PUBLIC BOARD MEETING

Thu 02 October 2025, 13:00 - 14:30

MS TEAMS

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Frances Martin

Jane Ives, Kieran Lappin and Sarah Shingler.

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 4 September 2025

Decision *Frances Martin*

3. PUBLIC BOARD MINUTES - SEPTEMBER 2025 LF.pdf (7 pages)

13:03 - 13:05
2 min

4. Matters Arising and Actions Update Report

Discussion *Frances Martin*

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

13:05 - 13:35
30 min

5. Items for Review and Assurance

5.1. Managing Directors Report

Discussion *Katie Osmond*

5.1 Managing Directors Report.pdf (4 pages)

5.2. Integrated Performance Report

Discussion *Katie Osmond*

5.2 WVT Full Pack Month 2 - IPR_Board.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 - 13:50
15 min

6. Items For Approval

6.1. Terms of Reference Hoople Board

Decision *Gwenny Scott*

- 6.1 Hoople Terms of Reference Update Report to Board October 2025.pdf (1 pages)
- 6.1a Hoople Board Terms of Reference V1.2 June 2025 draft.pdf (3 pages)

6.2. Terms of Reference Financial Recovery Board

Decision *Gwenny Scott*

- 6.2 WVT FRB Terms of Reference Front Sheet.pdf (1 pages)
- 6.2a WVT FRB Terms of Reference v3 - FINAL Version.pdf (3 pages)

6.3. Provider Capability Assessment

Decision *Gwenny Scott*

Main report to follow

- 6.3 Provider Capability Assessment Coversheet October 2025.pdf (2 pages)
- 6.3a - WVT Provider Capability Assessment September 2025 (1).pdf (1 pages)
- 6.3b - WVT Provider Capability Assessment Detailed September 2025 (2).pdf (11 pages)

13:50 - 14:15
25 min

7. Items for Noting and Information

7.1. Trust Infection and Prevention Annual Report

Discussion *Lucy Flanagan*

- 7.1 Front Sheet IPC Annual Report.pdf (1 pages)
- 7.1a IPC Annual Report 2024.25 Final LF to Quality Committee TIPCC.pdf (42 pages)

7.2. Trust Annual Objectives 25-26 – mid-year review

Information *Alan Dawson*

- 7.2 2025-26 Trust Objectives - mid year review Covering Report.pdf (1 pages)
- 7.2a 2025-26 Trust Objectives - mid year review - collated.pdf (5 pages)

7.3. Perinatal Safety Report (Maternity)

Discussion *Lucy Flanagan*

- 7.3 Perinatal Services Safety Report August 2025.pdf (16 pages)

7.4. Committee Summary Reports and Minutes

7.4.1. Charity Trustee Report and Minutes 12 June 2025

Discussion *Grace Quantock*

- 7.4.1 CT FS.pdf (1 pages)
- 7.4.1a CT REPORT - 12 JUNE 2025.pdf (2 pages)
- 7.4.1b Charity Trustee minutes ~ June 2025.pdf (3 pages)

7.4.2. Quality Committee Report and Minutes 31 July 2025

Discussion *Ian James*

- 7.4.2 Quality Committee Summary Report July 2025 - public.pdf (2 pages)
- 7.4.2a Minutes Quality Committee - July 2025.pdf (10 pages)

7.4.3. Integrated Care Executive Report

Discussion *Frances Martin*

- 7.4.3 ICE Escalation & Assurance Report June_Aug 2025.pdf (1 pages)
- 7.4.3a ICE Escalation & Assurance Report September 2025.pdf (1 pages)

14:15 - 14:20
5 min

8. Any Other Business

14:20 - 14:25
5 min

9. Questions from Members of the Public

Frances Martin

14:25 - 14:25
0 min

10. Acronyms

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

14:25 - 14:25
0 min

11. Date of Next Meeting

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

WYE VALLEY NHS TRUST
Minutes of the Public Board Meeting
Held on 4 September 2025 at 1.00 pm – 2.30 pm
Live Streamed

Present (Voting):		
Frances Martin	FM	Non-Executive Director and Meeting Chair
Chizo Agwu	CA	Chief Medical Officer
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):		
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Kieran Lappin	KL	Associate Non-Executive Director
Andy Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director
Gwenny Scott	GS	Associate Director of Corporate Governance
Sarah Shingler	SS	Incoming Managing Director – Observing
In Attendance:		
Val Jones	VJ	Executive Assistant for the minutes
Lou Robinson	LR	Deputy Company Secretary
Apologies		
Ellie Bulmer	EB	Associate Non-Executive Director
Glen Burley	GB	Foundation Group Chief Executive / National Financial Reset and Accountability Director
Russell Hardy, MBE	RH	Chairman and Meeting Chair
Justine Jeffery	JJ	Director of Midwifery

FM welcomed SS as our incoming Managing Director.

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**FM**	**Information**	**Verbal**
Noted as above.				
2.	**Quorum and Declarations of interest**	**FM**	**Information**	**Verbal**
The Board was quorate and there were no new declarations received.				
3.	**Going the Extra Mile Awards – Quarter 1**	**FM**	**Information**	**Verbal**
Team of the Quarter – Specialist Palliative Care Team – FM read out the reasons why the Team were nominated for this award.				

Employee of the Quarter – Kelsey Beddoes – FM read out the reasons why Kelsey was nominated for this award.

4.	**Minutes of meeting on 3 July 2025**	**FM**	**Approval**	**Enclosure 1**

Approved.

5.	**Matters Arising and Action Log**	**FM**	**Information**	**Enclosure 2**

The Board accepted the Action Log update.

6.	**Manager's Director Report**	**JI**	**Assurance**	**Enclosure 3**

NHS Oversight Framework and Segmentation - The 1st September marks the start of implementing the 10-year plan published in July. New Operating Guidelines for planning next year have been released, initiating formal strategic planning. A new Oversight Framework places Trusts into segments 1–4, with segment 5 for national intervention. The Trust is expected to be in segment 3, mainly due to our underlying financial deficit and being in receipt of financial support. Even with strong performance, financial issues prevent advancement to segment 2 or 1. JI was concerned about how segmentation is determined, suggesting that meeting financial plans should be prioritised over historical deficits.

Medium Term Planning – Guidance and timescales – The Five-year Strategic Commissioning Plan (by Commissioners) and the Five-year Integrated Delivery Plan (including financial recovery) have been published. Planning is already underway, with Financial and Service Planning meetings scheduled. There is a new requirement for a Neighbourhood Health Plan, focusing on a shift from Acute to Community care, emphasis on prevention over treatment and collaboration across GPs, Community services, and the voluntary sector. This will be led by the Health and Wellbeing Board, building on previous work under One Herefordshire.

ICB Changes - Local ICB leadership have been appointed to lead cluster arrangements. On a positive note, this will provide continuity and strong working relationships.

Powys Commissioning – There has been an extension of waiting times for routine patients as instructed by Welsh Powys Health Board. There are concerns over safety, especially for new referrals with the proposed 1-year wait. There are ongoing discussions and a letter of concern sent by the Chief Medical Officers.

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.

JI reflected on her 25 years on NHS Boards and 10 years working in the Trust. This marks the beginning of a farewell period, with the AGM in three weeks. She expressed gratitude to the team for their excellence and support.

SC noted that the Performance Framework and new Planning Cycles are starting to take shape, forming the architecture for the coming years. He suggested scheduling an update on this to a future Board session to explain how all the moving parts are coming together helpful for colleagues and the public to understand the overall direction. Much of the work will be done through Board development, but a formal Board discussion in a couple of months would be valuable. The emphasis is on transparency and helping others see how the strategy is being "knitted together." FM agreed noting that receiving the planning framework earlier than usual (before Christmas rather than in the new year) is a positive shift. This allows for proactive planning, which is welcomed from both provider and collaborative perspectives.

Action 6 – To discuss the progress on the new Performance Framework and Planning Cycles in a future Public Board meeting – SC.

The Board accepted the Managing Directors Report.

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

Service planning is evolving under the 10-year plan, with a stronger focus on engagement with patients, communities, and citizens. This marks a fundamental shift in how services are designed and delivered.

There are concerns about worsening mortality rates which have been addressed. The is partly due to the Trust being one of only 40 to update Same-Day Emergency Care recording in July 2024, which changed benchmarking and means that Trusts are not all being measured using the same data. Assurance can be gained that the Trust remains in a good position, and previous monitoring methods would have shown better results.

The Trust has been moved into Tier 1 in Q1 for our urgent care performance. This is disappointing since we have seen significant improvements in July and August, though recent days have been challenging. Urgent care is central to both quality improvement and financial recovery, requiring collaboration across the Acute, Primary Care, and partners.

The rising numbers of patients waiting over 52 weeks is a concern. Plans are in place to reduce this, aiming for only 1% of the waiting list to exceed a year by March 31st. Teams are clear on the task, but risks remain.

Recent recruitment of high-calibre Consultants is a major positive, especially in the Emergency Department, which previously had only two substantive Consultants. This has now increased to eight consultants, with strong recruitment across other specialties. This reflects the Trust becoming a more attractive employer due to ongoing improvements.

Compared to last year, the Trust is in a better financial position, slightly ahead of trajectory. Still, significant work remains to stay on track.

FM echoed the congratulations to the hard work and the positivity but recognised the significant pressure that our Emergency Department is experiencing. She encouraged patients to choose wisely and make the most of 111, Community Pharmacy's and other avenues through their GP before considering whether the Emergency Department is the most appropriate option.

The Board accepted the Integrated Performance Report.

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

Patient feedback has been expanded across all services, including new methods and detailed surveys to help with more in-depth feedback aimed at improving service quality. Podiatric surgery achieved a 100% response rate and 5-star ratings from all patients—setting a high standard for other services.

The Cancer Patient Experience Survey was published in July 2025, with a 60% response rate from 500 patients. Two focus areas where we did not perform so well are male cancer patient experience, a known national issue and Welsh patients receiving care across borders. Further detail on specific cancer pathways will be reviewed in the next quarter.

Pathology Accreditation (UKAS) - June–July visits identified 80 areas for improvement requiring a mandated response. Most issues were resolved quickly; subsequently evidence has been submitted to UKAS and 54 elements have already been accepted and closed, the others are under review. An area of greater concern was quality management oversight, especially audit and risk assessments. Recruitment is underway to strengthen the resource available for the Quality Manager role. A follow-up visit is scheduled for December.

Cleanliness Inspection – The Trust moved from intensive to enhanced monitoring following the inspection undertaken in May 2025. There are ongoing Executive meetings with Estates, Sodexo, and clinical teams to maintain momentum. A further review is scheduled for September with a view we may achieve routine monitoring status.

Interpreting Services – A new service was launched in April 2025, using Interpreters with healthcare experience. Positive feedback overall, with 35 languages used so far. Minor teething issues are being addressed.

CA advised that the SHMI continues to rise, showing a disparity between observed vs. expected deaths. However, the actual number of deaths remains low, providing reassurance. The disparity is understood to be due to the Trust removing Emergency Same Day Care from its denominator—only 40 Trusts have done this.

There are ongoing efforts to improve diagnostics and clinical pathways, including fractured neck of femur and Test-of-change initiatives which have led to more timely admissions and treatments. Sepsis audits indicate a reduction in mortality. Process mapping is scheduled for 18th September to further refine care pathways.

Focus continues on improving coding accuracy, including ensuring all patient spells are coded. We are reviewing patients with a CCI (Charlson Comorbidity Index) score of zero to ensure proper classification and maximise coding quality.

FM noted that the 12-month mortality index continues to show variation due to differences in data counting across Trusts. The Trust's actual mortality rate remains low, which is reassuring. The disparity is linked to the Trust's adoption of a revised accounting method (removing Emergency Same Day Care from the denominator), used by only 40 Trusts. Ongoing tracking is essential to avoid false assurance, and there is hope that other Trusts will adopt the same methodology soon.

FM praised the breadth and depth of the rollout of the Friends and Family Test. 100% satisfaction in Podiatric surgery is now seen as the benchmark. Public and service users are encouraged to share feedback, which is vital for improving care.
FM advised that today would have marked Martha Mills' 18th birthday. Her parents launched a national campaign to improve Critical Care Outreach and the ability for patients and families to request enhanced scrutiny or reassessment of care. Wye Valley Trust has adopted this initiative, encouraging patients, carers, and relatives to alert staff to any concerning changes in a patient's condition. The Trust is fully aligned and supportive of this national effort to improve safety and responsiveness in care.

The Board accepted the Quality (including Mortality) Report.

9.	**Activity Performance**	**AP**	**Assurance**	

The Trust is currently in Tier One, which is disappointing but reflects performance dips in Q1. Summer Workshops helped improve performance, with July and August showing significant recovery. Despite challenges in late August, August performance was notably better than Q1 with our 4-hour target: only 3% behind trajectory. Our 12-hour target: remains on plan. Ambulance handovers have improved, though still challenged.

Some performance improvements are proving sustainable, especially in non-admitted ED care. Phase Two Workshops starting this month will focus on SDEC optimisation, shifting mind-set from ED-first to SDEC-first, preparing for a capital build to triple SDEC capacity by February, enhancing streaming, direct admissions, and ambulance capacity. NHS England will provide critical friend reviews to validate plans. There is also focus on Ward-based processes, including digital transformation, discharge pathways, Home-first approach and focused discharge reviews, strengthening internal professional standards for early discharge and flow and Referral to Treatment and long waits.

18 week RTT performance is improving. 52WW remain a challenge in Gynaecology, Ophthalmology, Trauma & Orthopaedics and ENT (most significant issue). The Surgical Division has robust plans to recover position by Q3, with regular assurance reporting.

The Echocardiogram backlog reduced from 900 to 650 patients over six weeks. The target is to get to 400 by the end of October, 200 by the end of Q3. Endoscopy is now the focus. Plans include increased capacity at Ross On Wye Community Hospital (5-day service in October). This will be supported by positive recruitment efforts.

The Board accepted the Activity Performance Report.

10.	**Workforce**	**GE**	**Assurance**	

The consultation programme for Admin and Clerical staff has begun following discussions with Trade Union reps. The change programme will run for 4–5 weeks, with a commitment to handle it compassionately, fairly, and objectively. HR teams are actively supporting Line Managers, and Trade Unions are closely involved.

Early signs of reduced sickness absence following the introduction of a revised Policy. Reducing sickness absence remains a key focus for HR. National study on sickness absence has started, with Wye Valley Trust featured as a case study. Results expected next year.

Equality, Diversity & Inclusion remains a priority, with ongoing support for various activities across the Trust.

Health & Wellbeing Week is scheduled for 6th October, with a focus on promoting flu vaccinations to help reduce sickness absence during winter and encouraging staff to engage in wellbeing initiatives.

The Trust is on track with its Workforce Plan. Monthly monitoring using a workforce tracking tool shows positive progress, with a commitment to maintain momentum through the financial year.

FM encouraged Board members to get their flu vaccination. There has been positive feedback on the return to peer vaccinators, making it easier for 24/7 clinical teams to access flu jabs.

The Board accepted the Workforce Report.

11.	**Finance**	**KO**	**Assurance**	

The Trust is £327,000 ahead of plan, indicating a stable start to the year despite costs incurred from industrial action. Key contributors are the £400k savings from reduced Agency spend (lowest in years at 32% of pay bill in July) and the one-off rebate from maternity insurance.

Elective activity is on track; income is slightly behind due to timing issues but matched by delayed expenditure. We are £900k ahead of our efficiency target year-to-date. We have achieved 20% of the annual target in the first third of the year. Focus remains on mitigating risks to ensure continued delivery. Key risks include CPIP funding pressures, Welsh Commissioning decisions and other smaller financial risks. Risks are being tracked at Divisional and Trust-wide levels via Finance & Performance Executive and the Financial Recovery Board. The aim is to identify risks early and develop timely mitigations.

Cash balances are £5 million higher than planned (end of July). Deficit support secured for Q1 and Q2; future access depends on financial performance and efficiency delivery. Capital spend is ahead of plan due to faster-than-expected progress on schemes, but overall forecast remains on track.

Medium-term planning has begun, with a productive Workshop session held. More updates to follow in future Board meetings.

FM noted that the Trust provides care for around 40,000 residents in Powys, who are local patients, though commissioned differently due to their registration with Welsh GPs. Despite bureaucratic complexities, the Trust's commitment to high-quality, responsive care for Welsh patients is unwavering. Efforts continue to overcome logistical challenges and ensure equitable access to care.

FM highlighted that post-pandemic, NHS funding shifted from usual patterns; the Trust is now working to restore financial balance under the 10-year plan. Focus is on delivering right care, in the right place, at the right time, and avoiding delays that cause patient distress and inefficient use of resources. A recent clinical innovation was highlighted that accelerates the pathway from acute presentation to surgery, improving patient experience and outcomes. These efforts support the Trust's goal to live within its means and balance the books by year-end.

The Board accepted the Finance Report.

	ITEMS FOR APPROVAL			
12.	**Herefordshire/Wye Valley NHS Trust Winter Plan and Winter Board Assurance Statement 2025**	**AP**	**Approval**	**Enclosure 5**

The Winter Plan aligns with the Urgent and Emergency Care Strategy, not a separate plan, but a continuation of existing improvement efforts. A high-level summary of schemes is shared with the Board via presentation slides.

Performance Modelling - The Trust was asked to model its ability to meet the 78% emergency access standard under baseline, surge, and super surge scenarios. Surge modelling was used, as Wye Valley typically operates in surge conditions due to escalation spaces and boarding.

Key Schemes & Focus Areas include Discharge to Assess, admission avoidance, and frailty management via PCNs, the Respiratory mobile MDT teams are targeting 600 high-risk patients to prevent admissions and the use of emergency admissions predictor and discharge targets by day and pathway. The Community Diagnostic Centre is also launching this month, supporting urgent care and breathlessness pathways.

Partnership & Coordination – There is ongoing engagement with Powys teams, including regular reviews of their winter plans. We have updated Escalation Policies and matrix ahead of winter. This includes plans for vaccination, infection prevention control, and workforce management. Initial ICS-level stress testing with NHS England has begun. Further Regional and local exercises planned, including internal simulations led by the Emergency Planning Officer.

There is concern over rising emergency admissions and system capacity to deliver planned reductions. There is a risk that system-wide schemes may not sufficiently reduce bed use, impacting escalation bed availability. The Board is asked to note the risks and provide assurance sign-off for the Winter Plan.

FM noted that staff are stepping up to work out of hours to help keep services safe and expressed her appreciation for their dedication and flexibility.

The Board approved the Herefordshire/Wye Valley NHS Trust Winter Plan and submission of the Winter Board Assurance Statement 2025 to NHS England.

	ITEMS FOR NOTING AND INFORMATION			
13.	**Foundation Group Board Minutes and Action Log 6 August 2025**	**FM**	**Information**	**Enclosure 6**

The Board accepted the Foundation Group Board Minutes and Action Log 6 August 2025.

14.	**Quality Committee Report and Minutes 6 June 2025 and 26 June 2025**	**IJ**	**Information**	**Enclosure 7**

The Board accepted the Quality Committee Report and Minutes 6 June 2025 and 26 June 2025.

15.	**Perinatal Services Quality Report**	**LF**	**Information**	**Enclosure 8**

Since the last Board meeting new leadership appointments - Justine Jeffrey joined as Director of Midwifery (shared post with Worcestershire Acute and Susan Hughes started as Deputy Director of Midwifery.

The national investigation into Maternity and Neonatal services led by Baroness Amos is underway. Trusts selected to take part in this will be announced soon. The local response to the national investigation is outlined in the report, including a Charter developed through multidisciplinary summits to promote a positive culture and values and ongoing work to embed these values across teams.

Maternity Neonatal Voices Partnership (MNVP) – The MNVP provides independent scrutiny and valuable service user feedback. Concerns were raised about sustainability of this model due to staffing gaps and recruitment restrictions within ICB's. The issue was escalated Regionally and Nationally. Further discussion around this is planned at the Local Maternity and Neonatal System Board meeting which is due to take place in the forthcoming week.

FM advised that the recruitment issue affecting MNVP has been raised and flagged with Regional colleagues. MNVP provides a structured and invaluable user voice in shaping Maternity and Neonatal services. Losing this function would be detrimental to service quality and patient feedback. The Board values MNVP's role with a request for ongoing updates on progress. If needed, the Board is prepared to take formal action to support sustainability.

The Board accepted the Perinatal Services Quality Report.

16.	**Patient Experience Quarterly Report and Quality Priority Update**	**LF**	**Information**	**Enclosure 9**

Patient engagement and Friends and Family Test feedback were discussed earlier and reviewed in detail at the Quality Committee.

The Trust continues to receive a high number of complaints, making it an outlier nationally and within the Foundation Group. There is a high volume of "comebacks" (patients dissatisfied with initial complaint responses). Top complaint themes: communication, attitude, behaviours, and values (consistent with national trends but still concerning locally). A deep dive into complaints related to staff attitudes, values, and behaviours is underway and will be reviewed at the Quality Committee. There are plans to implement the Public Health Service Ombudsman (PHSO) guidance on complaint handling, focussing on early conversations and resolution and aim to reduce formal complaints and improve patient experience.

FM highlighted that the issue of patient complaints and feedback was discussed in depth at the Quality Committee, with strong interest and scrutiny from Non-Executive colleagues. Emphasis is on improving communication style and understanding how messages are perceived by patients. The Trust is committed to listening openly to concerns, acknowledging mistakes with gratitude and apology and learning from feedback to improve future care. A non-defensive culture is promoted, valuing early conversations with patients to better understand their needs. FM also recognised that many patients are highly satisfied with their care, thanks to the dedication of staff across the Trust.

The Board accepted the Patient Experience Quarterly Report and Quality Priority Update.

17.	**Any Other Business**			
FM advised that JI is approaching 45 years of service in the NHS, an extraordinary achievement. Her career began with nurse training at the John Radcliffe Hospital in Oxford, followed by various clinical roles. Leadership quickly became her path, with senior roles including Director of Nursing and Chief Operating Officer at South Warwickshire Foundation Trust. For the past 10 years, JI has served at Wye Valley Trust, including nine years as Managing Director, where she expanded into system leadership. She has been a driving force behind One Herefordshire, known for her tenacity, enthusiasm, and commitment to patient care. JI is admired for her resilience, always finding a way forward when faced with challenges. Her energy and adventurous spirit extend beyond work, embraced fully in her personal life. While she is retiring, it is clear this is just the start of a new chapter, and her legacy of leadership and innovation will continue to inspire. FM expressed deep gratitude and admiration for JIs contributions and wished her well for the future.			
18.	**Questions from Members of the Public**			
There were no questions received from members of the public.				
DATE AND TIME OF THE NEXT MEETING – Thursday 2 October 2025 – 1.00 pm – 2.30 pm				

WYE VALLEY NHS TRUST
ACTIONS UPDATE: PUBLIC BOARD MEETING – 2 OCTOBER 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 Private Board meeting.	Alan Dawson	October 2025	**Open**	Due October 2025.
September 2025	Action 6	Managing Directors Report	To discuss the progress on the new Performance Framework and Planning Cycles in a future Public Board meeting.	Stephen Collman	December 2025	**Open**	Due December 2025

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Managing Directors Update Report
Lead Executive Director:	**Managing Director**
Author:	Katie Osmond, Chief Finance Officer / Deputy 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 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. NHS Oversight Framework and Segmentation

The national performance league tables have now been published, and as expected we are confirmed as being in segment 3 based on performance in quarter one of 2025/26. Our performance across the range of metrics is strong. We remain focused on improving our Urgent and Emergency Care pathways and tackling our underlying financial deficit which currently triggers a financial override, meaning we cannot be higher than segment 3.

We have undertaken the Board self-assessment of capability across six thematic areas in line with the national timetable, and it is being considered for sign off by the Board today.

2. National Neighbourhood Health Implementation Programme

We are delighted that Herefordshire has been successful following a competitive bidding process to participate in the National Neighbourhood Health Implementation Programme (NNHIP) - one of 42 nationally and 7 in the Midlands. This is a significant opportunity for us to build on our previous success in integrating care with local partners, bringing to life the ambitions in the 10 Year plan, and particularly to reduce urgent and emergency demand at the acute hospital. Partners across Herefordshire came together last week to begin shaping our approach.

[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.

3. Community Diagnostic Centre

Our Community Diagnostic Centre (CDC) opened its doors to the first patients on Monday. It is a fantastic facility and will help not only with waiting times for diagnostics but to redesign pathways so that diagnostics are used earlier in patient pathways to improve outcomes and reduce secondary care demand. Thank you to all colleagues and partners who have been a part of making this project a reality.

4. Winter preparedness

We have collaborated with wider system and NHS partners to stress test our winter plans and ensure we are as well prepared as we can be as we head into the winter period.

During September the Trust undertook Integrated Care System (ICS) exercising of Winter plans, with partners, through detailed preparedness scenario exercises and attended System risk sharing workshops with operational and clinical teams across Primary and Secondary care. Executives from across the System then attend local ICS and Regional events to further test our readiness with NHS England. This resulted in key actions to address as our final Place and System assurance plans are completed that will be followed up with weekly ICS Winter Directors meetings across the autumn and winter period.

We are also gearing up to deliver our annual flu vaccine campaign and would encourage all staff to take up the offer.

5. Medium Term Planning

Following publication of the draft planning framework, we have been working to complete activities in phase one, designed to ensure a robust understanding of the financial baseline from which NHS organisations will exit 2025/26. Having clarity on the exit baseline is critical to ensure medium term plans are based on credible planning assumptions.

At our workshop today we have reviewed progress with the planning process. Internally we have started operational planning with divisional and corporate teams working to deliver the core planning assumptions such as workforce planning, demand and capacity assessments and identification of transformation opportunities including Neighbourhood Health. Developing our clinical strategy, engaging with our specialties through specialty reviews is a key enabler underpinning our integrated delivery plan.

We are anticipating publication of the final planning guidance in early October, and conclusion of the initial planning cycle before the end of 2025.

6. Powys Commissioning

Our position in respect of the Powys commissioning changes remains unchanged. We have enacted the extension of routine adult elective inpatient / day case waiting times. We have not actioned any change to waiting times for outpatients in light of our assessment of the associated operational, clinical and financial risk. We remain committed to working with our partners in Powys to reach a resolution that works for all parties.

7. Welcome to our new Managing Director

October sees the arrival of our new Managing Director, Sarah Shingler. A very warm welcome to Sarah from all of the team at Wye Valley.

8. More from our Great Teams – Medical Division

Urgent and Emergency Care

Continued high ED attendances combined with high acuity remains a significant challenge to maintain efficiency and safety within the department. The resilience demonstrated by our staff across acute and emergency is something we continue to be proud of. Our departmental efforts are ongoing considering our CQC visit in December 2023 and positive developments have been implemented despite ongoing operational pressures, including:

- Improved 4-hour EAS performance
- Implementation of a minor illness service in ED
- Front door streaming: Nurse navigator
- Ongoing positive medical and nursing recruitment against business cases

4-hour performance has improved from 65.9% in February 2025 to 70.9%% in July 2025, following a very positive period that focused on service improvement as part of June Test of Change schemes under the Valuing Patient Time workstream. During this period, we are proud that AMU length of stay reduced by 1.3 days per person on average, as part of pathway optimisation for GP expected patients. We have also seen our time to triage decrease.

Our nurse navigator is continuing well supporting non-admitted performance, whilst we maintain a renewed focus on reducing inter-person variation moving forward. This includes welcoming and working with our ECIST colleagues as we head into the winter period.

We are also proud and pleased that a strategic outline business case has recently been approved at Trust Management Board that supports our strategic estate plans to expand our SDEC footprint offering, which is linked to our stepwise plan of returning to NHS constitutional standards and a 78% 4-hour emergency access standard by the end of March 2026.

Plans for further improvement:

- Reduction in ambulance handover times
- Nurse navigator role to be expanded
- Medical SDEC optimisation
- Further Test of Change improvement programme involving ECIST from October
- ED/GP direct referral pathway
- Expansion of ambient AI on the acute floor to all clinicians
- Launch of our ED Safety Champion programme

Ambulatory & Frailty

The Geriatric service remains a pillar of strength within the Medical Division. We are proud to have been a key player in the working group reviewing our fractured neck of femur over recent months and are extremely pleased to see reducing mortality trend in September's data.

As we head toward winter, the Geriatric team in tandem with the Integrated Care Division have been reviewing the Virtual Ward model, and as part of an endeavour to maximise and optimise our Virtual Ward bed base, will be testing a new Frailty led model as part of the October Test of Change improvement schemes.

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

be needed to support model C, this is being worked through with the ICB. In recent months we are proud to see that pre-hospital video triage pilot has gone live, whilst also seeing positive Stroke CNS recruitment that has recently allowed us to return to a 7 day presence by the that team.

Diabetes and Endocrine are performing well as a service delivery stable RTT, some challenges with Hybrid Closed Loop funding from Powys but again conversations are being had and seeking a resolution with the health board in wales.

Meetings with Worcester colleagues to discuss the future of Renal services at Herefordshire have been progressing to review the WVT service offer as part of succession planning when the Consultant at WVT retires in August 2026 – good cross organisational working and a can do attitude to make sure the patients of Herefordshire receive good care has been the focus – and is being brought forward into a Trust Management Board paper for approval in October.

Medical Specialties

Medical workforce recruitment has been a very positive and proud factor for the Directorate since the previous CEO report. Plans have progressed in recent months with the recruitment now of 4wte Speciality Doctor CESR posts for the Respiratory team. More we have recruitment plans in place to appoint to our final 7th and 8th Consultant Cardiologist vacancies by Christmas and a 7th Gastroenterology Consultant (with Hepatology specialism) starting in November. Alongside continued recruitment focus, we have worked hard on regularly reviewing our locum use to address gaps in consultant ward cover that reduce MTS spend and support our CPIP targets in 25/26.

Successful job plan reviews delivered across Cardiology CNS team which has improved productivity and utilisation of the CNS workforce across Cardiology. Productivity gains has included increasing direct clinical care time delivered in each job plan, with more clinics being delivered weekly and increase of New and Follow up capacity delivered by the CNS team. The standardisation of clinic templates has also contributed to an increased capacity for the service. Furthermore, following a period of workforce redesign, we are proud to have recruited x2 Cardiology ACP's who will directly support in-reach to ED for the specialty to support the UEC challenge.

We are pleased to have significantly reduced our waiting times for Echocardiography with the support of insourcing. Recruitment plans have progressed with 3x international trainees appointed and have started in post supporting a 'grow your own' approach for a hard to recruit to service. We have taken steps to address demand by implementing GIRFT guidance and building in acceptance/rejection criteria for echo requests across the hospital.

The Directorate have also played their part in supporting the rollout of our diagnostic modalities being undertaken at the new CDC, opening in September, and are very excited to be working out of this fantastic new facility.

We are very excited by the opportunity of ambient AI being extended to support ward rounds, following a recent successful trial on Lugg ward, with plans and actions to now be taken forward that aim to quantify the benefit and productivity gains for staff and patients.

Integrated Performance Report

August 2025

Managing Director – Executive Summary

Jane Ives
Managing Director

The National oversight framework ratings (NOF) have now been published and we are in segment three and cannot move above this level due to the 'financial override' in place because of the financial support still in place. We perform strongly in all areas other than UEC.

We have been authorised through a competitive bidding process to be part of the National Neighbourhoods Health Implementation Programme (NNHIP) – one of 42 nationally and 7 in the Midlands. This is a big opportunity for us to build on our previous success in integrating care with local partners and particularly to reduce urgent and emergency demand at the acute hospital. There is no doubt that we need the programme to be successful in improving the forward planning for vulnerable patients and so managing demand in the community without need for acute hospital admission. The Hereford County hospital site – after a short respite over the summer is now over full with significant numbers of patients boarding on wards and departments and waiting for prolonged periods in ED for admission.

Congratulations to our senior nursing teams and Sodexo colleagues for the improvement they have made in cleanliness which has resolved some long standing issues. Close attention needs to be paid to ensuring we maintain the standard we have now set.

Our elective productivity metrics continue to improve with more improvement to be delivered for the pre-operative assessment pathway work. We are meeting our activity plans, but we are not on our trajectory for patients waiting over 52 weeks and this is receiving the attention that it needs to improve the numbers of long waiting patients so that we can meet the target at the end of March.

The Community Diagnostic Centre (CDC) opened its doors to the first patients on Monday. It is a fantastic facility and will help not only with waiting times for diagnostics but to redesign pathways so that diagnostics are used earlier in patients pathways to improve outcomes and reduce secondary care demand.

Our people metrics continue to perform well but of particular note is the reduction in sickness absence levels. There has been ongoing work over the course of the year with new policies and training for managers that underpins the improvement. I would be hopeful that our flu vaccines uptake for staff will improve this year now that the complexity of the Covid vaccine has been removed and this will help keep sickness levels lower as we move into flu season.

The WVT admin & clerical organisational wide change programme is underway and phase one is due to be completed by early November. Line managers are working closely with HR and trade union representatives to ensure that adequate steps are being taken to mitigate against compulsory redundancies. Clinical teams are being consulted on the proposals and all employees affected by the change programme are being offered appropriate support and individual consultation meetings.

Our financial performance over the first five months of the year has been strong, and ownership is evident throughout our divisions. The scale of the challenge increases as we move into the second half of the year, and will inevitably be impacted by the current high demand levels and winter period. We are focused on securing delivery of existing financial plans and developing further mitigations for assessed risks.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

NHSE Cleanliness Inspection

The Trust were subject to a follow up Cleanliness inspection with the NHS England IPC team and ICB colleagues on Thursday 18th September. This follows a 5 year period of intensive support from NHSE and the ICB due to performance not being where it needed to be. The end of May inspection saw the Trust move from intensive support to enhanced levels and this inspection acknowledged further improvements. The Trust has now been placed on routine monitoring, this is great news for all of our teams who have worked hard to address previous areas of concern. To ensure that this level of performance is embedded there will be a follow up meeting with Sodexo and estates colleagues in 3 months time to ensure ongoing momentum with lifecycle and estates work. Additionally, there will be a further sustainability inspection in the next 6 months to ensure that performance has been maintained.

Seasonal Flu vaccination campaign for staff – Winter 2025

The Trust flu vaccination campaign for staff commences on 6th October 2025. The Trust will be using a peer vaccinator model as in previous years. In line with the national requirements we are aiming to improve the uptake of flu vaccine given low numbers in previous years.

Ward Leader Development Programme

The Senior nurse and Practice Education team have developed an in-house programme to support the development of ward and team leaders. The programme aims to share practical tools and information to enable ward leaders to be clear about their roles and responsibilities and to flourish in their roles. The programme officially launched on 1st September and includes:

- Leading an Empowered Organisation training
- Action learning sets
- Buddy support
- Targeted training – essentials for ward/team leadership

National Patient Surveys

The Trust National Inpatient Survey results were published in September 2025. Analysis is currently underway however overall the Trust scored similar to other Trusts in the majority of questions. A breakdown of the results and associated action plans will be presented to Quality Committee in November 2025.

The National Maternity Survey results will be published in November 2025.

Quality & Safety Performance – Mortality

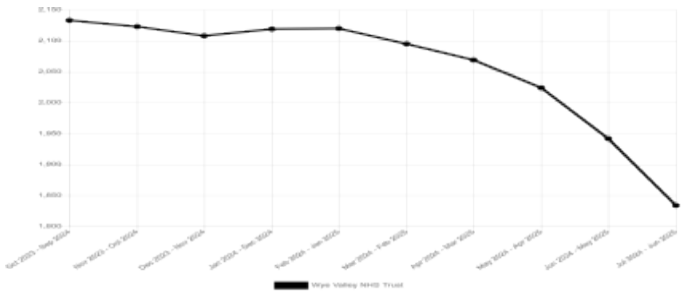
We are driving this measure because:

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)*	Mar-25	109.9	*1.6*
SHMI (HES based)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	May-25	113.5	*3.5*
SHMI (in hospital)			109.8	*5.1*
SHMI (out-of-hospital SHMI)			122.0	*-0.33*

Number of mortalities (12 mth rolling)



CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	May-25	107.59	28.81	31	12.13
Congestive Heart Failure		124.94	50.42	63	4.64
Fractured Neck of Femur		143.67	29.93	43	-0.68
Pneumonia		116.83	149.79	175	8.44
Septicemia		105.04	93.30	98	4.61
Stroke (*Acute Cerebrovascular Disease*)		100.58	76.55	77	3.41

Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from June 2024 to May 2025 shows Wye Valley NHS Trust at 113.5, which is a further increase of 3.5. The NHS England SHMI, which is for the period of April 2024 to March 2025, shows an increase of 1.6 to 109.9. Whilst SHMI is rising, the actual number of deaths in 12 month period is falling. The discrepancy is due to removal of SDEC data from admitted data but also due to coding issues (increased number of uncoded spells and % coded as having Charlson score of 0)
- The latest **crude** mortality rate for August 2025 was 1.66% for all admissions, which equates to 73 deaths.
- Our key mortality outlier groups, with the latest SHMI figures (June 2024 to May 2025):
- **#NOF** – The latest SHMI data has indicated a small reduction, but remains at a significantly 'higher than expected' level with 43 observed deaths against an expected 30 deaths. Over the past 12 months, there has been a significant amount of effort to drive improvements and performance in the care pathway, which have started to show some positive impacts in the national data. A summary of the impacts has been provided by the clinical lead, which can be viewed through the link below.
- **Heart Failure** – A further rise in the latest SHMI to 124.9. A significant driver behind this rise is the sudden drop in the number of provider spells accounted for in heart failure, which would normally be around 30 – 40 per month and has dropped to 10 – 15 for April and May 2025. A lower number of provider spells will mean a much lower number of expected deaths. The actual number of deaths has stayed below the average (~4 per month).
- **Pneumonia** – The latest data has indicated a significant rise in mortality rates for Pneumonia to 116.8. Similar to Heart Failure, the data suggests that this is driven primarily by the reduction in spells. On average, there are around 80 – 100 provider spells for Pneumonia, but for the latest month May 2025, there were just 29 spells. For assurance, the actual number of deaths has been reducing, based on previous years averages.
- **Sepsis** – This month has reported a small rise to just above the National average at 105. Provider spells have almost dropped to a quarter of the normal activity reported for this group.
- **Stroke** – The SHMI for stroke deaths has risen this month, but remains on the National average for mortality rates at 100. This diagnostic group has also been affected by the reduction in provider spells, but has also seen significant reductions in the numbers of actual deaths.
- 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.
    - Increased focus on reducing the backlog of uncoded spells. An initial audit has been undertaken by IQVIA of those patients with a Charlson score of 0.
    - Over the past month, a clear plan has been developed for the coding and re-submission of those currently un-coded patients. The key focus has been ensuring that April 2025 is re-submitted as a priority, which has been completed and ready for re-submission. The un-coded patients from May and June 2025 will be coded by the end of September, which when refreshed into the mortality data will have a significant impact.
    - A programme is being developed with our Coding team to continually review deaths in those smaller SHMI diagnostic groups, including 'Other' type groups. Details of these patients will be provided to the Clinical Coding team for review each month.
    - Coder & Consultant meetings are being set up with General Surgery and Cardiology, which will allow leads to review the coded diagnosis and co-morbidities of their patients to ensure they are all captured appropriately.
- At this month's Learning from Deaths Committee, there were presentations by our team in the Acute Medical Unit and the Learning Disabilities team.

Quality & Safety Performance – Quality Priority Updates

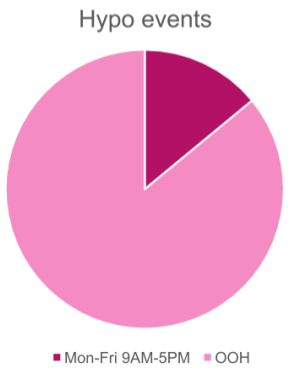
Aim- Improve the safety of inpatient care for patients with diabetes

Drivers- Patient care quality, Workforce and training, Assessments, Patient Empowerment, Hypoglycaemia management

We are driving this measure because:

The Trust confirmed the quality priority for Diabetes Safety in the Trust Quality Account published in June 2025.

Diabetes Safety



Update	Issues	Action.
57 inpatient episodes of hypoglycaemia examined • Hypos identified through Unipoc (weblinked glucose) • 29 people with diabetes • during the month of August • across 9 wards	**Age of sample:** Median age 79 years (15 PWD were aged 80 – 88 years old) • The goal in this age group is hypoglycaemia avoidance given the associated cognitive and physical dysfunction	
	Clinical safety • Only n=28 had a glucose recheck within recommended 15 minutes • Some had no recheck • A few Incorrect initial treatment	Presenting audit findings at Sisters Meetings We are participating in National Hypo Awareness Week 6-12 Oct
	Recurrent hypoglycaemia • Lack of proactive/preventative measures • Only n=3 had evidence that long acting carbohydrate was provided after initial treatment • Only n=21 had evidence of treatment review post hypo • Only n=3 had evidence a snack pre-bed was offered and only n=2 had snacks pre-bed on prescription	Diabetes team to start prescribing snacks pre-bed in patients treated with insulin and SU Encourage this practice across other teams/prescribers (CEF) Revise hypoglycaemia care bundle to highlight proactive/preventative measures sections
	Hypos occurring mostly overnight and OOH	

Agenda	Diabetic foot Pathway workstream: Collaborating with Alex Harrington, Clinical Manager for Podiatry Services		
Sep 25	Update	Issues	Action.
Template for documenting foot screening	Working with the IM&T team to develop a template linked to waterlow assessment in nursing documentation	Until this is complete we have no system pullable method of measuring this KPI. Required engagement and training across nursing teams once ready	IM&T team CL & JG
Foot Screening	SOP draft written and out for comments to diabetes team	Waiting for maxims template to be written into nursing noting	Roll out action and education plan when template written
Education plan	Scoping out has started on the education plan. Need to roll out across the county and community hospital sites	Required engagement across nursing team teams	AH to write plan
Diabetic foot Harms	NaDIA, a new diabetic foot ulcer developing more that 72 hours after admission is considered a hospital acquired harm. We are not reporting any.	Seen as pressure ulcers	AH to raise with pressure ulcer panel
Data collection	Initial data collection for baseline audit. Will re run following roll out Plan when diabetic foot screening starts will help ID patients with diabetic foot	Historically very poor	AH and CL to work on data plan

The focus in the first quarter was to confirm and establish the Diabetes Safety governance arrangements and agree the key improvement projects to support the aims of the objective; foot assessments, self management of insulin, patient empowerment and safe hypoglycaemia management. The priority leads presented updates on the foot assessment and safe hypoglycaemia management projects at Quality Committee in September.

The table (above right) outlines the plans to improve foot assessments after a recent audit showed poor compliance across the trust. Foot assessment should be completed within 24 hours of admission.

Safe hypoglycaemia management- to identify the problem a snapshot audit was undertaken. The pie chart above shows the majority of hypoglycaemic events occur out of hours and during the night. The table (above centre) details the audit findings and initial improvement actions.

This priority also has 2 linked quality priorities – Food service and Time critical medications; we are aiming to explore availability, accessibility and range of snack options that are available to support diabetic patients. Additionally, the time critical medications priority will support in enabling and empowering patients to self administer insulin when they have an inpatient episode and to ensure insulin administration is timely.

Quality & Safety Performance – Staffing - August data

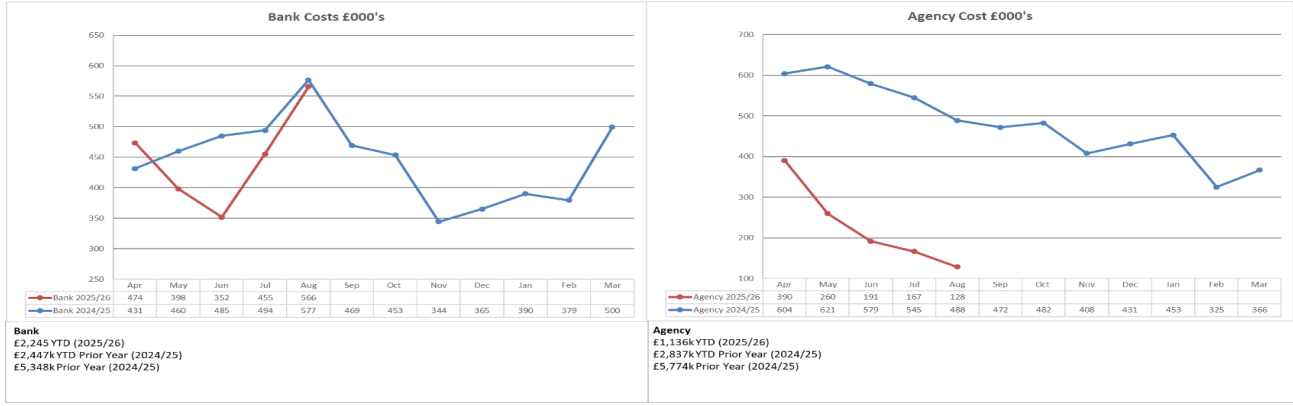
Fill Rate & CHPPD Data

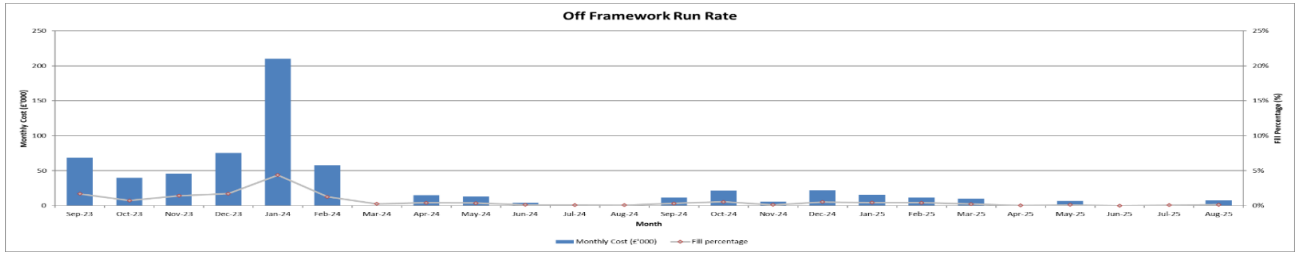
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPP
Primrose Unit	76%	72%	100%	66%	12.8
Maternity Ward	95%	92%	95%	90%	5.9
Children's Ward	123%	97%	123%	78%	20.1
Lugg Ward	131%	83%	121%	99%	6.8
Wye Ward	122%	78%	125%	81%	7.2
Cardiac Care Unit	100%	87%	100%	100%	11.4
Leominster Community Hospital	156%	78%	98%	119%	7.3
Bromyard Community Hospital	103%	77%	103%	80%	7.9
Ross Community Hospital	97%	102%	140%	115%	6.4
Teme Ward	121%	52%	94%	51%	12.9
Redbrook Ward	90%	125%	134%	123%	7.8
Special Baby Care Unit	104%	-	104%	-	19.8
Intensive Care Unit	119%	-	118%	-	29.4
Gilwern Ward	100%	131%	100%	106%	6.4
Acute Medical Unit	124%	81%	101%	131%	8.0
Ashgrove Ward	106%	90%	101%	116%	7.4
Dinmore Ward	140%	77%	106%	95%	7.6
Garway Ward	123%	88%	103%	118%	7.3
Frome Ward	118%	77%	100%	124%	6.8
Arrow Ward	147%	66%	140%	90%	7.7
Women's Health	118%	101%	100%	-	11.4

Those areas with fill rates above 100% are for the following reasons:

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

Bank & Agency





The Trust continues to be part of the collaborative working with the NHSE Regional Team

Agency spend has continued to reduce and currently our reduction/productivity target is £952k ahead of plan (YTD)

The increase in bank is partly to offset agency and partly due to operational pressures in month 5 with additional escalation beds, escalation areas and boarding patients compared to the prior month

A small handful (7) off framework shifts were required to maintain patient safety

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

The start of September has already seen renewed pressure across our Urgent and Emergency Care (UEC) pathways. Despite the progress made over the summer in improving 4-hour Emergency Access Standards, reducing 12-hour waits in the Emergency Department (ED), and mitigating ambulance handover delays, we are now experiencing a sharp rise in higher acuity major cases — the highest levels seen since November and December last year. This increase is placing significant strain on our admitted pathways, despite continued operational and clinical focus on our *Valuing Patients' Time* initiatives developed earlier in the year. These pressures underscore the importance of our winter preparedness and system-wide coordination as we move into the most challenging months of the year.

This has had a detrimental impact on our UEC recovery and our ability to maintain the performance trajectories successfully achieved over the summer months. Operational and clinical teams remain focused on sustaining improvements, particularly in our minors and non-admitted performance. As part of Tier 1 support, we are working closely with Regional and National NHS teams and have started to engage with local on-site support from the Emergency Care Intensive Support Team (ECIST) engaging with Divisions. Their involvement is aligned with our *Valuing Patients' Time* agenda, supporting workstreams, clinical conversations, progress and pace across key schemes to improve patient flow ahead of and throughout the winter period.

In September and October, we are prioritising three key areas of work to drive further improvement:

- Same Day Emergency Care (SDEC): Ensuring criteria, pathways, and direct access for Ambulance and Community services are in place ahead of the capital build to expand our Ambulatory care estate.
- Working Better Together & Internal Professional Standards: Strengthening collaboration between ED, SDEC, and specialties to improve handovers, escalation processes, and shared accountability for patient flow.
- Ward-Based Processes & Discharge Planning: Reviewing how Board and Ward rounds are conducted to enable earlier flow, increase admissions from ED by lunchtime, and reduce the number of discharges occurring late in the day.

Our Winter Plans have been "stress tested" through local and regional reviews with the Integrated Care Board and NHS England and we are refining delivery plans and recommendations that have arisen form these reviews. Including exercising local escalation plans and how we use early warning systems across health and social care to predict impacts on UEC pathways and support to Care Homes to prevent ED attendances and admissions through direct access to our Community Integrated Response Hub.

Elective activity remains on plan to date, despite on-going challenges within key specialities in terms of workforce which are the main drivers in the on-going under delivery of our reduction in English patients waiting over 52 weeks for treatment. Our Theatre Utilisation remains on an upward trajectory of improvement as we look to implement a digital Pre Operative Assessment System using clinical decision support algorithms to help streamline workflows and improve how our clinical and administrative teams operate. The Surgical Division are also working on the implementation of the NHS Federated Data Platform (FDP),for elective inpatients that has seen improvements to Theatre Utilisation across other Acute Trusts, through operational efficiencies in Theatre scheduling and waiting list management. Both of these schemes are key priorities for 25/26 in making the shift from analogue to Digital and key factors in achieving Theatre Hub accreditation in the Quarter 4 this year.

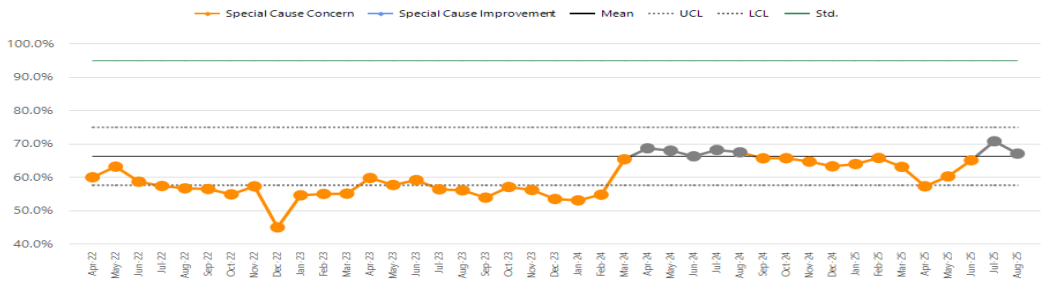
September also sees another milestone in the Trust improvement journey as we open the doors to our Community Diagnostic Centre (CDC). As we increase our substantive capacity to deliver a number of imaging and diagnostic modalities for our patients whilst reducing the pressure on the County Hospital site. Along with improving access for our UEC patients we are working with Primary Care and Community Services on strengthening direct access and developing revised pathways, such as chronic breathless and patients with possible lung and prostate cancer.

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

We are driving this measure because:

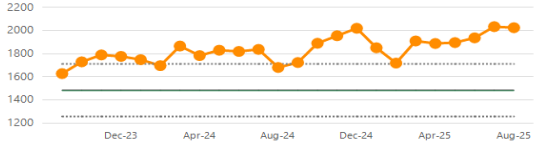
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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



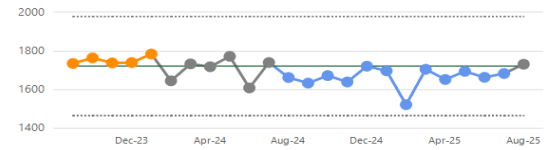
% Patients Spending More Than 12 Hours In ED

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
- Herefordshire and Powys 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
- August's 4 hour Emergency Access Standard [EAS] Performance was 67.2%

Performance & actions

- 5,883 Type 1 patients attended ED in August which 424 fewer than the previous month. The range of all attendances varied from 168 to 224 with 189 being the average daily attendances.
- 1,731 ambulances conveyed to the Trust in month which was 48 more than last month. The range in month was 43 to 71. This includes 10.7% from Powys [186].
- Ambulance handover delays over 1hr were 21.4% [332] of all conveyances with 28.7% [445] waiting over 45 minutes and 58.9% [913] having a handover within 30 minutes. All measures were a deterioration against last month.
- Same Day Emergency Care [SDEC] treated 1,223 of all admissions [46.2% 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.
- 10.9% [780] of patients spent 12 or more hours in ED which was 3% more than last month.
- Key actions being taken to recovery our 4hr EAS :

➢ 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

➢ Plan to recover non-admitted performance to 84%

➢ Strengthen Nurse Navigation to internal and external pathways. Utilisating Community and in / out of hours Primary Care pathways in improve patient experience.

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

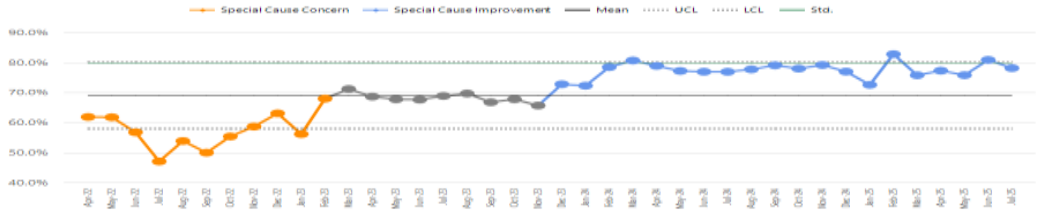
Operational Performance – Cancer Performance [July 25]

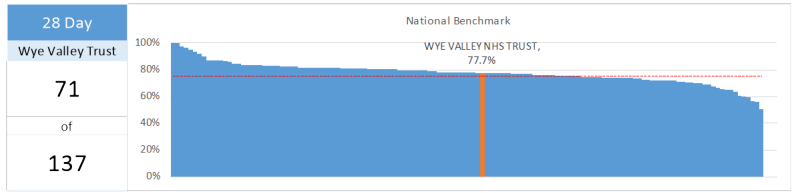
We are driving this measure because:

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

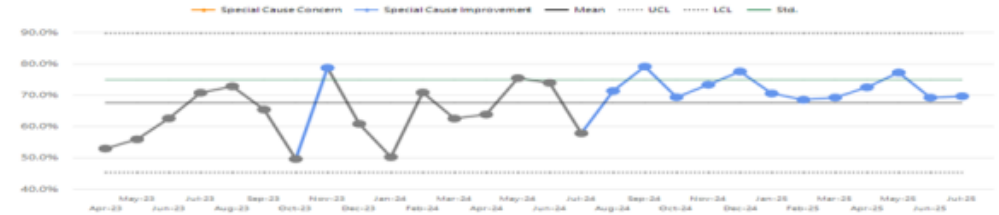
Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

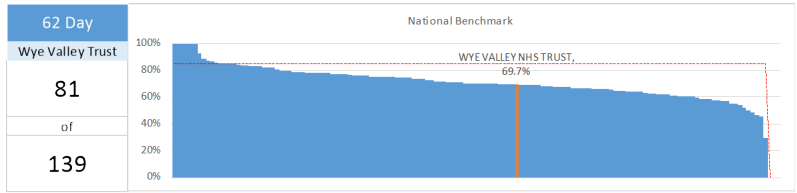
28 Days (Performance & Benchmark)





62 Days (Performance & Benchmark)





Performance & actions

Referrals:
As of July 2025, urgent suspected cancer referrals have risen by 23% compared to the same period three years ago. Referrals for Skin, Gynaecology and Urology have seen significant increases of 66%, 35% and 47%, over the same time period. Efforts are still ongoing to audit incoming referrals to ensure they align with guidance and new referral forms built by cancer services and specialty teams are being used, but continue to see delays in these being uploaded to teamnet, a system managed by Primary Care, and currently only a few specialties have been completed.

Cancer Performance:
In July 2025, the Trust met the Faster Diagnosis Standard (FDS), achieving a performance rate of 77.7%, but did not meet the trust's internal trajectory of 78%. We have seen four specialities achieving higher than the target, Head and Neck (H+N) at 88%, Skin 97%, Head and Neck 88% and Breast at 79%. WVT is presenting the H+N pathway at the expert advisory group hosted by West Midlands Cancer alliance this month due to being top five in the region consistently.

We did not meet compliance for the 31-day (85.4%) and 62-day (70.6%) cancer treatment standards in July. The main contributing factors were delays in Breast and Urology specialties .To address the shortfall in Breast services, additional workforce capacity has been planned, including extra clinical sessions. We anticipate that this will lead to performance improvements in the coming months. In Urology, delays have been driven by extended turnaround times for MRI prostate diagnostics and Radical Retropubic Prostatectomy procedures. A robotics training console is scheduled to arrive in October, which will support improvement in 62-day performance through the training of three clinicians. The community diagnostic centre opening at the end of September will have a positive impact for all cancer performance targets, especially the MRI prostate which requires a 48 hour turnaround.

Developments updates
- Liver surveillance navigator started to support programme for earlier diagnosis with liver cancer
- A new Patient Tracking List format has been drafted and is scheduled for implementation in the coming weeks with operational teams. The revised format aims to improve visibility of performance against trajectory, with clearly defined timelines for action completion
- Phase 1 of Best Practice Timed Pathway dashboards for all specialties now completed with testing underway to share with specialties

What the charts tell us

- 28 Day faster diagnosis performance was 78% below the year end target of 80%
- 62 Days start of treatment target was 71% below the year end target of 75%

Risks

- Cancer referrals continuing to remain above predicted 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

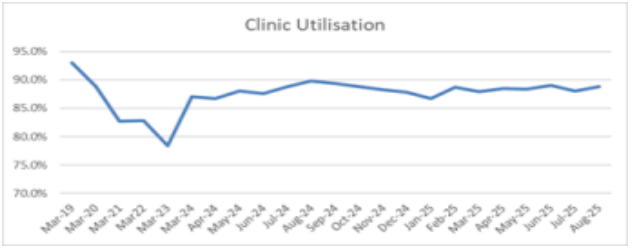
New/First Attendances

Total vs Plan	This Year	Plan	Diff / Var
	31,571	31,576	-5 / 0%
Vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	31,571	25,929	5642 / 22%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**

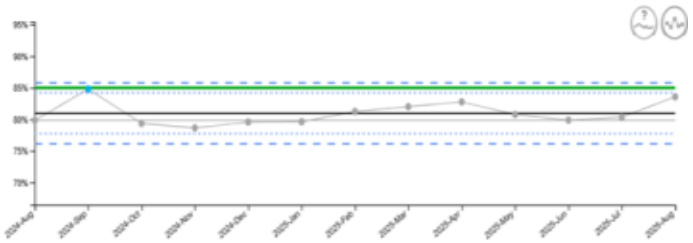
IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	11,435	11,100	335 / 3%
vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	11,435	9,935	1500 / 15%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**

Clinic Utilisation



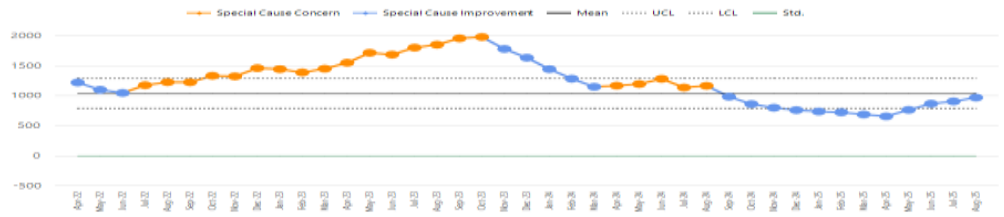
Theatres Utilisation (Uncapped)



Follow Up Attendances

Total Vs Plan	This Year	Plan	Diff / Var
	71,531	63,690	7841 / 12%
Total vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	71,531	55,004	16527 / 30%
Waitlist Clearance (wks)	**Total**	**> See By Date (SBD)**	**% Past SBD**

Patients over 52 weeks on Incomplete Pathways Waiting List



Performance & actions

Theatres:

- Theatre utilisation rose by over 3 percentage points compared to the previous month, reaching 83.6%, despite ongoing workforce pressures and delays to theatre openings following scheduled shutdown maintenance.
- Several specialties recorded notable improvements, with five specialties exceeding 85% utilisation. In particular, Trauma & Orthopaedics, Urology, Ear, Nose and Throat [ENT] General Surgery, Plastic Surgery, and Podiatric Surgery all achieved their highest utilisation rates of the financial year to date.
- Podiatric Surgery stood out with an impressive 88.7% utilisation in Month 5, marking a nearly 20% increase compared to two months prior.
- Conversely, Breast Surgery experienced its lowest utilisation this financial year at 78.5%, largely due to continued staffing challenges in August that the Division has been managing closely. However, early indicators for September suggest a significant recovery.
- Operational efficiency also improved, with the average late start reduced to 12 minutes, placing in the lowest quartile nationally for late starts, according to Model Hospital data. Work continues to focus on reducing early finishes as a divisional priority.

Long Waiting Patients

- 1 patient waited over 78 weeks at the end of August
- 65 week position at the end of August was 29 English patients. We are predicting less c23 at the end of September
- 780 English patients were waiting over 52 weeks for treatment at the end of August, an increase of 29 patients from the end of July 25. Mitigation plans for the top four specialties driving the position are in place and being monitored weekly to get our 52 week position in line with our year end trajectory during Quarter 3.

What the charts tell us

- Performance against English RTT standard in August was 61%
- 3.3% of English patients on our Waiting List were waiting more than 52 weeks at the end of August.
- Performance against the Welsh RTT standard in August was 68.8%.

Risks

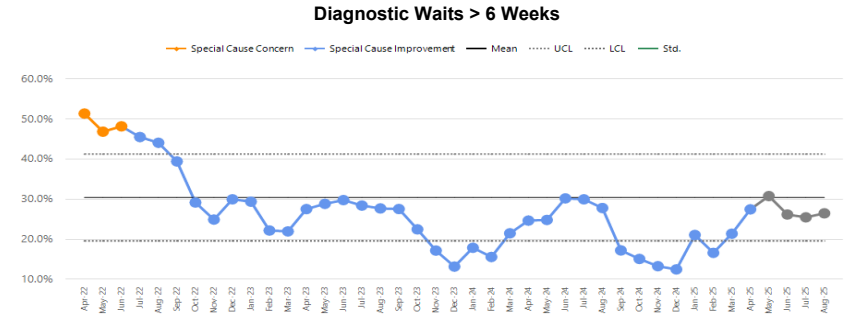
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.

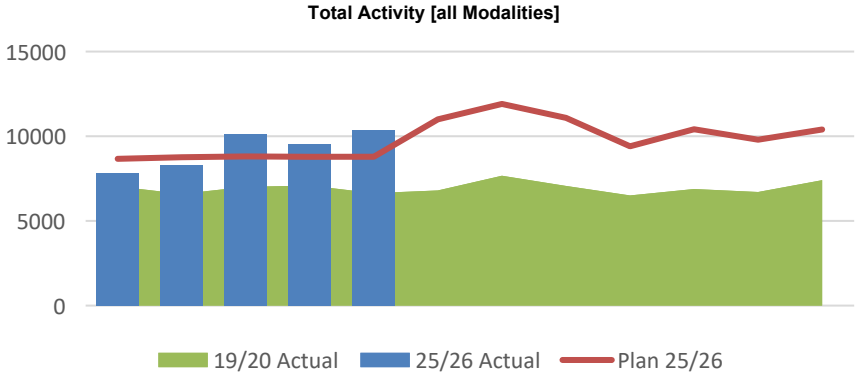
Operational Performance – Diagnostic Performance

We are driving this measure because:

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

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





Performance & actions

Overall Diagnostics is delivering 111% of 25/26 activity plan which is 152% compared with 19/20 activity. The Community Diagnostic Centre (CDC) slippage plan commenced in June which is contributing to over-delivery against plan.

Imaging:
6 week wait positon at the end of M5 has maintained at 94% overall
Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 7 days and 12 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 is planned as a priority to improve access via the Community Diagnostic Centre (CDC) pathway.

Audiology:
Audiology Assessment 6 week wait position has improved to 71%, as a result of Adult improved clinic utilisation and cross-service working with ENT Agreed insourcing solution for Paediatrics recommenced August to help reduce the number of long waiting patients.. Substantive B7 interviews that took place were unsuccessful. 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 and term time only contracts reduced.

Neurophysiology:
<6weeks waiting has decreased temporarily to 70% for M5 due to reduced clinician availability in such a small workforce. The number of patients waiting >13wks has reduced from 21 in March 25 to 3, all have appointments booked. A service review is in final draft which aims to improve service sustainability.

Endoscopy
<6 weeks is currently 54 % of the current waiting list. <13 weeks is currently reduced slightly to 15% of the current waiting list.
Demand continues to increase overall across Endoscopy referrals for 2025 by 18.2% YTD compared to our plan. Identifying source of referral is a difficulty and Division is working with information team to review data provided.
To support this we are utilising additional lists to cover any vacant weekday slots as well as sessions at evenings and weekends. Ross is increasing capacity from 3 days to 5 with 4 additional sessions per week from October

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 August 73.5% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

The WVT admin & clerical organizational wide change programme is underway and phase one is due to be completed by early November. Line managers are working closely with HR and trade union representatives to ensure that adequate steps are being taken to mitigate against compulsory redundancies. Clinical teams are being consulted on the proposals and all employees affected by the change programme are being offered appropriate support and individual consultation meetings.

Sickness absence has reduced to 4.2 % with Long Term Sickness at 2.61%.and Short Term sickness at 1.62%. This is the lowest % of sickness absence in the past few years. The main reasons for sickness absence are colds/flu. mental health conditions, gastro and pregnancy related illness. We will continue to take appropriate management actions to reduce sickness in line with our refreshed absence policy and this remains a priority area for HR. OH and senior nurses will be leading the flu vaccination programme for the Trust and we are determined to meet the NHS target.

Staff turnover has dropped to 8.3% and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at to 6.44% but turnover for band 2/3 hcsw staff now stands at 19.61%. We have restarted the centralised recruitment process and are working actively with the DWP to fill our vacancies. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments. We have also restarted the drop-in recruitment sessions at F Barnes and are conducting a deep dive on the recruitment & retention of clinical support workers to establish further interventions to be implemented.

In September we promoted National Inclusion Week and highlighted the principles that helped build our NHS – those of tolerance, respect and compassion. These principles are even more important in difficult times. We reiterated our ongoing commitment to ensure those values are being demonstrated to colleagues consistently as we are determined to maintain a compassionate and inclusive workplace where everyone can thrive and feel valued. We will be celebrating Black History Month and promoting Freedom To Speak Up Month throughout October.

Our annual health & wellbeing week will be held from 6th to 12th October supported by internal and external practitioners including Halo and Stoptober trainers to help staff quit smoking. 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, e-expenses is now fully functional and generating financial savings to the Trust. E-rostering has been implemented in nursing areas and is being rolled out to other clinical areas over the next few months as this is a key area in enhancing workforce productivity.

We are on track with our annual workforce plan with the workforce movement tracking tool showing a difference of 7.18wte (Aug) Vs plan.

The 2025 NHS National Staff Survey is now live and we will be taking active steps to meet ensure we have a completion rate of over 50%. Working with ICS colleagues we are rolling out the Active Bystander programme to improve the working environment and support a more compassionate and healthy culture across all organisations.

Performance appraisals have improved to 76.0% and WVT continues to perform well with mandatory training which now stands at 90.4%.

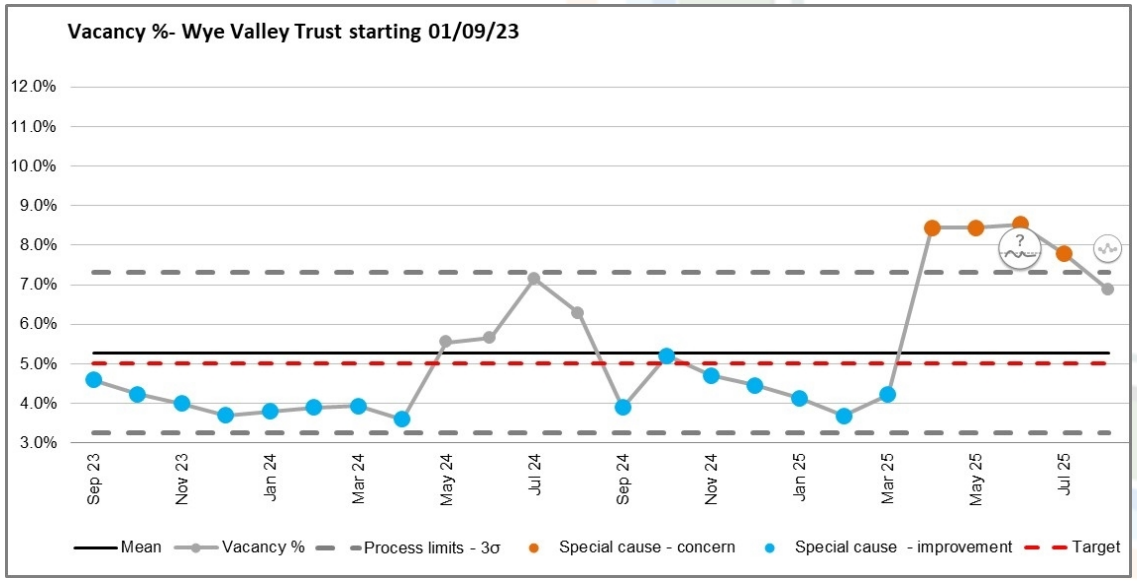
Workforce Performance – Vacancy

We are driving this measure because:

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

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
6.3%	3.9%	5.2%	4.7%	4.5%	4.1%	3.7%	4.2%	8.4%	8.4%	8.5%	7.8%	6.9%

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 – 34.02 wte vacancies with 6 new staff due to start in October. Actions to reduce vacancies includes centralised recruitment, open drop in HR recruitment sessions, active recruitment boot camps and job fairs with DWP to fill vacancies. We are also promoting career development through apprenticeships and encouraging bank staff to join WVT on a permanent basis. We are conducting a deep dive on the recruitment & retention of HCSWs.

N&M - we have paused our international recruitment due to an in crease in UK based applicants. We currently have < 10 wte vacancies.

CDC – 75.61wte appointments have been made which equates to 89.43% 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 67.88wte vacancies.

All admin & clerical vacancies are now restricted to internal candidates only and we are holding vacancies for the redeployment of staff affected by the organisational wide change programme.

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 and 5 this has now decreased as budget has started to be moved to CIP codes.

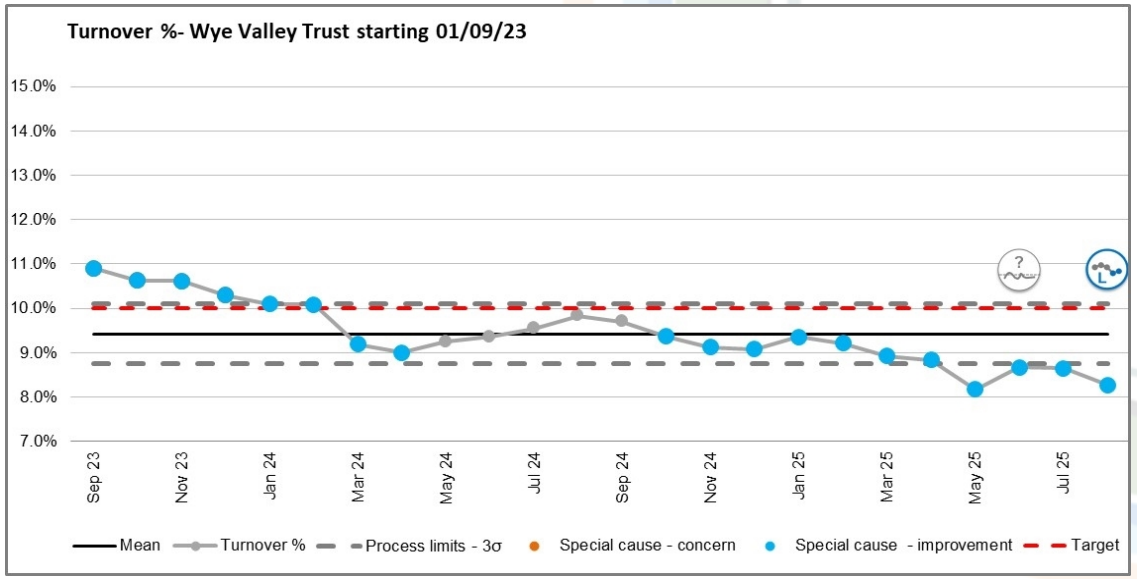
Workforce Performance – Turnover

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.

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
9.8%	9.7%	9.4%	9.1%	9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%	8.3%

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 8.3% 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 (19.61%) and this is still the case across the NHS. We have the centralised recruitment process and have strengthened the pastoral care support and training being provided to new starters. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships. Turnover rates for qualified nurses remains low at (6.44%) 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

High turnover for 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 with a decrease last month.

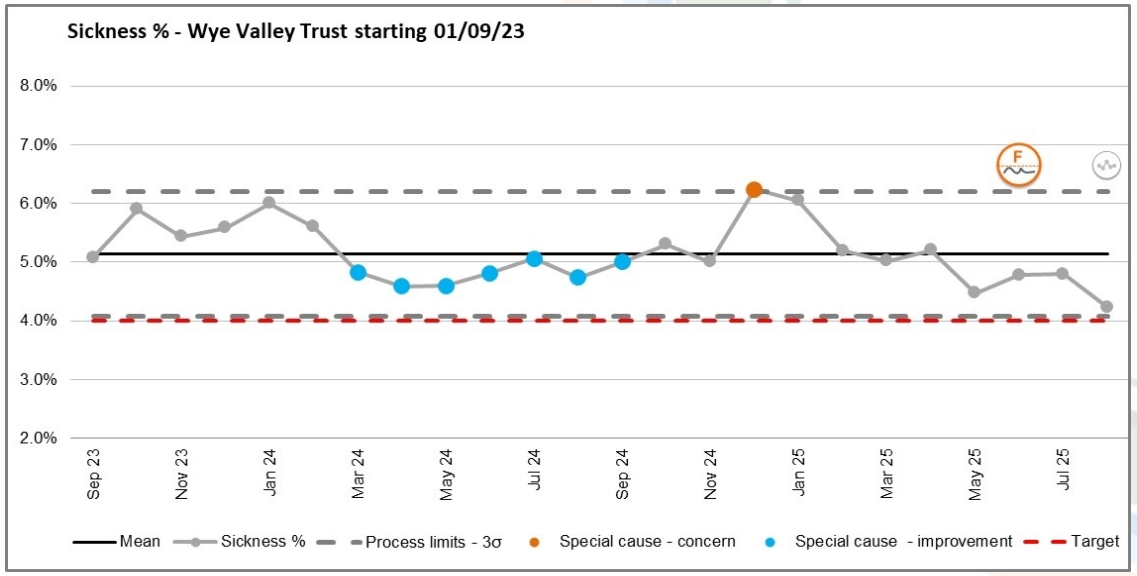
Workforce Performance – Sickness

We are driving this measure because:

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

Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
4.7%	5.0%	5.3%	5.0%	6.2%	6.0%	5.2%	5.0%	5.2%	4.5%	4.8%	4.8%	4.2%

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



Performance & actions

Overall sickness at Trust level stands at 4.2 % which is the lowest % over the past few years. The main reasons for absence are still colds/flu, mental health issues, gastro and pregnancy related illness.

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 is having a positive impacts. 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 is participating in an NHS wide absence study.

Risks

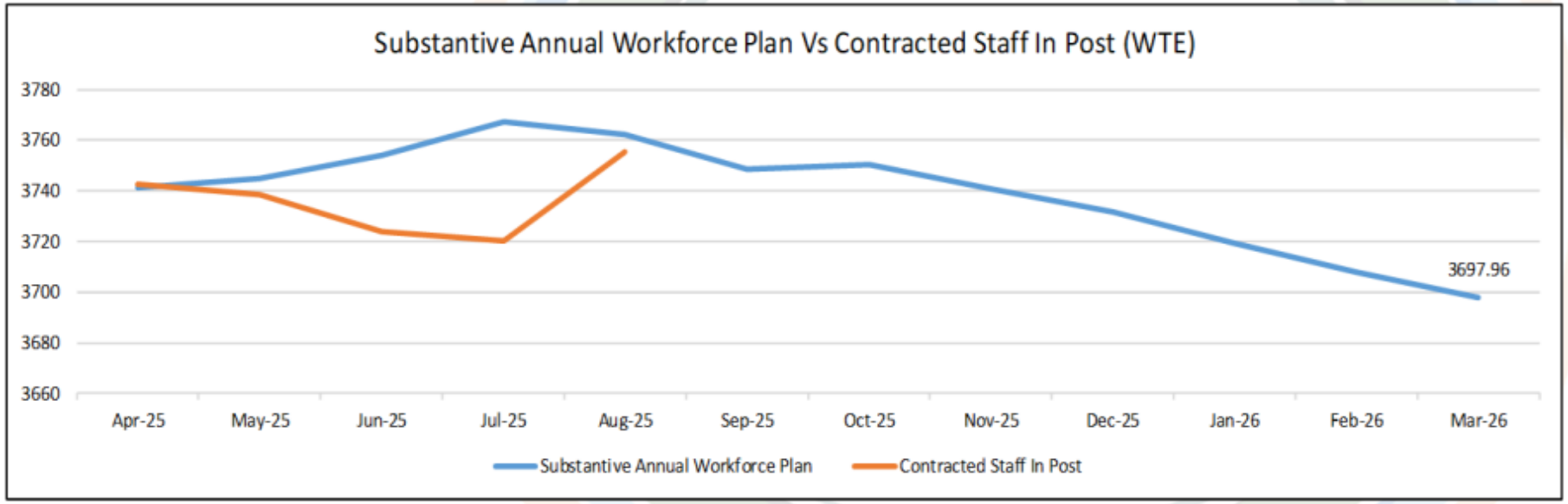
What the chart tells us

The rolling 12 month position shows a decrease position in the final 3 months of 24/25 reduced to pre winter pressure levels. This has slightly increased in the 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 reverting back down last month to the lowest position in the last 2 years.

Workforce movement chart

Workforce movement tracking tool shows a difference of 7.18 wte (Aug) Vs plan. Increase in contracted staff in post (Aug) mainly due to planned recruitment to Radiology CDC.

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	3697.96	**21.15**
Contracted Staff In Post	3742.72	3738.39	3723.91	3720.31	3755.23								**12.51**
Difference	(1.47)	6.47	29.97	47.00	7.18								



*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	122.19							
Total Leavers	22.27	24.31	36.72	34.52	102.17							

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 5 Income and Expenditure position

Overall month 5 is performing better than plan, a positive position for the first five 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 5 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, despite a challenging month due to Urgent and Emergency Care demand. 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 remains in opportunity. 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 August are £4m lower than planned but remain at a satisfactory level. The risks above (Welsh parity and full achievement of CPIP) translate into risks of delivering the planned cash position by the end of the year. Capital expenditure is ahead of plan YTD due to the number of schemes carried forward to 2025/26. The Year end forecast remains at plan.

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 also now launched our internal operational planning process. We are working to the NHSE planning framework 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 5 - 31st August 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	358,564	149,172	147,776	(1,395)	(31)
Drugs Excluded	26,098	10,874	10,532	(342)	(184)
Other operating income	15,617	6,508	6,578	71	71
Donations from non current asets	240	27	857	830	(10)
Total Operating Income	**400,520**	**166,581**	**165,743**	**(837)**	**(154)**
Substantive Pay	(220,852)	(92,877)	(92,007)	870	514
Bank & WLI Pay	(16,123)	(7,373)	(7,734)	(362)	(256)
Agency pay	(8,046)	(4,246)	(3,707)	539	136
Subtotal Pay	***(245,020)***	***(104,496)***	***(103,449)***	***1,047***	***394***
Non Pay Expenditure	(101,325)	(43,300)	(42,649)	651	211
Excluded Drugs	(25,795)	(10,748)	(10,602)	146	124
Total Operating Expenditure	**(372,140)**	**(158,544)**	**(156,700)**	**1,844**	**1,124**
EBITDA	**28,380**	**8,037**	**9,044**	**1,007**	**970**
Depreciation	(13,414)	(5,590)	(5,211)	379	86
Impairment	(4,584)	0	0	0	0
Interest Receivable	527	220	858	639	122
Interest Payable on Loans	(180)	(75)	(68)	7	(1)
Interest Payable on PFI	(2,944)	(684)	(684)	0	0
Dividends on PDC	(4,296)	(1,790)	(1,790)	0	0
Operating Surplus/ (Deficit)	**3,489**	**117**	**2,149**	**2,032**	**1,177**
Technical Adjustments					
Donated Assets Adjustment	536	296	(522)	(819)	12
Net impact of asset impairments	4,584	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	(8,609)	(4,010)	(4,244)	(234)	(142)
Adj. financial performance retained Surplus/ (Deficit)	**(0)**	**(3,595)**	**(2,617)**	**979**	**653**

Performance & actions

The position at the end of Month 5 (August) was a deficit of £2,617k YTD. This is performing better than plan with an overall positive variance of £979k YTD. Within Month 5, backdated pay award values have been transacted offset against the provision in month 4.

- Income shows an adverse variance of (£837k) Excluding the donated asset adjustment this is £1.6m adverse to plan. This is largely due to phasing of stretch target with the ICB (£458k), excluded drugs (£342k and largely matched with expenditure), the remainder of the variance is in relation to matching associated spend levels (£538k) and other smaller variance (£329k)

- Pay is favourable by £1,047k at month 5, of which £394k is in month. £300k in month movement relates to a one off benefit in relation to the pay award. The net position in month includes agency — 2.94% of total pay costs in month which is an improvement from 3.24% in M4. Bank use at premium rates further increases the total temporary staff proportion to 6.27% of overall pay, including costs for a Critical Incident in Month 1 and Industrial Action costs in Month 4. Nurse agency usage has remained low on HCSW posts, with minimal usage in August.

- Total Non Pay (operating & non operating) is favourable by £769k YTD including technical adjustment benefits. The favourable variance is largely due to a CNST rebate in Month 4, credit notes relating to gas bills and a change in drugs finance process leading to an in month benefit of £300k. There are technical adjustments for donated assets, which is offset in income. Interest receivable continues to be favourable due to higher cash balances than planned.

- Within Adjustments, there is a PFI £234k adverse variance driven by a one off 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

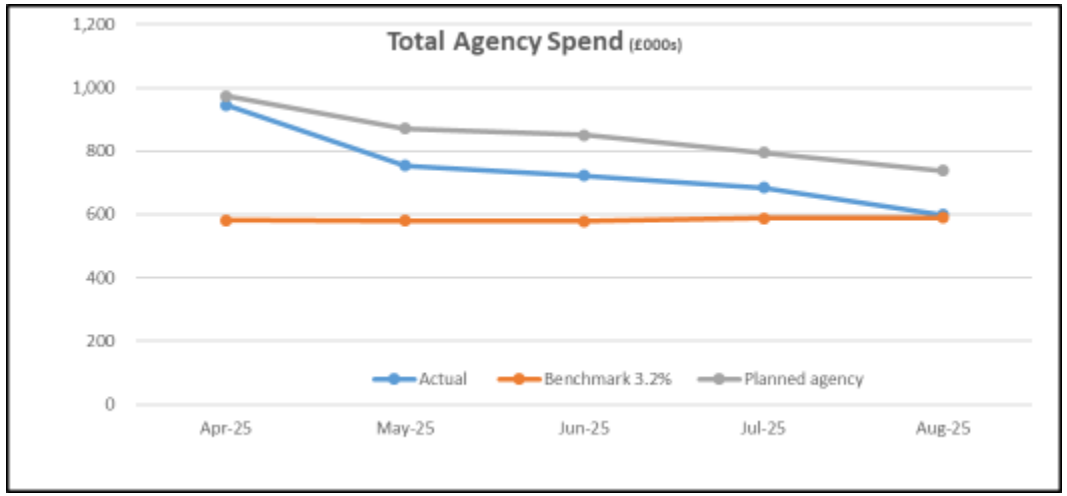
What the chart tells us

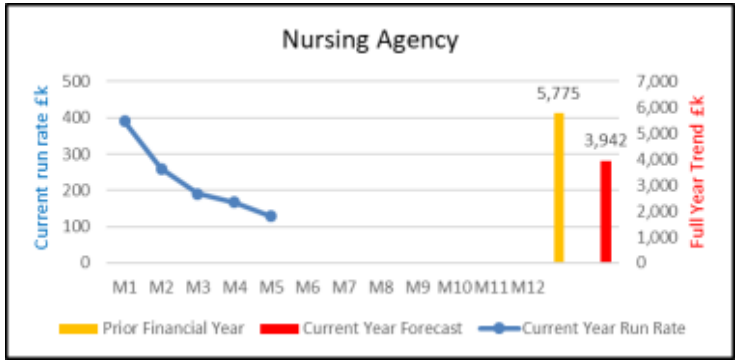
There are no material variances in this month, though the plan includes a number of known financial risks.

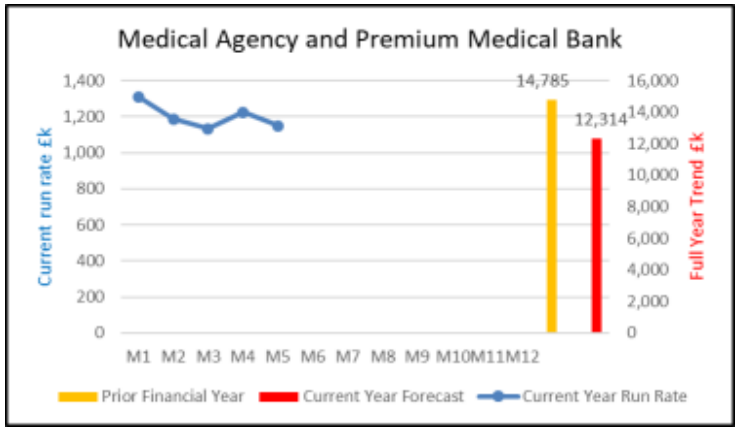
Finance Performance – Agency Spend

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 2.94% of total pay costs year to date. The Trust is now 0.26% below the national target of 3.2% evidencing the commitment to sustainable temporary workforce reduction. Agency performance is currently better than plan by £539k. Total agency spend year to date (excluding premium cost medical bank) is £3.7m.

- **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 had been achieved in M4, with minimal use in M5. The cost for nurse agency spend in August was £128k down from £167k in M4.

- **Off framework Nurse Agency:** There have been 7 off framework shifts in August compared to 4 in July (17 YTD). 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 M5 is £1,032k, a decrease from £1,223k in M4. The increase in spend in month is largely due to the impact of sickness & leave cover as well as emergency demand. Industrial action happened in M4.

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

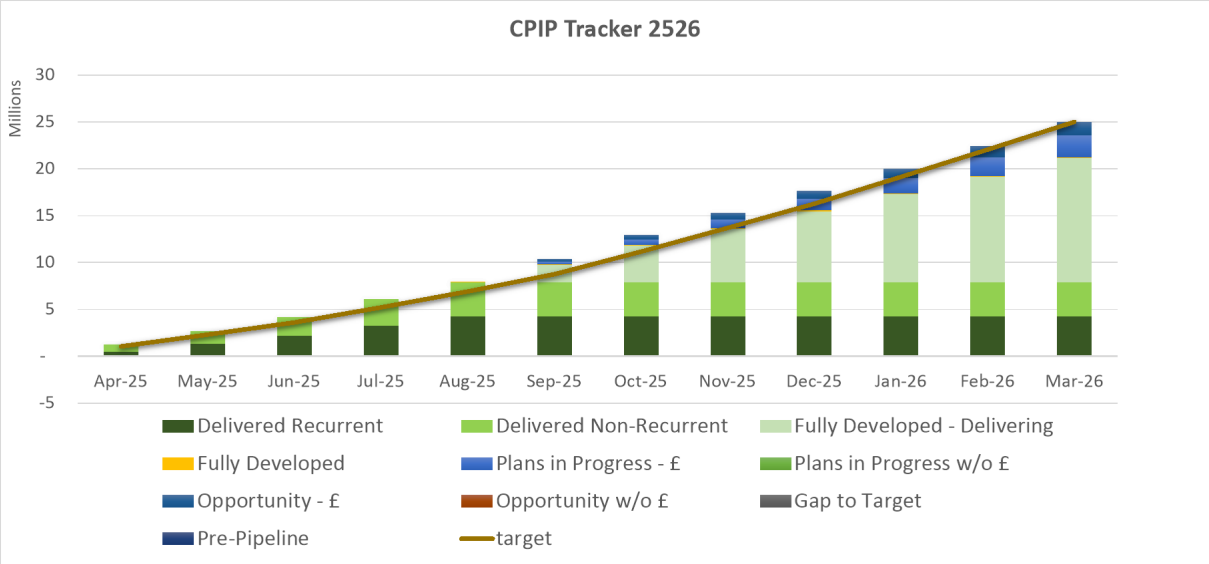
What the charts tell us

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.



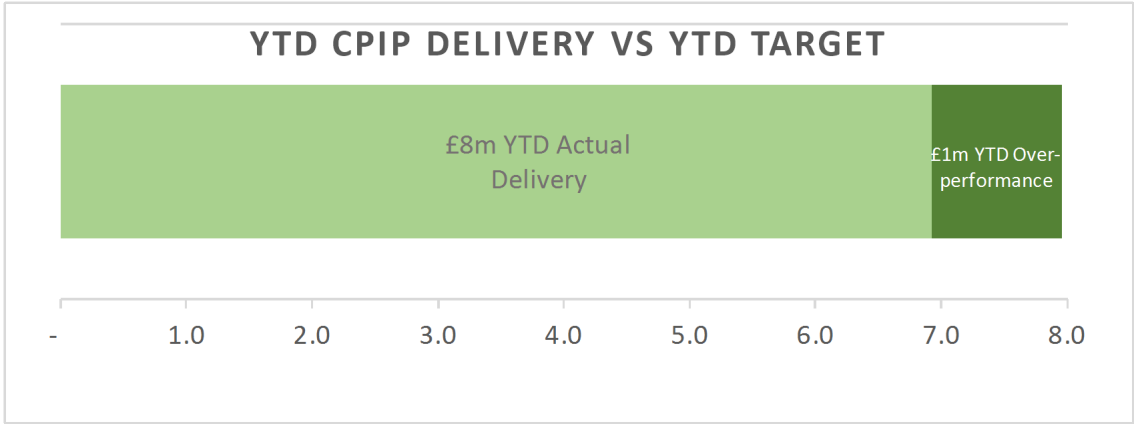
Performance & actions

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 £6.9m with a Trust delivery of £8.0m resulting in a £1.0m over-performance to plan. This does include £4.3m of recurrent delivery, £0.3m 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 and 20% in Quarter 2.

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.

Schemes have progressed, with further movement from Opportunity to Plans in Progress and a continued focus on derisking 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.

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Cash

Cash Balance				
Month	Performance	Target	Direction	Rating
June	30.1	38.4		
July	34.3	29.3		
August	30.6	34.5		
Cash balances are £4m lower than plan, due to higher debtors (mainly Powys) and capital expenditure being more front loaded than plan.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
June	99.3%	95.0%		
July	98.7%	95.0%		
August	98.9%	95.0%		
In August the Trust paid 98.9% of invoices within 30 days. This equates to 99.9% by invoice value. This is the twentieth 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			Full Year	
			Budget £k	Actual £k	Variance £k	Forecast £k	Variance £k
Local CDEL funded	Owned	2,798	736	1,169	(433)	2,798	(0)
IFRS16 Leases	Leased	2,460	69	13	56	2,460	0
National PDC schemes	Owned	10,060	887	1,186	(299)	10,060	0
Grant funded and Donated	Owned	5,253	2,112	2,077	35	5,253	0
Total Capital Programme		20,571	3,804	4,444	(640)	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 debtors and capital expenditure being higher than planned at this stage in the year are the main drivers of the cash balance being lower than planned at the end of August. 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

August 2025	2024/25	2025/26			2025/26 Full Year		
	Accounts £000s	M5 Plan £000s	M5 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	159,386	158,765	161,823	3,058	175,402	174,750	(652)
Intangible Assets	11,572	10,402	8,370	(2,032)	8,766	9,418	652
Trade and Other Receivables	429	429	1,176	747	429	1,197	768
TOTAL Non Current Assets	**171,387**	**169,596**	**171,369**	**1,773**	**184,597**	**185,365**	**768**
CURRENT ASSETS:							
Inventories	5,087	5,087	5,087	0	5,087	5,087	0
Trade and Other Receivables	24,244	26,109	31,297	5,188	19,231	18,442	(789)
Cash and Cash Equivalents	37,906	34,557	30,564	(3,993)	45,995	45,995	0
TOTAL Current Assets	**67,237**	**65,753**	**66,948**	**1,195**	**70,313**	**69,524**	**(789)**
TOTAL ASSETS	**238,624**	**235,349**	**238,317**	**2,968**	**254,910**	**254,889**	**(21)**
CURRENT LIABILITIES							
Trade and other payables	(37,582)	(39,372)	(40,662)	(1,290)	(37,582)	(37,582)	0
Borrowings - Loans, PFI and Finance Leases	(15,067)	(15,067)	(8,681)	6,386	(15,067)	(15,067)	0
Provisions	(49)	(49)	(46)	3	(49)	(49)	0
Total Current Liabilities	**(52,698)**	**(54,488)**	**(49,389)**	**5,099**	**(52,698)**	**(52,698)**	**0**
NET CURRENT ASSETS/(LIABILITIES)	**14,539**	**11,265**	**17,559**	**6,294**	**17,615**	**16,826**	**(789)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**185,926**	**180,861**	**188,928**	**8,067**	**202,212**	**202,191**	**(21)**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(40,822)	(34,095)	(41,681)	(7,586)	(28,985)	(28,985)	0
Provisions	(1,529)	(1,529)	(1,511)	18	(1,529)	(1,508)	21
Total Non-Current Liabilities	**(42,351)**	**(35,624)**	**(43,192)**	**(7,568)**	**(30,514)**	**(30,493)**	**21**
ASSETS LESS LIABILITIES	**143,575**	**145,237**	**145,736**	**499**	**171,698**	**171,698**	**0**
TAXPAYERS EQUITY							
Public dividend capital	325,841	327,555	325,855	(1,700)	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)	(199,858)	(197,117)	2,741	(196,486)	(196,317)	169
TOTAL	**143,575**	**145,237**	**145,736**	**499**	**171,698**	**171,698**	**0**

Performance & actions

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

Non-Current Assets
Non-Current assets are £1.8m higher than plan. Carried forward 2024/25 capital programme schemes have incurred expenditure in 2025/26 (see capital section, above). 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 increased by £3.8m compared to plan, mainly due to invoices to Powys for parity of funding - net of higher expenditure accruals. This, with the additional capital expenditure and our favourable I&E variance, has led to a corresponding cash balance decrease of c£4m 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 5 reflects the deficit 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 5.

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	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 80.0%	Variable	Improvement - High		77.1%	72.7%	82.9%	75.9%	77.4%	75.9%	81.0%	78.3%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		84.3%	85.9%	79.1%	83.8%	84.1%	82.5%	72.3%	80.6%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		20.0%	15.4%	0.0%	16.7%	0.0%	13.3%	16.7%	27.3%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		96.5%	90.2%	94.1%	95.4%					
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		7	3	7	9	11	6	8	9	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause		71.3%	69.5%	67.2%	67.7%					
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		100.0%	88.9%	100.0%	100.0%					
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		87.9%	77.1%	74.3%	78.8%					
	Cancer 62 days Combined	Cancer	>= 75.0%	Variable	Improvement - High		77.6%	70.6%	68.6%	69.3%	72.6%	77.3%	69.3%	69.7%	
	Cancer: number of cancer patients waiting over 62 days	Cancer		No Target	Common Cause		54	52	60	74	69	72	66	50	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		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		85.9%	85.2%	86.6%	86.2%	87.3%	87.1%	87.8%	87.9%	88.0%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Common Cause	Yes	104.0%	100.3%	96.3%	102.0%	99.0%	95.5%	100.1%	100.4%	98.6%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Common Cause	Yes	49.4%	54.3%	60.3%	55.2%	44.3%	53.8%	60.4%	69.6%	58.9%
	Ambulance handover within 45 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Fail	Common Cause		38.0%	34.8%	26.4%	32.6%	45.7%	35.1%	26.6%	17.8%	28.7%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Variable	Concern - High		30.9%	29.7%	21.4%	26.6%	38.5%	28.6%	18.9%	11.6%	21.4%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		124.1%	121.1%	121.7%	127.3%	117.9%	117.6%	115.5%	124.3%	121.9%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		46.4%	47.2%	46.7%	49.1%	47.1%	46.8%	48.6%	45.9%	46.2%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	63.4%	64.1%	65.9%	63.2%	57.4%	60.4%	65.2%	70.9%	67.2%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause	Yes	13.3%	14.6%	13.0%	13.2%	16.4%	14.2%	11.6%	8.1%	10.9%
	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		2.0%	1.8%	1.5%	1.9%	1.7%	1.8%	1.6%	1.6%	1.6%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		232	322	219	293	277	249	234	182	207
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause	Yes	9.1%	8.7%	8.9%	9.1%	9.2%	8.0%	9.4%		

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 61.0%	Variable	Concern - Low	Yes	55.1%	56.0%	56.4%	56.5%	57.1%	59.4%	59.8%	61.4%	61.0%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care		No Target	Common Cause	Yes	68.4%	69.2%	70.3%	70.0%	70.8%	70.4%	70.1%	70.3%	68.8%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		27766	27410	27488	27476	27943	28097	27296	27198	27294
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		764	740	727	692	660	768	871	909	973
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		3	2	5	5	2	5	2	6	11
	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			
	GP Referrals	Elective care		No Target	Common Cause	Yes	105.2%	98.8%	91.6%	103.1%	97.3%	93.1%	101.6%	100.0%	97.1%
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		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	101.4%	104.4%	94.0%	82.0%	101.2%	99.7%	99.7%	99.5%	91.5%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		109.6%	109.2%	109.8%	140.1%	126.7%	118.8%			
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Common Cause	Yes	111.4%	113.4%	98.0%	86.0%	108.7%	107.7%	107.9%	106.6%	98.7%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		100.8%	104.4%	104.0%	127.6%	106.7%	110.3%			
	Total Elective Activity (volume v plan)	Elective care		No Target	Common Cause		90.4%	97.9%	91.0%	77.2%	93.9%	99.5%	99.9%	97.4%	88.8%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Improvement - High		80.9%	80.3%	83.1%	82.0%	82.8%	80.8%	81.6%	80.3%	83.6%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		39	35	20	26	26	16	20	22	36
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Improvement - High	Yes	103.5%	86.8%	86.6%	102.7%	90.8%	95.9%	111.5%	108.7%	108.3%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Improvement - High	Yes	83.3%	80.1%	89.1%	78.9%	100.9%	94.4%	88.9%	87.6%	134.8%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Improvement - High	Yes	109.7%	93.4%	88.3%	119.2%	99.3%	94.0%	120.3%	99.2%	145.4%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Common Cause	Yes	12.5%	21.1%	16.6%	21.4%	27.5%	30.8%	26.2%	25.5%	26.5%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Improvement - High		93.7%	97.1%	97.7%	97.8%	99.1%	96.6%	98.0%	96.9%	94.8%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause	Yes	17.8%	20.4%	22.5%	21.8%	19.8%	21.1%	19.8%	19.4%	15.2%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High		65.1%	64.6%	61.5%	66.5%	67.9%	64.8%	62.1%	67.8%	69.2%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High		90.2%	89.7%	89.2%	90.8%	88.7%	86.8%	87.7%	89.1%	89.5%
	Maternity Activity (Deliveries)	Elective care		No Target	Common Cause	Yes	94.9%	101.4%	93.8%	88.0%	91.1%	97.0%	91.2%	101.6%	100.0%

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Improvement - Low		6.5%	6.2%	5.9%	5.4%	5.6%	5.9%	5.7%	5.7%	5.8%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High		87.8%	86.7%	88.7%	88.0%	88.5%	88.3%	89.0%	88.1%	88.8%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		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	116.7%	117.9%	99.9%	88.0%	112.3%	111.6%	111.8%	110.0%	102.2%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		20.1%	21.4%	21.4%	19.9%	19.3%	19.6%	20.1%	20.1%	19.7%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term		No Target	Common Cause	Yes	7.9%	8.0%	8.4%	7.4%	8.1%	10.9%	7.4%	6.3%	4.3%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		98.8%	99.9%	99.7%	94.7%	97.7%	99.9%	99.9%	98.9%	98.3%
	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		69	129	81	64	117	90	146	105	46
	Patient ward moves emergency admissions (acute)	Safe, high quality care	4.0%	Pass	Concern - Low		6.7%	7.0%	6.5%	6.4%	6.4%	7.6%	5.9%	5.3%	5.9%
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		6	7	6	6	6	7	6	6	6
	ALoS – General & Acute Elective Inpatients	Safe, high quality care	<= 3	Variable	Common Cause	Yes	2	2	2	2	2	2	2	2	2
	Medically fit for discharge - Acute	Safe, high quality care	5.0%	Pass	Common Cause		15.1%	17.2%	19.3%	17.3%	16.7%	18.0%	17.5%	18.1%	16.7%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low		38.8%	38.5%	36.6%	24.9%	20.8%	36.1%	39.3%	37.4%	39.6%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		4.5%	4.8%	4.5%	5.0%	4.9%	4.4%	4.8%		
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Concern - High		105	107	108	110					
	Never Events	Safe, high quality care	0	Variable	Concern - Low	Yes	0	0	0	0	0	0	0	1	0
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Improvement - High	Yes	0	0	0	1	1	0	0	0	1
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause		0	2	1	2	0	0	1	1	0
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care	44	Fail	Common Cause		6	0	3	3	1	5	6	2	4

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Safe, high quality care	Number of falls with moderate harm and above	Safe, high quality care		No Target	Common Cause		1	2	1		1	0	2	2	1
	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Concern - Low	Yes	89.0%	92.0%	92.0%	91.0%	90.0%	89.5%	90.4%	86.4%	87.9%
	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		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	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	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	26	33	26	33	38	48	30	35	28
	Number of complaints referred to Ombudsman	Safe, high quality care	<= 0	Variable	Improvement - Low		0	0	0	0	0	0			
	Complaints resolved within policy timeframe	Safe, high quality care	>= 90.0%	Fail	Common Cause		48.1%	60.0%	45.5%	25.7%	58.0%	59.0%	58.0%	42.0%	42.9%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		73.7%	80.0%	80.6%	76.4%	72.6%			84.7%	84.7%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes	83.6%	86.7%	86.8%	85.7%	81.3%			90.2%	91.0%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		92.3%	93.3%	94.1%	100.0%	100.0%			81.3%	100.0%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause		17.0%	18.0%	19.0%	19.0%	19.0%			13.7%	13.3%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Common Cause	Yes	15.0%	15.0%	16.0%	15.0%	15.0%			12.2%	13.3%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		21.0%	23.0%	31.0%	24.0%	23.0%			14.3%	14.4%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		4.8%	5.3%	4.0%	2.6%	4.5%	3.7%	3.5%	3.2%	2.9%
	Appraisals	Looking after our people	>= 85.0%	Fail	Common Cause	Yes	79.8%	79.7%	77.6%	77.7%	73.5%	71.7%	72.1%	75.2%	76.0%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Common Cause	Yes	88.8%	89.3%	89.3%	89.4%	89.8%	89.5%	89.6%	89.8%	90.4%
	Overall Sickness	Looking after our people	<= 4.0%	Variable	Improvement - Low		6.2%	6.0%	5.2%	5.0%	5.2%	4.5%	4.8%	4.8%	4.2%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%	8.3%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Common Cause	Yes	4.5%	4.1%	6.9%	4.2%	8.4%	8.4%	8.5%	7.8%	6.9%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause		(£1260k)	(£3002k)	(£133k)	£5805k	(£798k)	(£875k)	(£959k)	£223k	(£209k)
	I&E - Margin (%)	Finance		No Target	Concern - High		(£0k)	(£0k)	(£0k)	£0k	£0k	(£0k)	(£0k)	£0k	(£0k)
	I&E - Variance from plan (£k)	Finance		No Target	Concern - High		(£953k)	(£2908k)	(£39k)	£5901k	(£17k)	£37k	£31k	£273k	£653k
	I&E - Variance from Plan (%)	Finance		No Target	Improvement - Low	Yes	(£0k)	(£0k)	(£0k)	£0k	(£0k)	£0k	£0k	(£1k)	(£1k)
	CPIP - Variance from plan (£k)	Finance		No Target	Common Cause	Yes	(£489k)	(£798k)	(£487k)	(£931k)	£191k	£209k	£157k	£364k	£110k
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low		£582k	£2848k	£804k	£1069k	£947k	£754k	£723k	£685k	£598k
	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	(£431k)	£175k	(£873k)	£2271k	(£440k)	(£441k)	£199k	£29k	£56k
	Cash - Balance at end of month (£m)	Finance		No Target	Concern - High		£25k	£21k	£31k	£26k	£35k	£35k	£30k	£34k	£31k
	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:	**02/10/2025**
Title of Report:	Hoople Board Terms of Reference Update
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Company Secretary
Reporting Route:	n/a
Appendices included with this report:	Hoople Group Board Terms of Reference
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Terms of Reference of the Hoople Board have been updated with some minor changes to reflect the current ways of working.

The changes are tracked within the attached document.

Recommended Actions required by Board

The Board is asked to approve the amendments set out in the attached Terms of Reference.

Executive Director Opinion[1]

The proposed changes have been approved by Nicola Twigg, Non-Executive Director/member of Hoople Board and Jane Ives, Managing Director

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

TERMS OF REFERENCE – HOOPLE BOARD

1. Membership

1.1 The membership comprises four directors of Hoople. Two ~~directors~~ appointed by Herefordshire Council (HC) Shareholder Committee, one ~~director~~ appointed by Wye Valley NHS Trust (WVT) and one ~~director~~ appointed by Lincolnshire County Council (LCC)

1.2 The Chief Executive Officer and Executive Management Team are invited to support the Board of Directors. Other individuals such as internal officers or external advisers may be invited to attend for all or part of any meeting, as and when appropriate and necessary.

1.3 The Chair is nominated by the Board and rotated between Herefordshire Council ~~Non-Executive~~appointed Hoople Directors and Wye Valley NHS Trust appointed ~~Non-Executive Director~~ at least annually, unless otherwise agreed by the board. In the absence of the Chair, the Board must appoint a deputy.

2. Secretary

2.1 The Company Secretary or her nominee shall act as the secretary of the Board.

3. Quorum

3.1 The quorum necessary for the transaction of business shall be two directors one of whom must be a Herefordshire Council appointed Hoople Director and one of whom must be a Wye Valley NHS Trust appointed Hoople Director. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Board.

3.2 The quorum for the transaction of business at a meeting of directors is any two directors including at least one principal member drawn from Herefordshire Council and Wye Valley NHS Trust.

4. Meetings

4.1 The Board shall meet bi-monthly and otherwise as required.

4.2 The frequency and timing of meetings will differ according to the needs of the company.

4.3 With permission of the Board Chair, virtual meetings can take place via telephone or other electronic means providing members are able to express their opinions and exercise the right to vote, and any decisions agreed are formally noted.

5. Notice of Meetings

5.1 Meetings of the Board shall be called by the secretary of the Board at the request of the Chair or Chief Executive Officer.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Board, any other person required to attend, no later than five business days before the date of the meeting. Supporting papers shall be sent to members and to other attendees, as appropriate, at the same time.

6. Minutes of Meetings

6.1 The secretary shall minute the proceedings and resolutions of all committee meetings, including the names of those present and in attendance.

6.2 Draft minutes of meetings shall be circulated within five business days to the Chair of the Board and Chief Executive Officer. The draft minutes will be circulated to all other members of the board as part of the next meetings board pack for final approval.

7. The role of the Board

7.1 The company's business is managed under the direction of the Board of Directors. The Board delegates to the Chief Executive Officer, and through that individual to other executive and senior management, the authority and responsibility for managing the company's business.

7.2 The Board's role is to oversee the strategic direction, the management and governance of the company.

8. Duties

8.1 The Board responsibilities and principles were adopted in September 2015, as follow:

8.1.1 **Responsibilities**

1. Sets the group's strategic aims, ensures that the necessary financial and human resources are in place for the group to meet its objectives, and reviews management performance;
2. Sets the group's values and standards and ensures that its obligations to its shareholders and others are understood and met; and,
3. Develops and reviews group policies and practices on corporate governance.

8.1.2 **Principles**

1. Accommodates multiple shareholders
2. Aligns directly with shareholder priorities and objectives
3. Establishes common governance across all activity
4. Ensures all delivery assets remain common and shared
5. Provides transparent and simplified day to day governance
6. Engages with the wider stakeholder community
7. Delivers Teckal compliance and enables trading activity

8.2 The Scheme of Reservation and Delegation further outlines the Board of Directors responsibilities. This document is reviewed and approved by Board.

9. Other Matters

The Board shall:

9.1 have access to sufficient resources in order to carry out its duties, including access to the company secretariat for assistance as required.

9.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

9.3 give due consideration to laws and regulations, the provisions of the Code and the requirements of any other applicable Rules, as appropriate.

9.4 in line with with the Articles of Association arrange for review of the Scheme of Resrervation and Delegation every six months and at least annually the terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary.

10. Authority

10.1 The Board and the Chief Executive Officer are authorised to obtain, at the company's expense, outside legal or other professional advice on any matters within its terms of reference.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Financial Recovery Board Terms of Reference
Lead Executive Director:	**Chief Finance Officer**
Author:	Katie Osmond, Chief Finance Officer / Gwenny Scott, Company Secretary
Reporting Route:	via Financial Recovery Board
Appendices included with this report:	Updated Terms of Reference
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**
Brief Description of Report Purpose	
The Terms of Reference have been amended to reflect the changing requirements including to strengthen the purpose, accountability arrangements, responsibilities and membership of the Board.	
Recommended Actions required by Board or Committee	
Following review and acceptance at the Financial Recovery Board, the Board is requested to approve the updated Terms of Reference.	
Executive Director Opinion[1]	
The Terms of Reference have been amended to reflect the current requirements. The FRB NED session have reviewed and agreed the Terms of Reference to go forward for final approval.	

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

Wye Valley NHS Trust
Financial Recovery Board

TERMS OF REFERENCE

Remit	The purpose of the Financial Recovery Board (FRB) is to provide a formal forum for the collective ownership and oversight, by senior clinical and non-clinical leads, of the Financial Recovery Plan
Accountability Arrangements	The FRB is established in accordance with the Trust's Standing Orders and Scheme of Delegation. The FRB is accountable to the Trust Board and is authorised by the Board to oversee delivery of the Trust's annual Financial Plan, including the Cost and Productivity Improvement Programme (CPIP) and associated workforce and operational performance. . It is authorised to investigate any activity within its terms if reference and seek any information it requires including from any employee or professional advisors. All employees are directed to co-operate with any request made by the FRB. The FRB is authorised by the Trust Board to decide upon and require officers to implement appropriate action to ensure achievement of, or to correct deviation from, the Financial Plan. The FRB will make decisions based on the delegated authority of those in attendance as set out under the Scheme of Delegation and other views as may be delegated by the Trust Board from time to time.
Responsibilities	The overall duty of the FRB is to provide assurance to the Trust Board that the Trust is monitoring performance against the Financial Plan. The FRB will investigate and oversee any issue where the Trust Board may require additional assurance or where a Trust Board decision is required and will: • Determine the membership, priorities and term of the FRB stepping up and down as appropriate. • Receive status updates covering all CPIP and run-rate improvement schemes • Aim to prevent the realisation of adverse impacts through early identification of risks and issues. • Receive remedial proposals where significant variation exists from plans to deliver the elective activity /income. • Receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources. • Provide assurance to the Board that the programmes of work are being progressed as required and will escalate any significant concerns or variance to plan that have the potential to adversely impact delivery of the Trust's plans. • Test the assumptions and mechanics of the plan, seeking assurance that the plan is

	reasonably based including triangulation with activity / performance and workforce metrics. • Ensure that an action plan with specific ownership is created for each component of the plan and is tracked to completion. • Seek formal assurance from SROs that financial controls on key drivers of the deficit are operating effectively through regular reports. • Agree status reporting and items of escalation to the Trust Board. • Ensure that Quality Impact assessments are considered as appropriate. • Ascertain where increased focus is required through Finance and Performance Executive meetings to provide greater assurance on the delivery of detailed elements of the financial plan.
Membership / Attendance	Members of the FRB are: • Chairman • Non-Executive Directors • Associate Non-Executive Directors • Chief Executive Officer • Managing Director • Chief Finance Officer • Chief Operating Officer • Chief Strategy Officer • Chief People Officer • Chief Medical Officer • Chief Nursing Officer Members are expected to attend all meetings with deputies only being permitted by exception and must be capable of responding to actions. In attendance: • Other staff may be invited to attend as required to present reports or contribute to discussions. • Those from outside the Trust with relevant experience and expertise, where this is considered necessary. • Programme SROs and other key supporting officers may be invited to meetings as required to allow focus on particular areas of escalation or concern requiring FRB intervention.
Chair	The meeting will be chaired by the Trust Chairman
Quorum	The quorum for the transaction of business is four members (not including deputies) including two non-executive directors.
Reporting Arrangements	Relevant elements will feed into the Integrated Performance Report to the Trust Board. The Managing Director will chair an informal executive-led meeting, to review a highlight report on progress, risks and issues and capture key actions for progress prior to the next meeting of the FRB.
Frequency of Meeting	The FRB will usually be held monthly. The Chair may call an additional or special purposes meeting if they consider one is necessary.
Administration	The Deputy Company Secretary will organise the collation and distribution of the papers and keep a record of actions and matters arising to be carried forward.

	Papers will be issued a minimum of 48 hours before meetings and in exceptional circumstances tabled as necessary given the live status of the programme.
Date Approved	FRB: August 2024 FRB: September 2025 Trust Board: October 2025
Date Review	To be reviewed annually. Next review due by: September 2026

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Provider Capability Assessment
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Company Secretary/Associate Director of Corporate Governance
Reporting Route:	n/a
Appendices included with this report:	1. Provider Capability Self-Assessment Template 2. Provider Capability Full Assessment (to follow)
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

As part of the NHS Oversight and Assessment Framework, NHS England will assess NHS trusts' capability, to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards have been asked to assess their organisation's capability against a range of expectations across six areas derived from the Insightful Provider Board.

The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability and assign a capability rating to the trust as follows:

Green	High confidence in management
Amber-green	Some concerns or areas that need addressing
Amber-red	Material issue needs addressing or failure to address major issues over time
Red	Significant concerns arising from poor delivery, governance and other issues

Guidance has been provided, which includes indicative examples of the evidence boards should use or lines of enquiry they might consider taking to assess whether they can positively self-certify against each criterion.

A self-assessment template has been provided, within which there are three options for each of the six domains: confirmed, partially confirmed or not met. For any domain which is not 'confirmed' the self-assessment must describe the reasons and the actions being taken by the Board to improve.

A self-assessment has been undertaken by the Executive Directors. The completed template is at attachment 1. Limited information is included in the template, so to support the Board's decision making, the rationale and evidence used for each line of enquiry is set out in attachment 2.

NHSE has invited every provider to an event on 26 September to clarify the new process. The self-assessment will be finalised after this event for submission to the Board.

Recommended Actions required by Board
The Board is asked to review attachment 2 and approve the self-assessment in attachment 1 for submission to NHSE.
Executive Director Opinion[1]
The Executive Directors contributed to the self-assessment process and approved submission to the Board.

[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.

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Partially confirmed**	*The Board recognises that there is an opportunity to improve its approach to monitoring the quality of care provided to those with protected characteristics through the following actions:* *•Improve collection of patient characteristics data (particularly ethnicity).* *•Embed review of patient experience data by protected characteristics and deprivation in standard reporting.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*The Board recognises that there is an opportunity to improve its approach to monitoring the quality of care provided to those with protected characteristics, with two actions:*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*The Trust is not currently meeting national standards for emergency access or 52-week waits, though it is on an improvement trajectory. There are two main plans in place to address this:* *•Implement UEC delivery plan* *•Implement Elective Recovery Plan*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature

Name

Date

Wye Valley NHS Trust
Provider Capability Self Assessment: Internal Assessment Template

Self-assessment criteria	Indicative evidence or lines of enquiry	Rationale	Evidence	Assessment	Action Required
I. Strategy, Leadership & Planning					
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	Are the trust's financial plans linked to and consistent with those of its commissioning ICB or ICBs, in particular regarding capital expenditure?	The Trust's financial plan and those of its partner trusts in the ICS were developed as both local, standalone plans and as part of the wider ICB financial plan (including capital). The Board was well sighted on and involved in the development of the plan from both perspectives through workshops and meetings of the Board and Financial Recovery Board. The Trust participated in the development of the ICS Joint Capital Resource Plan 2025/25 (published July 2025).	Financial Planning reports to Board, Feb 25, March 25. Operational Planning Board Assurance Statement. ICB Financial Plan and Delivery 25/26 report May 2025. ICS Joint Capital Use Resource Plan 2025/26.	Confirmed	
	Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?	The digital stategies of all the NHS providers in the ICS link with the ICS Digital Strategy. Programmes of work in common include Shared Care Record, NHS App and Patient Portal.	ICB Digital Strategy; Trust Digital Strategy; ICB Board reports.	Confirmed	
	Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?	The Trust plays a key role in One Herefordshire Partnership, leading programmes of work linked to Trust and regional objectives for the benefit of public health. Partnership Board meetings are chaired by members of the Board including the Integrated Care Executive, which oversees the Better Care Fund. Herefordshire has been selected as one of the 43 areas in England chosen to take part in the national neighbourhood health implementation programme.	ICE and One Herefordshire Partnership Board papers.	Confirmed	
	Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	The Trust's transformation plans are an integral part of the wider system strategy. This includes Building Sustainable Futures, Neighbourhood Health and other programmes of work overseen by the One Herefordshire Partnership Board (OHPB).	Respective 1H, ICS and Trust strategies; papers of 1HPB and ICB.	Confirmed	
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	· Is the trust currently complying with the conditions of its licence?	The Annual Governance Statement 24/25 includes details relevant to compliance including a summary about how risks to compliance is managed. The Annual Internal Audit Plan provides assurance on a number of conditions, including corporate goernance, financial management and fit and proper person regulations.	Annual Governance Statement 2024-25; Internal Audit Annual Report.	Confirmed	

	· Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	There are no discretionary requirements or undertakings on the Trust's Licence and the Trust is not part of the PIP.	n/a	Confirmed	
3. The board has the skills, capacity and experience to lead the organisation	· Are all board positions filled and, if not, are there plans in place to address vacancies?	All positions are filled.	Website	Confirmed	
	· What proportion of board members are in interim/acting roles?	There is an Acting CEO during the temporary secondment of the substantive CEO.	Website	Confirmed	
	· Is an appropriate board succession plan in place?	For Executives, the deputy chief officer tier provides a succesion plan for the majority of executive directors. This information is being incorporated in a single Foundation Group succession plan. For Non-Executives, a succession plan is renewed upon each appointment and reappointment to ensure consistency, stability and appropriate refreshing of the Board. This is supported by a model of associate non-executive directors.	Remuneration Committee papers. NED Term planning documents.	Confirmed	
	· Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	Each area is aligned to an executive director who leads an operational and management structure.	Trust structure; Executive role descriptions	Confirmed	
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served	· Is the trust contributing to and benefiting from its NHS trust collaborative?	The Trust collaborates with its ICS, Foundation Group and county partners to support achievement of many of its objectives. Examples include work on fragile services with Worcestershire, the Better Care Fund work as part of One Herefordshire and Improvement work and procurement service as part of the Foundation Group.	OHPB, Foundation Group Board, Foundation Group Strategy Committee and ICB Board and committee papers.	Confirmed	

	· Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system?	The MD and Acting CEO are members of the ICB. Other executives and non-executives are members of ICB committees. Meetings of the One Herefordshire Board (described above) are chaired by the MD (Board business) or Deputy Chair (Integrated Care business). The Trust is part of the Foundation Group with its system partner (Worcestershire Acute) and together they meet as a FG Board with the other partners where there is a particular focus on system challenges, common issues and shared learrning. There are regular meetings between executives of the three NHS trusts in the ICS to consider system challenges.	Board and committee papers.	Confirmed	
	· Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	Collaboration with the wider health economy is central to the Trust's strategic objectives. This is mainly delivered through the One Herefordshire Partnership Board. Examples of workstreams include Primary/Secondary Care Interface, Enhancing Urgent Neighbourhood Health Services, Discharge2Assess and Best Start in Life. Impact of this work includes admission avoidance, earlier discharge, post discharge support and reduced readmissions. The Trust also collaborates with its system partner on improvements to fragile services and with its Foundation Group partners on sharing resources such as Procurement, Research and Improvement. The Trust also works closely with Herefordshire Council via the Health and Wellbeing Board, of which the Trust MD is the Vice CHair.	Papers from OHPB, FG Strategy Committee, FG Board. Trust Strategic Objectives 2025/26.	Confirmed	
II. Quality of care					
5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	· The trust can demonstrate and assure itself that internal procedures:				
	o ensure required standards are achieved (internal and external)	Internal procedures ensure compliance with required standards, overseen by the Quality Committee. The Quality Committee subcommitte structure includes clinical audit and effectiveness, infection prevention, patient safety and patient experience committees each of which reviews the required standards and compliance with them. Examples include but not limited to ward accreditation process, national audits, implementation of national patient safety guidance, Maternity Safety Standards, CQC compliance, CQC action plan implementation, infection prevention and control and safeguarding standards compliance and PSIRF. The Committee also oversees the Trust's response to other quality regulators with all external reviews reported through this Committee. Incidents, complaints and negative feedback are closely monitored to ensure improvements are made where standards are not met.	Reports to Quality Committee, Integrated Performance Report to Board.	Confirmed	

o investigate and develop strategies to address substandard performance	The Trust has well established arrangements, overseen by Quality Committee to manage complaints and incidents, manage risks, respond to recommendations from regulators and third parties, learn from deaths, inqests and claims, listen to and respond to feedback from stakeholders and use benchmarking to identify opportunities for further improvement. The Quality Committee receives reports from each division, which include as routine issues the division is worried about, enabling the Committee to hold them to account for implementing their rectifiation plans. Through this work and triangulation with performance and workforce information, the Committee develops annual quality priorities for Board approval, which receive enhanced focus throughout the year.	QC papers, Quality Account 24-25	Confirmed	
o plan and manage continuous improvement	The Trust has a range of improvement schemes in place, including its Quality, Service Improvement and Redesign Programme, GIRFT programmes, collaboration with the Foundation Group on Improvement and Transformation and implementation of its annual strategic objectives, many of which are transformational.		Confirmed	
o identify, share and ensure delivery of best practice	In addition to the national benchmarking information such as GIRFT and Model Hospital and internal approaches such as Safety in Sync (a forum to share learning and find solutions on patient safety issues) and Transformation Tuesday, the Trust has the benefit of regular benchmarking through the Foundation Group, both through formal review of data at Board level and through collaboration on improvement schemes such as an annual Transformation Week improvement event.	Monthly Safey in Sync Newsletter (Quality Matters), Quality Account	Confirmed	
o identify and manage risks to quality of care	The Trust has a well-established risk management framework, which includes an Executive Risk Management Committee which meets regularly to oversee progress in managing risks at divisional and corporate department level, including regular deep dives. An annual internal audit of risk management (including board assurance framework) provides independent assurance, which for 2024/25 was rated 'substantial' with recomendations for improvement where necessary. Significant strategic risks infuence the development of strategic objectives which are renewed annually.	Executive Risk Management Committee papers; Annual Governance Statement; Internal Audit: BAF and Risk Management 2024/25.	Confirmed	

	· There is board-level engagement on improving quality of care across the organisation	Improving the quality of care is central to the Trust's strategy and Board and committee business. At an individual level, Board member engagement includes the alignment of each clinical area to a Non-Executive Director, Board level safety champions for both Maternity/Neonatal and the Emergency Department. There are regular quality engagement visits led by an Exec Director and joined by a NED to teams and departments across the organisation. Prior to each of its formal meetings the Board holds a workshop which includes topics such as innovation and quality improvement intiatives at a department level. Every Board meeting starts with a patient story.		Confirmed	
	· Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients	As well as standard reporting on quanitative metrics and information pertaining to quality, quantative information considered by the Board, its committees and its individual members include the work of the Maternity/Neonatal Safety Champions and Emergency Department Safety Champions, ward and department visits, meetings between departments and their dedicated non-executive director, patient and staff stories at board workshops, including those incorporated in presentations on QI and transformation. The Executive/NED engagment visits described above are used to engage with staff and patients about their experiences.	Emergency Department Safety Champion Report to Board	Confirmed	
	· Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community	The Trust's objectives, aligned to those of the wider system, are built around patient flow, neighbourhood health and ensuring people are on the right discharge pathways. Much of this work is undertaken as part of the Better Care Fund and overseen by the One Herefordshire Partnership Board as described above.	Trust Strategic Objectives, OHPB papers.	Confirmed	
	· Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust	The Board uses a wide range of data from elsewhere as learning and benchmarking as described above, including when things go wrong, such as recommendations arising from national reviews. This work is overseen by the Quality Committee. The Trust also participates in peer reviews by regional speciality networks and shares learning with its Foundation Group Parters.		Confirmed	
	· Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement	The Trust uses a range of methods to foster a culture of continuous improvement, including our Quality, Service Improvement and Redesign programme, which includes training courses. There is wide engagement in this, including all clinical leads. Each year the Trust runs a poster competition whereby clinical departments submit a poster describing a successful improvement, innovation or redesign project. The winning posters are displayed to encourage learning and further improvement projects. The appraisal process is aligned to the Trust objectives and requires a personal development plan for each individual. Recent positive engagement in test of change processes (including for UEC) demonstrated a good culture of continuous improvement in the Trust.	QSIR information. Appraisal documentation. Test of Change information.	Confirmed	

6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	· Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?	The Board, mainly through the work of the Quality Committee, triangulates quantative and qualitative data and comparative benchmarks, including complaints and patient feedback data and content, patient reported outcome measures, patient survey data, including comparative data, patient stories, joint reports from all foundation group partners on particular issues, visits to wards and departments and listening to the voices of staff and patients through the work of the Board level maternity and ED safety champions. The Trust engages well with Healthwatch, who are invited to Board meetings. The Trust has a Patient Engagement Forum which meets monthly and participates in the development of improvement projects. The Board also considered operational performance data in the context of patient experience, such as waiting times and discharge delays.	Quarterly Patient Experience Report to Board; reports to Quality Committee; Quality Account.	Confirmed	
	· Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities?	The Board/Quality Committee considers the following relevant information: national patient survey results, which include health inequalities data (e.g. national cancer patient experience survey, Aug 25); waiting times in ED (deprivation), elective waits (children and young people), PLACE results (dementia and disability); patient experience data for geriatric and paediatric wards. The Trust participates in the ICS Health Inequalities Strategy. The Board engages with the staff network groups, which provide a valuable perspective of patient experience through a health inequalities lens.	Quality Committee reports; Annual Report; ICS HI	Partially Confirmed	Improve collection of patient charactersistics data (particularly ethnicity). Embed review of patient experience data by protected characteristics and deprivation in standard reporting.
	· Is the board satisfied that it receives timely information on quality that is focused on the right matters?	Board and Committee meetings take place monthly, which provides an opportunity for formal discussion of issues that may have occurred outside of usual reporting cycles. Non-Executive Directors are regularly briefed by the Managing Director. Individual non-executive directors are separately briefed on urgent matters pertaining to their roles. The Quality Committee agrees an annual reporting schedule, which aligns to quality priorities, covers mandatory areas and enables a regular deep dive into every division and into departments where there are concerns.	Quality Committee minutes and reporting schedule.	Confirmed	
	· Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?	The Board has set an objective to improve its response to patient feedback and the Quality Committee regularly receives an update on progress, alongside regular reporting on FFT and other patient feedback data. An improved system was introduced in July following consultation with and testing by the Patient Experience Forum; this has made it easier for patients to leave feedback and for earlier reaction to issues. Themes of negative feedback and the action taken in response are detailed in reports.	Patient Experience Reports to Quality Committee.	Confirmed	
	· How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?	The Patient Engagement Forum provides feedback, participates in consultation and improvement schemes and tests planned changes. Information about this work is reported in the regular patient experience report to the Quality Committee. Themes from patient experience information are used to inform the prioritisation of quality priorities and strategic objectives relating to quality, which are embedded in the Trust's governance arrangements.	Quarterly PE report to QC; Quality Account, Annual Governance Statement	Confirmed	

	· Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?	The non-executive board members have a breadth of experience which includes nursing, health and social care leadership, social care, health improvement, research, and digital service delivery.	Annual report and website describe Board members' expertise and experience.	Confirmed	
	· Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	The Trust has set a quality priority to improve responsiveness to patient feedback (including complaints). Progress is monitored closely by the Quality Committee. The complaints team holds weekly review meetings, overseen by the clinical quality matron, where any serious matters are escalated. Complaint information is reviewed for themes and triangulated with incident information and other sources of intelligence for oversight and action.	Quarterly patient experience report; Quality Account	Confirmed	
III. People and culture					
7. Staff feedback is used to improve the quality of care provided by the trust	· Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?	The Board reviews the staff survey data in detail, including the WRES and WDES data, which is also also reviewed alongside the data of the other trusts within the Foundation Group. Action plans are developed at department level to address issues.	Board reports	Confirmed	
	· Does the board engage with staff forums to continually consider how care can be improved?	Each Non-Executive Director is allocated to a staff network. NEDs also participate in quality engagement walkabouts to engage directly with staff on wards and in departments. Each clinical department has a designated NED to provide support and with whom staff can raise any concerns. The FTSU NED is proactive in engaging with staff. In addition to the Maternity Neonatal Safety Champions, the Board has created an equivalent role for the Emergency Department.		Confirmed	
	· Can the board evidence action taken in response to staff feedback?	A Trust Staff Survey Action Plan is developed each year and communcated to staff with a 'you said-we did' element. Examples of action taken in response to feedback include the development of the occupational health service and wellbeing offer, a physiotherapy servive, mental health service, menoause support and the introduction of Schwartz rounds.	Staff Survey reports to Board	Confirmed	
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	· Does the trust regularly review skills at all levels across the organisation?	As part of the business planning round the divisions highlight any skills or workforce gaps and develops an annual training plan based on the required skills. This also informs the leadership and management programmes.	Annual Business Plans	Confirmed	
	· Does the board see and, if necessary, act on levels of compliance with mandatory training?	Mandatory training rates are included in regular Integrated Performance Reports to Board together with planned actions for improvement. Training rates in particular topics such as safeguarding are reported through the quality governance structure. Health and safety training rates including fire safety training are reported to the Health and Safety Committee, which reports to the Executive Risk Management Committee, which reports to the Board.	Integrated Performance Reports; ERM reports to Board.	Confirmed	

9. Staff can express concerns in an open and constructive environment	· Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?	There is an annual FTSU report to the Board and a quarterly report to the Trust Management Board. The designated NED FTSU Champion proactively engages with staff and the FTSUG.	FTSU reports to Board and Trust Management Board	Confirmed	
	· Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?	The FTSU Guardian has access to all executices and engages with the relevant exeutivec in relation to complex/sensitive cases, with oversight from the NED lead, the CPO and the MD.	FTSU reports to Board and Trust Management Board	Confirmed	
	· Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?	The FTSU process is set out in the policy and is described to staff during induction, with details for existing staff set out on the staff intranet, including flow charts. As well as the FTSUG there are FTSU champions across the Trust, in nearly every department, some of whom have training in as specialist area. FTSU training is now mandatory for all staff. Where possible without impacting confidentiality, examples of the outcome of speaking up are given during events such as FTSU month and HR roadshows. Actions taken in response to FTSU concerns include provision of civility and respect training and active bystander training and the introduction of cultural ambassadors to reduce unfairness in recruitment practices.	FTSU Annual Report. FTSU Policy. FTSU Guidance documents.	Confirmed	
	· Is there a safe reporting culture throughout the organisation? How does the board know?	Monitoring of incident reporting, including near misses; FTSU numbers are high. Rumour Mill - system of anonymous comments that can be responded to immediately. Staff Survey response on questions related to voicing concerns were above average for the benchmark group. Benchmarking with the other trusts in the Foundation Group is also included in the board report on the staff survey results.	Staff Survey report to Board April 2025. PSIRF reports to Quality Committee; FTSU reports; Quality Account.	Confirmed	
	· Is the trust an outlier on staff surveys across peers?	The Trust's results were above peer group average on all scores and on an improving trajectory.	Staff Survey Results; Staff Survey Report to Board April 25	Confirmed	
IV. Access and delivery of services					
10. Plans are in place to improve performance against the relevant access and waiting times standards	· Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary?	The emergency access standards are not currently being met but are improving. The Trust is working with system partners on discharge pathways and reducing emergency admissions. The Trust is also working with partners to improve performance on 52-week waits, particularly on referral management and elective pathways. This includes joint appointments between the Trust and adult social care to manage discharge pathways.	Integrated Performance Report (IPR) to Board.	Partially Confirmed	Implement UEC delivery plan and Elective Recovery Plan
	· Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this?	The IPR includes detail of the drivers of performance behind plan. Many of the intiatives supporting improvements in performance are overseen by the OHPB. The NEDs routinely observe Finance and Performance Executive meetings with the divisions to maintain a detailed understanding of issues at divisional level.	IPRs, OHPB papers, F&PE minutes	Confirmed	
	Is there a plan to deliver improvement?	There is a comprehensive UEC delivery plan for 2025/26, covering the whole pathway from admission avoidance to discharge. Recovery plans for 52 weeks are in place for the 5 specialities that are driving the current position as part of the elective recovery plan.	UEC Delivery Plan; Elective Recovery Plan.	Confirmed	

11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	· The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place	ED waiting times are monitored by deprivation levels arnd reported to Board. The Children and Young People Committee tracks long elective (including therapies) waits and compares against the overall waiting list to ensure there is no disadvantage and they are being seen in a timely way. Ethnicity data recording requires improvement to enable analysis.	Children and Young People Committee Reports. ED reports to Board.	Partially Confirmed	Improve collection of patient charactersistics data (particularly ethnicity). Embed review of patient experience data by protected characteristics and deprivation in standard reporting.
12. Appropriate population health targets have been agreed with the ICB	· Is there a clear link between specific population health measures and the internal operations of the trust?	The Trust is a member of the One Herefordshire Partnership, a place based partnership focused on providing services tailored to meet the needs of local people by breaking down organisational boundaries. OH oversees implementation of plans to achieve Prevention and Population Health Management Priorities. These include priorities which the Trust can both directly deliver and contribute to/influence through partnship working. Examples are: reduction in ED attendance, reduction in older age adult emergency admissions (frailty), smoking cessation, childhood obesity and continuity of care for complex patients. The foundations laid by the work of OneH led to Herefordshire being selected to take part in the NNHIP.	OHPB and ICS Board papers	Confirmed	
	· Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	There are many examples across the Trust of teams working directly to achieve this aim, such as those working on admission avoidance pathways, as well as those seeking to reduce hospital admission for people with long term conditions such as cardiac, respiratory and diabetes and gastroenerology. Teams working within the Integrated Care Division are involved in work that is part of the system/OneH approach to population health management, including Virtual Wards, Bridging Teams who work to bridge the gap between primary and secondary care, post discharge follow-up to prevent readmission and the Community Referral Hub. In preparation for winter, teams are working with care homes to identify people at the highest risk of hospital admission and provide mobile respiratory MDT support.	OHPB, ICE papers. Winter Plan (sept 25)	Confirmed	
V. Productivity and value for money					
13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	· Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to:				
	o review its performance against peers	The Foundation Group 4 Boards meeting provides an opportunity for benchmarking on key operational performance and qaulity indicators. The Integrated Performance Report, submitted to each Trust Board meeting, includes peer benchmarking data on a number of metrics including UEC and cancer. The Trust uses Model Hospital, NHS Futures and Federated Data Platform benchmarking. There is a programme of work to review and implement up to date GIRFT guidance; the Trust is a member of a Faster Further GIRFT cohort to improve productivity on elective access standards.	IPR and FGB performance reports	Confirmed	

	o identify and understand any unwarranted variations	Benchmarking data is part of standard reporting and deep-dive reviews at Board meetings and workshops and of reporting at Finance and Performance Executive meetings for each division, which are observed by NEDs.	IPR and FGB performance reports	Confirmed	
	o put programmes in place to reduce unwarranted negative variation	The Trust has a PMO that supports produvtivity, recovery and GIRFT programmes. The ICS Urgent Care Programme Board and Diagnostic Programme Board provides additional benchmarking data.	IPR and FGB performance reports	Confirmed	
	· The trust's track record of delivery of planned productivity rates	The Trust has focused on improvement in this area post-Covid and the implied productivity level demonstrably improved in 2024/25 compared to 2023/24. Local examples of particular improvement include theatre utilisation and DNAs.	Board papers	Confirmed	
VI. Financial performance and oversight					
14. The trust has a robust financial governance framework and appropriate contract management arrangements	· Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data	The Internal Audit Plan includes core areas including risk management and financial controls. We work with the auditor to agree the priority area of financial systems for focus each year. The plan also includes a data quality review, focused on a different data set each year.	IA annual plan 25-26; IA annual report 24/25	Confirmed	
	· Have there been any contract disputes over the past 12 months and, if so, have these been addressed?	The Trust is working through appropriate channels on a contractual issue with NHS Wales.	Correspondence with NHSE; FRB papers	Confirmed	
	· [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?	The Trust's workforce, activity and financial plans are developed alongside each other and triangulated. Delivery is monitored through an Integrated Performance Report. Agency/bank usage reduction is progressing according to plan.	Integrated Performance Report. MARP and NARP reports to Financial Recovery Board	Confirmed	
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	· Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care?	The Trust has an established quality impact assessment process as part of the development of CPIP schemes and major service change plans. CPIP delivery is monitored alongside quality metricsand risk register entries to determine any emerging quality impact. Investment is prioritised in areas of known risk and pressure.	Financial Recovery Board papers.	Confirmed	
	· Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing?	As above	Financial Recovery Board papers.	Confirmed	
	· Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	In 2024 the Board established a Financial Recovery Board, which comprises all Board members for the purpose of a detailed monthly review of financial delivery progress, including CPIP and any recovery plans as necessary, including drivers for under-performance.	Financial Recovery Board papers.	Confirmed	
16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial	· Is the board contributing to system-wide discussions on allocation of resources?	The CFO and a Trust NED are members of the ICB Finance Committee; the CEO and MD are members of the ICB. The ICS CFOs and planning leads meet outside the governance structure to collaborate on the development of plans.	ICB Finance Committee and ICB papers.	Confirmed	

outturn	· Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system?	The Trust's financial plan and those of its partner trusts in the ICS were developed as both local, standalone plans and as part of the wider ICB financial plan (including capital). The Board was well sighted on and involved in the development of the plan from both perspectives through workshops and meetings of the Board and Financial Recovery Board. The Trust participated in the development of the ICS Joint Capital Resource Plan 2025/25 (published July 2025).	Financial Planning reports to Board, Feb 25, March 25. Operational Planning Board Assurance Statement. ICB Financial Plan and Delivery 25/26 report May 2025. ICS Joint Capital Use Resource Plan 2025/26.	Confirmed	
	· Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	The Trust's strategy aligns with the ICS strategy. The Trust takes a lead role at PLACE on behalf of the ICS. There is a delegated MOU in place for delivery of the Better Care Fund.	ICB papers; OneH papers	Confirmed	

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Trust Infection and Prevention Annual Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Laura Weston, Lead Infection Prevention Nurse
Reporting Route:	Trust Infection Prevention Committee, Quality Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**
Brief Description of Report Purpose	
To receive the Trust Infection Prevention and Control annual report.	
Recommended Actions required by Board or Committee	
To receive the report and note performance and action being taken to address areas of concern.	
Executive Director Opinion[1]	
Quality Committee reviewed this report and provided due scrutiny at the meeting last week, additionally, Quality Committee also receive quarterly performance updates. This report is written in line with suggested best practice and includes our performance against those performance indicators as set out in the NHS standard contract. Where performance is off trajectory the report covers actions being taken. The infection prevention improvement plan is specifically focussed on improving performance and practice.	

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

NHS
Wye Valley
NHS Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2024/25

CONTENTS

EXECUTIVE SUMMARY

This report summarises the key infection prevention and control (IPC) initiatives and activities of Wye Valley NHS Trust (WVT) from the 1st April 2024 to 31st March 2025.

The year has continued to be dominated by high prevalence of respiratory infections, and our annual report reflects this. Our focus on hand hygiene, cleanliness and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas. The Quality Committee continued to scrutinise our infection prevention performance at quarterly intervals on behalf of the Board throughout 2024-2025.

SECTION 1: KEY OUTCOMES OF 2024/25

- The Trust reported one Trust attributed Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias during the year 2024/25 against a threshold of zero.
- Sixty nine patients were identified with a Gram negative blood stream infection (GNBSI). This included 46 Escherichia coli (E. coli) GNBSI, 16 Klebsiella species (Klebsiella spp.) GNBSI and 7 patients with a Pseudomonas *aeruginosa* GNBSI.
- Eight of the reported GNBSI were linked to the presence of an indwelling device. Areas of learning predominantly related to the completion of device documentation.
- The Trust reported 61 cases of hospital attributable *Clostridioides difficile* infection (CDI) against an NHS England set trajectory of no more than 38. Post infection reviews identified that 25 of these cases had learning opportunities
- There were 139 patients who were deemed to have probable or definite hospital onset COVID-19 infection.
- There were 34 infection outbreaks reported during the year. This included 24 outbreaks due to COVID-19, 2 due to norovirus infection, 5 outbreaks of Influenza and 3 due to the bacteria Carbapenemase producing Enterobacteriaceae (CPE)
- Hand hygiene and bare below the elbow (BBE) audits of compliance are completed monthly by the Infection Prevention nurse team and ward/ department based clinical staff. The mean compliance score for hand hygiene practice was recorded as 95.7% and 98.2% for BBE compliance.

SECTION 2: INTRODUCTION

All NHS Trusts have a legal obligation under the Health and Social Care Act 2012 to produce an annual report and make this available to the public. It is essential for demonstrating robust governance, alignment with Trust values, and public accountability. Its primary purpose is to assure that the Trust maintains high standards of compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance, last updated in

December 2022. Accordingly, this annual report is structured around the ten compliance criteria outlined in the Code of Practice.

These criterion are used by the Care Quality Commission to judge a registered provider against the IPC requirements detailed in the legislation. It looks at all aspects of IPC, including monitoring and surveillance, environment, cleaning, staff, policies and laboratory provision.

Criterion Compliance	What the registered provider will need to demonstrate
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4	Provide suitable accurate information on infections to service users and their visitors & any person concerned with providing further support or nursing/medical care in a timely fashion.
Criterion 5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide secure adequate isolation facilities.
Criterion 8	Secure adequate laboratory support as appropriate.
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Ensure, as far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

The Trust supports the principles that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection must be in place within the Trust.

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2025-26 as we continue to manage and move beyond the challenge of winter pressures.

WVT provides both acute and community healthcare services, including neighbourhood teams, maternity and children's services for Herefordshire. Acute and general services are provided from the Hereford County Hospital Site with 304 inpatient beds across 19 wards and departments.

Community inpatient care is provided in three community hospitals Ross, Bromyard and Leominster with a core bed base of 76 beds.

The Hereford County Hospital site is a private finance initiative (PFI) site and the NHS Trust partners are Mercia Healthcare and Sodexo. Estates and facilities services are provided in house at the community sites.

The term Infection Prevention Service is a collective term used throughout the report and includes the Infection Control Doctor and the Infection Prevention nursing team.

A list of abbreviations used throughout this report can be found in Appendix 1.

SECTION 3: COMPLIANCE

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

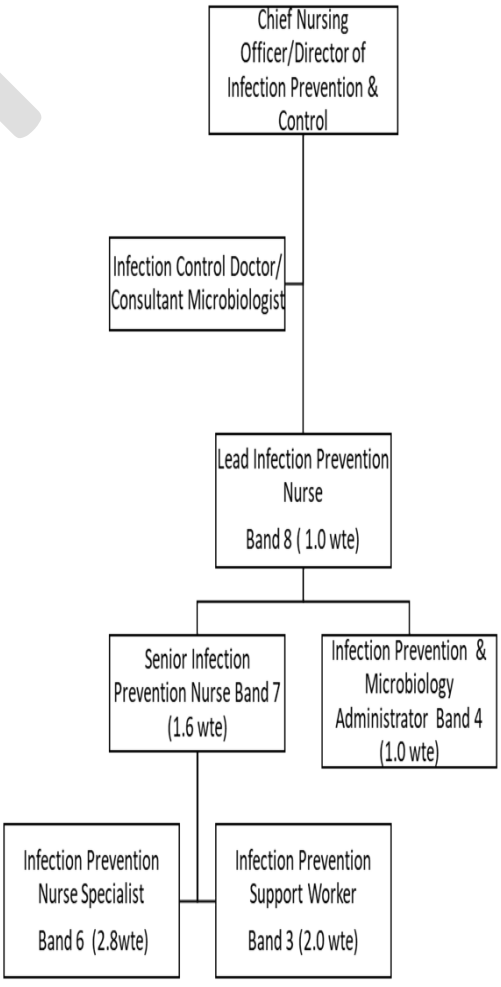
3.1 Infection Prevention Service & structure

The Infection Prevention Service provide IPC advice and support to wards and departments. The IPC nursing service is provided five days a week between 07:00-17:00 between April to September ; this increases to a seven day week between October and March with weekend cover 08:00- 16:00 . Out of hours Microbiologist cover is provided by the on-call Consultant Microbiologists from Hereford and Worcester.

The Chief Nursing Officer also holds the role of Director of Infection Prevention & Control (DIPC) and has overall responsibility for the Infection Prevention team.

Between April 2024 and January 2025 the Infection Control Doctor post was fulfilled by an Associate Specialist in Microbiology. On completion of the Certificate of Eligibility for Specialist registration (CESR) qualification, the incumbent doctor was appointed as consultant microbiologist. The role of Infection Control Doctor is supported by the Microbiologist team in their absence.

The IPC nursing team remain in the Corporate division directly line managed by the Chief Nursing Officer. Nursing team members have been allocated to each division to support infection prevention practice and governance within those divisions. To ensure that IPC is at the forefront of divisional governance, information is disseminated to the Board and Divisions via monthly infection prevention reports.



The IPC service continued to support frontline staff and prioritise urgent IPC issues during the waves of respiratory illnesses including COVID-19, resurgence in infections such as pertussis and during winter pressures. Any priorities that were not completed throughout the year have been reviewed and added to the Infection Prevention 2024-25 schedule as appropriate.

3.2 Committee structures and assurance processes

3.2.1 Trust board

The Code of practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive has overall responsibility for the control of infection at the Trust, the Trust designated Director of Infection Prevention and Control (DIPC) role is undertaken by the Chief Nursing Officer. The DIPC attends Trust Board meetings with detailed updates on IPC matters.

3.2.2 Quality committee

The Quality Committee is a sub- committee of the Trust Board and has overarching responsibility for managing organisational quality risks. This committee reviews high level infection prevention key performance data monthly and a detailed report is presented to the committee by the Lead Infection Prevention Nurse quarterly. This report outlines the Trust's compliance with statutory obligations and work streams, providing board assurance. The Chief Nursing Officer is a member of the Quality Committee.

3.2.3 Trust Infection Prevention & Control committee

The Trust Infection Prevention & Control Committee (TIPCC) is chaired by the DIPC and in their absence, by the Infection Control Doctor. The sub-committees of the Infection Prevention Committee are:

- Decontamination Committee
- Cleanliness Committee
- Water Management Group
- Ventilation Committee
- Surgical Site infection surveillance group
- Antimicrobial stewardship
- Food safety

The Trust Infection Prevention Committee then reports directly to the Quality Committee.

3.2.4 Other meetings and committees attended by members of the Infection Prevention Service are as follows:

- Post infection reviews with appropriate clinical staff and colleagues from the Herefordshire and Worcestershire Integrated Care System (H&W ICS)
- Capital planning and equipment committee (CPEC)
- Health and Safety committee
- Estates and Facilities performance meetings for acute and community
- Countywide healthcare associated infection forum chaired by H&W ICS
- Countywide *Clostridioides difficile infection* reduction forum chaired by H&W ICS

- New build and re-design meetings
- Incident meetings as they arise
- Infection Prevention service meetings
- Joint cleanliness monitoring with WVT and the private finance initiative partner.
- Patient Experience Forum & Committee
- Patient led assessment of the care environment (PLACE)

3.2.5 Antimicrobial Management Group

The Trust has an Antibiotic Stewardship Team consisting of an Antimicrobial Pharmacist and the Antimicrobial Stewardship lead / Associate Specialist in Microbiology. The group meets monthly and produce a quarterly report on antibiotic use and audit results which is presented at the Trust Infection Prevention & Control Committee (TIPCC). With effect from July it was agreed that the Patient Safety Committee would oversee prescribing practices and make recommendations for changes to formulary and practice.

3.2.6 External assurance reviews

The Trust remains at an Intensive Support level of support with NHS England for IPC following the multi-agency visit in October 2022. During 2024/25, the Infection Prevention service has received support and supervision from ICS and NHSE IPC specialist colleagues.

The H&W ICS Infection Prevention Nurse has also undertaken regular assurance reviews throughout 2024/25. Feedback is provided and reported to Department leads as appropriate.

The Infection Prevention service continue to address the areas highlighted for improvement raised in 2023/24 and logged in the Infection Prevention Improvement Plan (Appendix 2). The adherence and completion with the plan has been monitored via TIPCC and the Quality Committee on a quarterly basis.

The Infection Prevention Annual Plan for 2025/26 will continue to focus on these elements to ensure IPC standards become embedded into Trust practices.

3.2.7 Board assurance Framework

NHSE issued a National Infection Prevention and Control Board Assurance Framework (BAF) in 2022, updated in September 2023. This BAF supports all healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control manual (NIPCM) and other related infection prevention and control guidance. The framework helps identify risks associated with infectious agents and provides an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability.

Compliance against the 10 key lines of enquiries (KLOE) has been regularly reviewed by the Infection Prevention service with the support of the Quality & Safety team and reported quarterly to the infection Prevention Committee. By year end, 5 of the 10 KLOE are fully compliant; 5 KLOEs require additional evidence to ensure full assurance is achieved and 0 are non-complaint. Actions to support achieving compliance have been developed and included in the Trust's Infection Prevention Improvement plan.

3.3 Infection Surveillance

In June 2024, the NHS Standard Contract for 2024/25 was published. This stipulated that all Community Onset Healthcare Associated (CO-HA) and Hospital Onset Healthcare Associated (HO-HA) infections are to be included in Trust's data reporting.

Hospital onset healthcare associated: (>AD+1) - HO-HA	Cases that are detected in the hospital two or more days after admission (where day one is day of admission).
Community onset healthcare associated: (<AD+1) CO-HA	Cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (where day one is day of admission).

3.3.1 Healthcare Associated Infections Review Panel

All healthcare associated infections (HCAI) that occur within the organisation are appraised by the HCAI Review Panel. The review panel meets weekly with the primary objectives of providing a multidisciplinary review of all HCAI incidents, identifying areas of good practice/ improvement and ensuring that any HCAI that causes moderate harm are identified and escalated.

The panel consists of the Infection Control Doctor, Lead Infection Prevention Nurse, and Quality & Safety manager, H&W ICS Infection Prevention Nurse Specialist and Clinical Representatives.

All HCAIs are logged as incidents on the Trust incident reporting system.

3.3.2 Meticillin resistant Staphylococcus aureus (MRSA) bacteraemias

Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult to treat infections in humans. The Department of Health continues to drive a Zero-tolerance approach to MRSA bacteraemia.

During 2024/25, one Trust appointed MRSA bacteraemia cases was reported. The case was reviewed at the HCAI Review Panel and escalated to the Trust Patient Safety Group to look for preventable causes and identify any future learning opportunities.

Outcome from the reviews have been shared with the Division.

3.3.3 Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemias

MSSA is the much commoner antibiotic sensitive version of *Staphylococcus aureus*. As a formal target for reduction of MSSA bacteraemia cases has not been defined in the NHS Standard Contract for 2024/25, it has been agreed in TIPCC to establish a local threshold for MSSA bacteraemias to support local monitoring and enable effective benchmarking. The calculation used to set the GNB threshold in the NHS Standard Contract 2024/25 was utilised to set the MSSA threshold; this was set at 12 cases for 2024/25

Fifteen MSSA bacteraemia cases were apportioned to the Trust for the period 2024/245 in comparison to 21 in 2023/24.The 2024/25 cases included 6 CO-HA and 9 HO-HA cases. All cases were reviewed to look for preventable causes when the source of infection was unknown or device related. Eight cases were identified as being linked to the patients underlying health concerns. Seven patient were noted to have an indwelling invasive devices such as Urinary catheters and/ or peripheral venous cannulas; Learning opportunities were noted in regarding the documentation of ongoing invasive device care and management.

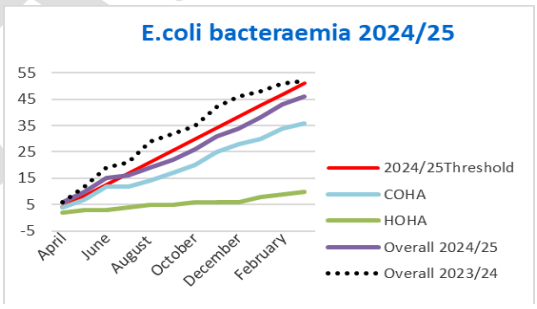
The Infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

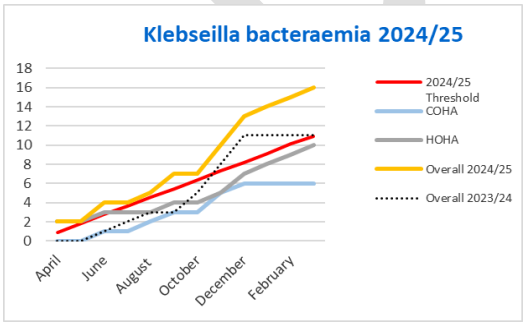
3.3.4 Gram negative blood stream infections

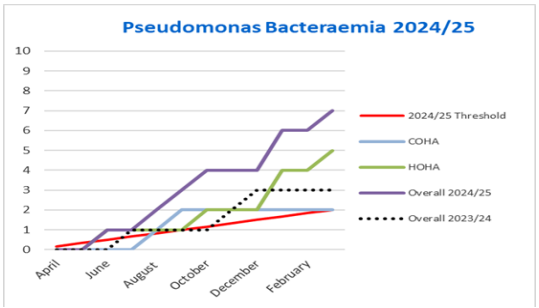
A healthcare associated Gram-negative blood stream infection (GNBSI) is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days. The top three GNBSI causative organisms which account for 72% of all Gram negative bacteraemias are: Escherichia coli (*E. coli)*, *Pseudomonas aeruginosa* (*Pseudomonas spp.*) and *Klebsiella* species (*Klebsiella*).

The focus is on the reduction of the top three GNBSIs and includes all CO-HA and HO-HA reported cases. In 2024/25 the following cases of GNBSI were reported:

Bacteraemia	Standard Contract Threshold for WVT	End of year tally
E.coli	51	46
Klebsiella spp.	11	16
Pseudomonas	2	7







All cases were reviewed and root cause analysis carried out to look for preventable causes when the source of infection was unknown or device related.

Twenty three of the cases were identified as being linked to the patients underlying health concerns. Eight of the reported GNBSI were noted to have an indwelling invasive devices such as urinary catheters and/ or peripheral venous cannulas; Learning opportunities were noted regarding the documentation of ongoing invasive device care and management

The infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

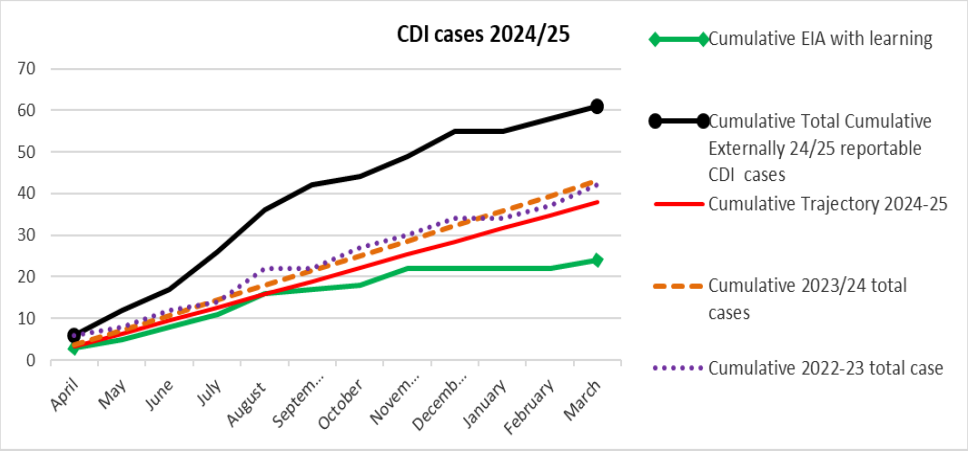
3.3.5 Clostridioides difficile infection (CDI)

Clostridioides difficile (also known as C. difficile of C.diff) is a bacterium found in the gut which can cause diarrhoea after antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. It forms resistant spores which require very effective cleaning and disinfection to remove them from the environment.

C. difficile Infection (CDI) is nearly always preceded by antibiotic treatment but antibiotics may have been stopped up to 6 weeks before the patient presents with symptoms. Although most antibiotics have been implicated, broad-spectrum agents such as cephalosporins, quinolones and carbapenems (e.g. meropenem) are most likely to cause it as they wipe out the "normal flora" of the gut which usually holds *C. difficile* in check.

The reportable cases of CDI are CO-HA and HO-HA CDI cases that are positive by two tests, polymerase chain reaction (PCR) and enzyme-linked immunosorbent assay (EIA).

WVT was given an externally set trajectory of 38 cases of CDI this year. This included CO-HA and HO-HA cases. The Trust reported 61 CDI cases by the end of March 2024. This included 26 CO-HA cases and 35 HO-HA cases.



All reportable cases of CDI are investigated by the HCAI review panel. Learning opportunities were identified in 25 cases. Learning opportunities noted included:

• Hand Hygiene & BBE practices	• Environmental cleanliness
• Clinical equipment cleaning	• Stool sampling processes
• Documentation	• Prescribing and/or administrating antibiotics outside of guidelines

The Trusts CDI mortality rate at year end was 21.3%. This is 8% above the national benchmark. Analysis on the 13 patient cases has been undertaken to identify any areas for learning and improvement. Plus a review of the mortality structured review process is being undertaken to streamline the reviews of patients with HCAI linked deaths.

The Trust remain an outlier for CDI rates compared to other Trusts in the region and nationally. Some of the high rate but not all of it is explained by the fact that the denominator for the rate is taken from the NHSE quarterly KH03 occupied overnight bed data and does not include the community hospital beds.

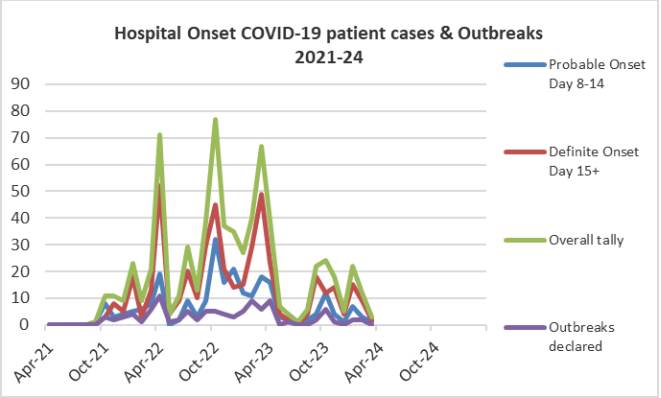
Action taken:

- A review of all Trust practices with diarrhoeal and CDI management is being undertaken; An IPC nurse has been dedicated to review all cases to ascertain any trends in demographics, infection acquisition and pre hospital care.
- Collaborative working with H&W ICB colleagues and sister organisations to monitor and understand relapsed cases.
- Review antibiotic therapy in the treatment of CDI

3.3.6 COVID-19

In total, 139 patients were deemed to have probable or definite hospital onset COVID-19 infection (See Appendix 3 for COVID-19 onset definition); this is a reduction from 176 reported patient cases in 2023/24.

Twenty four outbreaks were declared due to COVID-19 linked transmission. This is the same number reported in 2023/24.



The prevalence of COVID -19 infection both internally and within the Herefordshire community was regularly discussed in the Herefordshire & Worcestershire ICS led meetings to ensure a unified system approach to the peaks in reported cases.

National recommendations for COVID-19 management have been implemented by the Trust following approval at the Infection Prevention Committee and or Trust Management Board. Outbreak meetings were held as required and were attended by key stakeholders including NHS England and UKHSA. The Infection Prevention Service continued to be heavily involved in planning and supporting patient pathways and providing staff education. The communications team issued key messages and updates for staff as required.

3.3.7 Carbapenemase-producing *Enterobacteriaceae* (CPE)

Carbapenemase – producing *Enterobacteriaceae* are bacteria that are very resistant to the last line of defence antibiotics, the carbapenems. They present a significant risk to healthcare. When isolated from a microbiological specimen, infection control measures are instigated to reduce the risk to other patients. The Trust has a CPE policy in place which reflects screening guidance recommended by UKHSA.

During 2024/25, 43 patients were identified as being colonised with CPE and outbreaks of CPE were declared in the following areas:

- Ross wards
- ITU
- Ashgrove

The outbreaks on the Intensive Therapy Unit (ITU) and Ashgrove ward reported only 2 patients each. The outbreaks were contained and no additional spread was reported. Outbreak meetings were held and the IPC service had oversight of all actions undertaken including patient and environmental screening & monitoring, reviewing standards and providing training to staff. Both incidents were stepped down after a set period as per guidance.

The CPE outbreak on Ross wards remained active from July 2024 – March 2025. This affected 39 patients with the last linked patient case reported in January 2025. Restrictions to patient admission, discharges and transfers to the Ross wards were in place during this time and the IPC team provided dedicated support to the Ross team during this period. Numerous learning opportunities were identified and an action plan was developed and monitored by the Integrated Care division.

Enhanced decontamination of the affected environment and patient shared equipment was undertaken with Hydrogen Peroxide Vapour (HPV) as per national recommendations.

Throughout the outbreak period, regular outbreak meetings were been held. Colleagues from Hereford and Worcester Integrated Care System, NHSE and UKHSA have attended and provided advice and support.

3.3.8 Measles

No cases of Measles were reported in Wye Valley NHS Trust.

UKHSA guidance and campaign materials were cascaded Trust wide to ensure staff awareness. Patient pathways have been developed to ensure safe management of patients attending Wye Valley NHS Trust.

3.3.9 M-POX

National and regional guidance on managing the virus m-pox (previously referred to as Monkeypox) has been published by NHSE and UKHSA; all organisations have been advised to have IPC measures in place to identify, manage and treat any patients presenting with suspected mpox.

All published national guidelines have been disseminated trust wide as recommended. Patient pathways have been developed to ensure safe management of patients attending Wye Valley NHS Trust. Enhanced isolation suites have been planned for high risk areas- ED, Critical Care and Ashgrove ward.

The Trust IPC team are liaising with Regional colleagues to attend National Train the Trainer PPE session to enable High Consequence Infectious Disease (HCID) PPE training can be cascaded Trust wide.

No cases of Mpox were reported in Wye Valley NHS Trust.

3.3.10 Tuberculosis (TB)

There were no healthcare associated TB incidents reported in 2024/25.

3.3.11 Seasonal infections

- Norovirus

All stool samples submitted to the laboratories are tested for Norovirus as routine. 205 patients were identified as having Norovirus whilst inpatients in Wye Valley NHS Trust.

Two norovirus outbreaks were declared; one in July 2024 and 1 in February 2025. In total 10 patients and 2 staff were affected by the outbreaks. All incidents were managed as per Trust policy. Patient flow restrictions were applied to contain the spread of infection.

See Appendix 3 for details on Norovirus associated outbreaks.

Outbreak meetings were held as required and were attended by key stakeholders including NHSE and UKHSA.

- Influenza

592 patients were reported as having influenza by the Trust Microbiology department during September 2024-March 2025; 428 patients were admitted. The majority of these cases were recorded in the months December, January and February. This was reflective of the national picture and also of enhanced testing.

Five outbreaks due to Influenza were declared as per national and regional guidance; Two in December and 3 reported in January. The wards remained open as infection spread was contained. See Appendix 3 for details on Influenza associated outbreaks.

Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

2.1 Decontamination

There has not been a significant incident linked to Decontamination practices during this financial year. Incidents, if they occur, are discussed at the Decontamination Committee.

Endoscopes continue to be processed at the County Hospital in Hereford and at Ross Community Hospital in their respective Endoscopy departments. Ear, nose and throat scopes are also processed in the Endoscopy Decontamination suite at the County Hospital, bringing a centralised process to the clinics within the trust.

A Joint Advisory Group (JAG) audit on all endoscopy services was completed in 2025 and actions are currently being collated ahead of working through them. This audit process provides assurance in the safety and quality of endoscopy decontamination activities and ensures the processes are appropriate. Site wide reviews by the Trust appointed Authorising Engineer and the company Tristel with no serious concerns identified.

All surgical instruments continue to be re-processed in the sterile services department at the Hereford County Hospital which is run by our PFI partner. Protein detection has been implemented and it is effective in assisting Central Sterilising Services Department (CSSD) in managing their decontamination processes. Furthermore CSSD services have increased capacity to cope with surgical robot instruments and increased turnover of standard instruments due to the opening of the new theatres.

Local decontamination of dental instruments is undertaken in most of the Dental Access Centres (DAC). The washer disinfectors at all sites were on a loan contract. However, these assets now belong to the Trust. The Trust has extended the service contract with the current service provider. Competitive quotes have been obtained for new decontamination equipment (autoclaves and washer disinfectors) in 2024 and this currently underway. Leominster and Gaol Street DAC's have had new autoclaves installed.

A Laundry assurance visit occurred on the 3rd December 2024. The visit gained assurance of the laundry providers processes. The laundry provider Elis provide a microbiology report to the Trust every month, which is reviewed, monitored and discussed at the Decontamination Committee.

A review of the Decontamination committee has been carried out and it was agreed to meet quarterly rather than bimonthly in 2025/26. This coincided with the potential restructuring of Decontamination Lead post. The Decontamination authorised person roles are still in the process of appointment.

2.2 Cleanliness Monitoring

The Trust has now completed three full years of input to deliver the requirements set out under National Standards for Healthcare Cleanliness 2021 (NCS21). The standards have been embedded into our Cleanliness culture whereby the monthly Cleanliness meetings are generally well attended by all areas of the Trust. Clinical leads are aware of their expectations and the standards to be met.

During 2024/25 we have embedded the utilisation of the monitoring tool Ambinet, a bespoke auditing system created specifically for NCS21 monitoring. In the initial implementation of Ambinet a difference in Cleanliness scores was noted from previous trends. This appears now to have stabilised with audits reporting similar trends across the Trust and each of the Functional Risk categories (FR1 to FR6). Secondly, the Trust now monitors jointly with Sodexo and members of the IPC team and a local Clinical representative. These audits therefore provide a much greater level of assurance and management input than previously known. The speed of defect rectification has subsequently improved greatly due to this level of input at the time of audit.

High Risk (FR1) clinical areas continue to receive significant focus with local action plans receiving input from Clinical and Estates management. FR1 audits are completed weekly and scores have improved over 2024/25. General Ward areas (FR2) receive audits on a monthly basis; FR2 audit scores have remained more consistent and very few action plans are required for Audits that receive a 3 star (*) rating or below.

Analysis of the 2024 scores (Appendix 4) show a sustained/continued improvement in Domestic Cleans and a reduction in Clinical Clean scores from the previous year across both FR1 and FR2 risk areas.

We therefore start 2025/26 aiming to improve our Clinical Cleaning scores. However clinical staffing levels with appropriate training and supervision would appear to be greatest challenges in achieving these improvements.

Enhanced environmental decontamination by hydrogen peroxide vapour (HPV) was bought in-house from February 2025. Previously undertaken by an external provider, this role has now been allocated to competency trained staff across all 4 inpatient sites. This will ensure decontamination can be completed in a timely and more cost effective manner.

2.3 Ventilation

The Ventilation Safety Group (VSG) was set up in November 2022. The purpose of the group is to allow all duty holders to demonstrate that there are suitable governance, competence and accountability arrangements in place to provide safe ventilation systems and appropriate clinical environments in the Trust's healthcare premises.

The Group is a sub-committee of the Trust Infection Prevention Control Committee (TIPCC). Ventilation reports are presented quarterly at TIPCC or sooner if areas of concern have been identified.

There has not been a significant incident linked to Ventilation during this financial year. Incidents, if they occur, are discussed at VSG.

Air handling units (AHU's) continue to have their annual verifications and newly installed AHU's receive their validations before the area being served is used for clinical procedures. Where official verifications cannot be carried out due to access issues a local interim verification is carried out by on site engineers to provide assurance. Where access issues persist these are escalated through VSG and/or Access committee.

All new builds and developments have included consultation with the Authorising Engineer for Ventilation during both the design and build phases of construction for approval on Ventilation systems.

2.4 #WyeClean Quality Improvement campaign

#WyeClean has continued throughout 2024/25. Themed IPC roadshows have been held throughout the year focusing on key clinical cleaning responsibility's such as specific equipment cleaning, cleaning products to promote and embed standardization of practice.

#WyeClean will continue into 2025/26 to embed training.

2.5 Patient Led Assessments of the Care Environment (PLACE)

The PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

The aim of PLACE assessments is to provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

Clinical facilities across all four Wye Valley Hospitals were inspected by PLACE assessors between September and October 2024.

The results were published February 2025. Action plans addressing all issues highlighted by the assessment have been developed. This is being overseen via the Patient Experience Committee.

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

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

Analysis of the scores show that this is the second year with declining scores in Privacy, dignity & wellbeing, Dementia and Disability scores. A full review of the scores has been undertaken and action plans developed to support improvement. The Trust Dementia lead Nurse is supporting the actions highlighted in the Privacy dignity & wellbeing, Dementia and Disability domains

PLACE 2025 inspections are planned to commence in September 2025.

Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

3.1 Antimicrobial stewardship 2024/25

The Trust has an antimicrobial stewardship team consisting of consultant microbiologists / Infectious diseases specialist, a 0.6 Whole Time Equivalent (WTE) antimicrobial pharmacist, and 0.5WTE pharmacy technician.

The team aims to ensure that antibiotics are used carefully and in ways which minimise side effects and the development of antibiotic resistance, whilst maximising efficacy and treatment outcomes.

An updated national 5 year action plan was published in 2024 setting out strategic ambitions to reduce Antimicrobial Resistance across all sectors UK 5 year action plan for antimicrobial resistance 2024/2029. We are working with our partners in the H&W ICS to align to these ambitions.

A major focus of the work over the past year has been to stabilise and build on the Trust's OPAT (Out Patient Parenteral Antibiotic Therapy) service, and to incorporate the routine use of 24 hour antibiotic infusions in the domiciliary environment. Work on this is ongoing and has been slower than expected due to significant governance concerns which are being

addressed, and, once resolved, will enable us to safely manage more complex patients in an outpatient setting, and optimise antibiotic choice.

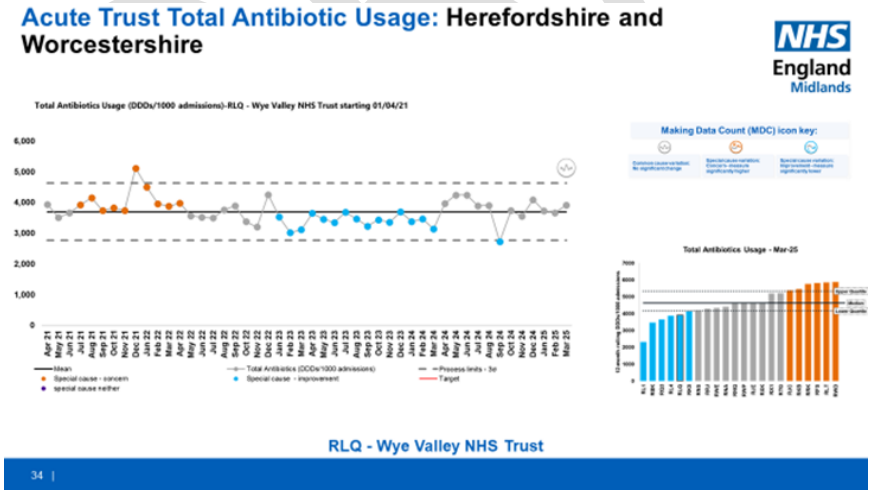
Key achievements in 2024/25 include:

- Relaunching the Trust AMS group
- Participation in the system wide AMS group
- Ongoing regular audits of antibiotic use across the Trust
- Completing “deep dive audits” for non-adherence to guidelines, ward audits as part of Enhanced review periods following C difficile cases
- Introduction of a weekly antibiotic ward round on Arrow ward
- Introduction of a formalised antibiotic management plan for OPAT patients completed on referral to OPAT services
- Reporting quarterly to the TIPCC
- Move from Microguide to Eolas as a platform for accessing antibiotic guidelines over mobile devices
- Launch of a calculator for once daily gentamicin dosing in endocarditis
- Launch of a MSSA Bacteraemia pathway

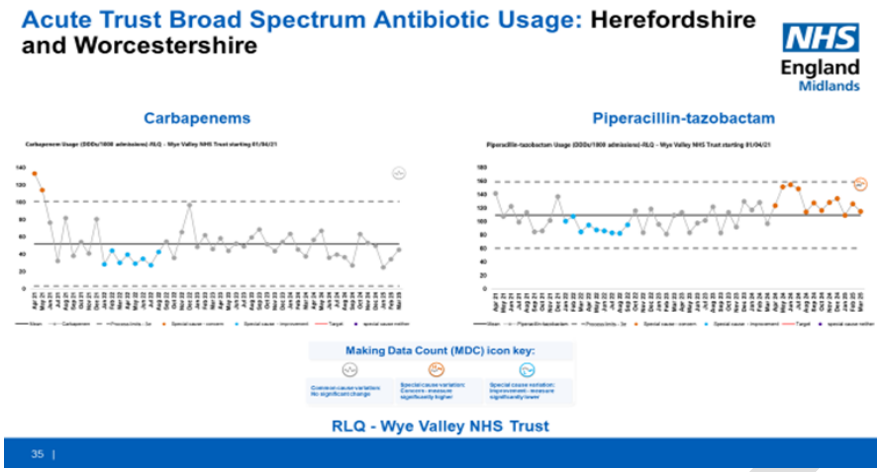
There are a number of work streams in progress / ongoing including a general review of antibiotic guidelines, update and relaunch of vancomycin prescribing guidelines, introduction of a penicillin de- labelling protocol and major updates to the Trust antibiotic and OPAT policies (PR.71 and PR.148)

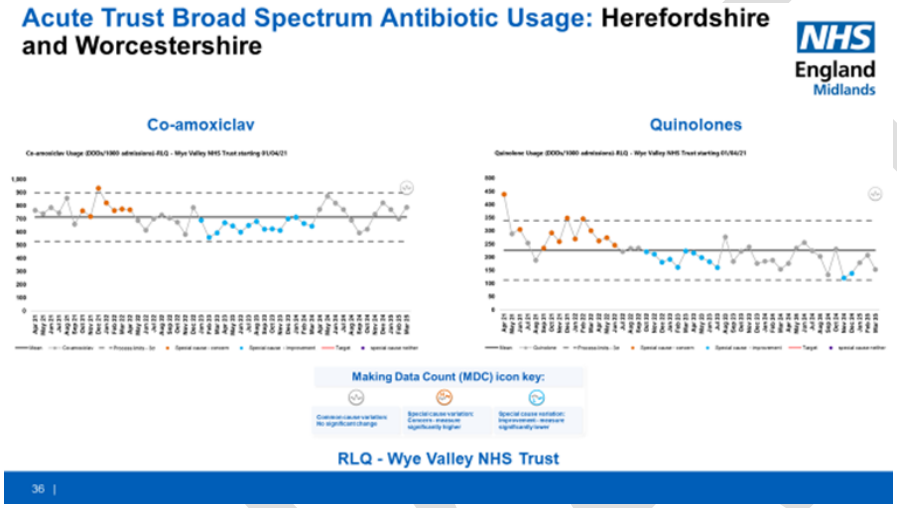
Antibiotic usage:

- Antibiotic usage within the Trust remains stable as demonstrated in the graphs below
- Overall our rate of antibiotic use is the fifth lowest in the region



Broad spectrum antibiotic use, carbapenams, piperacillin, tazobactam and co-amoxiclav remain steady, and we have seen a consistent decline in quinolone use following the MHRA safety alert issued in January 2024.





Criterion 4:

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

4.1 Patient leaflets

The infection prevention related leaflets are available in hard copy or through the Trust intranet and public facing web sites. All leaflets are reviewed by the Trust reading group prior to publication.

4.2 Communication Team

Establishing a clear communication programme is a key requirement in the improvement of patient care, the instigation of IPC initiatives, public information and visitor safety, as the way we all worked had to change, often at short notice.

The Infection Prevention Service has worked closely with the Communications Team throughout the year. They have been instrumental in assisting with in ensuring the correct media information has been developed in a timely and clear manner.

The Communications Team attend incident and outbreak meetings to ensure that appropriate messages are delivered both to Trust staff and to the public. They have issued frequent Trust bulletins throughout 2024/25 with regular contributions from the Infection Prevention Service team members. Wider dissemination of current issues is also achieved by global emails and through the Trust weekly Team Brief newsletter.

4.3 Trust Intranet

The Trust website has a dedicated IPC site which provides pages on general IPC issues and guidance including link nurse information, information on specific HCAI management. Resources such as policies, audit tools and patient information leaflets can be accessed via this portal.

Criterion 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

5.1 Prompt identification

Notification of infections in a timely fashion is facilitated by laboratory reports directly to the Infection Prevention nurse team from the laboratory staff. These are also available electronically via the MAXIMS laboratory system. The ward area is then either telephoned or visited by their appointed IPC nurse to ensure that the correct information is available for treatment and care of that patient.

If patients have been identified as having CDI or MRSA and they have been discharged, a letter is sent to their general practitioner.

The IPC nurses advise the Clinical Site Management team and ward staff regarding isolation and management of patients with known or suspected infections. The electronic patient record system, MAXIMS, has a notification flag on it so that patients with a history of alert organisms such as MRSA can be brought to the attention of nursing and medical staff when accessing the electronic patient record. The Infection Prevention nurse team also attend the daily bed meetings to advice on patients with known or suspected infections and on bay and ward closures.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

Compliance with screening for COVID-19, MRSA colonisation and CPE is also monitored. This information is reported to the Infection Prevention committee monthly.

5.2 Surveillance of Blood Culture Contamination (BCC) rates

Blood culture collection remains the gold standard to diagnose bacteraemia. The emergency department (ED) remains the frontline in identifying and initiating investigations for unwell patients where majority of blood cultures are generated.

Accurate blood culture results allow safe, timely, effective, efficient care for septic patients and those with serious infections, and the prevention of antimicrobial resistance. Higher BCC rates contribute to increased hospital length of stay, unnecessary or inappropriate antimicrobial treatment, negative impact on patient safety and an increased costs to the health care system.

The current recommendation by the Clinical and Laboratory Standards Institute and the UK Standards for Microbiology Investigations (Investigation of Blood Cultures) is to maintain a BCC rate of less than 3%.

However, reported figures vary significantly with literature from different countries including Australia, New Zealand and the United States of America identifying rates of between 3–12 %. Blood culture contamination rates in the UK typically range from 3% to 10%, but can vary between hospitals and even within different units of the same hospital.

The BCC rate at WVT as follow:

Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
AE - 2024/25	7.18%	5.50%	5.58%	7.07%	5.09%	7.20%	5.61%	8.53%	6.56%	6.70%	9.88%	6.99%
All Trust - 2024/25	6.24%	4.44%	4.96%	5.44%	4.21%	5.37%	4.40%	6.31%	5.11%	5.51%	7.28%	4.86%

Action taken

- Review of Blood Culture training and competency assessment
- Review products used for Blood culture collection

5.3 Mandatory surgical site infection surveillance (SSI)

During the financial year April 2024 – March 2025, 282 hips operations and a total of 379 knee operations took place in WVT.

The Trust has undertaken continuous data collection and has participated in all data collection periods. WVT will continue to participate in each of the quarterly data collection periods going forward. WVT has received the UKHSA reports back for all 4 of the 4 data collection periods during this financial year.

The inpatient data and the post discharge data collection has been undertaken by designated clinical members of staff on Teme Ward where the patients were cared for post-surgery & data collection has been inputted onto the UKHSA database by the Admin staff in the Surgical Directorate. The Infection Prevention Team reviews the data prior to submission and reconciliation.
In the period of Jan – Mar 2025: 1 externally reportable SSI was identified for knee operations.

WVT received a notification from UKHSA regarding the Jan – Mar 25 data collection period to highlight the Trust was an outlier for knee SSI. Although the overall SSI rate is below the

National average (0.8% SSI for WVT compared to National 1.0% SSI rate overall) the SSI rate for SSI in Inpatient/Readmission was 0.8% for WVT compared to 0.2% SSI rate for Inpatient/Readmissions in National Average for Trusts who issue post discharge questionnaires.

IPC Team has contacted the UKHSA & informed them that this will be discussed at the next Trust SSI meeting.

Type of surgery	April- June 2024	Jul– Sep 2024	Oct– Dec 2024	Jan– Mar 2025
Knee replacement	0.0%	0.0%	0.0%	0.8%
National rate	1.0%	1.0%	1.0%	1.0%
Hip replacement	0.0%	0.0%	0.0%	0.0%
National rate	0.8%	0.7%	0.7%	0.7%

5.4 Outbreak and incident management

The Infection Prevention Service is involved in the management of outbreaks, periods of increased incidence and incidents.

The IPC nurse team monitor all alert organisms to identify trends and potential links between cases based on their location. If links are identified a meeting is convened to discuss potential cases. This is a manual process and completed without the aid of an automatic surveillance system.

All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC and lessons learnt are shared with the Trust and disseminated through communications such as Safety Bites bulletin.

Attendees at outbreak and incident meetings include the DIPC, Infection Control Doctor, and IPC nurses, Leads of the affected areas and Estates and Facilities colleagues'. Colleagues in the H&W ICS, UKHSA and NHS England are informed and dial in to participate in the meeting if necessary.

A list of all outbreaks declared in 2024/25 can be found in Appendix 3.

Criterion 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 Wye Valley NHS Trust staff responsibilities

Each member of WVT staff has their responsibility for IPC within their job description. All staff are required to attend induction training before they work clinically and an annual refresher training session. This process is then monitored via the electronic staff record and

is key to pay progression and revalidation. The block booked agency staff, have their in-house training as well as a local induction delivered by the area that they are working in. All contractors have IPC training which has been prepared by the IPC nurse team but is delivered by our estates team and our PFI partner.

Education resources on Personal protective equipment (PPE), Standard infection control precautions and hand hygiene have been developed to educate and support the Trust's Infection Prevention Champions.

6.2 Infection Prevention Team/Team Development

The Infection Prevention Service found this a challenging year due to the ongoing surges of the respiratory infections and the re-emergence of infections such as measles and pertussis, staff shortages and clinical demands. Staff have attended regional & national infection prevention conferences held by the Infection Prevention Society.

Additional team training has included the Infection Prevention Society Marion Reed Education programme. One Infection Prevention Nurse has completed the Royal College of Nursing led Infection Prevention Degree course.

The Infection Control Doctor completed the CESR qualification in January 2025.

Criterion 7

Provide or secure adequate isolation facilities.

All wards have side rooms available to them. There are a total of 82 side rooms across the County Hospital site, 12 of these are specially ventilated rooms. Three of these are positive pressure rooms and nine are negative pressure rooms. The Infection Prevention nurse team monitor and prioritise the usage of side rooms for patients with known or suspected infections.

The Trusts Prioritisation Reference Guide has been updated in Line with the National Infection Prevention and Control Manual for England (NIPCM, NHS 2022). This was developed for the Clinical Site Management team to follow out of hours. The team are also receive regular updates on the priority side rooms for environmental decontamination using the ultra violet and hydrogen peroxide environmental decontamination equipment.

Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for WVT are located in the purpose built Pathology Laboratory on-site at the County Hospital site. The Microbiology Laboratory has full UKAS accreditation. The Trust has declared microbiology as a fragile service due to limited substantive consultant cover. A grow our own workforce strategy continues with specialty doctors being supported by an experienced consultant microbiologist. The service is fully staffed although some of this is by the use of locum staff. The department also has a trainee Consultant Clinical Scientist in post.

Despite these challenges, the Microbiology department were heavily involved in both the laboratory side of developing testing systems, providing IPC and antimicrobial stewardship advice and assisting with HCAI outbreak management.

The Infection Prevention nurse team work closely with the Microbiologists and laboratory staff to ensure prompt handover of alert organism data and management response.

Criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

9.1 Policies

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Policies are available for staff to view on the Trust intranet. The Infection Prevention Service has a rolling programme of policies which require updating each year. In addition, policies are updated prior to review date if national guidance changes.

In 2024/25 the team updated the following IPC polices & Standard operation procedures:

- IC.10 Management of an infection free ward
- IC.21 Notification of known or suspected infections
- IC.25 management of varicella zoster virus infection (chickenpox or shingles)
- IC.26 meningococcal disease
- IC.32 Carbapenemase – producing Enterobacterales
- IC.34 Policy for the prevention & control of TB in Herefordshire
- IC.40 Management of infection prevention & control
- IC.41 High Consequence Infectious Diseases Policy for Initial Management and Investigation of Possible Cases
- PR.203 Animals in the Healthcare Environment
- PR.58 Aseptic Non Touch Technique (ANTT) policy

All information regarding emerging organisms, infection management guidelines, protocols, pathways and practices have been available to Trust staff via a dedicated IPC page on the Trust Intranet. This was updated regularly throughout the year in line with changes to national and regional guidelines. Information has also been cascaded to staff via the email, Trust Talk and are available on the Trust staff myWVT app.

An IPC A-Z of Common Infections is available on the trust's intranet. This significantly enhances the quick location of key infection prevention guidance by our front line staff in regards to common infections. Staff also have a direct link from the intranet to the Royal Marsden polices on nursing procedures.

9.2 Infection Prevention team audit program

The Trust have an IPC programme of audits in place, in order to demonstrate compliance with the Health and Social Care Act: Hygiene Code. The audits are undertaken by both clinical areas and the IPC nurse team, to ensure that areas are consistently complying with evidence based practice and policies.

This year's programme of audit continued to concentrate on gaining assurance that standard infection control standards were being upheld across the Trust (Appendix 4). Any deferred audits have been added to the IPC audit plan for 2025/26.

All audit results are reported into the post infection reviews and reported to Divisions. Any issues identified were fed back to the divisions for action at the time of auditing. The audits provided a balanced picture of the wards involved.

In response to the audits undertaken, Divisions develop local action plans in response to the audit findings. These are reported by Division to the Infection Prevention Committee.

9.3 Hand Hygiene & Bare below the elbow (BBE) compliance

The Trust expected compliance for hand hygiene and BBE practices for staff working within clinical settings has been set locally as 100%. Compliance with this objective is monitored monthly by clinical areas. The IPC nursing team undertake validation audits of compliance monthly throughout the Trust. 8941 observations were completed in the year; an increase on the 6509 observations reported in 2023/24. The overall annual scores:

- Hand Hygiene Compliance: 95.75%
- Bare below the Elbows compliance: 98.2%

9.4 Saving Lives: High Impact Intervention audits

Saving Lives: High Impact Intervention (HII) are audits that monitor compliance with best practice for a number of clinical interventions that will reduce the risk of healthcare associated infections in specific aspects of nursing care. The original audits were amended by NHS Improvement & the Infection Prevention Society in 2017. From April 2018, Wye Valley Trust has implemented modified audits which have been adapted by the Infection Prevention team to incorporate the stipulated care bundles and additional information that will support local initiatives.

The following audits are undertaken quarterly by each clinical area by point prevalence and the results are collated by the infection prevention team.

- Preventing infection associated with peripheral vascular access devices
- Preventing infection associated with central venous access devices
- Preventing catheter associated urinary tract infection

The HII audit data is shared with clinical leads for action and learning. The results per division are displayed in the clinical settings on eth IPC notice boards.

Three HII are not completed as a separate audit by the Infection Prevention nurse team as they duplicate work already undertaken within the organisation. These are:

- Preventing infection in chronic wounds
- Preventing surgical site infection
- Stewardship in antimicrobial prescribing

Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

10.1 Personal Protective Equipment including FFP3 mask fit testing

All clinical staff working within the organisation have been offered personal protective equipment (PPE) training & Filtering Face Piece protection level 3 (FFP3) Fit mask testing.

The Trust Mask fit testing service has been managed by the Lead Infection Prevention Nurse from November 2022. The service runs Monday – Friday 08:00-16:00. However, additional sessions can be rostered based on clinical needs.

All training and testing records are stored centrally on the Trust electronic staff record system.

Training and fit testing will continue throughout the coming year and compliance with national recommendations for fit mask testing will be reported via the Infection Prevention Committee.

10.2 Staff mandatory infection prevention training

All staff must attend Trust induction before commencing work within WVT. Infection prevention constitutes part of formal teaching on the clinical staff induction and annual refresher sessions. If there are any emerging infection threats or increased incidents of infection, extra targeted training sessions are undertaken. Training has also been provided for specific staff groups as requested. The Trust threshold for mandatory compliance is 85%. In 2024/25 Trust compliance with IPC mandatory refreshing training:

- Level 1 (Non clinical staff): 94.69%
- Level 2 (Clinical staff): 86.43%

10.3 The Occupational Health vaccination service.

The Occupational Health team have continued to provide a screening and vaccination service for occupational risks such as:

- MMR
- Hepatitis A & B
- Typhoid
- Varicella,
- Pertussis

- Meningitis
- TB screening (IGRA)
- Exposure Prone Procedures (for staff working in high risk areas)

From October 2024 to February 2025, COVID-19 and Influenza vaccinations where offered to all Trust staff in line with national guidance. Staff COVID-19 vaccinations were provided by TAURUS Healthcare.

- Trust uptake for COVID-19 vaccinations 2024/25: 959

Influenza vaccinations were delivered in-house by the Occupational Health team and supported by Taurus Healthcare and a small team of Peer Vaccinators.

- Trust uptake for Influenza vaccinations 2024/25: 1542 staff

The Influenza Peer Vaccinator programme will be expanded in 2025/26 to support vaccine delivery in the workplace with an aim to increase Trust compliance by 5% as per national recommendation.

10.4 Infection Prevention Champions

The WVT Infection Prevention Service is supported by over 80 Infection Prevention Champions across all divisions and professional groups. The Champions receive regular information which provides education on incidents that have occurred within the Trust with lessons learnt.

Infection Prevention Champions are expected to cascade information received to their teams.

SECTION 4: IPC AMIBITION FOR 2025/26

IPC is a priority for Wye Valley NHS Trust. Our ambition for 2025/26 will be:

- Reduce the incidence of HCAI infections
- Develop strategies to improve the decontamination of the clinical environment and shared patient equipment
- Improve HCAI management strategies with District Nurse teams to strengthen HCAI management in the community setting.
- Review practices and the documentation process on the insertion and ongoing care of invasive devices
- Embed a robust IPC Champions network including education sessions
- Review & embed HCID training for all Clinical staff with focus on high risk areas such as ED and ITU

SECTION 5: CONCLUSION

Eliminating avoidable healthcare-associated infections remains a priority for Wye Valley NHS Trust to protect patients, staff, and the public. The Infection Prevention Service works collaboratively with staff across Wye Valley NHS Trust to ensure that IPC is fully integrated into all activities. This helps protect both patients and staff from avoidable infections.

Furthermore, the Trust can demonstrate compliance with the Hygiene Code across all its sites, as outlined in the Board Assurance Framework.

For the year ahead, there is a comprehensive IPC programme that incorporates learning opportunities, experience, and quality improvement projects. This programme aims to improve patient safety and experience while reducing infection rates.

We continue to thank all Trust staff for their dedication and hard work throughout the year.

SECTION 6: REFERENCES

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-onthe-prevention-and-control-of-infections-and-related-guidance

NHS (2022) Infection prevention and control board assurance framework. Updated 13/09/24 Available online 01/05/25: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2022) National infection prevention and control manual (NIPCM) for England Version 2.10 Updated March 2025 Available online 01/05/25 https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2025) National Standards of Healthcare Cleanliness 2025. Available online 01/05/25: NHS England » National Standards of Healthcare Cleanliness 2025

APPENDIX 1: List of Abbreviations

BAF	Board Assurance Framework
BBE	Bare below the elbow
CDI	Clostridioides difficile infection
CESR	Certificate of Eligibility for Specialist registration
CO-HA	Community Onset- healthcare associated
CPE	Carbapenemase-producing Enterobacteriaceae
CPEC	Capital planning & equipment committee
CSSD	Central Sterile Services Department
DAC	Dental Access Centre
DIPC	Director of infection prevention and control
EIA	Enzyme-linked immunosorbent assay
E. coli	*Escherichia coli*
FFP3	Filtering face piece – protection level 3
FR	Function Risk
GNBSI	Gram negative blood stream infection
HCAI	Health care associated infection
HCID	High Consequence Infectious Disease
H&W ICS	Herefordshire & Worcestershire Integrated Care system
HO-HA	Hospital Onset- healthcare Acquired
HPV	Hydrogen Peroxide Vapour
HII	High Impact Intervention
IPC	Infection prevention and control
ITU	Intensive Therapy Unit
JAG	Joint Advisory Group in GI Endoscopy
Klebsiella	*Klebsiella* species

KLOE	Key lines of enquiry
MHRA	Medicines and Healthcare products Regulatory Agency
MRSA	Meticillin-resistant *Staphylococcus aureus*
MSSA	Meticillin sensitive *Staphylococcus aureus*
NHS	National Health Service
NHSE	National Health Service for England
NIPCM	National Infection Prevention & Control Manual for England
NSC21	National Standards for Cleanliness in Healthcare 2021
OPAT	Out Patient Parenteral Antibiotic Therapy
PCR	Polymerase chain reaction
PFI	Private Finance Initiative
PPE	Personal protective equipment
Pseudomonas	Pseudomonas aeruginosa
PSIRF	Patient safety incident review framework
UKAS	United Kingdom Accreditation Service
UKHSA	United Kingdom Health Security Agency
PLACE	Patient led assessments in the Clinical environment
SSI	Surgical site infection
TB	Tuberculosis
TIPCC	Trust Infection Prevention & Control Committee
WTE	Whole time equivalent
WVT	Wye Valley NHS Trust

APPENDIX 2: Infection Prevention Improvement plan 2024/25

Priority	Link to H&S care Act 2012	Programme of QI work	Rationale (Why)	Target date	RAG
1: AMS	Criterion 5	Undertake a training needs analysis on Antimicrobial prescribing and stewardship across Trust and Staff roles undertaken	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	31/03/2025	On hold- under review
1: AMS	Criterion 5	Explore local risk reduction strategies for high-risk patients such as patient information leaflets, going home leaflets, antibiotic (high risk) leaflets.	Support Gram Negative Bacteraemia reduction System working Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029	31/03/2025	On hold- under review
1: AMS	Criterion 5	Update antibiotic prescribing guidelines	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	31/03/2025	Delayed- Minor
1: AMS	Criterion 5	Consider EOLAS platform for making infection prevention and AMS guidelines more accessible	To gain assurance of standardised practice Support staff access to information	31/03/2025	Complete
1: AMS	Criterion 5	Consider initiatives for penicillin de-labelling	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	31/03/2025	Delayed- Minor

2: Devices	Criterion 5	Embed HOUDINI catheter management initiative; Monitor compliance with Urinary catheter care pathway	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction	31/12/2024	Complete
2: Devices	Criterion 5	Review current education on indwelling devices, to include venepuncture and blood culture collection	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction Trained workforce	30/09/2024	Complete
2: Devices	Criterion 5	Assess current ANTT practices in Urinary catheterisation & peripheral venous cannulas including insertion practices in ED	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction	30/09/2024	Complete
2: Devices	Criterion 5	Participate in ICS Catheter and Hydration task and finish group	Assurance that best practices for all catheter management include urinalysis(dipstick) are in place Trust wide Support Gram Negative Bacteraemia reduction System working	30/09/2024	Complete
2: Devices	Criterion 5	Launch annual national hydration campaign for 2024/25	Support Gram Negative Bacteraemia reduction	31/08/2024	Complete
2: Devices	Criterion 5	Develop a plan to relaunch the invasive devices working group	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction	31/01/2025	Complete
3: Cleaning	Criterion 2	Formalise Estate (incl. Cleanliness) Scrutiny/ Response Meetings	Strengthen governance on HCAI	30/09/2024	Complete

3: Cleaning	Criterion 2	Cleaning training compliance will be included in all divisional reports to the Trust Infection Prevention and Control committee. This is to include: - Commode and toileting aid training - Cleaning for confidence training * expected minimum compliance 85% compliance	Improve staff knowledge and awareness around cleaning TIPCC oversight of local improvement plans	31/08/2024	Complete
3: Cleaning	Criterion 6	Refresh staff clinical staff knowledge on cleaning responsibilities. Including type terminology - Red, Violet, Amber & Green	Ensure the correct clean is requested/ undertaken post patient transfer/ discharge Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	~~31/10/2024~~ 31/03/25	Delayed- Minor
3: Cleaning	Criterion 2	Audit implementation of the Clinical Cleaning policy	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	28/02/2025	Complete
3: Cleaning	Criterion 2	Embed PLACE lite programme of audits for 2024/25	Strengthen governance on clinical cleanliness To support the Trusts prompt identification of cleanliness & estates concerns in the clinical environment	30/04/2024	Complete
3: Cleaning	Criterion 2	Review Trust policies on cleanliness to ensure any changes to Domestic cleaning methods and products are approved by the Trust Cleanliness Committee and in accordance with National	To gain assurance of standardised practice	30/11/2024	Complete

		guidance			
3: Cleaning	Criterion 2	Strengthen assurance from Domestic service providers that a robust process is in place that ensures the Domestic trollies and store cupboards are clean, fit for use and used appropriately by their staff	Deficit in standard identified on assurance walk rounds. Improvement required. Improve clinical cleaning standards	31/08/2024	Complete
3: Cleaning	Criterion 2	Assess Trust compliance with NSC21 Exemplar status	Improve cleaning standards	31/03/2025	Complete
3: Cleaning	Criterion 2	NSC21 Improvement plans for areas scoring 3 stars or below will be presented at divisional governance meetings. This will be logged on the HCAI Infection incident on InPhase	Strengthen Trust Governance on Cleanliness Compliance with NSC21	31/10/2024	Complete
3: Cleaning	Criterion 2	Ensure clarity of responsibility for frequency of cleaning and responsible staff groups for a list of elements as contained within National standards	Strengthen Trust Governance on Cleanliness Compliance with NSC21 Improve staff awareness on cleaning responsibilities	30/11/2024	Complete
3: Cleaning	Criterion 2	IP team to undertake quarterly Quality IP Ward Walkabouts trust wide with Matrons/ Lead nurses across divisions to strengthen IPC governance.	Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	31/12/2024	Complete
4: Surveillance	Criterion 5	Oversight of compliance with collecting Type 5-7 stool for sampling in line with Trust and national policy.	Benchmarking against policy. Early identification of infection	31/01/2025	Complete
4: Surveillance	Criterion 5	Embed Gloves off initiative	Support Gram Negative Bacteraemia reduction Embed Hand hygiene and BBE best practice Trust wide	28/03/2025	Complete

4: Surveillance	Criterion 5	Undertake a structured mortality review on CDI related deaths	Trust wide learning Learning from incidents	30/11/2024	Delayed- Minor
4: Surveillance	Criterion 5	Align WVT IP annual priorities plans with the National & ICS HCAI reduction strategies	Benchmarking against policy.	31/05/2024	Complete
4: Surveillance	Criterion 5	Consider groups of patients who are at high risk of developing *C difficile* and possible actions that can be taken to reduce this risk.	Early identification of infection	31/03/2025	Complete
4: Surveillance	Criterion 5	Undertake a Deep dive into relapse cases	Trust wide learning Learning from incidents	31/03/2025	Complete
4: Surveillance	Criterion 5	Consider the use of CDI passport.	Support patient education and clinical management Collaborative working with ICS colleagues	31/03/2025	Complete
4: Surveillance	Criterion 1	Review and benchmark WVT HCAI review processes in line with National, regional and local PSIRF guidance	Benching against national guidance	30/09/2024	Delayed- Minor
4: Surveillance	Criterion 1	Develop & embed local response plan to HCAI patient safety incidents	Processes in line with PSIRF	~~30/09/2024~~ 31/03/25	Delayed- Minor
4: Surveillance	Criterion 1	Develop a proposal to streamline the IPS annual IPC audit plan for 2024-25	Streamline current process to provide timely rectification to issues raised and ensure key themes are recognised and acted upon	~~30/09/2024~~ 31/03/25	Complete
4: Surveillance	Criterion 6	Analyse results of Hand hygiene audits to allow training to target specific staff groups and / or key moments & tasks	HCAI reduction Compliance with policy	31/08/2024	Complete

4: Surveillance	Criterion 5	Review current Blood culture policy & education in line with national guidelines. To include the monitoring & escalation of blood culture contaminants.	Assurance that best practices are in place Trust wide for Blood culture collection Support Gram Negative Bacteraemia reduction Identify areas for improvement	31/10/2024	Complete
4: Surveillance	Criterion 5	Blood culture data including contamination rates are presented at TIPCC quarterly	Assurance that best practices are in place Trust wide for Blood culture collection Support Gram Negative Bacteraemia reduction Identify areas for improvement	31/10/2024	Complete

APPENDIX 3: Hospital declared Infection outbreaks

COVID-19 infection onset definition

Community onset:	<= 2 days after admission to trust	Day 0= Day of admission
Hospital onset **indeterminate** healthcare associated	First positive specimen date 3- 7 days after admission to Trust .	
Hospital onset **PROBABLE** healthcare associated	First positive specimen date 8- 14 days after admission to Trust .	
Hospital onset **DEFINITE** healthcare associated	First positive specimen date 15 or more days after admission to Trust .	

COVID-19 Outbreaks – 24 Outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
Leominster	09/04/2024	22/04/2024	3	0
Arrow	25/04/2024	10/05/2024	6	0
Lugg	25/04/2024	10/05/2024	5	0
Wye	30/04/2024	13/05/2024	2	0
Leominster	09/05/2024	24/05/2024	5	1
Lugg	10/05/2024	24/05/2024	3	1
Arrow	22/07/2024	09/08/2024	12	0
Gilwern	12/09/2024	26/09/2024	3	0
Arrow	16/09/2024	30/09/2024	3	0
Lugg	17/09/2024	02/10/2024	5	0
Ross	26/09/2024	06/10/2024	5	10
Leominster	27/09/2024	11/10/2024	7	0
Wye	03/10/2024	17/10/2024	3	0
Ashgrove	07/10/2024	26/10/2024	8	0
Ross	17/10/2024	30/10/2024	2	0
AMU	22/10/2024	04/11/2024	3	0
Leominster	01/11/2024	17/11/2024	3	0
Leominster	26/11/2024	15/12/2024	6	0

Ross	11/12/2024	24/12/2024	2	0
Bromyard	09/01/2025	24/01/2025	5	1
Wye	10/01/2025	25/01/2025	3	0
Bromyard	04/02/2025	18/02/2025	5	0
Redbrook	19/02/2025	05/03/2025	2	0
Leominster	15/03/2025	28/03/2025	3	0

Norovirus Outbreaks- 2 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
Garway	24/07/2024	29/07/2024	7	0
Frome	20/02/2025	25/02/2025	3	2

Influenza outbreaks- 5 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
Leominster	14/12/2024	28/12/2024	3	2
Wye	18/12/2024	31/12/2024	2	0
Redbrook	03/01/2025	31/01/2025	8	0
Bromyard	08/01/2025	24/01/2025	4	1
Ashgrove	12/01/2025	26/01/2025	2	0

CPE outbreaks- 3 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
Ross	08/07/2024	09/05/2025	39	0
ITU	25/09/2024	19/10/2024	2	0
Ashgrove	06/12/2024	28/12/2024	2	0

APPENDIX 4: FR1 & FR2 Domestic and Clinical cleaning scores 2021-2025

Year	FR1 Domestic Cleans	FR1 Clinical Cleans	Star Rating	Combined Star Rating
2021/22	95.8%	94.3%	4* & 3*	N/A
2022/23	96.3%	94.25%	4* & 3*	4*
2023/24	98.2%	94.16%	5* & 3*	5*
2024/25	97.5%	94.4%	5* & 4*	4*
Year	**FR2 Domestic Cleans**	**FR2 Clinical Cleans**	**Star Rating**	
2021/22	93.7%	95.1%	4* & 5*	N/A
2022/23	93.9%	93.75%	4* & 4*	4*
2023/24	97.9%	92.4%	5* & 4*	5*
2024/25	97.5%	91.5%	5* & 3*	4*

APPENDIX 5: Infection Prevention team audit plan 2024/25

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Progress
Post infection Spot Check Clinical Environment (Including hand hygiene, & BBE compliance)	Not applicable	Completed post HCAI acquisition	Locally developed tool focusing on the cleanliness of the clinical environment and equipment	HCAI Review panel	Completed
Hand hygiene & bare below the elbow (BBE) compliance	Monthly in all inpatient & outpatient clinical areas Bi annual in neighbourhood team	Completed post HCAI acquisition	Based on the Infection Prevention Society's hand hygiene observation tool	Infection Prevention Committee	Completed
Commode & toileting aid cleanliness compliance	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquisition	Locally developed tool focusing on the equipment's cleanliness	Infection Prevention Committee	Completed
MRSA Screening compliance	Not applicable	Monthly in High Risk areas Monthly review of 28 day screening Monthly monitoring of patients with known alert	Surveillance data	Infection Prevention Committee	Completed
Infection Prevention Matrons Checklist	Monthly in all inpatient & outpatient clinical areas by Matrons	Monthly, supporting Matrons as per plan	Locally developed tool focusing on environmental cleanliness and clinical practices	Division Governance meetings	Completed

Audit of Diarrhoea & C. difficile infection prevalence, isolation and management documentation	Not applicable	Planned annual review	Locally developed tool reviewing the prevalence of patients with diarrhoea and their subsequent management	Infection Prevention Committee	Deferred
Audit use and completion of transfer documentation when patients are discharged to community hospitals and into district nurse care	Not applicable	Planned annual review	Locally developed tool monitoring communication between providers regarding a patients infectious status & management	Infection Prevention Committee	Deferred
High Impact Interventions - Urinary indwelling catheter - Peripheral venous cannula - Central Venous Access Device - Ventilated patient	Quarterly	Following lapses in care being identified following HCAI Review panel - Completed as planned	Based on the Infection Prevention Society's High Impact Intervention care Bundles	Infection Prevention Committee	Completed
Audit of Time to isolation	Not applicable	Planned annual review	Locally developed tool monitoring compliance with the Trust isolation policy	Infection Prevention Committee	Completed

National Standards for healthcare Cleanliness 2021: Efficacy audits:	Not applicable	Planned annual review of all patients facing FR1,2,3 and 4 areas	National tool	Cleanliness committee	Completed
Mattress cleanliness and integrity audit	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquisition & manage annual review	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Completed
	Annual IPC lead spot check of mattresses and trolley toppers	Annual programme supported by external suppliers	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Completed

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Trust Annual Objectives 25-26 – mid-year review
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Executive Team
Reporting Route:	N/A
Appendices included with this report:	Trust Annual Objectives 25-26 – mid-year review
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report sets out the Trust's mid-year progress against the twelve Trust Objectives for 2025/26.

Recommended Actions required by Board or Committee

That members note the progress being made against the Trust Objectives.

Executive Director Opinion[1]

It is important that, as a Board, we take stock of our efforts to deliver our annual objectives. Overall, good progress is being made despite the significant operational challenges that the Trust has faced.

[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.

Mid-year review of the Trust's 2025/26 objectives.

Pillar	Quality	**Description**	Improve urgent and emergency care with our One Herefordshire system partners, resulting in reduced demand for acute in patients beds and more care in the community
Lead	Chief Operating Officer	**KPIs**	UEC constitutional standards
Progress	Quarter 1 25/26 was a challenged period of Urgent Emergency Care (UEC) which saw our 4hr Emergency Access Standards, 12 hour waits for in our Emergency Department (ED) and Ambulance Handovers all deteriorate over the period. Hence the Trust in now in the highest level of NHS England support to work with our teams to try and recovery since August 2025. There was positive recovery of ED clinical Key Performance Indicators (KPIs) seen in July and August along with increased referral to our Urgent Community Response team for community pathways for the summer months with increased levels of emergency admission avoided compared to last year. 111 ED dispositions to Urgent Community Response (UCR) to be implemented ahead of winter to reduce ED footfall and deliver care closer to home. There is on-going work with Primary Care around admissions avoidance schemes for care of the elderly patients which will be expedited through the successful Herefordshire bid as one of the first cohort of places to pilot the National Neighbourhood Health Implementation Programme (NNHIP). Over the summer period we have seen a reduction in bed days lost due to discharge pathway delays across the Trust, but there is further work to do in the second half of the year. There is Discharge to Assessment (D2A) work to focus on reducing "over staying" patients on Pathway 1 and increasing Therapy resource through the Better Care Fund ahead of winter. There is ongoing work with Powys partners to strength admission avoidance and expedite discharges, including Frailty Same Day Emergency Care (SDEC) transfers to Powys Community Hospitals for the winter.		

Pillar	Quality	**Description**	Improve the inpatient experience by working with our partners to improve food quality
Lead	Chief Nursing Officer	**KPIs**	We will measure our success by triangulating a number of data sources relating to patient experience of our meal service. This includes analysis of the national patient survey data, meal service audits from our partners and annual PLACE (Patient-Led Assessments of the Care Environment) audits.
Progress	There has been a review of the menu options for patients with oversight from dietetics ensuring that our menu choices have appropriate nutritional value and choice. New crockery has been introduced and the meal service itself is subject to auditing by the Nutrition Care Group. Engagement of the whole team has markedly improved with this approach.		

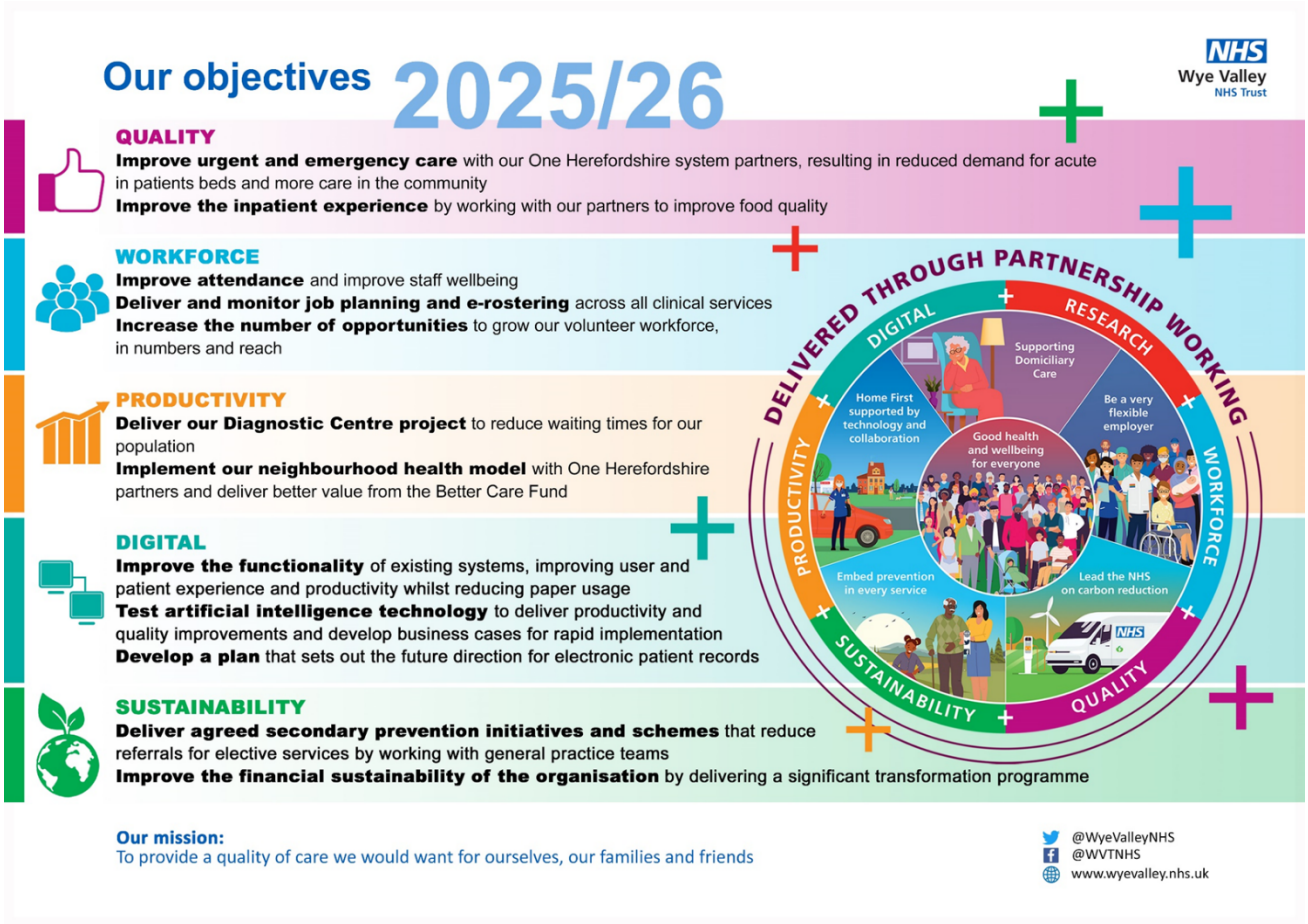
	Auditing has demonstrated that patients are not always offered the variety of snacks that are available and colleagues are receiving further training to improve this aspect of our service. The National in-patient survey has recently published and due for presentation at Quality Committee next month we will continue to triangulate available data sources to measure improvements.		
Pillar	Digital	**Description**	Improve the functionality of existing systems, improving user and patient experience and productivity whilst reducing paper usage
Lead	Chief Finance Officer	**KPIs**	A further reduction in movement of paper notes by at least 65% by March 2026. Reduction in postage costs. Proportion of patients signed up to the Patient Portal.
Progress	Following the Clinical Summit in 2024, all agreed usability improvements have now been deployed within Maxims with the exception of the summary report which is in testing prior to roll out. Since outpatient clinical noting went live the overall reduction in the number of outpatient notes delivered per week, as a percentage across all specialties, is 55%. This has enabled a reduction in Health Records staff of 5.56 WTE (£125k) compared to 2023. A dashboard is being developed to record ongoing progress centrally. Building on these successes is a key part of the Digital First business case which is going through governance in Q3 2025. This will adopt a targeted approach to further paper reduction with nearly fifty prioritised opportunities identified. Progress towards this objective is also included in the aims of the Future EPR project which is closely linked to Digital First, will utilise shared resource and ensure continuity of benefits realisation across the Trust.		
Pillar	Digital	**Description**	Test artificial intelligence technology to deliver productivity and quality improvements and develop business cases for rapid implementation
Lead	Chief Finance Officer	**KPIs**	Measurable benefits realisation model for ambient AI technology to support business case for investment. Proportion of clinicians utilising the tools by March 2026. Improved productivity through elective pathways. Cost improvement in the pilot projects.
Progress	During summer 2025 the Trust has adopted a widespread approach to proof-of-concept pilots of AI-enabled technology. The largest of these has involved the use of ambient voice technology by over five hundred clinical staff. The pilot projects have identified that there are clear productivity benefits to the rapid deployment of standalone commercial off the shelf technology but that a non-integrated approach carries a level of risk. A Trust procurement exercise is being conducted to enable continued use of ambient voice technology to support the needs of the Trust's restructuring of its administrative workforce. The Trust is also part of a regional procurement which may further reduce the costs of this technology. Some of the Trust's existing suppliers are developing AI solutions and pilot projects are also being developed with T-pro digital dictation and Epro for discharge summary automation. However, these technologies are less mature and will require more resource to implement so should be regarded as longer-term opportunities.		

Pillar	Digital	**Description**	Develop a plan that sets out the future direction for electronic patient records
Lead	Chief Finance Officer	**KPIs**	Board to receive outcome of review by end June 2025. Agreed forward plan for EPR programme by end Sept 2025
Progress	The outcome of the initial, strategic EPR review was presented as planned to Board Workshop on 5th June 2025. This proposed a strategy of how the Trust could benchmark its current EPR against the market through a compliant procurement process which would also allow the option, subject to a case for investment, for the Trust to select a new supplier. A timeline was proposed to prepare the Outline Business Case for governance by January/February 2026 whilst concurrently commencing clinical workshops and developing a specification to enable procurement to follow promptly after the approval of the OBC. The shared resource to deliver this is included in the Digital First business case.		
Pillar	Sustainability	**Description**	Deliver agreed secondary prevention initiatives and schemes that reduce referrals for elective services by working with general practice teams
Lead	Chief Medical Officer	**KPIs**	5% reduction in GP referrals for routine and urgent on 2024/25 outturn. 30% reduction in internal referrals on 2024/25 outturn (Forecast for 24/25 = 13,300)
Progress	Year to date SPC data indicates as at week 24 there has been an overall decrease in GP referrals by -1.9% against 24/25 (Routine and Urgent down -7.0%). Year to date SPC data indicates as at week 24 an overall increase of 4.8% against 24/25 on Trust internal referrals – routine referrals down -2.0% (with increases in 2ww 30.5% (205) and urgent 8.3% (303)). Data validation is ongoing. Referral Management / Working Better together is a standing agenda item within the Primary and Secondary Care Interface Programme Board, which meets bi-monthly as is co-chaired by WVT Medical Director and Taurus Director of Quality & Clinical Integration. Initial data has been presented, and has enabled open conversation to address issues raised within Secondary and Primary Care.		
Pillar	Sustainability	**Description**	Improve the financial sustainability of the organisation by delivering a significant transformation programme
Lead	Chief Operating Officer	**KPIs**	NHS Constitution Standards, elective income, productivity metrics
Progress	There have been positive moves on a number of Productivity and performance KPIs, with the exception of our 52 week, long waiting elective patients, remaining off track: • RTT 18 weeks increased from 56.4% at start of April to 61.2% by middle of September (to date) • 3.5% of patients waiting over 52 weeks at which is off trajectory to get to 1% by end of March 2026 but the Trust has robust plans in place to recover performance. • Theatre utilisation at 84% in August and consistently above 80% since start of year, as well as improved metric for late starts and early finishes. Latest Model Hospital data for theatre utilisation shows WVT at the upper end of the 3rd quartile and 8th of 22 Midlands Trusts (12 week rolling data period). • Did Not Attends (DNAs) averaging below 6% which compares well nationally. • Patient Initiated Follow Ups (PIFU) increased from 5% in April to 6.7% in August • Outpatient clinic utilisation comfortably in excess of national target of 46% each month at over 49% for last 2 months • Elective income at month 5 on plan		

Pillar	Workforce	**Description**	Improve attendance and improve staff well being
Lead	Chief People Officer	**KPIs**	To maintain sickness absence at 4%
Progress	Following the introduction of a refreshed sickness absence policy with more stringent measures / targets to manage attendance, we now have the lowest absence rate (4.2%) at the Trust. The management of sickness absence remains a high priority area for the HR department and we will continue taking appropriate actions to reduce sickness absence.		
Pillar	Workforce	**Description**	Deliver and monitor job planning and e-rostering across all clinical services
Lead	Chief People Officer	**KPIs**	Attain 100% compliance with e-job plans and implement e-rostering across key clinical areas by March 2026
Progress	Electronic job plans are now in place across the Trust for all consultants and our compliance rate currently stands at 80% which is much higher than in many other NHS trusts. Our attainment level of 2/3 out of 4 is amongst the top performing organisations NHS wide. E-rostering has been implemented in nursing areas and it is being rolled out to other clinical areas. We are reviewing the resources required to ensure that the workforce team have adequate personnel to roll out e-rostering to all clinical areas over the coming year.		
Pillar	Workforce	**Description**	Increase the number of opportunities to grow our volunteer workforce, in numbers and reach
Lead	Chief Nursing Officer	**KPIs**	Numbers of: volunteer hours contributing to WVT services; volunteers recruited; areas supported by volunteers
Progress	Volunteer numbers have increased month on month this year. Progress has also been made in developing new volunteer roles and expanding volunteer roles to improve the volunteer and patient experience. The Trust are commencing working with Helpforce to support with initiative to reduce DNA's and improve patient's experience in their last 1000 days of life. Improved oversight and governance of the volunteer service internally has helped to shape service priorities and recruitment initiatives.		
Pillar	Productivity	**Description**	Deliver our Diagnostic Centre project to reduce waiting times for our population
Lead	Chief Strategy and Planning Officer	**KPIs**	Diagnostic waiting times
Progress	The Wye Valley NHS Trust Community Diagnostic and Treatment Centre opened on the 29th September. The Centre has opened nearly a month late due to delays with the build but the Trust has managed to complete the planned activity within existing facilities. The six week wait positon at the end of Month 4 has improved to 94.5% and the average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and CT Colonoscopy (CTC]) were 9 days and 11 days respectively.		
Pillar	Productivity	**Description**	Implement our neighbourhood health model with One Herefordshire partners and deliver better value from the Better Care Fund
Lead	Managing Director	**KPIs**	Acute admissions of patients aged over 65/ 100,000 population, Reduce time from discharge ready date to discharge date, reduce admission to long terms residential care

Progress	>65's Acute admissions have not reduced and are broadly the same as 24/25. The gainshare agreement is in place from Q2. National discharge ready to discharge date is not yet available nationally. Admissions for long term care are below the BCF target of 66 per 100,000 at 48 for the year to date. We have been selected as a national implementer site for Neighbourhood health based on our track record of integrated working and the work has just commenced.

Trust Objectives 2025-26



WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Perinatal Services Quality Report August 2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Lyndsey Morris – Patient Safety Midwife Elaine Evans, Neonatal Unit Sister
Reporting Route:	Surgical Divisional Governance
Appendices included with this report:	
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 covering the period August 2025.

Recommended Actions required by Board or Committee

Board is asked to note the contents of the report.

Executive Director Opinion[1]

This report was presented at Quality Committee last week along with an overview of the safety incidents and complaints cases.

The number of times specialist and community based staffing were moved to meet the acuity of the unit was discussed and acknowledged to be high in comparison to previous months.

At the end of quarter 2 we will revise our reporting structure to Board.

[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 – August 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.

1.2 This report features the monthly reporting requirement data for August 2025. A more detailed report was shared for scrutiny and challenge at Quality Committee.

2. PERFORMANCE

2.1 Activity

There were 125 Dashboard births in August 2025. The ratio is stable.

Midwife to birth ratio (<1:24)	17

2.2 Red flags

Red flags are reported via Inphase or the Birth rate Acuity Tool. The red flags in August 2025 are recorded as:

				August
Red Flags	WVT	Inphase	Delay in Induction >2hrs	5
	WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	4
	WVT	Inphase	Delay in administering medication	0
	WVT	Inphase	Delay in starting syntocinon/ARM >30mins	0
	WVT	Inphase	Delay in Suturing >60mins	0
	WVT/PQSM		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	38
	WVT		Delayed recognition of and action on abnormal vital signs	0
	WVT		DSC lost - supernumerary status	1
	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 August 2025, there were 5 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 4 delays in Category 1 caesarean section, these were completed at 31, 32, 34 and 36 minutes. Two delays delay were due to aneasthetic delays, 1 was due to raised BMI complications and one was due to a competing emergency taking priority. There were no poor outcomes for mum or baby.

2.3 Delivery Suite co-ordinator supernumerary status/1:1 care in labour and escalations.

In August the Delivery Suite Coordinator was supernumerary 100% of the time and all women received one to one care in labour.
The Manager on call attended the unit to provide support on one occasion due to an anaesthetic emergency and admission to ITU and a competing obstetric emergency.

2.4 RCOG Obstetric attendance

To promote safety compliance with the RCOG list of instances when an Obstetric Consultant must attend delivery suite is monitored. In August 2025 compliance was achieved.

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

2.5 SCBU Activity

There were 16 admissions to SCBU in August 2025.

<26 weeks	26-30+6 weeks	31-36weeks	>36 weeks
0	2*	10	4

BAPM 2011 Level of care on first day of admission

ITU	HDU	SCBU
2	4	10

In-utero/Ex Utero Transfers

Type of Transfer	June 25 - July 25	
	In	Out
IUT Transfer for clinical reasons as per network pathway	1	0
IUT Transfer for non-clinical reasons	0	0
IUT Transfers outside of the network	0	1
Ex-utero Transfers for clinical reasons as per network pathway	1	3
Ex-utero Transfers out of network	0	2
Delays in Transfers in/out	0	0
IUT or Ex-utero exceptions.	0	2

2 SAFETY

2.1 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.

The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee, a forum where scrutiny and assurance are gained, and is restricted to the 'private' section of Board.

Minimum Data Set incident summary:

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

SCBU – Total Inphase for August 25 = 7

Staffing Only 1 QIS on duty x 2	Unexpected term admission	Neonatal Death	Microbiology - Lost blood sample	Medication – Missed medication	CUSS request for wrong patient

2.2 **Concerns and Complaints**

The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board.

August 2025	**Complaints**
Maternity	1
SCBU	0

There was one complaint submitted for maternity the month of August 2025. The main themes for this were staff attitudes and professionalism. Learning has been shared and the maternity team are committed to improve professional behaviour.

3 WORKFORCE

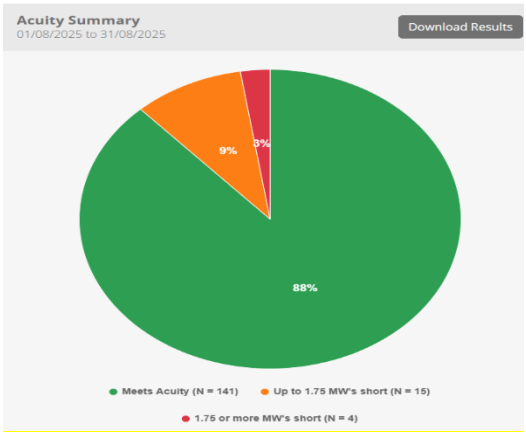
3.1 Safe Staffing – Midwifery

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

3.1.1 The Birth rate plus acuity tool for Delivery Suite was completed 86.02% (Last Month 89.25%) of the expected intervals, which is a good reliability factor. The data presented below reports that staffing met acuity 88% of the time. For 12% of the time the service was short by up to 1.75 midwives.



3.1.2 This data is collected prior to mitigation taking place. There were a total of 36 instances of staff being redeployed internally to cover acuity which is an increase from last month's data. There were 5 occasions where community midwives were deployed to support Delivery Suite. There were 5 occasions where specialist midwives supported clinical services. There were 13 occasions where acuity was escalated to the manager on call for support to ensure that the service remained safe on all shifts

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

3.2 **Obstetric workforce**

3.2.1 In August the obstetric rotas have been covered as outlined below. No short-term locums have been recruited over the period.

AUGUST '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	120	200	60.00	80	200	40.00	0	200	0.00
Consultant: On Call	405.5	478.5	84.74	73	478.5	15.26	0	478.5	0.00
Consultant: Cold Week	88	104	84.62	16	104	15.38	0	104	0.00
Consultant: Antenatal Clinic	46.75	63.75	73.33	0	63.75	0.00	17	63.75	26.67
Middle Grade: delivery suite	117	180	65.00	63	180	35.00	0	180	0.00
Middle Grade: Antenatal Clinic	144.5	161.5	89.47	17	161.5	10.53	0	161.5	0.00

3.3 Neonatal Medical Workforce

The Neonatal workforce data is not 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.

3.4 Anaesthetic workforce

The anaesthetic rotas have been covered throughout August 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	8	16%	9	15%

3.5 MDT ward rounds

MDT ward rounds take place at 08:30 and 20:30 daily. Medical staff attendance is expected to be100%, however due to high acuity for example, this may not always be possible.

	08:30	20:30
Anaesthetist	97%	94%
Obstetric Consultant	100%	100%

4. Workforce – Neonatal

4.1 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 (August 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 August 2025 measured against BAPM Standards:

	WVT	National average
% of shifts staffed to BAPM recommendations	100%	88.39%
% of shifts QIS against Neonatal Toolkit standards	100%	95.09%
% of shifts with supernumerary shift lead	3.28%	22.88%
% of Nursing shifts covered by bank	3.59%	6.25%

- WVT SCBU in August remained 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 by the Trust for our capacity and acuity at WVT and is on the risk register.
- The percentage of shifts covered by bank remained consistent with July at 3.59% but below the national average. The reason for this is the additional expectation from the WMNPN that assurance will be given that there are two QIS nurses on all shifts and a slight increase in short-term sickness throughout August.

4.2 Daily Regional Sit Rep Reporting

The West Midlands Perinatal Network (WMPN) are now recording the unit's OPEL status as 'Black' when only one QIS nurse is expected to be on shift – this is to ensure there is 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 SCBU. The definition of 'Black' will be updated to reflect this change, and adopted by the East Midlands network.

The OPEL report is completed following the morning safety huddle seven days per week. A daily Network report is released daily Monday to Friday with exception of bank holidays.

Breakdown for August 25

GREEN FOR STAFFING	RED FOR STAFFING (only 1 QIS but 2nd QIS covered by Senior Nurse in Office.	BLACK – only one QIS on duty
16	X 4	X2

Our staffing status was black on two occasions, this was due to 1 x late sickness reported and 1 x bank holiday where we had long term sickness of the 2nd allocated QIS nurse and we were unable to backfill.

4.3 Qualified in Speciality Staffing Report.

The 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 – October 25

		May25	June 25	July 25	August 25	September 25	October 25
Total QIS %		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 a second staff nurse with commence the course in December 2025.

WMPN have provided additional funding to support further development of staff through the QIS courses for 2025/26 but require assurance from the Trust that they will honour the commitment of funding two places each year until the required 70% is achieved.

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..

4.4 **Sickness and Maternity Leave SCBU**

Month	Sickness (Trust Target <3%)	Maternity Leave (WTE)
August 25	**4.88%**	**1.0wte**

Overall sickness is down slightly in August, but remains above the Trust's target. This is primarily due to a long term sickness episode within our Band 6 team that is being managed in accordance with the Sickness and Absence Policy combined with some seasonal short term sickness.

5. TRAINING COMPLIANCE

5.1 To ensure that the workforce is effectively trained the following courses require 90% compliance. Compliance in August is as follows:

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%

Some courses are yet to meet the required 90% compliance however there is a clear plan in place to ensure that all staff have attended by the required deadline to meet the requirements set out in safety action 7. This will be closely monitored monthly and plans put in place if any deviations are identified.

Training	Expected Target	August 25
Mandatory (Core)	**>90%**	**98.64%**
Mandatory (Essential)	**>90%**	**95.32%**
Newborn Life Support (Annual Update)	**100%**	**94.4%**
Maternity Breastfeeding Update	**>90%**	**95%**

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 in August 13th to maternity services.

Actions from the walkabout included:

Antenatal Clinic templates under review to ensure that all women are seen/counselled by the correct level of obstetrician. This is being monitored and a stakeholder meeting is planned this month regarding this.

GP referrals to triage were discussed where the presenting complaint was not pregnancy related. This is being monitored and findings will be shared with Primary Care colleagues to improve services for women.

5.4 ATAIN – Avoiding Term Admissions into Neonatal Unit

National benchmark 6% and best practice 3%

April 25	May 25	June 25	July 25	August 25
3.47%	1.49%	2.2%	4.58%	To be reviewed

5.5 CNST Safety Action 3

- Transitional Care quarterly audits continue and are shared at the Maternity and Neonatal Safety Champions Meeting. Q1 for 2025/26 will be available to share September 2025.
- QI Project – Administration of IVAB for well babies on maternity ward registered with Trust as this year's QI project. Update will be shared with LMNS October/November 2025.

	Are	Dashbo	Framewo	Indicator Description	June	July	August
Antenatal	Booking	LMNS	LMS	Total bookings	149	127	116
		LMNS	LMS	Women who were booked before 9+6 weeks	110	107	93
		LMNS	LMS	% Women who were booked before 9+6 weeks (target 90%)	73.8%	84.3%	80.2%
		LMNS	LMS	Women who were booked after 9 + 6 weeks	39	20	23
		LMNS	LMS	% Women who were booked after 9 + 6 weeks	26.2%	15.7%	19.8%
		LMNS	LMS	Women who were booked before 12 + 6 weeks	146	123	110
		LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	98.0%	96.9%	94.8%
		LMNS	LMS	Women who were booked after 12 + 6 weeks	3	4	6
		LMNS	LMS	% Women who were booked after 12 + 6 weeks	2.0%	3.1%	5.2%
		LMNS	LMS	Midwife led care at booking	31	17	26
		LMNS	LMS	% Midwife led care at booking	20.8%	13.4%	22.4%
	Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	51	27	38
		LMNS	LMS	% Women with BMI of 30 and over at booking	34.2%	21.3%	32.8%
		LMNS	Better Births	% Antenatal Personalised Care Plan completed	100.0%	97.5%	98.6%
		LMNS	Better Births	% Intrapartum Personalised Care Plan completed	62.7%	65.9%	63.2%
		WVT		% Portal Access Consent	100.0%	100.0%	100.0%
		LMNS	LMS	% Portal Access - Women who registered and logged in	91.3%	89.0%	89.7%
		LMNS	Ockenden	% Contacts were place of birth suitability was recorded	65.7%	76.9%	66.7%
		LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	66.9%	84.4%	80.20%
		LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	87.8%	89.1%	83.2%
		LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	92.0%	83.4%	82.9%
		LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	83.0%	92.8%	94.2%
	Smoking	WVT		Recorded Smoking Status at Booking - Yes	11	8	5
		WVT		Recorded Smoking Status at Booking - No	138	119	111
		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 Babies Lives	Women who were current smokers at booking	11	8	5
		LMNS	Saving Babies Lives	% Women who were current smokers at booking	7.4%	6.3%	4.3%
		LMNS	Saving Babies Lives	Smokers who were referred to smoking cessation services	11	8	5
		LMNS	Saving Babies Lives	% Smokers who were referred to smoking cessation services	100.0%	100.0%	100.0%
		LMNS	Saving Babies Lives	Smokers who accepted CO screening at booking	10	7	5
		LMNS	Saving Babies Lives	% Smokers who accepted CO screening at booking	90.9%	87.5%	100.0%
	Carbon Monoxide	LMNS	Saving Babies Lives	Women who were screened for CO at booking	145	120	111
		LMNS	Saving Babies Lives	% Women who were screened for CO at booking (of total bookings)	97.3%	94.5%	95.7%
		LMNS	Saving Babies Lives	Women with CO reading of 4 ppm or more at booking	12	7	6
		LMNS	Saving Babies Lives	% Women with CO reading of 4 ppm or more at booking (of total bookings)	8.1%	5.5%	5.2%

	Area	Dashboa	Framework	Indicator Description	June	July	August
	Deliveries	LMNS/PQSM	Contractual	Total births (deliveries)	135	130	125
		WVT		Home Births	1	1	2
	Delivery Method	WVT		BBA's	3	2	0
		LMNS	Contractual	Vaginal births (deliveries)	59	45	52
		LMNS/PQSM	LMS	% Vaginal births (deliveries)	43.7%	34.6%	41.6%
		LMNS	LMS	Ventouse & forceps births (deliveries)	14	13	16
		LMNS/PQSM	Contractual	% Ventouse & forceps births (deliveries)	10.4%	10.0%	12.8%
	C-Section Deliveries	LMNS/PQSM	LMS	RG*1 having a caesarean section with no previous births	3	4	1
		LMNS/PQSM	LMS	RG*1 Deliveries	21	15	19
		LMNS/PQSM	LMS	RG*1 % C-section deliveries	14.3%	26.7%	5.3%
		LMNS/PQSM	LMS	RG*2 having a caesarean section with no previous births	20	28	23
		LMNS/PQSM	LMS	RG*2 Deliveries	35	32	33
		LMNS/PQSM	LMS	RG*2 % C-section deliveries	57.1%	87.5%	69.7%
		LMNS/PQSM	LMS	RG*5 having a caesarean section with at least one previous birth	25	28	12
		LMNS/PQSM	LMS	RG*5 Deliveries	26	29	13
		LMNS/PQSM	LMS	RG*5 % C-section deliveries	96.2%	96.6%	92.3%
		WVT		Total Elective C-Sections	25	36	26
		WVT		Total Emergency C-Sections	37	36	31
		LMNS	LMS	Total Caesarean births (deliveries)	62	72	57
		LMNS	LMS	% Total Caesarean births (deliveries)	45.9%	55.4%	45.6%
		LMNS	LMS	% Grade 1 C-Sections within 30 minutes	71.4%	75.0%	33.3%
		LMNS	LMS	% Grade 2 C-Sections within 75 minutes	92.3%	100.0%	81.8%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	25	24	17
		LMNS	LMS	% Midwife led (low risk care) births	18.5%	18.5%	13.6%
		LMNS	LMS	Home births (deliveries) - midwife led only	0	1	0
		LMNS	LMS	% Home births (deliveries)	0.0%	0.8%	0.0%

Intrapartum	Births	LMNS	Contractual	Total number of babies born	136	132	126
		LMNS	Saving Babies Lives	Babies born preterm (singletons born 36+6 or less)	9	10	12
		LMNS	Saving Babies Lives	% Babies born preterm (singletons born 36+6 or less)	6.62%	7.6%	9.5%
		LMNS	LMS	Singleton babies born 26+6 or less	0	0	0
		LMNS	LMS	% Singleton babies born 26+6 or less	0%	0.00%	0.00%
		LMNS	LMS	Babies (multiples) born 27+6 or less	0	0	0
		LMNS	LMS	% Babies (multiples) born 27+6 or less	0%	0.00%	0.00%
		LMNS/PQSM	LMS	Stillbirths	0	1	0
		LMNS/PQSM	LMS	% Stillbirths	0.0%	0.8%	0.0%
		LMNS	LMS	Stillbirths rate per 1,000	0.00	7.58	0.00
	Breastfeeding	LMNS	National	Live births where breastfeeding initiated (first feed = breastmilk)	120	101	99
		LMNS	National	% Live births where breastfeeding initiated (first feed = breastmilk)	88.9%	78.3%	79.8%
	Smoking	WVT		Women who were current smokers at booking (delivered mothers)	9	10	12
		WVT		% Women who were current smokers at booking (delivered mothers)	6.7%	7.7%	9.6%
		LMNS	Saving Babies Lives	Women who were current smokers at birth (delivery)	8	8	10
		LMNS	Saving Babies Lives	% Women who were current smokers at birth (delivery)	5.9%	6.2%	8.1%
		LMNS	Saving Babies Lives	% Women with CO measured at 36 weeks	100.0%	100.0%	100.0%
		LMNS	Saving Babies Lives	% CO >= 4ppm at booking and below 4 ppm at 36 weeks	7.4%	7.6%	8.8%
	Risk Management	LMNS	Saving Babies Lives	Late pregnancy loss (singletons 16+0 - 23+6)	0	0	1
		LMNS	Saving Babies Lives	% (as a % of all singleton births)	0.00%	0.00%	0.79%
		LMNS	Saving Babies Lives	% Detection rate for FGR (below 3rd centile)	11%	13%	9.1%
		LMNS	Better Births	Women who had a PPH of 1,500ml or more	4	5	6
		LMNS	Better Births	% Women who had a PPH of 1,500ml or more	3.0%	3.8%	4.8%
		LMNS	Better Births	Women who sustained a 3rd or 4th degree tear	0	0	2
		LMNS	Better Births	% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	0.0%	0.0%	2.94%
		LMNS	Better Births	Induction of labour	50	43	47
		LMNS	Better Births	% Induction of labour rate (of all births)	37.0%	33.1%	37.6%
		WVT		Routine Enquiry Domestic Violence - Asked	90	77	113
		WVT		Routine Enquiry Domestic Violence - Unable to ask	42	50	10
		WVT		Routine Enquiry Domestic Violence - Unknown	3	3	2
		WVT		% Asked routine enquiry domestic violence	66.7%	59.2%	90.4%
		WVT		Midwife to birth ratio	1:23	1:25	1:24
	Red Flags	WVT	Inphase	Delay in Induction >2hrs	0	2	5
		WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1	1	4
		WVT	Inphase	Delay in administering medication	1	0	0
		WVT	Inphase	Delay in starting syntocinon/ARM >30mins	0	1	0
		WVT	Inphase	Delay in Suturing >60mins	0	0	0
		WVT/PQSM		Unable to provide 1:1 care in labour	0	0	0
		WVT		Delay in Triage >30mins	0	0	0
		WVT	Birth Rate +	Community midwives on call covering maternity unit	2	1	1
		WVT	Birth Rate +	Any movement of midwifery staff from any area to provide midwifery cover	24	22	38
		WVT		Delayed recognition of and action on abnormal vital signs	0	0	0
		WVT		DSC lost - supernumerary status	0	0	1
		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 Movements	WVT		Number of women presenting to service with reduced fetal movements	272	254	217
		WVT		Number of women presenting with RFM who are recorded as having a CTG	272	248	214
		WVT		% of women presenting with RFM who received CTG	100.0%	97.6%	98.6%
	Area	Dashboa	Type	Indicator Description	June	July	August
Neonatal	Admissions	LMNS	Integer	Total admissions to neonatal care	9	13	13
		LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	4	7	5
		LMNS	%	% Unexpected admissions of full-term babies to neonatal care	3.1%	5.7%	4.4%
	SCBU admission temps	WVT	Born	Eligible Babies (<34 wks gestation)	0	2	1
		WVT		% taken within hour	0.0%	100.0%	100.0%
		WVT		Adm temp <36.5 degrees	0	0	0
		WVT	All babies	Eligible Babies	14	19	24
		WVT		% taken within hour	100.0%	100.0%	87.5%
		WVT		Adm temp <36.5 degrees	4	3	1
	Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	2	2	4
		LMNS/PQSM	Integer	Neonatal deaths	0	0	1
		LMNS/PQSM	%	% Neonatal deaths	0.0%	0.0%	0.8%
		LMNS	Integer	Neonatal mortality per 1,000 births	0.00	0.00	7.94
		LMNS	Integer	Neonatal transfers for therapeutic hypothermia	0	0	0
		LMNS	%	% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a
		LMNS/PQSM	Integer	Neonatal brain injuries	0	0	0
		LMNS/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	3	0
		LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	0	3	1
		LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	0.0%	100.0%	0.0%
		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	Dashboa	Framework	Indicator Description	June	July	August
Postnatal	Risk Management	LMNS	Local	Obstetrics admissions to ITU	1	0	1
		LMNS/PQSM	LMS	Maternal deaths	0	0	0
		LMNS	Better Births	% Postnatal Personalised Care Plan completed	97.8%	99.3%	95.9%
		LMNS	LMS	Postnatal readmissions within 28 days (mothers)	14	13	5
		LMNS	LMS	Postnatal readmissions within 28 days (babies)	6	4	6
	Suspended Access to Service	WVT		Number of times Maternity Services Suspended per month	0	0	0
		WVT		Number of hrs Maternity Services suspended	0	0	0
		WVT		Number of times Home Birth services suspended per month	3	0	3
		WVT		Number of hrs Home Birth services suspended	0	0	0
		WVT		Number of times SCBU suspended per month	0	1	0
		WVT		Number of hrs SCBU suspended per month	0	6	0
	Insight	PQSM	Integer	Number of inphase incidents graded as moderate or above/PSII reported (total)	0	2	1
		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
	Workforc	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0	
		PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	0	0	
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	TBC	TBC	
		PQSM		Inphase related to workforce (service provision/staffing)	24	22	
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	
	volveme	PQSM		Service User feedback: Number of Compliments (formal)	0	0	
		PQSM		Service User feedback: Number of Complaints (formal)	1	1	
		PQSM		Staff feedback from frontline champions and walk-abouts (number of themes)	0	0	
	proveme	PQSM		Progress in achievement of CNST /10	10	10	
		PQSM	%	Training compliance in PROMPT: Midwives	92%	95%	94%
		PQSM	%	Training compliance in PROMPT: Obstetric Consultants	100%	89%	89%
		PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	89%	100%	100%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	75%	75%	75%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	91%	82%	82%
		PQSM	%	Training compliance PROMPT: Maternity Support Workers	100%	96%	90%
		PQSM	%	Annual NLS update compliance: Paediatric Consultants	89%	100%	100%
		PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	80%	80%	83%
		PQSM	%	Annual NLS update compliance: Paediatric Juniors	88%	100%	75%
		PQSM	%	Annual NLS update compliance: Midwives	91%	83%	95%
		PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	95%	95%

		PQSM	%	Fetal Wellbeing update day: Obstetrics	83%	100%	81%
		PQSM	%	Fetal Wellbeing update day: Midwives	90%	86%	83%
		PQSM	%	Midwifery update day (Core Competency): Midwives	89%	86%	88%
		PQSM	%	Midwifery update day (Core Competency): Support Staff	93%	96%	90%

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	0								
Band 6 Vacancy Gap (5.2wte)	0	0	0	0.4	0.4								
Band 5 Vacancy Gap (13.5)	2	3.1		4.47	4.47								
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	0	0	0	0								
Band 2 Vacancy Gap (1.0wte)	0.2	0.2	0.2	0.2	0.2								
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0	0	0	0	0								
Attrition Rate (WTE)	0	0	0.62	0	0								
Maternity Leave (WTE)	1	1	1	1	1								
Sickness (<3.5%)	1.09%	1.39%	4.12%	5.63%	4.88%								
Safe Staffing													
% Shifts staffed to BAPM Standards	92%	84%	100%	100.00%	100.00%								
QIS % (standard = 70% of registered workforce)	44.4%	44.4%	52.5%	57.60%	**57.60%**								
% of shifts QIS to toolkit	98.31%	100%	100%	100.00%	100.00%								
% Shifts with supernumerary shift co-ordinator	3.39%	3%	26.67%	5.17%	3.28%								
% Shifts covered with Bank	1.1%	1.4%	5.7%	3.70%	7.00%								
Appraisal Rate	85%	67%	94.74%	100%	88.89%								
Mandatory Training Core	98.75%	97.50%	97.83%	96.67%	98.64%								
Mandatory Training Essential	89.8%	92.14%	94.78%	94.26%	95.32%								
Basic Life Support	43%		86.36%	90.00%	90%								
Newborn Life Support >90%	96%	95%	95%	95.00%	94.4%								
Maternity Breastfeeding update.	77.27%	77.27%	90.48%	94.74%	95%								
Safeguarding Level 3	100%	100%	100%	100%	95%								
Compliments/Complaints/Concerns													
Complaints/Concerns	0	0	0	0	0								
Infection Prevention													
Overall - Star rating.	4	5	5	5	5								
Ward Assurance Audit	82%	100%	88%	92%									
Hand Hygiene	100%	100%	100%	100%	100%								
Bare Below the Elbow	100%	100%	100%	100%	100%								
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	4	2	12	6								
Medication Errors	0	1	0	1	1								
Staffing	0	0	0	1	1								
Service Escalation (OPEL RED/BLACK)	0	Red x 4	0	Red x 1	Red x 2								
Exception reports - ex-utero outside of care pathway	0	0	0	0	2								
Exception reports - in utero transfers outside of pathway/network	1	1	1	2	1								
Audits													
Quaterly CD Audit		96%			100%								
IV Fluid Prescription - Target 90% Compliance	97%			97%									
Clinical Notes Audit - Correct Completion target 90%	57%												
Cannula Care Plan (Peripheral Cannula) Target 90%	89%			95%									
Gentamicin Clinical Audit	96%			100%									
NGT Misplacement NPSA Safety Alert 2016 Target 90%	86%			70%									
Pain Audit Tool Completed Correctly Target 80%	60%			77%									
IVAB administered within 1 hr of decision to give													
Growth parameters Audit	82%			76%									

Version 1: July 2025

Transitional Care and Term Admissions													
% Unexpected admissions of full-term babies to neonatal care (of all live term births) m(National Average 5% Best Practice <3%)	3.47%	1.49%	2.2%	4.58%									
TC Bed occupancy rate on SCBU % including parent bedroom	40.0%	54.00%	40%	52.3%	65%								
Number of babies born between 34-36 wks gestation and admitted to SCBU	3	7	4	3	6								
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	1	3	0	2	0								
Neonatal Outreach Team													
Total Patients	11	19	20	10	13								
NewReferrals	4	12	8	4	11								
Existing Patients continuing care	7	7	12	6	2								
No. NGT Feeding in the community	8	5	3	4	8								
Receiving EBM on discharge from SCBU	5	10	13	7	10								
Receiving EBM on discharge from 0/R	3	1	9	5	3								
Numbers Discharged from outreach	5	2	9	7	3								
Number of Incidents (Inphase)	0	0	0	0	0								
Home Phototherapy	1	1	1	0	0								
Prolonged Jaundice Screening Referrals	27	24	34	34	32								
Prolonged Jaundice Screening - Total Number of Referals meeting criteria for outreach	21	22	32	30	28								
Prolonged Jaundice Screens - Outreach	18	22	20	25	26								
Prolonged Jaundice Screens - RAC	5	2	6	5	5								

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	Charity Trustee 12 June 2025 Minutes and Escalation Report
Lead Executive Director:	Choose an item.
Author:	Grace Quantock, Committee Chair and NED
Reporting Route:	Direct to Board
Appendices included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
To present the minutes and a summary of the Charity Trustee proceedings and to escalate any matters of concern.	
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]	

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

Charitable Funds Committee Report - June 12th, 2025

Matters for Noting

1. **Quarter 4 Financial Position 2024/25**: At the end of Q4, total funds held were £2.1m with £1.9m in restricted funds. An adjustment is being made with £228k received from the PGMC Charity, moving funds previously shown as unrestricted against the Education Centre to restricted funds as it is for medical education benefit.
2. **Annual Accounts and Report Plan 2024/25**: A clear plan is in place to meet the deadline for submitting annual accounts to the Charity Commission by 31st January **2026**. Key milestones include external audit independent examination between July and September, draft annual accounts to the September meeting, and final accounts to the December meeting for approval. The Committee agreed that submission two weeks prior to the deadline would be preferable.
3. **Administration Recharge Review**: The current £12k annual recharge from the Trust to the Charity for administration expenses has been reviewed following audit recommendations. The recharge calculation hadn't been updated since 2021/22. Two options were presented:
    - **Option A**: Full cost analysis showing actual support now equates to approximately £26k annually (an increase of £14k)
    - **Option B**: Reduced cost option shifting some responsibilities back to fund managers (with higher risks of mismanagement)

    The Committee approved Option B as an interim measure pending further benchmarking and review at the September meeting.

4. **Fundraising Updates**:
    - **Memorial Garden**: The project is now finished with a soft opening scheduled for next week, including a separate opening for parents. Thanks were given to FM for attending a fundraiser to receive a cheque and to John Burnett, Communications Manager, for compiling a video for the fundraising event.
    - **Capacity and Future Projects**: The Fundraising Manager now has increased capacity with the Education Centre scheme currently on pause. A list of possible future fundraising project ideas will be brought to the next meeting.
5. **Staff Lottery Fund Proposal**: Discussion took place regarding using a proportion of staff lottery funds to support staff health and wellbeing programmes and staff networks. This could enhance staff morale and align with the Trust's ambition to be a model employer while potentially boosting staff participation in the lottery, which currently has limited uptake. General support was expressed for developing a formal proposal with clear policy on lottery fund usage.

Matters for Escalation

None.

Actions Arising

- Benchmarking to be undertaken within Foundation Group to establish staff lottery uptake
- List of possible future fundraising project ideas to be developed for next meeting
- Administration recharge review and benchmarking to be completed for September meeting

WYE VALLEY NHS TRUST
Minutes of the Charity Trustee
Held on 12th June 2025 at 1.00 – 2.00 pm
Via MS TEAMS

Present:		
Grace Quantock	GQ	Non-Executive Director and Chair (NED)
Chizo Agwu	CA	Chief Medical Officer
Eleanor Bulmer	EB	Associate Non-Executive Director (ANED)
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Lucy Flanagan	LF	Chief Nursing Officer
Jane Ives	JI	Managing Director
Frances Martin	FM	Non-Executive Director (NED)
Katie Osmond	KO	Chief Finance Officer
In Attendance:		
Vicky Brownbridge	VB	Executive Assistant (for the notes)
Louise Robinson	LR	Deputy Company Secretary (Observing)
Katie Farmer	KF	Charity Fundraiser
Heather Moreton	HM	Associate Chief Finance Officer
Apologies:		
Glen Burley	GB	Chief Executive
Sharon Hill	SH	Non-Executive Director (NED)
Ian James	IJ	Non-Executive Director (NED)
Kieran Lappin	KL	Associate Non-Executive Director (ANED)
Russell Hardy	RH	Trust Chairman, MBE
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director (NED)

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**GQ**	**Information**	**Verbal**
Noted as above				
2.	**Quorum and Declarations of Interest**	**GQ**	**Information**	**Verbal**
The meeting was quorate and there were no new declarations of interest.				
3.	**Minutes of the Meeting held on 13th March 2025**	**GQ**	**Approval**	**Enclosure 1**
The minutes of the meeting held on 13th March 2025 were agreed as an accurate record of the meeting and signed by the Chair.				
4.	**Matters Arising and Actions Update Report**	**GQ**	**Information**	**Enclosure 2**
There were no matters arising or actions update to note.				
5.	**Items For Review and Assurance**			
5.1	**Quarter 4 Charitable Funds Finance Report**	**HM**	**Assurance**	**Enclosures 3, 3.1**
The report was taken as read.				

At the end of Q4 there were £2.1m total funds held, £1.9m in restricted funds. Adjustment is to be made with £228k received from the PGMC Charity showing as unrestricted against the Education Centre being moved to restricted funds as it is for medical education benefit.

The Committee accepted the Quarter 4 Charitable Funds Finance Report.

5.2	Annual Accounts and Report Plan 2024/25	HM	Assurance	Enclosure 4

Assurance was provided there is a plan in place to meet the deadline to submit the annual accounts to the Charity Commissioner for the end of January 2026.

Key milestones were noted to include the external audit independent examination to take place between July and September with the draft annual accounts coming to the September meeting. Final accounts will come to the December meeting for approval prior to 31st January submission deadline.

It was agreed that submission two weeks prior to the deadline would be preferential.

The Committee accepted the Annual Accounts and Report Plan 2024/25.

5.3	Administration Recharge Review	HM	Approval	Enclosure 5

There is currently a recharge from the Trust to the Charity of £12k per annum to cover administration expenses that aren't directly charged to the Charity. The recharge is based on a calculation that hasn't been updated since 2021/22. The Audit management report for 2023/24 accounts made recommendation that the recharge be reviewed as it is outdated.

There were two options outlined:

Option A – A cost analysis has been undertaken identifying actual support provided now equating to approximately £26k annually - an increase of £14k reflecting increased workload and resource use.

Option B – A reduced cost option which would shift some responsibilities back to fund managers. This would carry higher risks of mismanagement.

There was discussion whether to adopt this full increase or consider the reduced cost model. Concerns were raised about performance issues, the need for process streamlining and the importance of maintaining financial integrity. There was agreement on the requirement for further benchmarking to establish if WVT is an outlier and also an understanding of risks associated with Option B.

There was agreement to enact Option B as an interim measure and to undertake further review and benchmarking for further discussion at the next meeting where the recharge could be adjusted based on findings.

ACTION 5.3.1: To undertake further review and benchmarking of administration recharge review options and to return to September meeting for further discussion - ALL

The Committee accepted and APPROVED the proposal for Option B - Administration Recharge Review with a review to take place at the September meeting before a final decision is made.

5.4	Fundraising Update	KF/AD	Assurance	Enclosure 6

KF took the paper as read and the following key points were highlighted:

The Memorial Garden is now finished with a soft opening next week. There is to be a separate opening for parents.

Thanks were given to FM for attending a fundraiser to receive a cheque and also John Burnett, Communications Manager, for compiling a video for the fundraising event.

Emphasis was placed on consideration of next steps in terms of capacity as the Fundraising Manager now has more capacity and with the Education Centre scheme currently on pause. A list of possible projects is to be brought back to the next meeting.

ACTION 5.1: To provide a list of possible future fundraising project ideas - ALL

The Committee accepted the Fundraising Update.	
6.	**Any Other Business**
GE asked whether consideration could be given to using a proportion of staff lottery funds to support staff health and wellbeing programmes and staff networks. It was suggested that this could enhance staff morale and align with the Trust's ambition to be a model employer. It was noted that this may boost staff participation in the lottery which currently has limited uptake. It was highlighted that while the lottery contributes to the general purpose fund, alternatively a set annual budget from that fund could be allocated for staff wellbeing, independent of the lottery. Emphasis was placed on the need for a clear policy on how lottery funds are used with regular Trustee review. There was general support for the proposal and for a formal paper to be submitted to the Charity Trustee meeting if appropriate. **ACTION 6.1: To undertake benchmarking within Foundation Group to establish uptake of staff lottery - KF**	
Date Of Next Meeting **Thursday 18th September 2025, 1.00 – 2.00 pm via MS Teams**	

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**02/10/2025**
Title of Report:	**Quality Committee July 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, July 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 but comparative analysis is difficult due to inconsistent approaches to inclusion of SDEC patient data. Committee was assured that crude mortality remains low – 61 deaths in June – the lowest since 2018. Issues with accuracy of coding are also impacting on SHMI and a review and resubmission process is also underway.
2. **Quality Priority – Transition of Care** – Committee welcomed the first report on how the Trust is working to improve the transition that young people experience as their care moves from paediatric to adult services. This is particularly challenging for children with complex conditions. In welcoming the work, Committee asked for consideration to be given to the terminology associated with the improved support.
3. **Quality Priority – Providing Patients with Timely VTE Risk Assessments** – The latest figures show achievement of 88% against the 24 hour target of 95% with a focus on elective compliance improvement, on ensuring accuracy in reporting and ensuring the Maxims upgrade is able to drive better performance On the key outcome measure of readmissions due to VTE, numbers have halved in the last year.
4. **Quality Priority – Food Quality and Safety** – Committee welcomed the work on food quality which addresses both overall patient satisfaction with food provided and need to strengthen responses to patients susceptible to nutritional risks.
5. **Safeguarding Quarterly Reports** – The Adults Safeguarding discussion centred on the need to improve training and support for staff in relation to patients at risk of absconding. For children Committee asked for further work on an identified single point of failure in midwifery due to having only 1 Safeguarding Midwife.
6. **Patient Flow Report** – Committee acknowledged the improvements made to patient flow following the recent initiatives and commended the work involved – with boarding reduced by 100 beds in May and June.
7. **Staffing Report** – Stability of nurse staffing continues to improve with fill-rates positive, vacancies and sickness low and agency usage continuing to reduce. Committee welcomed the plans to better link staffing data with quality metrics.
8. **UKAS Pathology Accreditation** – The annual accreditation visit had acknowledged a number of key strengths as well as a number of non-conformities which are currently being addressed. A theme from the visit related to need to strengthen quality governance and funding has now been agreed for a full time Quality Manager.
9. **Divisional Report – Surgery** – Committee received a summary detailing a range of quality and safety indicators for the Division. Of note was the work to achieve improved VTE assessment, work to support reducing the pressure in ED and the positive feedback from the national GIRFT Team about orthopaedic services. Concerns remain about complaints in Gynaecology and Obstetrics and Committee was assured that these are being addressed.
10. **Divisional Report – Integrated Care** – Discussion focussed on the positive work to support unnecessary hospital admissions including the community emergency response service and work of the East Locality Frailty Team. Pressure Ulcers remain a problem and it was agreed to receive a report back on a planned cluster review.
11. **Perinatal Safety Report** – Committee reviewed information on red flags, incidents and complaints and, focussed, in particular, on work to reduce haemorrhages and to improve support and guidance to mums planning to deliver outside guidance.
12. **Patient Experience Committee Summary Report Escalation – Private Spaces for Families during End-of Life Care** – PEC had asked to escalate the issue of lack of privacy for families during end of life care. It was agreed that while space is a challenging problem there should be further exploration of potential solutions.

Matters for Escalation - None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 31st July 2025 at 10.00-12.30
MS TEAMS

Present:		
Ian James	IJ	Non-Executive Director (Chair)
Chizo Agwu	CA	Chief Medical Officer
Eleanor Bulmer	EB	Non-Executive Director
Lucy Flanagan	LF	Chief Nursing Officer
Rachael Hebbert	RH	Associate Director of Nursing
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director – Joined 1.30pm
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director Quality Governance
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
In Attendance:		
Hemantha Balehithlu	HB	Consultant Paediatrician (for item 4.1)
Jonathan Boulter	JB	Associate Chief Operating Officer Surgical Division
Ingrid Du Rand	IDuR	Consultant Respiratory and Acute Medicine
Kirstie Gardiner	KG	Named Nurse Children in Care (for item 8)
Justine Jeffery	JJ	Director of Midwifery
Dan Harding	DH	Associate Chief Operating Officer Medical Division
Helen Harris	HH	ICB Representative
Tom Morgan Jones	TMJ	Deputy Chief Medical Officer (left after item 6)
Leah Hughes	LH	Operational Lead Radiographer
Linda Kehoe	LK	Matron Stroke and Ambulatory
Emma Lunn	EL	Lead Nurse Adult Safeguarding (for item 8)
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
James Pethick	JP	Head of Blood Sciences (for item 12)
Sara Powell	SP	Matron Women and Children (for item15)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Sarah Seed	SS	Clinical Manager Dietetics (for item 7)
Kym Teale	KT	Research Manager (for item 9)
Amy Tootell	ET	Specialist Nurse Advisor Safeguarding Children (for item 8)
Apologies:		
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Jo Rouse	JR	Associate Non-Executive Director
Emma Smith	ES	Deputy Chief Nursing Officer
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 26th June 2025**	**IJ**	**Approval**	**Enclosure 3**
Approved.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**
The actions were reviewed and updated. All other items were on the agenda.				
4.	**BUSINESS SECTION**			
4.1	**Quality Priority Transition of Care**	**HB**	**Information**	**Enclosure 4**

Transition is a critical phase in the care journey for young people with chronic conditions from paediatric to adult services. Historically, this has been a weak link, with many falling through the cracks, leading to poor outcomes and experiences.

Since 2018, significant strides have been made, with established pathways for diabetes, epilepsy, cystic fibrosis, and rheumatology. Transition is treated as a process, beginning around age 11 and continuing to age 17.

Various resources are available including 'Ready, steady, go' to assess readiness and joint clinics with adult consultants for early introduction to adult team members. There is also ongoing support post-transfer. A number of other smaller specialties are managed on a case by case basis.

A successful pilot funded by the ICB placed youth workers in diabetes and epilepsy services. They have helped map journeys and improve experiences. Youth works are also collecting feedback from young people around diabetes and epilepsy.

The main area of challenge is with complex cases, involving multiple specialties who need specific transition pathways, e.g. cerebral palsy which may have multiple clinical teams involved. There is also a challenge engaging adult services for those children who need bespoke transition models.

Work over the next 12 months will develop a local framework for transition of care from paediatric to adult services. The Transition Passport is nearing completion and will be accessible via the Maxims alert system. A transition register is also being set up which tracks young people from age 15 to plan timely transitions and identify any barriers early.

In-patient transitions from paediatric to adult services was flagged as particularly challenging for young people and families as children with complex conditions are offered open access to wards in paediatrics and there is an abrupt change to adult services. A 16 and 17 year old policy has been developed to address issues, including in-patient stays and out-patient appointments.

It is Important to gain adult clinician input before finalising the passport as the emphasis is on preparing young people for autonomy in adult services. It was suggested that some consideration also be given to rename the passport to avoid confusion or stigma related to the word transition which will be considered offline. **ACTION HB**

Actions:

Consideration also be given to rename the passport to avoid confusion or stigma related to the word transition which will be considered offline. **HB**

5.	**Mortality Report**	**CA**	**Information**	**Enclosure 5**
SHMI has risen to 1.1. Crude mortality rate for June is 0.6, equating to 61 deaths, which is the lowest since 2018.				

The main reason for SHMI increase is removal of SDEC data from inpatient figures. This reduces the denominator, making mortality rates appear higher. Benchmarking inconsistencies exist as not all trusts in the group have removed SDEC from data which was due to become mandatory for all trusts in July but has not yet been implemented. Worcester have also removed SDEC and have seen a high rise in SHMI.

A review and resubmission process is underway with the coding team as a number of patients have been identified who co-morbidity had incorrectly recorded as zero. Also misclassification of disorders such as, vascular dementia coded as senility.

Fractured neck of femur has shown improvements in admission and surgery following test of change activity. Timeline data is awaited on mortality impact.

Sepsis SHMI is also reducing but remains above 100. Regular audits are undertaken and full pathway mapping is planned.

Stroke metrics remain strong and heart failure deaths are down year-on-year despite rising SHMI.

Benchmarking against foundation peers shows 6.4% of Wye Valley patients had 3 or more admissions and died within 90 days which is the lowest among foundation peers, which range from 9–12%.

The Committee discussed using crude mortality as a more reliable internal measure, also to give some consideration to explore a way to recalculate to estimate SHMI impact if SDEC had not been removed.

6.	**Quality Priority – Ensure patients receive a timely VTE risk assessment in line with NICE guidance**	**TMJ**	**Information**	**Enclosure 6**

In April 2024 the timeframe for VTE assessment changed from 24 hours to 14 hours post-admission, posing challenges across NHS England. No region has met the 95% target.

Wye Valley Trust remains below the 95% target; latest figures show 88% compliance. The Maxims upgrade will enable direct linkage between VTE assessment and prescribing and significantly improve compliance and workflow.

Reporting logic fixes are also being implemented to correct discharge logic errors and is expected to improve compliance by 2–3%. A new test of change has been launched to improve VTE assessment for elective patients.

Readmissions due to VTE have halved in the past year, down from 80–90 cases annually to 43 cases. Wye Valley Trust now has the lowest re-admission rate in the Foundation Group.

The Trust will continue to report on the 24-hour standard, aligning with national practice. Plans to move to 14-hour reporting will be considered once national consistency is achieved. Focus remains on quality improvement, coding accuracy, and system upgrades.

7.	**Quality Priority – Food Quality and Nutritional Risk**	**RH/SS**	**Information**	**Enclosure 7**

The objective of this quality priority is to improve the food and drink strategy across wards. Targeted meal service audits have been done on wards on a rotating basis, using patient feedback and data triangulation to inform improvements and will monitor compliance through annual inpatient surveys, PLACE audits, and Sodexo ward audits.

Audit of snack provision showed that 48% of patients were not offered snacks during tea and coffee rounds and is now being monitored more closely. The choice of snack has been expanded to include gluten-free and soft foods. A whole site-audit is planned in six months' time.

The Nutrition Care Group, led by Sarah Seed, meets fortnightly across wards and reviews patient feedback, meal service, and ward-specific concerns. The group includes representatives from Sodexo, ward teams, and patient ambassadors.

Malnutrition Universal Screening Tool (MUST) Results:

Every patient should be MUST screened on a weekly basis. Annual audit shows that screening is being done, but accuracy and follow-up actions are inconsistent. Some issues were identified in inaccurate scoring, incomplete follow-up actions and challenges with digital documentation in Maxims.

Focused training has been rolled out on both AMU and Redbrook ward. Redbrook is showing improvement and staff are fully engaged with training.

Improvement work is ongoing by Sodexo to explore ward specific food needs, for example requirements for paediatric wards is not the same as those of a surgical or frailty ward. The Sodexo Patient Ambassador is also undertaking monthly surveys on patient experience and will be asked to focus on national survey questions. An update will be brought in the next report.

The digital nurse noting dashboard has been developed and whilst it would not show if a MUST score was completed correctly it would demonstrate compliance SS to speak to Cath Davies on how to use that intelligence in future reporting.

8.	**Safeguarding Quarterly Reports**	**EL/AT/ KG**	**Information**	**Enclosure 8**

Adult Safeguarding

There are concerns in relation to a number of patient safety incidents where patients absconding from hospital, some are vulnerable and have deprivation of liberty safeguards or mental health sections. Some staff lack the skill set on de-escalation training and some security guards are not restraint trained. In most cases police will return the patient to hospital but this is inconsistent due to limited powers. This has been escalated through security meetings and has been added to the risk register and MABO training is planned for staff and security teams. Community hospitals are also vulnerable and MCA and DOLS Lead is to deliver training to improve legal understanding.

Feedback shows that despite the domestic abuse question prompts which appear on Symphony in ED some questions are not appropriately asked by staff. This is not just related to ED, and has happened around the hospital.

There has also been an increase in domestic abuse referrals and The Domestic Abuse Lead is exploring training options, benchmarking with other trusts in the foundation group. Planned face to face sessions to take place with clinical staff in high risk areas such as A&E and Obstetrics and Gynaecology. Also production of video modules for non-clinical and clinical staff. Exploring ways to have targeted training for the workforce and make the training essential to role for those individuals who need it for their working practice.

Children's Safeguarding

There has been 100% attendance at initial child protection conferences by School Nurses and Health Visitors. Supervision rate for health visitors has risen and Community Midwives remain at 100%. High compliance to level 3 training is seen across all teams.

Continue to run joint Think Family Safeguarding Forums, working to promote across the trust.

Data is being collected for admissions to ED of children who are presenting with intoxication, under the influence of drugs, self-harm and stabbings. The first quarter results show that there has been a marked increase in the number under the influence or intoxicated. This is being monitored across Herefordshire to determine if this is a seasonal trend or a wider issue.

ED Level 3 training has increased slightly but remains low at 71% and has been raised with service leads. The risk, however is mitigated by paediatric staff compliance at 91% and there is always a paediatric trained member of staff on duty in ED 24/7.

There has been an increase in escalations to Children's Services, mostly from midwifery following a four month pause of the pre-birth panel. The majority of these are being addressed through escalations and improved collaboration and a decrease in escalations is expected in the next quarter. The pre-birth panel has been re-established.

Looked after Children

100% of children with medical consent were offered Initial Health Assessments within statutory timeframes. There is also fast turnaround on consents, maximum 12 days. There has been consideration regarding removal from the risk register, however new practice requiring social worker attendance at initial health assessments could cause delays as additional adoption related consents are now required earlier. This is best practice and not mandated and therefore a health assessment would still go ahead should a Social Worker not be available to attend.

Also of concern, is a single point of failure risk has identified in the midwifery team for completion of forms when the Safeguarding Midwife is on leave.

There are significant delays in assessments for children placed in Worcestershire due to backlog which is not anticipated to clear until March 2026. The Wye Valley team have stepped in to complete assessments for 10 children and there is ongoing monitoring and collaboration with ICB and Worcester colleagues.

9.	Clinical Research Report	IDuR	Information	Enclosure 9

280 patients were recruited to 22 trials across 11 specialties. Seven non-commercial and one commercial trial opened.

The trust is ranked 14th of 27 West Midlands organisations, achieved despite staffing challenges

The research strategy is making good progress and the period for research strategy may extend to 2027. Recruitment for an F3 Research Clinical Fellow is underway.

The sponsored multicentre stroke trial led by an occupational therapist has over recruited. The first paper expected by end of August.

There is high satisfaction from patients; most strongly agreed or agreed they would participate in research again. Positive feedback has been received on time spent and clarity of information provided by research nurses.

The infrastructure of the team is now established - Emma Collins Lead Research Nurse; Kym Teal Research Manager. An NIHR-funded Herefordshire Research Manager post has also been established and the team are working on SOPs and expanding research capacity.

There have been changes in the network the previous Clinical Research Network has become the Research Development Network. The funding model is shifting to performance-based; fixed funding secured for one year and future planning will benefit from three year financial projections.

A primary research study on boarding and staff impact is to be submitted for ethics approval in September.

The academic programme is robust and continue to collaborate with University of Worcester and the long-term goal is to achieve academic hospital status. This requires 9 clinicians with joint appointments and two posts are advertised to support this journey.

It is estimated that a 5-year strategy will reach university status.

10.	Patient Flow Report	NO	Information	Enclosure 10

Ambulance hand over metrics are improving and decision to admit before 8am is embedding well with 29% of admissions hitting target.

Pressures in ED over 12 hour stays remain stable, over 24 hour stays spike during periods of pressure.

Boarding reduced by 100 beds from May and June and is expected to reduce further.

Incident themes include uncoordinated care, which should improve with ongoing test of change work.
Some highlights from test of change included 24 of 31 fractured neck of femur patients reached the ward within 4 hours; no boarding reported on the day of the meeting and improvements noted in patient and staff experience.
Further updates to be shared through Transformation Tuesday and Safety in Sync forums.

No new complaint themes were reported.

The committee gave recognition of the significant progress made through the test of change initiatives.
It was also noted that this report originated as a boarding report and had evolved into a broader flow report.
Optimism was expressed that improved flow may eventually eliminate the need for a dedicated report.

11.	Staffing Report	LF	Information	Enclosure 11

There has been positive progress in agency reduction. Key achievements include the complete elimination of Band 2 agency usage and full compliance with NHS cap rates for specialist and general nurses.

The Trust is currently £600,000 ahead of its CPIP target for agency spend.

Most workforce metrics are trending positively. Sickness rates are decreasing, and the Trust maintains a strong vacancy position. Although maternity leave rates are higher than average across the Foundation Group, the Trust mitigates this by recruiting 100% permanent backfill for Band 5 and Band 6 roles, avoiding less attractive fixed-term contracts.

Staffing fill rates are generally positive. Lower percentages are observed in elective areas where staffing is adjusted based on demand. Higher fill rates are attributed to additional beds, boarding patients, or increased acuity.

The Trust plans to enhance the existing nursing dashboard and triangulate staffing data with quality metrics to assess the impact of improved staffing stability on patient safety and care quality. This analysis is expected in the coming months.

12.	UKAS Pathology Accreditation Outcome/Action Plan	JP	Information	Enclosure 12

The UKAS assessment for pathology services at Wye Valley NHS Trust took place between 27 June and 23 July 2025. This annual visit evaluated compliance against the ISO 15189:2022 standard, covering all pathology disciplines and the quality management system, including both technical and clinical aspects.

UKAS acknowledged the knowledgeable, competent, and engaged staff with excellent technical and scientific outputs. Several key strengths were identified within the team.

There were a total of 89 non-conformities against standards identified, most of which are straightforward and expected as part of the assessment process. However, six key areas for improvement were highlighted:

- Allocation of resource for support and implementation, management, and improvement of the quality management system.
- Allocation of resource to support the management of microbiology.
- Management of the audit calendar and implementation of a risk-based approach.
- Management of nonconformities to include consideration of clinical patient impact.
- Provision of publicly available information.
- Management of quality indicators.

Many of the findings are already being addressed, and evidence is being gathered for submission to UKAS.

Funding has now been secured to create a full-time Quality Manager post, which has been advertised internally with strong interest. The closing date for applications is 10 August 2025.

Due to delays in the audit calendar, UKAS will conduct a three-month re-assessment visit to verify progress. The Trust is confident that with the new Quality Manager and ongoing actions, the findings will be successfully closed and a further update will be brought to Quality Committee following that visit.

13.	**Divisional Quarterly Report – Surgery**	**JB**	**Information**	**Enclosure 13**

VTE Risk Assessment progress has been noted across the division, with support from Tom Morgan-Jones. There was some concern in Women's and Childrens which has historically had performance of between 80-85%. A deep dive showed 98% compliance in Gynaecology with underperformance driven by Obstetrics due to BadgerNet reporting. Plans are in place to resolve reporting challenges and test of change around elective patient capture.

Last quarter NELA results show good progress against compliance and quarter 4 confirms that best practice tariff was met. This is reflective of behind the scenes work into addressing resource challenges.

Launch of PMB Pathway in Gynaecology has been implemented to improve patient experience and reduce unnecessary referrals. It is expected to reduce 2 week wait referrals by 50% and improve cancer access.

The test of change UEC scheme in Acute Surgical Unit successfully reduced ED pressure and improved patient flow. During the course of 4 weeks, over 50 patients benefited from earlier treatment and some discharged directly and avoided admission.

Gynaecology SDEC and improvements to the baby loss pathway has enhanced patient experience through ring-fenced beds and revised admission criteria.

The Elective Surgical Hub has treated over 4,500 patients in the first year, with improved theatre utilisation and reduced cancellations. Enabled emergency access improvements and supported the hot Laparoscopic Cholecystectomy pathway, saving £338,000 in six months.

The division won first, second and third place in the 'We learn, we share' initiative in the poster competition.

The Orthopaedics GIRFT national team visit was positive and praised the orthopaedic service as 'unrecognisable' compared to 12 months ago. Length of stay has reduced from 3.8 to just over 2 days for hips and knees.
There are some further concerns regarding culture in Obstetrics and Gynaecology and complaints remain mostly around communication. MDT leadership and communication training is underway. Actions include customer care training and forums for discussion.

Five children remain on Risperidone medication. Regular MDT meetings and psychiatrist reviews are planned to manage ongoing care. A separate paper will be brought to the next meeting to update on progress. **ACTION CA.**

The Chair acknowledged how the Public Health Nursing Contract was successfully adapted to new working model with positive outcomes over the past year.

11 colleagues attended the communication training from NHS Elect. The session was well received and there are plans to expand training in September.

ACTIONS:

There are three open PSIIs and one on clock stop within the division. An update on the timescale for completion will be given in the next report. **ACTION: Surgical Team**

The next quarterly report will have a focus on breast service **ACTION: Surgical Team**

Five children remain on Risperidone medication. Regular MDT meetings and psychiatrist reviews are planned to manage ongoing care. A separate paper will be brought to the next meeting to update on progress. **ACTION CA.**

14.	Divisional Quarterly Report – Integrated Care	SM	Information	Enclosure 14

The division maintains a strong reporting culture with increasing incident reports. There are no active complaints

A spike in community hospital falls was noted in June.

There are no major concerns regarding medication errors and infection prevention control.

Children's therapy wait times continue to improve.

The division showcased its community urgent response work at the operational conference in May. Highlights include the use of pocket cards for paramedics to encourage pre-conveyance calls and the successful implementation of virtual and hub GPs available 8am–8pm.

The East PCN's frailty team, including two Occupational Therapists, has effectively reduced hospital admissions through MDT collaboration.

Pressure ulcers remain a persistent issue, particularly in district nursing due to workload pressures. A cluster review will take place to determine if this and moisture skin damage had any link to the recent change in continence product and the results will be brought back to quality committee. **ACTION: SM**

HH also added that pressure ulcers were flagged as a concern in ICB and a number Regulation 28s had been issued across the region. A paper is due in autumn and following that some system work will be planned.

Cultural concerns have emerged at Ross Community Hospital. Meetings are taking place with staff face to face, challenging performance and ways of working. Cleanliness issues persist which is also of concern. Leadership development and training and supervision support are being implemented for a number of new Band 6 nurses.

The SNNAP stroke audit has changed its criteria, resulting in a drop from an 'A' to an 'E' rating. To note, this reflects national trends and does not indicate a decline in care quality. Therapy teams face challenges meeting new daily therapy time requirements, which may also impact future scores.

15.	Perinatal Safety Report	CL	Information	Enclosure 15

One Category 1 C-Section case had a 6-minute delay due to a concurrent emergency. No harm occurred and safety standards were maintained.

Delivery Suite Co-ordinator Supernumerary status achieved 100% compliance. RGOG Obstetric attendance also maintained 100% compliance in recent cases.

During June, one case of moderate psychological harm occurred due to communication issues between theatre and midwifery staff. This was escalated promptly and debrief and reflections completed within 2 days. Cultural improvement work has commenced and is reflected in staff working.

There were two complaints in June, one a follow-up; communication remains a key theme. NHS Elect training was positively received.

PMRT reporting shows significant decrease and all recent cases have been graded A and B and continue to scrutinise all cases.

Triangulation ongoing themes include haemorrhage and birth outside guidance. Terminology is under review to change from ‘outside guidance’ to 'off pathway'. SOPs and personalised care plans are also in development. There was some concern from the committee that the change in terminology may dilute the perspective of risk for some families. However, it was agreed that the crux was informed decision making together with robust documentation. It was noted that part of the discussion should inform that distance from home to service availability, also ambulance transfer time.

There is notable reduction in postpartum haemorrhage over 1.5L, this is due to improved reporting and use of prompt sheets. Guidelines update is pending.

Anaesthetic Consultant training compliance is at 75%. A plan is in place for full compliance by 1st December. Governance monitoring is ongoing.

Progress against CNST year 7 requirements is ongoing. Safety Action 6: (saving babies lives care bundle) NICE guideline alignment is required. Trust support and meetings are planned. PIGF testing is not yet implemented; business case is in progress.

Safety Action 7: (service user involvement via MNVP) is ongoing despite recruitment delays. Strategic meetings and neonatal lead support is in place.

<u>Neonatal - Sara Powell</u>

QIS status has improved. Working is ongoing with the regional team in relation to workforce challenges. Having 2 QIS nurses on shift is prioritised on weekends and night shifts, utilising Ward Manager and practice educator during week day shifts. Benchmarking across the foundation group is underway, George Elliot is most similar to Wye Valley.

JJ provided assurance regarding MNVP engagement work. The inability to recruit into these posts due to ICB transition, is has been escalated to the regional team as a barrier to recruiting in ICB and asked for the recruitment ban to be removed for MNVP posts to enable engagement work to continue. Assuring that can still meet CNST compliance. It was noted that appendices 3 and 4 were new to the report and needed some commentary to aid understanding. Noted that the format for future Quality Committee reports was under review				
16.	**Infection Prevention Committee Summary Report NHSE Inspection Outcome Letter**	**LF**	**Discussion**	**Enclosure 16**
The IPC visit outcome letter was attached for information. A re-inspection is scheduled to take place on 18th September. Fortnightly touchpoint meetings are taking place with Sodexo and infection prevention colleagues to ensure estates and maintenance issues are addressed in a timely manner in advance of that inspection. There were four MRSA bacteraemia cases in last 4 month; 3 were community onset cases. A cluster review has been requested to identify lessons learnt. Surgical site infections for hips and knees are in the fifth quarter free of infection.				
17.	**Clinical Effectiveness and Audit Committee Summary Report**	**NO**	**Discussion**	**Enclosure 17**
The paper was taken as read. To note the first meeting has taken place with new committee chair.				
18.	**Patient Experience Committee Summary Report**	**NO**	**Discussion**	**Enclosure 18**
The Patient Experience Committee had highlighted concerns regarding the lack of dedicated space for families and carers during end-of-life care. Families often do not have a private or sensitive area to receive difficult news or spend time with loved ones. This affects the overall experience and dignity of care for patients and their families during critical moments. The issue was formally noted as an escalation. While it is acknowledged as a challenging problem due to space constraints, it was agreed that it needs further exploration and potential solutions. The committee will revisit this issue in future meetings, particularly through the CEAC (Safety, Effectiveness and Audit Committee) and Patient Experience Summary reports.				
19.	**CONFIDENTIAL SECTION**			
19.1	**PSIRP Evaluation Report**	**NO**	**Discussion**	**Enclosure 19**
20.	**Any Other Business**	**All**	**Discussion**	
21.	**Date of Next Meeting**			
Thursday 28th August 2025 – 1.00-4.00pm MS Teams				

Escalation and Assurance Report

Report from:	One Herefordshire Partnership Board: Integrated Care Executive
Date of meetings:	24 June and 12 August 2025
Report to:	Wye Valley NHS Trust Board
Chair:	Frances Martin, Deputy Chair
Author:	Gwenny Scott, Company Secretary

Integrated Care Executive (ICE) is now part of the One Herefordshire Partnership Board and meets every six weeks.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Better Care Fund (BCF)**
Rating rationale	**Finance** In June there was a forecast overspend of £0.745m. A mitigation plan was in development, focused in particular on hospital discharge. The July position had deteriorated further, with a forecast adverse variance of £0.832m. Two of eight savings plans were being achieved. There was a forecast £1m overspend on D2A. Mitigation plans required more oversight at service level. **Performance** All KPIs for 2024/25 were achieved but this was not reflected in the volume of non-elective hospital admissions. **Plan** The 2025/26 Plan had two new objectives regarding a shift from sickness to prevention and from hospital to home. Integration of discharge funding would provide more flexibility for delivery.
Outcome	Accepted
Item/Topic	**Discharge to Assess (D2A)**
Rating rationale	Progress was positive. Key achievements included sustained reduction in length of stay for community hospital patients, and better engagement between partnership organisations in identifying delays. Improving occupancy in LICU continued to be an area of focus and options to address this were under review. Other concerns to be considered by the D2A Board included readmissions from D2A beds and delays for patients awaiting fast track. A workshop was planned in September to review the model to ensure it matched the system-wide approach.
Outcome	Accepted
Item/Topic	**Virtual Ward (VW) and Falls Service**
Rating rationale	VW utilisation was high over the quarter, particularly for IV OPAT. There was a continued focus on increasing occupancy, including a plan to increase the number of frailty beds to 30. Audit analysis demonstrated that high numbers of bed days could be saved on OPAT instead of hospital admission. The Falls Service had been successfully integrated, increasing flexibility and efficiency. Now the service was operational, a joint audit with WMAS would be undertaken
Outcome	Accepted

To Note: Items received for information or approval	
Item/Topic	**Enhanced Health in Care Homes**
Summary	The audit results showed: • Most hospital admissions from care homes were appropriate • Digital ReSPECT forms needed more detail; this would be addressed by the pending introduction of digital forms. • Sheltered Housing contributed to the majority of admissions from one area. Benchmarking would be undertaken to determine whether this was a county wide picture.
Outcome	Noted

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

Escalation and Assurance Report

Report from:	One Herefordshire Partnership Board: Integrated Care Executive
Date of meeting:	23 September 2025
Report to:	Wye Valley NHS Trust Board
Chair:	Frances Martin, Deputy Chair
Author:	Gwenny Scott, Company Secretary

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Better Care Fund (BCF) Finance Report**
Rating rationale	The financial position had deteriorated further with a forecast outturn variance of £1.492m before mitigations and £0.973m after. This was due to overspend on Discharge to Assess services on purchasing of care home beds, due to under-utilisation in LICU and overstays. This was a conservative forecast and there were some additional mitigations that these had not yet been worked through in detail. These included a planned reimbursement for care provided to patients not eligible for BCF. The report set out some areas of underspend year to date but several related to an accounting lag and were expected to reduce as the year went on. Concern was expressed about the level of detail in the financial plan and clarity in the finance report which was linked to the different accounting methods within the different organisations.
Outcome	Actions: 1. Review the presentation of the finance report to enhance clarity on the financial position and forecast. 2. Ahead of the next meeting provide clarity to the Committee members on the financial position. 3. At the next meeting present a detailed operational mitigation plan to recover the financial position.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Better Care Fund (BCF) Performance Report**
Rating rationale	The target for emergency admissions to hospital for people aged over 65 was not met and demand remained high. The Frailty Same Day Emergency Bridging Team was supporting patients to go home on the same day to prevent inpatient admission.
Outcome	Accepted
Item/Topic	**Discharge to Assess (D2A)**
Rating rationale	High numbers of referrals into CAAST continued and performance by Hoople Care Home First and Hillside Services was positive. The main concerns continued to be the underutilisation of LICU and readmission from D2A beds. A test of change was about to commence, where a therapist would be involved from day one of discharge to assess whether more therapist resource could support a reduction in readmission rates.
Outcome	Accepted
Item/Topic	**Falls and Urgent Care Response (UCR)**
Rating rationale	Post discharge welfare calls were being piloted on one of the frailty wards. The effectiveness of the pilot in reducing readmission rates would be assessed before wider roll-out, initially across all frailty wards, then all other wards as well. Working with care homes to encourage the use of UCR, even when outside their local policy, was a key area of focus. WMAS referrals continued to increase and engagement with WMAS and primary care was strong. Work was in progress to enhance communications about the service to ensure all stakeholders across the system understood what the service could achieve. Falls activity had increased compared to pre-handover activity data; whether this was a real increase or a data collection issue was unclear. Existing call handlers were being trained into a hybrid role, able to flex into a falls response role as well. Missed referrals, calls and missed opportunities were continuously monitored.
Outcome	The report was welcomed, including the positive progress and the focus on continuous improvement.

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

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