Public Trust Board

Tue 10 June 2025, 13:00 - 14:30

Teams

Agenda

13:00 - 13:05
5 min

1. Welcome and Apologies for Absence

Information *Russell Hardy*

13:05 - 13:05
0 min

2. Declarations of Interest

Information *Russell Hardy*

13:05 - 13:10
5 min

3. Minutes of WAHT Board Meeting held on 31 March 2025

Decision *Russell Hardy*

3. Trust Board Minutes 31 March 25 Public 1.pdf (5 pages)

3.1. Actions and Matters Arising from the meeting held on 31 March 2025

Information *Russell Hardy*

3.1 Public actions.pdf (1 pages)

13:10 - 13:10
0 min

4. Foundation Group Minutes, Actions and Matters Arising from 7 May 2025

Information *Russell Hardy*

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

13:10 - 13:20
10 min

5. Chief Executive’s Report

Information *Stephen Collman*

5. CEO Board Report 100625 Final.pdf (5 pages)

13:20 - 13:40
20 min

6. Integrated Performance Report

Information *Stephen Collman*

6. Trust Board IPR Jun-25 (Apr-25_Data)_0-1.pdf (21 pages)

6.1. Introduction

Stephen Collman

6.2. Operational Performance

Chris Douglas

6.3. Quality & Safety

Sarah Shingler/Jules Walton

6.4. Workforce

Alison Koeltgen

6.5. Finance

Neil Cook

13:40 - 13:45
5 min

7. Safe Staffing Report

7.1. Midwifery

Information *Justine Jeffery*

- 7.1 Midwifery Safe Staffing Report April 2025.pdf (6 pages)

7.2. Nursing

Information *Sarah Shingler*

- 7.2 1 Safer Staffing report Covering Report Trust Board June.pdf (1 pages)
- 7.2 2 Staffing paper Apr 25 FINAL SS.pdf (8 pages)

13:45 - 13:50
5 min

8. Quality Account

Decision *Sarah Shingler*

- 8. Quality Account 2024-25 paper.pdf (3 pages)
- 8.1 Appendix 1. Quality Account for Trust Board v1.pdf (98 pages)
- 8.2 Appendix 2. Summary Quality Account working draft v2.pdf (12 pages)
- 8.3 Appendix 3. DRAFT Quality House 2526 for Trust Board 30052025.pdf (2 pages)

13:50 - 13:55
5 min

9. Scheme of Delegation & Standing Financial Instructions

Decision *NEIL COOK*

- 9. Trust Board - AAC SoD and SFI Header Sheet -10.06.2025.pdf (3 pages)
- 9.1 Scheme of Delegation March 2024 V10 March 2025 - final.pdf (42 pages)
- 9.2 SFIs v8 - March 2025.pdf (52 pages)

13:55 - 14:00
5 min

10. Board Committee Reports

10.1. Quality Governance Committee

Information *Dame Julie Moore*

- 10.1 Minutes for Quality Governance Committee April final.pdf (6 pages)

10.2. Audit & Assurance Committee

Information *Colin Horwath*

- 10.2 AAC Escalation & Assurance Report 8 May 2025.pdf (3 pages)

10.3. People & Culture Committee

Information *Karen Martin*

10.3. 04.02.25 PC Minutes.pdf (7 pages)

10.4. PFI Expiry Committee

Information *Tony Bramley*

10.4 draft PFI Expiry Committee Escalation & Assurance Report 2 June 2025.pdf (1 pages)

14:00 - 14:00
0 min

11. Trust Seal

Information *Gwenny Scott*

11. Report on the Use of the Trust Seal 2024-25_Board June 25.pdf (1 pages)

14:00 - 14:00
0 min

12. Quality Governance Committee Terms of Reference

Decision *Sarah Shingler*

12. Front sheet QGC ToR for approval.pdf (1 pages)
12.1 ToR QGC Nov 2024.pdf (6 pages)

14:00 - 14:00
0 min

13. Charles Hastings Education Centre Update Report

Information *Tony Bramley*

13. C Hastings update Report.pdf (2 pages)

14:00 - 14:05
5 min

14. Date of Next Meeting

Information *Russell Hardy*

WAHT Trust Board - 8 July 2025

14:05 - 14:05
0 min

15. Any Other Business & Questions from the Public

Information *Russell Hardy*

14:05 - 14:05
0 min

16. Acronyms

Information

16. Acronyms.pdf (3 pages)

Trust Board
31 March 2025 at 1:00pm
Via Microsoft Teams and live streamed on YouTube
Part 1 in Public

Board Members Present (voting)			
Russell Hardy, Chair	RH	Simon Murphy, Non-Executive Director	SM
Stephen Collman, Managing Director	SC	Glen Burley, Chief Executive Officer (for item 6 onwards)	GB
Karen Martin, Non-Executive Director	KM	Sarah Shingler, Chief Nursing Officer	SSh
Neil Cook, Chief Finance Officer	NC	Julie Moore, Non-Executive Director	JM
Tony Bramley, Non-Executive Director	TB	Jules Walton, Chief Medical Officer	JW
Board Members Present (non-voting			
Ali Koeltgen, Chief People Officer	AK	Jo Newton, Chief Strategy Officer	JN
Julian Berlet, Chief Clinical Strategy Officer	JB	Chris Douglas, Interim Chief Operating Officer	CD
Rebecca Brown, Chief Digital Information Officer	RB	Michelle Lynch, Associate Non-Executive Director	ML
Sue Sinclair, Associate Non-Executive Director	SSi	Catherine Driscoll, Associate Non-Executive Director	CD
Attending			
Gwenny Scott, Company Secretary	GS	Elizabeth Faulkner, Deputy Chief People Officer	EF
Justine Jeffery, Director of Midwifery	JJ	Richard Haynes, Director of Communications & Engagement	RH
Apologies			
Colin Horwath, Non-executive Director	CH	Alex Moran, Associate Non-Executive Director	AM

Ref	Item	Lead	Purpose	Format	Outcome
1	Apologies for Absence	RH	Information	Verbal	Noted as above
2	Declarations of interest	RH	Information	Verbal	No new declarations
3	Minutes	RH	Approval	Report 1	Approved

AK referred to page 3, workforce section to be amended to 'Establishment growth across a number of areas'.

The actions were reviewed.

4	Chief Executive's Report	GB	Information	Report 2	None

The report was taken as read in the absence of GB. RH summarised the key points, including congratulations to the Executive Team for delivering its cost and productivity improvement targets in 2024/25, which gave confidence for 2025/26. The Board acknowledged the positive impact of Foundation Group membership on the Trust culture and ways of working in supporting this achievement.

The Board noted the report.

5	Integrated Performance Report	SC	Information	Report 3	None

SC introduced the report and highlighted the following key points:

- Improvements were reported around a number of UEC targets, particularly with ambulance handovers, which had been an area of focus. There was still more work to do, especially with regard to 12 hour waits.
- Elective and cancer performance were holding, though there were more improvements to be made. The current focus was on productivity, with a number of schemes planned.
- Quality areas to focus on related to infection prevention and control and sepsis compliance. There had been improvements with complaints management.
- The staff survey results indicated that the Trust was the third most improved Trust nationally on staff recommendation as a place to work.

Operational Performance (CD)

Cancer

Faster Diagnosis Standard performance was 80%, meeting the national target, however only 60% of patients with a cancer diagnosis were informed within 28 days.

62-day performance was 62% in February, which was a drop in comparison with recent months. Improvements were required particularly within skin, breast and urology. The Trust was working with WVT and the ICB on a sustainable solution for dermatology across the region.
Four tumour sites were below target for 31 days. There had been a backlog in skin due to capacity and an increase in referrals.

Elective
One patient was reported as waiting over 104 weeks due to an administration error; a full harm review would be undertaken. More robust systems were now in place following local investigation.
There was an improved position on 65 weeks but improvements still needed to be made.
52 weeks delivery plans were being finalised with a focus on productivity.
The Trust was working with WVT on ENT and T&O waiting lists.

Urgent and Emergency Care
UEC performance was improving along with the emergency access standard.
A national tier 1 visit took place during February, and a number of areas were identified for support, including access to beds in community hospitals.
The ambulance pit-stop and community gen-med model were working well and being showcased regionally.

The Board discussed the following:
- the use of Artificial Intelligence (AI) to make improvements, noting opportunities around theatre list utilisation and work underway relating to Did Not Attends. There was an appetite for AI among staff.
- The use of volunteers to make a real difference, for example those involved with Pharmacy, which had been a great success in freeing up nursing time.

Quality (SSh and JW)
There had been a reduction in C.Difficile infections Covid and flu numbers were also reducing but an increase in norovirus was reported.
The incidence of both falls and pressure ulcers continued to reduce.
Complaints management was improving, with the majority of the backlog now cleared.

Improvement plans on trauma and fractured neck of femur pathways were being refreshed.

Workforce (AK)
Continued positive improvements were reported, indicating workforce stability, with low vacancies, low staff turnover and good recruitment rates, particularly consultants.
Agency and temporary staffing remained a concern, largely driven by the continued use of temporary escalation spaces. Driving down the reliance on agency staff would be a key element of workforce planning of
30-40% of staff absences were due to stress or mental health issues. A range of support offers were in place. SM advised that the Charity had agreed to fund a new pilot to enhance staff wellbeing support.
There was a continued focus on job planning to meet the new target.

TB queried the consequences of not achieving the 95% national target for job planning. AK replied that the impact of how it will be managed was currently unknown. Though focus was on increasing compliance, it is a significant challenge for a number of Trusts.

Finance (NC)
Positive performance was reported in line with the forecast, which gave confidence in the forecasting.
The use of extra operational capacity over winter continued to drive a cost pressure into spring.
There was strong performance against CPIP as referenced above.
Capital had seen significant slippage. Schemes profiled to deliver over the final month of the year were being monitored weekly.
There was a significant cash balance.

The Board noted the report.

6	Perinatal Safety Report	JJ	Information	Report 4	None

JJ presented the report and the Board discussed the following key points.

- The 12+6 bookings KPI was not met but no harm was reported.
- Workforce KPIs were in a challenging position particularly for sickness and turnover.
- Training remained on target, however there were challenges with medical staff.
- 3 stillbirths and one neonatal death were reported in month.
- Perinatal mortality remained below the national average.
- Consultant workforce had increased but issues with middle-grades remained. Mitigations were in place to ensure safe rotas.
- The CNST submission outcome was awaited.

The Board noted the report.

7	Safer Staffing Reports	JJ/SSh	Information	Report 5	None

Midwifery (JJ)
Staffing was safe across all shifts.
Sickness was being reviewed with teams to ensure support was in place.
Onboarding was underway. By mid-April the Trust would be in a positive vacancy position.

Nursing (SSh)
Safe nurse staffing levels were maintained throughout the Trust, despite a high turnover of patients and fluctuating acuity levels.
No incidents relating to safe staffing levels were reported.
Boarding continued but areas were safely staffed.
The vacancy rate was currently 1%.
Overnight staffing of SDEC at WRH continued as part of a daily risk assessment to support UEC flow.
Off-framework agncy usage was now minimal.

The Board noted the report.

8	Staff Survey	AK	Information	Report 6	None

AK presented the report highlighting the following:
The results of the Staff Survey were being celebrated, with an increase in uptake from 31-46% which was reflective of a shift in the culture of engagement.
Increases were seen within engagement and morale scores above the national average.
The Trust was in the top 3 most improved across the country in terms of recommending the Trust as a place to work.
Though there were elements of improved experience in some indicators, people were still reporting bullying and harassment based on race or disability. Focused work was required to ensure that everyone feels recognised, valued and treated with dignity and respect.

GB applauded the overall engagement score, adding that the regional analysis indicated that the Trust has had a year on year increase in engagement. There was a balance between celebrating progress and recognising pockets of further work required to make improvements.

The Board noted the report.

9	Emergency Planning, Resilience and Response Annual Report	RB	Approval	Report 7	Approved

RB presented the report and highlighted the following key points:
The Trust was substantially compliant under the national framework, with 55/62 core standards being met. The remaining 7 were partially compliant.
Section 11 of the report outlined the annual plan for the next year, which focused in particular on business continuity and cyber. Live exercises and training had been scheduled.

The Board approved the Annual Report.

10	Annual Plan	JB	Approval	Report 8	Approved

JB presented the report.
The Annual Plan was approved by delegated authority following review by the Financial Recovery Board and submitted to the ICB on 27th March.

The Workforce Plan included a significant reduction in temporary workforce and a reduction to infrastructure roles.
The Trust had submitted a break-even financial plan, contingent on £47.3m system support allocation and a challenging CPIP target of £53m.
There was a £10m increase to the CPIP target compared to the earlier draft plan. This included cost pressures related to additional capacity and £6m of system efficiencies, which was reliant on wider service change across the system, including a reduction in length of stay in community beds
Risks had been discussed by the Financial Recovery Board.
A staff engagement week focused on flow was planned for next week and there was a need to develop further the efficiencies through workforce and clinical services design.

The Board:

- Ratified the 2025/26 annual operational plan submission.
- Noted the risks and assumptions within the plan.

11	Trust Strategy	JB	Approval	Report 9	Approved

JB presented the new strategy for the next 5 years, which had been developed through engagement with a range of stakeholders including staff and Board members and external partners.

The strategy linked to the recently refreshed Trust values and had a particular focus on collaboration at system level.

Detailed strategic objectives would now be developed under each pillar of the Strategy, each with a lead executive director. These would be focused on the outcomes the Trust was working towards and the key commitments for the next financial year. Subsequently the clinical and operational teams would be supported to develop their clinical strategies.

The Board welcomed the clear, succinct approach and the work involved in developing the strategy through a strong focus on engagement.

The Board approved the Trust Strategic Narrative and noted the next steps to developing the strategic objectives.

12	Committee Summary Reports & Minutes	RH	Information	Report 10	None

Quality Governance Committee
JM updated that some long running estates issues were being resolved and gave thanks to the team which was under new leadership. Other items highlighted at the Committee had been covered during the meeting.

Audit and Assurance Committee
In CH's absence, TB highlighted the Committee's consideration of bank and agency costs and job planning referred to earlier in the meeting.

The Committee minutes were accepted.

13	PFI Exit Committee Terms of Reference	SC	Approval	Report 11	Approved

SC informed the Board that a new Committee was being established to oversee the PFI contract expiry which would occur in 7 years' time. A programme of work would be developed for this major area of work.

TB would chair the Committee and added that the Trust was collaborating with WVT on the work, which was further advanced in a similar programme of work.

The Board approved the PFI Exit Committee Terms of Reference.

14	Date of Next Meeting	RH	Information	n/a	Noted

The next Trust Board meeting in public would be held on 10 June 2025.

15	Any Other Business and Questions from the Public	RH	Information	n/a	Noted

There was no other business.
There were no questions from members of the public.

The Board resolved to exclude members of the public from Part II of the meeting as matters under discussion were exempt from disclosure to the public under the Freedom of Information Act.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC ACTIONS UPDATE REPORT

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
003/24	Update on telephony provided to TB	RB	Update provided. BT are phasing out public switch telephone numbers. There is a plan within the capital budget to replace with more modern telephony.
ACTIONS IN PROGRESS			
006/25	Consider how to capture benefits realisation of workforce investments at the Financial Recovery Board.	NC	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present

Russell Hardy	(RH)	Group Chair
Chizo Agwu	(CAg)	Chief Medical Officer WVT
Varadarajan Baskar	(VB)	Chief Medical Officer SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Chief Clinical Strategy Officer WAHT
Tony Bramley	(TB)	NED WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer SWFT
Adam Carson	(AC)	Acting Chief Executive GEH/SWFT
Oliver Cofler	(OC)	NED SWFT
Stephen Collman	(SC)	Acting Chief Executive WAHT/WVT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Catherine Free	(CF)	Managing Director GEH
Phil Gilbert	(PG)	NED SWFT
Natalie Green	(NG)	Chief Nursing Officer GEH
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WAHT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Haq Khan	(HK)	Chief Finance Officer GEH
Kim Li	(KLi)	Chief Finance Officer SWFT
Anil Majithia	(AMa)	NED GEH
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Jo Newton	(JN)	Chief Strategy Officer WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Andrew Parker	(AP)	Chief Operating Officer WVT
Sarah Raistrick	(SR)	NED and Vice Chair GEH
Najam Rashid	(NR)	Chief Medical Officer GEH
Jackie Richards	(JR)	NED GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED and Vice Chair SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Chief Medical Officer WAHT
Robert White	(RW)	NED SWFT
Umar Zamman	(UZ)	NED GEH

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

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In attendance:

Rebecca Brown	(RBr)	Chief Information Officer WAHT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Catherine Driscoll	(CDr)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Chief Strategy Officer SWFT
Fiona Gurney	(FG)	Communications WVT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT
Jo Kirwan	(JK)	Deputy Director of Finance WAHT (deputising for Chief Finance Officer WAHT)
Rosie Kneafsey	(RK)	ANED GEH
Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KLa)	ANED WVT
Michelle Lynch	(ML)	ANED WAHT
Alex Moran	(AMo)	ANED WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Mary Powell	(MP)	Head of Strategic Communications SWFT
Nicholas Rees	(NRe)	Interim Deputy Chief People Officer SWFT (deputising for Interim Chief People Officer SWFT and Interim Chief People Officer GEH)
Louise Robinson	(LR)	Deputy Company Secretary WVT (observing)
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Robin Snead	(RS)	Chief Operating Officer GEH
Adrian Stokes	(AS)	Group Strategic Financial Advisor
Vidhya Sumesh	(VS)	Group Business Information Specialist (observing)
James Turner	(JT)	Head of Communications GEH

Apologies:

Paul Capener	(PC)	ANED GEH
Neil Cook	(NC)	Chief Finance Officer WAHT
Paramjit Gill	(PGi)	Nominated NED SWFT
Simone Jordan	(SJ)	NED GEH
Elva Jordan-Boyd	(EJB)	Interim Chief People Officer SWFT
Zoe Mayhew	(ZM)	Chief Commissioning Officer (Health and Care) SWFT
Sara MacLeod	(SMa)	Interim Chief People Officer GEH
Dame Julie Moore	(JM)	NED WAHT
Bhanti Patel	(BP)	ANED SWFT
Grace Quantock	(GQ)	NED WVT
Sue Sinclair	(SSi)	ANED WAHT

There were four SWFT Governors and one member of the public also in attendance.

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

Public Minutes of the Foundation Group Boards Meeting
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MINUTE		ACTION
25.023	**DECLARATIONS OF INTEREST** No new declarations of interest were declared. **Resolved – that the position be noted.**	
25.024	**PUBLIC MINUTES OF THE MEETING HELD ON 5 FEBRUARY 2025** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 5 February 2025 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.025	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.025.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.026	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the key discussions that had taken place in the Foundation Group Boards Workshop earlier that day. This included an interesting presentation on large scale change by Helen Bevan, Professor at Warwick Business School. The Group Boards then heard from Distie Profit, Vice-President and General Manager of Oracle Health UK, which provided opportunity for a conversation on Electronic Patient Records and Artificial Intelligence (AI). The Group Chair took the time to celebrate the team in WVT, on seizing the opportunities arising through AI. The Group Chair continued that in the second half of the Foundation Group Boards Workshop, the Group Chief Executive updated on all things taking place in the wider NHS which highlighted areas where the Group could drive transformational change. The Foundation Group Boards Workshop concluded with the Chief People Officers updating on the position of Talent and Succession Management across the Foundation Group. **Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.**	
25.027	**FOUNDATION GROUP PERFORMANCE REPORT** The Acting Chief Executive's for each Trust highlighted key points from the Foundation Group Performance report as follows:	

MINUTE		ACTION

WVT

The Managing Director for WVT informed the Foundation Group Boards that the Cancer standards for 62-Days and Faster Diagnosis Standard (FDS) had been met for the patients of Hereford and Mid Powys over the last year. She commended the teams involved for their efforts and noted the increasing challenge these standards would pose in the coming year as they increase and become harder to achieve. The Managing Director for WVT explained that Theatre productivity had previously been a challenge throughout the year, however improvements were starting to be seen. In the last quarter there had been a 5% increase in utilisation, and this would continue to be focused on moving forward. Patient Initiated Follow Up (PIFU) had started to increase, which had been mainly due to a technical change in the Electronic Patient Records (EPR) that had allowed patients to initiate their own follow up in a safe and effective way. The Managing Director for WVT was concerned about Urgent and Emergency Care (UEC) as performance had deteriorated with ambulance handover delays increasing and a significant number of temporary escalation spaces being used. This had both a quality, and a financial impact and was therefore being treated as WVTs highest priority for improvement. The Managing Director for WVT explained that one of the ways to improve UEC would be to use National Capital that had been awarded to the Trust to expand the assessment and Same Day Emergency Care (SDEC) areas in the Emergency Department (ED). WVT would also be working in collaboration with General Practitioners (GPs) on a neighbourhood health model to support care at home. Finally, an internal hospital process redesign would take place, with clinical engagement, on how UEC pathways work through the hospital.

SWFT

The Acting Chief Executive for GEH/SWFT started by celebrating SWFTs ability to maintain Elective Care performance during a challenged winter period operationally. This had been down to the teams and the work involved in managing to maintain and ring-fence Elective beds. This had improved outpatient services and strong PIFU processes had contributed significantly to capacity. The Acting Chief Executive for GEH/SWFT shared that the area he had a significant concern over was Cancer performance. SWFT had seen a significant increase in Oncology wait time, and although leadership roles had been recruited too and systemic changes initiated, performance had not improved. This has been exacerbated by staff shortages and service dependencies from University Hospital Coventry and Warwickshire NHS Trust (UHCW). The Acting Chief Executive for GEH/SWFT explained that there was significant planning work to still be done, however the team was in place and conversations were happening to continue to drive improvement forward. He concluded that UEC was an area SWFT were watching with a continued deterioration in 4-hour ED performance, largely due to an increase in self-presenting patients and high bed occupancy. The Acting Chief Executive for GEH/SWFT continued that intelligent conveyancing had also declined slightly but did not offset internal demand pressures. Estates limitations in the ED were now a critical issue for SWFT and a bid for national funding to expand front-door services had been submitted.

Public Minutes of the Foundation Group Boards Meeting
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MINUTE	ACTION

GEH
The Managing Director for GEH presented the GEH metrics to the Foundation Group Boards. Firstly 4-hour performance in ED had been the worst on record, with overcrowding in the department, particularly overnight, being identified as a root cause. Recent weeks had shown improvement, however the challenges with medically fit for discharge (MFFD) patients remained a challenge. Positive steps had been made towards improving MFFD, which was credit to two members of staff, one from the GEH Complex Discharge Team and the other from SWFT Community Services. This has led to promising conversations with Integrated Care Board (ICB) colleagues and external stakeholders on how to do things differently. The Managing Director for GEH went on to highlight GEHs sickness levels, which were still well above the 4% target at 5.3%. These had improved on the previous 6% but would remain a focus area. She explained that the elevated sickness levels were driving temporary staffing costs and impacting financial performance. Cancer performance continued to be challenged. However, there was variable performance, particularly against the FDS which was almost at the target. She acknowledged that there was more work to be done to pick up cancer performance. The Manager Director for GEH continued that Referral to Treatment (RTT) would be particularly challenged in 2025/26 with more challenging national targets. She explained that whilst GEH 65-week wait list had been eliminated in September 2024, these had re-emerged due to conflicting priorities towards the end of the year with the need to hit financial targets and the need to deliver performance. This could also be seen in the ERF figures. Whilst Outpatients was doing well this had dipped towards the end of the financial year. She concluded by celebrating the improvements in Theatre utilisation and PIFU rates. She thanked colleagues from across the Foundation Group for the operational learning which had been a key enabler in the improvements.

WAHT
The Acting Chief Executive for WAHT/WVT explained that UEC continued to be an issue for WAHT and although ambulance delays had improved slightly, overall performance remained a key area of concern. WAHT had recently had its first Tier 1 Improvement Review, and three priorities were identified to focus on: internal discharge process improvement, frailty pathway integration across community and acute care, and community hospital length of stay. A 30/60/90-Day Plan had been created to rapidly improve. Work was taking place with partners to improve flow, particularly for patients who needed onward support once they left hospital. The Acting Chief Executive for WAHT/WVT explained that Sarah Shingler, Chief Nursing Officer for WAHT had been leading on important work to help support flow. This included Virtual Hospital implementation with support from the ICB, and the 'Out by 5' programme which focused on discharging patients safely by day five and getting proper rehab back into community hospitals. The results were looking positive with length of stay (LoS) going from 29 days to 14. He concluded by providing an update on Cancer Services for the Trust. He explained that WAHT had done a lot of work with partners to reduce the 62-Day backlog, and this has started to improve.

MINUTE **ACTION**

Despite this work was required with tertiary partners to address the ongoing challenges and fragility.

The Group Chair requested an update from each Trust on their financial position at year end for 2024/25 compared to the planned position. Each Acting Chief Executive and Managing Director provided this information as follows: -

Trust	Planned Position	Actual Position	Variance/Comment
WVT	Break-even	£5.6m Deficit	Under delivery of Cost Improvement Programme (CIP) by £6m; higher target carried into 2025/26.
SWFT	£1.3m Surplus	£1k Surplus	Hit break-even; surplus effected by Community Recovery Service (CRF) costs.
GEH	£0.7m Surplus	£3.0m Deficit	CRS contributions effected actual position but not entirely.
WAHT	£5.7m Deficit	£5.5m Deficit	Delivered £200k ahead of plan.

The Chair highlighted that SWFT remained the only Midlands trust with a break-even performance and had reported a break-even position for over a decade. He also emphasised that a national financial reset was anticipated. The Group Chief Executive noted that some Trusts would show a break-even position but would have received deficit support. The intention was to take that out to get the true picture.

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

The Group Chief Executive raised concerns around SDEC data and queried the validity of zero LoS metrics, particularly at GEH. It showed that WVT had converted a lot to SDEC but WAHT and GEH didn't show that. The Chief Operating Officer for GEH explained that the data showed GEH to have 49.3% of ED patients requiring admission, being turned around without an overnight hospital stay. This was a combination of patients going through SDEC, Surgical Assessment Area (SAU), Gynaecology Assessment Unit (GAU), Fraility Assessment Unit (FAU), and all ambulatory pathways.

Resolved – that the Foundation Group Performance report be received and noted.

25.028 **OUTPATIENTS DEEP DIVE**

The Chief Operating Officer for WAHT presented the Outpatients Deep Dive. He explained that there had been a lot of positive work taking place across the

MINUTE		ACTION

Foundation Group on Outpatients, and all Trusts had benefited from the Getting it Right First Time (GiRFT) Further Faster programme. Clinic utilisation showed that overall, there was good clinic utilisation, however GEH had the most opportunity for increased productivity and improving the percentage of patients waiting under 18-weeks for a first outpatient appointment. The Chief Operating Officer for WAHT highlighted the shared learning was taking place and this included pathway analysis and use of PIFU, maximising clinic templates, approach and findings to follow up waiting list review, outpatient improvement programmes and approach to monitoring blocked appointments. Data showed there was a variance in the average appointments per clinic in some specialities and therefore identified potential improvements for further consistency. The Chief Operating Officer for WAHT explained that work was needed on making clinic templates consistent, but also how benchmarking could be done across the Foundation Group and nationally. It was important to match those clinic expectations into job plans, and identify how things could be done differently to enable patient being seen in a timelier manner. The Chief Operating Officer for WAHT presented the Did Not Attend (DNA) data for March 2025 and the rates were as follows, GEH 3.7%, SWFT 5.6%, WAHT 4% and WVT 4%. All Trusts had areas of opportunity to improve DNA rates across varying specialties. There had been several pieces of work done so far to address DNA rates and these included implementing a two-way text reminder service, calling patients who had a history of missed appointments and transferring DNA patients to Patient Owns Contact (POC).

The Chief Operating Officer for GEH presented the data on PIFU, which highlighted some variance across the Foundation Group in services that were actively using PIFU. This identified that there was more work to be done to identify what was driving the variance in the specialties and how to standardise the approach. All Trusts within the Foundation Group had submitted plans that would achieve, or better, the national target for PIFU. Shared learning was already taking place to ensure these plans were met. This included ensuring that clinicians were discharging patients where medically appropriate rather than moving them to a PIFU pathway and clinical discussions between Trusts to discuss pathways where PIFU was applied were taking place. The Chief Operating Officer for GEH explained that engagement with services that had a successful approach for PIFU was also taking place to help with engaging and educating specialties achieving less than 5%. On top of this GiRFT recommendations and learnings continued to be reviewed and exploring the option of an opt out rather than an opt in approach. The Chief Operating Officer for GEH concluded by highlighting plans to run an internal Further Faster programme to deep dive into a different speciality each month, driven by the productivity dashboard.

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

The Acting Chief Executive for WAHT/WVT celebrated the success of the Foundation Group Operational Conference that had taken place in May 2025.

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	He queried whether PIFU had the right clinical engagement to drive improved delivery. The Foundation Group Boards agreed with this, and it was agreed to make an action for PIFU clinical engagement to be sourced. The Group Chief Executive agreed with the Acting Chief Executive for WAHT/WVTs comment and added that it was clear clinical adoption was holding PIFU back. He added that the New to Follow Up ratios should also be looked at as part of PIFU, as there were probably opportunities there to also improve and free up capacity. **Resolved – that** **A) The Outpatients Deep Dive be received and noted, and** **B) Clinical leadership and engagement with PIFU be agreed to help drive delivery, and**	**CMOs**
	C) New to Follow Up Ratios be looked at for any potential capacity opportunities.	**COOs**
25.029	**URGENT AND EMERGENCY CARE IMPACT ON MORTALITY AND MORBIDITY** The Foundation Group Boards received the presentation on the correlation between prolonged ED waits and patient outcomes, with the data gathered from 1 January 2025 to 31 March 2025. The Chief Medical Officer for WVT presented the key findings for WVT, which aligned with the Office for National Statistics (ONS) confirming that increased waiting times in ED were associated with higher mortality rates. She explained that a cohort analysis was undertaken, excluding patients who were under sixteen and patients attending with minor injuries. This left WVT with 11,000 patients. The Chief Medical Officer for WVT continued those patients who waited over 12hours in ED had an average age of 71, compared to 57 for those who waited under five hours. The data showed that patients who waited longer in ED also had a longer admitted LoS, averaging 7.6-days for over 12hour waits vs 2.8-days for those under 5hours. Patients discharged to care homes consistently experienced the longest LoS averaging between 15-20-days and this was regardless of ED wait time. The Chief Medical Officer for WVT confirmed that mortality was significantly higher among those waiting over 12hours at 6.3% vs 2.1% for under 5hours. She explained that it was the elderly population that were most affected by this, with the average age of patients having died after waiting more than 5hours being 82, compared to 84 for those who had waited less than 5hours. Men were also noted to be seven years younger on average at time of death compared to women. The Chief Medical Officer for WVT presented the mitigations that WVT were taking to reduce overcrowding in ED and therefore long waits. This included focusing on reducing demand, improving flow, expediting discharges and addressing delays for MFFD patients.	

MINUTE		ACTION
	The Chief Medical Officer for SWFT presented the SWFT data and key findings. This was very similar findings, and the numbers were quite similar with around 11,000 patients being seen between 1 January 2025 and 31 March 2025. SWFT were a positive outlier with less than 10% of patients experiencing ED waits exceeding 12hrs, however the mortality trends mirrored those identified at WVT. However, he emphasised that this was not causality, it just underscored the importance of identifying the cohort of patients waiting the longest and why. The Chief Medical Officer for SWFT explained that a deep dive would follow that would evaluate operational contributors, including MFFD and frailty team interception. The Chief Medical Officer for GEH confirmed that GEH identified similar trends, however they had included minor injury patients. He noted that despite the figure being small, it was important to recognise that patients were dying within the Foundation Groups EDs, including those arriving post-cardiac arrest and palliative care patients due to lack of hospice access within the North of the county. GEH had introduced a Bluebell Room which was a quieter area in ED for those patients at end of life to die in dignity and respect with their families. The Chief Medical Officer for GEH continued that there was established evidence linking prolonged ED stays to increased mortality and LoS. He concluded by explaining there was a real need to expedite the care of frail, elderly patients with general medical conditions. Patients with pre-diagnosed conditions, did tend to move through the system more efficiently already. The Chief Medical Officer for WAHT assured the Foundation Group Boards that WAHTs figures were very similar to that of the Trusts in the Group. WAHT had done a further deep dive into these findings on a cohort of 200 patients. She explained that post the Covid-19 pandemic pressures on ED services in the UK had resulted in increased waiting times and spikes in excess deaths which is what had triggered the review. Long-wait patients (those waiting over 12hours) were more likely to arrive by ambulance and had a longer ambulance handover. These patients were typically older, had multiple comorbidities and were often admitted under general medicine rather than specialist pathways. These patients experienced delays in medical review, decision making, discharge with higher crude mortality rates, had more tests and care whilst waiting, and more complex inpatient journeys. The Chief Medical Officer for WAHT cautioned against attributing causation but stressed the significant implications for quality of care and patient experience. She continued that it was important to address the findings and use them to better patient care. The Chief Medical Officer for WAHT informed the Foundation Group Boards that WAHT had already begun a service redesign, including improvement to frailty models, early discharge pathways and pre-identifying high-risk patients early to support more proactive interventions. The Group Chair invited questions and perspectives and of particular note were the following points.	

MINUTE		ACTION
	The Group Chief Executive noted there were two key areas to this work. One was improving flow through ED to enhance outcomes but also ensuring patients were being cared for in the right setting. Whether that be outreach services, advice and guidance or end of life care. The Managing Director for WVT advised the Foundation Group Boards that she chaired the End-of-Life Programme Board for Herefordshire and Worcestershire. As part of that work she had been trying to get a digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form implemented. Digital ReSPECT forms would travel with the patient wherever they were, drive higher-quality clinical conversations and improve continuity of care. Sarah Raistrick, NED and Vice Chair GEH, supported the proposal of a digital ReSPECT form. She also suggested a research opportunity to track the impact particularly when patients documented wishes were not honoured. **Resolved – that** **A) The UEC impact on mortality and morbidity be received and noted, and** **B) The Acting Chief Executives identify Foundation Group representation to continue driving the digital ReSPECT form proposal forward.**	**ACEs**
25.030	**ANNUAL SAFE STAFFING OVERVIEW (INCLUDING NURSE PER BED RATIO)** The Chief Nursing Officer for WVT presented the Annual Safe Staffing Overview and dashboard. The dashboard included the number of funded beds for each organisation and new data on the number of additional patients being cared for beyond the funded capacity. The Chief Nursing Officer for WVT explained that the figures included escalation beds, the number of patients cared for in temporary escalation spaces and the number of patients waiting in ED with a decision to admit at 8am. This information was presented to provide context, particularly regarding the workforce pressures and staffing implications resulting from overcapacity. All trusts were operating above their funded bed base. The Chief Nursing Officer for WVT explained that Trusts were required to submit “Safer Staffing Return” to NHS England (NHSE). This submission, broken down at ward level, compared planned staffing levels to actual staffing levels on the day. The data consistently showed that the four Trusts in the Foundation Group had filled over 100% of planned staffing levels, primarily due to the increased demand from the additional beds open beyond funded levels. The Chief Nursing Officer for WVT presented the wider workforce metrics to the Foundation Group Boards, and it was reiterated that a substantive workforce delivered better quality care, improved continuity, and greater productivity. This was due to substantive staff being more familiar with local systems and processes. She continued that nationally, a vacancy factor of less	

MINUTE		ACTION
	than 5% was considered a good benchmark and it was reported that all Four trusts within the Foundation Group had achieved this for Registered Nurses (RNs) which was positive. However, there was greater variability in the Healthcare Support Worker (HSW) Group, with continued challenges in both recruitment and retention. This group remained a key focus for 2025/26. The Chief Nursing Officer for WVT presented the sickness absence data. All four Trusts in the Foundation Group demonstrated levels of sickness absence above the national benchmark with a particular challenge in the HSW group of staff. There was no national benchmark for maternity leave; however, the Foundation Group budgeted 1% headroom in its establishments to account for staff on maternity leave. The data indicated high maternity leave levels across the Group. The Chief Nursing Officer for WVT highlighted that the Quality and Safety metrics included in the Friends and Family Test (FFT) showed all Trusts consistently achieving positive response rates above 90% which was considered excellent. However, response rates to the survey itself remained below desired levels. The Chief Nursing Officers across the Foundation Group had recognised this as an area requiring further improvement. All four Trusts made good progress in reducing agency spend over the last twelve months. Collaborative efforts through the Regional Nurse Agency Reduction Programme had contributed to these improvements, particularly by enforcing NHSE capped rates and eliminating the use of high-cost, off-framework agencies. While all trusts had made progress, some were advancing faster than others, offering opportunities for shared learning and best practice. The next phase of the Programme would be to focus on bank rates, with all trusts committing to participate. Additionally, each trust had set agency and bank reduction targets for 2025/26 in alignment with national expectations. **Resolved – that the annual safe staffing overview be received and noted.**	
25.031	**FIT AND PROPER PERSONS TEST ANNUAL COMPLIANCE** The Trust Secretary for GEH/SWFT presented the Fit and Proper Persons Test annual compliance to the Foundation Group Boards. The report provided assurance against the Fit and Proper Person Test Framework and the processes that were in place across all four boards to assess Board members and their fit and proper persons status prior to the annual submission to NHS England. **Resolved – that the Foundation Group Boards receive and note the Fit and Proper Persons Test Annual Compliance.**	
25.032	**FOUNDATION GROUP OBJECTIVES IN COMMON 2025/26** The Group Chief Executive presented the Foundation Group objectives in common for 2025/26. He explained that whilst the Foundation Group didn't have specific Group objectives, each Trust's personal objectives were	

MINUTE		ACTION
	compared and key themes identified to encourage collaboration. WAHT were still finalising their objectives after completing their strategy refresh, however it was possible to see the Trust's direction. The Group Chief Executive identified the objectives in common for the Group as UEC Pathway Improvement, Care Closer to Home, the implementation of Neighbourhood Health, sustainability, reducing paper records, and EPR. He did highlight that he was surprised to not see more explicit focus on productivity and appreciated that whilst some of the objectives would deliver against productivity, he felt it needed more of a focus. This could be achieved though the Community Diagnostic Centres set up and updated through the Foundation Group Strategy Committee. He also noted that the NHS financial reset would see individual organisation numbers change, and financial recovery plans become an area of high focus. **Resolved – that the Foundation Group Objectives in Common for 2025/26 be received and noted.**	
25.033	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON THE 18 MARCH 2025** The Foundation Group Boards received and noted the Foundation Group Strategy Committee report from the meeting that took place on the 18 March 2025. **Resolved – that the Foundation Group Strategy Committee Report from the meeting held on 18 March 2025 be received and noted.**	
25.034	**ANY OTHER BUSINESS** No further business was discussed. **Resolved – that the position be noted.**	
25.035	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS** No questions were received. **Resolved – that the position be noted.**	
25.036	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.037	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.038	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 5 FEBRUARY 2025**	
25.039	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 7 May 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
25.040	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 17 DECEMBER 2024**	
25.041	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.042	**PROPOSAL TO MITIGATE RISKS IN THE JOINT ELECTRONIC PATIENT RECORDS PROGRAMME – GEH/SWFT ONLY**	
25.043	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 6 August 2025 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chair) Date: 6 August 2025
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 6 AUGUST 2025

AGENDA ITEM	ACTION	LEAD	COMMENT
ACTIONS COMPLETE			
ACTIONS IN PROGRESS			
25.028 (07.05.2025) Outpatients Deep Dive	Clinical leadership and engagement for PIFU be agreed to help drive delivery. New to Follow Up Ratios be looked at for any potential capacity opportunities.	C Agwu / N Rashid / V Baskar / J Walton H Heran / R Snead / A Parker / C Douglas	
25.029 (07.05.2025) Urgent and Emergency Care Impact on Mortality and Morbidity	The Acting Chief Executives identify Foundation Group representation to continue driving the digital ReSPECT form proposal forward.	A Carson / S Collman	
REPORTS SCHEDULED FOR FUTURE MEETINGS			

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**10/06/2025**
Title of Report:	Chief Executive Officer's 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

This report is to brief the Board on various local and national issues.

Recommended Actions required by Board or Committee

The Trust Board is requested to note this report.

Executive Director Opinion[1]

1. <u>Model ICB Development</u>

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

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

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

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

Core Functions of a Model ICB**:**

ICBs will focus on four principal commissioning functions:

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

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

Functional Realignment and Transition

The blueprint outlines a phased approach to reconfiguring ICB functions:

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

Capabilities and Enablers

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

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

Cost Reduction and Delivery in 2025/26

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

Key points include:

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

ICB Cluster arrangements

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

ICB Update

Building a Sustainable Future (BSF) Programme

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

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

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

Joint Forward Plan (JFP) Refresh

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

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

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

Tier 1 Urgent and Emergency Care

The Trust with system partners ahs agreed the programme of work that will be undertaken in support of improving our Urgent and Emergency performance and pathways. These are:

- Support reviewing Emergency Department processes
- Reducing Community Hospital Length of Stay
- Acceleration of the system wide Frailty model

2. Operational Excellence Conference

Operational leaders from across the Foundation group completed their development programme and finished with a conference of presentations and speakers. Congratulations to Jane on organising and leading this. It demonstrated the value the group brings in the sharing of improvement and skills across the four Trusts. The challenge is to now take this and meet our challenges of innovation and productivity at scale that is evident through this. A focus we can develop is adapting this approach to clinical leaders across the group.

More from Our Great Teams:

Mum and baby both on life support brought together to share first skin-to-skin contact at Worcestershire Royal Hospital

Board colleagues may have seen the extensive media coverage of the efforts made by our teams to bring together a mum and her newborn baby after both found themselves in separate intensive care units at Worcestershire Royal Hospital – a great example of clinical teams living our value of ensuring people feel cared for.

This extremely rare event where both mother, Helen and her newborn daughter, Maeve needed the help of ventilators to breathe, led to a touching moment where clinical staff brought them together for Helen to have her first skin-to-skin contact with her newborn daughter to help bond despite both still requiring intensive care.

Helen has a rare condition called Myasthenia Gravis which can cause muscle weakness and shortness of breath. In this case some of Helen's antibodies appear to have crossed to Maeve who had to be admitted to the Neonatal Intensive Care Unit at Worcestershire Royal Hospital very shortly after birth with weakness and breathing difficulties.

At first Maeve required some basic breathing support, but her condition worsened, and she needed intubation and ventilation - procedures where a tube is inserted to open the airway and then a machine is used to help the patient breathe. Shortly after delivering Maeve, Helen's condition also deteriorated, and doctors had to admit her to the Intensive Care Unit for intubation and ventilation to help her breathe as well. Due to her condition, Helen couldn't visit Maeve in the Neonatal Intensive Care Unit and so hadn't been able to hold her newborn daughter.

As Helen and Maeve both remained stable on their ventilators, the neonatal team at Worcestershire Royal Hospital worked out a plan to transport Maeve using a Neonatal Transport Incubator with a ventilator to the adult Intensive Care Unit to be by her mother's side. When Maeve arrived in the unit, staff were able to place her on her mother's chest for their first skin-to-skin contact, with husband and father Justin watching on alongside Helen's parents. A couple of days later, thanks to great teamwork and flexibility from both departments, staff were also able to bring Helen to visit Maeve in the Neonatal Intensive Care

Unit whilst both were still on ventilators. In between this time, staff took photos of Maeve and placed them around Helen's bed for her to see and even used iPads to give Helen a FaceTime video call with her newborn baby.

The good news is that mum and baby are now back home and doing well.

Improvement Week

Congratulations and well done to members of our Improvement Team and other colleagues from across our Trust who took part in the Foundation Group Improvement Week (May 12-16). The week provided a host of opportunities for colleagues to gain practical improvement skills, discover impactful projects, and connect with like-minded colleagues from across all the Foundation Group of Trusts. Colleagues (including Board members) can catch up on recordings of the Improvement Week sessions using links in the Improvement Hub on The Source. Our Improvement Team also used the week as the chance to hold the first in what will be a series of live pop-up sessions, giving colleagues the chance to meet them in person and find out more about simple steps they can take to make improvements in their own areas.

Volunteers Week

Finally, last week (June 2-8) was Volunteers' Week, a chance for us to say a big 'thank you' to the 300-pluis volunteers who give up their time to provide a vital service across our hospitals. As well as hosting thank you lunches at each of our three sites, there were also a series of 'Appreciation Station' information stands to promote the volunteering service and gather staff and patient feedback.

Our volunteers have generously given us more than 12,000 hours of support over the last 12 months, helping out across many areas of our hospitals, including our new Discharge Response service, Chaplaincy, Wayfinders, Therapy Dog volunteers and Breastfeeding Friends. Thank you all!

NHS
Worcestershire
Acute Hospitals
NHS Trust

Integrated Performance Report

Trust Board

JUNE 2025

ACTING CHIEF EXECUTIVE OFFICER – EXECUTIVE SUMMARY

Stephen Collman

Acting Chief Executive Officer

Quality

- Positively, mortality rates remain within expected ranges, infection rates have decreased, including the incidence of flu and Covid, and the number of falls continues to come down and remains below national average. We continue to focus on improvements in complaints management, with a reduction in the number of open complaints, and on the fractured neck of femur pathway, with major changes planned through June.

Operations

- UEC continued to experience challenges throughout April, with high demand and long waits impacted by high bed occupancy and average length of stay, particularly at the Worcestershire Royal site, which inhibited patient flow. Collaboration within the system is critical to resolving this.
- Cancer performance deteriorated slightly with an increase in referrals continuing.
- In elective services, we continue to see improvements in the waiting list; however, the number of patients waiting over 52 weeks increased and we continue to have a number of patients waiting over 65 weeks. We have clear plans in place at speciality level to address this.

Workforce

- Our workforce indicators remain strong on turnover, vacancies and sickness. Reducing reliance on agency staff is one of our key priorities but remains a challenge, particularly due to the additional operational capacity needed in UEC.

Finance

- Our month 1 performance against our balanced plan for 2025/26 was £0.2m adverse to plan, driven by additional unfunded capacity and under delivery of CPIP.

OUR QUALITY & SAFETY

Dr Jules Walton

Chief Medical Officer

Our Mortality Indices remain in the “as expected” range with work ongoing to monitor and respond to any developing trends within our learning from deaths framework.

Particular focus continues on redesigning our sepsis screening process to align with updated NICE 2024 and Academy of Royal Colleges guidance. A proposal to change the metrics to reflect the changes in guidance is being developed which will be incorporated into our deteriorating patient and sepsis pathway in the Electronic Patient Record.

Significant changes are planned for implementation in June 2025 to delivery the necessary improvements for our patients who sustain a fractured neck of femur. These include the commencement of an Orthogeriatric Service, reconfiguration of trauma beds and a workforce review of both resident and consultant doctors in this area.

In April 25 cases of CDiff decreased to 4 (from 5 in March 25) and is now showing common cause variation. E Coli, MSSA and klebsiella have also decreased in April 25 whilst pseudomonas aeruginosa BSI increased but is still showing common cause variation. One case of MRSA BSI was declared in April 25, the first case since March 2024. . The number of patients with flu have continued to decrease as have covid and RSV cases. Norovirus cases have also decreased. All the 11 high impact intervention audits were compliant in April 25.

The complaint compliance target to close within 25 days did not meet the target in April 25 but is still showing an improvement trajectory. The Trust had an increased number of complaints still open at the end of April 25 at 110 compared to 97 in March 25. Of these 110 open complaints, with Surgery accounting for 35 and Urgent Care for 28 of the open complaints and a total of 26 complaints overall had breached 25 days.

Sarah Shingler

Chief Nursing Officer

Wells Jan 05/06/2025 16:05:15

The total number of falls in April 25 has decreased to 105 (from 132 in March 25) and remains below the national benchmark with 3.80 total falls per 1,000 bed days (national benchmark of 6.63). Highest number of falls in Speciality Medicine Division (48) due to increased LOS and acuity, however there were zero falls with severe harm in April 25 and only 3.8% classed as moderate. The total number of HAPUs in March 25 decreased to 19 from 25 in March 25 (0.54 HAPU per 1,000 bed days). There were 2 cat 3 HAPU reported in April 25 which are being investigated for related harm, but zero Cat 4’s. There are a number of education improvement projects continuing with the Tissue Viability team including support with classification. The mattress roll out has been completed at WRH and is now in progress at AGH. There is also an implementation of a wound SBAR at discharge to further inform community services.

The friends and family recommended rates have met the recommended target (95%) across inpatients (95.8%) and maternity (98.2%). Outpatients only just missed the target at 94.0%. ED (80.5%) in April 25 shows a slight decrease from March 25 (82.5%). Patient Experience Lead Nurse and Quality Matron continue to monitor and review the use of FFT throughout QAV visits and Ward Accreditation processes.

All Divisional teams continue to raise awareness of FFT at internal meetings and to action and promote feedback making every contact count.

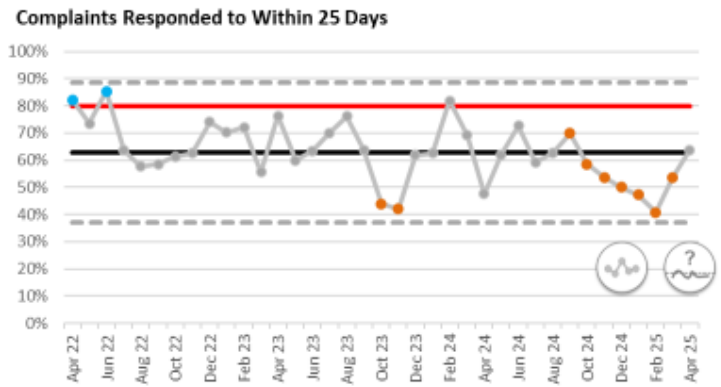
OUR QUALITY & SAFETY – COMPLAINTS

We are driving this measure because

We are aware from public feedback that a prompt, real-time, comprehensive service for the public using the Complaints services can be effective in resolving the majority of complaints, queries or outstanding concerns.

Performance

- Compliance with complaints closed within 25 days increased for the 2nd consecutive month to 63.79% in Apr-25 but did not meet the target.
- In total there were 75 new formal complaints received within Apr-25 with 26 (47.27%[1]) called within 5 days to discuss the complaint.
- The Trust had 110 complaints still open at the end of Apr, of which 23 have been reopened.
- Of these 110 complaints, 26 have breached 25 days (8 of which have been reopened).



- Surgery Division accounts for 35 (31.8%) and Urgent Care Division accounts for 28 (25.5%), of the open complaints.

1 *The Denominator used when calculating the "% New Formal Complaints Telephoned in 5 Days" excludes those New Complaints received in the last 5 working days of the month*

Actions

- The Complaints Team continue to work closely with the divisions in monitoring the timeframe
- The weekly sitrep provides data to clearly identify complaints overdue and those due within 7 working days and is shared widely within the divisional governance and executive teams
- The number of complaints received in April 2025 is one less that 2024 with 43.42% of the 2024 complainants being called to discuss their complaint. The 2025 figure is a comparable improvement for contact
- The responding to complaints training that is delivered twice per month includes guidance and positive reasoning for making this first contact with 5 working days
- One of the focuses by the complaints team is to reduce the number of further concerns (re-opened complaints). This is being addressed by:
  - Complaints team when acknowledging a complaint ask for specific questions to be identified
  - The Lead Investigator making contact within the first 5 days to establish/confirm Terms of Reference
  - Datix has been updated to be able to add reasons for further concerns – this will allow the opportunity to potentially identify where we can learn and make improvements to prevent further concerns being received

Risks

Reputational Damage, further resource depletion due to ongoing correspondence with extended open cases, distress to patients and relatives

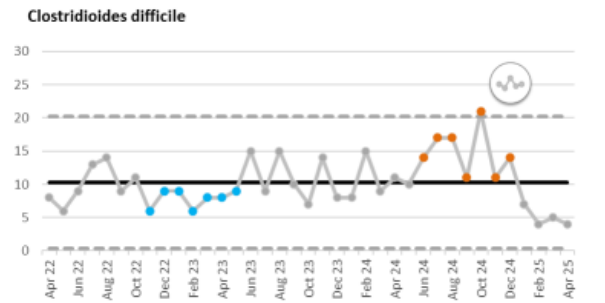
What the charts tell us

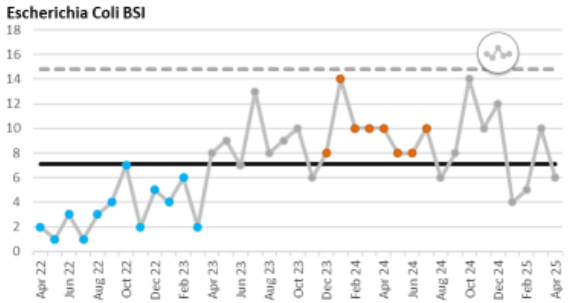
The metric is now showing common cause variation.

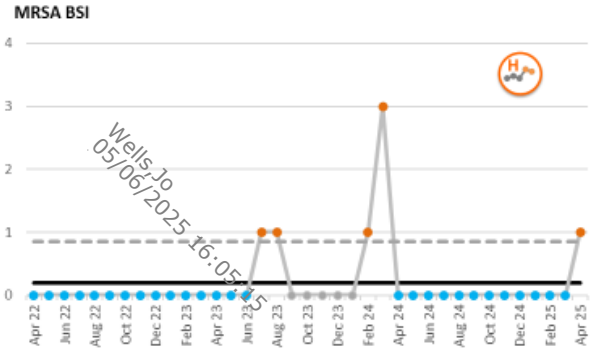
OUR QUALITY & SAFETY – INFECTION PREVENTION AND CONTROL

We are driving this measure because

There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.







Performance and Actions

- *Clostridiodes difficile* (C.diff) **dropped** in Apr-25 (4 c.f. 5 in Mar-25) and is showing common cause variation.
- E-Coli BSI **dropped** in Apr-25 (6 c.f. 10 in Mar-25) and is showing common cause variation.
- Internal ambition: MSSA BSI **dropped** in Apr-25 (3 c.f. 4 in Mar-25) and is showing common cause variation.
- The internal ambition threshold has been reviewed in TIPCC and increased to 40 for 2025/26.
- Klebsiella species BSI **dropped** in Apr-25 (1 c.f. 2 in Mar-25), and is showing common cause variation
- *Pseudomonas aeruginosa* BSI **increased** in Apr-25 (1 c.f. 0 in Mar-25) , but is still showing common cause variation
- One MRSA BSI was declared in Apr-25, the first since Mar-24.
- Hand Hygiene Compliance (99.5%) has met the target (98%) every month since Apr-22 and is showing common cause variation.
- Hand Hygiene Audit participation was unchanged in Apr-25 (98.3%) but is still showing special cause variation of improvement.
- All 11 of the High Impact Intervention (HII) audits were compliant (95%) in Mar-25.

Actions

- Focus during April has needed to be on respiratory infections and diarrhoea and vomiting to support capacity and flow, given very high numbers of patients with influenza, as well as COVID, RSV and Norovirus infections.
- Divisions have reviewed patients with C.diff from February and March and presented to the TIPCC HCIA Scrutiny and Learning Group. Action plans are in place to address learning which will be fed into TIPCC in May.
- The team participated in the system meetings led by NHSE to review C.diff and continue to attend the weekly NHSE briefings. A new task and finish group is being established for 2025/26 by NHSE to focus solely on C.diff and the Trust will participate in this. The Trust is also attending the CDI review meetings instigated by the ICB.
- Our internal ambition for no more than 40 cases of MSSA per year will remain in place for the new financial year.
- A meeting was held in May to review the MRSA bacteraemia to determine in there are any lessons to be learned. These are in the process of being disseminated throughout the Trust
- The team will be promoting hand hygiene and scrub the hub for clean your hands day in May.

Risks

Capacity: Level 4 actions impact on IPC actions as planned meetings involving clinical staff have been cancelled. The level of activity and high level of bed occupancy limits the ability to isolate patients in a timely manner, increasing risk of infection spread. This has been particularly challenging during this winter period due to high number of respiratory symptomatic patients including COVID-19, flu and RSV and patients presenting with diarrhoea, vomiting and Norovirus. The impact is mitigated where possible, but a number of patients with infections have been unable to be isolated. This has impacted on the cleaning and deep cleaning of areas. Continuing bedpan washer issues impact the ability to undertake high level disinfection of bedpans and other items. Work on a solution is in progress with trials of equipment taking place.

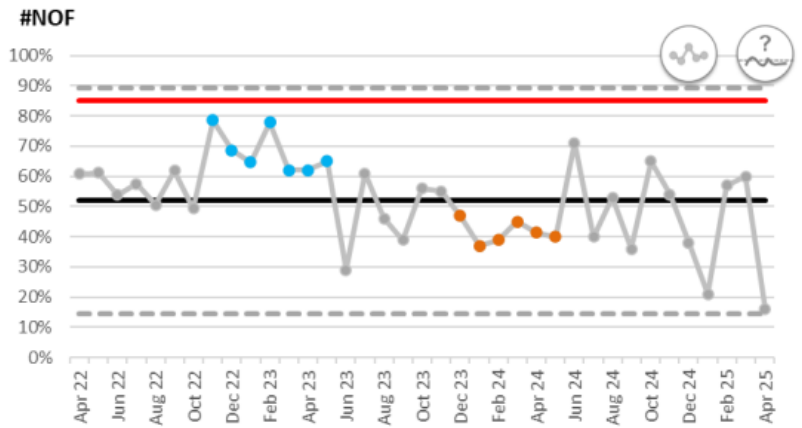
What the charts tell us

- *Clostridiodes difficile* is now showing common cause variation after a period of special variation of concern.
- Note an increased in *Clostridiodes difficile* has been a common pattern nationally with UKHSA currently running a national incident.

OUR QUALITY & SAFETY – FRACTURED NECK OF FEMUR (#NOF)

We are driving this measure because

Prompt surgery and appropriate involvement of geriatric medicine has benefits in terms of improved patient outcomes, increased number of independent individuals and reduced mortality, shorter length of stay and more cost-effective care.



- The Trusts Crude Mortality Rate for the period Mar-24 to Feb-25 was 16.21% for the diagnostic group #NOF (in-hospital 6.67% & Out of hospital 9.54%)[1]
- This is the 17th lowest (of 21 Midland Acute Trusts), with the figures ranging from 7.57% to 17.76%.[1]
- The ALOS for #NOF patients in the period Mar-24 to Feb-25 was 14.48 days.
- This is the 5th lowest ALOS amongst Midland Acute Trusts during this period, with figures ranging between 6.80 days and 22.85 days[1]

[1] *Source: HED, accessed 12/05/2025*

Performance and Actions

- #NOF compliance dropped significantly in Apr-25 to 15.9% (BPT) and 15.7% (all) and the target (36 hours) has still not been achieved since Mar-20.
- There were 88 (BPT) and 102 (All) #NOF Admissions in Apr-25
- There were a total of 74 (BPT) and 86 (All) breaches in Apr-25
- The primary reasons for BPT breaches in Apr-25 were Bed Issues (40) and Theatre capacity (23).
- The average time to theatre was 61.7 hours (BPT) and 66.0 hours (All).

Risks

Theatre and bed capacity continue to be the biggest risks to the effective delivery of the #NOF pathway.

What the charts tell us

- #NOF Time to Theatre is currently showing common cause variation.
- In terms of assurance, it is still showing that whether the target will be met is due to random variation.

OUR OPERATIONAL PERFORMANCE

Chris Douglas

Chief Operating Officer

April has been a challenging month from an operational performance point of view. High demand in our Emergency Departments, alongside continued high bed occupancy particularly on the Worcestershire Royal site where occupancy has regularly been over 110% of our funded ward beds have had an impact on the performance of our Urgent and Emergency Care metrics. We have continued to occupy additional ward spaces at additional cost and reliance on support from nursing teams through our bank or via agency.

The focus now with partners remains on reducing our bed occupancy so that we have sufficient flow across the Trust to enable internal improvement in our Emergency Department metrics to reduce the length of time that our patients wait to have their healthcare needs met. The number of patients in our hospital beds whose care needs could be better met elsewhere remains high (more than 100 patient at any given time) and delays in accessing that care persist. In addition, there are opportunities within our hospital for us to work differently , including refreshing the expectations on our specialty and ward teams and the vital contribution they make to enabling patients to leave our hospitals when they can do so. We continue to focus on delivering our plan with partners and the support from our colleagues from the Emergency Care Intensive Support team, who are support work on our frailty model, Hospital at Home and our internal Emergency Department systems and processes, alongside the support to our colleagues in the community Trust, who have a programme to reduce the length of stay in community hospitals.

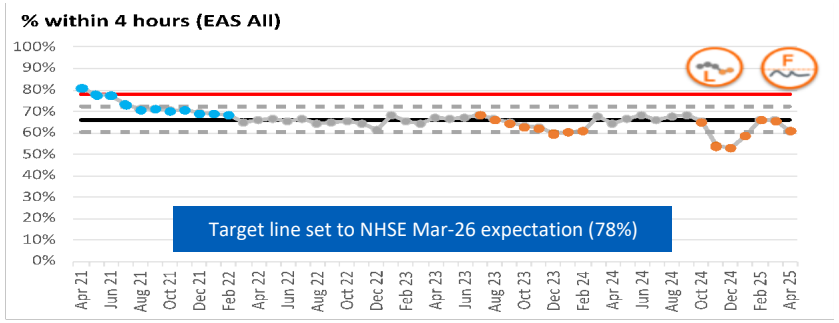
Referrals remain at high levels for suspected cancer and in several specialties, we have seen unseasonal peaks in demand recently, which has had a knock-on impact on several cancer standards. The focus on delivery for our patients remains the key focus of our teams and every specialty is monitoring and managing the situation closely, but there is clearly more to do. We do need to resolve some significant capacity challenges in oncology and are working with commissioners to enable us to do this in the best interests of our patients. We are also challenged in some specialties where we are reliant on partner organisations for elements of the pathway and we are working with the Cancer Alliance and commissioners to seek solutions. There will always be more we can do make improvements internally and every tumour site has refreshed its improvement plans as we continue performance recovery journey.

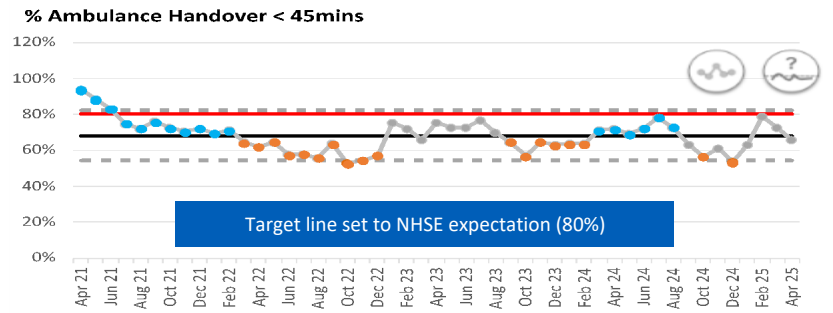
For patients on our waiting lists, at the end of April, almost 60% had been waiting less than 18 weeks and the percentage of patients waiting less than 18 weeks for an outpatient appointment has increased again. Overall, in the last 12 months, our waiting list has decreased by circa 10%. Whilst we've seen a slight increase in month of the number of patients over 52 weeks, 88% of those waiters are waiting in five specialties, with almost a third in one specialty, which has been recognised across a number of organisations nationally. The continued focus on Our elective recovery approach to reduce the waiting time for treatment in our hospitals through a comprehensive programme to make our outpatient clinics and operating theatres as efficient as possible and make the best use of our clinical teams' time. We continue to collaborate with other providers locally, regionally, and nationally, both within the NHS and the independent sector, to reduce waiting times

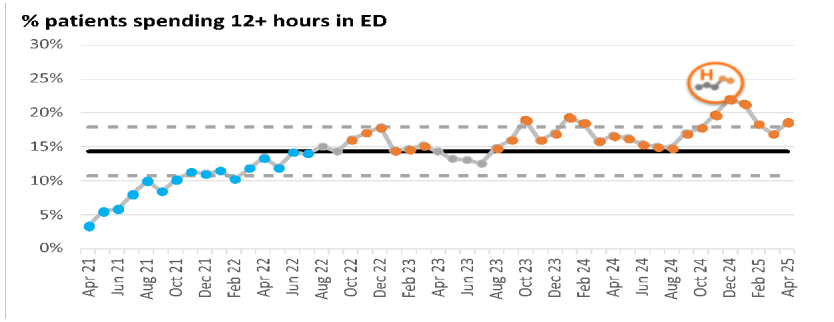
OUR OPERATIONAL PERFORMANCE – URGENT & EMERGENCY CARE

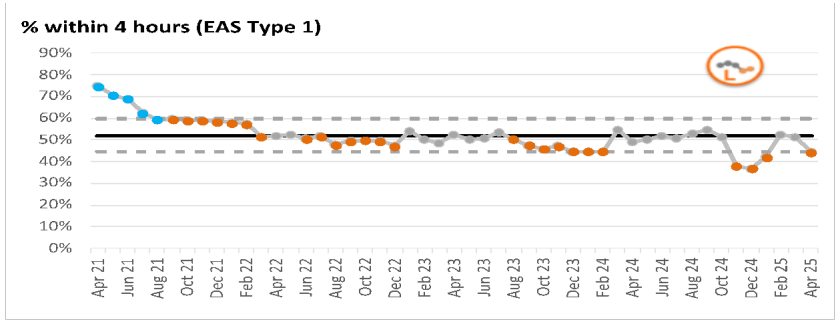
We are driving this measure because

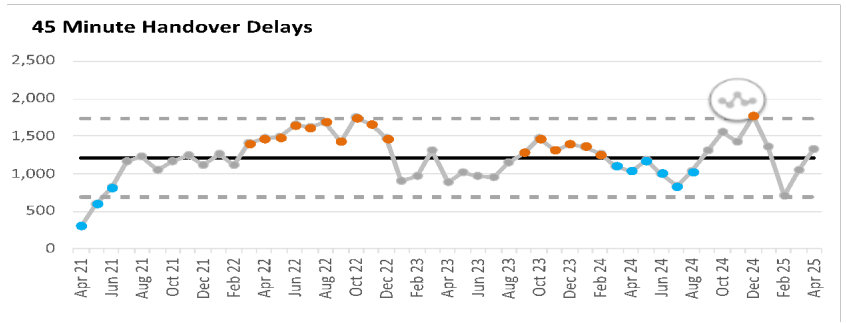
The national Emergency Access Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at any Emergency Department. In addition, the effective and timely handover of patients arriving by ambulance enables patients waiting in the community to access care in a timelier manner and is an indicator of system flow.

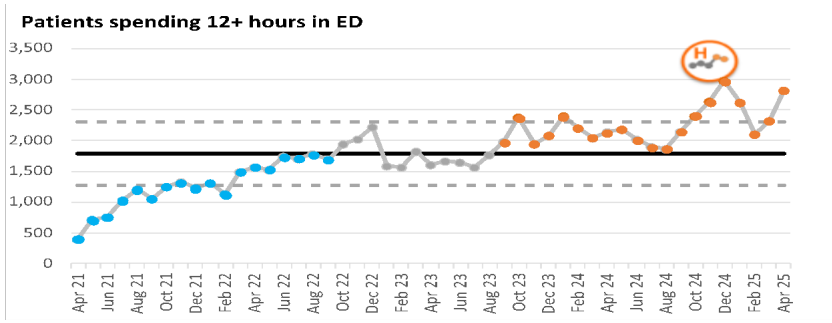












Understanding the performance

- EAS performance for April 60.9% (system) 44.6% (organisation) Performance driven by increased ED attendance, 5.8% compared to previous month (March to April)
- Walk in attendances remain predominant with an average per day in April of 317 compared to 313 in March (up 4.5% on April 2024)
- Amb atts were up 0.7% March 25 to April 25 with an average number per day of 130 in April compared to 125 in March. Up 2.3% on April 2024. Pitstop continues to redirect 16% from ED.
- ED non-admitted performance declined by 8.8% and Ambulance Handover Performance in April was 65.9% a 7.2% decline compared to March 25. Contributing factors include agency skill mix, departmental capacity and processing, junior doctor rotation.
- % of patients spending more than 12 hours in the department increased by 4 this increased from 16.9% in March to 18.6% in April so a 1.5% increase.
- GP Expected, at WRH in April there 565 atts for GP expected Pts compared to 539 in March - a 5% increase (also a 4% increase on April 2024).
- Surgical specialties have seen an increase in activity through the front door during April (334 referrals compared to 254 in March), mirroring an increase in GP expected patients by 38% month on month.

Actions (SMART)

- Unplanned Care Operational Management Steering Group established, 1st meeting to take place May 25.
- Emergency Access Standards Improvement Plan now in draft – to be monitored via unplanned care operational management steering group.
- Triage improvement plan developed and actions being implemented to improve performance - monitored via weekly EAS and Non Admitted Non Referred divisional meeting
- Recruitment campaign for Acute Medicine Consultants launched via new web page Recruiting Acute Medical Consultants - Worcestershire Acute Hospitals NHS Trust
- Plan agreed to increase number of Trauma beds within surgical bed base WRH target date June.
- Reduction in number of face-to-face appointments in fracture clinic - referral criteria under review , training /education plan , plan for plaster tech to attend ED. Target completion date 31st May
- Reduction in LOS Trauma – improved efficiency of theatre lists -Improvement team undertaking observations w/c 26th May
- Review of ward rounds/ Rotas' & Staffing commenced target implementation 31st August
- Proposal in draft for reconfiguration of Acute Medical floor, benefits realisation to be presented to executive team by End of May 25.
- Workforce plan in draft. To be presented to TMB in June 2025.

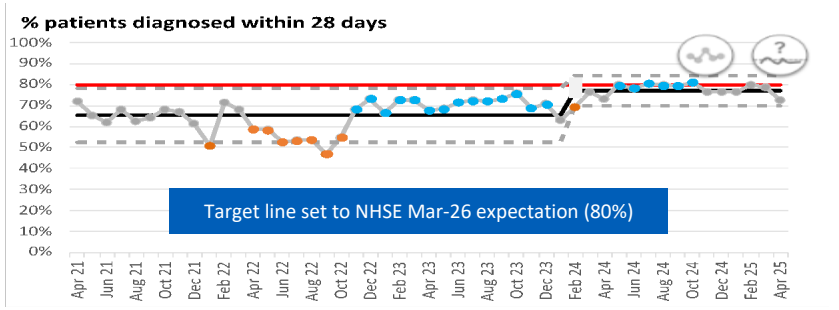
Risks

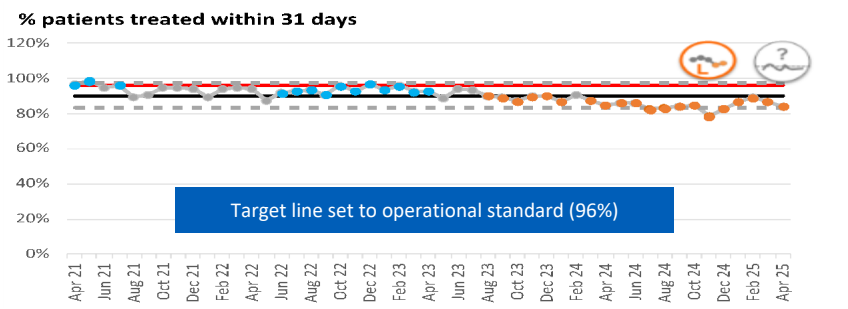
- Agency Usage/Switch from Direct engagement to none direct engagement
- Hospital flow and late discharges increasing
- Pathway patients and those with no reason to reside…??
- Long delays for Ambulance Patients resulting in increased risk of harm and deteriorating patient (GRAT process in place for assessment)
- Few alternative pathways for walk in patients that are not SDEC, MIU provision/UTC/redirection options few
- Increased in Trauma requirement with seasonal change, already seeing impact at front door
- Ability to recruit to Acute Medicine and ED – national supply/competition
- Acute Oncology capacity
- WMAS uptake of call before you convey and redirection before ED to Mental Health suite and SDEC (Pitstop mitigation supporting)
- Financial risk associated with managing safety in overcrowded department
- Additional capacity driving overspend and need to implement mitigating action to manage safety.

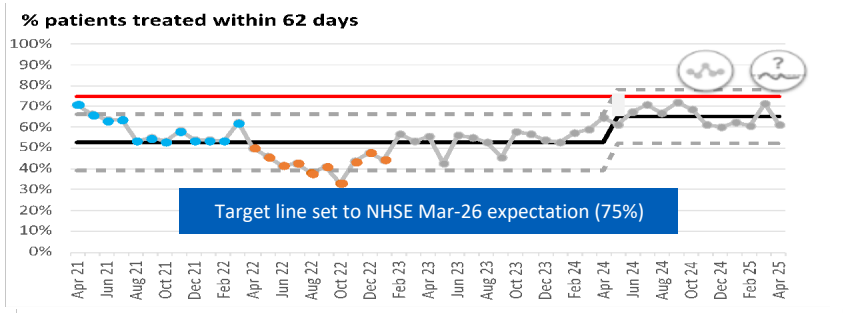
OUR OPERATIONAL PERFORMANCE - CANCER

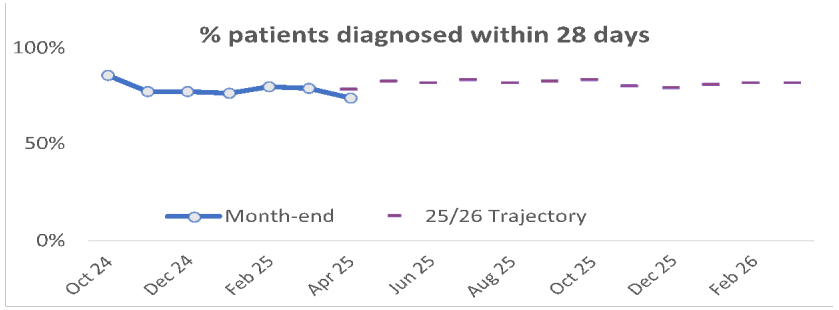
We are driving this measure because

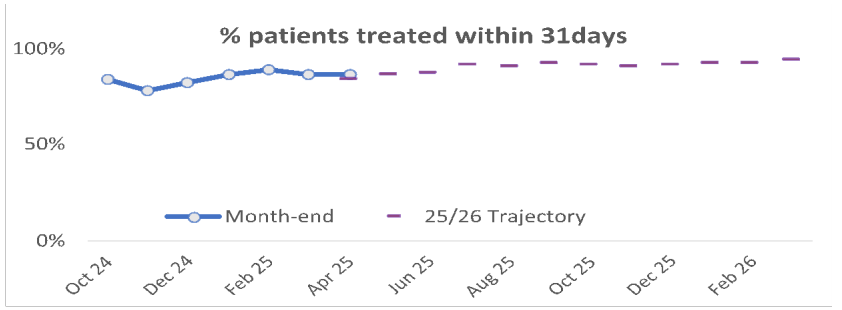
Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime.

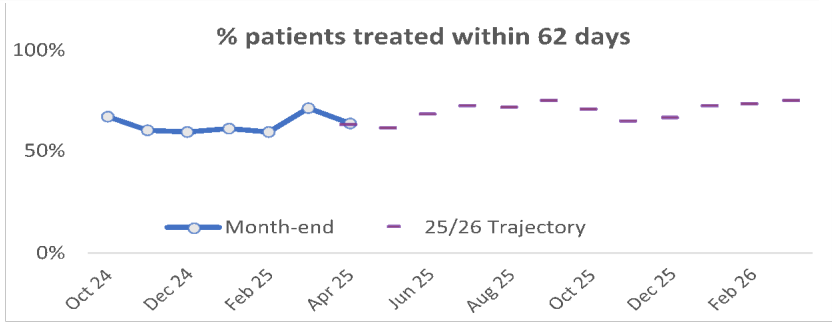












Understanding the performance

- Following the peak of 3,000 in Jan-25, in-month cancer referrals continue the recent trend of over 2,850 a month.
- The decrease in 28-day performance (74%) is below our annual plan target. Seven specialties saw a decrease in performance between March and April. 129 fewer breaches would have resulted in achieving the April target.
- The 31-day performance (86%) is above our annual plan target. Although 4 specialties did achieve the 96% operational standard, they contribute low numbers of patients to the numerator and denominator. Skin is our most challenged specialty for this metric, followed by Head & Neck and Breast.
- The 62-day performance (64%) is at our annual plan target. Although the interim target of 75% isn't to be achieved until Mar-26, two specialities (Haematology and Head & Neck) are currently achieving this standard.
- Breast, Skin, Upper GI and Urology are the specialties that are contributing the most breaches to our month end position.

Actions (SMART)

- Fortnightly oversight, monitoring and support from ICB and NHSE
- Service level improvement plans developed and monitored.
- Breast – action plan in place to rectify performance. Includes triage of high priority cases, set up of under 40s clinic and development of low-risk breast referrals pathways to manage demand. Capacity review of radiologist underway and 'Mega Wednesday' clinics set up to target backlog. Aim to recover position August
- Skin – Introduction of tele-dermatology commences June 25
- Adverts out for Locum Consultants for skin and substantive Max Fax Consultant
- Re-introduction of one stop dermatology clinics with max fax support
- Gynaecology – short term mitigation WLIs in place. Implementation of revised PMB (post-menopausal bleeding) pathway to start June 2025
- Lung – Agency locum. Micro-management of waiting list to maximise use of limited resource.
- Urology – Appointed to WMCA funded Consultant to increase outpatient appointment post MDT- July 2025. Close monitoring of steps within the LATP process.
- Development of business case to extend operating capacity to support urology and colorectal cancer pathways.

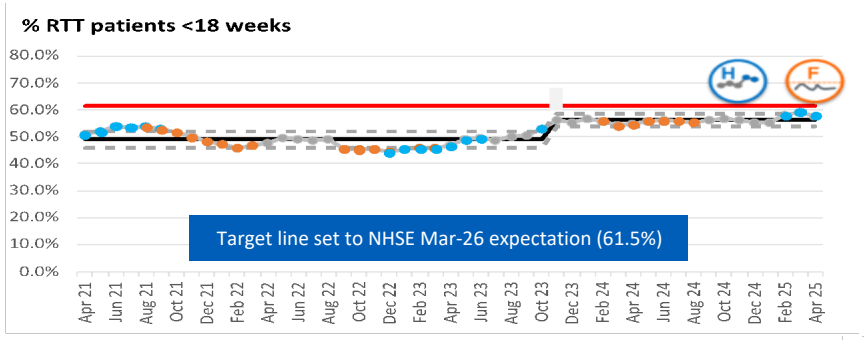
Risks

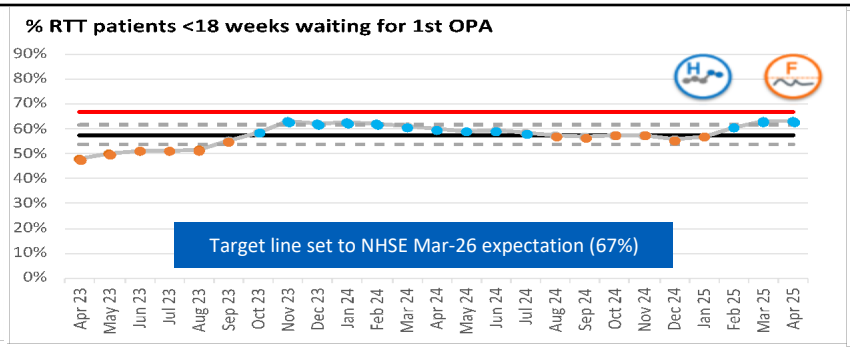
- Impact to achieving delivery of 31 and 62 days resulting from insufficient Oncology capacity
- Ongoing financial impacts associated with the use of high-cost diagnostic outsourcing solutions in histology and radiology.
- Risk to delivery of FDS, 31- and 62-day targets due to service model fragility particularly for skin (which also relates to fragile max fax service) which does not have a permanent solution for service delivery.
- Delays in Histology reporting impacting on prostate pathway
- Financial impact due to use of agency locum Consultants in Urology.

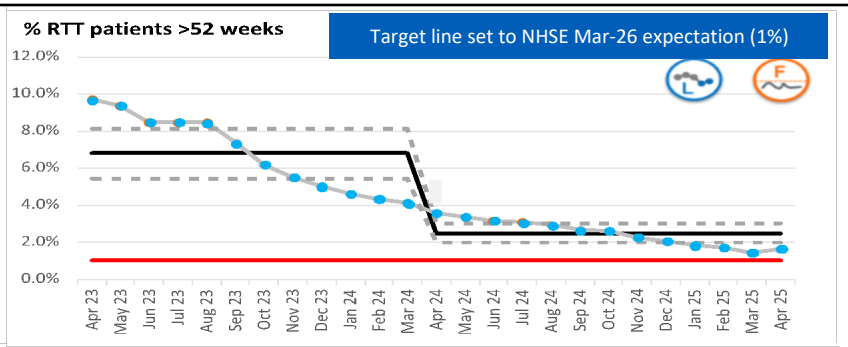
OUR OPERATIONAL PERFORMANCE – REFERRAL TO TREATMENT

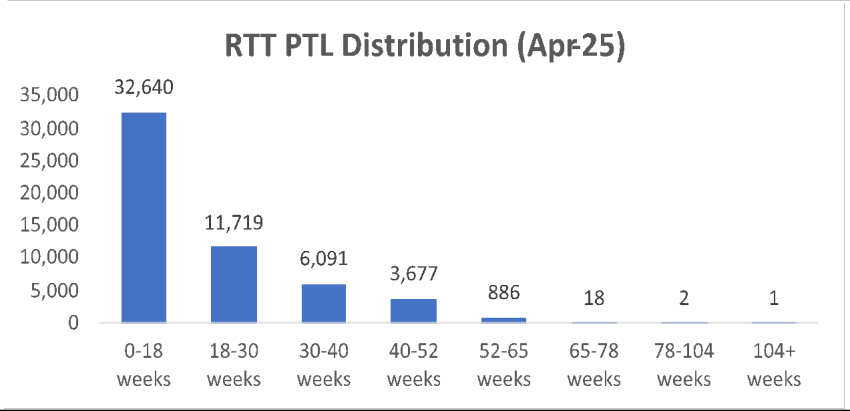
We are driving this measure because

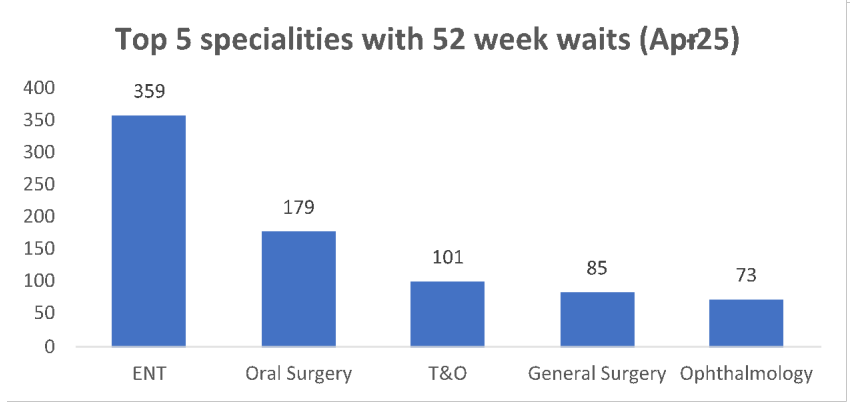
It is a key priority to ensure that patients can access the elective treatment they need in as timely a manner as possible and to continue to recover to the 18-week Referral to Treatment standard as set out in the NHS constitution.

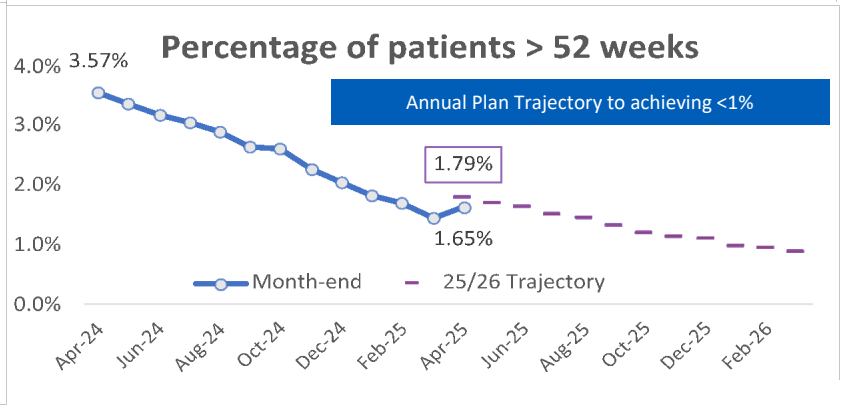












Understanding the performance

- At the end of Apr-25, 59.3% of patients, of a waiting list of 55,034, were waiting less than 18 weeks for their first definitive treatment. This continues the recent trend of significant improvement.
- For those patients waiting for their first appointment, we have seen an improvement in the proportion waiting less than 18 weeks to 63.1%.
- Although the number of patients waiting over 52 weeks has gone up, this was identified through the forecast modelling undertaken during the annual planning round. The performance seen in month; 907 patients (1.65% of the total waiting) was better than plan.
- The top 5 specialties with 52-week waiters contributed 88% to the Trust overall position.

Actions (SMART)

- Fortnightly oversight, monitoring and support from ICB and NHSE
- Weekly COO oversight and monitoring of our longest wait patients
- Focus in general surgery to bring all new OPAs to under 30 weeks and reduce risk of late referrals to externally sourced diagnostics, therefore reduce risk to patients breaching 65 weeks.
- All corneal transplants listed and treated by end of June therefore all future patients under 52 weeks.
- Divisional oversight and micro-management of patients on admitted pathways requiring surgical treatments which exceed 52 weeks
- All divisions reviewed at risk specialties and confirmed plans to achieve elimination of 52 week waits by March 2025. – May 2025

Risks

- Risk to elimination of 65+ week waiters due to late onward referral to external diagnostic services with limited capacity i.e. manometry, proctograms
- Risk to delivery of eliminating all waits over 52 weeks by Mar 2026 particularly for ENT, T&O and pain services, without in year process change/ services transformation
- Financial impacts of ongoing use of insourcing and outsourcing solutions particularly in dermatology
- Availability of corneal transplant tissue impacting on long waiters in ophthalmology
- Delivery of 52 weeks target for OMFS due to fragility service resulting from medium to long term absence of Consultants.