PUBLIC BOARD MEETING

Thu 04 September 2025, 13:00 - 14:30

MS TEAMS

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Frances Martin

Glen Burley and Russell Hardy.

13:01 - 13:02
1 min

2. Declarations of Interest

Frances Martin

13:02 - 13:03
1 min

3. Minutes of the Meeting held on the 3 July 2025

Decision *Frances Martin*

3. PUBLIC BOARD MINUTES - JULY 2025 KO, LF.pdf (6 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

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

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Managing Directors Report

Discussion *Jane Ives*

5.1 MD Report FS.pdf (1 pages)
5.1a SEPTEMBER 2025 - MANAGING DIRECTORS REPORT.pdf (8 pages)

5.2. Integrated Performance Report

Discussion *Jane Ives*

5.2 WVT Full Pack Month 2 - IPR_Board - JI.pdf (27 pages)

5.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Discussion *Andy Parker*

5.2.3. Workforce

Discussion *Geoffrey Etule*

5.2.4. Finance Performance

Discussion *Katie Osmond*

13:35 - 13:45
10 min

6. Items For Approval

6.1. Herefordshire / Wye Valley NHS Trust [WVT] Winter Plan and Winter Board Assurance Statement 2025

Decision *Andy Parker*

Item 6.1b - Patient Flow and Escalation Policy available separately on Admin Control under documents - Folder named "Embedded documents September 2024 Public Board " due to size.

- 6.1 Herefordshire and WVT Winter Plan 2025 Cover Sheet Trsut Public Board September 25.pdf (2 pages)
- 6.1a WVT Winter Plan 2025_26 v4.5.pdf (26 pages)
- 6.1c - Escalation Matrix 2025 - Embedded doc 2.pdf (2 pages)
- 6.1d - Daily Flow Escalation Matrix - Embedded doc 3.pdf (2 pages)
- 6.1e - Winter Plan - BAF - Embedded doc 4.pdf (6 pages)

13:45 - 14:10
25 min

7. Items for Noting and Information

7.1. Committee Summary Reports and Minutes

7.1.1. Foundation Group Board Minutes and Action Log 6 August 2025

Discussion *Frances Martin*

- 7.1.1 Draft Public FGB Minutes - 6 August 2025.pdf (16 pages)
- 7.1.1a Public Matters Arising and Actions Update Report.pdf (1 pages)

7.1.2. Quality Committee Report and Minutes 6 June 2025 and 26 June 2025

Discussion *Ian James*

- 7.1.2 Quality Committee Summary Report May 2025 - public.pdf (2 pages)
- 7.1.2a May Minutes Quality Committee.pdf (7 pages)
- 7.1.2b Quality Committee Summary Report June 2025 - public.pdf (2 pages)
- 7.1.2bb QC MINS JUNE - Public Board.pdf (10 pages)

7.2. Perinatal Services Quality Report

Discussion *Lucy Flanagan*

- 7.2 Perinatal Services Safety Report July 2025 Final.pdf (16 pages)

7.3. Patient Experience Quarterly Report and Quality Priority Update

Discussion *Lucy Flanagan*

- 7.3 Patient experience report August 2025 V3.pdf (13 pages)

14:10 - 14:15
5 min

8. Any Other Business

14:15 - 14:20
5 min

9. Questions from Members of the Public

Discussion *Frances Martin*

14:20 - 14:20
0 min

10. Acronyms

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

14:20 - 14:20

11. Date of Next Meeting

0 min

The next meeting will be held on 2 October 2025 at 1.00 pm

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

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

RH advised that this week is pivotal for the NHS, marked by the launch of a 10-year plan by the Prime Minister and the Secretary of State for Health and Social Care, alongside a revision of the National Operating Framework. The Board has been actively discussing practical and rapid improvements aimed at enhancing patient experiences in Wye Valley Trust and the wider community. The overarching goal is to shift more healthcare delivery closer to home, which benefits patients and enables hospitals to focus on acute care rather than handling issues that could be addressed earlier.

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**RH**	**Information**	**Verbal**
Noted as above.				
2.	**Quorum and Declarations of interest**	**RH**	**Information**	**Verbal**
The Board was quorate and there were no new declarations received.				
3.	**Minutes of meeting on 5 June 2025**	**RH**	**Approval**	**Enclosure 1**
Approved.				

4.	**Matters Arising and Action Log**	**RH**	**Information**	**Enclosure 2**

June 2025 – Action 6 – PFI Performance Issues - PFI performance issues are scheduled for discussion in October. Significant behind-the-scenes work is underway, as the contract nears its final years. Both the organisation and the PFI provider aim to ensure a smooth conclusion to avoid reputational damage, especially for the Provider. Previous Board commitments are being closely monitored, and early signs of improvement are emerging. A more positive performance report is anticipated by October.

June 2025 – Action 20 – Freedom To speak Up Annual Report - RH strongly encouraged staff to speak up about any safety concerns or issues affecting citizens. Freedom To Speak Up is a key part of Wye Valley Trust's culture, and all voices are valued and welcomed.

The Board accepted the Action Log update.

5.	**Chief Executive's Report**	**SC**	**Assurance**	**Enclosure 3**

NHS 10-Year Plan: Recently launched and will be discussed in detail at upcoming Board meetings. It positions the Trust well, especially in integrated care, thanks to strong partnerships and neighbourhood teams.

National Oversight Framework: Reflects a shift in expectations, with increased demands for rapid delivery. The Trust is committed to implementing changes safely and sustainably.

Urgent & Emergency Care (UEC) - A new national UEC plan has been introduced, aligning with existing initiatives. Key changes include a maximum 45-minute ambulance handover target and the Trust's ongoing "test of change" projects in UEC are well-aligned with national priorities.

Winter Planning: This year's winter planning is being brought forward with more emphasis and resources. A formal plan will be presented to the Board in the coming months, building on current UEC initiatives.

Maternity Services - A national rapid inquiry is underway into maternity care failures. The Trust is focusing on workforce culture and safety, racial and socioeconomic inequalities, Board-level assurance and prioritisation of key safety indicators with an emphasis on maintaining vigilance and clarity in identifying safety issues.

Finance - Increased scrutiny on agency and temporary staffing spend. Targets are integrated into the Financial Plan and highlighted for public transparency.

Divisional Report – Surgical Division - Positive developments in Urgent and Emergency Surgical Care, especially in the Acute Surgical Unit. The Elective Surgical Hub is delivering significant benefits to patients in Herefordshire.

NT asked whether partners like West Midlands Ambulance Service are truly engaged and implementing the Call Before Convey principle effectively. She also queried whether the new central strategy would mandate this, making it a formal requirement.

NT then went on to ask whether digital and data initiatives—seen as critical—will be centrally funded or require internal budget cuts.

SC advised regarding the first question, funding is expected to be a mix of central and local sources. Regarding the second question, the new NHS 10-year plan marks a shift: digital investment is now being kept separate from the main capital budget, reducing the risk of it being diverted to other pressures. This change reflects a recognition that digital transformation is key to meeting productivity challenges. SC is more optimistic than in the past about securing central funding, though local support and resourcefulness will still be needed to deliver effectively.

JI noted that the volume of calls to the Urgent Community Response Hub has doubled. 50% of calls now come from the Ambulance Trust, split evenly between 111 and 999 services. The increase reflects growing adoption of the Call Before Convey principle. Success depends on consistent, high-quality responses—positive experiences encourage repeat use by paramedics.

The Board accepted the Chief Executive's Report.

6.	**Integrated Performance Report**	**JI**	**Assurance**	**Enclosure 4**

UEC remains the top concern and opportunity for both quality improvement and financial impact. The Trust is heavily investing in improving access and managing demand, including encouraging Ambulance Services to contact Community Services first and engaging patients earlier in their care journey, especially before acute illness.

End-of-Life Care Insight - A recent audit across Herefordshire and Worcestershire on one particular day showed 30% of all acute inpatients had died within 12 months. On Frailty Wards, this rose to 50–60%. Many patients are receiving non-acute care in acute settings, highlighting the need for earlier, meaningful conversations about care preferences. The Trust is developing Neighbourhood Health Teams to support care closer to home, with pilots starting August this year. The Trust hopes to be selected as a national pioneer site, with additional funding.

Finances are a key concern alongside UEC. The Trust is making steady progress on cost reduction and productivity plans. AI and digital tools are being explored to improve efficiency, particularly in admin and clerical functions, with plans to redeploy affected staff.

The Trust is on plan financially for the second and likely third month of the year.

Cancer targets are being met, ensuring timely diagnosis and treatment—an important achievement as targets become more challenging.

The Board accepted the Integrated Performance Report.

7.	**Quality (Including Mortality / Learning from Deaths)**	**LF/CA**	**Assurance**	

LF advised that a new Emergency Department (ED) Safety Champion role is being introduced, modelled on the successful Maternity Safety Champion Framework. The purpose is to enhance floor-to-board oversight, amplify staff and service user voices, and foster a safe, supportive culture. Nominated NED Lead is Frances Martin, with LF, CA and AP the Executive Leads. This will include monthly safety walkabouts, check-in sessions with frontline Safety Champions, focus groups for deeper insights and quarterly Board reports on Safety Champion activity.

Included the in pack is the falls data with overall falls rate decreasing, especially among high-risk patients (e.g. those with dementia or delirium). Most falls result in low or no harm, indicating effective prevention strategies. No new or emerging safety concerns identified, suggesting current improvement plans are working. Bed rail compliance has significantly improved following recent audits. The Trust is reviewing NICE guidance to ensure alignment with best practice. We are launching the “Moving Safely” campaign later this month to balance mobility and safety for patients.

CA advised that the rolling 12-month SHMI has risen to 108 as of February 2025. Despite this, the total number of deaths is lower than last year, especially in major diagnostic groups like heart failure, COPD, pneumonia, stroke and sepsis. Fractured neck of femur remains a challenging area with delays in timely admissions. A fast-track pathway is being trialed under a test of change this month. Early results are promising, but sustainability is yet to be confirmed.

A reduction in expected deaths is affecting SHMI calculations, likely due to removal of SDEC data from admissions, lowering the denominator. Increased cases coded with Charlson Comorbidity Index of zero, suggesting missing comorbidity data. These are being addressed through recoding and resubmission, and further investigation is underway.

A member of the public raised a question regarding sepsis noting that a recent National Report suggest that some NHS patients are dying unnecessarily due to delays by doctors and nurses in identifying and treating patients with sepsis quickly enough. With regard to this, what is the position within WVT? For instance, how may WVT patients have been diagnosed with sepsis in the last year? Of these, how many have died? How does this compare with similar hospital Trusts? CA responded advising that sepsis-related mortality is improving. Monthly audits by the Sepsis Clinical Lead tracks compliance with Sepsis 6 standards. A live dashboard in ED helps identify patients needing antibiotics and screening, enabling timely intervention.

JI advised that there is a strong focus on improving data quality to ensure mortality figures accurately reflect patient outcomes. Although the SHMI has increased, the actual number of deaths is stable or lower than last year. The leadership team (KO, CA and SC) are actively working to restore data accuracy, ensuring that reported mortality rates are not inflated due to coding or data recording issues.

IJ, Chair of Quality Committee advised that the recent mortality discussion reflects the Trust’s proactive approach to quality and safety. The Quality Committee is closely examining the underlying causes of the SHMI increase, which is not currently a cause for concern. The Trust is well aware of its challenges and is responding appropriately. Despite operating in a high-pressure environment, there is strong focus and scrutiny on maintaining quality and safety standards.

The Board accepted the Quality (including Mortality) Report.

8.	Activity Performance	AP	Assurance	

The Trust has undertaken a pause and reset of its UEC and "Valuing Patients' Time" agenda. Focus areas include: improving patient flow, reducing ED congestion, enhancing ambulance handovers, meeting 4-hour access standards and reducing 12-hour ED waits. Progress is being driven by three MDT workshops, resulting in 21 Trust-wide tests of change, currently being piloted. These initiatives align with the Winter 2025 UEC Plan and aim to reduce reliance on temporary escalation spaces. Early signs of recovery in ED quality indicators are emerging.

Elective activity remains on plan, despite challenges in May (e.g. anaesthetic cover and senior workforce gaps). Mutual aid is being used across the Foundation Group and System to support long-wait patients. Divisional teams are implementing activity changes and preparing for Outpatient delivery adjustments in Q3.

Q1 saw a deterioration in the 6-week diagnostic standard, but since 1 June, a 5% improvement has been achieved. Focus areas include echocardiograms, non-obstetric ultrasound, CT/MRI, and Radiology. Further improvements are expected with the opening of the Community Diagnostic Centre, aiming to reach 85% compliance by September.

Urgent and Emergency Care remains AP top concern. While early improvements are visible, the focus is on ensuring these become sustained, long-term changes.52-week elective waiting list growth is also a major worry. Although some long waits are reducing, hitting the 1% target by March requires further action, which teams are actively working on.

The Board accepted the Activity Performance Report.

9.	Workforce	GE	Assurance	

Sickness absence has dropped from over 6% to 4.5%, with further reductions expected. Recent Policy changes are contributing to this positive trend.

Healthcare Support Worker vacancies and turnover have improved with fewer than 20 vacancies remaining. Turnover rate has dropped from 19% to below 15%. Progress is encouraging, though ongoing work is needed.

A redesign of admin and clerical functions is underway. A streamlined model is expected by October.

E-Rostering has begun in Community Nursing, aiming to improve productivity and efficiency. Further rollout to other clinical areas is planned over the coming year.

The Trust remains fully committed to its EDI and staff wellbeing agendas. Ongoing collaboration with Staffside representatives and networks is helping to promote and support national programmes at the Trust.

The Board accepted the Workforce Report.

10.	Finance	KO	Assurance	

Financial Performance – Month 2 - The Trust has had a stable start to the financial year, with performance £21,000 better than plan. The goal is to break even this year, which is a challenging target.

Agency spend is £143,000 below plan, supported by reduced sickness absence and focused medical and nursing agency reduction programmes. Cost improvement delivery is £400,000 ahead of plan, though some gains are non-recurrent. There is continued focus on developing sustainable, recurrent savings to improve the exit run rate for future years.

Run rate reporting has been enhanced and is now being used at Divisional and Trust-wide levels. Financial risks are being actively managed via the Financial Recovery Board, including Welsh contract disputes over funding parity, elective commissioning challenges and the overall scale of the cost improvement challenge.

Cash is stable, slightly behind plan but not a concern at this stage. Access to planned deficit support funding depends on financial performance and delivery of planned cost efficiencies. This is being monitored Regionally on a quarterly basis, and the Trust currently retains access.

KL highlighted that the Month 2 financial position may appear more favourable than it truly is if key risks, such as Welsh contract funding, are not resolved. KO confirmed this, noting that the Trust is assuming approximately £7 million in income from Wales across the year, spread evenly month by month. If this funding is not received, it would negatively impact the year-to-date financial performance.

The Board accepted the Finance Report.

	ITEMS FOR APPROVAL			
11.	**Refresh of the Green Plan**	**AD**	**Approval**	**Enclosure 5**

The Board is asked to approve the refreshed Green Plan, which outlines the Trust's sustainability strategy for the next three years. Wye Valley Trust is recognised as a leader in the NHS for its commitment to the green agenda and net zero, with climate change impacts reinforcing the urgency of this work.

Key Features of the Refreshed Plan - Format updated to align with national guidance, developed in collaboration with partners across Worcestershire and the wider system. Emphasis on the link between sustainability and productivity, aligning with the Trust's efficiency goals. Includes SMART objectives, with annual reporting to track progress. We are moving from an engineering-led approach to one that is clinically relevant. Introduction of a Net Zero Clinical Chapter, starting with a focus on critical and perioperative care .Integration of the Digital Strategy, including use of AI and digitisation of records and workflows.

Pharmacy and Medicines: Focus on sustainable prescribing, packaging, and nitrous oxide reduction. Estates and Infrastructure: Continued work on the Integrated Energy Centre at the County Hospital site. Expansion of intelligent building systems to improve energy efficiency across other sites.

The Board approved the Refresh of the Green Plan.

	ITEMS FOR NOTING AND INFORMATION			
12.	**Perinatal Summary Report (Maternity)**	**LF**	**Information**	**Enclosure 6**

No safety concerns flagged in the report. Minor delays in inductions of labour and a caesarean section were appropriately managed with no adverse outcomes. Maternity staffing is stable with no escalations.

Neonatal unit staffing concerns raised by the Region last month have been responded to and ongoing benchmarking is in progress. The Region is satisfied with the Trust's response and actions.

Maternity and Neonatal Voices Partnership Representatives in Herefordshire have recently resigned, leaving key posts vacant. Due to wider NHS workforce and financial constraints, recruitment to these roles has not yet been approved. LF escalated the issue, and has received confirmation from the Local Maternity System and ICB that it will be resolved, with a follow-up call scheduled.

SH, NED Safety Champion, Maternity fully endorsed LF update, especially the concerns raised about the lack of a Service User Voice in maternity triangulation work. She expressed relief and optimism following the positive news that steps are being taken to resolve the issue and emphasised the importance of consistency in Service User engagement, particularly given the national focus on maternity services.

The Board accepted the Perinatal Summary Report (Maternity).

	COMMITTEE SUMMARY REPORTS AND MINUTES			
13.	**Audit Committee Report 15 May 2025 and 24 June 2025**	**NT**	**Information**	**Enclosure 7**

The Trust received a clean audit, completed within deadlines. The Audit team, Deloitte, praised Wye Valley for being exceptionally well-prepared, noting it was likely their only client to deliver on time this year. The audit process highlighted effective collaboration and continuous improvement, with lessons from previous years successfully applied. Both internal and external audit processes were commended for driving ongoing quality and assurance.

The Board accepted the Audit Committee Report 15 May 2025 and 24 June 2025.

14.	**Quality Committee Report and Minutes 27 March 2025 and 24 April 2025**	**IJ**	**Information**	**Enclosure 8**
The Board accepted the Quality Committee Report and Minutes 27 March 2025 and 24 April 2025.				
15.	**Any Other Business**			
There was no further business to discuss.				
16.	**Questions from Members of the Public**			

Q1. Just over a month ago the national press reported "Hospitals in England are cutting staff, closing services and rationing care to make "eye-watering" savings demanded by NHS bosses". More recently there was another article suggesting that funding for rural areas, including hospitals was to increase. To the public, these contradictions can be confusing. Can you please provide a summary of what the effects of changes to NHS funding will have on staffing and provision of services at WVT?

A1. JI advised that the Trust now receives £14 million annually from NHS England to support the additional costs of rural service delivery. This funding does not yet apply to Wales, but efforts are ongoing to address that gap. Despite the rural funding, the Trust is still managing an underlying deficit and remains committed to achieving a break-even position. By year-end, the Trust expects to have approximately 150 fewer staff, primarily through service redesign and technology adoption, especially in admin and clerical roles. While methods of service delivery are changing, there are no plans to cut existing services. Innovations like neighbourhood health teams are part of the transformation. The Trust is embracing AI to streamline administrative tasks and support Clinicians. This approach is generating efficiency savings and is seen as a model for the wider Foundation Group. Key staff have been instrumental in driving Clinical-side AI adoption.

The Board accepted the Questions from Members of the Public.

DATE AND TIME OF THE NEXT MEETING - Thursday 4 September 2025 – 1.00 pm – 2.30 pm

WYE VALLEY NHS TRUST
ACTIONS UPDATE: PUBLIC BOARD MEETING – 4 SEPTEMBER 2025

Public Board Reporting Action Log 2025/26							
Month	**Ref.**	**Item**	**Action**	**Lead**	**Due date**	**Status**	**Update**
June 2025	Action 6	PFI Performance Issues	To provide an update to assess progress on maintenance resolution by Mercia and Sodexo at the October Public Board meeting.	Alan Dawson	October 2025	**Open**	Due October 2025.
June 2025	Action 18	25/26 Operational/ Financial Plan and Budgets	To provide the Chairman with a version of Table 1 in the Financial Plan showing financial values.	Katie Osmond	End July 2025	**Closed**	Completed - Table 1 reflected RTT activity, there is a small volume of other activity making up the total activity plan against which our total income plan aligns. Following the work to devolve clinical income to specialties, a summary table showing activity and income will be circulated (end July).

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	Managing Directors Update Report
Lead Executive Director:	**Managing Director**
Author:	Jane Ives, Managing Director
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To update the Board on the reflections of the Managing Director on current operational and strategic issues.

Recommended Actions required by Board or Committee

For Information.

Executive Director Opinion[1]

Assurance can be provided that the information within this update report is accurate and up to date at the time of writing.

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

1. NHS Oversight Framework and Segmentation

We are expecting the publication of the new national performance league tables and announcement of our allocations to a segment (from 1- 4 with 1 representing best performance) imminently.

We expect to be in segment 3 due to a financial override that has been put in place that means that no Trust in receipt of deficit support can be higher than segment 3.

In addition there has just been publication of a Board self-assessment of capability to be completed and returned by October 22nd.

The capability assessment is against 6 themes;

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

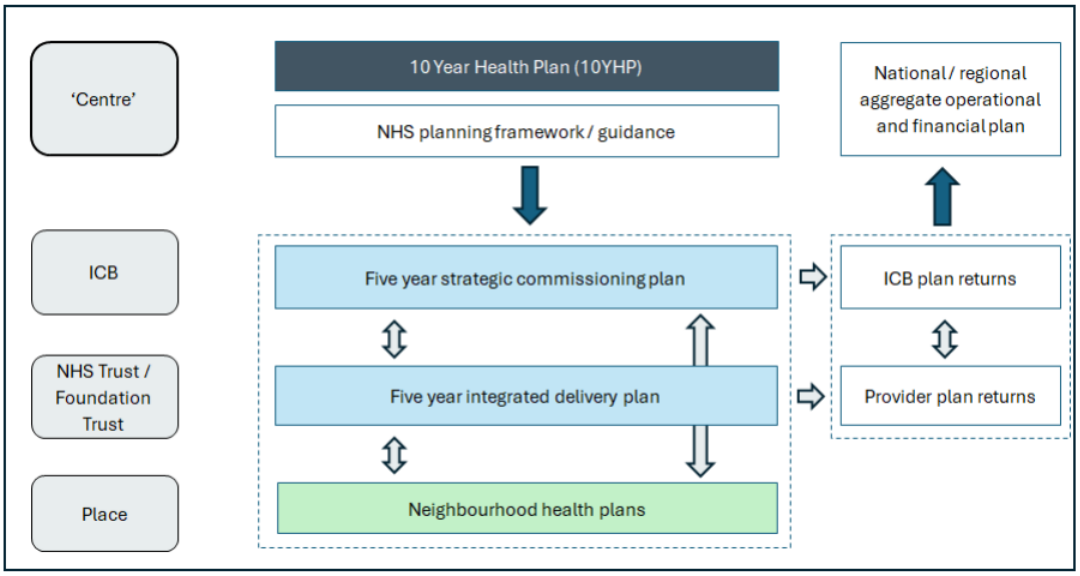
NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of our capability.

We will prepare our self-assessment for sign off at the next Board meeting.

This alongside our performance and segmentation will form the basis of any regional or national support.

2. Medium Term Planning – Guidance and timescales

Relationship between key elements of the national planning architecture



There has also been recent publication of draft planning guidance. The expectation is that over Quarter 3 ICB's will finalise their 5 year strategic commissioning plans and providers will develop a 5 year integrated delivery plan. Plans will then be authorised Quarter 4 ready for 2026/27 new financial year.

Neighbourhood Health plans will also be developed by health and care partners and signed off by health and wellbeing boards. There is more guidance expected on the development of Neighbourhood health plans, but we would expect our submission to be a national pilot for neighbourhood health to be the core of any plan.

At our workshop today we have reviewed the long term financial plan and route to break-even. This alongside the planned clinical specialty reviews we have planned in Q3 and normal operational activity and workforce planning will underpin our integrated delivery plan.

3. ICB changes

The agreed clustering of Herefordshire and Worcestershire ICB with Coventry and Warwickshire practically comes into effect on September 1st when Simon Trickett assumed CEO responsibility for both ICB's. Appointment to the executive team structure will take place over the autumn and the full structure by the end of the financial year incorporating a near halving of running costs. The chair of the 2 ICB's will be announced in the near future,

4. Powys Commissioning

We have started to action the extension of routine adult elective inpatient/daycase waiting times from 1st July and there have been numerous press articles and FOI requests on the topic.

We have not actioned an extension of waiting times for outpatients and our view remains that the operational and clinical risk remains too high to action this and that the financial costs, which we would expect them to pay for, would outweigh any savings they might make.

The medical directors (SaTH, RJAH, WVT) wrote to Powys expressing their concerns. They have acknowledged the letter and we are awaiting a formal response in September.

5. National Neighbourhood Health Implementation Pilot

We have registered our interest and submitted our plans to be authorised as a national pilot for neighbourhood health implementation and expect to hear whether we have been successful in the next week.

6. And it's goodnight from me

Today is my last Board meeting after some 10 years of involvement in and 9 years as Managing Director of Wye Valley Trust.

I can only say what an extraordinary privilege it has been and to thank my colleagues, our partners and all our staff for their support, their kindness and their unswerving commitment to improving the care we deliver to our patients 24 hours a day, every day of the year.

7. More from our great teams - Clinical Support Division Update

PATIENT ACCESS

Virtual Fracture

In Outpatients there have been a number of developments which support the specialties to deliver improved services. The Virtual Fracture service commenced in April 2025 and the Senior Plaster Technicians are seeing up to 12 patients per virtual clinic which will reduce the need for patient attendance in the busy fracture clinics. This service has also provided career progression within the Plaster Team to support recruitment and retention. We have also provisioned support from Pedicabs in Herefordshire and Wales to provide free delivery of the patient orthotics. We are now recycling orthotics through a charity who provide this service to soldiers for the Ukraine.

Wound Service

To support the continuation of elective and emergency surgery following the cessation of primary care wound services (as a result of collective action), the wound clinic is continuing through Outpatients via the Geoffrey Lewis Van. Since the start of the service in January 2025 around 6000 appointments have been attended by over 2060 patients. 91% of the patients are for wound checks/dressings with only 9% for Removal of stitches/Sutures. Feedback from friends and family continues to be very positive, we are waiting confirmation from the ICB re the future of the service.

Room Utilisation

Building works for the Outpatient transformation project has been fully completed with positive feedback. Apart from reduced clinics in June due to a high level on clinical leave the room utilisation has improved with 84% in May and 82% in July, work still underway with forward looks with specialties to reduce DNA's and short notice cancellations.

Referral Management Centre

e-RS roll out currently still at 14 specialities waiting feedback from other specialties to go live. Bid has been submitted to the NHS England for 100K to support API's from e-RS to maxims the current quote is £200K working with Blackpool on combined request with Maxims, this bid is currently for ASI's only due to the cost of A & G API being over £300K.

Referral Management Team went the extra mile validating lists, supporting EPR with testing and working to resolve the ongoing issues with the upgrade issues ensuring the additional workarounds were actioned as a failsafe.

Mortuary/Bereavement

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

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

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

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

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

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

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

Premises Enhancements
The installation of the new Mortuary flooring has significantly improved the working environment and overall presentation of the facility. This upgrade has also enhanced compliance with Infection Prevention and Control (IPC) standards, ensuring a safer and more professional space for staff and visitors.

Increased Storage Capacity
Permanent fridge capacity has been expanded from 51 spaces to 61 spaces, with further plans in place to increase to 65 spaces. This additional capacity provides greater resilience during periods of increased demand, such as winter months or other high-mortality periods, reducing reliance on external storage facilities such as Three Elms.

Strengthened External Partnerships
- Positive engagement has taken place with the new Herefordshire Coroner. This has led to the establishment of stronger working relationships and collaborative discussions on improving standards and streamlining processes.
- Permission has also been secured to facilitate training and educational visits for external professionals, including police officers and paramedics. These sessions will enhance understanding of mortuary procedures across partner organisations, improving communication and professional standards for the County.

Expansion of Bereavement Support
The Bereavement Service is being extended to cover community hospitals, with implementation planned for the start of September. This will ensure families across a wider geography receive consistent, compassionate, and timely support during the bereavement process.

Regulatory Assurance and Positive Feedback
- An unannounced inspection by the Human Tissue Authority (HTA) was carried out on a day with minimal staffing. Despite these challenges, Inspectors were pleased with the high standards of care provided to the deceased, as well as the cleanliness of the environment.
- Inspectors were particularly impressed with the introduction of new traceability and governance systems, including Eden and Passport, which have strengthened compliance, oversight, and accountability across the service.

Improved Guidance and Support for Clinical Colleagues
A new guidance document has been developed for ward staff outlining after-death procedures. This resource, currently under review by the policies team, will support consistency, reduce errors, and ensure dignity and respect are maintained throughout the process.

Staff Development and Service Resilience
The Bereavement Officer and Bereavement Assistant have received additional training to support clinical duties, including the receipt and release of the deceased. This upskilling initiative provides greater flexibility within the team, reduces service disruption during periods of reduced staffing, and enhances overall service resilience.

Implementation of Optima Allocate Rostering
The department has now transitioned to using Optima Allocate for rostering. This system provides improved oversight of staffing levels, enables more efficient rota management, and strengthens workforce planning. The move has enhanced governance, reduced administrative burden, and ensures appropriate cover is consistently maintained across Mortuary and Bereavement services.

CANCER SERVICES

Significant improvements have been made in our cancer performance. In June 2025, the Trust exceeded the 28-day Faster Diagnosis Target of 75% by 6%, achieving an overall rate of 81%. Current projects expected to further improve our cancer outcomes include the introduction of a post-menopausal bleeding pathway and the rollout of text messaging across all services, enabling patients to receive their results more quickly and efficiently.

The Lynch Service is now operational with a part time Clinical Nurse Specialist (CNS), funded by the West Midlands Cancer Alliance until November 2026. This service works closely with the Colorectal and Gynaecology multi-disciplinary teams to ensure genetic testing is completed, and appointments are scheduled to review family history and manage complex genetic referrals. The CNS also co-ordinates with Oncology and other specialty teams regarding Lynch syndrome diagnoses, which can influence treatment decisions.

Our New Palliative Care Consultant did start in May 2025 and this has meant the team is now fully recruited with substantive. This enables appropriate cross cover at WVT and SMH.

DIAGNOSTIC SERVICES

The Radiology team have continued to deliver significantly increased capacity across main modalities including; MRI (Magnetic Resonance Imaging), CT (Computed Tomography), NOUSS (Non-Obstetric Ultrasound Scan) and DEXA (Dual Energy X-ray Absorptiometry/bone density scan) achieving; 103%; 102%; 116% and 95% against 2025/26 plan year-to-date. The modalities combined average is delivering above 94% of patients seen within 6 weeks of referral.

The Wye Valley Community Diagnostic Centre remains on track, with the official opening confirmed for 29 September 2025. Workforce recruitment is around 80% to plan. Implementation of the CDC slippage plan (June 2025) and Radiologist on-call job plan changes are now fully embedded, with positive impacts on waiting times already evident

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

Audiology waiting times continue to improve, with the under 6 week position rising to 64% in July 2025. Both Services have been restructured with a Head of Service and Deputy roles in place, establishing a clear clinical hierarchy and succession planning. Term-time only contracts have ended, operating hours have been extended, and flexible cross-working across services has been introduced, supported by consolidated training. Like many local services, Audiology faces ongoing workforce challenges. Insourcing support for Paediatric Audiology resumed in August 2025, with recruitment underway to fill remaining vacancies and enable full withdrawal of insourcing.

PHARMACY

Pharmacy recruitment is still on a journey but there has been a vast improvement compared to the position last year. We are continuing to see vacancies across all the staff groups. The improved establishment position has allowed the clinical service, which includes; Pharmacists, Pharmacy Technicians and Pharmacy Assistant Technical Officers (ATOs), to return to ward-based working. The collaborative effort across speciality areas within the department to release ward-based staff is shown through our productivity gains: TTO turnaround times now reached 74% July 2025 (highest in 3 years). Outpatient Prescription turnaround times have also improved by 15% over the past 12 months.

Our Management of Change Consultation (Management of Opportunity) was launched on the 18th August 2025 and this will provide a new structure for Medicines Procurement, Provision and Homecare, creating a more sustainable workforce structure and creates opportunity for development for our staff. This will be fully implemented by the end of the financial year.

Pharmacy are trialling and exploring innovative ways to improve productivity within the services; use of AI to support medicines reconciliation, obtaining automated dispensing cabinets to support stock management at ward level, submission of two first of type of national ending applications for digital integration and innovative workforce roles e.g. Pharmacy Technician to support CDC. Previous innovations have been recognised nationally with three Pharmacy Technicians being nominated for APTUK awards for their roles within ED and within Rheumatology.

The Pharmacy department footprint remains an issue as the work and staffing levels grow and our Aseptic Unit requires significant upgrade to meet the national standards. The business case for the development of the aseptic unit is ongoing and requires further consideration for a more collaborative approach across the ICS and a review of what the onsite facilities for WVT need to be.

PATHOLOGY

Histology turnaround times (TATs), have been maintained with WVT achieving the highest TATs in the region for both 7-day and 10-day reporting specimens in May and June.

Digital Pathology works are now progressing well with plans to increase its functionality and usage by early 2026.

Blood Sciences – The Managed Laboratory Services (MLS) works are due to begin in the next 4 weeks after some delays in contract signature. The implementation plan is over a 9-month period and once fully implemented it is expected that there will be efficiency gains within Blood Sciences but also much improved TAT's for ED one-hour standard patients.

Histology MLS Business Case is progressing with ROCHE agreed as the supplier for this project across the South Midlands Pathology Network, despite the uncertainty of the Network the MLS contracts are hoped to progress within the individual Trusts.

The Pan Pathology Quality Manager role, which was not allocated sufficient hours with only 0.2 WTE in post, has been increased to a 1.0 WTE role with interviews due to be held on the 12th September. The lack of Pan Pathology Quality Manager has been one of the Divisions highest rated risks for the past two years but with this increase both risks associated with this can be closed on appointment.

ENDOSCOPY

Endoscopy workforce optimisation business case approved in March 2025, which increased and stabilised workface within Endoscopy with the employment of an additional 1.0 WTE Band 8A Clinical Nurse Endoscopist (Lowers), 2.5 WTE Band 5 Nurses, and 1.0 WTE Band 3 Decontamination Technician. This has improved utilisation of Endoscopy lists and will increase capacity with Ross to increase to 5 days per week from 3 from October 2025.

The FIT@80 bowel screening pathway is going well and has increased its capacity from 3 sessions per week to 4.

Decontamination which has been a previous concern has been deemed as safe as is reasonably possible. However, to ensure lifecycle of ventilation is aligned with future proofing there are plans to relocate the decontamination unit to increase its functionality in April 2026.

7. GEMs Board September 2025 - Winners from Quarter 1

Team of the Quarter – Quarter 1 – Specialist Palliative Care Team

The Specialist Palliative Care Team is an integrated team working across the acute hospital and in the community supporting patients and families with complex needs at a very distressing time in their lives. They step into very challenging situations every day where other health professionals may stand back.

In the current health climate where there is immense pressures on services they all go above and beyond their roles to ensure patient and families get an extremely high standard of care and are frequently innovative about the ways we can give person centred holistic care.

The Team never compromise on excellence.

Employee of the Quarter – Quarter 1 – Kelsey Beddoes

Kelsey has recently joined the team and previously we have had issues with students, but I am always asking her questions and contacting her for different things. She is so efficient and supportive, her communication is amazing and very timely. She has been a real asset to us as a team and especially to me whilst I am still developing my role.

Kelsey consistently demonstrates each of the trusts values in endless amounts – a role model for our team, colleagues across the trust and students alike.

Compassion • Accountability • Respect • Excellence

NHS Wye Valley NHS Trust

Integrated Performance Report

July 2025

Managing Director – Executive Summary

Jane Ives
Managing Director

I am really pleased to see the increased use of text messaging and QR code to get feedback from patients on their experience of our services. Fundamental to delivering the 10 year plan is better engagement with patients. It is encouraging to see the improvements in scores in the first half of the year, particularly in ED where we have improved our responsiveness to patients requiring urgent care.

The work that has been done to unpick the impact of SDEC recording on our mortality is reassuring, but it will take more than a year for this to unwind out of national data as only 40 Trusts complied with the recommended recording of SDEC in July 2024.

The improvement of urgent care is at the heart of maintaining our improvement across our financial and other challenges. The stark improvement seen in June and July is stagnating a little in August with higher numbers of patients accommodated in temporary escalation spaces. Whilst it was disappointing to be placed in tier 1 for UEC performance based on our quarter 1 performance, it will be helpful to have expert support as we reinvigorate our improvement with two workshops planned in September to build on the successes at the beginning of the summer and improve further before the winter.

On the whole our elective performance is where it needs to be and the waiting list is falling, but I am worried about the rise in the number patient waiting over 52 weeks and we are not on trajectory to deliver less than 1% of the waiting list over 52 weeks by March. Focused attention is going into specialty level planning to make sure we deliver the target by the end of the year.

Our people metrics are generally positive and we have made excellent progress in consultant medical recruitment in recent weeks which will improve temporary spend on doctors along with job planning progress that has released more core activity in a number of specialties. The 70% reduction in nurse agency spend compared to the same time last year is above our planned reduction and represents both a financial and quality improvement as more care is delivered by staff supported within their own team.

Our financial performance is a significant improvement over the same time last year where we were some way from our plan. Our CPIP is delivering above plan (albeit the proportion that is non-recurrent remains too high) and we are at £327k positive variance to our plan at month 4 despite the additional costs of industrial action.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Cancer Patient Experience Survey Results

The 2024 Cancer Patient Experience Survey results were published in July 2025. Local analysis identified overall the Trust scored highly in two domains and scored below expected range in two domains (shown below). Results are then broken down by cancer site and a wealth of information in relation to health inequalities is also provided. Site specific action plans are being developed. Two key areas that require further work to understand are the experience of male cancer patients (who report poorer experiences than females in line with national trend) and to better understand the experience of our Welsh patients. Improvement work will be reported to the Cancer Board and Patient Experience Committee.

Questions above expected range	Case mix adjusted scores			National score
	2024 score	Lower expected range	Upper expected range	
Q16. Patient was told they could go back later for more information about their diagnosis	92%	80%	90%	85%
Q19. Patient found advice from main contact person was very or quite helpful	99%	93%	99%	96%

Questions below expected range	Case mix adjusted scores			National score
	2024 score	Lower expected range	Upper expected range	
Q17. Patient had a main point of contact within the care team	87%	87%	96%	91%
Q58. Cancer research opportunities were discussed with patient	28%	34%	58%	46%

UKAS Pan Pathology Accreditation Visit

During June and July 2025 the Trust Pathology service received their annual UKAS accreditation review**.** The review is rigorous and assesses all aspects of service delivery and quality assurance across all pathology services against the international standard ISO 15189:2022. UKAS were positive about the knowledgeable, competent and engaged pathology team demonstrating excellent technical and scientific outputs, however there were 80 findings requiring improvement and a mandatory response – most of these were minor and straightforward and remedied immediately. There were however more serious concerns relating to Biochemistry in particular and our wider Quality Management System, with a requirement to update risk assessments and completion of audits. The pathology team have responded with urgency and have submitted evidence of compliance and progress within the timescales prescribed by UKAS. A further visit will be conducted by UKAS in 3 months time.

Cleanliness standards

- Between April to June we have undertaken 282 joint monitoring audits in line with the national cleanliness standards and compliance is detailed in the table opposite – these results are really positive
- NHSE and ICB colleagues undertook a review of our IPC practice and cleanliness during a visit at the end of May 2025 – positively the Trust moved from intensive to enhanced support
- A further inspection will take place on the 18th September – we are aiming to move to routine monitoring/support and NHSE colleagues were confident that we can achieve this
- We are working with Sodexo and Estates colleagues to address lifecycle and maintenance works prior to the inspection

Star rating	Percentage of areas achieving compliance	Number of areas achieving compliance
5 stars	84%	238areas
4 stars	15%	43 areas
3 stars	1%	4 areas
2 stars	0%	0 areas
1 star	0%	0 areas

Quality & Safety Performance – Mortality

We are driving this measure because:

A continued rise in the rolling 12 month SHMI, approaching a 'higher than expected' mortality rate.

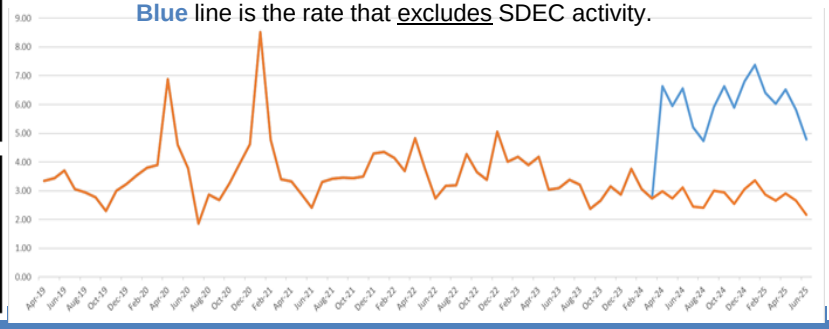
Data

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Feb-25**	108.3	*1.5*
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	**Apr-25**	111.8	*1.7*
SHMI (in hospital)			107.1	*1.9*
SHMI (out-of-hospital SHMI)			122.4	*0.87*

Crude Mortality Rate from April 2019 – July 2025

Orange line is the rate that includes SDEC activity.

Blue line is the rate that excludes SDEC activity.



CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	Apr-25	**98.27**	28.49	28	-4.93
Congestive Heart Failure		**121.93**	53.31	65	0.55
Fractured Neck of Femur		**145.83**	31.54	46	-7.24
Pneumonia		**110.96**	155.91	173	6.48
Septicemia		**103.70**	94.50	98	-2.35
Stroke *(Acute Cerebrovascular Disease)*		**101.13**	79.11	80	6.30

Monthly Headlines

- Latest 12 month rolling **SHMI** (*HES Based*) from May 2024 to April 2025 shows Wye Valley NHS Trust at **111.8,** a further increase of 1.2. The NHS England SHMI (March 2024 to February 2025) shows an increase of 1.5 to **108.3.**
- A recent report has released by NHS England, which has reviewed the data quality of the SHMI nationally. The report highlights the significant impact of removing SDEC activity from the submitted dataset with many Trusts reporting a similar and continued rise in their SHMI in response to the removal of SDEC activity. With the SDEC activity removed from our dataset, NHS England suggest that the continued rise in the SHMI is caused primarily by two factors. The observed number of deaths remains approximately the same as the mortality rate for the SDEC cohort is very low, while the expected number of deaths decreases because a large number of spells are removed, all of which would have had a small, non-zero risk of mortality contributing to the expected number of deaths.
- The latest **crude mortality** rate for July 2025 was **0.97%** for all admissions, which equates to 65 deaths and continues at some of the lowest rates reported over the past few years.
- Our key mortality outlier groups, with the latest SHMI figures (*March 2024 to April 2025):*

- **#NOF** – A further reduction reported this month in the latest rolling 12 month SHMI to 145. The 'test of change' with the ring-fenced bed for #NOF patients has significantly improved the length of times for patients to get from the Emergency Department to the specialist ward and subsequently to definitive surgery.
- **Heart Failure –** A new mortality lead has been identified to support the mortality governance within Cardiology with a planned start date in November. There is a planned thematic audit of a sample of 20 patients within the Heart Failure SHMI. This will aim to identify any issues or concerns with the pathway and patient care, but also identified any key learning or changes required.
- **Pneumonia** –The latest data has reported a 6.5 rise in the rolling 12 month SHMI to 110. During April 2025, there was a significant drop in the number of provider spells attributed to Pneumonia with the actual number of deaths remaining stable, which is the main driver behind the large increase in the SHMI.
- **Sepsis** – Process mapping workshop planned for 18th September, aiming to understand the current process and identify the potential barriers in completing the Sepsis Six bundle within the National target of 1 hour.

- With the rising SHMI, there has been an analysis of the other key diagnosis areas to ensure that we are reviewing all areas. There has been the following groups identified that have over 20 deaths in a 12 month period and a 'higher than expected' SHMI. A sample of patients from each group will be reviewed by the appropriate clinical lead to ensure there are no concerns or issues with the clinical care being provided.
  - *Acute Renal Failure, Aspiration Pneumonitis, Cancer of Colon & Organic Mental Disorders.*
- Due to the impact of **Clinical Coding** on the overall SHMI, there are several priority actions in progress to ensure that our current submitted dataset accurately reflects the activity at WVT.
  - Review of patients with a Charlson score of 0 – which would indicate little to no comorbidities.
  - Develop a Forward Planner for the re-submission cut-offs dates. The key focus will be ensuring that April 2025 is re-submitted.
  - Review of the smaller SHMI diagnostic groups, including 'Other' type groups, which appear to have rising number of deaths in lower weighted areas.
  - Plans to re-establish Coder & Consultant meetings to review coding for deaths, ensuring all approaches co-morbidities, procedures and diagnosis are correct.
  - Establish weekly surveillance of those un-coded patients to ensure patients are prioritised, coded and re-submitted.

Quality & Safety Performance – Patient Engagement

We are driving this measure because:

As part of our quality priority for patient experience, improving engagement with patients through responsiveness to feedback and providing better patient experiences is of high importance. Two new services introduced in Q1 demonstrate our commitment to improving patient experience.

FFT Service Expansion

The Trust has used a text messaging service to seek feedback from patient using the Friends and Family Test for the last 2 years. Roll out to all services was delayed due to complexities in restructuring the informatics framework to ensure data was collated under the correct services (for example community services reported under outpatients). The text messaging service averaged a response rate of 15-20%. The service has now been expanded and rolled out to all services with the addition of a QR code and survey link so patients can leave feedback at any time not just when prompted by a text message. In addition, the patient experience team are exploring how volunteers can support patients to leave feedback where technology is not as accessible. The refreshed service went live on 1st July 2025 and positive feedback ratings are shown below.

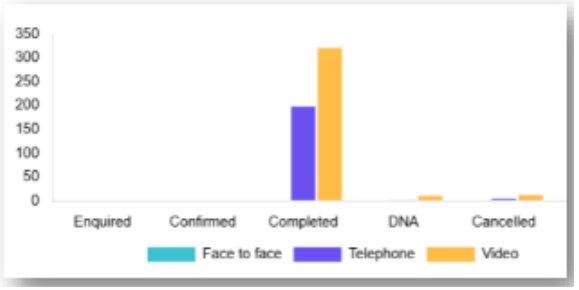
There has been an initial reduction in response rate, which was anticipated as the denominator for messages sent has increased with the rollout to all services. In addition to use of QR codes and survey links is not yet embedded. The response rate is not nationally monitored however this will be tracked closely to ensure the new service has expanded capacity for feedback as predicted.

Positive rating

Department	March 2025	July 2025
Trust Overall	91.66%	92.83%
Outpatients	94.20%	94.86%
Inpatients	85.71%	90.63%
Community	N/A – not live	90.32%
Emergency Department	76.39%	84.84%
Day Case	96.10%	97.10%

New remote interpreting service provider

Service	Bookings	Service Split	Fulfilment
Telephone	214	32%	99%
Video	436	67%	98%



Due to a number of issues with our previous remote interpreting provider and limited local availability for some languages for face to face interpreting a new remote interpreting provider was procured from 1st March 2025. The Trust Management Board also approved a remote interpreting first approach from 1st April 2025. The focus of this change was improving the patient experience with more reliable interpreting provision leading to less appointment cancellations, more timely treatment and use of interpreters with healthcare training. Overall the service has been received positively, with staff becoming more confident in using the system, and where issues arise these are resolved in a timely way either by the Patient Experience team or the remote provider. The data opposite (1st March- 31st May 2025) provides a breakdown of booking fulfilment and interpreting method. Since the service was introduced we have had 395 users register, 650 bookings via the portal and delivered 35 different languages.

Quality & Safety Performance – Staffing - May data

Fill Rate & CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPP
Primrose Unit	85%	90%	100%	81%	11.0
Maternity Ward	93%	90%	95%	98%	5.6
Children's Ward	126%	109%	126%	85%	18.0
Lugg Ward	136%	79%	112%	97%	6.9
Wye Ward	122%	81%	126%	78%	7.1
Cardiac Care Unit	100%	99%	100%	100%	12.1
Leominster Community Hospital	167%	75%	102%	121%	6.9
Bromyard Community Hospital	102%	79%	100%	78%	7.7
Ross Community Hospital	106%	104%	158%	123%	6.5
Teme Ward	137%	65%	97%	60%	13.4
Redbrook Ward	99%	121%	132%	117%	7.7
Special Baby Care Unit	97%	-	103%	-	14.9
Intensive Care Unit	118%	-	104%	-	27.7
Gilwern Ward	100%	125%	100%	100%	6.8
Acute Medical Unit	127%	97%	104%	147%	8.4
Ashgrove Ward	115%	91%	104%	110%	7.2
Dinmore Ward	121%	80%	106%	95%	7.4
Garway Ward	124%	91%	103%	107%	7.1
Frome Ward	122%	88%	103%	112%	6.8
Arrow Ward	134%	74%	131%	87%	7.4
Women's Health	134%	87%	100%	-	11.0

The NHS England staffing return detail is provided below (over and under fill)

- Paediatric Ward – Additional RN's required to support ED, and patients needing enhanced care RMN support
- Dinmore, Garway and Ashgrove Wards – Due to backfill for band 4 posts where clinically required
- AMU, Lugg, Redbrook, Gilwern Ward, Leominster and Ross Community Hospital – Due to patient acuity and dependency, additional staff needed to support individual care needs, including RMN support (Redbrook and Lugg)
- Wye Ward, Frome Ward and Teme Ward - Due to Band 5 backfill for band 4 posts
- Arrow Ward – Due to the number of patients requiring non-invasive ventilation (NIV)
- Women's Health Ward – Due to Clinical Specialist (CNS) showing on ward rota
- Primrose and Teme – requirements adjusted due to capacity changes on the wards

Bank & Agency

The Trust continues to focus on agency reduction and engages with the regional collaborative on agency reduction, successes in month 4 include:

- CPIP delivery - favourable variance of £778k YTD
- 99.5% of all nursing shifts are NHS price cap compliant
- Only 2 off framework shifts
- Increased bank use to offset agency and increase in spend reflecting pay award
- Zero usage of Health care supporter worker agency in M4

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Following the three UEC workshops previously reported to the Board, we have seen clear improvements across our urgent and emergency care Key Performance .indicators.

Performance against the 4hr Emergency Access Standard has improved to 70.9% in July, ahead of our planned trajectory of 69.6%. Time in department over 12 hours has now been below trajectory for the second consecutive month and is at its lowest level since July 2021. Average ambulance handover times have also improved, reducing to 32 minutes.

Along with continued high performance from our Urgent Community Response teams. In July, Community Integrated Referral Hub received 755 referrals. Of these, 327 met the criteria for a two-hour response, with 81.8% attended within this timeframe, meeting the two-hour response KPI.

However, given the performance challenges seen in April and May, the Trust has been placed in Tier 1 enhanced support with NHS England. While this is disappointing following our rapid engagement and recovery planning, we remain confident that with the progress demonstrated in June and July we will be in a strong position to exit enhanced support in the very near future. We also see this as an opportunity to work with national experts to strengthen our improvement journey and to build further Quality Improvement projects following our second round of workshops in September.

System and community schemes remain integral to sustaining this progress. These include: streaming 111 calls with ED dispositions to the Community Integrated Response Hub; the Neighbourhood Health programme aimed at admission avoidance for over-65s; deployment of a mobile respiratory team to support c.600 high-risk patients over winter; and discharge follow-up calls to reduce re-admissions. Discharge planning schemes are also focusing on Care Act assessment processes to prevent overstays on pathways, alongside increased therapy support for Discharge to Assess. A strategic workshop is planned for September to review Discharge To Assess to evaluate current process and plans

Our Winter Plan is being finalised with system partners and Powys Health Board. The plan aims to strengthen UEC processes through reducing avoidable admissions and shortening length of stay, while increasing navigation at the ED front door to direct patients more effectively into the right primary and secondary care pathways. We are also prioritising increased utilisation of SDEC, supported by a process and criteria review and a capital bid to expand estate capacity. At ward and system level, improvements to discharge processes remain critical, including how we review and refresh our Internal Professional Standards, “Working Better Together” standards within, and across, local clinical teams. There is particular focus on increase same day pathways and reducing discharge delays linked to Powys patients, where the potential impact of long-waiting elective cases on UEC pathways continues to be a concern as we head into winter.

Elective activity has remained on plan despite the challenges posed by industrial action and some significant workforce pressures. Referral to Treatment (RTT) 18-week performance remains positive, though the number of patients waiting over 52 weeks has increased, concentrated in Orthopaedics, ENT, Ophthalmology, and Gynaecology. Divisions are developing robust mitigation plans to improve performance in these specialties.

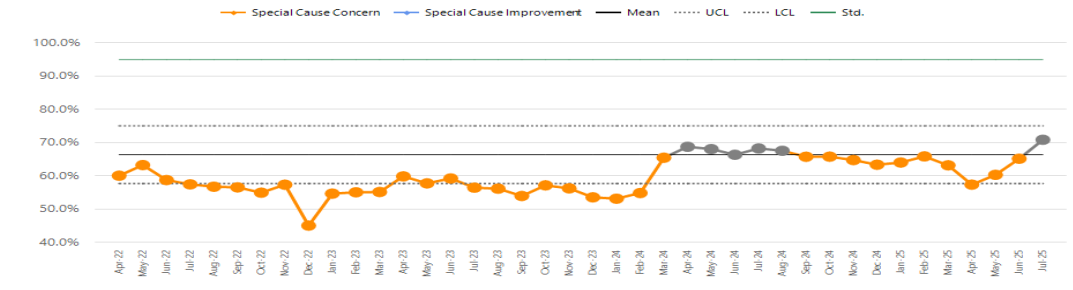
Diagnostic performance against the 6-week standard has stabilised, with the volume of patients waiting over 6 weeks reducing. The main pressures remain in Echocardiography and Audiology, where mitigation plans are being implemented. Endoscopy remains a concern, as routine waits are not reducing at the required pace, although cancer performance continues to be strong. From October, additional sessions at Ross Community Hospital combined with successful consultant recruitment will strengthen the medium-term recovery plan for Endoscopy.

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

We are driving this measure because:

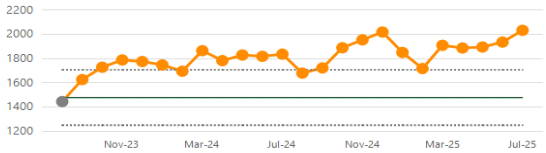
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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

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

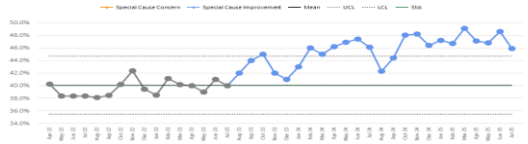


% Patients Spending More Than 12 Hours In ED

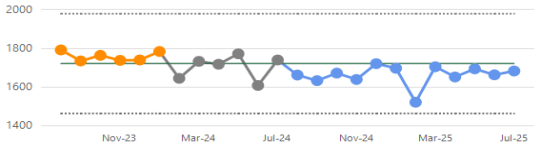
Emergency Admissions



% Admissions on Same Day Emergency Care (SDEC) Pathway



Ambulance Conveyances



Risks

- Sustained pressure in Type 1 ED attendances and continued challenges with demand and high acuity with fluctuating high levels of attendances and Ambulance conveyances. Along with increase >0 Length of Stay emergency admissions
- System patient flow constraints.

What the chart tells us

- Improved performance seen again from December 2020 to March 2021 but coinciding with reduced volumes of attendances due to the impact of the COVID19 pandemic
- July`s 4 hour Emergency Access Standard [EAS] Performance was 70.9%

Performance & actions

- 6,307 Type 1 patients attended ED in July which 137 more than the previous month. The range of all attendances varied from 172 to 256 with 203 being the average daily attendances.
- 1,683 ambulances conveyed to the Trust in month which was marginally more than the average through 2024/25 [1,674]. The range in month was 43 to 67. This includes 12.1% from Powys [203] which was the highest volume since Jan-24 [also 203].
- Ambulance handover delays over 1hr were 11.6% [173] of all . On average, 313 patients per month waited over an hour for handover through 2024/25. 28.6% [426] of all ambulance conveyances had a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,251 of all admissions [45.9% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 49 / 122 Type 1 Trust in England for July.
- 8% [619] of patients spent 12 or more hours in ED which was 3% less than last month.
- Key actions being taken to recovery our 4hr EAS :

➢ Time to Specialty Refer to outcome remains high over 2.5 hours and notable delays throughout the month with Surgical team and Orthopaedic teams. Ongoing work to strength our “Working Better Together” processes.

➢ Radiology pathways to improve diagnostics access and reporting.

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

➢ Engage with colleagues in Foundation Group and nationally re: front door processes & benchmarking processes

➢ Operational “Go Live” of electronic bed management system ahead of the peak winter periods

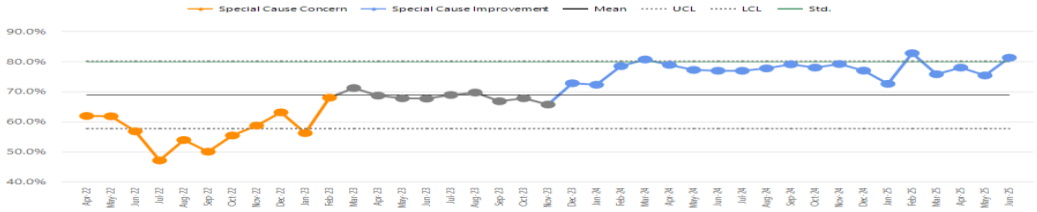
Operational Performance – Cancer Performance [June 25]

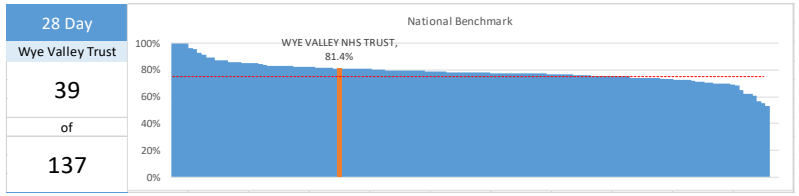
We are driving this measure because:

Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer, known as the Faster Diagnosis Standard [FDS], and 75% start first treatment within 62 days to be achieved by March 2026

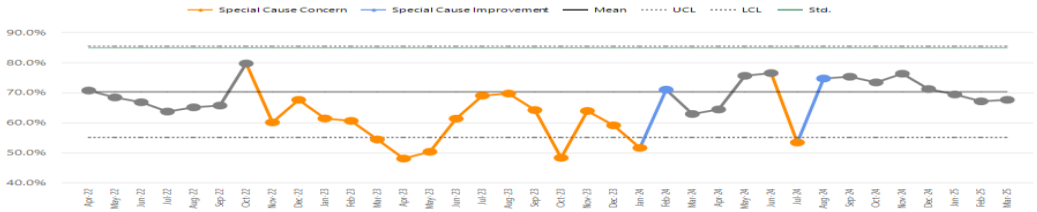
Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

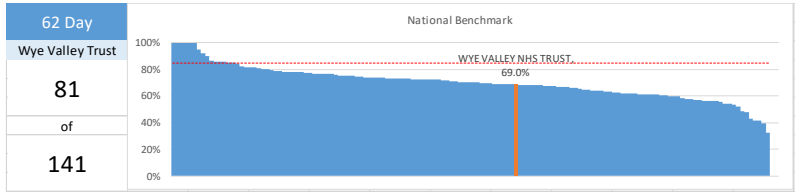
28 Days (Performance & Benchmark)





62 Days (Performance & Benchmark)





Performance & actions

Referrals:

As of June 2025, urgent suspected cancer referrals have risen by 23% compared to the same period three years ago. Referrals for Skin and Urology have seen significant increases of 65% and 48%, over the same time period. Efforts are ongoing to audit incoming referrals to ensure they align with guidance but we have seen delays in these being uploaded to teamnet, a system managed by Primary Care.

Cancer Performance:

In June 2025, the Trust met the Faster Diagnosis Standard (FDS), achieving a performance rate of 81%, once again exceeding the Trust's trajectory. We have seen three specialities achieving higher than the target, Head and Neck (H+N) at 89%, Colorectal at 83% and Lung at 82%. WVT have been invited to present our pathway at the H+N expert advisory group hosted by West Midlands Cancer alliance in September due to being top five in the region consistently.

Breast performance still remains a concern as non compliant with the 62 day standard in June achieving 36%. Additional clinics continue to be scheduled and also additional theatre sessions, with anticipation that performance will continue to improve over next couple of months.

Delays in access to scans in radiology also continue to pose challenges on cancer pathways, mainly Breast, Colorectal and Urology. The Community Diagnostic Centre (CDC) is expected to play a vital role in strengthening and supporting cancer pathways. Reporting times for all cancer scans have shown an improvement where all are being turned around within 24 hours.

<u>Developments updates</u>

- Post menopausal pathway is now live and we anticipate a reduction in urgent suspected cancer referrals, which we will measure over the up coming months
- Lynch pathway now developed and have received our first few diagnoses of Lynch through the pathway where these individuals will be part of a national cancer screening programme
- Liver surveillance navigator to start in September to support programme for earlier diagnosis with liver cancer

What the charts tell us

- 28 Day faster diagnosis performance this month was 81.5%.
- 62 Days start of treatment target was 73% below target of 69%

Risks

- Cancer referrals continuing to remain above 19/20 levels
- Breast service capacity were challenged during the month. Urology and Gynaecology are also key risk areas that are being supported to improve with oversight at our Trust Cancer Board

Operational Performance – Elective Activity / Productivity / Referral To Treatment Performance

We are driving this measure because:

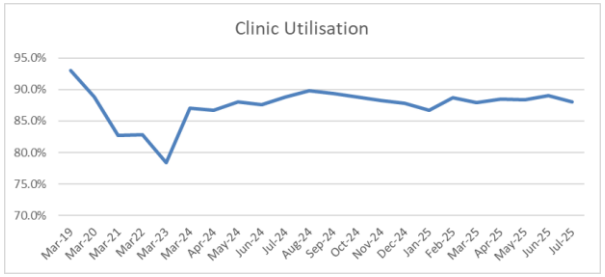
Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks for English patients and 26 weeks for Welsh patients from when the referral is received by the Trust either booked through the NHS e-Referral Service, or when a referral letter received. Activity plans are measured against the Trust's agreed plans as part of the annual Business Planning process with commissioners

New/First Attendances			
Total vs Plan	This Year	Plan	Diff / Var
	27,667	27,703	-36 / 0%
Vs 2019/20	This Year	2019/20	Diff / Var
	27,667	22,912	4755 / 21%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	10.1	3.5	65.7%

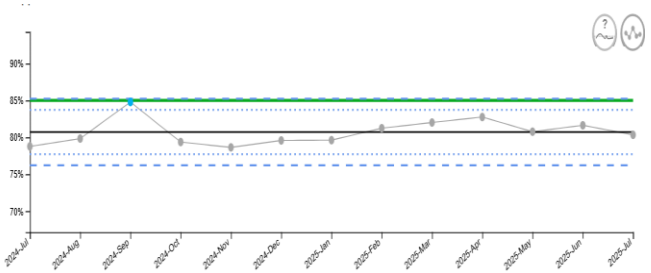
IP/DC Admissions (excl. Endoscopy)			
Total Vs Plan	This Year	Plan	Diff / Var
	10,048	9,745	303 / 3%
vs 2019/20	This Year	2019/20	Diff / Var
	10,048	8,701	1347 / 15%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	14.0	7.2	48.6%

Follow Up Attendances			
Total Vs Plan	This Year	Plan	Diff / Var
	62,436	55,685	6751 / 12%
Total vs 2019/20	This Year	2019/20	Diff / Var
	62,436	47,810	14626 / 31%
Waitlist Clearance (wks)	Total	>See By Date (SBD)	% Past SBD
	15.6	5.0	60.0%

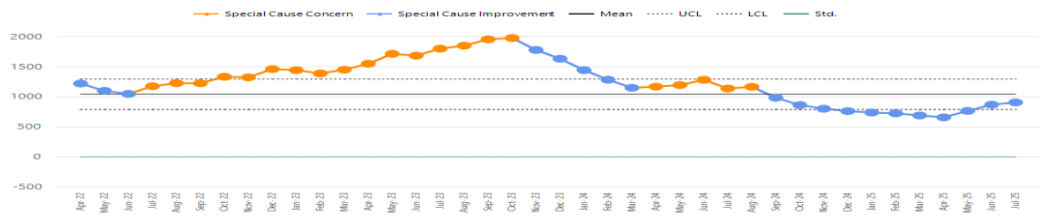
Clinic Utilisation



Theatres Utilisation (Uncapped)



Patients over 52 weeks on Incomplete Pathways Waiting List



Performance & actions

- Theatre utilisation fell back slightly last month to 80.1%, driven by clinical workforce challenges in two large specialties. Early data for the current month indicates a recovering position
- Notwithstanding overall utilisation reducing, notable improvements at a speciality basis have been made. Ear, Nose and Throat [ENT] has increased by 8% and Gynaecology by 7% last month
- Several new projects and ways of working launched last month: Diamond patient in ENT, where any patients not fit to proceed on the day are replaced by standby patients is now live, and Gynaecology have begun trailing same day discharge hysterectomy procedures
- Anaesthetic job plan changes, alongside the continued implementation of the Theatres & Anaesthetics workforce strategy, is reducing the number of elective sessions reliant on bank anaesthetists for cover. The Directorate has realised a 35% reduction in the number of elective lists covered by bank anaesthetists over the last 3 months. Individual patient cancellations as a result have also significantly reduced over the same period while also delivering more robust on call rotas

Long Waiting Patients

- No patients waited over 78 weeks at the end of July.
- 65 week position at the end of July was 17 English patients. This is likely to increase in August as we contend with some unforeseen Theatre outage and unplanned Consultant absence.
- 751 English patients were waiting over 52 weeks for treatment at the end of July, an increase of 23 patients from the end of June 25. An increasing concern and a focus of mitigation plans for the top four specialties driving the position.

What the charts tell us

- Performance against English RTT standard in April was 61.4%
- 3.1% of English patients on our Waiting List were waiting more than 52 weeks at the end of April.
- Performance against the Welsh RTT standard in April was 70.3%.

Risks

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

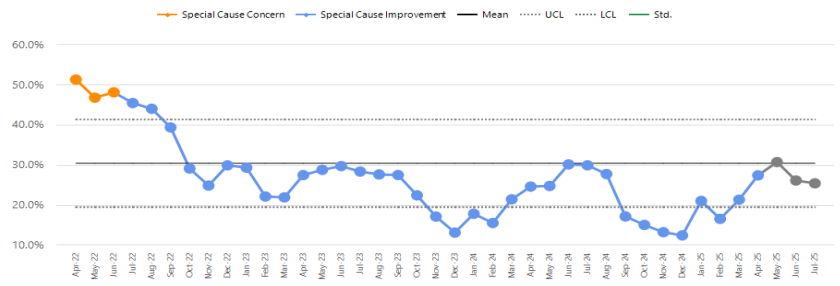
Operational Performance – Diagnostic Performance

We are driving this measure because:

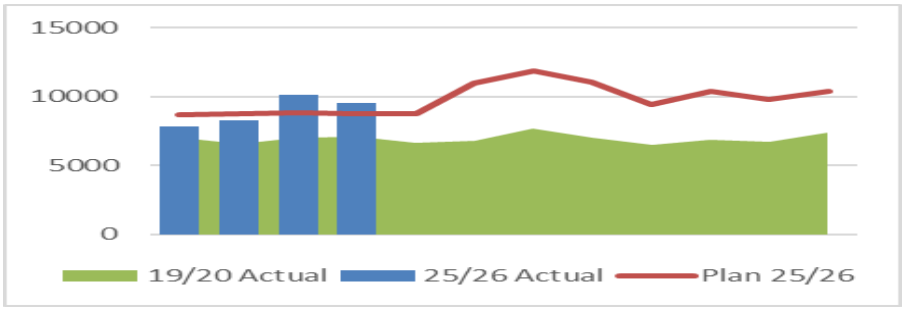
Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] may include a diagnostic test; therefore, ensuring patients receive their diagnostic test within 6 weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks/26 weeks. Less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

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

Diagnostic Waits > 6 Weeks



Total Activity [all Modalities]



Performance & actions

Overall Diagnostics is delivering 102% of 25/26 DM01 activity plan which is 129% compared with 19/20 activity

Imaging:
6 week wait positon at the end of M4 has improved to 94.5%
Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 9 days and 11 days respectively.
The CTC bloods/prescription tool has now gone live and corresponding improvements are being realised, however, the issue persists for requestors who are non-prescribers. MRI Prostate and MRI is being looked at as a priority to improve access via the Community Diagnostic Centre (CDC) pathway.
M4 25/26 is 107% of DM01 plan YTD, with the CDC slippage plan having commenced delivery from 1st June.

Audiology:
Audiology Assessment 6 week wait position is 64% with a slight increase in patients waiting >13weeks in M4
Agreed insourcing solution for Paediatrics recommences in August. Substantive B7 interviews that took place were unsuccessful - an internal candidate has since expressed interest with interview scheduled in August. Cross-working from Adults into Paediatrics has recently commenced to support mitigating risk where appropriate, this has increased to up to 2 clinic per week with a balance of waiting list risk across both specialities. Both teams formal restructure has concluded. However increased sickness has impacted the Adults team considerably in July.

Neurophysiology:
<6weeks waiting has improved to 80% for M4
Number waiting >13wks has reduced from 21 in March 25 to 4, all have appointments booked. A service review is currently being instigated in order to develop more sustainable plans.

Echocardiograms (Echos):
The position has started to improve, since the end of July and we are now seeing a week on week reduction of the 6 week backlog.
Whilst we look to stabilise the workforce additional out of hours working has commenced using the CDC workforce and use of interim insourcing capacity so we can get the volume of patients over 6 weeks down,
One of our Cardiologists has been leading the review of Echo referrals to managed demand and this is being implemented currently.

Risks

Increased inpatient / acute floor referring impacting on capacity of service particularly for CT and Echos.
Audiology and Cardiac Physiology capacity / workforce challenges

What the charts tell us

End of July 74.5% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

Following formal consultation with trade union representatives on 21st August 2025, we have now launched the WVT admin & clerical organizational wide change programme. Formal consultation with the affected employees will run throughout September and staff can be assured that managers are working closely with trade union representatives and HR to ensure that the change programme is conducted in a compassionate, fair and objective manner.

Sickness absence stands at 4.8% with Long Term Sickness at 2.75%.and Short Term sickness at 2.04%. The main reasons for sickness absence are colds/flu, mental health conditions, gastro and pregnancy related illness. We are taking appropriate management actions to reduce sickness in line with our revised absence policy and this remains a priority area for HR. OH teams will be leading the 2025 flu vaccination campaign working closely with matrons and ward managers. The NHS wide study on sickness absence has now started and a report featuring WVT will be available in 2026.

Staff turnover remains steady at 8.7% and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at 5.67% and turnover for band 2/3 hcsw staff has fallen form 20.34% to 17.46%. We have restarted the centralised recruitment process and are working actively with the DWP to fill our vacancies through a number of recruitment events across Herefordshire.

We supported the South Asian Heritage History Month and Men's Health Week working with Sodexo. WVT employees are involved in the ICS Active Bystander trainers programme and our line managers are signing up to the NHS Inclusive Leadership Pledge.

Our annual health & wellbeing week will be held from 6th to 10th October supported by internal and external practitioners. Promoting health & wellbeing activities and actively encouraging staff to get ready for winter by taking the flu jab will be a central theme of the wellbeing week.

On workforce productivity and efficiency, we have implemented e-expenses and this is already generating financial savings to the Trust. E-rostering has been implemented in nursing areas and will be rolled out to other clinical areas over the next few months as this is seen as one key measure to enhance workforce productivity.

We are on track with our annual workforce plan with the workforce movement tracking tool showing a difference of 47.00wte (July) Vs plan.

Performance appraisals have improved to 75.2% and WVT continues to perform well with mandatory training which now stands at 88.8%.

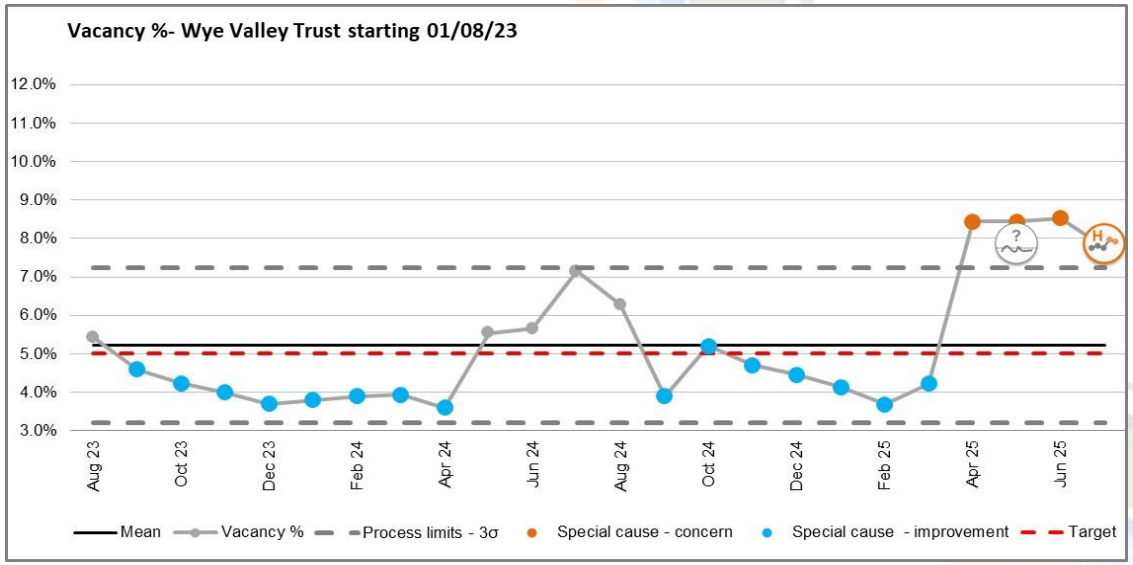
Workforce Performance – Vacancy

We are driving this measure because:

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

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
7.1%	6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	3.7%	4.2%	8.4%	8.4%	8.5%	7.8%

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



Performance & actions

HCSW – 21.48 wte vacancies with 9 new staff due to start in September. Actions to reduce vacancies includes centralised recruitment, open drop in HR recruitment sessions, active recruitment boot camps with DWP to fill vacancies.

N&M - we have paused our international recruitment due to an in crease in UK based applicants. We currently have 7.81wte vacancies following offers made in August.

CDC – 64.61wte appointments have been made which equates to 76.42% positions filled to-date.

M&D - we are working with a number of international recruitment agencies with UK based and global drs seeking new job opportunities. Regular meetings with CMD, Medical Staffing Manager & Strategic Medical HR Lead to review progress with vacancies and cases of concern. Overseas recruitment of medics to continue over the coming year. We currently have 55.64wte vacancies.

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

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

The penultimate 4 months of 24/25 showed a decreasing position, increasing in the last month mainly due to a decrease in substantive staff. There is a large increase in the first month of 25/26, mainly related to an increase of substantive budget due to realignment of reserves, together with a bottom up exercise and review of rostering areas, this rate was maintained in month 2 and 3. In month 4 this has now decreased as budget has started to be moved to CIP codes.

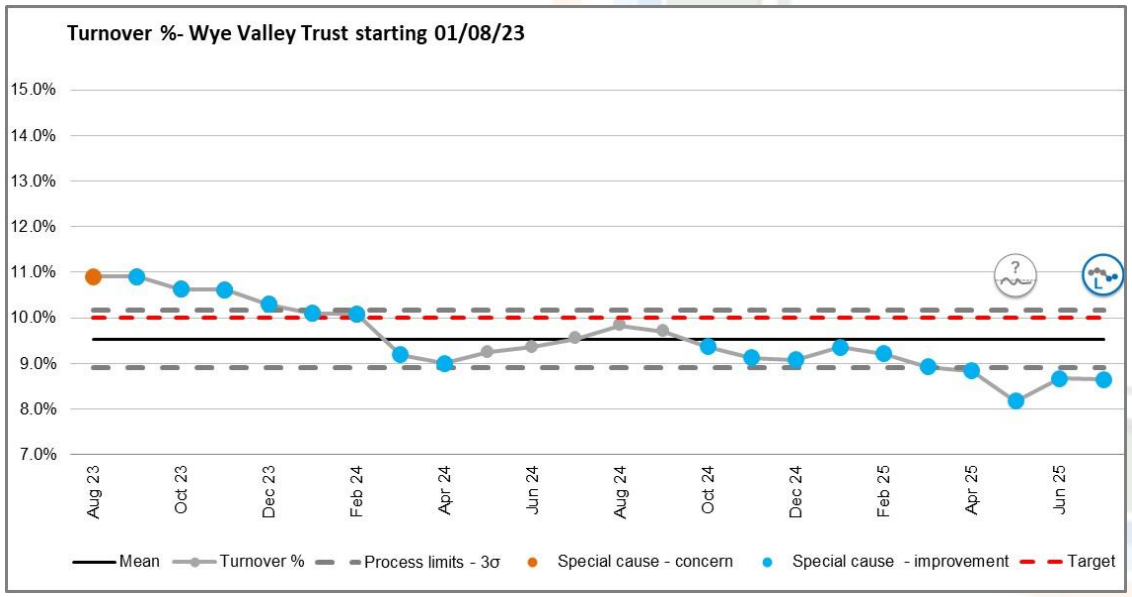
Workforce Performance – Turnover

We are driving this measure because:

To improve retention of staffing levels, maintaining standards to provide high quality care as well as reducing the reliance on temporary staffing, namely agency.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
9.5%	9.8%	9.7%	9.4%	9.1%	9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%

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



Performance & actions

Turnover at Trust level is at 8.7% and we are taking steps to ensure this stays below 10.0%.

Clinical support workers at band 2 level have the highest turnover rate at the Trust (17.46%) and this is still the case across the NHS. We have the centralised recruitment process and have strengthened the pastoral care support and training being provided to new starters. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships. Turnover rates for qualified nurses remains low at (5.67%) and divisional teams are using a variety of flexible working options and development opportunities to retain staff.

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

.

Risks

Turnover of clinical support workers

What the chart tells us

The rolling 24 month position shows an overall decreasing trend in the last 12 months. An improved position present from March and April 24 due to now removing retire and returnees. A slight decrease in month 2 of 25/26, returning to previous levels in month 3 and 4.

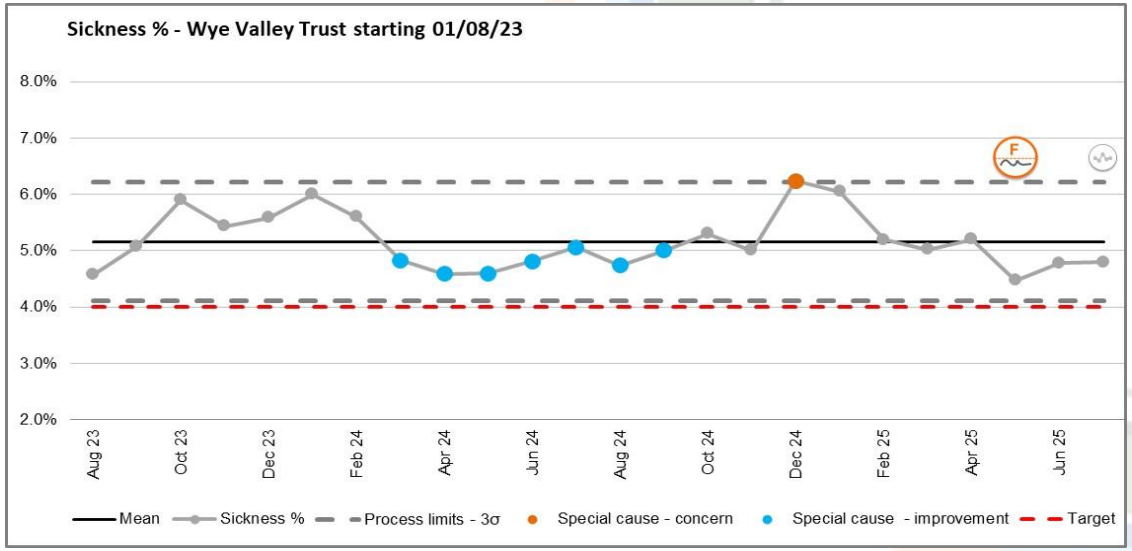
Workforce Performance – Sickness

We are driving this measure because:

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

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

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



Performance & actions

During this month, overall sickness at Trust level stands at to 4.8 %. The main reasons for absence are still colds/flu, mental health issues, gastro and pregnancy related illness.

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

HR teams continue to sensitively support the management of long and short term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team based wellbeing support for staff. The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for cases of concern. The HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence and WVT will participate in an NHS wide absence study this year.

Risks

High absence in clinical areas

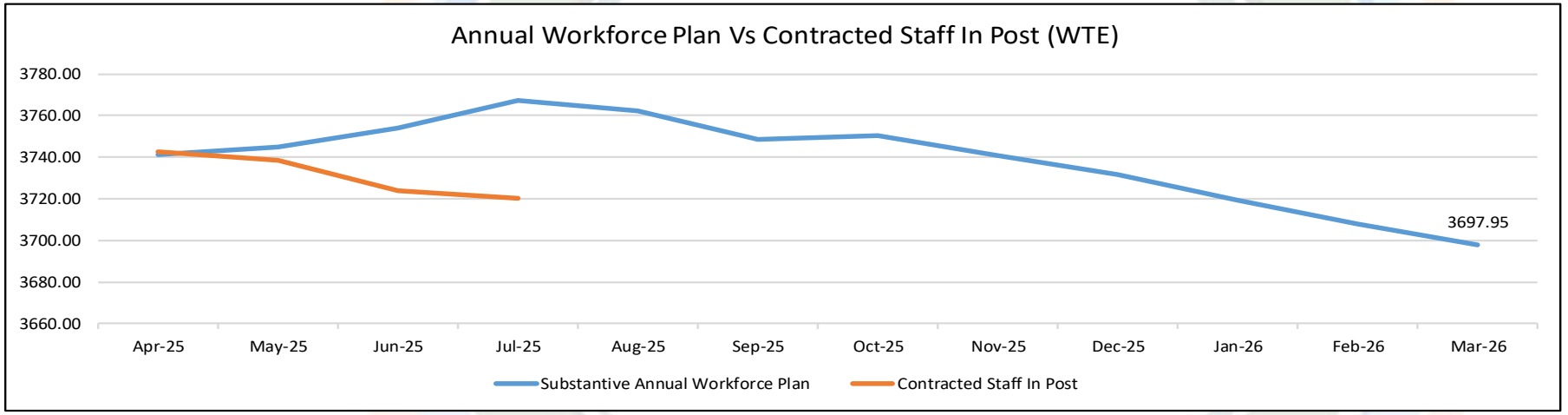
What the chart tells us

The rolling 12 month position shows a decrease position in the final 3 months of 24/25 reduced to pre winter pressure levels. This has slightly increased in the first month of 25/26 but reduced in month 2 to the position from 12 months ago, with a slight uptick in month 3, maintained in month 4.

Workforce Movement Chart

Workforce movement tracking tool shows a difference of 47.00wte (July) Vs plan

WTE	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Movement
Substantive Annual Workforce Plan	3741.26	3744.86	3753.88	3767.31	3762.41	3748.75	3750.35	3740.95	3731.55	3719.15	3707.75	3697.95	**26.05**
Contracted Staff In Post	3742.72	3738.39	3723.91	3720.31									**-22.42**
Difference	(1.47)	6.47	29.97	47.00									



*Plan includes 62.39 wte Radiology Community DC

WTE	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Starters	39.17	23.18	31.25	32.92								
Total Leavers	22.27	24.31	36.72	34.52								

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 4 Income and Expenditure position

Overall month 4 is performing better than plan, a stable position for the first four months of the year. The Trust has set a breakeven plan for 2025/26, which includes a £25m CPIP challenge devolved to budget holders for delivery.

In month 4 we saw a continued improvement in agency use and associated spend linked to the range of actions within our medical and nursing agency reduction programmes, mitigating the impact of the Industrial Action in July. This also supports our ambition to achieve the nationally expected 40% reduction on agency and 15% reduction on bank spend already factored into our plan. Cost Improvement delivery remains ahead of plan, primarily through additional non recurrent schemes. Continued focus remains on ensuring schemes are fully developed and will have a positive impact on the run rate. Substantive pay continued to under spend against plan as progress is made on identifying schemes to deliver the planned headcount reductions, with a particular focus on admin and clerical and corporate roles. Though elective activity levels were broadly in line with plan, overall contract income was behind plan driven by known timing issues and planned income and expenditure not yet realised.

The annual plan does include a high level of risk including items such as Welsh Parity income (assumed within the year to date income positon), income stretch (planned in the latter part of the year), and the risk around full achievement of the CPIP given a proportion of the target is not yet fully identified. The level of risk is tracked along with the forecast and wherever possible identifying in year mitigations. The well established Financial Recovery Board (FRB) remains in place and will continue to maintain strong oversight of the risks and mitigations to support delivery of the plan and improvement in our underlying position, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability.

Cash and Capital

Cash balances at the end of July remain stable being £5m higher than planned and £4m higher than at the end of June. Capital expenditure is ahead of plan YTD due to the number of schemes carried forward in 2025/26. The Year end forecast remains at plan. There remains a risk to receipt of the national Deficit Support in the event of financial underperformance.

Medium Term Operational Planning

As part of early preparations for Medium Term Operational Planning, work is underway to review and refresh our assessment of the underlying deficit position and to review the current fixed elements of the commissioning contracts. We have recently had sight of the planning framework through NHSE, and will need to ensure our approach remains aligned with national requirements.

Finance Performance – Year to Date Income and Expenditure

We are driving this measure because:

The Income and Expenditure plan reflects the Trust's breakeven plan, operations and the resources available to the Trust to achieve its activity, workforce and financial objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

STATEMENT OF COMPREHENSIVE INCOME - To Month 4 - 31st July 2025 - 2025/26

	2025-26 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE CUMULATIVE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Operating income from patient care activities	358,561	119,743	118,378	(1,365)	(321)
Drugs Excluded	26,098	8,699	8,541	(158)	(95)
Other operating income	15,620	5,207	5,207	0	65
Donations from non current asets	240	17	857	840	(10)
Total Operating Income	**400,520**	**133,666**	**132,983**	**(683)**	**(361)**
Substantive Pay	(220,852)	(74,281)	(73,925)	356	55
Bank & WLI Pay	(16,123)	(5,943)	(6,049)	(106)	(102)
Agency pay	(8,046)	(3,511)	(3,108)	403	132
Subtotal Pay	***(245,020)***	***(83,735)***	***(83,082)***	***653***	***85***
Non Pay Expenditure	(101,325)	(34,766)	(34,326)	440	283
Excluded Drugs	(25,795)	(8,598)	(8,577)	22	79
Total Operating Expenditure	**(372,140)**	**(127,099)**	**(125,985)**	**1,115**	**531**
EBITDA	**28,380**	**6,567**	**6,998**	**431**	**170**
Depreciation	(13,414)	(4,472)	(4,179)	293	85
Impairment	(4,584)	0	0	0	0
Interest Receivable	527	176	693	517	112
Interest Payable on Loans	(180)	(60)	(52)	8	2
Interest Payable on PFI	(2,944)	(547)	(547)	0	0
Dividends on PDC	(4,296)	(1,432)	(1,432)	0	0
Operating Surplus/ (Deficit)	**3,489**	**231**	**1,481**	**1,249**	**369**
Technical Adjustments					
Donated Assets Adjustment	536	242	(589)	(831)	12
Net impact of asset impairments	4,584	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	(8,609)	(3,208)	(3,300)	(92)	(23)
Adj. financial performance retained Surplus/ (Deficit)	**(0)**	**(2,733)**	**(2,408)**	**327**	**274**

Performance & actions

The position at the end of Month 4 (July) was a deficit of £2,408k YTD. This is performing better than plan with an overall positive variance of £327k YTD. Within Month 4, pay award values have been adjusted from the 2.8% built into original plan uplifted to agreed published rates.

- Income shows an adverse variance of £683k. This is largely due to phasing of stretch target with the ICB, other income and excluded drugs, the remainder of the variance is in relation to matching associated spend levels.
- Pay is favourable by £653k at month 4, of which £85k is in month. The net position in month includes agency — 3.24% of total pay costs in month which is an improvement from 3.53% in M3. Bank use at premium rates further increases the total temporary staff proportion to 6.7% of overall pay, partly linked in month to Industrial Action. Nurse agency usage has significantly reduced on Healthcare Support Worker (HCSW) posts, with no usage in July.
- Total Non Pay (operating & non operating) is favourable by £357k YTD including technical adjustment benefits. The favourable variance is largely due to a CNST rebate in month and reduction in drugs costs. There are technical adjustments for donated assets and PFI IFRS16 adjustments, which are offset in income. There continues to be additional interest received due to higher cash balances.
- Within Adjustments, there is a PFI £92k adverse variance driven by a technical adjustment to the control total for historical accounting changes on PFI.

Risks

Key Financial risks

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

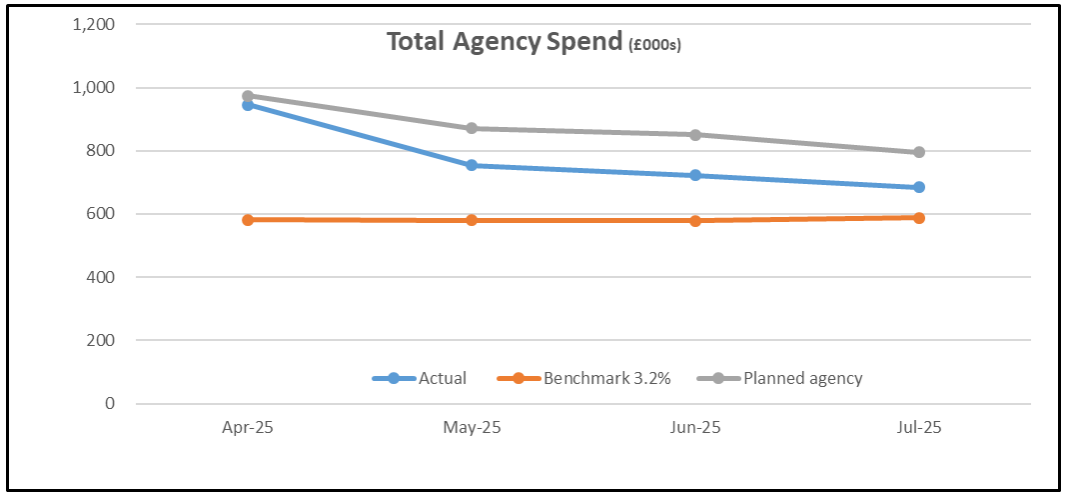
What the chart tells us

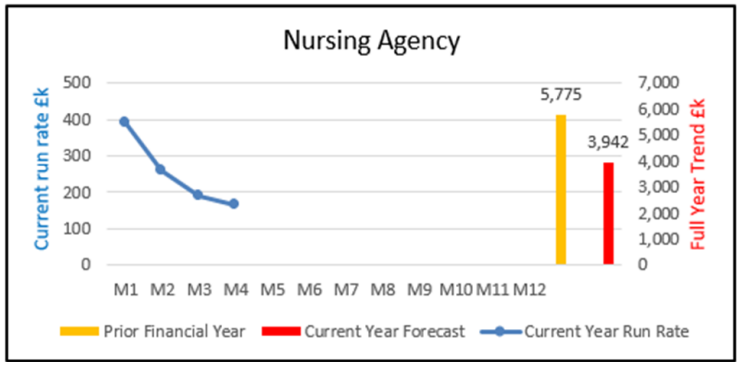
There are no material variances in this month, though the plan includes a number of known financial risks.

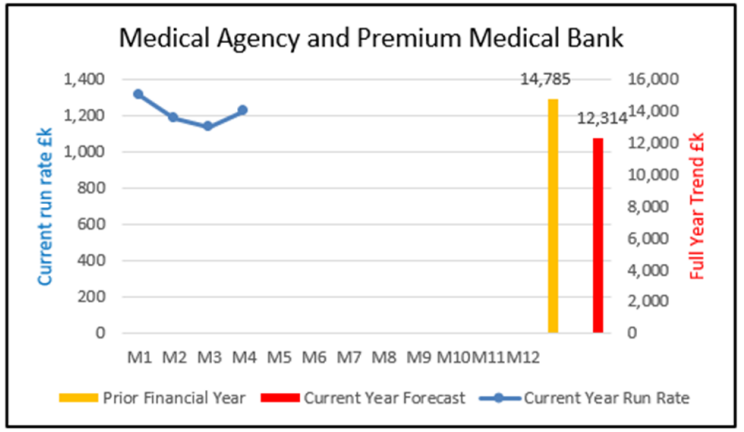
Finance Performance – Agency Spend

We are driving this measure because:

Tackling our high agency spend levels (volume and price) is key to successfully mitigating financial risk and delivering the financial plan. Agency spend, though within the planned level at this stage of the year remains above the NHS benchmark and is adversely impacting on our use of resources.







Performance & actions

Agency represents 3.74% of total pay costs year to date, 0.54% above the national target of 3.2%. Agency performance is currently better than plan by £403k. Total agency spend year to date (excluding premium cost medical bank) is £3.1m.

- **Nursing agency:** Total spend in 2024/25 was £5.8m, which will be significantly reduced in 2025/26 through efficiencies. Rate reduction changes have significantly reduced agency costs over the last 12 months and the elimination of HCSW agency spend has been achieved in M4. The cost for nurse agency spend in June was £167k down from £191k in M3.
- **Off framework Nurse Agency:** There have been 4 off framework shifts in July compared to 0 in June. The total shifts booked in 2024/25 was 135.
- **Medical staffing agency and bank:** The Trust spent £14.8m in 2024/25 which will be significantly reduced in 2025/26 through efficiencies. The total spend in Month 4 is £1,223k, an increase from £1,132k in M3. The increase in spend in month is largely due to the impact of the Medical bank pay award uplift (planned) and Industrial action.

Risks

Level of Agency (% of pay)

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

Supply and Demand price pressures

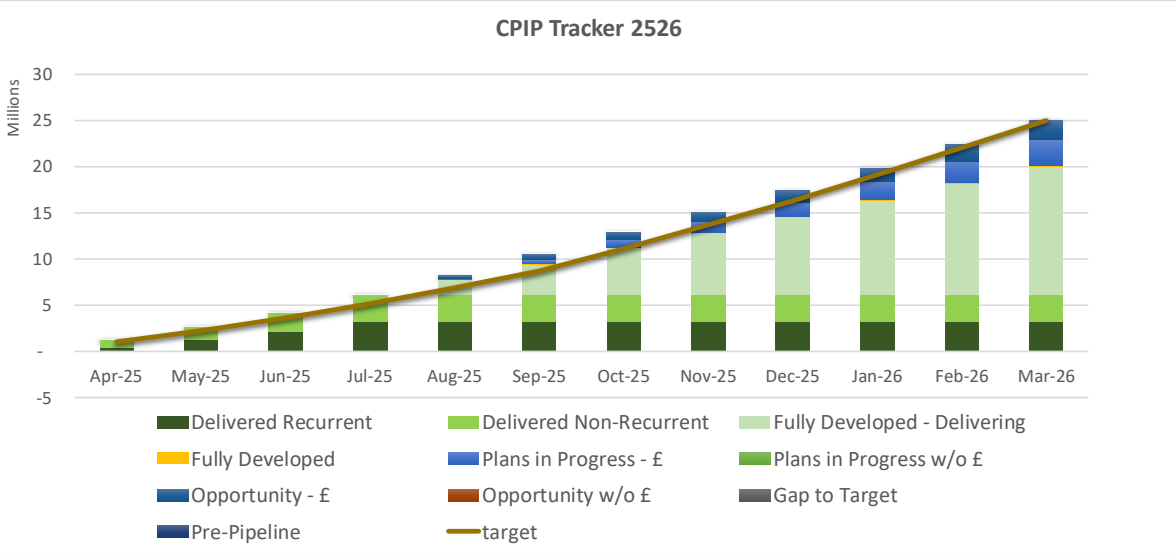
What the charts tell us

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

Finance Performance – Cost Improvement Programme

We are driving this measure because:

Delivering our cost efficiency programme is key to successfully mitigating financial risk and delivering the financial plan. Maximising recurrent efficiencies is critical to our financial sustainability and tackling our underlying deficit in the medium term.

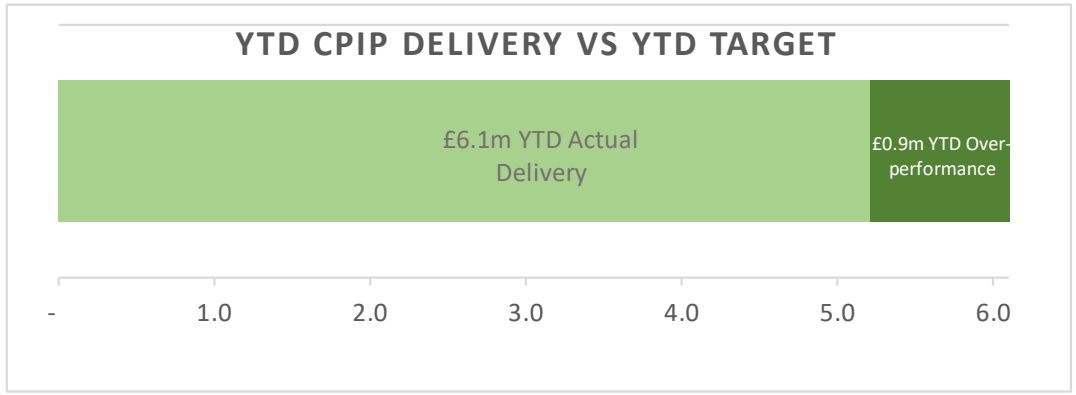


Performance & actions

The £25m target is set to be delivered through Pay £15.5m & Non Pay £9.5m, which includes a recurrent assumption of £17.35m. The £25m represents a cost reduction in 2025/26, including notable schemes of Agency reduction (40% year on year), Bank reduction (15% year on year) and a 150 WTE reduction. The programme includes a continued focus on reducing growth from pre Covid levels.

The current position on CPIP delivery to date reflects a plan of £5.2m with a Trust delivery of £6.1m resulting in a £0.9m over-performance to plan. This does include £3.3m of recurrent delivery, £0.1m less than plan YTD, expected to be delivered later in the year. The plan is phased to increase across the financial year, with just under 15% of the total assumed in Quarter 1.

The FRB continues to focus on furthering identification and delivery of CPIP in order to achieve our breakeven plan. As part of the FRB, monthly Check and Challenge meetings with Divisions continue to place to specifically focus on identification and delivery of savings schemes.



Risks

Under achievement of Cost Improvement (CPIP)
Achievements relying on non recurrent delivery
Opportunity and Plans in Progress schemes not developing at pace needed for full delivery
Undelivered / non recurrent CPIP could be taken forward into 2026/27 target

What the charts tell us

Challenging CPIP target of £25m forecast to be delivered in 2025/26. Focus is on identifying and de-risking schemes as quickly as possible to move into deliverable schemes, in order to deliver a sustainable level of savings.

Finance Performance – Cash and Capital

We are driving this measure because:

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

The Trusts capital resources require careful management to limited resources are prioritised effectively.

.

Cash

Cash Balance				
Month	Performance	Target	Direction	Rating
May	32.1	33.3		
June	30.1	38.4		
July	34.3	29.3		
Cash balances are £4.9m higher than plan, due to a £6m increase in net working balances (receivables less payables), driven by deferred income, net of capital expenditure being £2m higher than plan and our surplus to date.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
May	98.9%	95.0%		
June	99.3%	95.0%		
July	98.7%	95.0%		
In July the Trust paid 98.7% of invoices within 30 days. This equates to 99.7% by invoice value. This is the nineteenth month, in a row, that we have achieved the 95% (by volume) target.				

Capital

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month Budget £k	Year to Date - Month Actual £k	Year to Date - Month Variance £k	Full Year Forecast £k	Full Year Variance £k
Local CDEL funded	Owned	2,798	460	1,143	(683)	2,798	0
IFRS16 Leases	Leased	2,460	43	0	43	2,460	0
National PDC schemes	Owned	10,060	553	658	(105)	10,060	0
Grant funded and Donated	Owned	5,253	1,685	1,884	(199)	5,253	0
Total Capital Programme		20,571	2,741	3,684	(943)	20,571	0

What the charts tells us

Cash
The month end cash balance has increased, due to a reduction in net working capital (receivables less payables). The Trust remains above the 95% target for Better Payment Practice.

Capital
Capital Expenditure is ahead of plan YTD, due to timing.

Performance & actions

Cash
Higher creditors net off capital expenditure being higher than planned at this stage in the year are the main drivers of the cash balance being higher than planned at the end of July. Both the working balances and overall cash positon continue to be closely managed.

Capital
The variance is due to timing within 2025/26 as more expenditure is happening earlier in the year with a number of schemes carried across from 2024/25.

Risks

Cash
At this stage in the year, there are a number of risks to delivering the planned cash balance by the end of the year. These include: full delivery of the CPIP plan through cash releasing savings, Welsh parity income and the ability for NHS debtors to be able to pay us in a timely manner due to their cash pressures.

Capital
Management of the limited local CDEL allocation remains a challenge with the value of bids exceeding the resources available. Uncertainty around national funding for digital schemes presents a risk. These risks are managed by CPEC.

Finance Performance – Statement of Financial Position

We are driving this measure because:

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

Statement of Financial Position

July 2025	2024/25	2025/26			2025/26 Full Year		
	Accounts £000s	M4 Plan £000s	M4 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	159,386	158,587	161,809	3,222	175,402	174,750	(652)
Intangible Assets	11,572	10,636	8,655	(1,981)	8,766	9,418	652
Trade and Other Receivables	429	429	1,171	742	429	1,197	768
TOTAL Non Current Assets	**171,387**	**169,652**	**171,635**	**1,983**	**184,597**	**185,365**	**768**
CURRENT ASSETS:							
Inventories	5,087	5,087	4,991	(96)	5,087	5,087	0
Trade and Other Receivables	24,244	30,476	32,473	1,997	19,231	18,442	(789)
Cash and Cash Equivalents	37,906	29,368	34,277	4,909	45,995	45,995	0
TOTAL Current Assets	**67,237**	**64,931**	**71,741**	**6,810**	**70,313**	**69,524**	**(789)**
TOTAL ASSETS	**238,624**	**234,582**	**243,376**	**8,794**	**254,910**	**254,889**	**(21)**
CURRENT LIABILITIES							
Trade and other payables	(37,582)	(39,014)	(45,321)	(6,307)	(37,582)	(37,582)	0
Borrowings - Loans, PFI and Finance Leases	(15,067)	(15,067)	(9,714)	5,353	(15,067)	(15,067)	0
Provisions	(49)	(49)	(46)	3	(49)	(49)	0
Total Current Liabilities	**(52,698)**	**(54,130)**	**(55,081)**	**(951)**	**(52,698)**	**(52,698)**	**0**
NET CURRENT ASSETS/(LIABILITIES)	**14,539**	**10,801**	**16,660**	**5,859**	**17,615**	**16,826**	**(789)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**185,926**	**180,452**	**188,295**	**7,843**	**202,212**	**202,191**	**(21)**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(40,822)	(34,153)	(41,717)	(7,564)	(28,985)	(28,985)	0
Provisions	(1,529)	(1,529)	(1,510)	19	(1,529)	(1,508)	21
Total Non-Current Liabilities	**(42,351)**	**(35,682)**	**(43,227)**	**(7,545)**	**(30,514)**	**(30,493)**	**21**
ASSETS LESS LIABILITIES	**143,575**	**144,770**	**145,068**	**298**	**171,698**	**171,698**	**0**
TAXPAYERS EQUITY							
Public dividend capital	325,841	326,974	325,855	(1,119)	340,007	339,838	(169)
Revaluation reserve	17,709	17,540	16,998	(542)	28,177	28,177	0
Income and expenditure reserve	(199,975)	(199,744)	(197,785)	1,959	(196,486)	(196,317)	169
TOTAL	**143,575**	**144,770**	**145,068**	**298**	**171,698**	**171,698**	**0**

Performance & actions

General

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

Non-Current Assets

Non-Current assets are £2m higher than plan. Carried forward 2024/25 capital programme schemes have incurred £0.9m expenditure earlier than planned in 2025/26 (see capital section, above). Depreciation is £0.3m lower than planned YTD. Non-current debtors have increased due to reclassification of the debtor for the Gloucester radiotherapy building.

Working balances

Net working balances - receivables less payables - have reduced by £4m compared to plan. This is mainly driven by the timing of deferred income relating to quarterly advances to support the PFI unitary payment and partially offset by debtors being £2m higher than plan. This, net of capital expenditure and our I&E surplus has led to a corresponding cash balance increase of £4.9m when compared to plan.

Borrowings

Borrowings balances differ (plan versus actual) due to timing issues at plan formulation compared to year-end outturn.

Taxpayers Equity

PDC and revaluation reserve balances differ to plan due to timing issues at plan formulation compared to year-end outturn. The income and expenditure reserve balance for month 4 reflects the retained surplus for the year to date and, again, differs slightly to plan due to timing issues at plan formulation.

Risks

The level of risk included in the Income and Expenditure plan presents an ongoing risk to the strength of the SOFP, as does the higher than planned level of receivables at Month 4.

What the chart tells us

Current assets outweigh current liabilities.

Trustwide KPIs

Quality of Care, Access & Outcomes

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 80.0%	Variable	Improvement - High		79.3%	77.1%	72.7%	82.9%	75.9%	78.1%	75.5%	81.4%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		86.4%	84.3%	85.9%	79.1%	83.8%	83.9%	82.5%	72.3%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		7.7%	20.0%	15.4%	0.0%	16.7%	0.0%	0.0%	16.7%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		91.9%	96.5%	90.2%	94.1%	95.4%				
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		8	7	3	7	9	11	6	8	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause		76.4%	71.3%	69.5%	67.2%	67.7%				
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		66.7%	100.0%	88.9%	100.0%	100.0%				
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		65.9%	87.9%	77.1%	74.3%	78.8%				
	Cancer: number of cancer patients waiting over 62 days	Cancer		No Target	Common Cause		38	54	52	60	74	69	72	66	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		108.6%	118.3%	126.1%	110.5%	108.0%	116.0%	117.5%	116.5%	125.0%
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		87.3%	85.9%	85.2%	86.6%	86.2%	87.3%	87.1%	87.8%	87.9%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Improvement - High	Yes	105.2%	104.0%	100.3%	96.3%	102.0%	99.0%	95.5%	100.1%	100.4%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Common Cause	Yes	55.2%	49.4%	54.3%	60.3%	55.2%	44.3%	53.8%	60.4%	69.6%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Variable	Concern - High		25.1%	30.9%	29.7%	21.4%	26.6%	38.5%	28.6%	18.9%	11.6%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		128.9%	124.1%	121.1%	121.7%	127.3%	117.9%	117.6%	115.5%	124.6%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		48.2%	46.4%	47.2%	46.7%	49.1%	47.1%	46.8%	48.6%	45.9%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	64.8%	63.4%	64.1%	65.9%	63.2%	57.4%	60.4%	65.2%	70.9%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause	Yes	12.2%	13.3%	14.6%	13.0%	13.2%	16.4%	14.2%	11.6%	8.1%
	A&E - Time to treatment	Urgent and emergency care		No Target	Common Cause		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care		No Target	Improvement - Low		1.9%	2.0%	1.8%	1.5%	1.9%	1.7%	1.8%	1.6%	1.6%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		256	232	322	219	293	277	249	234	182
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause	Yes	9.2%	9.1%	8.7%	8.9%	9.1%	9.2%	8.0%		

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 61.0%	Variable	Improvement - High	Yes	56.0%	55.1%	56.0%	56.4%	56.5%	57.1%	59.4%	59.8%	61.4%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care		No Target	Common Cause	Yes	70.0%	68.4%	69.2%	70.3%	70.0%	70.8%	70.4%	70.1%	70.3%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		28246	27766	27410	27488	27476	27943	28097	27296	27198
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		804	764	740	727	692	660	768	871	909
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		1	3	2	5	5	2	5	2	6
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		0	0	0	0	0	0	0		
	GP Referrals	Elective care		No Target	Common Cause	Yes	91.0%	105.2%	98.8%	91.6%	103.1%	97.3%	92.9%	101.1%	95.1%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		109.2%	108.3%	112.6%	113.8%	148.4%	119.5%	112.1%		
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Common Cause	Yes	78.0%	101.4%	104.4%	94.0%	82.0%	101.2%	99.6%	99.6%	99.4%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		107.9%	109.6%	109.2%	109.8%	140.1%	126.7%	118.8%		
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	83.2%	111.4%	113.4%	98.0%	86.0%	108.6%	107.5%	107.6%	105.8%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		100.5%	100.8%	104.4%	104.0%	127.6%	106.7%	110.3%		
	Total Elective Activity (volume v plan)	Elective care		No Target	Common Cause		78.3%	90.4%	97.9%	91.0%	77.2%	93.9%	99.4%	99.8%	97.3%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Improvement - High		78.8%	80.9%	80.3%	83.1%	82.0%	82.8%	80.8%	81.6%	80.3%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		31	39	35	20	26	26	16	20	21
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Improvement - High	Yes	107.9%	103.5%	86.8%	86.6%	102.7%	90.8%	95.9%	111.5%	108.7%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Concern - Low	Yes	71.8%	83.3%	80.1%	89.1%	78.9%	100.9%	94.4%	88.9%	87.6%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Concern - Low	Yes	127.4%	109.7%	93.4%	88.3%	119.2%	99.3%	94.0%	120.3%	99.2%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Common Cause	Yes	13.3%	12.5%	21.1%	16.6%	21.4%	27.5%	30.8%	26.2%	25.5%

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Elective Care	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Improvement - High		94.0%	93.7%	97.1%	97.7%	97.8%	99.1%	96.6%	98.0%	96.9%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Concern - High		18.4%	17.8%	20.4%	22.5%	21.8%	19.8%	21.1%	19.8%	19.4%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High		61.8%	65.1%	64.6%	61.5%	66.5%	67.9%	64.8%	62.1%	67.8%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High		88.2%	90.2%	89.7%	89.2%	90.8%	88.7%	86.8%	87.7%	89.1%
	Maternity Activity (Deliveries)	Elective care		No Target	Improvement - High	Yes	95.4%	94.9%	101.4%	93.8%	88.0%	91.1%	97.0%	91.2%	102.4%
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Common Cause		6.3%	6.5%	6.2%	5.9%	5.4%	5.6%	5.8%	5.7%	5.6%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High		88.3%	87.8%	86.7%	88.7%	88.0%	88.5%	88.3%	89.0%	88.1%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		107.4%	110.2%	107.8%	108.0%	136.5%	130.2%	122.0%		
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Improvement - High	Yes	85.8%	116.7%	117.9%	99.9%	88.0%	112.2%	111.4%	111.5%	108.9%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		20.2%	20.1%	21.4%	21.4%	19.9%	19.2%	19.5%	20.0%	19.5%
Prevention and long term conditions	Maternity - Smoking at Delivery	Prevention and long term		No Target	Common Cause	Yes	8.7%	7.9%	8.0%	8.4%	7.4%	8.1%	10.9%	8.7%	
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		99.4%	98.8%	99.9%	99.7%	94.7%	97.7%	99.9%	99.9%	98.9%
	Bed occupancy - Community Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%
	Mixed Sex Accommodation Breaches	Safe, high quality care	<= 0	Variable	Improvement - Low		150	69	129	81	64	117	90	146	105
	Patient ward moves emergency admissions (acute)	Safe, high quality care	4.0%	Pass	Concern - Low		7.5%	6.7%	7.0%	6.5%	6.4%	6.4%	7.6%	5.9%	5.3%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		6	6	7	6	6	6	7	6	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Improvement - Low		2	2	2	2	2	2	2	2	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Common Cause		16.6%	15.1%	17.2%	19.3%	17.3%	16.7%	18.0%	17.5%	18.1%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low		49.0%	38.8%	38.5%	36.6%	24.9%	20.8%	36.1%	39.3%	37.4%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		5.0%	4.5%	4.8%	4.5%	5.0%	5.0%			

Trustwide KPIs

	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Safe, high quality care	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Concern - High	Yes	103	105	107	108					
	Never Events	Safe, high quality care	0	Variable	Concern - Low		0	0	0	0	0	0	0	0	0
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Common Cause	Yes	0	0	0	0	1	1	0	0	0
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause		2	0	2	1	2	0	0	1	2
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care	44	Fail	Common Cause		5	6	0	3	3	1	5	6	2
	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		3	1	2	1		1	0	2	2
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Concern - Low	Yes	91.0%	89.0%	92.0%	92.0%	91.0%	90.0%	89.5%	90.4%	86.4%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Common Cause	Yes		99.4%			98.8%				
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Common Cause		67.6%	63.0%	51.5%	65.5%	65.4%	67.6%	59.4%	84.2%	74.3%
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause	Yes	80.0%	71.4%	54.5%	66.7%	66.7%	64.7%	36.4%	75.0%	60.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause	Yes	86.0%	80.9%	73.9%	80.4%	75.9%	81.5%	78.8%	82.1%	92.0%
	Number of complaints	Safe, high quality care		No Target	Common Cause	Yes	25	26	33	26	33	38	48	29	34
	Number of complaints referred to Ombudsman	Safe, high quality care	<= 0	Variable	Improvement - Low		0	0	0	0	0	0	0		
	Complaints resolved within policy timeframe	Safe, high quality care	>= 90.0%	Fail	Common Cause		67.9%	48.1%	60.0%	45.5%	25.7%	58.0%	59.0%	58.0%	40.0%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		76.8%	73.7%	80.0%	80.6%	76.4%	72.6%			84.7%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes	82.5%	83.6%	86.7%	86.8%	85.7%	81.3%			90.2%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		87.9%	92.3%	93.3%	94.1%	100.0%	100.0%			81.3%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause		18.0%	17.0%	18.0%	19.0%	19.0%	19.0%			13.7%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Common Cause	Yes	16.0%	15.0%	15.0%	16.0%	15.0%	15.0%			12.2%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		32.0%	21.0%	23.0%	31.0%	24.0%	23.0%			14.3%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		4.6%	4.8%	5.3%	4.0%	2.6%	4.5%	3.7%	3.5%	3.2%
	Appraisals	Looking after our people	>= 85.0%	Fail	Concern - Low	Yes	79.5%	79.8%	79.7%	77.6%	77.7%	73.5%	71.7%	72.1%	75.2%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Concern - Low		88.6%	88.8%	89.3%	89.3%	89.4%	89.8%	89.5%	89.6%	89.8%
	Overall Sickness	Looking after our people	<= 4.0%	Variable	Common Cause		5.0%	6.2%	6.0%	5.2%	5.0%	5.2%	4.5%	4.8%	4.8%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.1%	9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Common Cause	Yes	4.7%	4.5%	4.1%	6.9%	4.2%	8.4%	8.4%	8.5%	8.3%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause		(£202k)	(£1260k)	(£3002k)	(£133k)	£5805k	(£798k)	(£875k)	(£959k)	£223k
	I&E - Margin (%)	Finance		No Target	Common Cause		(£0k)	(£0k)	(£0k)	(£0k)	£0k	£0k	(£0k)	(£0k)	£0k
	I&E - Variance from plan (£k)	Finance		No Target	Common Cause	Yes	£106k	(£953k)	(£2908k)	(£39k)	£5901k	(£17k)	£37k	£31k	£273k
	I&E - Variance from Plan (%)	Finance		No Target	Improvement - Low	Yes	£0k	(£0k)	(£0k)	(£0k)	£0k	(£0k)	£0k	£0k	(£5k)
	CPIP - Variance from plan (£k)	Finance		No Target	Concern - High	Yes	(£598k)	(£489k)	(£798k)	(£487k)	(£931k)	£191k	£209k	£157k	£364k
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low		£634k	£582k	£2848k	£804k	£1069k	£947k	£754k	£723k	£685k
	Agency - expenditure as % of total pay	Finance		No Target	Improvement - Low		£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k	£0k
	Capital - Variance to plan (£k)	Finance		No Target	Common Cause	Yes	(£345k)	(£431k)	£175k	(£873k)	£2271k	£0k	(£881k)	£199k	£29k
	Cash - Balance at end of month (£m)	Finance		No Target	Common Cause	Yes	£29k	£25k	£21k	£31k	£26k	£35k	£35k	£30k	£34k
	BPPC - Invoices paid <30 days (% value £k)	Finance		No Target	Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k
	BPPC - Invoices paid <30 days (% volume)	Finance		No Target	Concern - High		£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k	£1k

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	Herefordshire / Wye Valley NHS Trust [WVT] Winter Plan and Winter Board Assurance Statement 2025
Lead Executive Director:	**Chief Operating Officer**
Author:	Andrew Parker
Reporting Route:	
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

To provide the Board with the Herefordshire and Powys plans to manage demand, patient flow, mitigation and outstanding risks ahead of the oncoming Winter.

The report summaries the current challenges and pressures along with how our System will approach these challenges together in conjunction with System Partners going into a predicted difficult winter period.

Our Winter plan includes:

- Operational modelling for the delivery of improved Emergency Access Standards (EAS), meeting the 45 minute Ambulance handover standard and Bed capacity.
- Clinically led schemes to deliver reduced Emergency Department (ED) attendances, emergency admissions, reduce Length of Stay (LoS) across acute and community sites.
- Improved Discharge planning and System partners engagement to reduce delayed discharges
- Deliver improved flu vaccination for staff
- Clear Infection Prevention Control (IPC) plans to reduce cross infection and manage outbreaks
- Workforce planning and well-being

The Valuing Patients Time 2025/25 plan has been designed by both clinical and operational leads, cross referenced to the Urgent Emergency Care (UEC) GIRFT checklist, aligned to the 2025/26 UEC planning submission and the ICS Sustainable Future Programme around Frailty (including End of Life management). The programme focus areas are:

- Maximise Neighbourhood Health (frailty focus and aligned to the Neighbourhood Health Plan submission)
- Ensure ED decongested
- Reduce non admitted breaches
- SDEC – increase capacity and improve flow
- Improve inpatients flow (Internal Professional Standards (IPS) & SAFER Care Bundle)
- Ensure partners progress discharge pathway delays with set targets for provider for discharge delays
- Primary care admission avoidance

Despite comprehensive planning there are still areas of risk ahead of this winter. These are detailed within the paper. High level areas of concern are:

- Increased emergency attendances and emergency admissions beyond predictions both volume and time period.
- Ongoing reliance on escalation beds / patients boarding on inpatients wards / Temporary Escalation Spaces (TES) in order to maintain patients safety during times of high escalation / surge
- Ongoing assurance around Powys Health and Adult Social Care plans ahead of winter to deliver. Along with the Quality Impact Assessment mitigation of the increased waits for elective patients on the UEC pathways for Powys
- Workforce challenges
- Impact of on-going estate work to deliver a revised Same Day Emergency Care (SDEC) / increased emergency Ambulatory area during winter

Recommended Actions required by Board or Committee

The Board are asked to approve the Herefordshire / WVT Winter plan for 2025 and to approve the Board Assurance Statement for onward submission NHS England.

Executive Director Opinion[1]

The attached winter plan follows months of work to agree the schemes that will make significant improvements in our UEC pathways across Herefordshire and WVT ahead of winter 2025.

There has been ongoing collective work within WVT via Valuing Patient Time workshops, Test of Changes, Capital bids, along with work with One Herefordshire Partners, including Discharge to Access Board, to strengthen our position for our patients and staffing.

The delivery and oversight of these schemes, along with support from the Emergency Care Improvement Support Team (ECSIT), in the autumn and early Winter, will ensure the Trust, and its partners, are in the best possible position before the winter months.

However, there remains a risk that our modelled bed occupancy will not deliver the level of capacity required to maintain sufficient flow and therefore high levels of escalation beds may well be required despite positive level of LoS and reduce numbers of patients who do not meet the criteria to reside.

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

WVT Winter Plan 2025/26

Contents

1. National NHSE Expectations
2. ICS Priorities
3. Introduction and Context
4. How did winter 2024/25 look (data)
5. How did winter 2024/25 feel (staff narrative)
6. Areas of Focus for 2025/26
7. Herefordshire/WVT UEC Schemes
8. Powys ASC and Health Plans
9. Winter 2025 Bed Occupancy, 78% EAS and Ambulance Handover Plans
10. Revised Escalation Policy and Matrix (incorporating OPEL)
11. IPC/Cohorting Patients Plan
12. Workforce (planning and wellbeing)
13. Staff Vaccination Plan
14. Risks
15. Board Assurance Framework Checklist

NHS England Expectations

Expectations of Boards and ICBs
As you finalise and submit your winter plans, we ask for clear articulation in four key areas during Board-level review and sign-off:

1. **Learning from 2024/25** What have you learned from last winter that will make a tangible difference this year? Whilst we have your winter Lessons Learned documents, we are particularly interested in what will be carried forward into this winter, to mitigate the challenges likely to be seen.

2. **Mitigating Wider System Change** As we undergo significant changes to our operating model nationally and regionally, how will your organisation maintain standards and manage risk across UEC and elective care pathways?

3. **Leadership Capacity – Appointing a Designated Winter Director** Each ICB and provider organisation must have a named Winter Director at Director level. Their presence and leadership will be essential for system coordination, escalation, and assurance throughout winter.

4. **Assurance on Delivery Impact** Are you assured, as a Board, that the plans submitted are sufficient to mitigate the anticipated impacts of increased winter pressure, including surge and super-surge scenarios?

ICS Priorities

The 2025/26 ICS Priorities are:

- Delivery of 30-Minutes Category 2 Mean Performance
- Delivery of 45-Minutes Maximum Ambulance Offload
- Delivery of 78% Emergency Access Standard Performance (EAS) by March 2026
- Improve the numbers of children see within 4 hours of arrival at the emergency department
- Reduce the percentage of patients waiting 12 hour's or over for admission or discharge to under 10%
- Reduce the numbers of patients waiting 24 hours or over for a mental health admission
- Reduce discharge delays / Returning to discharge to assess
- Eradication of Corridor Care

WVT Plans

Introduction and Context

- Review of 2024/25 data carried out. Debrief in May 2025 as part of Valuing Patients Time Workshop 1
  - Increased ED attendances – including
    - Increased Length of Stay for Admitted and Non-admitted
    - Increased Ambulance handovers over 60mins
    - Increased number of patients waiting >12hrs in ED
  - Increased Emergency Admissions
  - Reduced reliance on escalation beds
  - Boarding beds remain high across 24/35

- Three Valuing Patients Time workshops carried out in May and June with 21 Tests of Change beginning 16th June 2025

- Year to date – The Tests of Change have been designed to improve:
  - 4 hour EAS and 12hr Time in department in department performance
  - ED congestion
  - high use of TES
  - delayed discharges 1-3

Areas to Focus on for 2025/26

The Valuing Patients Time 2025/25 plan has been designed by both clinical and operational leads, cross referenced to the UEC GIRFT checklist, aligned to the 2025/26 UEC planning submission and the ICS Sustainable Future Programme around Frailty (including EoL management). The programme focus areas are:

- Maximise Neighbourhood Health (frailty focus and aligned to the Neighbourhood Health Plan submission)
- Ensure ED decongested
- Reduce non admitted breaches
- SDEC – increase capacity and improve flow
- Improve inpatients flow (Internal Professional Standards (IPS) & SAFER Care Bundle)
- Ensure partners progress discharge pathway delays with set targets for provider for discharge delays
- Primary care admission avoidance

Clinical and Operational co-design will continue ahead of winter with further workshops planned for September and October. ECIST support will be provided across areas of focus.

Herefordshire / WVT UEC Scheme 25/26

Area	Key Action/Objective	KPI Impact
Care Closer to Home	111 ED dispositions to Community Integrated Care Hub [SPoA]	ED attendances
	Increase Call before Convey	ED attendances / Increase use of UCR
	Neighbourhood Health programme (National Submission sent in August, announcement in September) Implementation of 6 core components	ED attendances / NEL Admissions
	Respiratory Community mobile MDT focus on c600 high risk patients across the winter	ED attendances / NEL Admissions
	Frailty PCN Community MDT for 65+yrs – aim to reduce 5 NEL admissions per day	ED attendances / NEL Admissions
	Increase Virtual Ward Step up / down bed occupancy [Frailty / Primary Care lead]	NEL Admissions / LOS
	Discharge follow up to prevent readmission	NEL Admissions / ED attendances
	Community Catheter pathway	ED attendances
Acute Floor	Nurse Navigation 12/7 – embed / educate / develop – internal and external pathway including increase streaming to Primary Care OOH	ED attendances / 4hr EAS / Ambulance Handover
	24/7 Pitstop Presence ensured there is a senior decision maker allocated to Pitstop all hours of the day	4hr EAS / Ambulance Handover
	Reviewing our Same Day Emergency Care capacity and criteria. Increase internal utilization of our SDECs and how we increasing capacity for external referrals from Primary Care , 111 and Urgent Community Response teams. Review current pathways and FUP activity UEC capital bid: Medical SDEC optimisation plans to increase capacity [Surgical / Frailty / Gynae	4hr EAS / ED attendances / NEL admissions
	Criteria to Admit: 4 question tool implemented in ED	4hr EAS / NEL admissions
	Radiology pathways review to improve CT & diagnostics reporting KPIs.	4hr EAS
	ED shift patterns re-aligned according to demand: increased end of week and weekend Spdr cover – in line with medical and nurse business cases to uplift staffing – additional Senior Decision making / support ahead of Winter 25	4hr EAS
	Benchmarking review / Internal Audits; Engage with colleagues in Foundation Group and regular “missed opportunities” audits for Call before Convey/ SDEC / Navigation	4hr EAS / Ambulance Handover / NEL admissions / ED attendances
	Review of Internal Professional Standards / Working Better Together ED and Specialities – based on GIRFT Clinical Operational Standards	4hr EAS / Ambulance Handover
	Implementation of NED / Exec led ED Safety Champion scheme	Quality focused on Ward to Board escalations / assurance

Herefordshire / WVT UEC Scheme 25/26

Area	Key Action/Objective	KPI Impact
Inpatient Wards	Optimising Patient Flow through Acute and Community integrated Trust wide electronic bed management process	LOS / SAFER / CtR
	Internal Professional Standards [IPS] – Working Better Together – Acute and Community Simplify and consolidate electronic discharge processes in relation to our Internal Professional Standards September VPT workshops to collectively refresh and co-design with wider clinical and operational teams / ECIST support Power BI Dashboard monitoring in place	LOS / SAFER / CtR
	Introduction of an Acute Surgical Unit - Reduction in wait times for admission and earlier commencement of treatment / Capital bid to expand elective recovery areas to support ASU / Surgical SDEC capacity	LOS / ED Congestion / Ambulance Handover
	Critical Care Revised standard operating procedure for the transfer of wardable patients to wards / Develop a proposal for ITU to accommodate outreach patients to provide additional surge and super-surge capacity	LOS
	Enhanced weekly Discharge reviews on target wards with Integrated Discharge Team and ACS [Herefordshire and Powys]	LOS / CtR
Clinical Support Services	Review escalation policy and use of escalation beds to include TES	LOS / ED Congestion / Ambulance Handover
	Improvement to Inpatient TTO turnaround time within 2 hours / Ensure ward based pharmacy service as first point of contact for discharges to aid patient flow	LOS / SAFER
	POCT for Respiratory Virus testing to achieve rapid diagnosis and aid early patient placement and appropriate treatment	LOS / ED Congestion / Ambulance Handover
	Community Diagnostic Treatment Centre - CDTC will provide the following additional imaging which will release on-site capacity to increase access to scan for ED/INP/SDEC to meet Diagnostic UEC KPIs	LOS / NEL Admissions
Discharge / D2A	Review of Care Act Assessment process to prevent D2A overstays to create flow in D2a provide services	LOS / CtR / Pathway 1-3 delays
	Increase Therapy support for D2A via BCF – Business Case	LOS / CtR / Pathway 1-3 delays
	Review Provider of last result process / Housing related Discharge support	LOS/ CtR / Pathway 1-3 delays
	D2A Dashboard – management of daily / weekly capacity and overstays across providers	LOS/ CtR / Pathway 1-3 delays

Valuing Patients Time – Herefordshire D2A

D2A Board- monthly oversight	Integrated Board with partners from system- monitor commissioned D2A services and drive improvement
Discharge delays – daily monitoring	Monitored daily for Herefordshire, Powys, Worcs, Shropshire and others by IDT management team Daily meeting with Hfdshire partners to review delays Weekly silver call with Herefordshire and Powys to review delays Fast track/CHC delays escalation direct to ICB Other counties- escalation via ICB if no plans

Discharge targets by pathway

Target	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekly
Current	45	50	47	53	54	30	25	305
	47	49	50	54	53	30	30	314
P0	41	42	41	45	46	24	28	268
P1	4	5	5	5	5	4	2	30
P2	1	1	2	2	1	1	0	8
P3	1	1	2	2	1	1	0	8

Valuing Patients Time – Clinical Support

WVT Community Diagnostic Treatment Centre,

CDTC will rovide the following additional imaging which will release on-site capacity to increase access to scan for ED/INP/SDEC.
Opening **29th September 2025**

CDC Modalities	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Acute Priorities
MRI	+338	+246	+187	+272	+246	+246	ED, SDEC and IP: Highest demand for MRI Head, Spines, MRCPs
MMPR (Prostate)	+46	+40	+35	+42	+40	+40	Existing MMPR 12 pwk retained to support 48hr pathway
CT	+1352	+1176	+1060	+1029	+979	+955	ED, SDEC and IP: Highest demand for CT Head, Thorax/Abdo/Pelvis, CTPA, Cervical Spines. CT3 to deliver CTCA at WVT (pts currently travelling to WHAT/UHB) *needs BC to increase operating hours of CT3 to meet anticipated demand*
TLHC				+173	+173	+173	TLHC (low dose contrast CT) new pathway from Jan 26, all activity would be delivered at the CDC, therefore no acute impact to from this new demand
USS	+225	+196	+170	+202	+196	+196	ED and IP : Highest demand Abdo, Renal/Pelvis, Lower Limb Doppler
TVUS (PMB)	+419	+364	+328	+380	+364	+364	Direct access to PMB pathway live from Acute Aug 25, the activity will be moved to CDC

CDC **slippage plan** started delivering **June 25**, as a result:

- **NOUS impact is mixed**, with modest success in **SDEC**
- Supporting a **sustained increase in CT**, helping with growing demand, **ED and SDEC CT** exams showing strong growth
- Boosted **MRI throughput**, particularly where prior suppression existed with **INP MRI** showing the largest gain

4 new Consultant Radiologists have started in post, with induction in progress. This will help towards the capacity required to **report these additional exams**. TATs will need to be closely monitored.

Powys ASC & Health Plans

Increased assessment capacity & domiciliary care

Increased Domiciliary Care

Paying retainers

Work with providers to understand barriers to picking up packages in rural areas and develop retainer framework to maintain workforce capacity and secure packages for discharge.

Enhanced brokerage capacity

Review and refresh of dynamic purchasing system to improve response, capacity and performance of contracted domiciliary care providers. All terms and conditions reviewed. More detailed terms and conditions and KPIs. Increased control to leverage the market.

Increased Assessment Capacity

Expansion of Hospital Team

To increase from September the Social Work capacity in Hospital Team by 5 workers. This will expand the remit to include community hospitals as well as DGH's increasing the effectiveness of the D2A pathway and availability of 7-day coverage where needed. Dedicated ward and MDT support including at Ready to Go Home Units.

- Reduction of those awaiting Social worker allocation
- Reduced number of days delayed
- Reduction in numbers awaiting assessment by social care.

Trusted Assessment

Develop Trusted Assessor pathway with external providers. This will be facilitated by a dedicated project officer in partnership with colleagues in PTHB.

Methodology successfully piloted in two residential care homes now ready for scaling.

Admission Avoidance Pathways

Scheme	Overview
Virtual Ward	Primary Care MDT identification and active management of 0.5% highest risk frailty population. Standardised reporting now developed and contracted for, with further work ongoing to establish consistent approach across Clusters. Includes care home support and Treatment Escalation Plan development.
Fracture liaison	Newly developed function, Consultant led, with aim to support improvement in bone health management
Frailty clinics	Consultant and GPsI clinics commenced to review patients with complex multi-morbidity and chronic health conditions.
Step up admissions	GP admission direct to PTHB community hospitals

Same Day Urgent Pathways

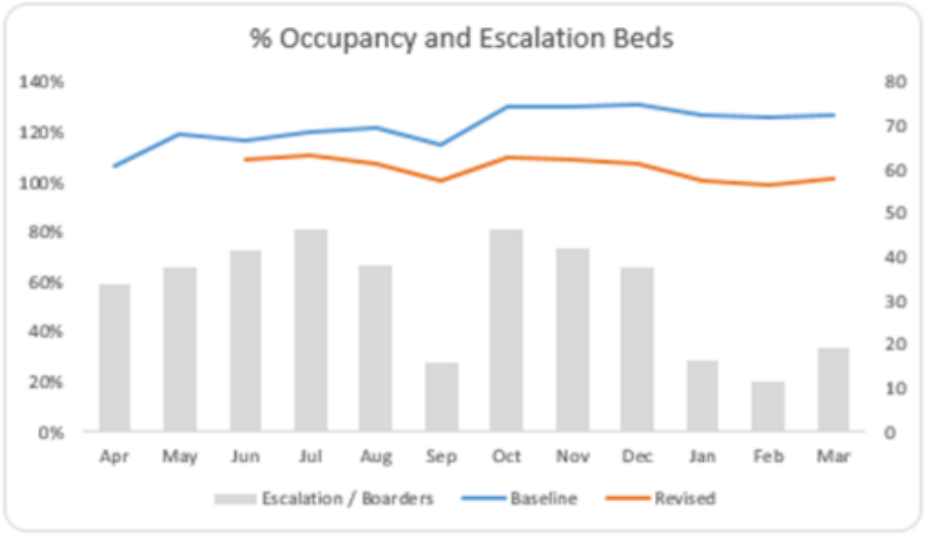
Scheme	Overview
Single Point of Access (SPOA)	Originally developed from the existing flow hub, a clinically resourced SPOA is under development. Expectations are for soft launch in September, with all community urgent care referrals for treatment, admission and community management being directed through this service.
Community frailty service	A mixed model across the Cluster footprints, these teams join up the responsive care needs for frail patients in the community, drawing together the existing community teams to wrap comprehensive community assessment and treatment planning around patients with escalating needs.
Falls response	An existing Tier 1 offer via St Johns Ambulance is being extended to include Tier 2 falls assessment and response via existing community teams including reablement and Nursing.
MIU development	Recognising the need to extend the capability & capacity of the existing services, a clinical lead is in place to support continued skills and service development for the service.
Community Reablement	Now formally separated from the community enablement offer, the team has been heavily recruited to, with increased capacity across all clusters.
Community Nursing	Now standardised across all Clusters, with a7 day 8-8 offer across all teams, the service has increased capacity at weekends, is due to commence a pilot for a number of community Matron roles and is to provide the refreshed offer around IVOPAT across Powys.

Discharge Pathways

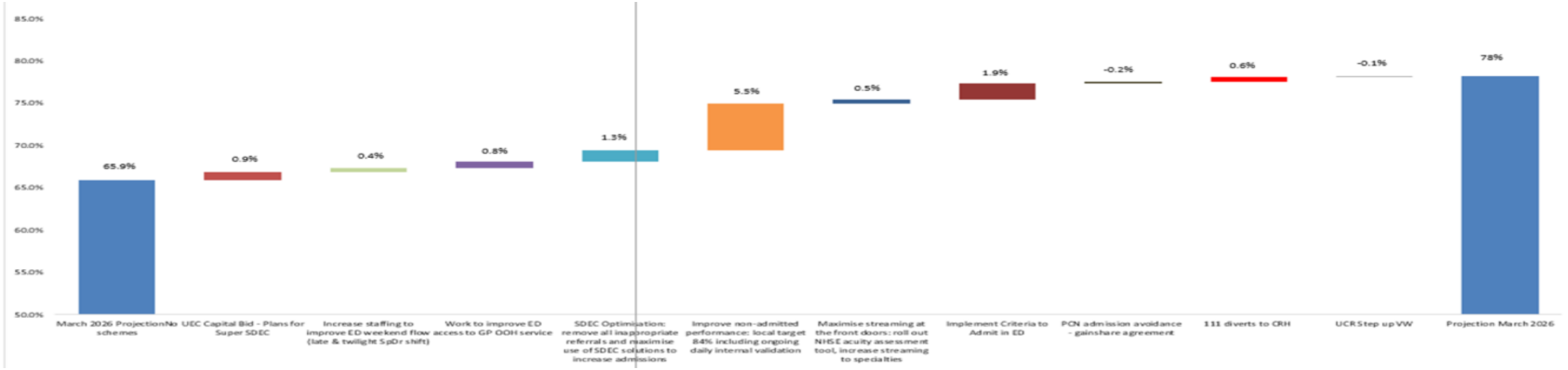
Scheme	Overview
RTGHU	The Health Board have elected to retain these temporary changes, utilising the two locations as areas to deliver care to patients stranded and awaiting transfer to onward care. The units have been developed to optimise independence, reduce the risks for hospital acquired functional decline and to maximise flow from acute hospitals.
Community Reablement	In addition to the community functions referenced in the Same Day Urgent Pathways, the Health Board have further developed the offer around step down care in Glan Irfon and Cottage View, in order to maximise discharge flow.
IVOPAT	Following temporary cessation of this function, a pathway is in development that is supported by PTHB medicines management and microbiology, that will support the re-commencement of this pathway. Expected to launch in September, the expectation will be to retain secondary care prescribing, with delivery via the community Nursing teams of the Health Board.
Digiflo & Board Rounds	With a strengthened focus on community hospital inpatient flow, the adoption of the R2G principles, Board rounds to be included in a newly refreshed GP SLA and a strengthened DLO team, improved flow can be expected across the PTHB bed base.
Trusted assessor - D2RA & BI	Further developing the offer of our embedded Care Transfer Coordinators, the adoption of Trusted Assessor processes across our teams has further increased the capacity and support to our PCC colleagues.

Winter 25 – Bed Occupancy Tool

			Winter Focus								
			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Baseline												
Emergency Admissions			1,492	1,631	1,586	1,592	1,785	1,816	1,912	1,798	1,585	1,820
Avg LOS			6.3	6.0	6.4	5.8	6.0	5.9	5.9	6.0	6.0	5.8
Bed Days			9,369	9,748	10,131	9,257	10,709	10,666	11,199	10,789	9,451	10,556
Unmet ED Demand	*Assume 8 per day*		240	248	248	240	248	240	248	248	224	248
Unmet Bed day demand	*Assume 2.5 day LOS*		600	620	620	600	620	600	620	620	560	620
Non Elective Beds required			332	334	347	329	365	376	381	368	358	361
Elective beds required			23	31	23	22	30	21	18	18	25	26
Beds Required			356	365	370	351	395	397	399	386	383	386
Beds Available			304	304	304	304	304	304	304	304	304	304
Baseline Occupancy			117%	120%	122%	115%	130%	131%	131%	127%	126%	127%
Avg Daily Boarders												
Avg Daily Escalation beds												
Plans												
		Reduction in Monthly Admissions	120	155	205	235	308	335	380	416	383	416
Total		Reduction in Beds per Day	0.3	0.3	0.3	0.3	0.7	0.7	0.7	0.7	0.8	0.7
		Additional Beds										
Final												
Beds Required			330	335	327	305	335	331	326	305	300	308
Beds Available			304	304	304	304	304	304	304	304	304	304
Baseline Occupancy			109%	110%	108%	100%	110%	109%	107%	100%	99%	101%
Core Beds Occupied			289	289	289	289	289	289	289	289	289	289
Core beds empty - Elective day case / Clean Ward			15	15	15	15	15	15	15	15	15	15
Escalation / Boarding beds required [Surge / Super Surge]			**41**	**47**	**38**	**16**	**46**	**42**	**38**	**16**	**11**	**19**
Boarders			30	33	27	11	33	30	27	12	8	14
Escalations			12	13	11	4	13	12	11	5	3	5

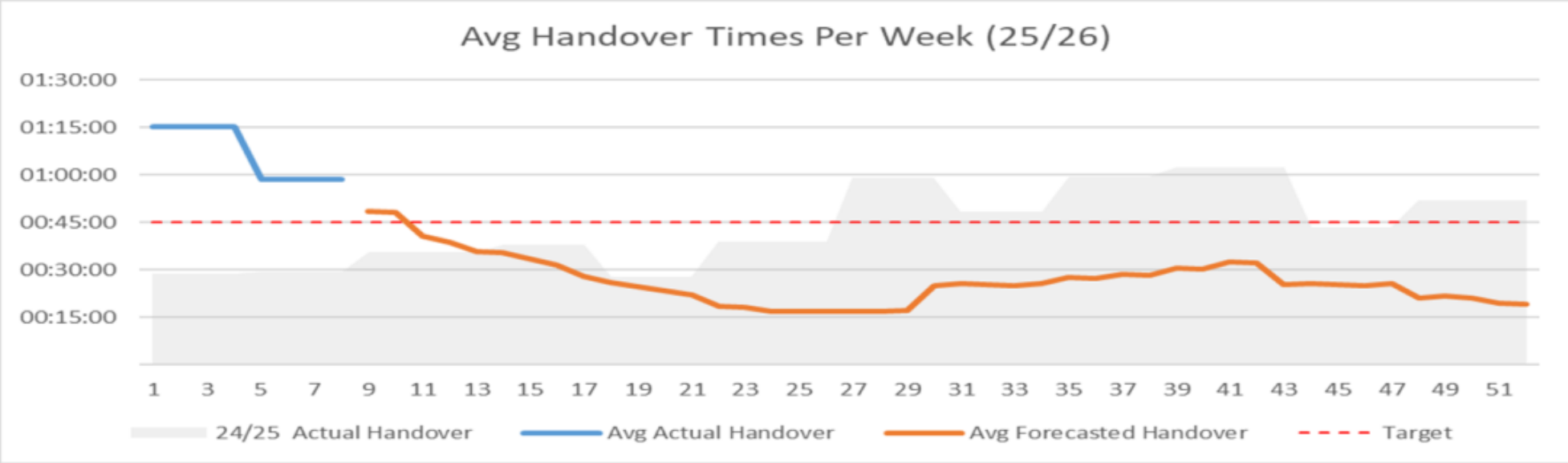


Winter 25 – 78% EAS Plan



Forecast 2025/26		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Predicted Attendances (main A&E)		6,119	6,295	6,382	6,479	6,378	6,393	6,767	6,485	6,675	6,134	6,071	6,863	77,041
Predicted Breaches based on current average daily		3,084	2,915	2,760	2,666	2,635	2,490	2,666	2,520	2,790	2,635	2,352	2,803	32,316
Total Attendances - All Types		**7,241**	**7,355**	**7,693**	**7,809**	**7,644**	**7,661**	**8,111**	**7,770**	**7,998**	**7,346**	**7,268**	**8,224**	**92,120**
Average Number of Attendances per day (main A&E)		204	203	213	209	206	213	218	216	215	198	217	221	211
Total	**Footfall reduction**	**0**	**0**	**0**	**0**	**170**	**215**	**220**	**225**	**230**	**235**	**235**	**235**	**1765**
	Breach reduction	**0**	**0**	**0**	**165**	**340**	**409**	**464**	**490**	**506**	**580**	**651**	**1043**	**4647**
Revised Attendances		**7241**	**7355**	**7693**	**7809**	**7474**	**7446**	**7891**	**7545**	**7768**	**7111**	**7033**	**7989**	**90355**
Revised Breaches		**3084**	**2915**	**2760**	**2501**	**2295**	**2081**	**2202**	**2030**	**2284**	**2055**	**1701**	**1760**	**27669**
Revised Performance (%)		**57.4%**	**60.4%**	**64.1%**	**68.0%**	**69.3%**	**72.1%**	**72.1%**	**73.1%**	**70.6%**	**71.1%**	**75.8%**	**78.0%**	**69.4%**
Quarterly Performance (%)				**60.7%**			**69.7%**			**71.9%**			**75.1%**	
Performance gain		**0.0%**	**0.0%**	**0.0%**	**2.1%**	**3.8%**	**4.6%**	**5.0%**	**5.5%**	**5.5%**	**7.0%**	**8.2%**	**12.1%**	**4.5%**
Planning Submission 2025/26		**68.3%**	**68.6%**	**69.6%**	**69.9%**	**70.6%**	**71.8%**	**71.0%**	**71.9%**	**70.2%**	**71.9%**	**75.7%**	**78.0%**	

Winter 25 – Ambulance Handover Plan



To	24/25 Actual Handover	Avg Forecasted Handover	Comments
06/07/2025	00:35:32	00:36:00	
03/08/2025	00:38:00	00:28:00	
07/09/2025	00:38:59	00:18:40	
05/10/2025	00:38:59	00:17:00	
02/11/2025	00:59:04	00:25:00	UEC capital works commence
07/12/2025	00:59:24	00:27:40	
04/01/2026	01:02:26	00:30:40	
01/02/2026	01:02:26	00:25:20	
01/03/2026	00:43:30	00:25:40	UEC capital works complete
05/04/2026	00:51:55	00:19:20	

Winter 25 – Revised Escalation Policy and Matrix incorporating OPEL

Patient Flow and Escalation Policy

Escalation Matrix 2025

Daily Flow Escalation Matrix

IPC/Cohorting Patients

- Microbiology continue to provide a 7 day service Between October – March IPC nurse team work a 7 day week to support and oversee outbreak management.
- LFD testing in ED is in place to enable prompt identification of key respiratory infections.
- Information on detection and management of Norovirus will be circulated in October to raise staff awareness
- An outbreak is classed as 2 or more patients linked to time and place with same infection. IPC nurse team risk assess each outbreak and assess current rate of local transmission and prevalence.
- If the current cross infection rate is low, the ward will remain open and only the affected area (e.g. one bay) will be closed. If transmission rate is wide spread throughout the area, fully ward closure to contain any additional spread will be considered
- IPC will work daily with CSM team to review allocation of beds in any closed areas to enable maximum use of any empty restricted beds as appropriate to infection type/ risk
- Protocols relating to isolation management of patients with infection/ suspected infection including guidelines on cohorting plans and side room prioritisation available
- All outbreaks are declared internally and also to the ICB & UKHSA
- Regular outbreak meetings will be held to monitor actions taken and the associated Trust wide risks. Colleagues from ICB & UKHSA will be invited to attend
- FFP3 Mask fit testing service provided in house. Testing available to all Clinical staff with targeted training provided to High Risk areas
- PPE stock monitored to ensure products availability. Promotion on correct PPE usage cascaded trust wide.

Winter 25 – Workforce (planning & wellbeing)

- A modelled Workforce Plan for 2025/26 in place designed to ensure workforce resilience, flexibility, and wellbeing throughout the winter period, in line with NHSE requirement's. The plan is structured around key strategic themes

    - Surge Planning scenarios
    - Executive Leadership
    - Health and Wellbeing
    - Vaccination Uptake
    - Flexible Working
    - Recruitment
    - Real-Time Workforce Intelligence

Staff Wellbeing and Vaccination; To support staff during the winter period, the Trust will launch a comprehensive Winter Wellbeing Campaign, including:

- Access to mental health support
- Designated rest and recovery spaces
- Provision of hot meals and hydration stations

Additionally, the Trust will work to ensure high uptake of flu and COVID-19 vaccinations among staff to protect both workforce and patients.

Staff Vaccination Plan

- Flu launch at County Hospital on the 06/10/25 with OH staff offering flu vaccinations at all main entrances
- Re-introduction of peer vaccinator model; This model is proven to open up access to staff in all settings in community and on the County site
- The programme will include
  - Roving teams
  - Drop in clinics in Occupational Health – no appointment required
  - Peer vaccinators in all settings including community sites
  - Weekend / day time/ late and night shift sessions
- Trust wide promotion and communication cascade
- Flu preparation meeting occurring fortnightly
- All staff to complete a form to capture those who have received their vaccine elsewhere, those declining and staff unable to receive the vaccine

Winter 25 – Risks

- Increased emergency Type 1 / >0LOS Activity activity
- Increased acuity
- Increased numbers of Medically Fit for Discharge (MFFD) patients in inpatient beds
  - Herefordshire – Discharge Pathways 2 & 3 - Lack of transparency in community capacity
  - Powys Delays
  - Other out of area delays
- Workforce challenges
  - Recruitment to key roles
  - Impact of Industrial Action
  - Increased demand on staff
    - Burnout and impact on morale
    - Retention concerns
    - Increased sickness
- Specific risk of 45-minute Rapid Ambulance offload requirements
  - No increase in Hear and Treat / Call before Convey
- Financial Challenge – impact on escalation
  - Bank and agency costs

Winter 25 – Risks

- On going use of TES to maintain flow and reduce ED congestion
- Impact of Acute Floor estates work to deliver increase SDEC / Ambulatory capacity – planned work Oct 25 to Feb 26
- Maintaining high levels of Elective activity / Ring fenced Elective capacity
- Powys:
  - UEC admissions avoidance schemes not mirroring English pathways e.g. Same Day Emergency Care
  - No D2A in place leading to increase Pw 1-3 delays
- Estates challenges as a result of Capital bids and implementation works
- Competing priorities over winter period – Elective Vs Non-elective
- Successful implementation of transformation schemes

Board Assurance Framework

Board Assurance Framework

Escalation Matrix - NB* All bold actions reflect OPEL escalation levels

Surge Level					Surge	Super-surge
Location/Function		**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		• There is capacity for the expected emergency and elective demand • Staffing is sufficient • Good flow through ED & other access points • The 4hr target is consistently being delivered • There is one bed available in each of the following areas: ICU, HDU, CCU, Stroke, Trauma/#NOF, NIV, WHW, GAA	• Actions at Status Level 1 have failed to deliver sufficient capacity • Insufficient discharges to create capacity for the predicted/expected emergency and elective activity resulting in the need to outlie • Lower levels of staff available but are sufficient to maintain safe services • Anticipated pressure in maintaining 4hr standard in ED • Anticipated pressure in facilitating ambulance handovers • Infection control issues some single and 4 bedded areas compromised • No beds available in the following areas but patients have been identified who could transfer out of the department to make capacity: ICU, HDU, CCU, Stroke, Trauma/#NOF, NIV, WHW, GAA	• Actions at Status level 2 have failed to deliver sufficient capacity • Predicted pathway 0 discharges insufficient, insufficient pathway 1 – 3 discharges to create capacity for the predicted/expected emergency and elective activity resulting in the need to open extra capacity • Activity in the ED department is becoming unmanageable and there are patients with a decision time to admit (DTA) and no plan for admission to a bed or transfer to Acute Medical Unit (AMU); resus capacity is full • There is likely to be a significant failure of the ED 4hr standard • Patients waiting ambulance handover > 30 minutes • The maintenance of elective surgery is compromised • Infection control issues ward closures or high number of bay closures • Significant short notice staff absence affecting ability to cover rotas • There are no beds available in the following areas and/ or no wardable patients or no beds to transfer out to: ITU, HDU, CCU, Stroke, Trauma/#NOF, NIV, WHW, GAA	• Actions at Status level 3 have failed to deliver sufficient capacity • The number of discharges is insufficient to create capacity for expected emergency and elective activity despite extra capacity beds being utilised • Urgent Care Pathway significantly compromised • Unable to offload ambulances • ED patients breaching 12hr standard • Patients waiting ambulance handover >1hr • Significant unexpected reduction staffing numbers • Routine elective admissions cancelled and urgent elective work under review • Ability to accept stroke, poly trauma or critical care patients is severely compromised	• Actions at Status level 4 have failed to deliver sufficient capacity • Insufficient capacity to meet ongoing demand • Urgent Care Pathway severely compromised • Unable to offload ambulances • Multiple ED patients breaching 12hr standard • Patients waiting ambulance handover approaching 2+hrs • Insufficient staffing numbers • All elective work cancelled • Ability to accept stroke, poly trauma or critical care patients is severely compromised • If the risk of enactment of EPRR Framework due to operational pressures, remains for >48hrs then the ICB Director (or DoC) must agree with the region the escalation steps to the national iUEC team (OPEL).
Divisional Escalation	**Medicine**	Ward & ED Sister/NIC/Medical Flow Coordinator	Medical Flow Coordinator/Matron/ED Capacity	ED Capacity/DGM/GM/Matron	ACOO/ACNO/ACMO	ACOO/ACNO/ACMO
	Surgery	Ward sister/charge nurse/Surgical SDEC Lead Nurse/Elective Flow Coordinator	Surgical Flow Co-ordinator	General Manager/Matron/Clinical Director	ACOO/ ACNO-Deputy Chief Nurse/ACMO	ACOO/ ACNO-Deputy Chief Nurse/ACMO
	Integrated	Ward Sisters/DGM's/Team Leads	GM's/Matron	ACOO/ACAHP	ACOO/ACAHP	ACOO/ACAHP
	Clinical Support	Departmental Manager	GM's/Clinical Manager	GM's/Clinical Manager/Clinical Lead/CD Path & Pharm	ACOO/Professional Lead/ACMO	ACOO/Professional Lead/ACMO
Capacity		Business as Usual	Review demand regularly, utilising SDEC's fully	Review demand regularly, utilising SDEC's fully, reminder out for call before convey. Boarding against discharges may be required	Additional TES to be used according to Escalaton Policy	Potential activation of critical incident unless measures taken are leading to de-escalation
Emergency WMAS/WAST		Business as Usual	Business as Usual. Update CMS	Discuss situation with WMAS SOC re managing pressures at borders. Update CMS with narrative on ED pressures	Discuss with WMAS the imapct of intelligent conveyancing. Consider COO/Level 4 discussion on full divert WMAS and WAS. Ask for support with corridor care. Notify WMAS and WAST of situation, promote call before convery.	Request cessation of all intelligent conveyancing. COO/Level 4 discussion on full divert WMAS and WAS. Ask for support with corridor care. Notify WMAS and WAST of situation, promote call before convery.
PTS Provision		Business as Usual	Ensure capacity meets demand for projected discharges.	Check capacity with EZEC. Transport Liaison Officer to attend capacity meetings	Discuss with EZEC and CCG scope for addtitional transport provision	Discuss with EZEC and CCG scope for addtitional transport provision.
Emergency Department	**Clinical**	Nurse Navigator, Triage Nurse, Nurse in Charge as per Follow Rapid Assessment and Treatment (RAT) Protocol **Ensure initial assessment complete within 15 minutes**	Joint assessment of delayed handover patients between ambulance and ED staff RAA Nurse, Nurse in Charge, B7 Sister and EPIC	Ambulance and RAT team huddles, mdt huddles, ED capacity engagement, attend capacity meetings	NIC and B7 Sister with EPIC, Ambulance and RAT team review of deteriorating patients. Consultant on call notified.	EPIC assess patients on back of ambulances, call for additional support as required, direct admissions, consultant on call notified and present.
	Staffing	Ensure staffing compliment achieved	Consider targeted additional staffing for specific areas of risk	Prioritise ED staffing - ensure sufficient clinical resource to meet demand and volume of patient in department including corridors etc.	Stand down routine non-clinical activities and redeploy staff to priority areas (staff training, quality and safety team etc.) Request support from other speciality teams to enhance 'Decide to Admit' in speciality patients for avoidance of admission	Stand down routine non-clinical activities and redeploy staff to priority areas (staff training, quality and safety team etc.) Request support from other speciality teams to enhance 'Decide to Admit' in speciality patients for avoidance of admission
	Portering	Business as Usual	Business as Usual	Redirect portering resource to support patient moves etc. in ED	Call for additional porter' to be based in ED to support flow from ED, SDEC/FSDEC & AMU	Call for additional porter' to be based in ED to support flow from ED, SDEC's, DL & AMU
	Mental Health Services	Business as Usual	Request additional support to ED (where required) to ensure timely assessment	Request additional support to ED (where required) to ensure timely assessment and/or move patients to Stonebow for ongoing assessment and care.	Request additional / onsite support to ED (where required) to ensure timely assessment and/or move patients to Stonebow for ongoing assessment and care.	Request additional / onsite support to ED (where required) to ensure timely assessment and/or move patients to Stonebow for ongoing assessment and care.
	Primary Care	Ensure streaming to primary care services, 24/7	Ensure streaming to primary care services, 24/7	Ensure streaming to primary care services, 24/7	Ensure streaming to primary care services, 24/7 Discuss increased primary care support via system calls Ensure full implementation of GP Telephone triage to specialities	Ensure streaming to primary care services, 24/8 Discuss increased primary care support via system calls Ensure full implementation of GP Telephone triage to specialities
	Speciality teams	Respond within 60 minutes for all requests to review referred patients	Respond within 30 minutes for all requests to review referred patients	Respond within 30 minutes for all requests to review referred patients	Respond within 30 minutes for all requests to review referred patients	Specialty Reg or Consultant based in ED for admission avoidance
Acute Medicine		Business as Usual	Business as Usual	Business as Usual	Expand Acute Medicine capacity for front door decision making	Expand Acute Medcine capacity for front door decision making
Inpatient Wards	**Ward rounds**	Consultant-led 'ward-round' by 12md and review 'board-round' pm	Consultant-led 'ward-round' by 12md and review 'board-round' pm	Consultant-led 'ward-round' by 12md and review 'board-round' pm Escalate any delays in diagnostics or specialty reviews	Consultant-led 'ward-round' by 12md and review 'board-round' pm Escalate any delays in diagnostics or specialty reviews	Rolling consultant-led 'ward-round' /review 'board round' at 4pm to review results and discharge Consider cancellation of all non-urgent activity to free up clinical time
	Elective Care	Business as Usual	Business as Usual	Business as Usual	Consider cancellation of some non-urgent activity if it releases usable capacity Request additional support to ED to support in avoidance of admission If activity cancelled ensure patients are contacted and clinicians informed to assess individual clinical risk	Consider cancellation all activity with assesment of impact based on short v medium term. If prolonged escalation, consider flipping ward to support Release clinicians to provide support to ED to 'Decide to Admit' for avoidance of admission If activity cancelled ensure patients are contacted and clinicians informed to assess individual clinical risk
Community Hospitals	**Bromyard Community Hospital**	Provide discharge profiling and ACP escalation of delays	Provide discharge profiling and senior escalation of delays	LoS review and challenge to discharge profiling	Senior clinical review of all inpatients, LoS review and challenge to discharge profiling Escalation all OOC delays through divisional management to Silver Meeting	Identify additional medical support and open 8 additional temporary beds Escalation all OOC delays through divisional management to Silver Meeting
	Leominster Community Hospital	Provide discharge profiling and ACP escalation of delays	Provide discharge profiling and ACP escalation of delays	LoS review and challenge to discharge profiling	Senior clinical review of all inpatients, LoS review and challenge to discharge profiling Escalation all OOC delays through divisional management to Silver Meeting	Senior clinical review of all inpatients, LoS review and challenge to discharge profiling. Potential to open 2 additional beds Escalation all OOC delays through divisional management to Silver Meeting
	Ross Community Hospital	Provide discharge profiling and ACP escalation of delays	Provide discharge profiling and ACP escalation of delays	LoS review and challenge to discharge profiling	Senior clinical review of all inpatients, LoS review and challenge to discharge profiling Escalation all OOC delays through divisional management to Silver Meeting	Senior clinical review of all inpatients, LoS review and challenge to discharge profiling. Escalation all OOC delays through divisional management to Silver Meeting
Community Nursing		Business as Usual	Business as Usual	ACPs to review all 'high-risk' patients and offer support to Community hospitals and GP Streaming service	Where achievable, consider stand down of routine activity and deploying released clinical time to support Hgh risk clinical areas, to include IN-REACHING to Community hospitals and HCH Consider bridging domiciliary POC to support discharge from HCH	Where achievable, consider stand down of routine activity and deploying released clinical time to support high risk clinical areas, to include IN-REACHING to Community hospitals and HCH Consider bridging domiciliary POC to support discharge from HCH
Delayed discharges/MFFD		Twice weekly multi-agency teleconference call to discuss issues and escalations	Consider increasing frequency of MFFD calls to daily (if MFFD driving poor position)	Increase frequency of MFFD calls to daily (if MFFD driving poor position) Consider alternative discharge pathways for P1 discharges Discuss utilisation of Hospital @ Home capacity to bridge Home First gap Update with ASC senior managers at Huddle- re spot purchase out of block	Multi agency support to RISK MANAGE enhanced discharge profile for DTOC next 48hours – Risk assess P1 to ascertian if reduction of calls could be implemented to make safe at home Consider additional funding for POC	Multi agency support to RISK MANAGE enhanced discharge profile for DTOC next 48hours – Risk assess P1 to ascertian if reduction of calls could be implemented to make safe at home Consider additional funding for POC
Departments	**Radiology**	Prioritise ED, AMU and SDEC areas diagnostics - aim for all inpatients to be imaged on same day as referral. Prioiritise dishcarge dependent imaging. Support IP discharge to return for OP imaging	Prioritise ED, AMU and SDEC areas diagnostics - aim for all inpatients to be imaged on same day as referral. Prioiritise dishcarge dependent imaging. Support IP discharge to return for OP imaging	If necessary, reduce planned routine activity to prioritise ED, SDEC and IP diagnostics Aim for all inpatients to be imaged on same day as referral. Support IP discharge to return for OP imaging	Consider cancelling routine planned activity if required to create capacity. All inpatients to be imaged on same day as referral Support IP discharge to return for OP imaging (retain IP imaging date)	Cancel routine planned activity if required to create capacity. All inpatients to be imaged on same day as referral. Support IP discharge to return for OP imaging (retain IP imaging date)
	Pathology	Business as Usual	Prioritise ED, AMU and SDEC areas diagnostics - all inpatient reports to be processed and reported on same day.	All inpatient reports to be processed and reported within 2 hours Deploy phlebotomists to ED and assessment areas	Consider reduction in routine activity to prioritise ED, AMU, SDEC areas. All inpatient reports to be processed and reported within 2 hours Deploy phlebotomists to critical risk areas.	Reduce planned routine activity to prioritise ED, AMU, SDEC areas. All inpatient reports to be processed and reported within 2 hours Deploy phlebotomists to critical risk areas.
	Discharge Lounge	Business as Usual - actively 'pull' from wards	Non-use of discharge lounge is by exception	Directorate to provide senior clinical support and point of escalation.	Cosnider extending hours and/or expand capacity Directorate to provide senior clinical support and point of escalation. Pharmacy to provide dedicated support Consider activating transfer teams with support from Divisions	Extend hours and/or Expand capacity Directorate to provide senior clinical support and point of escalation. Pharmacy to provide dedicated support Consider activating transfer teams with support from Divisions Potential use of DL for in-patients
	Pharmacy	Business as Usual	Business as usual	Prioritise discharge support to acute medical wards and escalation areas.	Prioritise discharge support to acute medical wards and escalation areas. Work closely with Discharge Lounge & Escalation Areas	Pharmacy to provide dedicated support for extension of pharmacy opening hours Prioritise discharge support to acute medical wards and escalation areas. Work closely with Discharge Lounge & Escalation Areas
	Therapy	Business as Usual	Where clinically appropriate, therapy teams to prioritise discharge support	Reduce planned routine activity to prioritise immediate clinical need and discharge support	Cosnider reducing planned routine activity to prioritise immediate clinical need and discharge support Therapists to identify MFFD & Not therapy fit Review for possible same day discharge or escalation for community home support	Cease planned routine activity to prioritise immediate clinical need and discharge support Therapists to identify MFFD & Not therapy fit Review for possible same day discharge or escalation for community home support
	AMU	Business as Usual	Business as Usual	3 TES	3 TES	4 TES Consider additional nurse staffing dependent on acuity
	Gilwern	Business as Usual	Business as usual	2 TES	2 TES	2 TES
	Garway	Business as Usual	Business as usual	4 TES	4 TES	6 TES 1 in Clinical/Therapy room and additional patient in SR 4 Additional nurse staffing would be required. RN or HCA dependent of the acuity and dependency of the patients on the ward.

Boarding	**Ashgrove**	Business as Usual	Business as usual	4 TES	4 TES	5 TES Use resource room Additional nurse staffing would be required. RN or HCA dependent of the acuity and dependency of the patients on the ward.
	Dinmore	Business as Usual	Business as usual	3 TES	3 TES	3 TES - Excludes ring fenced #NOF bed
	Arrow	Business as Usual	Business as usual	3 TES	3 TES	3 TES - Excludes ring fenced NIV bed
	Wye	Business as Usual	Business as usual	2 TES	2 TES	4 TES - Excludes ring fenced HASU bed
	Lugg	Business as Usual	Business as usual	2 TES	3 TES	3 TES - Excludes ring fenced MI bed
	Redbrook	Business as Usual	Business as usual	3 TES	3 TES	3 TES
	Frome	Business as Usual	Business as usual	3 TES	3 TES	6 TES Additional nurse staffing would be required. RN or HCA dependent of the acuity and dependency of the patients on the ward.
	Women's Health Ward	Business as Usual	Business as usual	Business as usual	Business as usual	1 TES
Escalation Areas	**Same Day Emergency Care - Medical, Surgical and Frailty SDEC's**	Business as Usual	Business as usual	Business as usual	Consider capacity to be utilised to bed patients in Frailty SDEC overnight - deescalate ASAP	Maximise use of Frailty SDEC Consider use of SDEC's to support super-surge
	Primrose	Unit to provide capacity for day case patients	Unit to provide capacity for day case patients	Unit to provide capacity for day case patients	Consider cancelling routine planned activity, utilise capacity	Cancel all routine elective activity, consider cancellation of urgent and cancer work use up to 12 spaces
	Endoscopy	For Endoscopy use only	For Endoscopy use only	For Endoscopy use only	Consider using endoscopy to support over night situation Plan to de-escalate ASAP	Cancel routine endoscopy work Consider recovery of patients in other areas e.g. Day Surgery Unit
	Theatre Recovery	Normal use only (unless isolated Critical care pressure see SOP)	Normal use only (unless isolated Critical care pressure see SOP)	Normal use only (unless isolated Critical care pressure see SOP)	Normal use only (unless isolated Critical care pressure see SOP)	Consideration must ALWAYS be given to maintaining urgent theatre capability Usage of capacity if appropriate patients and staffing are all in place De-escalation ASAP
	Radiology Recovery	Business as Usual	Business as Usual	Business as Usual	Consider using 3 TES will need 2 trained nurses	Consider using 3 TES will need 2 trained nurses
	Teme Ward	Ring-fenced for elective orthopaedic activity Side rooms and free capacity to be utilised only in line with ward admissions policy	Ring-fenced for elective orthopaedic activity Side rooms and free capacity to be utilised only in line with ward admissions policy	Ring-fenced for elective orthopaedic activity Side rooms and free capacity to be utilised only in line with ward admissions policy	Ring-fenced for elective orthopaedic activity Side rooms and free capacity to be utilised only in line with ward admissions policy	Work up plan to allow access to available capaity without impeding the safety of elective orthopaedic patients Cancel all routine elective activity, consider cancellation of urgent work - use up to 20 spaces
	Fred Bulmer Medical Day Case	Business as Usual	Business as Usual	Business as Usual	Business as Usual	Up to 3 TES in minor ops and 4 TES in Discharge Lounge - 7 total Area will require staffing and may result in cancelled activity or activity to be moved to Oxford Suite cancelling OPA's
	Cardiac Catheter Laboratory	Business as usual	Business as usual	Business as usual	Business as usual	Up to 4 TES - will require staffing
Outlier management	**All outliers**	Ensure every patient has a senior medical review. Adequately resourced outlier team absed on number of patients	Ensure every patient has a senior medical review. Adequately resourced outlier team absed on number of patients	Ensure every patient has a senior medical review. Adequately resourced outlier team absed on number of patients	Enhanced outlier team to include senior nurse, therapist, dedicated discharge co-ordination	Enhanced outlier team to include senior nurse, therapist, dedicated discharge co-ordination
Staffing	**Acute/Community**	Business as Usual	Business as usual	Ensure all escalation areas are staffed, inpatient wards and ED. 48 hour profiling required	Ensure all escalation areas are staffed, inpatient wards and ED. 48 hour profiling required	Redploy admin and other support staff to support acute flow Cancellation of all training and redeployment of staff Canclation of targeted activity to release medical and nursing staff
Communications	**Health and Social Care**	Routine Daily Communications	Routine daily communications and targeted messaging re specific identified issues	Wider system communications and targeted messaging re specific identified issues	Conference call to request additional resource to enable enhanced same day discharge (Domiciliary care / Care Home)	Escalate to ICB for additional support for all OOC delays
	General Public	Routine Communications	Consider targeted messaging via social media and traditional media outlets	Issue targeted messaging via social media and traditional media outlets	Issue targeted messaging via social media and traditional media outlets	Issue targeted messaging via social media and traditional media outlets. Liaise with ICB re wider messaging. Regional NHSE/I Comms requirement.
Oversight and coordination	**Internal**	Business as Usual	Business as usual	Business as usual	Business as usual	Activate Control Room - Virtual or on site to be defined Cancel all non-essential meetings to aid focus on flow Trigger additional ward rounds Consider cancellation of all elective activity if no signs of de-escalation
	External	Business as Usual	Business as usual	Business as usual	Establish multi agency gold command and silver control room dependent upon incident called Hold system-wide teleconference for confirmation of mutual aid requirements and actions	Establish multi agency gold command and silver control room dependent upon incident called Hold system-wide teleconference for confirmation of mutual aid requirements and actions Inform ICB of escalation level and include in Site Safety meetings

Daily Management and Escalation of Flow Matrix				
Escalations	**Surgical Division**	**Integrated Care Division**	**Clinical Support Division**	**Medical Division**
Escalations for internal flow delays	Elective Flow Co-ordinator	CH Ward Sister/NIC	Department leads	Ward Sister/NIC
	Ward Sister/NIC	DGM/GM/Matron	DGM/GM/Matron	DGM/GM/Matron
	DGM/GM/Matron	ACOO/ACAHP	ACOO	Divisional Tri
	Divisional Tri			
ED **Staffing** **Safety** **Triage delays** **Ambulance handovers** **Estates/Housekeeping/ IPC**	Surgical Flow Co-ordinator to liaise with CSM's regarding allocation of beds from ED and movement of patients	N/A	N/A	Band 7 Sister ED Capacity Manager GM/Matron Divisional Tri
Trauma	Trauma Co-ordinator	N/A	N/A	CSM to liaise with Trauma Co-ordinator on all trauma
LOS review 21 days	Elective Flow Co-ordinator	Community Hospital (weekly) >21 days M/W/F	N/A	Wards (twice weekly)
	Wards (twice weekly)	Ward Sister/Matron		Ward Sister/Matron
	Ward Sister/Matron	DGM/GM		DGM/GM
	DGM/GM	ACOO/ACAHP		Divisional Tri
	Divisional Tri			
LOS review 7 days	Elective Flow Co-ordinator	Weekly at CH	N/A	Wards (twice weekly)
	Wards (twice weekly)	Ward sister/Matron		Ward Sister/Matron
	Ward Sister/Matron	DGM/GM		DGM/GM
	DGM/GM	ACOO/ACAHP		Divisional Tri
	Divisional Tri			
Criteria to Reside (complete and action)	Elective Flow Co-ordinator	Community Hospital (daily)	N/A	Wards (daily)
	Wards (daily)	Ward Sister/Matron		Ward Sister/Matron
	Ward Sister/Matron	DGM/GM		DGM/GM
	DGM/GM	ACOO/ACAHP		Divisional Tri
	Divisional Tri			
EDD review and update	Surgical Flow Co-ordinator	Wards (daily)	N/A	Wards (daily)
	Wards (daily)	Ward Sister/Matron		Ward Sister/Matron
	Ward Sister/Matron	DGM/GM		DGM/GM
	DGM/GM	ACOO/ACAHP		Divisional Tri
	Divisional Tri			
Identify stepdown patients	Surgical Flow Co-ordinator	N/A	N/A	Wards (daily)
	Wards (daily)			Ward Sister/Matron
	Ward Sister/Matron			DGM/GM
	DGM/GM			Divisional Tri
	Divisional Tri			
Radiology **Ensure in-patient requests complete asap** **Diagnostic test within 24hrs of request**	Wards (daily)	IDS raise any delays in discharge pending diagnostic test	Daily review of Inpt requests	Wards (daily)
	Ward Sister/Matron		Radiology Services Manager/Lead Radiographer	Ward Sister/Matron
	DGM/GM		GM	DGM/GM
	Divisional Tri		ACOO	Divisional Tri
Pharmacy - EDS Medication **Wards to ensure EDS completed asap**	Wards NIC	N/A	Dispensary	Wards NIC
	DGM/GM/Matron		Dispensary Manager	DGM/GM/Matron
	ACOO		Divisional Lead Pharmacists	ACOO
			Deputy Chief Pharmacist	
Pathology – Urgent results	Ward/Dept telephone Microbiology/Blood Sciences	CH/VW/UCR staff raise with Microbiology/Blood Sciences	Departmental staff raise with Microbiology/Blood Sciences	Ward/Dept telephone Microbiology/Blood Sciences
	Microbiology/Blood Sciences Manager	UCR/CH/VW Band 7	Dept sister	Microbiology/Blood Sciences Manager
	General Manager Pathology	GM	GM	General Manager Pathology
	ACOO	ACOO	ACOO	ACOO
Discharge Lounge **Identify suitable pts** **Early transfer of pts**	Elective Flow Co-ordinator	IDS identify patients for CH's on day prior to discharge and confirm on day of discharge	N/A	Sister Discharge Lounge
	Wards NIC			Wards NIC
	DGM/GM/Matron			DGM/GM/Matron
	ACOO			ACOO
Review of Discharge Delays - all to actively secure OOC solutions	Ward staff to work closely with IDT and provide updates on any changes in pts condition	Daily Huddle with ASC/Hoople/Therapy	N/A	Ward staff to work closely with IDT and provide updates on any changes in pts condition
		DGM		
		GM		
		ACOO/ACAHP		
Out of County Delays	Ward staff to work closely with IDT and provide updates on any changes in pts condition	IDT Fast Track Delays	N/A	Ward staff to work closely with IDT and provide updates on any changes in pts condition
		IDT Lead Powys and Powys Co-ordinator		
		DGM		
		GM		
		ACOO/ACAHP		
VW Daily Oversight and Pull	Wards Refer to VW	Virtual Ward Band 7	N/A	Wards refer to VW
		DGM		
		GM		
		ACOO/ACAHP		

Referral's for CH bed	Acute Ward staff to make timely referral to CH	Allocate CH bed and enter onto tracker – IDT Co-ordinator	N/A	Acute Ward staff to make timely referral to CH
	DGM/GM/Matron	Lack of referral for CH – escalate to Matron at acute		DGM/GM/Matron
	ACOO			ACOO
ITU Stepdown - 48 hrs post wardable and clinical priority	Surgical Flow Co-ordinator	N/A	N/A	CSM to identify stepdown beds
	DGM/GM/Matron			DGM/GM
	ACOO			ACOO
Nurse Staffing Ensure adequate cover	Ward Sister/NIC	Ward Sister/NIC	N/A	Ward Sister/NIC
	Matron	Locality Manager		Matron
	ACNO	ACOO/ACAHP		ACNO
Medical Staffing	Medical Staffing	GM	GM	Medical Staffing
	DGM/GM	ACOO	ACOO	DGM/GM
	ACOO/ACMO			ACOO/ACMO
Transport Call before convey – daily push Discharge and transfer journeys to be booked asap	Elective Flow Co-ordinator	UCR Band 7	N/A	CSM
	Ward Stister/NIC	General Manager		Ward Stister/NIC
	DGM/GM/Matron	ACOO/ACAHP		DGM/GM/Matron
	Divisional Tri			Divisional Tri
Baby Loss	Surgical Flow Co-ordinator co-ordinates Baby Loss Bereavement Plan	N/A	N/A	N/A

Daily Senior Oversight Responsibilities	**Duty ACOO**	**Senior Nurse**
	Provide operational oversight to flow	Provide clinical oversight to flow
	Receive escalations from ICB	Provide staffing oversight
	Agree plan for the day/night proposed by CSM	
	Attend 08.30 and 16.00 bed meeting and others according to escalation and surge level	
	Agree TES increases	
	Point of contact to receive updates from divisional leads related to flow	

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Wye Valley NHS Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Presentation pack to trust board 4th September 2025
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Trust-wide risk register and board assurance framework utilised to scope schemes and develop mitigation plans included in the winter plan
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Wider Herefordshire schemes developed in conjunction with system partners both admission avoidance and enhanced discharge planning. Overseen by 1Herefordshire Partnership and D2A Board.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Ye	Planned for 2nd September across the ICS by NHSE
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	COO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Winter modelling and Patient Flow Escalation Policy
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the	Yes	4hr 78% realigned in July / 12hr / RTT trajectories submitted as part of

Provider:	Wye Valley NHS Trust

trajectories already signed off and returned to NHS England in April 2025.		Operational Planning submissions

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Increased peer vaccinator programme aimed to increase staff uptake for flu vacation ahead of winter
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Modelled within Demand Capacity for surge within plan Surge and Super Surge in Escalation Policy and Matrix
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Revised ED senior Leadership rotas for Medical and Nursing and enhanced senior decision makers for medical overnight rotas over this winter
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Target discharges by pathway modelled. Pathway 1-3 agreed trigger levels in place with system partners.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Ring-fenced capacity within Day Case Surgical Unit / Teme ward / Frome elective beds CDC operational in September to increase elective diagnostics and increase access and

			turnaround for inpatients and UEC
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Plans agreed with lead IPC nurse and microbiologist
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Plans in place led by Lead IPC nurse
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	As above
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

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 6 August 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
Neil Cook	(NC)	Chief Finance Officer WAHT
Stephen Collman	(SC)	Acting Chief Executive WAHT/WVT
Catherine Free	(CF)	Managing Director GEH
Phil Gilbert	(PG)	NED SWFT
Paramjit Gill	(PGi)	Nominated NED SWFT
Natalie Green	(NG)	Chief Nursing Officer GEH
Harkamal Heran	(HH)	Chief Operating Officer SWFT
Jane Ives	(JI)	Managing Director WVT
Ian James	(IJ)	NED WVT
Simone Jordan	(SJ)	NED GEH
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
Dame Julie Moore	(JM)	NED WAHT
Simon Murphy	(SMu)	NED and Deputy Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Grace Quantock	(GQ)	NED WVT
Najam Rashid	(NR)	Chief Medical Officer GEH
Jackie Richards	(JR)	NED GEH
Robert White	(RW)	NED SWFT
Umar Zamman	(UZ)	NED GEH

In attendance:

Leigh Brooks	(LB)	Interim Head of Communications SWFT
Rebecca Brown	(RBr)	Chief Information Officer WAHT
Ellie Bulmer	(EB)	Associate Non-Executive Director (ANED) WVT
John Burnett	(JB)	Head of Communications WVT
Paul Capener	(PC)	ANED GEH
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT

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 6 August 2025 at 1.30pm via Microsoft Teams

In Attendance Continued:

Catherine Driscoll	(CDr)	ANED WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Acting Managing Director/Chief Strategy Officer SWFT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT
Elva Jordan-Boyd	(EJB)	Human Resources (HR) Director SWFT
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
Ed Mitchell	(EM)	Deputy Chief Medical Officer WAHT (deputising for Chief Medical Officer WAHT)
David Mowbray	(DM)	Group Medical Advisor
Alex Moran	(AMo)	ANED WAHT
Jenni Northcote	(JNo)	Chief Strategy Officer GEH
Andrew Parker	(AP)	Chief Operating Officer WVT
Bharti Patel	(BP)	ANED SWFT
Alison Robinson	(AR)	Deputy Chief Nursing Officer WAHT (deputising for Chief Nursing Officer WAHT)
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Sue Sinclair	(SSi)	ANED WAHT
Emma Smith	(ES)	Deputy Chief Nursing Officer WVT (deputising for Chief Nursing Officer WVT)
Robin Snead	(RS)	Chief Operating Officer GEH
James Turner	(JT)	Head of Communications GEH
Ashi Williams	(AW)	Chief People Officer GEH/SWFT

Apologies:

Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Sharon Hill	(SH)	NED WVT
Colin Horwath	(CH)	NED WAHT
Zoe Mayhew	(ZM)	Chief Commissioning Officer (Health and Care) SWFT
Sarah Raistrick	(SR)	NED and Vice Chair GEH
Sarah Shingler	(SS)	Chief Nursing Officer WAHT
David Spraggett	(DS)	NED and Vice Chair SWFT
Adrian Stokes	(AS)	Group Strategic Financial Advisor
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Chief Medical Officer WAHT

There were four SWFT Governors also in attendance.

MINUTE		**ACTION**
25.044	**DECLARATIONS OF INTEREST**	

MINUTE		ACTION
	Bharti Patel, ANED SWFT, declared that she had been involved in a commercial consultancy capacity in relation to the development of the Aseptics Services proposal which was referenced to in the Foundation Group Strategy Committee Minutes within the 7 May 2025 meeting papers (Minute 25.033 refers). **Resolved – that the position be noted.**	
25.045	**PUBLIC MINUTES OF THE MEETING HELD ON 7 MAY 2025** It was noted that under the Foundation Group Performance Report (Minute 25.027 refers) WVT's planned position was incorrect and should be amended to read £3.1m deficit and not break even. **Resolved – that, subject to the above amendment, the public Minutes of the Foundation Group Boards meeting held on 7 May 2025 be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.046	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.046.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.047	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair gave an overview of the Foundation Group Boards Workshop, highlighting its focus on artificial intelligence (AI). He described AI as a major technological shift and stressed the need for the Foundation Group to lead in leveraging its potential. He praised the WVT team for their innovative work in frontline AI implementation. The Group Chair continued that the Foundation Group Boards Workshop also explored the integration of prevention strategies across Foundation Group activities, led by the Chief Strategy Officers. Progress had been made in population health management. The Group Chair identified obesity and teenage mental health as major challenges and acknowledged public health efforts in supporting this, along with smoking cessation and alcohol reduction programmes. He encouraged the public to seek healthier lifestyles if needed and emphasised that the National Health Service (NHS) was there to support them. Finally, the Foundation Group Boards Workshop received an update on the ongoing Joint Electronic Patient Records (JEPR) programme at SWFT and	

MINUTE		ACTION

GEH. This including potential risks to the programme and plans moving forward to mitigate these.

Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.

25.048 **FOUNDATION GROUP PERFORMANCE REPORT**

The Acting Chief Executive's and Managing Directors for each Trust highlighted key points from the Foundation Group Performance Report. It was important to note for August 2025, that the Performance Report had not effectively captured the intended narrative across all four Boards. The Group Analytics Board (GAB) had been tasked with revisiting the report format.

WVT
The Managing Director for WVT proceeded with her standard update structure, highlighting one area of concern, one area of strength, and one area under close observation. The primary concern was Urgent and Emergency Care (UEC) performance, which had significantly declined in quarter one (Q1). WVT was the furthest from its trajectory within the Foundation Group, with the downturn beginning in mid-March 2025 and continuing through April 2025. In response, a three-day deep dive was conducted in May 2025, led by the Chief Medical Officer and Chief Nursing Officer, involving frontline staff to identify improvement strategies. This initiative resulted in a ten-percentage-point improvement, sustained over six weeks. By July 2025, performance had exceeded trajectory, although WVT had entered tier one for UEC in Q1. Based on current trends, it was expected to exit tier one in Q2.

The Managing Director for WVT identified Cancer performance as an area of strength, with WVT continuing to benchmark well against national standards. WVT continued to focus efforts on pathway optimisation and the implementation of a pathway dashboard via the business intelligence system.

The Managing Director for WVT explained that Mortality was under observation, specifically the Summary Hospital-level Mortality Indicator (SHMI). This was because twelve months prior had seen WVT achieve a SHMI score below 100 for the first time (98), but the score had since risen to 110, with a recent update indicating 111. The Managing Director clarified however, that this was a statistical anomaly rather than a performance issue. In April 2024, WVT began recording Same Day Emergency Care (SDEC) activity as type five Emergency Department (ED) performance, this was in line with a national requirement effective from July 2024. However, this early adoption temporarily impacted mortality statistics, as nearly half of emergency admissions were excluded from the SHMI denominator. While WAHT had also adopted this reporting method, GEH and SWFT (along with most other Trusts nationally) had not. The Managing Director for WVT added that a deep dive conducted by the Quality Committee confirmed that crude mortality had decreased in both percentage and absolute terms. Therefore, the team did not consider this a

MINUTE		ACTION

performance concern, although WVT was expected to appear as an outlier for at least the next twelve months. It remained unclear whether the national mandate for type five ED reporting had been universally implemented. The Managing Director for WVT concluded by emphasising that while the data suggested deterioration, underlying performance had not worsened.

The Group Chair invited questions and perspectives and of particular note was the following point.

The Group Chief Executive highlighted that generally the performance of WVT had improved significantly and that it was good to see UEC performance pick up which had been a worry previously. Having gone through the period of industrial action, he was pleased to see activity levels had maintained in all four Trusts in the Foundation Group.

GEH

The Managing Director for GEH reported that key performance indicators during the period reported reflected a negative picture particularly in relation to timely patient access. June 2025 performance data and May 2025 Cancer Services metrics showed delays, and indicators were categorised into areas of improvement and concern. For UEC, national benchmarks were used, with GEH's four-hour standard at 69.5%, placing GEH in the lowest national quartile, and 10.4% of patients waiting over twelve hours. The Managing Director for GEH explained that these figures were attributed to ongoing bed occupancy and patient flow challenges. In July 2025, targeted efforts led to an improvement in four-hour performance to 76%, moving GEH to mid-table nationally. The Managing Director for GEH explained that this was driven by a reduction in non-admitted breaches, however concerns remained about the sustainability of this progress. This was due to the data reflecting a period affected by school holidays and industrial action, during which senior staff supported frontline services. The Managing Director for GEH continued that bed pressures persisted, and while external bed purchases were being considered, discharge arrangements remained unresolved. She raised that Elective Care performance placed GEH in tier one support, and Referral to Treatment (RTT) performance was 60.7%, with 52-week breaches at 3.4%. By late July 2025, RTT had improved to 61.2% and breaches reduced to 2.3%, which was supported by increased capacity in Ear, Nose and Throat (ENT) and Gynaecology. This trend was expected to continue.

The Managing Director for GEH informed the Foundation Group Boards that Cancer Services performance remained a concern. The 62-day standard was 64.4%, and the Faster Diagnostic Standard (FDS) was 66.8%, placing GEH in the lower national rankings. Early signs of improvement were noted in July 2025, with targeted actions in Lower Gastrointestinal (GI) and Gynaecology underway. The Managing Director for GEH concluded that recent interventions were yielding positive results, and the focus moving forward would be to continue improving FDS and sustaining ED performance.

MINUTE **ACTION**

WAHT

The Acting Chief Executive for WAHT/WVT focused on key headlines for WAHT, with UEC having seen slower improvements in the Emergency Access Standard (EAS) than anticipated. However, progress was evident, particularly in the improvement of surrounding metrics. Notably, there was a clear reduction in twelve-hour waits within ED, and this reduction was expected to contribute positively to EAS performance. The Acting Chief Executive for WAHT/WVT explained that WAHT had been placed in tier one and received targeted support in collaboration with community partners. Encouragingly, clinical integration between community hospitals and acute services had begun to generate benefits. One area of success was the Stroke pathway, where clinicians had started outreach into community hospitals. This initiative led to notable reductions in length of stay (LoS). He explained that to support improvements, the Trust had undertaken internal reconfigurations, with Trauma services relocated to a larger bed base, and a similar adjustment was being made for Stroke services. Early feedback from divisions indicated that these changes were having a positive impact and were positioning WAHT well, not only for continued improvement but also in preparation for the upcoming winter period.

The Acting Chief Executive for WAHT/WVT continued that in terms of Cancer performance, Skin Cancer and Breast Cancer were driving WAHT's metrics. Positively, the Trust had recently launched a new Teledermatology service, and the Breast Cancer service had successfully recruited additional staff, increasing capacity. The Trust had a trajectory in place with expected recovery in these areas by September 2025. Elective care also continued to present challenges, particularly with patients waiting over 65-weeks, and while options were being explored, focus remained strong. However, encouraging signs of productivity were emerging across divisions, particularly in Orthopaedics.

The Acting Chief Executive for WAHT/WVT concluded that UEC, Cancer Services and Elective Care were central to many of the other metrics under discussion. For instance, improvements in UEC and patient flow were closely linked to enhancements in the quality metrics. As occupancy declined, the Trust had observed corresponding reductions in falls and other indicators, which also positively influenced the financial position. He explained that as WAHT prepared for the final six months of 2025/26 they remained vigilant. For completeness, WAHT was currently tier two for Cancer Services and anticipated a downgrade from tier one to tier two in UEC.

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

The Group Chief Executive reflected on the tiering at WAHT noting that the Acting Chief Operating Officer for WAHT had planned to meet with two colleagues elsewhere in the Foundation Group to facilitate shared learning. He continued that based on his experience, the tiering process can be time-consuming and best avoided where possible. However, it was acknowledged that the focus on UEC performance, especially ambulance handover delays,

MINUTE **ACTION**

had led to marked improvements. He noted that performance at the Alexandra Hospital site had been consistently strong. In contrast challenges remained at the Worcestershire Royal Hospital site, which continued to experience higher levels of UEC demand and required further resolution.

The Group Chair sought assurance on how the Community Beds project at WAHT was progressing. The Acting Chief Executive for WAHT/WVT explained that the tiering process experience had been helpful in progressing efforts and accelerating progress. He credited the newly appointed Chief Executive of the Community Mental Health Trust, for placing significant emphasis on the initiative, which had begun to produce tangible benefits. One such area of improvement was the Pathway Discharge Unit. Although previously perceived as a potential source of delay, occupancy levels had started to reduce more frequently and consistently.

SWFT

The Acting Chief Executive for GEH/SWFT provided SWFT's performance update, focusing on his greatest concern first which was Cancer services. He explained that SWFT had fallen behind its planned trajectory and, as a result, had been placed under tier 2 regional scrutiny. Three primary issues contributed to the challenges in Cancer performance. The first was access to Oncology Services from the Trust's tertiary provider, University Hospitals Coventry and Warwickshire NHS Trust (UHCW). This presented a significant obstacle to meeting the 62-day target. Without timely access to Oncologists, achieving this standard was not feasible. The Acting Chief Executive for GEH/SWFT explained that SWFT had been working closely with UHCW to address this issue and collaborative efforts led by the Chief Operating Officer, Chief Medical Officer and Chief Nursing Officer had been underway to streamline pathways and secure the necessary resources. Additionally, mutual aid options were explored with other partners, including WAHT, to help mitigate these challenges. The Acting Chief Executive for GEH/SWFT explained that the second issue was a substantial increase in referrals in certain specialties, for example Head and Neck referrals rose from approximately 160 in June 2024 to 196 in June 2025, a 25% increase. This surge had a notable impact, particularly on the FDS, and work had been done with clinical teams to ensure adequate capacity. The third challenge was specific to the Dermatology service, which remained one of SWFT's highest referral specialties. Staff sickness had reduced available capacity and to address this, insourcing arrangements had been implemented to help stabilise the service.

The Acting Chief Executive for SWFT/GEH then updated on RTT, the positive news was that SWFT had no patients waiting over 65-weeks. A longstanding issue in Orthodontics, which was part of a national challenge due to limited consultant availability, had been resolved thanks to support from regional partners. This represented a significant achievement, and the Acting Chief Executive for GEH/SWFT commended the teams involved for their efforts. Across the board, SWFT continued to manage long waits effectively. However, RTT performance was slightly off plan, primarily due to the challenges in

MINUTE		ACTION
	Dermatology. He assured the Foundation Group Boards that he was confident that the insourcing measures introduced would help bring performance back on track, but it was being monitored closely. Finally, the Acting Chief Executive for GEH/SWFT highlighted ED performance, which had been particularly strong. Despite experiencing some of the Trust's busiest months in terms of attendances, SWFT remained ahead of their planned trajectory for the four-hour standard. This success was attributable to the dedicated work of emergency teams in refining ED processes and ensuring that the wider hospital supported patient flow effectively. Performance had not only been sustained but had improved further in July 2025, despite continued high referral volumes. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chief Executive noted that while the four-hour standard remained the primary UEC metric, it only represented around 60% of current urgent care activity. Patients were increasingly receiving rapid care through alternative pathways such as ambulance treat-and-leave, call-before-convey services, and SDEC. He reassured members of the public that these models were delivering timely care, even if not reflected in traditional metrics. The Acting Chief Executive for WAHT/WVT picked up on previous discussions around Cancer Services and reported that he and the Group Medical Advisor were planning to reconvene Cancer Leads across Trusts in September 2025 to develop a coordinated improvement plan for Cancer Services. The aim was to accelerate progress through shared learning, particularly given the common tertiary provider. **Resolved – that the Foundation Group Performance Report be received and noted.**	
25.049	**URGENT AND EMERGENCY CARE (UEC) AND WINTER PLAN PLANNING, PREPAREDNESS AND ASSURANCE STOCKTAKE 2025/26** The Chief Operating Officer for WVT presented the Winter Planning update. The presentation outlined shared learning and strategic alignment across the Foundation Group, referencing the UEC 2025/26 plan circulated in June 2025. Key priorities included improving ambulance handovers, achieving 78% EAS compliance, reducing twelve-hour ED waits, addressing prolonged LoS, enhancing Children and Young People (CYP) performance, and strengthening discharge planning through the Better Care Fund. Each Trust had aligned its winter plans with UEC recovery strategies, supported by data modelling on attendances, bed capacity, escalation protocols, and workforce. Assurance meetings were held at Trust level, with real-time dashboards and OPEL systems informing operational decisions. Teams focused on ED front-door navigation, virtual ward optimisation, and SDEC capacity reviews. Shared	

MINUTE		ACTION

learning was drawn from models across GEH, SWFT, WVT, and WAHT, with capital investment supporting ambulatory and SDEC expansion.

The Chief Operating Officer for WVT continued that workforce planning had also taken place, addressing staffing models, sickness management, and wellbeing initiatives. Lessons from WAHT's tier one support were being adopted across sites, and surge and super-surge plans aimed to reduce reliance on escalation beds and corridor care. These would be supported by initiatives such as "Home First", discharge events, and ward-based dashboards. The Chief Operating Officer for WVT explained that Trusts had enhanced seven-day working, protected elective capacity, and deployed digital tools including Electronic Prescribing and Medicines Administration (EPMA) and ward whiteboards. System-wide collaboration focused on virtual ward criteria, admission avoidance schemes, therapy support, and improved visibility of community and social care capacity. Efforts continued to expand urgent community response and refine paramedic decision-making through the "call before convey" model.

The Chief Nursing Officer for GEH provided an update on the preparatory work undertaken across the Foundation Group in anticipation of winter pressures. A key focus had been the winter vaccination programme, following low uptake in the previous year. In response, all organisations committed to achieving at least a 5% improvement in vaccination rates. The programme was scheduled to run from October 2025 to March 2026, with efforts made to maximise staff accessibility through varied delivery methods and targeted myth-busting initiatives. The Chief Nursing Officer for GEH continued that collaboration with Public Health and the UK Health Security Agency (UKHSA) had continued, aiming to strengthen local messaging by leveraging national communications. She added that preparations also addressed the anticipated rise in respiratory infections. Protocols were revised in line with global trends and communication across teams was reinforced, with reminders on hand hygiene, personal protective equipment (PPE) usage, and stock readiness. The Chief Nursing Officer for GEH noted that concerns remained regarding side room capacity for isolation, with rapid testing and turnaround times identified as critical. Particular attention was given to the potential impact of Respiratory Syncytial Virus (RSV) in children, especially if coinciding with adult respiratory illness which could increase pressure on EDs.

The Chief People Officer for WAHT provided an overview of the workforce resilience planning undertaken across the Foundation Group in preparation for winter. It was noted that managing both the pressures placed on staff and the need for additional staffing would be critical components of the overall winter preparedness strategy. This had been addressed through several key approaches. Firstly, effective roster management had been prioritised, secondly, the management of sickness absence and staff wellbeing had remained a central focus and lastly, governance around operational decision-making had been strengthened. It was acknowledged that maintaining staff wellbeing and morale would be particularly important during the winter months,

MINUTE		ACTION
	especially in the context of potential industrial action. This remained a key area of focus and risk for all Trusts within the Foundation Group. The Chief Operating Officer for SWFT acknowledged the extensive planning underway across the Foundation Group and emphasised the importance of managing demand within agreed budgets. She noted that this remained one of the most challenging aspects for all four Trusts, particularly counting existing workforce pressures. While workforce modelling had already been discussed, she highlighted the need for stress testing and confirmed that the Foundation Group was considering conducting its own internal stress testing exercises, in addition to those planned by NHS England (NHSE). She concluded that the Foundation Group's collaborative environment could allow for more detailed and tailored testing. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chair sought assurance on the Partnership Trust's role in supporting patient flow ahead of winter. The Acting Chief Operating Officer for WAHT reported improved collaboration with the Health and Care Trust, evidenced by a reduction in patients with no criteria to reside and increased bed availability in the Pathway Discharge Unit at WAHT. He noted that internal preparations for a system-wide discharge programme, set to launch in early September 2025, were already delivering benefits. While current data on community hospital LoS was unavailable, he expressed confidence in ongoing progress. The Group Chief Executive acknowledged the Group Chair's concerns and noted that the issue appeared to be one of patient choice rather than access, which was particularly concerning. He expressed confidence in the collaboration across Clinical Operational Units and the strength of the plans presented. He emphasised the importance of electronic bed management systems, noting that the transparency of real-time bed availability was a critical factor in improving patient flow. The Group Chief Executive referred to the final slide of the presentation, which indicated a shortfall of 188 beds. Whilst this was a significant figure, he pointed out that the average LoS data across the Foundation Group revealed a 45% variation between the highest and lowest performing sites, suggesting substantial opportunity for improvement in flow. He continued that he was surprised internal professional standards had not been explicitly included in the flow section of the presentation and sought confirmation on whether the agreed clinical process timelines were being refreshed ahead of the winter period. The Chief Operating Officer for WVT confirmed that work had started to refresh these ahead of winter. The Group Chair requested further work be done on flow ahead of winter. Emphasising the importance of having a consistent and reliable measure of flow across the Foundation Group to operational planning and oversight.	**COOs**

MINUTE		ACTION
	Simon Murphy, NED and Vice Chair for WAHT queried about the consistency of consultant-led ward rounds across the Foundation Group. Specifically, whether patients requiring urgent attention were being prioritised and discharge planning addressed early. The Chief Nursing Officer for SWFT confirmed that their Board Round Standard Operating Procedure (SOP) was being refreshed to reflect this prioritisation and offered to share it with others. The Chief Medical Officer for SWFT added that internal professional standards would reinforce this approach, including expectations for weekend rounds and criteria-led discharge. The Chief Medical Officer for WAHT confirmed that similar work was underway at WAHT with plans to share their model once implemented. The Acting Chief Executive for WAHT/WVT raised concerns about the recurring narrative around winter pressures and staff wellbeing. He noted that while the overall bed gap across the Foundation Group was significant, individual site shortfalls could appear less severe, potentially leading to complacency. He advocated for a shift in mindset from reactive to proactive, framing winter demand as predictable and controllable. Robert White, NED for SWFT, questioned the effectiveness of alternative healthcare provisions such as NHS 111 and primary care pathways. The Chief Operating Officer for SWFT confirmed that active engagement with system partners and ongoing stress testing with NHSE was taking place. She did however highlight the need for improved Mental Health planning, as well as the impact of ambulance services, and the effectiveness of extended GP hours. She emphasised that weaknesses in community services would directly affect acute care, making this a continued area of focus. **Resolved – that** **(A) the Chief Operating Officers develop a consistent measure of flow across the Foundation Group ahead of winter to aid with operational planning and oversight, and** **(B) the UEC and Winter Plan Planning, Preparedness and Assurance Stocktake for 2025/26 be received and noted.**	**COOs**
25.050	**EQUALITY UPDATE REPORT** The Chief People Officer for WAHT presented this report which provided a summary of key developments in equality, diversity, and inclusion (EDI). She noted that each Trust had published individual equality reports on their respective websites for further detail. The Chief People Officer for WAHT emphasised that the summary reflected areas of collective progress over the past year, as well as initiatives the Foundation Group was particularly proud of. She acknowledged the strength and growth of staff networks across the Foundation Group. While the structure and naming of these networks varied between Trusts, they consistently served as safe and inclusive spaces for staff to engage in dialogue and action around protected characteristics. She explained that allies were actively encouraged and engagement within these networks had continued to grow, which was evident by annual staff survey data.	

MINUTE		ACTION
	The Chief People Officer for WAHT added that survey data informed statutory race and disability reporting and enabled targeted, localised action planning. Each Trust had reported on its use of staff survey insights to drive improvements with a focus on year-on-year progress. Inclusive recruitment remained a shared priority across the Foundation Group and whilst approaches differed, all Trusts were working to widen access to ensure fair recruitment processes and promote employment opportunities within the communities they served. The Chief People Officer for WAHT concluded that training and development were identified as key tools in addressing inequality and promoting anti-hate messaging. The presentation included examples such as active bystander training and neurodiversity awareness programmes, noting that all Trusts were now working proactively in the neurodiversity space. This involved implementing toolkits, resources, and training to support colleagues. With approximately one in seven people in the UK identifying as neurodiverse, awareness and support were steadily increasing across the Foundation Group. The HR Director for SWFT provided a summary of national staff survey outcomes, noting that results across all thematic areas had remained broadly static. However, she highlighted that in contrast to the national trend, where engagement scores had declined for acute trusts, all four Trusts within the Foundation Group had demonstrated improvement in their engagement scores. This was recognised as a significant achievement with each Trust positioned within the "strong and improving" category on comparative charts circulated at the time of the survey's release. The HR Director for SWFT emphasised the importance of the engagement score as a key indicator within the wider EDI agenda, reflecting the extent to which staff felt engaged and listened to across the Foundation Group. The Chief People Officer for WVT concluded by highlighting that promoting EDI, as well as addressing health and workforce inequalities, had been formally embedded into the performance appraisal framework for all Board members. This had become a key requirement within the appraisal process, reinforcing the strategic importance of EDI at the highest levels of leadership. He confirmed that across the Foundation Group, there was a strong and collective commitment to fostering an inclusive and compassionate culture. Senior managers were actively encouraged to sign up to the NHS Inclusive Leadership Pledge, enabling them to lead with kindness and compassion in their day-to-day operations. He noted that the overarching aim of this work was to create the right culture, the right working environment and the right experience for every individual across the Foundation Group. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chair reinforced the importance of developing a culture rooted in kindness and compassion. He acknowledged comments shared in the meeting	

MINUTE		ACTION
	chat regarding unacceptable societal discourse and emphasised that such behaviour had no place within the Foundation Group. The Group Chair explained that kindness and compassion were essential leadership qualities, applicable to all staff regardless of role, and that every individual within the four Trusts served as an ambassador for the organisation. He reiterated the principle that "civility saves lives," underscoring the responsibility of healthcare professionals to model commendable behaviour, irrespective of external societal challenges. The Group Chair took the opportunity to commend Simon Murphy, NED and Vice Chair for WAHT, and Oli Hiscoe, ANED for SWFT, for their outstanding contributions to staff networks and volunteer support. The Managing Director for GEH acknowledged the breadth of initiatives underway and suggested that future EDI reports be further enhanced by including impact and comparative data, such as likelihood of being shortlisted, staff experience, and progression metrics. She noted that given the range of approaches being implemented across the Trusts, there were likely to be areas of high effectiveness as well as those requiring further development which would provide valuable insight and help identify best practice.	**CPOs**
	Resolved – that **(A) the Chief People Officers include impact and comparative data in future EDI Annual Reports, and** **(B) the Equality Update Report be received and noted.**	**CPOs**
25.051	**NHS OVERSIGHT FRAMEWORK (NOF)** The Group Chief Executive presented this report which provided an overview of the revised NOF. He explained that the updated framework, shaped by a national consultation, introduced a streamlined, rules-based approach that replaced previous judgement-based segmentation. Performance improvements now triggered automatic upward movement through segments, with implications for freedoms, incentives, and intervention regimes. Q1 results were provisionally available with full data expected later in August 2025. The Group Chief Executive clarified that the framework ranked organisations comparatively, meaning a Trust's position could decline even if its performance remained stable if other trusts improved. Organisations in the lowest quartile were subject to capability assessments and potential placement in segment five under the Provider Improvement Programme. The framework focused on three core elements: operational performance (including Cancer, RTT, and Accident and Emergency (A&E)), finance and productivity, and quality. Acute providers with A&E departments faced more indicators than specialist trusts. Strong performance could unlock access to the Foundation Trust pipeline and integrated care opportunities, while a financial override prevented Trusts in deficit from scoring above segment three. The Group Chief Executive continued that efforts were underway to reset block contracts, particularly in urgent care, to ensure activity was appropriately funded. He also noted the importance of aligning board-approved plans moving forward with delivery	

MINUTE		ACTION

profiles across the year, as performance against these plans would be assessed under the new framework. The Group Chief Executive acknowledged the need for future indicators to reflect strategic goals such as prevention and tackling inequalities, though data maturity remained limited.

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

The Managing Director for GEH sought clarification on the timing of the proposed activity reset and potential changes to the payment-by-results model, and whether they were expected to take effect within the current or next financial year. The Group Chief Executive confirmed that data capture had begun and that changes were expected within the current financial year, influencing future financial planning.

Frances Martin, NED and Vice Chair for WVT, welcomed the simplification of the framework but cautioned that measurable indicators did not always reflect areas of greatest impact. She advocated for continued focus on upstream solutions. The Group Chief Executive agreed and noted the challenge of balancing individual accountability with system-wide collaboration.

The Acting Chief Executive for WAHT/WVT supported the revised NOF and sought clarification around the need for more responsive and timely transitions between performance segments, noting that entry into a segment could be swift while exit had historically been slow. Also he commented on the framework's planning approach, which assessed delivery against agreed plans, and acknowledged this as a sound principle but noted that the current year was transitional, with past planning often misaligned with operational realities. He anticipated some short-term challenges but believed the framework would ultimately improve clarity and outcomes. The Group Chief Executive agreed and emphasised the importance of integrating segmentation into the broader outcomes framework. He reiterated the need for clear, rules-based criteria for national interventions and stressed that performance oversight should be aligned with meaningful improvement and support.

The Managing Director for WVT raised concerns about the financial override in the revised NOF. She noted that, unlike other domains where performance was assessed based on delivery against plan, the financial domain imposed a fixed cap, preventing organisations in deficit from progressing beyond segment three, even if they were meeting agreed recovery plans. She felt that this approach could be discouraging for Trusts with multi-year plans to return to financial balance and advocated for a model that recognised progress over time. The Group Chief Executive confirmed that while being on plan contributed positively to scoring, the financial override remained in place. He acknowledged that this affected three organisations within the Foundation Group and referenced national leadership's stance that Trusts reliant on deficit support could not be rated as high performing. He emphasised the need for a fair

MINUTE		ACTION
	funding allocation methodology, which was still in development, and noted that WVT would have qualified for segment two if not for the override. **Resolved – that the NOF report received and noted.**	
25.052	**FOUNDATION GROUP STRATEGY COMMITTEE (FGSC) REPORT FROM THE MEETING HELD ON 17 JUNE 2025 (INCLUDING FGSC ANNUAL REPORT AND SELF-ASSESSMENT OF EFFECTIVENESS)** This report was taken as read with no comments received. **Resolved – that the FGSC Report from the meeting held on 17 June 2025, including the FGSC Annual Report and Self-Assessment of Effectiveness, be received and noted.**	
25.053	**ANY OTHER BUSINESS** No further business was discussed. **Resolved – that the position be noted.**	
25.054	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
25.054.01	Jeremy Shearman – SWFT Staff Governor (Medical and Dental) The following question was asked by Jeremy Shearman, SWFT Staff Governor (Medical and Dental): *"We have heard a lot about organisations continuing to do what they have always been doing and trying to do it better. But what I have not heard much about is clinical research and innovation. Is there a separate forum in which the Foundation Group talk about an aligned strategy for adopting clinical research and innovate practice?"* The Group Chair noted that he and the Acting Chief Executive for GEH/SWFT had recently met with Warwick Medical School (WMS) to discuss research collaboration. The Managing Director for GEH confirmed that efforts were underway to strengthen group-wide research activity. A Group Research Lead had been appointed, and plans were in place to convene research leads and Chief Medical Officers from across the organisations after the summer to explore opportunities for joint research and income generation. The Group Chair expressed his aspiration for all parts of the Foundation Group to achieve University Trust status, highlighting the strong educational partnership between GEH and Coventry University as an example of potential. The Acting Chief Executive for GEH/SWFT added that discussions with Warwick Business School (WBS) had also identified promising opportunities for collaboration in research and leadership development.	

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 6 August 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	Resolved – that the position be noted.	
25.055	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.056	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.057	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 7 MAY 2025**	
25.058	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.059	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 18 MARCH 2025**	
25.060	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.061	**JOINT ELECTRONIC PATIENT RECORDS PROGRAMME UPDATE – SWFT / GEH ONLY**	
25.062	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams.	

Signed _____ (Group Chair) Date: 5 November 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	DUE DATE	LEAD	COMMENT
ACTIONS COMPLETE				
ACTIONS IN PROGRESS				
25.049 (06.08.2025) Urgent and Emergency Care and Winter Plan Planning Preparedness and Assurance Stocktake 2025/26	The Chief Operating Officers look into a consistent measure of flow across the Foundation Group ahead of winter to aid with operational planning and oversight.		A Parker / H Heran / C Douglas / R Snead	
25.050 (06.08.2025) Equality Update Report	The Chief People Officers include impact data in the annual EDI report moving forward.		A Williams / A Keoltan / G Etule	
REPORTS SCHEDULED FOR FUTURE MEETINGS				
25.028 (07.05.2025) Outpatients Deep Dive	Clinical leadership and engagement for Patient Initiated Follow Up (PIFU) be agreed to help drive delivery.	5 November 2025	C Agwu / N Rashid / V Baskar / J Walton	Update as of 30 July 2025 – Chief Medical Officers requested that an update against this action be deferred to November 2025 meeting to allow further discussions to take place.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	**Quality Committee 6 June 2025 Minutes and Escalation Report**
Lead Executive Director:	**Chief Nursing Officer**
Author:	**Ian James, Non-Executive Director and Chair**
Reporting Route:	**Direct to Board**
Appendices included with this report:	**Minutes of Quality Committee, May 2025**
Purpose of report:	**☒ Assurance ☐ Approval ☐ Information**

Brief Description of Report Purpose

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

Recommended Actions required by Board or Committee

To consider the summary report and minutes and to raise issues and questions as appropriate.

Executive Director Opinion[1]

N/A

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

Matters for Noting

1. **Quality Priority – Improve Timeliness of High-Risk Critical Medications** – The focus on Parkinson's' medication resulted in improvements in timely administration in 2024/25. A review of options for focus in 25/26 had included consideration of a number of areas and the recommendation was to support a programme to support patient self-administration of medication. Quality Committee was very supportive of this as a key measure to improve timely administration of medication
2. **Patient Flow Report** – Boarding continues to be our greatest area of challenge for quality and safety of patients and Committee discussed the increase in incidents and complaints. Committee heard that the whole range of issues impacting patient flow are currently subject of a series of workshops aimed at identifying changes to improve flow that will be subject to testing in June..
3. **Quality Priority – Patient Experience** – Committee was updated on 2 areas: Family and Friends data collection is currently paused pending development of a new system; implementation of PHSO guidance for complaints and concerns is underway. Complaints from Powys had increased from T&O patients relating to longer waits. These relate to planned changes requested by Powys Health Board and it is important patients understand these are not decisions of the Trust.
4. **Divisional Report – Medicine** – Committee received a summary detailing a range of quality and safety indicators for the Division. Of note:
   Use of AI is having a significant impact on time taken to type up notes and letters and improving timeliness of communications.
   Increased staffing on Redbrook Ward has improved staff morale and reduced complaints and incidents.
   Good performance on mandatory training and on cleanliness audits
   ED over-crowding remains the greatest Divisional risk.
5. **Perinatal Safety Report** – Committee was informed of 2 red-flag incidents which were subject of investigation and a QI initiative. A previously reported MNSI cases was updated. This had been graded as B, but there had been considerable discussion about whether the grading should be B or C and, due to the complexities, a further review was to be undertaken. Further to the escalation of issues around neo-natal staffing, Committee was informed that 2 qualified speciality nurses are now available nights and weekends.

   Committee received a presentation on Robson Group classifications showing trends in C-section rates for the Trust and compared to national trends. This demonstrated that WVT rates are in line with national averages. It was agreed to receive an annual update of the Robson Group presentation

6. **Infection Prevention quarterly Report** – Committee focussed in particular on CDI mortality rates where the Trust is an outlier. Infection Prevention and Mortality Teams are working together to audit CDI related deaths to understand underlying issues and areas for improvement.

Matters for Escalation - None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 6th June 2025 at 10.00-12.30
MS TEAMS

Present:		
Ian James	IJ	Non-Executive Director (Chair)
Lucy Flanagan	LF	Chief Nursing Officer
Rachael Hebbert	RH	Associate Director of Nursing
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director Quality Governance
Emma Smith	ES	Deputy Chief Nursing Officer
Nicola Twigg	NT	Non-Executive Director
In Attendance:		
Jo Clutterbuck	JC	Dietician (on behalf of Medical Division for item 8)
Leah Hughes	LH	Operational Lead Radiographer
Hamza Katali	HK	Associate Chief Medical Officer (for items 9 & 10)
Anne Miles	AM	Infection Control Nurse (for item 12)
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Hayley Pearson	HP	Clinical Director Pharmacy
Amie Symes	AS	Associate Director Midwifery (for items 9 & 10)
Rachel White	RW	Integrated Care Board (ICB) Representative
Raechel Wordsworth	RWo	Medicine Safety Officer (for item 4)
Apologies:		
Chizo Agwu	CA	Chief Medical Officer
Eleanor Bulmer	EB	Associate Non-Executive Director
Grace Quantock	GQ	Non-Executive Director
Jo Rouse	JR	Associate Non-Executive Director
Dan Harding	DH	Associate Chief Operating Officer, Medical Division
Emma Wales	EW	Associate Chief Medical Officer, Medical Division

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**IJ**	**Information**	**Verbal**
Noted as above				
2	**Declarations of interest**	**IJ**	**Information**	**Verbal**
There were no new declarations.				
3.	**Minutes of meeting 24th April 2025**	**IJ**	**Approval**	**Enclosure 3**
Approved.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**

The actions were updated:

April 2025. Item 6 – Quality Priority Food Quality Nutrition.
The naso-gastric policy from 2023-24 not fully signed off and a plan for final sign off is in progress and is currently with the DCMO - A policy is in place and we are able to supply NG feeding. The part of the policy to allow clinicians to safely sign off use requires further work. Practical training in place to achieve guidance for National Patient Safety alert is taking time to embed. Will pick up through Nutritional Steering Group. **CLOSED**

April 2025. Item 7 – Staffing Report
Clarification required on what is measured for percentage of agency and bank usage, whether is as percentage of pay bill or percentage of temporary workers being used vs substantive - Has been calculated as percentage of nursing pay bill. To bring in line with benchmarkable data, future reports will include as percentage of overall pay bill – which is the National measure. **CLOSED**

April 2025. Item 10 – Safeguarding Quarterly Report
ED doctors and not always offering a patient HIDVA referral when domestic abuse is disclosed. Clarification is needed on how disclosure has been picked up if referral has not been offered - There have been two cases whereby domestic abuse has been disclosed in ED but no referral to HIDVA was made. In these cases, referrals were made to Adult Safeguarding incorrectly instead of HIDVA. These cases were, therefore, picked up but this has highlighted the need for further training of ED staff in domestic abuse to ensure prompt and correct referrals. A change of screening questions in Symphony is also being implemented to prompt consideration of domestic abuse and onward referral to HIDVA. The team were also made aware of a domestic abuse case which was not referred to HIDVA or Adult Safeguarding where primary care informed us. **CLOSED**

No further matters arising.

4.	**BUSINESS SECTION**			
4.1	**Implement Quality Improvement project to target high-risk time critical medication as locally defined**	**RWo**	**Information**	**Enc 4**

Raechel Wordsworth gave an update on the progress of this quality improvement project:

The quality priority for 2024/25 was understanding missed critical medications, looking particularly at Parkinsons data. Successful improvements were demonstrated and data continues to be positive. Two further critical medications were reviewed to identify any themes of if further improvements were required regarding missed doses.

- Long acting insulin data showed a very small number of missed doses.
- Epilepsy medication data showed that again some doses were missed but never omitted completely.

Lack of self-administration was highlighted when collating Parkinsons data and therefore, the plan for the 2025/26 project is to explore the use and process of self-administration in order to ease pressures at ward level and ensure patients are empowered to self-administer.

Next steps:

- Look into what the policy is at Trust level and update in line with the Foundation Group.
- Ensure EPMA functions are usable and updated and roll out the policy trust wide
- Ensure staff are trained and engaged and obtain staff feedback
- Review and streamline the process at regular intervals and collect data

The Committee were very supportive of the approach and the focus of self-administration, particularly the importance of empowering patients.

5.	**Mortality Report**	**CA**	**Information**	**Enc 5**
The mortality report was taken as read				
6.	**Patient Flow Report**	**NO**	**Information**	**Enc 6**

Natasha Owen presented the patient flow report, highlighting the key points:

No new trends were seen in flow data, however there was a lag in some areas and work is underway to update these and a fuller report will be provided next month.

There are some new themes and trends emerging from incidents and complaints and there has been an increase in the number of complaints related to boarding; access to facilities due to where beds are placed, high acuity patients in boarding spaces with no call bells and lack of space.

There are a series of Urgent and Emergency Care workshops taking place with front line colleagues which have had very good engagement. The next workshop will focus on a specific 10 things to undergo test and change over the coming month in order to address some of the issues experienced with patient flow in both medical and surgical settings.

7.	**Staffing Report**	**ES**	**Information**	**Enc 7**

Emma Smith highlighted the key points from the monthly staffing report:

During both April and May internal and external corridors have been utilized in ED, escalation areas have remained open and extreme boarding in ward areas has continued as well as Community Hospitals.

There was a decrease in fill rates by 3%. This is partly due to the re-alignment of budgets and workbooks.

There were four staffing incidents in month, one in relation to skill mix

HCA vacancy rate has increased to 15%. This is also due to the budget re-alignment process. A centralised recruitment process and effective induction programme is in place for HCAs and new staff are commencing monthly.

The Trust continues to be part of the regional collaborative and have achieved capped rates for all general shifts. Agency use will also be stopping in Theatres and ITU, District Nursing Service and MRU nurses, with specialist nurses only being utilised within ED. The majority of those are at capped rates from June. Band 2 agency use will hard stop from end June.

Agency use has decreased in month and has seen a significant decrease in May.

There have been very few incidents or patient outcome concerns. The only area of concern remains Frailty due to high patient dependency and high number of additional boarding patients.

There has been some discussion with the Mental Health Trust to see if there is any scope to utilise their bank of Registered Mental Nurses but this has not progressed due to the Mastervend contract. Further work will be done in July to explore training programmes for Bands 2 and 3 and an advert is out to recruit RMNs to our own bank.

8.	**Divisional Quarterly Report – Medicine**	**JC**	**Information**	**Enc 8**

Jo Clutterbuck presented the Divisional Quarterly report for the Medical Directorate:

Mandatory training has improved across the Division with overall compliance 85.8% and cleanliness scores across all areas achieved 5 stars.

Heidi AI system roll out across the Division has had a significant impact on productivity reducing the typing backlog.

ED medical recruitment has been successful.

A new risk management process has been implemented to help to better manage lower level risks.

Increased staffing on Redbrook ward has had a positive impact leading to less complaints and incidents, improvements in overall staff wellbeing and morale and improvements in KPI compliance.

Incidents in ED in March were in the lower quartile. There are a number of low level incidents awaiting close off and there may be some opportunity to utilise AI to help with these. There is some functionality to come within In Phase and more work will be done to improve this.

Management of duty of candour has improved and had reduced from 30 in March to 8 in May.

ED over-crowding is an ongoing issue and carries the highest risk in the division at 20.

There had been an increase in complaints in March and April. No new themes have emerged and are predominantly around communication with patients.

An update on VTE compliance will be provided in the next report.

9.	**Perinatal Safety Report**	**AS/HK**	**Information**	**Enc 9**

Amie Symes presented the Perinatal Safety Report highlighting the key points:

Performance remains stable, there is a good birth to midwife ratio and deliveries are in line with expected numbers.

There were two red flag incidents related to delays in administration of pain relief following caesarean birth. These are both under investigation and a QI initiative in underway, led by the ward manager.

Positive data was noted on obstetric attendance for RCOG-specific emergencies, with 100% attendance and all Category 1 C-sections completed within the recommended 30 minutes.

There was one moderate safety incident related to post-partum haemorrhage. A multi-disciplinary review identified findings linked to the thematic quality improvement programme. This did not, under PSIRF meet the needs to be escalated to Patient Safety Panel.

Early indicators of PPH improvement work are showing a reduction in high volume PPH and has been consistent enough to provide assurance of that work.

There were two previously reported MNSI cases, The first case, graded as B resulted in safety recommendations and action plans formulated to address the issues identified; including improvements in care for women who choose not to engage fully in care. For the second case, also graded as B, it was recommended provision of information to patients relating to Group B Streptococcus and the rollout of a new neonatal observation monitoring tool.

There had been one complaint linked to an MNSI case around information provided to the Pathology team.

Workforce remains stable and are on track to meet both compliance and all of the year 7 CNST requirements.

LF noted that an escalation had been taken to Trust Board around neonatal staffing.

ES also confirmed that two qualified specialty nurses are now available on nights and weekends in response to region.

Hamza Katali, presented the Robson Group summary of findings:

Some key changes had been made in practice following the term breech trial, Ockenden review and NICE guidance.

The objective of the project was to look at Lower Segment Caesarean Section across last 5 years to examine in depth the rates according to Robson group classification.

The Robson group classification criteria, categorize C-sections into ten categories based on 5 basic obstetric characteristics – parity, number of foetuses, previous C-section, onset of labour, gestational age and foetal presentation.

Over the past five years, C-section rates at the Trust have remained relatively stable and are in line with national averages. The main category, category 5, women who have undergone previous C-Section, has remained static.

Having a multidisciplinary approach to supporting women, involving obstetricians, midwives, and other healthcare professionals, updated C-section guidelines as well as centralised CTG monitoring and computerised CTG with regular CTG reviews, has ensured consistent and well-informed care with better outcomes for all.

The Committee felt assured from the presentation, particularly to note that the Trust numbers were in line with UK average and it was agreed that Robson report to be presented to Quality Committee annually

ACTION – Robson report to be added to the Quality Committee annual planner to present annually.

10.	**CQC Inspection Maternity Update and Closure Report**	**AS**	**Information**	**Enc 10**

This item was presented as a formal closure of the CQC inspection action plan. The inspection had previously identified areas for improvement, and the Trust had been working through those actions.

The report was taken as read and the committee agreed that the item be formally closed and return to business as usual.

This item also marked the final Quality Committee meeting for Amie Symes, who was thanked by both LF and the Chair for her leadership over the past three years.

11.	**Patient Experience Quarterly Report and Quality Priority update**	**NO**	**Information**	**Enc 11**

Natasha Owen gave the key highlights from the Patient Experience Quarterly Report:

There are two main projects to continue to improve responsiveness to patient experience.

- Family and Friends Test data collection is paused while a new system is developed, including a webpage where patients can leave feedback without being prompted by a text, which will give the service greater reach.
- The implementation of the PHSO model guidance for complaints and concerns is underway, with the goal of improving how concerns are managed and resolved. This includes everyday conversations and support for staff in handling complaints.

The response rate is stable and in line with national average. There had been an increase in the number of new complaints and the number of comebacks had increased significantly. Of note, feedback on staff attitude had increased and initiatives will be looked at to improve on this.

It was observed that a spike in complaints has been seen at the same time each year and a deep dive would take place to look into the reasons for this.

Several patients from Powys had contacted the Trust recently regarding T&O appointments and longer waits due to the new commissioning arrangements effective from 1st July. These concerns will be shared with Powys and will be asking them to share the response.

12.	Infection Prevention Quarterly Report	AM	Information	Enc 12

Anne Miles gave the highlights from the Infection Prevention Quarterly Report.

E. coli rates are under the 2024/25 threshold, indicating that effective prevention measures are in place. Other infections are above the threshold, requiring further investigation and action. The threshold for 2025/26 has not yet been set.

The CPE outbreak at Ross Community Hospital has now been stepped down to practice as usual. The IPC continue to support and perform audits and visits with other colleagues.

PLACE 2024 scores in privacy dignity and wellbeing, dementia and disability were below the national average.

The HPV cleaning system is now operational and contributing to improved infection control and there had also been a positive outcome from a recent inspection and a high level of compliance with the Infection Prevention Control Board Assurance Framework.

It was noted that mortality rates are shown to be significantly higher than National average and it is thought that this is due to small numbers but will be looked at in more detail. Help has been sought from the Infection Prevention and Mortality teams and agreed a high level audit is required of all C. difficile-related deaths to identify patterns and areas for improvement. In addition closing the loop between Medical Examiner reviews and the Infection Prevention Team to ensure comprehensive analysis of relevant cases.

13.	Trust Infection Prevention Committee summary report	LF	Information	Enc 13

The Trust Infection Prevention Committee Summary report was taken as read.

14.	Infection Prevention Committee Terms of Reference and Forward Planner	LF	Approval	Enc 14a, b, c

Infection Prevention Committee Terms of Reference and forward planner were submitted for annual review and approval.

The Terms of Reference have been updated, adding in oversight of the flu and Covid vaccination programme with a monthly update on the programme moving towards winter.

The Terms of Reference were agreed by the Committee.

15.	Clinical Effectiveness and Audit Committee summary report	NA	Information	Enc 15

Natasha Owen presented the Clinical Effectiveness and Audit Committee Summary report:

To note that Hamza Katali has stepped down as Chair of the Clinical Effectiveness and Audit Committee and will be succeeded by John Chapman.

There has been some concern regarding the sustainability and momentum of the NELA audit which has been managed via Finance and Performance Executive meetings. There has been good engagement from anaesthetic colleagues and also working with colleagues in frailty. The main area of challenge is inputting of data, however some provision has been made to address this in the short term.

16.	**Clinical Effectiveness and Audit Committee Terms of Reference and Forward Planner**	**NO**	**Approval**	**Enc 16a, b, c**
The Clinical Effectiveness and Audit Committee Terms of reference and forward planner were submitted for annual review and approval with the following minor changes: New Chair, John Chapman and Vice Chair Natasha Owen **The Terms of Reference were agreed by the Committee.**				
17.	**Patient Experience Committee Terms of Reference and Forward Planner**	**NO**	**Approval**	**Enc 17a, b, c**
The Patient Experience Committee Terms of Reference and Forward Planner were submitted for annual review and approval.				
18.	**Patient Experience Committee Summary Report**	**NO**	**Information**	**Enc 18**
Natasha Owen gave the key updates from the Patient Experience Committee Summary report: The Medical Examiner Service is working to strengthen pathways for feedback to ensure the feedback is responded to in a timely way and to improve how both concerns and positive feedback are shared with teams. The new interpreting service has been rolled out in all areas. There is overall good engagement with the system and are starting to realise some financial savings. However, there has been an over reliance on pre-booking of interpreters and some areas have not been fully embracing the on demand functionality. Work is ongoing to build confidence in using the on demand service with the possibility, in future to remove the pre-booked service				
19.	**CONFIDENTIAL SECTION**			
19.1	**Patient Safety Priority – Quarterly Overview Report**	**NO**	**Information**	**Enc 19**
20.	**Prevention of Future Deaths Response**	**LF**	**Information**	**Enc 20a, b, c**
21.	**Any Other Business**	**All**	**Information**	
	No further business was raised.			
22.	**Date of Next Meeting**			

Thursday 26th June 2025 – 1.00-4.00pm
MS Teams

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	**Quality Committee 26 June 2025 Minutes and Escalation Report**
Lead Executive Director:	**Chief Nursing Officer**
Author:	**Ian James, Non-Executive Director and Chair**
Reporting Route:	**Direct to Board**
Appendices included with this report:	**Minutes of Quality Committee, June 2025**
Purpose of report:	**☒ Assurance ☐ Approval ☐ Information**

Brief Description of Report Purpose

To present the minutes, to provide a summary of the Quality Committee proceedings and to escalate any matters of concern in support of Committee's purpose to provide assurance to Board that we provide safe and high quality services and in the way we would want for ourselves and our family and friends.

Recommended Actions required by Board or Committee

To consider the summary report and minutes and to raise issues and questions as appropriate.

Executive Director Opinion[1]

N/A

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

Matters for Noting

1. **Mortality Report** – SHMI rose again to 108.5 which is concerning but difficult to assess implications as comparisons with other Trusts is impossible due to some Trusts still including SDEC figures in their reporting. Notwithstanding this we do need to ensure we are coding accurately; also that we continue to review outlier groups. Committee also requested further work to assess trends both with and without SDEC numbers
2. **Quality Priority – Increasing our Volunteer Workforce** – Committee welcomed the update on efforts to increase the work of volunteers supporting the Trust. Volunteer hours are up and volunteers are working in an increasing range of services.
3. **Children and Young People National Survey** – Committee received the results from the survey of children and young people discharged from both A&E and the ward and from their carers. Overall the results were very positive, with some particularly strong scores in a number of areas including ward experience and communication with parents where Wye Valley is among the top-performing Trusts. Actions are being developed in areas where we can improve including advice and information on discharge.
4. **Quality Priority – Diabetes Safety** – The focus of this priority is to improve safety for patients with diabetes who amount to 1 in 4 of all patients and typically have longer stays, more frequent readmissions and are more prone to catching infections. Committee welcomed the initial actions to scope this work and to develop KPIs and work plans.
5. **Patient Flow Report** – Boarding continues to be our greatest area of challenge for quality and safety of patients and Committee discussed the increase in incidents and complaints. Reduction in the number of boarded patients is how this needs to be addressed and Committee welcomed the initiatives developed through a “Test of Change” programme which will go live during June.
6. **Staffing – Biannual Acuity and Dependency Audit** – Committee welcomed the report aimed at assessing the safety of our staffing levels using evidence-based tools and professional judgement. The key implications are for staffing levels at Ross and Leominster Community Hospitals, currently subject to work on business cases and in AMU and on Arrow Ward, both subject to further work to refine data.
7. **Divisional Report – Clinical Support** – Committee received a summary detailing a range of quality and safety indicators for the Division. Of note:
   Key leadership appointments in Pathology, Endoscopy and the Community Diagnostic Centre.
   Improvements in Pharmacy support to speed up discharges.
   The Audiology Service remains fragile due to staff shortages.
   Work is needed to strengthen capacity in Microbiology.
8. **Perinatal Safety Report** – Committee reviewed information on red flags, incidents and complaints and, in particular, the concerns expressed regionally about the number of speciality nurses on duty in SCBU. The trust meets national requirements and continues to talk with regional colleagues to allay any concerns.
9. **Maternity Culture Update** – Further to the ‘summit’ in March a lot of work has progressed to improve joint working in Maternity and to strengthen patient experience and responsiveness. Committee welcomed the excellent progress so far and emphasised the need for continued commitment to this work.

Matters for Escalation - None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 26th June 2025 at 10.00-12.30
MS TEAMS

Present:		
Ian James	IJ	Non-Executive Director (Chair)
Eleanor Bulmer	EB	Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director Quality Governance
Grace Quantock	GQ	Non-Executive Director
Gwenny Scott	GS	Company Secretary
Emma Smith	ES	Deputy Chief Nursing Officer
Nicola Twigg	NT	Non-Executive Director
In Attendance:		
Chris Beaumont	JC	Mortality Project Manager
Annette Arnold	AA	Matron Maternity In-Patients
Claire Carlsen	CC	Associate Chief Operating Officer Clinical Support Division
Hannah Duggan	HD	General Manager Women and Children
Helen Harris	HH	ICB Representative
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Leah Hughes	LH	Operational Lead Radiographer
Ehab Hafiz	EH	Consultant Obstetrics and Gynaecology
Christina Lange	CL	Diabetes Specialist Nurse (for Item 7)
Joytish Govindan	JG	Consultant Diabetic Retinopathy (for Item 7)
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Hayley Pearson	HP	Clinical Director Pharmacy
Sara Powell	SP	Matron Women and Children
Emma Wales	EW	Associate Chief Medical Officer Medical Division
Apologies:		
Chizo Agwu	CA	Chief Medical Officer
Tom Morgan Jones	TM-J	Deputy Chief Medical Officer
Rachael Hebbert	RH	Associate Director of Nursing
Jo Rouse	JR	Associate Non-Executive Director
Hamza Katali	HK	Consultant Obstetrics and Gynaecology

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**IJ**	**Information**	**Verbal**
Noted as above				
2	**Declarations of interest**	**IJ**	**Information**	**Verbal**
There were no new declarations.				

3.	**Minutes of meeting 6th June 2025**	**IJ**	**Approval**	**Enclosure 3**
Approved.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**
The update on quality priority transition of care will be deferred to July 2025. The actions were reviewed and updated.				
4.	**BUSINESS SECTION**			
4.1	**Mortality Report**	**CB**	**Information**	**Enc 4**

SHMI rose to 108.5 driven by a steady rise in the number of deaths and a significant drop in number of expected deaths, widening the gap. Other trusts in the group also reported SHMI increases.

50% of trusts still include Same Day Emergency Care (SDEC) data in SHMI, while Wye Valley removed it in early 2024, skewing comparisons. Many patients with Charlson scores of 0, no comorbidities, are dying, impacting SHMI. This highlighted the importance of accurate coding to ensure a true expected deaths number and It was agreed to conduct a like-for-like comparison of deaths and admissions to assess true mortality trends.

Crude mortality remains high post-winter, with a total 75 deaths in May, 12 of these were in community hospitals and a number of them were expected end of life care. To note, some of these patients were waiting long periods of time for packages of care but died before these were in place.

Fractured neck of femur remains a priority and National Hip Fracture Database had flagged the trust as an outlier. Due to operational pressures within ED it has not always been possibly to achieve timely transfer from ED to specialist wards in a timely fashion and a test of change is underway in ED to improve the pathway. Will also Finalise the communication protocol with ambulance services for early notification and monitor impact of revised mobility assessments on hip fracture data.

Stroke mortality had dropped significantly to below 100. A presentation of the latest review findings and learning was given by the Clinical Lead at the Learning from Deaths Committee in June.

There had also been small reductions in COPD and pneumonia which had remained within expected ranges.

<u>Learning from Deaths</u>

A new Coroner has been appointed for Herefordshire, causing some initial delays due to new ways of working. An initial meeting had been held and a plan on how to take forward in conjunction with the Medical Examiner Service.

There were two positive bereavement care feedbacks received for ED and Arrow Ward. This month a newsletter will be shared with medical staff to share some of the learnings from Medical Examiner structured judgement reviews and mortality review panel.

There was some concern from the committee that the trust remains an outlier for the number admissions in last 90 days of life, and this would be an area to look at in more detail. However, there is now well established mortality governance in place to review all deaths.

ACTIONS:
Conduct a like-for-like comparison of deaths and admissions, excluding SDEC, to assess true mortality trends - CB

Investigate high number of admissions in the last 90 days of life with a view to improve community-based end-of-life planning to reduce unnecessary hospital deaths - CB

5.	Quality Priority – Increase the number of opportunities to grow our volunteer workforce in numbers and reach	NO	Information	Enc 5

Despite a slight drop in volunteer numbers in May, which was expected due to the youth engagement cohort completing their 6-month cycle, total volunteer hours had increased. Three volunteers had left due to personal reasons or travel issues.

Demand for volunteers is increasing across the trust and many long-term volunteers are now contributing in multiple areas e.g., pharmacy, contact centre, patient engagement, which boosts overall hours despite fewer individuals.

National Volunteer Week activities, including a coffee morning and social media outreach, led to 16 new volunteer applications and five new volunteers were inducted recently.

The contact centre model continues. The Helpforce Programme will support a tailored project for each trust and is currently planned to be focused on DNA reduction, with potential to expand into post-discharge check-ins, surgical patient support and end-of-life outpatient profiling.

The NHS Responders service has concluded nationally. The service was positively received by the trust and the team is exploring a business case to continue the service locally.

Volunteer Training is being streamlined with support from the education team to ensure safety and efficiency.
Wye Valley is adopting Worcester's Volunteer Management system to improve processes and free up resources for recruitment and innovation. Collection of volunteer feedback will also be explored.

6.	Children and Young People National Survey	SP	Information	Enc 6

The survey was completed for young people discharged from both A&E and the ward.

There was good uptake and results showed mixed performance with several high scores and a few areas needing improvement. The overall Experience Score was 8.5/10 which was consistent across all age groups and parent feedback.

Areas of Strong Performance:

- Ward Experience (Parents/Carers): score 9.6 — among the highest scoring trusts.
- Communication with Parents (0–7 years): 8.8 high score, matching top-performing trusts.
- Being Looked After (All Ages): Consistently strong scores.
- Hospital Facilities (Older Children): 8.2 Highest scoring in the region although parent/carer scored 6.8
- Pain Management (Parent Feedback): 8.6 High score.
- Hospital Food: Average (5.6), but better than expected.
- Overall experience 8.5 (both parents and children). High score

Areas for improvement:

- Talking to Hospital staff (Children's feedback) (8–15 years): Score: 8.1 — in the lower range.

Action: Working with the play team to improve communication and distraction techniques.

- Pain Management (Children's Feedback): 8.1 - Lower than parent feedback.

Action: An audit is underway in A&E to improve timeliness and reassessment of pain relief and will be presented at the Divisional Governance meeting.

- Operations & Procedures (Children's Feedback): Score: 7.9 — average.

Action: Collaborative work planned with surgical teams.

- Discharge Information: Children and parents are unclear on follow-up and future care.

Action: Replicating ED QR code system on the ward and reviewing patient information leaflets.

- Leaving hospital advice parents – 7.5 low. Not clear on follow up processes.

Action: Parent information leaflets to be reviewed. Have QR codes

Will continue to implement the action plan and maintain areas scoring well. Also share best practice with all relevant specialties and prepare for the next survey cycle, likely to take place every 3 years.

The Committee congratulated on great results and noted the opportunity to share learning with group colleagues.

7.	**Quality Priority – Diabetes Safety**	**CL**	**Information**	**Enc 7**

The aim of this quality priority is to improve safety of in-patient care for people with diabetes.

90% of people admitted to hospital with diabetes are admitted for another reason. One in 4 in-patients have diabetes and in Herefordshire there is an added pressure of an older population likely to have diabetes. To note 26% of 65 year olds in Herefordshire have diabetes, which is significantly higher than National average.

<u>KPI plan</u>

Diabetic patients typically have longer stays and higher readmission and infection rates and it is planned to monitor and compare these metrics to national benchmarks.

Explore use of a diabetes-specific PREM (Patient Reported Experience Measure) as the Friends & Family Test is deemed too broad for diabetes-specific insights.

Education and training ensuring that at least 85% of relevant staff are trained in safe insulin use.

Four areas of clinical care for diabetes where improvements can be made.

- Foot Assessments. Ensure all diabetic patients receive one within 24 hours of admission.
- Insulin Safety. Reduce inappropriate insulin omissions in the first 24 hours and to improve timing of meal-time insulin administration.
- Hypoglycaemia management. Ensure prompt and appropriate treatment.
- Patient empowerment with an emphasis on enabling patients to manage their insulin safely while in hospital.
- Development of a perioperative diabetes passport to support patients before and during hospital stays.

<u>Data and Measurement Plans</u>

- Data sets from National audits, where available
- EPMA (Electronic Prescribing and Medicines Administration) data
- Internal audits run by nursing associates
- Exploring automation of data capture, e.g. linking foot assessments to nursing documentation systems.

It is also planned to benchmark with the Foundation Group partners in the future in the absence of national inpatient diabetes audits.

The Diabetes Safety Board will be re-established and will report to Patient Safety Committee. The first meeting is scheduled for July 2025 to finalise terms or reference, KPIs and future work plans.

A link to patient experience video will be circulated after the meeting.

8.	Patient Flow Report	NO	Information	Enc 8

There is sustained pressure in ED and an upward trend in over 60 minute ambulance handovers and ED stays over 24 hours have increased notably in March and April.

Use of discharge lounge continues to improve but use of boarding space continues to be high month on month.

There is no significant difference in the number of moves between patients with and without dementia. Whilst a slight improvement was noted in April and May for dementia, the May data gap may link to the coding backlog.

There has been an increase in both incidents and complaints, particularly in relation to patient transport delays or cancellations. Some patients having been moved to discharge lounge and then returned to boarding spaces due to transport issues.

Staff are raising patient safety issues and not feeling heard. A specific incident which occurred out of hours, involved a confused male patient placed in a boarding space with an end-of-life patient, raising concerns about dignity and privacy. A roundtable is being organised to review the use of temporary escalation spaces, prompted by this incident.

It was noted that escalation pathways are less clear out of hours and staff sometimes feel less supported during nights and weekends and although staff are encouraged to make decisions, sometimes feel overridden.

On the whole patients are very tolerant of being placed in boarding spaces but training on difficult conversations will be included in Band 6 and 7 development programmes. Emphasis on ensuring staff feel heard and supported, especially when raising concerns about patient placement or safety.

A new quality improvement Test of change project is also underway to address ED flow and boarding with more detail expected at the upcoming board workshop.

9.	Staffing Report	ES	Information	Enc 9

There is continued pressure on ED and escalation areas due to high attendances and extreme boarding levels persist, impacting on staffing levels and staff safety.

Test of change is underway and is hoped will help to improve flow through ED and in turn see a reduction in escalation and board spaces.

A new system has been implemented via Allocate to track daily staffing concerns. Only 5 red flag incidents were reported in each of the last two months.

Sickness rates are falling, especially among Healthcare Assistants, where sickness has historically been around 10%. There is a slight improvement in HCA turnover, with steady recruitment continuing.

Continue to see reduction in agency spend with an 88% decrease in HCA agency use in May. Only one WTE agency HCA was used in the last week and all agency use to cease by end June.

Continue to work with region to meet cap rates. 80% of nursing agency shifts now meet regional cap rates and work is ongoing to bring AHPs and Healthcare Scientists into compliance by Autumn. An increase in internal bank staffing will mitigate this.

There was concern regarding 150% staff levels on Garway ward. This is mainly due to high numbers of boarding patients and at risk patients. There are ongoing reviews and acuity assessments to ensure staffing levels are proportionate.

10.	Biannual acuity and dependency audit – in patient areas	ES	Information	Enc 10

The purpose of this biannual audit is to assess safe staffing levels by using evidence-based tools and professional judgment, in line with National Quality Board guidelines.

Although the monthly staffing report provides some assurance to board level. The bi-annual report gives more in-depth information.

Within ward areas a triangulated approach is used to judge staffing levels. An evidence based tool for inpatient wards, Paediatric, ED and District Nursing; the Safer Nursing Care Tool, which is used in 98% of NHS trusts, alongside professional judgements, nursing dashboards for patient outcomes, complaints, number of pressure ulcers, falls and medication incidents.

Data is collected twice yearly (winter and summer) to account for seasonal variation. The latest data is January–February 2025 but there will be no changes to establishment made until several sets of data have been collected.

The CNST audit tool was reviewed nationally last year and improvements made; it is now possible to look at how many wte are needed for an establishment and for enhanced care. The tool is not valid for some smaller areas where professional judgement is utilised.

General benchmarking shows the trust to be in the second quartile nationally for care hours per patient day and most wards are within expected staffing levels.

Also part of the review process is headroom allowance, the Carter report recommendation is 25% although most trusts are at 22-23%. WVT is at 21% although the real level runs at about 25% due to sickness levels above 3.5% and high levels of maternity leave. Although the recommendation is 25% there is a need to recognise the financial position of the trust and, given recruitment to maternity leave means that headroom allowance does not pose a specific issue for the trust at present as it is appropriately mitigated. Maternity leave averages to 4.5% and time out allowance is looked at for every ward area. Levels of study leave can also be high and will continue to be monitored.

Next steps of the overall review are to look at other clinical areas, ensuring CNS job plans are up to date, alongside demand and capacity work.

The following recommendations were made as a result of the audit:

Leominster and Ross Community hospitals are under-established but using high levels of temporary staff. Business case is in progress to increase establishment, which is expected to be cost-neutral due to reduced agency usage. A paper is in progress for submission to Trust Management Board.

AMU – there have been some issues collecting acuity and dependency data previously but a robust data collection suggests a 15 WTE uplift is needed, this did not feel appropriate when professional judgement applied and therefore an extended 60 day data collection is underway for better accuracy.

Arrow ward has high use of temporary staff despite the tool not indicating a need for uplift. Also undergoing an extended 60 day data collection.

An additional demand and capacity review has been requested for Colorectal and will be considered in business plans for next year.

Review against the workforce standards is included. The red standard is due to there being no robust process for reviewing Allied Health Professional staffing levels in the trust. There is a working group looking at AHP staffing nationally to address this.

Recommendations 11 and 12 are amber as Quality Impact Assessments are not consistently completed for all staffing changes. Improvements are needed in documentation and process.

LF noted that the evidence based tool is only part of decision making and also need to allow for professional judgement and outcome measures. The use of the tools does add value and can demonstrate safety when making investment or disinvestment decisions.

11.	**Divisional Quarterly Report – Clinical Support**	**LH**	**Information**	**Enc 11**

There had been an increase in incidents reported over the last quarter. A number related to peracitic acid alarms, patients in endoscopy and lack of consultant support in cancer services. All are linked to open risks in the area.

There have been new appointments is several areas. Site and Accreditation Leads have now been appointed for the Community Diagnostic Centre, Clinical Nurse Endoscopist and Clinical Director for Pathology have also been appointed.

Pathology has been nominated for four Biomedical Science Awards. The ceremony is set to take place in early July.

Two pharmacists completed independent prescribing qualifications.

Throughout June 80% of ward-based discharges were completed within 2 hours by pharmacy and an increase in medicines reconciliation.

There are improved turnaround times for MRI CTC and non-obstetric ultrasound.

A streamlined process has reduced mortuary length of stay from 9 to 7 days and successfully passed an external mortuary governance audit. HTA local committee undertakes a quarterly report providing divisional oversight.

Wound clinics continue to receive excellent feedback and are continuing whilst confirmation from ICB is awaited around funding.

Urgent suspected cancer referral forms have been updated and Medical Day Case Unit will be realigned under Cancer Services from July.

There are some areas of concern; emergency diagnostics demand continues to rise and the “I-Refer” system is in testing phase to help manage referrals.

Audiology remains a fragile service, particularly in paediatrics.

Microbiology workforce planning and resilience is under review. There are some issues around Consultant capacity and a business case is in development to address this.

There is some concern across the division regarding accreditation support and regulatory body reporting and are looking for a sustainable way to manage these.

Mortuary also has a fragile workforce (1 qualified, 1 trainee) and there are concerns about out-of-hours service gaps. SOPs and training are under review.

There are several vacancies in Pharmacy - ATO-level vacancies due to job matching delays, resignation of Education and Training Lead and upcoming maternity leave.

Breast cancer performance has been impacted by sickness and backlog. A locum has been secured and additional clinics are being explored.

The Haematology service is also still fragile, but a new specialist is expected in summer.

The South Midlands Pathology Network is currently on pause and in the meantime discussions are ongoing to explore closer collaboration with the wider group and continue to work more closely with Worcester.

12.	Perinatal Safety Report	AA	Information	Enc 12

Annette Arnold presented the Perinatal Safety report. The report was taken as read and the following key points were highlighted:

There were 3 red flags reported:

- Delayed induction of labour caused by Special Care Baby Unity being at full capacity. No activity could proceed on Delivery Suite for 48 hours. This was managed well be the MDT.
- Delay in Artificial Rupture of Membranes also due to SCBU capacity issues.
- Delay of Category 1 C-Section of 2 minutes beyond the 30 minute target. On review mother had a BMI of 56 which added complexity to anaesthesia. There was no harm to mother or baby.

There was 100% compliance supernumerary delivery suite co-ordinator

One incident when obstetric attendance was not there for patient with a BMI of greater than 50 which has been escalated to the clinical lead for review.

There were 2 moderate incidents:

- Patient returned to delivery suite from home following postpartum haemorrhage, in addition, a missed third-degree tear not identified following birth. A Consultant led review is underway.
- 24-week pregnant woman was admitted to ITU for appendicitis and following urine test was found to have E-coli. Further issues were identified in communication and co-ordination across departments and learning to be shared across teams.

Two Complaints were received in May:

- A patient felt that she had not been given sufficient information or time to make an informed decision. This is planned to become a quality improvement project led by the Consultant Midwife.
- Patient believed that a foot cannula may have contributed to a deep vein thrombosis

Sickness rates are high at 9.7%. All cases are being actively managed and supported by line management.

Training compliance is on track for CNST year 7 and there has been an improvement in the use of prompt cards during emergencies, especially haemorrhage.

There is some regional concern over SCBU staffing and the status level is at black in relation to the number of trained in-speciality nurses per shift. There is a national requirement for two in-specialty nurse to be on each shift, which the trust adheres to. There is also recommend a supernumerary nurse per shift . Due to the size of the unit there is no

requirement for a supernumerary shift lead and Monday to Friday the unit manager is on shift, extra to numbers and holds a QIS qualification. A meeting has taken place with the network and plans are in place in relation to the actions.

- Rotas have been adjusted to ensure two qualified speciality nurses on shift on nights and weekends by moving staff. During the day the Sister and Practice Educator are on shift and also hold QIS qualification.

- Benchmarking has commenced against foundation group colleagues at George Elliott, as region felt that establishment was low. However, there were no concerns as a safe service is being provided, outcomes are positive and there have been no significant incidents. A peer review was also positive and no concerns were raised about staffing. There are currently 49% nurses qualified in specialty. New starters to commence in June although increasing staff numbers will reduce numbers in qualified in speciality proportionally. Two nurses undertaking specialty qualification this year.

- A robust education plan is in place for newly qualified nurses. A new foundation course has been introduced to fast-track qualifications and will continue to monitor and feedback to the network.

13.	**Maternity Culture Update/Action Plan**	**EH/HD**	**Information**	**Enc 13**

Ehab Hafiz and Hannah Duggan gave an update on the recent Maternity culture summit.

The summit was held in March 2025 and brought together Medical and Midwifery staff to identify cultural challenges and commit to improvements and focus on building a positive, collaborative, and respectful working culture across maternity services.

The main challenges identified were:

- Communication – Need for better listening and clearer dialogue.
- Shared Ownership – Reduce hierarchy and promote joint decision-making.
- Professional Behaviour – Address incivility and ensure respectful conduct.
- Informed Decision-Making – Improve patient experience and autonomy.
- The following commitments were made:
- Work as a unified multidisciplinary team.
- Understand self and others to improve collaboration.
- Increase awareness of roles and responsibilities.
- Shift from “challenging” to “curious” mindsets.
- Develop a clear vision and strategy.
- Recognise and celebrate staff achievements.

The goal is for this to become engrained in day to day working and changes in leadership will help to solidify this and main actions for Quarter 2 are as follows:

- Review and optimize meeting formats to allow time for relationship-building and improvement work.
- Strengthen leadership, being visible as a leadership team and ensure response to issues in a timely fashion.
- Plan annual away days to foster team cohesion
- Use education sessions for insights personality profiling, patient story reflections and joint learning across disciplines.
- Gain greater knowledge and understanding of other roles and challenges. Support sharing of roles.
- Develop a shared vision and strategy for maternity services with new leadership team members.
- Staff recognition – ensuring achievements are recognised using Friday Feedback, GEM awards, and “Learning from Excellence” cards. Also relaunch “Good Care” log on the incident reporting system.
- Plan to repeat the culture survey to measure progress and consider quarterly pulse surveys for real-time feedback.

- Use reduction in complaints and incidents as indicators of improvement.

It was noted that some excellent work has been done so far. There is a focus nationally across maternity services and so much of quality and safety is ultimately about culture between doctors and midwives. It is about relentless commitment from leaders to reflect on own and colleagues behaviours. The leadership team are committed to and will be held to account for implementation of the action plan and cultural change.

LF had attended national call re public enquiry and task force. A commitment has been made to reduce the complexity of existing oversight arrangements. A range of tools and guidance are due to be launched later in the year to support improvements and oversight.

14.	**Patient Safety Committee Summary Report**	**NO/LF**	**Information**	**Enc 14**

The paper was taken as read and the following points highlighted.

There was positive discussions around falls reports and a number of policies were reviewed and approved.

To improve clinical engagement in antimicrobial stewardship without adding additional meetings, it has been agreed to create an AMS task and finish group which will report through Patient Safety Committee.

15.	**CONFIDENTIAL SECTION**			
15.1	**Patient Safety Incidents Report**	**NO**	**Discussion**	**Enc 15**
16.	**EDS Summary Report**	**NO**	**Discussion**	**Verbal update**
17.	**Any Other Business**			
18.	**Date of Next Meeting**			

Thursday 31st July 2025 – 1.00-4.00pm
MS Teams

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	Perinatal Services Quality Report July 2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Candice Lewis – Perinatal Quality and Safety Matron Lyndsey Morris – Patient Safety Midwife Elaine Evans, Neonatal Unit Sister
Reporting Route:	Surgical Divisional Governance
Appendices included with this report:	Appendix 1 – PQSM dashboard Appendix 2 – SCBU dashboard Appendix 3 – Local response to independent investigation into maternity services
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide oversight and assurance of the safety and efficiency of the Perinatal service; providing detail to meet local and national reporting standards. The report includes detail in line with monthly reporting requirements for July 2025.

Recommended Actions required by Board or Committee

Board is asked to note the contents of the exception report and pursue any key lines of enquiry.

Executive Director Opinion[1]

There are no exceptions for escalation to Board in relation to the maternity and neonatal services. Board is asked to note the mitigations in place for neonatal nurse staffing.

The overview of our local response to the national requirements, following the announcement of the national inquiry into maternity services is to be noted (appendix 3).

Since our last Board meeting our new Director and Deputy Director of Midwifery have commenced in post.

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

Perinatal Services Safety Report – July 2025

1. INTRODUCTION

1.1 Since 2016 the spotlight has been on maternity services to work towards achieving a national target of reducing stillbirths, neonatal deaths and intrapartum brain injuries by 50% by 2025. The Perinatal Safety Report considers and meets the requirements set out within the NHS Resolution Maternity Incentive Scheme (CNST) Year 7, the Maternity Self-assessment Tool, and embeds the NHSEI Perinatal Quality Surveillance Model (PQSM). The information in this report provides an update on key maternity and neonatal safety initiatives against locally and nationally agreed measures, to support WVT to achieve the national ambition. The full data set can be found in appendix 1.

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

2. PERFORMANCE

2.1 Activity

There were 130 births in July 2025. The ratio is stable.

Midwife to birth ratio (<1:24)	18

2.2 Red flags

Red flags are outlined within CNST standards and are all subject to an incident report and MDT review.

The red flags in July 2025 are recorded as:

			July
WVT	Inphase	Delay in Induction >2hrs	2
WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1
WVT	Inphase	Delay in administering medication	0
WVT	Inphase	Delay in starting syntocinon/ARM >30mins	1
WVT	Inphase	Delay in Suturing >60mins	0
WVT/PQS M		Unable to provide 1:1 care in labour	0
WVT		Delay in Triage >30mins	0
WVT	Birth Rate +	Community midwives on call covering maternity unit	1
WVT	Birth Rate +	Any movement of midwifery staff from any area to provide midwifery cover	22
WVT		Delayed recognition of and action on abnormal vital signs	0
WVT		DSC lost - supernumerary status	0
WVT		Full clinical examination not carried out when presenting in labour	0
WVT		Delay of more than 30 minutes in providing pain relief	0

In the month of July 2025, there were 2 inductions of labour delayed by more than two hours. These were both due to acuity and the women were invited for a maternal and fetal wellbeing check on the day they were delayed. There was 1 delay in starting syntocinon/ARM again due to acuity and unexpected obsetric emergencies overnight that took priority, the lady was cared for on maternity ward until transfer to delivery suite was achieved. There was one delay in Category 1 caesarean section, this was completed at 33 minutes, there was no adverse outcome for mum or baby.

Delivery Suite co-ordinator supernumerary status

Upon reviewing July 2025, the role of the Delivery Suite Coordinator as supernumerary has proven to be highly effective. We have achieved 100% compliance with all relevant protocols and performance indicators, a significant accomplishment that reflects positively on our team. This success not only demonstrates our commitment to operational excellence but also ensures that we meet the CNST Year 7 requirements, further reinforcing the high standards of care and safety within the Delivery Suite.

2.3 RCOG Obstetric attendance

CNST requires compliance with the RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. Our performance in July 2025 is noted below, but it should also be highlighted that the team remain fully compliant with attendance as required in all instances.

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	N/A	
Caesarean birth for women with BMI>50	0	N/A	
Caesarean birth <28/40	0	N/A	
Premature twins (<30/40)	0	N/A	
4th degree perineal tear repair	0	N/A	
Unexpected intrapartum stillbirth	1	100%	
Eclampsia	0	N/A	
Maternal collapse e.g. septic shock / MOH	0	N/A	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%	

2.4 SCBU Activity

There were 11 admissions in July 2025 to SCBU.

<26 weeks	26-29+6 weeks	30-35+6weeks	>36 weeks
0	0	6	5

BAPM 2011 Level of care on day of admission

ITU	HDU	SCBU
1	4	6

- There were no exceptions outside of pathway during July 2025
- There were 20 HDU cot days in July 2025
- There were 2 x ITU days (other than on day of admission) for babies that initially required HDU level of care and deterioration leading to transfer out

3. SAFETY

3.1 **Incidents**

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

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee. The minimum data set for July is summarised below.

3.1.2 Minimum Data Set incident summary:

	No. of cases			**Concern raised**			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
July	1	0	2	0	0	0	0

In the month of July there were two moderate physical harm incidents reported. Both of these incidents were Major Obstetric Haemorrhages. No immediate issues have been identified in either cases but a full multidisciplinary review will further analyse these for improvement.

InPhase Incident reports - SCBU.

There were eleven InPhase for SCBU during June 2025; these included;

- Medication error x 1
- Staffing x 1
- Unexpected Admissions x 5
- Treatment/Assessment x 2
- Clinical Assessment x 1
- Other x 1

3.2 **Concerns and Complaints**

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is potentially patient identifiable and is discussed in detail at Quality committee and summarised for Board purposes.

July 2025	**Complaints**
Maternity	1
SCBU	0

4. WORKFORCE

4.1 **Safe Staffing - Midwifery**

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

- Completion of Birthrate plus acuity tool
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags, also monitored for CNST compliance
- Shift fill data

- Daily SitRep reporting
- Sickness absence, vacancy and turnover rate

4.1.1 The Birth rate plus acuity tool for Delivery Suite was completed 89.25% (82.2% last month) of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 92% of the time. For 8% of the time the service was short by up to 1.75 midwives.

4.1.2 This data is collected prior to mitigation and mitigations evidence that there were a total of 22 instances of staff being redeployed internally to cover acuity which is a slight decrease from last month's data of 24 times. There were 2 occasions where community were redeployed to support Delivery Suite. There were 5 occasions where specialist midwives supported clinical. There were 3 occasions where acuity was escalated to the manager on call for support highlighting a culture where the team feel able to highlight issues and that the pathway in place is effective.

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	15	60%
MA2	Redeploy from community	2	8%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	5	20%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	3	12%
MA11	Maternity Unit on Divert	0	0%

4.1.3 Midwifery fill rates are collected from Allocate rosters. There has been no indication to reintroduce agency since it ceased in November 2023.

4.2 **Obstetric workforce**

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

JULY '25	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	220	220	100.00	0	220	0.00	0	220	0.00
Consultant: On Call	442	467	94.65	25	467	5.35	0	467	0.00
Consultant: Cold Week	104	104	100.00	0	104	0.00	0	104	0.00
Consultant: Antenatal Clinic	51	51	100.00	0	51	0.00	0	51	0.00
Middle Grade: delivery suite	153	198	77.27	45	198	22.73	0	198	0.00
Middle Grade: Antenatal Clinic	85	140.25	60.61	55.25	140.25	39.39	0	140.25	0.00

4.3 **Neonatal Medical Workforce**

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that the Neonatal Medical Workforce does not use locum support as they are fully funded and recruited to BAPM standards.

4.4 **Anaesthetic workforce**

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

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	30	84%	30	85%
Anaesthetist extra days	3	16%	5	15%

The directorate team advise that the increase in extra shifts is due to industrial strike action and a rota locum gap which is expected to resolve in coming weeks.

4.5 MDT ward rounds

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

	08:30	20:30
Anaesthetist	100%	90%
Obstetric Consultant	100%	90%

4.6 Workforce – Neonatal

4.6.1 Safe Staffing Standards

Neonatal Nurse staffing is monitored by:

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

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

1:1 Intensive Care (IC)
1:2 High dependence (HD)
1:4 Special Care (SCBU)
Supernumerary Shift Co-ordinator

Our Neonatal Workforce Establishment is defined by the BAPM service and quality standards for provision of neonatal care in the UK

Neonatal Staffing Summary (July 2025)

Nursing Position	Budgeted WTE	Contracted WTE	Maternity leave	Long Term Sickness.
Band 7	2.0	2.0	0	0
Band 6	5.2	4.9	0	(0.62wte)
Band 5	13.5	9.1	1	0
Neonatal Outreach	1.26	1.26	0	0

Neonatal Staffing July 2025 measured against BAPM Standards:

	WVT	National average
% of shifts staffed to BAPM recommendations	100%	86.94%
% of shifts QIS against Neonatal Toolkit standards	100%	95.52%
% of shifts with supernumerary shift lead	5.17%	22.9%
% of Nursing shifts covered by bank	3.7%	5.91%

- WVT SCBU shifts were 100% compliant for staffing to BAPM recommendations and for percentage of shifts with QIS against Neonatal Toolkit standards
- We do not have an establishment to achieve a supernumerary shift leader on all shifts, but this is recognised as an acceptable risk given our capacity and acuity at WVT
- There was a slight reduction from 5.7% to 3.7% in July in the percentage of shifts covered by bank, bank was required in order to meet the expectation from the WMNPN that there are two QIS nurses on all shifts

4.6.2 Daily Sit Rep Reporting

WMPN will now be recording a unit's OPEL status as 'Black' where only one QIS nurse is expected to be on shift – this is to enable situational awareness in terms of other units/NTS' perception of the position a unit is in in terms of being able to take more babies, e.g. repatriations in the case of a SCU. The definition of Black will be updated to reflect this change, and our East Midlands network colleagues have said they will make the same change.

During July 2025 our OPEL (staffing) status was recorded as BLACK only on two occasions, both were for Day shifts; one was a data entry error and the second occurred as a result of late sickness resulting in the Band 7 specialist nurse in the office stepping in to cover.

4.6. 3 Qualified in Speciality Staffing Report.

West Midlands Perinatal Network (WMPN) is newly auditing shift-by-shift QIS compliance, namely to ensure that each unit has at least two QIS trained nurses available on each shift. WVT has been identified as an outlier in that shifts appear to be routinely staffed by only one QIS trained nurse. The position of the WMPN is this is not considered an acceptable norm; and that it could pose a safety risk in the event that more than one baby requires stabilisation care at a time or in managing multiple babies with ongoing high dependency, care needs. The WMPN identify that the risk is enhanced for WVT based on both the fact that it is a small SCU with low activity levels managing higher acuity HDU-level babies, and its geographic isolation meaning that external support or speedy transfer out are not available.

After a meeting with the WMPN the following actions were agreed:

- WMPN to apprise the regional specialised commissioning team of these discussions, and suggest that this issue is dispatched into regular contracting discussions between NHSE and the Trust, which will most likely look at trajectories for improving the Trust's QIS rate towards the 70% standard.
- WVT to redouble its efforts to identify a 3rd nurse to send on the QIS course in the next 12 months, and to take an approach whereby 3 nurses per year are sent on QIS training until 70% is reached, at which time 2 nurses per year generally allows for maintenance of that level.
- WVT to work with Foundation Group partners to benchmark the SCU nursing establishment differential, noting that WVT have markedly less nurses than their FG counterparts, despite having a similar number of cots and the addition of higher acuity HDU babies due to the current derogation.

WMPN noted whilst the expectation is that two QIS nurses should be on every shift, the group recognised that WVT is unable to achieve this with immediate effect. We discussed the importance of ensuring night and weekend shifts are prioritised for having two QIS nurses on shift when there is no supernumerary support on site. In terms of expectations moving forward, WMPN will defer to commissioner led discussions/decision making but will continue to offer support to both the unit team and NHSE.

The Neonatal Toolkit (2009) defines that:

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

Trajectory of QIS from April 25 – September 25

	April 25	May25	June 25	July 25	August 25	September 25
Total QIS %	44.4%	44.4%	52.5%*	52.5%	52.5%	52.5%

The trajectory for the overall QIS compliance indicates an improving picture from June 2025 until September 2025, this is because we have had one staff member successfully complete and pass the Neonatal Intensive Care and High Dependency Module in June. However our trajectory will fall again by October 2025 as we have three newly qualified nurses joining the team in September 2025. We have one Band 5 enrolled on the critical care course at Birmingham City University commencing November 2025 and one to start in February 2026.

4.3 Quality nurse Roles and AHP Provision

There is no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7 wte Practice Education Lead (B7) with 0.3 wte Clinical working within role (=1.0 wte) and 0.2 wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2 wte B7 funding has been used to support a B6 Developmental Care on a fixed term contract which has been extended to March 2026.

4.6.4 **Sickness and Maternity Leave SCBU**

Month	Sickness (Trust Target <3%)	Maternity Leave (WTE)
July 2025	**5.2%**	**1.0wte**

- Our overall sickness has increased from 4.12% in June and 5.2% in July, this is primarily due to a Long Term Sickness episode.

5. COMPLIANCE

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

July 2025:

Training compliance in PROMPT: Midwives	95%
Training compliance in PROMPT: Obstetric Consultants	89%
Training compliance in PROMPT: Obstetric Middle Grades	100%
Training compliance in PROMPT: Anaesthetic Consultants	75%
Training compliance in PROMPT: Anaesthetic Middle Grades	82%
Training compliance PROMPT: Maternity Support Workers	96%
Annual NLS update compliance: Paediatric Consultants	100%
Annual NLS update compliance: Paediatric Middle Grades	80%
Annual NLS update compliance: Paediatric Juniors	100%
Annual NLS update compliance: Midwives	83%
Annual NLS update compliance: Neonatal Nurses	95%
Fetal Wellbeing update day: Obstetrics	100%
Fetal Wellbeing update day: Midwives	86%
Midwifery update day (Core Competency): Midwives	86%
Midwifery update day (Core Competency): Support Staff	96%

There is a clear plan in place for all training to be above the required CNST standards by December 2025. This will be closely monitored monthly and plans put in place if any deviations are identified.
Nursing July 2025.

Training	Expected Target	July 25
Mandatory (Core)	**>90%**	**96.67%**
Mandatory (Essential)	**>90%**	**94.26%**
Newborn Life Support (Annual Update)	**100%**	**95%**
Maternity Breastfeeding Update	**>90%**	**94.74%**

5.2.1 Personal Development Reviews – SCBU Nursing

July 2025
100%

5.3 Safety Champions

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

A walkabout took place on 9th July, with visits to the Delivery Suite, Maternity Ward, Triage, and SCBU.

The environment within the delivery suite was observed to be calm, clean, and well-organized. The team were unable to review Room 1 which had undergone refurbishment to allow for the fixed birthing pool as it was in use. The CTG connectivity was discussed and although there has been marked improvements, the connectivity of these to Badgernet is an ongoing issue.

The SCBU was observed to be clean and tidy, and calm during the visit. The team further discussed the central monitoring system in the unit, a critical safety feature that was flagged during a previous peer review. Although no time frame was able to be given for the central monitoring launch this was expected to be very soon and hopefully to have them set up by the August Walkabout.

Safety champions requested a high level overview of the requests from NHS England following the announcement of the independent investigation into maternity services, this is attached at appendix 3.

5.5 CNST MIS Year 7

MIS Year 7 was published in April. We have reviewed this and identified the new guidance has undergone minimal change since year 6.

5.6 ATAIN – Avoiding Term Admissions into Neonatal Unit

National benchmark 6% and best practice 3%

July 25
4.5%**

To be verified after ATAIN meeting on the 27th August 2025.

5.7

CNST Safety Action 3

- Transitional care Quarterly audits continue and shared at Maternity and Neonatal Safety Champions Meeting. Q1 for 2025/26 will be available to share August/September 2025.
- Quality improvement (QI) – Administration of IV antibiotics for well babies on maternity ward registered with Trust as this year's QI project. Update will be shared with LMNS October/November 2025.

APPENDIX 1 – PQSM Dashboard

	Are	Dash	Framew	Indicator Description	May	June	July
Antenatal	Booki	LMNS	LMS	Total bookings	119	149	127
		LMNS	LMS	Women who were booked before 9+6 weeks	95	110	107
		LMNS	LMS	% Women who were booked before 9+6 weeks (target 90%)	79.8%	73.8%	84.3%
		LMNS	LMS	Women who were booked after 9 + 6 weeks	24	39	20
		LMNS	LMS	% Women who were booked after 9 + 6 weeks	20.2%	26.2%	15.7%
		LMNS	LMS	Women who were booked before 12 + 6 weeks	115	146	123
		LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	96.6%	98.0%	96.9%
		LMNS	LMS	Women who were booked after 12 + 6 weeks	4	3	4
		LMNS	LMS	% Women who were booked after 12 + 6 weeks	3.4%	2.0%	3.1%
		LMNS	LMS	Midwife led care at booking	23	31	17
		LMNS	LMS	% Midwife led care at booking	19.3%	20.8%	13.4%
	Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	38	51	27
		LMNS	LMS	% Women with BMI of 30 and over at booking	31.9%	34.2%	21.3%
		LMNS	Better	% Antenatal Personalised Care Plan completed	99.3%	100.0%	97.5%
		LMNS	Better	% Intrapartum Personalised Care Plan completed	59.4%	62.7%	65.9%
		WVT		% Portal Access Consent	100.0%	100.0%	100.0%
		LMNS	LMS	% Portal Access - Women who registered and logged in	90.8%	91.3%	89.0%
		LMNS	Ockenden	% Contacts were place of birth suitability was recorded	64.9%	65.7%	76.9%
		LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	52.3%	66.9%	84.4%
		LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	87.0%	87.8%	89.1%
		LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	79.6%	92.0%	83.4%
		LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	88.7%	83.0%	92.8%
	Smoking	WVT		Recorded Smoking Status at Booking - Yes	13	11	8
		WVT		Recorded Smoking Status at Booking - No	106	138	119
		WVT		Recorded Smoking Status at Booking - Unknown	0	0	0
		WVT		% of mothers with a recorded Smoking Status at Booking	100.0%	100.0%	100.0%
		LMNS	Saving	Women who were current smokers at booking	13	11	8
		LMNS	Saving	% Women who were current smokers at booking	10.9%	7.4%	6.3%
		LMNS	Saving	Smokers who were referred to smoking cessation services	12	11	8
		LMNS	Saving	% Smokers who were referred to smoking cessation services	92.3%	100.0%	100.0%
		LMNS	Saving	Smokers who accepted CO screening at booking	13	10	7
		LMNS	Saving	% Smokers who accepted CO screening at booking	100.0%	90.9%	87.5%
	Carbon Monoxide	LMNS	Saving Babies	Women who were screened for CO at booking	116	145	120
		LMNS	Saving	% Women who were screened for CO at booking (of total bookings)	97.5%	97.3%	94.5%
		LMNS	Saving	Women with CO reading of 4 ppm or more at booking	9	12	7
		LMNS	Saving	% Women with CO reading of 4 ppm or more at booking (of total bookings)	7.6%	8.1%	5.5%
	Area	Dashb	Framewor	Indicator Description	May	June	July
	Deliveries	LMNS/PQSM	Contractual	Total births (deliveries)	131	135	130
	Delivery Method	WVT		Home Births	0	1	1
		WVT		BBA's	2	3	2
		LMNS	Contractual	Vaginal births (deliveries)	51	59	45
		LMNS	LMS	% Vaginal births (deliveries)	38.9%	43.7%	34.6%
		LMNS	LMS	Ventouse & forceps births (deliveries)	15	14	13
		LMNS	Contractual	% Ventouse & forceps births (deliveries)	11.5%	10.4%	10.0%
	C-Section Deliv	LMNS	LMS	RG"1 having a caesarean section with no previous births	4	3	4
		LMNS	LMS	RG"1 Deliveries	12	21	15
		LMNS	LMS	RG"1 % C-section deliveries	33.3%	14.3%	26.7%
		LMNS	LMS	RG"2 having a caesarean section with no previous births	24	20	28
		LMNS	LMS	RG"2 Deliveries	40	35	32
		LMNS	LMS	RG"2 % C-section deliveries	60.0%	57.1%	87.5%
		LMNS	LMS	RG"5 having a caesarean section with at least one previous birth	18	25	28
		LMNS	LMS	RG"5 Deliveries	21	26	29
		LMNS	LMS	RG"5 % C-section deliveries	85.7%	96.2%	96.6%
	eries	WVT		Total Elective C-Sections	30	25	36
		WVT		Total Emergency C-Sections	35	37	36
		LMNS	LMS	Total Caesarean births (deliveries)	65	62	72
		LMNS	LMS	% Total Caesarean births (deliveries)	49.6%	45.9%	55.4%
		LMNS	LMS	% Grade 1 C-Sections within 30 minutes	75.0%	71.4%	75.0%
		LMNS	LMS	% Grade 2 C-Sections within 75 minutes	92.3%	92.3%	100.0%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	19	25	24
		LMNS	LMS	% Midwife led (low risk care) births	14.5%	18.5%	18.5%
		LMNS	LMS	Home births (deliveries) - midwife led only	0	0	1
		LMNS	LMS	% Home births (deliveries)	0.0%	0.0%	0.8%
	Births	LMNS	Contractual	Total number of babies born	134	136	132

Intrapartum		LMNS	[illegible]	% Babies born preterm (singletons born 36+6 or less)	10.45%	6.62%	7.6%
		LMNS	LMS	Singleton babies born 26+6 or less	0	0	0
		LMNS	LMS	% Singleton babies born 26+6 or less	0%	0%	0.00%
		LMNS	LMS	Babies (multiples) born 27+6 or less	0	0	0
		LMNS	LMS	% Babies (multiples) born 27+6 or less	0%	0%	0.00%
		[illegible]	LMS	Stillbirths	0	0	1
		[illegible]	LMS	% Stillbirths	0.0%	0.0%	0.8%
		LMNS	LMS	Stillbirths rate per 1,000	0.00	0.00	7.58
	Breastfeeding	LMNS	National	Live births where breastfeeding initiated (first feed = breastmilk)	102	120	101
		LMNS	National	% Live births where breastfeeding initiated (first feed = breastmilk)	77.9%	88.9%	78.3%
	Smoking	WVT		Women who were current smokers at booking (delivered mothers)	11	9	10
		WVT		% Women who were current smokers at booking (delivered mothers)	8.4%	6.7%	7.7%
		LMNS	[illegible]	Women who were current smokers at birth (delivery)	9	8	8
		LMNS	[illegible]	% Women who were current smokers at birth (delivery)	6.9%	5.9%	6.2%
		LMNS	[illegible]	% Women with CO measured at 36 weeks	100.0%	100.0%	100.0%
		LMNS	[illegible]	% CO >= 4ppm at booking and below 4 ppm at 36 weeks	7.8%	7.4%	7.6%
	Risk Management	LMNS	[illegible]	Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0
		LMNS	[illegible]	% (as a % of all singleton births)	0.00%	0.00%	0.00%
		LMNS	[illegible]	% Detection rate for FGR (below 3rd centile)	11%	11%	13%
		LMNS	[illegible]	Women who had a PPH of 1,500ml or more	3	4	5
		LMNS	[illegible]	% Women who had a PPH of 1,500ml or more	2.3%	3.0%	3.8%
		LMNS	[illegible]	Women who sustained a 3rd or 4th degree tear	0	0	0
		LMNS	[illegible]	% Women who sustained a 3rd or 4th degree tear (of total vaginal birth	0.0%	0.0%	0.0%
		LMNS	[illegible]	Induction of labour	57	50	43
		LMNS	[illegible]	% Induction of labour rate (of all births)	43.5%	37.0%	33.1%
		WVT		Routine Enquiry Domestic Violence - Asked	74	90	77
		WVT		Routine Enquiry Domestic Violence - Unable to ask	57	42	50
		WVT		Routine Enquiry Domestic Violence - Unknown	0	3	3
		WVT		% Asked routine enquiry domestic violence	56.5%	66.7%	59.2%
		WVT		Midwife to birth ratio	1:22	1:23	1:25
	Red Flags	WVT	Inphase	Delay in Induction >2hrs	3	0	2
		WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1	1	1
		WVT	Inphase	Delay in administering medication	0	1	0
		WVT	Inphase	Delay in starting syntocinon/ARM >30mins	1	0	1
		WVT	Inphase	Delay in Suturing >60mins	0	0	0
		[illegible]		Unable to provide 1:1 care in labour	0	0	0
		WVT		Delay in Triage >30mins	0	0	0
		WVT	[illegible]	Community midwives on call covering maternity unit	1	2	1
		WVT	[illegible]	Any movement of midwifery staff from any area to provide midwifery c	21	24	22
		WVT		Delayed recognition of and action on abnormal vital signs	0	0	0
		WVT		DSC lost - supernumerary status	0	0	0
		WVT		Full clinical examination not carried out when presenting in labour	0	0	0
		WVT		Delay of more than 30 minutes in providing pain relief	0	0	0
	Reduced Fetal Move	WVT		Number of women presenting to service with reduced fetal movements	233	272	254
		WVT		Number of women presenting with RFM who are recorded as having a t	232	272	248
		WVT		% of women presenting with RFM who received CTG	99.6%	100.0%	97.6%
	Area	**Dashb**	**Type**	**Indicator Description**	**May**	**June**	**July**
	Admissions	LMNS	Integer	Total admissions to neonatal care	11	9	13
		LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	3	4	7
		LMNS	%	% Unexpected admissions of full-term babies to neonatal care	2.5%	3.1%	5.7%
	SCBU admission temps	WVT	Born	Eligible Babies (<34 wks gestation)	0	0	2
		WVT		% taken within hour	0.0%	0.0%	100.0%
		WVT		Adm temp <36.5 degrees	0	0	0
		WVT	All babies	Eligible Babies	14	14	19
		WVT		% taken within hour	100.0%	100.0%	100.0%
		WVT		Adm temp <36.5 degrees	4	4	3

Neonatal	Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	2	2	2
		LMNSI PQSM	Integer	Neonatal deaths	0	0	0
		LMNSI PQSM	%	% Neonatal deaths	0.0%	0.0%	0.0%
		LMNS	Integer	Neonatal mortality per 1,000 births	0.00	0.00	0.00
		LMNS	Integer	Neonatal transfers for therapeutic hypothermia	0	0	0
		LMNS	%	% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a
		LMNSI PQSM	Integer	Neonatal brain injuries	0	0	0
		LMNSI PQSM	%	% Neonatal brain injuries	n/a	n/a	n/a
		LMNS	Integer	Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	0	0	3
		LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	0	0	3
		LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	0.0%	0.0%	100.0%
		LMNS	Integer	Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0
		LMNS	Integer	Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0
		LMNS	%	% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a
	Area	**Dashb**	**Framewor**	**Indicator Description**	**May**	**June**	**July**
Postnatal	Risk Management	LMNS	Local	Obstetrics admissions to ITU	1	1	0
		LMNSI PQSM	LMS	Maternal deaths	0	0	0
		LMNS	Better	% Postnatal Personalised Care Plan completed	97.9%	97.8%	99.3%
		LMNS	LMS	Postnatal readmissions within 28 days (mothers)	11	14	13
		LMNS	LMS	Postnatal readmissions within 28 days (babies)	3	6	4
	Suspended Access to Service	WVT		Number of times Maternity Services Suspended per month	1	0	0
		WVT		Number of hrs Maternity Services suspended	0	0	0
		WVT		Number of times Home Birth services suspended per month	0	3	0
		WVT		Number of hrs Home Birth services suspended	0	0	0
		WVT		Number of times SCBU suspended per month	1	0	1
		WVT		Number of hrs SCBU suspended per month	12	0	6
	Insight	PQSM	Integer	reported (total)	0	0	2
		PQSM	Integer	New MNSI SI referrals accepted	0	0	0
		PQSM	Integer	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0
		PQSM	Integer	Coroner Reg 28 made directly to Trust	0	0	0
	orkforc	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0	0
		PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	0	0	0
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	1.8wte	TBC	TBC
		PQSM		Inphase related to workforce (service provision/staffing)	21	24	22
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%
	olveme	PQSM		Service User feedback: Number of Compliments (formal)	1	0	0
		PQSM		Service User feedback: Number of Complaints (formal)	1	1	1
		PQSM		Staff feedback from frontline champions and walk-abouts (number of t	0	0	0
	provem	PQSM		Progress in achievement of CNST /10	10	10	10
		PQSM	%	Training compliance in PROMPT: Midwives	91%	92%	95%
		PQSM	%	Training compliance in PROMPT: Obstetric Consultants	89%	100%	89%
		PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	89%	89%	100%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	75%	75%	75%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	92%	91%	82%
		PQSM	%	Training compliance PROMPT: Maternity Support Workers	97%	100%	96%
		PQSM	%	Annual NLS update compliance: Paediatric Consultants	100%	89%	100%
		PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	80%	80%	80%
		PQSM	%	Annual NLS update compliance: Paediatric Juniors	89%	88%	100%
		PQSM	%	Annual NLS update compliance: Midwives	97%	91%	83%
		PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	95%	95%
		PQSM	%	Fetal Wellbeing update day: Obstetrics	83%	83%	100%

Appendix 2 SCBU Dashboard – 2025/2026

SCBU DASHBOARD 2025- 2026													
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Comments
Staffing: Vacancy Gaps, Attrition Rate, Sickness													
Band 7 Vacancy Gap (2.0wte)	0	0	0	0									
Band 6 Vacancy Gap (5.2wte)	0	0	0	0.4									
Band 5 Vacancy Gap (13.5)	2	3.1		4.47									
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	0	0	0									
Band 2 Vacancy Gap (1.0wte)	0.2	0.2	0.2	0.2									
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0	0	0	0									
Attrition Rate (WTE)	0	0	0.62	0									
Maternity Leave (WTE)	1	1	1	1									
Sickness (<3.5%)	1.09%	1.39%	4.12%	5.63%									
Safe Staffing													
% Shifts staffed to BAPM Standards	92%	84%	100%	100.00%									
QIS % (standard = 70% of registered workforce)	44.4%	44.4%	52.5%	57.60%									
% of shifts QIS to toolkit	98.31%	100%	100%	100.00%									
% Shifts with supernumerary shift co-ordinator	3.39%	3%	26.67%	5.17%									
% Shifts covered with Bank	1.1%	1.4%	5.7%	3.70%									
Appraisal Rate	85%	67%	94.74%	100%									
Mandatory Training Core	98.75%	97.50%	97.83%	96.67%									
Mandatory Training Essential	89.8%	92.14%	94.78%	94.26%									
Basic Life Support	43%		86.36%	90.00%									
Newborn Life Support >90%	96%	95%	95%	95.00%									
Maternity Breastfeeding update.	77.27%	77.27%	90.48%	94.74%									
Safeguarding Level 3	100%	100%	100%	100%									
Compliments/Complaints/Concerns													
Complaints/Concerns	0	0	0	0									
Infection Prevention													
Overall - Star rating.	4	5	5	5									
Ward Assurance Audit	82%	100%	88%	92%									
Hand Hygiene	100%	100%	100%	100%									
Bare Below the Elbow	100%	100%	100%	100%									
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	4	2	12									
Medication Errors	0	1	0	1									
Staffing	0	0	0	1									
Service Escalation (OPEL RED/BLACK)	0	Red x 4	0	Red x 1									
Exception reports - ex-utero outside of care pathway	0	0	0	0									
Exception reports - in utero transfers outside of pathway/network	1	1	1	2									

Version 1: July 2025

Audits													
Quaterly CD Audit		96%											
IV Fluid Prescription - Target 90% Compliance	97%												
Clinical Notes Audit - Correct Completion target 90%	57%												
Cannula Care Plan (Peripheral Cannula) Target 90%	89%												
Gentamicin Clinical Audit	96%												
NGT Misplacement NPSA Safety Alert 2016 Target 90%	86%												
Pain Audit Tool Completed Correctly Target 80%	60%												
IVAB administered within 1 hr of decision to give													
Growth parameters Audit	82%												
Transitional Care and Term Admissions													
% Unexpected admissions of full-term babies to neonatal care (of all live term births) m(National Average 5% Best Practice <3%)	3.5%	1.5%	2%	4.5%**									
TC Bed occupancy rate on SCBU % including parent bedroom	40.0%	54.00%	40%	52.3%									
Number of babies born between 34-36 wks gestation and admitted to SCBU	3	7	4	3									
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	1	3	0	2									
Neonatal Outreach Team													
Total Patients	11	19	20	10									
NewReferrals	4	12	8	4									
Existing Patients continuing care	7	7	12	6									
No. NGT Feeding in the community	8	5	3	4									
Receiving EBM on discharge from SCBU	5	10	13	7									
Receiving EBM on discharge from 0/R	3	1	9	5									
Numbers Discharged from outreach	5	2	9	7									
Number of Incidents (Inphase)	0	0	0	0									
Home Phototherapy	1	1	1	0									
Prolonged Jaundice Screening Referrals	27	24	34	34									
Prolonged Jaundice Screening - Total Number of Referals meeting criteria for outreach	21	22	32	30									
Prolonged Jaundice Screens - Outreach	18	22	20	25									
Prolonged Jaundice Screens - RAC	5	2	6	5									

Appendix 3	Response to the Independent Investigation into Maternity and Neonatal Services Board Update
National Ask	**Local Progress and Actions**
Tackle poor behavior and team culture without delay	Following feedback from staff, complaints and the 2024 Care Quality Commission survey, a Maternity Culture Summit was held to explore professional behaviors, communication and psychological safety. An action plan was drafted to address concerns however triangulation with the findings of the staff survey and the culture survey will now be undertaken to ensure that all issues are addressed. The new obstetric and midwifery leadership team are committed to address poor behavior and work collaboratively to improve team culture.
Listen directly to families experiencing harm; support open learning and manage staff robustly	Families who have experienced stillbirths and neonatal deaths are invited to provide feedback and questions about their care as part of the PMRT process. The finding from these reviews are used to share learning across the system and wider region and inform training for staff locally. Families are also invited to take part in all MNSI investigations, agree the findings of the report and make recommendations for improvements in care. These will be shared at Patient Panel going forward and via the Perinatal Safety Report and Incident Report. The Director and Deputy Director of Midwifery will work closely with local families and the MNVP to ensure that the voice of all families is heard. The debrief service is currently under review across the system to ensure that it is meeting the needs of families and clear signposting is available to those who have experienced birth trauma.
Set the right culture through coproduction with maternity voices and local families	We work closely with the Maternity and Neonatal Voices Partnership to coproduce perinatal services. Regular listening events and co-produced activities are undertaken to enhance family and community engagement. This work will be reported to Board via the new reporting process. Currently there are resource limitations, which has been escalated to the LMNS SRO. A new delivery model will be discussed at the next LMNS Board meeting in September. The BRAINS work is the most recent and ongoing coproduced improvement that will underpin all clinical pathways and support informed decision making for women and birthing people.
Review quality data, monitor outcomes and experiences, and deliver improvements	Outcome data is monitored via the maternity dashboard and shared locally via the Perinatal Safety Report. Improvements have been seen in the preterm birth and neonatal death rates. The new LMNS dashboard will be available in September and once completed further work on the local dashboard will need to be undertaken to include local and national benchmarking. Neonatal services have improved through integrated electronic records and early warning systems.
Tackle inequalities	The Local Maternity and Neonatal System Equity & Equality Action Plan has been agreed. Equity indicators (ethnicity, deprivation, language) are embedded within data systems to target interventions. The Core20PLUS5 framework focuses on smoking cessation, maternal obesity, antenatal access, and infant feeding. Translation services have been improved.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/09/2025**
Title of Report:	Patient Experience Quarterly Report and Quality Priority Update
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	Quality Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To present the quarterly patient experience report.

Recommended Actions required by Board

Board is asked to note;

- FFT now live for all services with new text message, QR code and survey link available to expand opportunities to gain patient feedback
- Complaints- comparison of data between Q1 in 2024/24 and 2025/26 shows an overall increase of 6.5% in new complaints received in the same period
- PALS service back to full complement at end of the first quarter

Executive Director Opinion[1]

The Board is asked to note

- The positive approach to FFT with an anticipation that responses and depth of feedback will improve and be informative for service improvement
- The number of complaints received and our handling of these remains a concern
- Communication and information giving is a feature in the vast majority of complaints and concerns – a recent customer care workshop was delivered to MDT team members within the Women & Children's Directorate; this was well received and helped team members focus on team working, communication and engagement. There is a plan to deliver more sessions over the forthcoming months.

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

Patient Experience Report

Introduction

The report provides an update on patient experience key metrics and areas of improvement in support of the Trust Quality priority for patient experience.

Headlines

- FFT now live for all services with new text message, QR code and survey link available to expand opportunities to get patient feedback.
- Complaints- comparison of data between Q1 in 2024/24 and 2025/26 shows an overall increase of 6.5% in new complaints received in the same period.
- PALS service back to full complement at end of Q1.
- Overall positive feedback on transition to new remote interpreting service provider.

Quality Priority- Improve responsiveness to patient experience data

This report provides a quarterly update on patient experience metrics used to measure improvement again the quality priority for 2025-26 to demonstrate progress;

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

The 2025-26 quality priority will focus on two defined projects;

- Implement the PHSO model complaints framework/ standards.
- Expand ability to leave feedback through improvement of the FFT system.

Friends and Family Test (FFT)

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

FFT project- Expand ability to leave feedback through improvement of the FFT system.

One of the fundamental principles underpinning the FFT is ‘all patients and people who use services have the right to provide anonymous feedback quickly and easily, when they want to’. To be able to achieve this principle and working with the provider of the text messaging service, the project team reviewed our system hierarchy and introduced a survey format that could be utilised via text messaging, QR code or a web link.

No changes were made to the FFT questions asked and the collection of demographics introduced. However the new survey style means only one text message is sent to patients and they follow a link to complete the survey. This reduces the number of messages sent to one patient.

The aim of the project was to:

- Provide another mechanism for patients to leave feedback when they choose
- Improve response rate
- Reduce costs – removal of back and forth text message
- Fully roll out FFT to all clinical areas across the Trust

Our patient engagement forum was consulted throughout the process and patient volunteers included in the testing process. Their feedback was invaluable and helped shape the survey.

The following tasks were undertaken to support 'Go Live' during the month of July:

- Internal communication to staff
- Training provided on navigating the Envoy system to access and analyse data
- Trust FFT posters distributed to all clinical areas for displaying in waiting/clinic rooms
- Pull up banners advertising the need for feedback via FFT displayed in main hospital buildings entrances (Hereford, Ross, Leominster, Bromyard)
- WVT web page updated with the ability to leave FFT via the landing page

FFT service rollout

The following services went live from the 1st July for both text messaging and the ability to leave feedback at any time via QR code or web link;

- All inpatient areas (inc. community beds, children's ward/SCBU and Women's Health)
- All outpatient departments
- Emergency Department
- All day case
- All maternity
- All paediatrics
- All community services

FFT Results

Due to a pause in sending data whilst building the new survey, there is no data for Q1 1st April 2025 – 30th June 2025. Data will be available from Q2.

Data for the month of July compared to the last full month of data prior to the pause in FFT shows the following;

Response Rate

Department	March 2025	July 2025
Trust Overall	15%	9%
Outpatients*	14%	7%
Inpatients	15%	13%
Community	N/A – not live	10%
Emergency Department	19%	14%
Day Case	20%	13%

The Trust has unfortunately seen a decrease in response rate, this was anticipated as a result of a higher proportion of text messages being sent as a result of full roll out. It was also anticipated as use of the QR code and survey link are new and will take time to embed.

Promotion via social media, web site, posters and banners has only just commenced and relied on the system being configured and the new QR code and link being live.

There is a plan to conduct an in depth analysis of results and for information services to review the data sent to ensure there are no anomalies that could inadvertently be affecting the results. There may also be an element of survey fatigue for patients who access our services more frequently. However response rate is not a nationally monitored metric, and whilst more feedback is better, the focus should be on how we use the feedback for improvement.

**Community services have been separated into their own department, previously some community services were sat within outpatients which contributes to the reduced response rate in outpatients.*

Positive rating

Department	March 2025	July 2025
Trust Overall	91.66%	92.83%
Outpatients	94.20%	94.86%
Inpatients	85.71%	90.63%
Community	N/A – not live	90.32%
Emergency Department	76.39%	84.84%
Day Case	96.10%	97.10%

Positive ratings have increased in all areas. If Divisions focus on using feedback for improvement the Trust should see a continued rise in positive ratings, reacting to feedback at this early stage could potentially reduce concerns and complaints. Sharing with patients how we have used their feedback will encourage feedback to be provided in the future as we are seen as a Trust that acts on the feedback it receives.

Case Study- Podiatric Surgery

Podiatric Surgery did not have access to the text messaging service and have only received FFT feedback since the new survey went live on 1st July 2025. In the first month 77 text messages were sent to patients and 77 responses were received with 100% positive feedback. The team were delighted with this response.

Next steps for FFT

- Introduce a mechanism for those patients to leave FFT feedback that either choose not to or cannot use technology.
- Response rates will continue to be monitored and any action taken to increase will be explored.
- Exploration of how we can utilise QR code and web link more effectively by attaching to appointment letters and the patient portal.
- For those departments that do not discharge regularly, explore how we can use the QR code and web link for targeted requests for feedback.
- Understand how our volunteers can help.
- Have 'You said..We did' visible across the Trust, use examples of improvement from FFT via social media on a regular basis and include in our annual Quality Accounts.

Complaints

This section of the report provides;

- KPI data update Q1
- Analysis of complaints position by Division
- PHSO cases update

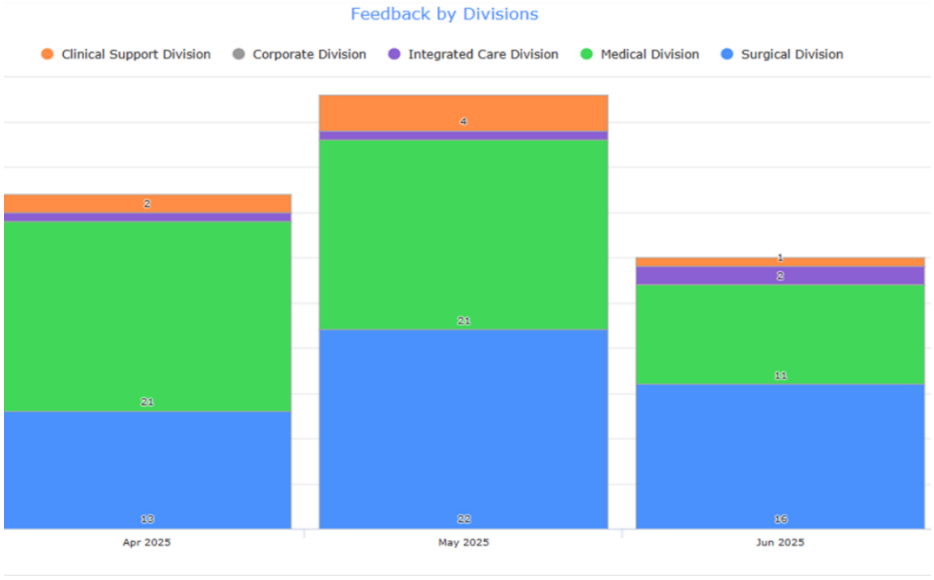
Complaints position

(New complaints only)

KPI	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Q1	Total Q2	Total Q3	Total Q4	Total Apr-Mar (inc)
Number of complaints **2024/25**	46	31	30	29	21	32	46	27	27	34	28	35	107	82	100	97	386
Number of complaints **2025/26**	36	48	30										114 ↑6.5%				

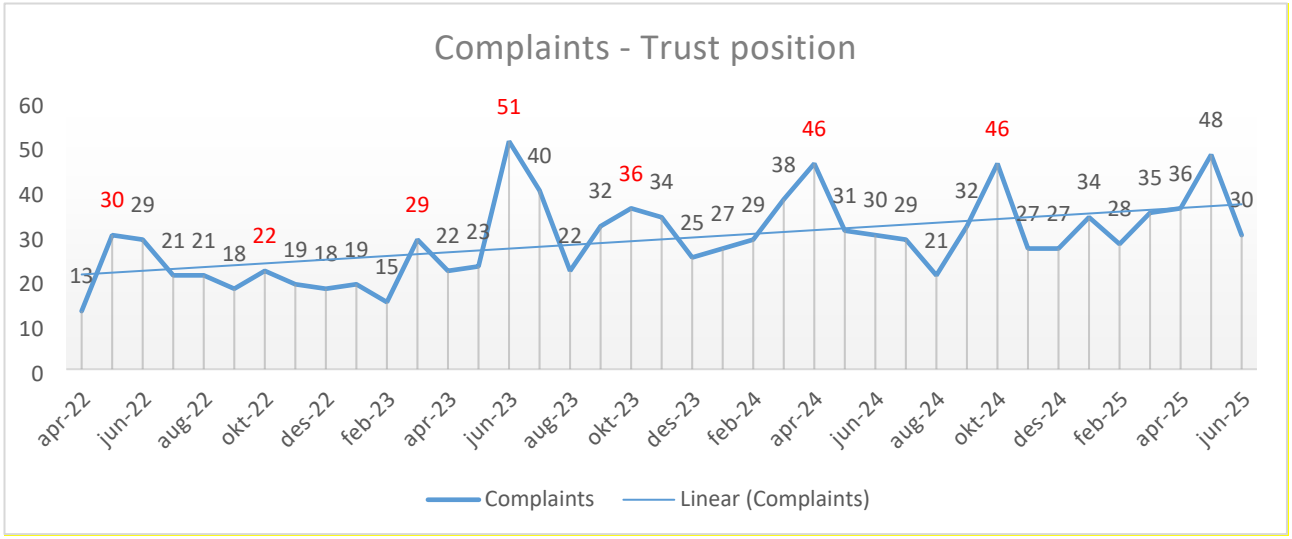
A comparison of data between Q1 in 2024/24 and 2025/26 shows an overall increase of 6.5% in new complaints received in the same period.

The chart below shows the new complaints received by Division each month:



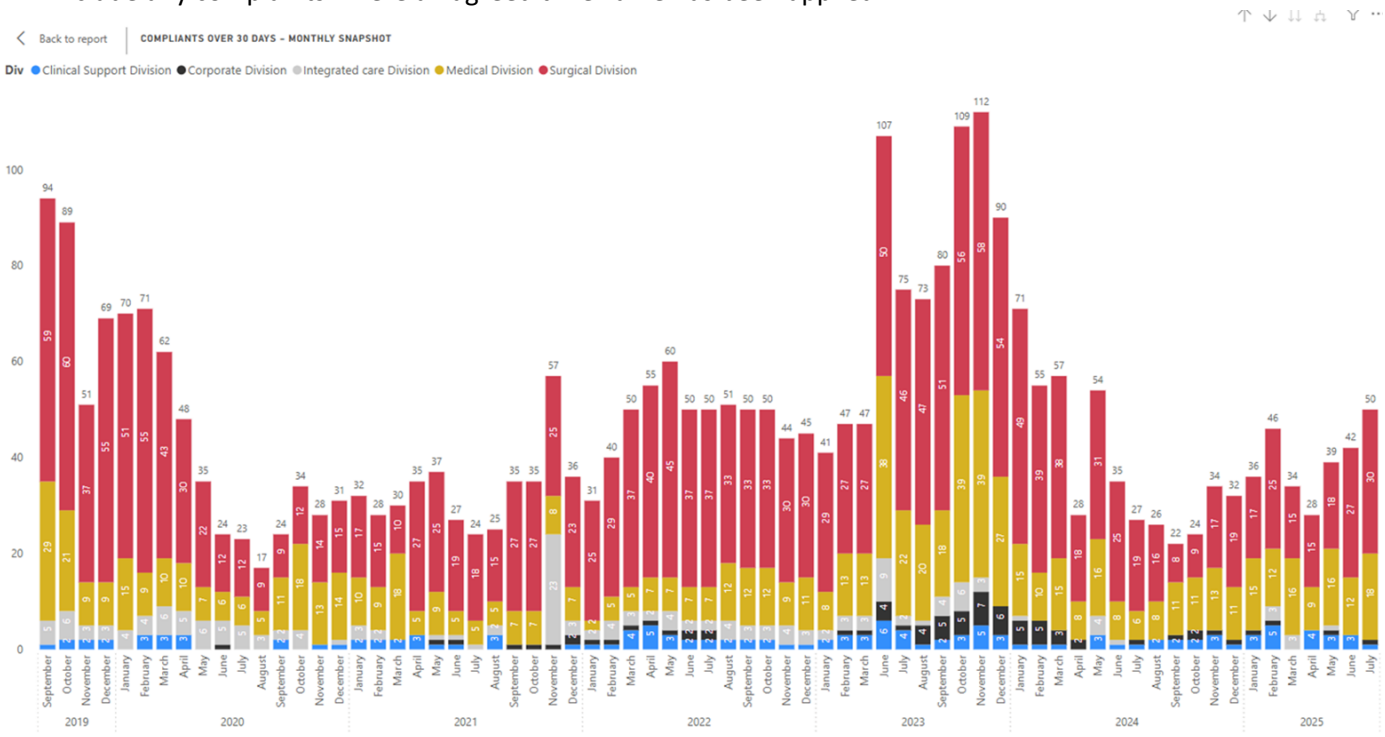
There are 92 open complaints (as of 08.08.25), with 50 in surgery, 40 in medicine and 2 in clinical support. Head Neck and Orthopaedics, Emergency Department and Women & Children's Directorates have the most open complaints.

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



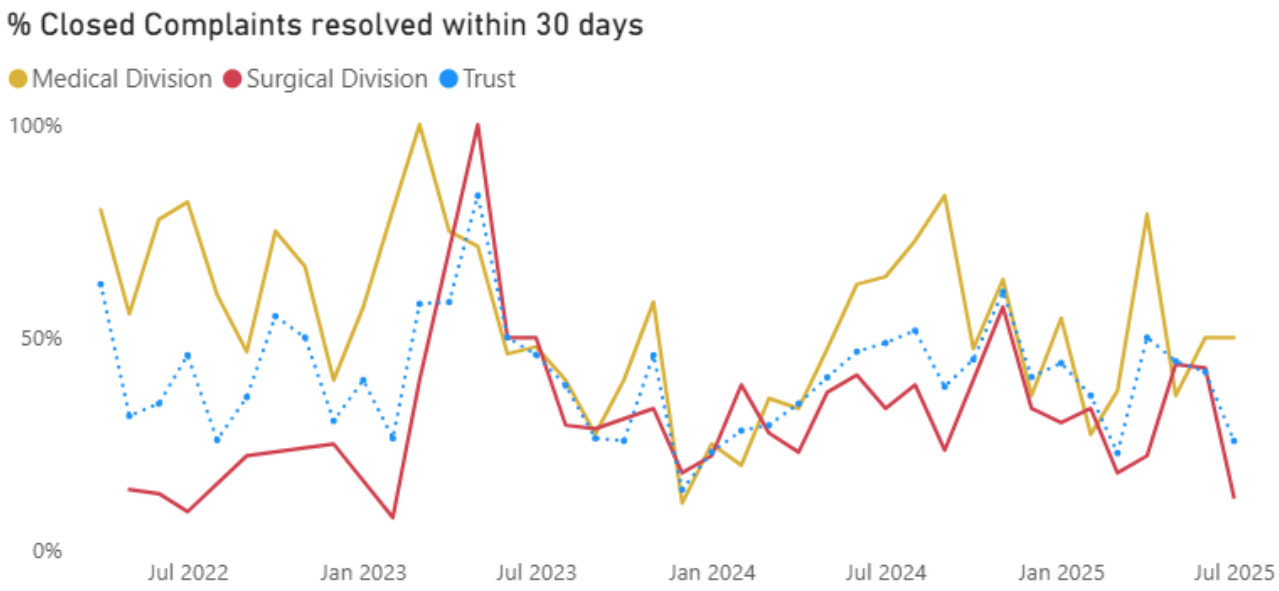
Complaint response times

The chart below highlights the current number of complaints open over 30 days by division. These figures will include any complaints where an agreed timeframe has been applied.

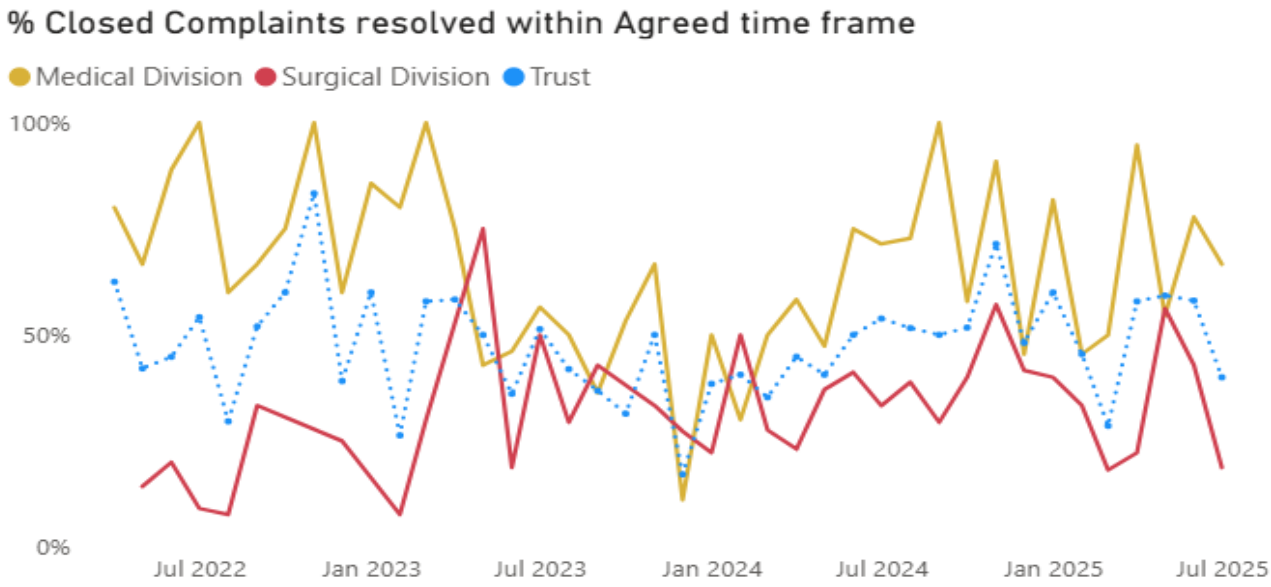


The chart below shows the percentage of complaints being resolved within the 30 day timeframe (rolling 3 month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers.

Q1 saw an improvement for Medical Division and Surgery from the previous quarter, but the Trust can demonstrate compliance with this KPI in only 40-50% of complaints.



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



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

Ensuring the Complaints department are notified of any extensions required prior to expiry of the 30 day target will ensure the complainant is kept informed and additional time can be agreed to provide a comprehensive response.

Comebacks

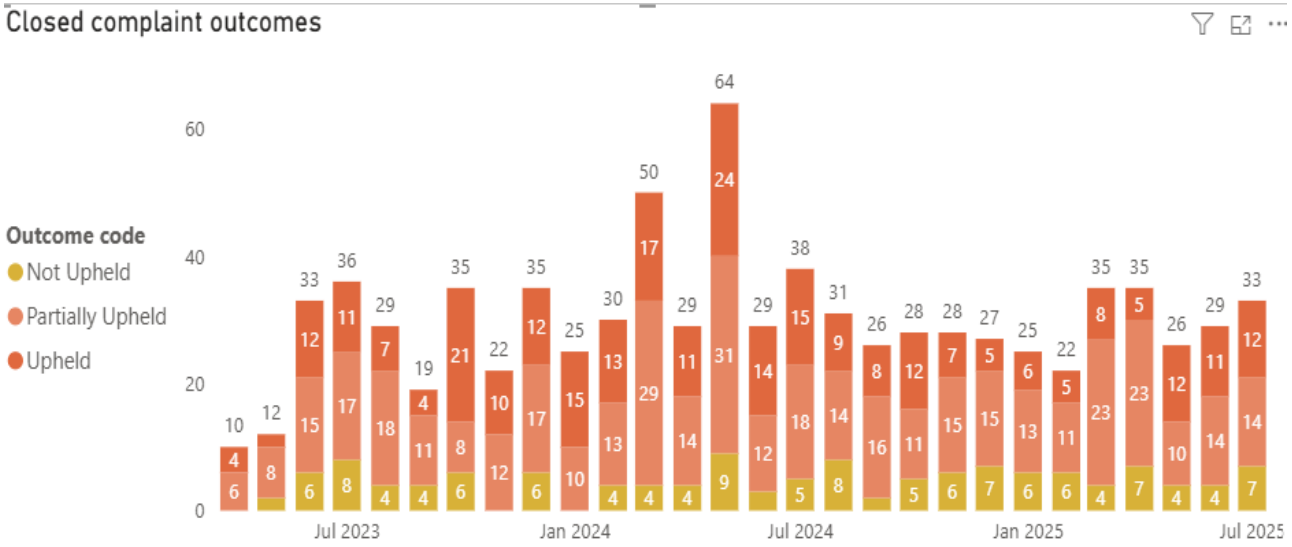
When also considering the number of complaints that are reopened ('comebacks') that Divisions also need to respond to, this increases the total number of complaint responses required. The number of comebacks has doubled since last year. Analysis shows that improved accuracy and ensuring all questions asked are responded to will support a reduction in comebacks.

The chart below provides the number of comebacks year and year.

Number of comebacks 2022/3	36
Number of comebacks 2023/4	26
Number of comebacks 2024/5	49
Number of comebacks 2025/6 (Q1)	12

Complaint Outcomes

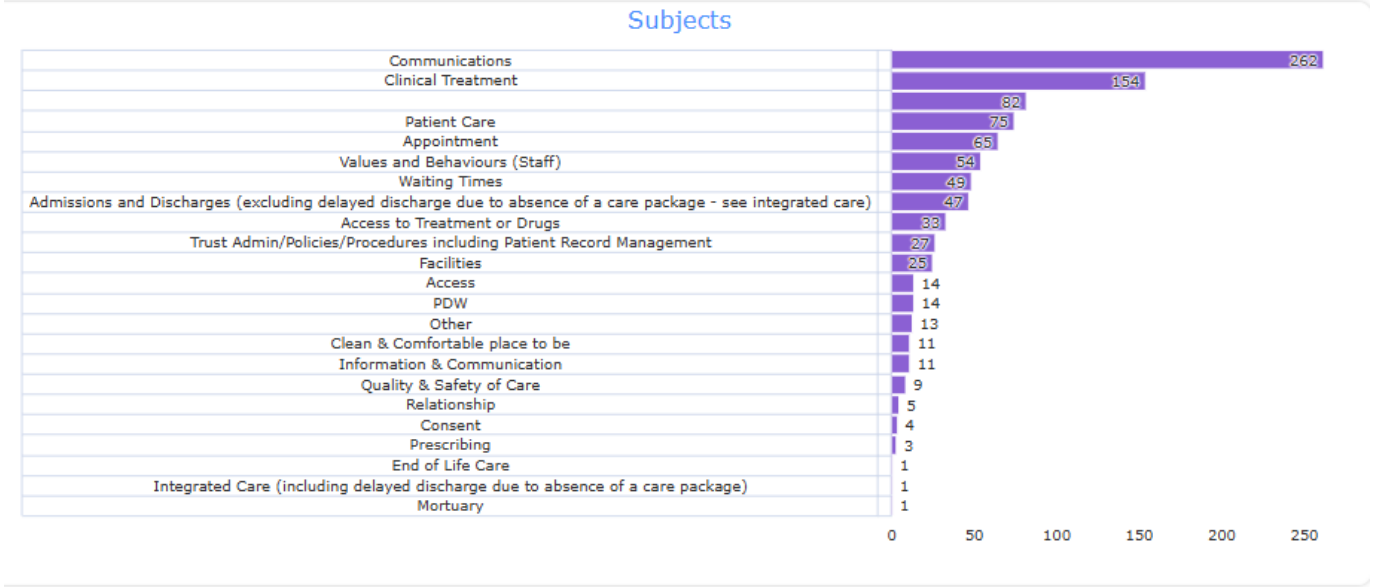
The chart below shows the Trust complaint outcomes as decided by the Divisions for new complaints and comebacks received in month. There are open complaints in Q1 that will not yet have an outcome code.



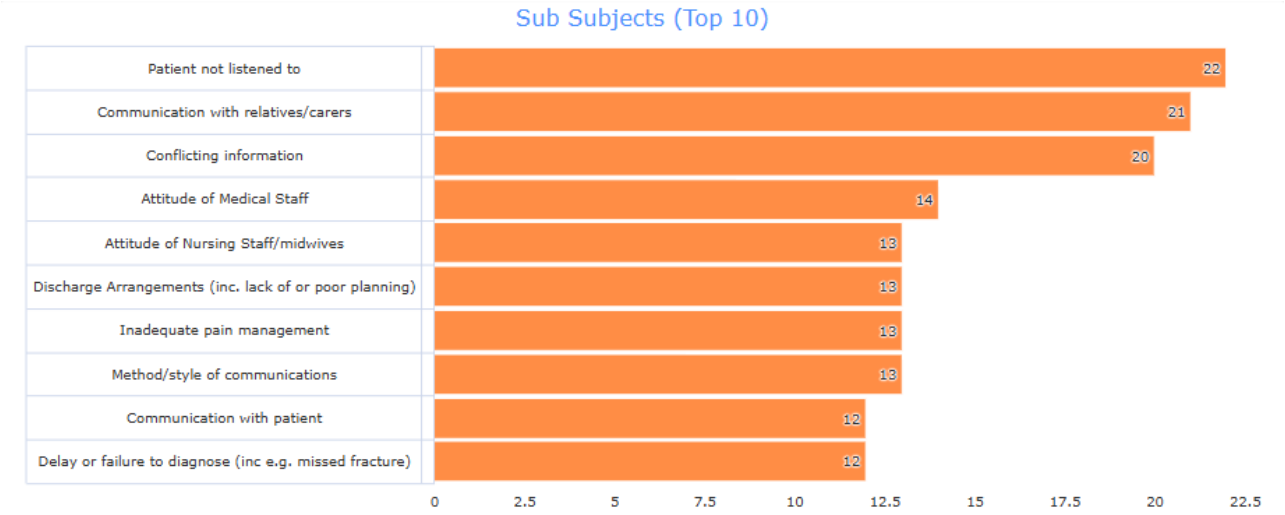
Complaint categories

There can be multiple categories and sub categories identified in a complaint. These are analysed and recorded in a triage process by the complaints team based on the complainant's perception of the events.

The below chart shows the complaint categories for Q1



The below chart shows the top 10 complaint sub-categories for Q1



Complaints regarding poor communication or concerning the attitudes of medical and nursing staff have been identified frequently and is our top complaint category.

A summary of ED complaints relating to values and behaviours has been passed to the Division to review, and further trust wide analysis is being undertaken by the complaints team and will be presented as a deep dive in the next quarterly report.

Parliamentary and Health Service Ombudsman (PHSO) update

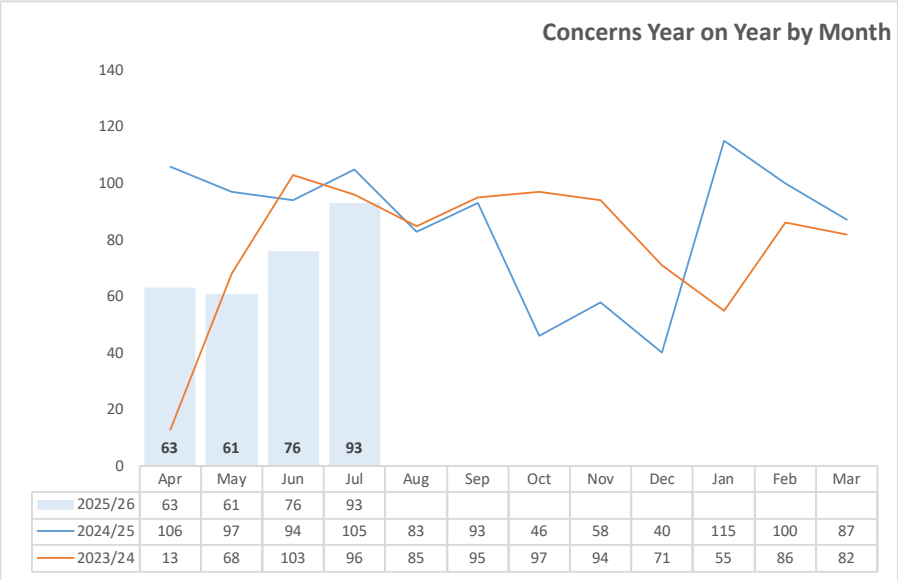
There was a sharp increase in cases referred to the PHSO in 2024. Analysis across the group shows that WVT is not an outlier for referral.

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

There are no current open PHSO investigations, although there have been 2 requests for information pending decision.

Concerns

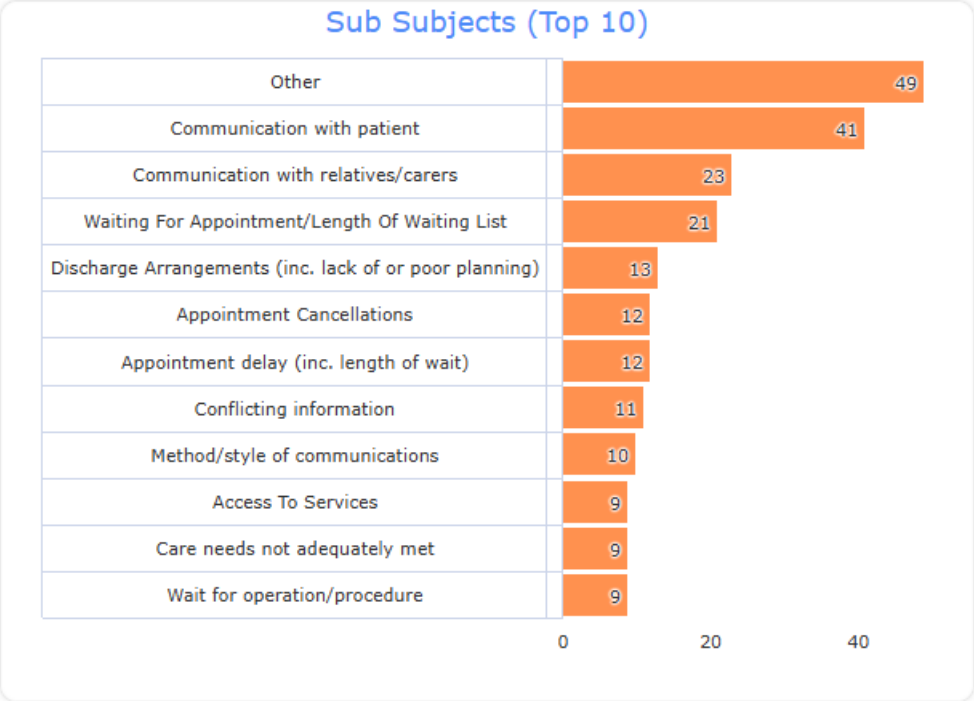
When reviewing the concerns data for Q1, we have noted that concern numbers continued to demonstrate a reduced trend month on month, compared to previous years. However, there was a small increase in June which has continued into the start of Q2. This may be the result of increased access to PALS after a period of reduced service. Further monitoring will be required to establish if this is an ongoing trend.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/26	63	61	76	93								
2024/25	106	97	94	105	83	93	46	58	40	115	100	87
2023/24	13	68	103	96	85	95	97	94	71	55	86	82

The largest number of concerns, comments and enquiries are still logged for surgical and medical divisions, with the most commonly reported subject remaining communication.

A further breakdown of sub-subjects giving more insight into the overall theme of communication, are outlined below:



PALS service

After a team restructure and successful recruitment process, Q1 saw the PALS service finally return to a full staffing complement, by the end of the reporting period and a full PALS service has now been reinstated. This may be reflected in the increase in PALS activity towards the end of the quarter.

Further monitoring of activity data is needed to establish if this is a true increasing trend in concerns, or a return to service users raising concerns directly with PALS rather than seeking early resolution through 'every day conversations' with clinical teams as per the PHSO model complaint guidance.

Patient Experience Committee

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

Patient Engagement Forum

The patient engagement forum continues to meet monthly with many staff bringing projects to the group for input and support. During Q1 the group have:

- Reviewed the Quality Account to ensure readability appropriate to service users
- Provided feedback on implementation of AI systems such as HEIDI
- Reviewed "This is me" document and provided feedback on implementation process
- Approved plans for MRU mural designs
- Support with PLACE lite audits

Plans for Q2/Q3 include:

- Review of patient engagement charter
- Co-design of new posters and information leaflets for complaints and concerns processes
- Continue support for PLACElite and main PLACE audits

Patient Surveys

There were no patient surveys published in Q1. The Q2 report will cover the Cancer Patient Experience Survey, National Inpatient Survey and National Maternity survey results.

Conclusion

When reviewing the data against our quality priority measures we are seeing progress and improvement in a number of areas, however recognise there is more work to do to deliver the quality priority going into 2025-26.

Measure	2024/25 Update year end	Q1 update	Q2 update	Q3 update	2025/26 year end update
Evidence use of FFT feedback to generate improvement (projects/ case studies)	Due to delays in rolling out to all services further projects stalled. Will continue to review next year with introduction of expanded system	FFT system live at end of quarter.			
Improvement in national patient survey results	No further survey results reported.	No results reported in Q1			
Evidence use of survey feedback to generate improvement (projects/ case studies)	Improvement projects continue and new quality priority introduction for 2025-26 for nutrition and food quality.	No results reported in Q1			
Reduction in complaints and concerns	3% increase in complaints overall.	Increase in complaints compared to Q1 2024/25. Reduction in concerns however needs to be analysed due to administrative changes.			

Improved response times to complaints and concerns	Overall an improving trend continues. However overall the Trust only responds to a complaint within agreed timeframes for 50 of complaints.	No real change from previous report. However better at responding within agreed timeframe than 30 day KPI.			
Reduction in overdue responses to complaints and concerns.	Overall improvement but not meeting board KPI of 90%.	No improvement in Q1 and same issues seen as in previous year.			
Reduction in comebacks or re-opened cases.	Comebacks doubled from 2023-2024. Deep dive into underlying issues undertaken and shared with divisions.	Comebacks in Q1 show a trajectory in line with 2024/25 figures which were double the previous year			
Increased patient engagement and collaboration on improvement projects	Group fully embedded and supporting a number of projects. Members report positive experience of being in the group and being part of service level change.	Increase in initiatives being taken to the group to involve patients in changes and developments.			

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

HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICB	Integrated Care Board
ICP	Integrated Care Provider
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
LTP	Long Term Plan
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
NMC	Nursing Midwifery Council
OBC	Outlined Business Case
OOC	Out Of County
OHP	One Herefordshire Partnership
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RTT	Referral to Treatment

SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAHT	Worcestershire Acute Hospitals Trust
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur