# PUBLIC BOARD MEETING

*Thu 03 July 2025, 13:00 - 14:30*

**MS TEAMS**

# Agenda

**13:00 - 13:01**
1 min

## 1. Apologies for Absence

*Russell Hardy*

Frances Martin, Jo Rouse and Nicola Twigg.

**13:01 - 13:02**
1 min

## 2. Declarations of Interest

*Russell Hardy*

**13:02 - 13:03**
1 min

## 3. Minutes of the Meeting held on the 5 June 2025

*Decision* *Russell Hardy*

3. PUBLIC BOARD MINUTES - JUNE 2025 - LF, KO.pdf (9 pages)

**13:03 - 13:05**
2 min

## 4. Matters Arising and Actions Update Report

*Discussion* *Russell Hardy*

4. PUBLIC BOARD ACTION LOG - JULY 2025.pdf (1 pages)

**13:05 - 13:40**
35 min

## 5. Items for Review and Assurance

### 5.1. Chief Executive's Report

*Discussion* *Stephen Collman*

5.1 WVT CEO Board Report July 2025.pdf (4 pages)

### 5.2. Integrated Performance Report

*Discussion* *Jane Ives*

5.2 WVT IPR Month 2 - final.pdf (30 pages)

#### 5.2.1. Quality (including Mortality)

*Discussion* *Lucy Flanagan/Chizo Agwu*

#### 5.2.2. Activity Performance

*Discussion* *Andy Parker*

#### 5.2.3. Workforce

*Discussion* *Geoffrey Etule*

Job Evaluation Paper

5.2.3 Covering Report - Job evaluation at WVT.pdf (2 pages)

#### 5.2.4. Finance Performance

*Discussion* *Katie Osmond*

**13:40 - 13:50**
10 min

## 6. Items for Approval

### 6.1. Refresh of the Green Plan

*Decision* *Alan Dawson*

- 6.1 2025_06_26 Green Plan Covering Report Board.pdf (1 pages)
- 6.1a 2025_06_20 Green plan DRAFT incl SMART objectives.pdf (22 pages)

**13:50 - 14:05**
15 min

## 7. Items for Noting and Information

### 7.1. Perinatal Summary Report (Maternity)

*Discussion* *Lucy Flanagan*

- 7.1 Perinatal Safety Report Board version May 2025 Maternity.pdf (15 pages)

### 7.2. Committee Summary Reports and Minutes

#### 7.2.1. Audit Committee Report 15 May 2025 and 24 June 2025

*Discussion* *Sharon Hill*

- 7.2.1 Audit Committee Escalation & Assurance Report 15 May 2025.pdf (2 pages)
- 7.2.1a Audit Committee Escalation & Assurance Report 24 June 2025.pdf (2 pages)

#### 7.2.2. Quality Committee Report and Minutes 27 March 2025 and 24 April 2025

*Discussion* *Ian James*

- 7.2.2 Quality Committee Summary Report March 2025 Public.pdf (2 pages)
- 7.2.2a Quality Committee Minutes March 2025.pdf (16 pages)
- 7.2.2b Quality Committee Summary Report April 2025 - public.pdf (2 pages)
- 7.2.2bb Minutes Quality Committee - April.pdf (8 pages)

**14:05 - 14:10**
5 min

## 8. Any Other Business

**14:10 - 14:15**
5 min

## 9. Questions from Members of the Public

*Russell Hardy*

**14:15 - 14:15**
0 min

## 10. Acronyms

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

**14:15 - 14:15**
0 min

## 11. Date of Next Meeting

The next meeting will be held on 4 September 2025 at 1.00 pm

**WYE VALLEY NHS TRUST**
**Minutes of the Public Board Meeting**
**Held on 5 June 2025 at 1.00 pm – 2.30 pm**
**Live Streamed**

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

RH provided a brief overview of the Board Workshop held this morning.

| Ref | Item | Lead | Purpose | Format |
|---|---|---|---|---|
| **1.** | **Going The Extra Mile Award Winners Quarter 4 2024/25** | **RH** | | |

Team of the Quarter – Cath Lab Team – RH read out the reasons why the Team were nominated for this award.

Employee of the Quarter – Dan Fearn – RH read out the reasons why Dan had been nominated for this award.

| | | | | |
|---|---|---|---|---|
| **2.** | **Apologies for Absence** | **RH** | **Information** | **Verbal** |

Noted as above.

| | | | | |
|---|---|---|---|---|
| **3.** | **Quorum and Declarations of interest** | **RH** | **Information** | **Verbal** |

The Board was quorate and there were no new declarations received.

| | | | | |
|---|---|---|---|---|
| **4.** | **Minutes of meeting on 3 April 2025** | **RH** | **Approval** | **Enclosure 1** |
| Approved. | | | | |
| **5.** | **Matters Arising and Action Log** | **RH** | **Information** | **Enclosure 2** |
| All actions in the log were completed. | | | | |
| **6.** | **PFI Performance Issues** | **AD** | **Discussion** | **Enclosure 3** |

AD advised that the Trust experienced significant operational and patient care issues over the winter due to failures in estate-related services. These problems persisted for several weeks during a peak period, prompting a contractual response. The Trust invited Mercia and Sodexo to account for their performance. They initially accepted but then declined to attend and instead submitted a written response.

A four-year backlog exists. Our PFI Partners have made a commitment to resolve this within the next four months. Capitec will conduct an independent audit of maintenance procedures to provide assurance. There is also a commitment for the continued improvement of the Trust and to invest in people on site

There is a significant Life Cycle Plan to deliver as part of the PFI Contract. We need to ensure that Mercia and Sodexo can take on large estates works forward over the next 4 years. The response is cautiously welcomed but lacks assurance until plans and reports are reviewed along with emphasis on learning from past issues through root cause analysis. We will continue to report back to the Board via our PFI Partnership meetings.

JI advised that last week the Regional Team visited the Trust regarding assurance and oversight in terms of infection prevention, where they noted significant improvements. Concern remains about estate issues, particularly the condition of showers and toilets—again linked to backlog maintenance.

**Action 6 – To provide an update to assess progress on maintenance resolution by Mercia and Sodexo at the October Public Board meeting – AD.**

**The Board accepted the PFI Performance Issues.**

| | | | | |
|---|---|---|---|---|
| **7.** | **Chief Executive's Report** | **SC** | **Assurance** | **Enclosure 4** |

Model ICB Development Anticipated National Plans – The 10-Year Plan and Urgent and Emergency Care National Plan are expected soon. We will monitor publication and align local strategies accordingly.

ICB Reconfigurations & Clustering - Herefordshire and Worcestershire will cluster with Coventry and Warwickshire. We will leverage existing relationships and Foundation Group structures to support integration and collaboration.

Strategic Consistency Amid Change - Despite national and regional flux, the Trust maintains a consistent strategic direction focused on Prevention, Community-based care and Digital transformation.

Operational Excellence Conference – We celebrated the success of operational managers sharing improvement projects. We need to expand this initiative by involving Clinicians to drive further transformation. SC thanked JI for all her hard work around this.

Integrated Care Division Initiatives – SC highlighted the urgent care response improvements, including support for West Midlands Ambulance Service and reducing ED pressure. We need to share best practice across the Foundation Group and continue shifting care out of acute settings.

RH noted regarding the ICB reconfiguration, this is a very unsettling time for our ICB colleagues.

**The Board accepted the Chief Executive's Report.**

| 8. | Integrated Performance Report | JI | Assurance | Enclosure 5 |
|---|---|---|---|---|

Financial Performance – We have had a positive start to the year with Month 1 targets met. Cost and Productivity Improvement Plans (CPIP) identified, though many are still in conceptual stages. We need to transition CPIP schemes from ideas to implementation.

Income Risk from Welsh Commissioners - Welsh Commissioners are reducing routine and elective work and extending wait times (up to 2 years for procedures). This will effect around ten thousand appointments/procedures and creates financial strain due to stranded costs, and risks of a future backlog and emergency demand. We need to finalise the financial impact analysis and develop mitigation strategies. This is a poor value for money proposition for patients. We expect to be seeing additional emergency numbers due to these patients having to wait longer than originally.

Urgent and Emergency Care – This has been Identified as the biggest risk across performance, quality, and finance. We need to continue intensive scrutiny and improvement efforts, including workshops and targeted initiatives.

New Safety Oversight – We have introduced a Non-Executive Director (NED) Safety Champion for the Emergency Department (ED), modelled after the successful maternity safety initiative. RH suggested that this NED Safety role could be expanded to other regions such as Worcestershire.

**The Board accepted the Integrated Performance Report.**

| 9. | Quality (Including Mortality / Learning from Deaths) | LF/CA | Assurance | |
|---|---|---|---|---|

IPC Board Assurance Framework (BAF) Self-Assessment – LF advised that the quarterly self-assessment continues as best practice. April submission shows no areas of non-compliance and only a few partial compliance areas, none posing patient safety risks (mostly related to audit/reporting). Ventilation systems have now moved from partial to full compliance. We will continue quarterly assessments and address minor audit/reporting gaps.

CPE Outbreak at Ross Community Hospital – The NHS England inspection occurred on 6 March. The outbreak status was stepped down to surveillance, then fully lifted on 7 May. We will maintain surveillance and ensure continued compliance to prevent recurrence.

We have been under Intensive support from NHSE and ICB colleagues regarding cleanliness with a full inspection of the County site undertaken on 30 May. This included an inspection of 5 clinical areas. We were moved from intensive to enhanced monitoring which is very positive. There is a potential move to routine monitoring if estate maintenance issues are resolved. We need to collaborate with Sodexo to address the estate backlog (as they have given us a formal timescale in their response) and prepare for the provisional September re-inspection.

Mortality Indices – CA advised that the 12-month mortality index rose to 106 over the winter. Despite this, actual deaths in key diagnostic areas (heart failure, sepsis, and stroke) have decreased. The rise is attributed to a drop in expected deaths, not an increase in actual mortality. We will investigate potential data quality and coding issues, particularly around capturing co-morbidities.

Fractured Neck of Femur – This continues to be a focus of quality improvement. Following a Workshop, we are looking closely to identify pathway challenges that hinder sustained improvement. We need to refine and embed improvements in the care pathway.

Data Accuracy & Coding – JI noted that this is likely a data quality and coding issue affecting mortality statistics. There is an option to resubmit data, although it requires additional resources. We need to prioritise accurate coding to ensure reliable statistics and public transparency.

IJ, Quality Committee Chair expressed overall assurance in how the Trust is managing quality and safety. We will continue with regular Committee oversight and ensure follow-up on identified issues.

The annual Quality Account to be reviewed later in the agenda for broader assurance.

**The Board accepted the Quality (including Mortality) Report.**

| 10. | Activity Performance | AP | Assurance | |
|---|---|---|---|---|

Performance Challenges – There are significant pressure on our 4-hour emergency access standards. Workforce issues include ED and acute floor rota gaps, new staff onboarding, sickness, and weekend/out-of-hours coverage. We have also had record ED attendances and winter-level acuity in April. There have been infection outbreaks (COVID, flu, D&V) across Acute and Community sites. All of this resulted in an internal critical incident post-Easter and deterioration in ED performance metrics.

Improvement Plan - A detailed 78% Improvement Plan is in place for UEC and 4-hour targets. Immediate actions include addressing rota gaps and senior oversight, enhancing front-door streaming and supporting a capital bid for ED estate improvements. We also need to expand ambulatory care to reserve ED for critical cases.

System-Wide Collaboration – We are working with One Herefordshire and Community partners to reduce unnecessary admissions and improve discharge processes. The target is to reduce >0-day length of stay admissions by 5 per day before winter.

Workshops & Engagement – Two Workshops have been held involving the whole MDT of operational teams to discuss Valuing Patients Time and Urgent and Emergency Care. Focus areas were front-door navigation and streaming, reducing ED congestion and time to be seen, improving ward processes and reducing reliance on escalation spaces and enhancing patient experience and safety. The final session will be used to define and test improvement actions. A summary of these outcomes will be included in the next report to the Board.

We are awaiting the release of the new national UEC plan. Once published, we will ensure that this aligns with our local plans.

**The Board accepted the Activity Performance Report.**

| 11. | Workforce | GS | Assurance | |
|---|---|---|---|---|

The new NHS Very Senior Managers Pay Framework has been published and will be discussed at the upcoming Remuneration Committee.

The 2025–2026 pay awards have been announced, however the BMA are balloting Resident Doctors for potential strike action. We are preparing contingency plans for service continuity pending ballot results in July.

We have high sickness absence and have therefore revised the Sickness Absence Policy with stricter attendance measures introduced. We will monitor for expected reduction in sickness rates over the coming months.

Workforce & Admin Review – There is an ongoing review of Corporate Departments and admin structures to conclude by the end of June. We will use the findings to inform a Trust-wide Workforce Plan.

Recruitment & Retention - Healthcare Support Worker turnover is high (18%), especially within the first 6 months. We plan to implement enhanced pastoral care, mentorship, and apprenticeship pathways to improve retention. Domestic nurse recruitment is improving, reducing reliance on international hires. This has been attributed to strong support programs, University partnerships and positive staff survey results. We will sustain and build on these initiatives to maintain attractiveness as an employer.

E-Rostering Rollout – We plan to extend E-rostering to all clinical staff groups over the coming year. A smooth implementation will enhance workforce efficiency and productivity.

Staff Well-being & Engagement – We are promoting initiatives like Equality and Human Rights Week and National Walking Month and will continue to fostering a supportive and healthy work environment.

The Annual Wye Valley Family and Fun Day is scheduled for 21 June at the Halo Leisure Centre. GE encouraged participation to strengthen community and staff morale.

IJ noted the high turnover rates for HCSW at entry level and queried if the 18% includes new starters or current staff. GE advised it is a combination of both. New entrants into the workforce are leaving for a variety of reasons within 6 months with a plans in place to support these staff as described.

NT noted that we are not employing internal nurses this year due to the number of UK based nurses. Is this sustainable and why are they choosing to come to Hereford? GE advised that there have been more applications nationwide. We also have a good support programme in place and are a good modern employer with positive staff survey results which makes us an attractive proposition.

**The Board accepted the Workforce Report.**

| | | | | |
|---|---|---|---|---|
| **12.** | **Finance** | **KO** | **Assurance** | |

The report covers Month 1, with Month 2 nearly complete. The organisation is currently on plan financially. There is a small overachievement in the CPIP despite operational pressures and staff sickness. A significant risk lies in the assumption of funding from Wales, based on fair shares parity with English Commissioners. This funding is still under dispute and has been escalated to NHSE and NHS Wales.

Good progress has been made in reducing unidentified CPIP targets. Focus remains on de-risking and converting opportunities into firm plans and delivery. There is emphasis on not becoming complacent, as more work is needed in the coming months.

Cash balances at the end of Month 1 are healthy. However, access to deficit support funding is contingent on overall financial performance, delivery of CPIP targets, and close monitoring of cash flow which is essential.

A discussion on theatre productivity was noted as a potential area for further financial opportunity, especially in light of the Welsh funding challenge.

**The Board accepted the Finance Report.**

| | | | | |
|---|---|---|---|---|
| **13.** | **Use of the Trust Seal** | **GS** | **Information** | **Enclosure 6** |

The Board accepted the Use of the Trust Seal.

| | | | | |
|---|---|---|---|---|
| | **ITEMS FOR APPROVAL** | | | |
| **14.** | **Board Assurance Framework and Risk Appetite Report** | **GS** | **Approval** | **Enclosure 7** |

The Executive Risk Management Committee reviewed the BAF risks in light of new strategic objectives and priorities such as the Green Plan and PFI expiry. A total of 12 BAF risks have been identified, considered a manageable number based on benchmarking. These risks are approved as appropriate and will be detailed in a new BAF format, already approved by the Audit Committee.

Most of last year's BAF risks will transition into the new framework. Some risks will be closed or moved to the Operational Risk Register.

The risk appetite remains largely unchanged from last year. One adjustment is the increased risk appetite for people-related risks, reflecting a more ambitious strategy.

Included is a summary of BAF discussions and oversight of Divisional risks.

FM welcomed the new format and thanked GS for simplifying and clarifying this.

NT advised that we had just had the latest Internal Audit Report on Risk Management and the BAF which has moved to substantial assurance. She thanked GS for all her hard work and focus on this area.

RH queried if we are making enough of the Welsh income challenge. GS expected this to be a feature under finance risks which will form part of the assurance from KO's Report.

**The Board approved the Board Assurance Framework and Risk Appetite Report.**

| | | | | |
|---|---|---|---|---|
| **15.** | **Trust Annual Quality Account 2024-25** | **LF** | **Approval** | **Enclosure 8** |

The Quality Account is presented for approval ahead of its end-of-June publication deadline, as required nationally. It no longer aligns with the Annual Accounts and Annual Report due to differing timelines. Audit opinion is no longer required post-COVID, allowing for more flexibility in presentation.

The report has been developed in line with national requirement and has been reviewed virtually by the Quality Committee and endorsed by the Managing Director and Chair of the Quality Committee. Final proofreading and inclusion of ICB partner statements are pending.

Special thanks were given to Rachel Murray, who compiles the report annually which includes all the great things that staff do every day.

IJ thanked the Patient Engagement Committee who were involved in the report this year to ensure that it consists of easily assessable sections which makes it a more readable document.

IJ noted that quality and safety is complicated and this reflects the breadth of perspectives considered by the Quality Committee in evaluating safety and service quality. The Trust's mission is to deliver care of a quality that staff would want for themselves and their loved ones and this comes across the entire Quality Account.

**The Board approved the Trust Annual Quality Account 2024-25, acknowledging that minor edits may follow the final review.**

| | | | | |
|---|---|---|---|---|
| **16.** | **Herefordshire and Worcestershire NHS Five Year Joint Forward Plan Update for 2025/26** | **AD** | **Approval** | **Enclosure 9** |

The report was taken as read.

There is a limited refresh as this document is presented annually. This has been updated to reflect what is being delivered across the System in 2025/26.

The Board are being asked to endorse this as the ICB approve this.

**The Board endorsed the Herefordshire and Worcestershire NHS Five Year Joint Forward Plan Update for 2025/26.**

| | | | | |
|---|---|---|---|---|
| **17.** | **Emergency Preparedness, Resilience and Response (EPRR) Annual Report** | **AP** | **Approval** | **Enclosure 10** |

The purpose of this report is to provide the Board with an annual update on EPRR activities, as required by the NHS Core Standards and the Civil Contingencies Act.

The report ensures the Board is sighted on EPRR performance over the past 12 months. This includes updates on core standards compliance, training and exercises, incident management and lessons learnt.

The organisation is on a path to improve from partial compliance with core standards. Progress has been made since the last update approximately nine months ago.

There is uncertainty around the role of the Integrated Care Board (ICB) in EPRR going forward. It is likely that responsibility will remain with Regional Bodies and Providers, with the ICB stepping back.

The organization currently relies on a single EPRR Lead.

Benchmarking shows low EPRR capacity compared to other Groups and Regions.

A Corporate review is underway to ensure collaborative working across the ICS and to prevent gaps in provision.

The report seeks Board approval and assurance on the current EPRR status and future planning.

**The Board approved the Emergency Preparedness, Resilience and Response Annual Report.**

| | | | | |
|---|---|---|---|---|
| **18.** | **25/26 Operational/Financial Plan and Budgets** | **KO** | **Approval** | **Enclosure 11** |

The document outlines the annual financial plan, including risks, mitigations and Divisional budgets. It represents the final governance step in confirming the plan for the current year.

The plan was submitted through the national process under delegated authority, following review by the Financial Recovery Board.

The Board is now asked to ratify the plan.

KL noted that, per NHS governance standards, the plan should have been approved by March. This delay is acknowledged as a system-wide governance issue, not a reflection on staff efforts.

RH raised a question about Table 1 in the report and whether this reflects activity volume or financial values. KO confirmed it shows activity volume.

**Action 18 - To provide the Chairman with a version of Table 1 in the Financial Plan showing financial values – KO.**

**The Board approved the 25/26 Operational/Financial Plan and Budgets.**

| | | | | |
|---|---|---|---|---|
| | **ITEMS FOR NOTING AND INFORMATION** | | | |
| **19.** | **Powys Elective Commissioning Intentions** | **KO/AP** | **Information** | **Enclosure 12** |

Discussion was held around the ongoing efforts to manage the operational and financial impacts of delays in care for Welsh patients compared to English patients. These delays create complexities and inefficiencies for staff, who are thanked for their continued efforts. The issue of selective commissioning was also noted.

**The Board accepted the Powys Elective Commissioning Intentions.**

| | | | | |
|---|---|---|---|---|
| **20.** | **Freedom To Speak Up Annual Report** | **JS** | **Information** | **Enclosure 13** |

JS presented a presentation to the Board.

FTSU is central to the organization's culture of openness. Staff are encouraged to speak up to the Executives, FTSU Champions, or the FTSU Lead.

JS identified three key improvement challenges - Civility Saves Lives, Leadership and mentoring and a Buddy system for new managers. These will be explored further by Executive colleagues and reported back at the next Board meeting.

It was noted that there has been significant improvement in FTSU visibility and engagement under JS's leadership, and increased uptake of "Listen Up" training for managers.

There needs to be focus on supporting first-time managers in handling complex staff situations. LF advised of the new senior nurse development program launching in July, incorporating all three focus areas.

CA advised of the ongoing leadership and management training for medical staff.

RH emphasised the need to continue to learn from FTSU themes and embed support structures across the organization.

**Action 20: To provide an update on the Tackling Themes challenge in the Freedom To Speak Up Annual Report presentation at the next Board Meeting – AP/GE.**

**The Board accepted the Freedom To Speak Up Annual Report.**

| | | | | |
|---|---|---|---|---|
| **21.** | **Patient Experience Quarterly Report** | **LF** | **Assurance** | **Enclosure 14** |

This will be presented to the Quality Committee tomorrow for a fuller discussion.

Concerns – There are a high number of complaints and unresolved issues after initial responses. There is generally positive feedback in the Friends and Family Test. However, when this is triangulated with other data, there are ongoing challenges regarding staff attitude despite a focus on this area from the Patient Experience Committee and Divisions on improving staff interactions.

Monitoring – The new interpreting service launched in April is showing positive feedback, early financial savings and improved patient experience. Some concerns have been raised about the digital-first approach over face-to-face; further evaluation is planned.

Positive Developments – It is National Volunteer Week this week with a coffee morning being held tomorrow to promote volunteering. It is noted that unlike national trends, volunteer numbers are increasing at Wye Valley Trust. The Contact Centre rollout is helping reduce Outpatient no-shows. There is a commitment to expanding the volunteer workforce for broader organisational impact.

RH asked the for Board's thanks to be extended to the Complaints Team for their vital and often underappreciated work.

**Action 21: To thank the Complaints Team on behalf of the Board of Directors for their vital work – LF.**

**The Board accepted the Patient Experience Quarterly Report.**

| | | | | |
|---|---|---|---|---|
| | **COMMITTEE SUMMARY REPORTS AND MINUTES** | | | |
| **22.** | **Audit Committee Report 15 May 2025** | **NT** | **Information** | **Enclosure 15** |
| **The Board accepted the Audit Committee Report 15 May 2025.** | | | | |
| **23.** | **Foundation Group Board Minutes and Action Log 7 May 2025** | **RH** | **Information** | **Enclosure 16** |
| **The Board accepted the Foundation Group Board Minutes and Action Log 7 May 2025.** | | | | |
| **24.** | **Quality Committee Report and Minutes 27 February 2025** | **IJ** | **Information** | **Enclosure 17** |
| **The Board accepted the Quality Committee Report and Minutes 27 February 2025.** | | | | |
| **25.** | **Integrated Care Executive Update Report** | **FM** | **Information** | **Enclosure 18** |

The One Herefordshire Executive structure is being reviewed to improve how it functions.

The Integrated Care Executive (ICE) has dual accountability: to both the Trust Board and One Herefordshire. Changes are being made to increase the seniority of those scrutinising ICE services at One Herefordshire meetings and streamline reporting to reduce duplication and improve efficiency. These changes will not affect reporting to the Trust Board but will enhance oversight at the One Herefordshire leadership level. Final details are being worked out by JI and key staff.

**The Board accepted the Integrated Care Executive Report.**

| | | | | |
|---|---|---|---|---|
| **26.** | **Perinatal Safety Report** | **LF** | **Assurance** | **Enclosure 19** |

The report was taken as read.

The Trust submits daily staffing reports to Regional and National teams regarding Neonatal Nurse Staffing.

A recent Regional escalation raised concerns about the Neonatal Unit's ability to meet BAPM (British Association of Perinatal Medicine) standards for nurse staffing. The issue relates to the number of nurses qualified in specialty on duty, especially overnight and on weekends. The unit always has one qualified-in-specialty nurse on duty 24/7. The Region requested to have two qualified-in-specialty nurses during out-of-hours periods. The Trust has committed to increasing out-of-hours coverage where possible. We have initiated benchmarking with similar-sized units to ensure that we are not an outlier. We have also ensured new staff are enrolled in foundation training to become qualified in specialty. The Regional team is satisfied with the Unit's safety and staffing oversight with no concerns about patient outcomes identified.

FM advised that the Quality Committee will conduct a more detailed review and this is discussed on the Monthly Walkabouts. She expressed confidence in the Unit's leadership and the culture of flexibility and safety.

**The Board accepted the Perinatal Safety Report.**

| | | | | |
|---|---|---|---|---|
| **27.** | **Any Other Business** | | | |
| There was no further business to discuss. | | | | |
| **28.** | **Questions from Member of the Public** | | | |
| There were no questions received. | | | | |
| **DATE AND TIME OF THE NEXT MEETING - Thursday 3 July 2025 – 1.00 pm – 2.30 pm** | | | | |

NHS
Wye Valley
NHS Trust

**WYE VALLEY NHS TRUST**
**ACTIONS UPDATE: PUBLIC BOARD MEETING – 3 JULY 2025**

| Public Board Reporting Action Log 2025/26 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Month** | **Ref.** | **Item** | **Action** | **Lead** | **Due date** | **Status** | **Update** |
| June 2025 | Action 6 | PFI Performance Issues | To provide an update to assess progress on maintenance resolution by Mercia and Sodexo at the October Public Board meeting. | Alan Dawson | October 2025 | **Open** | Due October 2025. |
| June 2025 | Action 18 | 25/26 Operational/ Financial Plan and Budgets | To provide the Chairman with a version of Table 1 in the Financial Plan showing financial values. | Katie Osmond | End July 2025 | **Open** | Table 1 reflected RTT activity, there is a small volume of other activity making up the total activity plan against which our total income plan aligns. Following the work to devolve clinical income to specialties, a summary table showing activity and income will be circulated (end July). |
| June 2025 | Action 20 | Freedom To Speak Up Annual Report | To provide an update on the Tackling Themes challenge in the Freedom To Speak Up Annual Report presentation at the next Board Meeting. | Andy Parker/ Geoffrey Etule | July 2025 | **Closed** | Initial meeting held with Geoffrey Etule and colleagues on an approach. Wider discussion to be held in July to flesh out the detail with the plan for the programme to be in place from September onwards. |
| June 2025 | Action 21 | Patient Experience Quarterly Report | To thank the Complaints Team on behalf of the Board of Directors for their vital work. | Lucy Flanagan | | **Closed** | Completed. |

## WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **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. National Urgent and Emergency Care Plan

The plan sets out urgent reforms to improve patient experience, safety, and flow across urgent and emergency care (UEC), particularly in preparation for Winter 2025/26.

**Key Priorities for NHS Trusts and Systems**

1. Improving Access and Flow in Emergency Departments

- Meet a maximum 45-minute ambulance handover time; target a 15-minute trajectory.
- Ensure 78% of A&E attendances result in admission, transfer, or discharge within 4 hours.
- Reduce long emergency department waits to under 10%.
- Increase the number of children seen within 4 hours.
- Eliminate mental health ED (Emergency Department) waits over 24 hours and reduce inappropriate out-of-area placements.

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

2. Reducing Unnecessary Hospital Admissions

- Expand Urgent Community Response teams, virtual wards, and neighbourhood multidisciplinary teams.
- Implement “call before convey” principles system-wide.
- Increase use of Same Day Emergency Care (SDEC) and co-located Urgent Treatment Centres (UTCs).

3. Improving Discharge and Reducing Delayed Transfers

- Set stretching targets for Pathway 0–3 discharges.
- Eliminate delays over 48 hours and reduce patients delayed over 21 days.
- Maximise use of community and home-based care, especially during winter surges.

4. Digital and Data Enablement

- Adopt NHS Federated Data Platform across trusts.
- Ensure 100% ambulance access to Connected Care Records by end of 2025/26.
- Use digital forecasting and discharge tracking tools.

5. Vaccination and Infection Prevention

- Set stretch targets for staff and patient flu vaccinations.
- Improve RSV and childhood flu vaccine uptake.
- Ensure winter IPC plans are robust and implemented across systems.

6. Mental Health Crisis and Inpatient Care

- Invest in mental health crisis assessment centres.
- Shorten inpatient stays and reduce high-intensity user re-admissions.
- Eliminate inappropriate out-of-area placements by 2027.

7. Leadership and Accountability

- Submit board-approved winter plans by summer 2025.
- Ensure leadership presence in key operational areas.
- Publish transparent data on corridor care and discharge delays.

## 2. Winter Plan

The expectations for winter planning have been set out. The submissions need to be made by August 2025 and there is a focus on board visibility and assurance of these. I have summarised the key themes and expectations as:

Priority Areas for System Plans

- Vaccination Coverage:
    - Detailed plans for staff and eligible cohort flu vaccinations (children, adults 18–64 with at-risk conditions, and those 65+).
- Infection Prevention and Control (IPC):
    - Systems must show readiness for outbreak management, surge capacity, and Service continuity.

- Board-Level Assurance Requirements

    - Learning from 2024/25: Highlight actionable insights from last winter.
    - Mitigating System Change: Address how standards will be maintained amid national/regional transitions.
    - Leadership Capacity: Appoint a named Winter Director at Director level with operational authority.
    - Delivery Assurance: Boards must confirm that submitted plans are robust enough to handle surge and super-surge scenarios.

    These will drive our qualitative requirements for the plan which are modelling across three scenarios: Baseline, Surge, and Super Surge.

    1. Demand and Capacity

    - Forecasts for ED attendances, emergency admissions, ambulance and NHS 111 activity, mental health crises, and paediatric respiratory trends.
    - Bed capacity across acute, community, social care, virtual wards, and specialist units

    2. Surge Planning

    - Define escalation triggers, capacity stretch limits, and sector-specific impacts.

    3. Vaccination and IPC

    - Weekly vaccination uptake forecasts.
    - IPC impact projections: bed closures, extended length of stay, workforce disruption.

    4. Workforce Resilience

    - Weekly staffing forecasts, absence modelling, surge staffing plans, and bank/agency deployment.

**3. Maternity**

The Secretary of State has announced a rapid independent investigation into maternity and neonatal services, alongside a new independent taskforce and immediate improvement actions. This follows significant and persistent failings in maternity care across parts of the NHS.

Key concerns highlighted:

- Systemic failures in listening to women and families.
- Ongoing racial and socioeconomic inequalities, particularly affecting Black and Asian women and those in deprived areas.
- Cultural and safety issues within the maternity workforce.
- Wide variation in care quality across trusts.

The actions required by the Trust Board are :

- Ensure that our teams are working effectively together with a positive culture to safety and outcomes.
- Listen directly to affected families and manage staff who lack compassion or openness when mistakes happen.
- Foster the right culture through co-production with local women and Maternity and Neonatal Voice Partnerships.

- Enhance data monitoring on outcomes and experiences to drive improvement.
- Prioritise tackling inequalities

## 4. Temporary Staffing Spend

There is a renewed focus regarding the goal of minimizing waste in NHS expenditures and an expectation to reduce agency staffing costs by at least 30% in the next financial year, aiming for complete elimination by the end of the current government term.

The Trust is very focussed on Temporary Staffing and in line with the national direction of reducing reliance on agency staff and encourages trusts to prioritize bank work for staffing needs.

## 5. Surgical Division – CEO Report July 2025

Since the last Surgical Divisional update within this report in late 2024, the Division has been able to 'turn the dial' on a number of key productivity metrics that have supported improved utilisation of our resources. Most significantly, operating theatre utilisation has increased to above 80% and has been sustained at this level for the last 6 months. Focused work has also seen notable improvement in how our theatre lists are used, with considerably more of our theatre lists starting on time and with this improvement being continued for 4 months. We are also approaching the 12 month anniversary of the opening of our Elective Surgical Hub, which has been a fantastic addition to our theatre estate and has enabled more patients to be treated, while unlocking many improvement and productivity opportunities such as an increased number of higher volume theatre lists. Post the last Divisional update, the Trust experienced urgent and emergency care challenges during early 2025 and despite this, the ring fenced Elective Surgical Hub ensured the vast majority of elective activity continued with significantly fewer patient cancellations on the day due to flow challenges that we have seen in previous winters. Elective Surgical Hub theatre utilisation attained 84.9% in April, against the national target of 85% and has supported the Trust's rise up the regional utilisation league tables. There is still a huge amount more to do to sustain these gains and further improve over the coming months. Further improvements are front and centre of the Division's objectives for 25/26.

These key productivity improvements have directly translated into patient care: another Divisional focus has been reducing the number of patients waiting more than 65 weeks for routine elective care and working to reduce waits to 52 weeks by the end of the financial year. The Division has made good progress in a number of specialities with waiting times now below 65 weeks in many of the Division's departments, but there are still some patients waiting longer than we would like for treatment. Plans are in place to continue to improve waiting times, particularly in specialities of focus such as Orthopaedics and ENT.

The Surgical Division continues to work closely with Medical Divisional colleagues to improve the patient experience within our Emergency Department. As part of a 'test of change' live trial, an Acute Surgical Unit (ASU) has begun operation. This enables appropriate General Surgical patients who are waiting to be admitted from ED to move out of the Emergency Department sooner and commence treatment earlier in ASU, while a ward bed is being prepared. This project aims to support an improvement in the ED 4 hour standard, decongesting ED and critically, enabling patients to commence treatment earlier.

A key area of focus within the Division has also been reducing both emergency and elective length of stay. The team have introduced a number of new emergency pathways, including a revised emergency laparoscopic cholecystectomy pathway, that has significantly reduced wait times for procedure along with reducing the number of inpatient admissions ahead of surgery, while ensuring improved clinical outcomes and patient experience. From an elective perspective, our Orthopaedics team have received positive recognition from the national Getting it Right First Time (GIRFT) team for the improvements made in length of stay for arthroplasty patients. Average length of stay has decreased from around 4 days to 2.3 days, supporting improved mobility times post procedure and patient experience.

# Integrated Performance Report

## May 2025

# Managing Director – Executive Summary

**Jane Ives**
Managing Director

There is a lot of change in the air with the 10 year plan due for publication before our next Board meeting, but our main focus is on the here and now to deliver our plans for this year. As ever managing activity, quality and resources is a fine balancing act and we continue to develop the analytical tools to support our teams to understand local and national benchmarks and improvement opportunities.

Urgent and emergency care remains the largest challenge (and therefore opportunity) for performance and finance. The Board workshop this morning has had the opportunity to scrutinise in detail the improvement plans. On June 16th we started the change programme and the first 10 days have shown an 8% performance improvement in 4 hour waiting times for patients from our April and May baseline.

As part of our approach to reducing demand for emergency care, particularly for the frail elderly we are developing our approach to Neighbourhood health multi-disciplinary teams and on July 1st our Herefordshire health and care system are meeting with a pioneering team from Northamptonshire to learn from their successes. We aim to have the transformed community service up and running by the autumn to support more people being cared for at home, meeting their wishes and enhancing their dignity. This will also improve our SHMI mortality indicator which is driven by the out of hospital deaths with 30 days of discharge as both Herefordshire and Worcestershire have high rates of emergency admission in the last 90 days of life.

A significant programme of cost reduction, productivity improvement and transformation is scrutinised by the financial recovery board each month and it was good to report that we have met our month 2 financial plan and have over delivered on our CPIP plan year to date. The plan get progressively more difficult over the course of the year. Workforce changes make up a good proportion of the savings plans and both medical and nursing spend is just below plan with good progress on agency reduction and substantive recruitment. Plans for redesigning our administration and clerical support in light of implementing new technology are well advanced and will be implemented by the end of the summer. Our sickness absence level remains too high, whilst benchmarking satisfactorily and our HR teams are focussed on supporting managers in implementing the new policy.

We have now formally written to Powys Health Board outlining the financial, operational and quality impacts of their intention to increase waiting times for routine elective patients. We will be reducing activity for people who live in Wales with a Welsh GP practice who require an in patients admission from July onwards.

We are meeting our elective activity plans in numbers but income recovery is below plan, which does represent an opportunity to improve our financial position further as we catch up. In addition our 52 week waiting time position is currently moving in the wrong direction - the plan is to have no more that 1% of our waiting lists waiting over 52 weeks by the end of the year and we currently stand at 3.3% which is a concern.

More positively for our patients with cancer or suspected cancer we met our 24/25 targets for 62 days from referral to treatment and 28 days from referral to diagnosis and are well place to meet the more challenging targets this year.

# Our Quality & Safety – Executive Summary

**Chizo Agwu**
Chief Medical Officer

**Lucy Flanagan**
Chief Nursing Officer

**Emergency Department Safety Champion role**

Given emergency department unprecedented pressures the trust has recently held 3 urgent and emergency care workshops to engage with frontline colleagues to develop quality improvement “tests of change” which are being trialled and tested during June/ July.

As part of this we have agreed to establish an Emergency Department Safety Champions role and approach. The approach has been established based on the successes and lessons learnt from the maternity safety champion process.

The Emergency Department approach will include a non executive safety champion, executive champions, service level safety champions and members of the directorate and divisional teams.

The overarching aim is to:

- Strengthen “floor to board” by developing strong partnerships
- Enable a strong service voice
- Promote professional cultures
- Supportive approach to resolving issues/concerns
- Supportive challenge and oversight
- Ensuring the views and experience of patients and staff are heard
- Safe space to share and be heard

The approach will include:

- Safety champion “check in” – meeting with safety champions and Board level leads every 6 weeks
- Safety champion “walkabout” – at least once a month
- Regular focus groups with members of the wider MDT or particular staff groups to gain a deeper understanding of frontline successes and frustrations
- Quarterly reporting through to Board

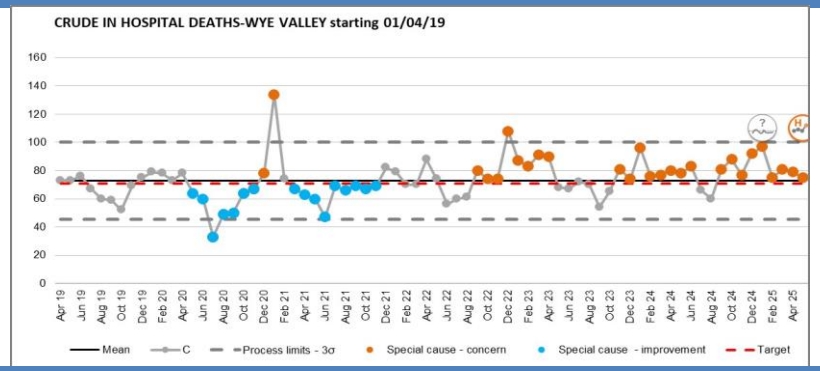
# Quality & Safety Performance – Mortality

## 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** | ***2.2*** |
| **SHMI (HES based)** | *Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)* | **Feb-25** | **108.5** | ***2.0*** |
| *SHMI (in hospital)* | | | **103.7** | ***2.1*** |
| *SHMI (out-of-hospital SHMI)* | | | **119.9** | ***1.62*** |




| CCS Group/Origin of Alert | Data month | SHMI | SHMI Change | Expected Deaths | Actual Deaths |
|---|---|---|---|---|---|
| Chronic Obstructive Pulmonary Disease | Feb-25 | **101.70** | **-4.26** | 28.51 | 29 |
| Congestive Heart Failure | | **114.57** | **4.01** | 56.74 | 65 |
| Fractured Neck of Femur | | **153.90** | **7.11** | 31.84 | 49 |
| Pneumonia | | **104.04** | **-1.09** | 173.02 | 180 |
| Septicemia | | **108.72** | **0.43** | 96.58 | 105 |
| Stroke (*Acute Cerebrovascular Disease*) | | **96.40** | **-5.97** | 85.06 | 82 |

## Monthly Headlines

The latest 12 month rolling **SHMI** (*HES Based*) from March 2024 to February 2025 shows Wye Valley NHS Trust at **108.5,** which is a further increase of 2.0. The NHS England SHMI, which is for the period of January 2024 to December 2024, remains at 105.

Latest **crude mortality** rate for May 2025 was **1.20%** for all admissions, which equates to 75 deaths including ED and CH's. During May, there were 12 deaths in the Community Hospital setting, which is significantly higher than we normally report. The clinical leads reviewed all 12 cases and the findings have showed that the vast majority of the patients were on End of Life care with no immediate concerns in the care provided. The cases will all be subjected to full Structured Judgement Review process at the CH M&M meetings in due course.

Due to the rising SHMI reported over the past few months, we requested HED (WVT *mortality data provider*) to do an initial analysis of our latest data to identify any concerns or areas for further investigation. Areas being explored include the impact of removing SDEC data from admissions, the increasing number of patients coded with Charleston co-morbidity score of zero . Meetings arranged to ensure robust coding.
Our key mortality outlier groups, with the latest figures (*March 2024 to February 2025*):

- **Heart Failure** – A small rise has been reported in the latest 12 month rolling SHMI to 114.5. Although for this 12 month period, there was 1 less reported actual death.
- **#NOF** – A Quality Improvement initiative is being piloted during June to support the earlier expedition of patients from the Emergency Department to the specialist ward. The pilot aims to admit 100% of confirmed femoral fractures in ED within 4 hrs to the ward. The fast-track bleep system is still in place to ensure the key teams are aware that a patient is in ED and start preparing. During May 2025, a further NHFD outlier alert was received for the higher than expected mortality rates. A response has been provided, which outlines our current efforts and challenges with implementing the various elements of the pathway – *see Appendix*.
- **Pneumonia –** A positive month reported with a reduction in our biggest cohort of deaths in the Trust. The latest 12 month period shows 3 less deaths than previously reported in May, remaining firmly within 'as expected' levels.
- **Sepsis** – Remains within 'as expected' levels with the latest 12 month rolling SHMI at 108.7.
- **Stroke** – The latest data has reported a significant reduction in the 12 month rolling SHMI with a 6 point reduction to 96.4. A presentation of the latest review findings and learning will be provided by the Clinical Lead at the June Learning from deaths committee.

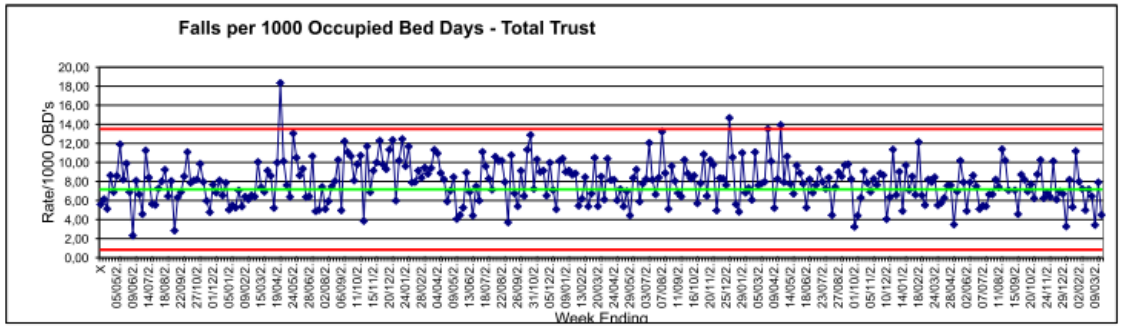
At the May Learning from Deaths Committee, there were presentations from our neonatal team, acute medicine and general medicine. Each presentation discussed learning and findings from their recent structured judgement reviews, including any actions taken to address them.

# Quality & Safety Performance – Falls

## We are driving this measure because:

Falls are one of the Trusts highest reported incidents and form part of the Patient Safety Incident Response Plan – the following information forms part of our oversight and monitoring

## Data




### Community Hospital falls rate

| National 2014 | WVT 2018/19 | WVT 2019/20 | WVT 2020/21 | WVT 2021/22 | WVT 2022/23 | WVT 2023/24 | WVT 2024/25 |
|---|---|---|---|---|---|---|---|
| 8.6 | 8.89 | 8.86 | 10.59 | 10.98 | 8.87 | 9.10 | 7.85 |

### Acute site falls rate

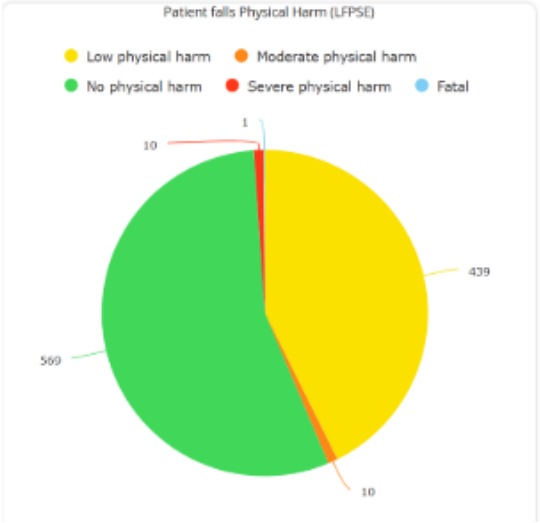
| National 2014 | WVT 2018/19 | WVT 2019/20 | WVT 2020/21 | WVT 2021/22 | WVT 2022/23 | WVT 2023/24 | WVT 2024/25 |
|---|---|---|---|---|---|---|---|
| 6.63 | 6.33 | 6.52 | 8.80 | 7.39 | 7.92 | 7.63 | 6.86 |

### Community Hospital harm rate

| National 2014 | WVT 2018/19 | WVT 2019/20 | WVT 2020/21 | WVT 2021/22 | WVT 2022/23 | WVT 2023/24 | WVT 2024/25 |
|---|---|---|---|---|---|---|---|
| 0.19 | 0.07 | 0.15 | 0.46 | 0.20 | 0.36 | 0.24 | 0.22 |

### Acute site harm rate

| National 2014 | WVT 2018/19 | WVT 2019/20 | WVT 2020/21 | WVT 2021/22 | WVT 2022/23 | WVT 2023/24 | WVT 2024/25 |
|---|---|---|---|---|---|---|---|
| 0.19 | 0.12 | 0.12 | 0.19 | 0.14 | 0.17 | 0.16 | 0.14 |




## Monthly Headlines

- The overall falls rate has reduced previous 12 months
- Falls rates for acute and community are reducing following the covid rise in numbers
- No harm/low harm falls make up the greatest proportion of falls
- Whilst benchmarking is no longer recommended/available our harm rates are consistently low
- We have a high incidence of unwitnessed falls
- Recent national audit of inpatient falls identified areas for improvement for post fall medical review within 30 minutes
- Recent audit has demonstrated improving compliance with bed rails assessment and compliance with bed rail positions

## Areas of focus

- NICE guidance published and under review against current practice
- Falls policy also under review as part of routine updating and mapping against NICE guidance
- Falls, dementia, frailty steering group reinstated
- Increased frequency of bed rails audit to check assessment and position compliance
- New Falls simulation training in place
- ‘Moving safely’ campaign planned for July/August to support a reduction in falls and prevention of hospital acquired functional decline

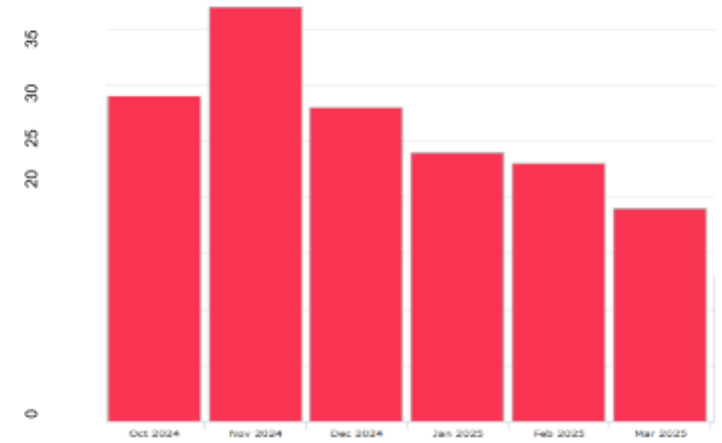
# Quality & Safety Performance – Falls- Patient Safety Priority Update

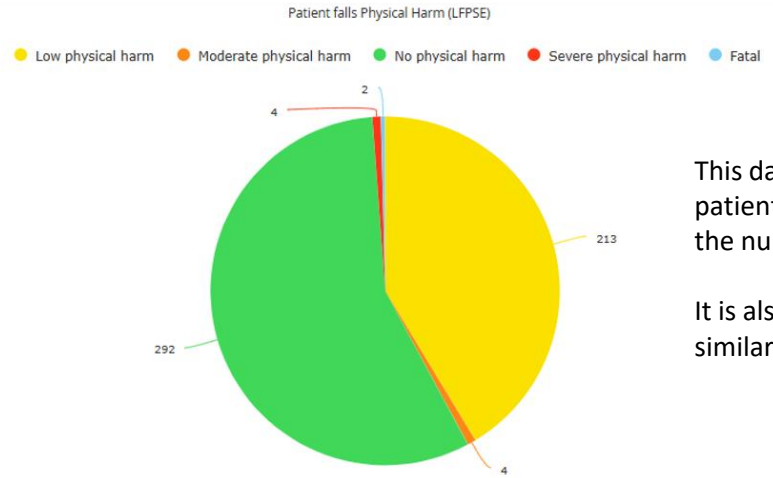
## We are driving this measure because:

Falls for patients with dementia or delirium were identified as a patient safety priority in the Trust Patient Safety Incident Response Plan launched in October 2023.

## Data

Inpatient falls in patients with dementia, delirium or a known high risk of falls:




This data shows us that the total number of reported falls per month for patients with dementia, delirium or who are known to be high risk of falls – the numbers are reducing each month.

It is also pleasing to note that the harm rates are mainly low and no harm similar to the profile seen on the previous slide – which relates to all falls

## Monthly Headlines

Individual divisions/service areas have developed localised improvement plans where falls are a safety priority for their area. Actions that arise from local review or defined learning responses are fed into the Divisional improvement plans for ongoing monitoring of effectiveness.

In addition, the Trust falls lead presents quarterly updates to the Patient Safety Committee as can be seen on the previous slide. When we review falls as part of the Patient Safety Response plan, there does appear to be no new or emerging learning opportunities identified yet key themes being addressed in improvement plans are:

- A focus on the accuracy and consistency of falls risk assessments
- A focus on the assessed need for observation and whether this is achieved
- Balancing privacy and dignity for unwitnessed falls in bathrooms when patients are on level 3 (line of sight) observation

Positive insights:

- Immediate post fall assessments are timely and thorough with some requirement to improve medical review within 30 minutes
- Method of retrieval is appropriate and safe

This patient safety priority is likely to move from intense focus to ongoing improvement with Divisional oversight when the Trust Patient Safety Incident Response Plan is reviewed in the latter part of this year.

# Quality & Safety Performance – Staffing - May data

## Fill Rate & CHPPD Data

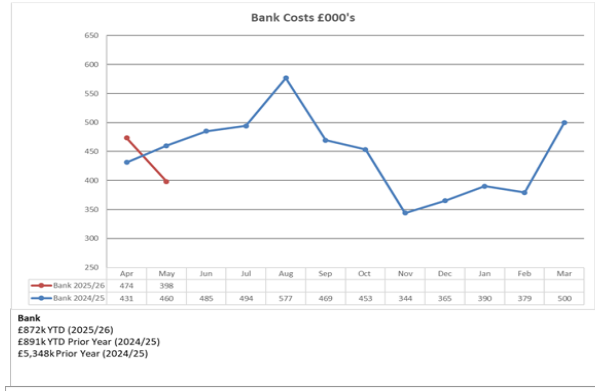
| | Day | | Night | | |
|---|---|---|---|---|---|
| | RN Fill | HCA Fill | RN Fill | HCA Fill | Overall (Actual) CHPP |
| Primrose Unit | 94% | 96% | 103% | 114% | 10.2 |
| Maternity Ward | 89% | 94% | 92% | 96% | 6.2 |
| Children's Ward | 114% | 96% | 128% | 80% | 22.5 |
| Lugg Ward | 131% | 78% | 117% | 103% | 6.5 |
| Wye Ward | 121% | 73% | 118% | 87% | 6.4 |
| Cardiac Care Unit | 100% | 98% | 100% | 99% | 11.8 |
| Leominster Community Hospital | 155% | 74% | 100% | 100% | 6.5 |
| Bromyard Community Hospital | 131% | 93% | 100% | 98% | 7.6 |
| Ross Community Hospital | 96% | 102% | 148% | 98% | 6.0 |
| Teme Ward | 124% | 61% | 91% | 73% | 13.4 |
| Redbrook Ward | 102% | 121% | 134% | 124% | 7.5 |
| Special Baby Care Unit | 99% | - | 107% | - | 12.3 |
| Intensive Care Unit | 110% | - | 97% | - | 25.3 |
| Gilwern Ward | 101% | 130% | 100% | 97% | 6.4 |
| Acute Medical Unit | 123% | 95% | 101% | 137% | 8.1 |
| Ashgrove Ward | 138% | 90% | 133% | 104% | 7.4 |
| Dinmore Ward | 133% | 76% | 113% | 91% | 7.1 |
| Garway Ward | 148% | 94% | 135% | 124% | 7.8 |
| Frome Ward | 124% | 83% | 105% | 120% | 6.7 |
| Arrow Ward | 166% | 75% | 171% | 90% | 8.6 |
| Women's Health | 134% | 99% | 100% | - | 11.1 |

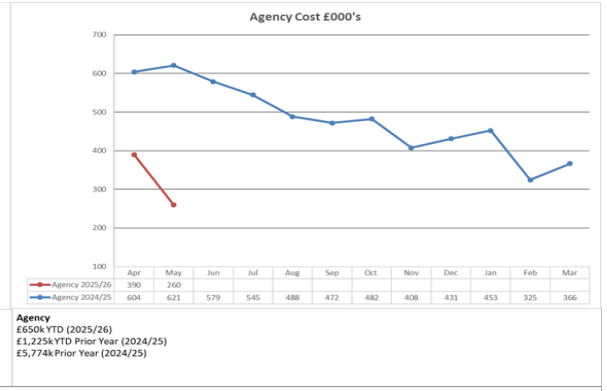
The NHS England staffing return is detailed above and includes the minimum expectations in terms of national quality board reporting requirements.

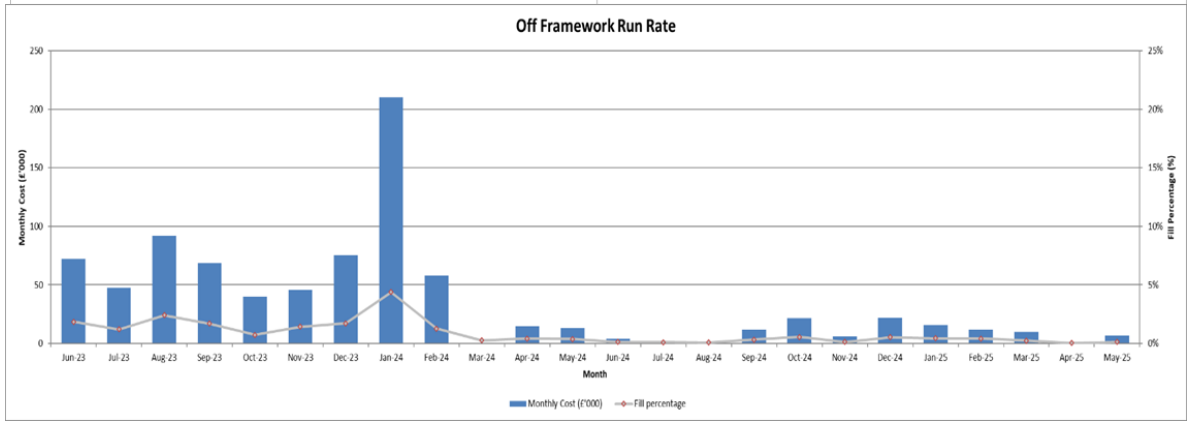
Areas of overfill are due to the following circumstances;

- Specific individual needs of patients particularly on Redbrook and the childrens ward
- Additional beds at Bromyard and Leominster community hospitals
- High numbers of patients requiring non invasive ventilation on Arrow Ward
- Higher numbers of patients being cared for in Temporary Escalation Spaces (TES), particularly on the frailty wards
- There continues to be some band 5 backfill for band 4 gaps hence higher RN fill and lower HCA in some areas

## Bank & Agency




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. Since the last report we have been working hard with our agency supplier to provide specialist nurses at capped rates, whilst this has been challenging the contract performance has improved significantly and we aim to be fully compliant with capped rates by the end of June for all nursing shifts.

As part of the collaborative work the Trust will also be stopping all Health Care Assistant agency usage by the end of June. Our local plans to achieve this have been to increase our bank provision for this staff group. During the month of May we used an average of 37 shifts per week compared to an average of 100 per week in April. June has seen this figure reduce further.

Our over all cost and productivity target for bank and agency reduction in month 2 has over achieved by £236k

# Our Performance – Executive Summary

**Andy Parker**
Chief Operating Officer

Our journey in shaping the next phase of our Urgent and Emergency Care (UEC) improvement programme, with the aim of reducing delays, improving flow, and ensuring safer, more responsive care across the Trust has moved on over the month with Trust wide engagement of the challenges we face.

Over 60 staff from across clinical, operational, and corporate teams participated in three full-day UEC workshops. These sessions were designed to accelerate thinking around front-door navigation, internal flow, discharge processes, and reliance on escalation capacity — and have resulted in a clear set of priority actions for testing and implementation.

Seventeen tests of change have been developed and are now moving into operational testing. As discussed in the morning Board workshop, the focus areas include:
- Maximising Nurse Navigation at the ED front door, improving streaming and earlier redirection to SDEC, specialty services or community alternatives;
- Expanding capacity across Medical and Surgical Same Day Emergency Care and defining revised criteria;
- Establishing a dedicated Acute Surgical Unit, supporting improved flow, earlier decision-making, and reduced impact on elective capacity;
- Embedding revised ward handover processes, ensuring MDT ownership and standardisation of communication to improve discharge planning;
- Streamlining community hospital transfers, including faster handover and documentation processes to reduce avoidable inpatient waits.

These schemes will also support the UEC capital bid success to redesign and increase our Same Day Emergency Care and Ambulatory facilities to ensure that we move from an “Emergency Department (ED) as default” model to “SEDC as default” model.

Since the publication of the NHS UEC Plan 2025/26, we have commenced a rapid review of our seventeen tests of change to ensure alignment with national priorities, particularly around:
- Improving 4-hour Emergency Access Standard (EAS) performance;
- Reducing 12-hour waits and crowding in ED;
- Accelerating ambulance handovers to improve responsiveness;
- Reducing system-level delayed discharges and inappropriate escalation bed use.

We are working closely with operational and system partners to embed these priorities into our Winter Plan for 2025, with the aim of delivering sustainable improvements in flow, capacity resilience, and patient safety during periods of peak demand.

As of M2 2025/26, the Trust is broadly on plan for English elective activity. Divisions continue to deliver against contracted volumes, and our internal productivity metrics remain positive in several key areas, including outpatient throughput and day-case delivery. Focus remains on increasing theatre utilisation and maintaining momentum on diagnostic recovery in preparation for the opening of the Community Diagnostic Centre (CDC) later this year.

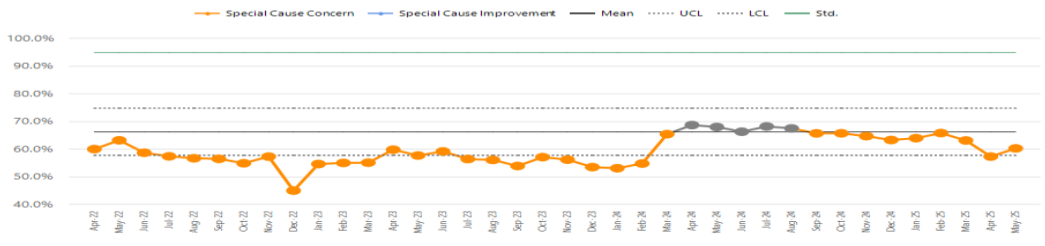
Divisions are currently working through the impact of revised commissioning arrangements with Powys Teaching Health Board, following notification of changes to elective volumes and pathway flows. While detailed activity forecasts are being finalised, there is early indication of potential reductions in theatre sessions. In parallel, we are reviewing how to absorb these changes into our overall capacity and cost planning, including the profiling of reduced fixed costs and ensuring flexibility in how resources are deployed. The opportunity to reallocate internal capacity toward English activity, while reducing spend on independent sector solutions, forms a key part of this planning.

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

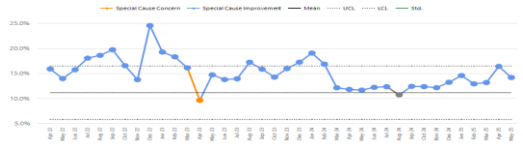
## We are driving this measure because:

The National Emergency Access Standard (EAS) 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.

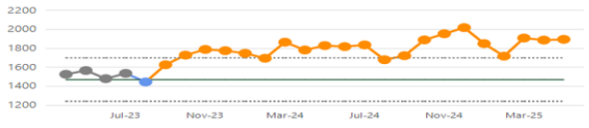
| Assurance | Variation | Data Quality Mark |
|---|---|---|
| The system is expected to consistently Fail the target | Special cause variation - cause for concern (indicator where LOW is a concern) | Reasonable Assurance |



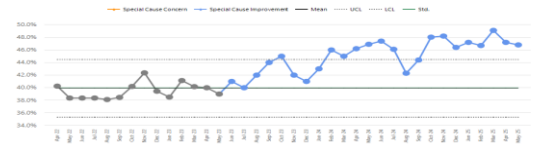

% Patients Spending More Than 12 Hours In ED



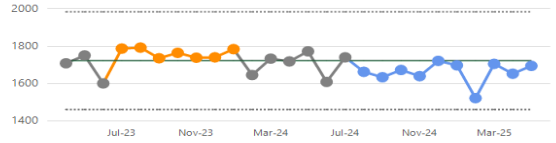
Emergency Admissions




% 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 60.4%

## Performance & actions

- 6,131 Type 1 patients attended ED in May which 126 more than the previous month. The range of all attendances varied from 157 to 258 with 200 being the average daily attendances.
- 1,649 ambulances conveyed to the Trust in month which was marginally more than the average through 2024/25 [1,674]. The range in month was 44 to 71. This includes 10.4% from Powys [177].
- Ambulance handover delays over 1hr were 28.6% [438] of all . On average, 433 patients have waited over an hour for handover since October-24. 53.8% [823] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,243 of all admissions [46.8% of all admissions] via a Same Day pathway within no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 59 / 123 Type 1 Trust in England for May.
- 14.2% [979] of patients spent 12 or more hours in ED which was 2% less 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 have been completed .

➢ Focus on improving our non-admitted performance for patient who do not require an inpatient bed. This have improved in month to 72% of non-admitted patients to be seen and discharged within 4hours . Our aim is for 84% to deliver the overall 4hr EAS requirement by March 26.

➢ Maximise and standardisation of Navigation at the front door to ensuring patients are treated and managed via the correct clinical pathway. Revised criteria to Navigate direct to Medical and Surgical SDECs in place.

➢ 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.

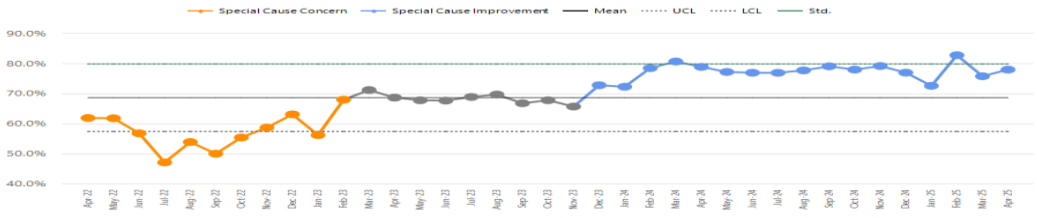
# Operational Performance – Cancer Performance [April 25]

## We are driving this measure because:

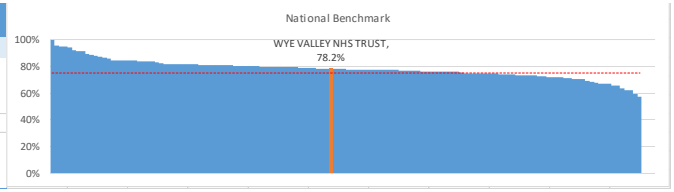
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or 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 |

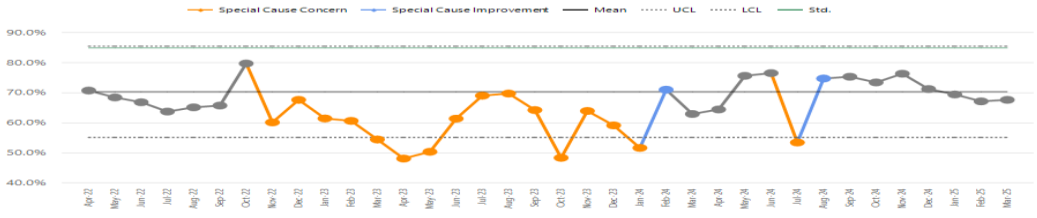
**28 Days** (Performance & Benchmark)



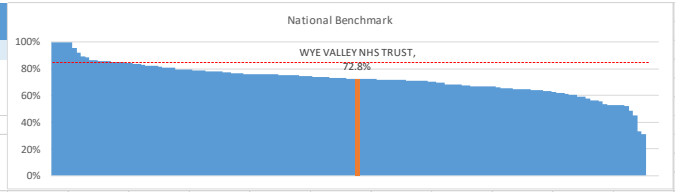

| 28 Day |
|---|
| Wye Valley Trust |
| 65 |
| of |
| 136 |




**62 Days** (Performance & Benchmark)




| 62 Day |
|---|
| Wye Valley Trust |
| 72 |
| of |
| 140 |




## Performance & actions

Referrals:

As of April 2025, overall referrals have risen by 19% compared to the same period three years ago. Notably, referrals for Gynaecology and Urology have seen significant increases of 38% and 44%, respectively. Efforts are ongoing to audit incoming referrals to ensure they align with guidance. Although the numbers remain relatively low, Lung referrals have more than doubled, showing a 103% increase over the same timeframe.

28 FDS:

In April 2025, the Trust met the Faster Diagnosis Standard (FDS), achieving a performance rate of 78.2%, exceeding the Trust's trajectory. Upper Gastrointestinal (UGI), Head & Neck, and Skin pathways all surpassed the 77% target. Since the introduction of benign result text messaging and letters within the UGI pathway, performance has improved by 20% compared to April 2024.

Breast FDS performance remains a concern reporting 59% compliance in April against the standard. Additional clinics are being created to manage demand, with recovery anticipated in June. Work is also on-going to streamline the MDT.

Delays in access to scans in radiology continue to pose challenges, with both short- and long-term measures being implemented to address the issue. The Community Diagnostic Centre (CDC) is expected to play a vital role in strengthening and supporting cancer pathways. Reporting times for Computed Tomography Colonography (CTC) have significantly improved, with average waits reduced to 2 days, down from 4.5 days in March.

<u>Developments updates</u>

- Text messaging for benign results is live in all cancer specialties. Cancer navigators will continue to review the use with results of the audit to be shared in the coming months.
- Endoscopy 28 day FDS discharge. Standard Operating Procedure process mapping to agree Endoscopist able to discharge from cancer pathway at appointment to provide patients with earlier reassurance on their cancer pathway.
- CTC prescription tool is now live which will allow quicker receipt of prescriptions into Pharmacy to reduce delays in prescribing prep to patients

## What the charts tell us

- 28 Day faster diagnosis performance for April was 78.1%.
- 62 Days start of treatment target was 73% below target of 72.8%

## Risks

- Cancer referrals continuing to remain above 19/20 levels
- Radiology and breast service capacity were challenged during the month.

# 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 |
|---|---|---|---|
| | 14,837 | 14,779 | 58 / 0% |
| **Vs 2019/20** | **This Year** | **2019/20** | **Diff / Var** |
| | 14,837 | 12,511 | 2326 / 19% |
| Waitlist Clearance (wks) | **Total** | **> 18 Wks** | **% <18 wks** |
| | **10.4** | **3.6** | **65.8%** |

**IP/DC Admissions (excl. Endoscopy)**

| Total Vs Plan | This Year | Plan | Diff / Var |
|---|---|---|---|
| | 5,343 | 5,058 | 285 / 6% |
| **vs 2019/20** | **This Year** | **2019/20** | **Diff / Var** |
| | 5,343 | 4,637 | 706 / 15% |
| Waitlist Clearance (wks) | **Total** | **> 18 Wks** | **% <18 wks** |
| | **13.9** | **7.1** | **48.8%** |

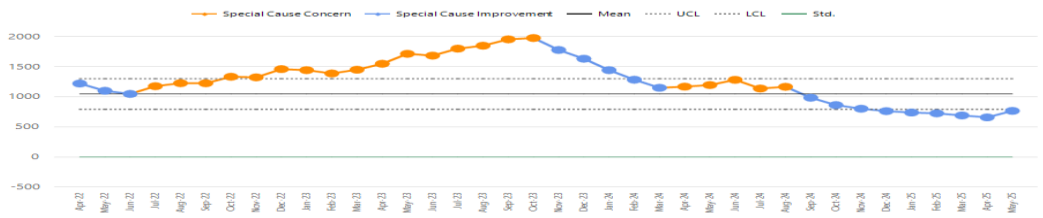
**Follow Up Attendances**

| Total Vs Plan | This Year | Plan | Diff / Var |
|---|---|---|---|
| | 33,536 | 29,951 | 3585 / 12% |
| **Total vs 2019/20** | **This Year** | **2019/20** | **Diff / Var** |
| | 33,536 | 26,058 | 7478 / 29% |
| Waitlist Clearance (wks) | **Total** | **> See By Date (SBD)** | **% Past SBD** |
| | **15.5** | **5.4** | **60.3%** |

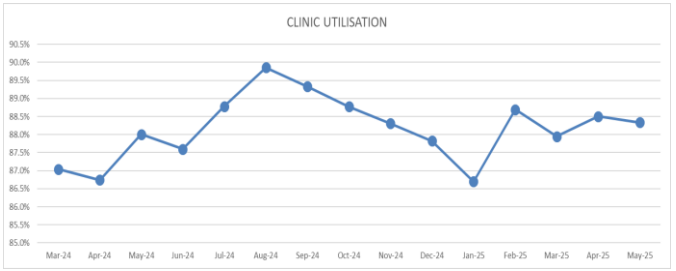
**Endoscopies**

| Total Vs Plan | This Year | Plan | Diff / Var |
|---|---|---|---|
| | 1,935 | 1,874 | 61 / 3% |
| **vs 2019/20** | **This Year** | **2019/20** | **Diff / Var** |
| | 1,935 | 1,997 | -62 / -3% |
| Waitlist Clearance (wks) | **Total** | **> 18 Wks** | **% <18 wks** |
| | **16.7** | **1.0** | **93.9%** |

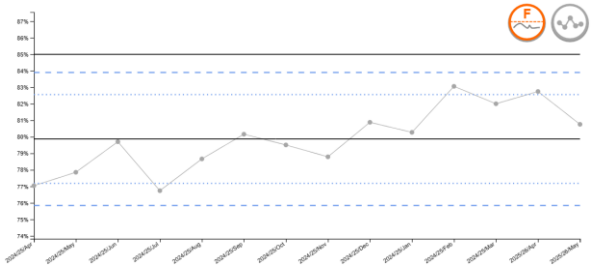
**Patients over 52 weeks on Incomplete Pathways Waiting List**




**Clinic Utilisation**




**Theatres Utilisation (Uncapped)**



## Performance & actions

Theatres:

- Focused work on reducing late starts in theatres continues to realise improvements. The average late start in May was 15 minutes, a reduction on the 6 month average of 35 minutes
- Anaesthetics workforce challenges resulted in an increase in cancellations on the day The Directorate continue to work through and implement the Board approved Theatres & Anaesthetics workforce strategy. Job planning has so far delivered additional elective sessions within budget and more robust on call rotas
- Pre Operative Assessment optimisation work continues: % of patients requiring additional pre op appointments has reduced and the DNA rate has fallen. Following upskilling of the nursing workforce to improve productivity across pre op and theatres, the percentage of patients requiring anaesthetist review has also fallen

Long Waiting Patients:

- No long waiting Welsh long waiting patients over 104 week within May.
- 4 English long waiting patients waited over 78 weeks at the end of May which is 3 more than April driven by Cornea Tissue waits for surgery and 1 Breast patient.
- 65 week position at the end of May was 28 English patients. June`s position is expected to be 50% less c14 patients in total.
- 602 English patients were waiting over 52 weeks for treatment at the end of May. The Trust has had continued reduction in this position since July-23, although we have seen an increase in month despite an improved RTT position overall for the Trust . This equates to 2.36 of English patients waiting over 52weeks at the end of May.

## What the charts tell us

- Performance against English RTT standard in May was 59.4%
- 2.5% 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 May was 70.8%.

## Risks

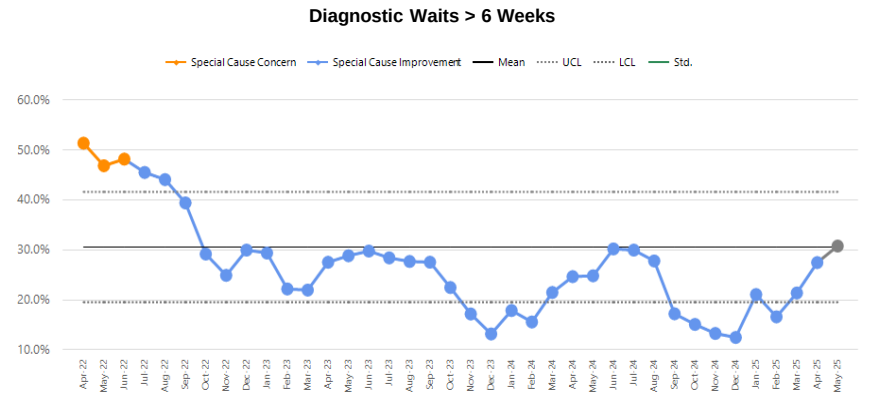
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.
- Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

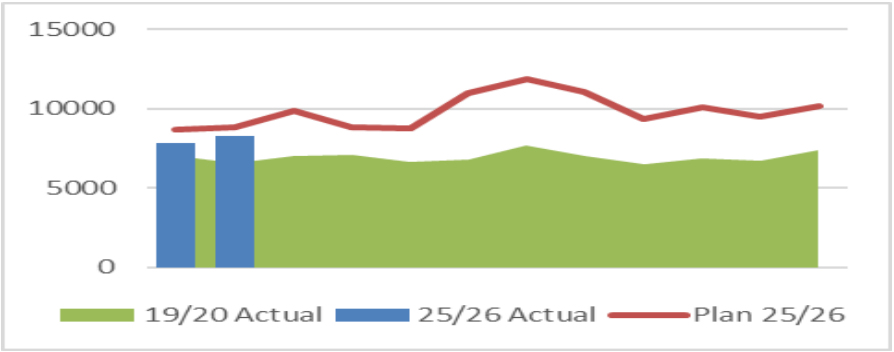
# Operational Performance – Diagnostic Performance

## 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 is delivering 92% of 25/26 DM01 activity plan which is 118% compared with 19/20 activity. The main areas of under delivery were in Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Audiology and Neurophysiology.

Imaging:
6 week wait positon at the end of M2 was 87.4%
Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 9 days and 13 days respectively. One of the main causes of delays is CTC bloods/prescription. Implementation of the software solution has now occurred. MRI Prostate MRI is being looked at as a priority to improve access via the Community Diagnostic Centre (CDC) pathway.
M2 25/26 is 94% of DM01 plan, due further unplanned scanner downtime impacting on elective activity.

Audiology
Audiology Assessment 6 week wait position is 65% with a slight increase in patients waiting >13weeks in M2
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 that took place at the end of May were unsuccessful. Cross-working from Adults into Paediatrics has recently commenced to support mitigating risk where appropriate, this is limited to 1 clinic per week currently due to budget constraints and balance of waiting list risk across both specialities. Both teams are in progress of formal restructure, which will conclude in M3.

Neurophysiology
<6weeks waiting is 75% for M2
Number waiting >13wks has reduced from 21 in March 25 to 2, both of which have appointments booked. 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 overall waiting list is challenged over first part of Q1 due to ongoing challenges with workforce / recruitment timeframes and operational “go live” of new staff. The position has stabilised over the last month but we are yet to reduce the backlog of long waiting patients. At the end of May we had c277 patients over 13 weeks and c880 over 6 weeks. Our trajectory aims to eliminate our 13 weeks waits by the end of and working through 6 week trajectory. Insourcing support reinstated mid May, but have not been fully implemented until June where additional weekend capacity doubles in June in line with agreed capacity and budgetary plans.

## 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 May 69.2% of patients waiting less than 6 weeks for a diagnostic test.

# Our Workforce – Executive Summary

**Geoffrey Etule**
Chief People Officer

Following detailed work with the business intelligence team and finance colleagues over the past 4 months, a monthly workforce movement tracking chart is now in place. This enables the workforce team to identify all workforce movements by professional staff groups, departments and divisions on a monthly basis so any anomalies can be addressed in a timely manner.

Resident doctors are being balloted by the BMA for potential strike action over pay. We will be informed about the outcome of the ballot by 7th July and we will have contingency plans in place as required.

Sickness absence has dropped from 5.2% to 4.5% with Long Term Sickness at 2.51%.and Short Term sickness at 1.96%. The main reasons for sickness absence are colds/flu. mental health conditions, gastro related illness. The revised absence policy is being implemented and we will continue taking appropriate management actions to reduce sickness over the next year.

Staff turnover has dropped to 8.2% and HR teams are leading divisional recruitment & retention working groups to ensure that local actions are being implemented to maintain staff turnover at a reasonable level. Turnover for qualified nurses & midwives remains low at to 6.29% but turnover for band 2/3 HCSW staff now stands at 18.68%. Staff changes within the recruitment team have impacted this area. HR business partners are now leading weekly review meetings with operational managers in areas of high turnover to ensure presence at recruitment events and are conducting stay at WVT interviews to reduce turnover. More work is also being done to recruit & retain support staff through DWP events, open recruitment drop in sessions at Franklin Barnes and local recruitment fairs across Herefordshire.

Active measures are being taken to reduce corporate and admin & clerical costs through a comprehensive organisational change programme. Following benchmarking across the Group, the programme is reviewing admin structures for all pay bands and identifying opportunities to use Ai and cross cover arrangements in view of developing a new streamlined admin operating model by October.

We supported Pride Month in June as part of our ongoing commitment to promote good relations for all WVT employees. The Active Bystander programme has now commenced and WVT employees will be trained over the next year in view of having over 30 Active Bystanders across the Trust.

To enhance our health & wellbeing programmes for staff and ensure we are providing more mental health and menopause support at work, we have submitted our application to NHS Charities seeking 50k for staff wellbeing.

On workforce productivity and efficiency, e-rostering is now embedded in nursing areas and e-expenses is now in place at WVT. The project to roll out e-rostering to community nursing has commenced and e-rostering will be rolled out to other clinical areas in 2025/26 in order to enhance workforce productivity.

WVT continues to perform well with mandatory training which now stands at 89.5%. Performance appraisals have fallen to 71.1% and this will be addressed at finance & performance review meetings.

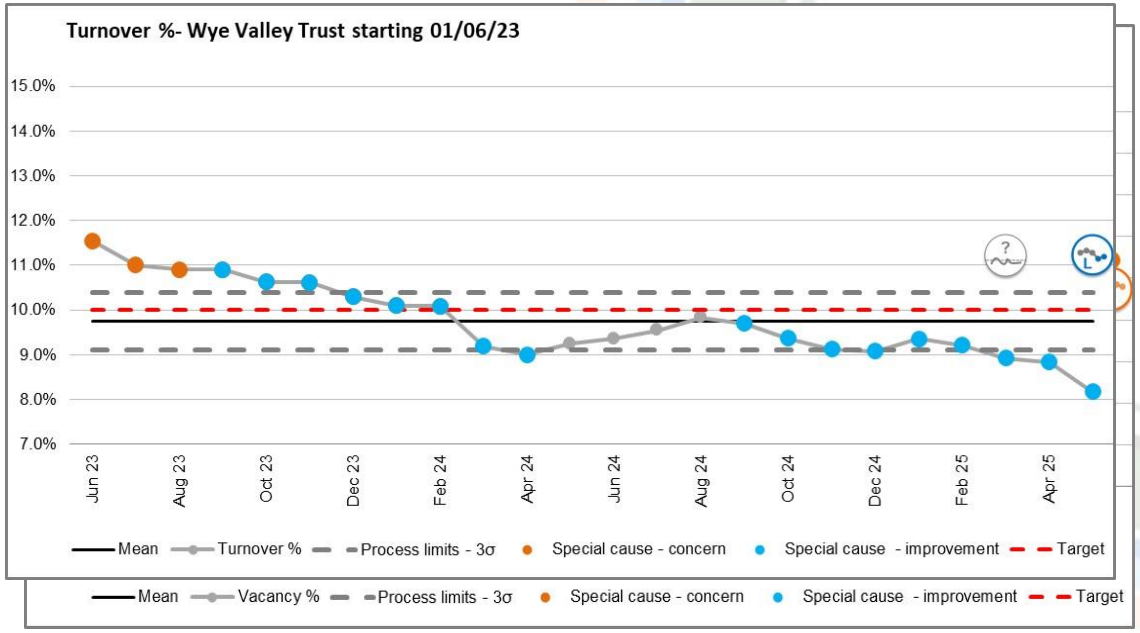
# Workforce Performance – Vacancy

## We are driving this measure because:

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

| May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.5% | 5.7% | 7.1% | 6.3% | 3.9% | 5.2% | 4.7% | 4.5% | 4.1% | 3.7% | 4.2% | 8.4% | 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** – 24.9 wte vacancies with 5 new staff due to start in July. Actions to reduce vacancies includes centralised recruitment, open drop in HR recruitment sessions, active work with DWP to fill vacancies.

**N&M** - we have paused our international recruitment due to an in crease in UK based applicants. We currently have 22.35wte vacancies.

**CDC** – 56.83 wte appointments have been made which equates to 67.32% positions filled to-date.

**M&D** - we are working with a number of international recruitment agencies with UK based and global drs seeking new job opportunities. 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 45.64wte vacancies.

All admin & clerical vacancies are now restricted to internal candidates only.

## 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, this rate was maintained in month 2.

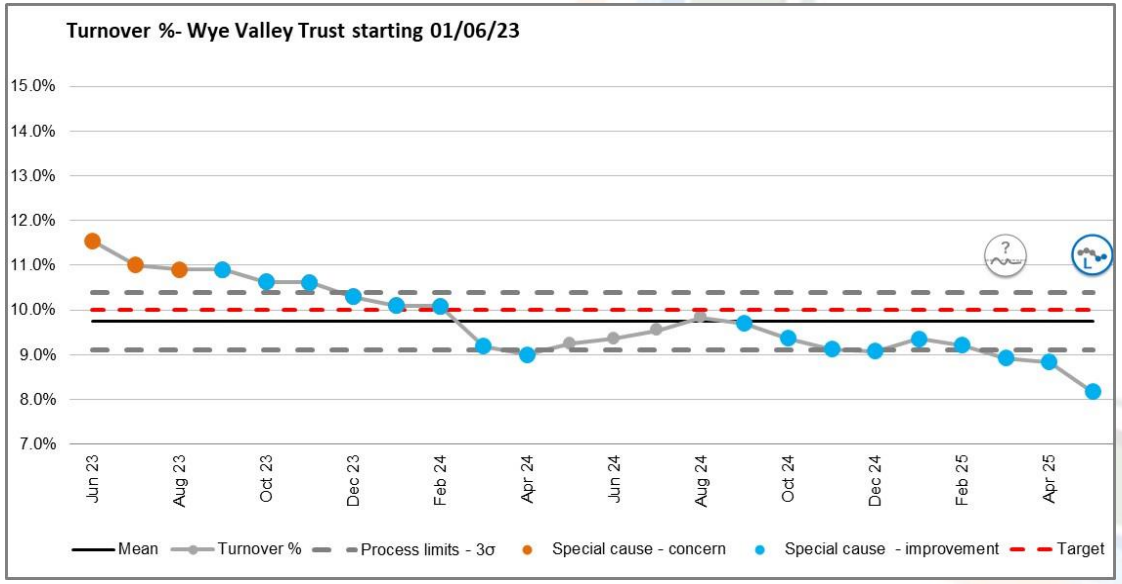
# Workforce Performance – Turnover

## 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.

| May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9.2% | 9.4% | 9.5% | 9.8% | 9.7% | 9.4% | 9.1% | 9.1% | 9.4% | 9.2% | 8.9% | 8.8% | 8.2% |

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




## Performance & actions

Turnover at Trust level is at 8.2% and we are taking steps to ensure this stays below 10.0%.

Clinical support workers at band 2 level have the highest turnover rate at the Trust (18.68%) and this is still the case across the NHS. We have the centralised recruitment process and have strengthened the pastoral care support and training being provided to new starters. 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 (6.29%) 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

HCSW staff turnover

## 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.

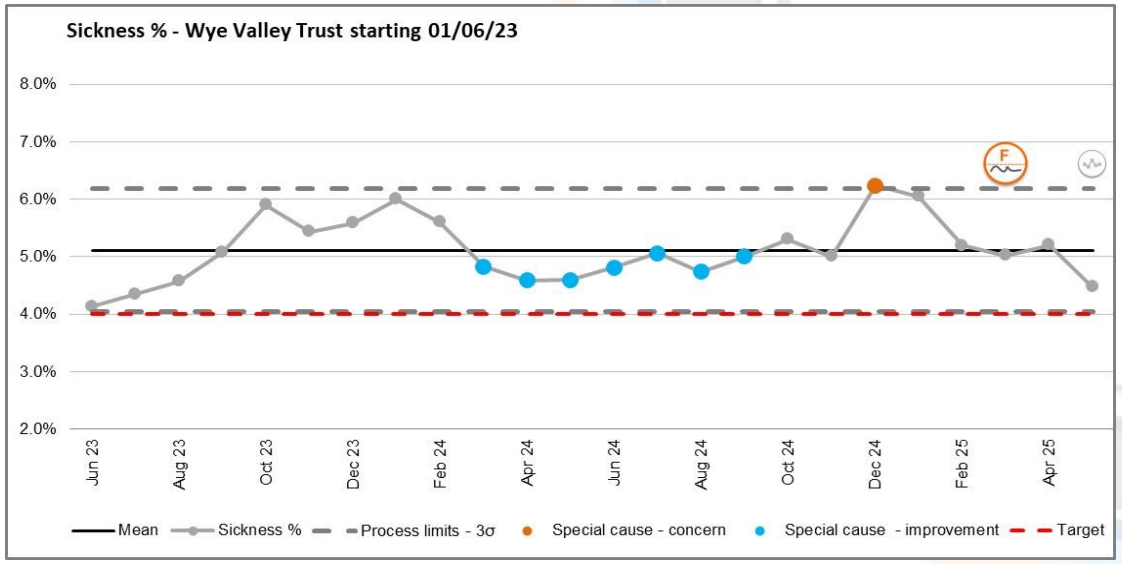
# Workforce Performance – Sickness

## 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.

| May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.6% | 4.8% | 5.1% | 4.7% | 5.0% | 5.3% | 5.0% | 6.2% | 6.0% | 5.2% | 5.0% | 5.2% | 4.5% |

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




## Performance & actions

During this month, overall sickness at Trust level has reduced to 4.5 %. The main reasons for absence are colds/winter ailments, mental health issues and gastro related illness.

We have revised the absence policy and key changes includes new attendance targets, rolling period of 6 not 12 months,  scope to escalate high absence to the final stage for newly appointed staff. At F&PE meetings, divisions will continue to present comprehensive data on sickness absence which includes heat maps, costs, no. of reviews and % of return to work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

HR teams continue to sensitively support the management of long and short term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team based wellbeing support for staff.

The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for cases of concern. The  HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence and WVT will participate in an NHS wide absence study this year.

## RISKS

## What the chart tells us

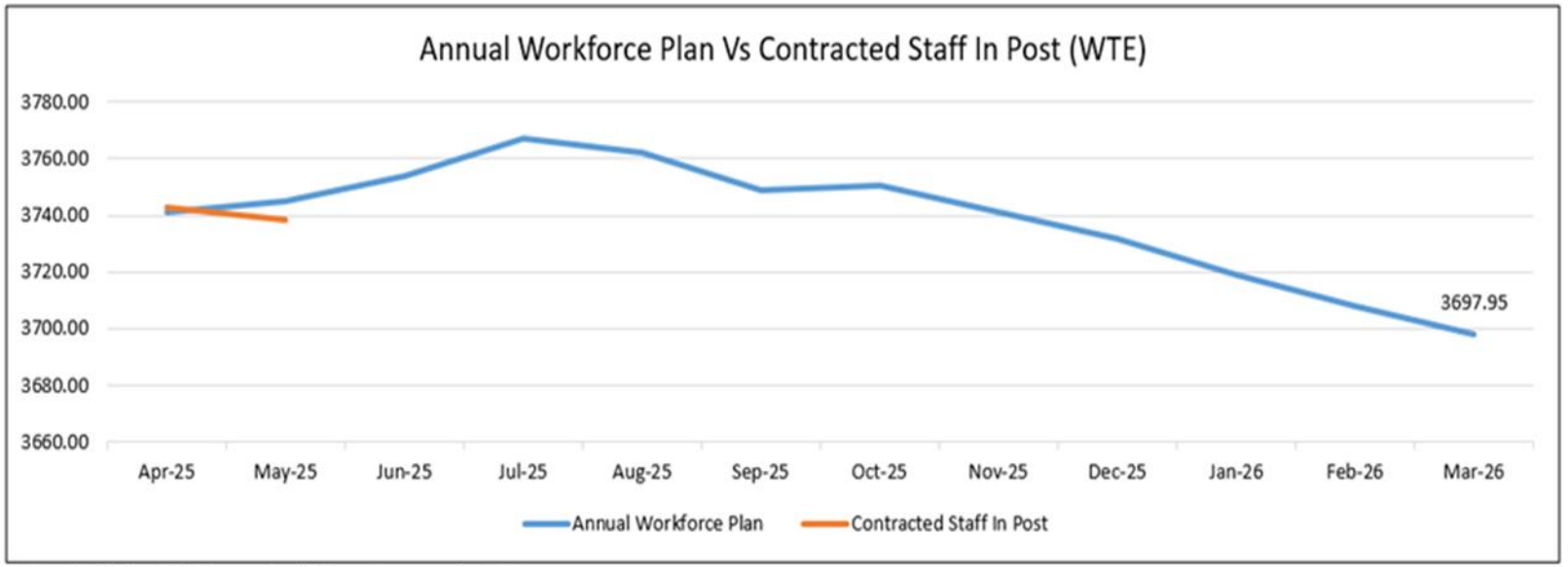
The rolling 12 month position shows a decrease position in the final 3 months of 24/25 reduced to pre winter pressure levels. This has slightly increased in the fist month of 25/26 but reduced in month 2 to the position from 12 months ago.

# Workforce Movement Chart – 2025/2026

New chart showing workforce movements on a monthly basis aligned to the WVT workforce plan for 2025/2026

.

| WTE | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Movement |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Annual Workforce Plan | 3741.26 | 3744.86 | 3753.88 | 3767.31 | 3762.41 | 3748.75 | 3750.35 | 3740.95 | 3731.55 | 3719.15 | 3707.75 | 3697.95 | 3.60 |
| Contracted Staff In Post | 3742.72 | 3738.39 | | | | | | | | | | | -4.33 |
| Difference | (1.47) | 6.47 | | | | | | | | | | | |




*Plan includes 62.39 wte Radiology Community DC

# Our Finance – Executive Summary

**Katie Osmond**
Chief Finance Officer

**Month 2 Income and Expenditure position**

Overall month 2 remains on plan, a stable position for the first two months of the year. The Trust has set a breakeven plan for 2025/26, which includes a £25m CPIP challenge devolved to budget holders for delivery.

In month 2 we saw an improvement in agency use and associated spend linked to the range of actions within our medical and nursing agency reduction programmes. This supports our ambition to achieve the nationally expected 40% reduction on agency and 15% reduction on bank spend already factored into our plan. Cost Improvement delivery remains ahead of plan, primarily through additional non recurrent schemes. Continued focus remains on ensuring schemes are fully developed and will have a positive impact on the run rate. Substantive pay continued to under spend against plan as progress is made on identifying schemes to deliver the planned headcount reductions, with a particular focus on admin and clerical and corporate roles. Though elective activity levels were broadly in line with plan, overall contract income was behind plan suggestive of a difference in case mix.

The annual plan does include a high level of risk including items such as Welsh Parity income (assumed within the year to date income positon), income stretch (planned in the latter part of the year), and the risk around full achievement of the CPIP given a proportion of the target remains in opportunity and pre-pipeline. We are tracking the level of risk to the forecast and wherever possible identifying in year mitigations. 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 May were £1m lower than planned and will continue to be closely monitored.

Access to planned Deficit Support remains contingent on financial performance and delivery of planned efficiencies.

**Cash Balance**

| Month | Performance | Target | Direction | Rating |
|---|---|---|---|---|
| March | 37.9 | 27.4 | | |
| April | 35.3 | 28.1 | | |
| May | 32.1 | 33.3 | | |

Cash balances are £1m lower than plan, due to an increase in net working balances (receiveables less payables), driven by expected ICB receipts.

**Better Payment Practice Code**

| Month | Performance | Target | Direction | Rating |
|---|---|---|---|---|
| March | 99.2% | 95.0% | | |
| April | 98.4% | 95.0% | | |
| May | 98.9% | 95.0% | | |

In May the Trust paid 98.9% of invoices within 30 days. This equates to 98.5% by invoice value. This is the seventeenth 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 2 - 31st May 2025 - 2025/26**

| | 2025-26 ANNUAL BUDGET | YEAR TO DATE BUDGET | YEAR TO DATE ACTUAL | CUMULATIVE VARIANCE | VARIANCE IN CURRENT MONTH |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Contract Income | 349,652 | 58,207 | 57,442 | (765) | (696) |
| Excluded Drugs | 10,484 | 1,747 | 1,735 | (12) | 86 |
| Excluded Drugs | 15,614 | 2,602 | 2,626 | 23 | 52 |
| Non Contracted Activity (NCA's) | 2,021 | 387 | 315 | (72) | (79) |
| Other Income for Patient Care | 12,612 | 2,102 | 2,237 | 135 | 119 |
| Donations For Non Current Assets | 240 | 0 | 857 | 857 | 857 |
| Other Non Patient Income | 8,093 | 1,349 | 1,271 | (78) | 19 |
| ERF | 0 | 0 | 0 | 0 | (16) |
| **Total Operating Income** | **398,717** | **66,394** | **66,482** | **88** | **341** |
| Substantive Pay | 219,132 | 36,870 | 36,600 | 270 | 94 |
| Bank & WLI Pay | 16,123 | 3,008 | 3,135 | (127) | 6 |
| Agency pay | 8,046 | 1,844 | 1,701 | 143 | 116 |
| Non Pay Expenditure | 101,241 | 17,425 | 17,250 | 175 | 295 |
| Excluded Drugs | 25,795 | 4,299 | 4,334 | (35) | (161) |
| **Total Operating Expenditure** | **370,337** | **63,446** | **63,020** | **426** | **349** |
| | | | | | |
| **EBITDA** | **28,380** | **2,948** | **3,462** | **514** | **690** |
| Depreciation | 13,414 | 2,236 | 2,114 | 122 | 61 |
| Impairment | 4,584 | 0 | 0 | 0 | 0 |
| Interest Receivable | 527 | 88 | 367 | 279 | 137 |
| Interest Payable on Loans | 180 | 30 | 26 | 4 | 2 |
| Interest Payable on PFI | 2,944 | 274 | 274 | 0 | 0 |
| Dividends on PDC | 4,296 | 716 | 716 | 0 | 0 |
| **Operating Surplus/ (Deficit)** | **3,489** | **(219)** | **700** | **920** | **891** |
| **Technical Adjustments** | | | | | |
| Donated Assets Adjustment | 536 | 129 | (723) | (852) | (854) |
| Net impact of asset impairments | 4,584 | 0 | 0 | 0 | 0 |
| Impact of IFRS16 Implementation of PFI Contract | (8,609) | (1,604) | (1,650) | (46) | 1 |
| Adj. financial performance retained Surplus/ (Deficit) | **(0)** | **(1,693)** | **(1,673)** | **21** | **37** |

## Performance & actions

The position at the end of Month 2 (April) was a deficit of £1,673k YTD. This was largely on plan with an overall positive variance of £21k YTD.

- Income shows a favorable variance of £88k of which £857k relates to the Salix income which is budgeted to come in future months less elective activity income below plan of (£765k).
- Pay is favorable by £285k at month 2, of which £216k is in month. The net position in month includes agency — 3.66% of total pay costs in month which is a decrease from 4.54% in M1. Bank use at premium rates further increases the total temporary staff proportion to 7.53% of overall pay. Nursing agency usage has reduced significantly on band 2 posts in particular in month as we move towards full cessation of HCSW agency.
- Total Non Pay (operating & non operating) is adverse by £352k YTD including technical adjustment benefits. The adverse variance is largely due to the technical adjustments for donated assets and PFI IFRS16 adjustments, which is offset in income. The remainder is offset by additional interest received due to high cash balances.
- Within Adjustments, there is a PFI £46k adverse 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: e.g.. Winter and Critical Incident impact on financial performance
- Marginal Cost of delivering activity

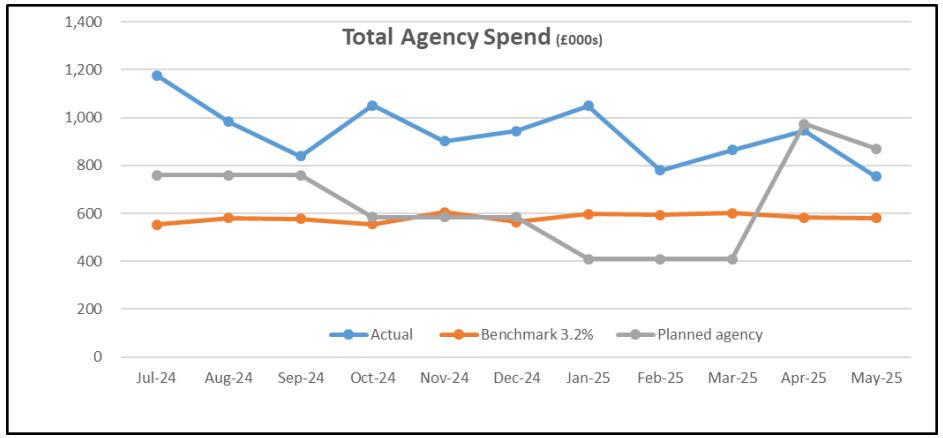
## What the chart tells us

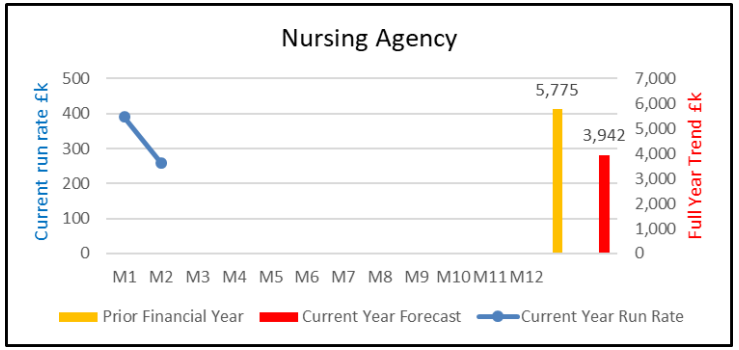
There are no material variances in this month, though the plan includes a number of known financial risks.

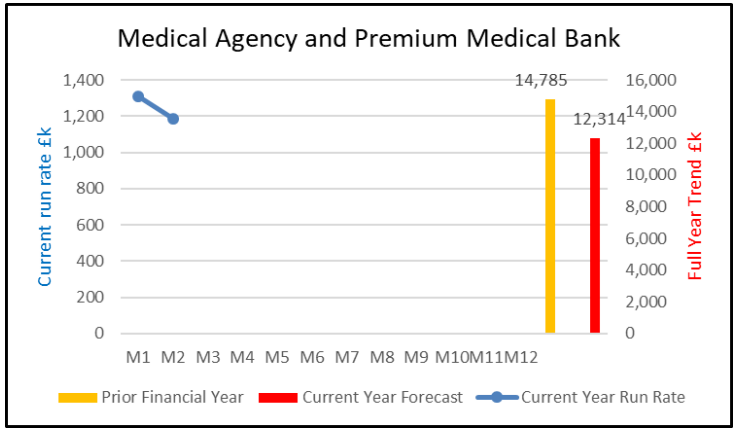
# Finance Performance – Agency Spend

## 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, though within the planned level at this stage of the year remains well above the NHS benchmark and is adversely impacting on our use of resources.




## Performance & actions

Agency represents 4.10% of total pay costs year to date, 0.9% above the national target of 3.2%. Agency performance is currently better than plan by £143k. Total agency spend year to date (excluding premium cost medical bank) is £1,701k.

- **Nursing agency:** Total spend in 2425 was £5.8m. Rate reduction changes have significantly reduced agency costs over the last 12 months and the elimination of band 2 agency spend is well under way as reflected by the position. The cost for nurse agency spend in May was £260k down from £390k in M1.
- **Off framework Nurse Agency:** there has been an increase in off framework use in month with 7 shifts booked in May compared to 2 in April. The total shifts booked in 2425 was 135.
- **Medical staffing agency and premium cost bank:** The Trust spent £15.3m in 2324 and £14.8m in 2425. The total spend in month 2 is £1,186k, a slight reduction from £1,311k in M1, which included the critical incident.

## Risks

Level of Agency (% of pay)

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

Supply and Demand price pressures

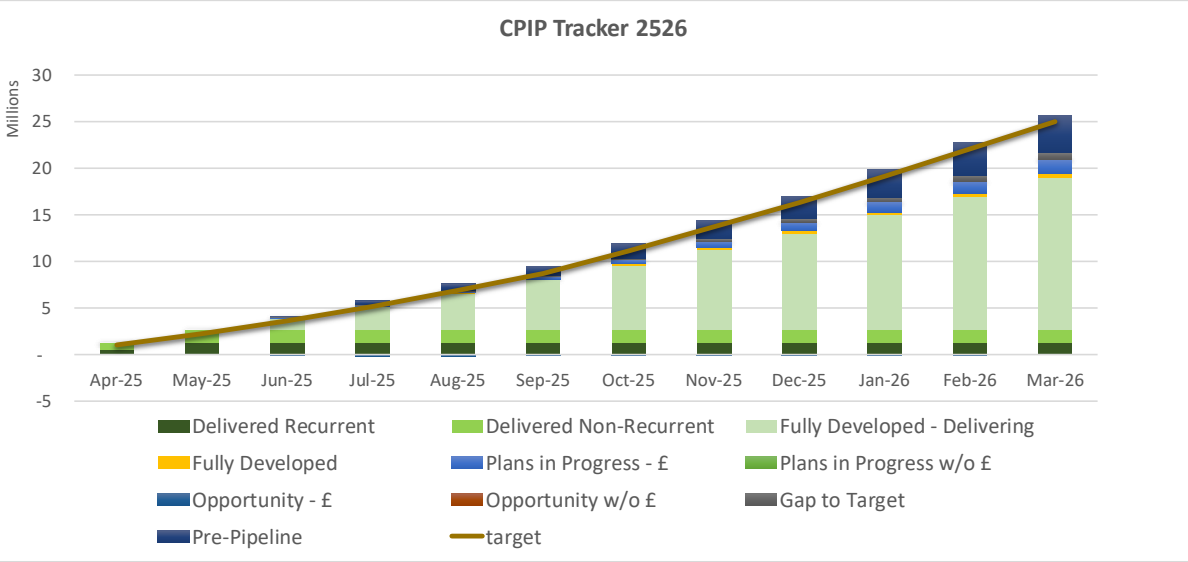
## What the charts tell us

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.

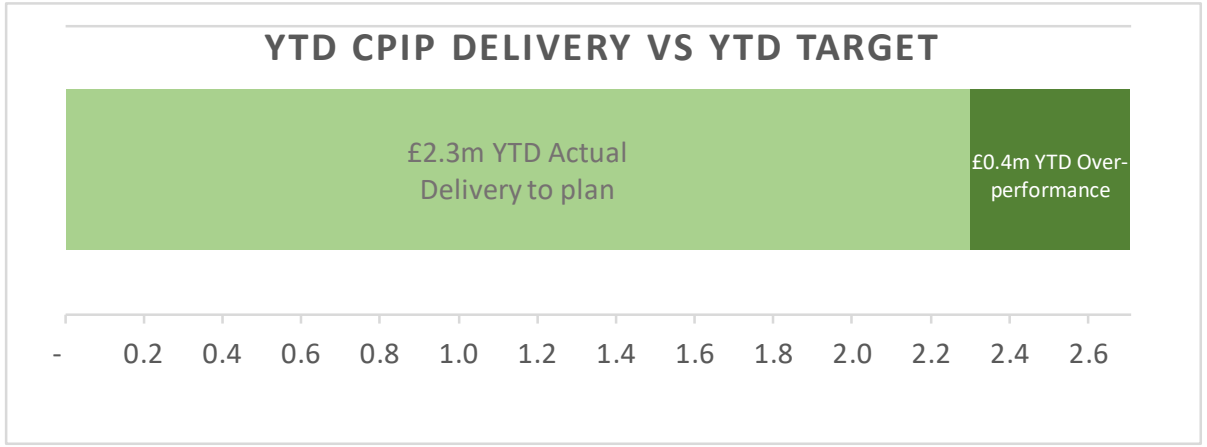



## Performance & actions

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 150 WTE reduction. The programme includes a continued focus on reducing cost growth from pre Covid levels.

The current position on CPIP delivery to date reflects a plan of £2.3m with a Trust delivery of £2.7m resulting in a £0.4m over-performance to plan. This does include £1,345k of recurrent delivery, £107k less than expected in the month.

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 with £4m with status of Pre-pipeline. 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 HRG X price) that supports that. This is a complex piece of work.
- We are continuing to work closely with all commissioners to agree contract values and IAP's.

**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.
- We have continued to work to model the impact of the proposals including the reduction in income and are in the process of formally responding to Powys. Our modelling suggests that there will smaller net impact on elective income that Powys anticipated and that there will stranded costs which we aiming to recover from Powys. In addition we are also looking to recoup the costs of the administrative burden of operationalising this.

**Income budgets and reporting**

- There are still a number of moving parts and we continue to develop our income reporting as we move towards activity x price contracting.

**Month 2: All Commissioners including Powys activity and £ by POD**

| | APRIL M1 202404 | MAY M2 202405 |
|---|---|---|
| DC | £2,155,040 | £2,338,879 |
| EL | £1,084,873 | £1,130,006 |
| | £3,239,913 | £3,468,885 |
| OPAFA | £1,353,864 | £1,351,748 |
| OPROC | £1,249,236 | £1,140,452 |
| | £2,603,100 | £2,492,200 |
| **Grand Total** | **£5,843,013** | **£5,961,085** |

## Risks

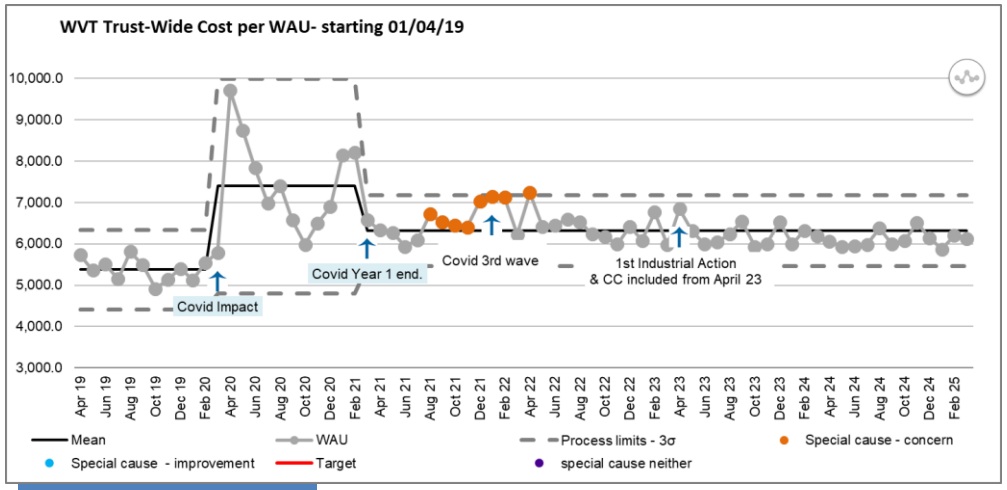
- Further work is required to triangulate the income plan, budget and elective activity monitoring to ensure we have correct reporting
- Agreement of the indicative plans with H&W ICB and other commissioners
- Agreement of Welsh elective activity plan

# Finance Performance – Productivity Improvement

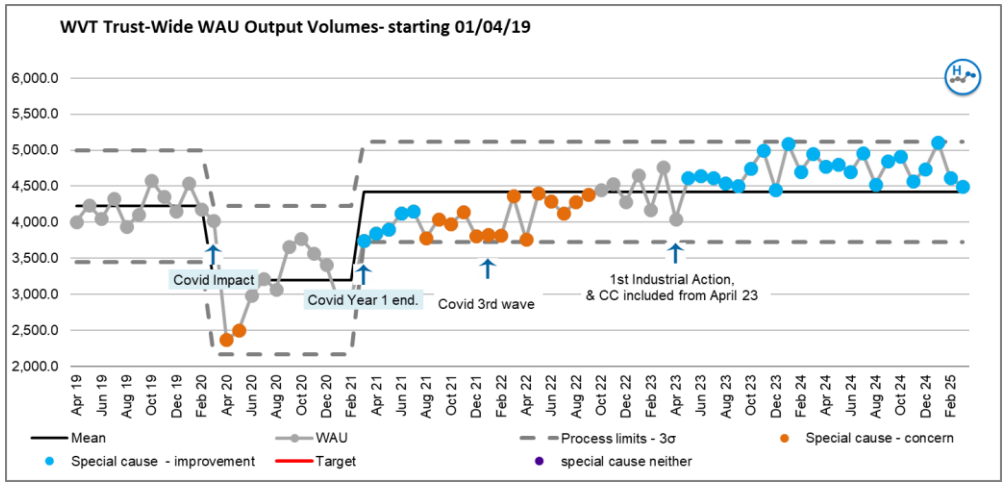
## Cost per Weighted Activity Unit (WAU) – Group Aligned Methodology

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

### Cost per WAU




### WAU Output Volumes




### Cost per WAU - Alignment in methodology across the Foundation Group

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

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

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

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

### What the charts tell us

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

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

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

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

# Finance Performance – Capital

This is a measure of the utilisation of Trust capital resources for the year to date.

| Capital Scheme | Type of Capital Expenditur | Full Year Plan | Year to Date - Month 2 | | | Full Year | |
|---|---|---|---|---|---|---|---|
| | | | Budget | Actual | Variance | Forecast | Variance |
| Local Schemes | | | | | | | |
| Digital Schemes | Owned | 1,193 | 0 | 67 | (67) | 1,193 | 0 |
| Clinical Equipment | Owned | 1,188 | 0 | 0 | 0 | 1,188 | 0 |
| Minor Building Schemes | Owned | 956 | 0 | (10) | 10 | 956 | 0 |
| Backlog Maintenance | Owned | 400 | 0 | 0 | 0 | 400 | 0 |
| Estates Schemes | Owned | 200 | 0 | 51 | (51) | 200 | 0 |
| CDC Cfwd | Owned | 700 | 0 | 0 | 0 | 700 | 0 |
| Education Centre | Owned | 0 | 0 | 1 | (1) | 0 | 0 |
| Cfwd 2425 | Owned | 0 | 0 | 218 | (218) | 0 | 0 |
| **Total - Local CDEL funded** | | **4,637** | **0** | **326** | **(326)** | **4,637** | **0** |
| Grant funded and donated | | | | | | | |
| Integrated Energy Scheme | Owned | 5,013 | 834 | 1,841 | (1,007) | 5,013 | 0 |
| Donated assets | Owned | 240 | 0 | 0 | 0 | 240 | 0 |
| Education Centre | Owned | 0 | 0 | 1 | (1) | 0 | 0 |
| Donated Clinical Equpt | Owned | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total - Grant funded and Donated** | | **5,253** | **834** | **1,842** | **(1,008)** | **5,253** | **0** |
| National funding | | | | | | | |
| Clinical Diagnostics Centre | Owned | 2,000 | 0 | 548 | (548) | 2,000 | 0 |
| Diagnostics Equpt | Owned | 337 | 0 | 0 | 0 | 337 | 0 |
| Emergency Obstetrics Theatre | Owned | 2,299 | 0 | 0 | 0 | 2,299 | 0 |
| Endoscopy compliance | Owned | 701 | 0 | 0 | 0 | 701 | 0 |
| UEC Expansion | Owned | 4,308 | 0 | 0 | 0 | 4,308 | 0 |
| Day Case Facility / Additional Day C | Owned | 415 | 0 | 0 | 0 | 415 | 0 |
| **Total - National PDC schemes** | | **10,060** | **0** | **548** | **(548)** | **10,060** | **0** |
| Leases | | | | | | | |
| IFRS 16 Leases | Leased | 621 | 0 | 5 | (5) | 621 | 0 |
| **Total - IFRS16 Leases** | | **621** | **0** | **5** | **(5)** | **621** | **0** |
| **Total Capital Programme** | | **20,571** | **834** | **2,722** | **(1,888)** | **20,571** | **0** |

## What the charts tells us

**Performance and actions**

The Trust has a capital budget of £20,571k of which £15,305k relates to larger schemes funded from national PDC awards or from grant funding. The balance of £5,258k relates to the Trust internal capital programme. The internal programme has not yet been finalised and priorities are being considered at CPEC. Most of the expenditure plan is phased into the second half of the financial year.

**Year to date variances from plan**

Most expenditure to date is within existing schemes (CDC and IES) which are continuing in to 2025/26. Although the overall variance is adverse YTD it is due to timing at this stage in the year.

**Risks and mitigations**

Existing national funded schemes are well understood and any risks in relation to additional cost are being considered within the internal capital programme. The new nationally funded schemes are being developed at present and the main risk to these is the ability to spend the awarded funds within the financial year. The internal capital programme is currently greater than the available resource due to existing commitments and the value of high priority schemes. This is being addressed through CPEC.

**What the table tells us**

Expenditure to date is largely limited to carry forward schemes and other scheme expenditure carried forward from 2024/25.

# Finance Performance – Statement of Financial Position

## We are driving this measure because:

Our Statement of Financial Position (Balance Sheet) is a core financial statement and reflects the overall financial position of the Trust in terms of its assets and liabilities. It provides insight across revenue and capital funding streams, and beyond the current financial year.

**Statement of Financial Position**

| May 2025 | 2024/25 | 2025/26 | | |
|---|---|---|---|---|
| | Accounts £000s | M2 Plan £000s | M2 YTD £000s | Variance £000s |
| **NON-CURRENT ASSETS:** | | | | |
| Property, Plant and Equipment | 159,386 | 158,450 | 162,340 | (3,890) |
| Intangible Assets | 11,572 | 11,104 | 9,227 | 1,877 |
| Trade and Other Receivables | 429 | 429 | 429 | 0 |
| **TOTAL Non Current Assets** | **171,387** | **169,983** | **171,996** | **(2,013)** |
| **CURRENT ASSETS:** | | | | |
| Inventories | 5,087 | 5,087 | 4,831 | 256 |
| Trade and Other Receivables | 24,244 | 27,360 | 40,499 | (13,139) |
| Cash and Cash Equivalents | 37,906 | 33,334 | 32,064 | 1,270 |
| **TOTAL Current Assets** | **67,237** | **65,781** | **77,394** | **(11,613)** |
| **TOTAL ASSETS** | **238,624** | **235,764** | **249,390** | **(13,626)** |
| **CURRENT LIABILITIES** | | | | |
| Trade and other payables | (37,582) | (38,298) | (49,878) | 11,580 |
| Borrowings - Loans, PFI and Finance Leases | (15,067) | (15,067) | (11,884) | (3,183) |
| Provisions | (49) | (49) | (46) | (3) |
| **Total Current Liabilities** | **(52,698)** | **(53,414)** | **(61,808)** | **8,394** |
| **NET CURRENT ASSETS/(LIABILITIES)** | **14,539** | **12,367** | **15,586** | **(3,219)** |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **185,926** | **182,350** | **187,582** | **(5,232)** |
| **NON-CURRENT LIABILITIES:** | | | | |
| Borrowings - Loans, PFI and Finance Leases | (40,822) | (37,466) | (41,788) | 4,322 |
| Provisions | (1,529) | (1,529) | (1,521) | (8) |
| **Total Non-Current Liabilities** | **(42,351)** | **(38,995)** | **(43,309)** | **4,314** |
| **ASSETS LESS LIABILITIES** | **143,575** | **143,355** | **144,273** | **(918)** |
| **TAXPAYERS EQUITY** | | | | |
| Public dividend capital | 325,841 | 326,010 | 325,841 | 169 |
| Revaluation reserve | 17,709 | 17,540 | 16,998 | 542 |
| Income and expenditure reserve | (199,975) | (200,195) | (198,566) | (1,629) |
| **TOTAL** | **143,575** | **143,355** | **144,273** | **(918)** |

## Performance & actions

**General**
The table identifies the statement of financial position as at 30 May against the plan.

**Non-Current Assets**
Non-Current assets are £2m higher than plan due to carried forward 2024/25 capital programme schemes incurring expenditure earlier than planned during 2025/26 (see capital section, above).

**Working balances**
Net working balances - receivables less payables - have increased slightly (£1m) compared to plan, due to timing of income receipts. This has led to a corresponding cash balance reduction of £1m when compared to plan.

**Borrowings**
The variances on current and non current borrowings are due to opening balances differing from plan, where plan was based on a forecast outturn.

**Taxpayers Equity**
PDC and revaluation reserve balances are again due to differences in the actual opening balances compared to those forecast in the plan.
The income and expenditure reserve balance for month 2 reflects the deficit for the year to date and, again, differs slightly to plan due to the timing of the plan formulation.

## Risks

The level of risk included in the Income and Expenditure plan presents an ongoing risk to the strength of the SOFP, as does the higher than planned level of receivables at Month 2.

## What the chart tells us

Current assets outweigh current liabilities. Cash balances are lower than planned, mainly driven by an increase in net working balances compared to plan.

# Trustwide KPIs

## Quality of Care, Access & Outcomes

| Sub Domain | KPI | Subject | Target | Target Expectation | Variation | Exception | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | 28 day referral to diagnosis confirmation to patients | Cancer | >= 80.0% | Fail | Improvement - High | | 79.2% | 78.1% | 79.3% | 77.1% | 72.7% | 82.9% | 75.9% | 78.1% | |
| | 2 Week Wait all cancers | Cancer | >= 93.0% | Variable | Concern - Low | | 92.1% | 91.3% | 86.4% | 84.3% | 85.9% | 79.1% | 83.8% | 83.9% | |
| | Urgent referrals for breast symptoms | Cancer | >= 93.0% | Variable | Concern - Low | | 39.1% | 21.4% | 7.7% | 20.0% | 15.4% | 0.0% | 16.7% | 0.0% | |
| | Cancer 31 day diagnosis to treatment | Cancer | >= 96.0% | Variable | Improvement - High | | 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 | | 7 | 5 | 8 | 7 | 3 | 7 | 9 | 11 | |
| | Cancer 62 days urgent referral to treatment | Cancer | >= 85.0% | Variable | Common Cause | | 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 | | 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 | | 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 | | 61 | 50 | 38 | 54 | 52 | 60 | 74 | 69 | |
| Primary care and community services | Community Service Contacts - Total | Primary care and community | | No Target | Improvement - High | | 108.9% | 124.2% | 108.6% | 118.3% | 126.1% | 110.5% | 108.0% | 115.8% | 117.0% |
| | % emergency admissions discharged to usual place of residence | Primary care and community | >= 90.0% | Variable | Concern - Low | | 87.4% | 86.3% | 87.3% | 85.9% | 85.2% | 86.6% | 86.2% | 87.3% | 87.1% |
| Urgent and emergency care | A&E Activity | Urgent and emergency care | | No Target | Common Cause | Yes | 103.4% | 101.2% | 105.2% | 104.0% | 100.3% | 96.3% | 102.0% | 99.0% | 95.5% |
| | Ambulance handover within 30 minutes (WMAS Only) | Urgent and emergency care | >= 98.0% | Fail | Concern - Low | | 62.9% | 51.1% | 55.2% | 49.4% | 54.3% | 60.3% | 55.2% | 44.3% | 53.8% |
| | Ambulance handover over 60 minutes (WMAS Only) | Urgent and emergency care | <= 0.0% | Variable | Concern - High | | 18.8% | 29.1% | 25.1% | 30.9% | 29.7% | 21.4% | 26.6% | 38.5% | 28.6% |
| | Non Elective Activity - General & Acute (Adult & Paediatrics) | Urgent and emergency care | | No Target | Improvement - High | | 120.2% | 118.9% | 128.9% | 124.1% | 121.1% | 121.7% | 127.3% | 118.0% | 117.9% |
| | Same Day Emergency Care (0 LOS Emergency adult admissions) | Urgent and emergency care | >= 40.0% | Variable | Improvement - High | | 44.4% | 48.0% | 48.2% | 46.4% | 47.2% | 46.7% | 49.1% | 47.2% | 46.8% |
| | A&E - % of patients seen within 4 hours | Urgent and emergency care | >= 95.0% | Fail | Concern - Low | | 65.8% | 65.8% | 64.8% | 63.4% | 64.1% | 65.9% | 63.2% | 57.4% | 60.4% |
| | A&E - Percentage of patients spending more than 12 hours in A&E | Urgent and emergency care | | No Target | Improvement - High | | 12.5% | 12.4% | 12.2% | 13.3% | 14.6% | 13.0% | 13.2% | 16.4% | 14.2% |
| | 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 | | 1.8% | 1.7% | 1.9% | 2.0% | 1.8% | 1.5% | 1.9% | 1.7% | 1.8% |
| | A&E Quality Indicator - 12 Hour Trolley Waits | Urgent and emergency care | <= 0 | Fail | Concern - High | Yes | 284 | 270 | 256 | 232 | 322 | 219 | 293 | 277 | 249 |
| | A&E - Unplanned Re-attendance with 7 days rate | Urgent and emergency care | 3.0% | Pass | Common Cause | | 7.7% | 8.9% | 9.2% | 9.1% | 8.7% | 8.9% | 9.1% | | |

# Trustwide KPIs

| Sub Domain | KPI | Subject | Target | Target Expectation | Variation | Exception | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective care | Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard | Elective care | >= 61.0% | Variable | Improvement - High | Yes | 55.1% | 55.8% | 56.0% | 55.1% | 56.0% | 56.4% | 56.5% | 57.1% | 59.4% |
| | Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard | Elective care | | No Target | Common Cause | Yes | 69.5% | 70.0% | 70.0% | 68.4% | 69.2% | 70.3% | 70.0% | 70.8% | 70.4% |
| | Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List | Elective care | | No Target | Improvement - High | | 28783 | 28761 | 28246 | 27766 | 27410 | 27488 | 27476 | 27943 | 28097 |
| | Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List | Elective care | <= 0 | Fail | Improvement - Low | | 987 | 865 | 804 | 764 | 740 | 727 | 692 | 660 | 768 |
| | Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List | Elective care | <= 0 | Fail | Improvement - Low | | 9 | 4 | 1 | 3 | 2 | 5 | 5 | 2 | 5 |
| | Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting | Elective care | <= 0 | Fail | Improvement - Low | | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | GP Referrals | Elective care | | No Target | Common Cause | Yes | 94.7% | 103.3% | 91.0% | 105.2% | 98.8% | 91.6% | 103.1% | 95.0% | |
| | Outpatient Activity - New attendances (% v 2019/20) | Elective care | | No Target | Improvement - High | | 111.4% | 116.6% | 109.2% | 108.3% | 112.6% | 113.8% | 148.4% | 119.5% | 112.1% |
| | Outpatient Activity - New attendances (volume v plan) | Elective care | | No Target | Common Cause | Yes | 83.1% | 111.4% | 78.0% | 101.4% | 104.4% | 94.0% | 82.0% | 101.2% | 99.5% |
| | Total Outpatient Activity (% v 2019/20) | Elective care | | No Target | Improvement - High | | 110.8% | 113.3% | 107.9% | 109.6% | 109.2% | 109.8% | 140.1% | 126.7% | 118.8% |
| | Total Outpatient Activity (volume v plan) | Elective care | | No Target | Improvement - High | Yes | 90.8% | 115.7% | 83.2% | 111.4% | 113.4% | 98.0% | 86.0% | 108.3% | 107.0% |
| | Total Elective Activity (% v 2019/20) | Elective care | | No Target | Improvement - High | | 110.1% | 107.9% | 100.5% | 100.8% | 104.4% | 104.0% | 127.6% | 106.7% | 110.3% |
| | Total Elective Activity (volume v plan) | Elective care | | No Target | Common Cause | | 87.8% | 104.9% | 78.3% | 90.4% | 97.9% | 91.0% | 77.2% | 94.1% | 99.7% |
| | Elective - Theatre utilisation (%) - Capped | Elective care | >= 85.0% | Fail | Improvement - High | | 80.2% | 79.5% | 78.8% | 80.9% | 80.3% | 83.1% | 82.0% | 82.7% | 80.7% |
| | Cancelled Operations on day of Surgery for non clinical reasons | Elective care | | No Target | Common Cause | | 32 | 26 | 31 | 39 | 35 | 20 | 26 | 25 | 19 |
| | Diagnostic Activity - Computerised Tomography | Elective care | | No Target | Concern - Low | Yes | 118.0% | 104.4% | 107.9% | 103.5% | 86.8% | 86.6% | 102.7% | 90.8% | 95.9% |
| | Diagnostic Activity - Endoscopy | Elective care | | No Target | Concern - Low | Yes | 93.3% | 91.4% | 71.8% | 83.3% | 80.1% | 89.1% | 78.9% | 100.9% | 94.4% |
| | Diagnostic Activity - Magnetic Resonance Imaging | Elective care | | No Target | Concern - Low | Yes | 116.2% | 113.6% | 127.4% | 109.7% | 93.4% | 88.3% | 119.2% | 99.3% | 94.0% |
| | Waiting Times - Diagnostic Waits >6 weeks | Elective care | | No Target | Common Cause | Yes | 17.2% | 15.1% | 13.3% | 12.5% | 21.1% | 16.6% | 21.4% | 27.5% | 30.8% |

# Trustwide KPIs

| Sub Domain | KPI | Subject | Target | Target Expectation | Variation | Exception | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-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 | | 88.9% | 94.6% | 94.0% | 93.7% | 97.1% | 97.7% | 97.8% | 99.1% | 96.6% |
| | Robson category - CS % of Cat 1 deliveries (rolling 6 month) | Elective care | <= 15.0% | Variable | Concern - High | | 15.6% | 16.2% | 18.4% | 17.8% | 20.4% | 22.5% | 21.8% | 19.8% | 21.1% |
| | Robson category - CS % of Cat 2 deliveries (rolling 6 month) | Elective care | <= 34.0% | Fail | Concern - High | | 55.3% | 55.6% | 61.8% | 65.1% | 64.6% | 61.5% | 66.5% | 67.9% | 64.8% |
| | Robson category - CS % of Cat 5 deliveries (rolling 6 month) | Elective care | <= 60.0% | Fail | Concern - High | | 85.9% | 87.8% | 88.2% | 90.2% | 89.7% | 89.2% | 90.8% | 88.7% | 86.8% |
| | Maternity Activity (Deliveries) | Elective care | | No Target | Common Cause | Yes | 108.4% | 92.9% | 95.4% | 94.9% | 101.4% | 93.8% | 88.0% | 91.1% | 97.0% |
| Outpatient transformation | DNA Rate (Acute Clinics) | Outpatient transformation | <= 40.0% | Pass | Common Cause | | 6.5% | 5.9% | 6.3% | 6.5% | 6.2% | 5.9% | 5.4% | 5.6% | 5.8% |
| | Outpatient - % OPD Slot Utilisation (All slot types) | Outpatient transformation | >= 90.0% | Fail | Improvement - High | Yes | 89.3% | 88.8% | 88.3% | 87.8% | 86.7% | 88.7% | 88.0% | 88.5% | 88.3% |
| | Outpatient Activity - Follow Up attendances (% v 2019/20) | Outpatient transformation | | No Target | Improvement - High | | 110.5% | 111.8% | 107.4% | 110.2% | 107.8% | 108.0% | 136.5% | 130.2% | 122.0% |
| | Outpatient Activity - Follow Up attendances (volume v plan) | Outpatient transformation | | No Target | Improvement - High | Yes | 94.8% | 117.7% | 85.8% | 116.7% | 117.9% | 99.9% | 88.0% | 111.8% | 110.6% |
| | Outpatients Activity - Virtual Total (% of total OP activity) | Outpatient transformation | <= 25.0% | Variable | Improvement - Low | | 20.1% | 19.9% | 20.2% | 20.1% | 21.4% | 21.4% | 19.9% | 19.0% | 19.2% |
| Prevention and long term conditions | Maternity - Smoking at Delivery | Prevention and long term | | No Target | Common Cause | Yes | 6.7% | 7.5% | 8.7% | 7.9% | 8.0% | 8.4% | 7.4% | 8.1% | 10.9% |
| Safe, high quality care | Bed Occupancy - Adult General & Acute Wards | Safe, high quality care | <= 90.0% | Variable | Concern - High | | 99.8% | 99.9% | 99.4% | 98.8% | 99.9% | 99.7% | 94.7% | 97.7% | 99.9% |
| | Bed occupancy - Community Wards | Safe, high quality care | <= 90.0% | Variable | Concern - High | | 89.5% | 89.5% | 89.5% | 89.5% | 89.5% | 89.5% | 89.5% | 89.5% | 89.5% |
| | Mixed Sex Accommodation Breaches | Safe, high quality care | <= 0 | Variable | Improvement - Low | | 204 | 348 | 150 | 69 | 129 | 81 | 64 | 117 | 90 |
| | Patient ward moves emergency admissions (acute) | Safe, high quality care | 4.0% | Pass | Concern - Low | | 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 | | 6 | 7 | 6 | 6 | 7 | 6 | 6 | 6 | 7 |
| | ALoS – General & Acute Elective Inpatients | Safe, high quality care | <= 3 | Variable | Common Cause | | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | Medically fit for discharge - Acute | Safe, high quality care | 5.0% | Pass | Concern - Low | | 13.8% | 15.5% | 16.6% | 15.1% | 17.2% | 19.3% | 17.3% | 16.7% | 18.0% |
| | Medically fit for discharge - Community | Safe, high quality care | 10.0% | Pass | Concern - Low | | 47.5% | 53.1% | 49.0% | 38.8% | 38.5% | 36.6% | 24.9% | 20.8% | 36.1% |
| | Emergency readmissions within 30 days of discharge (G&A only) | Safe, high quality care | 5.0% | Pass | Concern - Low | | 4.9% | 4.5% | 5.0% | 4.5% | 4.5% | | | | |

# Trustwide KPIs

| Sub Domain | KPI | Subject | Target | Target Expectation | Variation | Exception | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe, high quality care | Mortality SHMI - Rolling 12 months | Safe, high quality care | <= 100 | Fail | Concern - High | Yes | 100 | 102 | 103 | 105 | 107 | | | | |
| | Never Events | Safe, high quality care | 0 | Variable | Concern - Low | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | MRSA Bacteraemia | Safe, high quality care | 0 | Variable | Concern - Low | Yes | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| | MSSA Bacteraemia | Safe, high quality care | | No Target | Common Cause | | 0 | 0 | 2 | 0 | 2 | 1 | 2 | 0 | 0 |
| | Number of external reportable >AD+1 clostridium difficile cases | Safe, high quality care | 44 | Fail | Common Cause | | 6 | 2 | 5 | 6 | 0 | 3 | 3 | 1 | 5 |
| | Number of falls with moderate harm and above | Safe, high quality care | | No Target | Common Cause | | 1 | 2 | 3 | 1 | 2 | 1 | | 1 | |
| | VTE Risk Assessments | Safe, high quality care | >= 95.0% | Fail | Concern - Low | Yes | 92.0% | 92.0% | 91.0% | 89.0% | 92.0% | 92.0% | 91.0% | 89.1% | 88.8% |
| | 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 | 65.8% | 64.4% | 67.6% | 63.0% | 51.5% | 65.5% | 65.4% | 67.6% | 59.4% |
| | Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving | Safe, high quality care | >= 90.0% | Variable | Common Cause | Yes | 66.7% | 100.0% | 80.0% | 71.4% | 54.5% | 66.7% | 66.7% | 64.7% | 36.4% |
| | Stroke Indicator 80% patients = 90% stroke ward | Safe, high quality care | >= 80.0% | Variable | Common Cause | | 76.5% | 75.0% | 86.0% | 80.9% | 73.9% | 80.4% | 75.9% | 81.5% | 78.8% |
| | Number of complaints | Safe, high quality care | | No Target | Concern - High | Yes | 31 | 44 | 25 | 26 | 33 | 26 | 33 | 38 | 48 |
| | Number of complaints referred to Ombudsman | Safe, high quality care | <= 0 | Variable | Improvement - Low | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Complaints resolved within policy timeframe | Safe, high quality care | >= 90.0% | Fail | Common Cause | | 50.0% | 51.7% | 67.9% | 48.1% | 60.0% | 45.5% | 25.7% | 58.3% | 55.2% |
| | Friends and Family Test Score: A&E% Recommended/Experience by Patients | Safe, high quality care | >= 95.0% | Variable | Common Cause | | 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 | | 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 | | 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 | 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 | | 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 | | 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 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Looking after our people | Agency (agency spend as a % of total pay bill) | Looking after our people | >= 6.4% | Variable | Concern - Low | | 4.5% | 4.1% | 4.6% | 4.8% | 5.3% | 4.0% | 2.6% | 4.5% | 3.7% |
| | Appraisals | Looking after our people | >= 85.0% | Fail | Concern - Low | Yes | 79.8% | 80.1% | 79.5% | 79.8% | 79.7% | 77.6% | 77.7% | 73.5% | 71.7% |
| | Mandatory Training | Looking after our people | >= 85.0% | Pass | Concern - Low | | 88.0% | 88.3% | 88.6% | 88.8% | 89.3% | 89.3% | 89.4% | 89.8% | 89.5% |
| | Overall Sickness | Looking after our people | <= 4.0% | Variable | Common Cause | | 5.0% | 5.3% | 5.0% | 6.2% | 6.0% | 5.2% | 5.0% | 5.2% | 4.5% |
| | Staff Turnover Rate (Rolling 12 months) | Looking after our people | <= 10.0% | Variable | Improvement - Low | | 9.7% | 9.4% | 9.1% | 9.1% | 9.4% | 9.2% | 8.9% | 8.8% | 8.2% |
| | Vacancy Rate | Looking after our people | <= 5.0% | Fail | Concern - High | Yes | 3.9% | 5.2% | 4.7% | 4.5% | 4.1% | 6.9% | 4.2% | 8.4% | |

## Finance and Use of Resources

| Sub Domain | KPI | Subject | Target | Target Expectation | Variation | Exception | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | I&E - Surplus/(Deficit) (£k) | Finance | | No Target | Common Cause | | £12576k | (£602k) | (£202k) | (£1260k) | (£3002k) | (£133k) | £5805k | (£798k) | (£875k) |
| | I&E - Margin (%) | Finance | | No Target | Common Cause | | £0k | (£0k) | (£0k) | (£0k) | (£0k) | (£0k) | £0k | £0k | (£0k) |
| | I&E - Variance from plan (£k) | Finance | | No Target | Common Cause | Yes | (£645k) | (£178k) | £106k | (£953k) | (£2908k) | (£39k) | £5901k | (£16k) | (£5k) |
| | I&E - Variance from Plan (%) | Finance | | No Target | Common Cause | | (£0k) | (£0k) | £0k | (£0k) | (£0k) | (£0k) | £0k | (£0k) | (£0k) |
| | CPIP - Variance from plan (£k) | Finance | | No Target | Common Cause | | £539k | (£498k) | (£598k) | (£489k) | (£798k) | (£487k) | (£931k) | £19k | £381k |
| | Agency - expenditure (£k) | Finance | | No Target | Common Cause | Yes | £573k | £755k | £634k | £582k | £2848k | £804k | £1069k | £947k | £754k |
| | Agency - expenditure as % of total pay | Finance | | No Target | Improvement - Low | Yes | £0k | £0k | £0k | £0k | £0k | £0k | £0k | £0k | £0k |
| | Capital - Variance to plan (£k) | Finance | | No Target | Common Cause | Yes | (£242k) | (£697k) | (£345k) | (£431k) | £175k | (£873k) | £2271k | £0k | £881k |
| | Cash - Balance at end of month (£m) | Finance | | No Target | Concern - High | Yes | £14k | £37k | £29k | £25k | £21k | £31k | £26k | £35k | £35k |
| | BPPC - Invoices paid <30 days (% value £k) | Finance | | No Target | Concern - High | | £1k | £1k | £1k | £1k | £1k | £1k | £1k | £1k | £1k |
| | BPPC - Invoices paid <30 days (% volume) | Finance | | No Target | Concern - High | | £1k | £1k | £1k | £1k | £1k | £1k | £1k | £1k | £1k |

## WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **Title of Report:** | Job Evaluation at WVT |
| **Lead Executive Director:** | **Chief People Officer** |
| **Author:** | Geoffrey Etule, Chief People Officer |
| **Reporting Route:** | |
| **Appendices included with this report:** | |
| **Purpose of report:** | ☒ **Assurance** ☐ **Approval** ☒ **Information** |

**Brief Description of Report Purpose**

The Secretary of State for Health and Social Care published a written ministerial statement (WMS) on Wednesday 23 April 2025, which confirms the Government's acceptance of a range of recommendations arising from the 2023 NHS pay deal and particularly emphasises the critical role of NHS organisations in correctly and robustly applying the NHS job evaluation scheme.

This paper sets out the job evaluation process at WVT which is in line with the Agenda for Change job evaluation handbook.

**Recommended Actions required by Board or Committee**

The Board can be reassured that the Chief People Officer supported by the Deputy Chief People Officer do ensure that the WVT local job evaluation process is being implemented correctly in partnership with trade union representatives.

**Executive Director Opinion**[1]

All job matching and consistency checking at WVT are done in accordance with the Agenda for Change handbook and in partnership with trade unions representatives. This ensures fairness and consistency in the local job evaluation process.

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

# Job Evaluation

## Overview

The Secretary of State for Health and Social Care published a written ministerial statement (WMS) on Wednesday 23 April 2025, which confirms the Government's acceptance of a range of recommendations arising from the 2023 NHS pay deal and particularly emphasises the critical role of NHS organisations in correctly and robustly applying the NHS job evaluation scheme. This is essential to ensure that the Agenda for Change (AfC) contract is locally compliant with the Equality Act 2010 and that staff receive equal pay for work of equal value.

Ensuring the correct local implementation of national employment contracts is important as ineffective application of local job evaluation processes may lead to significant consequences that ultimately have negative effects on patient outcomes, including reduced staff morale, industrial relations tensions, and the associated HR, legal and financial costs impacting local budgets arising from any corrective measures.

WVT works in partnership with staff side representatives to ensure that job evaluations and consistency checking are completed in accordance with the Agenda for Change job evaluation handbook. This protects the Trust from potential employment tribunal claims and poor industrial relations.

## New Nursing & Midwifery profiles

Following the publication of updated job matching profiles (bands 4 – 9) for nursing and midwifery roles in June 2025, a Midlands wide project group to review the profiles over the next 3 to 6 months has been set up and representatives from WVT(Deputy Chief Nursing Officer, Deputy Chief People Officer) are involved in the project.

Through the Midlands project group, all organisations are working collaboratively to ensure a consistent approach in applying the new profiles for nursing and midwifery roles. Early indications are that the profiles are similar to the current ones in place and it is unlikely that there will be any significant claims for regrading staff.

## Job evaluation process at WVT

WVT is committed to achieving an equitable and robust pay structure through the application of a fair, consistent and transparent job matching system. The principles of the NHS Job Evaluation Scheme are used to determine the correct pay band for all AfC posts across the organisation

Unlike other Trusts facing significant difficulties with band 2 Healthcare Support Workers (HCSW), we developed a WVT career development framework with revised job descriptions for band 2 and band 3 staff in 2023. This ensured that our band 2 HCSW can develop their careers at WVT and progress to band 3 positions upon the attainment of defined competencies.

At WVT, all Agenda for Change job roles are evaluated against national profiles by HR, managers and trade union representatives to determine the most appropriate pay banding. This ensures consistency across the Trust by aligning job descriptions with national benchmarks. It also helps ensure fair and transparent evaluation of job roles, providing clarity and consistency in pay and responsibilities but also helps protect the Trust from potential equal pay issues or claims by adhering to a robust and equitable framework. All members of WVT job matching panels are trained in the NHS job evaluation scheme and are committed to avoiding bias and ensuring fairness.

## Next steps

To support the Midland wide job review work, a WVT working group with HR, finance, nursing leaders, and trade union reps has now been established to review and develop a set of standardised job descriptions. The group will also review and assess current local job evaluation practices using the new NHS Staff Council checklist. Any areas of concern will be highlighted to executive directors for immediate actions to be taken.

# WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **Title of Report:** | Refresh of the Trust Green Plan |
| **Lead Executive Director:** | **Chief Strategy and Planning Officer** |
| **Author:** | Alan Dawson, Nick Exon, Christian Homersley, Lee Stockton |
| **Reporting Route:** | Sustainability Group |
| **Appendices included with this report:** | Green Plan |
| **Purpose of report:** | ☐ **Assurance** ☒ **Approval** ☐ **Information** |

**Brief Description of Report Purpose**

The Green plan (Previously called the Sustainable Development Management Plan (SDMP)) outlines projects and activities which will lead the Trust over the next three years towards its target of net zero, covering areas such as clinical pathways, through to technical schemes aimed at reducing carbon emissions produced from the Trust's activity

This Plan will be approved by the Trust Board with a progress report submitted every six months.

Sustainable development is championed by the Trust's Board of Directors and specifically led by the Chief Strategy and Planning Officer, who chairs the Trust Sustainability Group, which meets quarterly.

We seek to include and engage senior management, our PFI partners, sustainability champions and staff side, to promote our Green agenda by setting objectives, reviewing progress and providing assurance on a regular basis.

There has also been Foundation Group and Integrated Care System engagement in the development of this plan.

**Recommended Actions required by Board or Committee**

Members are asked to approve this plan.

**Executive Director Opinion[1]**

This is a refresh of the existing plan (previously the SDMP) developed through the Trust Sustainability Group.

The document is the final draft for approval and contains SMART objectives which will enable us to manage and monitor the plan, reporting back to Board annually.

[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.

# Green Plan 2025-2028

# DRAFT

# Contents



# Introduction

This Green Plan outlines projects, schemes and activities which will lead the Trust over the next three years towards its target of net zero, covering areas such as workforce and leadership, through to technical schemes aimed at reducing carbon emissions generated by the Trust's activity

This Plan will be approved by the Trust Board with a progress report submitted every 12 months.

Sustainable development is championed by the Trust's Board of Directors and specifically led by the Chief Strategy and Planning Officer, who chairs the steering group which meets quarterly.

We seek to include and engage with senior management, our PFI partners, sustainability champions and staff side, to promote our Green agenda by setting objectives, reviewing progress and providing assurance on a regular basis.

There has also been Foundation Group and System engagement in the development of this plan.

# About Wye Valley NHS Trust

Wye Valley NHS Trust is the provider of acute healthcare services at Hereford County Hospital, based in the city of Hereford, along with community services for Herefordshire. We also provide healthcare services at community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard.

The Trust exists to improve the wellbeing, independence and health of the people we serve.

Our workforce of around 3,800 provides a range of specialist and generalist functions. We have strong clinical network connections with trusts in Birmingham, Worcester, Gloucester and Cardiff.

With an annual turnover of around £350 million, the Trust serves the population of Herefordshire, and also provides urgent and elective care to a population of more than 40,000 people in mid-Powys, Wales. Our catchment area is characterised by its rural nature and remoteness, with more than 80 per cent of our service users living five miles or more from Hereford city or a market town.

Herefordshire is one of the most rural and sparsely populated counties in England, with a population of 195,000, the third smallest of any ceremonial county in England with an area of 2180km$^2$ giving a population density of 88 people per km$^2$ the third lowest density in the country.

Powys has a total population of 132,000 and the biggest area of 5180km$^2$ giving it the lowest population density in Wales with 26 people per km$^2$

The Trust has one of the smallest rural hospitals in England. We work hard to deliver across traditional boundaries to provide integrated care in order to deliver a standard of care we would want for ourselves, our families and friends.

Although the Trust is relatively small compared with other NHS organizations, it is still a large consumer of natural resources, annually spending in excess of £2.8 million on electricity, £2m on gas, with an additional £323K spent on water and sewage and £455K on waste in 2023/24. The Trust also uses substantial quantities of fuel, food, paper, clinical products and pharmaceuticals. As a result, the Trust has a sizeable carbon footprint, contributing to the effects of climate change and its associated impacts.

The Trust is part of a 'Foundation Group' with South Warwickshire NHS Foundation Trust (SWFT), George Eliot Hospitals NHS Trust (GEH) and Worcester Acute Hospitals Trust (WAHT).

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.

# Organisational Vision

As a healthcare provider, Wye Valley NHS Trust is committed to protecting the natural environment for the benefit of human health.

The importance of sustainable development is reflected within national legislative drivers and strategies such as Delivering a Net Zero National Health Service for the NHS and the 2021/22 NHS Standard Contract which set out requirements for Trusts to develop a Green Plan; progress against these objectives is measured by HM Treasury Sustainability Reporting Framework and the NHS Estates Return Information Collection.

The Intergovernmental Panel on Climate Change (IPCC) and the World Health Organisation (WHO) set out clear guidelines to ensure sustainable development is adopted into law, policy and practice. These guidelines state the need to mitigate and adapt to the impacts of climate change in order to realise the wider co-benefits for health.

The Carter Report (2016) reinforced the need for local action, highlighting the inefficient use of energy and natural resources as a major concern which require attention. These areas of work were identified within the previous NHS Sustainability Strategy (2014-2020) and are updated in this new plan.

# Why do we need this plan?

As a leading anchor institution, we play an important role beyond the boundaries of our estate and need to lead the way in delivering the national and international targets. As a result, this plan represents our focus on the next steps needed to drive change.

All NHS organisations are required to have a Board-approved Green Plan. Furthermore we are legally obliged to address climate change; the government has set a net zero carbon target by 2040. Since the last plan we have made improvements in many areas but they have not yet had the scale of impact that will be required in the future.

Continuing with business as usual is no longer an option and with the constraints on the Trust we need to change throughout the organisation. Some of the specific constraints for the Trust are:

- a recurrent underlying deficit
- a very limited amount of internally generated capital resource and reliance on external agencies to support any future investment
- relatively small scale and serving a rural area
- limited resources to deliver the Green Plan

# Priority areas

The Trust Green Plan is broken down into the following priority areas:

- Workforce and Leadership
- Net Zero Clinical Transformation
- Digital transformation
- Medicines
- Travel and transport
- Estates and facilities
- Supply chain and procurement
- Adaptation
- Food and nutrition
- Estates, energy and waste

# Workforce and Leadership

The Trust values the importance of protecting our natural environment for the benefit of the physical and mental health and well-being of our community, including our patients and staff, now and in the future.

To achieve effective results from our green initiatives require system-wide engagement and development through a simple and effective communication strategy that adopts various channels to communicate with staff and patients, including internal and external websites, an annual report, engagement events and opportunities throughout the year such as;-

- Staff surveys,
- Trust Talk
- Green champions
- Campaign to save energy
- Key infrastructure partners' corporate sustainability commitments.

## We have

Designated a board-level net zero lead, ensuring responsibility and accountability for sustainability is clear

Further embedded our Sustainability Group and engagement across the organization

Ensured sustainable development and social value are a material consideration in all business cases through the requirement of Sustainability Impact Assessment

Embedded appropriate staff behaviours through our Leadership Charter

We have included a specific corporate objective about sustainability within out Trust Objectives

## We Will

Develop a dashboard and report key performance indicators to the Trust Board annually

Communicate our Green Plan and annual updates to staff, patients and the local community.

Work with volunteers and other members of our local community in the delivery of our Green plan

## Trust Vision

*"To improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas".*

## Trust Specific Issues

*To consider sustainability impact of all key decisions including all policies and developments.*

## TOP 3 THINGS WE NEED TO DO.

1. Develop a dashboard to demonstrate progress
2. Put in place appropriate clinical leadership for the Green Plan
3. Ensure sustainability is embedded with key strategic decision making processes

# Net Zero Clinical Transformation

The ICS partners have developed a Joint Forward Plan to address some of the local health and care inequalities we have, to improve health outcomes for people across the area, and to ensure we can continue to provide safe and sustainable care into the future. The aim of our ICS is for: 'Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people.'

We want to provide safe, effective and sustainable health and care services across all our communities which will be achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage.

Clinical sustainability is central to this refresh of our Greener Plan and signals a move from an Estates-led, engineering focussed, Plan to one more focussed on the emissions generated by our clinical workload.

## We have

Worked with partners and stakeholders to identify and deliver solutions that reduce the number of hospital stays, such as the provision of treatment closer to home.

Focussed on valuing our patients' time, reducing unnecessary delays during assessment and treatment.

Supported the processes of care through enhancing workflows and targeted clinical effort

Worked on health promotion and prevention

Piloted the redesign of selected care pathways to drive out any unnecessary stages

## We Will

Identify and appoint a clinical lead with oversight of net zero clinical transformation.

Focus on critical and perioperative care pathways initially

Move on to schemes in urgent and emergency care, diagnostics and medical pathways

Create a Trust-wide clinical network to improve staff engagement and support


## Trust Vision

*The Trust is committed to improve staff and patient experience by moving towards more sustainable models of care and workplace practices.*

## Trust Specific Issues

*Herefordshire is one of the most rural and sparsely populated counties in England.*

*Powys is the most sparsely populated county in Wales.*

## TOP 3 THINGS WE NEED TO DO.

1. Develop a clinical network to support pathway change
2. Initiate projects focused on clinical pathways and opportunities to improve their sustainability
3. Continue the focus on valuing our patients' time as a way of increasing productivity and reducing waste.

# Digital transformation

The Trust seeks to use existing digital technology and systems to streamline our service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions.

Embedding more efficient practises and new technologies into the organisation is one-step and improving staff awareness will improve the efficient use of our utilities across our estate.

Focus on bringing in innovation to cope with the changing demands of healthcare, and these are the factors to bear in mind to enable digital success:

- Sustained focus on what matters in healthcare
- Engaging clinicians, stakeholders and patients more and aligning their actions with the needs of the organizations and patients
- Building the healthcare ecosystem to support a variety of things
- Building digital health capacity, which includes a team of IT experts and clinical informaticists.

## We have

Delivered our Digital Strategy, reducing our reliance on paper-based records and reducing the transport associated with it.

Commissioned a standardised and structured electronic patient record system that is always accessible by all caregivers

Delivered community scheduling systems and electronic patient records which means that community staff no longer have to travel to their base so often and can reduce duplicated effort by sharing records with primary care.

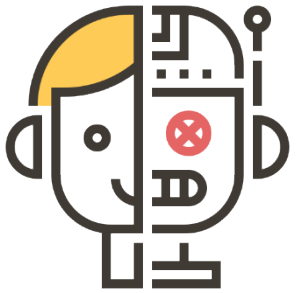
Delivered a Shared Care Record that multiple agencies can access, reducing duplicated effort.

## We Will

Fully deliver the benefits of our digital ambitions by minimizing the use of paper notes and their transport

Consider how AI can automate functions and improve efficiency and productivity

Explore how the Trust can minimize the carbon footprint of its Digital Strategy implementation, including AI roll-out



## Trust Vision

*To exploit digital capabilities to support more carbon efficient ways of working, ensuring that digital methods of communication are used where possible*

## Trust Specific Issues

*Network coverage is poor in parts of Herefordshire and this limits the opportunities for IT related solutions.*

## TOP 3 THINGS WE NEED TO DO.

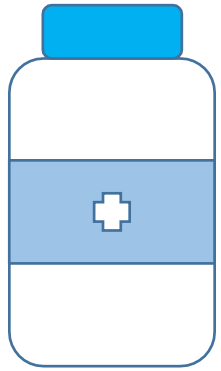
1. Continue to deliver our Digital Strategy, reducing waste and transport
2. Continue to be at the fore-front of AI adoption
3. Explore ways of reducing the carbon footprint of our digital innovation

# Medicines

Medicines account for 25% of emissions in the NHS, with anaesthetic gases contributing 2% and metered dose inhalers responsible for 3% of all emissions.

The Trust needs to examine the key opportunities to reduce the carbon emissions related to the organisation's prescribing and use of medicines and medical products.

Areas of focus include medicines optimisation and reducing waste; responsible capture or disposal of waste medicines and considering lower carbon alternative medicines..



## Trust Vision

*The Trust is committed to net zero; reducing carbon emissions related to the organisation's prescribing and use of medicines and medical products, is a key task*

## Trust Specific Issues

*Maintaining clinical efficacy and positive patient outcomes are essential whilst making any changes to the way we prescribe and use medicines*

## We have

Ceased the use of desflurane the anaesthetic agent with the highest carbon footprint, and have significantly reduced the use of anaesthetic gas though engagement with anaesthetists, advances in equipment and improvement in techniques.

Reduced unnecessary dispensing through utilising patient's own drugs whilst in hospital and as part of discharge.

Used a new stock control system to limit the waste caused by medicines expiring

Started recycling unopened blister packs

## We Will

Reduce the use of metered dose inhalers

Investigate measures to further reduce the use of nitrous oxide

Further promote the use of the patient's own drugs whilst in hospital

Reduce the amount of pharmacy packaging

Reduce the amount of waste generated by Pharmacy

## TOP 3 THINGS WE NEED TO DO.

1. Reduce the use of nitrous oxide
2. Reduce waste associated with medicines
3. Engrain best practice into our medicine choices

# Travel and transport

Active travel can play a significant part in reducing traffic on the roads whilst also promoting health and wellbeing through exercise, and improving local air quality.

We are working with the Council to identify staff commuting hot spots and opportunities for cycling, walking and car-sharing.

## We have

Reviewed and updated our Travel Plan in 2024.

Promote active travel as a means of travel to and between our sites for work, including putting Beryl Bike stands on Trust sites.

Put measures in place to encourage walking and cycling.

Distributed a local map to promote cycling and walking from the surrounding areas.

Reduced our Grey Fleet mileage by incentivising alternative, more sustainable, travel methods.

## We Will

Offer **only** zero-emission vehicles through vehicle lease salary sacrifice schemes

Make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only

Work with Herefordshire Council to improve transport links for staff and public

Increase the number of staff that commute via active travel or public transport

Install EV charging points at the County Hospital for fleet vehicles and possibly staff/public

## Trust Vision

*The Trust is committed to reducing the impact of our travel and transport by encouraging sustainable and active travel, reducing the carbon and air quality impact of our organization.*

## Trust Specific Issues

*We are situated in a rural location and are geographically isolated from big urban centres. Whilst the train station in Hereford is close to the County Hospital other transport links and cycling routes are poor.*

## TOP 3 THINGS WE NEED TO DO.

1. Enable our staff to use active travel and public transport
2. Purchase and lease only electric vehicles
3. Reduce the amount of staff and patient movement

# Supply chain and procurement

The NHS spends in excess of £40 billion each year on critical natural resources to deliver services.

Using our influence through the procurement process we can embed social value (environmental improvements, local social capital and economic value) in our contracts to encourage our suppliers to adopt sustainable practices for the products and services they provide.

It will soon be a requirement of all business cases, regardless of cost, to carry out a Sustainability Impact Assessment (SIA); the Trust needs to work through the Procurement Department and our Clinical Effectiveness Group to address the use of single-use items and encourage more suppliers to reduce or provide recyclable packaging.

## We have

Embedded sustainability and social value within our procurement practices.

Ensure facilities management contracts include sustainability within the specification and as part of the tender process to reduce consumption and promote efficiency of use.

Worked with Sodexo to reduce the use of single use plastics

Used a new stock control system to limit the waste caused by products expiring.

Used only 100% recycled paper since 2019

## We Will

Adopt a whole life cycle approach to purchasing, embedding sustainability into all of our procurement processes.

Work with suppliers to reduce the use of clinical single use plastics, and to support the procurement of sustainable PPE.

Implement materials management Trust-wide to reduce the amount of inventory and waste

## Trust Vision

*The Trust will work with key suppliers and contractors to reduce the environmental impact of the goods and services it uses.*

## Trust Specific Issues

*For infection prevention and control reasons, many consumables are both single use plastic and high waste generators.*

## TOP 3 THINGS WE NEED TO DO.

1. Work with PFI partners to deliver social value initiatives
2. Reduce single use products with re-usable alternatives where this is viable.
3. Implement materials management

# Adaptation

Climate change is potentially one of the biggest public health threats.

Extremes of weather conditions, such as flooding and heatwaves, are increasing in severity and frequency.

We must act now to adapt to a changing climate and mitigate the negative effects of past and future climate-altering actions.

We are embedding climate change awareness and action across our resilience plans with consideration of how our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts.

## We have

Approved a Climate Change Adaptation Plan and embedded the effects of climate change into our organisation's risk register

Developed local protocols aligned to national heat wave plans and cold weather plans in relation national plans

Issued instruction so that our staff know how to deal with different extreme weather scenarios such as how to keep clinical and ward areas cool in the event of hot weather and how to report high indoor temperatures.

Written a severe weather plan outlining actions required in the event of forecasted/actual severe weather.

Ensured adequate cascading of weather health alerts and relevant messaging across the organisation.

Formed an alliance with the public sector in Herefordshire to work on adaptation.

## We Will

Ensure that the organisation is prepared to deal with the effects of climate change, particularly extreme weather events.

Deliver our Climate Change Adaptation Plan, focusing on dealing with the flooding and water ingress risk and cooling our buildings in the summer.

Review the NHSE climate change adaptation toolkit and update the Trust plan

## Trust Vision

*The Trust is committed to adapting to the impacts of climate change and is forming business continuity and contingency plans to ensure our healthcare system is ready for changing times and climates.*

## Trust Specific Issues

*Due to our rural location the Trust is in a relatively good position regarding air pollution and urban heat. Conversely the fragility of travel links due to flooding need to be considered and mitigated.*

## TOP 3 THINGS WE NEED TO DO.

1. Deliver training on emergency preparedness
2. Use the NHSE toolkit to update our plans
3. Develop capital schemes to improve building resilience

# Food and nutrition

The Trust supplied over 390K main meals last year and produced 19 Tonnes of food waste in 2023/24; we need to consider ways to reduce the carbon emissions from the food made, processed or served within the organisation.

Where possible, this may include reducing overall food waste and ensuring the provision of healthier, locally sourced and seasonal menus high in fruits and vegetables, and low in heavily processed foods.

## Trust Vision

*Good food and nutrition are an essential part of healthy living and are critical to all patient stays.*

## Trust Specific Issues

*The rural location of the Trust makes the provision of local food appear easy however the supply of most of our food is via the PFI and the food supplied via a national contract.*

## We have

Required food suppliers to be compliant with Dolphin Friendly, Red Tractor and other ethical food production practices.

Started weighing food waste to enable monitoring of food wastage.

Ensured that all food waste at our community hospitals is sent for anaerobic digestion and then used as a soil conditioner.

## We Will

Ensure inventory management is in place to measure the reduction in food waste across our sites

Improve the patients' experience of food at the County Hospital to reduce food waste

Ensure all food waste is segregated and consider composting alternatives

Consider opportunities to lower the carbon footprint of hospital food by providing seasonal menus high in fruits and vegetables and low in heavily processed foods

## TOP 3 THINGS WE NEED TO DO.

1. Look to source more local food and introduce more seasonal menus
2. Reduce food waste
3. Explore ways of disposing of food waste that don't harm our environment

# Estates, energy and waste

Reducing our energy usage and our use of fossil fuels are two of the most important areas in our Green Plan, in order to help reduce our carbon emissions and impact on the environment.

The Trust's strategy is to deliver energy efficient buildings as part of a modern healthcare facility, that supports improvements to patient care.

## Trust Vision

*The Trust is committed to reducing the sustainability impacts from our buildings, critical infrastructure and equipment essential for the smooth running of the hospital.*

## We have

Installed LED lighting in all of our community hospitals and 3,170 low energy lights in the main hospital building.

Increased on-site energy generation from renewable sources including more than 300 solar panels on our main hospital building.

Specified that all new build and major refurbishments will achieve the BREEAM excellent standard and ensured that contractors are assessed against sustainability as part of the tender process for capital projects

Developed and implemented the first phase of an Integrated Energy Solution, saving 500 tonnes of carbon pa.

Reduced consumption of energy, water, anaesthetic gases, vehicle mileage and waste.

Created new gardens for staff, patients and visitors and worked with volunteers to improve our green spaces

Introduced recycling at community sites and a pilot project at the County Hospital

## Trust Specific Issues

*The Trust has a recurrent underlying deficit and a very limited amount of internally generated capital resource and is reliant on external agencies to support any future investment.*

## We Will

Increase our recycling rates at all sites, ensuring less waste goes for heat reclamation

Finalise Phase Two of our Integrated Energy Solution, which will decarbonize the County Hospital estate to 95%

Bid for funds to complete the decarbonisation of the County Hospital sites and the community sites where possible

Consider the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption

## TOP 3 THINGS WE NEED TO DO.

1. Bid for further Salix funds to decarbonise community sites
2. Explore intelligent buildings management systems with our PFI partners
3. Increase the amount of waste that is recycled

# SMART Objectives – Page 1

| Focus Area | "We will" statement | SMART Objective |
|---|---|---|
| **Workforce and Leadership** | Develop a dashboard and report key performance indicators to the Trust Board annually | Develop a dashboard from December 2025 and report key performance indicators to the Trust Board annually |
| **Workforce and Leadership** | Communicate our Green Plan and annual updates to staff, patients, visitors and the local community | Communicate our Green Plan and annual updates to staff (via TrustTalk), patients, visitors and the local community (via the Trust website) from December 2025 |
| **Workforce and Leadership** | Work with volunteers and other members of our local community in the delivery of our Green plan | Work with members of the Volunteer Steering Group to develop volunteering services for green space maintenance, transport and contact centre by March 2026 |
| **Net Zero Clinical Transformation** | Identify and appoint a clinical lead with oversight of net zero clinical transformation. | Identify and appoint a clinical lead with oversight of net zero clinical transformation by October 2025 |
| **Net Zero Clinical Transformation** | Focus on critical and perioperative care pathways initially | Develop options for critical and perioperative care pathways initially by summer 2026 |
| **Net Zero Clinical Transformation** | Move on to schemes in urgent and emergency care, diagnostics and medical pathways | Agree a prioritised list of schemes in urgent and emergency care, diagnostics and medical pathways by July 2026 |
| **Net Zero Clinical Transformation** | Create a Trust-wide clinical network to improve staff engagement and support | Create a Trust-wide clinical network to improve staff engagement and support by July 2027 |

# SMART Objectives – Page 2

| Focus Area | "We will" statement | SMART Objective |
|---|---|---|
| **Digital transformation** | Fully deliver the benefits of our digital ambitions by minimizing the use of paper notes and their transport | Reduce the use of paper notes and their transport by 80% by July 2028 |
| **Digital transformation** | Consider how AI can automate functions and improve efficiency and productivity | Pilot and evaluate our AI Strategy by December 2026 |
| **Digital transformation** | Explore how the Trust can minimize the carbon footprint of its Digital Strategy implementation, including AI roll-out | Undertake a sustainability impact assessment of the Digital Strategy by July 2027 |
| **Medicines** | Reduce the use of metered dose inhalers (MDI) | Scheme launched to ensure that patients are not started on MDI or are switched to alternatives by July 2026 |
| **Medicines** | Investigate measures to further reduce the use of nitrous oxide | Remove Nitrous Oxide outlets in theatres by March 2026 |
| | | Remove the Nitrous Oxide manifold by March 2027 |
| | | Review the use of Entonox as part of ICB-wide scheme by July 2028 |
| **Medicines** | Further promote the use of the patient's own drugs whilst in hospital | Work with WMAS and Pre-Op assessment to encourage patients to bring their own medication into hospital by July 2026 |
| | | Implement a patient self-administration approach within the County Hospital by December 2026 |
| **Medicines** | Reduce the amount of waste generated by Pharmacy | Monitor waste and implement dry recycling of Pharmacy packaging by July 2028 |
| | | Ensure that the most efficient and effective medicine choices are made, such as focusing on the oral route where possible |
| | | Reducing polypharmacy and waste of medicines by proactive medicines reconciliation and specialty support |
| | | Move to a paperless system in Pharmacy by July 2026 |

# SMART Objectives – Page 3

| Focus Area | "We will" statement | SMART Objective |
|---|---|---|
| **Travel and transport** | Offer only zero-emission vehicles through vehicle lease salary sacrifice schemes | Offer only zero-emission vehicles through vehicle lease salary sacrifice from December 2026 |
| **Travel and transport** | Make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only | Purchase, or lease zero-emission vehicles only from December 2027 onwards |
| **Travel and transport** | Work with Herefordshire Council to improve transport links for staff and public | Work with Herefordshire Council on their transport plans for the city, including car parking, in order that staff and patients can choose how they access services, by December 2026 |
| **Travel and transport** | Increase the number of staff that commute via active travel or public transport | Re-survey staff modes of transport in 2026 and 2028.<br>Reduce the number of staff that commute via car to 82% from 85% by 2028 |
| **Travel and transport** | Install EV charging points at the County Hospital for fleet vehicles and possibly staff/public | Undertake a needs assessment to establish potential demand for EV charging points at the County Hospital by March 2026 |
| **Supply chain and procurement** | Adopt a whole life cycle approach to purchasing, embedding sustainability into all of our procurement processes. | Encourage suppliers to exceed minimum requirements by engaging with the Evergreen Sustainable Supplier Assessment for streamlined sustainability discussions by July 2028 |
| | | Review our sustainable procurement approach to find relevant links that enable our Green Plan and work closely with NHS Supply Chain and NHS Improvement to promote their sustainability programmes by July 2028 |
| **Supply chain and procurement** | Work with suppliers to reduce the use of clinical single use plastics, and to support the procurement of sustainable PPE. | Investigate Clinical Product Reuse Schemes by July 2028 |
| **Supply chain and procurement** | Implement materials management Trust-wide to reduce the amount of inventory and waste | Implement a material management system at the County Hospital by December 2026 |

# SMART Objectives – Page 4

| Focus Area | "We will" statement | SMART Objective |
|---|---|---|
| Adaptation | Ensure that the organisation is prepared to deal with the effects of climate change, particularly extreme weather events. | Increase staff education, training and awareness on extreme weather events by March 2027 |
| Adaptation | Deliver our Climate Change Adaptation Plan, focusing on dealing with the flooding and water ingress risk and cooling our buildings in the summer. | Report on delivery of our Climate Change Adaptation Plan in the annual Board report by December 2025 |
| Adaptation | Review the NHSE climate change adaptation toolkit and update the Trust plan | Review the NHSE climate change adaptation toolkit and update the Trust plan by Dec 2025 |
| Food and nutrition | Ensure inventory management is in place to measure the reduction in food waste across our sites | Ensure inventory management is in place to measure the reduction in food waste across our sites by March 2026 |
| Food and nutrition | Improve the patients' experience of food at the County Hospital to reduce food waste | Improve the patient experience of food at the County Hospital to reduce food waste by achieving better than bottom quartile results in the Place & Inpatient surveys by March 2026 |
| Food and nutrition | Ensure all food waste is segregated and consider composting alternatives | Ensure all food waste is segregated by March 2026 |
| | | Explore alternative food waste composting by March 2027 |
| Food and nutrition | Consider opportunities to lower the carbon footprint of hospital food by providing seasonal menus high in fruits and vegetables and low in heavily processed foods | Work with PFI partners to lower the carbon footprint of hospital food by June 2028 |
| | | Assess whether the Trust can specify lower carbon menus in the post PFI specification by July 2027 |

# SMART Objectives – Page 5

| Focus Area | "We will" statement | SMART Objective |
|---|---|---|
| **Estates, energy and waste** | Increase our recycling rates at all sites, ensuring less waste goes for heat reclamation | Increase our recycling rates to 20% by July 2028 at all sites, ensuring less waste goes for heat reclamation |
| **Estates, energy and waste** | Finalise Phase Two of our Integrated Energy Solution, which will decarbonize the County Hospital estate to 95% | Complete Phase Two of our Integrated Energy Solution, which will decarbonize the County Hospital estate by March 2026 |
| **Estates, energy and waste** | Bid for funds to complete the decarbonisation of the County Hospital sites and the community sites where possible | Bid for funds to complete the decarbonisation of the County Hospital sites and the community sites where possible by July 2028 |
| **Estates, energy and waste** | Consider the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption | Assess whether the Trust can specify the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption in the post PFI specification by 2028 |

# Risk

Risks and opportunities related to sustainable development are managed by the Sustainability Strategy Group.

Significant sustainability risks are recorded on the Trust's Risk Register and managed accordingly including those identified from the Climate Change Adaptation Plan; to ensure they are mitigated as part of the Trust Estate Strategy.

Significant risks and opportunities associated with compliance obligations, objectives and targets and project delivery are reported directly to the Director of Strategy and Planning through the management review process. These risks and opportunities are also communicated to the Sustainability Strategy Group and to Trust Board twice a year.


**Key themes are:**

- Energy, carbon and transport costs are rising. Finance and availability of capital has never been more challenging.
- Non-compliance with legislation
- Not meeting carbon reduction targets
- Emissions - due to the nature of the Trust's services, as the intensity of our activities increases and the estate grows, our absolute carbon emissions may also increase. Because of this we will always measure and report on normalized (e.g. per patient contact, bed day or per m2) emissions, as well as absolute consumption.
- Reputation - it's important we are visible in taking a leading approach and have a robust strategy and reporting structure. We are required to provide assurance when bidding to deliver services.
- Climate change - the risks to the organization from climate change will be outlined in a Climate Change Adaptation Plan (CCAP). This includes risks to buildings, staff, health and wellbeing. Maintaining and delivering our plan is vital to address these risks.

**Finance**

To deliver the commitments in this strategy we will need finance in place. Increasing energy prices and waste disposal costs may mask some of the efficiency savings we make from delivering the strategy, so we will mitigate this risk by maintaining senior support and transparent reporting.

The Trust strives to adopt innovative ways to embed sustainable development within our services to deliver environmental, social and financial benefit. The current financial impact of each key area (energy, waste and water) will be properly calculated as part of the plan. We will also strive to estimate as much indirect cost and carbon such as the embodied carbon in procurement processes.

We will explore any local or national grant sources that may become available, for example investment in sustainable or active travel infrastructure.

# Get Involved

We want **YOU** to be part of the plan and team that helps us delivery our Green plan.

We would value your input and support.


Contact Sustainability for advice and support. :- sustainability@wvt.nhs.uk

No matter what role you have within the Trust, there will be something you can help with.

Talk, Shout about it, if you have an idea tell people. Talk to your colleague, line manager and help us embed sustainability practices within your area of work.

It doesn't matter it's a small or large project it all makes a difference.

NHS
Wye Valley
NHS Trust

# WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **Title of Report:** | Perinatal Services Report |
| **Lead Executive Director:** | **Chief Nursing Officer** |
| **Author:** | Amie Symes, Associate Director of Midwifery<br>Candice Lewis, Perinatal Quality & Safety Matron<br>Elaine Evans, Neonatal Unit Sister |
| **Reporting Route:** | Surgical Divisional Governance; Quality Committee |
| **Appendices included with this report:** | Perinatal Dashboard<br>SCBU 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 May 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 for escalation to Board in relation to the maternity service. Board is asked to note the mitigations in place for neonatal nurse staffing.

The region were satisfied with our mitigations and agreed actions for neonatal staffing and confirmed that there were no concerns over the safety of the unit or outcomes for babies in our care. Benchmarking is underway and will be reported through Quality Committee.

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

**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 May 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 131 births in May 2025. Due to annual leave the final midwife to birth ratio has not been finalised this will be updated in the next month's report, there have been no concerns in the previous months and is likely to remain in a stable position.

| | |
|---|---|
| Midwife to birth ratio (<1:24) | TBC |

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 May 2025 are recorded as:

| | May |
|---|---|
| Delay in Induction >2hrs | 3 |
| Delay in Catagory 1 C-Section >30mins | 1 |
| Delay in administering medication | 0 |
| Delay in starting syntocinon/ARM >30mins | 1 |
| Delay in Suturing >60mins | 0 |
| Unable to provide 1:1 care in labour | 0 |
| Delay in Triage >30mins | 0 |
| Community midwives on call covering maternity unit | 1 |
| Any movement of midwifery staff from any area to provide midwifery cover | 21 |
| Delayed recognition of and action on abnormal vital signs | 0 |
| DSC lost - supernumerary status | 0 |
| Full clinical examination not carried out when presenting in labour | 0 |
| Delay of more than 30 minutes in providing pain relief | 0 |

In the month of May, there were three instances of delayed induction of labour and one delay in artificial rupture of membranes (ARM) due to the SCBU unit being at full capacity under the OPEL framework. Throughout these situations, patient safety remained the highest priority. Wellbeing checks were consistently conducted for both mother and baby, and comprehensive multidisciplinary team discussions took place. The Manager on Call and the On-Call Consultant were actively involved in all decision-making processes to ensure safe and appropriate care was maintained.

Additionally, there was one delay in a Category 1 caesarean section, with the baby delivered at 32 minutes—2 minutes beyond the recommended timeframe. Upon review, it was identified that there were specific factors for the inidividual that added complexity and contributed to slight delays in surgical access and anaesthesia. Despite this, the team acted promptly and appropriately, with ongoing monitoring and prioritisation of both maternal and neonatal wellbeing throughout the procedure.

**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 May 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 | 1 | 0% | The consultant was informed but it is unclear from the documentation whether they attended and therefore this has been escalated to the clinical lead to review. |
| 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 | 0 | N/A | |

2.2 **Activity**

There were 20 admissions to SCBU during May 2025.

| <26 weeks | 26-30 weeks gestation | 31-36 weeks gestation | >36 weeks |
|---|---|---|---|
| **0** | 0 | 10 | 10 |

BAPM 2011 Level of care.

| ITU | HDU | SCBU |
|---|---|---|
| **0*** | 5 | 15 |

There are no exceptions cases to report as these babies met the unit criteria.

## 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 |
| **May** | 1 | 0 | 2 | 0 | 0 | 0 | 0 |

During May, two moderate clinical incidents and one PMRT case were reported, each subject to thorough review and ongoing investigation to ensure continuous service improvement and patient safety.

There were no moderate incidents in May 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 |
|---|---|---|
| **May 2025** | 0 | 2 |

One of the complaints related to communication, engagement and informed decision making and is an area of focus for the service.

There were no complaints or concerns in SCBU in May.

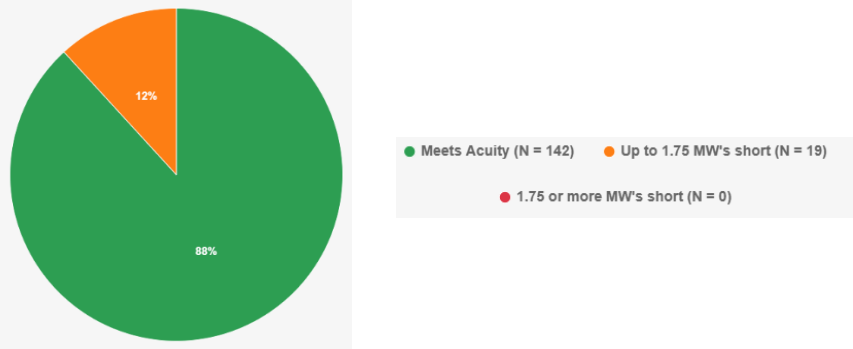
**4. WORKFORCE**

4.1 **Safe Staffing - Midwifery**

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

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

4.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 86.5% of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 88% of the time. For 12% 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 20 instances of staff being redeployed internally to cover acuity which is an increase from last month's data of 12 times. There was 1 occasion where community was redeployed to support Delivery Suite acuity again a decrease from last month's data where 5 were redeployed. There was 1 occasion where specialist midwives supported clinically. There were 6 occasions where acuity was escalated to the manager on call for support.

**Number of Management Actions**
01/05/2025 to 31/05/2025

Download Results

| Actions | Breakdown of Actions | Times occurred | Percentage |
|---|---|---|---|
| MA1 | Redeploy staff internally | 20 | 65% |
| MA2 | Redeploy from community | 1 | 3% |
| MA3 | Redeploy staff from training | 0 | 0% |
| MA4 | Staff unable to take allocated breaks | 1 | 3% |
| MA5 | Staff stayed beyond rostered hours | 0 | 0% |
| MA6 | Specialist MW working clinically | 1 | 3% |
| MA7 | Manager/Matron working clinically | 0 | 0% |
| MA8 | Staff sourced from bank/agency | 0 | 0% |
| MA9 | Utilise on call MW | 0 | 0% |
| MA10 | Escalate to manager on call | 6 | 19% |
| MA11 | Maternity Unit on Divert | 2 | 6% |
| TOTAL | | 31 | |

*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. Midwifery sickness in May is running at 9.7% and MSW in May is 5.43%. Human Resource colleagues have been asked to support with a deep dive into sickness given these high levels.

| | Fill Rate % | | | | | |
|---|---|---|---|---|---|---|
| | MW contracted | MW extra hrs | MW bank only | MSW contacted | MSW extra hrs | MSW bank only |
| AN clinic/DAU | 107.5% | 0% | 0% | 80% | 7.5% | 0% |
| Community | 84.59% | 7.14% | 0% | 98.44% | 0% | 0% |
| Delivery Suite | 87.5% | 4.85% | 1.02% | 75% | 5.65% | 13.71% |
| Maternity Ward | 79.03% | 10.48% | 0.81% | 82.26% | 3.23% | 8.87% |
| Triage | 87.9% | 3.23% | 0% | 41.94% | 14.52% | 25.81% |
| DSC | 95.97% | 2.5% | 0% | --- | --- | --- |

4.2 **Obstetric workforce**

4.2.1 The obstetric rotas have been covered throughout May 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.

| MAY '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 | 220 | 90.91 | 20 | 220 | 9.09 | 0 | 220 | 0.00 |
| Consultant: On Call | 296 | 491 | 60.29 | 195 | 491 | 39.71 | 0 | 491 | 0.00 |
| Consultant: Cold Week | 104 | 104 | 100.00 | 0 | 104 | 0.00 | 0 | 104 | 0.00 |
| Consultant: Antenatal Clinic | 46.75 | 46.75 | 100.00 | 0 | 46.75 | 0.00 | 0 | 46.75 | 0.00 |
| Middle Grade: delivery suite | 144 | 180 | 80.00 | 36 | 180 | 20.00 | 0 | 180 | 0.00 |
| Middle Grade: Antenatal Clinic | 110.5 | 153 | 72.22 | 42.5 | 153 | 27.78 | 0 | 153 | 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 May 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 | 29 | 94% | 24 | 77% |
| Anaesthetist extra days | 2 | 6% | 7 | 23% |

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 | 100% | 84% |
| 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 | 13.5 | 10.43 | 1 | 0 |
| Neonatal Outreach | 1.26 | 1.26 | 0 | 0 |

4.6.2 **Safe Staffing Standards.**

May 2025

4.6.3 **Neonatal Staffing – Qualified in Speciality**

- % of shifts staffed to BAPM Recommendations – 83.87%, (National Average 89.76)
- % of shifts QIS against Neonatal Toolkit Standards – 100% (National Average 96.63)
- % of shifts with supernumerary shift leader – 3.23% - (National Average 3.23%)

1. There was period of high acuity and capacity during May between the 10th and 13th on SCBU where we were at Capacity with 12 babies, these are the four shifts where we were not fully staffed to BAPM recommendations.
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 and appropriately mitigated by the presence of the ward lead and practice educator.
3. We provide assurance that there was always one nurse with QIS on all shifts throughout May increasing to 2 during high acuity, all shifts remained safe. From 1st June we will be required to have 2 qualified in speciality on all shifts, with a mitigation plan reported to the WMPN. When this is not achieved we will report this and our Risk score has increased from 9 to 12.

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 January 25 – September 25**

| | April 25 | May25 | June 25 | July 25 | August 25 | September 25 |
|---|---|---|---|---|---|---|
| **Total QIS %** | 49.3% | 49.3% | 63.17%* | 60% | 60% | 54% |

Although the trajectory for the overall QIS compliance indicates improvement from May 2025 this is because the overall number of registered nurses is currently reduced with vacant gaps in the Band 5 rota. Recruitment to these vacant positions are ongoing – with new staff commencing employment in July and September 2025. This will increase the overall nursing establishment, yet will reduce the % of staff with a neonatal qualification given the denominator will change.

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 from the WMPN

In June the Senior Network Manager for the Perinatal Network, raised concerns regarding the number of QIS nurses per shift and our percentage of QIS nurses in the organisation.

The Trust met with the Perinatal Network team to discuss their concerns and the following actions where agreed:-

- Plans to be developed to enable 2 QIS on nights and weekends and the ward sister and practice educator available in the week, who are bothy QIS trained. This plan is now in place.
- We will undertaking benchmarking against those in the foundation group and with other similar sized units.

4.3 Quality nurse Roles and AHP Provision

There is no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7wte Practice Education Lead (B7) with 0.3wte Clinical working within role (=1.0wte) and 0.2wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2wte B7 funding has been used to support a B6 Developmental Care Lead on a fixed term contract 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) |
|---|---|---|
| **May** | **1.39%** | **1.00wte** |

## 5. COMPLIANCE

5.1 CNST standards (Year 7) require compliance with training to be at 90% in all staff groups by 1st December 2025.

May 2025:

| | |
|---|---|
| Training compliance in PROMPT: Midwives | 91% |
| Training compliance in PROMPT: Obstetric Consultants | 89% |
| 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 | 100% |
| Annual NLS update compliance: Paediatric Middle Grades | 80% |
| Annual NLS update compliance: Paediatric Juniors | 89% |
| Annual NLS update compliance: Midwives | 97% |
| Annual NLS update compliance: Neonatal Nurses | 95% |
| Fetal Wellbeing update day: Obstetrics | 83% |
| Fetal Wellbeing update day: Midwives | 90% |
| Midwifery update day (Core Competency): Midwives | 94% |
| 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 | May 2025 |
|---|---|---|
| Mandatory (Core) | >90% | 97.5% |
| Mandatory (Essential) | >90% | 92.14% |
| Newborn Life Support (Annual Update) | 100% | 95% |
| Maternity Breastfeeding Update | >90% | 77.27%* |

**Personal Development Reviews – SCBU Nursing**

| April | May |
|---|---|
| 85% | 66.67% |

A robust timetable has been drafted to ensure staff appraisals are completed in a timely manner with the aim of increasing compliance to >90% by end of June 2025.

5.3 **Safety Champions**

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

During the May safety champion walkabout, safeguarding and patient access were key topics, reflecting recent patient interactions. All wards, including Triage, Delivery Suite, and SCBU (caring for 10 babies), were operating at high capacity.

Attention was drawn to the Bereavement cupboard, which requires reorganisation with wheeled crates to facilitate cleaning underneath. The Snowdrop Room's staff breastmilk fridge remains broken; The Public Health Midwife is collaborating with the Trust to implement a solution involving lockboxes.

The Antenatal Clinic (ANC) demonstrated updated boards and strong vaccination uptake, with a recommendation to present some data as absolute numbers rather than percentages. The Champions highlighted the need to increase awareness of the role of the Maternity and Neonatal Voices Partnership. Additionally, the Diabetes Survey QR code requires clearer communication to enhance engagement.

In SCBU, the recent launch of a paper-light system was mostly well received, though concerns about access and editing rights were noted. Progress on central monitoring continues, with IT internally and partner Hoople prepared for implementation; release of charitable funds is pending authorisation.

Lastly, the high cost of repairing a cot side in SCBU was discussed as an area for financial review.

5.5 **CNST MIS Year 7**

MIS Year 7 was published in April. We have reviewed this and identified the new guidance has undergone some change since year 6. The national compliance and monitoring tool has now been released which will assist this work.

**APPENDIX 1 – PQSM Dashboard**

| | Indicator Description | Januai | Februa | March | April | May |
|---|---|---|---|---|---|---|
| Antenatal | Total bookings | 137 | 131 | 136 | 111 | 119 |
| | Women who were booked before 9+6 weeks | 91 | 101 | 112 | 89 | 95 |
| | % Women who were booked before 9+6 weeks (target 90%) | 66.4% | 77.1% | 82.4% | 80.2% | 79.8% |
| | Women who were booked after 9 + 6 weeks | 46 | 30 | 24 | 22 | 24 |
| | % Women who were booked after 9 + 6 weeks | 33.6% | 22.9% | 17.6% | 19.8% | 20.2% |
| | Women who were booked before 12 + 6 weeks | 133 | 128 | 133 | 110 | 115 |
| | % Women who were booked before 12 + 6 weeks (target 90%) | 97.1% | 97.7% | 97.8% | 99.1% | 96.6% |
| | Women who were booked after 12 + 6 weeks | 4 | 3 | 3 | 1 | 4 |
| | % Women who were booked after 12 + 6 weeks | 2.9% | 2.3% | 2.2% | 0.9% | 3.4% |
| | Midwife led care at booking | 27 | 22 | 25 | 29 | 23 |
| | % Midwife led care at booking | 19.7% | 16.8% | 18.4% | 26.1% | 19.3% |
| | Women with BMI of 30 and over at booking | 42 | 42 | 46 | 26 | 38 |
| | % Women with BMI of 30 and over at booking | 30.7% | 32.1% | 33.8% | 23.4% | 31.9% |
| | % Antenatal Personalised Care Plan completed | 99.3% | 100.0% | 99.2% | 99.2% | 99.3% |
| | % Intrapartum Personalised Care Plan completed | 55.3% | 65.4% | 70.4% | 62.0% | 59.4% |
| | % Portal Access Consent | 98.5% | 100.0% | 100.0% | 100.0% | 100.0% |
| | % Portal Access – Women who registered and logged in | 80.7% | 76.3% | 80.1% | 88.3% | 90.8% |
| | % Contacts were place of birth suitability was recorded | 69.8% | 69.9% | 66.5% | 71.3% | 64.9% |
| | % High risk women assigned a named Consultant – within 7 days | 70.4% | 71.3% | 50.8% | 50.0% | 52.3% |
| | % High risk women assigned a named Consultant – at any time | 81.8% | 85.3% | 82.2% | 82.0% | 87.0% |
| | % Antenatal contacts with a reviewed / authorised risk assessment | 85.2% | 83.6% | 85.2% | 86.6% | 79.6% |
| | % Antenatal contacts with a risk assessment form completed | 92.9% | 94.9% | 93.4% | 93.8% | 88.7% |
| | Recorded Smoking Status at Booking – Yes | 11 | 11 | 10 | 9 | 13 |
| | Recorded Smoking Status at Booking – No | 126 | 120 | 126 | 102 | 106 |
| | Recorded Smoking Status at Booking – Unknown | 0 | 0 | 0 | 0 | 0 |
| | % of mothers with a recorded Smoking Status at Booking | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | Women who were current smokers at booking | 11 | 11 | 10 | 9 | 13 |
| | % Women who were current smokers at booking | 8.0% | 8.4% | 7.4% | 8.1% | 10.9% |
| | Smokers who were referred to smoking cessation services | 10 | 9 | 7 | 9 | 10 |
| | % Smokers who were referred to smoking cessation services | 90.9% | 81.8% | 70.0% | 100.0% | 76.9% |
| | Smokers who accepted CO screening at booking | 10 | 11 | 10 | 9 | 13 |
| | % Smokers who accepted CO screening at booking | 90.9% | 100.0% | 100.0% | 100.0% | 100.0% |
| | Women who were screened for CO at booking | 130 | 122 | 128 | 105 | 116 |
| | % Women who were screened for CO at booking (of total bookings) | 94.9% | 93.1% | 94.1% | 94.6% | 97.5% |
| | Women with CO reading of 4 ppm or more at booking | 13 | 11 | 7 | 8 | 9 |
| | % women with CO reading of 4 ppm or more at booking (of total bookings) | 9.5% | 8.4% | 5.1% | 7.2% | 7.6% |

| | Indicator Description | January | February | March | April | May |
|---|---|---|---|---|---|---|
| | Total births (deliveries) | 144 | 122 | 132 | 113 | 131 |
| | Home Births | 0 | 0 | 1 | 2 | 0 |
| | BBA's | 1 | 1 | 2 | 1 | 2 |
| | Vaginal births (deliveries) | 60 | 47 | 47 | 43 | 51 |
| | % Vaginal births (deliveries) | 41.7% | 38.5% | 35.6% | 38.1% | 38.9% |
| | Ventouse & forceps births (deliveries) | 15 | 12 | 18 | 18 | 15 |
| | % Ventouse & forceps births (deliveries) | 10.4% | 9.8% | 13.6% | 15.9% | 11.5% |
| | RG*1 having a caesarean section with no previous births | 6 | 4 | 2 | 1 | 4 |
| | RG*1 Deliveries | 23 | 13 | 15 | 17 | 12 |
| | RG*1 % C-section deliveries | 26.1% | 30.8% | 13.3% | 5.9% | 33.3% |
| | RG*2 having a caesarean section with no previous births | 19 | 23 | 21 | 19 | 24 |
| | RG*2 Deliveries | 36 | 37 | 27 | 28 | 40 |
| | RG*2 % C-section deliveries | 52.8% | 62.2% | 77.8% | 67.9% | 60.0% |
| | RG*5 having a caesarean section with at least one previous birth | 20 | 15 | 22 | 14 | 18 |
| | RG*5 Deliveries | 22 | 17 | 26 | 18 | 21 |
| | RG*5 % C-section deliveries | 90.9% | 88.2% | 84.6% | 77.8% | 85.7% |
| | Total Elective C-Sections | 35 | 30 | 33 | 25 | 30 |
| | Total Emergency C-Sections | 33 | 32 | 33 | 26 | 35 |
| | Total Caesarean births (deliveries) | 68 | 62 | 66 | 51 | 65 |
| | % Total Caesarean births (deliveries) | 47.2% | 50.8% | 50.0% | 45.1% | 49.6% |
| | % Grade 1 C-Sections within 30 minutes | 60.0% | 100.0% | 50.0% | 100.0% | 75.0% |
| | % Grade 2 C-Sections within 75 minutes | 91.7% | 87.5% | 91.3% | 93.3% | 92.3% |
| | Midwife led (low risk care) births | 27 | 17 | 18 | 25 | 19 |
| | % Midwife led (low risk care) births | 18.6% | 13.9% | 13.6% | 22.1% | 14.5% |
| | Home births (deliveries) – midwife led only | 0 | 0 | 0 | 0 | 0 |
| | % Home births (deliveries) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| | Total number of babies born | 144 | 122 | 135 | 115 | 134 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Intrapartum | Babies born preterm (singletons born 36+6 or less) | 8 | 4 | 13 | 8 | 14 |
| | % Babies born preterm (singletons born 36+6 or less) | 5.52% | 3.28% | 9.63% | 6.96% | 10.45% |
| | Singleton babies born 26+6 or less | 0 | 0 | 0 | 0 | 0 |
| | % Singleton babies born 26+6 or less | 0% | 0.0% | 0.00% | 0% | 0% |
| | Babies (multiples) born 27+6 or less | 0 | 0 | 0 | 0 | 0 |
| | % Babies (multiples) born 27+6 or less | 0% | 0% | 0% | 0% | 0% |
| | Stillbirths | 0 | 0 | 0 | 0 | 0 |
| | % Stillbirths | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| | Stillbirths rate per 1,000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Live births where breastfeeding initiated (first feed = breastmilk) | 116 | 101 | 109 | 97 | 102 |
| | % Live births where breastfeeding initiated (first feed = breastmilk) | 81.1% | 82.8% | 83.8% | 86.6% | 77.9% |
| | Women who were current smokers at booking (delivered mothers) | 12 | 11 | 8 | 8 | 11 |
| | % Women who were current smokers at booking (delivered mothers) | 8.3% | 9.0% | 6.1% | 7.1% | 8.4% |
| | Women who were current smokers at birth (delivery) | 9 | 8 | 9 | 7 | 9 |
| | % Women who were current smokers at birth (delivery) | 6.2% | 6.6% | 6.8% | 6.2% | 6.9% |
| | % Women with CO measured at 36 weeks | 100.0% | 99.1% | 100.0% | 100.0% | 100.0% |
| | % CO >= 4ppm at booking and below 4 ppm at 36 weeks | 9.1% | 4.3% | 8.6% | 5.0% | 7.8% |
| | Late pregnancy loss (singletons 16+0 - 23+6 ) | 1 | 0 | 0 | 1 | 0 |
| | % (as a % of all singleton births) | 0.69% | 0.00% | 0.00% | 0.90% | 0.00% |
| | % Detection rate for FGR (below 3rd centile) | 0% | 0% | 33% | 0% | 11% |
| | Women who had a PPH of 1,500ml or more | 9 | 5 | 7 | 4 | 3 |
| | % Women who had a PPH of 1,500ml or more | 6.3% | 4.1% | 5.3% | 3.6% | 2.3% |
| | Women who sustained a 3rd or 4th degree tear | 2 | 1 | 3 | 1 | 0 |
| | % Women who sustained a 3rd or 4th degree tear (of total vaginal birt | 2.6% | 1.7% | 4.5% | 1.6% | 0.0% |
| | Induction of labour | | | | | 5700.0% |
| | % Induction of labour rate (of all births) | 32.6% | 43.4% | 36.4% | 35.4% | 43.5% |
| | Routine Enquiry Domestic Violence - Asked | 86 | 66 | 99 | 75 | 74 |
| | Routine Enquiry Domestic Violence - Unable to ask | 53 | 52 | 31 | 37 | 57 |
| | Routine Enquiry Domestic Violence - Unknown | 6 | 4 | 2 | 1 | 0 |
| | % routine enquiry domestic violence | 95.9% | 96.7% | 98.5% | 99.1% | 100.0% |
| | Midwife to birth ratio | 1:24 | 1:21 | 1:21 | 1:21 | 1:22 |
| | Delay in Induction >2hrs | 1 | 4 | 4 | 0 | 3 |
| | Delay in Catagory 1 C-Section >30mins | 0 | 0 | 0 | 0 | 1 |
| | Delay in administering medication | 1 | 0 | 0 | 2 | 0 |
| | Delay in starting syntocinon/ARM >30mins | 1 | 3 | 2 | 0 | 1 |
| | Delay in Suturing >60mins | 0 | 0 | 0 | 0 | 0 |
| | Unable to provide 1:1 care in labour | 0 | 0 | 0 | 0 | 0 |
| | Delay in Triage >30mins | 0 | 0 | 0 | 0 | 0 |
| | Community midwives on call covering maternity unit | 0 | 2 | 0 | 5 | 1 |
| | Any movement of midwifery staff from any area to provide midwifery c | 3 | 27 | 31 | 23 | 21 |
| | Delayed recognition of and action on abnormal vital signs | 0 | 0 | 0 | 0 | 0 |
| | DSC lost - supernumerary status | 0 | 0 | 0 | 0 | 0 |
| | Full clinical examination not carried out when presenting in labour | 0 | 0 | 0 | 0 | 0 |
| | Delay of more than 30 minutes in providing pain relief | 0 | 0 | 0 | 2 | 0 |
| | Number of women presenting to service with reduced fetal movement | 207 | 205 | 225 | 203 | 233 |
| | Number of women presenting with RFM who are recorded as having a | 206 | 204 | 224 | 201 | 232 |
| | % of women presenting with RFM who received CTG | 99.52% | 99.51% | 99.56% | 99.0% | 99.6% |
| Neonatal | Total admissions to neonatal care | 14 | 8 | 21 | 9 | 11 |
| | Unexpected admissions of full-term babies to neonatal care | 6 | 4 | 10 | 5 | 3 |
| | % Unexpected admissions of full-term babies to neonatal care | 4.4% | 3.4% | 8.2% | 4.7% | 2.5% |
| | Eligible Babies | 0 | 1 | 2 | 1 | 0 |
| | % taken within hour | 0.0% | 100.0% | 100.0% | 100.0% | 0.0% |
| | Adm temp <36.5 degrees | 0 | 0 | 0 | 0 | 0 |
| | Eligible Babies | 20 | 17 | 28 | 17 | 14 |
| | % taken within hour | 95.0% | 100.0% | 92.8% | 58.8% | 100.0% |
| | Adm temp <36.5 degrees | 1 | 3 | 1 | 0 | 4 |
| | Babies born with an APGAR score between 0 and 6 (at 5 minutes) | 1 | 3 | 3 | 4 | 2 |
| | Neonatal deaths | 2 | 0 | 2 | 1 | 0 |
| | % Neonatal deaths | 1.4% | 0.0% | 1.5% | 0.9% | 0.0% |
| | Neonatal mortality per 1,000 births | 13.89 | 0.00 | 14.81 | 8.70 | 0.00 |
| | Neonatal transfers for therapeutic hypothermia | 0 | 0 | 0 | 0 | 0 |
| | % Neonatal transfers for therapeutic hypothermia | n/a | n/a | n/a | n/a | n/a |
| | Neonatal brain injuries | 0 | 0 | 0 | 0 | 0 |
| | % Neonatal brain injuries | n/a | 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 | 0 |
| | Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 | 0 | 1 | 2 | 1 | 0 |
| | % 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 | 0 |
| | Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6) | 0 | 0 | 0 | 0 | 0 |
| | % Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6) | n/a | n/a | n/a | n/a | n/a |

| | | | | | | |
|---|---|---|---|---|---|---|
| Postnatal | Obstetrics admissions to ITU | 0 | 0 | 0 | 0 | 1 |
| | Maternal deaths | 0 | 0 | 0 | 0 | 0 |
| | % Postnatal Personalised Care Plan completed | 96.6% | 96.8% | 95.3% | 93.1% | 97.9% |
| | Postnatal readmissions within 28 days (mothers) | 8 | 12 | 9 | 2 | 11 |
| | Postnatal readmissions within 28 days (babies) | 4 | 2 | 9 | 8 | 3 |
| | Number of times Maternity Services Suspended per month | 0 | 0 | 0 | 0 | 1 |
| | Number of hrs Maternity Services suspended | 0 | 0 | 0 | 0 | |
| | Number of times Home Birth services suspended per month | 0 | 0 | 0 | 0 | 0 |
| | Number of hrs Home Birth services suspended | 0 | 0 | 0 | 0 | 0 |
| | Number of times SCBU suspended per month | 0 | 0 | 0 | 0 | 1 |
| | Number of hrs SCBU suspended per month | 0 | 0 | 0 | 0 | |
| | reported (total) | 1 | 4 | 0 | 0 | 0 |
| | New MNSI SI referrals accepted | 0 | 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 | 0 |
| | Coroner Reg 28 made directly to Trust | 0 | 0 | 0 | 0 | 0 |
| | Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite | 0 | 0 | 0 | 0 | 0 |
| | Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite | 0 | 0 | 0 | 0 | 0 |
| | Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps) | 0 | 0 | 0 | 0 | 0 |
| | Vacancy rate for midwives (black = over establishment, red = under establishment | 2.07wte | 2.07wte | 3 wte | 1.8wte | 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% | 100.00% |
| | Service User feedback: Number of Compliments (formal) | | 2 | | 1 | 1 |
| | Service User feedback: Number of Complaints (formal) | 4 | 2 | 0 | 1 | 1 |
| | Staff feedback from frontline champions and walk-abouts (number of | 0 | 0 | 0 | 0 | 0 |
| | Progress in achievement of CNST /10 | 10 | 10 | 10 | 10 | 10 |
| | Training compliance in PROMPT: Midwives | 96% | 93% | 90% | 95% | 91% |
| | Training compliance in PROMPT: Obstetric Consultants | 90% | 100% | 90% | 90% | 89% |
| | Training compliance in PROMPT: Obstetric Middle Grades | 100% | 100% | 89% | 89% | 89% |
| | Training compliance in PROMPT: Anaesthetic Consultants | 100% | 100% | 100% | 75% | 75% |
| | Training compliance in PROMPT: Anaesthetic Middle Grades | 83% | 85% | 85% | 92% | 92% |
| | Training compliance PROMPT: Maternity Support Workers | 94% | 90% | 90% | 97% | 97% |
| | Annual NLS update compliance: Paediatric Consultants | 89% | 90% | 90% | 89% | 100% |
| | Annual NLS update compliance: Paediatric Middle Grades | 80% | 60% | 60% | 84% | 80% |
| | Annual NLS update compliance: Paediatric Juniors | 100% | 88% | 80% | 80% | 89% |
| | Annual NLS update compliance: Midwives | 99% | 96% | 96% | 96% | 97% |
| | Annual NLS update compliance: Neonatal Nurses | 86% | 95% | 95% | 100% | 95% |
| | Fetal Wellbeing update day: Obstetrics | 90% | 89% | 89% | 89% | 83% |
| | Fetal Wellbeing update day: Midwives | 93% | 91% | 97% | 92% | 90% |
| | Midwifery update day (Core Competency): Midwives | 99% | 91% | 89% | 92% | 94% |
| | Midwifery update day (Core Competency): Support Staff | 94% | 97% | 94% | 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 | 0 | | | | | | | | | | | |
| Band 6 Vacancy Gap (5.2wte) | 0 | 0 | | | | | | | | | | | |
| Band 5 Vacancy Gap (13.5) | 2 | 3.1 | | | | | | | | | | | |
| Band 4 Support Worker/RNDA (0.66) Vacancy Gap | 0 | 0 | | | | | | | | | | | |
| Band 2 Vacancy Gap (1.0wte) | 0.2 | 0.2 | | | | | | | | | | | |
| Neonatal Outreach Team B6 Vacancy Gap (1.3wte) | 0 | 0 | | | | | | | | | | | |
| Attrition Rate (WTE) | 0 | 0 | | | | | | | | | | | |
| Maternity Leave (WTE) | 1 | 1 | | | | | | | | | | | |
| Sickness (<3.5%) | 1.09% | 1.39% | | | | | | | | | | | |
| **Safe Staffing** | | | | | | | | | | | | | |
| % Shifts staffed to BAPM Standards | 92% | 84% | | | | | | | | | | | |
| QIS % (standard = 70% of registered workforce) | 49.3% | 49.3% | | | | | | | | | | | |
| % of shifts QIS to toolkit | 98.31% | 100% | | | | | | | | | | | |
| % Shifts with supernumerary shift co-ordinator | 3.39% | 3% | | | | | | | | | | | |
| % Shifts covered with Bank | 1.1% | 1.4% | | | | | | | | | | | |
| Appraisal Rate | 85% | 67% | | | | | | | | | | | |
| Mandatory Training Core | 98.75% | 97.50% | | | | | | | | | | | |
| Mandatory Training Essential | 89.8% | 92.14% | | | | | | | | | | | |
| Basic Life Support | 43% | | | | | | | | | | | | |
| Newborn Life Support >90% | 96% | 95% | | | | | | | | | | | |
| Maternity Breastfeeding update. | 77.27% | 77.27% | | | | | | | | | | | |
| Safeguarding Level 3 | 100.00% | 100.00% | | | | | | | | | | | |
| Compliments/Complaints/Concerns | | | | | | | | | | | | | |
| Complaints/Concerns | 0 | 0 | | | | | | | | | | | |
| Infection Prevention | | | | | | | | | | | | | |
| Overall - Star rating. | 4 | 5 | | | | | | | | | | | |
| Ward Assurance Audit | 82% | 100% | | | | | | | | | | | |
| Hand Hygiene | 100% | 100% | | | | | | | | | | | |
| Bare Below the Elbow | 100% | 100% | | | | | | | | | | | |
| Incident and Exception Reporting | | | | | | | | | | | | | |
| Number of Incidents (Inphase) | 5 | 4 | | | | | | | | | | | |
| Medication Errors | 0 | 1 | | | | | | | | | | | |
| Staffing | 0 | 0 | | | | | | | | | | | |
| Service Escalation (OPEL RED/BLACK) | 0 | Red x 4 | | | | | | | | | | | |
| Exception reports - ex-utero outside of care pathway | 0 | 0 | | | | | | | | | | | |
| Exception reports - in utero transfers outside of pathway/network | 1 | 1 | | | | | | | | | | | |
| Audits | | | | | | | | | | | | | |
| Quaterly CD Audit | | 96% | | | | | | | | | | | |
| 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% | | | | | | | | | | | | |

**Version 1: January 2025**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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%)** | 3.5% | 1.5% | | | | | | | | | | | |
| TC Bed occupancy rate on SCBU % including parent bedroom | 40.0% | 54.00% | | | | | | | | | | | |
| Number of babies born between 34-36 wks gestation and admitted to SCBU | 3 | 7 | | | | | | | | | | | |
| Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW | 1 | 3 | | | | | | | | | | | |
| Neonatal Outreach Team | | | | | | | | | | | | | |
| Total Patients | 11 | 19 | | | | | | | | | | | |
| NewReferrals | 4 | 12 | | | | | | | | | | | |
| Existing Patients continuing care | 7 | 7 | | | | | | | | | | | |
| No. NGT Feeding in the community | 8 | 5 | | | | | | | | | | | |
| Receiving EBM on discharge from SCBU | 5 | 10 | | | | | | | | | | | |
| Receiving EBM on discharge from 0/R | 3 | 1 | | | | | | | | | | | |
| Numbers Discharged from outreach | 5 | 2 | | | | | | | | | | | |
| Number of Incidents (Inphase) | 0 | 0 | | | | | | | | | | | |
| Home Phototherapy | 1 | 1 | | | | | | | | | | | |
| Prolonged Jaundice Screening Referrals | 27 | 24 | | | | | | | | | | | |
| Prolonged Jaundice Screening - Total Number of Referals meeting criteria for outreach | 21 | 22 | | | | | | | | | | | |
| Prolonged Jaundice Screens - Outreach | 18 | 22 | | | | | | | | | | | |
| Prolonged Jaundice Screens - RAC | 5 | 2 | | | | | | | | | | | |

# 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.<br>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.<br>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.<br>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.<br>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.<br>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:<br>• Community Services<br>• Medical Job Planning<br>• Theatre Productivity/Utilisation<br>• Board Assurance Framework (core review)<br>• Cyber Assessment Framework (core review)<br>• Fit and Proper Person Test (required every three years)<br>• Key Financial Controls (core review – this year would focus on contract management and devolved divisional budget management).<br>The plan would remain flexible, enabling a response to any new risks or issues emerging during the year.<br>Both executive and non-executive directors had been involved in development of the plan.<br>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.<br>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. |

# Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 24 June 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** | **Auditor's Annual Report** |
| **Rating rationale** | The report primarily focused on a value for money assessment.<br>Three significant weaknesses were identified, which were identical to the previous year:<br>• Failure to achieve a break-even position. No additional recommendations were made.<br>• Achievement of CPIP, with the Trust behind plan on 2024/25 and a gap in full plans for 2025/26.<br>• Governance – National Oversight Framework. The Trust remained at segment 3. There were no new recommendations.<br>The previous year's weakness related to the CQC reviews of Maternity and ED was not raised this year, with evidence demonstrating good progress on implementing both action plans. |
| **Outcome** | The Committee accepted the findings, which reflected areas of risk well understood by the Board.<br>**Action:** Schedule an update on the self-assessment of financial sustainability. |
| **Assure: Including assurance items rated green** | |
| **Item/Topic** | **Report on the Audit of the Financial Statements (ISA260)** |
| **Rating rationale** | The Audit was complete save for some minor points outstanding on the remuneration report (reflecting the complex requirements). An unqualified opinion would be issued on the Trust's financial statements.<br>The audit process was smooth with no concerns. There was no evidence of management override of controls.<br>There were some unadjusted misstatements, which if remained unadjusted would not affect the overall opinion. The CFO recommended that the statements remained unadjusted. |
| **Outcome** | The Committee welcomed and accepted the positive report and thanked both the Audit and Trust teams.<br>The CFO's recommendation on the unadjusted misstatements was accepted. |
| **Item/Topic** | **Letter of Representation** |
| **Rating rationale** | The letter was standard and the Committee's approval was recommended. |
| **Outcome** | Approved |
| **Item/Topic** | **Annual Internal Audit Report** |
| **Rating rationale** | The report included the Head of Internal Audit Opinion that 'the organisation has an adequate and effective framework for risk management, governance and internal control'. The opinion acknowledged that opportunities for improvement had been identified through delivery of the annual plan resulting in two partial assurance opinions.<br>There had been some delays in management responses to draft reports but this had been improved during the year.<br>The recommendation action tracker demonstrated a generally good approach to implementing actions. Only one medium priority action remained open, relating to a review of data quality in ED, implementation of which was reliant on action by NHSE.<br>The Head of Internal Audit made additional remarks commending a number of positive governance improvements during the year. |
| **Outcome** | The Committee welcomed the report and was assured that the Trust used the Internal Auditor appropriately to seek opportunities for improvement in areas of concern.<br>The Committee ratified the completion date extension for the one medium priority recommendation. |
| **Item/Topic** | **Internal Audit Report Review: Risk Management and Board Assurance Framework** |
| **Rating rationale** | The rating was substantial assurance – the highest rating. The review was undertaken at a point of transition between two formats. Five low priority recommendations were made. |
| **Outcome** | The Committee welcomed the report and thanked the Company Secretary team for the work involved in achieving the improvements. |

| **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: 24 June 2025
Report to: Trust Board

| Item/Topic | Annual Fit and Proper Person Test (FPPT) Compliance Report |
|---|---|
| **Rating rationale** | The report demonstrated full compliance with the Trust's policy and NHSE FPPT framework. A local audit highlighted some areas for improvement regarding the recording and presentation of evidence. An internal audit review was scheduled during the year in accordance with the framework. |
| **Outcome** | The report was accepted. |
| **Item/Topic** | **Annual Conflicts of Interest Report** |
| **Rating rationale** | The report was presented in accordance with the Trust policy, which was based on the national guidance.<br>The report was the first based on the new system for declarations of interest using ESR, which was launched in quarter 4 2024/25. The report demonstrated a good response to the annual requirement for declarations from senior decision making staff. A communication programme was planned in collaboration with the local counter fraud specialist to support improved understanding among all staff of the importance of making declarations.<br>The Committee welcomed the new report style and process, which provided improved opportunities for follow-up, escalation and management of potential conflicts. |
| **Outcome** | The report was accepted.<br>**Action:** Schedule an update on the approach to follow up and management of potential conflicts. |

| To Note: Items received for information or approval | |
|---|---|
| **Item/Topic** | **Annual Report 2024/25** |
| **Summary** | The report was final with the exception of a minor change to the Annual Governance Statement (previously reviewed by the Committee) to reflect the final Auditor's Annual Report and a planned change on the fair pay disclosure within the Remuneration Report.<br>The report had been subject to review by the Auditor to ensure compliance with the DHSC Group Accounting Manual. The Remuneration Report within the document had been subject to audit, alongside the financial statements. |
| **Outcome** | The Committee endorsed the report for Trust Board approval. |
| **Item/Topic** | **Annual Financial Accounts 2024/25** |
| **Summary** | No material changes had been made since the draft accounts were reviewed on 24 April at an informal meeting of the Committee members. A log of changes was included with the papers. |
| **Outcome** | The Committee endorsed the Accounts for Trust Board approval. |
| **Item/Topic** | **External Audit Sector Development Update** |
| **Summary** | The update included some recommendations for best practice in 2025/26. |
| **Outcome** | The update was noted.<br>**Action:** A management response would be provided on each recommendation. |
| **Item/Topic** | **External Audit NHS Sector Benchmarking** |
| **Summary** | The data covered NHS trusts across the country that were audited by Deloitte. The Trust's performance reflected its relative size and there were no areas where the Trust was a negative outlier.<br>Delivery of the Trust's capital programme was highlighted as a risk due to the provision of funding late in the year, which was reflected across the sector. |
| **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. |

## WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **Title of Report:** | Quality Committee 27 March 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 March 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 reviewed and sought assurance on a number of issues including delay to induction, recent moderate incidents and the learning that had emerged from neonatal deaths. Wider issues identified in patient feedback and peer review had been the subject of a Safety Summit which had identified further work to promote an effective working culture. Committee asked for further updates as this work progresses
2. **Annual Safeguarding Report** – Committee received the annual report covering adults' and children's safeguarding and the support to Looked After Children. Challenges remain in all areas but Committee focussed in particular on positive developments in a number of areas including the impact the of the work by the Domestic Abuse Lead, the impact of the additional post in the MASH and the leadership and support provided to the improvement programme for children's services in the county.
3. **Mortality Report** – The Trust's SHMI continues to perform well, albeit with a slight increase to 101.3. Perinatal deaths and stillbirths remain a concern and are being closely monitored.
4. **Quality Priority – Improving Care of the Deteriorating Patient** – Committee heard about the impact made by the Critical Outreach Team where 24 hour availability has resulted in a doubling of referrals with a consequent impact on mortality and reduced need to use critical care beds. We will continue to monitor the impact, including barriers to escalation, alongside the wider set of indicators reviewed by the Deteriorating patient Committee.
5. **PLACE Audit Results** – The PLACE audits resulted in a mixed set of outcomes for the Trust with Privacy, Dementia and Disability being 3 areas of focus for improvement. Committee stressed the need to prioritise areas for improvement and the need to take learning from elsewhere in the Foundation Group
6. **UEC and Boarding Report** – Boarding continues to be our greatest area of challenge for quality and safety of patients and Committee had a comprehensive report of all the work that is being progressed both to reduce need for escalation and to maintain safety and quality for all patients impacted. Risk of falls has been a particular area of focus as well as the need to understand how long patients have been in an escalation space. Discussion also focussed on work with system partners to assess how we might better use community alternatives to acute beds.
7. **Divisional Report – Integrated Care** – There has been good progress with the bed-rails improvement work which is now being rolled out to other community sites. Tissue viability remains a key area of focus but improvement is inconsistent. Committee commended the work to improve waiting times in children's therapy services and the dietetics work in North and West PCNs. Work is also underway with the Medicines Safety Officer to reduce incidents related to insulin administration.
8. **Divisional Report – Clinical Support** – Committee commended the excellent performance in histology – highest turn-round times in the region. Mortuary leadership and governance had a positive external audit and Committee asked for further feedback on out of hours availability which impacts on cultural needs related to funerals. Haematology services remain fragile and concerns were raised regarding the uncertainty of the future of the South Mids Pathology Network.
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 March 2025 at 1.00 – 4.00 pm**
**Via MS Teams**

| **Present:** | | |
|---|---|---|
| Ian James | IJ | Committee Chair and Non-Executive Director |
| Chizo Agwu | CA | Chief Medical Officer (CMO) |
| Eleanor Bulmer | EB | Associate Non-Executive Director (ANED) |
| Lucy Flanagan | LF | Chief Nursing Officer (CNO) |
| Rachael Hebbert | RH | Associate Director of Nursing (AND) |
| Jane Ives | JI | Managing Director (MD) |
| Kieran Lappin | KL | Associate Non-Executive Director (ANED) |
| Frances Martin | FM | Non-Executive Director (NED) |
| Tom Morgan-Jones | TMJ | Deputy Chief Medical Officer |
| Natasha Owen | NO | Associate Director of Quality Governance (ADQG) |
| Emma Smith | ES | Deputy Chief Nursing Officer (DCNO) |
| Nicola Twigg | NT | Non-Executive Director (NED) |
| | | |
| **In attendance:** | | |
| Helen Harris | HH | Integrated Care Boards (ICB) Representative |
| Leah Hughes | LH | Operational Clinical Lead Radiography |
| Susan Moody | SM | Associate Chief AHP, Integrated Care Division (ACAHP) |
| Hayley Pearson | HP | Clinical Director Pharmacy |
| Sara Powell | SP | Matron Women and Children (for item |
| Vicky Roberts | VR | Executive Assistant (for the minutes) |
| Gwenny Scott | GS | Company Secretary |
| Amie Symes | AS | Associate Director Midwifery |
| Caroline Waite | CW | Relief Approved Mental Health Professional, Community Wellbeing |
| Laura Weston | LW | Lead Infection Prevention Nurse |

| | | |
|---|---|---|
| **QC01/03.25** | **APOLOGIES FOR ABSENCE** | |
| | Mehmood Akhtar, Associate Chief Medical Officer, Grace Quantock, Non-Executive Director, Jo Rouse, Associate Non-Executive Director and Emma Wales, Associate Chief Medical Officer | |
| **QC02/03.25** | **QUORUM** | |
| | The meeting was quorate. | |
| **QC03/03.25** | **DECLARATIONS OF INTEREST** | |
| | There were no declarations of interest made. | |
| **QC04/03.25** | **MINUTES OF THE MEETING HELD ON 27th FEBRUARY** | |
| | The minutes of the meeting held on 27th February were agreed as an accurate record of the meeting. | |
| | **The minutes of the meeting held on 27th February were received and approved.** | |

| | | |
|---|---|---|
| **QC05/03.25** | **ACTION LOG AND MATTERS ARISING** | |
| | The actions were updated:<br><br>QC1-/11.24 - Patient Experience report. Maternity and Obstetrics summit has taken place and an update will be provided in the next report. **Completed.**<br><br>QC06/02.25 – Perinatal safety report. Focus around caesareans to be included in the quarterly report. The requested Robson's audit has been deferred. Date to be confirmed. | |
| **QC06/03.25** | **MORTALITY REPORT** | |
| | The latest SHMI was 101.3 which was expected to increase over the next few months due to the increase in deaths in December and January but should reduce to reflect a sharp drop in numbers of deaths February.<br><br>Fractured neck of femur and sepsis continued to reduce and the quality improvement project was moving at pace.<br><br>Extended perinatal mortality remained slightly higher, however stillbirths had reduced slightly to 4.95 per 1000. This is being closely monitored.<br><br>The Medical Examiner Service is robust and working well, picking up themes for learning and also examples of excellent practice. A deep dive will be done into deaths throughout December and will be looking at the impact of long stay in ED on mortality figures.<br><br>It is planned to develop a workstream to help to improve IV management.<br><br>The value of SJRs had been noted and although are done by specifically trained staff, input from all staff being involved in those was important. There is input from Matrons and local MDTs at Learning from Death committee. Ward sisters have now also been invited to attend to give a voice of care.<br><br>It was noted that re-coding of SDEC non-admissions had been a concern as the SHMI was expected to increase as a result of removing one third of admissions. However this did not appear to have had an impact and was therefore an indication of true improvements.<br><br>Of note was integration with EMIS and the ability to prove co-morbidities due to detailed documentation, which meant that calculation of expectation to die is much more accurate.<br><br>Perinatal and stillbirths are rolling 12 month figures and are externally reviewed. The vast majority were at A and B and the neonatal team are invited to attend Learning from Deaths Committee to understand further. | |
| | **The Mortality report was received and noted.** | |

| | | |
|---|---|---|
| **QC07/02.25** | **ANNUAL SAFEGUARDING REPORTS** | |
| | The Associate Director of Nursing presented the annual report covering the period 1st January to 31 December 2024.<br><br>There had been expansion of the health offer to the WVT MASH with an increase from one to two practitioners.<br><br>Some developments and progress had also been made with initial health assessments for children looked after and teams are now fully recruited. There had also been some developments in key relationships with Local Authority.<br><br>Liberty protection safeguards have been postponed indefinitely given the change in government and DoLS will be continuing for the foreseeable future.<br><br>There revised inter-collegiate guidance for health staff sets expectations that all front line staff to be level 3 trained for adult safeguarding. This would be onerous for the trust to achieve and is not yet resolved and to note that the trust therefore remains non- compliant with inter-collegiate document.<br><br>The annual reports would go to the Public Board in April and the board workshop update will be on children's services and therefore the Children Looked After annual report had been amended to make more narrative based for that purpose.<br><br>The Chair acknowledged the huge challenges in children's and adult safeguarding but had noted many positives from the annual report regarding the extent of partnership working in children's and the number of looked after children both in and out of county placements had reduced. Also noted that the numbers of children in Herefordshire looked after by other councils placed a large burden on services and asked for thanks to be passed on to the rest of the team who were unable to attend this meeting. | |
| | **The Annual Safeguarding reports were received and noted.** | |
| **QC008/03.25** | **QUALITY PRIORTIY – IMPROVING CARE OF DETERIORATING PATIENTS AND IMPLEMENTING MARTHA'S RULE** | |
| | The Chief Medical Officer gave an update on the progress of this quality priority.<br><br>Focusing on improving detection, escalation and management as well as prevention. To that effect 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 trust had stopped taking part in cardiac arrest audits but will now start to take part in the national audit which will give outcome data and also the ability to benchmark against other services.<br><br>The Critical outreach team went live in September providing a 24 hour service which has been a great success. The number of requests has doubled showing 50% to be out of hours and 50% within hours. Teams are reporting that they feel they are now able to provide more consistent care for patients.<br><br>Review of the outcomes for those patients showed 94% of patients still alive, and of those 94%, 75% remained on ward and 12% escalated to critical outreach. The general feeling from all divisions was that the outreach team were making a huge impact.<br><br>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 wait to hear whether this has been successful.<br><br>It was of particular note that this year there has been a significant reduction in the number of ITU beds in use. A meeting has been called to explore the reasons for this but it is felt that the acuity on wards is very high and that patients are being picked up earlier which had freed up capacity and gave more opportunity to provide the level of care needed on ward. There are still some incidents of escalation but had been a marked change.<br><br>Gynaecology BLS compliance had been low due to booking issues and there had been some difficulty in obtaining data. RH agreed to discuss with the team to understand the reasons for this **Action RH**<br><br>Lots of work had been done to improve care of deteriorating patient and critical outreach data shows more escalation. Data has been broken down for divisions so they can improve using their individual data. Mortality is stable and improving, and using less intensive care suggests improvement. Also doing work collecting incidents of failed escalation to identify barriers.<br><br>It was noted that critical care admission rates had also been low across many other units, which may be associated with outreach teams. This will take some time to show and be able to compare to previous seasons. | **RH** |
| | **A. The quality priority update was received and noted**<br><br>**B. There has been difficulty in obtaining gynaecology BLS data. RH to discuss with the team** | **RH** |
| **QC09/03.25** | **<u>UEC/BOARDING REPORT</u>** | |
| | The Associate Director of Quality Governance and Deputy Chief Nursing Officer presented the UEC/Boarding report. | |

| | | |
|---|---|---|
| | There had been a reduction in ED attendance and admissions since December 2024. January and February figures were 1000 higher than the same time in the previous year.<br><br>Ambulance handovers had shown improvement between December and February. However 30 minute hand over and those greater than 60 minute had seen an upward trend with a significant change seen in August each year.<br><br>ED pressures show an upward trend in all metrics relating to stay and waiting for a bed.<br><br>Use of boarding spaces had increased and discharge lounge figures have stabilised over recent months.<br><br>There had not been a great difference seen in average ward stays for all patients dementia patients although some fluctuation with dementia patients peaking at 2-2.5 average stays.<br><br>There were a low number incidents and complaints related to boarding, however an increase is anticipated in March given current intelligence. There had been increased reference to boarding as a contribution to falls investigations and there had been incidents where we are not always following the enabling flow SOP when boarding in extremis.<br><br>Improvement work:<br><br>There has been concern for some time around volumes of boarding patients and use of escalation areas. Ensuring that flow is looked at from both an operational and clinical view point. Some improvement work focussed on clinical leadership in the site team. 'Matron of the day' has been attending all bed capacity meetings with a leadership role alongside the ACOO for the day, making decisions where and when TES should be open. This has continued through March and a meeting is scheduled with ACOO colleagues to evaluate the improvement work and agree next steps.<br><br>There had been a recent clinical incident where a patient had passed away following an unwitnessed fall and had been a boarder in a large side room. The fall was not witnessed until the patient was found by a nurse during a later review despite being identified as a "line of sight" patient. Following this a round table took place to make alterations to boarding processes and that area is no longer used. To note, the cause of death has been confirmed and the patient did not die as a consequence of the fall. An update will be brought to this meeting following review.<br><br>There CNO, COO and CMO met to discuss boarding levels, the enabling flow SOP, extremis boarding and some of the strategies for relieving pressure in ED. It has been agreed a workshop facilitated by the transformation team, will take place to explore further. | |

| | | |
|---|---|---|
| | The ICB Representative asked if length of stay in extremis boarding cases was looked at by Matron of the Day and were patients who have been in boarding spaces for long length of time proactively moved. This is a focus at every operations meeting to try to move those patients on. We do not collate data to show how long a particular patient has been in a temporary escalation space but it is known that we have patients in boarding spaces for the duration of the stay we also know that some wards may be at extremis levels of boarding when the rest of the organisation is not, hence the need to review.<br><br>It was noted that following the opening of the new discharge lounge there had been an increase in use, however use has gone down recently, despite having the new post in place specifically around use of discharge lounge. This will form part of the planned workshop.<br><br>Growth in emergency admissions of patients over 65 is 15%, this would normally be 2%. To help with admission avoidance the UCR team and virtual ward have been set up. The Trust is an outlier and there are multiple reasons including changes in General Practice, threshold in terms of community services, pressure from patients and also front door and flow. The CMO is leading internal work and discussions are ongoing with system partners on how we might incentivise better use of community alternatives including neighbourhood health. The main concern being to ensure that these initiatives make a difference to the number of people in acute beds. | |
| | **A. The UEC/Boarding report was received and noted.**<br>**B. An update on clinical incident to be brought to Quality Committee following review** | **ES** |
| **QC10/03.25** | **<u>QUALITY PRIORITY – IMPLEMENTING NATSIPPS 2 STANDARDS AND IMPROVING MANAGEMENT AND OVERSIGHT</u>** | |
| | The Deputy Chief Medical Officer gave an update on this Quality priority<br><br>Following attendance at a small national networking group there had been mixed progress, ranging from complete implementation to those still in the early stages.<br><br>There was a small delay to initial implementation in January due to winter pressures but have now held two meetings with stakeholders. The second meeting saw a presentation from theatres and oral surgery to look at WHO surgical checklist.<br><br>Theatres were in a very good position when compared to other hospitals. Electronic checklists via tablets are in use and a large amount of data is now available.<br><br>Looking to areas to check that LocSSIP register is complete and any areas for improvement. Linking with clinical CSG to see how things can be done electronically and have access to tablets in certain areas. LocSSIP template is due for renewal and will be in the next report. | |

| | | |
|---|---|---|
| | Pilot areas in Podiatry and Ophthalmology are moving to electronic recording using MAXIMS and will be working to embed LocSIPPs, NatSSIP checklist and auditing from those areas.<br><br>A central mechanism needs to be in place as it is key to be safe in terms of procedures in use and in prioritisation in terms of timing of changes. | |
| | **The Quality Priority update was received and noted.** | |
| **QC11/03.25** | **DIVISIONAL QUARTERLY REPORT – INTEGRATED CARE** | |
| | Associate Chief AHP presented the quarterly report for the Integrated Care Division and highlighted the following key points:<br><br>Falls - Work had continued on the bed rails quality improvement project and is now rolling out to other community sites.<br><br>There had been a slightly higher falls rate at Ross Community Hospital but is showing improvement.<br><br>There were also still some issues with unwitnessed falls.<br><br>There are still a number of overdue incidents, this is due to most clinical senior nurses being included regularly in numbers. There is a low level of complaints and are being maintained across all directorates.<br><br>Tissue viability had not seen improvements and high quality assessment is not yet consistent. Training continues and a District Nursing Quality Matron is now in place. The data will be separated out between Community Hospitals and Community to see any differentiation.<br><br>District nursing notes audit is now up and running across all areas in district nursing. 10 sets per month from each district Nursing team.<br><br>Working closely with the Medicines Safety Officer. Who gives monthly updates on medication incidents. Themes are generally around insulin administration in the community.<br><br>There had been a positive Children's Services SEND inspection. The Children's Therapies transformation work had been very successful and wait time is now reduced to 18 weeks.<br><br>The North and West PCN undertaking a dietetics project has made a real difference and has made considerable savings since July. A prescribing checklist has also been developed to assist non-dieticians.<br><br>There is still some concern regarding the CPE outbreak at Ross. However there have been no new cases for some time. Working closely with IPC colleagues and starting to reduce screening and it is hoped to close the outbreak within the next 6 weeks. Key to this has been the leadership of the Matron who had to step into the sister role in this area. | |

| | | |
|---|---|---|
| | There had been a rise in moisture associated skin damage and this will be included in future reports to ensure that this is not associated to the recent change in continence product.<br><br>The CNO confirmed that following the assurance visit conducted by NHSE and ICB at Ross, the outbreak is now in the monitoring phase. Formal feedback on the visit is expected soon and will be shared with Quality Committee.<br><br>The Digital Nurse Noting Team have been putting risk assessments through AI to try reduce the number of questions asked when assessing risk. Jo Cleal is leading on falls risk assessments and the number of questions has been considerably reduced. This is now under pilot.<br><br>At a recent quality engagement visit to North and West District Nursing team there had been slight push back on the time taken to conduct tissue viability incident follow up. Some further focus is needed within the division to support the team.<br><br>It was noted that insulin was the main theme in medication incidents and is included in the quality priorities for the coming year and need to ensure that the division is engaged with that work.<br><br>There is also some work on enabling home care and care home providers to deliver insulin. There is opportunity to move that work elsewhere and free up resources as part of the CPIP programme or to increase capacity and reduce waiting time. This will be in the divisional plan for next year. | |
| | **The Divisional quarterly report Integrated Care was received and noted** | |
| **QC12/03/25** | **<u>FINAL DRAFT – QUALITY PRIORITIES PROPOSAL 2025-26</u>** | |
| | The Associate Director of Quality Governance presented the proposed quality priorities for 2025-26 which had been revised following the last meeting.<br><br>The proposal set out seven proposed priorities for agreement.<br><br>It was suggested that urgent care and pathways, being the biggest risk on the register, should be added as a priority. However, as Valuing Patent's Time Board focusses on this it would be a duplication. But it was agreed that there should be direct read across between BAF and risk registers and that the accompanying narrative needs to be clear.<br><br>There was support for patient experience in maternity. And the patient voice feedback to be captured in quarterly reports.<br><br>It was suggested that the two priorities patient experience and patient engagement be combined. | |

| | | |
|---|---|---|
| | The Committee were supportive of the priorities as suggested, following these minor amendments, and agreed that they go forward to Board for approval then further scoped by leads following agreement. | |
| | **The quality priorities for 2025/26 were agreed by the Committee to go forward to Board for approval** | |
| **QC13/03.25** | **DIVISIONAL QUARTERLY REPORT – CLINICAL SUPPORT DIVISION** | |
| | The Operational Clinical Lead Radiographer presented the quarterly report for the Clinical Support Division and highlighted the key points.<br><br>Incidents had increased slightly during November and December which was due to the movement of endoscopy through to the division.<br><br>Radiology and Audiology<br><br>Interventional recovery area is now in place providing blood and hydration sessions.<br><br>Continue to grow own workforce with two apprentice radiographers and apprentice Assistant Practitioner. Also working through a solution to provide service leadership for Audiology.<br><br>The waiting list position was not representative for some MRI patients. Validation of the lists has allowed the reduction of numbers waiting and some mutual aid has been sourced, however pacemakers remain an area of concern due to the inability to establish dedicated slots.<br><br>The staffing position in audiology is also quite fragile and it has not been possible to recruit to a fixed term position to cover maternity leave. This is out to advert and continue to use insourcing to minimise the impact on the service.<br><br>Pathology<br><br>There had been exceptional performance in Histology with turn-around times are highest in region. A substantive Microbiology consultant has also been appointed<br><br>There are still some patient safety concerns due to a locum in histology, the harm review process is ongoing. Also increasing demands on microbiology consultant workforce.<br><br>Endoscopy<br><br>New optical scopes are now in place for bowel screening which are reducing the need for histology requests and it is hoped to also adopt this in other areas.<br><br>There is some concern about the impact of using endoscopy recovery as an escalation area, although an alternative recovery area has been identified. | |

| | | |
|---|---|---|
| | There had been an increased demand for 2 week wait colonoscopy requests which had resulted in an increase in waiting times for some routine patients.<br><br><u>Mortuary and Bereavement</u><br><br>Eden is now fully implemented for adult deaths and has been extended to maternity deaths.<br><br>All SOPs are now on iPassport and hope to rollout to other areas.<br><br>Successfully passed an external audit on mortuary governance but there is still concern regarding out of hours service gaps in Mortuary. This is partly due to cultural requirements with funerals and an update will be given in the next report on how that will be managed. **ACTION**<br><br><u>Pharmacy</u><br><br>Hayley Pearson is now in place as Clinical Director and the International Pharmacist has also commenced in post completing recruitment to the Junior Pharmacist pool.<br><br>Pharmacy KPIs had significantly improved in the last year.<br><br><u>Patient Access</u><br><br>Virtual fracture clinics are now well embedded and excellent feedback has been received regarding the wound clinic.<br><br><u>Cancer Services</u><br><br>The cancer dashboard is progressing well rated 9th/128 in terms of data completeness and a marked improvement in 62 day performance.<br><br>There are still some concerns in Haematology, risk of being a fragile service due to a reliance on locums.<br><br>Prostate and Colorectal will be the next sites to be developed.<br><br>The Chair noted the pause in South Midlands Pathology Network and concern regarding the delay and loss of impetus and future planning. The MD agreed to follow up with SMP. **ACTION**<br><br>There was some concern regarding the risk to the haematology service. This has been under discussion with Worcester and has been highlighted as one of the services that ICB will focus on in next year in terms of sustainability. One Haematologist has been appointed and will start in July. | **LH**<br><br>**JI** |
| | **A. The Quarterly report Clinical Support Division was received and noted.**<br>**B. An update on Mortuary out of hours issues will be given in the next quarterly report.** | **LH** |

| | | |
|---|---|---|
| | **C. To follow up on progress following the pause in South Midlands Pathology Network.** | **JI** |
| **QC14/03.25** | **<u>QUALITY COMMITTEE TERMS OF REFERENCE AND 2025/26 MEETING PLANNER</u>** | |
| | The Associate Director of Quality Governance presented the revised Terms of Reference.<br><br>The items highlighted yellow were new additions to terms of reference and those highlighted in blue were in the terms of reference last year and require confirmation that the committee is happy that they are reflective of the Committee's work and membership and how it operates.<br><br>Frances Martin (NED) asked the Company Secretary if there would be merit in standardising the Terms of Reference across group. However, this would take lot of work and the terms are very specific and contain a lot of detail.<br><br>In terms of Executive membership need to make sure there is board accountability.<br><br>Section 2.4 Related to divisional colleagues. If a member is unable to attend this should be by exception and any deputy should be able to fully represent said member.<br><br>Section 6. Quorum. Deputy Chief Nursing Officer to be added as delegated deputy for CNO.<br><br>3.2 Oversight of quality impact assessments although done through CEAC would still come via Quality Committee for assurance.<br><br>Although all Non-Executive Directors have an open invitation and attend regularly, there should be clear designated NED(s) membership for Quality Committee. IJ and FM to discuss offline. **ACTION**<br><br><u>2025-26 Meeting Planner</u><br><br>The Perinatal report had been added into the schedule together with the patient flow report.<br><br>There is a change in reporting of patient safety priorities. It is planned to bring a quarterly overview of all improvement work to evaluate progress to date, plus new plans for approval. PSIRF report to change to report to bi-monthly.<br><br>Colposcopy and safety walkabout frequency to be confirmed.<br><br>The revised terms of reference and quality priorities would be submitted for Board oversight and approval. | **IJ/FM** |

| | | |
|---|---|---|
| | **The revised Terms of Reference and quality priorities were agreed to be submitted for Board oversight and approval**<br><br>**Nominated NEDs to be assigned as Quality Committee members.**<br><br>**2025/26 meeting planner was agreed** | **IJ/FM** |
| **QC15/03.25** | **PERINATAL QUARTERLY SAFETY REPORT** | |
| | The Associate Director of Midwifery presented the perinatal safety quarterly report and highlighted the following points:<br><br>The red flags were recorded and these were a delay in induction of labour/artificial rupture of membranes. There are ongoing assessments and communication plans in place with patients. Noted a stepped increase in movement of midwifery staff to cover services this is due to the changed date set to use the birth rate+ tool which is reported 4 hourly.<br><br>There were four moderate incidents in February– One baby resuscitated and transferred to SCBU. The baby is doing well and gone home with mild HIE but did not meet the threshold for an external report. Rapid review has taken place and will move to after action review and be reported back through the Patient Safety Panel. There were two haemorrhages reviewed in line with current tools and will also feedback to patient safety panel. Also retrospective review of cases where there had been an increase in numbers in a particular week. Also one post-natal breakdown of perineum for which the patient returned for procedure and following review, was downgraded.<br><br>There had been one concern and 2 complaints received, largely centred around communication.<br><br>The Matron Women and Children gave the neonatal update.<br><br>One complaint had been received.<br><br>Sickness levels were above trust target but were improving.<br><br>A request had been received from LMNS board to do a workforce plan to address the QIS figure. Two further staff will undergo training later this year although, with a stable workforce this is not felt to be a risk. Super-numary Shift coordinator is a known risk but are happy this is being managed safety. An increase in the number of those with new born life support training should be seen in next month's data.<br><br>A meeting had taken place recently re cot reconfiguration and feedback from the national team was awaited on what impact this may have on bed capacity. The CNO and CMO had met with the ODN network, who are leading the reconfiguration and the main implication was that whilst the original information given suggested we would not be affected by the cot reconfiguration the network are now discussing changing designation of our neonatal unit which would have implications for both maternity and | |

| | | |
|---|---|---|
| | families that come on to the unit. All are fully sighted and working through this.<br><br>The CMO asked what learning had been taken from the three neonatal deaths graded at C. One had been an expected death so no learning was taken, one had been very preterm and decision was made to withdraw care. Underwent rapid reviews for all cases and have actions which can be shared. One case, there had been a delay in administration of antibiotics and is with LMNS. A factual accuracy report has been received but there is reluctance to grade in the absence of a final report but indicative gradings were C. Learning will be included in the mortality committee report.<br><br>The Maternity Safety Summit took place on 24th March. There was good attendance and facilitation from Human Resources and the Maternity General Manager.<br><br>The purpose of the summit was to identify what the service should look like and identified a number of solutions to achieve that vision. Some of the solutions included wide reaching 360 feedback and it was agreed there would be some insight work to be facilitated. It was agreed to develop a maternity vision and strategy and committed to regular meetings to take this work forward and improve the culture of the service.<br><br>It was agreed to produce a plan on page to draw out discussion and agreed actions to move forward. RG/AS will be meeting next week to agree the plan. Due to the seriousness of the concerns it was agreed this should be discussed regularly at Quality Committee through the quarterly reports.<br><br>It had also been useful to have both Midwifery and Obstetric representation at previous Quality Committee meetings and an Obstetric representative will be invited to attend quarterly going forward. | |
| | **A. The Perinatal Safety report was received and noted**<br><br>**B. Obstetric representative to be invited to attend on a quarterly basis** | |
| **QC16/03.25** | **STAFFING REPORT** | |
| | The Deputy Chief Nursing Officer highlighted some key points from the nurse staffing report.<br><br>There had been high numbers through ED with high numbers boarding. There had been a slight decrease in escalation areas used in month. These additional beds and the need of additional staff when boarding patients does have an impact on Fill rates.<br><br>Work has been undertaken with the regional agency collaborative to reduce the rates paid. The capped rate for general nurses was met at the end January and fill rates at cap are increasing month on month. | |

| | | |
|---|---|---|
| | The overall fill rate (shifts requested versus filled) was down significantly in February to 65% which was a safety concern. Fill rates have now started to come back up to over 85%.<br><br>There has continued to be a decrease in use of Thornbury but WVT remain an outlier compared to the region. A decision has been made to have a hard stop in April. The only nuance being Registered Mental Health Nurses. There had been a reduction in need year on year but there are still a cohort of patients where it is required. There is a piece of work with Hereford and Worcester Health and Community Care Trust in relation to any support they can give for RMNs and they are happy for WVT to join the NHS professional bank. There is also work to see if there is anything more that can be done with NHS professionals for Band 2 to support patients with mental health concerns.<br><br>Collaborative work focus is currently on compliance with the cap rate for specialist nurses by end March. There has been a lot of work done with ID medical to achieve this.<br><br>The absence of up to date establishments makes holding to account and fill rates difficult to navigate. Finance colleagues plan to rectify this by May. The NHSE fill rate data is difficult to navigate although is a nationally mandated reporting requirement. We will locally work on a revised more meaningful staffing report for Quality Committee. | |
| | **The staffing report was received and noted** | |
| **QC17/03.25** | **CLINICAL EFFECTIVENESS AND AUDIT COMMITTEE REPORT** | |
| | The report was taken as read and The Associate Director of Quality Governance highlighted the following point.<br><br>The meeting last month had concentrated on clinical audits and having audits presented which showed a robust audit cycle where improvements could be shown. | |
| | **The Clinical Effectiveness and Audit Committee report was received and noted.** | |
| **QC18/02.25** | **INFECTION PREVENTION COMMITTEE QUARTERLY REPORT** | |
| | The Chief Nursing Officer presented the Infection Prevention Committee Quarterly report.<br><br>It was noted that the appended minutes were not yet approved by the IPC and were still in draft.<br><br>For clarification the minutes indicated that PCR testing would be replaced with LFT triple testing. This is not the case as he evidence base for LFT is limited and no trust has adopted this. The use of LFT triple test for screening and placement of patients will continue but PCR testing will remain. A post meeting amendment will be made to the minutes. | |

| | | |
|---|---|---|
| | **The Infection Prevention Committee Quarterly report was received and noted.** | |
| **QC19/03.25** | **PLACE AUDIT RESULTS** | |
| | The Lead Infection Prevention Nurse presented the PLACE audit results.<br><br>The audit was undertaken between September and November on all inpatient sites.<br><br>Question sets had not changed from the previous year and score towards one or more non-clinical domains:<br><br>• Cleanliness<br><br>• Combined food looks at food provision and whether met national standards. Also included tasting of food by patient reps and observed food service.<br><br>• Dementia and the physical environment and how it caters for patients.<br><br>• Disability including provision for car parking and access.<br><br>• Privacy, dignity and wellbeing - whether appropriate changing rooms are available for staff, private spaces for conversations to take place and access to external grounds for patients and staff.<br><br>• Condition appearance and maintenance<br><br>Trust met averages in cleanliness, organisational food service and condition and appearance (but not all sites).<br><br>Did Not score well in privacy, dementia and disability. Across all domains a drop of 7-11% was seen compared to last year. Bromyard had improved across all domains, however, averages from all sites are below national average.<br><br>There were a large number actions with common themes across sites. These themes remain the same as last year.<br><br>Some of reasons for not scoring well for dementia, disability and privacy are to do with our estate and rectifying these may be beyond our control such as provision of more accessible toilets. These domains will be reviewed to determine where the issues can be rectified and areas that cannot.<br><br>The results had also been presented to Patient Experience Committee and there was concern about dementia and disability and privacy and will be looking for further oversight. | |

| | | |
|---|---|---|
| | Need to prioritise the actions taking into account what would have the greatest impact and also taking learning from elsewhere in group. Only those relating to privacy, dignity and wellbeing and dementia to be of focus. | |
| | **The PLACE Audit results summary was received and noted.** | |
| | **CONFIDENTIAL SECTION** | |
| **QC20/03.25** | **PATIENT SAFETY INCIDENTS SUMMARY REPORT** | |
| **QC21/03.25** | **ANY OTHER BUSINESS** | |
| | The Chief Medical Officer asked the Committee to note the fragility of the respiratory service. During the last 8 months two locums had left leaving two Substantive consultants covering wards. A weekly meeting has been convened to support the team and look at solutions and would report back on progress. | |
| **QC22/03.25** | **DATE OF NEXT MEETING**<br><br>The next meeting is due to be held on 24 April 2025 at 1.00 - 4.00 pm via MS Teams. | |

## WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

| | |
|---|---|
| **Report to:** | **Public Board** |
| **Date of Meeting:** | **03/07/2025** |
| **Title of Report:** | **Quality Committee 24 April 2025 Minutes and Escalation Report** |
| **Lead Executive Director:** | **Chief Nursing Officer** |
| **Author:** | **Ian James, Non-Executive Director and Chair** |
| **Reporting Route:** | **Direct to Board** |
| **Appendices included with this report:** | **Minutes of Quality Committee, April 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. **Mortality Report –** Committee noted the increase in SHMI to 103.8 and noted the concerns about the quality of data being submitted regarding Fractured Neck of Femur deaths.
2. **Quality Priority – Ensuring Timely VTE Assessments for Patients** – This has been the focus of an improvement programme for the past year with a focus on education for staff, ensuring correct reporting of figures across all services and putting in place a dashboard to ensure effective oversight of performance. The latter enables focus on areas not performing well enough as well as identification of themes and trends. There are still improvements to be made as we are still short of the 95% though this is consistent with regional and national reporting trends.
3. **Patient Flow Report** – Boarding continues to be our greatest area of challenge for quality and safety of patients and Committee discussed a number of quality and safety incidents arising as a result. Committee welcomed the planned workshops taking place with a wide range of staff and services to identify opportunities to improve quality and safety for patients.
4. **Quality Priority – Food Quality and Nutritional Risk** – Food quality continues to be an area of poor patient feedback and Quality Committee welcomed renewed focus in this area. Alongside this the priority will also strengthen and embed a more robust process to ensure a nutritional risk assessment is in place for patients.
5. **Divisional Report – Surgery** – Committee received a summary of incidents and complaints including response times and themes. Of particular concern was the increase in complaints for the Gynaecology service and Committee will continue to monitor this area. Committee welcomed the assurance provided by the SEND inspection of services for children with special educational needs and disability and was pleased with reduced length of stay for hip-replacement and knee-replacement patients and the reduction in infection rates.
6. **Safeguarding Quarterly Reports** – Committee noted the question of referral processes from ED for domestic abuse victims and asked for clarification of issues and processes. For Looked After Children there was assurance regarding improvements of initial health assessments within timescales and the improvements in dental access were also noted. Review health assessments and for children living out of county remain challenging.
7. **Perinatal Safety Report** – There were no matters to report by exception and Committee noted the publication of the year 7 CNST standards. Committee did note the shortfall in neonatal post registration qualification numbers in SCBU but received assurance that this has not presented safety issues.
8. **Neonatal Peer Review** – Committee was very pleased with the positive feedback from the peer review. As would be expected there are some areas identified for improvement and Committee was assured that these were being actioned.

**Matters for Escalation -** None

**WYE VALLEY NHS TRUST**
**Minutes of the Quality Committee**
**Held on 24th April 2025 at 1.00 – 4.00pm**
**MS TEAMS**

| | | |
|---|---|---|
| **Present:** | | |
| Ian James | IJ | Non-Executive Director (Chair) |
| Eleanor Bulmer | EB | Associate Non-Executive Director |
| Lucy Flanagan | LF | Chief Nursing Officer |
| Rachael Hebbert | RH | Associate Director of Nursing |
| Sharon Hill | SH | Non-Executive Director |
| Jane Ives | JI | Managing Director |
| Frances Martin | FM | Non-Executive Director |
| Jo Rouse | JR | Associate Non-Executive Director |
| Emma Smith | ES | Deputy Chief Nursing Officer (items 7,8 and 9 only) |
| Grace Quantock | GQ | Non-Executive Director |
| Nicola Twigg | NT | Non-Executive Director |
| **In Attendance:** | | |
| Chris Beaumont | CB | Mortality Project Manager |
| Lynn Carpenter | LC | Quality and Safety Matron |
| Liz Davies | LD | Radiology Services Manager |
| Kirstie Gardiner | KG | Named Nurse Children in Care (item 10) |
| Helen Harris | HH | Integrated Care Boards (ICB) Representative |
| Hamza Katali | HK | Associate Chief Medical Officer |
| Susan Moody | SM | Associate Chief AHP, Integrated Care Division |
| Tom Morgan-Jones | TMJ | Deputy Chief Medical Officer |
| Hayley Pearson | HP | Clinical Director Pharmacy |
| Sara Powell | SP | Matron Women and Children (item 12 & 13) |
| Vicky Roberts | VR | Executive Assistant (minutes) |
| Amy Tootell | AT | Specialist Nurse Advisor Safeguarding Children (item 10) |
| Emma Wales | EW | Associate Chief Medical Officer, Medical Division |
| **Apologies:** | | |
| Chizo Agwu | CA | Chief Medical Officer |
| Leah Hughes | LH | Operational Clinical Lead Radiographer |
| Natasha Owen | NO | Associate Director Quality Governance |
| Gwenny Scott | GS | Company Secretary |

| Ref | Item | Lead | Purpose | Format |
|---|---|---|---|---|
| **1.** | **Apologies for Absence** | **IJ** | **Information** | **Verbal** |
| Noted as above | | | | |
| **2** | **Declarations of interest** | **IJ** | **Information** | **Verbal** |
| There were no new declarations. | | | | |
| **3.** | **Minutes of meeting 27th March 2025** | **IJ** | **Approval** | **Enclosure 3** |
| Approved. | | | | |

| | | | | |
|---|---|---|---|---|
| **3.1.** | **Matters Arising and Action Log** | **IJ** | **Discussion** | **Enclosure 3.1** |

The actions were updated:

QC13/03.25 – Follow up on progress following the pause in South Midlands Pathology Network – Working with Worcester and improvements have been made and is no longer considered to be a fragile service with the exception of Haematology.

No further matters arising.

| | | | | |
|---|---|---|---|---|
| **4.** | **BUSINESS SECTION** | | | |
| **4.1** | **Mortality Report** | **CB** | **Information** | **Enclosure 4a/4b** |

- The latest rolling SHMI is 103.8 which is a small increase.
- March 2025 crude mortality was 1.24% of admissions which equates to 81 deaths in the acute hospital setting.
- #NOF – Following several consecutive reductions, mortality rates are back within the expected range. The Clinical Lead re-reviewed all data which had been submitted to NHFD and was found to be of poor quality. Following review the data was re-submitted and it is projected to have a positive impact on SHMI in the coming months.
- #NOF fast track bleep is now in place and have a dashboard to monitor all patients' length of stay, time to specialist ward and time to surgery.
- Sepsis has shown reductions since mid-2024 and a summary of the audit and improvement work was presented at Learning from Deaths Committee. A lot of training has taken place and there have been improvements in care bundle compliance and antibiotics administration.
- Heart failure data has shown a further significant increase to 112. The expected number of deaths had dropped more quickly than expected due to depth of coding. Cardiology had also recently lost the mortality lead. This will be a priority going forward.
- During March there were 221 deaths across Herefordshire. All cases were reviewed and scrutinised by the Medical Examiner. Of the 96 hospital deaths that occurred, 14 had some clinical concerns and were escalated. However, 11 of those cases showed excellence in care.
- Main learnings from ME, SJRs and mortality review panel is identification of NIV patients. A workshop is taking place 1st May to start discussions and plans for improvement of that pathway.

| | | | | |
|---|---|---|---|---|
| **5.** | **Quality Priority – Ensure patients receive a timely VTE risk assessment in line with NICE guidance** | **TM-J** | **Information** | **Enclosure 5** |

- VTE assessment returned to contract in 2024 and patients are expected to be assessed within 14 hours rather than 24 hours. WVT are reporting to 24 hours until can be assured that everywhere is meeting the 14 hour requirement.
- An improvement plan has been implemented with teaching and education and have also reached out to the VTE specialist network.
- The Power BI dashboard is in place and is currently at 94%
- The difference achieved by the data logic revision related to previous incorrect reporting of SDECs.
- National reporting ran to 2020, with a pause during Covid, restarting in 2024. Nationally the percentage has not reached 95 in any region.
- Continue to work with the divisions to improve activity and there is need to address the elective pathway and are close to agreement to implement. Much is centred on the link between Maxims and EPRO. Testing is taking place to ensure the link is working and will launch soon thereafter.
- Certain wards are not performing as well as should be and this is shown in the power BI dashboard. This will be shared in near future
- There are a number of outstanding In-phase reports related to hospital acquired VTEs in the Medical division. These show some trends and themes and an impact assessment is being written to resolve this as quickly as possible.

| 6. | Quality Priority – Food quality and nutritional risk | RH | Information | Enclosure 6 |
|---|---|---|---|---|

- Some progress had previously been made to improve food quality in 2022-23. This new quality priority hopes to make an improvement to scores for in-patient food.
- Nutrition and quality of food for patients has received negative feedback and will be a highlight for 2025-26 with focus on implementing sections of the food and drink strategy for high quality and safe nutrition and hydration, developing more targeting meal service audits to include lead dieticians and Sodexo and ward staff.
- Nutritional governance structure have regular Nutritional Care Group meetings feeding into steering group. It has been challenging to get attendance but have used the roving model to highlight specific areas to look at meal service and food and to use patient feedback to inform improvements.
- Measurement will be made by triangulating annual in-patient audit, PLACE audit and Sodexo/ward team audit of the meal service.
- The previous in-patient survey data showed improvement in some areas but deterioration in others. PLACE audit results reflected more negatively.
- Moving forward there will be focus on particular ward areas initially, concentrating on those where there have been a higher number of complaints or concerns.
- In addition to quality of food there is also need to focus on nutritional risk assessment. A ward dashboard is now in place for teams to see which patients have had a risk assessment and there is also an annual audit of compliance by a lead dietician.
- LF noted that a recent meeting with some complainants had revealed that most issues were focussed on food service and food options and currently all patients receive the same food offer. There are also limited options for those patients with special dietary requirements and this will also be an area of focus. There had been a positive response to change of crockery. Sodexo have been asked to also address the issue of delivering bread to wards which is currently toasted by clinical colleagues. An early solution to this has been requested as is raised frequently as an issue.

It was noted that the naso-gastric policy from 2023-24 had not been fully signed off and a plan for final sign of was in progress and was currently with the DCMO. **ACTION TM-J**. To note there is a policy in place for placement of NG tubes and X-ray confirmation of them. The small part to resolve is the confirmation of number of competent doctors able to interpret the X-ray. **ACTION: TM-J**

| 7. | Staffing Report | ES | Information | Enclosure 7 |
|---|---|---|---|---|

- There had been a high level of boarders and additional beds had also been open at Bromyard Community Hospital and some escalation areas to accommodate pressures.
- There had been an outbreak of Norovirus which had led to closure of one of the frailty ward.
- Decant of ITU for routine works had impacted fill rates. Fill rate remains above 100% to support with boarding and also due to establishment not being correct for some areas. Work is taking place with Finance this month to ensure correct establishments and hope to see improvements for reporting in May.
- There had been a reduction of incidents in month relating to staffing. All were reported as no harm incidents.
- NARP data in ward areas for sickness had seen a downward trend in relation to vacancies for both nurses and HCA.
- There was an increase in maternity leave and continued to see high levels of pregnancy related sickness.
- Agency usage, the highest areas for temporary staffing remained ED, Frailty, Redbook and Frome wards and community hospitals, mainly to cover vacancies and sickness.
- Work continues with the regional collaborative to ensure all shifts are at cap rate with agency, which has been reducing since the start of the year. All band 2 agency use will stop across the region by end June 2025.
- It was noted that the regional collaborative was having the desired effect on agency working in that a number of agency nurses had been recruited to substantive roles.

Clarification is required on what is measured for percentage of agency and bank usage as whether is as percentage of paybill or percentage of temporary workers being used in comparison to substantive. This is recorded as percentage of pay bill in the Board Report and could be cause for confusion. **ACTION ES**

It was also noted that there had been some good work with Mental Health Trust around registered mental health nurses which, if brought to conclusion, would make a considerable saving.

| 8. | Patient Flow Report | ES | Information | Enclosure 8 |
|---|---|---|---|---|

- There had been an increase in the number of attendances in March. Admission through ED had seen a significant increase which had affected timely ambulance handovers.
- There had also been an increase in length of stay over 12 hours in ED, length of stay over 24 hours and numbers with decision to admit increased in mornings.
- Boarding patient numbers remained stable but were still at high level with an average 24 at any one time.
- Discharge lounge usage decreased slightly in month and will continue to be monitored.
- Level of incidents remained stable, however some new themes were seen on Arrow Ward procedure room used for boarding patients which impacts ability to treat patients in that area. Will continue to monitor and also ensure that wards can reverse board patients wherever possible.
- There are occasions when it is not possible to give therapy to boarding patients due to lack of space.
- Case regarding a boarding patient who had an unwitnessed fall on Garway ward and passed away. The patient was the second patient in a large side room with a temporary privacy screen and the patient was not in view. The cause of death was not attributed to the fall but following a round table boarding was stopped. GQ suggested the use of sensors to monitor movement of patients, however this had been tried previously had had not been successful.
- A number of quality improvement workshops are planned around enabling flow. These will be face to face and will include MDT colleagues across all divisions. Following this will run a test of change month to test some of those changes. Dates of workshops are to be confirmed but to allow sufficient time for clinical colleagues to re-arrange clinical commitments.
- It was important to ensure that the flow policy is followed and that only appropriate patients are boarded in certain areas.

| 9. | Divisional Quarterly Report – Surgery | ES | Information | Enclosure 9 |
|---|---|---|---|---|

- Incidents were stable between 250-300 each month
- There were no new PSIRF investigations and no never events in the reporting period. There are three ongoing PSIIs which are in progress. For assurance the division are reviewing actions from investigations and any learning embedded in practice. They are also taken back through Patient Safety Committee for further oversight.
- There were 40 new complaints in quarter plus one come back complaint. 34% of complaints were closed within 30 days. Themes were around poor communication and continue to work on these. There had also been a high number of compliments and Friends and Family score was at a high level.
- One MRSA bacteraemia case was reported which related to a patient who came in through ED. No lapses in care were identified on review. There had also been one case of Clostridium difficile.
- There were no concerns to note on tissue viability.
- There had been an increase in unwitnessed falls. Training has taken place and will continue to monitor.
- VTE compliance had increased slightly. Work continues mapping the VTE pathway for elective patients to undertake assessment at pre-operative stage.
- Feedback from the SEND inspection was received in February and there were several areas of good practice, including 'whilst you wait group' which helps to support children awaiting autism assessment. Within Health Visiting at the 3 year developmental review, additional needs are pick up early and onward referrals are made.
- There were a small number of actions - Standardisation of health education care plans for children with educational needs. Some additional training has been undertaken to support this and some SEND training for individuals working in that area
- A social media page is being developed for parents and families with overarching provision and advice.
- Within Trauma and Orthopaedics there have routinely been 6-7 patients suitable for Virtual Ward each week.
- Enhanced recovery hip and knee arthroplasty pathway has reduced length of stay. Hips now 2.8 days (previously 3.5) and knee 2.3 days (previously 3.7). National target for length of stay is 2.7 days.
- There had been a big improvement in surgical site infection with a zero rate over the last 5 periods.

- There had been an increase in complaints in the Gynaecology service over the last 6 months, particularly around communication and empathy. A safety summit, chaired by the CMO, was held in March to explore these in more depth. Actions to address were identified and will continue to monitor.
- There were also some concerns regarding the paediatric elective orthopaedic service is unable to see patients due to lack of specialist Consultant provisions. Those patients most at risk were those with development of dysplasia of hips and club foot. Birmingham Children's Hospital are able to provide this service and are looking to formalise this through Service Level Agreement. This on the Trust risk register and a further update will provided in the next report.
- The last report had raised concerns in relation to the National Emergency Laparotomy Audit data. Improvements have been made due to additional nursing support. The year 9 report data shows current mortality rate of 7.6% which is second lowest within the region.
- There are still several data issues related to NELA and these will be raised at CEAC in May.

| **10.** | **Safeguarding Quarterly Reports** | **RH/KG /AT** | **Information** | **Enclosure 10** |
|---|---|---|---|---|

Adult Safeguarding

- Both Children and Adult Safeguarding teams are doing combined training. There is continued good training uptake for MCA DOLs. However, there is limited level 3 Adult training at present due to the long wait for ICB training.
- Of concern is that ED doctors are not always offering a patient a HIDVA referral when domestic abuse is disclosed. Domestic Abuse Lead is doing some work on this and training is also planned for the District Nursing team. The CNO asked for clarification on how disclosure has been picked up if referral has not been offered. RH would pick this up with the DA lead and update at next meeting. **ACTION RH**

Children in Care

- Have succeeded with 70% of initial health assessments in quarter 4 within timescale which is a marked improvement.
- 73% children had seen a dentist in last 6 months and this would improve further as 2 community dentists have now been recruited.
- Challenge in getting review health assessments within timescale due to new staff induction and sickness.
- There is some concern as out of county children are waiting longer for assessments. There are particular challenges with one particular county and a plan is in place to mitigate.
- There are challenges to find clinic capacity and loss of clinic space at Belmont is likely to disrupt health assessments for children in Hereford. Further space has been secured for the next 12 months which should help this to improve.
- There was a drop in the number of children into care in quarter four.
- *Referrals had gone down and currently have a lot of children who have been looked after for long time, referred to as legacy children. Throughout 2025 it is anticipated that 70 children will turn 18.* Children coming into care now have more robust permanence plans. Is difficult to say what base level is at present until longer term looked after leave care. With this in mind, it was also noted that outcomes for children when they leave care had generally been poor and a lot of work had been done to improve. Also to improve health outcomes for those between the ages of 16-18.
- Suitability of accommodation for looked after children is part of the remit of the multi-disciplinary Better Outcomes Panel.

Child Safeguarding

- Health visitors and school nurses had been in attendance at 100% of initial case conferences
- Public Health nurses supervision rates have improved. Health visitors 96%, school nurses 100%.
- Community midwifery supervision remains high at 100%
- The Children and Adult Safeguarding Forum had been well attended by paediatric staff.
- Work around 'keep me safe around dogs' has launched and all webinars completed.

- The increased capacity in MASH has allowed practitioners to provide analysis of health information to ensure right decisions are being made for referrals.
- There is concern that the number of children subject to child protection plans has continued to decrease. Also a significant decrease in the number of children with domestic abuse referrals from Police and will be raised in the MASH operational meeting.
- ED compliance with level 3 training had decreased and has been raised with the service lead. The risk is however mitigated as paediatric assessment unit is fully staff by paediatric staff with level 3 compliance.
- Level 3 compliance in general had reduced to 84% and will continue to work to promote that.
- There had been *a reduction in the number of maternity escalations.*
- It was escalated that the WVT team had not invited to multi-agency Family Formulation Champions meeting that Children's Services have been holding. In response to that the team have now been invited to next meeting.

| 11. | **Patient Safety Committee Terms of Reference and Planner 2025/26** | **TM-J** | **Approval** | **Enclosures 11a/11b/11c** |
|---|---|---|---|---|

The committee were asked to note and approve the terms of reference and forward planner for the Patient Safety Committee.

The Terms of Reference have been updated to align with new workstreams, and purpose, membership and accountability to Quality Committee; have been presented to Patient Safety Committee and agreed for onward agreement at Quality Committee.

Learning and monitoring from incident investigations will be reflected back in to PSC through oversight.

**The Terms of Reference and planner for 2025/26 were approved by the Committee**.

| 12. | **Perinatal Safety Report** | **LF/SP** | **Information** | **Enclosure 12** |
|---|---|---|---|---|

- There was nothing to report by exception.
- Preterm pathway and post-partum haemorrhage remain a focus for quality improvement.
- Maternity incentive scheme years 6 declared 10/10 self-declaration to CNST. The official outcome is imminent. Year 7 has just published and will feedback main changes in future reports.
- The score card included in the quarterly report refers to incidents considered in the previous quarter and to aid with recollection of those more thematic oversight will be provided in future.

Neonatal

- A paper is being prepared for QIS data to LMNS board giving a trajectory of how going to achieve expected standards.
- Neonatal post registration qualification numbers and requirements has two separate elements – 1, based on size of units and number of cots WVT should have one per shift which is achieved majority of the time. If at higher capacity there should be two. Expected standard for SCBU is 70% and we are below that standard but has not presented safety issues. Post qualification is a lengthy process and work has been done with the university to expedite without reducing quality.
- The good work of the work of champions and good feedback from last visit was acknowledged

| 13. | **Neonatal Peer Review Outcome and Response** | **SP** | **Information** | **Enclosure 13** |
|---|---|---|---|---|

The peer review had been undertaken in November 2024. There was a positive outcome overall however the following actions were addressed:

1. Change position of cots to face inwards. Completed
2. Storage time for breast milk – Completed. Related to the amount of time the milk is on cots once removed from the fridge to align to regional guidance.
3. Security of specialised milk and supplements. Completed. Have agreed to secure them away but still offer a number of options to families.
4. Emergency pull cords in parent bathroom remains a risk. Awaiting quotes to resolve. Most patients are medically fit but mitigate the risk by being aware that the bathroom is in use.

5. Centralised monitoring system and being able to hear monitors alarming. Has been purchased and awaiting install.

- Lack of AHP support. Working with the LMNS and looking at disparity to Worcester. There is a responsive service for therapy with referrals put in when needed. Feedback from Worcester is that it is very difficult to evidence improvement. Lack of dedicated support is an issue due to the smallness of the trust and flexibility
- There were noted achievements in perinatal team working. High retention rates, infection control measures, number of midwives who can undertake the NIPE examination, use of donor milk, number of professional nurse and midwife advocates who are able to offer debriefs for staff.
- Very complimentary feedback received from parents on unit who were impressed with the information available on the unit.

It was agreed that the results were very positive. And that the excellent teamwork and commitment should be commended.

| 14. | Patient Safety Committee Summary Report | TM-J | Information | Enclosure 14 |
|---|---|---|---|---|

The report was taken as read.

- The Resuscitation Committee has re-established and meet quarterly. In addition, have re-commenced participation in the National Cardiac Arrest audit and benchmark against resuscitation quality standards.
- There have also been some novel solutions to improve training.
- There has been good collaboration with Gloucestershire Hospitals Trust to mitigate patient safety risks when undertaking PSII. New guidelines and alert care as the result of an incident.
- An area of concern is medicines training. The trust target of 85% has been achieved however managers have not be able to amend ESR records. The education team are assisting.
- The draft EDS issue is not yet resolved. A plan is in place to progress but there have been significant delays. There are a large number in maternity. It is agreed that for the 200 EDs from specialities outside maternity will write to primary care to warn of the process regarding discharge summaries. One week later, summaries will be sent via electronic portal. Maternity have 1600 summaries. It is planned to go through midwifery review to triage. It is anticipated that risk to those who have had babies is much lower than other groups and no harm has been identified so far. A summary will be brought to June Committee when the response from primary care is known.
- Escalations – NRfit transitions were overdue for closure. Assurance and risk assessments have been received and are satisfied that appropriate mitigation is in place and looking to turn off supply of non-NR fit equipment to key areas.

| 15. | Patient Experience Committee Summary Report | LC | Information | Enclosure 15 |
|---|---|---|---|---|

The report was taken as read.

- The main topic had been around the PLACE audit
- Improvements in all sections of the audit were seen at Bromyard
- The main areas of concern from the audit was the overall deterioration in 3 core areas showing no improvement from previous year.
- Feedback has been generally positive around the new interpreter service
- It had been previously identified within Quality Committee need to co-ordinate the action plan and monitor and support and to focus on key areas.
- It is key to see a reduction in the number of complaints and there had been gentle shift to PHSO guidance for complaints and highlighted key areas for need change and will work towards stakeholder engagement. There has been good work in terms of early resolution. It is in the policy mapping stage and an update will be brought to this meeting.

| 16. | Infection Prevention Committee Summary Report | LF | Information | Enclosure 16 |
|---|---|---|---|---|

Hip and knee surgical site infection rates had seen a strong performance with no infections.

- There had been 2 MRSA bacteraemia cases within the last month. The one featured in the Surgical Division report was an Ophthalmology patient who had ongoing care needs at home. She had been unwell when attended for her ophthalmology procedure and presented in ED 48 hours later. A further case has since reported for an in-patient and is undergoing rapid review.
- It has been agreed to move KPIs to quarterly reporting and to report exceptions on a monthly basis.

The report gives the impression of being a mortality outlier for Clostridioide and E.coli. It is not certain whether a true outlier or whether our outlier status is due to small numbers. A meeting recently agreed the following - All Clostridioide and E.coli cases are subject to post infection review to look at acquisition of infection and any underlying condition. It was agreed for the current process to continue but to do focussed audit of cases to identify any common themes or areas for focus. The Infection Prevention team are leading. It was also agreed that where medical examiners put forward cases for structured judgement review if any of these identify E.coli or clostridioide on death certificate this would feedback to the Infection Prevention Team. It is thought to be related to small numbers but requires further review to be clear.

| | | | | |
|---|---|---|---|---|
| **17.** | **CONFIDENTIAL SECTION** | | | |
| **17.1.** | **Patient Safety Incidents Summary Report** | **LC** | **Information** | **Enclosure 17** |
| **18.** | **Any Other Business** | **All** | **Discussion** | |

No further business was raised.

| | |
|---|---|
| **19.** | **Date of Next Meeting** |

**Thursday 29th May 2025 – 1.00-4.00pm**
**MS Teams**

| Acronym | |
|---|---|
| AAU | Acute Admissions Unit |
| AHP | Allied Health Professional |
| AKI | Acute Kidney Injury |
| AMU | Ambulatory Medical Unit |
| A&E | Accident & Emergency Department |
| BAF | Board Assurance Framework |
| BAME | Black, Asian and Minority Ethnic |
| BCF | Better Care Fund |
| CAMHS | Child and Adolescent Mental Health Services |
| CAS | Central Alert System |
| CAU | Clinical Assessment Unit |
| CCU | Coronary Care Unit |
| C. Diff | Clostridium Difficile |
| CPIP | Cost Productivity Improvement Plan |
| CNST | Clinical Negligence Scheme for Trusts |
| COPD | Chronic Obstructive Pulmonary Disease |
| COSHH | Control Of Substances Harmful to Health |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality & Innovation |
| DOLS | Deprivation of Liberty Safeguards |
| DCU | Day Case Unit |
| DNA | Did Not Attend |
| DTI | Deep Tissue Injury |
| DTOC | Delayed Transfer Of Care |
| ECIST | Emergency Care Intensive Support Team |
| ED | Emergency Department |
| EDD | Expected Date of Discharge |
| EDS | Electronic Discharge Summary |
| EPMA | Electronic Prescribing & Medication Administration |
| EPR | Electronic Patient Record |
| ESR | Electronic Staff Record |
| FAU | Frailty Assessment Unit |
| FBC | Full Business Case |
| FOI | Freedom of Information |
| F&F | Friends & Family |
| FRP | Financial Recovery Plan |
| FTE | Full Time Equivalent |
| GAU | Gilwern Assessment Unit |
| GEH | George Eliot Hospital |
| GIRFT | Getting It Right First Time |
| GMC | General Medical Council |
| 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 |