
Oral and Dentoalveolar Surgery - Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	X	N/A	The Trust could not engage in this study because of a shortage of clinical consultants, who needed to prioritise patient care. It is important to note that this

			project has now been excluded from the quality accounts list for the years 2025/2026
National Cardiac Arrest Audit (NCAA)	X	N/A	The Trust has temporarily withdrawn participation in this audit due staff resources within the resuscitation team but local data is being collected and reported and full participation to commence in April 2025
National Ophthalmology Database Audit	X	N/A	The Trust does not currently participate in this audit due to not having the electronic software systems required to upload the data

National Confidential Enquiries (NCEPOD)			
Eligible National Audits	**WVT participation in 2024-2025**	**Cases submitted**	**Eligible National Audits**
Maternal, Newborn and Infant Clinical Outcome Review Programme	NCEPOD	N/A	Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22 - Report published 10th October 2024 Perinatal Mortality Surveillance: UK perinatal deaths of babies born in 2022 - Report published 11th July 2024 Perinatal Confidential Enquiry: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death - Report published 12th December 2024

Medical & Surgical Clinical Outcome Review Programme	NCEPOD	N/A	Rehabilitation following critical illness - Data collection completed and submitted, report due to be published Spring 2025 Sodium - Data collection completed and submitted, report due to be published Winter 2025 Acute Illness in people with a Learning Disability - Data collection underway, report due to be published Summer 2026 Endometriosis "A Long & Painful Road - A review of the quality of care provided to adult patients diagnosed with endometriosis. Report published 11th July 2024 End of Life Care "Planning for the End" A review of the quality of care provided to adult patients towards the end of life. Report published 14th November 2024
Mental Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Mental Health Clinical Review Programme when required Suicide and safety in mental health (NCISH) Reports published13th February 2025
Child Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Child Health Clinical Review Programme when required – This year the studies are as follows: Juvenile idiopathic arthritis – "Joint Care" A review of the quality of care provided to children and young adults with juvenile idiopathic arthritis Report published 13th February 2025 Emergency procedures in children and young people - Data collection completed and submitted, report due to be published Late 2025

Appendix 3
NHS Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps

Our Medical and Surgical Divisions maintain detailed rotas identifying gaps. Detailed improvement plans are in place to address gaps.

Table A – 3rd rotation 03/04/2024 – 06/08/2024
Surgical Deanery Doctors

Grade	Entitled To	Filled	Gap	
Surgical FY1	13	12	1	1 x LAS covered Gap
Surgical FY2	9	8	1	1 x LAS covered Gap
GPST	7	5.8	1.2	1x 80% LTFT, 1x LAS covered
CTs	5	5	0	
ST	5	5	0	
ST3+	15	12.6	2.4	1x 60%LTFT, 1X 80% LTFT, 1 X LAS covered GAP

1st rotation 07/08/2024 – 03/12/2024

Surgical Deanery Doctors

Grade	Entitled To	Filled	Gap	
Surgical FY1	16	11.8	4.2	4X LAS, 1X 80%LTFT
Surgical FY2	11	11	0	
GPST	7	6	1	1X LAS Covered Gap
CTs	5	5	0	
ST	7	6	1	1X LAS Covered Gap
ST3+	16	14.5	1.5	1X LAS Covered Gap, 2x LTFT (1 AT 70%, 1 AT 80%)

2nd rotation 04/12/2024 – 01/04/2025
Surgical Deanery Doctors

Grade	Entitled To	Filled	Gap	

Surgical FY1	16	13.8	2.2	2X LAS, 1x 80% LTFT
Surgical FY2	11	9.8	1.2	1X LAS, 1X 80% LTFT
GPST	7	3.6	3.4	3 X VACANT, 1X60% LTFT
CTs	5	5	0	
ST	7	6	1	1 X LAS
ST3+	16	13.1	2.9	2X LAS, 3X LTFT 80%, 1 X LTFT 70%

Table A – 3rd rotation 03/04/2024 – 06/08/2024
Medical Deanery Doctors

Grade	Entitled To	Filled	Gap	
Medical FY1	22	17.6	4.4	3x LAS , 1X 80%LTFT, 1X 60%LTFT
Medical FY2	12	12	0	
GPST	7	6	1	1 XLAS
CTs/IMT	5	3.8	1.2	1 X LAS, 1 X 80%LTFT
ST3+/ IMT3	14	8.6	5.4	2.4 LTFT, 2 X LAS,1 X VACANT

1st rotation 07/08/2024 – 03/12/2024
Medical Deanery Doctors

Grade	Entitled To	Filled	Gap	
Medical FY1	25	23.6	1.4	1X LAS, 1X 60% LTFT
Medical FY2	13	10.6	2.4	2X LAS, 2X 80% LTFT
GPST	7	6.4	0.6	1X 80% LTFT, 1 X 60% LTFT
CTs/IMT	5	4.8	0.2	1 XLTFT 80%
ST3+/ IMT3	16	12.6	3.4	2X LAS, 1X VACANT, 2 X LTFT 80%

2nd rotation 04/12/2024 – 01/04/2025
Medical Deanery Doctors

Grade	Entitled To	Filled	Gap	
Medical FY1	25	21.8	3.2	2X LAS, 2 X 80% LTFT, 2 X 60% LTFT
Medical FY2	13	12.8	0.2	1 X LTFT 80%

GPST	7	4.8	2.2	2 X VACANT, 1 X 80% LTFT
CTs/IMT	5	4.8	0.2	1 X LTFT 80%
ST3+/ IMT3	16	11.8	4.2	3 X VACANT, 1 X LAS, 1 X 80% LTFT

Appendix 4

Comparable data summary from data available to the Trust from NHS Digital-awaiting detail from Martin on readmission to hospital

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. Wye Valley NHS Trust considers that this data in the table below is as described for the following reasons:

https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Performance information is consistently gathered and reported on monthly to the Trust

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2021/22)	0	0	3	20	0	Hospital Onset cases. Latest 2023-2024 Previous 2022-23 (09/2024 release)
MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to reduce incidence of MRSA and so the quality of services, by ensuring its strict cleaning, hygiene, hand-washing regimes, and bare below the elbows practice is adhered to. The trust also has a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.						
NHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile	37	42	77.4	326	0	Hospital & Community onset, Healthcare associated. Latest 2023-24 Previous 2022-23 (17/05/2024 release)
Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and the quality of services, by learning lessons from these investigations, sharing with the clinical area and presenting at the Trust's Quality Committee meetings.						
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported						No new release of data due to the change to the new Patient Safety Incident Reporting framework
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported Severe or death						No new release of data due to the change to the new Patient Safety Incident Reporting framework
Note: No new release of data since 19/20 due to the change to the new Patient Safety Incident Reporting Framework						
Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents and the outcome of investigations are shared throughout Divisional and Directorate governance meetings. Incident reviews that identify a new emerging risk or new learning are shared in a variety of forums and in the trust Safety Bites newsletter.						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level (Current Dec 2023 – Nov 2024) Band 2 (Previous Dec 2022 – Nov 2023) Band 2	1.028	1.0212	1.0	1.29	0.70	Data is banded 1-3 high to low Previous period Dec 2023 - Nov 2024
Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the (Current Nov 2023 – Oct 2024) (Previous Nov 2022 – Oct 2024)	24%	24%	45%	65%	17%	Reported as a percentage of all deaths.
SHMI data at trust level, Dec22-Nov23 (xls).xls (live.com) SHMI data - NHS England Digital						
Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by maintaining the implementation of the Mortality strategy and supporting quality improvement work in relation to mortality alerts and learning from deaths.						

Limited submissions for current year . Numbers not sufficient for the benchmarking tool to use

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	
PROMS Total HIP Replacement (latest 2023-24) (Previous latest 2022-23)	0.498	0.495	0.453	0.60	0.36	Using EQ-5D Index score (a combination of five key criteria concerning general health) ***This year Measuring Health gain*** Note for Hip sample small for accurate National comparison. Note last year updated to 2022-23 More info in link below
PROMS Total Knee Replacement Latest 2023-24 Previous 2022-23	0.292	0.34	0.323	0.40	0.23	

Patient Reported Outcome Measures (PROMs) - NHS Digital

Wye Valley NHS Trust is taking the following actions to improve PROMs outcomes and so the quality of services, by continuing to look at the issues with the PROM outcome scores in greater detail, in particular those patients who have had a negative outcome and analysing patient level information to look at the outliers and their impact on the overall scores. This analysis is undertaken by the surgical teams to understand how we can improve.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Section 5 Your care & treatment NHS Outcomes Framework - Indicator 4b Patient experience of hospital care Statistic: verall how was you experience….in Hospital	**7.90**	7.98	8.14	9.34	7.47	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to 2023 survey Nov sent Jan – April 2024 ***Published Sept 2024***
Adult inpatient survey 2023 - Care Quality Commission						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement						
d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d – 2024)	57	58	62	90	40	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 Previous December 2023
Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work (Q25c-2024)	62	61	61	79	35	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 survey latest available
NHS Staff Survey 2024 Benchmark Report Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.						
Friend and Family Inpatient services latest Jan 2025 Previous December 2023	88	84	95	100	72	Figures expressed as percentage who would recommend. Current Jan 2025 previous December 2023
Friend and Family Accident and Emergency services Jan 2025 Previous December 2023	80	72	80	97	56	
https://www.england.nhs.uk/fft/friends-and-family-test-data/ NHS England » Friends and Family Test data – January 2025 friends-and-family-test-inpatient-data--january-2025.xlsm						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
VTE risk assessed Current October to December Q3 2024-25 Previous VTE risk assessed Quarter 3 (October to December Q3 2019-20)	91%	92.2%	91%	99.6%	14%	Expressed as a percentage of patients requiring assessment
Statistics » Quarter 3 2024/25 (October to December 2024) https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/						
Wye Valley NHS Trust is taking the following actions to improve the number of patients who are risk assessed for VTE and so the quality of services by maintaining a focus on achieving the national target through the quality priority set for 2024-5 and continued audit of practice. **2025 latest published national data see VTE section for latest quarterly data. There was a National data suspension during the Pandemic**.						

Appendix 5

Contracted Services 2024-25 - Contract Monitoring Services

Surgical	Medical	Integrated Care	Clinical Support
General Surgery	Plastic Surgery	Physiotherapy	Palliative Medicine
Urology	Accident & Emergency	Occupational Therapy	Anti Coagulant
Breast Surgery	General Medicine	Dietetics	Chemical Pathology
Colorectal Surgery	Gastroenterology	Orthotics	Haematology
Upper GI	Endocrinology	Speech & Language	Radiology
Vascular Surgery	Hepatology	Podiatry	Audiology
Trauma & Orthopaedics	Diabetic Medicine	Medical Inpatient (Community Beds)	Pathology
ENT	Cardiology	Community Nursing Inc. Specialist Com. Nursing	Clinical Neurophysiology
Ophthalmology	Transient Ischaemic Attack	Community ACPs	Endoscopy
Oral Surgery	Dermatology	Community Referral Hub	
Orthodontics	Respiratory Medicine	Virtual Ward	
Anaesthetics	Respiratory Physiology		
Paediatrics	Stroke		
NeoNatology	Nephrology		
Gynaecology	Neurology		
Obstetrics	Rheumatology		
Midwifery	Geriatric Medicine		
ITU			
SCBU			
Community Child Health			
Community Dental			
Podiatric Surgery			
Public Health Nursing			
Health Visiting			
School Nursing			

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NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Herefordshire and Worcestershire NHS Five Year Joint Forward Plan update for 2025/26
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Alison Roberts, Associate Director, System Development & Strategy NHS Herefordshire and Worcestershire
Reporting Route:	ICB Governance
Appendices included with this report:	Joint Forward Plan update for 2025/26
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

NHS partners are required to produce a Five-Year Joint Forward Plan (JFP) to outline how they will contribute to the delivery of the ICS strategy and the two Joint Local Health and Wellbeing Strategies (JLHWS). The JFP must also outline how NHS partners plan to exercise their functions, meet mandatory national requirements in the NHS Long term plan and other operational priorities and statutory duties. The first Herefordshire and Worcestershire JFP was developed with a base year of 2023/24; hence this being the third year of delivery.

National guidance for planning stipulates that ICBs and trusts should carry out a limited refresh of the JFP for the start of each financial year. The anticipated publication of the 10-year health plan in summer 2025 will affect future updates, but given the publication timeline, it is not possible to reflect this for the current refresh. The latest national guidance can be found here: NHS England » Guidance on updating the joint forward plan for 2024/25

The current refresh focuses on the following areas:

- Updates on delivery of priorities and programmes in 2024/25
- New performance targets, outcomes and priorities for 2025/26
- Introduction of the Building a Sustainable Future programme
- Progress on population health management and neighbourhood health
- In year updates including the Point Prevalence Audit 2024 results, and the financial landscape

The final version of the JFP is attached and the board is asked to endorse this for publication. NHS Herefordshire & Worcestershire board endorsed the Joint Forward Plan at its Public Board meeting on the 21st of May. All NHS Trust partner boards, and representatives of general practice will also be asked to endorse the JFP for publication through their governance cycles, reflecting the “joint” element of the plan.

Another publication requirement is for the Health and Wellbeing Board (HWB) chairs to review and refresh their ‘opinions’ on the extent to which the JFP addresses the priorities set out in the JLHWS. They will be asked to do this alongside other organisational approvals, but this is not expected to happen until June, due to changes to HWB chairing arrangements at Worcestershire County Council. Following the receipt of all relevant endorsements, the JFP will then be published on the ICS website.

Structure of the Joint Forward Plan

Effectively the plan should address all services within the scope of the Integrated Care Board's statutory duties and system priorities for NHS partners. This results is a broad and comprehensive document. To make the plan easily navigable for readers, it has been structured in the following way:

Section	Pages	Focus
Main document	28	The main strategic focus of the plan is about outlining the NHS intention to drive a shift toward more focus on prevention and, when treatment/care is required, it is provided in the best value care setting. Best value care is defined within the plan as the setting that achieves the right balance between clinical need and optimal cost. During 25/26 this will be delivered through the Building a Sustainable Future Programme.
Appendix 1: Core areas of focus	35	This outlines the detailed plans for individual NHS service areas such as urgent care, cancer services, stroke, primary care, mental health etc.
Appendix 2 : Strategic enablers, cross cutting themes	21	This covers cross cutting themes (such as digital, personalised care, prevention etc) that impact on all NHS service areas and strategic developments such as place-based working and collaboration between NHS providers.
Appendix 3: Statutory requirements checklist	5	This covers a number of checklists to demonstrate how the JFP addresses specific areas. This includes a specific page cross referencing JFP actions to the priority areas set out in the JLWHS for Worcestershire.

Development of the 2025 draft JFP

A working group of the strategy directors across NHS and Primary Care organisations has overseen the approach to developing the JFP for 2024, in line with the group overseeing operational planning, due to the integrated nature of strategic and operational planning.

This version of the JFP has been approved by the ICB Board for H&W, Wye Valley Trust Board, Worcestershire Acute Trust Board and representatives of general practice in both counties. The main changes between the original publication in June 2023 and this refresh are:

Main document:

- Updates to leadership and Health and Wellbeing Boards
- Updates to strategic priorities for 2025/26.
- Addition of 2025/26 Building a sustainable future programme.
- Update to 2024 Point Prevalence Audit results and medium term financial plans.
- Updated section on Population Health Management approach and governance.
- Finalised summary of overall delivery during 2024/25.
- Updates to 2025/26 performance trajectories in line with national operational planning guidance when published.

Appendix 1,2 and 3:

- Summary of 2024/25 delivery added to each section.
- Priorities and actions updated to reflect the rolling 5-year period.
- Governance and ownership updated, including additional delegated services.

Recommended Actions required by Board or Committee
The board is asked to endorse the updated JFP (attached as Appendix X), ahead of its publication in July 2025.
Executive Director Opinion[1]
The JFP has been refreshed by strategy teams across the ICS and reflects the work of system, Group and the One Herefordshire Partnership at Place.

[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.

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice

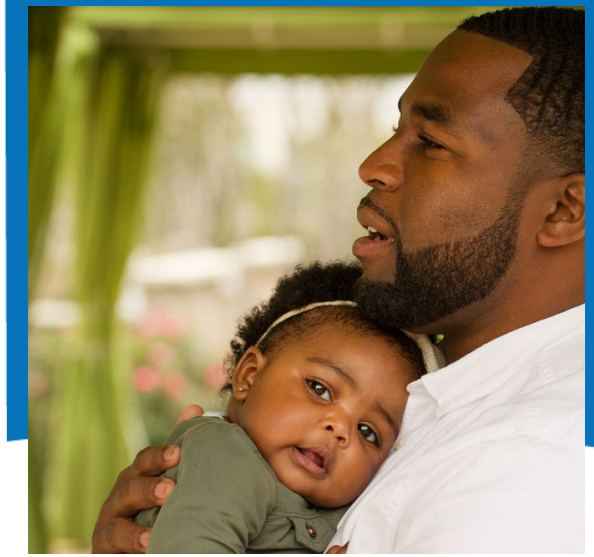
GENERAL PRACTICE WORCESTERSHIRE

NHS Wye Valley NHS Trust

NHS Herefordshire and Worcestershire Health and Care NHS Trust

NHS Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire and Worcestershire




Driving the shift upstream to more prevention and best value care in the right setting

NHS Five Year Joint Forward Plan 2025/26 – 2029/30

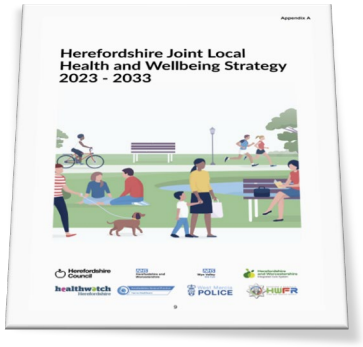
Version: 2025 Refresh, May 2025

The strategic intent of the Joint Forward Plan…

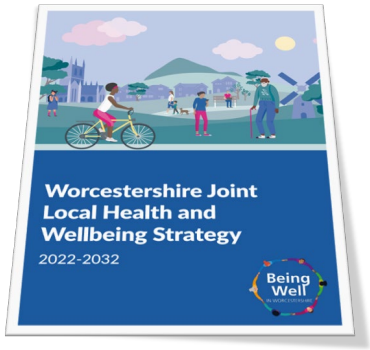
Driving the shift upstream to more prevention and best value care in the right setting

More focus on:

- **Self-care and independence**, enabling all people to look after their own health
- Promoting healthy behaviours which **reduce, delay and prevent** ill health
- **Co-production, personalised care and support**, meeting the needs of individuals
- **Population health management** and better use of data to target efforts
- **Sustainability of services,** and delivery of the right care models



Outlining the NHS contribution to the two Joint Local Health and Wellbeing Strategies.



Enabling reduction in:

- **Healthcare inequalities** – unequal access, outcomes and experience
- Days people spend in the **wrong care setting**
- The time spent **waiting** to access healthcare
- **Inefficient use of resources** and financial deficits
- **Avoidable pressures** on services
- People experiencing **digital exclusion**

Contents and navigating the Joint Forward Plan

Appendix 1 Core service areas and pathways	This section of the plan provides information on the development, transformation and improvement plans for specific service areas identified below:		
	• Maternity and neonatal care • Early years, children and becoming an adult • Elective, Diagnostics and Cancer Care • Frailty • Palliative and End-of-life	• Learning disability and autism care • Mental health and wellbeing • Long-term Conditions • Stroke care and cardiovascular disease	• Urgent and emergency care • Primary Care • General Practice • Pharmacy, Ophthalmic and Dentistry
Appendix 2 Key enablers and strategic system development	This section of the plan provides information on the key strategic enabler programmes and strategic developments that will support the core service areas and pathways:		
	• Quality, Patient safety and experience • Clinical and professional Leadership • Medicines and pharmacy • Health inequalities • Prevention	• Personalised care • Working with communities • Commitment to carers • Support to veteran health	• Addressing need of victims of abuse • Digital data and technology • Research and Innovation • Greener NHS
	• NHS Trust Provider Collaboratives • Mental health collaborative	• One Herefordshire Partnership • Worcestershire Place Partnership	• Office for the West Midlands ICBs
Appendix 3 The statutory requirements	The section outlines how the ICB meets its statutory duties as set out in the national guidance.		
	• Cross reference to show how the JFP addresses the specific requirements of the two health and wellbeing strategies. • Nominated lead officer for each duty and a cross reference for demonstrating which section of the JFP addresses the requirement.		

Introduction to the Joint Forward Plan

This, the third Joint Forward Plan for Herefordshire and Worcestershire has been produced by NHS Partners across Herefordshire and Worcestershire. This version contains minor updates, and a fuller refresh will be considered later in 2025/26 after the publication of the NHS 10 year plan. It describes the shared priorities that partners will collectively work on over the next five years. in response to the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies. The strategic intent is to collectively drive the shift upstream to more prevention and achieve best value care in the right setting.

We would like to thank the two Health and wellbeing boards for their ongoing support for the plan and recognising its contribution to delivering the two Joint Local Health and Wellbeing strategies. We will continue to work together to enable good health and wellbeing for the people of Herefordshire and Worcestershire.

As representatives of NHS partners in Herefordshire and Worcestershire we endorse the plan on behalf of our organisations, recognising our role in delivering the priorities within it.

Russell Hardy - Chair
Foundation group partner organisations

Crishni Waring - Chair
NHS H&W ICB

Mark Yates - Chair
H & W Health and Care NHS Trust

Dr Roy Williams - On behalf of Worcestershire General Practice

Dr Nigel Fraser - On behalf of Herefordshire General Practice

Opinion of Herefordshire Health and Wellbeing Board

The Herefordshire Health and Wellbeing Board are committed to improving the health of our local commu[illegible]es and tackling health inequalities. We recognise the val[illegible]rking with all our partners, and that our communiti[illegible]t the heart of how we work differently to em[illegible]s and reduce demand across health and so[illegible]

The NHS Five Year J[illegible] provides a key delivery mechanism for [illegible]mbitions as set out in the Integrated C[illegible]d the Joint Local Health and Wellbeing [illegible]gnising the importance of prevention and the wid[illegible]s that affect the health and wellbeing of our residents.

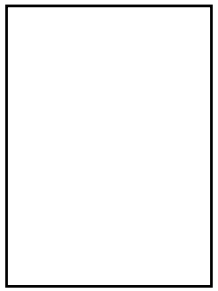
This opinion will be updated following the Herefordshire Health and Wellbeing Board – 9th June 2025

Councillor Carole Gandy
Chair of Herefordshire Health and Wellbeing Board

Opinion of Worcestershire Health and Wellbeing Board

Following the Worcestershire County council elections in May 2025 there will be a new Health and Wellbeing Board Chair, following which an opinion will be confirmed and included here.

This opinion will be updated following confirmation by the Worcestershire Health and Wellbeing Board Chair



To be confirmed,
Chair of Worcestershire Health and Wellbeing Board

Introduction to the Joint Forward Plan

The mandatory requirements for the JFP

- The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP).
- As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the Integrated Care Strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments.
- As such, the JFP provides a bridge between the ambitions described in the Integrated Care Strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions.
- Systems have the flexibility to determine the scope of their JFP, as well as how it is developed and structured. Systems are encouraged to use the JFP to develop a delivery plan for the Integrated Care Strategy that is owned by the whole system, including Local Authorities and Voluntary Community and Social Enterprise partners.
- As a minimum though, it should describe how the ICB, its partner NHS trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services.
- This should include delivery of universal NHS commitments and address the four core purposes of ICS.
- The guidance that systems are required to follow sets out 3 principles for Joint Forward Plans:

Principle 1	Principle 2	Principle 3
Fully aligned with the wider system partnership's ambitions.	Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.	Delivery focused, including specific objectives, trajectories and milestones as appropriate.

The planning framework within which the JFP is set

The Health and Care Act 2022 put **Integrated Care Systems (ICS)** on a statutory footing and has provided the opportunity for local partners across the NHS, Local Government and the Voluntary Community and Social Enterprise to work in a more integrated way in the pursuit of better outcomes for local people.

The act established **Integrated Care Boards (ICB)** and required ICBs to come together with Local Authorities that provide public health and social care functions to form an **Integrated Care Partnership (ICP)**. The core purpose of the ICP is to provide a platform for local partners to come together to agree and **Integrated Care Strategy** for the whole ICS area, addressing the 4 core purposes of ICSs:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The **Integrated Care Strategy** aligns to the two **Joint Local Health and Wellbeing Strategies (JLHWS)** in the ICS area, and identifies three shared priority areas, which address issues identified in the respective **Joint Strategic Needs Assessments**:

Integrated Care Strategy Shared Priorities across Herefordshire and Worcestershire		
Providing the best start in life	Living, ageing and dying well	Preventing ill health and premature death from avoidable causes

This **Joint Forward Plan (JPF)** sets out how NHS Partners will contribute to the delivery of:

- The shared priorities set out in the Integrated Care Strategy
- The priorities identified in the two Joint Local Health and Wellbeing Strategies
- National priorities for the NHS set out in the NHS Long Term Plan and mandatory national planning requirements.

The JFP will not set out new priorities; instead it will describe actions, timelines, targets and performance measures that will demonstrate the core areas of focus that NHS partners will focus on over the coming 5 years.

The JFP is the NHS contribution to ….. The Integrated Care Strategy ……

The Integrated Care Partnership approved the system Integrated Care Strategy in April 2023. The strategy sets out the shared ambition of system partners for achieving ***Good Health and Wellbeing for Everyone*****.**

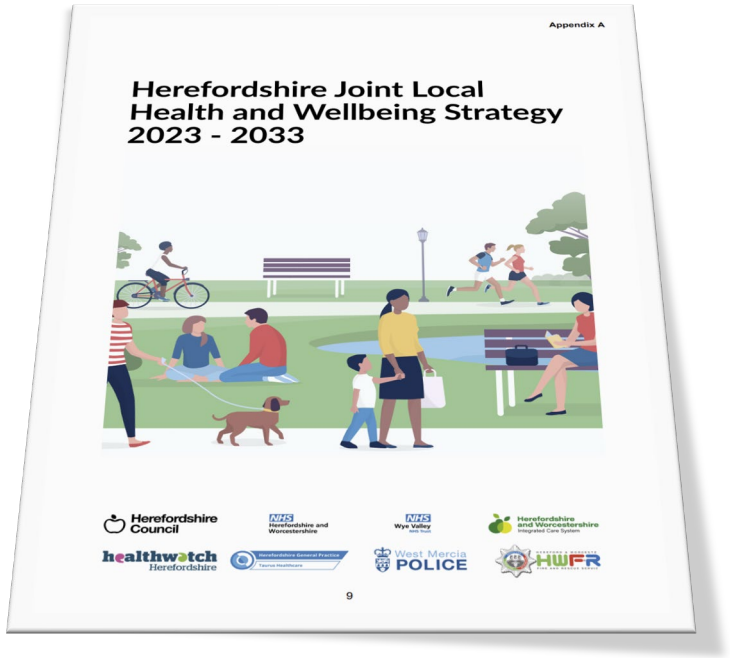
The ambition outlined in the strategy is for ***working together with people and communities to enable everybody to enjoy good physical and mental health and live independently for longer***.

Underpinning the strategy are 8 commitments that partners across the ICS have agreed as being fundamental to delivering integrated care.

The three shared priority themes and underpinning performance measures have been developed directly in response to the Joint Strategic Needs Assessments for each county and the priorities that are reflected in **Joint Local Health and Wellbeing Strategies**.

The strategic enablers bring partners together to work collectively in those areas that provide the essential platform for collaboration and working in a different way.

The JFP is the NHS contribution to ….. The two Health and Wellbeing Strategies



Herefordshire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in April 2023 and covers a 10-year period.

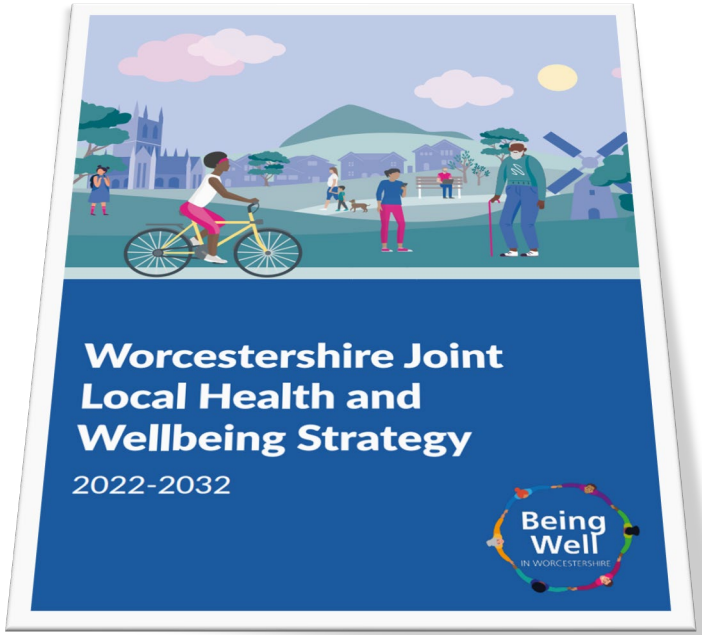
It was developed collectively by partners working together to agree a common ambition and set of priorities that were clearly identified through an extensive engagement exercise.

There is very strong alignment between the JLHWS and the Integrated Care Strategy, with both documents sharing a common vision and complementing priority areas of focus.

Worcestershire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in November 2022 and also covers a 10-year period.

Development of the strategy occurred in parallel with early work on developing the Integrated Care Strategy, which enabled strong alignment in some key areas.

Mental health runs through all three of the Integrated Care Strategy themes, mental health for children as part of the best start in life priority; good mental health through living ageing and dying well particularly focused on therapies and dementia care and reducing suicides as part of the third priority.



Herefordshire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Best start in life for children	●	●	
Good mental wellbeing throughout life	●	●	●

Worcestershire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Good mental health and wellbeing	●	●	●

● Directly aligned priorities where work led and undertaken at county level will directly deliver the Integrated Care Strategy priorities at System level

The key steps to deliver our JFP in 2025/26…

Building on what we have delivered together in the first two years of our JFP there are some specific pieces of work that will drive forward the delivery of our strategic intent during 2025/26:

Driving the shift upstream to more prevention and best value care in the right setting

The **'Building a Sustainable Future'** programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed. The Building a Sustainable Future programme forms the backbone of the system responses to the medium-term challenges of developing services able to meet the predicted increase in demand.

The overarching aim of the programme is to enable:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

Key to the success in the development of the Building a Sustainable Future programme has been building a strong base of **strong Clinical Engagement** to provide input and support the programme and the longer-term vision.

A successful Clinical Engagement event in Feb 2025 generated positive feedback and enthusiasm to drive the Building a Sustainable Future programme forward.

To support the delivery of the **Medium-term Financial Framework** a **benefits realisation framework** has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

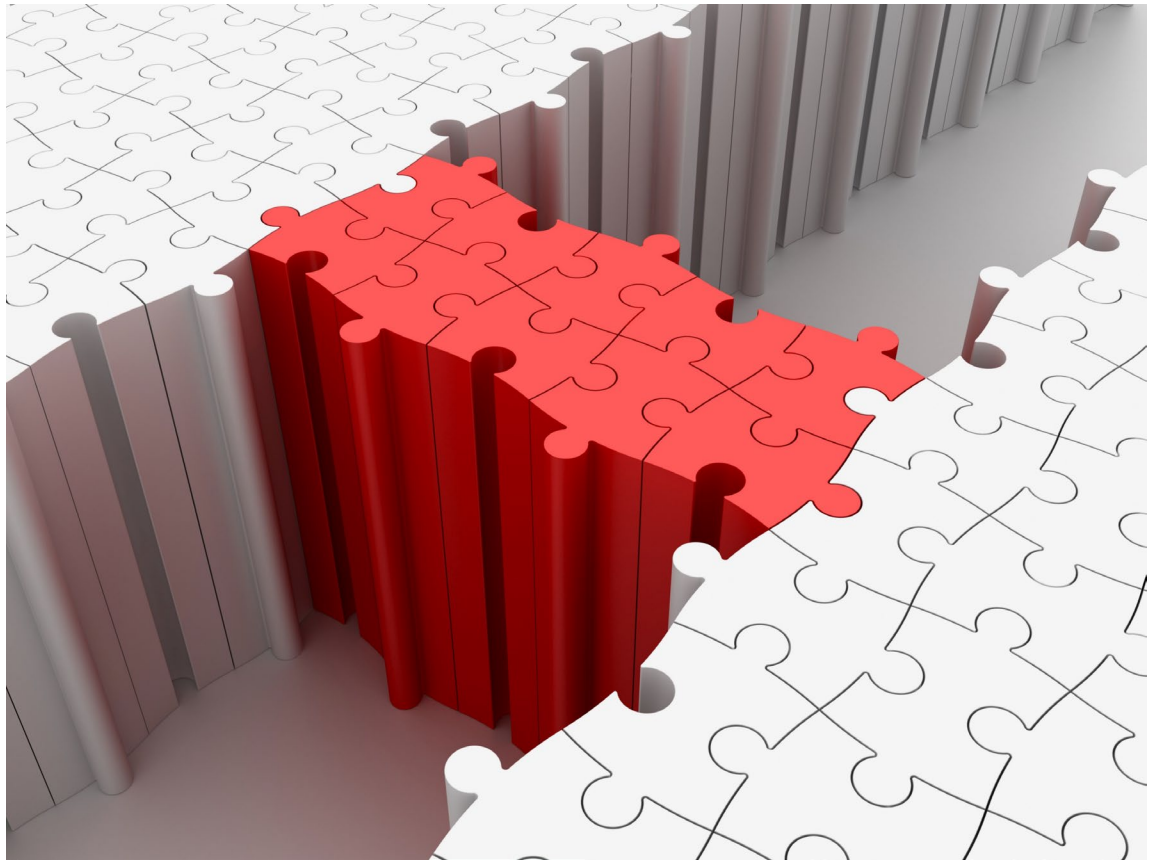
Delivering **Neighbourhood Health Activities** to Improve access to general practice and primary care. Prevent avoidable admissions to hospital, residential and nursing homes. Ensure unavoidable admissions are short and cost effective. Using population health management tools and techniques to standardise community services , develop multi disciplinary teams, intermediate care and home first, urgent neighbourhood services and modern general practice. This will support the **shift from acute to community**.

Develop and implement a **Work and Health Strategy** to articulate the NHS role in supporting **improved social and economic impact**. This will take the same type of strengths-based approach as we have done in targeting recruitment into health and social care from communities where access to employment opportunities are limited by existing barriers.

Herefordshire and Worcestershire are one of 15 systems across England to have been successful in bidding for a **grant of £2.4 million to deliver Workwell over 2 years.** The workwell programme is live and will continue to grow, using a coaching model to support people with health issues to stay in or return to work. This personifies our commitment to help address the wider determinants of health and to support vulnerable people in our communities by using existing partnerships across the NHS and Local Authorities. We will deliver a refreshed NHS Green Plan to contribute to wider sustainability.

Reducing health and healthcare inequalities remains a strong focus, with the local **Health Inequalities Ambassadors programme** now embedded through programmes. A key enabler will be the development of a **Population Health Management – Strategic Implementation Plan,** which will define a clear vision to engage our leadership and build a community of practice to enable us to provide access to the right data and insights and put it into the hands of those that can make a difference. A core facet of PHM is **engaging patients, service users and citizens** to understand their needs and look at how we can design services to effectively meet these needs within the resources available, improving access, outcomes, experience and reducing health inequalities. This will support the **shift from treatment to prevention.**

The Strategic Context for the Joint Forward Plan



Strategic Context - What is working well – The second year of our joint forward plan, 2024/25

Some of the best access to GP service in England

- The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.
- GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. About 4,000 self-referrals are made each month.

Reduced waits for patients awaiting cancer diagnosis

- Achieved 78.6% for the 28-day Faster Diagnosis Standard performance in March 2025 which is above the 2025/26 Operational Planning target of 75%.
- Achieved 69.5% of patients received first definitive treatment within 62-days of referral, narrowly missing the 70% target.
- We are the 8th highest performing area for cervical screening coverage in England.
- Lower gastrointestinal (GI) Urgent Suspected Cancer referrals accompanied with a FIT (faecal immunochemical test) remains consistently above the 80% target and 2nd highest in the Midlands.

Better adult learning disability care in the community

- 77.9% of people with learning disabilities received an Annual Health Checks.
- LeDeR reviews performance metrics continue to exceed national and regional performance, demonstrating that people with learning disabilities and Autism are supported in the community rather than inpatient care.

Positive impact on reducing health inequalities

- 5,000+ reached with essential prevention services in the most underserved communities (vaccinations, health checks, screening and early cancer referrals).
- HWICB exceeded the 90% eligible referral target into the NHS Digital Weight Management Programme with 2,384 eligible referrals (95%).

Recovering diagnostic and elective services

- As of March 2025, there are 1464 people waiting longer than 52-week, this is less than the system Operational Planning target. We will continue to work on eradicating these long waits in 2025/26.
- HWICS continue to be one of the highest performing ICB for Value Weighted Activity in elective care at over 135%.
- Waiting times longer than 13-weeks in Audiology achieved a 58.9% reduction in the number of people waiting. Pathway mapping and improved triage processes have led to this improvement.
- The percentage of people seen for diagnostics within 6-weeks reached 81.1% in March 2025, better than the average national average of 81.9%.

Better access to urgent and emergency care

- Both WVT and WAHT have improved emergency access standard (EAS) as of March 2025, with a system level of 65.4%.
- Ambulance Category 2 mean response time achieved less than 30 minutes as at February 2025. The performance throughout 2024/25 was better than 2023/24.
- Launched less than 45-minute ambulance handover protocol in March 2025 to improve on the timeliness of the handovers from ambulances to Emergency Departments.

Strategic Context - The biggest strategic challenges that NHS partners need to address

Tackling increasing demand for health and care services

The national challenges for health and social care providers are well documented. Delayed and reduced services during the Covid-19 pandemic increased the backlog for people waiting for urgent and elective services. Overall, there has been an increase in demand and complexity of need and services are struggling to provide a positive experience with good outcomes for individuals.

At the same time the population is ageing, with over 44,000 more over 65 years olds living in Herefordshire and Worcestershire by 2031, over a quarter of the increase being over 85 years old. By 2033 there will have been a 50% increase in the number of people who are over the age of 80. Alongside this demographic growth, there will be an increase in frailty, with projections indicating that people living with the highest levels of frailty will increase by around 28% over the next 10 years.

Securing sustainable workforce and clinical models for all services

There are around 39,000 people working in health and care services across the system. Around 18,500 work in Primary and Secondary Care and 20,000 in Social Care. Turnover is slowly reducing in the sector from an all-time high post COVID. In recent years, turnover has been at 10% for staff in the NHS and 26% of staff in social care. Vacancy rates range between 7% -10%. Recruitment activity to bring more people into Healthcare and care worker roles has had a positive effect but there remain critical areas of workforce shortages in nursing, some medical specialities and social workers There are around 300 nurse vacancies across the system (200 in the NHS and 75 in Social Care) and a reliance upon international recruitment. There is also a lack of pharmacy professionals across the system, with increased numbers moving to community pharmacies.

Sickness rates fluctuate at around 5.5% across the NHS organisations with mental health being cited as the main cause. That said, Staff engagement has improved over the last year and is in the top third of NHS organisations across the Midlands.

Workforce shortages in some specialties have resulted in increased levels of service fragility, particularly in cancer and stroke pathways. In the most extreme examples, such as haematology, emergency service changes have been needed whilst sustainable options were identified. In other instances, to fill gaps in substantive rotas and minimise risks to patients, health and care services have relied heavily on bank and agency staff.

However, with spend on agency staff in 2024/25 being over £50m and accounting for 6.2% of the total workforce budget, this is not a financially sustainable solution. As well as the financial pressure it creates, it can also lead to inconsistency in care provision and poorer experiences. Partners across NHS services are working together to reduce the reliance on agency staff to reduce these risks going forward.

Demand and workforce challenges can impact the effectiveness of services to see and treat patients in a timely and clinically safe manner, negatively impacting on healthcare outcomes. Addressing the signs of vulnerability requires early identification and solution-planning with the engagement of clinicians. Subsequently proactive work to pre-emptively identify vulnerabilities has led to the system developing a fragile services framework.

Financial sustainability and optimising use of services

As a deficit financial system, there is a requirement imposed on all system partners to implement stringent productivity, efficiency and savings programmes. This requires partners to introduce rigorous cost control measures and explore options for reducing service levels to bring spending into line with financial allocations. This includes freezing any new income and halting any service developments or business cases that do not identify lower cost delivery models or have clearly identified funding streams. This downward pressure needs to be understood in the context of the system being overfunded using the national formula.

In September 2024, partners replicated the study undertaken a year earlier to audit whether people were being cared for in the most appropriate care setting for their needs at the time. The study showed that just over 70% of the 1,679 people reviewed were being cared for in the right care setting – if an optimal balance between capacity, demand and flow efficiency was achieved. Showing there is a significant opportunity to improve processes and re-balance capacity across care settings, to deliver optimal outcomes.

Alongside this, the strategic demand and capacity model work suggest that without change, the system will require between an additional 365 acute beds by 2033. The upper end of this range is comparable to building new wards that are equivalent in scale to about 2/3rds the size of Hereford County Hospital. Even if the finances were available to fund such expansion, the workforce would not exist to staff it. Therefore, finding mitigating actions and alternative solutions is critical to the delivery of improved health outcomes and reduced health inequalities.

A focus on ensuring care is accessed in the right setting which means moving activity, treatment and resources towards more preventative rather than reactive treatments, as part of the solution. As will ensuring that the wider social determinants of health are addressed through effective alignment of vision, plans and effort with local authority and VCSE partners. For example, the development of the “Community Paradigm” concept and relevant application to local circumstances will be one of the key platforms for making local services both sustainable and effective in supporting improved outcomes for the population.

The ‘Building a Sustainable Future’ programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.

Strategic Context - Operational performance - Priorities for year 3, 2025/26

Reducing backlogs and long waits for elective care

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

Reducing long waits for cancer care

- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Improving access to primary care services

- Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
- Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Reducing waste and improving productivity

- Deliver a balanced net system financial position for 2025/26
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
- Close the activity/ WTE gap against pre-Covid levels

Improving safety and reducing health inequalities

- Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'
- Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
- Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Improving mental health and learning disability care

- Reduce average length of stay in adult acute mental health beds
- Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction

Reducing long waits for urgent care

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26

Strategic Context – Workforce - Creating a sustainable inclusive workforce

Building on the improvements of 2023/24, we have delivered a range of outcomes in attraction, retention, leadership and potential, the ICS Academy and culture and inclusion. We have also refocussed our efforts so that we can use these key 'workforce enablers' to help to alleviate some of the system challenges as well as to support the transformation work.

Another successful year of recruitment has reduced the number of vacancies across our NHS Providers. Each organisation has their own recruitment programme and there has been a system-wide attraction programme. Most of the NHS Trusts have recruited key posts in Nursing and Midwifery and are now managing turnover. We have commenced work on the NHS Universal Family Care Leaver Covenant Programme which will enable us to attract and recruit into our entry level vacancies. This is to tackle health inequalities, especially within under-represented groups, support workforce pipelines into both NHS and Social Care entry level roles/careers and to support the delivery of our Diversity and Inclusion objectives.

Turnover has been reduced through a range of mental health and wellbeing programmes delivered across the system. A combination of retention programmes, more flexibility, greater development and a focus on inclusivity has led to a greater number of people choosing to stay within the NHS. This is borne out in some strong engagement survey results for 2024.

In line with the NHS Long Term Workforce Plan, we have developed a shared workforce vision focused on providing opportunity for both existing and newly hired staff. To address our workforce challenges we have adopted a Grow Our Own approach to encourage local people into the system and are supporting them to stay through career and leadership development programmes. We have developed a shared approach to growing future nurses to mitigate against potential high levels of retirement over the next five years. This has been accomplished by working together to maximise the potential of our education providers and the new Three Counties Medical School. This work has allowed us to retain our staff through organisational support and crucially, prepared us to review and reform how services are delivered when workforce is not available.

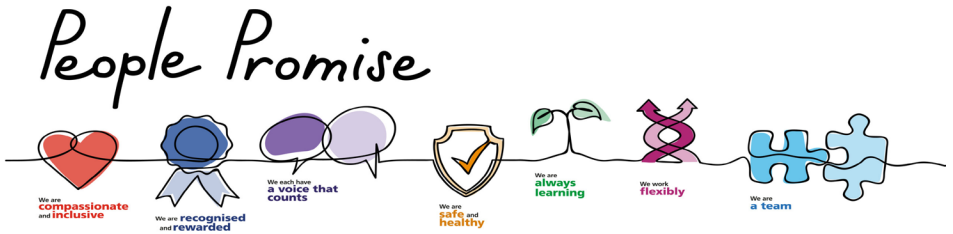
The collaborative and innovate work of the ICS Academy continues through the work of the faculty groups who meet as professional groups to share their workforce challenges and best practice. In 2024/25 the Healthcare Science faculty has improved connection between Herefordshire and Worcestershire teams and are now working together on career pathways and targeted recruitment activities in their field. The AHP faculty has worked to produce a fair share model for student placements. This will help to ensure that AHP students have a good placement experience. The Pharmacy faculty produced a workforce strategy and associated delivery plan. The VCSE faculty resumes in April 2025 with a new focus on workforce training and development. In 2025 a new Psychological Services Faculty will also be created and the Medical Faculty will expand to include Dental.

Training and development courses and resources offered through the ICS Academy Exchange continue to grow, supporting the ICS workforce to pursue their careers. Resources include career conversations supporting documents, career pathways in multiple fields, project and change management and the new ICS Leadership behaviours. A range of ICS wide course offers have also been advertised or booked through the ICS Academy Exchange including Mary Seacole Leadership Programme, QSIR, Reasonable Adjustment Digital Flag and Oliver McGowan which are easily accessible and popular.

During 24/25 we have co-designed and agreed our ICS Leadership Behaviours describing how we will all engage with each other when we are working across the system – these are Open, Inclusive, Courageous, Compassionate and Innovative. We launched the System Leader Connect programme, to engage and develop our senior leaders in effective system working with a key focus on building relationships. We have also expanded development support and capacity available to support the system and its leaders - including a cohort of new 360 feedback facilitators, a group of wider team and change facilitators and development opportunities to support our qualified coaches.

All NHS organisations have worked hard on to deliver an improved experience by delivering their people promise plans. The 2024 survey showed a positive shift in compared to 2023 demonstrating the impact of these efforts. All four NHS organisations have put a real focus on creating happy, safe and engaging places of work and the ICS has moved from the bottom half in the Midlands region to the top third on most of the indicators. A happy and engaged workforce will typically perform better and offer discretionary effort where it is needed so intrinsically linked to improvements in performance, and so, by extension an improved experience for the people who use their services.

In September 2024, we held our inaugural 'Big Inclusion Conversation' conference, where colleagues from across the system came together to celebrate our successes and plan our future work. At the event we launched 'Making Inclusion a Reality', our 5-year Culture and Inclusion strategy for the system and our new Active Bystander programme. We have now trained 18 facilitators who will deliver the Active Bystander programme across the ICS in 25/26.



Strategic Context – Workforce – Addressing our challenges

Workforce availability in some specialisms remains a key challenge for the system. Some of these are being covered by medical locums which can impact service delivery to patients. There is limited international recruitment and so we will work with the faculties and through direct engagement to understand the attraction and retention challenges for the different areas.

Our strategy is to grow-our–own skills wherever possible, particularly in entry level roles and Nursing and Allied Health Professional roles, encouraging local people to stay within the system and develop their career here.

Providing a good placement experience is vital to 'grow our own' particularly for Nursing, Midwifery and AHP students. An exercise to map the clinical student placement provision from NHS Trust and PCN providers and the allocation of students from different universities is currently being undertaken to find where more placements could be offered.

Targeted attraction of Health Care Assistants, Health Care Support Workers and Care Workers through marketing and promotional material provides a pool of entry level staff in short supply and where we compete with other local employers such as retail. We are also developing pipelines to ensure a sustainable route in for hard-to-reach groups and hard-to-fill vacancies.

Wellbeing, resilience and change management are an important focus for retention, enabling our people to navigate what appears to be a challenging period of change and transformation.

We will also work closely with our Transformation Programme – Building a sustainable future – as a key enabler we will work with leads to establish the workforce requirements of the different workstreams to enable change to support key priorities, including the three shifts (Hospital to community, treatment to prevention, analogue to digital).

System leader connect will have an eye to the future – ensuring that we have a succession plan for our senior leadership drawn from our aspiring, talented, local leaders.

Medical Staff	Clinical Support and Social Care	Pharmacy	Mental health nursing
• Medical 'faculty' working together with TCMS to increase the number of trainees across the system. • Working with Worcester University to ensure student placements do not limit student numbers. • Devising new approaches to attraction, including bespoke packages, new advertising campaigns and a focus on clinical leadership support • Target challenging vacancies through apprenticeships and grow our own initiatives • Promote and use career pathways to case studies and opportunities	• Growing numbers of Health Care Assistants and Health Care Support Workers through targeted outreach. • Improved promotional material to attract those New to Care including online presence. • Develop pipelines for employment through the universal family scheme and similar programmes. • Explore cadet/T-level and BTEC routes into this workforce • Leadership and management resources to aid retention • Establish a process to share apprenticeship levy to allow more social care providers to benefit from it.	• An innovative approach to attraction based on engagement with colleges in 2024 • Increased use of pharmacy apprenticeships • Development and promotion of career pathways, talent and succession plans. • Maintain and support the work of the pharmacy faculty.	• Engagement with the sector to understand attraction and retention challenges • Target areas of high vacancy for apprenticeships. • Outreach events targeted to Sixth Form and local colleges that offer relevant courses, and targeting regional universities with proximity to Worcestershire that have students qualifying in Mental Health Nursing in March 2026 • Agreed talent development offer for mental health nurses.

Strategic Context – Workforce – Attracting and Retaining People

Healthcare is a rewarding career but it can be stressful. In 24/25, NHS Trust providers have been asked to plan to deliver services with a significant reduction in bank and agency use and whilst reducing the number of non-clinical substantive roles. Retention, reduction in sickness absence and targeted attraction into vacancies that attract locum spend will be vital.

Continuing to maintain nurse capacity through 'grow our own' initiatives such as apprenticeships and other education programmes that ensure supply of critical clinical resources in the system will remain important to mitigate the risk posed by an aging workforce.

This includes our apprenticeship hub, which brings together system apprenticeship leads enables us to practically understand how we are prioritising our organisational levies and target these at the system risk areas. A case in point is the system approach to developing more nurses through the trainee nurse associate and registered nurse apprenticeship route.

Exit interview data and HR theory is clear that people want to feel that their wellbeing is supported, they have career opportunities to progress, they have good relationships with their line managers and that they feel a sense of belonging. Pay and reward are of course important factors but where the above is in place, they become slightly less pivotal.

Retention activities are therefore built around ensuring that these things are in place. Reducing sickness through providing quick access to Wellbeing support for staff, supported by capable managers, provides the basic cornerstone of retention. Offering development opportunities to move around in one's career and working with leaders and line managers to improve their capability means that people feel valued and empowered by their managers.

Delivering our Inclusion and EDI strategy means that everyone, regardless of their background will feel that they form an important part of the organisations in which they work. Through the work of the faculties and understanding key operational risks, these interventions will be targeted where they are likely to make the biggest difference.

The ICS Academy is now an established central point for collaborative working on innovative projects to ensure the retention of the ICS workforce. This yea this has included engagement outreach with local colleges where students participated in focus groups to understand how we can attract their age group into health and social care roles.

In addition, the new research and innovation strategy and the research consortium will be reporting into othe ICS Academy Steering group to showcase the work that is being undertaken and to highlight research as a career development opportunity that will keep high potential staff in our ICS workforce.

We will maintain our ambition to be a great place to work – our cross-system group will continue to meet to share best practice, learning and resources because we are better together – especially as we face into an uncertain period of change.

Activities to deliver this include:

- Development of pipelines for employment into entry level roles
- Development of bespoke attraction products to bring in medics to sure up fragile services
- Greater joint planning off the back of the staff surveys (end calendar year)
- Developing career pathways to enhance career ambitions for entry level jobs
- Wellbeing offer enhanced through leadership capability programme
- Improved placement capacity to support clinical education, including T-levels, apprenticeships and grow our own initiatives across the system including in the VCSE and Social Care Sectors.

Strategic Context – Workforce – Growing our Own and Reforming Services

Growing and developing our people, teams and organisations

While we will continue to attract people into our system to ensure we can deliver key services, we also want to retain key talent.

We therefore will focus on growing our own skills, offering job opportunities and long term careers for those that want to work within our system. The coming together of the organisations across the system offers a far wider range of options for people and an eco-system that they can move around in, while knowing that the experience that they gain will continue to benefit the sector locally.

Through offering a greater range of development opportunities for our various professions, developing educational links with further and higher education providers, creating more placements for the new Three Counties Medical School in Worcester University and making it easier for people to move around our organisations. We are also developing a suite of resources to support team development to not only enhance productivity and wellbeing but to improve attraction and retention.

We continue to deliver our 'Making Inclusion a Reality' strategy, through improving access to reasonable adjustments through a new Health and Wellbeing Passport for colleagues. We are also working to improve the experience of our neurodiverse colleagues with a 'Neurodiversity Toolkit'. Through the delivery of the Active Bystander programme, we will support colleagues to feel confident to take an early intervention approach to prevent negative behaviours from escalating. This will contribute to improving the health and wellbeing our staff and patients and people who draw on our support to grow a culture of civility and respect.

We link in with regional and national colleagues to develop system wide approaches to succession planning and talent management.

Activities to deliver this include:

- Development of innovative new roles, drawing upon clinical knowledge
- A joint talent and leadership development offer, available to all providers at ICS Academy, linked to career conversations and pathways
- Delivering our ICS Inclusion Strategy which brings together staff networks, ensuring everyone feels that they have representation
- Roll out and embedding of our leadership behaviours – developed with focus groups from across the system in 2024
- Delivery of our system leader connect programme

Reforming Services

While we can act quickly to bring in some of the skills we need, there are others that are so scarce nationally or take so long to grow that we must instead think differently about how we deliver our services. Making greater use of digital tools must also drive reform of services for the patient or user.

Providing organisational design and development expertise to clinicians and operational colleagues to think differently about the delivery of services is our approach to reimagining how services might be provided. This is supported with ongoing workforce planner business partnering to each service pathway so that when workforce is identified as a risk, they are able to help the service to consider how else it might continue to deliver.

Workforce is a key enabler for the 'Building a sustainable future programme. This work will focus our activities to those areas of transformation that have been prioritised to address critical need to reform the way services are delivered in Hereford and Worcester within its financial limits.

Activities to deliver this include:

- Developing workforce planning capability across the NHS through a transformation programme focussed on reviewing public health data for service pathways.
- The development of the faculties in workforce planning and consideration of public health data for their function.
- Deeper understanding of the operational workforce risks by service line using the STAR framework approach and how to mitigate those in the short and long term.
- The development of more integrated, cross-organsiational / systemwide roles where appropriate.
- Focussed work on converting high agency spend into longer term sustainable workforce through the use of apprenticeships, new roles and digital solutions.
- Aligning digital and data with people and workforce to increase the digital capability of staff, enabling them to be more open to future digitalisation of services.

Strategic Context – Finance - The financial history and financial plan for 2025/26

Actual Spending v Formula Allocated to Herefordshire and Worcestershire

Prior to the pandemic the system was under-funded against target using the national funding formula. The closing distance from target in 2019/20 for the 4 CCGs in the ICS area was -3.52%, equivalent to £35m. Any overspends against this allocation were funded using non-recurrent funding sources.

During the pandemic, costs were fully funded, and system baselines were reset at actual spend levels. In essence, this process resulted in historic overspends being incorporated into financial baselines generating a significant change to the base funding level for H&W ICS.

Going into 2025/26 this the system is now overfunded against fair share target, using the national funding formula by 3.9%. This is consistent with the previous financial year.

Change in spending pattern in recent years

Growth in spend over this period was seen in all areas, with the exception of running costs. The expenditure for the system includes Pharmacy, Ophthalmic and Dental (POD), as well as specialized commissioning (spec comm). Expenditure continues to grow in acute services, including the nationally allocated deficit support allocations and in continuing care. Growth has been seen in community services and primary care, these are lower than our forward-looking ambitions around a shift upstream to more prevention and out of hospital care, through neighborhood health care. The ambition over the life of the Joint Forward Plan is to change this position.

Spend Area	19/20	25/26 Plan	Change	
Acute	£559.2m	£1,032.6m	£473.4m	85%
Mental health	£110.5m	£176.0m	£65.5m	59%
Community Services	£130.0m	£215.6m	£85.6m	66%
Continuing Care	£68.0m	£119.4m	£51.3m	75%
Primary Care	£147.1m	£213.1m	£66.0m	45%
Primary Care Prescribing	£125.6m	£163.5m	£37.9m	30%
POD (Delegated)	£0.0m	£76.8m	£76.8m	100%
Spec Comm (Delegated)	£0.0m	£167.8m	£167.8m	100%
Other Programme	£22.3m	£24.3m	£2.1m	9%
Running costs	£16.3m	£11.1m	(£5.2m)	(32%)

The 2024/25 financial outturn

The original financial plan for 2024/25 was for a £79.9m deficit, before the inclusion of national deficit support to get the system to a balanced financial plan. Whilst the plan was not without financial risk in a number of areas, these were mitigated in-year across the system. Subject to external audit at the time of updating this document, the system has reported a balanced position for the year as shown in the table below. Efficiency delivery was slightly lowered than planned and whilst agency expenditure reduced from previous levels it was still above the plan agreed. Both areas were mitigated through non-recurrent financial opportunities.

The Plan for 2025/26

The system financial plan for 2025/26 has been agreed with NHS England at breakeven, in line with NHS England planning requirements. The position includes £73.2m of national deficit support monies. The plan includes a challenging efficiency requirement of £133.1m (6.1%), and a further reduction in agency expenditure to a maximum of £36.2m. Financial risks within the submitted plan have a level of identified mitigations but, the largest areas unmitigated relate to efficiency savings required. Management plans for both efficiency and financial risks are continually being developed. The table below sets out the plans for each organisation.

Surplus / (Deficit)	Integrated Care Board	Worcs Acute	Health and Care Trust	Wye Valley	ICS Total
24/25 plan (deficit)	+£8.8m	(£57.3m)	+£0.0m	(£31.4m)	(£79.9m)
24/25 out-turn (deficit)	+£11.3m	(£5.7m)	+£0.0m	(£5.6m)	£0.0m
25/26 plan (deficit)	+£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
Delivery Plan Requirements for 25/26					
Efficiency savings	£42.1m	£53.0m	£13.5m	£25.0m	£133.6m
% efficiency saving	1.9%	6.6%	4.4%	6.0%	6.1%
Trust Agency expenditure	-	£22.0m	£6.1m	£8.1m	£36.2m
% of Staffing Cost	-	4.7%	2.6%	3.3%	3.8%

Strategic Context – Finance – Building a Sustainable Future and benefits realisation

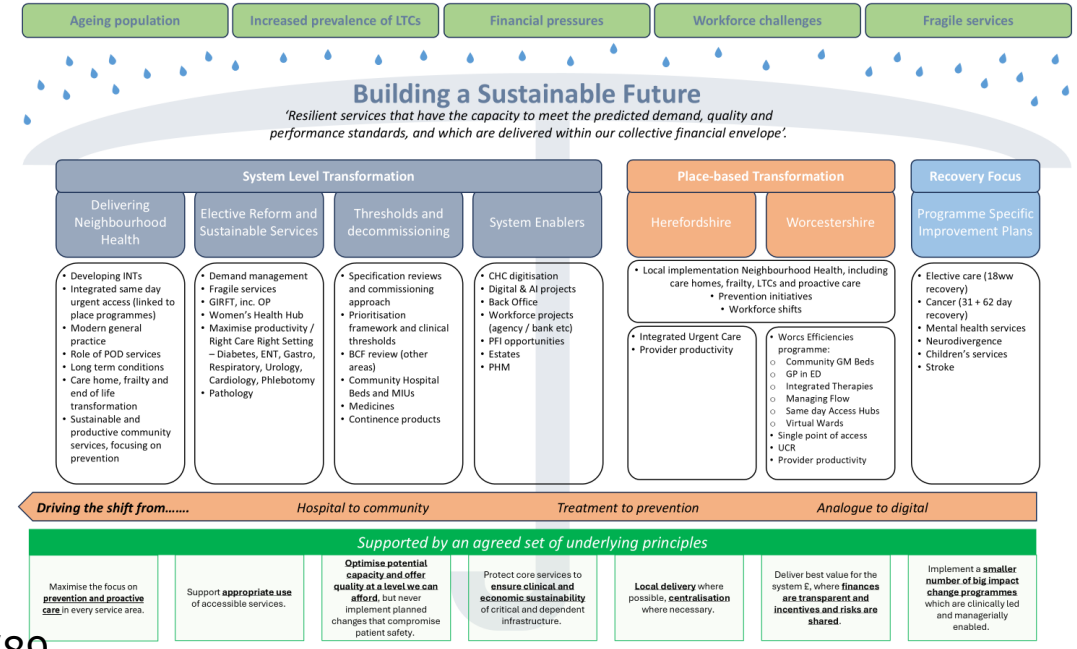
Building a Sustainable Future

Herefordshire and Worcestershire health and care partner organisations work together each year to develop a local operational plan that meets strategic and financial objectives as well as delivering the right services for our population. In recognition of the financial challenges facing the system in 2025/26 and beyond senior leaders, including Clinicians have worked together to develop a programme of work called "Building a Sustainable Future".

The overarching aim of the programme is to enable the delivery of:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

The 'Building a Sustainable Future' programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.



The Building a Sustainable Future programme forms the backbone of the system responses to meet the medium-term financial challenges, to deliver the predicted increase in demand, delivered within allocated budget. This supports all aspects of annual and medium-term planning, with a particular focus on the contribution to the Medium-Term Financial Framework.

Key areas of focus for 2025/26 have been agreed through the Building a Sustainable Future Board, chaired by the ICB Chief Executive Officer, and are summarised below:

1. Frailty
2. Elective Reform
3. Releasing time to care
4. Prioritisation of services
5. Population Health Management
6. Public awareness and education

The financial contribution to sustainability of the system is a key part of the detailed transformation plans which underpin the priority areas for 2025/26.

Benefits realisation

A benefits realisation framework has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

Investment Standards

Delivery of the Investment Standards that were developed for 2024/25, and continue into 2025/26, to support the Building a Sustainable Future programme have progressed, following the identification of potential savings. The focus has been on:

- Best Value Care in the Right Setting or "Left shift"
- Prevention and addressing Health Inequalities
- Virtual Wards
- Growing our own nursing workforce

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice | General Practice Worcestershire | NHS Wye Valley NHS Trust | NHS Herefordshire and Worcestershire Health and Care NHS Trust | NHS Worcestershire Acute Hospitals NHS Trust | NHS Herefordshire and Worcestershire

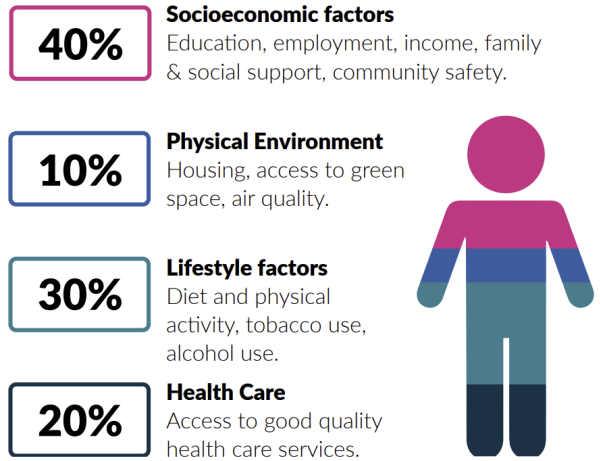
The core focus

Driving the shift upstream to more prevention and best value care in the right setting

What do we mean by driving the shift upstream to more prevention and best value care in the right setting?

A greater focus on prevention

The major focus of the JFP is on driving a shift to a model of healthcare that places greater emphasis on the **importance of preventing ill-health** rather than a focus on treating the symptoms of it. The NHS cannot achieve this by working in isolation only through effective partnership working and good engagement with communities. This is the emphasis of the Health and Wellbeing Strategies and the Integrated Care Strategy. The core focus of NHS partners in this JFP is on the "20%" of factors that contribute to people's health and wellbeing outcomes (as per the diagram right).



Adapted from an illustration of the impact of healthcare and non-healthcare factors on a person's health. Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014).

Whilst it is not the core business of the NHS to focus on the wider determinants of health, such as education, employment, housing and environment, as a major employer of around 2.5% of the local population (circa 20,000 employees), many of whom live in the ICS area, NHS bodies clearly have an important role to play and contribution to make.

The focus of this plan though is on the core business of the NHS, which is the provision of services. Through implementation of this plan, there will be a drive through planning and resource allocation approaches over time that increasingly rebalance the prevention v treatment equation:

During the early phases of implementation, the service areas outlined in appendix one, through their respective programme boards, will be charged with the task of identifying what specific actions can be implemented to contribute towards this overall ambition.

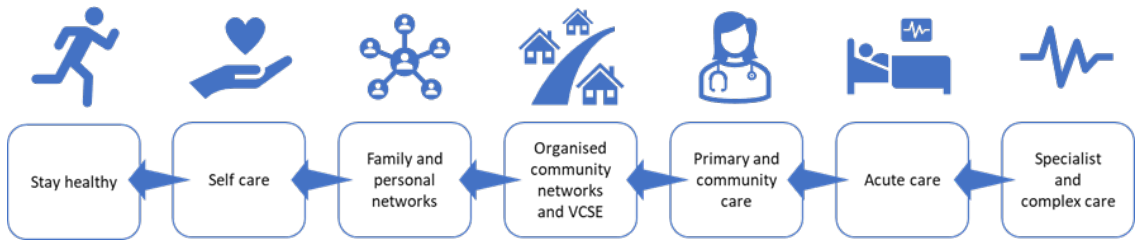
This ambition will also be incorporated in the medium-term financial strategy, 'Building a Sustainable Future'.

Providing best value care in the right setting

The role of the NHS is to provide care and treatment for people when they need it. The second element of shift in focus is on ensuring that the care is provided in the most optimal setting for the person's needs at any given point in time. Optimal represents the balance between quality, safety, appropriateness of setting and best cost care. Optimal is not just about cost reduction and financial savings, although savings are a clear beneficial by-product of getting optimal care.

Achieving optimal care settings will typically result in faster recovery from illness and a greater chance of return to independence. For example, a co-produced document called *"Supporting patients' choices to avoid long hospital stays"* highlighted that people's physical & mental ability and independence can decline if they are spending time in a hospital bed unnecessarily. As well as being at risk of acquiring hospital acquired infections, for people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Thus, there is a significant quality and service improvement benefit to be achieved by getting this right.

Providing care in the optimal setting requires NHS partners to work together to deliver more care towards the left-hand side of the spectrum below.



The Point Prevalence Audit undertaken in 2022, 2023 and 2024 identified that around 25% of people could be cared for further along towards the left-hand side of the diagram above. The financial opportunity associated with this cohort, if scaled up annually, was in the region of £12 to £15m, even taking account of the need for the additional capacity required to accommodate them in the other setting. Alongside the quality improvements, the opportunity to achieve this shift in focus is therefore very compelling.

Understanding the issues and opportunities around "optimal care settings" – The Point Prevalence Audit

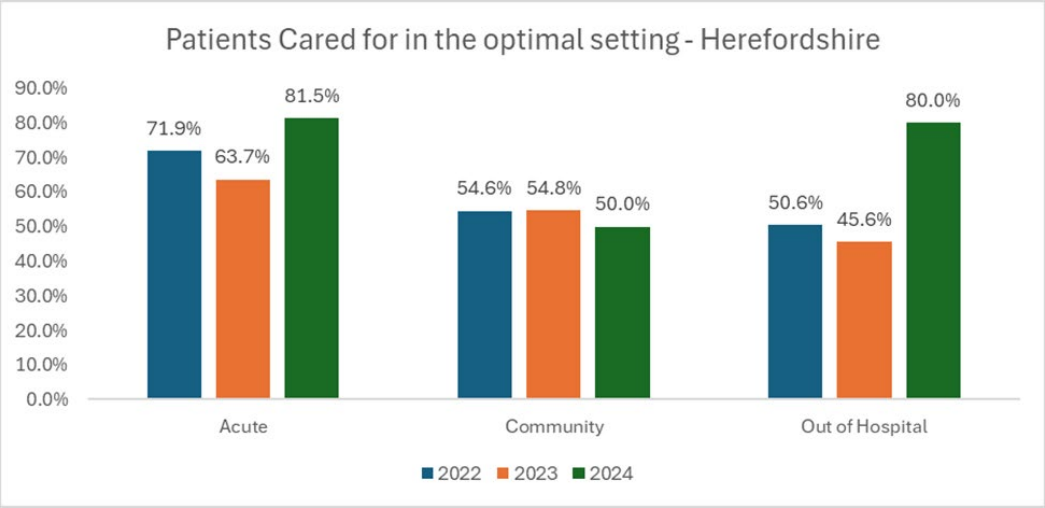
The Point Prevalence Audit

In September 2024 the system wide **Point Prevalence Audit** was conducted to assess the extent to which people in the health and care system are cared for in the most optimal care setting for their needs at the time. The audit, which replicated the method from 2022 and 2023 looked at 1,679 people across 103 care settings – including acute beds, community beds, discharge pathways and other home-based care such as community teams and virtual wards. The study showed that around 70% of patients audited were in the right care setting.

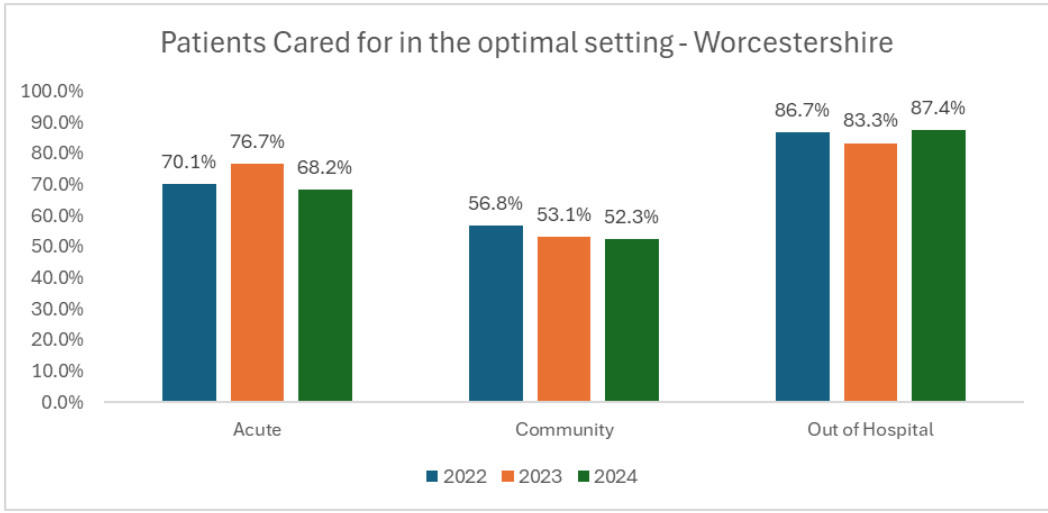
The charts below provide an overview of the shift in % of patients being cared for in the most optimal setting across the last three years.

Percentage of patients in the optimal care setting for their needs at the time

There were some notable changes to the results in PPA 3 compared to previous years, in particular in relation to Herefordshire's results. There were a far higher proportion of patients assessed as being in the right care setting in both acute beds and out of hospital care. However, there was very little change in the position for community hospitals.



In Worcestershire the position was similar for community hospitals and there was some slight improvement from an already high baseline for out of hospital care. However, there was a fall in the proportion of patients deemed to be in the right care setting in acute beds.



Opportunities to optimise care settings – the balance between hospital and community

The opportunity to realise the government policy ambition to see a shift from Hospital to Community can be seen most clearly in the use of community hospital beds. Across both counties, in all three years, no audit has shown that more than 60% of patients are in the optimal care setting for their needs at the time.

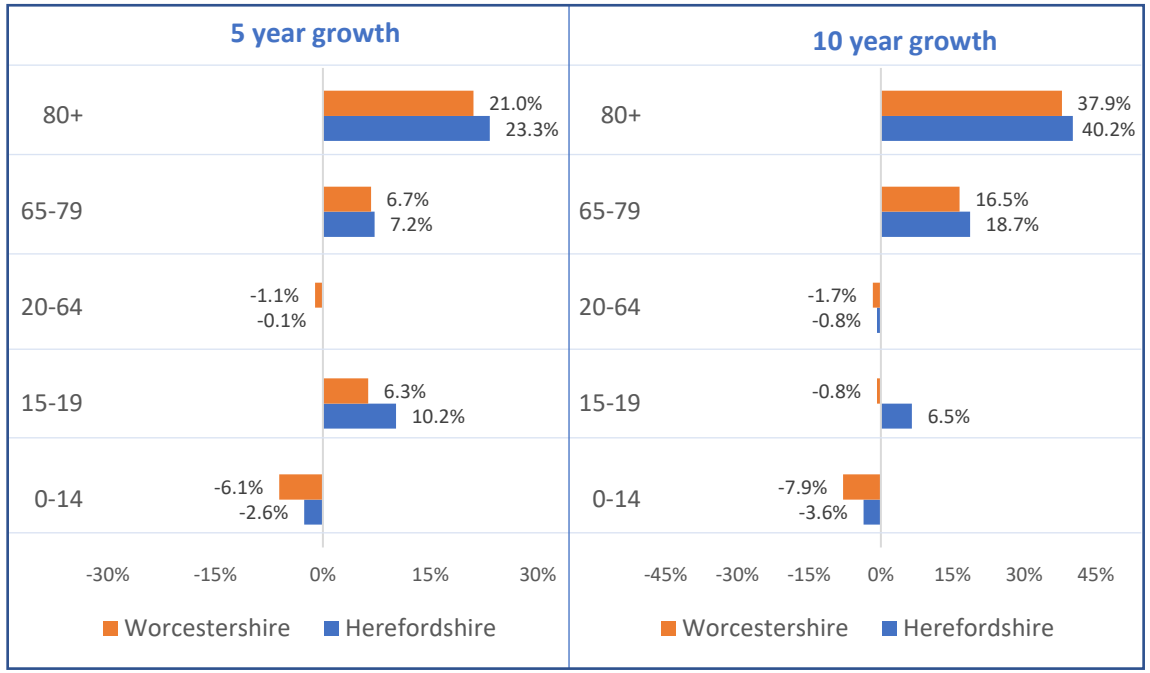
Creating additional capacity in home-based discharge pathways, accessing more capacity in domiciliary care and in residential / nursing homes would enable the system to operate more efficiently and effectively with fewer community hospital beds than are currently in use. The system will seek to address these opportunities through the Building a Sustainable Future Programme. This can be seen in the strategic demand and capacity modelling, described on the next two pages of this document.

If you would like to access further detail, you can do so here: Best Value Care in the Right Setting Update 2025

Developing a better understanding of future demand and capacity requirements

The final element in the strategic planning work to support the development of the JFP has been the development of a system wide **strategic demand and capacity model**. The point prevalence audit results indicated that there is a mismatch between demand and capacity; which ultimately leads to people being treated in care settings that are not optimal for their needs, frequently at higher cost to the system. The first phase of the demand and capacity model work has been to quantify the future impact over 5 years of not optimizing the provision of care. The second phase of the work, to be conducted during the first 3-6 months of JFP implementation will be to model the potential solutions to mitigate that growth in demand.

Population growth: Population numbers are forecast to grow most in the older age groups in the population – more than 20% over 5 years and nearly 40% over 10 years for people aged 80 years or more.



Likely Impact on Frailty Demand: Whilst age alone is not an indicator of future health demand, it does provide a basis for calculating likely levels of frailty that services are likely to be responding to. Initial model projections suggest the following impact:

Frailty Risk Category	10 Yr impact – Herefordshire	10 Yr impact – Worcestershire
No frailty score	+21%	+21%
Low score	+19%	+17%
Moderately low score	+28%	+27%
Moderately high score	+33%	+32%
Highest score	+36%	+38%

Unmet demand: The model calculates the impact of unmet demand (such as people waiting in ambulances or on trollies in A&E that would be admitted if beds were available). However, they are often cared for in unconventional settings for their whole hospital stay.

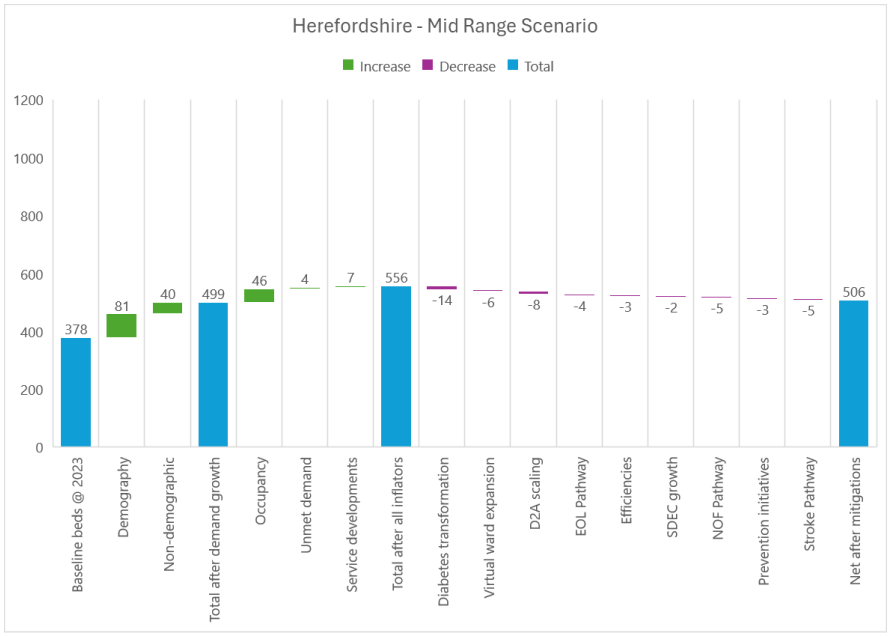
Sub-optimal flow: The model also calculates the impact sub-optimal flow on projected future bed numbers. There are two main mitigations to this, one of which is increasing the size of the bed pool to enable better flow, the other is to optimize practice to ensure that patients are only admitted when necessary and don't have any delays to their discharge.

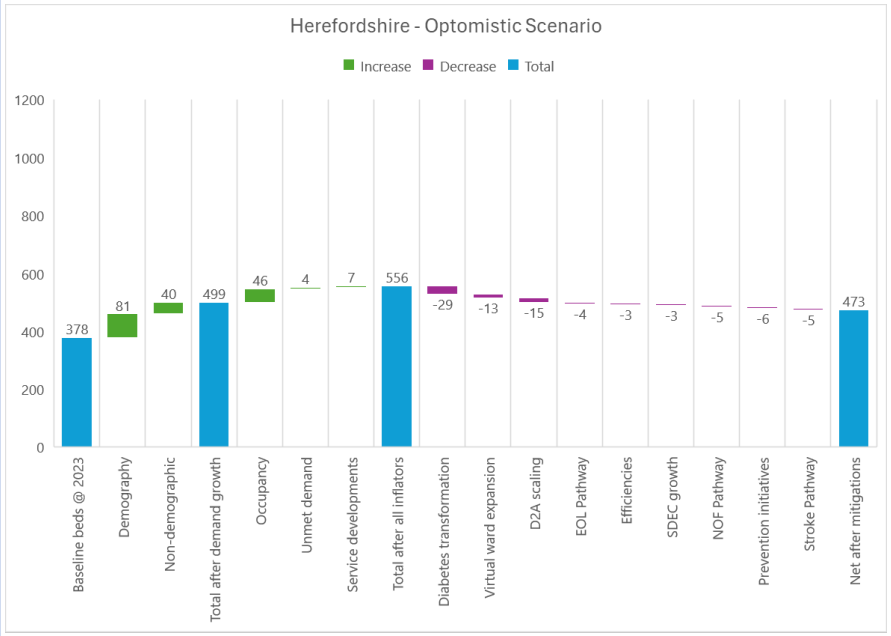
Initial aggregate demand impact: Bringing together all aspects of growth, the draft model indicates future demand growth that will need to be mitigated by actions to be delivered under the JFP is an additional 274 beds.

Aggregate acute bed requirement in 10 years under the do nothing scenario	Acute Bed Impact
Baseline beds	1,229
Demographic growth	+236
Non-demographic growth	+129
Measure of un-met demand	+8
Impact of sub optimal flow	+83
New service developments	+28
Mitigations, efficiencies and transformation programmes	-123
Net ten year bed requirement for acute care	1,540

+311

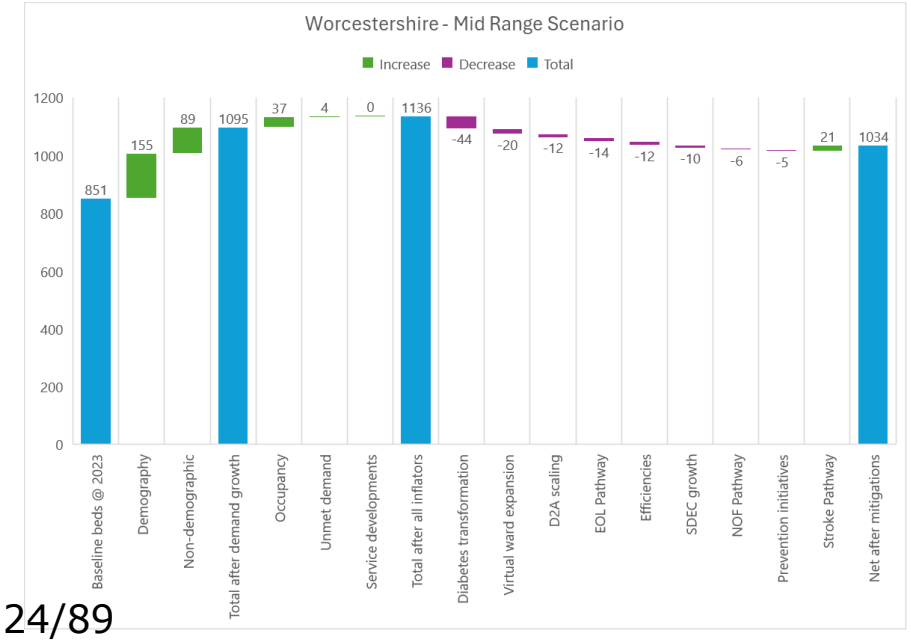
Developing a better understanding of future demand and capacity requirements – modelling the mitigations

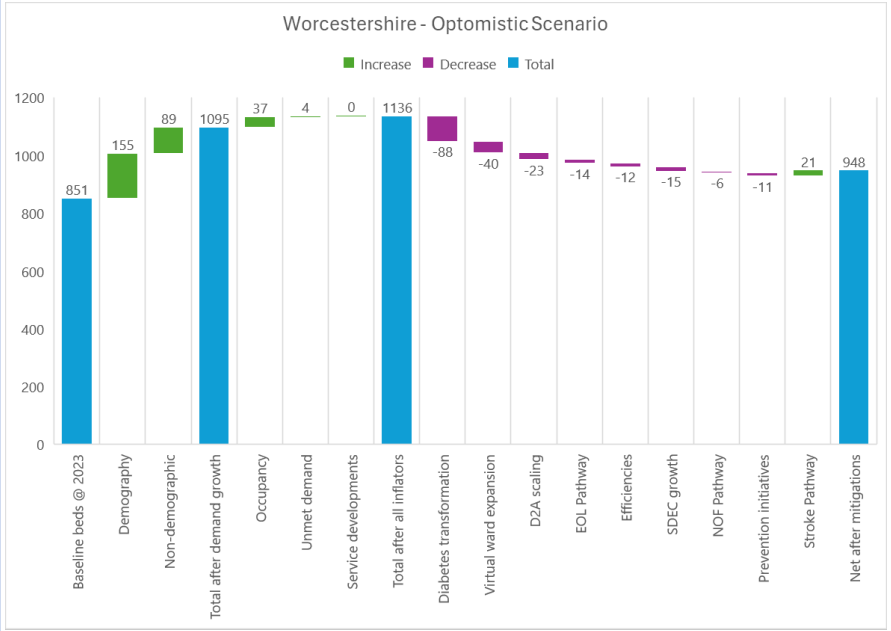




Herefordshire

- **Mid-range scenario** bed requirement by 2033 grows from 378 beds to 506 beds (+128).
- **Optimistic scenario** bed requirement by 2033 grows from 378 beds to 473 beds (+95).
- **Occupancy improvement** calculation is equivalent to 46 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations**: The biggest mitigation opportunities are diabetes transformation and D2A pathways.





Worcestershire

- **Mid-range scenario** bed requirement by 2033 grows from 851 beds to 1034 beds (+183).
- **Optimistic scenario** bed requirement by 2033 grows from 851 beds to 948 beds (+97).
- **Occupancy improvement** calculation is equivalent to 37 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and virtual ward scaling.

Population Health Management - Supporting the shift upstream to more prevention and best care in the right setting

Introduction

Population Health Management or PHM is for everyone working in integrated care. All ICS Partners working together to improve population health by data driven planning and delivery of proactive care to achieve maximum impact with the resources available, alongside the demand and capacity modelling described above.

PHM is a key strategic enabler delivery of the core areas of focus (Appendix 1) and the cross cutting themes (Appendix 2). PHM is not a new concept and is something that system partners already do. However. it is only at its most effective when both aspects come together and are tackled as part of a single coherent plan. In essence, PHM has three major components to it:

Integrate

- **Collate and integrate data** from a range of sources
- Clinical, socioeconomic and asset-based data

Insight

- Use **population segmentation** and **risk stratification** to identify groups with higher levels of unmet health need and higher resource use

Impact

- Combine **asset-based approaches** and **patient level approaches** to reduce unmet health need
- **Allocate resources** most efficiently to best meet the needs of the population

Population Health Management is a key enabler and sits within the **Building a Sustainable Future programme** as a key enabler. This includes both short and long-term activities. During 2024/25 the neighbourhood health accelerator sights tested the concept of integrated neighbourhood teams. Learning from this is being fed into the development of Neighbourhood Health activities. Increasing deployment of PHM is key to the successful delivery of this programme.

What next?

The ICB will facilitate the development and deployment of a of a system wide Population Health Management **Strategic Implementation Plan** during 2025/26, this will include:

- Taking astrength based approach, building on good practice where PHM tools and techniques are already being deployed.
- Identifying a clear leadership and programme delivery structure, brining together information, clinical and strategy capabilities.
- Endorsing a clear vision of PHM as an iterative evolution towards a new operating model to guide the change over a 5 years period.
- Calculating the return-on-investment time to support the shift upstream to prevention and enable Developing a community driving adoption, spread and sustainability via use cases choices, and building a movement.
- Developing a PHM infrastructure and analytics capability – including a clear road map linked to the wider analytics development plan.
- Developing an approach to linked data sets – including the required information governance agreements within a clear road map linked to the refreshed digital strategy.
- Building on the governance platform established through the Analytics Board and Health Inequalities, Prevention and Personalisation (HIPP) Programme Board.

How will we deliver?

Developing a robust Strategic Implementation Plan for Population Health Management is a central tenant of the shift upstream to prevention and will therefore become a key corporate project in 2025/26. Learning will be drawn from the national PHM Academy with opportunities to learn from other systems as well as from within Herefordshire and Worcestershire, focusing on the development of infrastructure to integrate data, draw insights and develop impactful changes to deliver improved outcomes for the comr

A system based PHM Steering group is being established to oversee the Development and delivery of the PHM Strategic Implementation Plan. This group will drive delivery, support shared learning and seek to mitigate Any risks to delivery of the plan.

Engagement Approach

Developing the Joint Forward Plan – Engagement approach

As a health and care system we are committed to close working with individuals, communities, partners and wider stakeholders. In developing the **structure and content** of our second Joint Forward plan, we have built on existing insights from recent engagement, these include:

- **The HW Integrated care strategy : 3 phases of engagement** - A thematic review of relevant existing patient and public engagement undertaken over the last two years. Extensive stakeholder engagement and broader feedback following the publication of the draft integrated care strategy.
- **Joint forward plan insights** – Complimenting the Integrated Care Strategy engagement, narrowing the scope to focus in on health services in line with the NHS Long term plan.
- **Specific engagement** – With NHS partners, including the 3 NHS Trusts, General Practice representatives and the Integrated Care Board.

The engagement strategy for the JFP recognises the benefit of aggregating together information from various sources and using this as a basis for filling in gaps in knowledge. The table below describes some of the engagement that has been undertaken by the ICB in partnership with providers:

Engagement activity – 2024/25 included...	
• Quarterly voices report produced and published, including engagement Accessible information • Autism (Adults) • Cancer – Macmillan Cancer Inequalities Project, Cancer – Patient Experience Survey • Diabetes • Frailty • Complaints, Concerns and Compliments • Mental Health • Menopause	• NHS 10 Year Plan • Palliative and End of Life Care Strategy • Public Perceptions of Health and Social Care • Stroke • Urgent and Emergency Care • General Practice • Long Term Plan • Maternity • Engagement on communications for ICB communications & engagement framework

In addition, these specific engagement activities there are various ongoing programmes of engagement with patient representatives engaging in meetings and specific activities.

Engaging individuals and communities

You can find more detail in **Appendix 2: Key enablers**, about our commitment to early engagement and ongoing dialogue with people and communities. You can also find out more about our wider system approach to engagement in our **ICS Engagement Strategy**.

Involvement opportunities are made available here:

https://www.hwics.org.uk/get-involved/involvement-opportunities

The Joint Forward Plan is owned equally by the ICB, the three NHS Trusts and the two General Practice Organisations that operate across the system. This joint ownership means that we can work together to support effective engagement and evaluation of delivery throughout the life of the plan.

Engagement insights will be used to develop programmes and also to evaluate their effectiveness. With the publication of the Joint Forward plan being an opportunity to share the core areas of focus for the system over the next few years. This should make it easier for local people to understand where change and improvements are being made and to get involved.

Next steps

- Opportunity to feedback and get involved in more in-depth engagement for specific clinical services pathways
- Embedding engagement insights into the delivery of the core strategic intent: ***"Driving the shift upstream to more prevention and best care in the right setting"***

Implementing the Joint Forward Plan

The implementation approach for the Joint Forward plan is now embedded in the infrastructure outlined at the beginning of appendix 1. This also reflects the landscape in terms of strategies and plan:

- **NHS System operational plan for 2025/26** - This outlines the key operational delivery priorities for healthcare during the third year of the Joint Forward Plan.
- **The Integrated Care Strategy for 2023-2033 –** This brings together a broad range of partners across the Integrated Care System, around a shared vision for improving health and well-being for everyone and three key priority areas.
- **Worcestershire Joint Local Health and Wellbeing Strategy** – This identifies a key priority focus on Good Mental Health and Well Being, supported by healthy living at all ages; safe thriving and healthy homes, communities and places; quality local jobs and opportunities.
- **Herefordshire Joint Local Health and Wellbeing Strategy** – This identifies two key priorities of Providing the Best Start in Life for Children's" and "Mental Health and Wellbeing", supported by six enablers: access, living and ageing well, good work for everyone, supporting those with complex vulnerabilities, housing/homelessness, reducing carbon footprint.

The Joint Local Health and Wellbeing Strategies and the Integrated Care Strategy provide the long-term frame, with the Joint Forward Plan translating this into NHS focused medium-term delivery priorities; and the Operational Plan focusing in turn establishing the annual priorities.

Year 3 implementation focus

During the second year of implementation there are two main streams for the Joint Forward Plan:

- **Stream 1:** Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the three shifts, expected within the NHS 10 year plan. Delivered through Population health management, evidence based decision making increasing the provision of pro-active care.
- **Stream 2:** Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1.

There is a significant role for existing programme boards with the system governance structure to develop, align content and instil ownership of delivery of the plan from the outset.

Stream 1: Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the approach to Population health management, evidence-based decision making increasing the provision of pro-active care.

Stream 1: Driving the shift upstream to more prevention and best care in the right setting.	Phasing
Development of Building a sustainable future programme on Neighbourhood Health	2025/26
Drive the shift from Treatment to Prevention through delivery of key prevention programmes, including implementation of the Population Health Management Framework	2025/26
Drive the shift in Acute to Community through implementation of actions outlined in response to the Best Value Care in the Right Setting and Poist prevalence reports	2025/26
Deliver the Building a sustainable Future priority programmes – System enablers. Including Digital Strategy and Transformation	2025/26

Stream 2: Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1 and 2.

Stream 2: Delivery of year 3 priorities for core areas of focus and cross cutting themes	Phasing
Delivery of the year 3 priorities for the core areas of focus: See appendix 1.	2025/26
Delivery of the year 3 priorities for the cross-cutting themes: See appendix 2.	2025/26
Ongoing focus on system development, ensuring that mechanisms for collaboration are strong and effective in enabling delivery of the priorities within the JFP.	2025/26

Joint forward plan – 25/26

Appendix 1:
Core areas of focus

This section sets out how the Joint Forward Plan addresses national requirements set out in **the NHS Long Term Plan** and **local priorities** to ensure the NHS makes a positive contribution to improved health outcomes for the population through delivery of high-quality patient centered pathways that are overseen by programme boards across the ICS. This includes a summary of what we have delivered in 2024/25 and what our focus is for 2025/26 and beyond.

Version: 2025 Refresh, May 2025

Delivering High quality, patient centred integrated pathways: INTRODUCTION

There are a broad range of work programmes across Herefordshire and Worcestershire, within place and neighbourhoods. These are established to develop and deliver programmes of work focused on local and national priorities including those set out in the https://www.longtermplan.nhs.uk/.

In this section you will find a high-level summary of year 2 delivery, and the priorities that are developed and overseen at a system level through Herefordshire and Worcestershire ICS Programme Boards.

Core areas of focus can be found in this document, which include:

1. Maternity and neonatal care
2. Early years, children and becoming an adult
3. Elective, Diagnostics and Cancer Care
4. Frailty
5. Palliative and End-of-life
6. Learning disability and autism care
7. Mental health and wellbeing
8. Long-term Conditions
9. Stroke care
10. Urgent and emergency care
11. Primary Care
12. General Practice
13. Pharmacy, Ophthalmic and Dentistry
14. Specialised Services

Cross cutting themes can be found in Appendix 2 and include:

1. Quality, Patient safety and experience
2. Clinical and care professional Leadership
3. Medicines and pharmacy
4. Health inequalities
5. Prevention
6. Personalised care
7. Working with communities
8. Commitment to carers
9. Support veteran health
10. Addressing the needs of victims of abuse
11. Digital data and technology
12. Research and innovation
13. Greener NHS

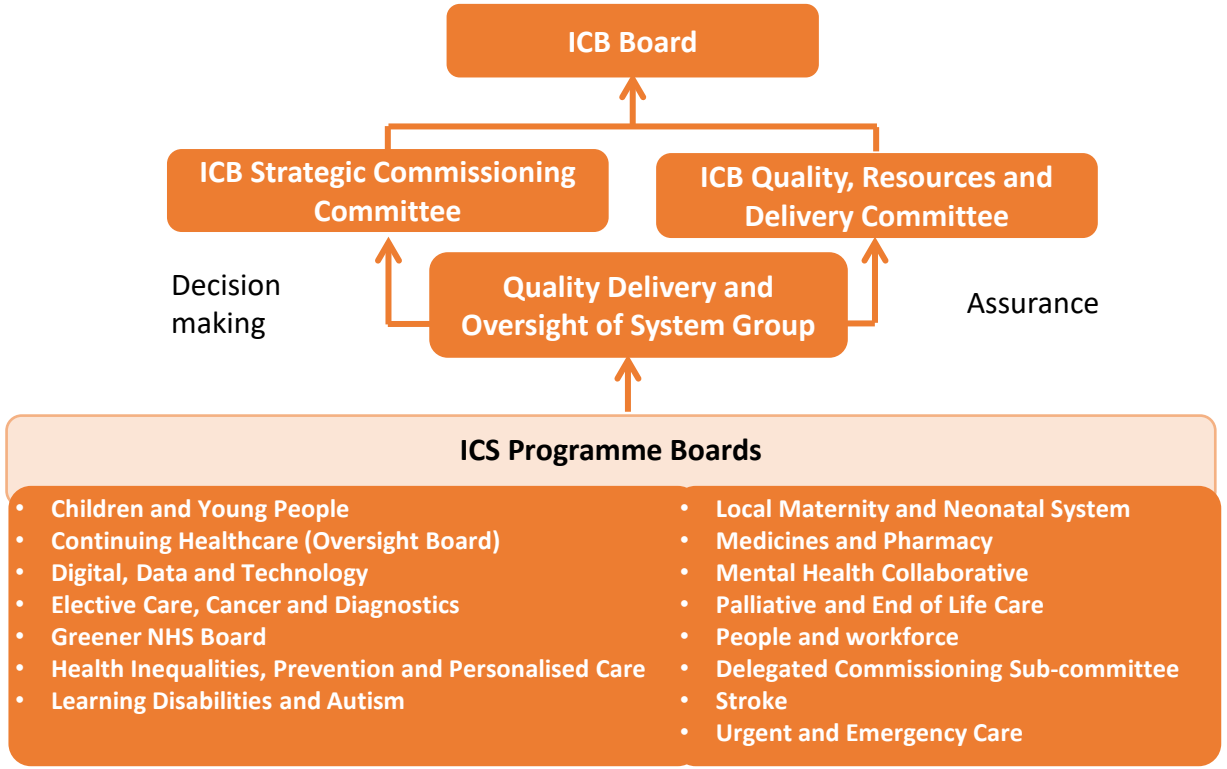
The role of an ICS Programme Board

The ICS Programme Boards are responsible for overseeing delivery of programmes across Herefordshire and Worcestershire, including the Joint Forward Plan, which will include regular reporting on progress against plan delivery and mitigating / escalating risks to delivery through to the ICB Quality, Resources and Delivery Committee.

The ICS Programme Boards bring together organisations to coordinate and oversee delivery of improvement and transformation activities across Herefordshire and Worcestershire. They are responsible for setting the strategic direction and ensuring that comprehensive delivery plans and monitoring frameworks are in place. Whilst the Programme Boards are not decision-making forums, the governance framework allows timely decision making through the ICB Strategic Commissioning Committee.

Joint ownership

The membership of each ICS Programme Board represents the key stakeholders engaged in a particular programme area, including NHS and Local authority partners, Healthwatch, networks and alliances and representatives of the patient voice, in addition to operational and clinical staff. The chart below summarises the governance structure.



Core areas of focus

In this section we answer the following questions for each core area of focus. The programmes of work included will be reviewed and refreshed in the Joint Forward Plan annually.

1. Why this is important?
2. What we are doing
3. What will we deliver and when?
4. Where you can find more detail

High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

1. Why is this important?

The Local Maternity and Neonatal System (LMNS) vision is to work together to deliver consistent, high quality, safe personalised care that is delivered equitably according to local need.

High quality maternity and neonatal care is essential in ensuring every child across Herefordshire and Worcestershire has the best start in life.

During 2024 we saw an increase in deliveries to 6,315.

- Our smoking in pregnancy rates remain higher than the national ambition of 6%.
- Whilst our initiation of breastfeeding rates were higher than the national average, we know that there are groups within our population where breastfeeding is much lower, and further work is needed to support this.
- Over a quarter of women who booked for maternity care had BMI>30, similar to 2023.

All of these factors contribute to health inequalities and poor outcomes for babies and families. Our LMNS continues to work in partnership to reduce health inequalities and providing safe, personalised, equitable care.

The LMNS consists of Herefordshire & Worcestershire Maternity and Neonatal Voices Partnerships, Wye Valley NHS Trust, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Integrated Care Board, Herefordshire and Worcestershire Health and Care NHS Trust, Herefordshire Council and Worcestershire County Council.

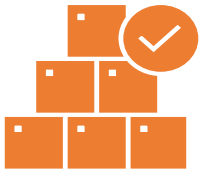
2. What have we delivered in our first two years, 2023 - 2025?

- The LMNS completed a 3-year pilot of Perinatal Pelvic Health Services and the service is now commissioned across Herefordshire and Worcestershire. The team have been recognised nationally as an area of good practice.
- The Maternity and Neonatal Voices Partnership (MNVP) has continued to develop, with Neonatal Champion role to ensure the voices of local Families who experience neonatal care are heard. An MNVP strategic role has commenced to enable further capacity for engagement across the system.
- A system led approach has been taken to ensuring our Trusts are compliant with the expectations of the Saving Babies' Lives Care Bundle Version 3. This will have an impact on reducing neonatal and maternal mortality, still births and intrapartum brain injury. The compliance rate for Saving Babies Lives has improved in Worcestershire from 49% in 23/24 to 94% 24/25 and in Herefordshire from 59% in 23/24 to 87% in 24/25.
- The LMNS continues to implement the Perinatal Quality Surveillance model, ensuring that there is trust board and ICB oversight of key factors that impact on perinatal quality and safety, such as staffing, culture and learning from incidents.
- The LMNS has worked with stakeholders to co-produce a strategy that outlines our deliverables and local plans for implementation to align with the NHS England Three Year Delivery Plan. The Digital and Reducing Health Inequalities strategies are being refreshed to ensure a continuous focus on digital innovation and reducing health inequalities, specifically reducing prematurity, access and prevention. The Infant Feeding Strategy was produced in 2024 and monitored through the Perinatal Health and Wellbeing Group.
- The LMNS continues to conduct Perinatal Mortality reviews to ensure shared learning to improve care. This has increased the opportunities for shared learning and external peer review.
- The LMNS programme team has conducted a series of insight visits, supported by NHS England Regional Perinatal team to review quality, safety and culture within our system.
- The LMNS has supported the Trusts to implement the BRAIN pneumonic to aid shared decision making and has funded birth rights and inclusive language training based on feedback from the MNVP.
- The locally delivered Movements Matter campaign highlighted the importance of acting on reduced fetal movements and not using home dopplers. It had a wide reach and social media activity showed a high click rate particularly from men.
- Partnership working within the system has improved through the LMNS Board Development programme facilitated by the Kings Fund, and through collaborative working with our buddy LMNS Coventry and Warwickshire.
- A preconception campaign (in collaboration with Tommy's & C&W LMNS) aimed at reaching more vulnerable groups is launching in March 25, linked to the Womens Health Hubs.

3. What are the priorities going forward?

In addition to national priorities, our local shared priorities of the LMNS are:

- Intelligence to identify and act on issues as early as possible
- Prevention and reducing health inequalities.
- High quality, safe maternity and neonatal care
- Listening to local women and birthing people and our staff



High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Listening to women and families with compassion	• Enable women to have personalised care through personalised care and support planning. • Provide Perinatal Pelvic Health services that meet the needs of patients. • Enable and empower our Maternity and Neonatal Voices Partnerships to gather intelligence and represent our local families, coproducing maternity and neonatal services.	2025/26
Growing and developing our workforce	• Develop and implement local evidence-based retention action plans • Deliver supervision, training and support as needed by staff. • Listen to, and act on, staff and student feedback • Continue to facilitate a workforce and culture that supports learning and delivers safe, equitable care.	2025/26
Developing and sustaining a culture of safety	• Share learning from incidents across the Local Maternity and Neonatal System and learning from incidents at a national and regional level. • Promote positive culture through supportive leadership. • Identify any concerns, raising them early and addressing them. • Improve quality through delivery of the SCORE action plan.	2025/26
Meeting and improving standards and structures	• Implement national evidence-based guidance such as the Saving Babies Lives' Care Bundle V3 and monitoring local progress against outcomes. • Use evidence-based tools such as MEWS and NEWTT-2 to better detect concerns and act sooner on safety issues. • Make better use of digital technology in maternity and neonatal services through implementing the Local Maternity and Neonatal System digital strategies. • Regular oversight and open scrutiny of intelligence to identify issues, inform learning and improve quality.	2025/26
Prevention and tackling health inequalities	• Deliver equitable care through the implementation of the LMNS reducing health inequalities strategy. • Improve outcomes through a focus on healthy lifestyles and mental health, from pre-conception through the perinatal period, and understanding and removing barriers to access • Support women and families with multiple complexities during pregnancy/perinatal period • Develop a dashboard to assist understanding of health inequalities, enabling focussed work to reduce Health inequalities.	2025/26

5. Where you can find more detail?

There are two active Maternity and Neonatal Voices Partnerships (MNVP) in Herefordshire and Worcestershire, this is an opportunity for members of the public to have a say in how maternity services are run in both counties.

If you would like to get involved please contact:-

hwicb.herefordshiremvp@nhs.net – Herefordshire MNVP
hwicb.worcsmvp@nhs.net- Worcestershire MNVP

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

1. Why is this important?

- Across Herefordshire & Worcestershire Children and Young People (CYP) represent approx. 19% of our population, with approximately 140,000 0-19 years old (Public Health Profiles 2021).
- Overall, this is a good place to live. There are relatively low levels of poverty and deprivation, and many children and young people are happy.
- For children and young people living in areas of high deprivation or experiencing poverty, there are barriers to accessing services.
- Some children and young people are at the biggest risk of poor outcomes. Including those with additional needs; exposed to family and behavioural risks; or with experience of the care system.
- 14.1% of children in Worcestershire and 12.2% in Herefordshire are living in low-income Families.
- 65% of children achieve a good level of development at the end of reception in Worcestershire and 71.8% in Herefordshire.
- Emotional wellbeing is a cause for concern in 39% of looked after children in Worcestershire and 42% in Herefordshire.
- The prevalence of overweight (including obesity) of children in Reception is 20% in Worcestershire and 25% in Herefordshire.
- Hospital admissions for children aged 0-14 is a rate of 71.9 per 10,000 for Worcestershire and 100.1 per 10,000 for Herefordshire.
- In Worcestershire 3.9 % of pupils have an Education Health and Care Plan and 2.6% in Herefordshire.

2. What have we delivered in our first 2 years 2023-2025?

- Development of CYP Health Inequalities pack to support interventions to improve health outcomes.
- Commissioned Lumi Nova, a digital based app suitable for 7-12 year olds to support low level anxiety related mental health issues.
- Undertaken a procurement exercise for emotional wellbeing and mental health services for 0-25 year olds. The service will commence in April 2025.
- Rolled out the national Asthma Care Bundle, delivered a pilot programme of community-based nurse led intervention and support to children at risk of poor asthma control and worked with housing colleagues on environmental factors and schools to support awareness raising and improve pupil attendance.
- Established a 2-year pilot programme of youth workers employed to support young people with long term conditions to transition from children to adults' health services.
- Piloted a psychological therapy programme to assist those children & young people with epilepsy.
- Jointly held transition clinics with adult services for children and young people with diabetes.
- Employed a Designated Clinical Officer for Special Education Needs & Disabilities (SEND) in Herefordshire.
- Agreed additional recurrent funding to support Paediatric therapist recruitment in Herefordshire and in Worcestershire.
- Initiated an evidence-based review of children's therapy delivery across the ICS – transformation in progress.
- Funding provided to Parent Carer Forum, and recruitment of Co-Production officers in Worcestershire to support SEND improvements through engagement and coproduction.
- Engaged with parents, carers and other stakeholders to design a future neurodivergence provision, including assessment and support.
- Engaged in two Local Area SEND Partnership inspections and started to address the improvements identified.

3. What are the priorities going forward?

- Development of locality based care pathways, redesigning community services.
- Review the CAMHS service ensuring clinical pathways are evidence based with a defined service specification.
- Continue to deliver the NHSE National Children and Young People's Transformation Programme to meet the commitments in the NHS Long Term Plan, as identified in the delivery plan.
- Enhance preparation for adulthood, recognising the needs of young people with long-term conditions and/ or complex needs.
- Continued engagement in Public Health-led Best Start in Life, particularly in early language and communication skills, as well as early identification and appropriate support of child development (at universal level).
- Continue to improve Special Educational Needs and Disabilities provision, including future model of community health services to address the needs of children and young people and reduction in waiting times particularly for neurodivergence assessments.
- Procure Neurodivergence support service.
- Review of Phlebotomy pathways across the system.

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Asthma - to support CYP with asthma, including diagnosis, care planning, and reducing emergency admissions.	• Co-production and launch of school asthma guidance to support best practice • Develop accreditation of asthma friendly schools in Herefordshire as part of the Healthy Schools programme • Pilot within Worcestershire with the Housing Association to review housing stock where Children and Young People with asthma are identified. • Roll out of resources to support families living with damp and mold, reducing the risk of an asthma attack.	By 2025/26
	• Embed the Asthma Care Bundle, risk stratification in Primary Care, understand & support clinical and CYP training needs • Toolkit for schools including development of training packages including videos for education settings to complement the schools asthma policies. • Develop local pathways of care for early diagnosis of asthma, ensuring appropriate referrals through to secondary care	By 2027/28
Epilepsy - Standardised approach to management of childhood Epilepsy.	• Continued improvement to the capacity of epilepsy nurse specialist support across ICS. • Evaluation of PAVES and Youth Worker projects to support development of options appraisal for provision of psychology and mental health support for Children and Young People with epilepsy.	By 2025/26
	• Identify and embed transition to adult services for children and young people with epilepsy. • Embed pilot projects as business-as-usual	By 2027/28
Obesity – to support a reduction in overweight and obese children across ICS.	• Obesity / Health Weight Summit as part of the Integrated Care Partnership Assembly to develop system wide strategy • Incorporate and embed CYP into the system wide Obesity strategy. • Pilot Social Prescribing/Coaching roles to take a Whole Family Approach	By 2025/26
	• Hard-to-reach CYP & Family's at risk of obesity & in areas of deprivation, are supported to access & shape support to address barriers to lifestyle changes.	By 2027/28
Diabetes - Reducing inequality and variation in outcomes.	• Evaluation of youth worker pilot • Further investigation and implementation of technology with individuals affected by health inequalities. .	By 2025/26
	• Prevention and education aligning with Obesity workstream and improving care and outcomes for CYP living with type 2 diabetes.	By 2027/28

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Infant Mortality – to reduce the infant mortality rate across Herefordshire and Worcestershire	• Continue to audit Saving Babies Lives V3 compliance • Work as a system within the Perinatal Health and Wellbeing Group to coordinate prevention and transformation work streams feeding into place based Best Start in Life programmes.	By 2025/26
	• Improve systems to identify and support families whose children are at risk of infant mortality due to modifiable risk factors	By 2026/27
Urgent & emergency care	• Develop and embed a robust seasonal illness plan • Further development of the Handi App, adding additional conditions to support self management • Continue to develop common conditions pathway document across both Herefordshire and Worcestershire	By 2025/26
	• CYP are engaged in transition services and effective management of long-term conditions to avoid crisis presentations. • Consistent pathways across the ICS to provide CYP appropriate care in the most appropriate setting.	By 2027/28
Neurodivergence	• Embed CYP components of All-Age Autism Strategy. • Improve timely and appropriate access to services providing support, advice, information, training and interventions across the system.	By 2025/26
	• Improve waiting times for children's Autism and ADHD diagnostic assessments • Raise awareness and understanding of Neurodivergence in CYP workforce. • Implementation of redesigned Neurodiverse pathways • Increase take-up of annual health checks for 14-25 yrs	By 2027/28
Special Educational Needs and Disability (SEND)	• Continued increase in the number of children who are school-ready with appropriate plans in place. • Continued transformation of Paediatric Therapies model of delivery to enhance timely support	By 2025/6
	• Further develop joint commissioning of support & intervention services in both counties. • Improve transition into adulthood • Deliver the SEND improvement plans in both counties (and priority action plan in Worcestershire)	By 2027/28
Address healthcare inequalities to improve outcomes for Children and young people	• Continue to follow the national framework for the Core 20 plus 5 model, developing interventions to address inequalities.	By 2025/6

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Mental Health and Emotional Wellbeing Transformation Plan.	• Improve timely information, advice, and support • Improve mental health support for 0-25yrs and their families • Enhance pathways to avoid crisis & enhanced community-based solutions • Improved CYP mental health access rates by offering a range of services	By 2025/6
	• Improve mental health services within schools – aligned with the national guidance of MHST's in all schools by 2030	By 2027/28
Health and Wellbeing of Children Looked After (CLA)	• Review of Looked After Children's Services model in Worcestershire to ensure statutory health assessments for CLA are completed within timeframes and health needs are identified and addressed. • Pilot and evaluation of Initial Health Assessments contracting arrangements • Improve the process & timeliness of Adoption Medicals in Worcestershire. • Increase uptake of vaccinations within LAC across Worcestershire – review of children on the caseload with reduced vaccination status, complete RHA and raise awareness of vaccination • Herefordshire to raise awareness of vaccinations within schools and young people - co-produce promotional materials, raise awareness with engagement. Review of communications sent to parents. Increase HPV vaccine uptake amongst boys	By 2025/6
CYP Community Health Services	• Review and update service specifications for CYP community health services • Review Community Paediatric provision - Capacity and Demand modelling to commence April 2025 • Complete review of Children Community Nursing services with particular focus on EoL care in Herefordshire • Implementation of redesign of provision in Therapy Services incorporating 'The Balanced Approach' - universal, targeted and specialist provision. • Provider led review of Worcestershire Child Development Service • Continued development of a universal strand of provision in Occupational Therapy and Physiotherapy with a prevention / early intervention focus.	By 2025/26
	• Embed system adoption of universal, targeted and specialist approach within children community health services linked with development of the Best Start in Life programme with a focus on prevention and Family Hubs • Explore shared workforce opportunities across the system.	By 2027/28
Children's Cancer and planned Care	• Work with NHS across Region to ensure specialist care continues to meet children's needs. • Support & enhance Paediatric oncology shared care unit (POSU) at Worcester Acute Hospital to deliver injection-based outpatient chemotherapy • Develop level 2 Paediatric Critical Care capability at Worcestershire Acute Hospital.	By 2026/27

4. Where you can find more detail?

Engagement opportunities are circulated through parent carer forums and the ICS communications system.

We listen to the voice and experience of children, young people and Family's facilitated by Action for Children and specific feedback via existing youth forums, compliments and complaints.

The identified priorities reflect the Place based Children & Young Peoples Plan where regular updates are provided

Requests for information can be made to the CYP team at hwicb.cypteam@nhs.net

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

1. Why is this important?

To improve patient safety, outcomes and experience we must eradicate all long elective, cancer and diagnostic waits for assessment and treatment.

Waiting times remain in a challenged position post-COVID with waiting times being higher than we would like.

Despite having the 2nd lowest referral rate per 1,000 population, demand has increased circa 14% year on year.

The pandemic had a significant impact on planned care services, with access to many elective services paused, limited access to diagnostic tests and a significant reduction in patients being referred with suspected cancer. Demand has now returned to above pre-Covid levels, resulting in many services struggling to manage the levels of demand alongside addressing the backlog of patients that accumulated during the pandemic. This has resulted in patients are waiting longer for the diagnostic investigations, clinical assessment and treatment of cancer and non-cancer conditions.

In addition to recovering services, incidence of many health conditions such as cancer is expected to increase, with Cancer Alliances nationally predicting a 10% year on year increase in urgent suspected cancer referrals.

2. What have we delivered in our second year, 2024/25?

- Elimination of elective waits over 104 weeks, and over 78 weeks in most specialties with significant progress towards elimination of 65-week waits .
- Continued good performance against diagnostics targets, although a small number of challenged modalities remain.
- Patient Initiated Follow Up (PIFU) and Personalised Care Follow Ups (PCFU) continuing to be rolled out across a number of specialties enabling more people to self-manage their follow-up pathways.
- Fragile services framework in place with agreed ways of working to increase service resilience and sustainability.
- Utilisation of the Independent Sector Provider accreditation framework to support patient choice and ensure quality of the services delivered.
- Routinely providing access to FIT testing in primary care in +80% of urgent suspected colorectal cancer referrals to enable higher risk referrals to be effectively identified and managed accordingly.
- Robust Getting It Right First Time (GIRFT) programme of work in place across a range of specialties to ensure effective use of resources.
- Consistently performing above stretch target for Specialist Advice.
- Development of common conditions documents to support management in primary care.
- Elective Surgical Hubs live in both Worcestershire and Herefordshire.
- Ongoing development of CDC2 in Hereford City with expected go live summer 2025.

3. What are the priorities going forward?

- Continuing recovery of elective, cancer and diagnostic services in line with 2025/26 Operational Planning priorities. This includes achievement of cancer standards, restoring waiting times in diagnostics and reduction in elective waiting times with 65% (or minimum improvement of 5% on 2024/25 performance) waiting less than 18-weeks by March 2026.
- Delivering the priorities identified within the Elective Care Reform guidance including transforming and transitioning services to maximise productivity and improve quality across the elective, cancer and diagnostics pathways, ensuring services are safe, sustainable and accessible to patients, embracing the digital agenda to enable services to modernise through better use of technological developments such as AI.
- Development of guiding principles in Planned Care services on what represents good quality services, working with Healthwatch in Herefordshire and Worcestershire to obtain patient and public feedback.
- Ensuring patient choice is available and offered to patients, whilst also ensuring equity of access to NHS services.
- Ensuring effective integration across services and providers of planned care by adopting a pathway approach to service change and improvements to support earlier intervention and therefore diagnosis.

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Restore waiting times for elective, diagnostics and cancer	• Work collaboratively with all providers locally, regionally and nationally to increase capacity to support elimination of long waiting times across planned care services. • Optimisation of system elective surgical hubs - Alexandra Redditch (WAHT) and Hereford (WVT) • Launch of Community diagnostic centre in Hereford – increase volume of diagnostic capacity Summer 2025 • Delivery of 65% (or minimum 5% improvement on current performance) patients waiting no longer than 18 weeks for elective treatment • Delivery of 95% diagnostic tests within 6-weeks.	By 2025/26
Outpatient transformation • Referral Optimisation • Maximise Productivity • Reduction of follow ups • Reduce elective waits	• Delivery of Out-Patient Transformation programme across the ICS to include embedding patient initiated follow up (PIFU), helping put patients in control of their follow up appointments and achieving national requirement (5% discharged/moved to PIFU pathway) • Deliver an appropriate reduction in outpatient follow up activity including use of remote consultations. • Explore opportunity to embed one stop clinics, aligned to diagnostic development of Community Diagnostic Centres (Phase 2/CDC 3). • Ensure optimum use of Specialist Advice to support effective referral management. • Delivery of robust GIRFT and Further Faster programme to maximise productivity and support ongoing reductions in waiting times. • Embed digital support/solutions to support delivery of patient pathways and improved patient experience.	By 2025/26
Improving screening uptake	• Reducing variation in screening uptake in the registered and non-registered populations, and addressing poor uptake in harder to reach cohorts or cohorts with poorer outcomes; • Optimisation of the PCN DES Supporting Earlier Diagnosis – targeting non-responders and hard to reach groups;	By 2025/26
Supporting earlier diagnosis	• Implementation of Lung Cancer Screening Programme (Q4 2025/26) and continuing focus on utilisation of FIT testing in primary care; • Targeting populations at higher risk of developing cancer such as people with learning disabilities and autism; • Implementation of Non-Specific Symptoms pathway; • Offering improved access to liver surveillance in patients with fatty liver disease/ cirrhosis to support earlier identification of liver cancer.	By 2025/26
Implementing Best Practice Timed Cancer Pathways (BPTP)	• Ensuring 5 BPTP are in place across the ICS with a focus on achieving above the 80% 28-FDS standard and delivery of over 75% patients starting their cancer treatment within 62-days; • Undertaking audits in line with national requirements to confirm compliance with BPTP and areas for improvement; • Reducing treatment variation across cancer pathways in line with best practice recommendations outlined in clinical and GIRFT audits; • Transformation and innovation in pathology services	By 2025/26
Empowering patients through personalisation of care	• Optimisation and expansion of Personalised Care Follow-up pathways; • Use of digital technology to support a better patient experience, including use of a Patient Portal to support self-management, electronic End of Treatment Summaries to improve transition of care between secondary and primary care, and improved communication. • Improving support services for patients living with cancer such as delivery of HOPE courses, better access to psychosocial care;	By 2025/26

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Understand and address health inequalities in planned care	• Ongoing understanding of inequalities in access, experience and outcomes of care for Core 20, BME populations and Inclusion Health Groups across Planned Care. • Working closely with stakeholders such as Healthwatch to reduce the impact of health inequalities on outcomes in planned care.	By 2025/26
Longer term vision for planned care	• Development of a system wide strategy for planned care based on the 10 Year Plan (and Cancer Plan) due to be published early in 2025.	By 2025/26

4. Where you can find more detail?

Regional and national strategies for Planned Care can be found at:

- Getting It Right First Time
- Home - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)
- NHS England » Publication of the plan to reform elective care for patients
- NHS England » 2025/26 priorities and operational planning guidance

Link to the National Cancer Patient Experience Survey:

- Tell us about your experience of cancer care - National Cancer Patient Experience Survey

High quality, patients centred services: FRAILTY

Theme 4

1. Why is this important?

Herefordshire and Worcestershire has an older population than the rest of England, with the number of people over 65 years increasing and younger populations decreasing.

By 2030 (compared to 2021), it is predicted that the number of people aged 80-84 years will increase by 48% in Herefordshire and by 51% in Worcestershire. The increase in the over 85 age group is forecast to be 36% in Herefordshire and 35% in Worcestershire.

The projected increase in ageing population means that a greater number of people living in Herefordshire and Worcestershire will be at risk of developing or living with Frailty.

Frailty is a long-term condition in which multiple body systems gradually lose their reserves and functions, resulting in an increased vulnerability and risk of unpredictable deterioration from minor events. The development of Frailty is strongly linked with increasing age but can affect anyone at any age. This growing number of people at risk of living with poor health will lead to more people needing greater support and care from social and health services.

The prevalence of Frailty within Herefordshire and Worcestershire is significant. In 2024, it was known that over 7,000 people registered with a GP are living with severe frailty, and 8% of Herefordshire's and Worcestershire's population that are aged 65 years or above are living with moderate Frailty.

2. What we have delivered in our second year, 2024/25?

- Delivery of an Integrated Care System (ICS) Frailty Strategy,
- Worcestershire Acute Hospital Trust (WAHT) have initiated their own internal Frailty Transformation Programme that aligns to ICS' Frailty strategy, and endorse the ethos of 'Making Frailty everyone's business',
- Frailty Same Day Emergency Care areas have been established in two of WAHT hospital sites, that are supported 7by Geriatric Emergency Medicine services (GEMs),
- Single Point of Access (SPoA) service has expanded to integrate both community and acute workforce which support Ambulance service to appropriately direct frail patients to the best place to meet their care needs and wishes,
- Enhancements proactive assessment and care planning for people with Frailty through more Comprehensive Geriatric Assessments being undertaken within General Practices, and progress being made with standardising across all Herefordshire and Worcestershire NHS healthcare providers.
- Progress with piloting Frailty focussed Integrated Neighbourhood Teams, which aims to improve the care coordination and delivery of care for patients living with Frailty,
- Wholistic review of the Falls care pathways and assessments, with improving access and outcomes of preventative and reablement services, alongside public resource to raise self-awareness about risk of falls and self-management.

3. What are the priorities going forward?

It remains that our integrated care vision that **"People living in Herefordshire and Worcestershire who are at risk of, or living with frailty will, live well in a supportive community with accessible, personalised and coordinated high-quality care delivered in the most appropriate setting whenever they need it."**

This vision will be realised through a wholistic and place-based approach whereby to health and social care organisations across Herefordshire and Worcestershire will work together to collaborate, develop and enhance integrated care services for people at risk of or living with Frailty, to improve their health outcomes and quality of life.

The ICS Frailty strategy states the nine key desired outcomes of which all transformation plans undertaken must strive to deliver:

1. Increased community interventions measures to prevent the onset and progression of frailty
2. Increased early identification of people living with or at risk of frailty
3. High quality proactive comprehensive assessment of people living with or at risk of frailty.
4. High quality accessible and coordinated personalised care for people living with frailty, their Family's and carers in every care setting
5. Frailty attuned acute care which facilitates timely discharge and smooth transitions between care settings
6. High quality reablement and rehabilitation after a period of illness and at times of transition from hospital
7. High quality end-of-life care for people with frailty, their Family's and carers.
8. Compassionate, timely and effective advanced care planning in all health and care settings.
9. A workforce with the appropriate skills to provide specialist care to patients in all health and care settings.

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Frailty onset prevention	• Map and raise awareness of the community resource available to residents to support them with reducing their risk and/or delay on the onset of Frailty.	By 2025/26
Early identification and proactive care for those living with Frailty	• Develop a standardised approach to proactively identify those living with Frailty in Primary, Community and Secondary Care services, supported by the development of risk stratify tools and consistent implementation of nationally recommended clinical frailty scoring *i.e.,* Rockwood Frailty Score. • Continue to develop and implement the proactive care and management in primary care of those living with Frailty through the Clinical Excellence and Investment Framework (CEIF) and requiring utilisation of a standarised multidimensional holistic assessments (*i.e.,* Comprehensive Geriatric Assessment) to inform care and treatment plans. • Self-assessment against national Proactive Care Framework, to seek and identify further opportunities for improving of proactive Frailty care across the ICS, and establish improvement plans for those opportunities deemed high priority and attainable.	By 2025/26 & beyond.
Reactive Care	• Establish the current urgent and emergency care processes and provision variation and fragmentation for those living with Frailty at place, and neighborhood levels by undertaking reactive pathway mapping. • Following mapping the 'as is' reactive pathway, co-produce the 'future' reactive pathway that addresses the inequities and inequalities with accompanying transformation plans. • Continue the development and expansion of Frailty Same Day Emergency Care Services as per the national FRAIL Strategy, • Reinforcement and develop Frailty specific Advice and Guidance services whereby primary care clinicians can access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making.	By 2025/26.
Reablement, rehabilitation and recovery	• Undertake a system wide self-assessment against the National Intermediate Care Framework to establish current alignment to nationally recommended good practice and guidance for step-down intermediate care for adults who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover. • Utilise the learning from the self-assessment to scope, prioritise and devise improvement plans for the gaps and opportunities identified.	By 2025/26

4. Where you can find more detail?

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty

NHS England » FRAIL strategy

NHS England » Advice and Guidance

Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Data & digital enablement	• Scope the development and maintenance of frailty integrated registers across primary, community and secondary services, and were possible social care and public sector services. • Move toward a Population Health Management approach and function to help drive a data led focus on person-centered care for those at risk of or living with Frailty. • Establish the system need and digital capabilities for community remote monitoring for those who are housebound and living with Frailty.	By 2025/26 & beyond.
Workforce	• Understand system partners Frailty workforce infrastructure and capabilities, alongside roles and responsibilities of providing care for those living with Frailty to establish required competencies and identify any upskilling needs. • Collaborate and co-produce standardised training and education support and resources for clinician and care providers across Herefordshire and Worcestershire. • Establish model for an 'Integrated Core Frailty' team that across all health and social care sectors and aligns to national Neighbourhood health Guidelines.	By 2025/26 & beyond.
Care Homes Transformationa nd Quality Improvement Programme	• Establish a system Programme which aims to improve health outcome and care practices for those who reside in Care Homes through a strategic and integrated Quality Improvement and Transformation programme approach and is sensitive place-based needs within Herefordshire and Worcestershire. • Review and recommission Enhanced Health Care Homes framework delivery, addressing the known variation in service provision, accessibility and outcomes. • Evaluate and continue to develop remote monitoring within Care Homes across Herefordshire and Worcestershire. • Establish the need and capabilities for Care Homes to have direct access to SPoA to appropriately direct frail patients who reside in a Care Home to the best place to meet their urgent care needs and wishes.	By 2025/26 & beyond.
Communication and Engagement	• Devise communications and engagement plans with system partners to advocate and champion Frailty across public and professional communities. • Set as standard the requirement across all Frailty and Care Home improvement work for planned and purposeful engagement with our communities, experts by experience and staff groups to encourage collaborative working on the redesign of services and pathways were appropriate.	By 2025/26 & beyond.

4. Where you can find more detail?

NHS England » Population Health Management

NHS England » Neighbourhood health guidelines 2025/26

NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework

NHSE (online) Ageing well and supporting people living with frailty. Available from: NHS England » Ageing well and supporting people living with frailty

British Geriatric Society. (2023) *Joining the dots: A blueprint for preventing and managing frailty in older people.* Available from: Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk)

High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

1. Why is this important?

Ageing population

Herefordshire and Worcestershire's population is due to increase by approximately 5.4%. H&W have older population structures than the rest of England, with over 65+ increasing and younger populations decreasing.

Increased multimorbidity

The ageing population increase will reflect a significant increase of people living with dementia, frailty and other long-term conditions.

Increased number of deaths

Nationally, deaths are predicted to increase by 22% 2030-2040

Increased number of people dying at home

- The majority of bereaved Family's included in the national VOICES survey believed the deceased had wanted to die at home (81%), with a selected sample showing 22% had home as place of death documented on death certificates.
- Community services will need to be available to support people to die well at home, if it is their wish and where it is possible.

2. What have we delivered in our second year, 2024/25?

- We continue to work towards improving the sharing of information with the use of the Shared Care Record. This has an End-of-Life tab which shares data coded in EMIS in line with the End- of-Life Professional Record Standards Body data set for appropriate health provides across the system to view.
- Our digital ReSPECT plan is in development with phase 1 planning to go live during early 2025
- A standard advance statement document called My Wishes has been created for use across the system. A paper version has been launched and this will go live on the patient portal app across the ICS early 2025
- Successful Fast Track Home pilot in Worcestershire which has been rolled out and is now business as usual
- Standardised EMIS protocol agreed for the safe prescribing of anticipatory medications across the ICS
- Development of a PEoLC dashboard collating data across the system
- Development of Bereavement Toolkit on ICS Academy Exchange
- Development of Transitions Toolkit for CYP

3. What are the priorities going forward?

The Palliative and End-of-Life Programme Board is implementing the Herefordshire and Worcestershire Personalised End-of-Life Care Strategy 2020-2025, working in partnership with representatives across the ICS.

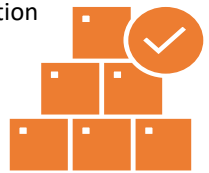
The vision is that "adults and children living in Herefordshire and Worcestershire, regardless of their diagnosis, will be supported to live well until the end of their life". It is imperative that care at the end-of-life is compassionate, tailored to the dying person and people important to them, and includes effective communication and assessments.

The six strategic outcomes are:

1. Increased and early identification of people who would benefit from end-of-life support and personalised care planning
2. High quality care for people at the end of life, their Family's and carers in every setting
3. Accessible, coordinated and digitally enabled palliative and end-of-life services for all patient groups
4. A workforce with the appropriate skills to provide people at the end of their life with high quality care and support
5. High quality bereavement care, support and information available to all
6. An embedded ReSPECT process which supports compassionate, effective and timely Advance Care Planning in all care settings

The key areas of delivery are:

- 24/7 Single point of access for palliative and end-of-life care advice and support for patients
- Making the best use of digital opportunities to improve communication and sharing of information, e.g. digitalisation of ReSPECT and Advance Statement; digitalisation of the palliative care register; and developing the Shared Care Record (ShCR)
- Review of Bereavement services
- Review of Anticipatory medications
- Development of Palliative and end-of-life care Virtual Ward



High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when?

Priorities	Deliverables	Year of Delivery
24/7 Single point of access to timely support and advice	Scope service need and options	By 2025/26
Coordinated education and training across the ICS focusing on communication and clinical skills to improve timely recognition of dying, promoting personalised care and advance care planning discussions	Early identification, ambitions mapping, ICS academy, End of Life Care Hub (ECHO) opportunities for sharing learning	By 2025/26
	Continued ambitions self-assessment, developments required based on those assessments. Continued development and work with ECHO hubs and the ICS academy	By 2027/28
Shared access to electronic patient information	Complete capability to share information: - Shared Care Record interoperability with EMIS. - Worcestershire out of hours access to the Shared Care Record	By 2025/26
	Develop access for Care Homes to Shared Care Record	By 2027/28
Embed digital ReSPECT process	Launch and promote digital ReSPECT Launch and promote digital Advance Statement	By 2025/26
	Review data collection, patient and carer feedback to inform promotion and take-up of ReSPECT	By 2027/28
Increased early identification of people who will benefit from end of life support and personalised care planning	Develop education for Primary Care and other practitioners.	By 2025/26
	Review of the new primary care template Develop ICS wide palliative care register-possibly with using clinithink	By 2027/28

4. What will we deliver and when continued ?

Priorities	Deliverables	Year of Delivery
High quality care for people at the end of life, their Family's and carers in every setting	Data dashboard to include core 20+5 data. Identify inequalities, geographical inequalities, engaging with hard-to-reach communities. Continue anticipatory medication work. CHC FT review and re procurement.	By 2025/26
	Review services and address inequalities ICS PEoLC virtual ward Review impact of changes from the anticipatory medications work CHC FT impact of new service	By 2027/28
Data dashboard and strategic needs analysis (SNA)	Work with data analytics team to create new data dashboard and collect new data to inform population needs. Meet with stakeholders to explore results of the SNA as part of new strategy	By 2025/26
	Continue to monitor and update data dashboard Develop any proposals to reflect findings of the SNA	By 2027/28
High quality bereavement care, support and information available to all	Bereavement group, mapping of services and update leaflets	Completed 2024/25
	Continue to monitor and review bereavement services	By 2027/28

5. Where you can find more detail?

Palliative and End of Life Care Programme:

- Herefordshire and Worcestershire Personalised End of Life Care Strategy 2020-2025
file (herefordshireandworcestershireccg.nhs.uk)
- Ambitions for Palliative and End of Life Care: A national framework for local actions 2021-2026
ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)
- NHSE NHS England » Resources and support
- Please email jadebrooks@nhs.net for more information, or to become a patient representative or person with lived experience on any of the palliative and end of life care groups.

High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

1. Why is this important?

National LeDeR report findings from 2021:

- 49% of deaths avoidable/ amenable to good health and social care (and at least 2 times higher than general population)
- Life expectancy 20 years less than general population

In addition, for autism, life expectancy is at least 10 years less than average for population, and over 80% of autistic adults experience mental health difficulties in their life.

One of the main factors is that people with a Learning Disability and autistic people (LDA) are underserved groups and do not have consistent access to health services in a timely way due to lack of reasonable adjustments and diagnostic overshadowing. This means health care is sometimes accessed or provided at a late stage of presentation, when the health condition is at an advanced stage or the person is in a crisis (leading to Mental Health Act assessment and hospital/ restricted environment admissions, Emergency Department attendance) and core universal services such as routine vaccinations and or cancer screening are delayed or missed.

2. What have we delivered in 2024/25?

- Continued to maintain Annua Health checks take up above national target.
- On track to complete sensory friendly assessments of 66% of all GP Practices.
- Continued local rollout of RADF, asking local organisations to audit their compliance as per national checklist.
- Fully recruited to key worker service and halved number of CYP in T4 beds
- LeDeR performance consistently above regional and national averages.
- Review of neurodivergence pathway for CYP ongoing.
- Invested £225k to reduce waiting times for young people aged 16-18 in Worcestershire.
- Primary Care CPD Day Held on September 2024 to improve awareness of LD Annual Health Checks.
- New templates in place for Annual Health Checks and Health Action Plans.
- New proposed pathway for LD Bowel Screening presented to the ICB Elective, Cancer and Diagnostic board for approval.
- 'Keeping well and looking after your lungs' video on respiratory health co-produced with Speak Easy Now and disseminated

3. What are the priorities going forward?

The Learning Disability and Autism Programme Board have oversight of the plans to improve outcomes for people with disabilities and people with Autism.

Our vision is that all people with a learning disability and/or autism can live healthy and positive lives, and we will do this by promoting reasonable adjustments and tackling health inequalities across the system.

In line with the NHS Long term plan commitments, we will:

- Taking action to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- The whole NHS family will improve its understanding of the needs of people with a learning disability and autism, working together to improve their health and wellbeing. Including training for the workforce, reasonable adjustments and a digital flag in patient records
- Reducing the waiting times for children and young people with suspected autism
- Increased investment in personalised care and community support.
- Continue to focus on improving the quality of inpatient care and timely discharge where appropriate.

High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Rollout sensory-friendly and accessible environments for autistic people into other NHS settings	At least 5 NHS settings will be assessed and have an improvement plan	By 2025/26
Good quality Learning Disability Annual Health checks routinely given to all people with a Learning Disability	Sustain up take of AHCs at 85%, Health Action Plans over 90%, including 14-24 year olds, supported by quality improvement programme focusing on Health Action Plans	By 2025/26
Vaccination and screening rate for people with a learning disability and autism comparable to general population	Awareness raising and targeted work, built around AHCs	By 2025/26
Reduction in avoidable deaths - Learning from the Deaths of People with a Learning Disability Review programme (LeDeR)	Programmes of work following on from LeDeR Learning into Action workstream. Current focus is healthy lifestyles; suicide reduction for autistic people	By 2025/26
Reduction in waiting times for autism diagnosis	Comprehensive review of neurodivergence pathway for CYP to ensure consistency across ICS and more timely diagnosis	By 2025/26
Support to autistic people post-diagnosis	Continued investment in adult support service and explore option for a service for CYP and families	By 2025/26
Raise awareness and inclusion of autistic people in mainstream services	Continued roll-out of Oliver McGowan Mandatory Training programme	By 2025/26
Keep number of young people in Tier 4 beds and adult inpatient numbers within national targets	Sustain low number of young people in T4 beds and reduce numbers of adults in locked rehab beds.	By 2025/26
Increase community Occupational Therapist, Physical Therapist, Speech and Language Therapist and epilepsy support capacity	Deliver service enhancements following agreed investment in community health service	By 2025/26
Tackle heath inequalities Ensure that people with complex needs are supported to live in the community and admission to in-patient units is avoided	• Over 85% of eligible people with a learning disability have an annual health check and over 90% of those have a health action plan • Vaccination and screening uptake is at least on a par with the rest of the population • In-patient rates are in line with or better than the national targets • Waiting lists for community support is less than 18 weeks • Oliver McGowan Mandatory Training has been rolled out across the system	By 2027/28

5. Where you can find more detail?

https://www.hwics.org.uk/our-services/learning-disabilities-and-autism

Co-production underpins our approach and we work closely with the Learning Disability Partnership Boards and the Autism Partnership Boards in Herefordshire and in Worcestershire. Experts with lived experience are actively involved, with support, in all strategic developments, and co-chair the Partnership Boards. Family carer voices are also strongly represented.

People with a learning disability can contact SpeakEasy NOW if they wish to become involved https://speakeasynow.org.uk/contact-us/

Our partnership arrangements also include the Acute and Community Provider Trusts, both Councils and the voluntary and independent sector.

High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

1. Why is this important?

We know that people are waiting longer than they should to access diagnosis and treatment.

After a decade of improving population wellbeing the COVID-19 pandemic is widely considered to have negatively impacted population mental health and wellbeing. Measures of population wellbeing worsened, particularly during the two main waves of the pandemic and have not fully recovered to pre-pandemic levels.

The proportion of adults aged 18 and over reporting a clinically significant level of psychological distress increased from 20.8% in 2019 to 29.5% in April 2020, then falling back to 21.3% by September 2020. There was a subsequent increase to 27.1% in January 2021, followed by a further decrease to 24.5% in late March 2021.

While there has been considerable economic recovery from the initial shocks of the COVID-19 pandemic, new challenges have emerged, with high levels of inflation and a rise in the cost of living.
Concerns have been raised about the impact this may have on population mental health, and nationally providers continue to report greater acuity of need across mental health services.

Furthermore, these challenges have highlighted and widened some of the existing inequalities in mental health and wellbeing in the population.

2. What have we delivered in 2024/25?

- Access to mental health services for children and young people has expanded significantly and will continue to expand into 2025/26, including broader treatment options through new commissioned services (e.g. Lumi Nova).
- A 3-year Mental Health Acute Inpatient Strategy has been developed to support improved quality of services, closer to home.
- Rapid expansion of NHS Talking Therapies staffing through trainee recruitment, to bring H&W Talking Therapies services in line with national workforce expectations and expand access to services.
- Re-procurement of Children and Young People's Emotional Wellbeing and Mental Health Services, including additional investment and expansion, across both counties.

3. What are the priorities going forward?

A key strategic development as part of the creation of the Integrated Care System has been the establishment of a **Mental Health Collaborative,** which brings together commissioning and provider functions, primary and secondary provision and broader connections to local stakeholders.

The overarching reason for creating the mental health collaborative has been to put the responsibility for organising services and pathways as close as possible to the front-line services that provide patient care. This marks a significant change from the traditional commissioning model of developing detailed services specifications that providers respond to; much more towards a model of agreeing outcomes that providers design service delivery models to address.

In 2024-25 a review was undertaken of the existing Mental Health Collaborative arrangements, with a series of recommendations to ensure clarity of governance processes and improve outcomes for patients. One of the key recommendations is to develop a mental health strategy.

Priority areas for 2025-26 include:

1. Reduction of inpatient average Length of Stay to prevent unnecessary delays, and Out of Area Placements
2. Redesigning Inpatient and Rehabilitation Pathways across the ICS
3. Increasing access to Individual Placement Support (IPS) services
4. Maintain and continue to increase access to CYP mental health services
5. Continue to expand NHS Talking Therapies workforce capacity while maintaining quality standards
6. Improve waits in UEC pathways for patients with mental health illness in line with national standards

The role of the Herefordshire and Worcestershire Mental Health Collaborative is described in more detail in Appendix 2, theme 15.

High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Children and young people	Continue to increase access to CYP mental health services (please see slide 8 on CYP mental health transformation)	By 2025/26
NHS Talking therapies	Delivery of all completed treatments and expansion targets while maintaining quality and waiting standards	By 2026/27
Early intervention in Psychosis	Continue to deliver required standards	By 2025/26
Dementia	Improve post-diagnostic support and timeliness of diagnosis	By 2025/26
Perinatal Mental Health	Maintain access standard for perinatal mental health services	By 2025/26
Out of areas placements (OAP) and inpatient LoS	Reduction of average Length of Stay and eliminaton of inappropriate OAPs in line with national standards	By 2025/26
Physical Health for people with a serious mental illness (SMI)	Maintain delivery of SMI health checks	By 2025/26
Adult community mental health	Take forward local review recommendations following Independent Mental Health Homicide Review	By 2025/26
Urgent mental health care	Delivery of 10 High Impact Actions for urgent mental health services	By 2025/26
Mental Health Strategy	• Mental Health JSNA to be completed • New Mental Health Strategy to be developed by the Mental Health Collaborative • Delivery of new national priorities • Reduction in health inequalities for people experiencing mental health illness	By 2025/26

5. Where you can find more detail?

The Worcestershire Health and Wellbeing Strategy 2022-2032 contains a strong mental health focus and is available here:
Health and Wellbeing Strategy 2022 to 2032 | Worcestershire County Council

The Herefordshire Health and Wellbeing Strategy 2023-2033 also contains a strong mental health focus and is available here:
Herefordshire Joint Local Health and Wellbeing Strategy 2023 - 2033

The Herefordshire and Worcestershire Mental Health Strategy is due to be reviewed during 2025, in line with new national NHS strategy.

Public engagement opportunities are advertised through the ICB and local authority websites, as well as on the Herefordshire and Worcestershire Health and Care NHS Trust website.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

1. Why is this important?

The prevalence of LTCs in H&W is projected to increase substantially over the next 10 years. Approximately 20, 000 more people will be living with Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Stroke or Diabetes in 2033 compared to 2023. This increased prevalence is estimated to cost the system £11 million more per year in urgent care utilisation alone.

These projections are in part driven by the increase in are over 65-years old population, which we anticipate to increase by 36, 000 by 2030. However, we are also seeing an increasing prevalence of type 2 diabetes in the 15-19 and 40-49 age ranges in our two counties, demonstrating a need for increased education and prevention to improve quality of life for younger people with LTCs and to prevent LTCs developing so early in life.

We are increasingly aware of growing excess mortality resulting from cardiovascular disease and this trend is greatest in our most deprived communities. People in our most deprived communities are developing multiple LTCs at a younger age than those in our least deprived communities. It is essential that we tackle this inequality difference to ensure all people can live as well as possible.

2. What have we delivered in our second year, 2024/25?

- Long Term Conditions Strategy 2024 – 2029 approved and published.
- Cardiovascular disease forum embedded (ICB & PCN Leads), focussing on sharing best practice and achievement of
- CVD Clinical Excellence and Improvement Framework (CEIF) developed to reduce unwarranted variation across areas which are resulting in high cost and poor health outcomes.
- Continued roll out of a video library for patients, enabling education and supported self-management across long-term conditions.
- Continuous Glucose Monitoring is being delivered as business as usual, with above average uptake regionally.
- Hybrid Closed Loop is being rolled out, with progress exceeding regional average.
- All Primary Care Networks delivering Spirometry testing, with continued increase in activity.
- Fractional exhaled Nitric Oxide (FeNO) testing is increasing by 23% average month on month.
- Continuation of the National Diabetes Prevention Programme demonstrating high retention rate.
- Following roll out of NHS Type 2 Diabetes Path to Remission Programme, there are positive results relating to course completion and weight loss.
- Reduction in both major and minor amputation rates resulting from Diabetes Foot Care service improvements.

3. What are the priorities going forward?

The work on long-term conditions is overseen and delivered through multiple programme boards, aligning to the strategy, which has the following priorities:

Prevention

- People will be actively signposted to appropriate education and organisations that can increase their knowledge, skills and confidence to live as well as possible, reducing their risk of developing long-term conditions.
- People will have improved access to evidence-based high impact interventions that prevent deterioration of long-term conditions.

Early and Accurate Diagnosis

- People who are at increased risk of developing a long-term condition will be proactively identified and supported.
- More people will have their LTC(s) identified sooner and closer to home.

Personalised Management

- People will be provided with education, support and resources to enable them to take a more active role in decisions about their care.
- People with multiple LTCs will receive proactive, holistic assessments, including medication and mental health reviews

Right care in the right setting

- Increase collaboration by services to enable care to be delivered as close to home as the complexity allows.
- Increase adoption of digital technologies that enable more effective self-management outside of a hospital setting.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Strategy	Long Term Conditions Strategy - Continued delivery in three priority areas of Diabetes, Respiratory and Cardiovascular Disease (including Heart Failure), with monitoring of delivery plans through maturity matrices.	Ongoing to 2029
Cardiovascular Disease (CVD)	Continued and enhanced delivery of high impact interventions for secondary prevention: • Community pharmacy hypertension case finding • Cholesterol search and risk stratification • NHS health checks • Case finding and direct-acting oral anticoagulation to prevent atrial fibrillation related strokes • Cardiac rehabilitation for patients post-ACS and diagnosis of heart failure • Optimisation of hypertension treatment • Optimisation of heart failure treatment through annual reviews • Optimising management post ACS, including lipid management.	By 2025/26, but ongoing throughout delivery of JFP
Diabetes National: Local:	• Develop an all ages Diabetes Service Specification that spans multiple providers and services. This will clarify the pathway, drive collaboration and support system wide accountability for outcomes. • Further improve the delivery of 9 diabetes care processes, including enhancements, e.g. the roll out of the Type 2 Diabetes in the Young programme. • Improve identification of individuals at high risk of Type II Diabetes and signpost to NHS Diabetes Prevention Programme or structured education as appropriate. • Improve NDPP uptake and engagement with people who have a Learning Disability or Autism, reducing inequalities. • Delivery of NICE Technology Appraisal for Hybrid Closed Loop by 2029 and improve access to Continuous Glucose Monitoring. • To begin / continue delivery of the following high impact interventions for secondary prevention. • Improve equity of access, and the quality of Diabetes structured education across the two counties.	Ongoing throughout delivery of JFP
	• Improve the Digital offer for enabling supported self-management in Type 1, including in Children and Young People. • Improve pre-diabetes screening and symptom awareness, with particular focus on addressing inequalities • Improve peri operative care of people with diabetes to reduce length of stay and outcomes. • Further development of a Diabetes Support Team in Primary Care Networks to deliver care closer to home (DiAST model of care) • Improve clinical leadership for MDFT	By 2027/28
Respiratory	• Reduce inequalities in access, experience and outcomes in pulmonary rehabilitation. • Establish Getting it Right First Time programme of work. • Ensure that Spirometry and FeNO provision is reflective of NICE guidance, is accessible, and of good quality. • Achieve accreditation for the Pulmonary Rehabilitation service. • Deliver Pulmonary Rehabilitation 5-year plan • Establish and embed a coordinated asthma transition pathway.	By 2025/26 By 2027/28
Neurology	• Develop an ICS plan to support service improvement across Neurology services.	By 2025/26

5. Where you can find more detail?

- Multiple_LTCs_Survey_-_Engagement_Report_-_Final.pdf (hwics.org.uk)
- https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/
- National Asthma and COPD Audit Programme (nacap.org.uk)
- pulmonary-rehabilitation-service-guidance.pdf (england.nhs.uk)
- spirometry-commissioning-guidance.pdf (england.nhs.uk)
- CVDPREVENT

High quality, patients centred services: STROKE CARE

Theme 9

1. Why is this important?

1. Lack of 7-day service provision in Hyper Acute/Acute stroke services, and unlikely to deliver in current format;
2. Current medical workforce challenges mean moving the service from 5 – 7 days (in and out of hours) is unlikely to be achievable;
3. Services at both Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trust (WAT) are classed as fragile due to longstanding medical establishment staffing gaps;
4. Increasing demand for stroke services over the next ten years increase this challenge further with expected demand to increase by 20% over the next 15 years across the ICS.
5. Achievement of **key clinical and performance standards** will continue to be a challenge and unlikely to be achievable unless changes are made to the existing service models;
6. National Clinical Guideline 2023 recommendations presents challenges in compliance;
7. Acute Stroke services have a current risk score of 16 on H&W ICB Risk Register.
8. System and regional level support for Service change to deliver a sustainable stroke service within the ICS for the future.

2. What have we delivered in our second year, 2024/25?

- Sustainable delivery of 7-day acute stroke care model
  - Proposed single site acute stroke model at Worcestershire Royal Hospital endorsed by NHS Clinical Senate;
  - Clinical Senate recommendations agreed by Stroke Programme Board and local action plan developed;
  - Pre-Consultation Business Case and Outline Business Case have been drafted to include demand modelling, workforce requirements and impact assessments.
- Service Improvement programme
  - Roll out of 'CT Perfusion' (advanced imaging) at both acute hospital sites to enable physicians to make faster, more accurate triage or transfer decisions;
  - Wye Valley NHS Trust are part of a national programme to improve Thrombolysis rates, with shared learning into Worcestershire;
  - SQuIRE quality improvement programme concluded with 4 improvement projects implemented across the ICS.

3. What are the priorities going forward?

ICS Stroke Programme Board (SPB) involves stakeholders across the stroke pathway (Herefordshire, Worcestershire and Powys Teaching Health Board) Healthwatch, West Midlands Ambulance Service, Stroke Association and Patient engagement. The Programme Board focusses on the entire Stroke Pathway, from Hyper-acute to Rehabilitation and Life After Stroke.

Priority 1: The Stroke Programme Board is committed to delivering a new, **sustainable 7-day acute stroke services model**. This will modernise how services assess and treat patients; ensuring optimal clinical model of care and the best use of resources across the entire pathway, including staffing and use of technology. To achieve this vision, the SPB has commenced a pre-consultation process, and a preferred clinical model has been agreed. SPB are now looking at the post-acute pathway, including life after stroke and are working towards an options appraisal process to agree a pathway that will align with the proposed endorsed acute pathway. It is recognised that this pathway model will require capital investment and is the longer-term strategy required to deliver sustainable stroke services for the future.

Priority 2: The **Stroke Services Improvement programme** focusses on:

- Workforce development;
- Digital enablers (for example, pre-hospital video triage);
- Performance Standards;
- Development of patient pathways, in line with national standards;
- Focus on health inequalities with a targeted CVD prevention programme to reduce the incidence of Stroke.

The Stroke Programme is aligned to and supported by the Integrated Service Delivery Network (ISDN) and The National Stroke Quality Improvement in Rehabilitation (SQuIRe) programme.

High quality, patients centred services: STROKE CARE

Theme 9

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Service Improvement Programme	• Workforce developments resulting in robust medical and nursing workforce with joint working/posts across Hereford County Hospital and Worcester Royal Hospital to ensure resilience. • Advances in digital technology embedded, with virtual consultations part of everyday practice where appropriate. • Development of a service specification for an integrated community stroke service. • Development of Clinical Guidelines for Stroke. • Improvement in performance standards.	By 2025/26
Sustainable delivery of 7-day acute stroke care model	• Agreement of post-acute pathway including Life After Stroke.	By 2025/26
	• Completion and presentation of Pre-Consultation Business Case and Outline Business Case. • Commencement of the Pre-Consultation process.	By 2025/26
	• Stroke services transformed with agreed pathways embedded and services delivered in line with national guidelines and performance standards.	By 2027/28

5. Where you can find more detail?

In January 2022 we considered all the previous patient and public feedback we had received about stroke services. This was summarised in a paper, which is available here.

A further Stroke Services issues paper was written in September 2022 and further engagement undertaken :-

Stroke Services :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

Integrated Community Service Specification - Feb 2022

National Clinical Guideline for Stroke 2023

Stroke - Getting It Right First Time - GIRFT

Integrated Life After Stroke Support

High quality, patients centred services: URGENT AND EMERGENCY CARE SERVICES

Theme 10

1. Why is this important?

The Urgent and Emergency Care (UEC) system in Herefordshire & Worcestershire is in a challenged position. However, ICB and system partners remain committed to making sustainable improvements across the entire health system to support timely care and efficient patient flow.

The National delivery plan for recovering UEC services sets out core indicators to Increase urgent and emergency care capacity by March 2024 including:

1. No less than 78% of patients (in Emergency Departments) are seen within 4 hours
2. Ambulance category 2 mean response time is less than 29 minutes
3. Achieve an average adult G&A bed occupancy of 96% or below

The system forecast outturn for 2025-26 against these targets which demonstrate the challenged situation are:

1. 78%
2. 29
3. 96%

2. What have we delivered in our second years, 2024/25?

- Launched of Single point of access covering Community and Acute Trusts, improving the coordination of people to the most appropriate service (in both counties)
- Continue to grow virtual ward beds in line with the UEC strategy of a model hospital
- Improvement in ambulance category 2 response times
- Implementation of national call-before-convey requirement, building upon the success of the urgent community response service.
- System Coordination Centre fully compliant with national standards and oversight of the day-to-day urgent and emergency care pressures.
- Improved and enhanced same day urgent care pathways
- Further development of same day emergency care with Frailty SDEC established at one of the sites

3. What are the priorities going forward?

- The Urgent and Emergency Care Programme Board is driving forward improvements for a responsive and affordable urgent and emergency system that meets the population's needs. This includes preventative or activities to manage ill-health before it becomes an emergency, and timely and efficient patient flow, resulting in less ambulance handover delays and minimising waits within Emergency Departments.
- Delivery of 78% EAS by March 2026.
- Delivery of less than 30-minute category 2 response times throughout 25/26
- Significant reductions to numbers of patients waiting over 12 hours in our Emergency Departments

The six priorities are:

1. Population management - To apply population health management approach to identifying those most at risk
2. Care at Home - To maximise the coordination of services to proactively intervene early and prevent the deterioration of frailty and ill-health
3. Future model of urgent care - To establish a model of integrated urgent care that supports people to access advice and interventions. This will include a procurement of out-of-hour GP provision, outbreaks management and enhancements to single point of access.
4. Emergency care - To consistently demonstrate an effective and efficient emergency care provision.
5. Discharge and recovery - To have a 'zero delay' approach to discharge planning with coordinated support for people to optimise their recovery.
6. Operational resilience - To demonstrate effective resource allocation to de-escalate or prevent pressure.

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Population Health Management	• Implement data gathering on health inequalities • Undertake population health assessments • Tailor approaches to people most-at-risk of requiring urgent & emergency care	By 2025/26 By 2025/26 By 2025/26
Care at Home	• Care at Home delivered by Integrated Neighbourhood Teams • Development of virtual hospital • Frailty competent workforce	By 2025/26 By 2025/26 By 2026/27
Future model of urgent care	• Procurement of Integrated Urgent Care including out-of-hours GP service, outbreak management and enhanced single point of access. • Delivery of a single point of access and enhance care navigation	By 2025/26 By 2025/26
Emergency care	• Consistently achieve under 29 minutes category two ambulance response times. • Achieve high performing Emergency Departments (emergency access standard) • Implement 'front door' streaming to right care setting • Maximise same day emergency care, including access to diagnostics 7-days	By 2025/26 By 2026/27 By 2025/26 By 2026/27
Discharge and Recovery	• Commit to returning home sooner #Homeforlunch • Enhance Frailty Rehabilitation & Discharge pathways • Improve Discharge-to-Assess pathways across the system	By 2025/26 By 2025/26 By 2025/26
Operational resilience	• Conduct annual winter and surge planning • Run public awareness campaigns to support people to use the right service • Develop shared training, common approaches and local knowledge across the workforce • Operate 7-day working across urgent & emergency care	Ongoing By 2025/26 By 2026/27 By 2026/27

5. Where you can find more detail?

The ICB and ICS system partners are refreshing the UEC Strategy, a link will be shared when this is available.

More information and context for the ICBs priorities can be found within the national recovery plan:

- B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf (england.nhs.uk)

Findings from Healthwatch talking to our patients will inform the focus of other workstreams to ensure care in the right place, at the right time, as close to home as possible, further engagement will be planned with Herefordshire:

What patients told us about why they "walk in" to A&E Departments in Worcestershire | Healthwatch Worcestershire

High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

1. Why is this important?

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS & providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.

Workforce challenges for General Practice include the attraction and retention of GPs and Practice Nurses. 28% of the GP workforce and 30% of the nursing workforce are over 50 years. In 2024-25 Partner numbers continue to decrease (-4%), but the numbers of salaried GPs is increasing (+16%). Overall the GP workforce has increased by 3.6 FTE.

2. What have we delivered in our second year, 2024/25

Implementation of the local Herefordshire and Worcestershire Primary Care Access Recovery Plan – Year 2

- Delivered **5.5 million appointments** in General Practice (2024). This is 20% more appointments than before the COVID-19 pandemic, and an increase on 2023. GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- By the end of March 2025, all practices will have implemented the Modern General Practice Access (MGPA) model to tackle the 8am rush, provide rapid assessment and response and avoid asking patients to ring back to book an appointment.
- For cloud-based telephony, online access to patient records, digital communication tools and Online Consultation solutions, we have 100% of our Practices offering these services.
- Online consultations are currently averaging around **70,000 admin or clinical contacts per month**.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. **About 4,000 self-referrals are made each month**.
- Primary-Secondary Care Interface is working in line with their 'working better together principles'. Consultant to Consultant referrals policy allows direct inter-hospital referrals when clinically needed, rather than going back through the GP.
- Bureaucracy has been reduced as part of the 'red tape challenge' event in December 2024. A Primary Care Liaison Officer is in post to work across the system on any barriers to facilitate change and improve capacity and patient care. NHS Trusts have established clear call and recall systems for patients for follow up tests or appointments.
- The Herefordshire & Worcestershire ICB's published Primary Care Access Plan was approved by the H&W ICB Board on 20 November 2024, which can be accessed via the website at agenda item 8: https://herefordshireandworcestershire.icb.nhs.uk/meetings/past-board-papers and was commended by NHS England.
- The ONS Health Insights Survey ranks Herefordshire & Worcestershire ICB top across the whole of England for patients reporting a 'good' overall experience of access to general practice.

Workforce

- Recruitment to the Additional Roles Reimbursement Scheme (ARRS) continued during 2024. On 1st August 2024, the government announced additional funding to support GP recruitment from Oct-March 24-25. By Jan 25, 6 PCNs had appointed 5.7 WTE ARRs funded GP.
- 25-26 funding has been expanded to included practice nurses as well as continued funding for GPs & GP joiners and leavers data has improved since March 2024.
- 371 direct patient care staff recruited up to Jan 25.
- General Practice Staff Survey – year 2 participation. Results demonstrate H&W equal to national survey average.
- General Practice workforce retention and attraction schemes implemented for 24-25.
- Support Level Framework (SLF) visits with Practices identified priorities and support offered through ICB General Practice Improvement Programme (GPIP) /Service Development Funding (SDF).

Estates

- Revision of General Practice estates plans as part of the draft ICS Infrastructure Plan 24/25, submitted 31st July 2024.
- Funding bid submitted in March 2025 to support General Practice to increase premises and appointment capacity as part of NHS England's Estates Modernisation and Utilisation Fund.

Governance

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services).

High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

3. What are the priorities going forward?

Enabling General Practice Strategy priorities

Planning and oversight is currently governed via the GP Sustainability and Transformation Forum, with overall accountability with the Strategic Commissioning Committee. Delivery via Herefordshire General Practice and General Practice Worcestershire Boards.

Integrated Neighbourhoods Teams – developing and supporting services delivered at a neighbourhood level – are central to transformation priorities of the Herefordshire & Worcestershire Integrated Care System

Enhancing services in primary care by prioritising workforce, estates and technology investment at a neighbourhood level will enable our citizens to have better local access to a wider range of services they need when they need it

Creating the conditions to better manage patient demand for primary care will enable GP practices to provide continuity of care to those who want and need it and give increased focus to prevention – support the ICS aspiration to reduce inequality and enhance outcomes.

All designed to ensure that the people who need and want to access primary care can get it, and that GPs have more time to provide continuity of care and deliver more preventative care going forward

5. Where you can find more detail?

- **Long Term Plan**
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

- **Hewitt Review**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/1148568/the-hewitt-review.pdf

- **Fuller Stocktake**
https://www.england.nhs.uk/wp- content/uploads/2022/05/next-steps-for- integrating-primary-care-fuller-stocktake- report.pdf

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Implementation of Fuller Report	• Lead & co-ordinate ICS response to Fuller & the moving towards a new model of care at Neighbourhood level. Starting in 2024\25 we want the System to orientate itself around 15 Neighbourhoods to reflect the needs of our Communities.	By 2024/25
General Practice	• Lead the co-production of a "Enabling General Practice" 3 year strategy with short, medium and long-term priorities. Set in the context current pressures, whilst raising ambition. • Drive a standardised and consistent offer to all residents of the highest standard • Focus and target unwarranted variation across all practices and see an improvement across accessing and ease of contact with practices as well as a broad range of long term conditions • Co-produce with General Practice a transformation programme which supports all practices in reaching their potential and builds capacity within practices to manage change and drive improvement	By 2024/25
Primary Care Estates	• Support General Practice to access funding and implement schemes to increase estates and access capacity via the Estates Utilisation and Modernisation Fund	By end of 2025/26
Primary Care Access Recovery Plan	• Engage on at scale solutions which sit within our PCARP and use this as a springboard to resilience, sustainability and transformation, utilising digital technology as additional forms of access. • Utilising additional workforce from the ARRS funding, and community pharmaices offering extra capacity for primary care. • Lead and coordinate the response to Year 2 of the National Access Recovery Plan – supporting practices and PCNs deliver their Access Improvement Plans, navigating the national Improvement Programmes to maximise implementation of transformation support tools locally to enact the necessary change. • Work across the system to enhance left shift activities delivering clear closer to patients while preventing unnecessary workload for GPs that should be undertaken in acute settings.	By end of 2025/26
GP Retention Review and refresh around	• Implement a GP Retention Plan and expect a drop in numbers leaving in early stage of their careers and a rise in well being • Review years 1 and 2 of – Enabling general practice and Dental Access strategy • Redefine priorities based on progress made and updated PCN/General Practice Contract from April 2024	By 2027/28 By 2024/25

General Practice Worcestershire's vision is to offer patient-centred healthcare which is high quality, cost-effective and fully integrated with our local partners to ensure a sustainable health service for our communities across Worcestershire. Our vision will be delivered by ensuring we have a happy, valued, supported multi-disciplinary workforce across General Practice.

What we delivered in 2024/25…

Access-

✓ Continued work to meet the three domains of Modern General Practice Access;

- Better digital telephony: telephony systems include call back functionality and reporting mechanisms to support capacity planning and access improvements
- Simpler online requests: online clinical and administrative requests can be submitted during core hours with appropriate responses and signposting enabled
- Faster care navigation, assessment and response.

✓ Introduction of PCN Hubs. The Same Say Urgent Access Hubs were introduced in Worcestershire in Autumn 2024 to support increasing demand for patients needing on the day care in General Practice and to reduce the impact of this on the wider system including Accident and Emergency. The hubs have been successful with high levels of uptake. Each of the 10 PCN's are providing a hub to support patients from their constituent practices, providing flexibility of access when demands across the network differ, whilst still providing care closer to home and maintaining some degree of continuity. When individual PCNs are under pressure, the hubs can be repurposed for cross county support.

Workforce-

✓ We have maintained recruitment within the ARRS workforce to meet national targets and flexed according to the ARRS changing criteria

✓ Introduction of Work & Health Coaches in collaboration with system partners as part of the Workwell initiative.

Sustainability

✓ **T**hrough General Practice Worcestershire Board, working to become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient.

✓ Metered dose inhaler changes as part of CEIF

Delivery of Integrated Neighbourhood Teams

✓ Continued work on the programme and timeline for implementation of the Fuller stocktake with phased delivery, via the Place-plan. Building on the learning from the 3 Accelerator sites to rapidly scale up efficiency and integration across community teams, general practice and social care.

✓ Continued District Collaborative working, with a focus on Prevention and Tackling Health Inequalities. Particular focus on CVD with targeted initiatives for this patient cohort. Increase in community involvement in local services such as menopause, smoking cessation, ageing well, diabetes prevention events.

✓ Working with our Community and Acute partners on Frailty, Virtual Ward, Primary/Secondary interface.

Work with the ICB on the "Enabling General Practice" 3 year strategy

✓ General Practice Worcestershire Board established and includes elected practice manager, ICB, LMC. The Board has continued to operate throughout 24/25 as central point of contact and has supported system wide meetings with GP representation.

What will we deliver over the next five years?

- **Access-**delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care. Focus on patients who would benefit most from continuity of care and the creation of a patient charter detailing what patients can expect from their GPs and practices. A recent national survey highlights significant improvement in patient experience of GP access, with the latest results for Hereford and Worcestershire showing the highest patient satisfaction of GP access of any across the country.

- **Workforce-** continue to flex recruitment to the ARRS workforce, stabilise General Practice workforce including the partnership model and retaining the workforce including clinical roles in training. Development of a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.

- **Sustainability**-Become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. Continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.

- **Delivery of Integrated Neighbourhood Teams -** Extend the Population Health Management approach beyond GP data and use the intelligence to maximise the impact of integration and reduce duplication as part of the implementation of the Fuller stocktake programme. Hosted visit from Claire Fuller to Stourport Medical Centre to highlight innovation in both counties

- **Deliver the general practice actions outlined in the "Enabling General Practice" 3 year strategy – progressing** beyond the ending of the PCN DES in 24/25, focusing on sustainable and resilience general practice.

High quality, patients centred services: GENERAL PRACTICE HEREFORDSHIRE

Herefordshire General Practice

Theme 12

In 2023/24, we established Herefordshire General Practice Collaborative. This model has successfully united representatives from all 19 Herefordshire practices, the Local Medical Committee (LMC), Primary Care Networks (PCNs) and Federation (Taurus Healthcare) to strengthen our working partnerships. The aim of the changes is to improve the delivery of 24/7 General Practice, create greater resilience for practices, provide variety and development for our workforce and to amplify the voice of General Practice in our local health and wellbeing system and is focussed on delivering this over the next five years.

Neighbourhood health

- HGP is committed to supporting and helping lead this next stage of development into neighbourhood health, and to build on use of the population health data.
- Ensuring we are an effective system partner, working with communities, health, care and voluntary partners to improve the experience of our services through integrated neighbourhood working and securing resources to deliver effective and appropriate out of hospital care
- Building on current success in expansion of MDT teams to further develop into future neighbourhood health integrated models

24/7 Integrated Urgent Care

- Developing the IUC agenda bringing together the pressures in the community alongside those of the acute, with integrated data sets that reflect capacity and demand in all sectors.
- Explore and develop a localised element of 111 that dovetails with existing IUC in a more seamless way, ensuring patients are supported to find the right care at the right time
- Retaining the OOH contract for local control that supports continuity of care and increasing integration of services.
- Build on the effective remote hub HRH, to support the IUC across the system, testing out the impact of face to face overflow.

Accessible, Sustainable general practice

- Continuing to deliver the modern general practice program to improve access
- Underpin the fair share of resources to ensure practices and primary care at scale remain financially viable, through both the national contracts, and the development of local contracts eg LES, CEIF
- Support the movement of work from the acute to the community, but with an appropriate shift of resources.
- Shape development & support delivery of ICS estates & digital plans, facilitating access and the delivery of integrated health & social care anchored around our neighbourhoods.

Develop New Services

- Deliver a new ADHD service that can provide a quality service that dovetails with general practice and mental health services, creating a more financially resilient service for the future.
- Explore the movement of services into the community that can support the system backlog and allows care closer to home, through subcontracting opportunities.

Primary secondary care interface

- Build on the supportive relationships to ensure that primary and secondary care reduce unnecessary shift of workload, reducing unnecessary appointments, whilst supporting workload shift into the community that is appropriately resourced.

Prevention

- Continue to develop the prevention agenda in the community, with talk wellbeing working alongside PCNs and practices to promote activities that support wellbeing and tackle inequalities
- Continue the workwell project to support people getting back to work

Thriving General Practice workforce

- Develop & implement a local General Practice workforce strategy to support recruitment, retention and role redesign, and that identifies the needs of our teams and attracts, values and supports our workforce
- Continue to implement ambitious plans to not only recruit but support and develop additional roles in General Practice, maximising our collective skills and expertise and our productivity
- Work together to embed new models of care, such as Herefordshire Remote Health, that not only supports patient access but offers increased flexibility for clinicians.

High quality, patients centred services: PRIMARY CARE SERVICES - PHARMACY, OPTOMETRY AND DENTAL (POD)

Theme 13

1. Why is this important?

NHS England delegated the commissioning of

the Pharmacy, Optometry and Dental (POD) services to H&W ICB in April 2023. The Office of the West Midlands (OWM) was established to support the six ICBs to deliver their commissioning responsibilities.

The Office of the West Midlands (OWM) is hosted by BSoL ICB who provide, oversight, leadership, and support for the workforce who were transferred from NHSE. This arrangement is supported by a formal hosting agreement between the West Midlands ICBs. All decisions are made through the 3 tier Joint Commissioning arrangement and their sub-groups which each ICB is a member of.

Herefordshire & Worcestershire has the Strategic Lead Role for POD services. What this means is – Simon Trickett, via the West Mids CEO Group is the Chief Exec lead for specific programmes such as developing a needs-based allocation formula to support Dental Services for example and escalating any issues to NHSE that may require dispute/resolution.

Specialised Services was also devolved in April 2024, and additional services such as Vaccinations & Immunisations and Screening programmes will be delegated in 2026.

Over the last 10 years there has been a decline in the number of Dental Practitioners providing NHS dental services to patients, this is particularly prevalent in Herefordshire and improving access to Dental services is a key priority in 2024/5.

2. What have we delivered in our second year, 2024/25

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services)
- Development of a local Dental Recovery Plan, which aims to improve access and support the dental workforce.
- Development of a Dental Services Equity Audit by the Consultant in Dental Public Health, which has helped to inform commissioning intentions.
- Dental access is slowly improving. Between March 2022 to December 2024, dental access increased from 46% to 56% for children and 33% to 36% for adults, with the benchmark being 55%, which was the level of access pre-pandemic.
- Mobilisation of a new dental practice in Hereford City in June 2024, with a 2nd site due to open in May 2025. Combined, these two new services will provide much needed additional dental access for around 7,000 residents.
- Implementation of a proof-of-concept Dental Training Centre, which aims to recruit more dentists from overseas, and support them through the mentoring process.
- Continued to build on relationships with Local representative Committees such as the Local Dental Committee (LDC), Local Optometric Committee (LOC) and Local Pharmaceutical Committee (LPC) to understand the challenges and opportunities for providers to inform future strategic commissioning intentions.
- Worked closely with Community Pharmacies to implement the community pharmacy element of the national Primary Care Access Recovery Plan. In the two-year programme:
  - *Pharmacy first commenced for seven common health conditions at the end of January - Sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women without the need to visit a GP practice in addition to 40+ conditions pharmacies routinely manage. To date **13,906 consultations** have been referred by GP practices FY 24 25 (4,557 through clinical pathways and 9,348 as minor illness referrals).*
  - *Oral contraception service has been expanded. Between April 2024 and December 2024, **3,124 consultations** completed for initiations and ongoing supply of oral contraception.*
  - *Blood pressure check service has been expanded, encouraging utilising technology, to improve efficiency of referrals to community pharmacies. 89 pharmacies signed up and the service is delivering over target at **139.3%** (Nov 2024)*
  - *Discharge medicine service - Working closely with secondary care pharmacy teams to increase referrals into this service. All 3 NHS Trusts have commenced the service helping to reduce 30-day readmissions*
  - *Approved for 3 H&W sites to host independent prescribing pharmacist clinics – acute conditions; contraception; hypertension and CORE20PLUS5 initiatives. Herefordshire and Worcestershire ICB are the only ICB to fulfil all sites.*
  - *Pharmacy Engagement PCN Lead role, working with PCNs to increase patient, public awareness and referrals.*
  - *Ensure safe use of medicines and the position of community pharmacy is routinely built into our commissioning arrangements including a major provider of Flu and COVID-19 vaccine delivery across HWICS*

3. What are the priorities going forward?

- Accelerate Pharmacy First National Services so that there is an equitable offer for patients to self-refer or be referred increasingly into pharmacy-based services. GP connect update and access record is required to be switched on in GP practices by October 2025 to enable more streamlined messages on clinical services provided by pharmacies.
- Continue to implement the local Dental Recovery Plan priorities.
- Continue to build relationships with Community Optometrists, and the development of integrated pathways
- Increase clinical pathway referrals from practices.

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Primary Dental services	Implement the local Dental Recovery Plan actions, in addition to the government manifesto for additional urgent dental appointments.	During 2025/26
Delegated responsibilities	Continue the governance and oversight of Pharmacy, Ophthalmic and Dental delegated responsibilities (in addition to General Medical Services) via the Delegated Commissioning Sub-Committee, established July 2024. .	During 2025/26
Increase Dental Access	Mobilisation of the 2nd dental service in Hereford City to increase access for patients Commence commissioning plans for additional dental activity, in accordance with the local Dental Recovery Plan	May 2025 By June 2025
Optometry	Continue to build relationships with Community Opticians and develop integrated pathways where clinically appropriate	During 2025/26
Community Pharmacy	Accelerate referrals into Pharmacy First services for minor conditions and clinical pathways plus BP checks and contraception services through integrated pathways. Full digital integration into discharge medicine pathways confirms patient understanding of changes made to medicines whilst in hospital after they are discharged. Continue to input into national learnings of independent prescribing by community pharmacists as part of the national pathfinder programme – essential to workforce plans	During 2025/26

5. Where you can find more detail?

Dental patients to benefit from 700,000 extra urgent appointments - GOV.UK

Pharmacy First: what you need to know - Department of Health and Social Care Media Centre (blog.gov.uk)

High quality, patients centred services: SPECIALISED SERVICES

Theme 14

1. Why is this important?

Specialised Services are a diverse portfolio of NHS pathways accessed by a small group of people living with rare or complex conditions, including cancer, neurological, genetic and complex mental health needs.

ICBs were established to work with all partners to create a system where decisions are taken as locally as possible.

In 2024/25 the ICB became responsible for 59 acute specialised services delegated from NHSE, following the delegation of pharmacy, optometry and dental services in 2023/24. In 2025/26 a further delegation of other acute and mental health specialised services, as well as vaccination, screening and child health information services, is to be delegated.

What does this mean for the population of Herefordshire & Worcestershire? It means that the ICB will be able to influence the development of an integrated care pathway (for example, a cancer pathway) thereby ensuring that it reflects the local needs of our population within the larger over-arching commissioning policy across the West Midlands.

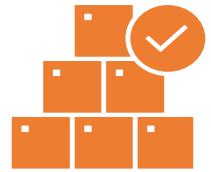
2. What have we delivered in 2024/25?

2024/25 saw the continuation of the joint work between NHSE and ICBs to facilitate the safe transition of the delegated services across the 11 Midlands ICBs. It is proposed that in 2025/26 - subject to consultation – NHSE staff in the West Midlands supporting all these services will transfer to NHS Birmingham and Solihull Integrated Care Board.

3. What are the priorities going forward?

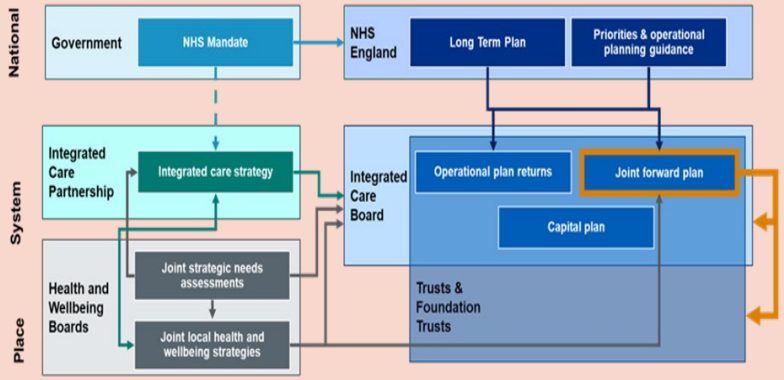
The over-arching national priorities for Specialised Services in 2025/26 are:

- Continue to reduce elective care waiting times – with 65% of patients waiting less than 18 weeks.
- Improve ambulance response and A&E waiting times – with a minimum of 78% of patients seen within 4 hours
- Improve patients access to general practice and urgent care dental care access, including 700,000 additional urgent dental appointments
- Accelerate patient flow in mental health crisis and outpatient care pathways



High quality, patients centred services: SPECIALISED SERVICES

Theme 14

Priorities	Deliverables	Year of delivery
To demonstrate NHSE priorities align with wider system partnership (ICB) ambitions, support subsidiarity and be delivery focused.	Production of an Integrated Commissioning Plan for 24/25 building on existing local strategies and plans, emphasising collaboration with local entities, and reflecting universal commitments. Whilst maintaining a delivery focused approach, incorporating specific objectives, trajectories, and milestones to ensure actionable plans and measurable outcomes 	**2024/25**
	Delivery of the integrated commissioning plan	**2025/26 and beyond**

5. Where can you find more detail?

NHSE Midlands

Joint forward plan – 25/26

Appendix 2: Strategic Enablers – Cross cutting themes

The section also identifies **how key enabling strategies** will be delivered to support the improved outcomes described in the core areas of focus section.

The section also describes the **strategic system developments** that will ensure that the system has the right structures, capacity and capabilities to deliver the plan.

Version: 2025 Refresh, May 2025

Strategic Enablers - cross cutting themes and strategic development areas

Cross Cutting Themes

Underpinning and supporting delivery of the core areas of focus outlined in Appendix 1 are a set of strategic enabling functions. These "cross-cut" all service areas and are fundamental components of delivering high quality, patient centred integrate services:

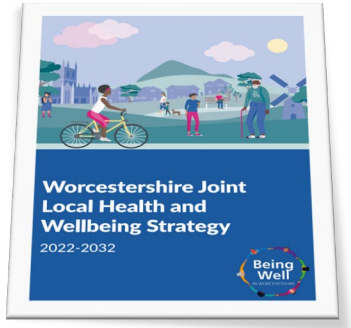
1. **Quality safety and patient experience**
2. **Clinical and care professional leadership**
3. **Medicines and pharmacy**
4. **Health inequalities**
5. **Prevention**
6. **Personalised care**
7. **Working with communities**
8. **Commitment to carers**
9. **Support veteran health**
10. **Addressing needs of victims of abuse**
11. **Digital, data and technology**
12. **Research and innovation**
13. **Greener NHS**

Strategic System Developments

In addition, there are a suite of strategic system developments that will support improved ways of working to maximise the opportunity for integration, enable greater focus on upstream prevention and delivery of best value health care in the right settings:

14. **Mental health collaborative**
15. **NHS Trust collaboratives**
16. **One Herefordshire Partnership**
17. **Worcestershire Place Partnership**
18. **Office for the West Midlands ICBs**

Together these supporting enablers provide the platform from which local NHS and Primary Care Partners can work together to deliver the priorities set out in the Integrated Care Strategy, the two Joint Local Health and Wellbeing Strategies and the NHS Long Term Plan



1. Quality, Safety and Patient Experience

Theme 1

Why is this important?

- What matters to people matters to us, listening to patients, their families and carers experience is essential to continuous improvement of services
- We have collective and individual responsibility to act in a manner that seeks ensure safe, effective and high quality care delivery and safeguard those in need of health and social care
- ICB has a Duty to ensure continuous quality improvement and as an ICS we are committed to this
- Learning and improvement cultures enable collaboration that leads to assurance of sustainable improvements in safety, clinical effectiveness and personalised experience

What have we delivered in 2024/25?

- Implementation and embedding of Patient Safety Incident Response Framework with continued growth of a system Patient safety specialist network and ICS Patient Safety Community of Practice to provide system opportunities for improvement and shared learning.
- This pilot project to safely develop, test and deliver an innovative approach of implementing AI into a patient management system to lead to better process flow and outcomes in CHC that is now being scaled up
- Improvement work related to Learning Disability and Autism including exemplary work around sensory friendly GP practices and children and adult admission avoidance. Surveillance status downgraded to 'by exception' which is the lowest level of surveillance the system can achieve.
- Establishment of ICS Collaborative for C-Diff Quality Improvement
- Oversight and governance processes established across the ICB to ensure patient safety quality and patient experience are central to ICB oversight

What are the priorities going forward?

- Improving indicators and experience of emergency care
- Improving system position for C-diff trajectories through quality improvement.
- Focus on implementation of Primary Care Patient Safety Strategy
- Further strengthen patient safety oversight with the development of patient safety dashboard
- Establish an ICS Deterioration Network and develop ICS strategy for PIER framework and Martha's Rule
- Delivering the national ambition to reduce still births, maternal and neonatal deaths and intrapartum brain injury Check planning guidance

ICS System Quality Group

The ICS System Quality Group met bi-monthly during 2024/25. The key aim of the group is to generate a shared commitment to improving quality and enable progress to be made on key system wide priorities.

The Group consists of key senior leaders from across the ICS and partner organisations who have a commitment to continuous quality improvement. Through discussion on key agenda items members have started to establish agreement about key cross cutting system priorities for improvement that are not otherwise managed through ICS Programme Boards.

During 2024/25 members have shared learning themes generated from organisation, 'place', system or Regional level processes, for the purpose of enabling system wide improvement.

What are we measuring?

During 2025/26 population health level dashboards will provide refreshed opportunities to understand what matters to people and track progress against priorities

- Rates of infection and antimicrobial prescribing
- Trends in mortality from specific causes and excess mortality
- Key metrics aligned to Saving Babies Lives Care Bundle
- Metrics agreed within each Trust and the ICS Patient Safety Incidents Response Plan
- Agreed quality, safety and experience Patient Safety Dashboard

Who is accountable?
ICS Forum for Healthcare acquired infection, Local Maternity and Neonatal System Board, ICS Mental Health Collaborative, ICS System Quality Group, Quality, Resources and Delivery Committee

Where can we see more detail?
System wide strategies on ICS webpage

Next steps
Continue working with partners across the system and regulators to agree, through the ICS System Quality Group, key system quality priorities that add value over and above the quality focus of each of the ICS Programme Boards.

2. Clinical and Care Professional Leadership

Theme 2

Why is this important?

As a system we are committed to embedding clinical and professional leadership throughout Primary Care Networks, neighborhood's, place and system structures and in our multidisciplinary forums across Herefordshire and Worcestershire. We have very string Clinical and professional Leadership forums in our two places, which are key but also are developing a culture of grass roots clinical engagement in service redesign and the "Building a Sustainable future" Programme, the system is held acocuntable to this through the Clinical Advisory Subcommittee which oversees Clinical transformation and policy.

Clinical and professional leaders

- Are trusted voices – connected with patients, communities and people working in health and care services
- Have the knowledge and expertise to make difficult decisions about how to use our limited resources most effectively, taking account of these int eh decisions they make
- Can use their diverse professional voices to create innovative solutions to problems
- Work effectively together across system and place, avoiding duplication, adding value, making a difference
- Are committed to collaboration and will seek to understand each others' professions and the unique contribution they make to improving health and care outcomes for local people – Including those who haven't been as involved in the past.
- Will make time for networking and building relationships across sectors
- Build on good practice and what works well, understanding that the transition to statutory ICS is an opportunity
- Embody leadership values and behaviours reflecting and connecting place and system

What will we deliver and when?

Clinical and Care leadership through delivering priorities: There is a strong clinical presence in the existing governance structures in H&W that support clinically led decision making

- Clinical leadership in the delivery of the **Getting it Right First Time (GiRFT) priority clinical areas**, focused on clinical productivity as a key enabler for reset and recovery and supporting the best use of resources programme.
- Clinical engagement and leadership of the **Building a sustainable future programme.**
- ICB Medical director, chair the **Quality, Delivery and Oversight** group and **Clinical advisory sub-committee,** providing support and challenge around solution focused decisions.

Who is accountable?

Clinical leader are in post to increase the capacity and capability in the ICB, driving improvement and transformation, Reporting to the CMO:

- Deputy Chief Medical Officers
- Interim Chief Clinical information officer
- Primary care, Veteran, military health and Vaccinations
- Clinical lead for social change
- End of life
- Ageing well and frailty

Where can you see more detail and get involved?

- The Clinical and Care Professional Leadership Framework describes the approach.

3. Medicines and Pharmacy

Theme 3

Why is this important?

- Medicines are the most common medical intervention in the NHS[1] and are an important part of preventing disease or slowing disease progression.
- In England in September 2024, 1,054,989 people received 10 or more medicines with 429,259 of them being aged 75 or over (8% of the population) and 143,982 aged 85 or over (8.9% of the population).[2]
- In December 2024[3], 7.2% of over 75s in H&W were prescribed 10 or more regular medicines in primary care which is a slight increase on December 2023 but lower than the national average.
- A person taking 10 or more medicines is 3 times more likely to suffer harm and 16.5% of unplanned hospital admissions are due to adverse drug reactions and polypharmacy. Over a 7-year period there was a 53% increase in the number of admissions caused by adverse drug reactions.[2]
- However, medicines are not always taken correctly, and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1]
- The NHS in 22-23 spent £18.5 billion on prescribed medicines in primary care in England.[4] H&W annual spend on medicines is in excess of £230 million, with approximately £152 million in primary care.
- Antimicrobial resistance (AMR) which is the loss of antimicrobial effectiveness is increasing. The UK Government recognizes this and supports effective and careful use of antimicrobials (antimicrobial stewardship AMS) in the NHS. [5]
- Community pharmacy is an essential part of primary care, offering easy access to health services with 80% of people in England living within a 20-minute walk of a pharmacy.[6] Community pharmacy is delivering an increasing number of clinical services, supporting the primary care access recovery plan.
- The expertise of pharmacists and the role of pharmacy technicians has evolved and expanded significantly to deliver clinically focussed person-centred care integrated into multidisciplinary care teams and local systems across primary care, in general practice, in community care and in hospital pharmacy. This has led to pressures within the existing workforce which combined with the reforms to Foundation Year (FY) training for pharmacists makes workforce a key priority.[7]

Who is accountable?

- Medicines and Pharmacy Board, involving representatives from all sectors of the pharmacy profession across the ICS, with oversight of the Medicines and Pharmacy Strategy.

What will we deliver and when?

- Our vision is to ensure the population of Herefordshire and Worcestershire receive safe and effective access to medicines and technologies at the right time and in the right place. Working collaboratively, we will strive to improve and transform services, reduce health inequalities and deliver new ways of working, always keeping the population and patients at the heart of activity.

References

1. NICE Medicines Optimisation Quality standard Introduction | Medicines optimisation | Quality standards | NICE
2. Health Innovation Network: The mechanics of tackling overprescribing and problematic polypharmacy, February 2025
3. Data from Epact polypharmacy dashboard
4. NHSBSA: Prescribing Costs in Hospitals and the Community
5. NICE. Antimicrobial Stewardship
6. Delivery plan for recovering access to primary care. May 2023
7. NHSE. Initial education and training of pharmacists (IETP) reform. February 2024

3. Medicines and Pharmacy

Theme 3

	Our key priorities are:	What we have delivered in 2024/25	What we plan to deliver in 2025/26
Improve Health Outcomes	• Defined clinical use of medicines and technologies across the ICS through up to date and approved clinical policy, guidance and position statements.	• Horizon scanning and planning for new interventions anticipated during 2025/26. • Introduction of anticipated new medicines for endometriosis, kidney disease, migraine, and weight management. • Year 1 of a 5 year plan for hybrid closed loop systems for managing blood glucose in type 1 diabetes for those with greatest clinical need. • Extension of the eligibility for COVID-19 treatments • Ongoing work in relation to the National Patient Safety Alert on valproate	• Prioritising the introduction of new medicines for respiratory and kidney disease, skin problems, migraine, endometriosis, diabetes weight management and the menopause. • Year 2 implementation of hybrid closed loop • Further extension of eligibility for COVID-19 treatments.
Reduce Avoidable Harm	• Working across all sectors to co-ordinate work designed to improve medication safety focusing on high-risk medicines. • Focus on safety as patients move between organisations eg. discharge from hospital with changes to medicines supported by the Discharge Medicines Service (DMS) across the ICS. • Increase system awareness and undertaking in medicines audits. • Support and implement local antimicrobial stewardship (AMS) plans.	• Increasing the use of the Discharge Medicines Service • Introduction of an ICS Medicines Safety Group • Production of a primary care AMS dashboard to focus on total antimicrobial prescribing, course length and choice of antimicrobial agent.	• Re-launch of Community Pharmacy Intervention Scheme • Reduction in total antimicrobial prescribing • Production of structured medication review data to support the national drive to tackle over prescribing • Participate in national project work to address inappropriate antidepressant prescribing • Use the ICS Medicines Safety Group as forum to oversee implementation of National Patient Safety alerts and share learning.
Productivity & Achieving Best Value	• Working with clinicians to ensure cost effective medicines choice and reducing use of medicines or technologies considered ineffective or low priority.	• Improved use of technology e.g Electronic Prescribing and Medicines Administration system (ePMA) • Introduction of biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Updated pathways for use of medical retinal treatments. • Improved use of blood glucose testing strips with the lowest acquisition costs.	• Introduction of more biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Review use of first line biologic medicines used for chronic diseases • Improved use of Hybrid Closed Loop devices with the lowest acquisition cost • Normalising use of generic consenting principles to ensure early adoption of cost-effective agents
Service Delivery & Sustainability	• Develop a pharmacy workforce plan to help build a sustainable workforce across all sectors of pharmacy • Using community pharmacy professional expertise for common conditions management; safe medicines use following hospital discharge; blood pressure checks; contraception services; vaccination services and new clinical services as they are introduced. Ensure referral pathways are robust for complete episodes of care.	• Production of Pharmacy Faculty workforce newsletters, attendance at careers/recruitment events and supporting providers with the Foundation Year training reforms. • Introduction of Pharmacy First service; Blood Pressure Checks and Contraception services through community pharmacy. • Community Pharmacy Independent Prescriber Pathfinder Programme.is live in all HW approved sites • Working together locally and across the Region to understand and plan for future service needs to support the aseptic (sterile) preparation of medicines. • Community Pharmacy PCN Engagement Role employed to increase collaborative working between GP practices and pharmacies – focusing on and integrating work into the neighbourhood accelerator work • Delivered a Pharmacy Connect IP Teach and Treat programme to build independent prescribing in the community pharmacy setting	• Evaluation of Community Pharmacy Independent Prescriber Pathfinder Programme. • Development of strategies for workforce and community pharmacy to complement the overall Medicines and Pharmacy Strategy. • Explore options for improving the number of pharmacist FY placements in Herefordshire and Worcestershire e.g. by creating a database of Designated Prescribing Practitioners (DPP) and supporting existing pharmacist Independent prescribers to become DPPs • EPMA roll out should increase DMS referrals – work closely with Acute Trusts • Further increase vaccination programme delivery via community pharmacies
Greener NHS	• Promote the use of environmentally friendly medicines and packaging	• Ensuring sustainability considerations for all new medicine applications. • Promoting switches away from unit dose eye drops to alternative preservative free eye drop bottles. • Eliminating the use of desflurane by using lower carbon anaesthetic gases	• Improve use of inhalers with a lower carbon footprint • Consideration of available medicine/device recycling schemes. • Identifying solutions to reduce use and waste of nitrous oxide

4. Health Inequalities

Theme 4

Why is this important?

- ICB's and Local Authorities have legal duties to have regard to reduce health inequalities.
- The NHS Long Term Plan requires every local area to develop plans and take action to reduce health inequalities.
- The range in life expectancy across the social gradient of the region is 7.9 years for men and 5.6 years for women in Worcestershire; (Fingertips Public Health Outcomes Framework) and 5.4 years for men and 4 years for women in Herefordshire (Herefordshire JSNA Summary 2024).
- Marmot Review estimated that health inequalities cost society £31bn in lost production per annum, in 2010 prices. Whilst this is a national figure, its in local jobs and economies where this impacts.
- The additional treatment costs of health inequalities are estimated to be in the region of £5.5bn per year to the NHS. These will be replicated locally – equivalent to around £77m on a flat population share basis.

What have we delivered in 2024/25?

- Established the Health Inequalities Ambassador (HIA) Network comprising of 25 named individuals representing every ICS programme Board and enabler group, to apply a health inequalities to everything the system delivers. An innovative approach that has been recognised as best practice nationally.
- The ICS HIPP Board has received 12 health inequality focused discussions by HIAs across a range board and work areas.
- ICB allocated £4.4m to work programmes that have tackling health inequalities as their core purpose. With most funding allocated out to Primary Care Networks (PCNs) - over £3.9m to support the development and delivery of local health inequality plans and CVD targeted improvements as part of the Clinical Excellence and Investment Framework (CEIF).
- Development of a Core20PLUS5 dashboard by PH Herefordshire, using EMIS data for to support PCNs with the identification and development of projects to address health inequalities, as funded through CEIF.
- PH Worcs LSOA analysis of statistically high ED admissions to help inform targeting of preventative programmes of work to address unmet need.
- This includes the ICB and partner commissioned outreach prevention services in Herefordshire and Worcestershire, targeting our most underserved communities offering a range of services to meet individual needs. The Herefordshire service was shortlisted for a national award and the Worcestershire service has won an award.
- A mid-point evaluation has been completed independently by Worcester University which has provided a Plan, Study, Act, Do cycle ensuring the services continually improve and flex the local needs and insight.
- A pilot of the high intensity user programme with the British Red Cross in Worcester has been evaluated and will be rolled out across Herefordshire and Worcestershire in 2025/26. This will complement the upstream work of the LSOA ED analysis, to intervene earlier.
- The ICB was successful in a bid for Community Connectors across H&W. Employed and managed by the VCSE, the Connectors are engaging with GRT communities and Pakistani and Bangladeshi women to uncover the insights on barriers to healthcare. The valuable insights are being shared across the system services and programmes to make changes that improve access, experience and outcomes.
- This includes read across to the partnership cancer health inequality programme with Macmillan – which focuses on the same cohorts.

What are the priorities going forward?

- The aim of the ICS Herefordshire & Worcestershire strategic intent remains to make addressing health inequalities everyone's business,, through the continuation of a range tangible actions:
- A review of the HI Ambassador Network will provide a series of recommendations to enhance and strengthen the network.
- Maximising on our outreach prevention services by removing barriers to access to secondary prevention services, by targeting areas using data, engagement and evidenced based interventions.
- Delivery of the DWP Workwell programme through PCNs, supporting people who at risk of leaving employment due to ill health, to remain or return to work.
- Continuing to build awareness and skills within the workforce of the practical and relevant actions that can be taken to reduce health inequalities, to make it everyone's business.
- Evaluation of the outreach prevention services and a view on long-term sustainability.

What are we measuring?

- Development of a Health Inequalities, Prevention and Personalised Care dashboard, by bringing together HIPP related metrics from across all ICS Boards into a single view to track progress.

Who is accountable?

- Health Inequalities SROs have been identified within ICB and across all provider Trusts.
- Responsibility and delivery of reducing health inequalities sits at system, Place, PCN and neighbourhood level – as such it should cut across all work.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health.

Where can you see more detail and get involved?

CORE20PLUS5 (england.nhs.uk)
CORE20PLU5 Children and Young People(england.nhs.uk)

5. Prevention

Theme 5

Why is this important?

Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022:

"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness".

What have we delivered in 24/25?

- Tobacco Dependency services fully implemented across all acute inpatient, mental health inpatient and maternity services in H&W as of June 2024. This achieves the Long Term Plan (LTP) deliverable of all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- There have been 2,012 eligible referrals into the Digital Weight Management Programme (DWMP) between April 24 and January 25, achieving 80% of the target so far. H&W have consistently been in the top 10 referring ICBs nationally for the DWMP for this financial year so far as of January 2025 data, as well as having the highest number of practices referring into the programme (91%).
- There have been 4,198 referrals into the NHS Diabetes Prevention Programme (NDPP) between April 24 and February 25.
- There have been 225 accepted referrals into the Type 2 Diabetes Path to Remission Programme between April 24 and January 25. There is an 80% acceptance rate for referrals into the programme. 127 service users have reached 6 months and have an average weight loss of 12.5kg. 38 service users have reached 12 months and have an average weight loss of 9.6kg.
- Continuation of the prevention outreach response services in both Herefordshire and Worcestershire, providing opportunistic testing of AF, blood pressure and lipid optimisation to our most underserved communities.
- CVD strategy has been drafted. An ICB Workshop was held in November 2024 to discuss opportunities to raise profile of national CVD high impact interventions.
- The development of a local dashboard and intelligence to map the patient journey. This work will complement the CVD Prevent Dashboard and information on this has been shared to promote engagement.

What are the priorities going forward?

- A broader review of the weight management pathway e.g. needs assessment, ICS system engagement.
- Exploration of targeted work with the National Diabetes Prevention Programme local provider, and GP practices to encourage referrals from PLUS groups (GP unregistered and rural communities) and exploring opportunities for LD/A groups.
- Delivery of prevention outreach service – targeting of GP unregistered citizens and the most underserved populations.
- Continuing to support Public Health colleagues and partners with the Loneliness and Isolation work within Worcestershire e.g. community grants.
- Monitoring of the delivery and implementation of the Joy Social Prescribing App across Worcestershire PCNs.

What are we measuring?

- A key element to the NHS LTP is tackling tobacco dependence, as tobacco smoking is the largest modifiable risk factor for health. The NHS will contribute to reducing the number of people smoking tobacco by delivering on the commitments outlined in Chapter 2 of the document: Prevention and Health Inequalities.
- To help tackle obesity, the LTP states that the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ *(also outlined in the above link to Chapter 2 of the LTP).*
- These metrics will be encompassed as part of the development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2025)

Who is accountable?

- Prevention SROs in place across the system provider organisations.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function is to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

- Information relating to the Long Term Plan priorities can be found here.
- Data is collated on the Regional Dashboards which can be accessed through the FutureNHS Collaboration Platform.
- Details around Your Health and Talk Wellbeing can be found on the ICS website. Information around what the service entails and upcoming events are included:
- Your Health – Worcestershire
- Talk Wellbeing – Herefordshire

6. Personalised Care

Theme 6

Why is this important?

Personalisation means health and care services delivering what matters most to each individual in a way that meets them where they are at. Engagement with our local population has told us that this relies on people having clear expectations of what is expected of them and what they can expect of their health and care professionals and services. Services are then able to offer support that is appropriate to the individual's level of need, making the best use of resources and getting the individual to the right support at the right time.

The Comprehensive model of Personalised Care outlines a three-tier approach to implementation: Universal (whole population) interventions; interventions targeted at those with Long-Term Conditions (LTCs) (30% of the population) and specialist interventions (5% of people with complex needs) (NHS, 2019). The NHS Long Term Plan outlines six interlinked components which underpin delivery: Shared Decision Making (SDM); Enabling Choice; Social Prescribing; Supported Self-Management (SSM); Personalised Care and Support Plans (PCSPs) and Personal Health Budgets (PHBs).

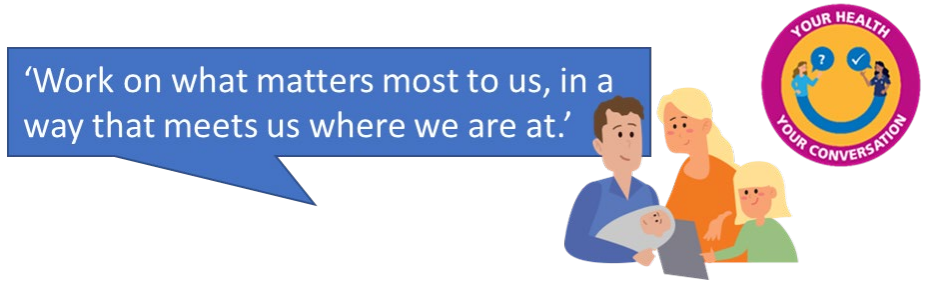
Supporting people with LTCs to self-manage is critical to addressing the rapidly growing demand this population represents . Our approach to supporting people to live well with their LTCs is to to raise awareness of how an individual's knowledge, skills and confidence, also termed activation, impacts on their ability to self-manage.

What have we delivered in 24/25?

- Developed and enhanced our training offer through the ICS Exchange platform. This now includes a Health Literacy training package and more modular and practical training.
- A health literacy network has been established, which is developing system wide health literacy commitments and a self-assessment tools to assess organisational maturity.
- A Personalised Care Toolkit has been developed to support system wide colleagues to implement personalisation approaches.
- There have been multiple examples of patient information improvements across the system, e.g. a Pulmonary Rehabilitation Guide, Endometriosis and Frailty videos.
- We continue to promote and develop our Long Term Condition video library, which provides health literate information on a range of topics.
- We piloted a Family Coaching service for children who are overweight, demonstrating positive outcomes from a whole family approach, the learning from this pilot has informed the children's hubs in Worcestershire and the service has been embedded in Herefordshire.
- We have piloted a service for high intensity users of urgent and emergency care services, SupportingYou. This is demonstrating a reduction in A&E attendances.

What are the priorities going forward?

- Continuation of the Supporting You Service in Worcestershire.
- Continuation of the Health Literacy programme.
- Continued development and delivery of the Health and Wellbeing and LTC video library.
- Promotion of the Peer Support Worker offer.
- Embedding use of Patient Reported Experience and Outcome measures across priority LTC services.



What are we measuring?

The dashboard that is in development is anticipated to measure: numbers of PHBs, number of personalised care and support plans (PCSPs), numbers of ARRS role team members and referrals to their services, the number of people accessing personalised care training and the number of registered carers. There are also specific outcome measures in place for the services that are being piloted and for the video library.

Who is accountable?

The Health Inequalities, Prevention and Personalisation Board is responsible for delivery of Personalised Care. This is a system wide meeting, with membership across health, the local authority and the Voluntary, Community Social Enterprise. The SRO is the ICB Chief Nursing officer.

Where can you see more detail and get involved?

Health Literacy - https://teamnet.clarity.co.uk/Topics/ViewItem/5813997c-1f90-477c-9de9-b10e00e42f56

Personalisation Toolkit - https://teamnet.clarity.co.uk/Topics/ViewItem/1680689e-80fe-4368-898e-b086007d97da

Any queries, please email: hw.personalisedcare@nhs.net

7. Working with Communities

Theme 7

Why is this important?
Our ambition is to place greater emphasis on early engagement and ongoing dialogue and partnerships with people and communities. From these early, open and genuine conversations we can work together with local communities, who are often better placed to create solutions to the health challenges we face.

What have we delivered in 24/25?
During 204/25 we have worked with all of our partners across the system to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This has included supporting people to sustain and improve their health and wellbeing, as well as working with people and communities to develop our plans and priorities, address health inequalities, and co-design services that equitably address the health challenges that our population faces.

Our key deliverables are detailed within the People and Communities Annual Reports and the Insights Reports:

1. People and Communities Annual Report – These reports are published annually and detail how the ICB has worked with ICS partners to engage with people and communities at a system, place and local level.
2. People and Communities Voices Report – Published quarterly, these reports collate soft intelligence and highlight key themes from the feedback garnered from people, communities and ICS partners, from across Herefordshire and Worcestershire. These insights are fed back to the key ICS and ICB decision makers for their consideration and to highlight any cross-cutting themes between services and areas of focus.

Some examples of our work include:

- NHS 10 Year Plan – Facilitated and ran two engagement events on the NHS 10 Year Plan. Representatives from Patient Participation Groups (PPGs) and health services from across Herefordshire and Worcestershire, joined us for two sessions. The interactive and informative sessions focused on national and local health priorities. Attendees had the opportunity to network, have their say on the NHS 10 Year Plan , engage on local plans, share best practices, and learn from each other's experiences. There was a lot of in-depth discussions and feedback generated from the two gatherings. The ICB has fed all the comments generated into the national NHS Change consultation, as well as internally using feedback to improve local health services and work on Integrated Neighbourhoods.
- Palliative and End of Life Care – This engagement exercise sought the views, stories and experiences of people who live, work or receive care in Herefordshire and Worcestershire, specifically targeting people who were receiving palliative or end of life care, those in the last year of life, and including carers. The feedback received was fed back to the programme board and will be used to shape the new Palliative and End of Life Care Strategy.

Priorities going forward
We intend to:

- Listen more and broadcast less, and where engagement is an ongoing and iterative process focused on what matters to people, not something 'done once'
- Hold ongoing conversations with communities about healthcare, built around community groups, forums, networks, social media, and any other place where people come together as a community
- Provide clear and timely feedback to local people about the impact of their involvement
- Develop plans and strategies that are fully informed by engagement with the public and patients
- Use insights and data to improve access to services and support reduction of health inequalities
- Focus on early prevention and supports communities to develop their own solutions to improving their health and wellbeing

Specific programme areas of focus are the NHS Ten Year Plan, Building a Sustainable Future (BSF) Programme and stroke services reconfiguration.

What we're measuring
- The ICB's compliance with undertaking our legal duties to involve the public in decision-making about NHS services.
- The feedback, sentiment and key themes that we have gathered from undertaking engagement with people and communities in Herefordshire and Worcestershire.
- The demographic details of the people and the communities we engage with. This is to ensure that we are listening to a wide and diverse range of people, and to highlight where more engagement needs to be undertaken with specific people, groups and communities.

Who is accountable?
- NHS Herefordshire and Worcestershire Integrated Care Board is responsible for ensuring that the statutory duty to involve are met across the system.
- The ICB is responsible for arranging effective health and care services for the Herefordshire and Worcestershire population; demonstrating that decision-making is clearly informed by insight
- Herefordshire and Worcestershire Integrated Care Partnership Assembly is responsible for ensuring that strategies for health and wellbeing are based on the needs and aspirations of local communities, and open to scrutiny and challenge
- The One Herefordshire Partnership and Worcestershire Executive Committee are responsible for delivering health and care services shaped by local need

Where can you see more detail and get involved?
Please see our strategy 'Working with people and communities in Herefordshire and Worcestershire' or for more information or contact the ICB Engagement Team.

8. Commitment to Carers

Theme 8

Why is this important?

Carers are a diverse group, and every caring situation is unique. Carers are people who care for a family member, a friend, or another person in need of assistance or support with daily living. They include those caring for children who have a disability or additional needs, older people, people living with long-term medical conditions, people with a mental illness, people with a disability, people with addiction, people experiencing substance misuse and those receiving palliative care.

The degree to which a carers own life is impacted by their caring role will vary. Parent carers are most likely to be caring the longest and experience the greatest financial impact. Some carers may find themselves caring for more than one person. The physical demands of caring may be greatest for those whose cared for is disabled or is frail. The emotional demands on carers may be greatest for those caring for someone at end of life or caring for someone with poor mental health.

According to the last Census (2021), there were 16,501 and 52,547 carers in Herefordshire and Worcestershire respectively, of which 7,701 (47%) and 25,171 (48%) care for more than 20 hours a week. This represents a rise in proportion of carers providing higher levels of care than in the previous census (around a third). Carer support organisations are in touch with 5,500 carers in Herefordshire, and 14,547 in Worcestershire. Worcestershire Association for Carers receives around 600 referrals per month, 85% of which result in 1 to 1 support. Local intelligence tells us that the complexity of caring roles is increasing. This includes carers maintaining responsibility for increasingly complex clinical needs against increasingly stretched finances. The number of carers is expected to rise by at least 60% by 2030 (Carers Trust).

By supporting carers, we enable people to remain living well within their communities, reducing the demand on health and social care and improving the health and wellbeing of both the carer and the cared for.

What have we delivered in our second year 2024/25?

1. Continued to support system partners to progress against Commitment to Carers statements.
2. Facilitated regular ICS Carer Reference Group (CRG). Key areas progressed include:
    - Empowering Carers at Discharge – working with pilot inpatient wards as part of the Accelerating Reform Fund project to identify and support carers, capturing learning to share systemwide
    - Improved recording of carer status across system partners.
    - Herefordshire carers strategy refresh and introduction of the Herefordshire Carers Partnership forum
3. Enabled opportunities, through the CRG and place-based forums, for carers to share their views and lived experience, and contribute to co-production of improvements in carer support.
4. Incentivised the following areas in primary care through the 2023/24 CEIF contract:

- Identification of GP practice carers lead.
- Delivery of carer awareness training.
- Drive to increase the number of carers identified and recorded in EMIS.
- Signposting to local carers support.
- Proactive offer of other support to carers, e.g., social prescribing.

What are the priorities going forward?

1. Continue the drive to recognise and support more carers across the system.
2. Capture and share Accelerating Reform Fund learning to enable improvement in carers support across Herefordshire and Worcestershire.
3. Continue to support carers forums across the two counties, strengthening the carer voice in planning and provision of services.
4. Work with system partners to develop carer awareness training package for staff.
5. Work with system partners to ensure carers voices are heard and the profile of work in support of carers is raised.

What are we measuring?

1. The number of carers identified across the system.
2. Qualitative progress towards the system Commitment to Carers by each provider organisation.
3. Feedback on patient and carer experience of services via periodic Healthwatch surveys.

Who is accountable?

The Carers programme is a component of the Personalised Care programme and accountability sits with the Health Inequalities, Prevention and Personalisation Board. The Carers Reference Group was established to develop and enable delivery against our system commitment to carers. These commitments are integral to place-based Carer Strategies held by our County Councils, which are supported by carer partnerships in both Herefordshire and Worcestershire.

Where can you see more detail and get involved?

Visit the ICB carers resource hub: [Resource Hub for Family, Carers and Loved Ones :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)]

9. Supporting the Armed Forces Community

Theme 9

Why is this important?

The Armed Forces community is made up of serving personnel, veterans and their Family's and carers. There are an estimated 2.4 million veterans living in the UK. Within Herefordshire and Worcestershire there are currently approximately 30,000 military veterans. Herefordshire and Worcestershire ICB has a high density of veterans making up about 4.7% of the patient base. The Armed Forces Act 2021 makes it a legal duty on specified public organisations to have due regard to the principles of the Armed Forces Covenant when exercising their functions. These duties apply to ICBs. As an ICB we are working with system partners to give due regard to the health and social care needs of the Armed Forces Community in the planning and commission of services. We are working on building our engagement with this community to build our understanding for how we can support their health and wellbeing.

What have we delivered in our second year 2024/25?

Within the first two years alongside signing the armed forces covenant, the ICB has been an integral part in supporting this cohorts through both primary and secondary care. Leads from the system were invited to an Armed Forces Health Symposium where there were valuable conversations to take away to help deliver the promises to the Armed Forces Community.
With the introduction of the Talk Wellbeing Service in Herefordshire, they have reported a large number of veterans engaging with their services and through the training which has been undertaken by the team has supported clinicians in engaging with this group.
More practices in Worcestershire are signing up to the veteran friendly practice scheme too with compared to the first year we are nearly 10% higher in sign up rates.

What are the priorities going forward?

Within the next year it is key to ensure that we can continue to keep signposting the Armed Forces community to healthcare available within the system and to continue the identification of them within the healthcare system.
We will continue to encourage practices to sign up to the veteran friendly practice scheme.

What are we measuring?

There are two key measurables which we are working towards.

1. Increasing the number of veteran friendly practices across Worcestershire (as Herefordshire are already 100%). This is being collated by the Royal College of General Practioners
2. Increase the number of coded veterans on clinical system, initially in Primary Care. This is being supported by local BI teams to assist in sourcing the data.

Who is accountable?

The Clinical Lead on the project is Dr Jonathan Leach OBE, with project management in place to support. This will be delivered through following the key commitments from the Armed Forces Forward View that ICBs use indicators to measure progress. We will work with partner and provider organisations to develop and deliver objectives and actions to reduce any health inequalities and improve healthcare for this population. We will work closely with the service users to understand their needs and requests within the services.

Where can you see more detail and get involved?

If you have any questions or for more information on how to get involved or how this community could benefit your work, please email: hwicb.partnerships@nhs.net

10. Addressing the specific needs of victims of abuse

Theme 10

Why is this important?

The ICB has a duty to address the particular needs of victims of abuse, including an assessment of need. Working with health, social care and statutory partners to support victims, tackle perpetrators and prevent abuse. This includes reducing the health inequalities faced by victims of abuse.

There are a range of initiatives and services in place that will be built upon over the lifetime of the joint forward plan, these include:

- The Serious Violence Duty (SVD) is based on a public health approach which requires co-operation and collaboration including data across a range of partners. This approach to tackling violence means looking at violence not as isolated incidents or a sole police enforcement problem. It is about taking a multi-agency approach to understanding the causes and consequences of serious violence and focusing on prevention and intervention.
- Training plan to support upskilling of talk wellbeing and your health outreach services to spot those vulnerable to domestic abuse / serious violence etc
- Collaboration between Policing partners and roving vaccination teams in areas of deprivation and inequality.
- Pan West Mercia data group in place – With leadership from Herefordshire Council.
- District collaboratives – working between district councils, primary care networks, community support officers, voluntary sector to identify needs in the local community
- Funding secured by Herefordshire PCN's to collaborate with 3rd sector organisations supporting victims of domestic abuse, exploitation and youth crime.

What have we delivered in our second year 2024/25?

Services have been developed and commissioned responding to identified cohorts or individuals to support prevention and reduction in serious violence, these are listed below:

- Serious violence duty actions including strategic needs assessment to support action.
- SVD - Develop system wide data group in partnership with Police, Local Authority, West Midlands Ambulance Service, CSPs and other relevant organisations.
- Worked with partners in preparation for implementation of the Victims and Prisoners Act (2024).
- Delivered trauma informed care training, supported by the Integrated Care Partnership Assembly.
- Commitment to integrate the Workwell programme, supporting people to get back to and stay in work, with the IRIS programme in 2025/26.
- Supported the White Ribbon Campaign across system partners, seeking to end male violence against women and girls.

West Mercia Rape & Sexual Abuse Support Centre

WEST MERCIA WOMEN'S AID

What are the priorities going forward?

There are a number of services and programmes in place to ensure that we are addressing the needs of victims of abuse, these include:

- **Domestic Abuse and Sexual Violence:** Working with the Police and Crime Commissioner as interim convener of the Victims and Prisoners Act 2024, implementing required actions.
- **IRIS:** A specialist domestic violence and abuse training support and referral Programme for General Practices that has been positively evaluated in a randomized controlled trial. Iris is a collaboration between primary care and third sector organisations specialising in domestic abuse. This service will continue in 2025/26 in Herefordshire, supported by Herefordshire Council and NHS Herefordshire and Worcestershire.
- **Climb:** A service which delivers early intervention and prevention for those at risk of criminal exploitation.
- **Purple Leaf and West Mercia Rape and Sexual Abuse Support:** A charity providing specialist front line support independent advocacy counselling and those affected by any form of sexual violence
- **Drive perpetrator programme:** A project which aims to reduce the number of child and adult victims of Domestic Abuse by deterring the perpetrator (in Place).
- **Steer Clear:** Prevention Programme working with young people who have been or could be involved in knife crime, continuing in 2025/26.

What are we measuring?

The overall approach is to ensure that all partners are sharing data and intelligence to build up a comprehensive picture of individuals and communities at risk of serious violence, domestic abuse or sexual violence. Those key hotspots across the system are being looked at and appropriate interventions will be put in place. This will be developed during 2025/26, working with West Merica Police and broader partners through Community Safety Partnerships.

Who is accountable?

The integrated care board (NHS Herefordshire and Worcestershire) has a specific duty to address the particular needs of victims of abuse. This will be delivered at place through the Herefordshire community safety partnership, Worcestershire community safety partnership and the crime reduction board.

11. Digital, Data, Analytics and Technology

Theme 11

Why is this important?

We cannot improve health outcomes and reduce health inequalities without data and technology, which is key to making health and care services more accessible to parts of our communities. This can be via remote and virtual care, better planning of services and enhanced sharing of patient information. Technology and data can play a core role to reduce elective backlogs, mitigating urgent care pressures, continuing to deliver responsive and timely community and primary care. Digital products can enable personalised preventative care by giving people more control over their lives by providing self-assessment, education, motivation and monitoring to help them manage their own health. We must ensure digital services are inclusive and provide for everyone's needs by listening to and designing with communities with seldom heard voices more closely.

What have we delivered in 2024/25?

- Written and published the system's Digital and Cyber Strategies to outline our ambitions and direction of travel.
- Continued the work on optimisation and increasing adoption of the Shared Care Record. This included a comprehensive evaluation of the service to date and taking action on the findings.
- Developed and enhanced our patient facing digital offer and Patient Portal to provide a front door to patients under our care.
- Worked closely with our system partners in work towards levelling up digital maturity.
- Embedded the enhanced BI and analytics service, delivering more aligned and standard performance and BI reporting and tools. Continuing to progress with the capabilities needed for effective population health management.
- Continued to work on refreshed technology to support staff capacity, efficiency and organisational productivity specifically unified communications, telephony and networks.
- Commenced work on Artificial intelligence pilots and initiatives to support productivity.

What are the priorities going forward?

Pillar 1: Getting the right infrastructure in place

- Sourcing and developing the essential operating systems, technology and software to enable us to deliver the best outcomes
- Levelling up the digital maturity and architecture of organisations

Including: Shared Care Record, Electronic Patient Records, Frontline Digitisation.

Pillar 2: Enabling integration of our data sources

- Ensuring systems and applications can talk seamlessly to each other – maximising interoperability
- Improving information to support decision-making

Including: Data Sharing Agreements, Agreed Standards, Data Security/Protection, Groundwork for Population Health Management and Federated Data Platform.

Pillar 3: Creating an environment to enable people to self-serve

- Providing our people with easy-to-use apps and systems, where they can access their information and help manage their own care and needs, closer to home where possible

Including: Patient Portal/NHS App, Patient access to their records, Improved and accessible information

Pillar 4: Supporting the transformation of services 'around the user'

- Ensuring all NHS staff have access to and are trained in the use of the right tools and systems to deliver the best care to and outcomes for our people

Including: AI and Automation Principles, Continuing Health Care, Piloting newer technologies

What are we measuring?

Each project measures outcomes and success. This will include improvements in productivity, efficiency, usability and usage. For example the number of people across our system using the Shared Care Record.

Who is accountable?

One of the ICS Programme Boards focuses on Digital, Data, Analytics and Technology and brings in the ICS Digital Clinical Leads, these two groups will be responsible for setting the digital agenda and collective vision. Their work will be informed by the ICS Analytics Board, Technical Design Authority and Clinical Safety Officer Group on digital transformation and improvement.

There are a number of Groups and Boards focusing on the technicalities of the deliverables including Shared Care Record, Cyber and Data Security and Primary Care. Based on the structures already in place in the NHS Trusts and primary care system in Herefordshire and Worcestershire, the ICB Digital Leaders will work closely with the organisation Boards and Steering Groups. There are strong links to the other five ICS Forums where digital plays a central role and vice versa delivery teams are accountable for the outcomes they are set up to deliver.

Where can you see more detail and get involved?

There is a digital section on the ICB website

Digital innovation :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

12. Research and innovation

Theme 12

Why is this important?
As a system we recognise the importance of promoting research an innovation in the provision of healthcare. The ICB Medical Director holds the responsibility for promoting this, ensuring it is clinically led and underpins the delivery of the Joint Forward plan.

What will we deliver and when?
- **Assets:** ICS Academy, Knowledge and research school, The Herefordshire and Worcestershire research consortium. Worcester University - Allied health professional school. I&I Bid – Engaging underrepresented communities. (Personalised care.) Innovation – Pods. Research network.
- **Resources:** Increase access to funding, ,E.g. NHIR and working in partnership with the academic health science network.
- **2024/25 priorities:** Delivering the new **5 year research and innovation strategy** developed and published last year. This will be led by the Herefordshire and Worcestershire research consortium, reporting into the ICS academy steering group.

Innovation - What are we building on?
To help promote innovation across the system, the ICB has created an Innovation Hub called: The CO-LAB www.icscolab.org.uk We believe this is the first example of an ICB-led Innovation Hub. It exists both virtually and physically, located deliberately in a rural community hospitals (Kidderminster Treatment Centre), where we know innovation traditionally receives less focus, but has real chance of improving health services. Approaching it's first year operating, it has had a number of successful initiatives and adoptions of innovation, including:

New Ways of Working and developing new knowledge:
- In partnership with Warwick University's "West Midlands Health and Wellbeing Innovation Network WMHWIN", The CO-LAB ran a 5-day Agile approach for one of our Trusts to help them co-design a new Heart Failure @ Home pathway with a "User focus". The co-design event included staff, commercial innovators and patients. Outputs included a framework for staff to use if interested in this type of approach, supplemented by education webinars.
- It is regularly used as a space anyone in the ICS can use for free to re-imagine pathways and processes. For example, it's used monthly by one of the trust's Transformation guiding board as part of it's Virginia Mason Programme.

Trial and Adoption of Innovation:
- The CO-LAB hosted certified VR anti-anxiety headsets and approached teams to trial. Following a successful trial on our Pediatric Oncology wards, where they reduced anxiety in children needing cannulas, improving patient experience and reducing clinic time, a number of headsets have been purchased for long-term use on those wards and are being trialed across multiple other wards within two Trusts (one within our ICS and one in a neighboring ICS)
- As the host for the first teleconsultation pod from a French-based innovator, The CO-LAB has worked extensively with the company on feasibility, demoing and real-world testing. The pods are now being used in the South East of England and is being deployed in system as part of an NIHR bid for the ICS.

Partnerships:
- The CO-LAB has partnered with innovative organisations to understand opportunities and art-of-the-possible to highlight to workstream leads, these include:
    - ICS Partnership with Amazon Web services, where the ICB participates in their Global Healthcare Incubator.
    - Satellite Catapult, currently arranging a trial of drone technology
    - IASME, working with a local innovator to train unemployed Neurodiverse young people for employment in cybersecurity
    - Partnership with multiple Universities, including a successful partnership with the University of Manchester on a systematic review of literature on the implementation of AI in health and care

Staff and wellbeing:
Early on in the hub's life it became apparent there was a significant ask for finding and spreading innovation practice for wellbeing of staff. Initiatives have included:
- Partnering with a Hypnotherapy provider, we setup an agreement to offer the hub's use whilst closed in return for free provision of sessions to front-line staff to address anxiety, sleep deprivation and relaxation. Sessions typically have 20 attendees, with great feedback
- The Hub is provided free of charge to ICS groups who want to host staff celebration or wellbeing events. For example, it is used as part of the International staff process, providing an area for them to come together, and celebrate pre-exam.
- NHSE provided sessions for Wellbeing in Leadership Roles, is being hosted at hub for several trusts in and out of the ICS.

Herefordshire and Worcestershire Research consortium
- Is the system wide group overseeing research in the system, we are looking to widen its brief to look at innovation too as part of the strategy refresh.
- It monitors performance / recruitment across the system, but also looks to broaden the scope of our research beyond organisational boundaries, looking at how we work with the local university as it develops
- Will hold oversight of delivery of the new strategy.
- Now reports into the ICS academy steering group, where previously it was not part of any formal governance.

13. Greener NHS

Theme 13

Why is this important?

The climate emergency is also a health emergency.

Poor environmental health contributes to major diseases including cardiac problems, asthma and cancer. Unaddressed, it will disrupt care and affect patients and people at all stages of their lives. Climate change impacts every single person and as such we all have a duty and responsibility to do something about it.

Herefordshire and Worcestershire ICS are committed to embedding environmental and sustainable practices into all areas of our work, as an enabler for better health. We see the work of the green agenda aligned to our principles of delivering high quality care; reducing health inequalities and improving the health and wellbeing for the communities we serve.

Reducing emissions will mean fewer cases of asthma, cancer and heart disease. Many of the drivers of climate change are also the drivers of ill health and health inequalities. In the UK, air pollution is attributable for 1 in 20 deaths, making it the greatest environmental threat to health. We can all play our part in tackling climate change through reducing harmful carbon emissions, which will improve health and save lives.

Environmental health impacts are often unfairly weighted in areas of deprivation and minority ethnic groups. For example, Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.

What have we done in our second year, 24/25?

- Deepened relationships with public sector partners to support strategic developments and build awareness to our populations
- Continued to embed the system-wide ICS wide Sustainability Impact Assessment (SIA) into decision making.
- Increased the number of virtual appointments and virtual wards available to our patients thereby reducing carbon emissions through travel.
- Continued to reduce the amount of nitrous oxide used through identifying leaks within our system and changes to manifolds.

What are the priorities going forward?

- To refresh the HWICS Green Plan for 2025-8.
- To continue to increase the use of low carbon inhalers.
- To continue to strengthen our networks and connections to create greater impact.
- To strengthen our focus on Clinical Transformation pathway opportunities.
- To support our efficiency and productivity agenda by reducing waste across the system.
- To support delivery of social value

Who is accountable?

- Greener NHS SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of Trust Green Plans sit at Trust provider level.
- Collectively agreed ICS Greener NHS actions sit at ICB level, working collaboratively with Providers to deliver through their existing governance groups.
- Engagement is undertaken directly with SROs, and operational working and engagement through a system Sustainability Leads group.

Where can you see more detail and get involved?

- ICS Green plan
- ICB Green Board papers

14. Mental Health Collaborative

Theme 14

Where we are now? – What we have achieved together

The Mental Health Collaborative met the national targets for:

- perinatal mental health
- access to mental health services for children and young people
- access to community mental health services
- recovery and improvement rates for people who have received talking therapies
- health checks for people with severe mental illness

The Collaborative recognised the challenge of Dementia diagnosis in our system, establishing a separate programme board with exclusive focus on Dementia care. A plan to improve dementia diagnosis is now in place that is tackling raising awareness and improving support for people living with Dementia.

A revised model of children and young people's emotional wellbeing and mental health service was procured, resulting in Melo being launched in April 2025.

The Collaborative conducted a governance review in 2024/25 to ensure there was greater focus on programme delivery, clearer accountability to the ICB and stronger collaborative strategic leadership.

Where next? – Areas of focus

The Collaborative will focus on five key delivery areas for 2025/26:

- Improving children and young people's mental health so there is multi-faceted and stratified support offer to children and families. This will include embedding the new Melo service, further expansion of MH in Schools and roll-out of Primary Partnership in Neurodivergence in Schools initiative. Additionally, the Collaborative will commission a support service for neurodivergent children and their families. The Collaborative wants children to be supported in a more timely manner and will focus on bringing down CAMHS waiting times.
- Inpatient care in acute psychiatric units. The Collaborative has put in place financial risk/share arrangements to remove the use of inappropriate out of area beds, so that people are cared for closer to their local communities and their families. Alongside this, length of stay will be reduced so that patients have a better opportunity for timely recovery. This will allow resources to be re-purposed for community mental health.
- The redesign of adult mental health acute and rehabilitation clinical pathways (using the GiRFT approach). This will deliver more modern, sustainable and appropriate recovery pathways, and the design will be undertaken with extensive consultation with patients, staff and wider community.
- Review of Adult Community Mental Health Services. This comprehensive review will ensure services provide the right support at the right time, and where necessary assertively, so that there is no risk of the homicides in Nottinghamshire occurring locally.
- Post-diagnostic dementia support. The offer will be recommissioned and will take account of feedback from Healthwatch consultation.

Strategic Focus:

For 2025/26, the Collaborative's strategic focus will be to:

- Ensure it is ready for the implementation of the Mental Health Bill
- Develop and agree a Mental Health Strategy for the local system. This will take account of the new 10 year NHS strategy and ensure that mental health remains a system priority.
- Review arrangements to ensure they are fit for purpose for the changing operational model for ICBs

15. NHS Trust Collaborations

Theme 15

Where we are now?

- Wye Valley NHS Trust (WVT) has been a full member of The Foundation Trust Group since 2016.
- Worcestershire Acute Trust (WAHT) became a full member of The Foundation Trust Group from July 2023 resulting in a joint Chief Executive and Chair across the four Foundation Group Hospitals.
- From April 2025, both trusts have a joint Acting Chief Executive Officer.
- WAHT and WVT has completed a service sustainability analysis, which influences areas of collaboration between the two trusts. There is continued mutual aid for vulnerable services with WVT being lead provider for dermatology and WAHT for MaxFax. Other areas identified as priority services for collaboration include ophthalmology, haematology and Interventional Radiology.
- WAHT and Herefordshire and Worcestershire Health and Care Trust – A Memorandum of Understanding is in place and a work programme agreed. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, the systemwide stroke pathway and urgent care pathway (including frailty and virtual wards). Practical coordination of services between the two trusts is helped by colocation of the acute trust Single Point of Access team in HWHCT premises alongside their Care Navigation Team.
- WAHT and University Hospitals Birmingham – a range of tertiary services provided for Worcestershire residents including some cancer services, renal services, cardiothoracic and trauma services.
- WAHT and University Hospitals Coventry and Warwickshire – MDT working on clinical services in head & neck cancer, Improvement partner for Virginian Mason methodology.
- WAHT and Birmingham Women's and Children's Hospital- collaborative work around paediatric services and work ongoing to collectively support further delivery of paediatric surgery in-county and the expansion of paediatric High Dependency Care at Worcestershire Royal Hospital.
- South Midlands Pathology Network – board approvals received for LIMs outline business case and SM Pathology network collaborative.
- Continued member West Midlands Cancer Alliance.
- Foundation Group collaboration includes work to consolidate pharmacy aseptic medicines preparation facilities across the Group.
- At Place level in Worcestershire, provider collaborative work also includes services within primary care, with close collaboration managed through the Interface group.
- The West Midlands Mental Health and Learning Disability and Autism Provider Collaborative was informally formed in 2021 bringing together 7 Trusts in the West Midlands, including Herefordshire and Worcestershire Health and Care NHS Trust. The specialist inpatient pathways of forensic, LDA< CAMHS, adult eating disorders and mother and baby services are under this Collaborative arrangement and the collective leadership has also developed a governance structure to work on the greatest challenges in the H and LDA and opportunities to address these through working at scale. This has included supporting local systems (ICSs) to improve population health outcomes, building on best practice and developing a regional approach developing innovative clinical and workforce solutions, horizon scanning to maximise WM PC influence and implementation of changes.

Where next? – Areas of focus

- Shared Executive leadership between Acute Trusts will help to continue to strengthen collaborations during 2025
- Within Worcestershire, it is recognised that there is potential to improve patient pathways through increased collaborative working between the acute and community trust.
- The ICB-led Building a Sustainable Future program has identified key services for collaborative working across the ICS.
- Provider review of areas of opportunity around corporate support functions at Foundation Group, system or Place as appropriate
- Taking forward the review of options for Stroke services across H&W
- Continuing the development of a Pathology Network across the South Midlands

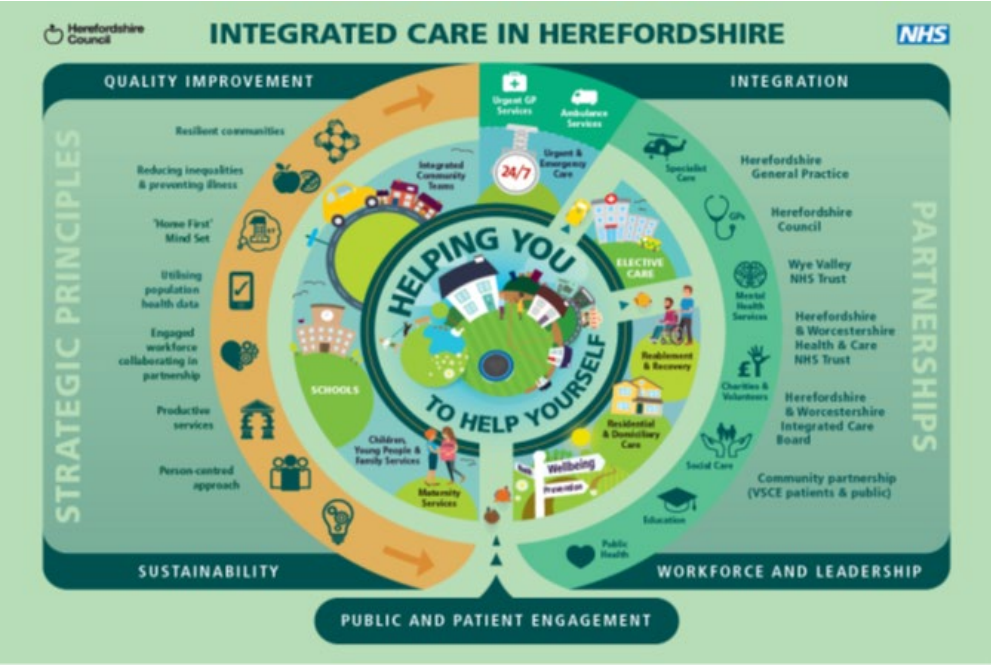
How we will get there? – Development steps

- Stratify provider collaborative arrangements based on service and population needs.
- Progress collaborative working through the Building a Sustainable Future program
- ICB-led methodology for vulnerable services is twofold:
    - At operational level to manage existing or at risk vulnerable clinical services with identified models to support in the short term.
    - Strategically a provider led self-assessment of all clinical services to theme by sustainability / resilience and / or growth domains as part of potential collaborative service model.

16. One Herefordshire Partnership

Theme 16

The One Herefordshire Partnership (1HP) drives the co-ordinated planning and delivery of the Herefordshire health and care system in order to deliver improvements in health and care outcomes through integrated working. 1HP partners share strategic objectives and reviews business cases, provides a forum for discussion on care pathway changes, oversees the Better Care Fund (BCF)and approves the objectives set by the Primary Care networks (PCNs).



Where we are now? What have we delivered in 2024/25

- Making a variety of improvements across the Best Start in Life programme
- Improving the primary/secondary care referral interface with direct access and internal referrals
- Providing improved value for money through the BCF with 22% more D2A purchases in 2024 than in 2023
- Improved collaboration with the Talk Community Healthy Lifestyle Service and delivering Talk Wellbeing Health Checks
- Developed a co-located Community Referral Hub with a SPA and virtual ward, delivering a material increase in WMAS referrals taken from the CAD

Where next? – Areas of focus

1HP 2025/26 priorities will remain as in the previous year.

- **Best Start in Life (HWBB Priority)**
- **Good Mental Wellbeing (HWBB Priority)**
- **Primary/Second Care Interface**
- **Integrated Urgent and Emergency Care**
- **Integrated Neighbourhood Development**
- **Driving Value Through the BCF**
- **Herefordshire Together (supporting VCSE schemes that deliver against 1HP priorities)**

In terms of improvements to outcomes, the partners are finalising a framework based around:

- Prevention and Population Health (HWBB Priorities) including child health, talking therapies and social isolation
- Management of complex community based care, including emergency admission reduction, discharge delay reduction and residential and care home admission reduction
- Improving access to services and early identification, including reduction of elective waiting times and increasing cancer identification

How we will get there? – Development steps

- Develop and agree the outcomes framework that sets out the improvements we will expect to see against the priorities
- Continue to refine the BCF and seek opportunities to improve value for money
- Consider how we might incentivise the urgent and emergency care pathway for general practice in order to prevent acute admissions
- Consider the structure of the partnership in light of the major changes to both the wider NHS structure and local authority boundaries and responsibilities

17. Worcestershire Place Partnership

Theme 17

The Worcestershire system spans many partner organisations and sectors. Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

We recognise the required shift to achieve greater integration and have been working to establish a framework for the culture within which we will work, between key partners, by agreeing and centring on our **shared vision and values** and putting people in our communities at the heart of everything we do. We understand that an **equal partnership** between NHS and health, local government and our VCSE sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:-

- Place equal value and emphasis on the **physical health and mental health** and wellbeing
- **Protect health** and focus on supporting the **conditions for good health**
- **Focus on prevention**; to prevent, reduce or delay need for care and support
- **Improve health disparities** particularly for those who are vulnerable, disadvantaged or living with a disability
- **Listen** to people who use our services and strive to improve, ensuring a **quality experience**
- Deliver **proactive and better coordinated** care to help people to stay healthy and independent**,** based on each person's needs
- Work together in an **evidence-based way** to take to **system wide approaches** to improve health across the life course
- Maximise **shared funding opportunities** to achieve **best value** (including social value)
- Develop and support our **workforce**

District Collaboratives: District Collaboratives bring together statutory health and care services, District Councils, the Voluntary, Community and Social Enterprise (VCSE) and wider partners to deliver against shared priorities with their communities. This is a new way of working and represents a shift in how communities and health and care providers work together. This should see greater local autonomy and resources directed into communities to enable greater control over addressing the underlying causes of ill health through interventions people design for themselves. There is a focus upon building strong, resilient communities, understanding and being able to optimise local assets, whilst articulating gaps and opportunities available to further improve the local offer. We are increasingly seeing that local partnerships are most effective in improving population health and tackling health inequalities.

Where next? – Areas of focus

- Priorities identified by the Worcestershire Health and Wellbeing Board: Good mental health and wellbeing, supported by (1) Healthy living at all ages (2) Safe, thriving and healthy homes, communities and place (3) Quality local jobs and opportunities
- Place based integrated performance report to drive assurance and prioritisation of activities.
- Strong integrated GP leadership across whole county and ensure full support to mature and develop
- Identification and building on local place-based assets to provide foundation for further 'left shift'
- Shared delivery plan across local NHSE Provider Alliance; shared delivery demonstrates maturity of relationship
- Support development and sustainability of VCSE Alliance as an equal partner
- Deliver agreed model of integrated urgent care and frailty action plan, further reducing pressure on ED front door and thereby supporting flow.
- Increasingly looking at shared resources, building on the work of place-based intelligence, engagement and communication cells.
- Support improvements to Stroke pathway to ensure sustainability and high-quality outcomes
- Consider wider integration with other statutory partners eg police, fire

How we will get there? – Development steps

- Developing relationships of trust through working together to deliver place priorities, as listed above.
- Develop systems thinking to enable shared understanding of challenges and solutions across providers.
- Consider implications of adopting Community Paradigm approach and how we can harness local assets to support District Collaborative objectives
- Maximise impact of the reinvigorated Place Leadership, collaboration between HWB and other place-based governance infrastructure to deliver sustainable improvements.

Worcestershire Place Partnership – Progress

The following 3 priorities have been identified and agreed by Worcestershire Place Partnership:

- **Frailty:** move to a systemwide model of care where people identified as living with frailty are proactively and reactively cared for at home, in their local neighbourhoods, and in hospital, by members of the integrated Worcestershire place-based teams.
- **Long Term Conditions:** priority areas of work - heart failure, diabetes and COPD (respiratory).
- **Integrated Neighbourhood Teams/Neighbourhood Health:** prototyping work is progressing in 3 Integrated Neighbourhood Teams Accelerator Sites across Worcestershire. The three sites have identified their priority areas which are to progress proactive care for frail patients in the community (2 sites) and focus on improving the proactive management of diabetes in the community (1 site).

18. Pan system collaboration – The Office of the West Midlands Integrated Care Boards

Theme 18

The six ICBs in the West Midlands are collaborating to form an Office of the West Midlands. NHS Birmingham and Solihull ICB will host the staff performing these functions from 01 April 2023 and staff will transfer to the BSOL ICB in July 2023.

From April 2024 BSOL will also host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

Herefordshire and Worcestershire ICB will be leading a project on development and delivery of the dental access recovery plan.

The VISION:

Through at scale collaboration and distributive leadership, the Office of WM will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.

Purpose:

The core purpose is to :

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making
- To identify shared priorities and goals and clear projects and work programmes to deliver them
- To bring together in a single host ICB the shared teams and staff supporting the Office of the West Midlands and their ICBs.
- To develop distributive leadership and expertise across an agreed range of functions/teams for the benefit of all ICBs
- To provide a single coherent voice for the West Midlands ICBs where appropriate /a single point of contact/shared voice for change
- To share learning and support improvement across the ICBs
- To achieve best value and efficiency by working at scale where appropriate

Work Programme	Host ICB	Lead CEO
POD / GMaST / Complaints / Secondary Dental – Dental access recovery plan	Herefordshire and Worcestershire	Simon Trickett
Operating Model Development	Coventry and Warwickshire	Phil Johns
Collaboratives		
Integrated Staff Hub and OWN hosting	Birmingham and Solihulll	David Melbourne
Specialised commissioning		
Commissioning Support Service Review	Shropshire, Telford and Wrekin	Simon Whitehouse
NHS 111/999 Services	Black Country	Mark Axcell
West Midlands Combined Authority		
Immunisations and Vaccinations	Staffordshire and Stoke	Peter Axon

NHS
Office of the West Midlands
Partnership of Integrated Care Boards

Herefordshire and Worcestershire
Integrated Care System

Joint forward plan – 25/26

Appendix 3: Statutory Requirements checklist

This section includes a **cross reference to the two Health and Wellbeing strategies** for Herefordshire and Worcestershire, to identify the extent to which the JFP addresses the priorities set out therein.

The section also identifies which section of the JPF (or other documents) **show how the ICB will meet its statutory duties** as laid out in Appendix 2 of the mandatory guidance.

Version: 2025 Refresh, May 2025

Mapping to the Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this
Core Priority Areas	Best Start in Life For Children	• **Appendix 1, Theme 1** (Maternity and Neo-natal Care), **Appendix 1, Theme 2** (Early years, children and becoming an adult): The core focus of these two areas is directly aligned to the Health and Wellbeing priority or providing the Best Start in Life for Children.
	Good Mental Wellbeing throughout life	• **Appendix 1, Theme 6** (Learning Disability and Autism Care), **Appendix 1, Theme 7** (Mental Health and Wellbeing), **Appendix 2, Theme 15** (Mental Health Collaborative): The core focus of these three areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life.
Supporting Priorities	Improving access to local services	• **Appendix 1, All Themes** – Improving access to core NHS services is a priority running through the work programmes of all core themes, including through the development of virtual wards and an overall ambition to invest more in preventative activities and to provide best value healthcare in the right setting. • **Appendix 1, Themes 11, 12 and 13** (Primary Care Themes): Improving access for primary care services will be a specific focus through implementation of the National Access Recovery Plan. Furthermore, the ICB is responsible for commissioning Dental Services from April '23 and is prioritising work to improve access, particularly for those with greatest need. • **Appendix 2, Theme 11** (Digital data and technology): A key theme of our digital strategy is to enable greater access to service through digital platforms and to support the development of virtual wards.
	Support people to live and age well	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, All Themes** – Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities • **Appendix 2, Theme 5 (Prevention):** This sets out how NHS services will work to support local prevention strategies through specific interventions.
	Good work for everyone	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.
	Support those with complex vulnerabilities	• **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 6** (Learning Disability and Autism Care), These sections outline out work to support people with complex needs. Other services, particularly Primary Care also tailor their approaches to support complex needs. • **Appendix 2, Theme 4** (Health Inequalities), **Appendix 2 Theme 6** (Personalised Care), **Appendix 2 Theme 8** (Commitment to carers), **Appendix 2, Theme 9** (Support to veteran health), **Appendix 2, Theme 10** (Addressing the needs of victims of abuse): These sections outline specific local actions that will ensure that NHS partners support those people with complex vulnerabilities.
	Improve housing, reduce homelessness	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes.
	Reduce Carbon Footprint	• **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.

Mapping to the Worcestershire Health and Wellbeing Strategy

Worcestershire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this	
Core Priority: Good Mental Health and Wellbeing	**Whole Population Approach**	• **Appendix 2, Theme 17** (Worcestershire Place Partnership): This section outlines how partners will work together at county and district collaborative level to put integration at the heart of our service delivery.	The core focus of these areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life: • **Appendix 1, Theme 6** (Learning Disability and Autism Care) • **Appendix 1, Theme 7** (Mental Health and Wellbeing) • **Appendix 2, Theme 14** (Mental Health Collaborative)
	Align and Support Local Strategies	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 11** (Digital, Data and Technology):	
	Commitment to reducing health inequalities	• **Appendix 2, Theme 4** (Health Inequalities), • **Main Document, Population Health Management section (p27)**	
	Engage local communities over the lifetime of the strategy	• **Appendix 2, Theme 7** (Working with Communities) • **Appendix 2, Theme 8** (Commitment to Carers)	
Supporting Priorities	**Healthy Living at All Ages**	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 4** (Frailty), **Appendix 1, Theme 8** (Long term conditions): Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities. • **Appendix 2, Theme 5** (Prevention)**:** This sets out how NHS services will work to support local prevention strategies through specific interventions.	
	Quality local jobs and opportunities	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.	
	Safe, thriving and healthy communities and places	• **Appendix 2, Theme 7** (Working with Communities): This section outlines how we will listen to our communities and use this intelligence to make sure we focus on doing the right things. • **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.	

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Describing the health services for which the ICB proposes to make arrangements.	**Chief Executive**	**Appendix 1, Core Areas of Service** provides an overview of the range of services that the ICB is making arrangements for. The ICB Operating Model and System Development Plan provides more detail on specific areas to demonstrate how services are organised and developed.
Duty to promote integration	**Executive Director of Strategy, Health Inequalities and Integration**	The duty to promote integration is inherent to the **design of the whole local system, as demonstrated in**: Integrated Care Strategy, JPF Main Document, JFP **Appendix 1 (Core areas of focus) and Appendix 2 (Enablers)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. Additionally, there are a myriad of other documents that outline this, including: ICB Operating Model and Organisational Structure, Better Care Fund, ICB Contribution to the Health and Wellbeing Strategies, Place Partnerships and HIPP Board, Fragile Services Framework, Clinical and Care Professional Leadership Networks
Duty to have regard to the wider effect of decisions	**Executive Director of Strategy, Health Inequalities and Integration** **Director of Corporate Services**	**The Four Pillars of Integrated Care Systems**, built up from the Triple Aim were the **basis of the strategic planning framework** that was used to develop the ICS Strategy, the Joint Forward Plan and the linkages they have to the Health and Wellbeing Strategies. The ICB Governance Design, as set out in the ICB Constitution and Governance Handbooks outlines how the Governance Structure of the ICB is designed to ensure that the ICB meets its duty to have regard to the wider effect of its decisions. The main committee for ensuring this happens is the ICB Quality, Resources and Delivery (QRD) Committee, which is supported by the ICB Quality Delivery and Oversight of System Group (QDOS), which pulls together the activities of all the ICS Programme Boards and Forums.
Financial duties	**Chief Finance Officer**	**Main Document, pages 18 - 19** outline the 25/26 Financial Plan. It also outlines arrangements for developing a Medium-Term Financial Strategy, which will be used to set out the plan for returning the system to financial balance. The ICS Finance Forum (chaired by Wye Valley NHS Trust Chairman) is the strategic group that bring finance professionals together to build consensus around the financial plan.
Implementing any Joint Local Health and Wellbeing Strategy	**Executive Director of Strategy, Health Inequalities and Integration**	**The JFP has been developed to specifically demonstrate how NHS partners will contribute to the delivery** of the Integrated Care Strategy and the two Joint Local Health and Wellbeing Strategies. The overall approach to the development of the Integrated Care Strategy and the Operating Model for the system (build around place) has been created to ensure alignment between all strategic plans.
Duty to Improve quality of services	**Executive Chief Nurse**	**Appendix 2, Theme 1 (Quality, Safety and Patient Experience)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to reduce inequalities	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 4 (Health Inequalities) and Theme 5 (Prevention)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to promote the involvement of each patient **Duty to involve the public**	**Director of Operations – System Programmes** **Director of Communications & Engagements**	**Appendix 2, Theme 6 (Personalised Care)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Appendix 2, Theme 7 (Working with Communities)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty as to patient choice	**Managing Director**	**Patient choice is a key focus for the ICB.** There is a plan for an accreditation process for new providers in development that will be ready in late 2023. Addition, there will be revised patient information to promote choice and support patients decisions. Progress against Patient Choice will be reported through the Elective, Diagnostic and Cancer Programme Board through the SRO for patient choice.
Duty to obtain appropriate advice	**Chief Executive, through individual Executive Leads**	**There are a myriad of different arrangements** in place for ensuring that the ICB obtains relevant advice when making decisions. This includes arrangements with a legal firm to provide legal advice, and MOU with public health to provide support for undertaking needs assessments, arrangements with the CSU for provide procurement advice etc.

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Duty to promote innovation	**Chief Medical Officer & Director of Workforce and Digital**	The Chief Medical Officer is responsible for coordinating work across the ICB for promoting Innovation and the ICB employs and Officer within the Digital Team to support this work. **Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty in respect of research	**Chief Medical Officer / LTC and Personalised Care Lead**	
Duty to promote education and training	**Chief People Officer**	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Duty as to climate change	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 13 (Greener NHS)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of children and young people	**Director of Operations – System Programmes**	**Appendix 1, Theme 2 (Early Years, children and becoming an adult)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of victims of abuse	**The Chief Nursing Officer**	**Appendix 2, Theme 10 (Addressing the specific needs of victims of abuse)** The Director of Partnerships and Health Inequalities and Chief Nursing Officer is coordinating work to link in with external partners to ensure that the ICB fulfils across these areas, in addition to the services in place across Herefordshire and Worcestershire.

Other Recommended Content	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Workforce	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Performance	**Main Document Page 13** sets out the specific short term performance trajectories that are being aimed for. Longer term trajectories will be developed as part of the new approach to Strategic and Operational Planning and will be incorporated in the first refresh of the JFP.
Digital / Data	**Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Estates	**The System Development Plan and ICS Operating Model documents** outline more detail on how the ICB and System Partners meet their statutory requirements in these areas.
Procurement / Supply Chain	
Population Health Management	**Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
System Development	**Appendix 2, Theme 14 to 18** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Supporting Wider Social & Economic Development	The ICB fulfils its statutory duties through **membership of the Health and Wellbeing Boards** and engagement and contribution to the two Joint Local Health and Wellbeing Strategies, which both have a focus on tackling the wider determinants to health.
Veteran's Health	**Appendix 2, Theme 9** for detail on our approach to supporting veteran's health

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Emergency Preparedness Resilience and Response (EPRR) Annual Report
Lead Executive Director:	**Chief Operating Officer**
Author:	Sean Smith, Emergency Planning Officer, EPRR
Reporting Route:	Trust Management Board
Appendices included with this report:	National EPRR Core Standards Framework 2024
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

To meet the mandatory national standard in updating the Trust Management Board on WVT EPRR work programme, linked to compliance with NHS Core Standards for EPRR, Civil Contingencies Act (2004) and the NHS Act (2006) amended by the Health and Social Care Act (2012), as required by the NHS England EPRR Framework.

Recommended Actions required by Board or Committee

Mandatory aspects of this report seeks board approval under the NHS Core Standards for EPRR which must be presented and signed off at Board level, in order that the Trust can meet the required standards. As such, Board is requested to approve the content of this report in line with the requirements in the NHS Core Standards for EPRR.

All recommendations contained within this report have been reviewed and approved by the Emergency Planning Committee.

Board is asked to:

- Approve this report, and specifically:
  - a) Resources allocated to EPRR (Section 10);
  - b) EPRR Policy (appendix 2); and
  - c) Trust Business Continuity Management System (Appendix 3) and the Business Continuity Statement (Appendix 4).
- Note the key activities and response to incidents during Q4 2024/ Q2 2025.
- Receive assurance that WVT is prepared to respond to an emergency and has resilience to continue the provision of safe patient care.

Executive Director Opinion[1]

This paper provides assurance on the Trust's EPRR arrangements.

In summary, a considerable amount of work continues in developing the Trust's EPRR, arrangements capability and progress in NHS Core Standards for EPRR assurance process. The Board is requested to receive this report, as this is a specific requirement under the NHS Core Standards for EPRR.

[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. Introduction

1.1 This paper provides a report on the Trust's Emergency Preparedness, Resilience and Response (EPRR) status to meet the requirements of the Civil Contingencies Act (2004) and the NHS Core Standards for EPRR.

1.2. The Trust has an established portfolio of EPRR plans to deal with Major, critical and Business Continuity incidents. These align with the Civil Contingencies Act (2004) and latest NHS guidance. All plans have been developed in consultation and collaboration with county and regional stakeholders to ensure they interface with multiagency partner plans.

1.3. This paper encapsulates the following topics:

a) EPRR training and exercise programme and the development of emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

b) The development of new plans and updates to existing plans and documents for managing incidents driven by national, regional, local lessons learnt process.

c) Incorporation of learning from national Inquiries to maintain best practice in all areas of planning, exercising, training and incident response.

d) Learning from the Regional NHSE lessons learnt process.

e) Alignment of the trust Business Continuity (BC) planning and business continuity management system to ISO 22301 and NHSE Business Continuity framework.

2. Background

2.1 EPRR is a statutory requirement under the Civil Contingencies Act (CCA) 2004, and is core function of the NHS. Enabling responses to emergencies and is a key function identified within the NHS Act (2006) as amended by the Health and Social Care Act (2012).

2.2 In December 2022, the Government published the UK Resilience Framework which sets out the ambitious approach to UK's resilience up to 2030.

2.3 Nationally, there is an expanding focus on the range of threats that NHS Trusts face and must prepare for. It is essential that the focus remains on the Trust's EPRR and Business Continuity arrangements, thereby advancing its reputation within the EPRR regional arena.

2.4 The Civil Contingencies Act (2004) outlines a framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level.

As a Category 1 Responder, the Trust is subject to the following statutory duties:

- Assess the risk of emergencies to inform contingency planning.
- Have in place emergency plans.
- Have in place business continuity management arrangements.
- Maintain arrangements to warn, inform and provide guidance to the public about civil protection matters and emergencies.
- Information sharing with other responders to enhance coordination.
- Cooperation with other responders to enhance coordination and efficiency.

2.5 To guide compliance, the Trust has an EPRR strategy which comprises of the following work streams:

- Emergency Planning.

- EPRR and On Call Training
- Testing and exercising Emergency plans and response.
- Safeguard Trust CBRNe capability is maintained and tested.
- Maintain a watching brief on NHS green agenda and climate adaptation and where appropriate incorporate initiatives into the trust wide emergency planning processes.
- Training of Divisional and Directorate staff in the process of Business Continuity.

2.6 Delivery of the Trust EPRR strategy is monitored and validated against each standard in the NHS Core Standards for EPRR. For 2024, the Trust achieved partial compliance with the intent to progress to substantial compliance for 2025.

3. WVT Core Standards update.

3.1 The EPRR Team have completed a mandatory process of self-assessment of the NHS Core Standards for EPRR 2024-2025. The Core Standards assess whether NHS Trusts are compliant with relevant EPRR regulation and legislation. This year the Trust has provided detailed assurance to the ICB EPRR lead and the NHSE regional EPRR team around the evidence of compliance with the Core Standards.

3.2 The updated Core Standards were released to the Trust in July 2024 for submission to NHSE in August 2024. The Trust had progressed however remained at partial compliance for 2024-2025.

Fully Compliant	Partially Compliant	Non- Compliant
51	11	0

Table 1: WVT Core Standards 2024/ 2025 compliance overview (total number standards 62)

3.3 For 2023/2024, the Trust achieved 82% with a 'Partial Compliance' for the Core Standards Assessment, whilst remaining partial for the year prior with score of 77% (2022/ 2023). To meet 'Substantially Compliant' status for 2024/ 2025, the Trust must score 89% Core Standards.

Domain	Core Standard	Areas of Partial Compliance	Status
Domain 3 - Duty to maintain plans	12	Infection Disease – High Consequence Infectious Disease Policy	Closed
	14	Countermeasures Plan	Closed
Domain 6 -Response	28	Management of business continuity incidents (Overarching BC plan)	Closed
Domain 7 - Warning and Informing	33	Warning and Informing (Senior On-Call Guidance/ Communications Presentation)	In progress
Domain 8 - Cooperation	37	LHRP Representation	Closed
Domain 9 - Business Continuity	46	Business Continuity Impact Analysis (BIA)	In progress
	47	Business Continuity Plans (Overarching BC plan)	Closed
	48	Testing and Exercise	In progress
	51	Business Continuity Audit	In progress
	52	KPI reporting (Trust Board)	Closed
	53	Supplier and Providers BC arrangements	In progress
Domain 10 - Hazmat/ CBRN	57	Decontamination capability availability 24 /7	Closed

Table 2: Core Standards Action Plan 2024/ 2025

3.4 The Hereford and Worcestershire ICB system demonstrates good compliance, with no providers ranked as non-compliant for core standards. Good practice and learning for EPRR have been highlighted from both the Trust and the local ICB system. The Midlands region Best Practice Report reflects this achievement, noting that a considerable number of learning points originated from Hereford and Worcestershire ICB system. Currently NHSE is conducting a review of all WVT EPRR documentation as part of collaboration with a secondary review supported by H&W ICB.

4. <u>Local Health Resilience Partnership update on Core standards for the ICB area.</u>

4.1 The Trust continues to play an active role in the Local Health Resilience Partnership (LHRP) for 2025 in support of improving EPRR processes for public and patients we deliver care to. The work of the LHRP includes system wide improvements to EPRR incident response.

4.2 All members of the Herefordshire and Worcestershire systems have seen an increase or remained stable in the core standards in the year of 2024

4.3 WVT remained at partially compliant although improvement had been achieve on the previous year with the intention of moving to substantially compliant in the forthcoming core standards assurance programme which takes place August 2025.

Organisation	Assurance Level 2024-2025	Organisation Type	Change from 2023-2024
H&W Integrated Care Board (HWICB)	Substantially Compliant	Integrated Care Board	⟷
Worcestershire Acute Hospitals NHS Trust (WHAT)	**Substantially Compliant**	**Acute Provider**	↑
Hereford & Worcestershire Health & Care Trust (HWHCT)	Substantially Compliant	Community & Mental Health Provider	↑
Wye Valley Foundation Trust (WVT)	**Partially Compliant**	**Acute Provider**	⟷

Table 3: Herefordshire and Worcestershire ICB system Core Standards 2023/24 compliance overview

Organisation	Assurance Level 2024-2025	Organisation Type	Change from 2023-2024
H&W Integrated Care Board (HWICB)	Substantially Compliant	Integrated Care Board	⟷
Worcestershire Acute Hospitals NHS Trust (WHAT)	**Substantially Compliant**	**Acute Provider**	↑
Hereford & Worcestershire Health & Care Trust (HWHCT)	Substantially Compliant	Community & Mental Health Provider	↑
Wye Valley Foundation Trust (WVT)	**Partially Compliant**	**Acute Provider**	⟷
Shropshire Telford & Wrekin Integrated Care Board	Partially Compliant	Integrated Care Board	↑
The Robert Jones & Agnes Hunt	Non-Compliant	Specialty Provider	⟷
Shrewsbury Telford Hospitals	**Partially Compliant**	**Acute Provider**	↑
Shropshire Community Health Trust	Substantially Compliant	Community Services Provider	↑
ShopDOC	Non-Compliant	Primary Care GP Provider	⟷

Table 4: West Mercia Local Health Resilience Partnership Core Standards 2023/24 compliance overview

5. Training Numbers

5.1 The Emergency Planning Officer has provided EPRR training across the Trust during 2024/25, encapsulating all EPRR plans assessed as part of the Core Standards assurance. Each training session comprises of a presentation and desktop offered across a number of manageable periods to ensure extensive accessibility. All EPRR training has now been made available to WVT Level 2 On-Duty colleagues, who initially receive EPRR awareness presentation as a foundation. A new additional to the EPRR training presentation portfolio is the WVT Communications Presentation which incorporate aspects of the new Senior Managers/ Directors On-Call guidance. Collectively this training builds upon the regionally delivered NHSE Principles of Health Command the Executive Team and Senior Managers On-Call are required to attend.

5.2 Training schedule is in place to deliver specialist training to Emergency Department staff on Chemical, Biological, Radioactive, and Nuclear (CBRNe) decontamination of contaminated patients.

5.3 The Switchboard forms a critical component for internal and external incident notifications, bi-annual and irregular testing takes place. External notification from the Local Resilience Forum is initiated by an automated voice call identified by caller ID and message format whereby Switchboard inform the Level 3 On-Call, who in turn reviews the WVT single point of contact email for the notification. This notification utilises JESIP terminology for the incident descriptor, and based on gravity acts as the mechanism for the control room mobilisation and information cascades to staff.

5.4 Other key areas of training include: clinical and nonclinical site management team as part the level 2 On-Duty Staff and the communications team. The Emergency Planning Officer has successfully delivered EPRR awareness training to new On-Call staff. For new WVT employees there EPRR component added to their Local Induction Managers Checklist covering EPRR documentation, with the intention of formalising this induction in collaboration with the E-learning team. General awareness sessions are delivered to trust staff through EPRR and Business continuity by the Emergency Planning Officer.

5.5 Business Continuity (BC) Awareness Training is being cascaded to divisions to enhance plan expectations, development and EPRR requirements such as plan testing. Key components of the training included:

BC Awareness Training:

- BC plan awareness (format, business impact analysis, supplier and providers etc.).
- WVT business continuity incident escalation process.
- BC plan testing through tabletop exercises focused on directorate/ function line managers and staff participation to ensure plan content, awareness and applicable workarounds.

Divisional Board Training:

- BC awareness training sessions at divisional level.
- Sessions were facilitated by the Emergency Planning Officer, emphasising BC organisational structure, plan expectations and integration at a strategic level.
- Emphasised placed on key areas such as Business Impact Analysis, Providers and Suppliers and key contacts.

5.6 The continuous delivery of BC training and strategic awareness sessions has elevated the organisation's overall business continuity framework and preparedness to deal with unplanned disruptions effectively. This is especially in light of the desktops now being cascaded to directorates and departments, including activities monitored through the BC training schedule and tracker.

See Appendix 1 Training Update

6. Incidents in the last year

6.1 In the last year the Trust has reported and responded to 2 critical incidents and 8 reported Business continuity incidents. This is an escalation from the previous year when the trust responded to 8 incidents. In line with EPRR Framework 2022 and Trust EPRR arrangements, the debrief process has been completed following all incidents, encapsulating a hot debrief and formal cold debrief. After Action Reports have been completed for all incidents noting good practice, and areas for improvement. Formalising of 'lessons learned' into the Trusts Lesson Learnt log is an ongoing process identifying actions and action owners. After Action Report are reviewed by those participating in the incident and lessons learnt are presented to the Emergency Planning

Committee, these documents are shared with the Integrated Care Board and NHSE regional EPRR team.

6.2 These incidents were as follows:

Critical Incident:

- 22-28 April 2025 - Capacity & Flow operational Pressures.
- 8- 13 January 2025 - Capacity & Flow operational Pressures.

Business Continuity Incident:

- 29 April 2025 - PACs outage
- 5-10 March 2025 - Maxims Outage (IT related.
- 8 February 2025 - Maternity Roof Leak
- 27-30 January 2025 - Emergency Department Roof Leak
- 20 November 2024 - EPMA outage (IT related)
- 20 November 2024 - Pathology Water Leak
- 14 November 2024 - PAC Outage (Radiology)
- 11 November 2024 - Water Leak (Frailty Block)
- 20 October 2024 - Clinical Noting Outage (IT related)

7. Exercises in the last year

7.1 In the last year the Trust has completed tabletops, live exercise and communication exercises in line with the NHSE EPRR Framework 2022. This includes tabletops for all emergency plans including: CBRN; Adverse weather; Protected Individuals; Evacuation and Shelter; Lockdown, Mass casualties; Suspect Package; threat and Marauding Attacker. With additional desktops being developed for the Communications; and Pandemic/ Countermeasures.

7.2 WVT has completed a live evacuation and shelter exercise at Bromyard Community Hospital in 2024, with 6 actors from a ward with a mixed inpatient economy including Acute, Rehabilitation, and Frailty ward to identified shelter locations. This exercise was successfully completed with the support from a number of trust staff.

7.4 The CBRN lead is planning a dry decontamination exercise as part of the NHSE assurance requirement combined with training for the Emergency Department with a after action report being developed thereafter.

8. Lessons and learning from incidents and exercises.

8.1 Incident learning forms a crucial part in rectifying gaps and shortfalls within plans and training, thereby pursuing improvements to future EPRR planning and response. There are various elements of the learning process, including: after action reports, exercise reports and shared learning from NHSE (Midlands) EPRR team. The following list summarises key learning identified over the last 12 months:

- Supplier and providers questionnaire – Validating business continuity arrangements.
- Out of hours communication cascades to staff and system partners.
- Alignment of Trust Business Continuity plans to the ISO22301 Standard.
- Additional BC plans being implemented for Pathology, Virtual Ward and Community Diagnostic Centre.
- Increased IT related incidents due to multitude of system failures/glitches (Picture Archiving and Communication System [PACs], Maxims, and EPMA) – Testing EPRR responses, BC and workarounds to maintain delivery.

- Increased water ingress into WVT facilities (frailty, maternity and ED) affecting service delivery – BC arrangements and workarounds invoked.
- Learning from national Inquires including Manchester arena, and the Grenfell tower incidents.

8.2 Using the Midlands regional learning, WVT assessed 118 points of learning with 20 areas requiring further analysis before being addressed.

9. CBRN statement of readiness and external CBRN Audit (including training)

9.1 The Trust has completed a self-assessment with the external audit for CBRNe being conducted by West Midlands Ambulance Service on the 10th July 2025. The Audit includes a review of the Trust Wide CBRNe plans, risk assessment, staff training logs, and equipment service logs. As part of the Audit process, the equipment was set up at the Front Door of Emergency Department, including the decontamination and dignity tents, power and water supply, safety equipment, other decontamination equipment, wastewater pumps, and wastewater storage. The equipment will be fully tested including running of water and electrical power as a full-scale equipment deployment.

9.2 The audit on may identify areas for improvement, those identified from last year have been rectified and are detailed below:

- Electronic rotas to identify CBRN trained staff to ensure 24/7 capability.
- Environmental considerations for contaminated liquid spillages.
- Additional lighting and contaminated water storage containers purchased (bladders).

9.3 Good practice and improvements were noted for WVT CBRN audit, commending the significant work that has taken place in the last 12 months.

9.4 In the last 12 months we have had full servicing on the CBRNe PRPS suits by Respirex. Additionally three pop-up dignity tents and screens have been procured.

10. Emergency Preparedness Resilience and Response resources and roles

10.1 The Trust is supported by a part-time Emergency Planning Officer whose role as follows:

- Trust wide lead for EPRR planning, strategy, representation for internal and external system lead groups, committees, West Mercia Local Resilience Forum (LRF); Local Health Resilience Partnership (LHRP); Health Emergency Planning Operational Group (HEPOG); LRF Risk Assessment Working Group (RAWG); Trust wide training lead, Strategic/ Tactical/ Operational advisor; and Midlands Acute EPRR Network. To ensure the development of emergency and service planning within the Trust which improves health and wellbeing, demonstrating a high standard in terms of effectiveness, efficiency, safety, enhancing staff and patient experience aligned to the Trust Values. To facilitate and support the development of relevant networks spanning health and social care organisations. Deliver support as a subject matter expert to the Executive and senior managers of the Trust in responding to major incidents across the Trust.

- Business Continuity Lead providing business continuity (BC) planning across corporate, divisional, directorate teams. Input and specialist advice to corporate functions, audit lead for BC best practice.

- EPRR support in the form of development and analysis of learning from incidents based on internally conducted debrief and the development of after actions report. Collating and development of the Personal Development Portfolio (PDP) for all On-Call incident response Directors, Managers and Level 2 On-Duty Staff.

- Across the Foundation Group our dedicated EPRR resource is significantly less than other Trusts. Our current EPRR resource is supported by current EPRR resource at the Integrated Care Board (ICB). The current capacity within our provision is already fragile and, depending on the decisions around the future role of the ICB within EPRR, this could increase the level of fragility. As part of the review of Corporate functions across the Integrated Care System, LHRP and Foundation Group consideration must be given to strength our capacity through network working and division of labour to deliver our statutory requirement.

11. EPRR Annual Plan 2025/ 2026

11.1 The work programme for the forthcoming year will take into account the continuing Trust response to Incidents, operational response issues, training and exercise, BC workshops, CBRNe, PRPS Training, Command and Control, Joint Emergency Services Interoperability Protocol (JESIP) Commanders and applicable updates, which will be reviewed, prioritised and agreed through the Emergency Planning Committee.

11.2 The key areas of focus for the EPRR Annual Plan will be:

- Update EPRR plans against changes to the National Risk Register and national guidance.
- Ongoing development and embedding WVT BC arrangements aligned to ISO22301.
- Further refinement of the New and Emerging Pandemic Plan, and Countermeasures Plan.
- Support the development Risk Assessments and Counterterrorism Plan aligned to Martyn's Law.
- Review all EPRR plans against recent collaboration with NHSE and multiagency partners.
- Enhance Lockdown Action Cards for localities (part of Martyn's Law).
- Review of EPRR plans action cards and communications cascades.
- Delivery of Trust-wide training programme in line with the NHS Minimum Occupational Standards (MOS), the National Occupational Standards (NOS) and Skills for Justice Requirements. NOS training to be annotated in On-Call Staff Personal Development Plans.

12. Emergency Preparedness Resilience and Response Statement of readiness

12.1 This statement is specific requirement of the Core Standards Framework:

Wye Valley NHS Trust requires to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. Incidents could be anything from extreme weather conditions, infectious disease outbreak, major transport accident or a terrorist act. This requirement is underpinned by legislation contained with the following: *Civil Contingencies Act 2004 (CCA 2004); CCA 2004 (Contingency Planning) Regulations 2005; NHS Act 2006; and the Health and Care Act 2022. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR). The Trust overall rating from the NHSE Core standards assessment is partially complaint for 2023-2024. Areas for improvement are monitored in the Core Standards Action Plan 2024-2025.*

13. Briefing on LRF, LHRP and HEPOG

13.1 The Trust has played an active role in the Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), and the Health Emergency Planning Operational Group (HEPOG), over the last 12 months. The Trust has contributed to the development of a Mass Fatalities Plan, the Communications work stream, development of Mass Countermeasures plan, Evacuation and Shelter System Wide Plan and Resilient Telecommunications plan. The system wide group have responded to a range of situations and emergencies including flooding, other weather-related situations, and response to support for the community. As a system the Trust have also attended training and exercising events to include planning for cybersecurity incidents, Pandemic, Mass casualties and Fatalities and weather-related incidents. Included on the work plan including a

national Pandemic exercise (Exercise Pegasus) later this year to test Health Response across the system.

13.2 Local Resilience Forum (LRF) 2025/2026 Workflow

During the Local Resilience Forum multiagency meeting have planned the following workflow for 2025/ 2026 are:

- Risk assessment Work Group (RAWG) to assess and agree regional risks.
- Mass Fatalities Work Program.
- Communications Work Program (warning and informing).
- Tactical Advisers Group (TAG), forms part of the work streams and approval process
- Chief Officers Group (COG) provides strategic overview and approves TAG outputs.
- Stronger LRF programme.
- Tactical Coordinating Group incident response for Herefordshire (predominately flooding for Herefordshire).

13.3 LHRP and HEPOG Workflows

At Local Health Resilience Partnership (LHRP) and the Health Emergency Planning Operational Group (HEPOG) work streams for this year are:

- Development of Evacuations and Shelter system wide Plans
- Core Standards
- Cyber incidents / Planning
- National Tier 1 Exercise
- Risk register updates.

14. Business Continuity and Statement Business Continuity Statement of readiness

14.1 Following a change to NHSE Business Continuity (BC) Management policy in 2023, the Emergency Planning Officer has overhaul of the trusts BC Plans. A new Business Continuity Management System (BCMS) was brought into effect and a review of all the trusts BC Planning arrangements have commenced. This has been refined through industry best practices and incident lessons learnt. Engagement has been limited due to organisational operational pressures. Continued awareness sessions are being delivered to all divisions with training is offered to managers and staff, aided with BC toolkits and templates to assist with the completion of BC plans.

14. 2 Currently a single PowerPoint slide is utilised as a activity tracker for all BC plans across the trust, capturing plan review, testing, date published on the intranet and plan owner. This process is accompanied by the suppliers and providers questionnaire, which internal services and product leads are required to complete. The questionnaire require to detail product/ service description, point of contact, level of coverage, business continuity arrangements workarounds, and alternate solutions etc. This process is essentially two pronged approached with requests from procurement shared services for visibility of contract business continuity arrangements in the endeavour to close an outstanding action.

14.3 System objective are to:

- To align all Trust BC plans to new format, validating plan currency, testing and availability.
- To capture supplier and providers business continuity arrangements, so these arrangements are understood and available to pertinent staff.
- Embedding processes so that divisions, directorate and departments update and test plans annually.

14.4 Whilst good progress is being made with the BC programme across the trust, resource limitations and operational pressures limit the pace of advancement. This poses a potential risk to the trust and its ability to adequately respond to incidents, however this is a diminishing potential as work progresses across the trust aligned with the three areas mentioned above.

15. EPRR Risks

15.1 Risk assessment and review is completed in all areas of EPRR Work programs. In 2024 the EPRR risks have been updated and are reported to the Emergency Planning Committee with escalation to the Trust Executive Risk Management Group and then through to Trust Management Board (TMB).

15.2 The key Trust EPRR currents risks are.

- CBRN response (InPhase Risk *1975) – Gaps resolved risk reduced to 5.
- The Effects of Climate Change (InPhase Risk *1711) – Accepted Risk.
- Maxims (InPhase Risk *1835)

15.3 The Emergency Planning Officer plays an active role with reviewing and mitigating risk from the Local Health Resilience Partnership (LHRP) Risk register. These are as follows:

- Disruption to Supplies/Supply Chain.
- Mass Casualty Incident, Non-Contaminated Casualties, Contaminated Casualties, PRPS National Procurement.
- Prolonged, severe capacity pressure in health and social care threatening ability to respond to EPRR incidents.
- Partial or full loss of critical service or premise or infrastructure.
- Cyber Attack.
- Infectious disease outbreak.
- Extreme weather inclusive of heatwave and cold weather alerts (excluding flooding).
- Regional failure of utilities network (Gas, Water, Electricity, and Communications).
- Workforce.
- Public or Environmental Health incident.
- Psychosocial support.
- Flooding Pluvial and Fluvial.

15.4 The EPRR Practitioners have an active role in the Risk Assessment Working Group (RWAG). Working with system partners as part of the Local Resilience Forum (LRF), the group review the national risk register and ensure the local risk register is kept up to date. Link attached to the LRF Public risk register. Community Risk Register | West Mercia Police

Appendices

Appendix Number	Appendix title	Supporting Document
1.	EPRR Training Update	WVT training - Board PowerPoint Insert.ppt
2.	WVT EPRR Policy	2025026 - EPRR Trust Wide Policy (EP.(
3.	WVT BCMS	20250130 - EP.07 WVT Business Contin(

4.	WVT BC Statement 2025	WVT KPI's.pdf

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	2025/26 Financial Plan and Budgets
Lead Executive Director:	**Chief Finance Officer**
Author:	Louise Caruana, Suzi Joberns, Heather Moreton
Reporting Route:	FRB
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

This paper sets out the final 2025/26 financial plan and divisional budgets for approval by Trust Board.

The timing of the national planning process has necessitated this coming forward later than would be intended. The paper reflects the plan as submitted through the national planning process.

Recommended Actions required by Board or Committee

Board are asked to:

- Ratify the approval of the financial plan which was necessarily submitted under delegated authority due to timing following the Extraordinary Board meeting – taken place on 19th March; and
- Endorse the divisional budgets and establishments, noting that the sign off process is underway.

Executive Director Opinion[1]

Following a detailed planning process, I am pleased to present the final financial plan and budgets for 2025/26 which reflect a break-even plan for the year. The plan is ambitious and not without a level of risk requiring mitigation. Financial Recovery Board will continue to oversee delivery throughout the year.

Context

[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.

This paper sets out the financial plan and divisional budgets for 2025/26, as submitted through the national process on 27th March 2025. Systems are expected to deliver a balanced financial plan alongside meeting the operational planning requirements for performance, activity and workforce.

The current plan delivers a balanced financial position for the Trust and the Integrated Care Board (ICB) though this is not without a level of risk requiring mitigation which is not unique to Herefordshire and Worcestershire. The internal operational planning process has run alongside the national process to enable setting of a baseline budgetary and activity trajectory against which we can monitor divisional, corporate and Trust wide performance.

Activity and Operational Performance

The activity plan is based on achieving high productivity through core capacity, and only using additional capacity where it offers value for money and supports our ability to meet the required elective activity levels and Referral to Treatment standard (RTT) targets. Core capacity is assumed to achieve 90% clinic utilisation, 85% theatre utilisation and less than 5% clinic DNA rate.

The majority of our activity is commissioned by Herefordshire and Worcestershire ICB, with our second largest commissioner being Powys Local Teaching Health Board. For 2025/26 Powys have signalled a change in commissioning intentions for routine elective waiting times, which may negatively impact on the activity plan currently set from quarter 2. Table 1 below sets out the planned activity volumes by point of delivery.

Table 1: Activity Plan

Division and Specialty		Activity Type				
DIVISION	Specialty	New	Follow Up	IP/DC Admissions	Endoscopy Admissions	Grand Total
Surgical	Breast Surgery	3,079	5,387	478		8,943
	Chronic Pain Service	492	542	252		1,287
	Community Paediatri	862	1,318			2,179
	ENT	5,919	6,036	904		12,859
	General Surgery	5,082	4,285	1,202	2,777	13,345
	Gynaecology	5,235	3,575	997		9,807
	Ophthalmology	12,807	34,853	2,812		50,472
	Oral Surgery	1,037	439	654		2,130
	Paediatrics	2,742	3,717	1,707		8,167
	Trauma & Orthopaed	9,675	18,877	2,940		31,491
	Urology	3,488	8,883	1,601	1,863	15,836
	Vascular Surgery	958	700	98		1,756
Surgical Total		**51,376**	**88,611**	**13,646**	**4,640**	**158,273**
Medical	Cardiology	4,675	12,493	1,265		18,432
	Dermatology	4,527	9,102	2,348		15,977
	Diabetic Medicine	284	2,120	15		2,419
	Endocrinology	721	2,729	353		3,803
	Gastroenterology	3,424	6,341	3,000	5,121	17,886
	Geriatric Medicine	479	383	60		922
	Nephrology	296	1,985	158		2,439
	Neurology	1,102	1,019	441		2,562
	Plastic Surgery	1,326	2,024	1,243		4,594
	Respiratory Medicine	3,047	10,620	1,028	364	15,059
	Rheumatology	1,435	6,084	988		8,506
Medical Total		**21,315**	**54,901**	**10,899**	**5,485**	**92,600**
Clinical Suppo	Haematology	726	6,194	2,200		9,120
Clinical Support Total		**726**	**6,194**	**2,200**		**9,120**
Grand Total		**73,417**	**149,706**	**26,745**	**10,124**	**259,992**

The activity plan is projected to deliver performance against the national operational planning metrics as set out in table 2 below.

Table 2: Operational Performance Requirements

Priority	Success Measure	WVT
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	61% (5% improvement from November 2024)
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*	72% (national target)
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	<1% (national target)
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	75% (national target)
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	82% (above national target)
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	78% (national target)

We operate a well-established Productivity Board to oversee delivery of the agreed activity plan, productivity improvements and actions linked to the national Getting It Right First Time (GIRFT) programme. This feeds into Trust Management Board (TMB) as well as performance oversight through Divisional Finance and Performance Executives (FPEs).

Workforce

The NHS as a whole has seen significant workforce growth since 2019/20, which has not been matched by equivalent increases in activity. Our workforce plan has been developed alongside the activity and financial plans and maps anticipated changes in staff in post over the course of the year including planned cost improvements resulting in workforce change. It is consistent with the national planning requirements to focus on reducing bank and agency use and restricting substantive workforce growth, particularly in support roles. Table 3 below sets out the planned changes in staff in post between March 2025 and March 2026. The staff in post at March 2020 is included for reference.

Table 3: Changes in staff in post

	WVT Staff in Post (SIP) Summary Year on Year				
	SIP Mar-25	SIP Mar-26	Variance	%Variance	SIP Mar-20
Substantive	3,737	3,698	(39)	-1.0%	2,927
Bank	249	208	(41)	-16.5%	178
Agency	116	53	(63)	-54.3%	101
Total	**4,102**	**3,959**	**(143)**	**-3.5%**	**3,206**

Our overall workforce is planned to reduce over 2025/26 with a particular emphasis on reducing reliance on temporary workforce (bank and agency). The workforce plan includes an increase in staff in post associated with the diagnostic centre, due to open later in 2025.

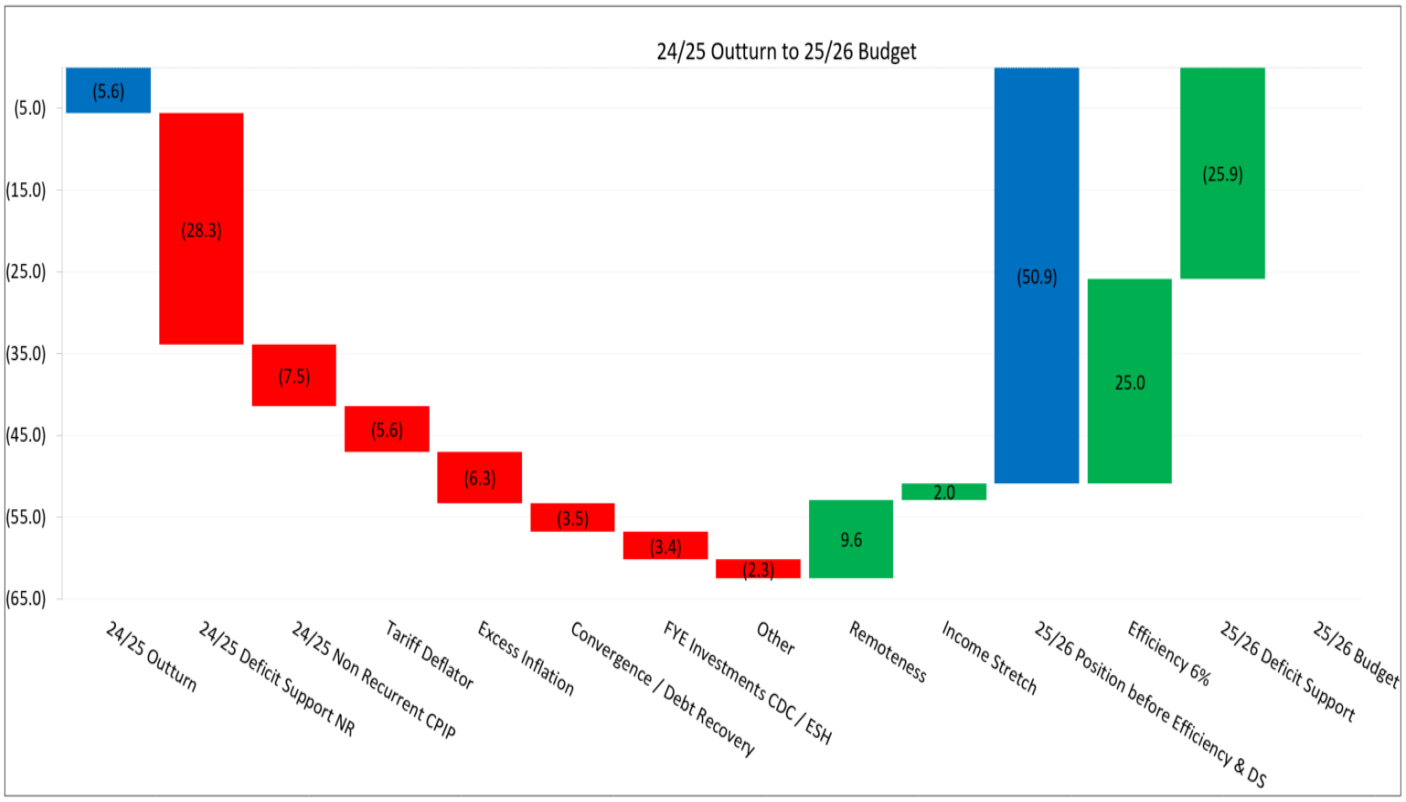
Alongside this staff in post projection, an approved funded establishment is set to align whole time equivalents (WTE) to the budgeted financial plan and agreed activity plan. This forms a control total for recruitment and rostering through the year. The divisional breakdown of the agreed establishment for 2025/26 is reflected later in this report.

Financial Plan (Income & Expenditure)

The Trust reported an outturn deficit of £5.6m in 2024/25, slightly adrift of the planned £3.1m deficit, primarily driven by lower than planned cost reductions. The underlying exit deficit after adjusting for a range of one off items within the 2024/25 outturn including national revenue support was assessed at £65m.

The financial plan builds from this underlying exit position, recognising planning assumptions and outputs from the planning round including inflation, changes in activity and income, and efficiency and productivity. The plan has been developed using both a top down assessment and the bottom up operational planning outputs to ensure it remains ambitious yet credible. Chart 1 below shows key bridging items from 2024/25 exit to 2025/26 plan.

Chart 1: Bridge 2024/25 to 2025/26 plan



The financial plan reflects a break even positon as shown in Table 4 below, as part of an overall system break even plan. The break-even plan has required a degree of stretched financial risk and work continues to explore further opportunities for mitigation. The financial plan for 2025/26 results in a projected underlying exit deficit at March 2026 of £54m, which will require mitigation over a three to five year period.

Table 4: Statement of Comprehensive Income (Income and Expenditure)

Statement of comprehensive income	£k												
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total 25/26
Operating income from patient care activities	31,990	31,754	31,658	32,347	31,429	31,682	32,291	32,051	31,447	32,065	31,788	32,053	**382,555**
Other operating income	1,325	1,325	1,332	1,334	1,335	1,335	1,340	1,339	1,345	1,357	1,413	1,382	**16,162**
Employee expenses	(20,919)	(20,803)	(20,784)	(20,716)	(20,611)	(20,483)	(20,105)	(19,987)	(19,884)	(19,729)	(19,676)	(19,604)	**(243,301)**
Operating expenses excluding employee expenses	(11,974)	(11,986)	(11,986)	(11,802)	(11,802)	(16,386)	(11,611)	(11,613)	(11,609)	(11,430)	(11,424)	(11,411)	**(145,034)**
OPERATING SURPLUS/(DEFICIT)	**422**	**290**	**220**	**1,163**	**351**	**(3,852)**	**1,915**	**1,790**	**1,299**	**2,263**	**2,101**	**2,420**	**10,382**
FINANCE COSTS													
Finance income	44	44	44	44	44	44	44	44	44	44	44	43	**527**
Finance expense	(152)	(152)	(152)	(152)	(152)	(152)	(152)	(1,454)	(152)	(152)	(152)	(150)	**(3,124)**
PDC dividend expense	(358)	(358)	(358)	(358)	(358)	(358)	(358)	(358)	(358)	(358)	(358)	(358)	**(4,296)**
NET FINANCE COSTS	**(466)**	**(466)**	**(466)**	**(466)**	**(466)**	**(466)**	**(466)**	**(1,768)**	**(466)**	**(466)**	**(466)**	**(465)**	**(6,893)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(44)**	**(176)**	**(246)**	**697**	**(115)**	**(4,318)**	**1,449**	**22**	**833**	**1,797**	**1,635**	**1,955**	**3,489**
Financial Performance Adjustments													
Add back all I&E impairments/(reversals)	0	0	0	0	0	4,584	0	0	0	0	0	0	**4,584**
Remove capital donations/grants I&E impact	65	65	58	55	55	55	50	50	45	32	15	(9)	536
Remove PFI revenue costs on an IFRS 16 basis	1,577	1,577	1,577	1,577	1,577	1,577	1,577	2,879	1,577	1,577	1,577	1,572	**20,221**
Add back PFI revenue costs on a UK GAAP basis	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,379)	(2,661)	**(28,830)**
Adjusted financial performance surplus/(deficit)	**(781)**	**(913)**	**(990)**	**(50)**	**(862)**	**(481)**	**697**	**572**	**76**	**1,027**	**848**	**857**	**0**

The following section sets out assumptions in relation to core components of the financial plan and drivers of the deficit position:

- **Cost Improvement and Productivity (CPIP)**: The plan recognises £25m / 6% efficiencies, going further than the national efficiency expectation of 2% to mitigate excess inflation, local pressures and the shortfall in delivery from 2024/25 CPIP. The plan includes around £3m of stretched financial risk agreed as part of concluding the planning process, profiled from the beginning of the financial year and currently unidentified requiring mitigation. Of the £25m, at this stage £18m has been identified underpinned by a broad plan for delivery, primarily weighted towards bank and agency reduction schemes, substantive infrastructure reductions, transformation and productivity opportunities and procurement / contract management. Of the £25m target, £11m is considered as high risk, recognising the scale and timeframe needed to deliver savings, as well as operational pressures that can occur throughout the year that will also require mitigation.

  Our CPIP opportunities are informed by benchmarking intelligence including the national productivity packs, GIRFT benchmarks, Corporate Services Benchmarking and Model Hospital.

  Governance arrangements are in place to oversee identification and delivery of the programme. A series of workshops and divisional check and challenge sessions have been held over quarter 4 to drive confidence in delivery of the CPIP from April. The Financial Recovery Board which has been operational since autumn will continue into the new financial year to maintain focus on delivery of the plan, cost and productivity improvement and risk mitigation.

  The activity plan assumes a level of productivity improvement within core capacity. Ultimately the Board will need to assure itself that the level of cost improvement is stretching yet credible in the context of the overall financial position and performance and quality priorities.

  Table 5 below summarises the distribution of the planned efficiencies including the stretched financial risk across divisions. Divisions will retain autonomy to vire cost improvement targets across their directorates and departments between pay and non-pay as they see fit and as opportunities present.

  Table 5: Efficiency

£'m	Pay	Non Pay	Total
Medical	5.8	1.2	7.0
Surgical	4.5	4.4	8.9
Clinical Support	2.8	1.9	4.7
Integrated Care	1.9	0.4	2.3
Estates	0.2	1.4	1.6
Corporate	2.6	0.2	2.8
Trustwide Risk Factor	- 2.3	-	- 2.3
Total	**15.5**	**9.5**	**25.0**

- **Excess Inflation**: the plan recognises approximately £6.3m of inflationary pressure over and above the level funded. The main drivers are the skill level mix at WVT and progression linked to length of service within a pay banding.

- **Capacity & Elective Recovery**: the plan assumes variable elective income broadly at the same level as 2024/25 outturn and is aligned to the capacity plan and achievement of the RTT performance targets. Delivery of this level of activity is not achievable solely within core capacity, despite the high productivity assumption. Where additional capacity is required to deliver the plan, a review of key performance areas has been undertaken.

- **Welsh Stretch Income**: The plan includes £7m of income from achieving parity of funding mechanism between English and Welsh commissioners. For example English commissioners pay towards rurality and additional income to achieve operational targets which we do not received from Welsh Commissioners. This was an assumption within the 2024/25 plan and has been invoiced to Welsh Commissioners though is currently in the dispute resolution process with support at a national and regional level.

Financial Risk and Opportunity:

- **Elective Funding / Contract approach:** The plan assumes a level of elective activity and income. Under the 2025/26 contract mechanism there is a financial risk if we over achieve on delivery of elective activity compared to our contracted activity plan. If we under achieve and are unable to remove the associated cost there is an adverse impact on our finances. Contracts have not yet been signed (expected during May 2025) which poses a potential risk if funding assumptions differ between parties. There is a known risk with our Welsh commissioners which is being progressed with NHSE support.

- **Delivery of CPIP:** Development of the full programme is not yet secure. Significant focus is currently on supporting divisions to convert opportunities to credible schemes and into delivery, and on identifying mitigation for the unidentified element.

- **Pay Settlement**: planning guidance assumes that the final pay award will not adversely impact the Trust's financial position. There is a risk that the national mechanism to mitigate the impact will not fully recognise local costs, for example linked to our PFI contract responsibilities which would impact our financial performance.

- **Winter / excess urgent care demand**: the financial plan is based on an assumed level of demand and commissioners have included an assumption of 0.50% demographic growth. We have seen significant UEC demand over the last two years and there is a risk that the costs of safely managing demand through temporary escalation capacity and other premium measures will adversely affect the financial performance. We are engaging with wider Place partners and primary care to seek mitigations.

- **Developments**: Other than where investment directly relates to the provision of additional capacity (such as for elective recovery), no provision has been made within the financial plan for new developments and this has been clearly communicated to divisions. A new business case initiation process has been established with clear criteria. Existing approved developments in their implementation phase have been included within the plan in line with the approved case, and will be subject to a structured review of benefits realisation in line with our business case process.

Delegated Budgets

In line with the budget setting process and the Standing Orders and Standing Financial Instructions, responsibility for delivery of the financial plan is delegated to named budget holders across our divisions, directorates and departments. This delegation of responsibility for budgets is important for ownership and accountability of effective use of resources. By exception, a very small number of items are held centrally at the initial budget issue to ensure the relevant governance process is followed before the funding is devolved.

As part of the routine governance process, budgets are issued to respective budget holders and a sign off process undertaken to ensure responsibility has been accepted for the delegated budgets, and associated financial, activity and workforce plans. This process is underway.

Whilst some of the Trust income is devolved already, the majority of the main commissioned income has not previously been devolved to a division and specialty level. The nature of the contracts, with a mix of Payment by Results (PbR), API (Aligned Incentive) fixed and variable make this a complex undertaking. We have the split the task into phases:

- Phase 1 for month 1. Elective variable activity. This is for all Outpatient (New, and Follow-Up with Procedure), Elective Inpatient and Daycase Activity and broadly following the rules as laid out in the guidance for 25/26. See table 6.
- Phase 2 for beginning of Q2. Non elective activity & Follow Up without a procedure.
- Phase 3 during Q2. Other income and contracts

Table 6 below sets out the delegated financial budgets by division, and Table 7 sets out the associated establishments.

Table 6: Delegated Budgets

	Delegated Budgets £'m					
Division	Operating Income	Other Income	Pay	Non Pay	Adjustments	**Grand Total**
Medical	25.1	0.8	(64.6)	(19.2)		(57.9)
Surgical	51.3	0.6	(78.2)	(21.2)		(47.5)
Clinical Support	2.1	1.7	(34.7)	(32.2)		(63.1)
Integrated Care	2.1	1.1	(29.2)	(3.8)		(29.8)
Estates and Facilities		1.8	(2.8)	(29.1)		(30.1)
Corporate & Other Management	302.0	10.1	(33.8)	(46.4)	(3.5)	228.4
Grand Total	**382.6**	**16.1**	**(243.3)**	**(151.9)**	**(3.5)**	**(0.0)**

Table 7: Establishments WTEs

	Establishment WTEs					
Division	Medical Staff	Registered Nursing	Support to Clinical Staff	Healthcare Scientists and ST&T Staff	NHS Infrastructure Support	**Grand Total**
Medical	196	385	367	19	1	**968**
Surgical	272	560	369	32	20	**1,252**
Clinical Support	44	94	284	254	30	**707**
Integrated Care	-	177	245	217	-	**639**
Estates and Facilities	-	-	4	4	61	**69**
Corporate & Other Management	15	43	10	2	251	**321**
Grand Total	**527**	**1,258**	**1,279**	**528**	**363**	**3,956**

Capital and Cash

- **Capital Planning:** Our headline allocation of £4.26m per year is significantly below our anticipated requirement. Our allocation is now lagging behind the level of depreciation that we are charging to revenue, effectively meaning cash designed to be available for replacement of assets cannot be fully utilised as there is insufficient resource limit cover. We continue to engage with NHSE to highlight the risk around limited access to capital.

  There remains limited availability of capital outside of these allocations, other than for targeted national programmes. Some funding streams for these national programmes are now known which has enabled us to plan with more certainty. We are awaiting confirmation on some bids and there is currently no certainty over access to funding for digital which poses a significant risk to our digital maturity journey.

  An initial prioritisation process was undertaken to develop the planned capital programme. This will now be refined through the existing internal processes to allow the programmes to commence. Table 8 shows the summarised capital programme for 2025/26, which currently includes an assumption of access to national incentive scheme capital linked to Urgent Care operational targets in 2024/25. We await the outcome of the national scheme to determine whether further de-prioritisation of the capital programme is necessary.

Table 8: Capital Programme

Scheme Type	System CDEL Allocation	National Schemes - PDC	Donated/ Grant Funded	IFRS 16	Total
	£k	£k	£k	£k	£k
CDC	700	2,337			**3,037**
Clinical Equipment	2,188				**2,188**
Day-case facility		415			**415**
Donated assets			240		**240**
Emergency Obstetrics Theatre		2,299			**2,299**
Endoscopy		701			**701**
Estates	1,556				**1,556**
ICT - Digital	1,193				**1,193**
IES			5,013		**5,013**
IFRS16 Leases				621	**621**
UEC Expansion		4,308			**4,308**
Total	**5,637**	**10,060**	**5,253**	**621**	**21,571**

- **Cash:** During 2024/25 we have not required revenue cash support as the funding mechanism and ICB support with profiling of payments has supported a manageable position. Given the risk and level of efficiency within the 2025/26 plan availability of cash remains a risk. There has to date been a national process to facilitate access to revenue cash for organisations with a cash shortfall. We have an established weekly cash management meeting and operate a rolling 12 month cash flow projection to highlight early if mitigating actions are required.

  Separately to revenue cash, there is a requirement for access to capital cash in 2025/26. The Trust's first call on its internal funding (depreciation) is capital liability repayments for the PFI and leases. In line with all NHS bodies, the Trust adopted IFRS16 liability re-measurements in 2023/24 which significantly increased both the PFI liability value and the associated liability repayments. For 2024/25 the overall capital liability repayments will exceed internal funding, resulting in PDC capital funding being required to cover both this shortfall and the schemes planned against system CDEL. A summary of funding sources is shown in table 9 below.

Table 9: Capital funding sources

Funding Source	System CDEL Allocation	National Schemes - PDC	Donated/ Grant Funded	IFRS 16	Total
	£k	£k	£k	£k	£k
Internal sources					
Depreciation	13,414				13,414
Less: PFI liability repayments	(12,754)				(12,754)
Less: Lease liability repayments	(1,006)				(1,006)
Total Internal funding available	**(346)**	**0**	**0**	**0**	**(346)**
Capex on IFRS 16 assets				621	621
Internal Cash cfwd	346				346
PDC - system capital support	4,937				4,937
PDC - cash cfwd from 24/25	700				700
PDC - central programmes		10,060			10,060
Income from grants/donations			5,253		5,253
Total capital funding sources	**5,637**	**10,060**	**5,253**	**621**	**21,571**

Next Steps

The plan reflects an ambitious and stretching financial positon yet is felt to be credible based on the assumptions made, and as has been set out above is not without risk. A final national re-submission process took place at the end April to resolve minor items, and did not result in any material changes to our plan.

The internal budget sign off process will conclude during May. In year reporting and monitoring at directorate and divisional level will include tracking against the income/activity plans, expenditure budgets net of CPIP, run rates and workforce levels to ensure triangulation across all dimensions of the operational plan.

Recommendations

The Board are asked to:

- Ratify the approval of the financial plan which was necessarily submitted under delegated authority due to timing following the Extraordinary Board meeting – taken place on 19th March; and
- Endorse the divisional budgets and establishments, noting that the sign off process is underway.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Powys Elective Commissioning Intentions
Lead Executive Director:	**Chief Finance Officer**
Author:	Andrew Parker (COO), Katie Osmond (CFO), Suzi Joberns (Deputy CFO)
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Trust provides a range of clinical services to Powys residents, with an estimated population base from Powys of around 40,000.

Linked to their own challenging financial situation, and seeking to achieve parity of waiting times across their range of English and Welsh providers they confirmed in March 2025 an intention to adhere to the NHS Wales waiting times standards i.e. that all patients will receive treatment within 104 weeks and 52 weeks waits for outpatients by March 2026. This is different to the NHS England standards of all patients being treated within 52 weeks by March 2026. This excludes children, urgent and cancer pathways and only applies to those patients that have both a Welsh GP and reside in a Welsh postcode.

Over the last few weeks we have been working with PLHB colleagues to understand the likely impact of application of this commissioning intention. The impact would be through a slowdown and reduction in planned care activity, with an expectation of a significantly reduced spend compared to 2024/25. We have not had sight of any detailed modelling.

In 2024/25 we received income in relation to planned care from Powys of approximately £10m. The Powys commissioning intention proposal could represent up to a 40% reduction. Our modelling suggests that when we include children, urgent and cancer pathways and those patients we will need to treat to avoid breaching the 104 weeks standard, the scale would be significant, though not as great a reduction as PLHB envisage.

To provide context, initial modelling indicates a reduction of c3,000 New and c5,500 Follow-up outpatient appointments with over 1,000 patient treatments compared to the volumes delivered in 2024/25. As an example, 120 fewer orthopaedic procedures and 212 fewer ophthalmology procedures for patients than we have historically undertaken.

No assumption has yet been made around any resultant impact on urgent and emergency care demand, due to delaying elective care for long waiting patients, nor the resultant step up in planned activity required to avoid breaches for Q1 of 26/27.

We are modelling the impact at a specialty level and are concerned about the risk of stranded fixed capacity which would result in lost productivity. It is not the case that reductions in demand from one

commissioner can be automatically filled with patients from anther commissioner due to the different contractual arrangements.

We are working with PLHB colleagues to understand their Quality Impact Assessment, undertake our own assessment and to agree appropriate communications materials and implementation plan.

Outside of the planned care commissioning intention, there are further proposals from PLHB around the urgent care elements of the contract and protocols for admitting Powys residents to Herefordshire Community Hospitals. We have rejected both initial proposals and continue to work with PLHB colleagues to find a mutually acceptable contractual position.

Finally our expectation that PLHB fund in parity with English commissioners i.e. payments for remoteness, excess PFI costs and excess inflation have been escalated to both Welsh Government and NHSE for resolution.

Recommended Actions required by Board or Committee

Board are asked to note the ongoing contractual negotiations with Powys commissioners, and the risk to Elective productivity and the financial plan as a result of the change in planned care commissioning intentions.

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.

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	**Freedom To Speak Up – FTSU.** **Annual report 2024/25**
Lead Executive Director:	**Chief People Officer**
Author:	Jo Sandford FTSU Guardian
Reporting Route:	Geoffrey Etule
Appendices included with this report:	Staff Survey Results National Guardian Report Civility Saves Lives
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

- This report provides broad details of Speaking Up events for the year 2024/2025.
- It provides an up-date from the Trust's Freedom to Speak Up Guardian (FTSUG) on progress, exceptions, any themes and learning and on-going plans to continue strengthening arrangements for staff to Speak Up and raise their concerns.
- It also informs the board and public of National FTSU and Local developments that will influence WVT strategy and development and where FTSU objectives contribute to Trust objectives.

Recommended Actions required by Board or Committee

Leaders to continue to promote :-

- Speaking up FTSU training within all departments. We do have a high percentage at 93.4% which is steadily increasing and an excellent percentage for mandatory training. Please contact ftsu@wvt.nhs.uk if you would like a breakdown provided for your area.
- E-Learning for line managers, Listen Up training as part of the appraisal process. 183 staff in the trust have completed Listen Up training to date.

The Organisation to :-

- Promote that senior staff do listen, are very supportive of FTSU and will take all speaking up seriously.
- To provide training for managers to ensure that bad behaviours within a team are tackled and not hoped they will disappear of their own accord.

Executive Director Opinion[1]

The annual report demonstrates significant progress made by the FTSU Guardian in ensuring employees have a voice at the Trust. The Trust continues to support an open, civil and inclusive culture and appropriate steps are being taken to enhance the working environment for all employees.

1. Executive Summary

This paper provides a summary of FTSU activity and themes of concerns raised with the Freedom To Speak Up Guardian (FTSUG) and FTSU Champions at WVT for 2024/25

A summary of FTSUG activity is detailed along with developments and actions that have been taken to further imbed the FTSU role and to encourage a culture of openness. As an example of WVT's commitment to FTSU the number of hours ring fenced for the FTSUG post was increased to 3 full days per week from April 2023. However, with the increased volume of cases and the development of the role the Guardian has been working full time hours from November 2023. This needs reviewing as we are providing an excellent speak up service at WVT but money needs investing to maintain it.

The role of the FTSUG touches many areas of the CQC Well-Led Framework. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question.

2. Summary of Speaking Up in 2024/25

Speaking up has had a very successful year. Due to significant amounts of promotional work and a vast number of Champions around the trust has resulted in not only a vast increase of cases but general awareness of the service. Being such a small Trust is a benefit and many staff are coming to the Guardian as their friends and colleagues have had such a positive experience. Cases are dealt with promptly and closed much quicker. Resulting in less stress and worry for those speaking up, which is giving FTSU an excellent reputation around the Trust.

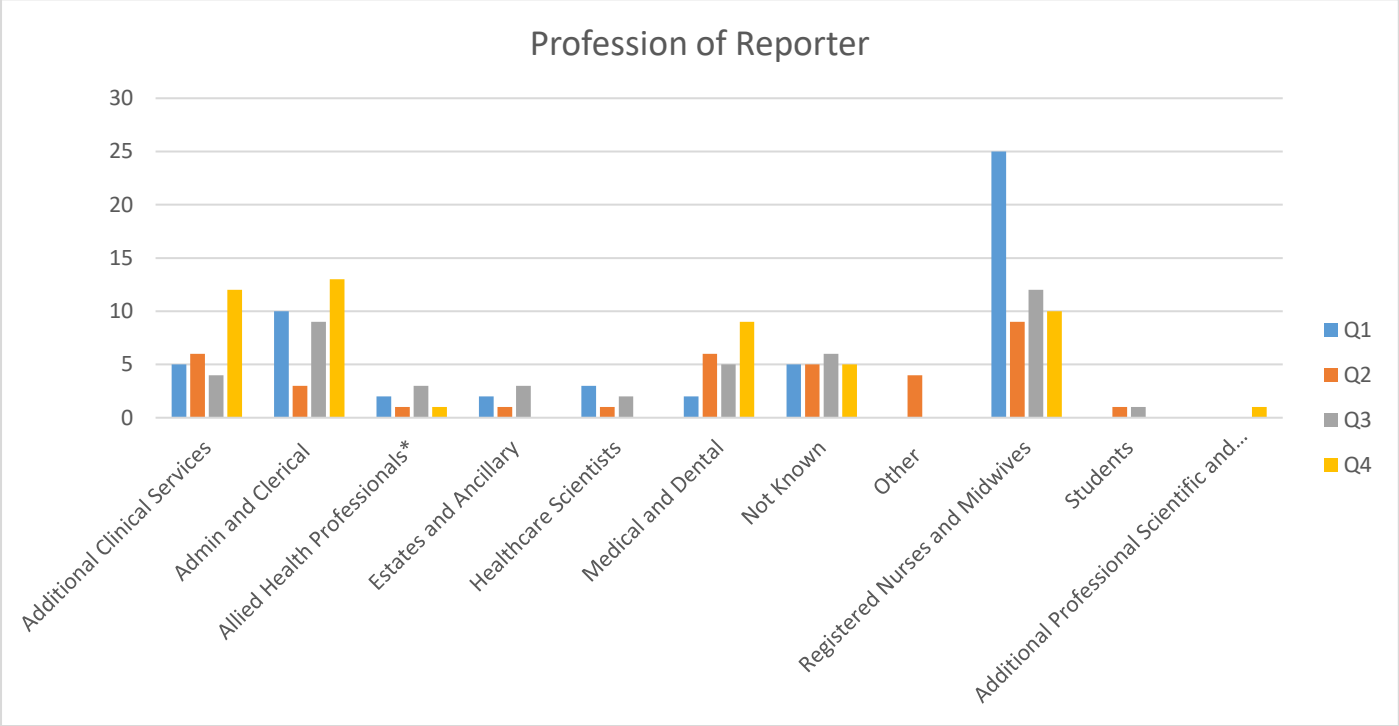
2.1. Speaking up data in 2024/25

There were a total of 187 cases in 2024/5. Only three of these still remain open. This is an increase of 49.6% on last financial year and an increase of 159.7% since commencing in the Guardian role on 1/4/23

Financial Year	Number of Cases
2018/19	24
2019/20	73
2020/21	70
2021/22	74
2022/23	72
2023/24	125
1014/25	187

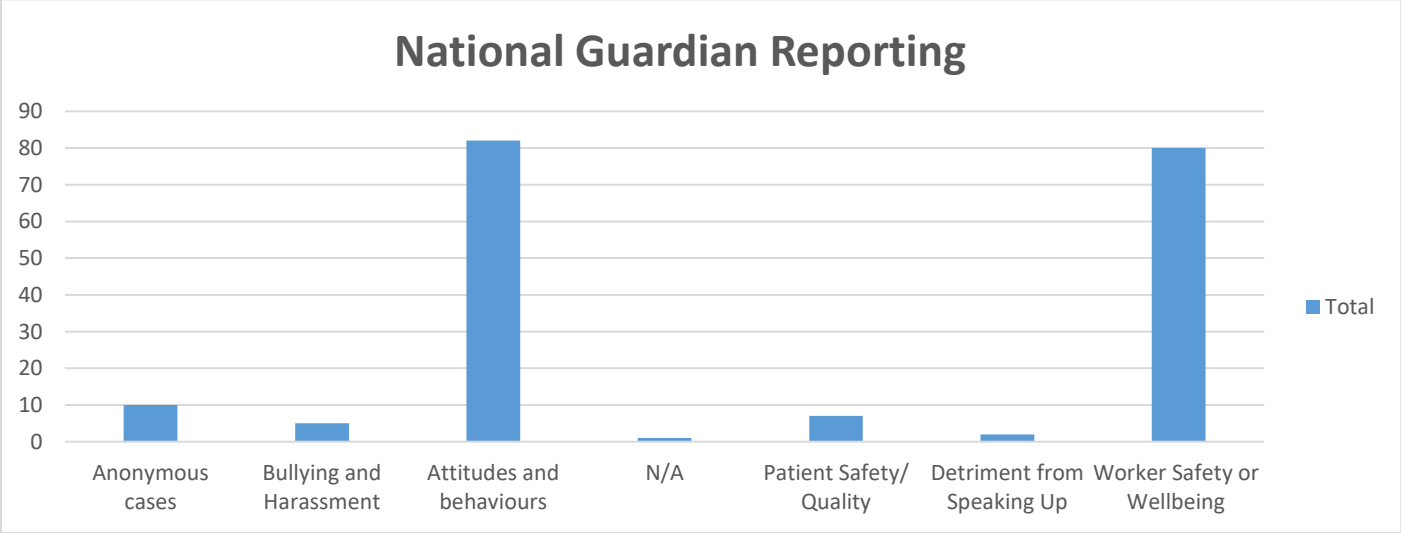
2.2 Speaking up Identified by Staff Group.

Administration and Clerical staff and registered Nurses and Midwives were the main groups of staff speaking up over the year. This is reflective of previous years. There has been a significant decrease in cases recorded as anonymous compared to previous years. These staff did not give their name when they approached the Guardian or they were comments/questions posed on the Trust's Rumour Mill anonymously that required a response from the FTSU Guardian or they were known to a FTSU Champion who acted as an intermediary. The decrease is hopefully a result of promotional work and communications demonstrating that concerns are acted upon and at WVT it is safe to speak up.



2.3 Data returns to National Guardian Office (NGO)

The six categories that are required within the NGO quarterly report are shown in the graph below.



Speaking up events are categorised from the perspective of the individual speaking up or subjectively by the Guardian from the information received and must be reported to the NGO quarterly. The categories are at times vague and if something relating to staff doesn't fall into any of the other categories it has to be recorded as worker safety/wellbeing. There have been numerous requests from Guardian Networks for the NGO to expand the number of categories to include things like trust policy and procedures not being adhered to.

Behavioural concerns from the three related categories (Detriment/ Bullying & Harassment / Inappropriate behaviours) shown in the chart above make staff relationships and interactions the subject of greatest concern with

53% of cases. Worker Safety or Wellbeing also accounts for where staff are suffering from stress or anxiety from incidents in the workplace. WVT is not an outlier in this. The NGO FTSU Annual report 2023/24 states, *"Poor behaviour remains a cause for concern, with the highest proportion of cases – a third **(32.3%)** – including an element of behaviours, such as **bullying/harassment.** This is a rise from 30.1% last year."* The 2024/25 report is due July 2025 but discussions within the Midlands FTSU Network reflect that the situation is likely to be similar.

"A recent study of people who experienced bullying in the workplace found that 75% reported a loss of concentration, memory and overwhelming anxiety, and over 80% felt the 'anticipation of the next negative event' – the feeling of constantly walking on eggshells" Tim Keogh – A Kind Life

While our clinical services are the key to WVT success, we can only maintain high standards of patient care if the welfare of all staff is made a priority. When concerns are raised we need to demonstrably show we are acting on them. Sometimes getting a timely response to action is difficult in the current climate. This then impacts on the staff speaking up and their mental health. To ensure an excellent FTSU service is maintained with a reputation that shows that WVT does listen and will act upon concerns raised, response times need to improve. Feedback to staff who speak up is always timely and comprehensive. The FTSUG works also side the HR team with their staff wellbeing agenda and promotions across the Trust.

2.4 Civility Saves Lives

In the past 12 months we have been able to deliver Civility Saves Lives (CSL) to 246 WVT staff. The Guardian has delivered train the trainer sessions and now has a team of 10 staff. Meaning we can now offer a monthly team's session and a monthly face to face session via the EDC. Bespoke team sessions are available too if requested. We also provide sessions for the preceptorship programme, leadership and management course, junior doctors and student nurses.

What is Civility Saves Lives?

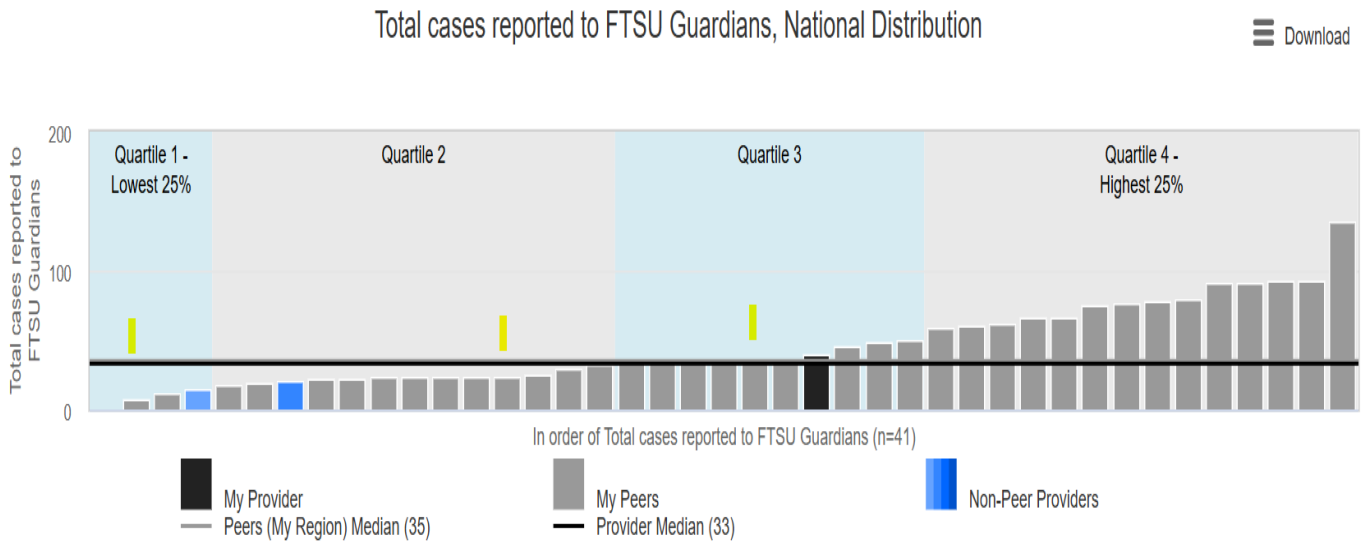
- It's about developing and sustaining an open and positive culture, creating a place of physiological safety for staff to feel confident to Speak Up.
- It's about Civility in the workplace. As Chris Turner from the CSL campaign shouts from the roof tops is critical for patient safety. It also encompasses staff safety and wellbeing, removing poor behaviours, bullying and harassment and micro aggression that communicate some sort of bias.
- It's about throwing defensiveness out of the window and being curious to concerns and challenges when things are not right or could be better when someone speaks up to you.
- It is simply being kind and respectful to our colleagues to improve team work and patient outcome.

"We are a collective voice for the importance of respect, professional courtesy and valuing each other. We aim to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can understand the impact of our behaviours" Dr Chris Turner, Consultant in Emergency Medicine

2.5 National Comparisons

Model Hospital's reporting for cases reported to FTSU Guardians is very behind so the graph below is for Quarter Four of 23/24 showing WVT into quartile 3 with 40 cases.

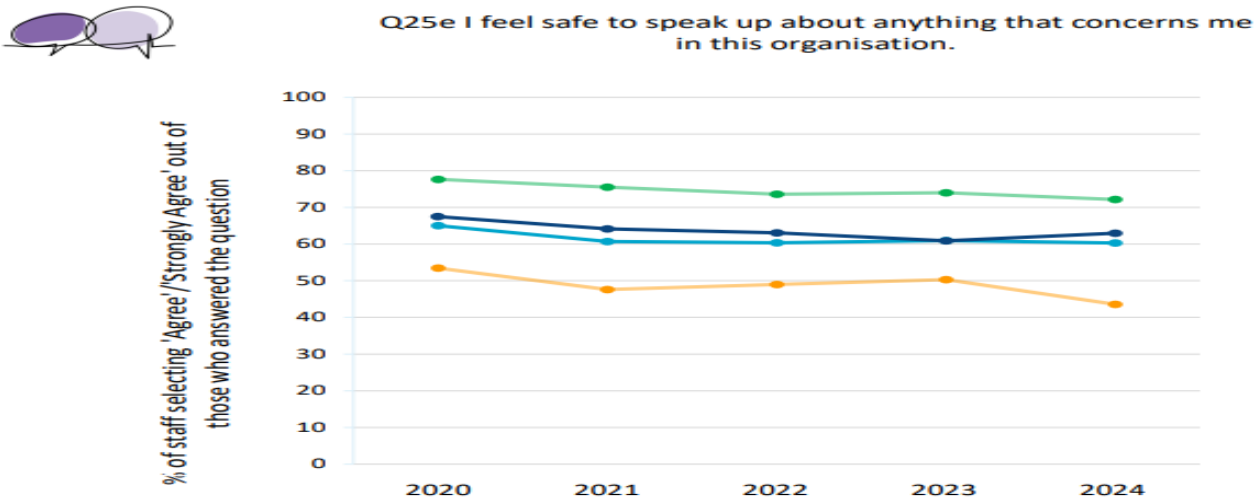
Wye Valley Trust – 40 cases
Worcester Acute Trust – 35 cases
South Warwickshire Foundation Trust – 24 cases
George Eliot Hospital - 8 cases



This does not mean that WVT have more issues than other hospitals. It means we have a speak up service that is trusted. Staff feel listened to and have faith that action will be taken as a result of them speaking up.

2.6 NHS National Staff Survey 2023

The questions that make up the People Promise section, we all have a voice that counts, raising concerns, is reviewed every year locally, regionally and nationally by all FTSU Guardians. This compares the Trust's performance nationally and is an indicator how safe staff feel to Speak Up and how confident they are the Trust will act. The 2024 Staff Survey published in March 2025 show that for feeling safe to speak up there was an increase of 2.1% which is a reflection on the promotional work around the trust, an increase in Champions and a high success rate for resolving issues and concerns.



	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

2.7 Lessons Learnt

1. **The use of English Language within the workplace**

   There have been a number of cases throughout the year in relation to the use of the English language in the workplace. This has been addressed as the subject of a presentation to Medical Matrons and Sisters and within Theatres and the surgical directorate. The presentation is to be made available for managers to use when this issue arises with an aim to get staff on board and to be aware of the Trust Statement that covers three distinct areas of the work place. The aim is assist staff to be aware of the many challenges to this subject and help them be compassionate and inclusive whatever their position is by putting themselves in everyone's position. Clinical areas is where English must be used so that everyone including patients are involved in communication. In staff communal areas a 'Read the Room' approach is suggested so that everyone feels included. There has been success from this approach with staff in Theatres who initially spoke up as they were told it was forbidden to speak their own language anywhere within the department.

2. **Responding to Speak up Barriers**

   The two themes that I hear as Guardian are that staff felt that their manager and the executives won't listen and even if they do they will not act upon the concerns raised. "Listen Up" training is now mandated for any staff member who manages another. This has been rolled out by including it as part of the appraisal process. To give them awareness of how important speaking up is.
   We also have a local film which highlights to staff that Executives do listen and are fully invested in the speak up service and that speaking up at WVT is actively encouraged. The film has had excellent feedback.

3. **Feedback to Staff**

   The importance of keeping staff updated is vital to providing an exemplary speak up service. It is important that staff responsible for investigating a concern answer emails in a timely fashion. The person who has spoken up is very often very stressed and anxious. Speaking up can be a big part of a staff member going off sick which costs the trust money. The fast closure of cases this year has significantly reduced the sickness episodes of those speaking up.

4. **Support and Development for Leaders**

   A common theme this year has been line managers not treating staff fairly or following the correct policy or procedure. The Guardian researched if there was a cause for this trend. Evidence suggests that new staff, especially those in an admin and clerical role are being promoted quite quickly within the trust and have no leadership or management experience. Although the trust offers a wide range of training courses and specifically a three day Leadership and management course, staff were not being sent on these courses to help them to develop within the role. The Guardian suggested to TMB in her last quarterly report that some kind of preceptorship programme is developed to help support new leaders which will then have a positive impact on their staff.

   These are just a few of many learning outcomes as a result of staff speaking up and the Guardian continues to review themes and make suggestions for improvement within the trust.

3.1 Exception Reports

For the year 2024/25 there were no cases open for more than 3 months. Only 3 cases from this financial year still remain open

Version 1 22020304

3.2 Mandatory Training for FTSU

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	131	131	126	96.18%
Additional Clinical Services	802	802	762	95.01%
Administrative and Clerical	875	875	833	95.20%
Allied Health Professionals	350	350	333	95.14%
Estates and Ancillary	131	131	121	92.37%
Healthcare Scientists	92	92	85	92.39%
Medical and Dental	447	447	360	80.54%
Nursing and Midwifery Registered	1,223	1,223	1,165	95.26%
Students	4	4	4	100.00%
Total	4,055	4,055	3,789	93.44%

WVT was one of the first Trusts in the Midlands to mandate module one, Speak Up via eLearning. It still remains one of the few trusts within the region that has made the training mandatory. The aim for all mandatory training is for the percentage is 85% or higher to be compliant. At the end of March 2025 FTSU was 93.44%. Only Medical and Dental are not achieving the required 85%. The National Guardian Office is calling for all three modules of FTSU eLearning to be mandated following on from the results of the 2022 Annual Staff Survey.

"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters" Jayne Chidgey-Clark National Guardian

The Guardian has reported to TMB that staff feel that managers will not listen or act upon their concerns. It has been agreed to mandate module two, Listen Up training for anyone who line manages another staff member.

4. The WVT FTSU Team

The Guardian is contracted for 22.5 hours with the flexibility to work additional hours to meet demand. At the beginning of 2023/24 there were only 22 champions trust wide. This was not enough to be representative of the current workforce and so on the FTSU Five Year Plan a target of 100 was set. This has been achieved by May 2024 and there are currently 112 Champions who have all received training. The aim is now to have one in every department across the trust. Work is ongoing to improve the visibility of Champions. This has included Lanyards, badges, a list available on the intranet and posters around the trust saying who the champion for that area is.

5. Breaking down Barriers

As part of the promotional work for this year I have tried to target minority groups who are reluctant to speak up. The BAME community is one of these groups and yet they make up more than a quarter of our workforce. I have recruited a lot of Champions and joined in with the monthly BAME meetings. Last year we had 7 BAME Champions but this year there are 15. The Chief People Officer and I are members of a What's App Group for all Indian Staff. We are hoping to widen this in the coming year to other nationalities that have formed communities because of their shared heritage.

I am also an ally of the LGBQT+ community and the disability awareness group in the trust. It is important that every staff member in the trust feels able to speak up and in a safe environment. There is now a designated FTSU Office. Due to the sensitive nature and for confidentiality purposes it is vital that a private space is available for those speaking up.

6. The Future of FTSU within WVT

The case load rose by 49.6% last financial and I was expecting that to plateau this year. To maintain the successful Speak up Service that has been developed over the last 12 months consideration to making the role full time needs to be addressed. I am looking forward to continually reviewing, improving and developing the FTSU Service within Wye Valley Trust over the next financial year.

Jo Sandford
Freedom to Speak Up Guardian
Wye Valley Trust
Version 1 22020304

WYE VALLEY NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Patient Experience Quarterly Report Q4 2024-25
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

To provide the quarterly patient experience report; including an update on performance measures associated with the Trust Quality Priority – Improve responsiveness to patient experience data.

Recommended Actions required by Board or Committee

The board is asked to note the detail of the report. The key headlines are;

- FFT data collection paused while new system developed.
- Complaints at year end were up 3% compared to the previous year and comebacks have doubled.
- Negative feedback now outweighs the positive with 'waiting times' for inpatient FFT.
- PALS service remains fragile but well supported by clinical teams.
- Partial compliance with metrics for the quality priority 2024-25. The same metrics will be used to measure improvement with the quality priority remaining in place for 2025-26.

Executive Director Opinion[1]

The volume of complaints and the time taken to respond remains an area of concern. The number of complainants that are dissatisfied with the first response (comebacks) is also an area that services must focus on.

The Patient Engagement Forum is now well embedded and the newly established Volunteer Steering Group has clear areas of focus.

The new interpreting service has been operational since April 2025, early feedback is positive; an evaluation of this will be covered in the next quarterly update.

[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.

Patient Experience Report

Introduction

The report provides an update on patient experience key metrics and areas of improvement in support of the Trust Quality priority for patient experience. The report summarises the year-end position of the trust quality priority for 2024-25 and outlines the objectives of the priority for 2025-26.

Headlines

- FFT data collection paused while new system developed.
- Complaints at year end were up 3% compared to the previous year and comebacks have doubled.
- Negative feedback now outweighs the positive with 'waiting times' for inpatient FFT.
- PALS service remains fragile but well supported by clinical teams.
- Partial compliance with metrics for the quality priority 2024-25. The same metrics will be used to measure improvement with the quality priority remaining in place for 2025-26.

Quality Priority- Improve responsiveness to patient experience data

This report has provided a quarterly update on patient experience metrics used to measure improvement again the quality priority for 2024-25. The year-end position for the priority is outlined below.

The quality priority remains in place for 2025-26 and the same metrics will be used to demonstrate progress;

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

The 2025-26 quality priority will focus on two defined projects;

- Implement the PHSO model complaints framework/ standards.
- Expand ability to leave feedback through improvement of the FFT system.

Friends and Family Test (FFT)

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

FFT text message service rollout

The text messaging service is live in the following services;

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

Outstanding is;

- Remaining community services
- Paediatrics

Previously reported issues with the rollout of FFT to community services and paediatrics have been resolved and work is in progress to allow these services to use the text messaging service.

FFT Results

Below is the FFT results data from 1st January 2025 – 31st March 2025.

Headlines

Between 1st January 2025 – 31st March 2025;

- The Trust has sent 84170 messages for feedback.
- 15998 responses were received (14% response rate overall).
- 92.33% of these responses are positive feedback.
- 11.45% of patients gave further comments in regards to how they scored their experience.

Between 1st April 2024 – 31st March 2025;

- The Trust has sent 282064 messages for feedback.
- 56086 response were received (14.87% response rate overall).
- 91.53% of these responses are positive feedback.
- 12.39% of patients gave further comments in regards to how they scored their experience.

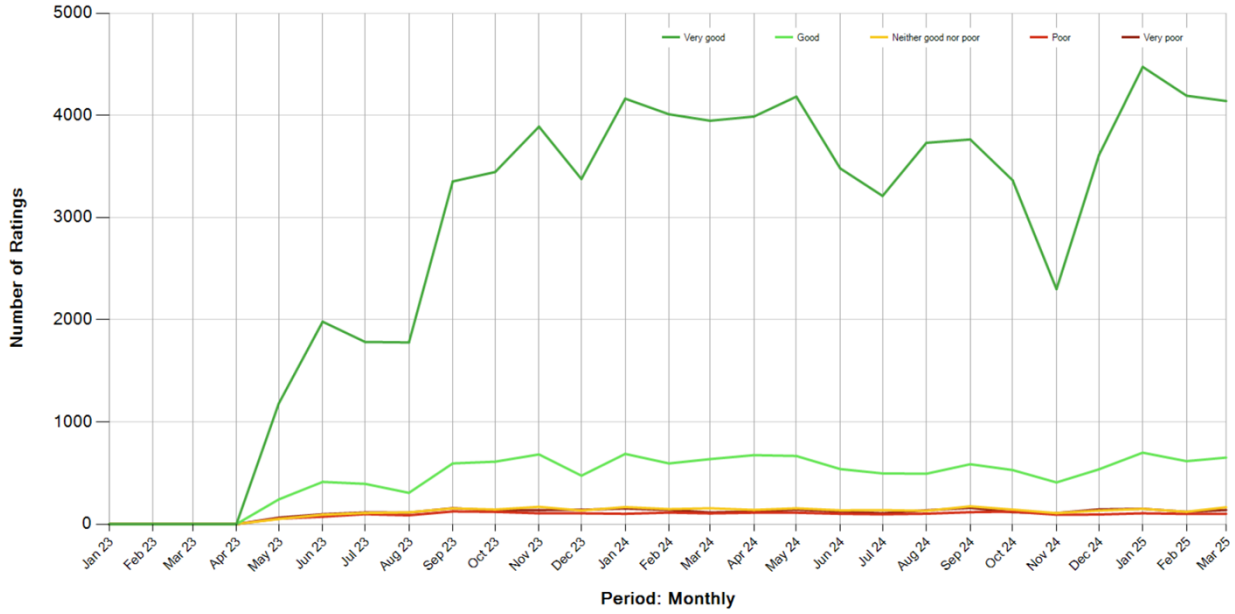
Quantitative Data

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

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Trust	91.74%	91.66%	91.99%	92.1%	91.91%	91.49%	91.35%	91.63%	90.19%	90.83%	89.05%	91.40%	92.27%	93.07%	91.66%
Inpt	85.65%	81.67%	88.63%	85.97%	82.79%	84.54%	80.65%	84.24%	82.68%	87.91%	82.49%	83.61%	86.67%	87.13%	85.71%
OP	94.32%	94.13%	93.91%	94.48%	94.11%	94.21%	94.46%	94.78%	93.03%	92.93%	92.32%	94.75%	93.87%	95.06%	94.20%

Overall, we continue to see the highest satisfaction ratings in outpatients, at a consistent level each month. Inpatients shows a fluctuating picture in comparison, due to the data problems experienced in November it is difficult to confirm whether we would have seen a more stable picture from October to the end of March.

The chart below shows the actual response received by patients and overwhelmingly the most popular response continues to be ‘very good’ month on month, increasing in January 2025 to be above 4000 and maintaining the trend for Q4. The past 12 months have shown a fluctuating picture for ‘very good’ but this has not been replicated in other responses which have remained stable.



The Trust's average response rate when introducing the text messaging service in January 2023 was 20%. From April 2024, we have continued to see the response rate decline reaching its lowest point in December 2024 at 12%, with a slight increase in January 2025 to 13%, Q4 has continued to see an upward trend.

To try to improve our response rate we are currently working with Healthcare Communication to introduce the additional ability for patients to leave feedback at any time through the Envoy system, in addition to receiving targeted text messages. This facility is due to go live in early June 2025, a delay on the original date of April due to significant time being spent on ensuring our 'hierarchy' is correct, we are currently at the 'Testing' stage. In addition, we are currently reviewing how we communicate and promote FFT with the development of new communication aids in the form of a new poster, pop-up banners and use of social media. A promotional campaign is timed for early June to promote the new facility and at regular intervals throughout the year to encourage feedback.

A breakdown by service type is shown in the table below.

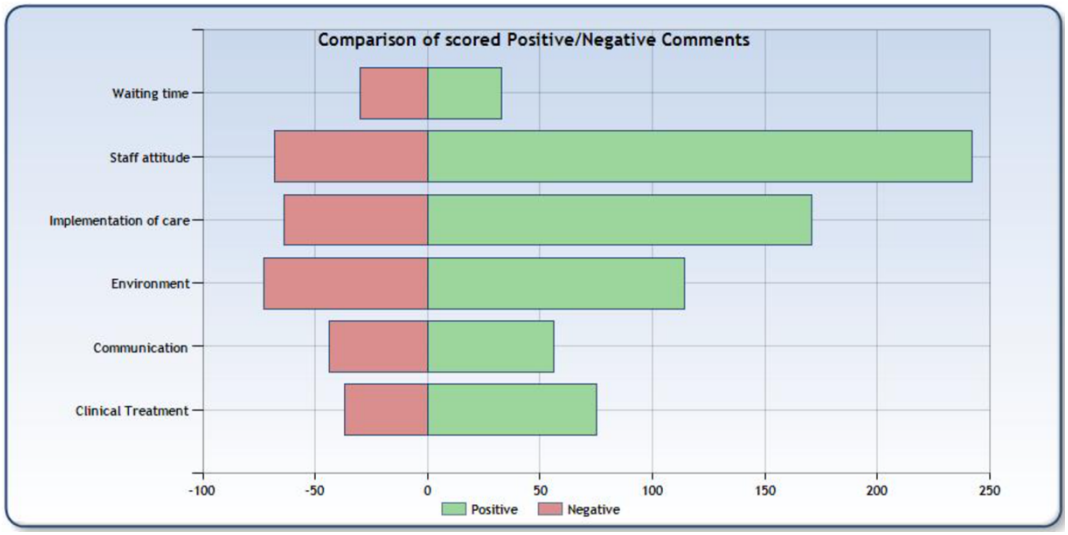
	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Trust	18%	18%	19%	18%	17%	17%	17%	17%	17%	16%	9%	12%	13%	13%	15%
Inpatient	18%	16%	17%	18%	16%	18%	15%	17%	15%	15%	7%	15%	15%	16%	15%
Outpatient	17%	18%	19%	17%	17%	16%	16%	16%	16%	15%	16%	11%	12%	12%	14%
Day case	24%	23%	25%	23%	23%	23%	23%	22%	21%	21%	23%	20%	20%	20%	20%

Qualitative Feedback

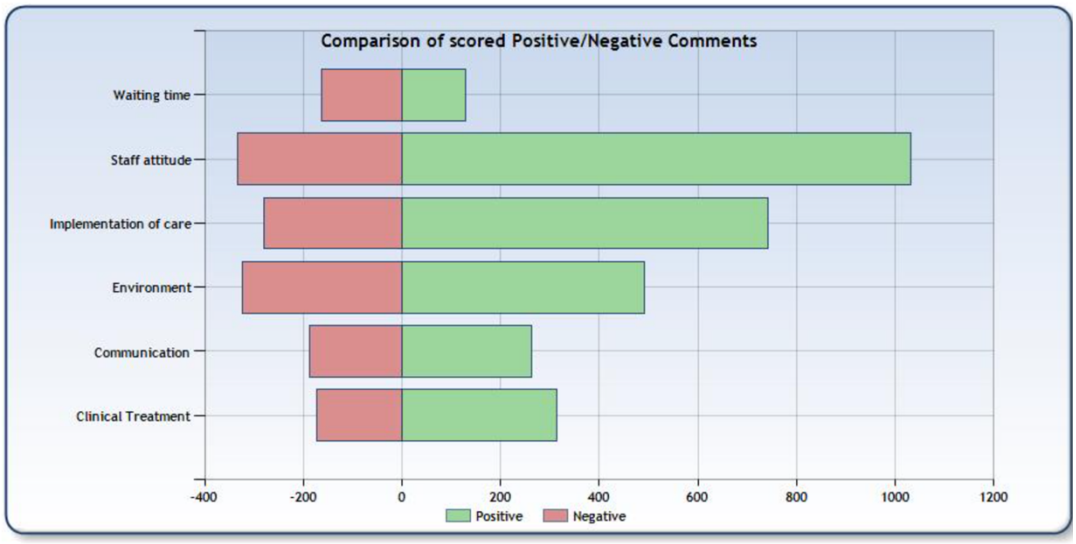
After patients have answered the initial FFT question, they are asked for comments. The free text comments message provides a wealth of qualitative data. The Envoy system allows themes to be identified and categorises the qualitative feedback thematically and by the negative or positive nature of the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

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

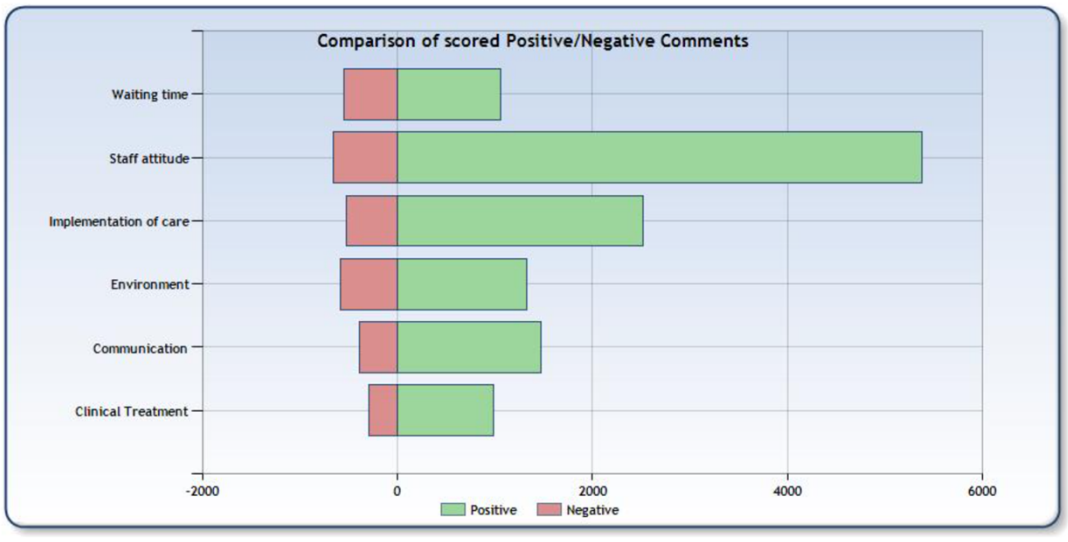
Inpatient responses Q4



Inpatient response 2024-25



Outpatient responses Q4



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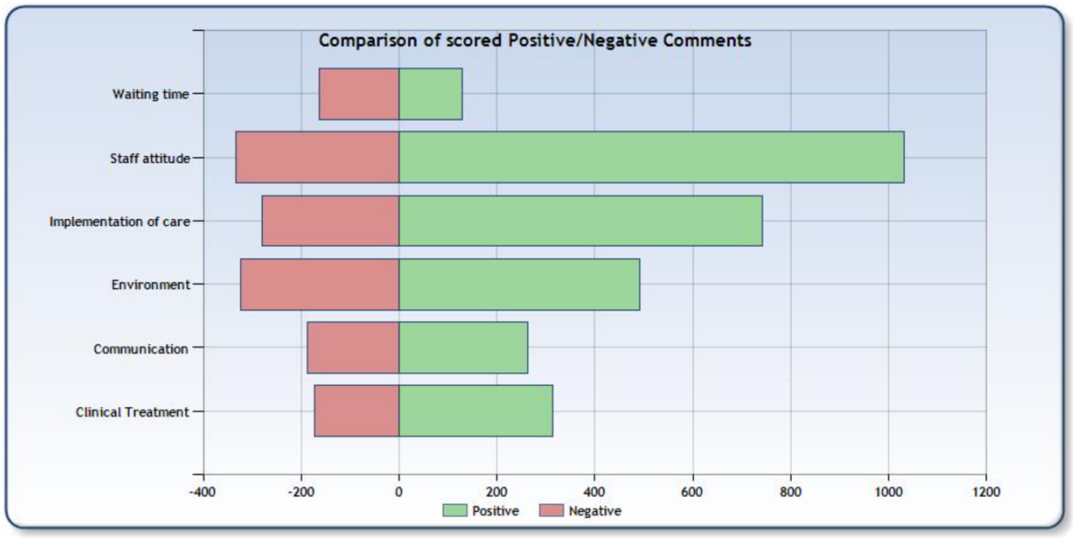
Outpatient response 2024-25



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

For both Outpatient and Inpatient areas 2024-25 showed that negative feedback outweighed the positive for waiting times.

Complaints

This section of the report provides;

- KPI data update Q4 and year-end for 2024-25
- Analysis of complaints position by Division
- 2024-25 complaint categories overview
- PHSO cases update
- Overview of outcome codes

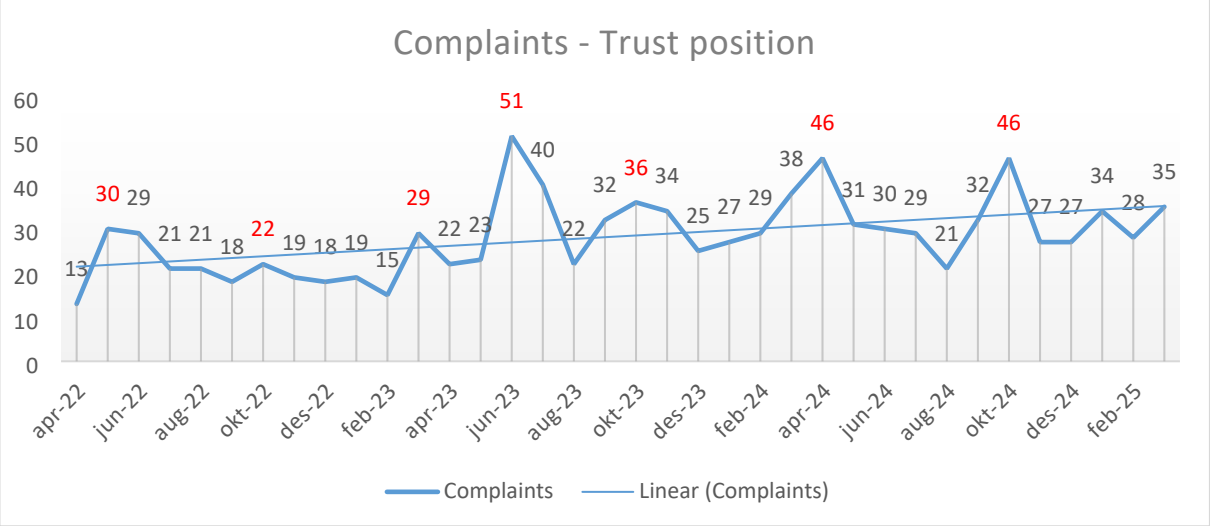
Complaints position

(New complaints only)

KPI	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Q1	Total Q2	Total Q3	Total Q4	Total Apr-Mar (inc)
Number of complaints **2023/24**	22	23	50	40	22	32	36	33	25	27	27	38	95	94	94	92	375
Number of complaints **2024/25**	46	31	30	29	21	32	46	27	27	34	28	35	107 ↑13 %	82 ↓13 %	100 ↑6%	97 ↑5%	386 ↑3%

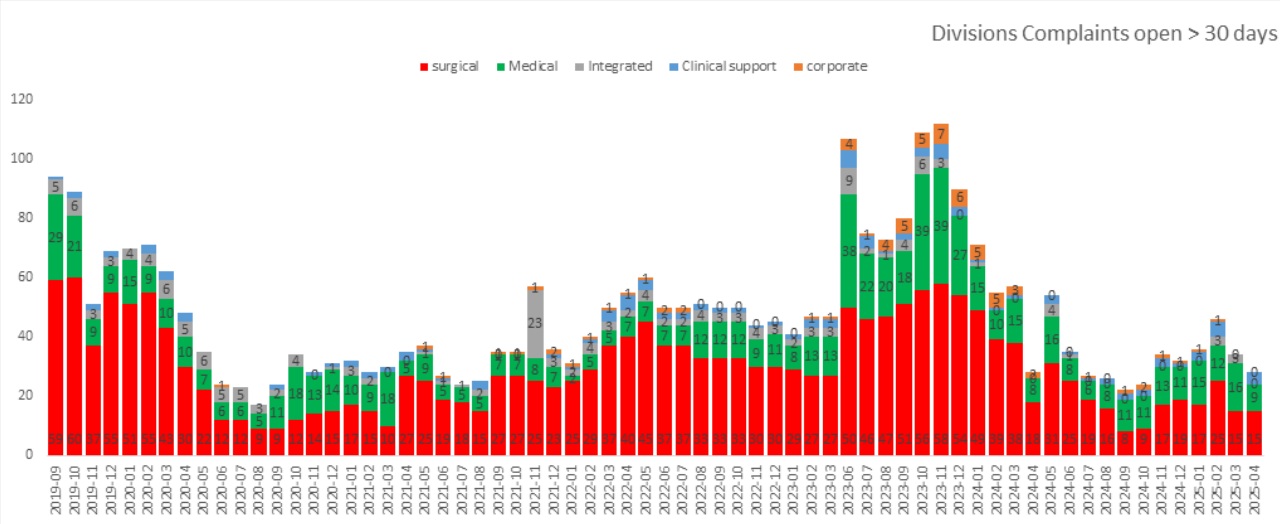
A comparison of data between Q4 in 2023 and 2024 shows an overall increase of 5% in new complaints received. Over the year, there has been a 3% increase in new complaints received compared to 2023.

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

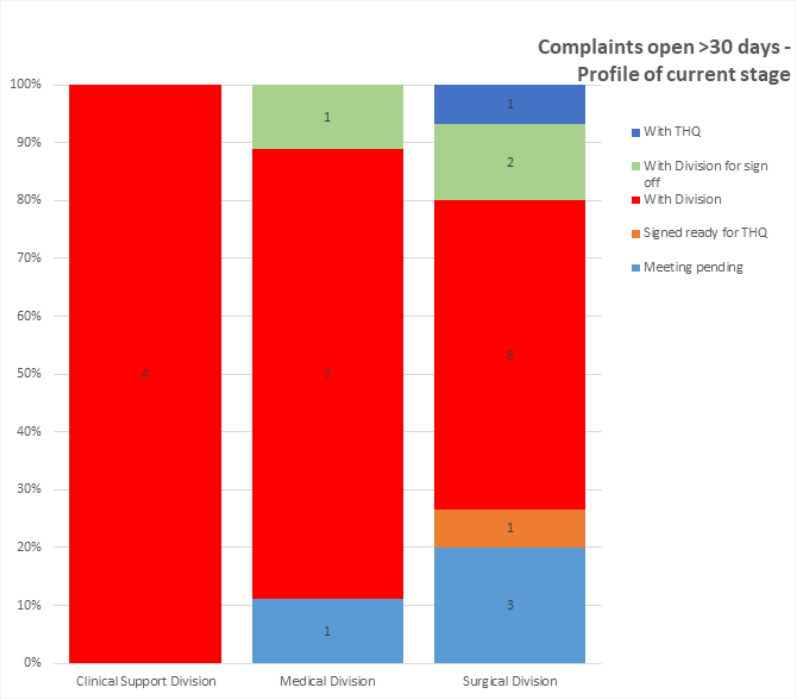


Complaint response times

The chart below highlights the current number of complaints open over 30 days by division. These figures will include any complaints where an agreed timeframe has been applied. Despite a marginal increase in Q4, the overdue complaints position has improved significantly since 2023.

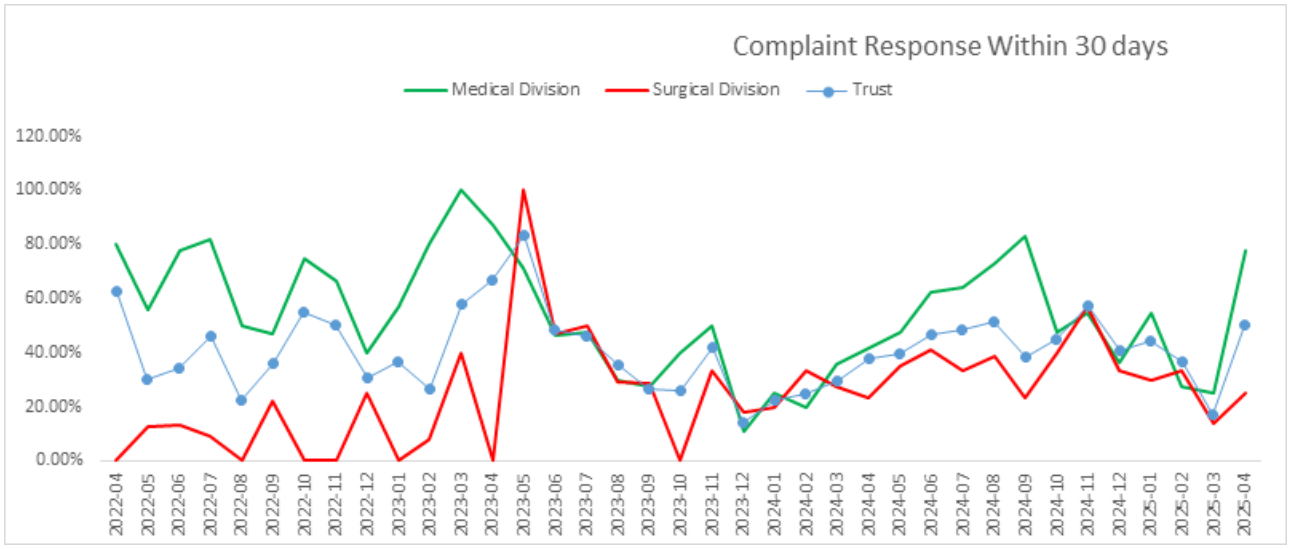


When reviewing the stage of current complaints open for more than 30 days, we can see that the majority are with the investigating officers to complete responses.

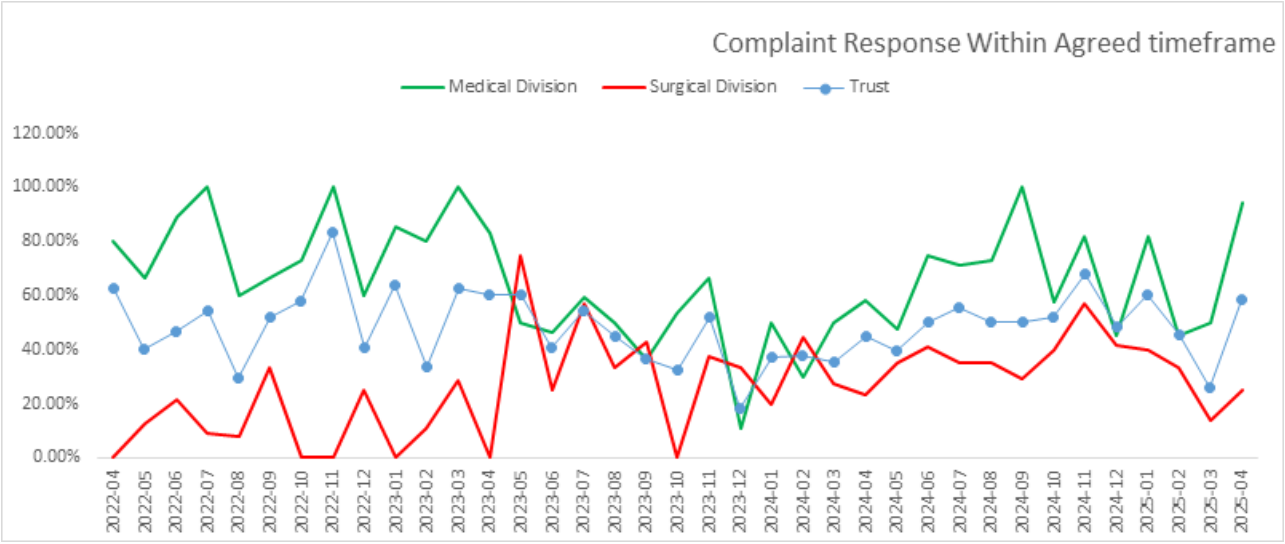


The chart below shows the percentage of complaints being resolved within the 30 day timeframe (rolling 3 month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers.

Q4 saw the lowest position in year with only 17% of open complaints answered within 30 days. Medicine have consistently better response rates than surgery, but the Trust can demonstrate compliance with this KPI in only 40-50% of complaints.



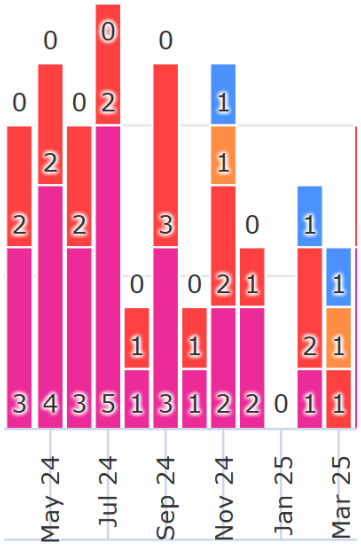
Often complaints are complex in nature and require multiple services to input to the investigation and response. Where this is the case, early engagement with the complainant should be undertaken to agree a timeframe for the response to be provided. The chart below highlights performance for these cases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



These charts demonstrate that whilst there is some improvement when agreeing the timescale to respond with complainants, we are still only meeting any individually agreed deadlines 50-60% of the time in year.

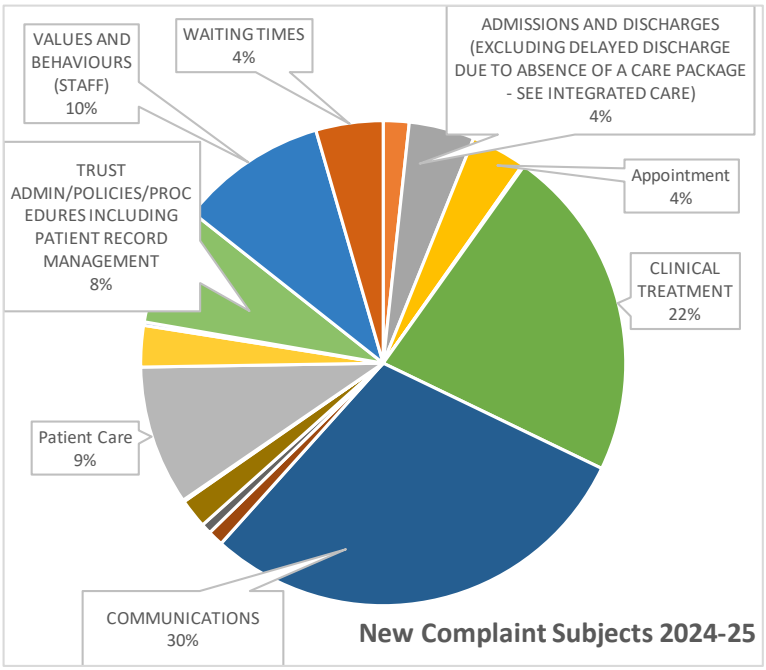
Comebacks

When also considering the number of complaints that are reopened ('comebacks') that Divisions also need to respond to, this increases the total number of complaint responses required. The number of comebacks has doubled since last year. Analysis shows that improved accuracy and ensuring all questions asked are responded to will support a reduction in comebacks.



Number of comebacks 2022	36
Number of comebacks 2023	25
Number of comebacks 2024	49

Complaint categories



62% of the complaints received in 2024/5 related to perceived issues with the following categories by complainants: These are largely the same as last year.

- Communications up 2 %
- Clinical treatment up 2%
- Values and behaviour down 1%

The main sub categories identified communication concerns with patients, relatives and carers and patients not feeling listened to although this has improved by 6% on last year's numbers.

A review of complaints relating to clinical treatment shows the following sub categories accounted for 67% of complaints in this category. Numbers in these sub-categories are down 19% on last year.

- Delay or failure in treatment or procedure
- Delay or failure to diagnose (inc e.g. missed fracture)
- Lack of clinical assessment
- Post-treatment complications
- Inadequate pain management

There may be more than one issue identified relating to values and behaviour within a single complaint e.g. attitude of staff, rudeness or failure to act in a professional manner. These complaints are down 9% on last year. These are added to the complaint at the triage process and are based on the complainants perception of their experience.

Parliamentary and Health Service Ombudsman (PHSO) update

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

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

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

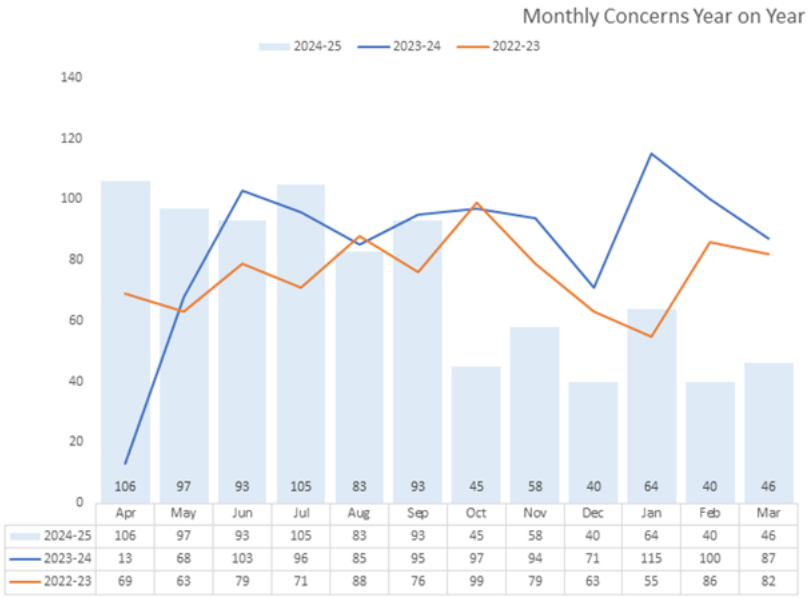
Year	Division/s	Issues	Resolution method	Outcome
Jan 2024	Surgical	Delay in referral to tertiary centre	Detailed investigation	Awaiting final decision
Feb 2024	Surgical	Care and treatment in maternity, poor communication, poor aftercare	Financial remedy	£500 paid - closed
May 2024	Medical	EOL care, communication with family	PHSO mediated meeting	Resolved with meeting – no further action
June 2024	Surgical	Delay in surgery, post op recovery concerns	Preliminary investigation	No further action - closed
July 2024	Welsh Ombudsman enquiry for PTHB investigation	Post op neurological care and rehabilitation delays	Detailed investigation PTHB as commissioner of WVT service to pay financial remedy	£500 from PTHB WVT to share final report findings
Aug 2024	Medical	Delay in cancer diagnosis	Preliminary enquiry	Not progressed – out of time
Feb 2025	Surgical	Delay in surgery, post op recovery concerns (same complainant as June 24, further questions escalated to PHSO)	Preliminary investigation	No further action - closed

Concerns

When reviewing the concerns data, since the service gaps within the PALS team were realised in October, we have noted that concern numbers have continued to demonstrate a reduced trend month on month.

Over the 12 month period, it is noted that there has been an increase in the overall concern numbers recorded, compared to the 2023-2024 period. However this is likely to be a reflection of data quality, as a result of the later go live date for the PALS feedback form during the initial introduction of the InPhase system in the early 2023-2024 period, leading to retrospective logging of concerns and enquiries data, compared to the same reporting period in 2022-2023

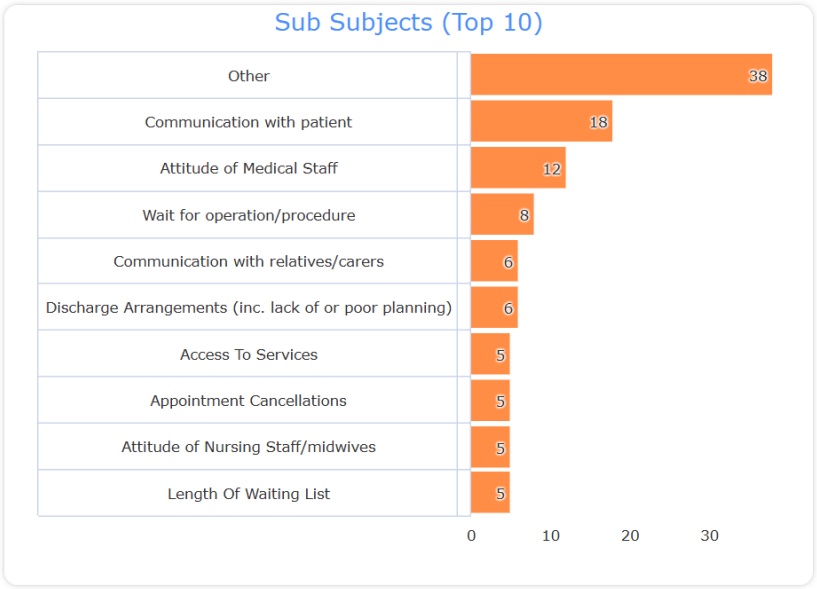
This is demonstrated in the charts below.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25	106	97	93	105	83	93	45	58	40	64	40	46
2023-24	13	68	103	96	85	95	97	94	71	115	100	87
2022-23	69	63	79	71	88	76	99	79	63	55	86	82

There is also an increase in concerns remaining open on the system. This is an administrative gap, as the PALS team provide this function and is not a reflection that concerns are not being resolved by clinical teams. It is projected this data will improve when the backlog of administrative tasks is managed once the team is fully recruited.

The largest number of concerns/comments and enquiries are still logged for surgical and medical divisions, with the most commonly reported subject relating to communication.



PALS service

The PALS service has remained in a fragile position during this reporting period whilst recruitment has taken place to ongoing vacancies within the team. This year has seen a high turnover of staff and a team restructure. This restructure also saw the interpreting service provision absorbed into the wider PALS structure. The next financial year should see a return to a more robust model of service provision.

After a successful pilot, agreement was reached with the Trust Board to change the primary provider for interpreting service provision and to adopt a remote first policy, with the aim to provide better access and a more cost effective option. Further data to demonstrate the success of this new service implementation will be available in the next reporting period.

During the final quarter of 2024-2025, the temporary process agreed for managing concerns to ensure provision of a minimum level of service provision has continued. This included signposting of patients and carers directly to services to raise their concerns for early resolution. This has meant that not all contacts with PALS have been logged as concerns, since this is a core team function and not done by clinical teams.

This method of working is reflective of the PHSO model complaint guidance which suggests that concerns that can be managed as 'every day conversations' should be signposted to clinical teams to resolve effectively and do not need to be managed via a formal procedure.

The situation is being constantly monitored and engagement has been ongoing with clinical teams to try to mitigate the impact on service users. During a time of increasing and fluctuating clinical pressures the support and cooperation of colleagues in working with the team to manage concerns differently has been greatly appreciated.

Patient Experience Committee

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

Patient Engagement Forum

The patient engagement forum continues to meet monthly with many staff bringing projects to the group for input and support. During Q4 alone the group have supported with initiatives such as:

- development of awareness materials for the new FFT portal
- development of a leaflet to support with retrieval of equipment from families of deceased patients
- updating of the WVT patient information leaflet template
- supporting health information week
- review of new general appointment letter template
- geriatric service strategic planning workshop, to help answer the question what does excellent geriatric care look like", from a patient and carer perspective, ensuring the patient and carer voice is at the centre of future service planning.

It is hoped that ensuring service users are included in the development of new patient information resources and service developments that this will show improvement in the concerns and enquiries trends related to communication.

Volunteer Steering Group

The group will have oversight of the Trust Objective and Quality Priority for expanding our volunteer offering across our services. Following an engaging discussion at a recent board workshop, the direction and priorities for the service and the group were clear;

- Expand use of current roles and fill gaps across our services
- Expand contact centre model
- Seek opportunities to work with system partners to develop new volunteer roles
- Streamline the training programme for volunteers
- Use advertising to increase recruitment opportunities for volunteers rather than relying on word of mouth.

Conclusion

When reviewing the data against our quality priority measures we are seeing progress and improvement in a number of areas, however recognise there is more work to do to deliver the quality priority going into 2025-26.

Measure	Update August 2024	Update October 2024	Update Feb 25	Update year end
Evidence use of FFT feedback to generate improvement (projects/ case studies)	Defined projects based solely on FFT in some areas. Other areas are triangulating and using data for improvement projects. This is reported to PEC by divisions.	Next update in Q4	PEC cancelled in February next update in March	Due to delays in rolling out to all services further projects stalled. Will continue to review next year with introduction of expanded system
Improvement in national patient survey results	Final data awaited.	Mixed results with some areas of improvement and good practice but other areas of deterioration.	Acute & Emergency care presented in December, Maternity presented in February	No further survey results reported.
Evidence use of survey feedback to generate improvement (projects/ case studies)	Whilst final data not verified. Initial results confirmed internal concerns in two areas; food quality and communication about medicines on discharge. Improvement work underway for both.	Improvement projects established to tackle the areas of concern noted in the survey as presented to QC in October.		Improvement projects continue and new quality priority introduction for 2025-26 for nutrition and food quality.
Reduction in complaints and concerns	Number of complaints increasing however a downward trend in recent months for concerns.	Complaints continue to increase along with comebacks and cases referred to the PHSO.	2% increase in complaints, reduced concerns reflective of reduced admin function	3% increase in complaints overall.
Improved response times to complaints and concerns	There is month on month improvement since February 2024 in response times to complaints.	Lowest number of overdue complaints since 2020	Slight increase in Q3, but remains lower than 22/23	Overall an improving trend continues. However overall the Trust only responds to a complaint within agreed timeframes for 50% of complaints.

Reduction in overdue responses to complaints and concerns.	Downward trend in number of overdue complaints with August 2024 showing the lowest number since February 2021.		Complaint response times trend improved since Dec 23	Overall improvement but not meeting board KPI of 90%.
Reduction in comebacks or re-opened cases.	There has been an increase in re-opened cases and comebacks year to date.	Reduction seen in Q2 but YTD still high. Issues known and discussion at PEC to seek support from divisions to remedy the issues.	YTD remains higher than 22/23. Analysis identified themes and feedback provided to divisions	Comebacks doubled from 2023-2024. Deep dive into underlying issues undertaken and shared with divisions.
Increased patient engagement and collaboration on improvement projects	The Patient Engagement Group is meeting regularly again with new and increased membership. The members are participating in a wide range of improvement work including; projects based on survey results. PLACE and PLACE lite, 15 steps and stakeholder engagement.	Continued and increased engagement at the Group, participating in more projects and seeking to increase membership more representative of the patient population.	Patient Engagement Group continuing to embed and collaborate with improvement projects	Group fully embedded and supporting a number of projects. Members report positive experience of being in the group and being part of service level change.

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 15 May 2025
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation
None.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Internal Audit Progress Report and Recommendation Action Tracker**
Rating rationale	One audit report had been issued since the last meeting (see below); two final audits from the annual plan were still in progress: Risk Management/Board Assurance Framework and DSPT/Cyber Security Assessment. The recommendation implementation tracker showed reasonable progress, though an update was needed on four recommendations related to data quality in the emergency department, which was thought to be an issue of communication rather than implementation – an update would be provided to the Committee outside the meeting.
Outcome	The Committee was assured by the reports and progress made.
Item/Topic	**Internal Audit Review: Digital Nurse Noting**
Rating rationale	The advisory review was commissioned to identify improvements to and opportunities to further embed the system which was introduced in 2024. The review included engagement with staff and found that the system continued to be developed but there were inefficiencies in completing notes which put pressure on nursing staff, which could impact data quality. The review recommended 10 actions for improvement, including developments to the system, many of which were already planned, and training for and engagement with staff to enhance communication channels. All recommendations were agreed and action deadlines ranged from May 2025 to September 2026.
Outcome	The Committee was assured by the management response to the recommendations and the continued development of the system.
Item/Topic	**Financial Governance: Losses and Special Payments Quarter four**
Rating rationale	The value was similar to the same period in the previous year, with the majority of losses relating to pharmacy and blood stock wastage. The cost of lost personal effects had increased compared with the previous year; this matter would be picked up by the Quality Committee.
Outcome	The report was accepted.
Assure: Including assurance items rated green	
Item/Topic	**Draft Head if Internal Audit Opinion**
Rating rationale	The annual opinion was based on the work of the Internal Auditor during the year. The opinion was positive: "*the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to…ensure that it remains adequate and effective*", and reflected the seven completed review findings, a constructive use of Internal Audit, a positive approach to developing the annual plan and good progress in implementing recommendations. Although two reports were still in progress, sufficient work on both had been undertaken to provide confidence that the conclusions would not change the draft opinion. Benchmarking within the Foundation Group and more widely indicated a general consistency in annual internal audit planning and no gaps. The Internal Auditor was satisfied that the plan was directed appropriately to areas of significant challenge.
Outcome	The Committee welcomed the draft opinion and expressed thanks to the teams who had implemented the recommendations for improvement in a timely way.

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

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 15 May 2025
Report to: Trust Board

Item/Topic	Annual Trust Board Register of Interests Review
Rating rationale	The Committee was assured that the 2024/25 Register highlighted no issues of concern and that there had been appropriate cross-checking as part of the Fit and Proper Person Test. The Register would be published on the Trust's website in line with requirements. The 2025/26 Register was now being used as a live document ahead of the next annual declaration process. The new system for annual declarations for decision making staff and ad hoc declarations for all staff was now live on ESR, enabling improved monitoring, reporting and management of potential conflicts of interest.
Outcome	The Committee was assured by the register of Trust Board member interests, the opportunities for monitoring through the new system and the approach to cross-checking and follow-up.
Item/Topic	**Local Counter Fraud Specialist Annual Report**
Rating rationale	The functional standard return was rated green overall and for each individual standard. Nine referrals were received during year and 15 (including some received the previous year) were investigated and closed. One investigation resulted in disciplinary action and recovery of £6,000. There had been a range of fraud awareness sessions for staff during the year; during 2025/26, conflicts of interests would be a focus of these sessions. The outcome of the investigations demonstrated good controls and staff awareness.
Outcome	The Committee welcomed the positive report.

To Note: Items received for information or approval	
Item/Topic	**Internal Audit Plan 2025/26**
Summary	The plan was based on analysis of the Trust's corporate objectives, risk profile and assurance framework as well as other factors affecting the Trust in the year ahead, and included the following: • Community Services • Medical Job Planning • Theatre Productivity/Utilisation • Board Assurance Framework (core review) • Cyber Assessment Framework (core review) • Fit and Proper Person Test (required every three years) • Key Financial Controls (core review – this year would focus on contract management and devolved divisional budget management). The plan would remain flexible, enabling a response to any new risks or issues emerging during the year. Both executive and non-executive directors had been involved in development of the plan. It was noted that there was less space on the plan for risk based reviews due to the increased number of mandatory/core reviews required.
Outcome	The Committee was satisfied that the plan appropriately covered core governance areas and key topics of risk to internal control and approved the plan. Action: Opportunities to supplement internal audit assurance with locally led assurance would be considered.
Item/Topic	**External Audit Progress Update**
Summary	The Audit was progressing well, with a clean set of accounts, timely provision of the Annual Report and no significant issues emerging to date.
Outcome	Noted.

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

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present

Russell Hardy	(RH)	Group Chair
Chizo Agwu	(CAg)	Chief Medical Officer WVT
Varadarajan Baskar	(VB)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Chief Clinical Strategy Officer WAHT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(AC)	Acting Chief Executive GEH/SWFT
Oliver Cofler	(OC)	NED SWFT
Stephen Collman	(SC)	Acting Chief Executive WAHT/WVT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Catherine Free	(CF)	Managing Director GEH
Phil Gilbert	(PG)	NED SWFT
Natalie Green	(NG)	Chief Nursing Officer GEH
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WAHT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Kim Li	(KLi)	Chief Finance Officer SWFT
Anil Majithia	(AMa)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Jo Newton	(JN)	Chief Strategy Officer WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Sarah Raistrick	(SR)	NED and Vice Chair GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Jackie Richards	(JR)	NED GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED and Vice Chair SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Chief Medical Officer WAHT
Robert White	(RW)	NED SWFT
Umar Zamman	(UZ)	NED GEH

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

In attendance:

Rebecca Brown	(RBr)	Chief Information Officer WAHT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Catherine Driscoll	(CDr)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Fiona Gurney	(FG)	Communications WVT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT
Jo Kirwan	(JK)	Deputy Director of Finance WAHT (deputising for Chief Finance Officer WAHT)
Rosie Kneafsey	(RK)	ANED GEH
Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KLa)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Alex Moran	(AMo)	ANED WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Mary Powell	(MP)	Head of Strategic Communications SWFT
Nicholas Rees	(NRe)	Interim Deputy Chief People Officer SWFT (deputising for Interim Chief People Officer SWFT and Interim Chief People Officer GEH)
Louise Robinson	(LR)	Deputy Company Secretary WVT (observing)
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Robin Snead	(RS)	Chief Operating Officer GEH
Adrian Stokes	(AS)	Group Strategic Financial Advisor
Vidhya Sumesh	(VS)	Group Business Information Specialist (observing)
James Turner	(JT)	Head of Communications GEH

Apologies:

Paul Capener	(PC)	ANED GEH
Neil Cook	(NC)	Chief Finance Officer WAHT
Paramjit Gill	(PGi)	Nominated NED SWFT
Simone Jordan	(SJ)	NED GEH
Elva Jordan-Boyd	(EJB)	Interim Chief People Officer SWFT
Zoe Mayhew	(ZM)	Chief Commissioning Officer (Health and Care) SWFT
Sara MacLeod	(SMa)	Interim Chief People Officer GEH
Dame Julie Moore	(JM)	NED WAHT
Bharti Patel	(BP)	ANED SWFT
Grace Quantock	(GQ)	NED WVT
Sue Sinclair	(SSi)	ANED WAHT

There were four SWFT Governors and one member of the public also in attendance.

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
25.023	**DECLARATIONS OF INTEREST** No new declarations of interest were declared. **Resolved – that the position be noted.**	
25.024	**PUBLIC MINUTES OF THE MEETING HELD ON 5 FEBRUARY 2025** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 5 February 2025 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.025	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.025.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.026	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the key discussions that had taken place in the Foundation Group Boards Workshop earlier that day. This included an interesting presentation on large scale change by Helen Bevan, Professor at Warwick Business School. The Group Boards then heard from Distie Profit, Vice-President and General Manager of Oracle Health UK, which provided opportunity for a conversation on Electronic Patient Records and Artificial Intelligence (AI). The Group Chair took the time to celebrate the team in WVT, on seizing the opportunities arising through AI. The Group Chair continued that in the second half of the Foundation Group Boards Workshop, the Group Chief Executive updated on all things taking place in the wider NHS which highlighted areas where the Group could drive transformational change. The Foundation Group Boards Workshop concluded with the Chief People Officers updating on the position of Talent and Succession Management across the Foundation Group. **Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.**	
25.027	**FOUNDATION GROUP PERFORMANCE REPORT** The Acting Chief Executive's for each Trust highlighted key points from the Foundation Group Performance report as follows:	

MINUTE		ACTION

WVT

The Managing Director for WVT informed the Foundation Group Boards that the Cancer standards for 62-Days and Faster Diagnosis Standard (FDS) had been met for the patients of Hereford and Mid Powys over the last year. She commended the teams involved for their efforts and noted the increasing challenge these standards would pose in the coming year as they increase and become harder to achieve. The Managing Director for WVT explained that Theatre productivity had previously been a challenge throughout the year, however improvements were starting to be seen. In the last quarter there had been a 5% increase in utilisation, and this would continue to be focused on moving forward. Patient Initiated Follow Up (PIFU) had started to increase, which had been mainly due to a technical change in the Electronic Patient Records (EPR) that had allowed patients to initiate their own follow up in a safe and effective way. The Managing Director for WVT was concerned about Urgent and Emergency Care (UEC) as performance had deteriorated with ambulance handover delays increasing and a significant number of temporary escalation spaces being used. This had both a quality, and a financial impact and was therefore being treated as WVTs highest priority for improvement. The Managing Director for WVT explained that one of the ways to improve UEC would be to use National Capital that had been awarded to the Trust to expand the assessment and Same Day Emergency Care (SDEC) areas in the Emergency Department (ED). WVT would also be working in collaboration with General Practitioners (GPs) on a neighbourhood health model to support care at home. Finally, an internal hospital process redesign would take place, with clinical engagement, on how UEC pathways work through the hospital.

SWFT

The Acting Chief Executive for GEH/SWFT started by celebrating SWFTs ability to maintain Elective Care performance during a challenged winter period operationally. This had been down to the teams and the work involved in managing to maintain and ring-fence Elective beds. This had improved outpatient services and strong PIFU processes had contributed significantly to capacity. The Acting Chief Executive for GEH/SWFT shared that the area he had a significant concern over was Cancer performance. SWFT had seen a significant increase in Oncology wait time, and although leadership roles had been recruited too and systemic changes initiated, performance had not improved. This has been exacerbated by staff shortages and service dependencies from University Hospital Coventry and Warwickshire NHS Trust (UHCW). The Acting Chief Executive for GEH/SWFT explained that there was significant planning work to still be done, however the team was in place and conversations were happening to continue to drive improvement forward. He concluded that UEC was an area SWFT were watching with a continued deterioration in 4-hour ED performance, largely due to an increase in self-presenting patients and high bed occupancy. The Acting Chief Executive for GEH/SWFT continued that intelligent conveyancing had also declined slightly but did not offset internal demand pressures. Estates limitations in the ED were now a critical issue for SWFT and a bid for national funding to expand front-door services had been submitted.

MINUTE		ACTION

GEH

The Managing Director for GEH presented the GEH metrics to the Foundation Group Boards. Firstly 4-hour performance in ED had been the worst on record, with overcrowding in the department, particularly overnight, being identified as a root cause. Recent weeks had shown improvement, however the challenges with medically fit for discharge (MFFD) patients remained a challenge. Positive steps had been made towards improving MFFD, which was credit to two members of staff, one from the GEH Complex Discharge Team and the other from SWFT Community Services. This has led to promising conversations with Integrated Care Board (ICB) colleagues and external stakeholders on how to do things differently. The Managing Director for GEH went on to highlight GEHs sickness levels, which were still well above the 4% target at 5.3%. These had improved on the previous 6% but would remain a focus area. She explained that the elevated sickness levels were driving temporary staffing costs and impacting financial performance. Cancer performance continued to be challenged. However, there was variable performance, particularly against the FDS which was almost at the target. She acknowledged that there was more work to be done to pick up cancer performance. The Manager Director for GEH continued that Referral to Treatment (RTT) would be particularly challenged in 2025/26 with more challenging national targets. She explained that whilst GEH 65-week wait list had been eliminated in September 2024, these had re-emerged due to conflicting priorities towards the end of the year with the need to hit financial targets and the need to deliver performance. This could also be seen in the ERF figures. Whilst Outpatients was doing well this had dipped towards the end of the financial year. She concluded by celebrating the improvements in Theatre utilisation and PIFU rates. She thanked colleagues from across the Foundation Group for the operational learning which had been a key enabler in the improvements.

WAHT

The Acting Chief Executive for WAHT/WVT explained that UEC continued to be an issue for WAHT and although ambulance delays had improved slightly, overall performance remained a key area of concern. WAHT had recently had its first Tier 1 Improvement Review, and three priorities were identified to focus on: internal discharge process improvement, frailty pathway integration across community and acute care, and community hospital length of stay. A 30/60/90-Day Plan had been created to rapidly improve. Work was taking place with partners to improve flow, particularly for patients who needed onward support once they left hospital. The Acting Chief Executive for WAHT/WVT explained that Sarah Shingler, Chief Nursing Officer for WAHT had been leading on important work to help support flow. This included Virtual Hospital implementation with support from the ICB, and the 'Out by 5' programme which focused on discharging patients safely by day five and getting proper rehab back into community hospitals. The results were looking positive with length of stay (LoS) going from 29 days to 14. He concluded by providing an update on Cancer Services for the Trust. He explained that WAHT had done a lot of work with partners to reduce the 62-Day backlog, and this has started to improve.

MINUTE **ACTION**

Despite this work was required with tertiary partners to address the ongoing challenges and fragility.

The Group Chair requested an update from each Trust on their financial position at year end for 2024/25 compared to the planned position. Each Acting Chief Executive and Managing Director provided this information as follows: -

Trust	Planned Position	Actual Position	Variance/Comment
WVT	Break-even	£5.6m Deficit	Under delivery of Cost Improvement Programme (CIP) by £6m; higher target carried into 2025/26.
SWFT	£1.3m Surplus	£1k Surplus	Hit break-even; surplus effected by Community Recovery Service (CRF) costs.
GEH	£0.7m Surplus	£3.0m Deficit	CRS contributions effected actual position but not entirely.
WAHT	£5.7m Deficit	£5.5m Deficit	Delivered £200k ahead of plan.

The Chair highlighted that SWFT remained the only Midlands trust with a break-even performance and had reported a break-even position for over a decade. He also emphasised that a national financial reset was anticipated. The Group Chief Executive noted that some Trusts would show a break-even position but would have received deficit support. The intention was to take that out to get the true picture.

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

The Group Chief Executive raised concerns around SDEC data and queried the validity of zero LoS metrics, particularly at GEH. It showed that WVT had converted a lot to SDEC but WAHT and GEH didn't show that. The Chief Operating Officer for GEH explained that the data showed GEH to have 49.3% of ED patients requiring admission, being turned around without an overnight hospital stay. This was a combination of patients going through SDEC, Surgical Assessment Area (SAU), Gynaecology Assessment Unit (GAU), Fraility Assessment Unit (FAU), and all ambulatory pathways.

Resolved – that the Foundation Group Performance report be received and noted.

25.028 **OUTPATIENTS DEEP DIVE**

The Chief Operating Officer for WAHT presented the Outpatients Deep Dive. He explained that there had been a lot of positive work taking place across the

MINUTE		ACTION

Foundation Group on Outpatients, and all Trusts had benefited from the Getting it Right First Time (GiRFT) Further Faster programme. Clinic utilisation showed that overall, there was good clinic utilisation, however GEH had the most opportunity for increased productivity and improving the percentage of patients waiting under 18-weeks for a first outpatient appointment. The Chief Operating Officer for WAHT highlighted the shared learning was taking place and this included pathway analysis and use of PIFU, maximising clinic templates, approach and findings to follow up waiting list review, outpatient improvement programmes and approach to monitoring blocked appointments. Data showed there was a variance in the average appointments per clinic in some specialities and therefore identified potential improvements for further consistency. The Chief Operating Officer for WAHT explained that work was needed on making clinic templates consistent, but also how benchmarking could be done across the Foundation Group and nationally. It was important to match those clinic expectations into job plans, and identify how things could be done differently to enable patient being seen in a timelier manner. The Chief Operating Officer for WAHT presented the Did Not Attend (DNA) data for March 2025 and the rates were as follows, GEH 3.7%, SWFT 5.6%, WAHT 4% and WVT 4%. All Trusts had areas of opportunity to improve DNA rates across varying specialties. There had been several pieces of work done so far to address DNA rates and these included implementing a two-way text reminder service, calling patients who had a history of missed appointments and transferring DNA patients to Patient Owns Contact (POC).

The Chief Operating Officer for GEH presented the data on PIFU, which highlighted some variance across the Foundation Group in services that were actively using PIFU. This identified that there was more work to be done to identify what was driving the variance in the specialties and how to standardise the approach. All Trusts within the Foundation Group had submitted plans that would achieve, or better, the national target for PIFU. Shared learning was already taking place to ensure these plans were met. This included ensuring that clinicians were discharging patients where medically appropriate rather than moving them to a PIFU pathway and clinical discussions between Trusts to discuss pathways where PIFU was applied were taking place. The Chief Operating Officer for GEH explained that engagement with services that had a successful approach for PIFU was also taking place to help with engaging and educating specialties achieving less than 5%. On top of this GiRFT recommendations and learnings continued to be reviewed and exploring the option of an opt out rather than an opt in approach. The Chief Operating Officer for GEH concluded by highlighting plans to run an internal Further Faster programme to deep dive into a different speciality each month, driven by the productivity dashboard.

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

The Acting Chief Executive for WAHT/WVT celebrated the success of the Foundation Group Operational Conference that had taken place in May 2025.

MINUTE		ACTION
	He queried whether PIFU had the right clinical engagement to drive improved delivery. The Foundation Group Boards agreed with this, and it was agreed to make an action for PIFU clinical engagement to be sourced. The Group Chief Executive agreed with the Acting Chief Executive for WAHT/WVTs comment and added that it was clear clinical adoption was holding PIFU back. He added that the New to Follow Up ratios should also be looked at as part of PIFU, as there were probably opportunities there to also improve and free up capacity. **Resolved – that** **A) The Outpatients Deep Dive be received and noted, and** **B) Clinical leadership and engagement with PIFU be agreed to help drive delivery, and**	**CMOs**
	C) New to Follow Up Ratios be looked at for any potential capacity opportunities.	**COOs**
25.029	**URGENT AND EMERGENCY CARE IMPACT ON MORTALITY AND MORBIDITY** The Foundation Group Boards received the presentation on the correlation between prolonged ED waits and patient outcomes, with the data gathered from 1 January 2025 to 31 March 2025. The Chief Medical Officer for WVT presented the key findings for WVT, which aligned with the Office for National Statistics (ONS) confirming that increased waiting times in ED were associated with higher mortality rates. She explained that a cohort analysis was undertaken, excluding patients who were under sixteen and patients attending with minor injuries. This left WVT with 11,000 patients. The Chief Medical Officer for WVT continued those patients who waited over 12hours in ED had an average age of 71, compared to 57 for those who waited under five hours. The data showed that patients who waited longer in ED also had a longer admitted LoS, averaging 7.6-days for over 12hour waits vs 2.8-days for those under 5hours. Patients discharged to care homes consistently experienced the longest LoS averaging between 15-20-days and this was regardless of ED wait time. The Chief Medical Officer for WVT confirmed that mortality was significantly higher among those waiting over 12hours at 6.3% vs 2.1% for under 5hours. She explained that it was the elderly population that were most affected by this, with the average age of patients having died after waiting more than 5hours being 82, compared to 84 for those who had waited less than 5hours. Men were also noted to be seven years younger on average at time of death compared to women. The Chief Medical Officer for WVT presented the mitigations that WVT were taking to reduce overcrowding in ED and therefore long waits. This included focusing on reducing demand, improving flow, expediting discharges and addressing delays for MFFD patients.	

MINUTE		ACTION
	The Chief Medical Officer for SWFT presented the SWFT data and key findings. This was very similar findings, and the numbers were quite similar with around 11,000 patients being seen between 1 January 2025 and 31 March 2025. SWFT were a positive outlier with less than 10% of patients experiencing ED waits exceeding 12hrs, however the mortality trends mirrored those identified at WVT. However, he emphasised that this was not causality, it just underscored the importance of identifying the cohort of patients waiting the longest and why. The Chief Medical Officer for SWFT explained that a deep dive would follow that would evaluate operational contributors, including MFFD and frailty team interception. The Chief Medical Officer for GEH confirmed that GEH identified similar trends, however they had included minor injury patients. He noted that despite the figure being small, it was important to recognise that patients were dying within the Foundation Groups EDs, including those arriving post-cardiac arrest and palliative care patients due to lack of hospice access within the North of the county. GEH had introduced a Bluebell Room which was a quieter area in ED for those patients at end of life to die in dignity and respect with their families. The Chief Medical Officer for GEH continued that there was established evidence linking prolonged ED stays to increased mortality and LoS. He concluded by explaining there was a real need to expedite the care of frail, elderly patients with general medical conditions. Patients with pre-diagnosed conditions, did tend to move through the system more efficiently already. The Chief Medical Officer for WAHT assured the Foundation Group Boards that WAHTs figures were very similar to that of the Trusts in the Group. WAHT had done a further deep dive into these findings on a cohort of 200 patients. She explained that post the Covid-19 pandemic pressures on ED services in the UK had resulted in increased waiting times and spikes in excess deaths which is what had triggered the review. Long-wait patients (those waiting over 12hours) were more likely to arrive by ambulance and had a longer ambulance handover. These patients were typically older, had multiple comorbidities and were often admitted under general medicine rather than specialist pathways. These patients experienced delays in medical review, decision making, discharge with higher crude mortality rates, had more tests and care whilst waiting, and more complex inpatient journeys. The Chief Medical Officer for WAHT cautioned against attributing causation but stressed the significant implications for quality of care and patient experience. She continued that it was important to address the findings and use them to better patient care. The Chief Medical Officer for WAHT informed the Foundation Group Boards that WAHT had already begun a service redesign, including improvement to frailty models, early discharge pathways and pre-identifying high-risk patients early to support more proactive interventions. The Group Chair invited questions and perspectives and of particular note were the following points.	

MINUTE		ACTION
	The Group Chief Executive noted there were two key areas to this work. One was improving flow through ED to enhance outcomes but also ensuring patients were being cared for in the right setting. Whether that be outreach services, advice and guidance or end of life care. The Managing Director for WVT advised the Foundation Group Boards that she chaired the End-of-Life Programme Board for Herefordshire and Worcestershire. As part of that work she had been trying to get a digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form implemented. Digital ReSPECT forms would travel with the patient wherever they were, drive higher-quality clinical conversations and improve continuity of care. Sarah Raistrick, NED and Vice Chair GEH, supported the proposal of a digital ReSPECT form. She also suggested a research opportunity to track the impact particularly when patients documented wishes were not honoured. **Resolved – that** **A) The UEC impact on mortality and morbidity be received and noted, and** **B) The Acting Chief Executives identify Foundation Group representation to continue driving the digital ReSPECT form proposal forward.**	**ACEs**
25.030	**ANNUAL SAFE STAFFING OVERVIEW (INCLUDING NURSE PER BED RATIO)** The Chief Nursing Officer for WVT presented the Annual Safe Staffing Overview and dashboard. The dashboard included the number of funded beds for each organisation and new data on the number of additional patients being cared for beyond the funded capacity. The Chief Nursing Officer for WVT explained that the figures included escalation beds, the number of patients cared for in temporary escalation spaces and the number of patients waiting in ED with a decision to admit at 8am. This information was presented to provide context, particularly regarding the workforce pressures and staffing implications resulting from overcapacity. All trusts were operating above their funded bed base. The Chief Nursing Officer for WVT explained that Trusts were required to submit “Safer Staffing Return” to NHS England (NHSE). This submission, broken down at ward level, compared planned staffing levels to actual staffing levels on the day. The data consistently showed that the four Trusts in the Foundation Group had filled over 100% of planned staffing levels, primarily due to the increased demand from the additional beds open beyond funded levels. The Chief Nursing Officer for WVT presented the wider workforce metrics to the Foundation Group Boards, and it was reiterated that a substantive workforce delivered better quality care, improved continuity, and greater productivity. This was due to substantive staff being more familiar with local systems and processes. She continued that nationally, a vacancy factor of less	

MINUTE		ACTION
	than 5% was considered a good benchmark and it was reported that all Four trusts within the Foundation Group had achieved this for Registered Nurses (RNs) which was positive. However, there was greater variability in the Healthcare Support Worker (HSW) Group, with continued challenges in both recruitment and retention. This group remained a key focus for 2025/26. The Chief Nursing Officer for WVT presented the sickness absence data. All four Trusts in the Foundation Group demonstrated levels of sickness absence above the national benchmark with a particular challenge in the HSW group of staff. There was no national benchmark for maternity leave; however, the Foundation Group budgeted 1% headroom in its establishments to account for staff on maternity leave. The data indicated high maternity leave levels across the Group. The Chief Nursing Officer for WVT highlighted that the Quality and Safety metrics included in the Friends and Family Test (FFT) showed all Trusts consistently achieving positive response rates above 90% which was considered excellent. However, response rates to the survey itself remained below desired levels. The Chief Nursing Officers across the Foundation Group had recognised this as an area requiring further improvement. All four Trusts made good progress in reducing agency spend over the last twelve months. Collaborative efforts through the Regional Nurse Agency Reduction Programme had contributed to these improvements, particularly by enforcing NHSE capped rates and eliminating the use of high-cost, off-framework agencies. While all trusts had made progress, some were advancing faster than others, offering opportunities for shared learning and best practice. The next phase of the Programme would be to focus on bank rates, with all trusts committing to participate. Additionally, each trust had set agency and bank reduction targets for 2025/26 in alignment with national expectations. **Resolved – that the annual safe staffing overview be received and noted.**	
25.031	**FIT AND PROPER PERSONS TEST ANNUAL COMPLIANCE** The Trust Secretary for GEH/SWFT presented the Fit and Proper Persons Test annual compliance to the Foundation Group Boards. The report provided assurance against the Fit and Proper Person Test Framework and the processes that were in place across all four boards to assess Board members and their fit and proper persons status prior to the annual submission to NHS England. **Resolved – that the Foundation Group Boards receive and note the Fit and Proper Persons Test Annual Compliance.**	
25.032	**FOUNDATION GROUP OBJECTIVES IN COMMON 2025/26** The Group Chief Executive presented the Foundation Group objectives in common for 2025/26. He explained that whilst the Foundation Group didn't have specific Group objectives, each Trust's personal objectives were	

MINUTE		ACTION
	compared and key themes identified to encourage collaboration. WAHT were still finalising their objectives after completing their strategy refresh, however it was possible to see the Trust's direction. The Group Chief Executive identified the objectives in common for the Group as UEC Pathway Improvement, Care Closer to Home, the implementation of Neighbourhood Health, sustainability, reducing paper records, and EPR. He did highlight that he was surprised to not see more explicit focus on productivity and appreciated that whilst some of the objectives would deliver against productivity, he felt it needed more of a focus. This could be achieved though the Community Diagnostic Centres set up and updated through the Foundation Group Strategy Committee. He also noted that the NHS financial reset would see individual organisation numbers change, and financial recovery plans become an area of high focus. **Resolved – that the Foundation Group Objectives in Common for 2025/26 be received and noted.**	
25.033	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON THE 18 MARCH 2025** The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting that took place on the 18 March 2025. **Resolved – that the Foundation Group Strategy Committee Report from the meeting held on 18 March 2025 be received and noted.**	
25.034	**ANY OTHER BUSINESS** No further business was discussed. **Resolved – that the position be noted.**	
25.035	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS** No questions were received. **Resolved – that the position be noted.**	
25.036	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.037	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.038	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 5 FEBRUARY 2025**	
25.039	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
25.040	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 17 DECEMBER 2024**	
25.041	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.042	**PROPOSAL TO MITIGATE RISKS IN THE JOINT ELECTRONIC PATIENT RECORDS PROGRAMME – GEH/SWFT ONLY**	
25.043	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 6 August 2025 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chair) Date: 6 August 2025
Russell Hardy

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

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 6 AUGUST 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
25.028 (07.05.2025) Outpatients Deep Dive	Clinical leadership and engagement for PIFU be agreed to help drive delivery. New to Follow Up Ratios be looked at for any potential capacity opportunities.	C Agwu / N Rashid / V Baskar / J Walton H Heran / R Snead / A Parker / C Douglas	
25.029 (07.05.2025) Urgent and Emergency Care Impact on Mortality and Morbidity	The Acting Chief Executives identify Foundation Group representation to continue driving the digital ReSPECT form proposal forward.	A Carson / S Collman	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Quality Committee February 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 27 February 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 highlighted 2 issues in particular:
    a. Haemorrhage rates which are high. It was reported that the majority of cases have high risk factors for PPH; however new measures have been introduced which have reduced blood loss.
    b. C-Section rates which are increasing. Committee asked for trends and issues associated with Caesareans, both elective and emergency to be given more prominence in future quarterly reports.
2. **Colposcopy Report** – Vacancies and staff sickness had resulted in increased waiting times but these issues were now resolved, with waiting times reduced and 2 week waits being seen quickly, with additional weekend sessions s required. A service restructure has been completed and succession planning for new staff is in place. A key risk is equipment age and failure and an inventory of all equipment together with monitoring of breakdown is being put in place.
3. **Mortality Report** – The Trust's SHMI continues to perform well with continuing improvement for key groups.
4. **Quality Priority – Improving Patient Experience** – It was reported that the Patient Experience Committee and Patient Engagement Group continue to flourish, with lots of staff reaching out wanting to meet the group and get support for service redesign and improvement. Challenges continue with complaints and concerns responses and improving the quality of responses to avoid "comebacks" is a key area of focus.
5. **Patient Safety Priority – Falls** – Committee was encouraged that fall rates are slightly lower at the point in the year; importantly moderate and severe harm falls are lower. Committee received an update on work regarding bed rail assessments following the Regulation 28 notice earlier in the year. Compliance is improving with focus now shifting to quality of assessments
6. **UEC and Boarding Report** – Challenges have continued with congestion in ED and 30+ boarding patients on some days, with need to use more escalation areas and more moves for patients.
7. **Divisional Report – Medical Division** – ED waiting times continue to be the biggest concern and committee heard of a range of developments to try and address this including the work of the Divisional Flow Coordinator and the filling of consultant vacancies. Estates issues continue to hamper improvement and concerns about Band 7 nurses needing to be more hands-on with increasing frequency was also reported.
8. **ED – CQC Inspection Update –** Committee received a full update on progress following the CQC inspection in December 2023 and complimented ED staff on their efforts and dedication in pursuing improvements. While focus continues in a number of areas – triage, pain management, sepsis and deteriorating patient were highlighted – committee noted tremendous progress overall.
9. **Infection Prevention Quarterly Report** – C-difficile numbers are well above trajectory as are fatalities within 30 days of diagnosis. This is the key area of concern, Fatalities are being investigated with the Mortality Team and the Trust is also working closely with the ICB to understand underlying causes.

Matters for Escalation – None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 27 February 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)
Rachael Hebbert	RH	Associate Director of Nursing (AND)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Frances Martin	FM	Non-Executive Director (NED)
Natasha Owen	NO	Associate Director of Quality Governance (ADQG)
Grace Quantock	GQ	Non-Executive Director (NED)
Jo Rouse	JR	Associate Non-Executive Director (ANED)
Emma Smith	ES	Deputy Chief Nursing Officer (DCNO)
Nicola Twigg	NT	Non-Executive Director (NED)
In attendance:		
Julia Cartwright	JCa	Consultant Emergency Medicine (for item 14)
Jo Cleall	JCl	Physiotherapist (for item 10)
Jo Clutterbuck	JC	(Representing Associate Chief Nurse, Medical Division)
Rose Gardiner	RG	GIRFT Outpatient Delivery Lead (for item 7)
Ehab Hafiz	EH	Consultant Obstetrics and Gynaecology (for item 6)
Helen Harris	HH	Integrated Care Boards (ICB) Representative
Leah Hughes	LH	Operational Clinical Lead Radiography
Candice Lewis	CL	Perinatal Quality and Safety Matron (PQSM) (for item 6)
Rachel Murray	RM	Clinical Quality Improvement and CQUIN Manager
Sara Powell	SP	Matron Women and Children (for item 6)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Gwenny Scott	GS	Company Secretary
Amanda Spooner	AS	Locality Manager Nursing
Emma Wales	EW	Associate Chief Medical Officer Clinical Division
Louise Weaver	LWe	Acute and Emergency Matron (for item 15)
Laura Weston	LW	Lead Infection Prevention Nurse

QC01/02.25	**APOLOGIES FOR ABSENCE**	
	Eleanor Bulmer, Associate Non-Executive Director, Lucy Flanagan, Chief Nursing Officer, Sharon Hill, Non-Executive Director, Jane Ives, Managing Director, and Tom Morgan Jones, Deputy Chief Medical Officer	
QC02/02.25	**QUORUM**	
	The meeting was not quorate, however as no key decisions were required the meeting continued as an exception	
QC03/02.25	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest made.	
QC04/02.25	**MINUTES OF THE MEETING HELD ON 30th JANUARY**	
	The minutes of the meeting held on 30th January were agreed as an accurate record of the meeting.	

	The minutes of the meeting held on 30 January were received and approved.	
QC05/02.25	**ACTION LOG AND MATTERS ARISING**	
	The actions were updated: QC06/01/25 - Information on areas of deprivation and ethnicity and the number of minutes by which the 30 minute standard was missed for Category 1 C-Sections would also be added to future reports - Information regarding Category 1 C-Sections was added to reports. Ethnicity is recorded on In-Phase. PMRTs are also added to trackers which will enable themes to be identified via triangulation for quarterly reports. **ACTION COMPLETE.**	
QC06/02.25	**PERINATAL SAFETY REPORT**	
	Perinatal Quality and Safety Matron, Consultant Obstetrics & Gynaecology and Matron Women's and Children's presented the Perinatal Safety Report. The report was taken as read and the following points were highlighted. There had been a rise in the number of births in January from 129 to 144. There were no Category 1 C-sections performed outside 30 minutes. There were two PMRT incidents. One of a known genetic condition diagnosed during pregnancy which was incompatible with life and a spontaneous neonatal death at 22 + 6 weeks. Both will pass through the PMRT process. There were four moderate incidents. Three were major obstetric haemorrhages which are being audited as part of the quality improvement work. There were four complaints in January. One concerned a lady who was given bloods where it was not clear if the blood had been screened for CMV. Worcester also had two cases in 2024 and will share mutual learning. Workforce remains stable. Consultant ward rounds have proved to be a success and the teams are working well together. Neonatal workforce BAPM standards require one additionally qualified nurse per shift on the Neonatal Unit. There were two shifts when it was not possible to achieve the standard due to the acuity and dependency of the patients. Working towards increasing staff qualified in specialty. This is predicted to increase to 50% in March but will decrease over coming months when additional staff are recruited. There remains a concern over lack of AHP support which is on the risk register.	

	Training remains high and weekly drills are undertaken. ATAIN information for January 2.3%. The ATAIN quarterly report will be shared at the Quality Committee in March. An unannounced Safety Champions visit took place in January with positive feedback received. The Chief Medical Officer asked why it was thought there such high rates of haemorrhage. It was noted that the majority have high risk factors for PPH. Blood loss has increased due to more accurate measuring and incidents have therefore increased as there is more focus on this issues with more accurate measure of blood loss. Rather than a true increase in incidents it is more accurate reporting. The amount of blood loss has reduced following the introduction of new measures but that it will take some time to see the full effect of those measures. Additional senior management intervention has also helped. It was noted that therapy support had been on the risk register for some time and if it was felt that if a child required therapy support it was available. There had also been some integrated care work to look at distribution of therapy. It was confirmed that there is a responsive approach with therapies and patients get support as needed. There is also liaison with the Integrated Care teams. It was also noted that over a quarter of women deliver by C-section and was this for social or for other reasons. The percentage is increasing all over UK and the trust has seen an increase in requests, whether for social reasons or stemming from a fear of labour. There has also been an increase in the number of requests for repeat elective section. All ladies are counselled regarding risks and try to reduce numbers as far as possible but they do have a right to request. There has also been a breakdown of electives and it is now clearer how many are maternal requests or other reasons. Also whether emergencies were preventable. The new Consultant Midwife will attend clinic and do some work on this and in the interim has encouraged community midwives to indicate if patients need more 1:1 counselling to support. The Chair asked for a focus around Caesareans as part of the next quarterly report. Also, for the percentage of elective vs emergency sections to be included. **ACTION**	**AS/CL**
	The Perinatal safety update was received and noted. **A Focus around Caesareans and the percentage of elective vs emergency will be included in the quarterly report.**	**AS/CL**

QC07/02.25	**COLPOSCOPY REPORT**	
	The GIRFT Out-patient Delivery Lead gave an overview of the colposcopy report which was taken as read. Colposcopy Failsafe Officer commenced in December 2024 filling the post vacated in early August. Additional colposcopy sessions have been introduced which has reduced wait times from 8 to 5 weeks and two week waits are being seen very quickly. There are still occasional peaks in referrals which require additional sessions, however further sessions are hindered due to the requirement for nursing staff with a specific skill set. Sickness absence in the consultant body is now resolved. Training for the nurse Colposcopist is progressing well and accreditation is planned for Autumn. Also a trainee Colposcopist anticipated accreditation Spring 2026. The service has undergone re-structure and there is good admin support. Audits are up to date but more work is needed regarding feedback to patients. Going forward there will be focus on equipment failure and lack of ability to do therapeutic work. There is currently no audit process to monitor age of and maintenance programmes for equipment. Frequency of breakdown is being monitored and it is planned to produce a full inventory of equipment. In order to improve clinic capacity and increase the number of colposcopy sessions staff have done additional/weekend work which has expanded sessions by 50%. Further sessions may be needed and will be monitored. There is also a lack of estate space and are looking at solutions. The committee were encouraged that there is a sense of what was needed to deliver the service required and wanted to ensure that the right level of support was available. In order to provide assurance ageing equipment has been raised previously by consultant staff and the risk to the colposcopy service has also been raised at Surgical Division monthly meetings. There may be some opportunity this year to purchase equipment either via trust capital or as part of PFI to be escalated to the Executive team if necessary. It was agreed to add a quadrant front sheet to future reports to focus discussion.	

	The Colposcopy report be received and noted and that future reports have a quadrant front sheet.	
QC008/02.25	**MORTALITY REPORT**	
	The CMO gave an update on mortality. The latest SHMI was reporting at 99 reporting on or under national average. Fracture NOF continues to improve. Quality improvement work is ongoing. The Trust are required to report to the National Hip Fracture team to inform of progress as although improving, still remain an outlier. All other high mortality groups are stable and heart failure continues to improve. The Medical Examiner Service remains robust and learning from deaths and mortality governance is now well embedded in trust. The Chair asked if Sepsis was the next area of concern. Some audits have been done and have seen some improvement, however it is still not where we would want it to be. This will be picked up at Deteriorating Patient Committee but is not well embedded in in-patient wards across the trust. The Mortality Review Panel is well attended by specialty mortality leads and there is good engagement. Individual cases which have been judged as having had poor care are reviewed and the panel judge whether a death had been preventable or if there are any collective actions.	
	The Mortality report was received and noted	
QC09/02.25	**QUALITY PRIORITY UPDATE – IMPROVING PATIENT EXPERENCE QUARTERLY REPORT**	
	The Associate Director of Quality Governance gave an update on this quality priority. The paper was taken as read and the following points were noted. FFT had seen a downward trend and the team have done a lot of work to see how this can be improved upon. As well as the text messaging service, a project will be piloted from April allowing patients leave feedback live through a link on the trust website. There will be some promotion of this with pop up banners to encourage people to feedback rather than wait for a text message. A deep dive will be done to see if there has been an increase in negative responses around waiting time for in-patients and will be included in the next report.	

	There had been a slight increase in complaints compared with the previous year but there had been improvement in response time and reduction in those overdue in quarter three. There were some concerns in Women's and children's and Urgent and Emergency Care had seen a slight delay which is likely due to the clinical pressures experienced during those months. A deep dive has taken place into Women's and Children's complaints issues which was previously reported. There had been a complaints spike from the last report in October with just under half of those complaints related to care in month, the remainder were out side of period. There had been an increase in come backs and this year has seen the highest number to date across the last 3 years. A deep dive into more recent ones show common themes of factual inaccuracies, additional questions asked in a meeting which had not been reflected in a final response. There is still further work to do but there were no new or emerging issues that were not aware of. There had been a sharp increase in PHSO cases. One received this year relating to one from June 2024 with the same complainant asking for a case to be re-reviewed. A decision on whether it will move to full investigation is awaited. Feedback on the Medical Examiner service and Bereavement and Medical Examiner team has been largely positive and negative feedback noted mainly around communication with families. The Quality and Safety team are working with the Bereavement and Medical Examiner Teams to ensure that when families require more support, either through the PALS or Complaints route, they are signposting appropriately and not adding any delay. There had also been a spike in concerns in November, but an overall reduction in number. The delays in closing of concerns down at the point they have been responded to are due to administrative gaps in teams. The Patient Experience Committee and Patient Engagement Group continue to flourish, are well established and have lots of engagement. Lots of staff are reaching out wanting to meet the group and get support for service redesign and improvement. The Volunteer Steering Group is yet to fully establish but there is a lot of positive work on the horizon and will link to trust objectives around volunteering. It was noted that staff attitude appeared in both positive and negative columns and a deep dive into free text comments from text message would take place to look further into this.	

	It was thought that wider messaging to manage expectations of family/loved ones on end of life would be helpful. This will be taken to Patient Experience Committee for wider discussion with colleagues around end of life agenda. It was agreed that the information now available was really helpful in understanding the position and it was important to look at how to use that information to effect a change. There has been good engagement in responding to patients but need to un-pick current constraints.	
	The Quality Priority update was received and noted.	
QC10/02.25	**PATIENT SAFETY PRIORITY - FALLS**	
	Jo Cleall, Physiotherapist attended to give an update on falls. The report was taken as read and the following points were highlighted. Falls rate runs 1 Apr 2024 to 31 March 2025 and is fitting within normal variation for rate of falls across the trust and was lower than at this point last year. The number of low harm falls were slightly higher but moderate and severe harm were lower. All were within normal variation. There had been a recent rise in falls which coincided with winter pressures in December and January. Year to date there had been two falls resulting in death. As part of the Regulation 28 report have been focussing on bed rails and position compliance. A multi-factorial risk assessment is completed and an audit takes place on weekly basis as part of Falls Panel. Compliance is improving, however, there are some issues around quality of assessments. Review of incidents report on In-Phase showed 93% of assessments have been completed. 90% were in the assessed position. Falls related to bed rails were a very small proportion of total falls at 21% or 72 falls but because of Regulation 28 findings and potential for harm this is still an important focus. Of those incidents found to be non-compliant there were a small proportion of bed rails in the raised positon. There is still work to be done at ward level and are collecting data from community hospitals. Leominster has shown marked improvement in compliance and the process has rolled out across all three community hospitals. This process could also be adapted for the acute hospital. A snap shot audit is done quarterly across the trust (10 patients per ward) looking at bed space environment, including bed rails. Compliance had dropped slightly in November. Overall there is still a need to monitor the quality of assessments for the next quarter.	

	Going forward there are some points relating to national audit: In patient falls and fractures up to January 2025 had only monitored hip fractures, this is now extended to head injury and any moderate harm and above. Training has been expanded in relation to bed rail concerns teaching falls prevention training as part of ADAPT training for nurses. E-learning has been reviewed and is live on ESR to help staff at ward level. The next area of focus on national audit is looking at severe harm falls. Whether patients had Analgesia administered, whether they were retrieved from the floor, whether they had a medical review. At present doing work with Geriatrics and a medical management template has been developed on Maxims. There will be a focus on compliance with retrieval from floor and will also provide moving and handling education. Will also expand data re moderate harm including wrist/rib fractures and head injury.	
	The Falls update was received and noted	
QC11/02.25	**<u>DRAFT QUALITY PRIORITIES 2025/26</u>**	
	The Associate Director of Quality Governance presented the draft of the suggested 2025/26 quality priorities. The paper was an assessment of seven priorities which have been monitored throughout the year. That assessment proposed that four priorities need to remain – VTE assessment, NATSIPS 2, Critical Medications and Patient Experience, but should be refined to make clear what we want to achieve. Whilst there was agreement in regards to patient experience, VTE and critical medications, it was proposed NATSSIPS2 could be removed due to improvement or improved governance arrangements for these areas. There were a further eight ideas for consideration going into next year and the committee was asked for their thoughts about those new priorities. There was support for a nutritional quality priority. Some work had been done in setting up a governance structure for nutrition but there are still some concerns regarding trust wide focus on nutrition and hydration. To also include patient food. The committee felt that some priorities could be combined, eg patient engagement and experience and were keen to focus on those which we could 'hit the ground running'. It was also thought that some priorities would benefit from being looked at system level rather than locally such as transition of care. NO to discuss with colleagues and also use Safety in Sync network. There was also support for transition from children's to adult care and diabetes.	

	The draft quality priorities update was received and noted	
QC12/02.25	**<u>UEC REPORT</u>**	
	The Deputy Chief Nursing Officer gave an update on boarding and patient flow. There had been a request from the committee to have focus on patient care and a deeper dive into data on safety across all areas. January saw a slight decrease in the number of attendances and admissions but there had been long lengths of stay making ED congested. Ambulance handover times had deteriorated over winter months with an increase in those waiting for more than one hour. There had been an increase in ED patients waiting over 12 and 24 hours and an increase in number patients waiting for a bed early in the morning. A change to the escalation policy led to boarding in extremis; 30 plus in the morning from overnight. As a result there had been an increase in escalation areas used, also utilising A&E external corridor. Normal escalation areas were open in ED, and additional beds in Community Hospitals and Endoscopy. Fred Bulmer Day Case Unit was also needed as an additional escalation area in January. The number of moves for our patients also increased. The average number of moves being 1.5 per person. The number of moves for patients with dementia had decreased slightly. New Discharge Lounge opened in December and the number of patients utilising it has increased month on month. There was an increase in the number of complaints in November and December and also one FTSU concern regarding boarding of patients. The main objective is to get flow through ED and reduce boarding patients. A test of change week had taken place, focused on how we manage flow from ED through to discharge, including transfers to our Community sites. The divisions have been working together to look at how we can improve the current process and a set of principles have been agreed. Now looking to embed those changes into the flow process. There are still concerns regarding boarding and poses one of the biggest risks for the trust at present. It was noted that there is a National focus on increased mortality associated with long stay in ED. Data is robust showing that if more than 4-5 hours are spent in ED that morality increases. It was acknowledged that space issues has a huge impact on both patients and staff.	
	The UEC report was received and noted.	

QC13/02.25	**DIVISIONAL QUARTERLY REPORT – MEDICAL DIVISION**	
	Jo Clutterbuck gave the highlights of the quarterly report for the Medical Division. The report from the information team had been used as the basis of this report and feedback offline on where it could be improved was invited. SSNAP audit for stroke continues to be SSNAP A. There was also consistent performance on skin cancer. 4 hour performance for non-admitted patients had increased to 74.8% turnaround in December 2024. Outpatient areas were improving regarding waiting times, particularly cardiology which was previously one of the biggest risk areas. There had been a reduction in the number of complaints and good feedback received from Non-Exec quality engagement visits on how caring staff are. The Nurse Navigator continued to navigate significant numbers of patients to minor illnesses and there had been some improving work in ED. The diabetes team have a poster at Diabetes UK conference There were concerns around Redbrook ward when it moved from Gilwern nurses were recruited and had concerns around their experience. There has been a lot of work done to support education and training and there has been a reduction in complaints, improved cleanliness, and sickness amongst staff. The Divisional Flow Co-ordinator has helped to improve usage of the new discharge lounge, particularly improving its early usage when it opened 20th December. There has been progress with Consultant recruitment. Consultant Rheumatologist has been appointed and interviews have been scheduled for substantive Stroke and ED Consultants. ED improvement work completed in September and subsequently some further work in the reception area. There has also been some work done around nursing teams and senior cover overnight. The overcrowding in ED remains the division's highest risk. It is also felt that the target of 78% for 4 hour performance in ED by end March will not be met. There had been an increase in falls on AMU and an improvement plan is in place, based on the frailty wards template.	

	Continue to have high numbers of overdue and low harm incidents open. The division has plans to support the clinical teams to complete over the next few months. There has been a reduction in complaint response turn around and this should also continue to improve over the next few months. There are a significant number of outstanding estates issues which need to be resolved. The frequency that Band 7 Sisters are going into numbers to support staffing levels is also becoming an area for concern. This is due to a significant decrease in shifts filled by master vend, day shifts being particularly bad. This is improving and are working with ID Medical, both operationally on a weekly and also as part of performance meeting. An audit will be undertaken and will be monitored at the Matron's meeting. The transfer hand over SOP is in development but is not agreed at present. It is an area of concern as several models have been tried but there are a lot of concerns from both ED and ward areas that this is still not being done effectively and efficiently. Within the division there is a proportionally very high usage of frailty block for boarding. Frailty team have done criteria for boarding to help to spread risk more evenly. There had been a PSII incident around detection, diagnosis and management of type II respiratory failure in ED. An index case had happened May last year for which the investigation is ongoing. The Investigating Officer is supported by the safety team. There are some outstanding VTEs which are awaiting second review at Thrombosis Committee. The committee were concerned about VTE risk assessment completion. It was noted that there is a poor rate of completion for elective surgery and some work has been done with the DCMO to help to resolve this. There will be a test of change week in March to ensure no patient goes to theatre without having VTE assessment completed. Theatre staff will monitor this. There is also a refresh of VTE meeting scheduled to take place. It is proposed for electives assessments to be completed at pre-op and then paper work be transcribed at the time of surgery.	
	The Quarterly report Medical Division was received and noted.	
QC14/02.25	**<u>ED CQC INSPECTION UPDATE</u>**	
	The Acute and Emergency Clinical Director and Acute and Emergency Matron gave an update on progress following the CQC Inspection of ED. There is now a much improved governance structure in ED and there is now far better oversight of what is happening in ED.	

	Education meetings take place monthly and have appointed a band 7 Lead Practice Development Nurse which will be integral to a number of the changes to be made. There has been improvement in level 3 safeguarding training for medics. Band 7 management of change has completed and will be moving to a new rota from March to cover a 23 hour period. Performance data shows care of sepsis is improving but bundles are not being completed and focus is now to improve completion of these bundles. Some training has been done and Symphony super users will add the bundles into the electronic system. A policy and guidelines meeting is scheduled to take place where the new sepsis bundles will be signed off which should see improvement. There are a low number of staff who have completed Level 3 Safeguarding for nursing staff, however the Practice Development lead is working to improve compliance. There is also work to do to improve the handover process from ED to wards, as mentioned in the Divisional report. Pain management is an area for concern. Data shows that initial pain management is good but is off track with ongoing management. This is about education and a visual marker has also been placed on Symphony. The division would like to escalate overcrowding in ED which remains as high on the risk register. Lack of resus capacity is also high risk. Looking at strategies to reduce the risk going forward. There is good understanding within the division and a solution discussed is the need to hold a space 24 hours a day and confirming the need to hold that space. This will also be raised at next Executive Risk meeting. Also for escalation are the significant number of estate issues, leaks in department which has made delivering care difficult. The Committee agreed that tremendous progress had been made since inspection. There are still some areas needing improvement - triage at front door and MTS. Training on how to triage is ongoing but it is acknowledged that further work is needed. There was concern that repeat observations of patients with NEWS of 5 had not been showing improvement. It was confirmed that the NEWS audit shows there are improvements with escalation of NEWS 5 and above and the ED Matron is assured that escalation has improved.	

	Planning for the future there are a number of changes which would help to decongest ED. Re-organising front door to ensure that patients are moved to the right areas, as they are often in fit to sit areas or waiting rooms which are highly congested. This is based on GIRFT and NHSE models over last few months and are confident it would work if could set up a more appropriate area to see these patients. Essential to role compliance and ability to deal with major trauma is improving. Some statistics were given in the appendix.	
	The ED CQC inspection update was received and noted.	
QC15/02.25	**EXTERNAL VISITS OVERVIEW REPORT**	
	The Clinical Quality Improvement Manager presented an overview of external visits. The report was taken as read and the following points highlighted. A process and policy was introduced for external visits and accreditation during the pandemic. Since visits started to recommence it has been widely publicised. The Quality team maintain the trust register and are reliant on being advised of visits and outcomes by the divisions. To help with this have introduced distribution of monthly prompt emails and added external visits as a mandatory item at all governance meetings. This has proved successful and generates notice of visits to the team. In 2024, management of external reviews transferred to the compliance team to manage the process as BAU. This year the team are to take a further review of the process, working closely with divisions to find solutions to address gaps. The process is not yet fully embedded into practice, a particular area identified is requirement to close the loop at the stage where a visit has happened. The process has been amended and all outcomes of external visits come to Quality Committee and the Committee was asked to consider whether oversight and feedback presented to them should be through individual report, via divisions or combination of both. Also any feedback on this report would be used as part of the compliance team's review and will support any process changes moving forward. The committee were assured to know that this process in place but felt that detail was not needed here at Quality Committee but needed to be assured that reports are going to the right places and are dealt with in the correct way.	

	It is helpful from a governance perspective to have advanced notice of visits happening and any risks if there may not be compliance. This also fits with board assurance. It was agreed that governance should be with Divisional reporting. It was noted that following a submission to HTA last year that there would be a Mortuary visit taking place, the date of visit is to be confirmed. There is still some work to be done around products of conception, however there is now better assurance around Mortuary and an external visit would be welcomed to sense check that progress.	
	The External Visits overview report was received and noted	
QC16/02.25	**STAFFING REPORT**	
	The Deputy Chief Nursing Officer presented the staffing report. Escalation areas and boarding spaces had impacted on fill rates across most wards. Sickness and vacancy rates had seen a slight improvement. There had been a slight increase in agency usage in month by 5.32 wte which had been predicted. This led to a small amount of Thornbury usage. Also in month have introduced a new process with ID medical utilising N24 agency nurses which is considerable saving against Thornbury.	
	The staffing report was received and noted	
QC17/02.25	**PATIENT EXPERIENCE COMMITTEE SUMMARY REPORT**	
	The report was noted and taken as read.	
	The Patient Experience Committee summary report was received and noted.	
QC18/02.25	**PATIENT SAFETY COMMITTEE SUMMARY REPORT**	
	The report was noted and taken as read.	
	The Patient Safety Committee Summary Report was received and noted	
QC19/02.25	**INFECTION PREVENTION COMMITTEE QUARTERLY REPORT**	
	The Lead Infection Prevention Nurse presented the highlights from the quarterly Infection Prevention Committee Quarterly report. There had been zero percent SSI infection rates in hip and knee infection. During April-June there were 70 hip and 81 knee replacements. The SSI working group looks at all data and standards.	

	National standards of cleanliness - There were 109 audits in quarter and 94 areas audited scored 4 stars or more in their cleanliness. The 15 areas not scoring well were predominantly non-clinical areas. Progress continues on the Infection Prevention BAF. Remain with 4 criterion fully compliant and the other 6 partially compliant, however more assurance is needed to make fully compliant. This is mainly Pharmacy, anti-microbial stewardship and the resources to manage that and is on the risk register. All Covid and Flu outbreaks have been managed to plan and areas opened quickly afterwards. There have been no closures to patient admissions. One case of CPE was reported in Ashgrove Ward. A known CPE patient was admitted and put into a bay. The patient was identified and transferred to side room. Appropriate screening was undertaken and one contact tested positive. No further patients were identified within 28 days. Model health data from ICB has set thresholds for gram negative bacteraemia, E.coli, Klebciella and Pseudemonus. Internal data shows breach of annual thresholds in Klebciella and Psuedemonus and are looking at anything missing in prescribing or management of these patients. Of cases so far this year, 10 were linked to underlying conditions and were not to do with care. CPE outbreak at Ross remains active. To date there had been a total of 39 cased. Work continues to look at practices and environment. The IPC have done many visits and provided regular support. There have been no new cases for several weeks. NHSE and ICB assurance visit is scheduled to take place next week and will review the action plan, clinical practice and environment and will inform of findings. To note that none of the patients have been infected with CPE, have been colonised and nobody has been so unwell that they have not been able receive scheduled care. There were no cases of C-difficile reported in January. Have asked for ICB to look at differing numbers. During quarter 3 there were 13 reported cases giving a total of 55 cases against a threshold 38. This is at the far end of quadrant on the model health framework and are one of seven trusts at the latter end of scale. Of those 55, 12 died within 30 days of diagnosis giving a case fatality rate of 21.8% vs national 12.9%. Working with the Mortality team to see if anything had been missed in reviews or if there were any underlying factors. Also working with the ICB regarding C-difficile. Cases are also rising nationally and in region.	

	A review group has been set to review relapse cases, looking at what defines a true relapse, where patients are coming from and looking at antibiotic prescribing before hospital. There is no evidence that they are due to hand hygiene and clinical cleanliness. The common thought at present is antimicrobial stewardship. M-Pox preparedness was raised as a concern and is now on the risk register. In August all organisations were asked to look at pathways and polices and also adopting new PPE guidance. In order to adopt new PPE a representative from every organisation is required to attend 2 days training to don and doff PPE. To date nobody in West Midlands has been able to get on the National training programme. This has been raised as a regional concern and is on the local risk register. NHSE and Midlands Region have agreed that it is acceptable for staff dealing with high consequence infectious diseases, including Mpox, to wear airborne PPE precaution. Airborne precaution training will be rolling out in the next 4-6 weeks. It was noted that C-Difficile is of biggest concern and questioned if cases were being counted correctly. It was noted that some patients counted as having hospital onset are symptomatic before they are admitted but are only picked up on sample several days later. Will be looking at how they can be labelled correctly and ensure we can get a better picture. PLACE results have been published and will report in due course.	
	The Infection Prevention Committee Quarterly report was received and noted.	
QC20/02.25	**INFECTION PREVENTION COMMITTEE SUMMARY REPORT**	
	The report was taken as read and noted.	
	The Infection Prevention Committee summary report was received and noted.	
QC21/02.25	**PATIENT SAFETY INCIDENTS SUMMARY REPORT**	
	The Associate Direct Quality Governance gave an update on patient safety incidents. National guidance is to aim to complete PSIIs within 6 months and we are outside that guidance with a number of incidents, moving away from the opportunity to implement learning at the best time and mitigate risks. All will be routinely looked at through panel to identify what barriers are and see how can support.	
	The Patient Safety Incidents Summary report was received and noted.	

QC21/02.25	**ANY OTHER BUSINESS**	
	There was no further business to discuss	
QC22/02.25	**DATE OF NEXT MEETING** The next meeting is due to be held on 27 March 2025 at 1.00 - 4.00 pm via MS Teams.	

Escalation and Assurance Report

Report from: Integrated Care Executive
Date of meeting: 13 May 2025
Report to: Wye Valley NHS Trust Board and One Herefordshire Partnership

Alert: Including assurance items rated red and matters requiring escalation
None

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Better Care Fund (BCF)**
Rating rationale	Following a delay, the 2025/2026 plan had been signed off by the Council and ICB with a savings target of £824k. Future reports would provide detail on each element of the budget and savings plan, including risks, enabling closer scrutiny of performance.
Outcome	Accepted
Item/Topic	**Discharge to Assess (D2A)**
Rating rationale	There were ongoing challenges with data quality and the need for better integration of data from various sources. There had been significant improvements in Pathway 1 performance and utilisation. Hillside occupancy has improved to around 80%; however, LICU occupancy remained low at around 57%. High re-admission rates, up to 25%, suggested early therapy to improve outcomes was essential.
Outcome	Accepted
Item/Topic	**Urgent Community Response**
Rating rationale	The UCR team continued to work to divert patients from ED to virtual wards, with some success, particularly with IV therapy cases. There were 780 total referrals including 300+ from GPs and a low rejection rate. Challenges included staff sickness and data collection. Call Before Convey had seen an increase in calls since promotional posters went live in March, but calls tended to drop significantly during peaks in hospital pressure. The Falls Responder service had been integrated into UCR from 1 May. A detailed update on the service would be provided in the next report. Services continued to be underutilised and promotion to care homes and agencies was needed, highlighting the positive impact on avoidable admissions.
Outcome	Committee members offered support with promotions and data collection.

To Note: Items received for information or approval	
Item/Topic	**Neighbourhood Health**
Summary	Five potential areas of focus had been identified: • Care Homes: Reduce avoidable hospital admissions by providing better support and interventions. • Frailty: Manage frailty more effectively, reducing the need for hospital admissions. • Heart Failure: (a separate focus to frailty) • Chronic obstructive pulmonary disease (COPD): Enhance services for patients to improve health outcomes and reduce hospital visits. • Frailty Post-Discharge Support: Ensure patients have the necessary support and resources to prevent readmissions and maintain their health at home.
Outcome	Noted
Item/Topic	**Integrated Care Executive structure**
Summary	The Terms of Reference would to be aligned with One Herefordshire governance. Details were yet to be clarified.
Outcome	Noted

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

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/06/2025**
Title of Report:	Perinatal Services Quality Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Amie Symes, Associate Director of Midwifery Candice Lewis, Perinatal Quality & Safety Matron Elaine Evans, Neonatal Unit Sister
Reporting Route:	Surgical Divisional Governance; Quality Committee
Appendices included with this report:	Perinatal Dashboard
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. The report includes detail in line with monthly reporting requirements for April 2025.

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.

Executive Director Opinion[1]

There are no exceptions to bring to Board attention this month for maternity services.

Of note the nurse staffing for the neonatal unit does fall short of the BAPM standards and is understood and accepted by our commissioner, the LMNS and the ODN network. This is an established and well mitigated risk on the trust risk register and the mitigations ensure the safety of the unit is not compromised in any way. The ODN are now raising some concerns regarding these derogations and a meeting is planned for early June.

[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 – May 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 April 2025. The report will be shared for scrutiny and challenge at Quality Committee, and for oversight and assurance at Trust Board. The report will then be shared with the LMNS Board and quarterly with the Chief Midwifery Officer for the Midlands, to align to CNST Year 7 standards.

2. PERFORMANCE

2.1 **Activity**

There were 113 births in April 2025. The midwife to birth ratio is very positive and should contribute to good care. This may be reflected in part by a lower number of births in the month of April compared to the average.

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 April 2025 are recorded as:

	April
Delay in Induction >2hrs	0
Delay in Catagory 1 C-Section >30mins	0
Delay in administering medication	2
Delay in starting syntocinon/ARM >30mins	0
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	5
Any movement of midwifery staff from any area to provide midwifery cover	12
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	2

In the month of April 2025, there were 2 delays in administration of medication, specifically pain relief for women following caesarean birth. The 2 delays in pain relief are the same incidents rather than separate issues. This may be linked to the lack of stat dose prescribing resulting in delays. Further improvements will be identified and implemented.

We are pleased to note that for the fourth month running there were no delays in Category 1 caesarean sections, which demonstrates effective MDT collaboration to ensure that babies were born within the recommended time.

Delivery Suite co-ordinator supernumerary status
We have achieved 100% compliance for this performance measure.

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 April 2025 is noted below.

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	N/A	
Caesarean birth for women with BMI>50	0	N/A	
Caesarean birth <28/40	0	N/A	
Premature twins (<30/40)	0	N/A	
4th degree perineal tear repair	0	N/A	
Unexpected intrapartum stillbirth	0	N/A	
Eclampsia	0	N/A	
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%	

2.2 **Activity**

There were 24 admissions to SCBU during April 2025

<26 weeks	26-30 weeks gestation	31-36 weeks gestation	>36 weeks
1*	1 *	8	14

BAPM 2011 Level of care.

ITU	HDU	SCBU
2*	4	18

Given the small numbers the detail of the exceptions cases* (and possibility of patient identification) these cannot be shared in public Board, the detail is provided and discussed at quality committee.

2.5 ROBSON GROUP DATA

The Medical Director has requested a review and presentation of Robson Group Data for the past year. The Obstetric team have undertaken this and this will be presented to Quality Committee.

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
April	0	0	1	0	0	0	0

There was one moderate incident during April where a woman had a post-partum haemorrhage (PPH). The case has been subject to a Rapid Review and immediate learning identified and implemented. Much of the learning is thematic to the ongoing PPH improvement work. The Rapid Review team identified this did not need escalating to the Patient Safety Panel in line with Trust PSIRF practices due to the ongoing thematic review and quality improvement work. Overall, the data from this work is demonstrating an improvement in the volume of blood loss in those experiencing a PPH.

There were no moderate incidents in April in SCBU.

3.2 **Concerns and Complaints**

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is potentially patient identifiable and is therefore contained in detail within the Minimum Data Set that is shared in private board and at Quality Committee, allowing us to summarise the numbers of concerns and complaints in this section.

	Concerns	Complaints
April 2025	0	1

The complaint received in April relates to post-mortem services at a provider Trust. This is currently being reviewed and investigated and learning has been identified and is being implemented.

There were no complaints or concerns in SCBU in April.

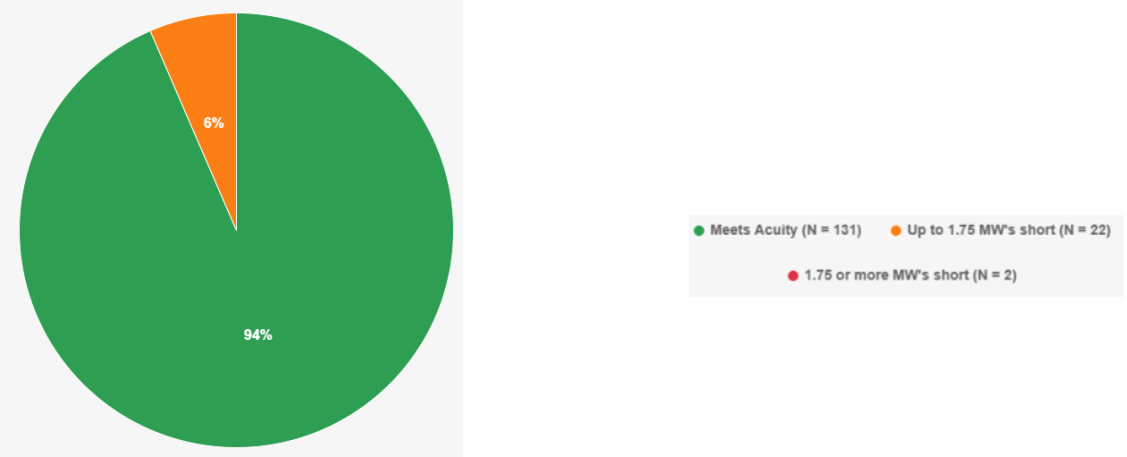
4. WORKFORCE

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 85.5% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 94% of the time. For 6% 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 12 instances of staff being redeployed internally to cover acuity which is a decrease from last month's data of 31 times. There were 5 occasions where community were redeployed to support Delivery Suite acuity again a decrease from last month's data where 1 were redeployed. There was 1 occasion where specialist midwives supported clinically. There were 3 occasions where acuity was escalated to the manager on call for support.

Number of Management Actions
01/04/2025 to 30/04/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	12	52%
MA2	Redeploy from community	5	22%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	1	4%
MA7	Manager/Matron working clinically	1	4%
MA8	Staff sourced from bank/agency	1	4%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	3	13%
MA11	Maternity Unit on Divert	0	0%
TOTAL		23	

*The % is rounded to nearest whole number

4.1.3 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November 2023.

4.2 **Obstetric workforce**

4.2.1 The obstetric rotas have been covered throughout April 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.

APRIL '25	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	200	200	100.00	0	200	0.00	0	200	0.00
Consultant: On Call	453.5	490	92.55	36.5	490	7.45	0	490	0.00
Consultant: Cold Week	96	104	92.31	8	104	7.69	0	104	0.00
Consultant: Antenatal Clinic	59.5	63.75	93.33	4.25	63.75	6.67	0	63.75	0.00
Middle Grade: delivery suite	189	198	95.45	9	198	4.55	0	198	0.00
Middle Grade: Antenatal Clinic	106.25	161.5	65.79	55.25	161.5	34.21	0	161.5	0.00

4.3 **Neonatal Medical Workforce**

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that 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 April 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	86%	21	70%
Anaesthetist extra days	4	14%	9	30%

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	97%	90%
Obstetric Consultant	100%	97%
Ward round completed	100%	100%

This has been shared with the Obstetric Lead for Anaesthetics who will look into the concern and update the team on expectations.

4.6 Neonatal Nursing

4.6.1 Safe neonatal nurse staffing is monitored by:

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

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

1:1 Intensive Care (IC)
1:2 High dependence (HD)
1:4 Special Care (SCBU)
Supernumerary Shift Co-ordinator

Our Neonatal Workforce Establishment is defined by the BAPM service standards for hospitals providing Neonatal Care.

The neonatal workforce is outlined as below:

Nursing Position	Budgeted WTE	Contracted WTE	Maternity leave	Long Term Sickness.
Band 7	2.0	2.0	0	0
Band 6	5.2	4.9	0	0
Band 5	10.4	8.61	0.92	1.0
Neonatal Outreach	1.26	1.26	0	0

4.6.2 Safe Staffing Standards.

April 2025

- % of shifts staffed to BAPM Recommendations – 91.53%,
- % of shifts QIS against Neonatal Toolkit Standards – 98.31%
- % of shifts with supernumerary shift leader – 3.3%

1. There were two shifts where we did not achieve BAPM standards and this was due to high acuity and capacity on the unit.
2. We do not have an establishment to achieve a supernumerary shift leader on all shifts, but this is recognised as an acceptable risk by the Trust for our capacity and acuity at WVT.
3. We provide assurance that there is always at least one nurse with QIS on all shifts, and all shifts remained safe.

4.6.3 Neonatal Staffing – Qualified in Speciality

The Neonatal Toolkit (2009) defines that:

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

4.6.4 Trajectory of QIS from October 24 – April 25

	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	April 25
Total QIS %	44.2%	44.2%	48.0%	43.5%	47.21%	49.3%	49.3%

Although the trajectory for the overall QIS compliance indicates an improving picture from February 2025 this is due to staff leaving making the proportion look better. Recruitment to these vacant positions is ongoing – with new staff commencing employment in September 2025 which will increase our number of registered staff, reducing the overall % of staff with a neonatal qualification. A separate report has been forwarded to the LMNS regarding ongoing plans to increase the overall percentage of staff with a neonatal qualification.

We currently have one Band 5 undertaking the critical care course at Birmingham City University (completion June 25) and we have been offered funding to support two staff members to undertake the Neonatal Critical Care Course at BCU in 2025/26.

Quality nurse Roles and AHP Provision

There is no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7wte Practice Education Lead (B7) with 0.3wte Clinical working within role (=1.0wte) and 0.2wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2wte B7 funding has been used to support a B6 Developmental Care Lead on a fixed term contract which has been extended until the end of March 2026.

4.6.5 **Sickness and Maternity Leave SCBU**

Month	Sickness (Trust Target <3%)	Maternity Leave (WTE)
April	**1.09%**	**1.92wte**

5. COMPLIANCE

5.1 CNST standards (Year 7) require compliance with training to be at 90% in all staff groups by 1st December 2025.

April 2025:

Training compliance in PROMPT: Midwives	95%
Training compliance in PROMPT: Obstetric Consultants	90%
Training compliance in PROMPT: Obstetric Middle Grades	89%
Training compliance in PROMPT: Anaesthetic Consultants	75%
Training compliance in PROMPT: Anaesthetic Middle Grades	92%
Training compliance PROMPT: Maternity Support Workers	97%
Annual NLS update compliance: Paediatric Consultants	89%
Annual NLS update compliance: Paediatric Middle Grades	84%
Annual NLS update compliance: Paediatric Juniors	80%
Annual NLS update compliance: Midwives	96%
Annual NLS update compliance: Neonatal Nurses	100%
Fetal Wellbeing update day: Obstetrics	89%
Fetal Wellbeing update day: Midwives	92%
Midwifery update day (Core Competency): Midwives	92%
Midwifery update day (Core Competency): Support Staff	94%

The training team have an annual plan to ensure compliance is delivered across all groups.

5.2 **Mandatory Training - Neonates**

Nursing

Training	Expected Target	April 2025
Mandatory (Core)	**>90%**	**98.75%**
Mandatory (Essential)	**>90%**	**89.8%**
Newborn Life Support (Annual Update)	**100%**	**96%**
Maternity Breastfeeding Update	**>90%**	**77%***

**There is a Neonatal update day scheduled in May 2025.

Personal Development Reviews – SCBU Nursing

March	April
88.89%	**85%**

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.

The planned safety walkabout in April was cancelled, however an unannounced visit was undertaken on Saturday 5th April and attended by the Executive and Non-Executive safety champion. All areas in maternity and SCBU were visited. The visit was used as an opportunity to talk to staff and service users – all feedback was wholly positive with no areas of concern.

5.4 **CNST MIS Year 6**

Full compliance has been accepted and confirmed by NHSR which has now been published via their website. This has enabled 3 consecutive years of full compliance. We are awaiting the final confirmation of reimbursement value which is due to be received in Trust by June 2025.

5.5 **CNST MIS Year 7**

MIS Year 7 was published in April. 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, the national compliance and monitoring tool will be released in June which will assist this work.

	Area	Indicator Description	Janua	Februa	March	April
Antenatal	Booking	Total bookings	137	131	136	111
		Women who were booked before 10 weeks	91	101	112	89
		% Women who were booked before 10 weeks (target 90%)	66.4%	77.1%	82.4%	80.2%
		Women who were booked after 9 + 6 weeks	46	30	24	22
		% Women who were booked after 9 + 6 weeks	33.6%	22.9%	17.6%	19.8%
		Midwife led care at booking	27	22	25	29
		% Midwife led care at booking	19.7%	16.8%	18.4%	26.1%
	Risk Management	Women with BMI of 30 and over at booking	42	42	46	26
		% Women with BMI of 30 and over at booking	30.7%	32.1%	33.8%	23.4%
		% Antenatal Personalised Care Plan completed	99.3%	100.0%	99.2%	99.2%
		% Intrapartum Personalised Care Plan completed	55.3%	65.4%	70.4%	62.0%
		% Portal Access Consent	98.5%	100.0%	100.0%	100.0%
		% Portal Access - Women who registered and logged in	80.7%	76.3%	80.1%	88.3%
		% Contacts were place of birth suitability was recorded	69.8%	69.9%	66.5%	71.3%
		% High risk women assigned a named Consultant - within 7 days	70.4%	71.3%	50.8%	50.0%
		% High risk women assigned a named Consultant - at any time	81.8%	85.3%	82.2%	82.0%
		% Antenatal contacts with a reviewed / authorised risk assessment	85.2%	83.6%	85.2%	86.6%
		% Antenatal contacts with a risk assessment form completed	92.9%	94.9%	93.4%	93.8%
	Smoking	Recorded Smoking Status at Booking - Yes	11	11	10	9
		Recorded Smoking Status at Booking - No	126	120	126	102
		Recorded Smoking Status at Booking - Unknown	0	0	0	0
		% of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%	100.0%
		Women who were current smokers at booking	11	11	10	9
		% Women who were current smokers at booking	8.0%	8.4%	7.4%	8.1%
		Smokers who were referred to smoking cessation services	10	9	7	9
		% Smokers who were referred to smoking cessation services	90.9%	81.8%	70.0%	100.0%
		Smokers who accepted CO screening at booking	10	11	10	9
		% Smokers who accepted CO screening at booking	90.9%	100.0%	100.0%	100.0%
	Carbon Monoxide	Women who were screened for CO at booking	130	122	128	105
		% Women who were screened for CO at booking (of total bookings)	94.9%	93.1%	94.1%	94.6%
		Women with CO reading of 4 ppm or more at booking	13	11	7	8
		% women with CO reading of 4 ppm or more at booking (of total bookings)	9.5%	8.4%	5.1%	7.2%

	Area	Indicator Description	January	February	March	April
Intrapartum	Deliveries	Total births (deliveries)	144	122	132	113
	Delivery Method	Home Births	0	0	1	2
		BBA's	1	1	2	1
		Vaginal births (deliveries)	60	47	47	43
		% Vaginal births (deliveries)	41.7%	38.5%	35.6%	38.1%
		Ventouse & forceps births (deliveries)	15	12	18	18
		% Ventouse & forceps births (deliveries)	10.4%	9.8%	13.6%	15.9%
	C-Section Deliveries	RG*1 having a caesarean section with no previous births	6	4	2	1
		RG*1 Deliveries	23	13	15	17
		RG*1 % C-section deliveries	26.1%	30.8%	13.3%	5.9%
		RG*2 having a caesarean section with no previous births	19	23	21	19
		RG*2 Deliveries	36	37	27	28
		RG*2 % C-section deliveries	52.8%	62.2%	77.8%	67.9%
		RG*5 having a caesarean section with at least one previous birth	20	15	22	14
		RG*5 Deliveries	22	17	26	18
		RG*5 % C-section deliveries	90.9%	88.2%	84.6%	77.8%
		Total Elective C-Sections	35	30	33	25
		Total Emergency C-Sections	33	32	33	26
		Total Caesarean births (deliveries)	68	62	66	51
		% Total Caesarean births (deliveries)	47.2%	50.8%	50.0%	45.1%
		% Grade 1 C-Sections within 30 minutes	60.0%	100.0%	50.0%	100.0%
		% Grade 2 C-Sections within 75 minutes	91.7%	87.5%	91.3%	93.3%
	Midwife Led Care	Midwife led (low risk care) births	27	17	18	25
		% Midwife led (low risk care) births	18.6%	13.9%	13.6%	22.1%
		Home births (deliveries) - midwife led only	0	0	0	0
		% Home births (deliveries)	0.0%	0.0%	0.0%	0.0%
	Births	Total number of babies born	144	122	135	115
		Babies born preterm (singletons born 36+6 or less)	8	4	13	8
		% Babies born preterm (singletons born 36+6 or less)	5.52%	3.28%	9.63%	6.96%
		Singleton babies born 26+6 or less	0	0	0	0
		% Singleton babies born 26+6 or less	0%	0.0%	0.00%	0%
		Babies (multiples) born 27+6 or less	0	0	0	0
		% Babies (multiples) born 27+6 or less	0%	0%	0%	0%
		Stillbirths	0	0	0	0
		% Stillbirths	0.0%	0.0%	0.0%	0.0%
		Stillbirths rate per 1,000	0.00	0.00	0.00	0.00
	Breastfeeding	Live births where breastfeeding initiated (first feed = breastmilk)	116	101	109	97
		% Live births where breastfeeding initiated (first feed = breastmilk)	81.1%	82.8%	83.8%	86.6%

	Smoking	Women who were current smokers at booking (delivered mothers)	12	11	8	8
		% Women who were current smokers at booking (delivered mothers)	8.3%	9.0%	6.1%	7.1%
		Women who were current smokers at birth (delivery)	9	8	9	7
		% Women who were current smokers at birth (delivery)	6.2%	6.6%	6.8%	6.2%
		% Women with CO measured at 36 weeks	100.0%	99.1%	100.0%	100.0%
		% CO >= 4ppm at booking and below 4 ppm at 36 weeks	9.1%	4.3%	8.6%	5.0%
	Risk Management	Late pregnancy loss (singletons 16+0 - 23+6)	1	0	0	1
		% (as a % of all singleton births)	0.69%	0.00%	0.00%	0.90%
		% Detection rate for FGR (below 3rd centile)	0%	0%	33%	0%
		Women who had a PPH of 1,500ml or more	9	5	7	4
		% Women who had a PPH of 1,500ml or more	6.3%	4.1%	5.3%	3.6%
		Women who sustained a 3rd or 4th degree tear	2	1	3	1
		% Women who sustained a 3rd or 4th degree tear (of total vaginal birt	2.6%	1.7%	4.5%	1.6%
		% Induction of labour rate (of all births)	32.6%	43.4%	36.4%	35.4%
		Routine Enquiry Domestic Violence - Asked	86	66	99	75
		Routine Enquiry Domestic Violence - Unable to ask	53	52	31	37
		Routine Enquiry Domestic Violence - Unknown	6	4	2	1
		% routine enquiry domestic violence	95.9%	96.7%	98.5%	99.1%
		Midwife to birth ratio	1:24	1:21	1:21	1:21
	Red Flags	Delay in Induction >2hrs	1	4	4	0
		Delay in Catagory 1 C-Section >30mins	0	0	0	0
		Delay in administering medication	1	0	0	2
		Delay in starting syntocinon/ARM >30mins	1	3	2	0
		Delay in Suturing >60mins	0	0	0	0
		Unable to provide 1:1 care in labour	0	0	0	0
		Delay in Triage >30mins	0	0	0	0
		Community midwives on call covering maternity unit	0	2	0	5
		Any movement of midwifery staff from any area to provide midwifery c	3	27	31	12
		Delayed recognition of and action on abnormal vital signs	0	0	0	0
		DSC lost - supernumerary status	0	0	0	0
		Full clinical examination not carried out when presenting in labour	0	0	0	0
		Delay of more than 30 minutes in providing pain relief	0	0	0	2
	Reduced Fetal Movements	Number of women presenting to service with reduced fetal movement	207	205	225	203
		Number of women presenting with RFM who are recorded as having a	206	204	224	201
		% of women presenting with RFM who received CTG	99.52%	99.51%	99.56%	99.0%
Neonatal	Admissions	Total admissions to neonatal care	14	8	21	9
		Unexpected admissions of full-term babies to neonatal care	6	4	10	5
		% Unexpected admissions of full-term babies to neonatal care	4.4%	3.4%	8.2%	4.7%
	SCBU admission temps	Eligible Babies	0	1	2	1
		% taken within hour	0.0%	100.0%	100.0%	100.0%
		Adm temp <36.5 degrees	0	0	0	0
		Eligible Babies	20	17	28	17
		% taken within hour	95.0%	100.0%	92.8%	58.8%
		Adm temp <36.5 degrees	1	3	1	0
	Risk Management	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	1	3	3	4
		Neonatal deaths	2	0	2	1
		% Neonatal deaths	1.4%	0.0%	1.5%	0.9%
		Neonatal mortality per 1,000 births	13.89	0.00	14.81	8.70
		Neonatal transfers for therapeutic hypothermia	0	0	0	0
		% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a	n/a
		Neonatal brain injuries	0	0	0	0
		% Neonatal brain injuries	n/a	n/a	n/a	n/a
		Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	0	1	2	0
		Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6	0	1	2	1
		% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)		100.0%	100.0%	0.0%
		Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0
		Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0	0
		% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a	n/a
Postnatal	Risk Management	Obstetrics admissions to ITU	0	0	0	0
		Maternal deaths	0	0	0	0
		% Postnatal Personalised Care Plan completed	96.6%	96.8%	95.3%	93.1%
		Postnatal readmissions within 28 days (mothers)	8	12	9	2
		Postnatal readmissions within 28 days (babies)	4	2	9	tbc
	Suspended Access to Service	Number of times Maternity Services Suspended per month	0	0	0	0
		Number of hrs Maternity Services suspended	0	0	0	0
		Number of times Home Birth services suspended per month	0	0	0	0
		Number of hrs Home Birth services suspended	0	0	0	0
		Number of times SCBU suspended per month	0	0	0	1
		Number of hrs SCBU suspended per month	0	0	0	

	Insight	reported (total)	1	4	0	
		New MNSI SI referrals accepted	0	0	0	0
		HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0
		Coroner Reg 28 made directly to Trust	0	0	0	0
	Workforce	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0	0	0
		Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	0	0	0	0
		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0	0
		Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled shifts)	TBC	TBC		
		Vacancy rate for midwives (black = over establishment, red = under establishment	2.07wte	2.07wte	3 wte	1.8wte
		Inphase related to workforce (service provision/staffing)	2	27	31	23
		MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%	100.00%
	Involvement	Service User feedback: Number of Compliments (formal)		2		1
		Service User feedback: Number of Complaints (formal)	4	2	0	1
		Staff feedback from frontline champions and walk-abouts (number of	0	0	0	0
	Improvement	Progress in achievement of CNST /10	10	10	10	10
		Training compliance in PROMPT: Midwives	96%	93%	90%	95%
		Training compliance in PROMPT: Obstetric Consultants	90%	100%	90%	90%
		Training compliance in PROMPT: Obstetric Middle Grades	100%	100%	89%	89%
		Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%	75%
		Training compliance in PROMPT: Anaesthetic Middle Grades	83%	85%	85%	92%
		Training compliance PROMPT: Maternity Support Workers	94%	90%	90%	97%
		Annual NLS update compliance: Paediatric Consultants	89%	90%	90%	89%
		Annual NLS update compliance: Paediatric Middle Grades	80%	60%	60%	84%
		Annual NLS update compliance: Paediatric Juniors	100%	88%	80%	80%
		Annual NLS update compliance: Midwives	99%	96%	96%	96%
		Annual NLS update compliance: Neonatal Nurses	86%	95%	95%	100%
		Fetal Wellbeing update day: Obstetrics	90%	89%	89%	89%
		Fetal Wellbeing update day: Midwives	93%	91%	97%	92%
		Midwifery update day (Core Competency): Midwives	99%	91%	89%	92%
		Midwifery update day (Core Competency): Support Staff	94%	97%	94%	94%

SCBU Dashboard

SCBU DASHBOARD 2025- 2026														
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Comments	
Staffing: Vacancy Gaps, Attrition Rate, Sickness														
Band 7 Vacancy Gap (2.0wte)	0													
Band 6 Vacancy Gap (5.2wte)	0													
Band 5 Vacancy Gap (10.5)	2													
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0													
Band 2 Vacancy Gap (1.0wte)	0.2													
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0													
Attrition Rate (WTE)	0													
Maternity Leave (WTE)	1													
Sickness (<3.5%)	1.09%													
Safe Staffing														
% Shifts staffed to BAPM Standards	92%													
QIS % (standard = 70% of registered workforce)	49%													
% of shifts QIS to toolkit	98.31%													
% Shifts with supernumerary shift co-ordinator	3.39%													
% Shifts covered with Bank	1%													
Appraisal Rate	85%													
Mandatory Training Core	98.75%													
Mandatory Training Essential	89.8%													
Basic Life Support	43%													
Newborn Life Support >90%	96%													
Maternity Breastfeeding update.	77%													
Safeguarding Level 3	100%													
Compliments/Complaints/Concerns														
Complaints/Concerns	0													
Infection Prevention														
Overall - Star rating.	4													
Ward Assurance Audit	82%													
Hand Hygiene	100%													
Bare Below the Elbow	100%													
Incident and Exception Reporting														
Number of Incidents (Inphase)	5													
Medication Errors	0													
Staffing	0													
Service Escalation (OPEL RED/BLACK)	0													
Exception reports - ex-utero outside of care pathway	0													
Exception reports - in utero transfers outside of pathway/network	1													
Audits														
Quaterly CD Audit														
IV Fluid Prescription - Target 90% Compliance	97%													
Clinical Notes Audit - Correct Completion target 90%	57%													
Cannula Care Plan (Peripheral Cannula) Target 90%	89%													
Gentamicin Clinical Audit	96%													
NGT Misplacement NPSA Safety Alert 2016 Target 90%	86%													
Pain Audit Tool Completed Correctly Target 80%	60%													
IVAB administered within 1 hr of decision to give														
Growth parameters Audit	82%													

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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%)	Data to be verified													
TC Bed occupancy rate on SCBU % including parent bedroom	Data to be verified													
Number of babies born between 34-36 wks gestation and admitted to SCBU	Data to be verified													
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	Data to be verified													
Neonatal Outreach Team														
Total Patients	11													
New Referrals	4													
Existing Patients continuing care	7													
No. NGT Feeding in the community	8													
Receiving EBM on discharge from SCBU	5													
Receiving EBM on discharge from O/R	3													
Numbers Discharged from outreach	5													
Number of Incidents (Inphase)	0													
Home Phototherapy	1													
Prolonged Jaundice Screening Referrals	27													
Prolonged Jaundice Screening - Total Number of Referals meeting criteria for outreach	21													
Prolonged Jaundice Screens - Outreach	18													
Prolonged Jaundice Screens - RAC	5													
		Excellent												
		Satisfactory												
		Requires Improvement												

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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
GP	General Practitioner
HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HEE	Health Education England
HSE	Health & Safety Executive
HAFD	Hospital Acquired Functional Decline

HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICB	Integrated Care Board
ICP	Integrated Care Provider
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
LTP	Long Term Plan
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
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
NMC	Nursing Midwifery Council
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