PUBLIC BOARD MEETING

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

MS TEAMS

Agenda

13:00 - 13:05
5 min

1. Going The Extra Mile Awards

Discussion *Russell Hardy*

13:05 - 13:06
1 min

2. Apologies for Absence

Information *Russell Hardy*

13:06 - 13:07
1 min

3. Declarations of Interest

Information *Russell Hardy*

13:07 - 13:09
2 min

4. Minutes of the Meeting held on the 2 October 2025

Decision *Russell Hardy*

- 4. PUBLIC BOARD MINUTES - OCTOBER 2025 - LF, FM.pdf (7 pages)

4.1. Foundation Group Board Minutes and Action Log

Discussion *Russell Hardy*

- 4.1 Draft Public FGB Minutes - 5 November 2025.pdf (17 pages)
- 4.1a. Public Matters Arising and Actions Update Report - 5 November 2025.pdf (1 pages)

13:09 - 13:10
1 min

5. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

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

13:10 - 14:00
50 min

6. Items for Review and Assurance

6.1. Chief Executive's Report

Discussion *Stephen Collman*

- 6.1 CEO Report.pdf (4 pages)

6.2. Integrated Performance Report

Discussion *Sarah Shingler*

- 6.2 WVT Full Pack - IPR_Board.pdf (27 pages)

6.2.1. Quality (including Mortality)

Discussion *Lucy Flanagan/Chizo Agwu*

6.2.2. Activity Performance

Discussion *Andy Parker*

6.2.3. Workforce

Discussion *Geoffrey Etule*

6.2.4. Finance Performance

Discussion *Katie Osmond*

6.3. Emergency Preparedness Resilience and Response Report

Discussion *Andrew Parker*

- 6.3 20251120 - WVT EPRR Board Template and Report.pdf (11 pages)

6.4. Midwifery Safe Staffing Report

Discussion *Justine Jeffery*

- 6.4 Midwifery Safe Staffing Report October 2025 WVT.pdf (7 pages)
- 6.4a Wye Valley NHS Trust Final Birthrate Plus report 26.11.2024.pdf (17 pages)

6.5. Perinatal Safety Report

Discussion *Justine Jeffery*

- 6.5 Perinatal Safety Report Q2 board version.docx.pdf (23 pages)

6.6. Guardian Of Safe Working Report

Discussion *Chizo Agwu*

- 6.6 GOSW Board Report 2025 Dec.pdf (2 pages)

6.7. Committee Summary Reports and Minutes

6.7.1. Audit Committee Escalation Report

Discussion *Nicola Twigg*

- 6.7.1 Audit Committee Escalation & Assurance Report 18 September 2025.pdf (3 pages)

6.7.2. Children and Young Peoples

Discussion *Jo Rouse*

- 6.7.2 CYP Committee Escalation Assurance Report 2025.pdf (3 pages)

6.7.3. Quality Committee Report and Minutes 28 August 2025 and 25 September 2025

Discussion *Ian James*

- 6.7.3 Quality Committee Summary Report August 2025 - public.pdf (2 pages)
- 6.7.3a Minutes Quality Committee - August 2025.pdf (9 pages)
- 6.7.3b Quality Committee Summary Report September 2025 - public.pdf (2 pages)
- 6.7.3c Minutes Quality Committee - September 2025.pdf (8 pages)

6.8. Patient Experience Report

Discussion *Lucy Flanagan*

- 6.8 - Patient Experience Report November 2025 Board version.pdf (12 pages)
- 6.8a - National Inpatient Survey 2024- October 2025 report v2.pdf (27 pages)

14:00 - 14:20
20 min

7. Items for Noting and Information

7.1. Use of Trust Seal - Biannual Report

Information *Gwenny Scott*

7.1 04-12-2025 - Use of Trust Seal~v1.pdf (1 pages)

7.2. Board Assurance Framework

Discussion *Gwenny Scott*

7.2 Board Assurance Framework Covering Report November 2025.pdf (1 pages)
7.2a Board Assurance Framework November 2025.pdf (14 pages)

14:20 - 14:25
5 min

8. Any Other Business

14:25 - 14:30
5 min

9. Questions from Members of the Public

Russell Hardy

14:30 - 14:30
0 min

10. Acronyms

Z Acronyms - updated 07.06.24.pdf (3 pages)

14:30 - 14:30
0 min

11. Date of Next Meeting

The next meeting will be held on Thursday 5 February 2026 at 1.00 pm

WYE VALLEY NHS TRUST
Minutes of the Public Board Meeting
Held on 2 October 2025 at 1.00 pm – 2.00 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 – Arrived during Item 5.1
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Ian James	IJ	Non-Executive Director
Katie Osmond	KO	Chief Finance Officer/Deputy Managing Director
Grace Quantock	GQ	Non-Executive Director
Nicola Twigg	NT	Non-Executive Director
Present (Non-Voting):		
Ellie Bulmer	EB	Associate Non-Executive Director
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Justine Jeffery	JJ	Director of Midwifery
Andy Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director
Gwenny Scott	GS	Associate Director of Corporate Governance
In Attendance:		
Val Jones	VJ	Executive Assistant for the minutes
Lou Robinson	LR	Deputy Company Secretary
Apologies		
Russell Hardy, MBE	RH	Chairman and Meeting Chair
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive 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.	**Minutes of meeting on 4 September 2025**	**FM**	**Approval**	**Enclosure 1**
Item 11 – Finance – To change to - lowest in years at *3.2%* of pay bill in July. **The Board accepted the minutes of the meeting held on 4 September 2025 with the one agreed amendment.**				

4.	**Matters Arising and Action Log**	**FM**	**Information**	**Enclosure 2**
The Board accepted the Action Log update.				
5.	**Manager's Director Report**	**KO**	**Assurance**	**Enclosure 3**

Oversight Framework & Segmentation: The organisation is confirmed in Segment 3 for Q1, aligning with performance expectations. Focus continues on improvement areas identified through metrics.

Board Self-Assessment: Completed and scheduled for review later in the meeting.

National Neighbourhood Health Implementation Programme: The Trust has been selected to participate, building on existing integrated work across Herefordshire. Initial planning with partners has commenced.

Community Diagnostic Centre (CDC): Officially opened on Monday. Early activity levels are promising, and the team is focused on maximising its use. Appreciation was extended to all contributors.

Winter Preparedness: Ongoing work on Urgent Care pathways and stress testing with System partners. Flu vaccinations have begun across the organisation, with Board members participating.

Medical Division Performance: Positive improvements noted despite challenges in Urgent and Emergency Care. Continued focus on Virtual Ward model and winter readiness. Successful recruitment in medical specialties supports service sustainability.

Innovation & AI: The Medical Division is piloting ambient AI with encouraging results. Further updates on AI initiatives are expected.

The Board accepted the Managing Directors Report.

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

Operational Performance - Continued focus on Urgent and Emergency Care improvements, supported by NHS England's ECIST team, who are helping review the entire Care pathway. Concerns remain around 52-week elective wait times, but Divisions have outlined clear action plans to address this.

Quality - Mortality metrics have worsened, as anticipated, due to inconsistent STEC recording and clinical coding challenges. Action plans are in place, with strong leadership from the CMO. Cleaning standards have been positively recognised following an NHS England Inspection.

Workforce - Sickness absence rates have decreased, reflecting targeted efforts and linking to the ongoing Flu Vaccination Campaign. Staff are encouraged to participate in the National Staff Survey, which is now live, to share feedback on their experience at Wye Valley.

The Board accepted the Integrated Performance Report.

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

Cleanliness & IPC Improvements - The Trust has progressed from intensive support to routine monitoring by NHS England following sustained improvements in cleanliness and infection prevention control following their visit in September. Continued collaboration with Sodexo and the Estates team will ensure momentum is maintained, with virtual and in-person follow-ups scheduled over the next six months.

Flu Vaccination Programme - Launched this week, with Board members receiving vaccinations to demonstrate leadership. The return to a Peer Vaccinator Model is expected to improve staff uptake. A Patient Vaccination Programme is being developed for those unable to access Primary Care Services, including long-stay hospital and Care Home residents.

Ward Leaders Development Programme - Refreshed to support leadership and staff wellbeing, which in turn enhances patient care. The programme includes participation in the Leading an Empowered Organisation programme, action learning sets, buddy support from experienced leaders and targeted training and virtual toolkits.

Quality Priorities – Diabetes Safety - Focus areas include Patient empowerment, Safe insulin management, Diabetic foot assessment and care and Management of hypoglycaemic episodes. Further details are included in the report pack and oversight is through Quality Committee.

Agency Spend - Continued positive progress in reducing Agency expenditure.

Mortality

Mortality Metrics - While mortality indices have increased, the overall number of deaths has decreased over the past 12 months. The rise in indices is attributed to the removal of STEC activity from admitted patient data and a backlog of uncoded patients due to team vacancies. Additional Agency Coders have been recruited to address the backlog and improve data accuracy.

Governance & Learning - Mortality governance remains strong, with active clinical engagement. Recent presentations from the Acute Medical and Learning Disabilities Teams demonstrated learning from deaths.

Martha's Rule Implementation - The Trust is rolling out patient wellness questions to help identify early signs of deterioration, as presented during the Board Workshop.

FM continued the emphasis on staff and patient vaccination across the county to reduce virus transmission and maintain workforce availability. The introduction of Peer Vaccinators is expected to improve access, especially for staff working off-site or out of hours. Staff are encouraged to check the intranet for vaccination routes.

FM highlighted the positive developments from the monthly One Herefordshire Quality Forum, which brings together staff across organisations to discuss clinical safety. Diabetes was a key topic, with a focus on improving awareness, training, and cross-team support to manage risks and complications effectively. Appreciation was expressed for the leadership driving this work.

The Board accepted the Quality (including Mortality) Report.

8.	**Activity Performance**	**AP**	**Assurance**	

Urgent & Emergency Care – This remains the Trust's top priority due to ongoing ED congestion and high bed occupancy, including use of temporary Escalation spaces. September's 4-hour performance was 66%, falling short of the improvement trajectory by 6%, impacted by increased emergency admissions and ED attendances.

Delayed Discharges - Bed days lost due to delayed discharges reached near-winter levels in September, particularly affecting Herefordshire and Powys.

Tier 1 Support & ECIST Engagement - The Trust is under Tier 1 support for Urgent and Emergency Care, with regular oversight from NHS England. The Emergency Care Intensive Support Team (ECIST) is engaged for six months, already contributing positively through recent workshops.

Improvement Focus Areas - Front door navigation and Same Day Emergency Care (SDEC), Ward-based flow and criteria-led discharge, Community schemes including Home First and Pathway 1, Frailty bridging team enhancements and Virtual Ward improvements, including Geriatrician involvement in the Community Response Hub.

Winter Planning - Plans have been submitted and stress-tested locally and regionally. Weekly system-wide meetings are held to monitor progress. Emergency preparedness teams are conducting scenario-based stress tests with Divisional and On-call teams.

Elective Care - Strong performance in elective activity and RTT delivery. Focus remains on reducing 52 week waits, with 30% of long-waiting patients removed from key specialty lists in the past seven weeks. Recovery trajectories aim for <1% of patients waiting over 52 weeks by March.

Community Diagnostic Centre – This successfully opened this week. AP extended his appreciation to staff and partners for its implementation.

FM expressed her appreciation to the Design, Procurement, and Implementation teams for delivering the CDC. Board members will visit the facility individually and collectively. The development is seen as a major innovation for Herefordshire.

FM extended an apology to patients experiencing delays in planned procedures and Urgent/Emergency Care. Efforts continue to improve capacity and responsiveness across services. She encouraged patients to choose care pathways wisely, considering alternatives to the ED when appropriate. Gratitude was expressed to GP and Primary Care colleagues for their ongoing collaboration.

The Board accepted the Activity Performance Report.

9.	**Workforce**	**GE**	**Assurance**	

Admin & Clerical Review - Phase one of the Review Programme is progressing well and expected to complete in early November.

Sickness Absence - Following the revised Sickness Absence Policy, the Trust now reports its lowest absence rates. Continued HR and management support will aim to sustain this improvement.

Equality, Diversity & Inclusion: - The Trust remains committed to fostering a compassionate and inclusive workplace. Activities in October included: National Inclusion Week, Black History Month and Freedom to Speak Up Month. These were supported by Staff-Side colleagues and the Freedom to Speak Up Guardian and Champions.

Health & Wellbeing Week – This is scheduled for next week, featuring a range of activities supported by internal and external partners. Staff vaccination will be actively promoted during the week.

Staff Survey - The annual Staff Survey is now live. All employees are encouraged to participate, as feedback is vital to improving the working environment and patient services.

FM emphasised the value of the National Staff Survey as a key tool for understanding staff experience and organisational culture. A high response rate is encouraged to ensure meaningful insights. Staff are urged to share feedback throughout the year, not just via the Survey. FM reassured staff that the Survey process is fully anonymous, including follow-up reminders. There is a strong correlation between staff wellbeing and the quality of patient care. The Board is committed to listening and acting on staff feedback to support both workforce and service improvement.

The Board accepted the Workforce Report.

10.	**Finance**	**KO**	**Assurance**	

KO advised that a detailed monthly review is held at the Financial Recovery Board.

Year-to-Date Position - At Month 5, the Trust reports a year-to-date deficit of £2.6 million, which is approximately £1 million better than planned. This reflects a strong start to the financial year.

Agency Spend - Agency costs have improved to 2.94% of total pay, now below the national benchmark of 3.2%—a significant milestone.

Efficiency Delivery (CPIP) - The Trust has overperformed on Cost Improvement Plans, delivering £1 million more than planned. However, a high proportion of this is from non-recurrent measures, requiring continued focus on sustainable efficiencies.

Forecast Risks - Risks remain around delivering the full-year efficiency target, particularly as key schemes like the Workforce Change Programme ramp up. Mitigation planning is underway.

Elective Income - Elective income is broadly on track, which is positive. However, funding parity issues with Wales remain unresolved and could impact the year-end forecast.

Capital & Cash - No significant concerns with capital delivery; national scheme funding is expected to be met. Cash remains stable but will be closely monitored due to the Trust's underlying financial position.

FM advised that the Board held a session earlier in the day to review medium-term financial planning. Current in-year performance is ahead of plan, but challenges are expected to intensify as the year progresses due to backloaded plans. She placed emphasis on the collective responsibility of all staff in managing resources—from everyday clinical decisions to strategic investments. Financial discipline is essential to reduce reliance on NHS England deficit support.

FM also recognised the progress made in reducing discretionary and variable expenditure, particularly Agency staffing. She stressed the need to maintain strong financial grip and focus throughout the year to support improved segmentation status nationally.

The Board accepted the Finance Report.

	ITEMS FOR APPROVAL			
11.	**Terms Of Reference Hoople Board**	**GS**	**Approval**	**Enclosure 5**

The updated Terms of Reference were presented with tracked changes. Changes are minor and reflect current working practices. The document is submitted for Board approval.

FM asked NT as the Trust's representative and Current Chair of the Hoople Board if she wanted to add any further comments. NT advised that amendments were made to clarify the roles and implications for Directors, Non-Executive Directors, and Council Members sitting on the Board. The update ensures alignment with the correct governance structure and responsibilities.

FM highlighted that Hoople is a key strategic partnership, particularly in collaboration with Herefordshire Council. It provides an important platform for delivering services and acting on behalf of the Trust. Board members were reminded of its significance, especially for those less directly involved.

The Board approved the Terms Of Reference Hoople Board.

12.	**Terms Of Reference Financial Recovery Board**	**GS**	**Approval**	**Enclosure 6**

The updated Terms Of Reference were previously reviewed by Board members at the recent Financial Recovery Board meeting. Changes reflect the Committee's evolution over the past year and current working practices. No significant amendments; primarily a tidy-up for clarity and accuracy.

FM acknowledged that while Public meetings may appear limited in duration, substantial governance, assurance, and scrutiny occur through other Committees and Boards. Sharing Terms Of Reference helps demonstrate the depth of oversight and collaboration between Executive and Non-Executive Directors in managing services for the community.

The Board approved the Terms Of Reference Financial Recovery Board.

13.	**Provider Capability Assessment**	**GS**	**Approval**	**Enclosure 7**

A new requirement under the NHS Oversight and Assessment Framework mandates a separate capability assessment, distinct from performance metrics. The Trust's first submission is due by the end of October and will be reviewed by NHS England Regional teams, who will assign a rating. This will become an annual process, aligned with the planning and reporting cycle, with future updates expected around April.

The Executive team has reviewed the six assessment areas and is confident in full compliance with most, proposing partial confirmation in two areas - Health Inequalities Data: Opportunities exist to improve local data collection and analysis and Urgent & Emergency Care / 52-Week Waits: Plans are in place but require full implementation.

Supporting evidence has been compiled and will be submitted alongside the self-assessment.

GS confirmed that the NHS capability assessment is due by 22 October, with flexibility to extend to 31 October if needed. NHS England acknowledges that Board meeting schedules may not align with the short submission window. The Trust's Board meeting timing allows for timely submission, but an extension can be requested if necessary.

The Board is asked to approve the capability assessment submission. It was agreed that Board members may provide further comments via SC or GS within the next week. If substantive feedback arises, the team will reconvene to address it. The working assumption is that the submission is approved unless significant concerns are raised.

The Board approved the Provider Capability Assessment unless significant concerns are raised during the next week.

	ITEMS FOR NOTING AND INFORMATION			
14.	**Trust Infection and Prevention Annual Report**	**LF**	**Discussion**	**Enclosure 8**

The Report consolidates infection prevention activities from the past year, including oversight from the Quality Committee, Trust Infection Prevention Committee, and related Subcommittees. It highlights the multifaceted nature of infection prevention and control, involving multiple stakeholders and supported by strong Policies, practices, and governance.

Performance against NHS standard contract trajectories is included, with detailed improvement plans in Appendix 1.

The Infection Prevention and Control Board Assurance Framework is reviewed quarterly and informs ongoing improvement actions. Most actions are either completed, in progress, or ongoing. Clostridioides difficile infections remain significantly off trajectory, reflecting a national trend. The Trust is actively participating in Regional collaboratives focused on antimicrobial stewardship and prescribing practices.

FM highlighted that the Quality Committee provides regular scrutiny of Infection Prevention Policies and practices, supported by the Trust Infection Prevention Committee and its Subcommittees. The Annual Perinatal Safety Report consolidates assurance across these structures and highlights the complexity and multi-stakeholder nature of infection prevention. FM welcomed efforts to streamline reporting for clarity and focus and acknowledged national concerns around Maternity and Neonatal care reinforcing the Trust's commitment to safety, transparency, and compassionate leadership. Special thanks were extended to LF and SH, the Executive and Non-Executive Safety Champions, for their continued dedication.

The Board accepted the Trust Infection and Prevention Annual Report.

15.	**Trust Annual Objectives 25-26 Mid-year Review**	**AD**	**Information**	**Enclosure 9**

The Report provides a midyear update on progress against this year's annual objectives, following the performance review shared at the recent AGM. Each objective is owned by an Executive lead, and the Report highlights both achievements and areas needing further progress.

Areas of Concern - Urgent & Emergency Care- Performance has deteriorated despite significant efforts, including summer test-of-change initiatives. Neighbourhood Health - While foundational work and partnerships are strong, impact on acute admissions is yet to be seen.

Highlights - Successful adoption of ambient AI technologies, strong delivery of the Transformation Programme, contributing to financial sustainability and productivity and the opening of the Community Diagnostic Centre, a major milestone after years of planning.

The Board accepted the Trust Annual Objectives 25-26 Mid-year Review.

16.	**Perinatal Safety Report (Maternity)**	**JJ**	**Discussion**	**Enclosure 10**

The Report provides assurance on the safety of Maternity and Neonatal Services and compliance with the Perinatal Surveillance Model. A recent update to the Model allows for quarterly reporting, which is recommended and supported by LMNS colleagues. Future Reports will be clearer and more focused, despite reduced frequency, maintaining the same volume of information over time.

Staffing - August saw increased staff redeployment due to higher sickness levels, though all shifts remained safe. Vacancy levels are minimal and Birth Rate Plus funding is in place.

Stillbirth - One stillbirth was reported and will be reviewed via the Perinatal Mortality Review Tool, with outcomes shared at Private Board meetings.

Training - CNST compliance is on track; support is needed to release Anaesthetic staff for training sessions.

Safety Champion Observations - Noted increase in triage referrals for non-pregnancy-related issues and ongoing review of care for higher-risk women in Antenatal Clinics.

The Board accepted the Perinatal Safety Report (Maternity).

17.	**Charity Trustee Report and Minutes 12 June 2025**	**GQ**	**Discussion**	**Enclosure 11**
The Board accepted the Charity Trustee Report and Minutes 12 June 2025.				
18.	**Quality Committee Report and Minutes 31 July 2025**	**IJ**	**Discussion**	**Enclosure 12**
The Quality Committee continues to provide detailed scrutiny across a wide range of issues. Summary Reports and minutes offer a clear picture of the Committee's work and assurance processes. **The Board accepted the Quality Committee Report and Minutes 31 July 2025.**				
19.	**Integrated Care Executive Report**	**FM**	**Discussion**	**Enclosure 13**
The Board accepted the Integrated Care Executive Report.				
20.	**Any Other Business**			
There was no further business to discuss.				
21.	**Questions from Members of the Public**			
There were no questions received from members of the public.				
DATE AND TIME OF THE NEXT MEETING – Thursday 4 December 2025 – 1.00 pm – 2.30 pm				

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

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

Present

Russell Hardy	(RH)	Group Chair
Ravi Basi	(RB)	Interim Chief Finance Officer GEH/SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Chief Clinical Strategy Officer WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer GEH/SWFT
Adam Carson	(AC)	Acting Chief Executive GEH/SWFT
Oliver Cofler	(OC)	NED SWFT
Neil Cook	(NC)	Chief Finance Officer WAHT
Stephen Collman	(SC)	Acting Chief Executive WAHT/WVT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Hayley Flavell	(HF)	Chief Nursing Officer WAHT
Paramjit Gill	(PGi)	Nominated NED SWFT
Sharon Hill	(SH)	NED WVT
Harkamal Heran	(HH)	Chief Operating Officer GEH/SWFT (Non-Voting for GEH)
Colin Horwath	(CH)	NED WAHT
Ian James	(IJ)	NED WVT
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Dame Julie Moore	(JM)	NED WAHT
Simon Murphy	(SMu)	NED and Vice Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED and Vice Chair GEH
Najam Rashid	(NR)	Chief Medical Officer GEH/SWFT
Sarah Shingler	(SS)	Managing Director WVT
David Spraggett	(DS)	NED GEH/SWFT and Vice Chair SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Chief Medical Officer WAHT
Robert White	(RW)	NED SWFT

In attendance:

Leigh Brooks	(LB)	Interim Head of Communications SWFT
Rebecca Brown	(RBr)	Chief Information Officer WAHT
John Burnett	(JB)	Head of Communications WVT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Catherine Driscoll	(CDr)	Associate Non-Executive Director (ANED) WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Chief Strategy Officer GEH/SWFT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT

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

Public Minutes of the Foundation Group Boards Meeting
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In attendance continued:

Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KLa)	ANED WVT
Tom Morgan-Jones	(TMJ)	Deputy Chief Medical Officer WVT (deputising for Chief Medical Officer WVT)
David Mowbray	(DM)	Group Medical Advisor
Alex Moran	(AMo)	ANED WAHT
Andrew Parker	(AP)	Chief Operating Officer WVT
Bharti Patel	(BP)	ANED SWFT
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Vidhya Sumesh	(VS)	Group Business Information Specialist (Observer)
Robin Snead	(RS)	Chief Digital Officer GEH/SWFT
James Turner	(JT)	Head of Communications GEH (present from Minute 25.074)
Ashi Williams	(AW)	Chief People Officer GEH/SWFT
Lesley Writtle	(LW)	Deputy Chair Sandwell and West Birmingham NHS Trust (Observer)

Apologies:

Chizo Agwu	(CA)	Chief Medical Officer WVT
Tony Bramley	(TB)	NED WAHT
Ellie Bulmer	(EB)	ANED WVT
Paul Capener	(PC)	NED GEH
Phil Gilbert	(PG)	NED SWFT
Michelle Lynch	(ML)	NED WAHT
Jackie Richards	(JR)	NED GEH
Sue Sinclair	(SSi)	ANED WAHT
Adrian Stokes	(AS)	Group Strategic Financial Advisor
Umar Zamman	(UZ)	NED GEH

There were five SWFT Governors and two members of public also in attendance.

MINUTE		**ACTION**
25.063	**CHAIRS REMARKS** The Group Chair highlighted the exceptional work that Andrew Wiliams, Portering and Transport Coordinator for WAHT, had been doing to reduce taxi bills at WAHT. The Group Chair thanked the Portering and Transport Coordinator for WAHT, for his leadership and commitment. The Group Chair also took the time to thank the Urgent and Emergency Care (UEC) team at SWFT for their continued hard work despite significant pressures. He explained that Warwick Hospital's Emergency Department (ED) had seen 393 attendees in one day at the end of October 2025, and only five type one (more unwell patients) attendees less then University Hospitals Coventry and Warwickshire NHS Trust (UHCW). For perspective UHCW's ED was over twice the size of Warwick Hospital's ED.	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
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MINUTE		ACTION
	The Group Chair ended by welcoming the Chief Nursing Officer for WAHT, and the Managing Director for WVT to their first Foundation Group Boards meeting in their new roles. **Resolved – that the position be noted.**	
25.064	**DECLARATIONS OF INTEREST** Bharti Patel, ANED SWFT, declared that she had been involved in a commercial consultancy capacity with Corbett Keeling Ltd as a healthcare specialist advisor. She also declared that she been supporting University Hospitals Birmingham NHS Foundation Trust (UHB) and SWFT on Aseptic Services, as well as supporting other NHS Trusts where needed. Bharti Patel, ANED SWFT, declared that her daughter had fully qualified as a General Practitioner (GP) and would be taking up a role within the Coventry and Warwickshire system. Her daughter had also expressed an interest to be involved in research activity to support Warwickshire. **Resolved – that the position be noted.**	
25.065	**PUBLIC MINUTES OF THE MEETING HELD ON 6 AUGUST 2025** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 6 August be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.066	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.066.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.067	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the Foundation Group Boards Workshop. A series of presentations were received including one on the work that the Foundation Group were doing to be at the forefront of working with Veterans and their families. The Group Chair thanked the Chief Information Officer at WAHT for the work she was doing to support veterans, and WVT who were at the heart of a community who were proud to have a military association. The Group Chair explained that a discussion then took place on the Foundation Group's sustainability work, particularly the work on carbon reduction. The Foundation Group Boards Workshop also talked about neighbourhood plans,	

MINUTE		ACTION

which were part of the NHS 10-Year Plan (10YP), to push healthcare closer to home. Each of the Chief Strategy Officers across the Foundation Group were advancing that work, especially in Warwickshire with the desire to become an Integrated Healthcare Organisation (IHO).

The Group Chair concluded that the Group Chief Executive had also provided a presentation on some of the work he had been doing nationally, including on the National Oversight Framework.

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

25.068 **FOUNDATION GROUP PERFORMANCE REPORT**

GEH

The Acting Chief Executive for GEH/SWFT provided a summary of performance at GEH. He informed the Foundation Group Boards that it was pleasing to see sustained improvement in cancer targets, particularly the 52-week performance. He explained that GEH were significantly ahead of trajectory with less than 1% of patients on the waiting list waiting over 52-weeks. The Acting Chief Executive for GEH/SWFT continued that his biggest worry was relating to ED performance, and the 12-hour standard. He explained that the Trust had made good progress with 4-hour waits in ED, however far too many patients continued to wait over 12-hours for a bed. This pointed to a wider issue of flow within the hospital, which was driven by a longer than expected length of stay (LoS) for patients, and the number of patients medically fit for discharge (MFFD). The Acting Chief Executive for GEH/SWFT explained that these two areas were the focus for GEH teams, and for the new joint Executive Team for GEH and SWFT over the coming months. He assured the Foundation Gorup Boards that several areas had already been identified where improvements could be made. The Acting Chief Executive for GEH/SWFT highlighted one of the benefits to the new joint Executive Team for GEH and SWFT was the ability to easily share learnings. For example, LoS and MFFD were two areas that SWFT did well, which would support the improvements needed at GEH.

SWFT

The Acting Chief Executive for GEH/SWFT presented the performance summary for SWFT to the Foundation Group Boards. He explained that ED continued to see a sustained increase over the past five years, around 35%, however it had been particularly challenged during October 2025 with some of the busiest days on record. Despite this it was reassuring to see the Trust's Same Day Emergency Care (SDEC) areas working well and helping manage emergency admissions. The Acting Chief Executive for GEH/SWFT explained that this had meant the Trust had not seen the same level of increases in admissions as it had attendances to ED. However, if demands continued at the current rate, the challenge would be unstainable as the Trust did not have the beds or capacity to manage.

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The Acting Chief Executive for GEH/SWFT also highlighted SWFT's cancer performance and Referral to Treatment (RTT) target. He explained that the Trust had been slightly off track for the last few months, notably the cancer Faster Diagnostic Standard (FDS). However, it was reassuring to see that in October 2025 numbers had improved. The Acting Chief Executive for GEH/SWFT explained that challenges around the FDS and RTT had been driven primarily due to staffing issues in Dermatology, and an increase in referrals. However, these had been improving with extra staffing, resulting in extra capacity. The Acting Chief Executive for GEH/SWFT was confident that by the end of 2025/26 SWFT would have recovered performance against the FDS, however cancer generally remained challenged across the Coventry and Warwickshire (C&W) system. He assured the Foundation Group Boards that discussion was taking place to address these issues with system partners.

The Acting Chief Executive for GEH/SWFT concluded by raising sickness rates as a challenge for both GEH and SWFT. However new absence management policies had been approved during October 2025, which would support managers with managing sickness but also support staff to remain in work.

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

The Group Chair highlighted UEC demand, and that it was frustrating to see the imbalance across the C&W system compared to other Trusts in the area. He continued that SWFT and GEH were being overloaded with demand and West Midlands Ambulance Service (WMAS) activity, whereas other Trusts were seeing declines in their UEC activity. He expressed the need for rebalancing, echoing the Acting Chief Executive for GEH/SWFT's comments that the current activity was unsustainable. The Group Chair also noted MFFD and agreed that this was an area for focus. He explained that NHS England (NHSE) had conducted a piece of work looking at the costs of MFFD patients being stranded in acute settings. For C&W, the number was £48m a year net cost wasted from patients being in an acute bed when they should be at home. The Group Chair explained that SWFT were amongst the very best in terms of MFFD performance. He concluded by thanking the Chief People Officer for WVT and his team for the work they had done on sickness protocols.

The Group Chief Executive noted that one of the issues with UEC demand was due to patient choice but also there was a bigger issue around flow and patients being treated at home where they could be. However, he reassured the public that work was taking place to look at how capacity could be expanded.

<u>WVT</u>
The Managing Director for WVT provided an update on WVTs performance, starting with its finance. She explained that the Trust's financial position was strong, sitting at £1m better than the planned year to date (YTD) position. The Managing Director for WVT expressed that she was 'blown away' by the

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engagement from both the clinical and operational teams in relation to cost improvement. She continued that despite this, the Trust was not being complacent and recognised that the second half of the year would be more challenging. Teams were working hard to support divisions to deliver targets.

The Managing Director for WVT reported that UEC continued to present challenges. Type one attendances had spiked in September 2025 but had started to reduce in October 2025, with the Trust remaining below the national average. WVT was undertaking a review to confirm whether the reduction was genuine and to understand the causes, noting that Primary Care had introduced new initiatives. Early Access Standard (EAS) performance remained challenged, with overall performance at 66.7%, which was 0.7% off trajectory. The gap was closing, and improvements were being made. Non-admitted performance stood at 78%, while admitted performance was significantly lower at 38%, which was identified as a key focus area moving forward. The Chief Operating Officer for WVT and other senior leaders were working with teams to improve 12-hour performance. The Managing Director for WVT explained that ED performance was not at the required level and was 1.4% off trajectory. Ambulance handover delays were reported at 68%. An increase in pathway delays was observed in October 2025, partly due to the loss of a care provider in Herefordshire, which necessitated sourcing several emergency care packages over a one-week period. The Managing Director for WVT highlighted ongoing issues related to Powys patients. These patients accounted for 30% of bed days lost, the highest level since May 2025, and stayed in beds 1.8 days longer than English patients. Work was ongoing with the Group Chief Executive supporting discussions with the national team to address this position.

The Managing Director for WVT concluded with an update on the RTT position. The position for September 2025 was 62.2%, with 42 patients waiting over 65 weeks at the end of the month. Improvements were noted, and the Trust was delivering its plan. For 52-week waits, there were 6,198 cases at the end of September 2025, representing an improvement of 80 cases from the end of August 2025. The unvalidated position was reported at 62.8%.

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

The Group Chief Executive noted that highlighting the delivery of some of the financial improvement targets was important. He explained that, beneath the surface, two key factors were driving this progress. Firstly, undertaking more elective work to reduce waiting times for patients; and secondly, innovation and improvement initiatives. He emphasised that this was not about cutting the cost of services in a negative way, but rather about making them more efficient. He commended the team for their efforts.

<u>WAHT</u>
The Acting Chief Executive for WAHT/WVT updated the Foundation Group Boards on WAHT's performance and noted that similar themes had been

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	picked up, however with a slightly different emphasis in terms of messaging and priorities. He reported that the Trust had performed well in the first half of the year financially but faced a significant challenge in delivering the largest efficiency programme the Trust had ever undertaken. He acknowledged the scale of the task but confirmed that the organisation was committed to achieving it. Two areas of progress were highlighted as part of this. Firstly, job planning, which had historically been a difficult area for the Trust, was now showing improvement. Benchmarking had previously placed the Trust amongst the lowest performers, but it was now achieving around 70%, bringing it back into line with peers. A clear plan was in place, led by the Chief Medical Officer for WAHT and the team, and there was positive engagement from divisional leadership, which was encouraging for the remainder of the year and into the next. The Acting Chief Executive for WAHT/WVT continued that reductions in temporary staffing were being seen. The Trust had previously been one of the highest users at 8%, with a target to reduce this to around 2%. Current usage was between 3–4%, representing a six-month downward trajectory. This progress was balanced with bank work, providing headroom to implement structural changes. The Acting Chief Executive for WAHT/WVT went on to emphasise a cultural shift within the Trust towards simplification, moving away from layering processes and instead focusing on keeping systems straightforward. Linked to this was progress on patient flow, particularly in increasing the number of daytime discharges and reducing length of stay (LoS). This was a major focus within UEC work for November 2025. Plans were in place to standardise the acute medical, frailty, and surgical assessment models for the first time, ensuring consistent timeframes. Work had also been undertaken to reduce bed moves, which were a key indicator of hospital pressure, early results of this were encouraging. The Acting Chief Executive for WAHT/WVT highlighted an increase in demand, particularly ambulance conveyances, which had risen by 11%. This was likely to be due to Worcestershire work previously being managed outside the county. While this created challenges for frontline teams, the Acting Chief Executive for WAHT/WVT stressed the importance of senior leadership taking responsibility and working collaboratively to develop solutions for UEC pathways in Worcestershire, rather than expecting radical changes from other partners. He concluded by reiterating that behind the performance data were real people, and the Trust remained mindful of patient experience. He noted that he and the Chief Nursing Officer for WAHT had met with individuals who had not had positive experiences within the UEC pathway. The Trust was committed to using this feedback as a springboard for improvement while ensuring clinical teams were not overloaded. The Group Chair invited questions and perspectives and of particular note were the following points.	

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	The Group Chief Executive noted the issue of UEC demand profile and the increase in ambulance attendances. He highlighted that, across all Accident and Emergency (A&E) departments in the Foundation Group, there was a clear correlation between patients' home addresses and their proximity to the A&E department in terms of attendance rates. He queried whether alternative primary care pathways could be further encouraged in those areas. The Acting Chief Executive for WAHT/WVT agreed, confirming that analysis had demonstrated proximity to hospital as a significant driver of attendances. He reported that work was ongoing with primary care colleagues, Integrated Care System (ICS) partners, and community teams to identify intervention points to prevent patients from presenting at ED. **Resolved – that the Foundation Group Performance Report be received and noted.**	
25.069	**CANCER PERFORMANCE DEEP DIVE** The Acting Chief Operating Officer for WAHT started the Cancer Performance Deep Dive by emphasising that earlier diagnosis and quicker treatment for cancer patients remained a key priority for the NHS and the Foundation Group. He noted that whilst progress had been made, further improvement was required to meet standards and deliver the best outcomes for patients. The Acting Chief Operating Officer for WAHT outlined the standards against which performance was monitored, and this was as follows: • 28-Day FDS – time from referral with suspected cancer to diagnosis. • 31-Day Standard – time from decision to treat to commencement of treatment. • 62-Day Standard – time from referral to treatment completion. The Acting Chief Operating Officer for WAHT explained that the data presented covered April 2025 to August 2025 and longer-term trends. 28-day FDS performance varied across the Foundation Group, while some organisations were performing well compared to peers, none were meeting the national target of 80%. Areas for improvement included Lower Gastrointestinal (GI) and Lung pathways at GEH, Head and Neck and Skin at SWFT, Urology at WAHT, and Breast at WVT. He explained that collaborative work was underway between WVT and WAHT to improve elements of the Breast pathway and noted that achieving the 28-day FDS was critical to improving 62-day performance. The Acting Chief Operating Officer for WAHT continued that the 31-day Standard target was 96%, and GEH demonstrated strong performance. However, WAHT faced challenges at 83.7%, particularly in Skin, Urology, and Head and Neck. SWFT had opportunities to improve in Gynaecology, and WVT in Breast. He explained that access to tertiary providers remained a challenge for GEH and SWFT, impacting reported performance and patient experience. The Acting Chief Operating Officer for WAHT highlighted that WAHT's skin	

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pathway performance at 60% was unacceptable and assured the Foundation Group Boards and members of the public that a recovery plan was in place.

The Acting Chief Operating Officer for WAHT concluded with the 62-day Standard update, noting that the target was 85% and all organisations needed improvement. Specific areas for development included Lower GI, Upper GI, and Colorectal at GEH; Lung, Neurology, and Head and Neck at SWFT; Breast and Neurology at WAHT; and continued progress at WVT in Lower GI, Lung, Skin, and Urology. Collaborative work was ongoing to share capacity across the Foundation Group, particularly to support WAHT's Urology service. He noted significant variation in monthly performance and reiterated that tertiary referrals were a major factor impacting compliance with the 62-day standard.

The Chief Operating Officer for GEH/SWFT presented further detail into the data presented above and emphasised the importance of transparency in reporting cancer performance across the Foundation Group. She highlighted that GEH and SWFT were facing significant challenges and the result of that had seen GEH be put into Tier 1 under the NHSE performance regime. This involved national oversight for areas of significant concern. This status was due to being off trajectory for both the 28-day FDS and the 62-day Standard. Despite this, there had been an improving picture since June 2025, with backlogs reducing and trajectories being met. The aim was to achieve the 28-day Standard by the end of November 2025 and the 62-day Standard by the end of December 2025. The Chief Operating Officer for GEH/SWFT noted that key delays were linked to Diagnostics capacity, which impacted the entire pathway, and actions to address these issues included escalation plans, waiting list initiatives, and process improvements. The Chief Operating Officer for GEH/SWFT explained that SWFT was currently in Tier 2 but was expected to move to Tier 1 due to continued challenges, primarily driven by unprecedented Skin Cancer demand and consultant sickness in Dermatology. The Trust had proactively escalated its position, recognising the risk, including additional pressures such as out of area demand. The Chief Operating Officer for GEH/SWFT offered assurance that recovery plans were in place, and trajectories for improvement were broadly on track, despite sustained high referral volumes.

The Chief Operating Officer for GEH/SWFT outlined systemic challenges across all four Trusts in the Foundation Group, including workforce shortages, reliance on Bank and Locum staff, recruitment difficulties, and Diagnostics constraints, particularly in Pathology. These issues made achieving the FDS difficult, which in turn impacted the 62-day Standard. Variability in Electronic Patient Record (EPR) systems and cancer dashboards added further complexity, although there was good practice to share, such as the adoption of a robust dashboard model.

The Chief Operating Officer for GEH/SWFT stressed the importance of collaborative learning, noting examples where this had been beneficial such as improvements in CT waiting times, one-stop Gynaecology clinics, and shared

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escalation policies. The Chief Operating Officer for GEH/SWFT also highlighted that observing cancer meetings across Trusts had helped empower Nurse Specialists and informed new joint posts and training modules. She also highlighted the 'Living With and Beyond Cancer' programme, which supported patients from diagnosis through treatment and beyond, as a key priority. While performance metrics were critical, the real impact on patients' lives must remain central. Challenges included completing treatment summaries, stratifying follow-up, and addressing funding constraints.

Finally, the Chief Operating Officer for GEH/SWFT referred to cancer patient survey results, which had informed action plans to improve patient experience. She concluded that workforce sustainability was vital and that ongoing collaboration across the Foundation Group was invaluable in addressing performance and process challenges. It was noted that having an external perspective to observe work, particularly in relation to Cancer Services, was extremely valuable given the national challenges in this area.

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

The Group Chief Executive noted the positive level of sharing across the Foundation Group, particularly the collaboration between Cancer Managers. He highlighted a potential opportunity to implement wider best practice around the Teledermatology pathway, referencing the model developed at WVT. He queried whether the impact on reducing activity in the acute setting had been assessed. The Chief Operating Officer for GEH/SWFT responded that progress at SWFT had only been possible due to support from the Chief Operating Officer for WVT and his team. She explained that implementation at SWFT had been challenging, and the ability to lift and shift established pathways had been critical. She noted that the data for SWFT did not currently demonstrate the same level of referral avoidance seen at WVT, but this was likely due to SWFT being later in implementation and having insufficient data at present. She confirmed that baseline data and learning from WVT had been invaluable and expressed gratitude for their support in establishing the pathway at SWFT.

The Group Medical Advisor observed that some cancer pathways were highly complex and largely manual, involving coordination of Multidisciplinary Teams (MDTs), Magnetic Resonance Imaging (MRIs), patient choice, and consultant availability. He queried whether there was any detailed work underway to provide software support for these pathways, noting that inefficiencies had previously arisen due to factors such as consultant leave or equipment downtime. The Chief Operating Officer for GEH/SWFT confirmed that while some tools were in use, coverage was limited. She acknowledged the significant complexity introduced by patient choice and diagnostic requirements. Examples included the use of 'Be True' for follow-up patients, enabling stratification and risk assessment, but there was no system currently managing the pathway end-to-end. She advised that NHSE was developing a tool aimed at streamlining cancer pathways, and GEH and SWFT had

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expressed interest in participating in a pilot. Progress was constrained by the EPR implementation at both sites, but she agreed that this represented a gap in NHS capability and an area requiring further development.

Robert White, NED SWFT, asked about the national and regional tiering support and whether these interventions were linked to medical workforce planning, including coordination with postgraduate or pipeline planning. He acknowledged that cancer care extended beyond medical posts but queried whether tiering could influence workforce supply. The Acting Chief Operating Officer for WAHT responded that WAHT had previously been in tiering for cancer and remained in Tier 2. He advised that tiering interventions were primarily focused on immediate recovery and returning to plan rather than addressing longer-term workforce planning. While conversations about additional support occurred, they did not typically feed into strategic workforce development. The Group Chief Executive added that NHSE was reviewing the tiering process in two key areas: firstly, ensuring that organisations delivering agreed trajectories were not unnecessarily retained or escalated within tiering; and secondly, improving the value of interventions offered. He noted that meetings often focused on performance data already known to Trusts and stressed the need for interventions to add tangible value, such as connecting organisations to IT solutions. He confirmed that the review was underway.

The Group Chair noted that evidence clearly showed early diagnosis led to better outcomes and asked the Chief Operating Officers what the three key factors were that were delaying early diagnosis and treatment. The Chief Operating Officer for GEH/SWFT explained that diagnostic capacity was a major constraint. There had been a significant increase in imaging demand from both UEC and suspected cancer referrals, and while straight-to-test pathways were being implemented, workforce shortages and limited capital funding for additional scanners remained significant challenges. She noted that initiatives such as FIT testing for Colorectal Cancer had demonstrated the benefits of early diagnosis, but success depended on sufficient diagnostic capacity. She added that early engagement in Primary Care was another critical factor. Analysis at SWFT had shown that some patients presenting via the ED with suspected Urological Cancer had not previously engaged with their GP despite having symptoms, highlighting the need for improved intervention at Primary Care level. Finally, she identified Pathology constraints as a key issue. Delays in Pathology processes significantly impacted the ability to meet the 28-day FDS, as Pathology was essential for confirming diagnosis. Any delay in this stage affected the entire cancer pathway.

The Chief Operating Officer at WVT agreed and noted that WVT faced similar challenges, particularly in Endoscopy capacity, which was a major constraint for meeting the 28-day FDS. He explained that the introduction of Community Diagnostic Centres (CDC) should improve access to Computed Tomography Colonography (CTC) and MRI prostate scans, but Pathology and reporting remained key bottlenecks. The Acting Chief Operating Officer for WAHT explained that there were numerous screening programmes already in place or

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	being launched, such as lung cancer screening and FIT testing. He stressed the need for providers and systems to ensure that adequate resources were available to deliver these programmes effectively. He added that it was equally important for members of the public to access screening when eligible, as this was the point at which cancers could be detected earlier, making treatment quicker and easier. He noted that early detection not only improved patient outcomes but also reduced treatment costs, highlighting the multiple benefits of screening uptake. The Group Chief Executive agreed with the importance of the public health message around screening and added that the challenge for all trusts was to ensure that the increased diagnostic capacity, including the new CDCs, was being fully utilised. He confirmed that the WVT CDC would officially open within the next few weeks and stressed the need to provide direct-to-test access for primary care, avoiding unnecessary consultant referrals. He suggested reviewing whether best practice in straight-to-test pathways was being delivered. The Group Chair concluded the discussion by requesting a deep dive on capacity constraints and the actions being taken to address the issues. He specifically would like a focus on whether these were within the Foundation Group's control or related to system partners such as Pathology Services or tertiary providers. He reiterated the need to focus on the three key areas previously highlighted by the Chief Operating Officer for GEH/SWFT and confirmed that this would be revisited at the March 2026 meeting. He acknowledged the significant effort across the Foundation Group to improve cancer performance. **Resolved – that** **A) The Chief Operating Officers provide a deep dive on Cancer Services in relation to capacity constraints, the actions being taken to address the constraints and delayed diagnosis, and** **B) the Cancer Performance Deep Dive be received and noted.**	**COOs**
25.070	**GENDER PAY GAP ANNUAL UPDATE** The Chief People Officer for GEH/SWFT introduced the Gender Pay Gap Annual Update report, noting that this was a statutory requirement for public sector organisations and formed part of the wider Equality, Diversity and Inclusion (EDI) compliance framework, alongside the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). She confirmed that the report covered 2025 data and highlighted that women comprised 70–80% of the NHS workforce nationally, a pattern reflected within the Foundation Group. Women were disproportionately represented in lower-paid roles, while men were more likely to occupy managerial and higher-paid clinical positions. Work was ongoing to address this imbalance. She also advised that a new mandatory update was expected in 2026–27 to incorporate	

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intersectionality, enabling reporting on gender pay gaps by disability and ethnicity.

The Chief People Officer for WAHT emphasised that the gender pay gap was not an equal pay issue, which would be unlawful, but rather a result of representation across job bands. Nationally set terms and conditions and incremental pay progression also influenced the gap. While progress had been made, it was too slow, and further action was required. She outlined measures within the Foundation Group's control, including promoting flexible working, supporting carers, and enabling career progression. Initiatives such as flexible paternity leave, women's networks, and showcasing positive progression stories were highlighted as key actions. She stressed the importance of reviewing policies continuously and staying ahead of legislative changes to remove barriers and support women's career development.

The Chief People Officer for WVT reinforced that closing the gender pay gap was not solely about numbers but about creating a supportive environment for female employees. He referenced leadership development, mentoring, and coaching programmes, which would be extended across the Foundation Group. He confirmed that female leadership networks had been established and would work closely with Human Resources (HR) and Organisational Development (OD) teams to implement actions identified in the report. He expressed confidence that these measures would address priority areas and ensure best practice was shared across the Foundation Group, positioning organisations as an attractive and compassionate employer of choice.

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

The Group Chief Executive thanked colleagues for the update and raised a concern about the potential unintended consequence of promoting flexibility as a key organisational priority. He questioned whether increased part-time working could negatively impact career progression and role stability and asked whether this issue was being considered by the working groups. The Chief People Officer for WVT confirmed that this was an important point and would be addressed as part of the ongoing work. He noted that data analysis was a key component of the action plan and that the working groups would explore this area further.

The Group Chair sought clarification on the pay quartile data presented in the report, asking whether the figures indicated that 83% of employees in the upper quartile of pay at GEH were female, compared to 67% at WAHT. The Chief People Officer for WVT confirmed that this interpretation was correct. The Group Chair reflected on the progress made in addressing gender inequality over recent decades, noting that the figures demonstrated significant improvement. He emphasised the importance of continuing this journey and extending progress to other areas of equality, including race and disability. He reiterated that the Foundation Group valued talent, competence, hard work,

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	and organisational values above all else and thanked colleagues for the update. **Resolved – that the Gender Pay Gap Annual Update be received and noted.**	
25.071	**PATIENT INITIATED FOLLOW UP (PIFU) AND CLINICAL ENGAGEMENT UDPATE** The Chief Medical Officer for WAHT introduced the update on PIFU explaining that PIFU allowed patients and their carers to arrange follow-up appointments as and when needed, based on symptoms and individual circumstances. This approach applied to both long-term and short-term conditions across a range of specialties and supported patient empowerment, shared decision-making, and a more patient-centred model of care. She explained that from an organisational perspective, PIFU contributed to elective recovery plans and waiting list management, enabling more efficient and timely treatment. The Chief Medical Officer for WAHT noted that the Foundation Group was performing well against the national target of 5% of follow-ups being PIFU, with most trusts achieving this threshold. GEH was slightly below target but had made significant progress and was expected to meet the standard shortly. All Foundation Group Trusts were performing strongly in several specialties, placing them in the upper quartile nationally. She emphasised the importance of clinical engagement and leadership in driving success, noting that specialties with strong clinical leads were achieving the best results. The discussion among Chief Medical Officers had highlighted that some services performing less well in PIFU were also considered fragile, and the Chief Medical Officer for WAHT suggested that a future deep dive into fragile services across the Group could be valuable for the Foundation Group Boards. She concluded by inviting questions and comments on the data provided and a broader discussion around clinical engagement and service resilience. The Group Chair invited questions and perspectives and of particular note were the following points. The Group Chair supported the proposal regarding a deep dive into fragile services and requested it be added to a future Foundation Group Boards agenda. The Group Chief Executive raised a concern about whether patients were being placed on PIFU pathways when they could instead be discharged from secondary care. He asked if there was any correlation between PIFU usage and new-to-follow-up ratios, and whether specialties with high follow-up ratios but low PIFU uptake could be targeted for improvement. The Chief Medical Officer for WVT acknowledged the importance of the question but advised that data was not immediately available and committed to providing feedback. The Chief Medical Officer for GEH/SWFT agreed with the Group Chief Executive's observation and noted that some specialties reported strong discharge rates,	

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	which needed to be considered alongside PIFU performance. He highlighted that GEH's current PIFU performance was 3.5%, significantly lower than other organisations, and identified opportunities for improvement through alignment with SWFT and closer collaboration across the Foundation Group. He also referenced the potential for shifting follow-up care into community settings via neighbourhood care teams and integrated Primary Care-led models. The Deputy Chief Medical Officer for WVT reiterated the need for further data to address the Group Chief Executive's question but confirmed that some areas demonstrated good discharge rates and increasing use of community pathways to reduce secondary care follow-up. The Vice Chair for WVT stressed the importance of taking a broader view, including referral rates and the impact of CDCs in reducing unnecessary referrals. She emphasised the need for consistency across the Foundation Group, adopting best practice where strong examples existed, while recognising individual clinical practice. The Acting Chief Executive for WAHT/WVT added that patient and population engagement was critical when implementing new models such as PIFU. He cautioned against a paternalistic approach and advocated for incorporating patient voice to ensure changes aligned with patient expectations and improved experience. **Resolved – that** **A) a deep dive into fragile services be added to a future Foundation Group Boards agenda;** **B) the Chief Medical Officers look into whether there was any correlation between PIFU rates, new-to-follow up ratios and discharge rates, and** **C) the PIFU and Clinical Engagement update be received and noted.**	**CMOs /CI** **CMOs**
25.072	**FOUNDATION GROUP BOARDS CALENDAR OF MEETINGS FOR 2026/27** **Resolved – that the Foundation Group Boards Calendar of Meetings for 2026/27 be approved and ratified.**	
25.073	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON 18 SEPTEMBER 2025** **Resolved – that the Foundation Group Strategy Committee report from the meeting held on the 18 September 2025 be received and noted.**	
25.074	**ANY OTHER BUSINESS**	
25.074.01	WAHT Staff Car Park	

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	The Group Chair took the time to remind WAHT staff that the Worcestershire County Council car park was available for them to use. **Resolved – that the position be noted.**	
25.075	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
25.075.01	SWFT Public Governor (West Stratford and Borders) The following question was asked by a SWFT Governor (West Stratford and Borders): *'What are we doing with our strategy for developing community estate to accommodate the community pathways that we've talked about today?'* The Acting Chief Executive for GEH/SWFT confirmed that significant investment had been made in the community estate, including developments at Lillington Health Hub, Ellen Badger Hospital, and the Orchard Centre in Rugby. He noted that the greatest challenges were in the north of Warwickshire, where there were shared premises with Coventry and Warwickshire Partnership NHS Trust (CWPT). However, a recent agreement had been made with CWPT to improve some of the worst areas in the next financial year. He advised that national changes to NHS Property Services were expected, which could provide greater flexibility and ownership for future investment. A review of the community estate strategy was planned over the next six to twelve months. **Resolved – that the position be noted.**	
25.076	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.077	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.078	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 6 AUGUST 2025**	
25.079	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.080	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 17 JUNE 2025**	
25.081	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.082	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 4 March 2026 at 1.30pm via Microsoft Teams.	

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

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

Signed _____ (Group Chair) Date: 4 March 2026
Russell Hardy

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

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 5 NOVEMBER 2025

AGENDA ITEM	ACTION	DUE DATE	LEAD	COMMENT
ACTIONS COMPLETE				
ACTIONS IN PROGRESS				
25.069 (05.11.2025) Cancer Performance Deep Dive	The Chief Operating Officers provide a deep dive on cancer services in relation to capacity constraints, the actions being taken to address the constraints and delayed diagnosis.	March 2026	H Heran / C Douglas / A Parker	
25.071 (05.11.2025) Patient Initiated Follow Up (PIFU) and Clinical Engagement Update	A deep dive into fragile services from the Chief Medical Officers be added to a future Foundation Group Boards agenda. The Chief Medical Officers look into whether there was any correlation between PIFU rates, new-to-follow up ratios and discharge rates.	March 2026 March 2026	N Rashid / J Walton / C Agwu / C Ireland N Rashid / J Walton / C Agwu	
REPORTS SCHEDULED FOR FUTURE MEETINGS				
25.050 (06.08.2025) Equality Update Report	The Chief People Officers include impact data in the annual Equality, Diversity and Inclusion (EDI) report moving forward.	August 2026	A Williams / A Koeltgen / G Etule	An update will be included in the Equality Update Report scheduled for Foundation Group Boards in August 2026.

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

Public Board Reporting Action Log 2025/26							
Month	**Ref.**	**Item**	**Action**	**Lead**	**Due date**	**Status**	**Update**
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	**Closed**	Medium term planning timescales were presented to the Finance & Performance Executive, and we now have set timelines for taking through Board approval. The Chief Strategy and Planning Officer will be taking our objectives through Board in the new year, following the plan submission. Therefore, the action has been superseded.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Chief Executives Update Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Stephen Collman, Chief Executive
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. Medium term Planning Framework

The national Medium Term Planning Framework was published at the end of October and its implications for the framework signals a fundamental shift in how the NHS is expected to plan, finance and deliver care, moving from short-term annual cycles to three time periods.

It sets out both the operational standards we must achieve and the structural reforms we are required to implement. The expectations of the Board will be to provide assurance that our response is credible, deliverable and aligned to both national expectations and local need.

The aim is to move away from centralised, directive control towards a model where local organisations are expected to lead change, but with much tighter accountability for delivery and financial discipline.

The framework has three core intentions:

- Stabilise access and performance while redesigning services for long-term sustainability.
- Shift care closer to people's homes through neighbourhood-based models.
- Introduce a more transparent and disciplined financial regime based on productivity and value.

Planning and governance, we are now required to produce:

- 3-year numerical plans covering finance, workforce and operational performance.
- 5-year strategic narrative plans setting out how we will transform services.
- Board assurance statements confirming plans are robust, risk assessed and deliverable.

[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.

The Performance expectations are by 2028/29 the NHS is expected to achieve:

• 92% of patients treated within 18 weeks.
• A&E performance of 85% within four hours.
• Diagnostics waits over six weeks reduced to 1%.
• Sustained delivery of cancer standards.

Financial regime and productivity, the Financial Model is being reset. Core requirements include:

• Delivery of at least 2% productivity improvement each year.
• Balanced or surplus financial position across the planning period.
• Exit from reliance on deficit support funding.
• Replacement of block contracts with new payment and incentive models.

Service transformation, the framework requires deep structural change, including:

• Moving Outpatient care to digital-first, patient-led models.
• Reducing low-value and unnecessary follow-up appointments.
• Expanding neighbourhood health services to reduce hospital dependency.
• Greater use of Advice and Guidance and direct access to diagnostics.
• Full adoption of digital platforms and electronic patient records.

2. One Herefordshire

As a designated Wave 1 site for the National Neighbourhood Health Implementation Programme (NNHIP), Herefordshire has contributed early feedback to DHSC on national Neighbourhood Health Framework proposals. The National Neighbourhood Health Framework is expected shortly and will introduce new requirements for Health and Wellbeing Boards to produce an Interim Strategic Neighbourhood Health Plan by April 2026, supported by an interim Operational Plan by September 2026. A review of Health Wellbeing Board membership, to align with the new Framework, has been initiated and a proposed approach has been submitted for approval by the Wye Valley Associate Director of Neighbourhood Health, and Herefordshire Council's Director of Public Health.

Following a recent One Herefordshire Partnership reset workshop, a refreshed governance model for the One Herefordshire Partnership is being developed to ensure the right oversight for Wye Valley Trust to become the lead provider and to establish shadow Integrated Health Organisation (IHO) arrangements, Better Care Fund reform, and delivery of the national and local neighbourhood health agenda.

The design and implementation of Integrated Neighbourhood Teams, and the wider elements of Neighbourhood Health and NNHIP delivery continues to progress well. Primary Care Networks (PCNs) have developed phase-one MDT plans for the initial target cohort (4+ LTCs and ≥1 admission), with operationalisation from January and one PCN aiming to implement a full Integrated Neighbourhood Team in the same timeframe. Relationship-building across partners has strengthened significantly, including emerging VCFSE "community anchor" arrangements.

A cross-system workshop on 25 November 2025 successfully translated aspirations into commitments and delivery actions, now being consolidated into an interim plan.

We have written to the National Programme Director, Minal Bakhai, offering to test new funding-flow models. Minal will visit Herefordshire on 11 December, including the Community Response Hub, St Michael's Hospice and the Community Diagnostics Centre. The visit is an opportunity to secure national backing for our digital hub ambitions (modelled on Washwood Heath), testing of shadow IHO and multi-neighbourhood provider models, and seed funding to strengthen VCFSE community capacity.

3. Integrated Care Division Update

Quarter 2 saw the Integrated Care Division focused on supporting the national Neighbourhood Health programme.

Our involvement in the programme is critical to ensure the Trusts delivery of the 10-year plan with focus on the shift from acute to community.

Continued enhancement of our Single Point of Access has seen a new pathway commenced rediverting 111 referrals away from the Emergency Department to CRH. A weekly review of activity and outcomes is in the plan.

Q3 will see us focus on moving unplanned District Nurse referrals to Urgent Community Response - this will enable our District Nurse teams to focus on the delivery of core service and support unplanned activity to be integrated with the wider urgent response.

Following a review of Virtual Ward, we have had agreement to reconfigure the beds to increase Frailty beds, to support both step up and step-down patients. A short-term winter plan, led by our Frailty team has been agreed, and ICD will support this new pathway within existing teams. The longer-term model, which will see the introduction of community geriatricians, is being led by the Medical Division, with ICD support.

Our ICB has commenced a plan to standardise community health services, providing much needed and long-awaited service specifications for several of our community services.

ICD are supporting the review of our system Discharge to Assess model, with a strategic and operational review in progress.

The Division are seeing shorter waits for several of our services following significant productivity focus, particularly for our CYP therapy services. Q3 will see a review of our SALT Autism pathway which is receiving a significant increase in referrals from the Community Paediatric team. The Division are committed to delivering our services within the current cost envelope but recognise that this area may require additional investment to meet the demand.

4. GEMs Board December 2025

Team of the Quarter – Quarter 2 – Lugg Ward

They have been closely involved in the care of a patient with highly complex psychological and medical needs that are not easy to meet. This is an individual who has experienced abuse throughout their childhood, consistently been met with rejection and abandonment and who has recently lost the only consistent positive figure in their life. The Lugg Ward team, but of special note, Poppy, Catherine and Kathy, have shown exceptional levels of compassion towards this highly vulnerable and isolated individual.

Their willingness to look beyond the surface and take the time to understand the complexities of the individual has made a significant impact on the patient's progress. They have spent time understanding the legal and ethical intricacies of the case as well as considering the individuals history and psychological aspects to their presentation. All of this takes place in the busy Ward environment where it would be easy to simply be "too busy" to take the time to help progress someone's care.

Poppy consistently takes this approach towards patients on Lugg Ward who have a psychiatric aspect to their treatment and jointly managing cases together is a pleasure because of this. Kathy is always keen to understand how she can support the Ward team to meet the needs of these complex patient groups and looks to support the ward team with the focus always being on the needs of the individual. Dr Catherine Bentley-Price has been instrumental in the amazing progress that has been achieved in this case. The care has been highly challenging to provide and despite this; exemplary care has been provided.

Employee of the Quarter – Quarter 2 – Marrena Taylor-Johns

When Neonatal Junior Sister, Marrena Taylor-Johns, quietly retired from nursing in 2016 to care for her terminally ill husband, she believed her career was over for good. But a global pandemic 4 years later saw her not only volunteering as a vaccinator, but back on SCBU once again, filling in for nurses who had been seconded to adult ITU. And she never left! Re-validating again this month, just 5 months before her 70th birthday, Marrena continues to bring all her experience, wisdom and heart to the Unit.

She looks after babies, families and the team alike, with all her energy and spirit. She is an inspiration for lifelong learning as she researches anything she doesn't understand, champions evidence-based changes, is constantly learning new languages and sharing her attempts with any surprised and grateful non-English speaking families on SCBU and is a better tech wizard than most of our Gen Z's! She supports students, junior members of the team, and Band 6 in-charge nurses, both young and old(er!!), benefit from her insights and wisdom.

Her deep empathy, sense of humour and indefatigable team ethic carry all of us through the long days, which Marrena still works several of each week, filling in on the roster wherever she is needed. She is a precious friend to all, who never forgets a birthday or an anniversary. Her personal challenges never affect the care she gives or the positive attitude she chooses to embrace, and she is often heard singing on the Unit!

If anyone ever deserved a Going the Extra Mile award, it's Marrena. She truly is wonderful, and the Unit would just not be the same without her.

Integrated Performance Report

October 2025

Managing Director – Executive Summary

Sarah Shingler
Managing Director

Despite operational and financial challenges, the Trust continues to demonstrate a strong commitment to quality, patient safety, and performance recovery. Strategic initiatives in urgent care, elective pathways, diagnostics, workforce, and financial sustainability are progressing. Continued focus on winter resilience, efficiency delivery, and workforce stability will be critical to achieving our objectives for 2025/26.
A big thank you to all our staff and system partners who supported this latest period of Industrial Action.

Quality & Safety
- Mortality indicators remain above expected levels (SHMI 114.3), driven by coding backlog and case mix complexity. Targeted thematic audits (e.g., heart failure) and pathway reviews are underway.
- Improvements in time-critical medication compliance for Parkinson's and epilepsy patients; self-administration initiatives progressing.
- Emergency Department Safety Champions embedded to strengthen "floor-to-board" engagement and mitigate corridor care risks.
- NHSE cleanliness inspection outcome positive: Trust moved from enhanced to routine monitoring.

Operational Performance
Urgent & Emergency Care:
- October ED attendances: 6,245 Type 1 patients; 4-hour EAS performance at 66.7%.
- 11.9% of patients experienced >12-hour stays; ambulance handover delays remain high (28% >1hr).
- Expansion of Same Day Emergency Care (SDEC) and Community Integrated Referral Hub progressing to reduce admissions and improve flow.

Elective & RTT:
- RTT performance: 63.5% (England), 67.7% (Wales); significant reduction in >52-week waits (653 patients, down ~100 from September).
- Theatre utilisation stable at ~81.5%; targeted improvement plans in Plastic and Podiatric Surgery.

Cancer:
- Faster Diagnosis Standard achieved (84.2%); 62-day treatment standard at 72.3%, impacted by surgical delays. Recovery plans in place with additional sessions and diagnostic capacity.

Diagnostics:
- 6-week wait compliance improved to 96%; Community Diagnostic Centre operational with workforce recruitment at 85%.
- Echocardiogram backlog reduced from 900 to 180 patients since August.

Workforce
- Sickness absence reduced to 4.7% (from 5.3% last year); flu vaccination uptake at 40% of staff.
- Turnover stable at 8.2%, though Band 2/3 HCSW turnover remains high (18.8%). Recruitment campaigns and retention initiatives ongoing.
- Mandatory training compliance at 89.7%; appraisals at 76.5%.
- AI implementation roadmap developed for administrative efficiency; consultation concluded with phased rollout by March 2026.

Finance
Income & Expenditure:
- Month 7 YTD deficit £2.7m, favourable to plan by £0.7m.
- CPIP delivery ahead of plan (£12.2m vs £11.2m), though recurrent savings lag behind target.

Agency Spend:
- Agency costs at 3.47% of pay (close to 3.2% national target); nursing agency spend reduced significantly; zero HCSW agency shifts since June.

Cash & Capital:
- Cash balances slightly above plan; capital expenditure behind schedule due to slippage on grant-funded schemes.
- Medium-term planning underway following national guidance release.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

NHSE Cleanliness Inspection

Board have been fully briefed in previous meetings of the outcome of the NHSE led infection prevention and cleanliness inspection which took place in September – the Trust were progressed from enhanced monitoring to routine monitoring given the improvements noted since the previous inspection earlier in the year.

A follow up meeting to maintain oversight of progress of maintenance, estates and life cycle work has been arranged for the 8th December and a follow up sustainability inspection is anticipated in Spring 2026.

The full outcome letter has been shared with the Trust Infection Prevention Committee, Quality Committee and with Board members.

Flu Campaign 2025 - staff

The staff flu campaign launched on 1st October and we have vaccinated over 40% of our workforce (1920 vaccinations), this places us in 7th place in the region with regional performance ranging from 20-49%. In 2024 we achieved only 29% of our workforce and are aiming for a minimum of 50% this year.

Flu campaign 2025 – eligible patients

This is the first year we have been required to vaccinate inpatients who meet the joint vaccination committee eligibility criteria, particularly focussing on patients with a long length of stay or whom are resident in residential/nursing home settings and who are likely to miss out on access to primary care vaccination. This has been a complex piece of work given the requirement to navigate a number of IT systems. We were able to commence vaccination for patients in mid-October. So far this year we have vaccinated 36 patients with the vast majority of these taking place at our community hospital sites.

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Quality & Safety Performance – Mortality

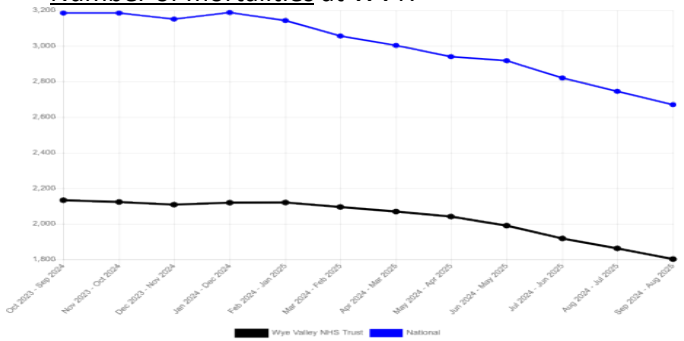
We are driving this measure because:

Mortality continues to report at 'higher than expected' levels for key national indicators, including SHMI.

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)	May-25	112.3	2.2
SHMI (HES based)	Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)	Jul-25	114.3	3.1
SHMI (in hospital)			111.3	4.2
SHMI (out-of-hospital SHMI)			120.7	0.51

Number of mortalities at WVT:



CCS Group/Origin of Alert	Data month	SHMI	Expected Deaths	Actual Deaths	SHMI Change
Chronic Obstructive Pulmonary Disease	Jul-25	102.79	28.21	29	0.79
Congestive Heart Failure		114.26	48.14	55	-3.69
Fractured Neck of Femur		160.34	29.31	47	13.04
Pneumonia		112.40	131.67	148	3.85
Septicemia		110.64	84.05	93	4.18
Stroke (Acute Cerebrovascular Disease)		102.18	74.38	76	4.43

Monthly Headlines

- The latest 12 month rolling **SHMI** (*HES Based*) from August 2024 to July 2025 shows Wye Valley NHS Trust at **114.3**. NHS England SHMI, which is for the period of June 2024 to May 2025, shows a small increase of 0.2 to **112.3.**
- **Crude mortality** rate for October 2025 was **1.40%** for all admissions, which equates to 73 deaths. In addition, there were 14 deaths in the Emergency Department, which has started to show a rise as we enter the winter months.
- **#NOF** – Latest 12 month rolling SHMI has seen a significant increase to 160. On reviewing the underlying data, there are two key drivers behind the most recent rise. Firstly, there is a large portion of un-coded patients which have subsequently reduced the number of expected deaths over this period, and secondly, there has been a rise in the number of deaths reported in comparison to an average month. These two factors have resulted in a significant increase in the SHMI.
- **Heart Failure –** The latest data has reported a sizeable reduction in the rolling 12-month SHMI to 114. During December, we are planning on commencing the thematic audit of heart failure deaths, which aims to highlight any concerns with the current clinical pathway. Feedback and findings will be reported through the Learning from Deaths committee.
- **Pneumonia** – The latest data has reported a small rise in the 12-month rolling SHMI to 112. On review of the data, the number of provider spells in the latest months (*June and July 2025*) has reduced to almost a third of the normal levels, which has resulted in a much lower number of expected deaths for this period. This combined with an average number of deaths has led to a small rise in the SHMI. In comparison, to this time last year, we are reporting over 50 less actual deaths for Pneumonia.
- **Sepsis** – During October, there were several workshops held to review the current front-door pathway for Sepsis, using previous real examples to highlight potential areas for concern. A core group for improving the Sepsis pathway has been identified, regular meetings are now in place including a Terms of Reference with the aim to address the issues and develop a robust pathway for these patients. Updates on the progress will be provided through the Learning from Deaths Committee.
- **Stroke** – Latest SHMI data has indicated a small rise to 102, which remains within 'as expected' ranges. At this months LfD Committee, it was highlighted that there has been a notable improvement in our mortality numbers from May to September 2025 compared with the period from January to April 2025. There are currently several QI projects on-going to the stroke pathway, including the set-up of pre-hospital video calls with the ambulance service and a new radiology communication pathway. These aim to get the right patient to the stroke ward in a timely fashion.
- **Clinical Coding** – As per the previous reports, there is a significant amount of work on-going within the department to ensure the large backlog of un-coded patient episodes are coded and re-submitted as part of the SHMI dataset.
    - 4x additional contract Coders are in place to support with the backlog.
    - Prioritised coding with the SHMI cut-off's.
    - Thematic review and learning – IQVIA to present and feedback their findings from set cohorts of patients.
- **SJR Training** session has been set up for 22nd January 2026 to ensure new mortality leads and engaged clinicians are trained to conduct SJR's. There will be adverts going out to staff in the coming weeks, which will have all the details.
- At the latest LfD Committee (November), there were presentation by the Trauma & Orthopaedics and Stroke departments on their latest reviews, learning and any actions taken.

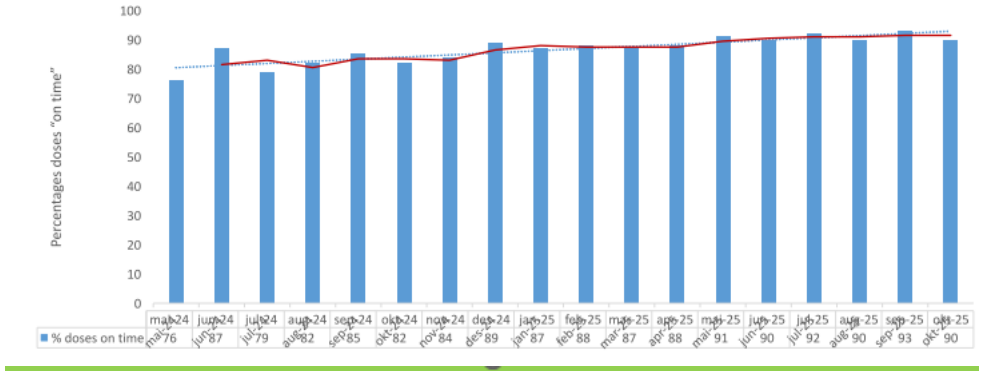
Quality & Safety Performance – Quality Priority Update – Time Critical Medications and Self Administration

Quality Priority Objectives:

To focus on ensuring time critical medications are delivered on time with an ongoing focus on Parkinsons medications and the addition of epilepsy medication since April this year. Empower patients and enable staff to encourage patient self administration where safe and appropriate to do so.

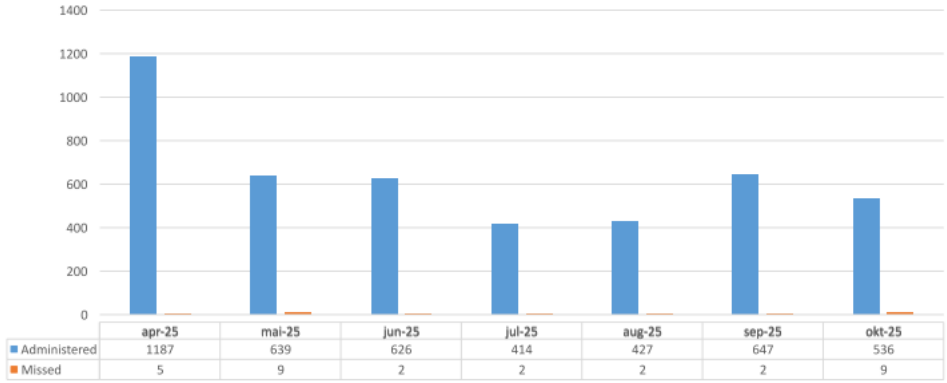
Latest data on missed doses

Overall % of Parkinsons Medications "on time every time"



The data shows that there is an increase in compliance with Parkinson's medication being given on time.

Epilepsy medications from April 2025



The Epilepsy medications data shows that the proportion of missed doses are small. A deep dive into this showed a lack of follow up when medicines were unavailable or patients refused medications. Learning is being shared with the wards for awareness.

Progress with self administration

- Audit of self administration and the EPMA system – 10 wards
- EPMA upgrade to include self administration option on the system
- Further training needs identified for staff in the policy and use of the system
- Review and update the self administration policy

Summary: Plan of Action

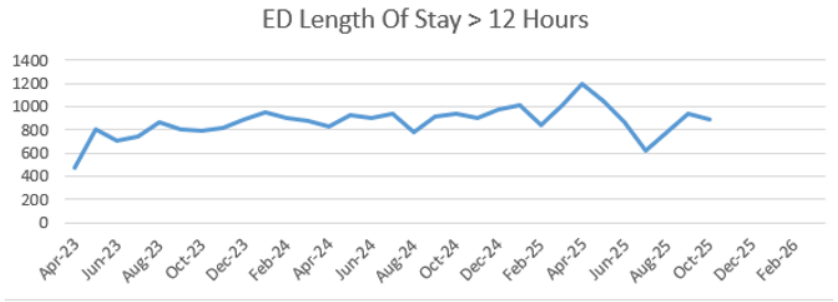
- Maintain data capture for Parkinson's and epilepsy medications
- Maintain links with and participation in the National Parkinson's Excellence network and national audit
- Introduce pink/red bags for delivery of critical medications to wards and departments

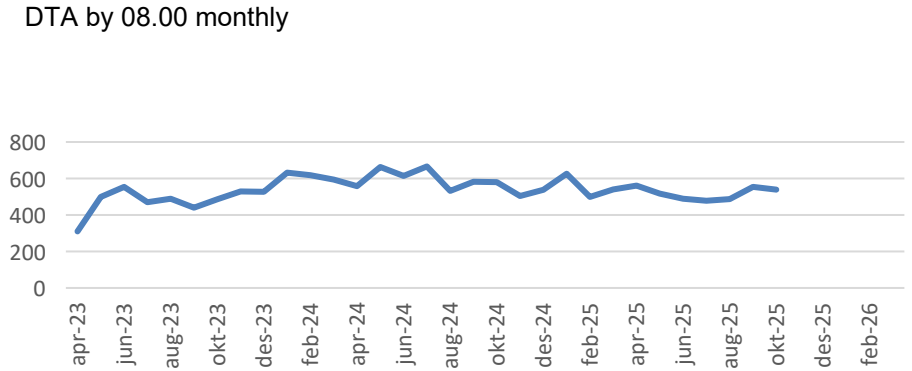
Quality & Safety Performance – Introduction of Emergency Department Safety Champions

We are driving this measure because:

The Emergency department is under significant pressure with many patients experiencing an increased length of stay and delays waiting for a bed

The evidence – the data





These graphs show the number of patients by month who have a length of stay greater than 12 hours in the emergency department and the average monthly number of patients who are waiting for a bed at 8.00 am

We have built on the success of patient safety champions in maternity

We have a number of safety champions including resident doctors, health care support workers, junior and senior nursing staff, consultants, reception and administrative staff

The engagement:

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

Safety champion update

The concept of safety champions in the Emergency department was agreed in June. We meet with safety champion representatives every 6 weeks and undertake safety visits to the department every month. The most recent visit and meeting focussed on:

- Corridor care and reducing/eliminating the use of the external corridor
- Safety within the “fit to sit area”
- Agreement to review escalation policy and priority order for escalation
- Consistency of practice and decision making with clinical site management team and operational response
- Use of Same Day Care Assessment space overnight for consideration – not yet agreed
- Review of navigation from the emergency department and optimising alternative pathways of care

Quality & Safety Performance – Staffing - October Data

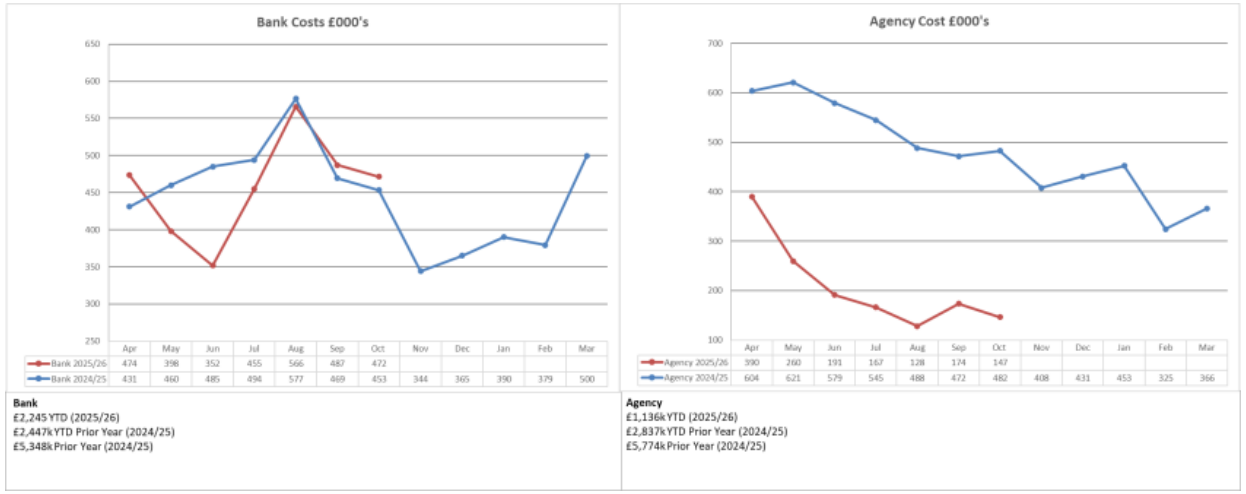
Fill Rate & CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Ac CHPPD
Primrose Unit	86%	90%	102%	108%	10.5
Maternity Ward	93%	81%	97%	94%	5.3
Children's Ward	122%	123%	124%	99%	21.0
Lugg Ward	124%	72%	103%	103%	6.1
Wye Ward	114%	82%	122%	105%	7.2
Cardiac Care Unit	99%	100%	100%	97%	11.8
Leominster Community Hospital	154%	73%	113%	105%	6.6
Bromyard Community Hospital	122%	75%	103%	98%	6.4
Ross Community Hospital	101%	103%	150%	106%	6.2
Teme Ward	139%	60%	97%	73%	11.9
Redbrook Ward	97%	96%	94%	122%	7.4
Special Baby Care Unit	113%	-	105%	-	21.8
Intensive Care Unit	126%	-	130%	-	30.8
Gilwern Ward	101%	126%	100%	102%	6.5
Acute Medical Unit	126%	91%	101%	117%	7.6
Ashgrove Ward	127%	81%	117%	117%	7.2
Dinmore Ward	127%	82%	104%	107%	7.4
Garway Ward	134%	90%	111%	132%	7.4
Frome Ward	120%	82%	101%	121%	6.8
Arrow Ward	148%	74%	153%	96%	8.1
Women's Health	103%	76%	100%	-	9.6

The areas with fill rates above/below 100% are for the following reasons:

- Paediatric Ward – Additional RN's and HCA required to support ED, and patients needing enhanced care - RMN support
- Frome, Dinmore, Garway and Ashgrove Wards – Boarding patients
- AMU, Lugg, Redbrook, Gilwern Ward – Due to patient acuity and dependency, additional staff needed to support individual care needs, including RMN support
- Wye Ward, Frome Ward, Teme Ward, - Due to Band 5 backfill for band 4 posts
- Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV)
- Leominster and Ross Community Hospitals – alignment of roster required
- Bromyard – Due to additional beds
- Teme staffing reduced given reduced capacity on the ward
- Other areas of low fill did not represent a safety issue and were appropriately mitigated

Bank & Agency



- The Trust continues to be part of the collaborative working with the NHSE Regional Team
- We have a cost productivity (CPIP) target of £4.4 million
- For CPIP delivery we have a favourable variance of £1.263K YTD
- 100% of all shifts are NHSE price cap compliant
- The increase in bank is partly to offset agency and partly due to operational pressures in month 7 with additional escalation beds, escalation areas and boarding patients compared to the prior month
- 2 off framework shifts were required to maintain patient safety
- Zero health care support worker agency shifts used in month 7 and none used since June.
- The trust is compliant with the NHSE requirement to eliminate all agency HCSW shifts across the NHS by end of January

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

Maintaining our focus on Urgent and Emergency Care (UEC), as the winter period is about to start, remains a key priority across our clinical and operational team, along with working with system partners, as we head into December.

More immediately over recent week our teams have also had to manage maintaining safe services, continuing our elective activity and reviewed business continuity plans for rosters over the recent period of 5 days of Resident Doctors Industrial Action in November. The efforts, flexibility and commitment of our teams, along with robust preparedness planning, resulted in a successful outcome in maintain our UEC and a majority of our Elective activity during this time. It is unfortunate that a total of c80 outpatients and endoscopy procedures were postponed. due to redeploying medical staff to critical clinical inpatient duties, and to those patients effected I offer my sincere apologies.

A big thank you to all our staff and system partners who supported this latest period of Industrial Action.

Our winter and UEC plan continues to focus on delivering:

- Admissions Avoidance through developing our Community Integrated Referral Hub (CIRH) into a fully developed Single Point of Access for the Health across Herefordshire. Including expansion of our Virtual Wards with dedicated Geriatric Senior support and care coordination of potential secondary care admissions.
- Improving our non-admitted 4-hour Emergency Access standard through increased “streaming” to the right pathways and developing our Same Day Emergency Care (SDEC) model ahead of completion of the new SDEC estate in late February 2026. This is including maximising the clinical criteria for SDEC to ensure we can navigate as many patients as possible away from ED, and ensuring that externally CIRH, Primary Care and Ambulance colleagues can admit direct to all our SDECs.
- Improving our admitted 4-hour Emergency Access Standard through embedding Criteria to Admit across the acute floor, implementing Criteria Led Discharge, which has been implemented across our frailty wards, and ensure we have “live” patient flow data through the roll out of our Electronic Patient Record White Boards to support and embed digitisation of clinical site management and optimise patient flow efficiencies.
- Reducing Discharge delays with System partners. Including in Herefordshire, reducing overstayers on Pathway 1 for Home First, reducing length of stay in bedded Discharge to Access (D2A) bedded pathways by utilising escalation beds in our Community Hospitals in a more structured way to improve flow. Whilst in Powys we are implementing how our Frailty team can refer patients directly from our Frailty SDEC to ring fenced Community Hospital beds and improve SDEC pathways by referring patients directly to community services via Powys`s Single Point of Access.

All this work in now supported by the Getting It Right First Time (GIRFT) team who are on site working with our teams on missed opportunity audits, pathway reviews, demand and capacity modelling and provide recommendations into UEC workgroups and schemes across Quarter 3 and 4.

All this work is focused on a ensuring we can manage the oncoming winter, make substantive changes to our UEC pathway for patients and reduce our overall bed occupancy and continue high use of escalation beds, temporary escalation spaces and continue to protect our elective pathways.

In other Operational areas our Referral to Treatment (RTT) activity is on plan whilst our RTT performance continue to improved since the start of the year and benchmarks as one of the most improved in the Midlands Region. Although we have a small number of patients waiting greater than 65 weeks the overall volume of patients waiting greater than 52 weeks has made significant reduction over the last period and confidence remains high that only 1% of our patients will be waiting greater than 52 weeks by the end of March 2026.

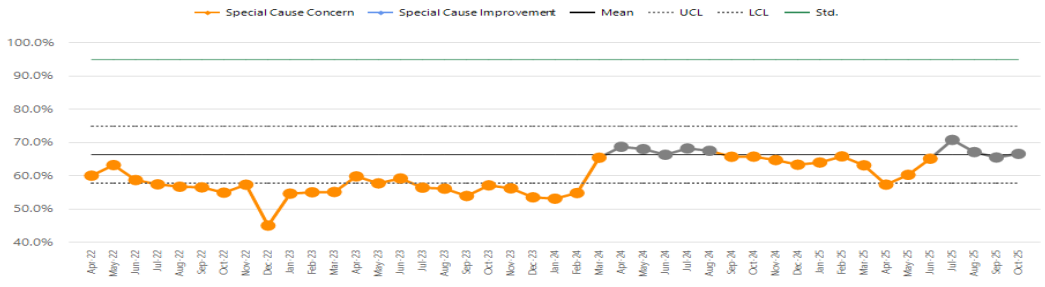
Pleasingly, our Diagnostic 6 weeks performance has also recovered over the last reporting period driven by the new Community Diagnostic Centre, improvements in Endoscopy, with the increased capacity at our Ross-on-Wye Community Hospital, and reducing the number of Echocardiogram patients waiting greater than 6 weeks from almost 900 patients waiting in August to 180 at the end of October.

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

We are driving this measure because:

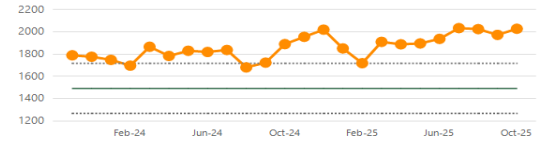
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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

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



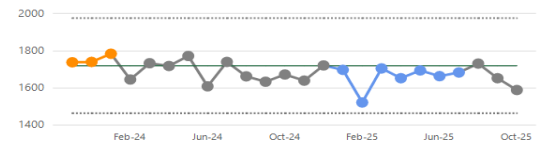
% Patients Spending More Than 12 Hours In ED

Emergency Admissions



% Admissions on Same Day Emergency Care (SDEC) Pathway

Ambulance Conveyances



Risks

- Sustained pressure in Type 1 ED attendances and continued challenges with demand and high acuity with fluctuating high levels of attendances and Ambulance conveyances. Along with increase >0 Length of Stay emergency admissions
- System patient flow constraints. Including delayed discharges for patients no longer requiring acute or community hospital care.

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
- October's 4 hour Emergency Access Standard [EAS] Performance was 66.7%.

Performance & actions

- 6,245 Type 1 patients attended ED in October which 166 more than the previous month. The range of all attendances varied from 168 to 266 with 201 being the average daily attendances.
- 1,588 ambulances conveyed to the Trust in month which was 64 fewer than last month. The range in month was 39 to 67. This includes 11.3% from Powys [179].
- Ambulance handover delays over 1hr were 28.1% [400] of all conveyances with 34.4% [489] waiting over 45 minutes and 53% [754] having a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,312 of all admissions [47.1% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 75 / 122 Type 1 Trust in England for October.
- 11.9% [828] of patients spent 12 or more hours in ED which was marginal reduction against last month.
- Key actions being taken to recovery our 4hr EAS :

➢ 111 ED dispositions to Community Integrated Referral Hub in November

➢ Rollout and standardisation of Electronic Patient Record ward whiteboards, including Criteria to Reside principles, to support and embed digitisation of clinical site management and optimise patient flow efficiencies.

➢ Consultant community Geriatrician role to support admissions avoidance and Frailty led Virtual Ward within our Community Integrated Referral Hub, to be implemented from 1st December

➢ Criteria Led Discharge on three ward frailty block in place with plans to roll out across all medical wards

➢ UEC Capital investment to expand the capacity of our SDEC areas by March 2026. Ongoing work with Operational and Clinical teams to refine criteria and working practices

➢ Getting it Right First Time [GIRFT] support to audits, reviews, demand and capacity modeling, pathways and provide recommendations into UEC workgroups and schemes across Quarter 3 and 4.

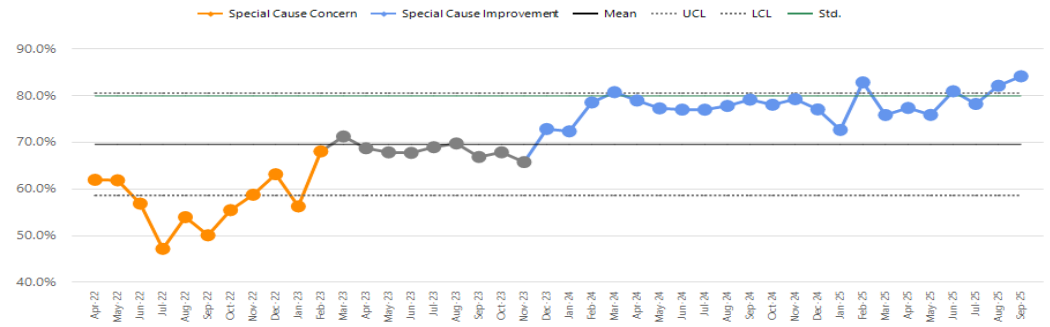
Operational Performance – Cancer Performance [September 25]

We are driving this measure because:

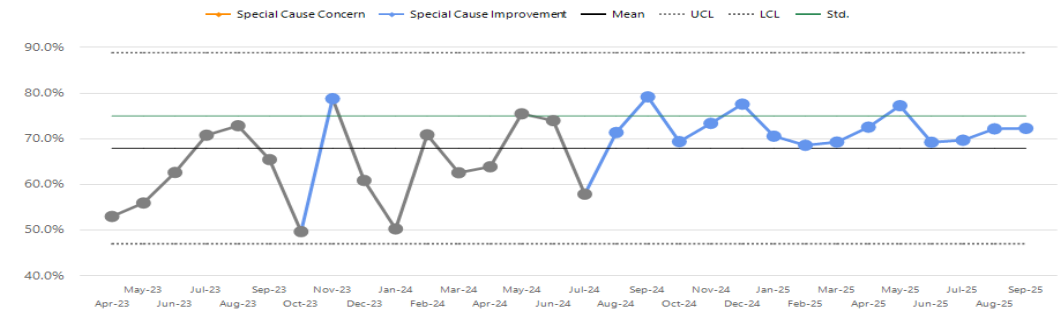
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or 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 September 2025, urgent suspected cancer referrals have risen by 20% compared to the same period two years ago. Referrals for Skin and Urology have seen significant increases of 68% and 45%, over the same time period. Cancer Navigators are currently finalising an audit of referrals from primary care to understand the increases we are seeing We plan to share the findings at the WVT Cancer Board and with primary care colleagues.

Cancer Performance:
In September 2025, the Trust met the Faster Diagnosis Standard (FDS), achieving a performance rate of 84%, which exceeded the trust trajectories target of 79.4%. We have seen six specialities achieving higher than the target, Head and Neck (H+N) at 92.5%, Skin 98.7%, Lower Gastrointestinal (GI) 76.5%, Lung 83.3%, Sarcoma 100% and Breast at 85.7%. Gynaecology did not meet the FDS target, achieving 71.6%. However, this represents an improvement of 21.6% compared to August. Operational and clinical teams continue to meet bi-weekly to progress the Gynaecology cancer action plans, which have already demonstrated positive impacts on performance.

We did not meet compliance for the 31-day (81.5%) and 62-day (72%) cancer treatment standards in September. The main contributing factors were surgical delays. To address delays in surgical specialties, additional clinical sessions have been scheduled for Breast, and further funding has been secured through the West Midlands Cancer Alliance (WMCA) to support waiting list initiatives in Gynaecology. We anticipate that this will lead to performance improvements in the coming months. In Urology, delays have continue to be driven by extended turnaround times for Magnetic resonance imaging (MRI) prostate diagnostics, the community diagnostic centre opened at the end of September where we expect to see a 48 hour turnaround for these scans by the end of the year.

Developments updates
- A new Patient Tracking List format has been implemented weekly with the operational trams which has improved visibility of performance against trajectory, with clearly defined timelines for action completion
- Best practice timed pathway dashboards are now live and all demos have been given to operational and clinical teams
- Cancer data analyst (WMCA funded) currently out to advert with the aim to improve cancer data visibility and dashboards
- Enhanced deep dives being undertaken on 31 day and 62 day performance to generate actions for improvements
- Improved validation process of breaches which has supported increase in performance

What the charts tell us

- 28 Day faster diagnosis performance this month was 84.2%.
- 62 Days start of treatment target was 72.3%

Risks

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

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

We are driving this measure because:

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

New/First Attendances

Total vs Plan	This Year	Plan	Diff / Var
	46,227	46,590	-363 / -1%
Vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	46,227	37,541	8686 / 23%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	9.7	**2.9**	**70.4%**

IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	16,661	16,416	245 / 1%
vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	16,661	14,506	2155 / 15%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	14.7	**7.4**	**50.0%**

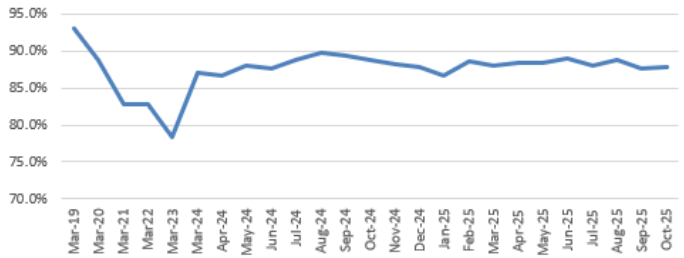
Follow Up Attendances

Total Vs Plan	This Year	Plan	Diff / Var
	104,262	93,559	10703 / 11%
Total vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	104,262	81,513	22749 / 28%
Waitlist Clearance (wks)	**Total**	**> See By Date (SBD)**	**% Past SBD**
	15.9	**4.8**	**63.2%**

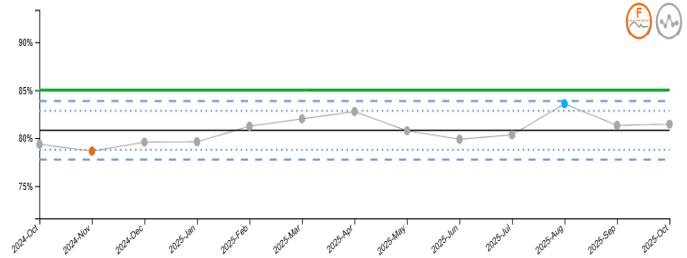
Endoscopies

Total Vs Plan	This Year	Plan	Diff / Var
	6,494	6,530	-36 / -1%
vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	6,494	6,563	-69 / -1%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	13.6	**0.2**	**98.5%**

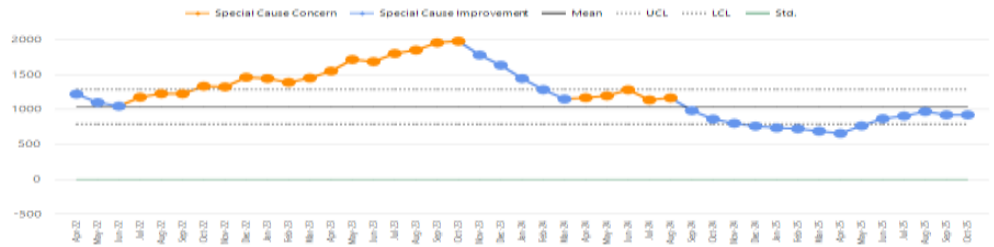
Clinic Utilisation



Theatres Utilisation (Uncapped)



Patients over 52 weeks on Incomplete Pathways Waiting List



Performance & actions

Theatres and Pre-Operative Assessment:

- Theatre utilisation dipped slightly in September to 81.3%, followed by a modest increase in October to 81.5%. Within Model Hospital data, WVT remains in Quartile 3 (mid-high utilisation).
- Key areas of concern include Plastic Surgery and Podiatric Surgery. Plastic Surgery teams are actively working with clinicians to improve utilisation, and positive impact is expected in the coming months. Additionally, the Operating Manager for Main Theatres has been allocated dedicated time to collaborate with Podiatric Surgery, reviewing current workstreams and identifying opportunities for efficiency improvements. Ongoing data validation has also influenced some utilisation figures.
- On a positive note, Colorectal and Oral Surgery consistently achieved utilisation above 85% in both September and October, with Orthopaedics also surpassing 85% in October.
- Model Hospital data indicates WVT remains in the mid-low quartile for early finishes (9.7%). Further improvements are anticipated through initiatives linked to the Federated Data Platform, scheduled to go live in late January 2026, which is expected to enhance utilisation performance.
- Pre-operative Assessment achieved an outstanding utilisation rate of over 96% in October, with a DNA rate below 3%. The MyPreOp+ implementation plan is progressing well, and the anticipated benefits are expected to be realised by Spring 2026.

Long waiting patients

- At the end of October we had 2 English patients were waiting 78 weeks and 29 English patients waiting 65 weeks.
- 653 English patients were waiting over 52 weeks for treatment at the end of October, a decrease of almost 100 patients from the end of September.

What the charts tell us

- Performance against English RTT standard in October was 63.5% / 2.9% of English patients on our Waiting List were waiting more than 52 weeks at the end of October.
- Performance against the Welsh RTT standard in October was 67.7%.

Risks

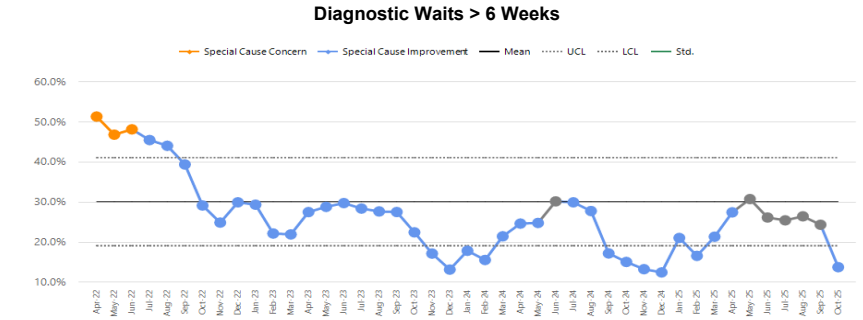
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.
- Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

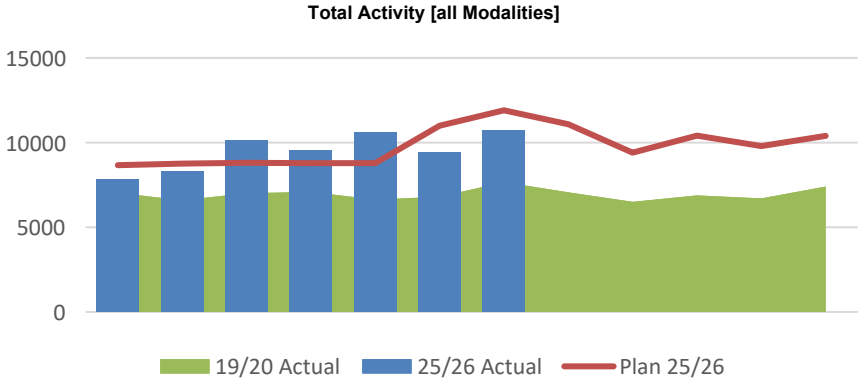
Operational Performance – Diagnostic Performance

We are driving this measure because:

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

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





Performance & actions

Overall Diagnostics is delivering 100% of 25/26 activity plan which is 136% compared with 19/20 activity. The Community Diagnostic Centre (CDC) opened at the end of October, although estates and equipment issues have delayed the centre being fully operational. CDC workforce plan is 85% recruited with active recruitment efforts ongoing.

Imaging:
6 week wait position at the end of October has improved by 2% to 96% overall, with notable improvement in DEXA delivered.
Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and Computed Tomography (CT) Colonoscopy (CTC]) were 7 days and 11.5 days respectively. 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 by 4.6% to 75.6%, as a result of improved clinic utilisation, cross-service working with ENT, waiting list validation.
Agreed insourcing solution for Paediatrics recommenced August to help reduce the number of long waiting patients.. Substantive B7 is being re-advertised. NHSE Apprentice bids were successful for a L2 and L6.

Neurophysiology:
<6weeks waiting has significantly improved from 70% to 93% for October. The number of patients waiting >13wks has reduced from 21 in March 25 to 2, all have appointments booked. A service review has been finalised for costing, which aims to improve service sustainability.

Endoscopy:
Waiting lists, patients >6 weeks is 32% of the current waiting list. >13 weeks has again reduced to 4.5% of the current waiting list. Aiming for no patients waiting longer than 13 weeks by the end of December.
To support this, we are utilising additional lists to cover any vacant weekday slots due to sickness or leave as well undertaking additional sessions at weekends. Ross has also increased capacity from 3 days to 5 with 4 additional sessions per week.
Demand continues to increase overall across Endoscopy requests for 2025 by 17.5% YTD compared to our plan.
A Bi-weekly forward look meeting is being implemented from December to review productivity of all lists and discuss the waiting list position. This is to ensure all long waiters are prioritised whilst maintaining our Urgent Suspected Cancer position.

Risks

Increased inpatient / acute floor referring impacting on capacity of service particularly for CT and Echocardiography (Echos)
Audiology, Echocardiogram and Endoscopy workforce challenges

What the charts tell us

End of October 86% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

Sickness absence stands at 4.7% compared to 5.3% (Oct 2024) with Long Term Sickness at 2.33%.and Short Term sickness at 2.38%. The main reasons for sickness absence are colds/flu. mental health conditions, gastro conditions and migraines. We are part of an NHS wide sickness absence management project being conducted by Kings College and the report will be published next year. From 1st December we will be working with Herefordshire GP Practice and Taurus Healthcare in launching the *WorkWell* programme at WVT which is an early intervention work and health assessment scheme from the DWP and the Department for Health and Social Care (DHSC). We will continue to take appropriate management actions to reduce sickness in line with our revised absence policy and this remains a priority area for HR. OH and IPC nurses are leading the flu vaccination programme and to-date over 1,920 staff have been vaccinated.

Staff turnover is at 8.2% and HR teams are engaged in divisional recruitment & retention working groups to ensure that prompt actions are being implemented to fill essential vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at 6.16% but turnover for band 2/3 hcsw staff now stands at 18.81%. We have restarted the centralised recruitment process and are working actively with the DWP to fill our vacancies. The recruitment team are also holding open drop-in sessions to attract and screen potential candidates for interviews. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments.

Our annual health and wellbeing week was held in October to actively promote the flu vaccination programme WVT wide. A variety of wellbeing programmes was provided for staff supported by Halo Leisure, students from The Royal College For the Blind and internal experts. Working with our Associate Chief Medical Officer for Surgery (Mr Akhtar) we promoted Men's Health Awareness Month in October and we will be supporting England's first ever Men's Health Strategy – *a 10-year plan to improve the health and wellbeing of men and boys* at WVT.

In October, we promoted Black History Month and we are encouraging all our line managers to sign up to the NHS Inclusive Leadership Pledge to demonstrate our commitment to maintaining a compassionate and inclusive working environment. We also supported Freedom To Speak Up Month and we are promoting Disability History Month in November working with our trade union representative and staff networks.

The formal consultation programme for admin and clerical staff ended in early October. From the constructive feedback and representations relayed to managers during the consultation process, it is clear that more work needs to be done in standardising and embedding Ai technology across the Trust. The clinical Ai sub group with lead clinicians and service managers are developing a timeline for the full implementation of Ai technology at WVT by 31 March 2026. To meet our headcount reduction target and financial gap, local management of change programmes will commence in early 2026. Quality impact assessments will be completed for all specialities with clinical leads and service managers and the next phase of the A&C review programme will be done locally and implemented in line with the Ai rollout programme.

The 2025 NHS National Staff Survey is ongoing and our response rate is currently 45% which is the highest % recorded at WVT to-date. The survey will close on the 28 November 2025 and the national reports should be available by March 2026.

We are implementing the NHS 10-point plan to improve the working lives of doctors led by the Chief Medical Officer. Key elements focuses on improving workspaces by addressing issues like parking and mess facilities, addressing administrative problems like payroll and leave, providing work schedules eight weeks in advance and ensuring peer representation.

WVT continues to perform well with mandatory training which now stands at 89.7%. Performance appraisals are at 76.5% and targeted HR support is being provided to line managers in departments with low completion rates.

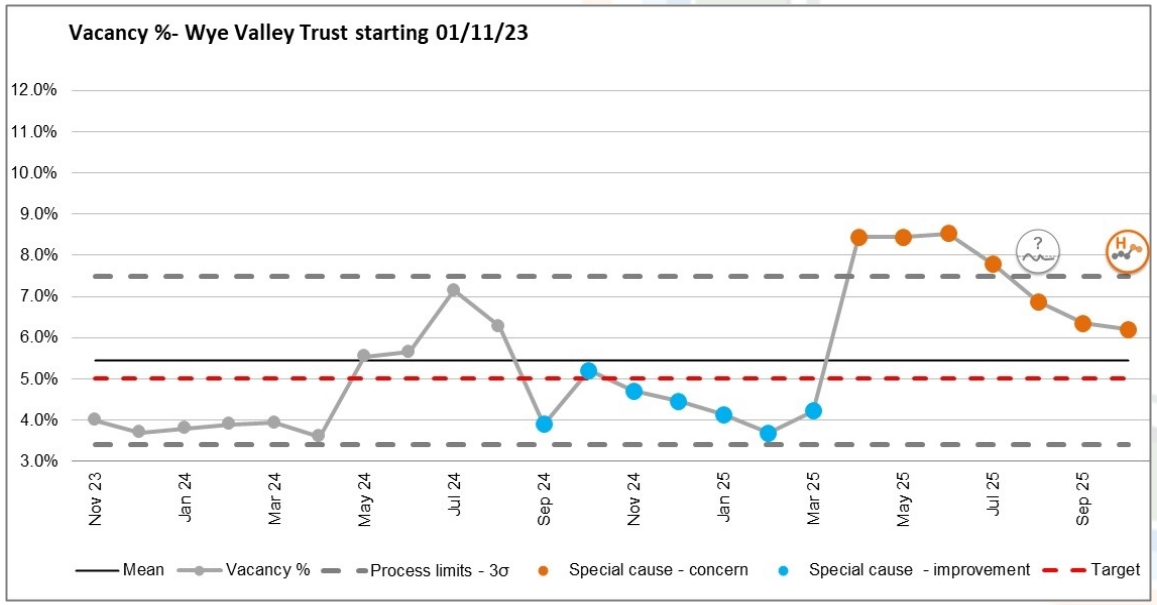
Workforce Performance – Vacancy

We are driving this measure because:

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

Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
5.2%	4.7%	4.5%	4.1%	3.7%	4.2%	8.4%	8.4%	8.5%	7.8%	6.9%	6.3%	6.2%

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

HCSW – with 22.21 wte vacancies we have re-introduced the centralised recruitment process and drop-in sessions by HR to screen potential candidates for interviews. We will be running a major recruitment campaign with open day recruitment sessions in late January. We are working closely with the DWP in organizing recruitment boot camp events to fill our vacancies.

N&M - we have paused our international recruitment as we seeing a significant increase in applications from UK based applicants for our vacancies. We currently have 19.13wte vacancies.

CDC – 78.61 wte appointments have been made which represents 92.27% of planned recruitment activity to support the new diagnostics centre.

M&D – since April, we have successfully recruited 15 substantive consultants and 12 locum consultants and this is supporting the reduction of agency expenditure at WVT. Regular meetings with CMD, CPO and Medical HR Lead to review progress with vacancies and cases of concern. Active recruitment of medics to continue over the coming year including international recruitment. We currently have 36.50 wte vacancies which is the lowest level over the past 5 years.

HR continues to work closely with DWP officers and local recruitment agencies in finding suitable applicants for our support worker vacancies. Over 48 WVT Ambassadors have signed up to support career events at schools, colleges and universities and this reflects our aim to promote WVT as a good employer of choice in the county.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

The penultimate 4 months of 24/25 showed a decreasing position, increasing in the last month mainly due to a decrease in substantive staff. There is a large increase in the first month of 25/26, mainly 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. From month 4 onwards this has now decreased as budget has started to be moved to CIP codes and headcount reduction.

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.

Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
9.4%	9.1%	9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%	8.3%	8.0%	8.2%

Assurance	Variation	Data Quality Mark
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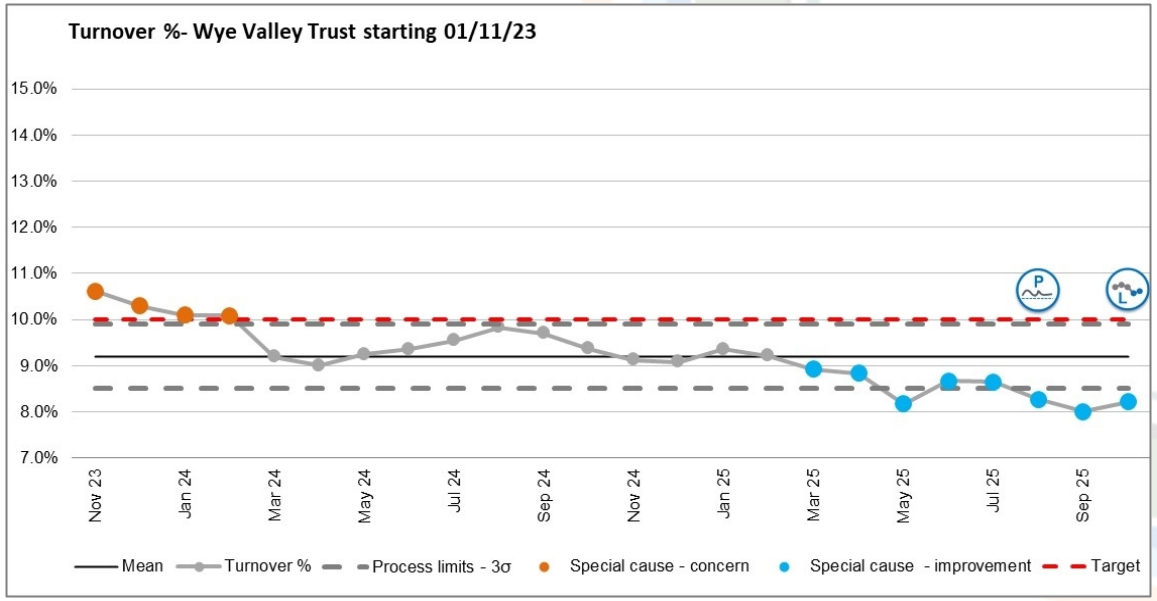


Performance & actions

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

Clinical support workers at band 2 level have the highest turnover rate at the Trust (18.81%) and this is still the case across the NHS. We have reintroduced the centralised recruitment process and are strengthening the pastoral care support and training being provided. 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 steady at 6.16% and divisional teams are using a variety of flexible working options and development opportunities to retain staff. Through divisional recruitment & retention working groups, HR and line managers review and analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group continues to oversee exit interview surveys and recruitment & retention areas of concern to ensure actions are being progressed in a timely manner to aid recruitment & retention of staff across the trust.

Risks

Staff turnover for 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 the last 2 months being maintained last month.

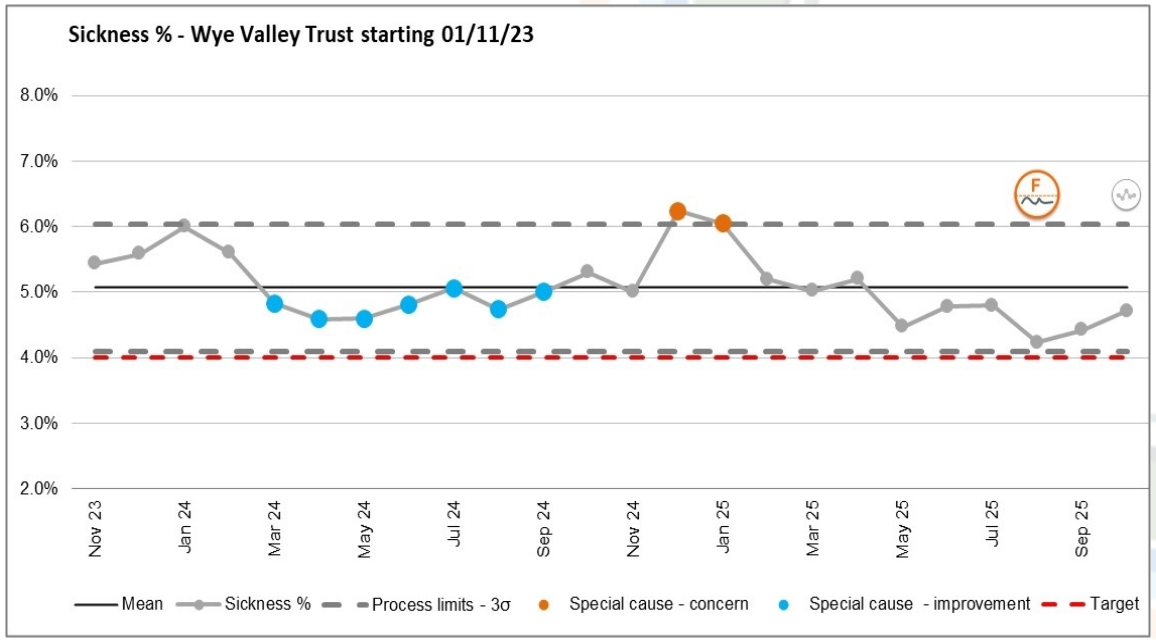
Workforce Performance – Sickness

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.

Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
5.3%	5.0%	6.2%	6.0%	5.2%	5.0%	5.2%	4.5%	4.8%	4.8%	4.2%	4.4%	4.7%

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



Performance & actions

During this month, overall sickness at Trust level is at 4.7% compared to 5.3% (Oct 2024) and the main reasons for absence are colds/winter ailments, mental health issues, and gastro conditions.

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 sickness absence cases and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, psychological and team based wellbeing support. The wide range of health & wellbeing initiatives (mental health support, employee assistance programme, NHS apps and support lines, face to face counselling, clinical psychology) are still in place for staff.

The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for all cases of concern to ensure the absence process is being managed appropriately. The HR team are also following NHSE Improving Attendance Toolkit, in managing sickness absence.

Risks

What the chart tells us

The rolling 12 month position shows a decrease position in the final 3 months of 24/25 reduced to pre winter pressure levels. This has slightly increased in the 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 to the lowest position in the last 2 years in month 5, before increasing in last 2 months as we approach winter.

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 7 Income and Expenditure position

Despite a deterioration in month (£0.3m), overall we continue to perform better than plan YTD by £0.7m, a positive position at this point of the year. The Trust set a breakeven plan for 2025/26, which includes a £25m CPIP challenge devolved to budget holders for delivery.

In October we saw a slight increase in agency use and associated spend though overall we remain in a strong position YTD linked to the range of actions within our medical and nursing agency reduction programmes. Cost Improvement delivery remains ahead of plan YTD, primarily through additional non recurrent benefits. The planned step up in efficiencies was not fully achieved in the month, primarily due to slippage on timing of implementing our workforce reduction schemes. The underachievement in month of £0.4m was largely against recurrent schemes, meaning we are slightly behind plan on recurrent delivery YTD. Continued focus remains on ensuring schemes are fully developed and will have a positive and recurrent impact on the run rate. Substantive pay continued to under spend against plan in month and YTD, though we saw pressure on bank and agency lines in month. 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 forecast position is being reviewed bottom up, across income, expenditure and efficiencies to understand any risk to delivery, and mitigating actions.

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, and the risk around full achievement of the CPIP given some of the target is not yet in fully delivered status. 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. In October we held CPIP Assurance Reviews with each of the clinical divisions and corporate teams.

Cash and Capital

Cash balances at the end of October are slightly higher than planned but have reduced in month. The balance remains 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 slightly less than planned YTD. The Year end forecast remains at plan.

Medium Term Operational Planning

Following completion of the Phase One planning tasks (assessment of the underlying deficit position and review of the current fixed elements of the commissioning contracts) we have now moved on to Phase Two and development of our integrated medium-term plans. National guidance has just been released at the time of writing, and a separate paper will be presented to Board ahead of the first submission date in December.

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 7 - 31st October 2025 - 2025/26

	2025-26 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Operating income from patient care activities	358,564	209,242	206,671	(2,571)	(659)
Drugs Excluded	26,098	15,125	15,527	402	958
Other operating income	16,833	9,723	9,931	208	65
Donations from non current asets	240	52	857	805	(15)
Total Operating Income	**401,736**	**234,141**	**232,985**	**(1,156)**	**350**
Substantive Pay	(221,590)	(130,129)	(129,251)	878	81
Bank & WLI Pay	(16,123)	(10,048)	(10,668)	(620)	(53)
Agency pay	(8,046)	(5,541)	(5,040)	501	(106)
Subtotal Pay	***(245,759)***	***(145,719)***	***(144,959)***	***759***	***(77)***
Non Pay Expenditure	(101,802)	(60,455)	(59,523)	933	191
Excluded Drugs	(25,795)	(15,047)	(15,438)	(391)	(1,001)
Total Operating Expenditure	**(373,356)**	**(221,221)**	**(219,920)**	**1,301**	**(965)**
EBITDA	**28,380**	**12,920**	**13,065**	**145**	**(616)**
Depreciation	(13,414)	(7,826)	(7,264)	562	99
Impairment (CDC & PFI)	(4,584)	(4,584)	10,227	14,811	10,227
Interest Receivable	527	307	1,173	866	122
Interest Payable on Loans	(180)	(105)	(94)	11	2
Interest Payable on PFI	(2,944)	(958)	(958)	0	0
Dividends on PDC	(4,296)	(2,506)	(2,506)	0	0
Operating Surplus/ (Deficit)	**3,489**	**(2,753)**	**13,644**	**16,395**	**9,835**
Technical Adjustments					
Donated Assets Adjustment	536	401	(395)	(795)	12
Net impact of asset impairments	4,584	4,584	(10,227)	(14,811)	(10,227)
Impact of IFRS16 Implementation of PFI Contract	(8,609)	(5,614)	(5,736)	(122)	14
Adj. financial performance retained Surplus/ (Deficit)	**(0)**	**(3,379)**	**(2,714)**	**667**	**(289)**

Performance & actions

The position at the end of Month 7 (October) was a deficit of £2,714k YTD. This is performing better than plan with an overall positive variance of £667k YTD.

- Income shows an adverse variance of (£1.2m) Excluding the donated asset adjustment this is £2.0m adverse to plan. This is largely due to phasing of the stretch target plus depreciation matched to spend which is due to catch up in later months and other lines to match expenditure. Excluded drugs is overachieving YTD by £402k due to the increased cost of buying in drugs whilst our aseptic unit is closed for maintenance.
- Pay is favourable by £759k at month 7. The net position in month includes agency — 3.47% of total pay costs in month which is an increase from 2.95% in month 6. Bank use further increases the total temporary staff proportion to 10.12% of overall pay, including costs for a Critical Incident in Month 1 and Industrial Action costs in Month 4 and urgent & emergency demand related spend. Nurse agency usage has remained low, with zero spend on HealthCare Support Worker agency in October.
- Total Non-Pay (operating & non operating) is favourable by £1.1m YTD including technical adjustment benefits. The favourable variance is largely due to a CNST rebate in Month 4, credit notes relating to gas bills in M5 and PFI CCN credits in M6. There is also an underspend on Depreciation/Amortisation due to timing of asset revaluation. 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 £122k 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

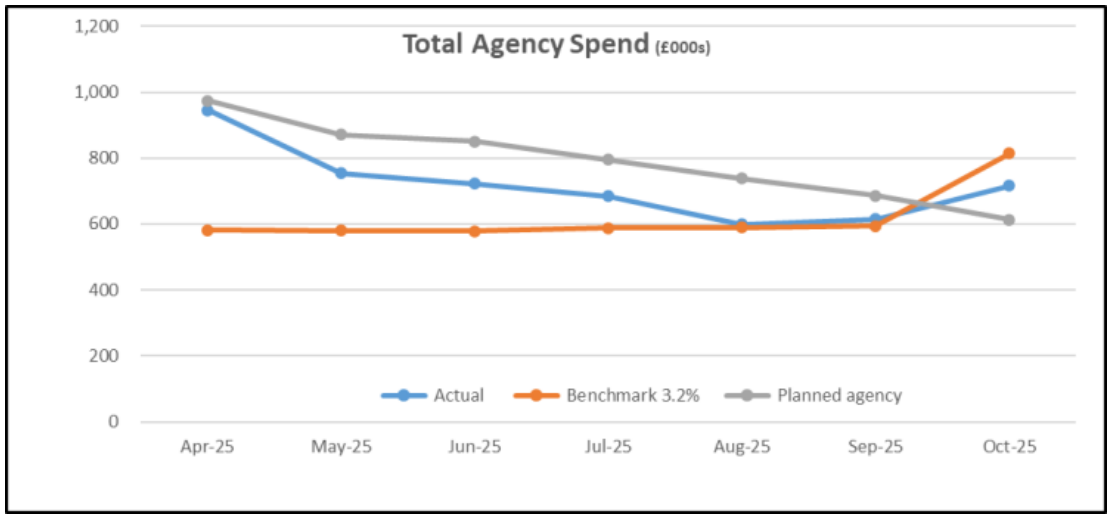
What the chart tells us

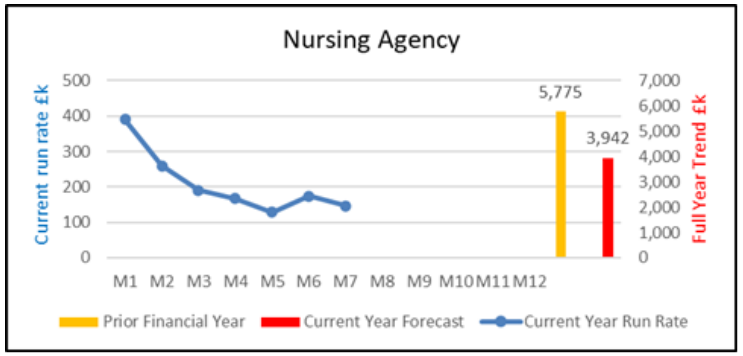
There are no material variances in this month, though the plan includes a number of known financial risks.

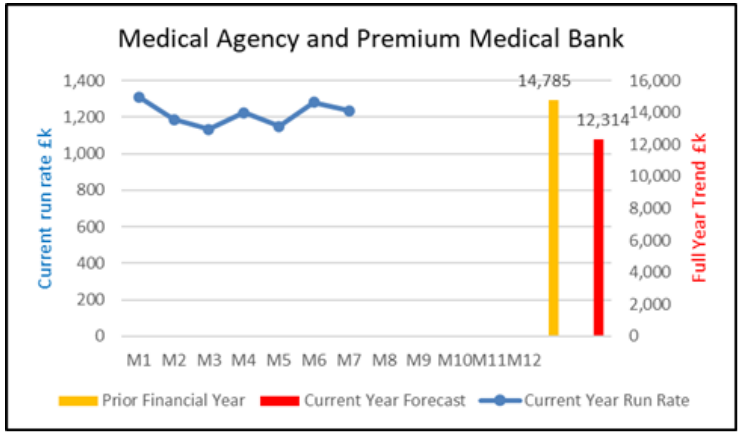
Finance Performance – Agency Spend

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 continues to be a significant opportunity to improve our use of resources.







Performance & actions

Agency represents 3.47% of total pay costs year to date. The Trust is now only 0.27% above the national target of 3.2% evidencing the commitment to sustainable temporary workforce reduction. Agency performance is currently better than plan YTD by £501k. Total agency spend year to date (excluding premium cost medical bank) is £5.0m.

- **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 from M4 (with a small spend in M5). The cost for nurse agency spend in October was £147k down from £174k in M6.
- **Off framework Nurse Agency:** There have been 2 off framework shifts in October compared to 5 in September (27 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 M7 is £1,236k, a small decrease from £1,280k in M6. 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

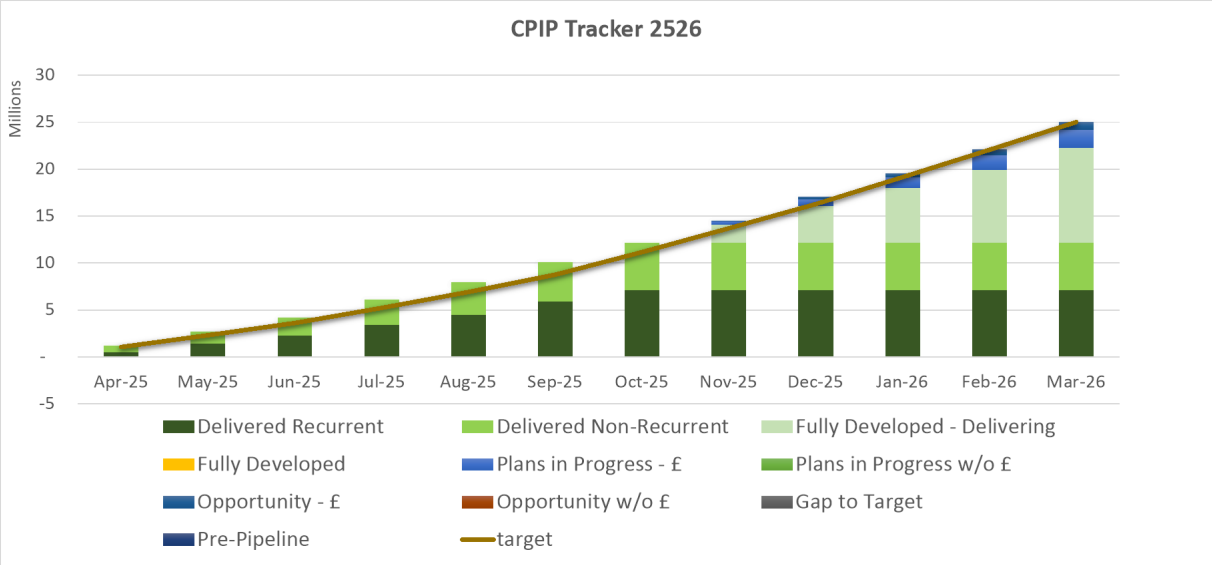
What the charts tell us

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 £11.2m with a Trust delivery of £12.2m resulting in a £0.9m over-performance to plan. This does include £7.1m of recurrent delivery, behind plan YTD. The plan is phased to increase across the financial year, with just under 15% of the total assumed in Quarter 1, 20% in Quarter 2 and 30% in Q3.

The step up in CPIP plan from October has not been fully met in the month, and there remains risk to the planned forecast. CPIP Assurance Reviews have taken place with clinical and corporate divisions, and the forecast is being re-assessed with further mitigations sought.

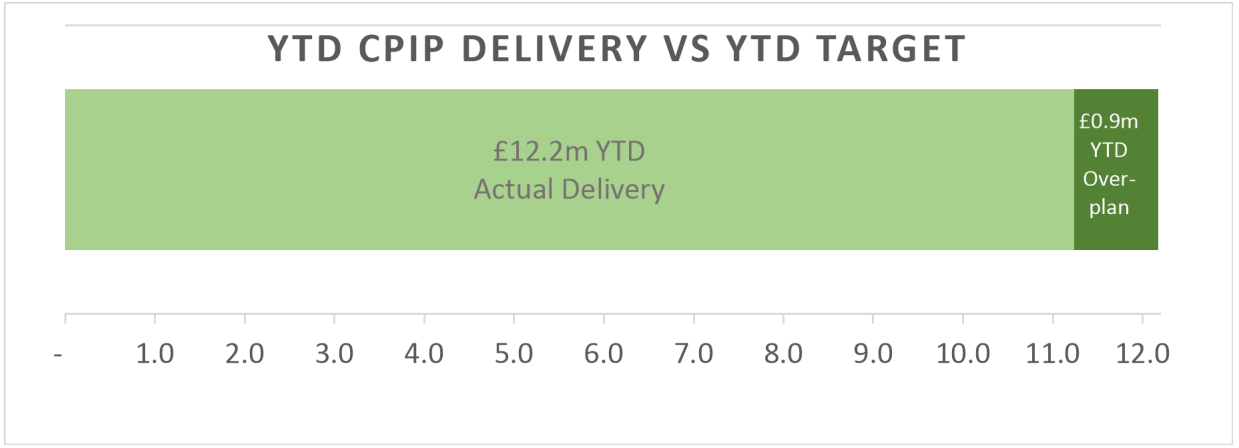
The FRB continues to focus on furthering identification and delivery of CPIP in order to achieve our breakeven plan. As part of the FRB, monthly Check and Challenge meetings with Divisions continue to place to specifically focus on identification and delivery of savings schemes. Schemes have progressed, 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
August	30.6	34.5		
September	36.4	40.1		
October	32.0	29.7		
Cash balances are £2m higher than plan, due to timing of the plan phasing				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
August	98.9%	95.0%		
September	98.4%	95.0%		
October	99.3%	95.0%		
In October the Trust paid 99.3% of invoices within 30 days. This equates to 99.8% by invoice value. This is the twenty second month, in a row, that we have achieved the 95% (by volume) target.				

Capital

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month Budget £k	Actual £k	Variance £k	Full Year Forecast £k	Variance £k
Local CDEL funded	Owned	2,798	999	1,392	(393)	3,250	(452)
IFRS16 Leases	Leased	2,460	134	(43)	177	2,008	452
National PDC schemes	Owned	10,060	2,168	2,192	(24)	10,060	0
Grant funded and Donated	Owned	5,253	2,971	2,246	725	5,253	0
Total Capital Programme		20,571	6,272	5,787	485	20,571	0

What the charts tells us

Cash
Cash balances are £2m higher than plan, however the cash balance has reduced in month. The Trust remains above the 95% target for Better Payment Practice.

Capital
Overall Capital Expenditure for the year to date is now behind plan due to slippage on the grant funded IES scheme.

Performance & actions

Cash
Although the cash balance is higher than planned this month, performance is expected to reduce below plan again for the rest of the year due to increased debtors for Welsh Parity dispute (with the national team). Both the working balances and overall cash positon continue to be closely managed.

Capital
Actions are being considered to address slippage on expenditure and to ensure that the capital allocation is utilised.

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. Uncertainty around national funding for digital schemes presents a risk and it assumed that no funding will be made available. Risks around slippage are also being addressed 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

September 2025	2024/25	2025/26			2025/26 Full Year		
	Accounts £000s	M7 Plan £000s	M7 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	159,386	165,516	172,014	6,498	175,402	175,196	(206)
Intangible Assets	11,572	9,934	7,949	(1,985)	8,766	8,766	0
Trade and Other Receivables	429	429	1,188	759	429	1,197	768
TOTAL Non Current Assets	**171,387**	**175,879**	**181,151**	**5,272**	**184,597**	**185,159**	**562**
CURRENT ASSETS:							
Inventories	5,087	5,087	5,740	653	5,087	5,087	0
Trade and Other Receivables	24,244	29,225	31,812	2,587	19,231	36,159	16,928
Cash and Cash Equivalents	37,906	29,672	32,008	2,336	45,995	29,156	(16,839)
TOTAL Current Assets	**67,237**	**63,984**	**69,560**	**5,576**	**70,313**	**70,402**	**89**
TOTAL ASSETS	**238,624**	**239,863**	**250,711**	**10,848**	**254,910**	**255,561**	**651**
CURRENT LIABILITIES							
Trade and other payables	(37,582)	(37,940)	(41,690)	(3,750)	(37,582)	(37,612)	(30)
Borrowings - Loans, PFI and Finance Leases	(15,067)	(15,067)	(14,457)	610	(15,067)	(15,067)	0
Provisions	(49)	(49)	(49)	0	(49)	(49)	0
Total Current Liabilities	**(52,698)**	**(53,056)**	**(56,196)**	**(3,140)**	**(52,698)**	**(52,728)**	**(30)**
NET CURRENT ASSETS/(LIABILITIES)	**14,539**	**10,928**	**13,364**	**2,436**	**17,615**	**17,674**	**59**
TOTAL ASSETS LESS CURRENT LIABILITIES	**185,926**	**186,807**	**194,515**	**7,708**	**202,212**	**202,833**	**621**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(40,822)	(30,803)	(33,519)	(2,716)	(28,985)	(28,985)	0
Provisions	(1,529)	(1,529)	(1,499)	30	(1,529)	(1,499)	30
Total Non-Current Liabilities	**(42,351)**	**(32,332)**	**(35,018)**	**(2,686)**	**(30,514)**	**(30,484)**	**30**
ASSETS LESS LIABILITIES	**143,575**	**154,475**	**159,497**	**5,022**	**171,698**	**172,349**	**651**
TAXPAYERS EQUITY							
Public dividend capital	325,841	329,026	327,916	(1,110)	340,007	339,838	(169)
Revaluation reserve	17,709	28,177	17,203	(10,974)	28,177	17,203	(10,974)
Income and expenditure reserve	(199,975)	(202,728)	(185,622)	17,106	(196,486)	(184,692)	11,794
TOTAL	**143,575**	**154,475**	**159,497**	**5,022**	**171,698**	**172,349**	**651**

Performance & actions

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

Non-Current Assets
Non-Current assets are £5.2m higher than plan due to the timing of the CDC impairment. The non-current debtors increase is due to reclassification of the debtor for the Gloucester radiotherapy building.

Working balances
Net working balances - receivables less payables - have reduced by c£2m compared to plan, mainly due to invoices to Powys for parity of funding, net of deferred income for education and training and payments in advance for PFI. These factors, coupled with not drawing planned PDC (£1m), has led to a corresponding positive variance on cash of c£2m 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 has not been drawn in line with plan, and the revaluation reserve balance is lower than plan due to the PFI revaluation benefitting the retained I&E rather than the revaluation reserve.
The income and expenditure reserve balance for month 7 reflects the deficit for the year to date and the reversal of previous I&E impairments resulting from the PFI building revaluation.

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 7.

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Cancer	28 day referral to diagnosis confirmation to patients	Cancer	>= 80.0%	Variable	Improvement - High		82.9%	75.9%	77.4%	75.9%	81.0%	78.3%	82.2%	84.2%	
	2 Week Wait all cancers	Cancer	>= 93.0%	Variable	Concern - Low		79.1%	83.8%	84.1%	82.5%	72.3%	80.6%	81.5%	85.6%	
	Urgent referrals for breast symptoms	Cancer	>= 93.0%	Variable	Concern - Low		0.0%	16.7%	0.0%	13.3%	16.7%	27.3%	18.8%	56.6%	
	Cancer 31 day diagnosis to treatment	Cancer	>= 96.0%	Variable	Improvement - High		94.1%	95.4%							
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Cancer		No Target	Common Cause		7	9	11	6	8	9	3	7	
	Cancer 62 days urgent referral to treatment	Cancer	>= 85.0%	Variable	Common Cause		67.2%	67.7%							
	Cancer 62-Day National Screening Programme	Cancer	>= 90.0%	Variable	Common Cause		100.0%	100.0%							
	Cancer consultant upgrade (62 days decision to upgrade)	Cancer	>= 85.0%	Variable	Common Cause		74.3%	78.8%							
	Cancer 62 days Combined	Cancer	>= 75.0%	Variable	Improvement - High		68.6%	69.3%	72.6%	77.3%	69.3%	69.7%	72.2%	72.3%	
	Cancer: number of cancer patients waiting over 62 days	Cancer		No Target	Common Cause		60	74	69	72	66	50	74	58	
Primary care and community services	Community Service Contacts - Total	Primary care and community		No Target	Improvement - High		110.5%	108.0%	116.1%	117.6%	116.8%	125.7%	119.8%	122.7%	
	% emergency admissions discharged to usual place of residence	Primary care and community	>= 90.0%	Variable	Concern - Low		86.6%	86.2%	87.3%	87.1%	87.9%	87.9%	88.0%	87.5%	86.9%
Urgent and emergency care	A&E Activity	Urgent and emergency care		No Target	Common Cause	Yes	96.3%	102.0%	99.0%	95.5%	100.1%	100.4%	98.6%	100.9%	97.4%
	Ambulance handover within 30 minutes (WMAS Only)	Urgent and emergency care	>= 98.0%	Fail	Concern - Low	Yes	60.3%	55.2%	44.3%	53.8%	60.4%	69.6%	58.9%	50.9%	53.0%
	Ambulance handover within 45 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Fail	Common Cause		26.4%	32.6%	45.7%	35.1%	26.6%	17.8%	28.7%	34.8%	34.4%
	Ambulance handover over 60 minutes (WMAS Only)	Urgent and emergency care	<= 0.0%	Fail	Concern - High		21.4%	26.6%	38.5%	28.6%	18.9%	11.6%	21.4%	26.7%	28.1%
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Urgent and emergency care		No Target	Improvement - High		121.7%	127.3%	117.9%	117.5%	115.5%	124.3%	121.6%	125.0%	124.3%
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Urgent and emergency care	>= 40.0%	Variable	Improvement - High		46.7%	49.1%	47.8%	47.3%	49.2%	46.8%	47.1%	49.0%	47.1%
	A&E - % of patients seen within 4 hours	Urgent and emergency care	>= 95.0%	Fail	Common Cause	Yes	65.9%	63.2%	57.4%	60.4%	65.2%	70.9%	67.2%	65.6%	66.7%
	A&E - Percentage of patients spending more than 12 hours in A&E	Urgent and emergency care		No Target	Common Cause	Yes	13.0%	13.2%	16.4%	14.2%	11.6%	8.1%	10.9%	14.0%	13.3%
	A&E - Time to treatment	Urgent and emergency care		No Target	Common Cause		0	0	0	0	0	0	0	0	0
	Time to be seen (average from arrival to time seen - clinician)	Urgent and emergency care		No Target	Improvement - Low		1.5%	1.9%	1.7%	1.8%	1.6%	1.6%	1.6%	1.9%	1.7%
	A&E Quality Indicator - 12 Hour Trolley Waits	Urgent and emergency care	<= 0	Fail	Concern - High		219	293	277	249	234	182	207	283	272
	A&E - Unplanned Re-attendance with 7 days rate	Urgent and emergency care	3.0%	Pass	Common Cause	Yes	8.9%	9.1%	9.2%	8.0%	9.4%	8.2%			

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Elective care	>= 61.0%	Variable	Common Cause	Yes	56.4%	56.5%	57.1%	59.4%	59.8%	61.4%	61.0%	62.7%	63.5%
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Elective care		No Target	Common Cause		70.3%	70.0%	70.8%	70.4%	70.1%	70.3%	68.8%	68.6%	67.7%
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Elective care		No Target	Improvement - High		27488	27476	27943	28097	27296	27198	27294	27214	26991
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		727	692	660	768	871	909	973	925	925
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Elective care	<= 0	Fail	Improvement - Low		5	5	2	5	2	6	11	18	28
	Referral to Treatment Number of Patients over 104 weeks on Incomplete Pathways Waiting	Elective care	<= 0	Fail	Improvement - Low		0	0	0	0					
	GP Referrals	Elective care		No Target	Improvement - High	Yes	91.6%	103.1%	97.7%	93.2%	101.8%	100.6%	97.7%	106.2%	
	Outpatient Activity - New attendances (% v 2019/20)	Elective care		No Target	Improvement - High		113.8%	148.4%	119.5%	112.1%					
	Outpatient Activity - New attendances (volume v plan)	Elective care		No Target	Common Cause	Yes	94.0%	82.0%	101.2%	99.6%	99.7%	99.5%	91.6%	102.1%	99.8%
	Total Outpatient Activity (% v 2019/20)	Elective care		No Target	Improvement - High		109.8%	140.1%	126.7%	118.8%					
	Total Outpatient Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	98.0%	86.0%	108.7%	107.7%	108.1%	106.9%	99.8%	108.1%	105.3%
	Total Elective Activity (% v 2019/20)	Elective care		No Target	Improvement - High		104.0%	127.6%	106.7%	110.3%					
	Total Elective Activity (volume v plan)	Elective care		No Target	Improvement - High	Yes	91.0%	77.2%	95.9%	101.8%	101.5%	99.4%	91.6%	100.7%	101.2%
	Elective - Theatre utilisation (%) - Capped	Elective care	>= 85.0%	Fail	Improvement - High		83.1%	82.0%	82.8%	80.8%	81.6%	80.3%	83.6%	81.3%	81.5%
	Cancelled Operations on day of Surgery for non clinical reasons	Elective care		No Target	Common Cause		20	26	26	17	20	21	36	22	
	Diagnostic Activity - Computerised Tomography	Elective care		No Target	Concern - Low	Yes	86.6%	102.7%	90.8%	95.9%	111.5%	108.7%	108.3%	78.6%	87.3%
	Diagnostic Activity - Endoscopy	Elective care		No Target	Improvement - High	Yes	89.1%	78.9%	100.9%	94.4%	88.9%	87.6%	134.8%	109.7%	100.1%
	Diagnostic Activity - Magnetic Resonance Imaging	Elective care		No Target	Concern - Low	Yes	88.3%	119.2%	99.3%	94.0%	120.3%	99.2%	145.4%	77.7%	79.4%
	Waiting Times - Diagnostic Waits >6 weeks	Elective care		No Target	Improvement - Low	Yes	16.6%	21.4%	27.5%	30.8%	26.2%	25.5%	26.5%	24.4%	13.8%
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Elective care	90.0%	Variable	Improvement - High		97.7%	97.8%	99.1%	96.6%	98.0%	96.9%	94.8%	95.2%	99.2%
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Elective care	<= 15.0%	Variable	Common Cause	Yes	22.5%	21.8%	19.8%	21.1%	19.8%	19.4%	15.2%	16.0%	19.0%
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Elective care	<= 34.0%	Fail	Concern - High		61.5%	66.5%	67.9%	64.8%	62.1%	67.8%	69.2%	67.1%	67.1%
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Elective care	<= 60.0%	Fail	Concern - High		89.2%	90.8%	88.7%	86.8%	87.7%	89.1%	89.5%	90.6%	92.3%
	Maternity Activity (Deliveries)	Elective care		No Target	Improvement - High	Yes	93.8%	88.0%	91.1%	97.0%	91.2%	101.6%	100.0%	93.0%	108.5%

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Outpatient transformation	DNA Rate (Acute Clinics)	Outpatient transformation	<= 40.0%	Pass	Improvement - Low		5.9%	5.4%	5.6%	5.9%	5.7%	5.7%	5.8%	5.7%	5.5%
	Outpatient - % OPD Slot Utilisation (All slot types)	Outpatient transformation	>= 90.0%	Fail	Improvement - High		88.7%	88.0%	88.5%	88.3%	89.0%	88.1%	88.8%	87.6%	87.8%
	Outpatient Activity - Follow Up attendances (% v 2019/20)	Outpatient transformation		No Target	Improvement - High		108.0%	136.5%	130.2%	122.0%					
	Outpatient Activity - Follow Up attendances (volume v plan)	Outpatient transformation		No Target	Improvement - High		99.9%	88.0%	112.3%	111.7%	112.2%	110.5%	103.8%	111.1%	108.0%
	Outpatients Activity - Virtual Total (% of total OP activity)	Outpatient transformation	<= 25.0%	Variable	Improvement - Low		21.4%	19.9%	19.3%	19.6%	20.3%	20.2%	20.4%	19.0%	19.5%
Prevention and long term	Maternity - Smoking at Delivery	Prevention and long term		No Target	Improvement - Low	Yes	8.4%	7.4%	8.1%	10.9%	7.4%	6.3%	4.3%	4.8%	8.1%
Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Safe, high quality care	<= 90.0%	Variable	Concern - High		99.7%	94.7%	97.7%	99.9%	99.9%	98.9%	98.3%	99.9%	99.8%
	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		81	64	117	90	146	105	46	119	100
	Patient ward moves emergency admissions (acute)	Safe, high quality care	4.0%	Pass	Concern - Low		6.5%	6.4%	6.4%	7.6%	5.9%	5.3%	5.9%	6.6%	
	ALoS - General & Acute Adult Emergency Inpatients	Safe, high quality care	<= 5	Fail	Common Cause		6	6	6	7	6	6	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	Concern - Low		19.3%	17.3%	16.7%	18.0%	17.5%	18.1%	16.7%	17.9%	17.7%
	Medically fit for discharge - Community	Safe, high quality care	10.0%	Pass	Concern - Low		36.6%	24.9%	20.8%	36.1%	39.3%	37.4%	39.6%	35.3%	37.7%
	Emergency readmissions within 30 days of discharge (G&A only)	Safe, high quality care	5.0%	Pass	Concern - Low		4.5%	5.0%	4.9%	4.4%	5.0%	5.4%	5.4%		
	Mortality SHMI - Rolling 12 months	Safe, high quality care	<= 100	Fail	Concern - High		108	110	110	112	112				
	Never Events	Safe, high quality care	0	Variable	Improvement - High	Yes	0	0	0	0	0	1	0	0	1
	MRSA Bacteraemia	Safe, high quality care	0	Variable	Concern - Low	Yes	0	1	1	0	0	0	1	1	0
	MSSA Bacteraemia	Safe, high quality care		No Target	Common Cause		1	2	0	0	1	2	0	2	2
	Number of external reportable >AD+1 clostridium difficile cases	Safe, high quality care	44	Fail	Common Cause		3	3	1	5	6	2	4	4	4

Trustwide KPIs

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Safe, high quality care	VTE Risk Assessments	Safe, high quality care	>= 95.0%	Fail	Common Cause		92.0%	91.0%	91.8%	92.2%	92.6%	90.1%	91.1%	92.7%	91.9%
	WHO Checklist	Safe, high quality care	>= 100.0%	Variable	Common Cause	Yes		98.8%			99.4%			99.8%	
	% of people who have a TIA who are scanned and treated within 24 hours	Safe, high quality care	>= 60.0%	Variable	Improvement - High		65.5%	65.4%	67.6%	61.3%	71.7%	90.9%	85.7%	82.2%	
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving	Safe, high quality care	>= 90.0%	Variable	Common Cause		66.7%	66.7%	64.7%	36.4%	75.0%	60.0%	70.0%	37.5%	50.0%
	Stroke Indicator 80% patients = 90% stroke ward	Safe, high quality care	>= 80.0%	Variable	Common Cause	Yes	80.4%	75.9%	81.5%	78.8%	82.1%	92.0%	93.0%	76.8%	79.6%
	Number of complaints	Safe, high quality care		No Target	Concern - High		26	33	38	48	30	35	27	35	31
	Number of complaints referred to Ombudsman	Safe, high quality care	<= 0	Variable	Improvement - Low		0	0	0	0					
	Complaints resolved within policy timeframe	Safe, high quality care	>= 90.0%	Fail	Common Cause		45.5%	25.7%	58.0%	59.0%	58.0%	42.0%	44.0%	42.9%	53.3%
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		80.6%	76.4%	72.6%			84.7%	84.7%	82.4%	81.1%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause	Yes	86.8%	85.7%	81.3%			90.2%	91.0%	93.6%	89.8%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Safe, high quality care	>= 95.0%	Variable	Common Cause		94.1%	100.0%	100.0%			81.3%	100.0%	100.0%	100.0%
	Friends and Family Test: Response rate (A&E)	Safe, high quality care	>= 25.0%	Variable	Common Cause		19.0%	19.0%	19.0%			13.7%	13.3%	14.7%	14.8%
	Friends and Family Test: Response rate (Acute inpatients)	Safe, high quality care	>= 30.0%	Fail	Common Cause	Yes	16.0%	15.0%	15.0%			12.2%	13.3%	11.2%	13.1%
	Friends and Family Test: Response rate (Maternity)	Safe, high quality care	>= 30.0%	Variable	Common Cause		31.0%	24.0%	23.0%			14.3%	14.4%	14.9%	12.1%

Trustwide KPIs

People

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Looking after our people	Agency (agency spend as a % of total pay bill)	Looking after our people	>= 6.4%	Variable	Concern - Low		4.0%	2.6%	4.5%	3.7%	3.5%	3.2%	2.9%	3.0%	3.5%
	Appraisals	Looking after our people	>= 85.0%	Fail	Concern - Low		77.6%	77.7%	73.5%	71.7%	72.1%	75.2%	76.0%	77.3%	76.5%
	Mandatory Training	Looking after our people	>= 85.0%	Pass	Common Cause	Yes	89.3%	89.4%	89.8%	89.5%	89.6%	89.8%	90.4%	89.6%	89.7%
	Overall Sickness	Looking after our people	<= 4.0%	Variable	Improvement - Low		5.2%	5.0%	5.2%	4.5%	4.8%	4.8%	4.2%	4.4%	4.7%
	Staff Turnover Rate (Rolling 12 months)	Looking after our people	<= 10.0%	Variable	Improvement - Low		9.2%	8.9%	8.8%	8.2%	8.7%	8.7%	8.3%	8.0%	8.2%
	Vacancy Rate	Looking after our people	<= 5.0%	Fail	Common Cause	Yes	6.9%	4.2%	8.4%	8.4%	8.5%	7.8%	6.9%	6.3%	6.2%

Finance and Use of Resources

Sub Domain	KPI	Subject	Target	Target Expectation	Variation	Exception	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Finance	I&E - Surplus/(Deficit) (£k)	Finance		No Target	Common Cause		(£133k)	£5805k	(£798k)	(£875k)	(£959k)	£223k	(£209k)	(£503k)	£407k
	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		(£39k)	£5901k	(£17k)	£37k	£31k	£273k	£653k	(£22k)	(£289k)
	I&E - Variance from Plan (%)	Finance		No Target	Common Cause	Yes	(£0k)	£0k	(£0k)	£0k	£0k	(£5k)	(£1k)	£0k	(£0k)
	CPIP - Variance from plan (£k)	Finance		No Target	Common Cause	Yes	(£487k)	(£931k)	£191k	£209k	£157k	£364k	£110k	£299k	(£396k)
	Agency - expenditure (£k)	Finance		No Target	Improvement - Low		£804k	£1069k	£851k	£851k	£723k	£685k	£598k	£616k	£718k
	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		(£873k)	£2271k	(£440k)	(£441k)	£199k	£29k	£56k	£210k	£170k
	Cash - Balance at end of month (£m)	Finance		No Target	Concern - High		£31k	£26k	£35k	£35k	£30k	£34k	£31k	£36k	£32k
	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

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Emergency Preparedness Resilience and Response (EPRR) Annual Compliance Report for 2025
Lead Executive Director:	**Chief Operating Officer**
Author:	Sean Smith, Emergency Planning Officer, EPRR
Reporting Route:	Emergency Planning Committee
Appendices included with this report:	National EPRR Core Standards Framework 2024
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

To meet the mandatory national standard in updating the Trust Management Board on WVT EPRR work programme, linked to compliance with NHS Core Standards for EPRR, Civil Contingencies Act (2004) and the NHS Act (2006) amended by the Health and Social Care Act (2012), as required by the NHS England EPRR Framework.

Recommended Actions required by Board or Committee

Mandatory aspects of this report seeks board approval under the NHS Core Standards for EPRR which must be presented and signed off at Board level, in order that the Trust can meet the required standards. As such, Board is requested to approve the content of this report in line with the requirements in the NHS Core Standards for EPRR.

All recommendations contained within this report have been reviewed and approved by the Emergency Planning Committee.

Board is asked to:

- Approve this report, and specifically:
  - a) Resources allocated to EPRR (Section 10);
  - b) EPRR Policy (appendix 2); and
  - c) Trust Business Continuity Management System (Appendix 3) and the Business Continuity Statement (Appendix 4).
- Note the key activities and response to incidents during Q4 2024/ Q2 2025.
- Receive assurance that WVT is prepared to respond to an emergency and has resilience to continue the provision of safe patient care.

Executive Director Opinion[1]

This paper provides assurance on the Trust's EPRR arrangements.

In summary, a considerable amount of work continues in developing the Trust's EPRR, arrangements capability and progress in NHS Core Standards for EPRR assurance process. The Board is requested to receive this report, as this is a specific requirement under the NHS Core Standards for EPRR.

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

1. Introduction

1.1 This paper provides a report on the Trust's Emergency Preparedness, Resilience and Response (EPRR) status to meet the requirements of the Civil Contingencies Act (2004) and the NHS Core Standards for EPRR.

1.2. The Trust has an established portfolio of EPRR plans to deal with Major, critical and Business Continuity incidents. These align with the Civil Contingencies Act (2004) and latest NHS guidance. All plans have been developed in consultation and collaboration with county and regional stakeholders to ensure they interface with multiagency partner plans.

1.3. This paper encapsulates the following topics:

a) EPRR training and exercise programme and the development of emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

b) The development of new plans and updates to existing plans and documents for managing incidents driven by national, regional, local lessons learnt process.

c) Incorporation of learning from national Inquiries to maintain best practice in all areas of planning, exercising, training and incident response.

d) Learning from the Regional NHSE lessons learnt process.

e) Alignment of the trust Business Continuity (BC) planning and business continuity management system to ISO 22301 and NHSE Business Continuity framework.

2. Background

2.1 EPRR is a statutory requirement under the Civil Contingencies Act (CCA) 2004 and is core function of the NHS. Enabling responses to emergencies and is a key function identified within the NHS Act (2006) as amended by the Health and Social Care Act (2012).

2.2 In December 2022, the Government published the UK Resilience Framework which sets out the ambitious approach to UK's resilience up to 2030.

2.3 Nationally, there is an expanding focus on the range of threats that NHS Trusts face and must prepare for. It is essential that the focus remains on the Trust's EPRR and Business Continuity arrangements, thereby advancing its reputation within the EPRR regional arena.

2.4 The Civil Contingencies Act (2004) outlines a framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level.

As a Category 1 Responder, the Trust is subject to the following statutory duties:

- Assess the risk of emergencies to inform contingency planning.
- Have in place emergency plans.
- Have in place business continuity management arrangements.
- Maintain arrangements to warn, inform and provide guidance to the public about civil protection matters and emergencies.
- Information sharing with other responders to enhance coordination.
- Cooperation with other responders to enhance coordination and efficiency.

2.5 To guide compliance, the Trust has an EPRR strategy which comprises of the following work streams:

- Emergency Planning.
- EPRR and On Call Training
- Testing and exercising Emergency plans and response.
- Safeguard Trust CBRNe capability is maintained and tested.
- Maintain a watching brief on NHS green agenda and climate adaptation and where appropriate incorporate initiatives into the trust wide emergency planning processes.
- Training of Divisional and Directorate staff in the process of Business Continuity.

2.6 Delivery of the Trust EPRR strategy is monitored and validated against each standard in the NHS Core Standards for EPRR. For 2024, the Trust achieved **Substantial** compliance with the intent to progress to substantial compliance for 202.

3. WVT Core Standards update.

3.1 The EPRR lead has completed a mandatory process of self-assessment of the NHS Core Standards for EPRR 2025-2026. The Core Standards assess whether NHS Trusts are compliant with relevant EPRR regulation and legislation. This year the Trust has provided detailed assurance to the ICB EPRR lead and the NHSE regional EPRR team around the evidence of compliance with the Core Standards.

3.2 The updated Core Standards were released to the Trust in July 2025 for submission to NHSE in August 2025. The Trust has progressed achieving Substantial compliance for 2025-2026.

Fully Compliant	Partially Compliant	Non- Compliant
56	6	0

Table 1: WVT Core Standards 2025/ 2026 compliance overview (total number standards 62)

3.3 Present and previous Core Standard scores for WVT:

2025-2026 = **90%** substantially compliant.

2024-2025 = **82%** achieving partial compliance.

2023-2024 =**78%** achieving partial compliance.

2022-2023 = **76%** achieved a non-compliant.

Areas of partial compliance for WVT 2025/ 202

Domain	Core Standard	Areas of Partial Compliance	Status
Domain 3 – Duty to Maintain Plans	**12**	**Infection Disease -** Outbreak policy requires updating to reflect Covid learning.	In progress
Domain 6 - Response	**28**	**Management of Business Continuity Incidents -** All BCPs had been tested.	In progress
Domain 9 Business Continuity	**48**	**BC Testing and Exercising** – As above.	In progress
	49	**Data Protection Security Tool Kit** – Four areas of improvement: • • Disclosure forms for non-N3 connection third party networks. • • Review use of MFA across the Trust against NHS policy. • • Use existing governance for access applications requests. • • Review and capture of networks, information systems and underlying technologies required to restore essential functions.	In progress
	51	**BC audit** - All WVT Business Continuity Plans to be tested, externally audited and audit report producing.	In progress
	53	**Supplier and Providers BC arrangements** - Completion of WVT Provider and Supplier questionnaire for all contracts.	In progress

Table 2: Core Standards Action Plan 2025/ 2026

3.4 The Hereford and Worcestershire ICB system demonstrates good compliance, with no providers ranked as non-compliant or partial compliant for core standards. Good practice and learning for EPRR have been highlighted from both the Trust and the local ICB system. The Midlands region Best Practice Report reflects this achievement, noting that a considerable number of learning points originated from Hereford and Worcestershire ICB system.

4. Local Health Resilience Partnership update on Core standards for the ICB area.

4.1 The Trust continues to play an active role in the Local Health Resilience Partnership (LHRP) for 2025 in support of improving EPRR processes for public and patients we deliver care to. The work of the LHRP includes system wide improvements to EPRR incident response.

4.2 All members of the Herefordshire and Worcestershire systems have seen an increase or remained stable in the core standards in the year of 2025

4.3 WVT has increased its position to substantially compliant with the intention of further its position going forward in the forthcoming core standards assurance programme which takes place August 2026.

Organisation	Assurance Level	Organisation Type	Changes 2024/ 2025
H&W Integrated Care Board (HWICB)	Substantially Compliant	Integrated Care Board	↑
Worcester Acute Hospitals NHS Trust (WAHT)	Substantially Compliant	Acute Provider	↑
Wye Valley NHS Trust	Substantially Compliant	Acute Provider	↑
H&W Health & Care Trust (WHCT)	Substantially Compliant	Community Services Provider	↑

Table 3: Herefordshire and Worcestershire ICB system Core Standards 2024/25 compliance overview

Organisation	Assurance Level	Organisation Type	Changes 2024/ 2025
Shropshire Telford &Wrekin Integrated Care Board	Substantially Compliant	Integrated Care Board	↑
Robert Jones & Agnes Hunt	Partially Compliant	Specialty Provider	↑
Shrewsbury & Telford Hospitals	Substantially Compliant	Acute Provider	↑
Shropshire Community Health Trust	Substantially Compliant	Community Services Provider	↔
H&W Integrated Care Board (HWICB)	Substantially Compliant	Integrated Care Board	↑
Worcester Acute Hospitals NHS Trust (WAHT)	Substantially Compliant	Acute Provider	↑
Wye Valley NHS Trust	Substantially Compliant	Acute Provider	↑
H&W Health & Care Trust (WHCT)	Substantially Compliant	Community Services Provider	↑

Table 4: West Mercia Local Health Resilience Partnership Core Standards 2024/25 compliance overview

5. Training Numbers

5.1 The Emergency Planning Officer will provide EPRR training across the Trust for 2025/26, encapsulating all EPRR plans assessed as part of the Core Standards assurance. Each training session comprises of a presentation and desktop offered across a number of manageable periods to ensure extensive accessibility. All EPRR training has now been extended to WVT Level 2 On-Duty colleagues, who initially receive EPRR awareness presentation as a foundation. Collectively this training builds upon the regionally delivered NHSE Principles of Health Command the Executive Team and Senior Managers On-Call are required to attend. Furthermore, all On-Call colleagues where possible are encouraged to attend Local Resilience Forum training and meetings as part of the exposure to multiagency workings.

5.2 Training schedule is in place to deliver specialist training to Emergency Department staff on Chemical, Biological, Radioactive, and Nuclear (CBRNe) decontamination of contaminated patients.

5.3 The Switchboard forms a critical component for internal and external incident notifications, bi-annual and irregular testing takes place. External notification from the Local Resilience Forum is initiated by an automated voice call identified by caller ID and message format whereby Switchboard inform the Level 3 On-Call, who in turn reviews the WVT Single Point of Contact (SPOC) email for the notification. This notification utilises JESIP terminology for the incident descriptor and based on gravity acts as the mechanism for the control room mobilisation and information cascades to staff.

5.4 Other key areas of training include: clinical and nonclinical site management team as part the level 2 On-Duty Staff and the communications team. The Emergency Planning Officer has successfully delivered EPRR awareness training to new On-Call staff. For new WVT employees there EPRR component added to their Local Induction Managers Checklist covering EPRR documentation, with the intention of formalising this induction in collaboration with the E-learning team. General awareness sessions are delivered to trust staff through EPRR and Business continuity delivered by the Emergency Planning Officer.

5.5 Business Continuity (BC) Awareness Training is being cascaded to divisions to enhance plan expectations, development and EPRR requirements such as plan testing. Key components of the training included:

BC Awareness Training:

- BC plan awareness (format, business impact analysis, supplier and providers etc.).
- WVT business continuity incident escalation process.
- BC plan testing through tabletop exercises focused on directorate/ function line managers and staff participation to ensure plan content, awareness and applicable workarounds.

Divisional Board Training:

- BC awareness training sessions at divisional level.
- Sessions were facilitated by the Emergency Planning Officer, emphasising BC organisational structure, plan expectations and integration at a strategic level.
- Emphasised placed on key areas such as Business Impact Analysis, expanding to Providers and Suppliers and key contacts.

5.6 The continuous delivery of BC training and strategic awareness sessions has elevated the organisation's overall business continuity framework and preparedness to deal with unplanned disruptions effectively. This is especially in light of the desktops now being cascaded to directorates and departments, including activities monitored through the BC training schedule and tracker.

See Appendix 1 Training Update

6. Incidents in the last year

6.1 In the last year the Trust has reported and responded to 2 critical incidents and 12 reported Business continuity incidents. This is an escalation from the previous year when the trust responded to 8 incidents and 2 critical incidents. In line with EPRR Framework 2022 and Trust EPRR arrangements, the debrief process has been completed following incidents, encapsulating a hot debrief and formal cold debrief. After Action Reports have been completed for all incidents noting good practice, and areas for improvement. Formalising of 'lessons learned' into the Trusts Lesson Learnt log is an ongoing process identifying actions and action owners. After Action Report are reviewed by those participating in the incident and lessons learnt are presented to the Emergency Planning Committee, these documents are shared with the Integrated Care Board and NHSE regional EPRR team.

6.2 These incidents were as follows:

Critical Incident:

- 22 June 2025 Radiology/ Pathology.
- 22-28 April 2025 - Capacity & Flow operational Pressures.

Business Continuity Incident:

- 31October-13 November 2025 - Blood Analysers Outage.
- 2 October 2025 - Community EMIS/ PACS and CIRS Outage.
- 19 August 2025 - Maxims Outage.
- 6 August 2025 – Nelson House Cyber Attack.
- 24-29 July 2025 - Resident Doctors Industrial Action.
- 22June 2025 Maternity Fire.
- 29 April 2025 - PACs outage
- 5-10 March 2025 - Maxims Outage (IT related.
- 8 February 2025 - Maternity Roof Leak
- 27-30 January 2025 - Emergency Department Roof Leak
- 20 November 2024 - EPMA outage (IT related)
- 20 November 2024 - Pathology Water Leak

7. Exercises in the last year

7.1 In the last year the Trust has completed tabletops, and communication exercises in line with the NHSE EPRR Framework 2022. This includes tabletops for all emergency plans including: CBRN; Adverse weather; Protected Individuals; Evacuation and Shelter; Lockdown, Mass casualties; EPRR communications; Suspect Package; threat and Marauding Attacker. With additional desktops being developed for Pandemic/ Countermeasures.

7.2 The CBRN lead has completed a no warning dry decontamination exercise as part of the NHSE assurance requirement, this exercise is combined with on-going training for the Emergency Department with an after action report developed thereafter.

8. Lessons and learning from incidents and exercises.

8.1 Incident learning forms a crucial part in rectifying gaps and shortfalls within plans and training, thereby augmenting improvements to future EPRR planning and response. There are various elements of the learning process, including: after action reports, exercise reports and shared learning from NHSE (Midlands) EPRR team. The following list summarises key learning identified over the last 12 months:

- Supplier and providers questionnaire – Validating business continuity arrangements.
- Alignment of Trust Business Continuity plans to the ISO22301 Standard.

- Additional BC plans being implemented for Pathology, Virtual Ward and Community Diagnostic Centre.
- Increased IT related incidents due to multitude of system failures/glitches (Picture Archiving and Communication System [PACs], Maxims, and EPMA) – Testing EPRR responses, BC and workarounds to maintain delivery.
- Increased water ingress into WVT facilities (frailty, maternity and ED) affecting service delivery – BC arrangements and workarounds invoked.
- Learning from national Inquires including Manchester arena, and the Grenfell tower incidents.

8.2 The latest Midlands regional learning has yet to be released, however analysis will be conducted identifying appliable lessons to be addressed and included into WVTs lessons learnt.

9. CBRN statement of readiness and external CBRN Audit (including training)

9.1 The Trust completed a CBRN self-assessment prior to West Midlands Ambulance Service audit which took place on the 10th of July 2025. The Audit included a review of the Trust Wide CBRNe plans, risk assessment, staff training logs, and equipment service logs. As part of the Audit process, the equipment was set up at the Front Door of Emergency Department, including the decontamination and dignity tents, power and water supply, safety equipment, other decontamination equipment, wastewater pumps, and wastewater storage. This equipment was fully tested including running of water and electrical power as a full-scale equipment deployment.

9.2 The audit identified areas for improvement, these areas are detailed below and are in the process of being addressed:

- Demonstrate electronic rotas able to identify CBRN trained staff to ensure 24/7 capability.
- The Emergency Department benefit from incident signage and tabards to aid command & control in an incident.
- Training suits storage unsuitable (ideally ground floor and lockable facility).

9.3 Good practice and improvements over the last 12 months were noted for WVT CBRN audit.

9.4 In the last 12 months PRPS suits have had full servicing and replacements where appropriate by Respirex.

10. Emergency Preparedness Resilience and Response resources and roles

10.1 The Trust is supported by a part-time Emergency Planning Officer whose role as follows:

- Trust wide lead for EPRR planning, strategy, representation for internal and external system lead groups, committees, West Mercia Local Resilience Forum (LRF); Local Health Resilience Partnership (LHRP); Health Emergency Planning Operational Group (HEPOG); LRF Risk Assessment Working Group (RAWG); Trust wide training lead, Strategic/ Tactical/ Operational advisor; and Midlands Acute EPRR Network. To ensure the development of emergency and service planning within the Trust which improves health and wellbeing, demonstrating a high standard in terms of effectiveness, efficiency, safety, enhancing staff and patient experience aligned to the Trust Values. To facilitate and support the development of relevant networks spanning health and social care organisations. Deliver support as a subject matter expert to the Executive and senior managers of the Trust in responding to major incidents across the Trust.

- Business Continuity Lead providing business continuity (BC) planning across corporate, divisional, directorate teams. Input and specialist advice to corporate functions, audit lead for BC best practice.

- EPRR support in the form of development and analysis of learning from incidents based on internally conducted debrief and the development of after actions report. Collating and development of the Personal Development Portfolio (PDP) for all On-Call incident response Directors, Managers and Level 2 On-Duty Staff.

- Across the Foundation Group our dedicated EPRR resource is significantly less than other Trusts. Our current EPRR resource is supported by current EPRR resource at the Integrated Care Board (ICB). The current capacity within our provision is already fragile and, depending on the decisions around the future role of the ICB within EPRR, this could increase the level of fragility. As part of the review of corporate functions across the Integrated Care System, LHRP and Foundation Group consideration must be given to strength our capacity through network working and division of labour to deliver our statutory requirement.

11. EPRR Annual Plan 2025/ 2026

11.1 The work programme for the forthcoming year will take into account the continuing Trust response to Incidents, operational response issues, training and exercise, BC workshops, CBRNe, PRPS Training, Command and Control, Joint Emergency Services Interoperability Protocol (JESIP) Commanders and applicable updates, which will be reviewed, prioritised and agreed through the Emergency Planning Committee.

11.2 The key areas of focus for the EPRR Annual Plan will be:

- Update EPRR plans against changes to the National Risk Register and national guidance.
- Ongoing development and embedding WVT BC arrangements aligned to ISO22301, including plan testing and external audit programme.
- Support the development Risk Assessments and Counterterrorism Plan aligned to Martyn's Law.
- Review all EPRR plans against recent collaboration with NHSE and multiagency partners.
- Enhance Lockdown Action Cards for localities (part of Martyn's Law).
- Review of EPRR plans action cards and communications cascades.
- Delivery of Trust-wide training programme in line with the NHS Minimum Occupational Standards (MOS), the National Occupational Standards (NOS) and Skills for Justice Requirements. NOS training to be annotated in On-Call Staff Personal Development Plans.

12. Emergency Preparedness Resilience and Response Statement of readiness

12.1 This statement is specific requirement of the Core Standards Framework:

Wye Valley NHS Trust requires to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. Incidents could be anything from extreme weather conditions, infectious disease outbreak, major transport accident or a terrorist act. This requirement is underpinned by legislation contained with the following: *Civil Contingencies Act 2004 (CCA 2004); CCA 2004 (Contingency Planning) Regulations 2005; NHS Act 2006; and the Health and Care Act 2022. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR). The Trust overall rating from the NHSE Core standards assessment is Substantially complaint for 2024-2025. Areas for improvement are monitored in the Core Standards Action Plan 2025-2026.*

13. Briefing on LRF, LHRP and HEPOG

13.1 The Trust has played an active role in the Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), and the Health Emergency Planning Operational Group (HEPOG), over the last 12 months. The Trust has contributed to a range of LRF work streams, including development mass countermeasures, pandemic, mass fatalities but no limited to. The system wide group have responded to a range of situations and emergencies including rail crash, road traffic accident, flooding, other weather-related situations, and response in support of the community. As a system the Trust have also attended training and exercising events to include planning for pandemic, mass casualties and fatalities and weather. These exercises included the national pandemic exercise (Pegasus) work plan to test Health Response across the system.

13.2 Local Resilience Forum (LRF) 2025/2026 Workflow

During the Local Resilience Forum multiagency meeting have planned the following workflow for 2025/ 2026 are:

- Risk assessment Work Group (RAWG) to assess and agree regional risks.
- Mass Fatalities Work Program.
- Communications Work Program (warning and informing).
- Tactical Advisers Group (TAG), forms part of the work streams and approval process
- Chief Officers Group (COG) provides strategic overview and approves TAG outputs.
- Stronger LRF programme.
- Tactical Coordinating Group incident response for Herefordshire (predominately flooding for Herefordshire).

13.3 LHRP and HEPOG Workflows

At Local Health Resilience Partnership (LHRP) and the Health Emergency Planning Operational Group (HEPOG) work streams for this year are:

- Continued development and alignment of EPRR Plans
- Core Standards
- Cyber incidents / Planning
- National Tier 1 Exercise
- Risk register updates.

14. Business Continuity and Statement Business Continuity Statement of readiness

14.1 Following a change to NHSE Business Continuity (BC) Management policy in 2023, the Emergency Planning Officer has overhaul of the trusts BC Plans. A new Business Continuity Management System (BCMS) was brought into effect, and a review of all the trusts BC Planning arrangements have commenced. This has been refined through industry best practices and incident lessons learnt. Continued awareness sessions are being delivered to all divisions with training is offered to managers and staff, aided with BC toolkits and templates to assist with the completion of BC plans.

14. 2 Currently a single PowerPoint slide is utilised as an activity tracker for all BC plans across the trust, capturing plan review, testing, plan owner and plan availability on the intranet. This process is accompanied by the suppliers and providers questionnaire, which internal services and product leads are required to complete. The questionnaire requires product detail or service description, point of contact, level of response coverage, business continuity arrangements and workarounds, including alternate solutions etc. This process is essentially two pronged approached with requests from procurement shared services for visibility of contract business continuity arrangements in the endeavour to close an outstanding action.

14.3 System objective are to:

- To align all Trust BC plans to new format, validating plan currency, testing and availability.
- To capture all supplier and providers business continuity arrangements, so these arrangements are understood and available to pertinent staff.
- Embedding processes so that divisions, directorate and departments update and test plans annually.

14.4 Whilst good progress is being made with the BC programme across the trust, resource limitations and operational pressures continue to limit the pace of advancement. This poses a potential risk to the trust and its ability to adequately respond to incidents, however this is a diminishing potential as work progresses across the trust aligned with the three areas mentioned above.

15. EPRR Risks

15.1 Risk assessment and review is completed in all areas of EPRR Work programs. In 2025 the EPRR risks have been updated and are reported to the Emergency Planning Committee with escalation to the Trust Executive Risk Management Group and then through to Trust Management Board (TMB).

15.2 The key Trust EPRR currents risks are.

- CBRN response (InPhase Risk *1975) – Gaps resolved risk reduced to 5.
- The Effects of Climate Change (InPhase Risk *1711) – Accepted Risk.
- Maxims (InPhase Risk *1835).
- Industrial Action (Inphase Risk 2189).

15.3 The Emergency Planning Officer plays an active role with reviewing and mitigating risk from the Local Health Resilience Partnership (LHRP) Risk register. These are as follows:

- Disruption to Supplies/Supply Chain.
- Mass Casualty Incident, Non-Contaminated Casualties, Contaminated Casualties, PRPS National Procurement.
- Prolonged, severe capacity pressure in health and social care threatening ability to respond to EPRR incidents.
- Partial or full loss of critical service or premise or infrastructure.
- Cyber Attack.
- Infectious disease outbreak.
- Extreme weather inclusive of heatwave and cold weather alerts (excluding flooding).
- Regional failure of utilities network (Gas, Water, Electricity, and Communications).
- Workforce.
- Public or Environmental Health incident.
- Psychosocial support.
- Flooding Pluvial and Fluvial.

15.4 The EPRR Practitioners have an active role in the Risk Assessment Working Group (RWAG). Working with system partners as part of the Local Resilience Forum (LRF), the group review the national risk register and ensure the local risk register is kept up to date. Link attached to the LRF Public risk register. Community Risk Register | West Mercia Police

Appendices

Appendix Number	Appendix title	Supporting Document
1.	EPRR Training Update	WVT training - Board PowerPoint Insert.ppt
2.	WVT EPRR Policy	EP.04 EPRR Trust Wide Policy V2.3 - Ap
3.	WVT BCMS	EP.07 WVT Business Continuity Manageme
4.	WVT BC Statement 2025	WVT KPI's 2025-2026.pdf

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	Public Board
Date of Meeting:	**04/12/2025**
Title of Report:	Midwifery Safe Staffing Report October 2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery, Director of Midwifery
Reporting Route:	Quality Committee
Appendices included with this report:	Birthrate Plus Workforce Report
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
The purpose of this report is to provide assurance that midwifery staffing is monitored and to note actions taken to mitigate any shortfalls	
Recommended Actions required by Board or Committee	
The board is asked to note how safe midwifery staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of midwifery staffing	
Executive Director Opinion[1]	
The report offers assurance to the Board that there are robust processes in place to monitor midwifery staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur. Future reports will include neonatal staffing.	

[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.

Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- Sickness absence, vacancy and turnover rates
- Recruitment & retention rates
- Monthly report to Board

In addition to the above actions, a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits.

The summary of the workforce KPIs are as follows:

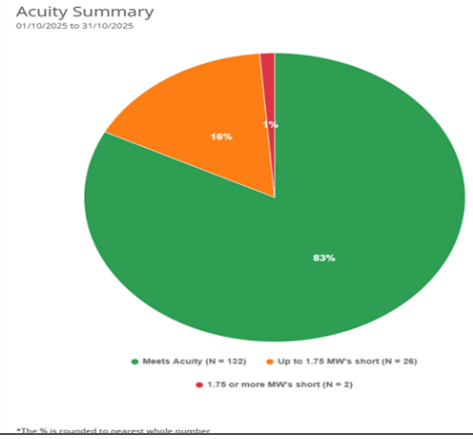
Metrics	Target	Current position (MW)	Current positon (MSW/MCAs)
Sickness rate	4%	7.07%	3.75%
Turnover rate (rolling)	11.5%	n/a	n/a
Vacancy rate (MW)	7%	0.61%	0%
Maternity Leave	-	4.8WTE	2.15WTE
Midwife to birth ratio (in post)	1:24	1:19	
1:1 care in labour	100%	Achieved	
Shift leader SN	100%	Achieved	

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 85% of the expected intervals and therefore the data presented is reliable. The diagram below presents when staffing met or did not meet the acuity.



From the information available, the acuity was met in 83% of the time and recorded at 17% when the acuity was not met prior to any actions taken. Safe staffing levels were maintained on all shifts in October following mitigation.

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=21) of when staff are reallocated from other areas of the inpatient service. The community teams were deployed to support the inpatient area on four occasions. There were no reports of staff not taking breaks or leaving their shift later than planned.

Number of Management Actions
01/10/2025 to 31/10/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	21	68%
MA2	Redeploy from community	4	13%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	6	19%
MA11	Maternity Unit on Divert	0	0%
TOTAL		31	

*The % is rounded to nearest whole number

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

NICE recommended red flags are reported in the acuity app and are presented below. There were no delays in care reported and one report of the Shift leader not being supernumerary during the shift however was initially rostered to be supernumerary.

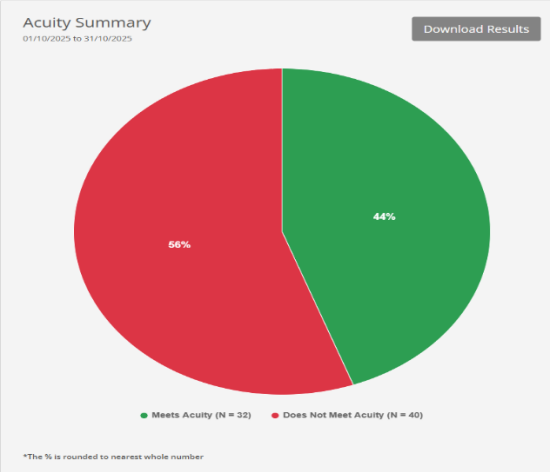
Number of Red Flags recorded
01/10/2025 to 31/10/2025
Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage over 30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process more than 1hr	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite co-ordinator not supernumerary	1	25%
RF11	Suspension Home Birth Service	3	75%
TOTAL		4	

*The % is rounded to nearest whole number

Antenatal/Postnatal Ward

The diagram below presents when staffing met or did not meet the acuity.



The acuity was met in 44% of the time and it is recognised that the ward requires additional staffing. This is also reflected in the most recent Birthrate Plus report. Funding has been identified to increase the roster template to 3 members of staff at night and in the daytime at the weekend to not only address the acuity issues on the ward but build in additional resilience for the inpatient service reducing the risk of the need to escalate from the community and Triage service.

There were no red flags reported by the ward staff during October.

Number of Red Flags recorded
17/11/2025 to 23/11/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
TOTAL		0	

*The % is rounded to nearest whole number

Birthrate Plus 3 yearly Audit.

In November 2024 the Trust received the final workforce audit report. The report recommended that the maternity service required 89 WTE midwives. Please note that the declared funded budget is not correct and the Director of Midwifery has reviewed both the pay budget and the PWR (taken from ESR) which confirms that the current funded establishment is 89 WTE.

As the current budgeted establishment is 89WTE there are no immediate requirement for investment. However, going forward and given that the current % uplift for training is 2% releasing staff to complete all of the role specific training will create a cost pressure for the Division and a case for further substantive investment will be made in 2026.

Summary of findings from the report:

Section 4c - Comparison of non-clinical midwifery roles

Current Funded Establishment	Birthrate Plus® recommended	Variance
11.00	12.31	**-1.31**

Table 10: Comparison of additional specialist and management wte

42. There is a deficit in the current funded establishment for non-clinical roles of **1.31wte.**

Section 4d - Summary of results

Current Funded Clinical, Specialist and Management wte	Birthrate Plus® Total recommended wte	Variance wte
84.89	89.24	-4.35

Table 11: Total Clinical, Specialist and Management wte

Staffing incidents

There were twenty - four staffing incidents reported via Inphase

1. Delay in ARM as no MW available to provide 1:1 care
2. Inpatient staff attended Homebirth as no community staff available due to sickness
3. Homebirth service suspended due to availability of community staff (sickness)
4. Both midwives deployed from Triage to DS to ensure 1:1 care was maintained.

Medication Incidents

There were five no harm incidents

1. Stock availability issue with anaesthetic drug stock – delay in CS elective list
2. CD stock incorrect
3. Variable Rate insulin Infusion removed prior to Cat 3 CS for failed induction of labour
4. Oral Vitamin K not provided as TTO (2)
5. Enoxaparin prescribed in error.

6. Anti D given – no traceability available (2)

Monitoring the midwife to birth ratio

The ratio in October was 1:19 (in post) and 1:19 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2024 (1:24).

Maternity SitRep (Pilot)

The local maternity SitRep pilot began in October and is recommended to be completed once per day. The report provides an overview of staffing, capacity and flow. Once embedded this will be increased to twice daily and shared daily with the local capacity team for better oversight of maternity services.

A regional OPEL SitRep is submitted daily.

National Maternity SitRep

A national maternity submission is completed each fortnight; it is expected that the regional SitRep will be rolled out across England – this is planned to for implantation in Q3.

Unify Data

The fill rates (actual) presented in the table below reflect the position of all areas of the maternity service.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Maternity Ward	93%	97%	81%	84
Community Midwifery	n/a	n/a	n/a	n/a
SCBU	113%	105%		

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the midwife in charge and the consultant and manager on call for that day. If there are any staffing concerns the manager on call will discuss with the Deputy Director of Midwifery with an escalation to the Director of Midwifery as required. Additional huddles will be held when required.

Vacancy

There are 3.7 unfilled midwifery roles B6 roles and currently no vacancies for support workers.

Sickness

Sickness absence rates for midwives are reported above the Trust target – a high level of assurance was provided following a recent deep dive into the management of absence.

Turnover

The turnover rate is not currently available for midwives and support workers however for Obstetrics it is 9.5%.

Conclusion
To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts in October. The escalation policy was utilised on 25 occasions to maintain safety. The community midwives were required to support the inpatient team. There are no reports of staff not being able to take a break and or staying beyond the end of their shift; the supernumerary status of the shift leader at the onset of the shift and 1:1 care in labour were achieved following deployment of staff. There was no harm caused from the reported staffing and medication incidents. Sickness absence rates for midwives remains above the Trust target and are likely to remain higher due to the expected seasonal variation; there is a high level of confidence that staff are being supported as per the Absence Policy. The vacancy rate is 0.6% for MWs and 0% for MSW's. Further recruitment is planned.
Recommendations
The Board is asked to note the content of this report for information and assurance.
Appendices
Birthrate plus report

BIRTHRATE PLUS® ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

NOVEMBER 2024

WYE VALLEY
NHS TRUST

Table of Contents

Section 1

Birthrate Plus®: The methodology and factors affecting maternity services.

Birthrate Plus® is a framework for workforce planning and strategic decision-making and has been in constant use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM).

The RCM recommends using Birthrate Plus® to undertake a systematic assessment of workforce requirements, since it is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3). Both the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) (NHSR 2024) and the Three-year delivery plan for maternity and neonatal services (NHSE 2023) include reference to using Birthrate Plus® as a midwifery staffing tool.

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have more than 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and birth. Each of the indicators has a weighted score designed to reflect the different processes of labour and birth and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and birth with a higher score reflecting medical comorbidity or the need or request for intervention during the labour and birth.

Other categories classify women admitted to the birth suite for other reasons than for labour and birth.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. These are reviewed and updated in line with recommendation from national reviews such as Ockenden (2002) and Kirkup (2023). Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick and study leave allowance and for travel in community**.**

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

The emphasis of community based care is on ‘normal/low risk/need care’ being provided in the woman’s home and other community setting by midwives and midwifery support workers. However, care of women and babies with safeguarding needs is an increasing demand upon community midwifery services.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there are women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwives once pregnancy is confirmed. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal women.

Section 2a

Discussion of Results for Hospital based care.

1. This is a ***final*** report of the midwifery workforce requirement for maternity services in Wye Valley NHS trust (WVT). The results show information for The County Hospital, Hereford (TCH) and the local community.

2. The Birthrate Plus staffing is primarily based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

3. Day to day management by ward and department managers, community team leaders and coordination of intrapartum services are included in the clinical establishments.

4. The decision was made to collect new casemix. The casemix has the major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V results in an increase from the one midwife to one woman ratio for Categories I and II. A 4 months' sample from January to March 2024 was obtained by the midwifery team and additional scrutiny provided by the Birthrate Plus consultant.

5. Table 1 shows the current casemix.

Casemix	**%Cat I**	**%Cat II**	**%Cat III**	**%Cat IV**	**%Cat V**
Delivery Suite	4.6	13.2	13.4	35.0	33.8
	31.2%			*68.8%*	

Table 1: Casemix

6. There has been an increase in the percentage of cases in the higher categories of IV and V compared to the previous studies (from 61.4% to 68.8%), which may reflect changes to pathways of care and increased medical comorbidities.

7. Table 2 shows the total annual birth activity.

	Annual Total
	TCH
Delivery Suite	1618
Home	40
Total Births	**1658**

Table 2: Annual Activity

8. All delivery suites have antenatal cases where women require monitoring and often treatment for obstetric or medical problems such as antepartum haemorrhage, preterm labour, reduced fetal movements, etc. Often the women are transferred to the maternity ward or to another unit if need a higher level of neonatal services. In addition, most maternity services provide care for women experiencing a pregnancy loss or termination for medical reasons. Postnatal readmissions may require a theatre procedure or enhanced midwifery care for conditions such as sepsis.

9. Table 3 shows all the recorded activity in TCH delivery suite and recommended staffing wte for each care activity. The roster template per shift is also included.

Intrapartum Services - Delivery Suite	**Annual Total**	**WTE**
Births	1618	19.30
Other activity	**Annual Total**	**WTE**
Antenatal Cases	217	1.69
Postnatal readmissions	23	0.08
In-utero transfers out	7	0.04
Non-registerable births	12	0.14
Total WTE		**21.25**
Roster template per shift		3.88

Table 3: TCH Intrapartum services – births and other activity

10. Often the inpatient antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital-based care. The antenatal admission episodes to the ward excludes inductions and elective sections.

11. Medical inductions of labour are mostly carried out on the ward. The annual total are actual insertions but may be less women as some may have multiple insertions.

12. The ‘extra care babies’ are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.

13. There is some readmission activity to the ward which may be mothers and or babies.

14. Staffing is included for the NIPE service provided by the ward midwives. NIPE for home births is routinely included in the community staffing.

15. Table 4 shows the annual activity on Maternity ward along with the recommend clinical staffing wte and roster template per shift.

Maternity ward	Annual Total	WTE
Antenatal care		
Antenatal admissions	324	1.09
Induction of labour	774	1.39
Postnatal care	**Annual Total**	**WTE**
Postnatal women	1618	14.30
Postnatal ward attenders	396	0.26
Postnatal Re-admissions	82	0.43
NIPE	475	0.23
Extra Care Babies	264	1.74
Total WTE		**19.44**
Roster template per shift		3.56

Table 4: Maternity Ward Activity

16. The staffing provision for Triage covers a 24-hour period, seven [7] days per week with 2 midwives on duty throughout the 24-hour. This is in line with the RCOG guidance paper 17, 2023 and BSOTS model (Birmingham Symptom-specific Obstetric Triage System). This includes telephone triage.

17. The Day Unit is staffed for 10 hours each day Monday to Friday with 1 midwife.

18. Outpatient Clinic services at the Trust are based on the average hours of each session time and numbers of staff to cover these, rather than on the number of women attending and a dependency classification. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service.

19. The staffing figures (Table 5) include an allowance of 22% uplift for annual, sick and study leave. This is at the lower end of the range seen in most maternity units. A comparison with an uplift of 24% is provided at the end of this report (appendix 2)

Breakdown of Birthrate Plus® Clinical Staffing for TCH

	TCH	Staff group
Intrapartum Services	21.25	RMs
Triage	10.94	RMs
Maternity Ward	19.44	RMs
Outpatient Services including frenulotomy	4.43	RMs
Day Unit	1.63	RMs
Total Clinical wte	**57.69**	**RMs**

Table 5: Birthrate Plus® Staffing 22 %

Section 2b

Discussion of Results for Community based care

20. The community annual total includes women who birth in neighbouring units and receive either antenatal or postnatal care, or a combination of both, from the Trust midwives (community imports). The birth episodes are provided by neighbouring units.

21. Every Trust will have a proportion of women with safeguarding needs that may not reach the threshold for formal intervention but require a significant input from the community midwives such as increased surveillance, support, and signposting to other services. Additional staffing resource has been included for this additional care.

22. All Trusts have attrition cases, namely, women who may book and/or see a midwife in early pregnancy but either move out of area or have a pregnancy loss.

23. In addition, many Trusts will have export cases; women who birth in their Trust but live outside of the geographical area and therefore receive community care in their local trust. Table 7 includes this figure for reference.

24. The total community cases in table 6 includes all imports and home births but excludes exports, and attrition cases

25. The total community activity in table 6 refers to all women being cared for and includes all community cases as noted in point 24 as well as the attrition cases.

26. The annual community activity is more than the hospital births. Community cases often differ to the birth numbers, and this should be considered when understanding the staffing required for each area.

27. The staffing figures (Table 6) include the current allowance of 22% uplift for annual, sick and study leave, and 12.5% for travelling time.

COMMUNITY SERVICES	**TCH**	
	Annual Total	**WTE**
Home Births	40	1.14
Community Cases (own births)	1543	15.29
Imports AN & PN care	87	0.86
Imports AN Care only	89	0.49
Imports PN Care only	92	0.4
Attrition Cases	137	0.18
Additional Safeguarding	188	0.88
*Exports **	*75*	
Total Community Cases		1851
Total Community Activity		1988
Hospital births		1618
Community activity compared to hospital births		+370
Total WTE		**19.24**
*figure included for reference only.		

Table 6: Community activity and wte at 22% uplift

Section 3

Specialist Midwifery and Managerial Roles

28. The total clinical establishment shown in Table 8 above excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.

29. All maternity units have Specialist Midwives who provide expert midwifery care to groups of women or provide support and training to colleagues.

30. In addition, they may have a strategic role in service delivery (RCM).

31. Some Specialist Midwives may have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The Specialist midwifery team contribute 2.3wte to the clinical care of women, directly through their specialist roles. The remaining % is included in the non-clinical roles (education, audit, quality improvement, policy development etc).

32. In addition, *every* maternity unit, irrespective of size of number of births, requires specific non-clinical managerial and leadership roles to support the overall functioning of the unit.

33. Table 7 below shows the Specialist roles along with the managerial posts at TCH.

WYE VALLEY NHS TRUST					
	WTE	Clinical input	Nonclinical WTE	Senior Management band 8a and above*(list roles)*	WTE
Bereavement Midwife	1.00	0.60	0.40	Inpatient Matron	1.00
Digital Midwife	1.00	0.00	1.00	Outpatient Matron	1.00
Public Health Midwife	1.00	0.10	0.90	Governance Matron	1.00
Diabetes Midwife	0.70	0.50	0.20	Associate Director of Midwifery	1.00
Antenatal and NB Screening	1.00	0.50	0.50		
Patient Safety Midwife	1.00	0.00	1.00		
Practice Facilitator & Retention	1.60	0.00	1.60		
Fetal Wellbeing Midwife	1.00	0.10	0.90		
Consultant Midwife	1.00	0.50	0.50		
TOTALS	**9.30**	**2.30**	**7.00**		**4.00**

Table 7: Specialist and Managerial posts

34. In addition to the above posts, consideration should also be given to recommendations from national reports such as Ockendon 2022 with regards to new roles, and the manifesto produced by the RCM in August 2019 which sets out seven steps to strengthen midwifery leadership.

35. Additional reports that have require specialist midwifery posts are shown below:

    i. Maternity and Neonatal Safety Improvement Programme (NHSE 2021)
    ii. The Culture and Leadership Programme (NHSE 2020/21)

iii. Maternal (and perinatal) Incentive Scheme Year 6 v1.2 (NHS Resolution Sept 2024)
iv. National Bereavement Care Pathway (2018)
v. Service Specification: perinatal pelvic health services (NHSE October 2023)
vi. Birth Trauma Report (APPG January 2024)
vii. Independent Culture Review (NMC July 2024)
viii. National Review of maternity services in England 2022 to 2024 (Care Quality Commission September 2024)
ix. Saving Lives, Improving Mothers' Care. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK October 2024)

36. Applying 16% to the Birthrate Plus® clinical wte provides 12.31wte additional staff for the above roles as well as providing some additional resource to ensure that there are adequate senior midwives to support both the operational and strategic needs of the service whilst also providing resilience and succession planning.

37. There are some additional roles that the service may wish to consider such as a Lead PMA, Deputy ADOM or Head of Midwifery and Preterm Specialist Midwife. It is a local decision as to which posts are required and appropriate hours allocated, supported by the national agenda for maternity services.

Section 4 – Comparison of current funded and recommended staffing including overall summary

Section 4a - Current Clinical Funded Bands 3 – 7

38. Comparisons are made with the current funded establishment as per table 8 below.

RMs Bands 5 – 7	RNs	Specialist Midwives contribution	MSWs band 3 and 4	Current Total Clinical wte
69.79	0.80	2.30	1.0	73.89

Table 8: Current Funded Establishment

Section 4b - Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	Birthrate Plus® establishment bands 3 – 7	Variance Bands 3 – 7
73.89	76.93	-3.04

Table 9: Comparison of Clinical Staffing

39. There is a deficit in the current funded clinical establishment of **3.04 wte**.

40. Larger maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), possibly Band 4 Nursery Nurses and sometimes Band 5 RNs working in postnatal

services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix, using professional judgement along with their local knowledge of the service.

41. Managing periods of high activity can be especially challenging in smaller units, typically those with less than 2000 births per annum and there is an increased likelihood of specialists and managers being used as part of the escalation policy. In addition, community midwifery staff are also likely to be redeployed to the intrapartum and ward during such times. This requires an adequate number of midwives who can work across all areas of the service and always ensure a safe service. The current skill mix is 98.6/1.4% and maintaining this skill mix ratio will help to ensure an adequate escalation process as well as ensuring there is an adequate number RMs available for mentoring and supervision of students and support workers.

Section 4c - Comparison of non-clinical midwifery roles

Current Funded Establishment	Birthrate Plus® recommended	Variance
11.00	12.31	**-1.31**

Table 10: Comparison of additional specialist and management wte

42. There is a deficit in the current funded establishment for non-clinical roles of **1.31wte.**

Section 4d - Summary of results

Current Funded Clinical, Specialist and Management wte	Birthrate Plus® Total recommended wte	Variance wte
84.89	89.24	-4.35

Table 11: Total Clinical, Specialist and Management wte

43. **Overall, the results show there is a deficit in the total funded establishment of 4.35wte with an overall birth to midwife ratio of 1:21.6.**

SUMMARY of DATA & REQUIRED WTE for

Wye Valley NHSFT

Final version 13/11/2024

Annual Data 2023/2024

22.00%

Total Births in service: 1658 | 85

Total Community Cases (inc. imports & home births): 1851

5.47

Jan - Mar 2024

	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	4.6	13.2	13.4	35.0	33.8
%Generic Casemix	*4.6*	*13.2*	*13.4*	*35.0*	*33.8*

		Annual Nos.	Required WTE	
Delivery Suite				
	Births	*1618*	19.30	**19.30**
Other DS Activity				
	Antenatal Cases	*217*	1.69	**1.95**
	Postnatal Readmisisons	*23*	0.08	
	Escorted Transfers OUT	*7*	0.04	
	Non-viables	*12*	0.14	
Triage, including telephone line		*0*	10.94	**10.94**
Maternity Ward				
Antenatal Services	Antenatal admissions	*324*	1.09	**2.48**
	Antenatal ward attenders	*0*	0.00	
	Induction Doses	*774*	1.39	
Postnatal Services	Postnatal women	*1618*	14.30	**16.96**
	Postnatal Ward Attenders	*396*	0.26	
	Postnatal Re-admissions	*82*	0.43	
	NIPE	*475*	0.23	
	Extra Care Babies	*264*	1.74	
Outpatients Services				
Antenatal Clinics	Midwife scan review clinics		1.24	**4.19**
	Obstetric AN clinics		0.84	
	Specialist Obstetric clinics		0.72	
	Vaccination clinics		0.99	
	Specialist MW clinics		0.40	
	click & name or description of clinic		0.00	
Frenulotomies			0.24	**0.24**
Day Unit		*0*	1.63	**1.63**
COMMUNITY SERVICES				
	Home Births	*40*	1.14	**19.24**
	Community Cases *(Own births)*	*1543*	15.29	
	Imports *(AN & PN care)*	*87*	0.86	
	Imports *(AN care)*	*89*	0.49	
	Imports *(PN care)*	*92*	0.40	
	Attrition Cases	*137*	0.18	
	Additional Safeguarding	*188*	0.88	

CLINICAL MIDWIFERY WTE REQUIRED **76.93**

Additional Management and Specialist roles **12.31**

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Birth

There are five [5] categories for mothers who have given birth during their time in the birth suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal birth with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental birth with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal birth will also be Category IV, as will those having a straightforward instrumental birth.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-birth. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

Appendix 2 – Comparison using 24% uplift

At the request of the DoM, a comparison has been made using an uplift of 24% which shows an increased overall deficit of 6.24wte.

	Current Budgeted wte	Birthrate Plus wte	Variance
Total clinical wte	73.89	78.56	-4.67
Additional Specialist and Management wte	11.0	12.57	-1.57
Total clinical, Specialist and Management wte	84.89	91.13	-6.24

birthrateplus® | Safe Staffing for Maternity Services

SUMMARY of DATA & REQUIRED WTE for

Wye Valley NHSFT

Final version 13/11/2024

Annual Data 2023/2024

24.00%

Total Births in service 1658 85

Total Community Cases (inc. imports & home births) 1851

5.56

Jan - Mar 2024

	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	4.6	13.2	13.4	35.0	33.8
%Generic Casemix	*4.6*	*13.2*	*13.4*	*35.0*	*33.8*

		Annual Nos.	Required WTE	
Delivery Suite				
	Births	*1618*	19.62	**19.62**
Other DS Activity				
	Antenatal Cases	*217*	1.72	**1.98**
	Postnatal Readmisisons	*23*	0.08	
	Escorted Transfers OUT	*7*	0.04	
	Non-viables	*12*	0.14	
Triage, including telephone line		*0*	11.11	**11.12**
Maternity Ward				
Antenatal Services	Antenatal admissions	*324*	1.12	**2.54**
	Antenatal ward attenders	*0*	0.00	
	Induction Doses	*774*	1.42	
Postnatal Services	Postnatal women	*1618*	14.67	**17.40**
	Postnatal Ward Attenders	*396*	0.27	
	Postnatal Re-admissions	*82*	0.44	
	NIPE	*475*	0.24	
	Extra Care Babies	*264*	1.78	
Outpatients Services				
Antenatal Clinics	Midwife scan review clinics		1.26	**4.25**
	Obstetric AN clinics		0.85	
	Specialist Obstetric clinics		0.73	
	Vaccination clinics		1.01	
	Specialist MW clinics		0.40	
	click & name or description of clinic		0.00	
Frenulotomies			0.25	**0.25**
Day Unit		*0*	1.65	**1.65**
COMMUNITY SERVICES				
	Home Births	*40*	1.17	**19.75**
	Community Cases *(Own births)*	*1543*	15.70	
	Imports *(AN & PN care)*	*87*	0.88	
	Imports *(AN care)*	*89*	0.51	
	Imports *(PN care)*	*92*	0.41	
	Attrition Cases	*137*	0.18	
	Additional Safeguarding	*188*	0.90	
			78.58	
CLINICAL MIDWIFERY WTE REQUIRED				**78.56**
Additional Management and Specialist roles				**12.57**

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Perinatal Safety Report – Quarter 2 25/26
Lead Executive Director:	**Chief Nursing Officer**
Author:	Elaine Evans, Neonatal Unit Sister Justine Jeffery, Director of Midwifery Susan Hughes – Deputy Director of Midwifery Lyndsey Morris – Patient Safety Midwife
Reporting Route:	Quality Committee
Appendices included with this report:	Appendices (included) Minimum data set Maternity dashboard SCBU dashboard Additional documentation (shared with Board separately) Safety action 2 – MSDS compliance Safety action 3 - (Q1, Q2 Transitional care audits and action plans and improvement project for IV antibiotics) (Q1 and Q2 ATAIN audits and action plan) Safety action 4 - SCBU staffing action plan Safety action 7 - Risk Register MNVP
Purpose of report:	**☒ Assurance ☐ Approval ☒ Information**

Brief Description of Report Purpose

The purpose of the paper is to provide a quarterly update on key maternity and neonatal safety initiatives which will support the Trust to achieve the national ambition. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety.

The requirement to ensure the Trust Board and LMNS Board are kept informed of present or emerging safety concerns and activities being undertaken to ensure safety and two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team was initially outlined in the 2020 NHSEI document 'Implementing a revised perinatal quality surveillance model'.

This has recently been superseded by the Perinatal Quality Oversight Model, published by NHS England in June 2025. The reporting template will be updated to reflect the Oversight Model in Q4.

In addition, this report presents the current evidence against each of the required safety actions within the Maternity Incentive Scheme (MIS), along with any concerns with compliance and actions implemented.
Recommended Actions required by Board or Committee
Board is invited to: • **Note** and **discuss** the content of the report, • **Receive** Assurance that our maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.
Executive Director Opinion[1]
The CNO offers assurance to the Board that the maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.

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

1. INTRODUCTION

The purpose of the report is to inform the WVT Trust Board and the LMNS Board of present or emerging safety concerns or activity being undertaken to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

This has recently been superseded by the Perinatal Quality Oversight Model, published by NHS England in June 2025. At present this is a draft document until the 10 Year Plan is published.

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety and will provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the LMNS Board.

2. PERFORMANCE

2.1 Activity

There were 132 Dashboard births in September 2025.

Midwife to birth ratio (<1:24)	1:18

2.2 Red flags

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

The red flags in September 2025 are recorded as:

				September
Red Flags	WVT	Inphase	Delay in Induction >2hrs	3
	WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1
	WVT	Inphase	Delay in administering medication	0
	WVT	Inphase	Delay in starting syntocinon/ARM >30mins	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	2
	WVT	Birth Rate +	Any movement of midwifery staff from any area to provide midwifery cover	24
	WVT		Delayed recognition of and action on abnormal vital signs	0
	WVT		DSC lost - supernumerary status	0
	WVT		Full clinical examination not carried out when presenting in labour	0
	WVT		Delay of more than 30 minutes in providing pain relief	0

In the month of September 2025, there were 3 inductions of labour delayed by more than two hours due to acuity. There was one delay in Category 1 caesarean sections, this was due to a category 2 cesarean section being changed to a category 1 following an acute bradycardia.

Whilst the red flag incidents continue to demonstrate an increase in movement of staff since Febuary 2025, with September being 24 the data source was changed from Inphase to BirthRate+ as this has shown to be a more accurate reporting method. This numbers for movement of staff since Febuary has stayed consistent giving us confidence in the accuracy of this data.

Delivery Suite co-ordinator supernumerary status

In July and September, the Delivery Suite Coordinator was supernumerary 100% of the time and all women received one to one care in labour. In August there was a report of one event where the shift leader was not supernumerary during a clinical incident. Escalation occurred immediately, with the MOC attending the unit within 10 minutes, and mitigations were put in place. No adverse outcomes occurred, and the case has been reviewed in detail.

NHS Resolution's CNST Maternity Incentive Scheme Year 7 guidance recognises that isolated, exceptional events may occur. Compliance is maintained where the incident is well documented, escalation is immediate, and there is evidence of mitigation and review. On this basis, this event does not affect compliance with Safety Action 5c, therefore, this has now been removed from the maternity dashboard as its previous inclusion (August 2025) did not accurately reflect compliance.

2.3 **RCOG Obstetric attendance**

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

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	100%	
Caesarean birth for women with BMI>50	0	100%	
Caesarean birth <28/40	0	100%	
Premature twins (<30/40)	0	100%	
4th degree perineal tear repair	0	100%	
Unexpected intrapartum stillbirth	0	100%	
Eclampsia	0	100%	
Maternal collapse e.g. septic shock / MOH	0	100%	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	3	100%	

2.4 SCBU Activity

The table below details the number of admissions (Activity) for SCBU throughout Quarter 2. There were a total of 38 admissions to SCBU during Quarter 2. Any exceptions have been discussed at Quality Committee.

Month	<26 weeks	26-30 weeks	31-36weeks	>36 weeks
July	0	1*	5	5
August	0	2*	10	4
September	0	0	5	6

Month	ITU	HDU	SCBU
July	1	4	6
August	2	4	10
September	1	5	5

BAPM 2011 Level of care on day of admissions

Month	Intensive Care	High Dependency
July	2	16
August	2	7
September	0	5

ITU and HDU continuing number of cot days on SCB (other than on day of admission)

In-utero/Ex Utero Transfers – Quarter 2.

Type of Transfer	Quarter 2		Comments
	In	Out	
IUT Transfer for clinical reasons as per network pathway	1	3	
IUT Transfer for non-clinical reasons	0	0	
IUT Transfers outside of the network	0	4	1 x Grange 2 x Singleton (Swansea) 1 x Queens Alexander Portsmouth 1 x Swindon
Ex-utero Transfers for clinical reasons as per network pathway	1	9	
Ex-utero Transfers out of network	0	1	1 x Grange
Delays in Transfers in/out	0		
IUT or Ex-utero exceptions.	0	6	

3. SAFETY

3.1 Incidents

Incidents graded moderate or above; including incidents reported to MNSI (formerly HSIB), NHS Resolution Early Notifications/Claims are reported. Whilst we transition to improved ways of working under PSIRF, this report also provides detail on cases determined as a PSII and any thematic reviews under PSIRF.

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

3.1.2 Minimum Data Set incident summary:

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

In September, one incident resulting in moderate psychological/physical harm was reported. The case highlighted several key areas for improvement, including the importance of actively listening to patient concerns, thoroughly reviewing clinical notes, and clearly documenting any deviations from the expected clinical pathway. It also emphasised the need for clear, comprehensive documentation of discussions with other departments, ensuring that either the individual clinician or those involved in interdepartmental communication accurately record the conversation and agreed plan. An initial review of care is scheduled to ensure learning and inform any necessary actions.

Total Number of In Phase – SCBU – Quarter 2

July	August	September
11	7	9

Key themes:
9 x Unexpected Term admissions
3 x Staffing
3 x Medication

3.2 **Concerns and Complaints**
The PQSM Minimum Data Set requires the service to share the detail of service user feedback with Trust Board. Similar to incidents, this information is potentially patient identifiable and is therefore shared in full at Quality Committee.

Complaints	July 25	August 25	September 25
SCBU	0	0	0

3.3 **PMRT (Perinatal Mortality Review Tool) / MBRRACE Performance**
In the last quarterly report, we identified an increase Year to Date on the number of stillbirths and neonatal deaths in WVT compared with previous years. In Q2 for 2025/26 the following cases have been reported:

	Stillbirths	Neonatal Death	Maternal Death
Q2	**1**	**1**	**0**

3.3.1 A quarterly PMRT summary of the reportable cases is available and shared with quality committee (not shared in public Board due to potentially patient identifiable information)

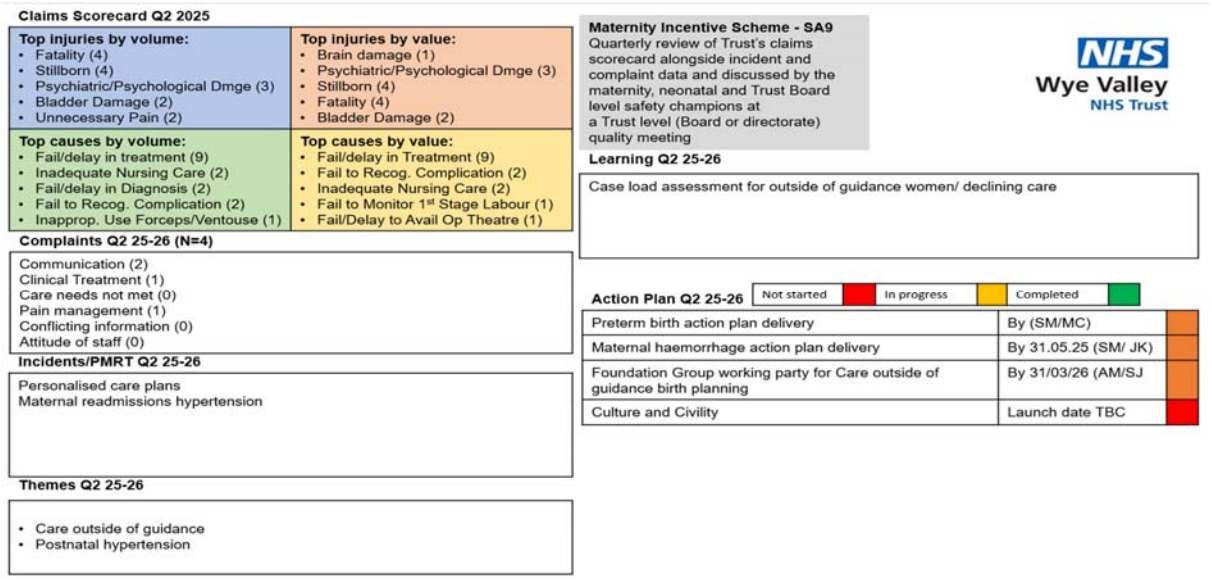
3.3.2 The report includes details of the deaths reviewed, highlights themes identified and the consequent action plans. The report demonstrates that the PMRT has been used to review eligible deaths and meets the required standards as outlined in Safety Action 1:
a) notification of all eligible deaths,
b) seeking parents' view of care and
c) reviewing the death and completing a review within specified timeframes.

3.3.3 In summary, all cases have been appropriately reported to MBRRACE, reviewed and managed within the appropriate timescales meeting the prescribed standards.

3.3.4 **Themes**:
Grading of cases identified there were no thematic issues.

3.4 TRIANGULATION

3.4.1 The NHS CNST Year 7 schemes encourages services to review the data from the Claims Scorecard, alongside the Complaints / Incidents / PMRT to determine themes and identify relevant learning and subsequent actions. Below is the recommended national template which is reported quarterly. This covers Q2 (July – September 25).



Claims Scorecard Q2 2025

Top injuries by volume:	Top injuries by value:
• Fatality (4) • Stillborn (4) • Psychiatric/Psychological Dmge (3) • Bladder Damage (2) • Unnecessary Pain (2)	• Brain damage (1) • Psychiatric/Psychological Dmge (3) • Stillborn (4) • Fatality (4) • Bladder Damage (2)
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (9) • Inadequate Nursing Care (2) • Fail/delay in Diagnosis (2) • Fail to Recog. Complication (2) • Inapprop. Use Forceps/Ventouse (1)	• Fail/delay in Treatment (9) • Fail to Recog. Complication (2) • Inadequate Nursing Care (2) • Fail to Monitor 1st Stage Labour (1) • Fail/Delay to Avail Op Theatre (1)

Complaints Q2 25-26 (N=4)

Communication (2)
Clinical Treatment (1)
Care needs not met (0)
Pain management (1)
Conflicting information (0)
Attitude of staff (0)

Incidents/PMRT Q2 25-26

Personalised care plans
Maternal readmissions hypertension

Themes Q2 25-26

- Care outside of guidance
- Postnatal hypertension

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS Wye Valley NHS Trust

Learning Q2 25-26

Case load assessment for outside of guidance women/ declining care

Action Plan Q2 25-26 — Not started | In progress | Completed

Preterm birth action plan delivery	By (SM/MC)
Maternal haemorrhage action plan delivery	By 31.05.25 (SM/ JK)
Foundation Group working party for Care outside of guidance birth planning	By 31/03/26 (AM/SJ
Culture and Civility	Launch date TBC

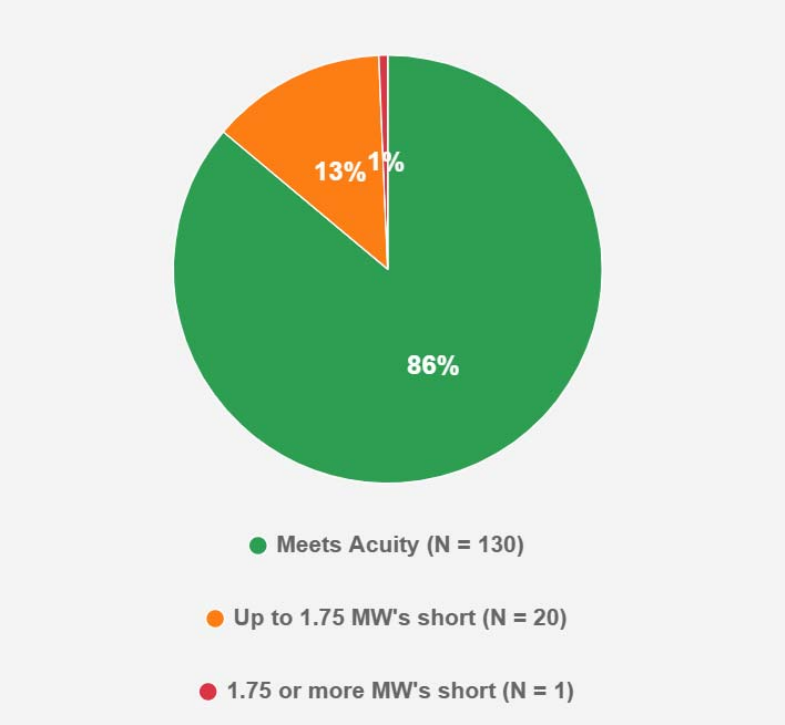
4. WORKFORCE

4.1 Safe Staffing – Midwifery

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

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

4.1.1 The Birthrate plus acuity tool for Delivery Suite was completed 83.89% (82.2% last month) of the expected intervals, which is a good reliability factor. A review of the data demonstrates that staffing met acuity 86% of the time. For 13% of the time the service was short by up to 1.75 midwives and for 1% of the time the service was more than 1.75 midwives short.



4.1.2 This data is collected prior to mitigation and mitigations evidence that there was a total of 18 instances of staff being redeployed internally to cover acuity which is a slight increase from last month's data of 17 times. There were 2 occasions where community were redeployed to support Delivery Suite. There were 4 occasions where specialist midwives supported clinical. There were 9 occasions where acuity was escalated to the manager on call for support highlighting a culture where the team feel able to highlight issues and that the pathway in place is effective.

Number of Management Actions
01/09/2025 to 30/09/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	18	51%
MA2	Redeploy from community	2	6%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	4	11%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	2	6%
MA10	Escalate to manager on call	9	26%
MA11	Maternity Unit on Divert	0	0%
TOTAL		35	

*The % is rounded to nearest whole number

4.1.3 Midwifery fill rates are collected from Allocate rosters.

4.2 Obstetric workforce

4.2.1 The obstetric rotas have been covered throughout the quarter as and an example of the fill rates from the quarter is reported below. The Obstetric workforce has remained compliant with the RCOG standards for recruitment of Locums during the CNST year as no short-term locums have been recruited over the period.

SEPTEMBER '25	Substantive Fill			Substantive Extra fill			Locum Fill			Totals:
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	
Consultant: Hot Week	220	220	100.00	0	220	0.00	0	220	0.00	100.00
Consultant: On Call	442	467	94.65	25	467	5.35	0	467	0.00	100.00
Consultant: Cold Week	104	104	100.00	0	104	0.00	0	104	0.00	100.00
Consultant: Antenatal Clinic	93.5	93.5	100.00	0	93.5	0.00	0	93.5	0.00	100.00
Middle Grade: delivery suite	164.5	198	83.08	33.5	198	16.92	0	198	0.00	100.00
Middle Grade: Antenatal Clinic	110.5	153	72.22	42.5	153	27.78	0	153	0.00	100.00

Compensatory rest

There is currently no local guidance to support medical staff to formally take compensatory rest. An action plan has been developed.

4.3 Neonatal Medical Workforce

4.3.1 The Neonatal workforce is not required to be reported but it should be noted that the Neonatal Medical Workforce does not use locum support as they are fully funded and recruited to BAPM standards. There is currently a review of the BAPM Standards for Medical Workforce which has not yet been finalised, but draft proposals will see changes that would require a review of the Medical Workforce Model for WVT with the requirement for a dedicated Consultant/Registrar to be available for SCBU 4 hours a day (5 days a week), separate to Paediatrics.

4.4 Anaesthetic workforce

4.4.1 The anaesthetic rotas have been covered throughout September 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	85%	30	84%
Anaesthetist extra days	4	15%	5	16%

The directorate team advise that the increase in extra shifts is due to leave and sickness which is expected to resolve in coming weeks.

4.5 MDT ward rounds

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

	08:30	20:30
Anaesthetist	97%	80%
Obstetric Consultant	100%	100%

4.6 Workforce – Neonatal

4.6.1 Safe Staffing Standards

Neonatal Nurse staffing is monitored by:

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

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

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

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

Neonatal Staffing Summary Quarter 2

Nursing Position	Budgeted WTE	Contracted WTE	Maternity leave	Long Term Sickness.
Band 7	2.0	2.0	0	0
Band 6	5.2	4.4	0	0
Band 5	13.5	12.55	1	0
Neonatal Outreach	1.26	1.26	0	0

Neonatal Staffing Quarter 2 measured against BAPM Standards:

	WVT Jul	Nat Av	WVT Aug	Nat Av	WVT Sept	Nat Av
% of shifts staffed to BAPM recommendations	100%	86.94%	100%	88.39%	98.18%	85.94%
% of shifts QIS against Neonatal Toolkit standards	100%	95.52%	100%	95.09%	100%	95.09%
% of shifts with supernumerary shift lead	5.17%	22.9%	3.28%	22.88%	10.91%	24.18%
% of Nursing shifts covered by bank	3.7%	5.91%	3.59%	6.25%	1.18%	4.98%

- WVT SCBU shifts were 100% compliant for staffing to BAPM recommendations for June and July.
- Our % of shifts QIS against Neonatal Toolkit standards remained at 100% throughout Quarter 2.
- We do not currently have an establishment to achieve a supernumerary shift leader on all shifts, this is currently recognised as an accepted and mitigated risk by the Trust for our capacity and acuity.
- We remain below national average for number of shifts covered by bank, however the percentage of shifts covered by bank staff has increased due to the additional expectation from WMPN that all Night and weekend shifts are staffed with 2 x QIS. Day shifts throughout the week are covered by senior staff in office if second QIS not available. This has been agreed as an acceptable mitigation by the WMPN

4.6.2 Daily Sit Rep Reporting

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

OPEL REPORTS – Quarter 2

July 25

During July 2025 our OPEL (staffing) status was recorded as BLACK only on two occasions, both were for Day shifts.

Mitigation:

On further investigation, one was a data entry error and the second occurred as a result of late sickness reported for the Band 6 NIC, resulting in the Band 7 specialist nurse in the office stepping in to cover and therefore unable to provide second QIS cover, so this was unavoidable.

August 25

During August 2025 our OPEL (staffing) status was recorded as Black on two occasions both were for Day shifts.

Mitigation

One was for Long term sickness of the allocated QIS (2nd QIS) and unable to backfill with 2nd QIS with Band 7 Ward Manager already working as first QIS cover on that shift.

Second was late reported sickness unable to find additional QIS cover for Night Shift, available staffing assessed against acuity and capacity – appropriate escalation measures taken, inphase completed and Manager remained on call for the Night Shift.

September 2025

OPEL Staffing reports were either green or red throughout September 2025 with no black.

4.6. 3 Qualified in Speciality Staffing Report.

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

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

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

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

The Neonatal Toolkit (2009) defines that:

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

- Babies requiring intensive care are cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under the supervision of a registered nurse/midwife (QIS). A minimum of a 1:1 staff to-baby ratio is provided at all times (some babies may require a higher staff-to-baby ratio for a period of time).

Trajectory of QIS from July 25 – December 25

	July 25	August 25	September 25	October 25	November 25	December 25
Total QIS %	52.5%	52.5%	52.5%	41.36%	41.36%	41.36%

The trajectory for the overall QIS compliance indicates an improving picture from July 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. The overall trajectory will decrease in October 2025 with 3 newly qualified staff nurses joining the Team in September 2025 increasing our overall establishment.

Month	Sickness (Trust Target <3%)	Maternity Leave (WTE)
July	**5.2%**	**1.0wte**
August	**4.88%**	**1.0wte**
September	**4.32%**	**1.0wte**

There is one Band 5 enrolled on the critical care course at Birmingham City University commencing November 2025 and one to start in February 2026 and another one commencing in December 2025. The three new staff nurses will commence the Foundation Module in April 2026. The West Midlands Network have provided additional funding to support the development of our ongoing education programme to increase the number of staff with a neonatal intensive care and high dependency qualification (QIS).

4.3 Quality nurse Roles and AHP Provision

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

4.6.4 **Sickness and Maternity Leave SCBU – Quarter 2**

- There has been an increase in our overall sickness during June and 2025 this is primarily due to a Long-Term Sickness episode within out Band 6 team which is being managed in accordance with the Sickness and Absence Policy, combined with some seasonal short-term sickness.

5. COMPLIANCE

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

Q2 2025:

Improvement	PQSM		Progress in achievement of CNST /10	10	10	10
	PQSM	%	Training compliance in PROMPT: Midwives	95%	94%	97%
	PQSM	%	Training compliance in PROMPT: Obstetric Consultants	89%	89%	89%
	PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	100%	100%	100%
	PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	75%	75%	75%
	PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	82%	82%	82%
	PQSM	%	Training compliance PROMPT: Maternity Support Workers	96%	90%	93%
	PQSM	%	Annual NLS update compliance: Paediatric Consultants	100%	100%	100%
	PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	80%	83%	100%
	PQSM	%	Annual NLS update compliance: Paediatric Juniors	100%	75%	100%
	PQSM	%	Annual NLS update compliance: Midwives	83%	95%	96%
	PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	95%	88%
	PQSM	%	Fetal Wellbeing update day: Obstetrics	100%	81%	90%
	PQSM	%	Fetal Wellbeing update day: Midwives	86%	83%	93%
	PQSM	%	Midwifery update day (Core Competency): Midwives	86%	88%	93%
	PQSM	%	Midwifery update day (Core Competency): Support Staff	96%	90%	90%

This will be closely monitored monthly, and plans put in place if any deviations are identified.

5.2 Mandatory Training – Special Care Baby unit

Training	Expected Target	July 25	Aug 25	Sept 25
Mandatory (Core)	**>90%**	**96.67%**	**98.64%**	**98.18%**
Mandatory (Essential)	**>90%**	**94.26%**	**95.32%**	**93.56**
Newborn Life Support (Annual Update)	**100%**	**95%**	**94.4%**	**85%**
Maternity Breastfeeding Update	**>90%**	**94.74%**	**95%**	**75%**

There is a drop below expected target for NLS and Breastfeeding – this is because of the three new staff members who are on induction throughout September/October, and they will receive their NLS training and BFI training/updates during their induction, prior to them completing the full course for NLS in 2026 and BFI in November 25.

5.2.1 Personal Development Reviews – SCBU Nursing

July 2025	August 2025	September 2025
100%	**88.89%**	**70%**

5.3 Safety Champions

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

A walkabout took place on 1st September, with visits to Maternity Triage and SCBU.

Feedback from the Regional Non-Executive Director (NED) Safety Champion Meeting was discussed including.

1. NED safety champion role description under review
2. Trusts being selected for the national inquiry
3. New MOSS system due to be launched in November
4. Single notification system will be launched shortly

Triage:

Maternity Triage Midwives expressed issues with communication between triage and the GP surgeries. Women are occasionally automatically diverted to Maternity Triage, despite their presenting complaint not being pregnancy related. This was to be monitored and if a recurrent theme for discussion either through GP leadership or SiS.

5.5 **CNST MIS Year 7**

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

Summary and evidence of current position:

Safety Action 2

Provided to Board

Safety Action 3 – Transitional Care

Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Required Standard:

A) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice
B) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.

Additional evidence provided to Board – Transitional care Q1 and 2 audits and action plans and quality improvement project for antibiotics for babies on the maternity ward.

5.6 **ATAIN – Avoiding Term Admissions into Neonatal Unit**

National benchmark 6% and best practice 3%

July 2025	August 2025	September 2025
4.58%	**3.12%**	**4.5%**

All unexpected term admissions are reviewed monthly at MDT review meetings, including neonatal and maternity representatives. Our overall performance against the ATAIN criteria remains below the National Benchmark of 6%.

There has been an increase in the number of term babies with low temperatures leading to additional thermoregulation and respiratory support requirements. A QI project was completed around monitoring environmental temperatures, and this saw a short-term improvement in the number of babies with low temperatures.

Additional work is now being completed to review and update local SOP's and improve staff education and the importance of thermoregulation management for ALL babies.

Additional audit information and associated actions have been shared with Board.

Safety Action 4: Neonatal Nursing Workforce

Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?

4.17 Is this formally recorded in Trust Board minutes?

4.18 If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.

Our Neonatal Establishment is BAPM compliant for our Level 1 Unit and cot capacity. However, due to unexpected ITU admissions or Peaks in number of babies on the unit there are occasions where we are not 100% compliant and actions are taken during these periods to minimise any risk, through OPEL Reporting and local Escalation Policy.

Our Annual Workforce Plan for 2025/26 has been benchmarked against SWFT and GEH models and the Gap Analysis has been used to develop our action plan. The action plan has been shared with Board.

Safety Action 6- Compliance with Saving Babies' Lives Care Bundle (v3)

This action requires maternity services to evidence full implementation of the Saving Babies' Lives Care Bundle (SBLCBv3).

- SBL Guideline Review:

Requirement: All relevant maternity clinical guidelines must be reviewed against current NICE guidance. Where guidance is not followed, a documented and clinically justified rationale must be provided.

Status: This work is *in progress* but currently *off track*. A number of guidelines remain outstanding for review and alignment.

Mitigation: The Deputy Director of Midwifery and Clinical Director for Obstetrics will jointly review how this work can be supported and, where feasible, factored into job planning. A process is being established for all new or revised guidelines to be reviewed against NICE recommendations, with clear rationale where deviations exist.

- PlGF-Based Testing (Pre-eclampsia Screening):

Requirement: Trusts must demonstrate implementation of or clear progress towards business planning for PlGF-based testing.

Status: Not yet started.

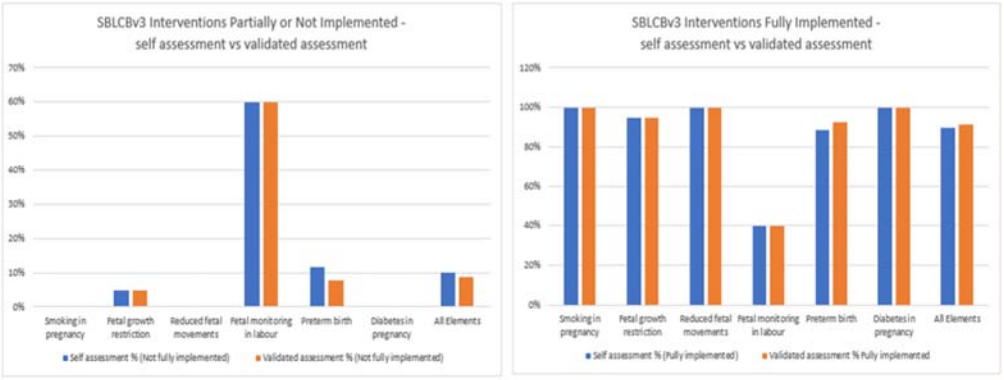
Mitigation: This has been escalated to the Clinical Director and Labour Ward Lead. Development of a business case is required and will be progressed with support from the clinical leadership team. Timescales for completion are being agreed.

However, there are two areas currently off track:

Current Position:

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	40%	Partially implemented	40%
Element 5	Preterm birth	Partially implemented	88%	Partially implemented	92%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	90%	Partially implemented	91%



Safety Action 7 – Service User Involvement and MNVP

This action requires maternity services to demonstrate meaningful, representative service user involvement in service development and quality improvement, typically through a functioning Maternity and Neonatal Voices Partnership (MNVP).

Given recruitment difficulties we have added this to the risk register and a copy has been provided for Board members.

Current Position:

- The ICB is currently reviewing the MNVP delivery model to determine how this will operate across Herefordshire and Worcestershire, in line with national recommendations.
- A single strategic lead is in place across both counties, which creates a single point of failure and limits capacity for local engagement.
- The two dedicated MNVP engagement leads are no longer in post and recruitment is required to re-establish local infrastructure.

Mitigation Plan:

While awaiting next steps from the LMNS and ICB, a local interim approach has been adopted to maintain service user insight and involvement. This includes:

- Systematic review and triangulation of service user feedback via debrief proforma, complaints, compliments, concerns, and survey data.
- Engagement from the MNVP neonatal voice lead, who is now visiting the maternity ward during SCBU visits to ensure maternity service user voices are captured and represented.

- Continued liaison with the ICB to support recruitment and contribute to shaping a sustainable MNVP model that meets CNST requirements.

REPORT ENDS

APPENDIX 1 – PQSM Minimum Data Set

	2025
	September
Findings of review of all perinatal deaths using the real time data monitoring tool	There were 2 cases reported to MBRRACE for PMRT
Findings of review all cases eligible for referral to HSIB/MNSI	0
Report on: **• The number of incidents logged graded as moderate or above and what actions are being taken** **• Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training** **• Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.**	Moderates: 1 Within narrative of report.
Service User Voice feedback	There was 1 complaint reported in September 2025
Staff feedback from frontline champions and walk-about	Outlined within narrative of the report.
HSIB/MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0
Coroner Reg 28 made directly to Trust	0
Progress in achievement of CNST 10	Year 7 published September 2025 – trajectory being developed.

APPENDIX 2 – PQSM Dashboard

	Area	Dashboard	Framework	Indicator Description	July	August	September
Antenatal	Booking	LMNS	LMS	Total bookings	127	116	113
		LMNS	LMS	Women who were booked before 9+6 weeks	107	93	84
		LMNS	LMS	% Women who were booked before 9+6 weeks (target 90%)	84.3%	80.2%	74.3%
		LMNS	LMS	Women who were booked after 9 + 6 weeks	20	23	29
		LMNS	LMS	% Women who were booked after 9 + 6 weeks	15.7%	19.8%	25.7%
		LMNS	LMS	Women who were booked before 12 + 6 weeks	123	110	110
		LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	96.9%	94.8%	97.3%
		LMNS	LMS	Women who were booked after 12 + 6 weeks	4	6	3
		LMNS	LMS	% Women who were booked after 12 + 6 weeks	3.1%	5.2%	2.7%
		LMNS	LMS	Midwife led care at booking	17	26	21
		LMNS	LMS	% Midwife led care at booking	13.4%	22.4%	18.6%
	Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	27	38	30
		LMNS	LMS	% Women with BMI of 30 and over at booking	21.3%	32.8%	26.5%
		LMNS	Better Births	% Antenatal Personalised Care Plan completed	97.5%	98.6%	97.8%
		LMNS	Better Births	% Intrapartum Personalised Care Plan completed	65.9%	63.2%	53.7%
		WVT		% Portal Access Consent	100.0%	100.0%	100.0%
		LMNS	LMS	% Portal Access - Women who registered and logged in	89.0%	89.7%	89.4%
		LMNS	Ockenden	% Contacts were place of birth suitability was recorded	76.9%	66.7%	75.4%
		LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	84.4%	80.20%	77.80%
		LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	89.1%	83.2%	84.9%
		LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	83.4%	82.9%	89.9%
		LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	92.8%	94.2%	95.7%
	Smoking	WVT		Recorded Smoking Status at Booking - Yes	8	5	6
		WVT		Recorded Smoking Status at Booking - No	119	111	107
		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	Women who were current smokers at booking	8	5	6
		LMNS	Saving Babies	% Women who were current smokers at booking	6.3%	4.3%	5.3%
		LMNS	Saving Babies	Smokers who were referred to smoking cessation services	8	5	6
		LMNS	Saving Babies	% Smokers who were referred to smoking cessation services	100.0%	100.0%	100.0%
		LMNS	Saving Babies	Smokers who accepted CO screening at booking	7	5	5
		LMNS	Saving Babies	% Smokers who accepted CO screening at booking	87.5%	100.0%	83.3%
	Carbon Monoxide	LMNS	Saving Babies	Women who were screened for CO at booking	120	111	108
		LMNS	Saving Babies	% Women who were screened for CO at booking (of total bookings)	94.5%	95.7%	95.6%
		LMNS	Saving Babies	Women with CO reading of 4 ppm or more at booking	7	6	7
		LMNS	Saving Babies	% Women with CO reading of 4 ppm or more at booking (of total bookings)	5.5%	5.2%	6.2%

	Area	Dashboard	Framework	Indicator Description	July	August	September
Intrapartum	Deliveries	LMNS/PQSM	Contractual	Total births (deliveries)	130	125	132
	Delivery Method	WVT		Home Births	1	2	1
		WVT		BBA's	2	0	2
		LMNS	Contractual	Vaginal births (deliveries)	45	52	46
		LMNS/PQSM	LMS	% Vaginal births (deliveries)	34.6%	41.6%	34.8%
		LMNS	LMS	Ventouse & forceps births (deliveries)	13	16	15
		LMNS/PQSM	Contractual	% Ventouse & forceps births (deliveries)	10.0%	12.8%	11.4%
	C-Section Deliveries	LMNS/PQSM	LMS	RG*1 having a caesarean section with no previous births	4	1	3
		LMNS/PQSM	LMS	RG*1 Deliveries	15	19	16
		LMNS/PQSM	LMS	RG*1 % C-section deliveries	26.7%	5.3%	18.8%
		LMNS/PQSM	LMS	RG*2 having a caesarean section with no previous births	28	23	25
		LMNS/PQSM	LMS	RG*2 Deliveries	32	33	39
		LMNS/PQSM	LMS	RG*2 % C-section deliveries	87.5%	69.7%	64.1%
		LMNS/PQSM	LMS	RG*5 having a caesarean section with at least one previous birth	28	12	18
		LMNS/PQSM	LMS	RG*5 Deliveries	29	13	20
		LMNS/PQSM	LMS	RG*5 % C-section deliveries	96.6%	92.3%	90.0%
		WVT		Total Elective C-Sections	36	26	29
		WVT		Total Emergency C-Sections	36	31	40
		LMNS	LMS	Total Caesarean births (deliveries)	72	57	69
		LMNS	LMS	% Total Caesarean births (deliveries)	55.4%	45.6%	52.3%
		LMNS	LMS	% Grade 1 C-Sections within 30 minutes	75.0%	33.3%	60.0%
		LMNS	LMS	% Grade 2 C-Sections within 75 minutes	100.0%	81.8%	96.7%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	24	17	27
		LMNS	LMS	% Midwife led (low risk care) births	18.5%	13.6%	20.5%
		LMNS	LMS	Home births (deliveries) - midwife led only	1	0	0
		LMNS	LMS	% Home births (deliveries)	0.8%	0.0%	0.0%
	Births	LMNS	Contractual	Total number of babies born	132	126	132
		LMNS	Saving Babies	Babies born preterm (singletons born 36+6 or less)	10	12	9
		LMNS	Saving Babies	% Babies born preterm (singletons born 36+6 or less)	7.6%	9.5%	6.8%
		LMNS	LMS	Singleton babies born 26+6 or less	0	0	0
		LMNS	LMS	% Singleton babies born 26+6 or less	0.00%	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	0.00%	0.00%	0.00%
		LMNS/PQSM	LMS	Stillbirths	1	0	0
		LMNS/PQSM	LMS	% Stillbirths	0.8%	0.0%	0.0%
		LMNS	LMS	Stillbirths rate per 1,000	7.58	0.00	0.00
	Breastfeeding	LMNS	National	Live births where breastfeeding initiated (first feed = breastmilk)	101	99	109
		LMNS	National	% Live births where breastfeeding initiated (first feed = breastmilk)	78.3%	79.8%	82.6%
	Smoking	WVT		Women who were current smokers at booking (delivered mothers)	10	12	7
		WVT		% Women who were current smokers at booking (delivered mothers)	7.7%	9.6%	5.3%

	LMNS	Saving Babies Lives	Women who were current smokers at birth (delivery)	8	10	7
	LMNS	Saving Babies Lives	% Women who were current smokers at birth (delivery)	6.2%	8.1%	5.3%
	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	7.6%	8.8%	1.7%
Risk Management	LMNS	Saving Babies Lives	Late pregnancy loss (singletons 16+0 - 23+6)	0	1	0
	LMNS	Saving Babies Lives	% (as a % of all singleton births)	0.00%	0.79%	0.00%
	LMNS	Better Births	% Detection rate for FGR (below 3rd centile)	13%	9.1%	33.3%
	LMNS	Better Births	Women who had a PPH of 1,500ml or more	5	6	6
	LMNS	Better Births	% Women who had a PPH of 1,500ml or more	3.8%	4.8%	4.6%
	LMNS	Better Births	Women who sustained a 3rd or 4th degree tear	0	2	2
	LMNS	Better Births	% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	0.0%	2.94%	3.17%
	LMNS	Better Births	Induction of labour	43	47	50
	LMNS	Better Births	% Induction of labour rate (of all births)	33.1%	37.6%	37.9%
	WVT		Routine Enquiry Domestic Violence - Asked	77	113	121
	WVT		Routine Enquiry Domestic Violence - Unable to ask	50	10	8
	WVT		Routine Enquiry Domestic Violence - Unknown	3	2	3
	WVT		% Asked routine enquiry domestic violence	59.2%	90.4%	91.7%
	WVT		Midwife to birth ratio	1:25	1:24	1:27
Red Flags	WVT	Inphase	Delay in Induction >2hrs	2	5	3
	WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1	4	1
	WVT	Inphase	Delay in administering medication	0	0	0
	WVT	Inphase	Delay in starting syntocinon/ARM >30mins	1	0	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	1	1	2
	WVT	Birth Rate +	Any movement of midwifery staff from any area to provide midwifery cover	22	38	24
	WVT		Delayed recognition of and action on abnormal vital signs	0	0	0
	WVT		DSC lost - supernumerary status	0	0	0
	WVT		Full clinical examination not carried out when presenting in labour	0	0	0
	WVT		Delay of more than 30 minutes in providing pain relief	0	0	0
Reduced Fetal Movements	WVT		Number of women presenting to service with reduced fetal movements	254	217	207
	WVT		Number of women presenting with RFM who are recorded as having a CTG	248	214	205
	WVT		% of women presenting with RFM who received CTG	97.6%	98.6%	99.0%

	Area	Dashboard	Type	Indicator Description	July	August	September
Neonatal	Admissions	LMNS	Integer	Total admissions to neonatal care	13	13	11
		LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	7	5	6
		LMNS	%	% Unexpected admissions of full-term babies to neonatal care	5.7%	4.4%	4.9%
	SCBU admission temps	WVT	Born	Eligible Babies (<34 wks gestation)	2	1	2
		WVT		% taken within hour	100.0%	100.0%	100.0%
		WVT		Adm temp <36.5 degrees	0	0	0
		WVT	All babies	Eligible Babies	19	24	19
		WVT		% taken within hour	100.0%	87.5%	100.0%
		WVT		Adm temp <36.5 degrees	3	1	1
	Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	2	4	4
		LMNS/PQSM	Integer	Neonatal deaths	0	1	0
		LMNS/PQSM	%	% Neonatal deaths	0.0%	0.8%	0.0%
		LMNS	Integer	Neonatal mortality per 1,000 births	0.00	7.94	0.00
		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)	3	0	2
		LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	3	1	2
		LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	100.0%	0.0%	100.0%
		LMNS	Integer	Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0
		LMNS	Integer	Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0
		LMNS	%	% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a

	Area	Dashboard	Framework	Indicator Description	July	August	September
Postnatal	Risk Management	LMNS	Local	Obstetrics admissions to ITU	0	1	0
		LMNS/PQSM	LMS	Maternal deaths	0	0	0
		LMNS	Better Births	% Postnatal Personalised Care Plan completed	99.3%	95.9%	97.9%
		LMNS	LMS	Postnatal readmissions within 28 days (mothers)	13	5	10
		LMNS	LMS	Postnatal readmissions within 28 days (babies)	4	6	12
	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	0	3	1
		WVT		Number of hrs Home Birth services suspended	0	0	0
		WVT		Number of times SCBU suspended per month	1	0	0
		WVT		Number of hrs SCBU suspended per month	6	0	0
	Insight	PQSM	Integer	Number of inphase incidents graded as moderate or above/PSII reported (total)	2	1	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
	Workforce	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	0	0	0
		PQSM	Hours	Suite	0	0	0
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	TBC	TBC	TBC
		PQSM		Inphase related to workforce (service provision/staffing)	22	tbc	tbc
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	100.00%	100.00%	100.00%
	Involvement	PQSM		Service User feedback: Number of Compliments (formal)	0	0	0
		PQSM		Service User feedback: Number of Complaints (formal)	1	1	1
		PQSM		Staff feedback from frontline champions and walk-abouts (number of themes)	0	0	0
	Improvement	PQSM		Progress in achievement of CNST /10	10	10	10
		PQSM	%	Training compliance in PROMPT: Midwives	95%	94%	97%
		PQSM	%	Training compliance in PROMPT: Obstetric Consultants	89%	89%	89%
		PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	100%	100%	100%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	75%	75%	75%
		PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	82%	82%	82%
		PQSM	%	Training compliance PROMPT: Maternity Support Workers	96%	90%	93%
		PQSM	%	Annual NLS update compliance: Paediatric Consultants	100%	100%	100%
		PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	80%	83%	100%
		PQSM	%	Annual NLS update compliance: Paediatric Juniors	100%	75%	100%
		PQSM	%	Annual NLS update compliance: Midwives	83%	95%	96%
		PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	95%	88%
		PQSM	%	Fetal Wellbeing update day: Obstetrics	100%	81%	90%
		PQSM	%	Fetal Wellbeing update day: Midwives	86%	83%	93%
		PQSM	%	Midwifery update day (Core Competency): Midwives	86%	88%	93%
		PQSM	%	Midwifery update day (Core Competency): Support Staff	96%	90%	90%

SCBU Dashboard – 2025/2026

SCBU DASHBOARD 2025- 2026													
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Comments
Staffing: Vacancy Gaps, Attrition Rate, Sickness													
Band 7 Vacancy Gap (2.0wte)	0	0	0	0	0	0							
Band 6 Vacancy Gap (5.49wte)	0	0	0	0.5	0.5	1							
Band 5 Vacancy Gap (13.5)	2	3.1		4.47	4.47	1.02							
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	0	0	0	0	0							
Band 2 Vacancy Gap (1.0wte)	0.2	0.2	0.2	0.2	0.2	0.2							
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0	0	0	0	0	0							
Attrition Rate (WTE)	0	0	0.62	0	0	0							
Maternity Leave (WTE)	1	1	1	1	1	1							
Sickness (<3.5%)	1.09%	1.39%	4.12%	5.63%	4.88%	4.32%							
Safe Staffing													
% Shifts staffed to BAPM Standards	92%	84%	100%	100.00%	100.00%	98.18%							
QIS % (standard = 70% of registered workforce)	44.4%	44.4%	52.5%	57.60%	**57.60%**	41.36%							
% of shifts QIS to toolkit	98.31%	100%	100%	100.00%	100.00%	100%							
% Shifts with supernumerary shift co-ordinator	3.39%	3%	26.67%	5.17%	3.28%	10.91%							
% Shifts covered with Bank	1.1%	1.4%	5.7%	3.70%	7.00%	1.18%							
Appraisal Rate	85%	67%	94.74%	100%	88.89%	70%							
Mandatory Training Core	98.75%	97.50%	97.83%	96.67%	98.64%	98.18%							
Mandatory Training Essential	89.8%	92.14%	94.78%	94.26%	95.32%	93.56%							
Basic Life Support	43%		86.36%	90.00%	90%	95%							
Newborn Life Support >90%	96%	95%	95%	95.00%	94.4%	85%							
Maternity Breastfeeding update.	77.27%	77.27%	90.48%	94.74%	95%	75%							
Safeguarding Level 3	100%	100%	100%	100%	95%	95%							
Compliments/Complaints/Concerns													
Complaints/Concerns	0	0	0	0	0	0							
Infection Prevention													
Overall - Star rating.	4	5	5	5	5	5							
Ward Assurance Audit	82%	100%	88%	92%									
Hand Hygiene	100%	100%	100%	100%	100%	100%							
Bare Below the Elbow	100%	100%	100%	100%	100%	100%							
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	4	2	12	6	9							
Medication Errors	0	1	0	1	1	1							
Staffing	0	0	0	1	1	1							
Service Escalation (OPEL RED/BLACK)	0	Red x 4	0	Red x 1	Red x 2	1 x amber, 1 x red							
WMPN Staffing Escalation Red/Black						2 x Red 1 x Black							
Exception reports - ex-utero outside of care pathway	0	0	0	0	2	0							
Exception reports - in utero transfers outside of pathway/network	1	1	1	2	1	1							

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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			Commence June 25										
Growth parameters Audit	82%			76%									
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%	3.12%	4.50%							
TC Bed occupancy rate on SCBU % including parent bedroom	40.0%	54.00%	40%	52.3%	65%	62%							
Total number of live births 34-36 weeks	4	10	4	5	6	3							
Number of babies born between 34-36 wks gestation and admitted to SCBU	3	7	4	3	6	3							
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	1	3	0	2	0	0							
Neonatal Outreach Team													
Total Patients	11	19	20	10	13	13							
NewReferrals	4	12	8	4	11	7							
Existing Patients continuing care	7	7	12	6	2	6							
No. NGT Feeding in the community	8	5	3	4	8	1							
Receiving EBM on discharge from SCBU	5	10	13	7	10	10							
Receiving EBM on discharge from O/R	3	1	9	5	3	4							
Numbers Discharged from outreach	5	2	9	7	3	7							
Number of Incidents (Inphase)	0	0	0	0	0	0							
Home Phototherapy	1	1	1	0	0	0							
Prolonged Jaundice Screening Referrals	27	24	34	34	32	33							
Prolonged Jaundice Screening - Total Number of Referals meeting criteria for outreach	21	22	32	30	28	33							
Prolonged Jaundice Screens - Outreach	18	22	20	25	26	27							
Prolonged Jaundice Screens - RAC	5	2	6	5	5	7							

Version 1: September 2025

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Guardian of Safe Working report
Lead Executive Director:	**Chief Medical Officer**
Author:	Dr Akshay Lekhi & Dr Chizo Agwu
Reporting Route:	Public Board
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**
Brief Description of Report Purpose	
The purpose of the Guardian of Safe Working Report is to provide assurance that Resident Doctors at Hereford County Hospital are working safe hours, and that Exception Reports are reaching a timely and satisfactory resolution.	
Recommended Actions required by Board or Committee	
Note the contents of this report.	
Executive Director Opinion[1]	
Assurance is provided that between July 2025 to September 2025, Resident Doctors at WVT worked safe hours.	

[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.

Guardian of Safe Working (GoSW) Report – Q2 (July–September 2025)

Introduction

Purpose: The Guardian of Safe Working role, introduced under the 2016 junior doctor contract, ensures compliance with safe working hours for doctors in training, safeguarding patient safety and staff wellbeing.

Key Responsibilities

Exception Reporting Oversight: Monitors reports where work hours or conditions deviate from agreed schedules.
Escalation & Resolution: Ensures timely action on issues raised.
Trend Analysis: Highlights systemic issues to clinical leads for resolution.

Governance

Each NHS Trust must appoint a named GoSW, listed on trainee work schedules prior to post commencement. Acts independently of rota management and provides assurance of contractual compliance.

Impact

Promotes safe working practices, reduces fatigue-related risk, and supports transparency and accountability.

Data Summary

Exception Reports (ER) – July to September 2025

Total ERs: 5

Reason for the Exception Report

Immediate patient safety issues: 0
Hours of working: 5
Pattern of work: 0
Lost Educational opportunities: 0
Relating to lack Service support available to doctor 0

Divisional Breakdown:

Surgical Division: 3 reports
Medical Division (Respiratory): 2 reports

Key Observations:

No reports related to immediate patient safety.
ER numbers decreased compared to previous quarter due to resolution of handover issues in Medicine.
Improved participation overall, though GP trainees remain underrepresented.

Current Position

GoSW role is vacant; advert for Expressions of Interest is live to recruit into position.

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 18th September 2025
Report to: Public Board

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Contract Management**
Rating rationale	The Trust had adopted the NHS funded Atamis system for all contracts and funding plans to improve central oversight. Temporary dedicated resource had been appointed to implement the system and collate contract information from across the Trust. Contract owners were being provided with training on the system, which could hold all information related to a contract. SLAs and commissioning contracts were not currently included. NHSE methodology had been applied to classify all contracts, with scoring based on cost and risk. As the system developed it would enhance control of processes such as single tender waivers.
Outcome	The Committee welcomed the progress made in the last 6 months and plans to continue developing the system to strengthen contract management and oversight. Action: Next report to include: • Breakdown of off-contract trends. • More detail on contracts classified as 'silver' and 'bronze' to provide assurance on contract management.
Item/Topic	**Internal Audit Report Review: DSPT (Data Security and Protection Toolkit) Cyber Assessment Framework**
Rating rationale	The advisory review assessed the overall risk rating as Very High across the five core objectives. This reflected the increased expectations and complexity of the CAF standards. The Confidence Level was assessed as Low due to discrepancies between the Trust's self-assessment and the auditor's findings. Much of this reflected the timing of the review when full evidence had not yet been collated. Of 13 agreed actions, 11 had already been completed with 2 high priority actions to be completed by the end of October.
Outcome	The Committee welcomed the rapid progress in addressing the recommendations in this challenging and high priority area. The Committee agreed to maintain close oversight of improvements and to receive an update at the next meeting.

Assure: Including assurance items rated green	
Item/Topic	**Business Case Evaluation: Radiology Managed Equipment Service (MES)**
Rating rationale	The MES was set up in 2018 and replaced all Radiology equipment in the Trust. The evaluation considered quality and operational benefits such as the equipment availability rate (98%), good maintenance turnaround times, improved equipment quality and the opportunity it created to redesign pathways. Financial benefits were difficult to quantify but were evident. The provider had also added value through its expertise in relation to care pathway improvements and the design phase of the new Community Diagnostic Centre. The contract was vendor neutral, and the service was flexible, incorporating equipment purchased outside the contract. The contract end date coincided with the PFI expiry date, so there may be opportunities for project alignment.
Outcome	The Committee was assured that the evaluation demonstrated achievement of the business case objectives.

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

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 18th September 2025
Report to: Public Board

Item/Topic	**Internal Audit Report Review: Fit and Proper Persons Test**
Rating rationale	The rating was substantial assurance, with one low priority recommendation.
Outcome	The Committee welcomed the positive report.
Item/Topic	**Final Annual Internal Audit Report and Opinion 2024/25**
Rating rationale	The final version was presented for completeness following presentation of a draft earlier in the year pending completion of one review. The opinion was unchanged from the draft: '*the organisation has an adequate and effective framework for risk management, governance and internal control*'.
Outcome	The Committee accepted the Annual Internal Audit Report 2024/25, which formally closed the 2024/25 internal audit cycle.
Item/Topic	**Annual Audit Committee Review 2024/25**
Summary	The review demonstrated good compliance with the Committee's terms of reference, which aligned with the HFMA guidance. Opportunities for improvement included enhancing the breadth of oversight and cross-committee collaboration. Work in progress at a Foundation Group partner trust would be shared to support further developments in Committee effectiveness.
Outcome	The Committee accepted the report and welcomed the plans for further development.
Item/Topic	**Internal Audit Progress Report and Recommendation Tracker**
Rating rationale	Good progress had been made on the 2025/26 plan, with one review (Fit and Proper Persons Test) complete. Two reviews were in progress (Community Services and Theatre Productivity) and four reviews were in the planning phase. 45 management actions were noted on the tracker, of which 15 had been implemented and 22 had not reached due date. There were no concerns regarding any actions that were outstanding following positive engagement with managers.
Outcome	The Committee was assured by progress of the plan and implementation of management actions, with an appropriate follow-up process in place.
Item/Topic	**Local Counter Fraud Specialist (LCFS) Progress Report**
Rating rationale	The proactive plan was progressing well. Regarding reactive work, two referrals had been received since 1 April 2025; one related to a person working whilst on sick leave. The job planning process had now been strengthened which provided an additional control. A potential banking fraud investigation was in progress, highlighting an absence of fraud but an error in an otherwise robust process, which had now been improved.
Outcome	The Committee was assured by the work in progress to deliver the plan and by the evidence of early learning in response to fraud investigations.
Item/Topic	**Losses and Special Payment – Quarter 1**
Rating rationale	Payments for lost patient property were lower than the same period last year. The Internal Audit Team had spent a volunteer day at Hereford Hospital, visiting wards and departments to talk about lost property processes and the potential cost. A report which would be shared, which made recommendations about processes to help reduce losses and costs.
Outcome	The Committee accepted the report and welcomed the added value provided by the Internal Auditor.
Item/Topic	**Single Tender Waivers**
Rating rationale	The report covered the period February to August 2025. The total number of waivers had increased but this was seen as a positive reflection of an improved process, with an electronic waiver form now prompted by the system and picked up by Procurement before an order could be made. The LCFS would present a benchmarking report to the Committee at its next meeting for assurance.
Outcome	The Committee accepted the report.

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

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 18th September 2025
Report to: Public Board

Item/Topic	Single Tender Waivers: PFI contract
Rating rationale	The report provided an overview of how non-unitary charge PFI works were procured, which was described as an exception in the SFIs. Works on the retained estate (owned by the Trust) were done under the PFI contract. All variations and change notices followed a formal governance process with procurement compliance checks, value-for-money assessments and escalation and approval through appropriate channels. Works outside the contract included major capital schemes and schemes where the PFI partner could not complete within the required timescale or demonstrate value for money.
Outcome	The Committee was assured by the process and agreed to schedule an annual update.

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: Children and Young People'sCommittee
Date of meeting: October 2024 – November 2025
Report to: Trust Board

Introduction

The Children and Young People's Committee was established in October 2024. The role of the CYP committee is to seek assurance in terms of meeting quality standards including the physical, emotional and developmental needs with the services we provide across the Trust for children and young people.

The committee recognises that the specialty service updates have not always contained sufficient information in relation to performance against quality standards, to provide assurance that standards are being met. Further information regarding the relevant quality standards has been circulated to all members, and over time the quality of the specialty reports has improved.

This report will usually be provided quarterly, as this is the first report it will briefly summarise the last 13 month's meetings.

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**None**

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Paediatric negative appendicectomy rate**
Rating rationale	The negative appendicectomy rate for children is higher than the national average of 5.8% (GIRFT), at 14%. An audit of cases March 2024 - March 2025 demonstrated a rate of 10.2%. A reaudit of cases April - October 2025 shows an improvement to 8.69% (21 out of 23 patients). Overall low post-operative complication rates.
Outcome	The committee was assured that progress is being made and will review again next year.
Item/Topic	**Circumcision rate**
Rating rationale	GIRFT recommendation to reduce circumcision rate in boys under 16 years to <1.5%, currently 3% at WVT. Practice is being reviewed and will continue to be monitored by this committee.
Outcome	To be brought back to committee in April 2026.
Item/Topic	**Facing the Future RCPCH standards**
Rating rationale	The majority of the RCPCH Facing the Future standards for acute general paediatric services are met with two exceptions; only 59% of children admitted with an acute medical problem were seen by a consultant paediatrician within 14 hours of admission and not all the general paediatric rotas are made up of 10 WTE posts (tier 2 rota made up of 6 WTE). To be re-audited in 2026. New BAPM standards require dedicated middle grade or consultant presence for SCBU.
Outcome	A roadmap of how the department will move towards a traditional consultant pattern of working whilst ensuring compliance with these standards to be developed and reviewed by this committee.
Item/Topic	**Neonatal nursing workforce qualified in specialty**
Rating rationale	BAPM (British Association of Perinatal Medicine) standards recommend that 70% of neonatal nursing workforce are qualified in specialty, currently 58% (an improvement from 44% in November 2024). Training and recruitment plan in place and there is always at least one QIS on each shift (as per BAPM standards).
Outcome	The committee was assured that progress is being made and will keep under review.
Item/Topic	**Lack of health psychology for children**
Rating rationale	A consistent theme from acute and community specialties is the lack of psychology services available, particularly for CYP with long-term conditions. The diabetes service has recruited to 0.4 WTE starting in January (historically funded by BPT), the epilepsy service has psychology input as part of an ICS NHSE pilot scheme but there is no other psychology support for CYP with chronic conditions or for parents of preterm babies. Previous business cases, discussion with the adult health psychology team and approaches to the ICB have been unsuccessful. Regional and national issue, not unique to WVT.
Outcome	The committee was assured that this is an accepted risk **given** the current economic climate. This **issue will** continue to be raised **via specialty reports** as psychology input is recommended in national **quality** standards for CYP with virtually all long-term conditions.

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: Children and Young People'sCommittee
Date of meeting: October 2024 – November 2025
Report to: Trust Board

Item/Topic	Manipulation of forearm fractures in ED
Rating rationale	It was identified at a WMCN (West Midlands Children's Network) surgery in children peer review that WVT has a low number of forearm fractures being manipulated in ED, as recommended by GIRFT, compared to those manipulated under anaesthetic. A protocol is being developed by ED and T&O to ensure that this can be done safely with appropriate analgesia in ED, although progress has stalled.
Outcome	The committee was encouraged to see that rates are improving but needs assurance that the protocol will be finalised and embedded so recommended standards can be met.
Item/Topic	**Management of neonatal orthopaedic conditions - DDH and talipes**
Rating rationale	Due to long term sickness within the T&O team, there is currently no provision for management of neonatal orthopaedic conditions, developmental dysplasia of the hip and talipes. Short term arrangements have been implemented so that all babies with these conditions are referred directly to Oswestry or Birmingham Children's Hospital. Discussions are ongoing with the ICB regarding longer-term plans for provision of this service across the ICB.
Outcome	The committee was assured that short term plans have mitigated the risk but a longer-term solution is required.
Item/Topic	**Paediatric ED Nursing**
Rating rationale	The Royal College of Nursing (RCN) and RCEM (Royal College of Emergency Medicine) Nursing Workforce Standards recommend a minimum of two registered children's nurses per shift, who must possess recognisable post-registration paediatric trauma and emergency training. Current staffing model is non-compliant as we only have the establishment for one RSCN within Paediatric ED – under review at present.
Outcome	The committee was assured that the ED nursing establishment is being reviewed and the outcome to be presented at a future meeting.
Item/Topic	**Transition**
Rating rationale	There are robust transition pathways for YP with specific conditions such as diabetes or epilepsy moving from paediatric to adult care. However, transition of YP with multi comorbidities has been highlighted as a risk. A transition passport and policy are in development to support this process. Paediatric consultant has dedicated time for transition lead.
Outcome	The transition lead will provide an update to committee in February 2026
Item/Topic	**Radiology environment**
Rating rationale	There is no specific waiting area for paediatric patients within radiology, this will be addressed as the department work towards Quality Standards for Imaging accreditation. Play team can support with making existing environment more child friendly.
Outcome	Further update to committee in 2026.
Item/Topic	**Therapies**
Rating rationale	There has been a reduction in waiting times across paediatric physiotherapy, occupational therapy and speech and language therapy, although there are still long waits for ASD assessments. There are issues with the quality of data extracted from EMIS, resulting in the need for manual data collection to ensure accuracy. Work is ongoing to ensure alignment and consistency with data reported in all forums.
Outcome	The committee was assured that a new triage pathway and action plan to reduce ASD assessment waiting times are being implemented and was aware of the pitfalls with data quality and the ongoing work to address this, will continue to monitor.
Item/Topic	**Paediatric BLS training compliance and reporting**
Rating rationale	It has been recognised that compliance with paediatric basic life support training is generally low across the Trust and that this is due in part to paediatric BLS not being captured within ESR. As a result, individual departments are relying on spreadsheets to track training.
Outcome	Escalated to Executive Education Committee.
Item/Topic	**Initial Health Assessments for Children Looked After**
Rating rationale	Statutory requirement for all children and young people new into care to have an initial health review within 20 working days, only 46% seen within timescale due to unpredictable demand and lack of capacity within the consultant workforce. Additional ad hoc clinics have been made available to increase capacity.
Outcome	The committee was assured that this is being closely monitored, and action has been taken to increase capacity to meet statutory responsibilities. Ongoing monitoring required.

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: Children and Young People'sCommittee
Date of meeting: October 2024 – November 2025
Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	**Health visiting and school nursing service**
Rating rationale	The majority of KPIs are being achieved, further work is required to ensure 95% of 12-month reviews are achieved before 15 months, admin processes are being reviewed to ensure timely review. Breast feeding rates about the national average. 99% of children taking up offer of National Child Measurement Programme in reception and year 6 (target 95%)
Outcome	The committee was assured about the quality of the service.
Item/Topic	**Gaps in provision for 16 and 17 year olds**
Rating rationale	Young people aged 16 and 17 often fall between paediatric and adult services, recognised as a problem nationally. A Trust-wide policy has been developed involving all stakeholders to ensure that all staff are aware of their roles and responsibilities in relation to caring for 16 and 17 year olds.
Outcome	The committee was assured that the new policy reduces the risks for these young people.
Item/Topic	**WVT Youth Worker Service**
Rating rationale	A 2-year youth work pilot project within the paediatric diabetes team has demonstrated significant improvement in health outcomes for this cohort of patients with a reduction in admission and DNA rates. There has been very positive feedback from clinical teams and children and young people. Funding required to continue to continue the service beyond the pilot period and expand youth work across the whole Trust to support CYP in acute and community settings and as they transition to adult services.
Outcome	Business justification to be submitted to the Executive Team.
Item/Topic	**Paediatric Diabetes Service**
Rating rationale	National Paediatric Diabetes Audit outcome indicators above regional and national averages. GIRFT review October 2025.
Outcome	The committee was assured about the quality of the service. The outcome of GIRFT review and latest national audit results to be reviewed in 2026.

To Note: Items received for information or approval	
Item/Topic	**WMCN SCBU Cot Reconfiguration**
Summary	The WMCN (West Midlands Children's Network) capacity planning and cot reconfiguration review has included several proposals They have all discussed the loss of derogation and increasing the minimum gestational age to 32 weeks, this is not disputed by the neonatal team. There is also a recommendation to increase the ITU stabilisation spaces from 1 to 2 to accommodate multiple births, again this agreed by the team. There is a further proposal to reduce the HDU space to 0. This raises significant safety concerns for the increased requirement to transfer babies out to level 2 units. There have been no clinical incidents that have indicated any risk to babies receiving high dependency care in Hereford. This will increase the number of in-utero transfers and the demand on the Neonatal Transport Service for ex-utero transfers. The implications of our rurality and the service we deliver to families from Powys have not been considered as part of this proposal. The loss of routine delivery of HDU care will reduce both medical and nursing staff skills and competency with delivery of HDU care, including high flow and CPAP and has the potential to increase the risk to babies needing this level of care due to reduced familiarity with the equipment. It is also likely to affect recruitment and retention of neonatal nurses.
Outcome	The Executive Team are being kept fully informed and discussions with the WMCN are ongoing.

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.

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

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	**Quality Committee August 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, August 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. It has also become clear that lapses in coding are also skewing the SHMI. Committee was assured that these coding errors are being addressed and corrected data is being resubmitted. Crude mortality remains within expected limits which gives some assurance.
2. **Quality Priority – High-Risk time-Critical Medications** – The continued focus on Parkinson's medication administration for a 2nd year continues to see improvements with high compliance. Epilepsy meds also continue to show positive trends. A key area of focus for this year is enabling more self-administration and initial work has concentrated on barriers experienced by staff.
3. **Quality Priority – Improving Responsiveness to Patient Experience Data** – Complaint response times continue not to meet timescales and current work to improve the position includes earlier contact with complainants and the employment of a Complaints Co-ordinator. Committee welcomed the breakdown of communications issues raised in complaints as this remains the number 1 issue raised.
4. **Colposcopy Report** – The service continues to face staffing challenges while facing increasing referral numbers with delays in seeing urgent referrals. The service is training a Nurse Colposcopist and has a trainee Colposcopist to address the staffing challenges..
5. **PLACE Audits Feedback** – The feedback highlighted key areas of challenge in relation to dementia, disability and privacy domains. While not all of these are in our immediate control being linked for instance to building-related limitations, a number can be addressed and this will form the basis for a response plan. .
6. **Patient Flow Report** – July saw a peak in ED admissions. Despite this, the use of temporary escalation spaces reduced as a result of better patient flow, as did the number of incidents related to Boarding. Committee welcomed these improvements which are a result of recent change initiatives, but was concerned that these need to be sustained.
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 commended the leadership behind these improvements noting that quality and safety are best served by a stable workforce.
8. **Update on UKAS Pathology Accreditation** – Committee noted the update and commended the Clinical Director and Divisional Team on the rapid turnround of work to address issues identified by UKAS. A follow-up visit is scheduled in December.
9. **Divisional Report – Medical Division** – Committee received a summary detailing a range of quality and safety indicators for the Division. ED overcrowding and long stays continue to pose risks to quality of care and safety for patients. Positively the recently appointed dementia lead has made a notable impact, enhancing ward care for patients with dementia.
10. **Cancer Survey Results** – Committee received the high-level results from the survey highlighting positive feedback in many areas with a number of areas identified for further analysis including lower scores in some areas for Welsh patients, for those aged over 85 and for men. More analysis will be provided in November.
11. **Perinatal Safety Quarterly Report** – Committee considered the summary report including details of staffing challenges and a response to NHSE's letter setting out national maternity review priorities including need to address poor professional behaviours, improving family engagement and tackling inequalities – all of which feature in local work, though current absence of a user representative means we need to prioritise recruitment.
12. **Trust Infection Prevention Quarterly Report** – A number of developments and concerns were discussed including the increase in MRSA bactaremia cases and low fit-mask testing compliance. Positively, following the NHSE inspection in May the Trust has been moved to a less intensive level of support.

Matters for Escalation - None

WYE VALLEY NHS TRUST

Minutes of the Quality Committee

Held on 28th August 2025 at 1300-1600

MS TEAMS

Present:		
Ian James	IJ	Non-Executive Director (Chair)
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Rachael Hebbert	RH	Associate Director of Nursing
Sharon Hill	SH	Non-Executive Director
Jane Ives	JI	Managing Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Grace Quantock	GQ	Non-Executive Director
Rebecca Reed	RR	Quality and Safety, Powys Teaching Health Board
Emma Smith	ES	Deputy Chief Nursing Officer
Nicola Twigg	NT	Non-Executive Director
In Attendance:		
Sadiah Akhtar	SA	Consultant Obstetrics and Gynaecology (for item 12)
Annabel Cracknell-Jones	AC-J	Cancer Transformation Manager (for item 10)
Lynn Carpenter	LC	Quality and Safety Matron
Hannah Duggan	HD	General Manager Women's and Children's (for item 10)
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Justine Jeffery	JJ	Director of Midwifery
Helen Harris	HH	ICB Representative
Susan Hughes	SH	Deputy Director of Midwifery
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Hayley Pearson	HP	Clinical Director Pharmacy
James Pethick	JP	Head of Blood Sciences (for item 11)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Gwenny Scott	GS	Company Secretary
Emma Wales	EW	Associate Chief Medical Officer Medical Division
Laura Weston	LW	Lead Infection Prevention Nurse (for items 15 and 16)
Raechel Wordsworth	RW	Medicines Safety Officer (for item 4)
Apologies:		

Eleanor Bulmer	EB	Associate Non-Executive Director
Dan Harding	DH	Associate Chief Operating Officer Medical Division
Leah Hughes	LH	Operational Lead Radiographer
Tom Morgan Jones	TMJ	Deputy Chief Medical Officer
Natasha Owen	NO	Associate Director Quality Governance
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director

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 31st July 2025**	**IJ**	**Approval**	**Enclosure 3**
Approved as correct record of the last meeting.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**
The actions were reviewed and updated.				
4.	**BUSINESS SECTION**			
4.1	**Quality Priority High Risk Time Critical Medication**	**RW**	**Information**	**Enclosure 4**

The ongoing quality improvement project is focused on the administration of time-critical medications, particularly Parkinson's and epilepsy drugs led by the Medicines Safety Team, and has shown significant progress. Parkinson's medication administration has reached a high compliance rate, with 90–91% of doses given on time over the past three months and only two missed doses in June and July.

This improvement is attributed to increased staff engagement and ownership, with ward teams now driving the initiative independently.

Epilepsy medication data also shows positive trends, though the volume of administrations is lower, and July data was not yet available.

The project also explored barriers to self-administration of medication by patients. A ward walk involving ten wards revealed that only two patients were self-administering, and many nurses were either unaware of the process or lacked confidence in implementing it. A key issue is the absence of a self-administration button in the EPMA system and nurses also found to be using incorrect documentation methods in EPMA. This has prompted the need for further staff education. The self-administration policy will also be updated to reflect current EPMA capabilities.

To address these issues, have engaged with the West Midlands Medication Safety Officer Group and reviewed self-administration policies from other trusts. Whilst the current policy is fit for purpose, there are some EPMA processes that are awaiting revision. Additional barriers include complex paperwork for assessing patient suitability and a lack of integration with clinical noting systems. Some patients also expressed a preference for nurse-led administration due to recent medication changes during their hospital stay.

To reduce missed doses, a pilot scheme was launched on Lugg Ward using bright pink and red bags to flag urgent medications recently delivered to the ward. This aims to alert staff more effectively to a delivery and ensure prompt action. Early feedback is promising, and further data will be collected to assess its impact.

Will continue links with Parkinson's Nurses and Parkinson's UK and gather epilepsy data to maintain momentum. Will also continue to promote all critical medicines related guideline trust wide.

5.	**Quality Priority Improve Responsiveness to Patient Experience Data**	**LC**	**Information**	**Enclosure 5**

The Friends and Family Test has been relaunched with improved accessibility via text messages, QR codes, and web links. Although response rates dipped due to changes in message distribution, positive feedback has increased across all areas. A notable success was in podiatric surgery, which achieved a 100% response rate and positive feedback in its first month of participation. Will continue to explore ways to leave feedback for those who do not have access to technology.

Complaints have risen steadily since 2022. The trust currently meets the 30-day response target only 40–50% of the time and mutually agreed timeframes only 60% of the time. To address this, the team is working on better early communication with complainants and staff to set realistic expectations and reduce frustration. There has also been an increase in come backs.

A new Complaints Co-ordinator has been appointed to improve consistency and efficiency.

A recurring theme in complaints is communication, which remains the highest category. Subcategories reveal that patients often feel unheard. There is also a growing concern about staff values and behaviours, particularly in ED. An initial analysis was done in ED which has been passed to the Division for review and action and a deep dive into trust-wide complaints is planned and will be presented in the next quarterly report. **ACTION**

Concerns have increased in June and July, possibly due to the full re-establishment of the PALS team. Administrative backlogs are being addressed, and communication remains the top category.

The interpreting service, managed by Word360, has shown strong performance, with high fulfilment rates even for on-demand requests. PALS continue to support teams and this has led to significant reductions in administrative time and cost.

Training for investigating officers is provided in house, with promotion of training modules provided by the Ombudsman. There are also ongoing discussions with Education to add formal training to the Ward Manager and Leadership programmes.

Continue to monitor and sustain improvements and acknowledge that more focus work is required, particularly in responsiveness to complaints.

Committee members welcomed the clearer breakdown of communication issues given in the report. And raised points about the importance of early resolution, and the potential to reframe complaints as opportunities for redress or improvement. Suggestions included simplifying the FFT process and adding prompts for improvement ideas.

ACTION: Results of deep dive into trust-wide complaints to be included in the next quarterly report. NO/LC

6.	**Mortality Report**	**CA**	**Information**	**Enclosure 6**

A notable discrepancy between rising SHMI and falling crude mortality rates was noted. The increase in SHMI is primarily attributed to the removal of SDEC data from national calculations, a change affecting 40 trusts nationwide. NHS Digital has acknowledged this issue, which has led to artificially inflated SHMI figures due to a reduced denominator. This has been raised with region who have escalated to national level. The national deadline remains July for the data change and a response on how is it being monitored for those trusts that have not implemented the change is awaited.

Despite this, the trust's crude mortality remains within expected limits, with July showing one of the lowest figures in recent months.

Quality improvement efforts are ongoing in key clinical areas. For fractured neck of femur, improvements in admission and surgery timing are expected to positively impact SHMI later in the year. Collaborative work between geriatrics and trauma teams is enhancing care pathways.

Heart failure, sepsis, and pneumonia are also under review, with a heart failure audit commissioned to confirm the impact of SDEC data removal. Sepsis process mapping continues to identify areas for improvement.

The committee also discussed coding challenges that have exacerbated the SHMI rise. In April, 500 deaths were left uncoded, further reducing the expected number and skewing SHMI results. Additionally, some cases were incorrectly coded as having no comorbidities. The trust is actively working with the coding team to ensure timely and accurate coding, resubmit corrected data, and address errors that result in high SHMI scores.

Extended perinatal mortality was also discussed. While stillbirth rates are improving, neonatal mortality remains largely due to congenital malformations. These cases are not expected to indicate an issue with care and are being reviewed through the Perinatal Mortality Review process, which has returned mostly A and B grades, indicating appropriate clinical management.

The committee acknowledged that small numbers can cause significant fluctuations in reported rates and emphasised cautious interpretation of the data.

7.	**Patient Flow Report**	**RH**	**Information**	**Enclosure 7**

Despite ongoing pressures, July saw a significant spike in ED admissions, exceeding 2,000—the highest since December 2024. Despite this, operational performance improved across several metrics. Ambulance handovers within 30 minutes increased, and those exceeding 60 minutes decreased, returning to levels seen in mid-2024.

Lengths of stay over 12 and 24 hours also reduced, and the number of patients in ED before 8:00 AM with a decision to admit dropped below 500 for the month.

The use of temporary escalation spaces and boarding areas declined, indicating better patient flow and reduced overcrowding.

A particularly encouraging development was the reduction in ward moves and stays for patients with dementia—the first improvement since April 2023. This may well be attributed to the impact of the newly appointed dementia lead, whose work has enhanced awareness and care for complex dementia patients and improved flow generally.

Incidents related to boarding also decreased, with no new themes emerging this month but continued to reference patients in boarding spaces being unsuitable.

The femoral fracture pathway, trialled during the 'test of change' week, showed strong results in improving time to surgery and ward placement, contributing to better outcomes and reduced mortality risk.

While the report was largely positive, concerns remain about sustaining these improvements long-term.

The committee discussed the importance of maintaining momentum from the test of change initiatives, particularly in ED, where pressures persist. There was acknowledgment that some departments outside ED may be experiencing a slight drop-off in compliance, and efforts are underway to address this through ongoing review and follow-up meetings.

8.	**Staffing Report**	**ES**	**Information**	**Enclosure 8**

Despite high ED activity in July, the reduction in boarding and use of escalation spaces helped stabilise staffing pressures.

Care hours per patient day remained consistent, and fill rates showed a month-on-month improvement following rota adjustments in April.

Nine staffing-related incidents were reported, most of which were not nursing-related. The trust has implemented red flag documentation via the Allocate system to proactively manage staffing risks. There were 44 nursing incidents in month but mitigations were in place to resolve.

A major success was the trust's 99% compliance with agency cap rates for nursing, which is well above the 80% target and regional average of 94%. Band 2 agency usage has been virtually eliminated, with only a few shifts requiring senior approval. This has led to a significant reduction in agency spend and increased reliance on bank staff. Compared to July 2024, temporary staffing usage dropped from 18% to 13%, and the proportion of bank staff rose from 56% to nearly 80%.

The trust has also made progress in cap rate compliance for AHPs and Healthcare Scientists. AHP agency usage has ceased entirely, and most Healthcare Scientists have transitioned to bank rates. The only exception is Cardiac Physiologists, whose rates remain above national caps due to a recognised national issue. The trust is actively working to bring these rates down.

The committee praised the sustained efforts and leadership behind these improvements, noting that quality and safety are better served by a stable, substantive workforce. A revised quality outcomes dashboard is in development and will be aligned with ward accreditation metrics.

9.	**Divisional Quarterly Report – Medical Division**	**SH**	**Information**	**Enclosure 9**

No never events occurred, and continue efforts to embed a just culture.

The division celebrated successful consultant recruitment and the implementation of a revised nursing establishment in ED, with Band 7 nurses now rotating out of hours.

The division's away days remain well-attended, with the latest focusing on duty of candour.

Several initiatives from the 'test of change' programme have positively impacted patient flow. These include enhanced nurse navigation, multi-specialty huddles taking place at midnight and 4 am, and also the presence of senior decision-makers in ED 24 hours a day. ED performance ranked in the top ten regionally, with over 70% of patients seen within one hour.

A revised nursing handover process has reduced time spent on phone communications for patient handovers.

The fractured neck of femur pathway, which includes a ring-fenced bed on Dinmore ward, and a four-hour admission target, showed strong results, with 24 of 31 patients meeting the target.

The newly appointed dementia lead has made a notable impact, improving ward environments and supporting staff with complex dementia care. Her work has enhanced education, relaunched the "This is Me" document. The Most noticeable impact has been her availability on wards for advice regarding correct treatment in a timely manner with family engagement where possible.

Concerns persist around ED overcrowding and prolonged stays, which continue to pose risks.

Pain management in both adults and children, has emerged as a recurring complaint theme, prompting an audit to determine the contributing factors and ways to improve.

Additionally, inappropriate use of the 'fit to sit' area led to a serious incident, now under investigation. Immediate actions include reviews by Band 7 staff and escalation protocols. Safety champions are being introduced to ED to support ongoing improvements.

Redbrook Ward was highlighted as a model of multidisciplinary collaboration, particularly in mental health care, with innovative use of space and has received consistently positive feedback.

LF clarified the ED safety champion role had been modelled on the template of Safety Champion roles in maternity. Two meetings have taken place with Chief Medical Officer, Chief Nursing Officer and Chief Operating Officer and the division have identified front line safety champions. Safety champion meetings will be scheduled and ward walks are planned and will report to board on a quarterly basis starting in October.

JI asked about progress of complaints following the response challenge noted in June, with more open than closed complaints. It was acknowledged that response time needs to improve but that the complexity of some complaints involve multi-disciplinary specialties and it was often difficult to identify an investigating officer, especially during peak

holiday period. It was also noted that a high number of complaints are inherited by the division as complaints come from patients who come to ED initially.

It was noted that VTE assessment compliance was low in Acute and Emergency which did not correlate to the high compliance seen in medical division. EW agreed to review the data to identify any anomalies. **ACTION**

10.	Cancer Survey Results	AC-J	Information	Enclosure 10

The Cancer Patient Experience Survey for 2024, conducted nationally, received a 60% response rate from approximately 500 patients treated at the trust.

The results showed a mix of scores, with some areas performing above expectations and others below. Notably, patients aged 85 and older, those from Welsh regions, and those with long-term conditions tended to report lower satisfaction, highlighting potential health inequality concerns. Male patients also scored lower than females, which aligns with national trends.

Two key areas of concern were identified: patients not having a clear point of contact within their care team, and limited discussion around cancer research opportunities. In response, the Trust has increased visibility of its clinical trials team and plans further engagement to improve awareness.

The Trust is following a model used by Worcester colleagues to benchmark and track progress year-on-year. A comparative analysis tool is being developed to assess improvements over time, with plans to report back in future meetings.

Results are being broken down by specialty to identify actionable insights from free-text comments. This will inform targeted action plans for each specialty.

Due to data suppression rules, some demographic insights were limited, especially for ethnic minorities and gender-diverse patients, prompting collaboration with community partners to fill these gaps.

Results regarding site specific cancers will be compared to last year's report and will be reported back in November.

11.	Update on Pathology UKAS	JP	Information	Verbal update

The Pathology department underwent its annual UKAS assessment in June and July 2025. The assessment resulted in 89 mandatory findings requiring corrective action.

The team successfully addressed all findings and submitted their responses by the deadline. As of the meeting, 54 of the findings had been reviewed and closed by UKAS; 43 were still under review, and only one had been rejected, which was under discussion regarding how best to present the department's business continuity plans.

A follow-up visit is scheduled for 16th December 2025, focusing on the audit schedule and ensuring that improvements in risk stratification and audit tracking are sustained.

Additionally, recruitment for a new Quality Manager is underway, with four internal candidates shortlisted and interviews scheduled for 12th September.

The committee commended the team for their strong performance and timely response to the assessment requirements

12.	Colposcopy Report	SA	Information	Enclosure 12

All audits are up to date, patient feedback has been excellent, and all Colposcopists have completed their reaccreditation.

Performance metrics show improvement from Quarter 3 to Quarter 4 and stability into Quarter 1 of the current year. The service met targets for two-week wait referrals in previous quarters.

The Masey colposcopy database was down for a few days, leading to clinical cancellations.

The service continues to face significant challenges with waiting times. Urgent referrals are currently being seen within 12 to 14 weeks, which is beyond the six-week target, with 64% of patients seen within the expected timeframe. This figure has remained static across the last two quarters. Additionally, while result communication has improved, a discrepancy in the database system has led to under reporting of performance, showing 85% compliance when internal calculations suggest over 90%. Although Quarter 1 saw a slight dip to 92% due to a single patient breach caused by incorrect contact details.

Patient attendances have increased significantly from 250 and 282 in earlier quarters to 355 and 337 in the most recent quarter. The service currently runs eight clinics per month but requires 13 to meet demand. Weekend clinics have been introduced and are well attended, with minimal missed appointments, but staffing challenges are compounded by the impending retirement of a senior colposcopist and two vacancies in the consultant obstetrics and gynaecology team. To address this, the Trust is training a Nurse Colposcopist and a trainee Colposcopist, both progressing well. Although their initial completion was expected in autumn 2025, delays in meeting curriculum requirements have pushed this to early 2026. Once qualified, the Nurse Colposcopist is expected to run three to four clinics per week, significantly boosting capacity.

The committee acknowledged the team's awareness of the challenges and their proactive approach to resolving them.

13.	**Perinatal Safety Quarterly Report**	**JJ**	**Information**	**Enclosure 13**

One antenatal stillbirth at 25 weeks was reported, which will undergo review through the Perinatal Mortality Review Tool and be presented to the patient panel in Quarter 3. There were no neonatal deaths or new referrals to the MNSI.

There was an increase in unexpected admissions to the neonatal unit, although the rate remains below the national benchmark of 6%. Additionally, two babies were born with APGAR scores below six, these cases will be reviewed by the foetal monitoring lead to assess whether earlier delivery could have been possible and to identify any learning opportunities.

Workforce data showed an error in the reported midwife-to-birth ratio, which will be corrected from 1:25 to 1:18.

Staffing challenges persisted, with difficulty meeting acuity levels and frequent staff redeployments, leading to some delays in care. A review of the Birthrate Plus report is underway to assess staffing against funded establishment and the Perinatal Workforce Review, with early indications being positive. An update will be brought in the next report.

The neonatal unit continues to face challenges in maintaining a supernumerary shift leader and ensuring the correct number of QIS-trained nurses. A plan is in place to improve these metrics over the next quarter.

One complaint was received, related to staff attitude and communication. It occurred within the last six months and will be addressed accordingly.

The report also included a response to NHS England’s letter outlining national maternity review priorities. These include addressing poor professional behaviours, improving family engagement and tackling inequalities. Locally, work is ongoing to address staff behaviours, with further actions to be added based on recent staff and score surveys. However, the absence of user representatives in the system poses a risk to co-production efforts, and recruitment is being prioritised.

There will be a change in future reporting. Monthly reports will continue through August and September, after which reporting will shift to a quarterly format. A separate monthly safe staffing report will be maintained.

LF introduced Susan Hughes, Deputy Director Midwifery reporting to the Director of Midwifery.

14.	**Trust Infection Prevention Committee Summary Report**	**LF**	**Information**	**Enclosure 14**

There has been an unusual rise in MRSA bacteraemia cases, with four reported since early 2025—two hospital-onset and two community-onset. This is a significant increase, however the trust is not considered an outlier nationally, as similar trends are being observed across the country. A cluster review of all MRSA cases is underway in collaboration with the ICB, aiming to identify systemic issues and learning opportunities.

One potential contributing factor is a gap between electronic systems, which may affect the continuity of care for patients colonised with MRSA—particularly in community settings where district nurses are involved. This issue is being investigated further and will be reported back to TIPCC it was also suggested that this could be discussed at the Safety in Sync forum.

Additionally, the committee reported Legionella indicators in water testing from the cath. lab. These are being mitigated through the use of filters, disinfection, and flushing protocols, with follow-up testing.

The minutes included with the papers were noted as draft as have not yet been approved by Infection Prevention Committee.

The committee acknowledged that while assurance cannot yet be given regarding the MRSA cases, proactive steps are being taken to understand and address the underlying causes.

15.	**Trust Infection Prevention Committee Quarterly Report**	**LW**	**Information**	**Enclosure 15**

There were several key developments and concerns for the quarter. The Trust received updated contract thresholds for healthcare associated infections, with notable reductions in allowable cases: Clostridioides difficile (C. diff) dropped from 60 to 38, E. coli to 36, Klebsiella to 11, and Pseudomonas to 2. The Trust has already reported 12 C. diff cases, 5 Klebsiella, and 1 Pseudomonas, indicating early pressure on these thresholds.

Additionally, one MRSA bacteraemia cases was reported in the quarter, with another hospital-linked case in August. This is a significant rise compared to historical data, where only two cases were reported over nine years. The increase mirrors a national trend, and a cluster review of all recent MRSA cases in Wye Valley is underway, including one from March. The IPC team is working with the Integrated Care Board to identify contributing factors pre-admission or any trends not identified on first review.

Following NHSE inspection in May, the Trust has been successful in moving from intensive support but remains under enhanced support. While progress has been made, longstanding estates and cleanliness issues persist. Regular meetings with Sodexo and estates teams are helping to prioritise and resolve these concerns.

Another area of concern is blood culture contamination rates, which exceed the national benchmark of 3%. The IPC team is reviewing training, competency packages, and clinical equipment to address this issue.

Fit mask testing compliance is low in high-risk areas such as ED, ITU, theatres, and maternity. The IPC team is manually compiling reports to identify gaps and working with clinical teams to improve compliance. The national requirement for dual-mask testing adds complexity and time, making staff release for testing a challenge.

Preparation for high-consequence infectious diseases is also a concern given the required competency-based PPE training has been unavailable regionally for 18 months. The West Midlands region is now planning to offer localised training, which the Trust hopes to access soon. Current training on how to don and doff is acceptable and therefore of no risk to staff.

ICB level information can be accessed for some infections but it is not possible to interrogate the data set at hospital level. Gram negative mortality rate appears high when compared to national benchmarking which is thought to be due to the small numbers involved. A high level audit has been undertaken which has not shown any obvious reason and will be shared with the CMO for further review. Infection-related deaths flagged for a structured judgment review will be fed back to the IPC team for deeper analysis.

16.	**PLACE Review Privacy, Dignity and Wellbeing**	**LW**	**Discussion**	**Enclosure 16**

The key elements noted from 2024 feedback showed that for the second year running decline in privacy and wellbeing and dementia domains.

The PLACE working group have reviewed results for dementia and disability and privacy domains to identify learning and see what improvements can be achieved prior to PLACE 2025.

Some key areas were identified. Signage across the sites, the visibility of them and whether they meet dementia requirements, also provision of changing facilities for adults are inadequate across all sites.

A total of 30 elements of the dementia domain were identified as being within our immediate control, seven of these could be achieved before the start of PLACE 2025 including picture signage on toilet doors and provision of wheelchairs at front of hospital. There were also three areas of challenge.

15 elements were not in our immediate control related to design of the hospital including the hospital having a less clinical feel; all rooms on wards having single occupancy an ensuite bathroom and all lifts having audio prompts.

29 elements of the privacy, dignity and wellbeing domain were identified including signage, relatives not having access to meals out of hours, visitor's rooms, space between beds and private rooms for conversations.

10 areas were in immediate control including replacing missing privacy curtains and marking up of single sex bathrooms.

14 elements were not in our immediate control including parking machines and how displayed, space around beds; access multi faith rooms at community hospitals. There were 6 areas of challenge.

PFI partners have been invited on future visits to provide support for any challenges made regarding estates.

There is optimism that scores will increase this year following improvements and feedback will be given in the next quarterly report.

The Chair stressed the need not to lose sight of issues not in immediate control as opportunities may present to implement – eg audio in lifts

17.	**CONFIDENTIAL SECTION**			
17.1	**PSIRP Evaluation Report**	**NO**	**Discussion**	**Enclosure 19**
18.	**Prescription and Monitoring of Antipsychotic Medication in Community Paediatrics**	**CA**	**Information**	**Enclosure 18**
19.	**Any Other Business**	**All**	**Discussion**	

CA made the committee of aware ongoing issues with the breast service. There is currently one clinician on sick leave and being covered with locums. A round table is planned to be able to provide some assurance about the service and will look at impact on waiting lists, improvements to service in terms of setting up seroma clinic, chronic wounds, MDTs and digitisation. An update will be provided in the surgery division report.

20.	**Date of Next Meeting**

Thursday 25th September 2025 – 1.00-4.00pm

MS Teams

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	**Quality Committee September 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, September 2025**
Purpose of report:	**☒ Assurance ☐ Approval ☐ Information**

Brief Description of Report Purpose

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

Recommended Actions required by Board or Committee

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

Executive Director Opinion[1]

N/A

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

Matters for Noting

1. **Quality Priority – Diabetes Safety Improvement** – This was the first report on this priority which focuses on 4 safety areas: foot assessment, hypoglycaemia management, insulin management and patient empowerment. 27% of admissions for over 65s have diabetes. Committee was updated on the first 2 areas. An initial audit shows low compliance with foot assessments within 24 hours. This is key as foot complications is single biggest area for hospital admissions. New SOP and training are focus for improvement. An audit of Hypoglycaemia episodes also shows scope for improvements to prevent episodes and to avoid recurrences.
2. **Mortality Report** – SHMI rose again but comparative analysis continues to be difficult due to incomplete coding. These coding errors are being addressed and corrected data is being resubmitted. This is expected to be completed by December. Crude mortality remains within expected limits which gives some assurance
3. **Patient Flow Report** – ED attendances and admissions continue to be very high. Boarding rates and use of escalation remains stable. Committee considered experiences of patients in ED – patients not boarded but experiencing similar care and safety risks
4. **Staffing Report** – Fill rates for nurse staffing have improved and continue to be stable. Vacancies and sickness low and improving with agency usage stable, though sickness has increased usage in ED. Concerns were noted in relation to HCA vacancies
5. **Divisional Report – Clinical Support** – Committee acknowledged a number of positive developments including the launch of endoscopy services in Ross, improved performance in Pharmacy and the planned opening of the new Community Diagnostic Centre. Audiology services and staffing sustainability remain a particular concern and a plan is being developed in collaboration with the ICB
6. **Perinatal Safety Report** – There were higher than usual levels of acuity in month with a need to supplement staff through redeployments and use of community midwives. July also saw higher than usual admissions to SCBU though reviews showed 2 potentially were avoidable and actions are being followed up.
7. **Infection Prevention Annual report** – Committee approved the annual report noting the challenges throughout the year while acknowledging the progress made and the considerable efforts being made by staff.

Matters for Escalation - None

WYE VALLEY NHS TRUST
Minutes of the Quality Committee
Held on 25th September 2025 at 1300 - 1600.

MS TEAMS

Present:		
Ian James	IJ	Non-Executive Director (Chair)
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Eleanor Bulmer	EB	Non-Executive Director
Rachael Hebbert	RH	Associate Director of Nursing
Sharon Hill	SH	Non-Executive Director
Kieran Lappin	KL	Associate Non-Executive Director
Frances Martin	FM	Non-Executive Director
Natasha Owen	NO	Associate Director Quality Governance
Grace Quantock	GQ	Non-Executive Director
Emma Smith	ES	Deputy Chief Nursing Officer
In Attendance:		
Joytish Govindan	JG	Consultant Physician, Diabetic Retinopathy (for item 4)
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Helen Harris	HH	ICB Representative
Leah Hughes	LH	Operational Clinical Lead Radiographer, Clinical Support Division
Justine Jeffery	JJ	Director of Midwifery
Christina Lange	CL	Diabetes Specialist Nurse (for item 4)
Abbi Maddox	AM	Matron Community and Antenatal Services
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Hayley Pearson	HP	Clinical Director Pharmacy
Vicky Roberts	VR	Executive Assistant (for the minutes)
Emma Wales	EW	Associate Chief Medical Officer Medical Division (joining late)
Laura Weston	LW	Lead Infection Prevention Nurse (for item 10)
Apologies:		
Claire Carlsen	CC	Associate Chief Operating Officer, Clinical Support Division
Jane Ives	JI	Managing Director
Hamza Katali	HK	Associate Chief Medical Officer, Obstetrics and Gynaecology
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Jo Rouse	JR	Associate Non-Executive Director
Nicola Twigg	NT	Non-Executive Director

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 28th August 2025**	**IJ**	**Approval**	**Enclosure 3**
Approved as correct record of the last meeting.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**
The actions were reviewed and updated.				

4.	BUSINESS SECTION			
4.1	Quality Priority Diabetes Safety Improvement	CL/JG	Information	Enclosure 4

This safety improvement workstream aims to enhance the safety of inpatient care for patients with diabetes.

The Diabetes Safety Board (DSB) has been re-established and now reports to the Patient Safety Committee. The terms of reference, attached to the meeting papers for information, were agreed at the Diabetes Safety Board meeting in September and are awaiting approval by the Patient Safety Committee.

The focus for this year is on four areas, foot assessment, safe management of insulin, patient empowerment, and safe hypoglycaemia management. Updates on two areas of improvement were provided for this meeting.

Diabetic foot assessment:

The goal is for all in patients to have a foot assessment within 24 hours of admission. A spot audit undertaken on 21st May showed only 5.3% compliance of this care process. There was a total of 75 people with diabetes in hospital on that day.

The assessment is important as foot complications are the largest single reason for hospital admission among those with diabetes. All patients should be checked for diabetic foot emergency as soon as possible on admission, if one is found then follow the diabetic active foot pathway urgently and is also an occasion to identify risk and put in preventative measures.

A template linked to the Waterlow assessment is being developed and the podiatry team have developed a draft SOP to support nursing and midwifery staff to undertake foot screening. Integration with the Waterlow assessments will be helpful to routinely audit through the digital record. An education plan is also to be rolled out.

Hospital-acquired diabetic foot ulcers are under reported and we are working with the Pressure Ulcer Panel to understand those diabetic foot ulcers which may have been wrongly categorised as pressure damage.

In-patient Management of hypoglycaemia:

57 episodes of hypoglycaemia, concerning 29 people were audited during August, more than half of the incidents occurred in patients over the age of 80 and the vast majority occurred out of hours and on a weekend. Clinical safety issues were noted with recurrent episodes and lack of preventative measures noted with only 28 episodes having had glucose rechecks within 15 minutes.

The audit findings were shared at the Diabetes Safety Board and presented at ward sister meetings and hypo awareness week is planned to take place 6-12th October. The diabetes team are also prescribing pre-bed snacks to reduced nocturnal hypoglycaemia and will work with Sodexo to make sure that the food offer meets the needs of diabetic patients.

The care bundle is under review to include preventative strategies and will continue to develop workstreams linked to KPIs. Services will present their data at the Diabetes Safety Board meetings.

It is important to emphasise the importance of diabetes care across all admissions, and it is noted that 93% of admissions are not directly due to diabetes and 27% of patients aged 65+ have diabetes as a comorbidity.

Comparative data and best practices from other trusts in the foundation group will also be explored.

5.	Mortality Report	CA	Information	Enclosure 5

SHMI continues to rise but the 12-month rolling number of deaths is 102, fewer than the previous year.

Coding issues were identified, which were due to vacancies in the coding team. There were approximately 5000 uncoded patients admitted which has skewed data in categories such as pneumonia, where admissions appear lower than expected. Agency coders have been recruited to clear the backlog. Progress is being tracked and updates provided to the Executive Team.

Once re-submitted, SHMI data will be refreshed by the national team, expected by November or December. In terms of quality 30 cases have been sent to the national team, 12 were recoded to better reflect comorbidities.

Work continues on deterioration detection initiatives. Patient wellness questions have been rolled out to 11 wards, with full rollout expected by year-end. Martha's Rule, next-of-kin escalation pathway, supported by the national team is to also be implemented before year-end.

The Chair asked if the range of outcomes from structured judgement reviews were as expected. The Mortality Panel carry out a deep dive, of all cases rated overall as poor to reach a consensus as to whether death was avoidable. The avoidability scores are explained as follows: Any score of 4 and above is unlikely to have been avoidable, scores 1–3 indicate potential avoidability and trigger patient safety investigations. Three PSII were declared in this reporting period.

FM found it helpful to see mortality related to length of stay in ED and thought that it would be helpful to see this comparison in future reports. CA explained that prior to test of change 12-hour ED stays had reduced to 8%. It had previously been 14–15%; which is known to be associated with 3 times increase in mortality. This reduction also correlated with lowest monthly deaths (56). The current rate of over 12 hour stays has risen to 11%; but sustaining improvements is a priority and would be included in future reporting.

6.	Patient Flow Report	NO	Information	Enclosure 6

There are sustained high levels of ED attendances and admissions, with ambulance handovers and ED wait times beginning to trend negatively. Despite this, boarding metrics remained stable and TES data was significantly lower than in previous months.

Ward stays for dementia patients have reduced slightly, showing positive impact.

Incident themes for boarding patients have included medication issues related to discharge and one ward patient discharged without a care package. It was noted that it is not uncommon for people to refuse care or for families to agree to bridge a gap and later are not able to do so. All incidents are reviewed in depth in the medical division.

Complaints are mainly focussed on discomfort in boarding spaces, particularly lack of call bells, bed tables and lockers and the impact on dignity and privacy.

The Committee were asked if future reports should include a metric relating to ED as part of patient flow. The current report does not adequately capture risks for patients attending ED but not admitted. Members of the committee emphasised the importance of maintaining a focus on boarding and caring for patients in temporary escalation spaces as a significant quality and safety issue rather than dilute the message. Members also felt that other risks were covered through divisional governance and other reporting mechanisms.

7.	Staffing Report	ES	Information	Enclosure 7

There continues to be high patient numbers through ED and admissions continue to impact on boarding patients which affects staffing levels, particularly due to boarding requirements.

Fill rates have improved and remain stable, with hours per patient day within normal levels, indicating safe staffing. Incident numbers were low, with most related to skill mix rather than staffing shortages.

Vacancy rates for nursing are stable and expected to reduce in September with new starters commencing from qualified cohorts coming out of university this month. Maternity leave rates remain high for registered nurses but are mitigated by permanent backfill recruitment to cover maternity posts.

Sickness rates have decreased, with RN sickness at 4% and Healthcare Assistant sickness below 6%.

Agency usage remains on a downward trajectory with 99% compliance to NHS cap rates; bank usage has slightly increased. Off-framework shifts were limited and related to registered mental health nurse shortages; three RMNs are due to start working for the Trust bank in October. ED staffing pressures due to sickness have increased agency demand, with off-framework considered only for safety-critical needs.

From the data presented, HCA vacancy rates appear to be increasing, and work is in progress across ward areas to ensure the data is correct. It is thought there are a number of posts where there is a small amount of WTEs on certain wards. Recruitment continues but high turn-over is being seen and is back to 20%. This is also being looked into.

8.	Divisional Quarterly Report – Clinical Support	LH	Information	Enclosure 8

Incidents remained stable, with a slight increase in overdue incidents attributed to management gaps and summer leave.

Key developments include a streamlined MRI referral process in audiology to reduce ENT waiting times, and a successful £240,000 CDC pathway bid to support pathways around breathlessness, HRT-related bleeding, prostate, and lung diagnostics.

Blood sciences modernisation has commenced, and histology turnaround times remain among the best in the West Midlands.

Pathology underwent a UCAS inspection with all significant findings addressed, and a follow-up visit is expected. New appointments for General Manager, Deputy General Manager and Quality Manager have also been made.

Endoscopy is now fully staffed and will launch a five-day service at Ross in October.

The Mortuary received positive feedback from the HTA inspection, particularly on SOP quality and their management on iPassport.

Pharmacy achieved a three-year high in TTO turnaround, with 75% completed within two hours, and three technicians were shortlisted for national awards with APT UK.

Fred Bulmer medical day case unit transition to Clinical Support management is imminent. Cancer services launched best practice pathway dashboards and were regionally recognised for head and neck performance.

The Community Diagnostic Treatment Centre is now complete and on track to open on Monday 29th September.

Concerns include fragile staffing in paediatric audiology and long-term audiology workforce sustainability. There are also consultant gaps in microbiology and histopathology, and persistent endoscopy wait times.

Mortuary staffing also remains limited, with reliance on a trainee pending qualification and Pharmacy also faces vacancies in ATO roles and the retirement of a key pharmacist.

Breast cancer pathway delays prompted a workshop to review the pathway and develop action plans.

The audiology peer review identified three children had suffered moderate harm due to delayed hearing aid fitting, though parents reported satisfaction with care. Duty of candour meetings were completed, and a revised staffing structure is underway. Recruitment challenges persist, prompting consideration of internal development. Collaboration with the ICB is ongoing to finalise the action plan associated with the peer review process, the updated action plan will be brought back to committee in October. **ACTION**: **LH**

It was acknowledged that the Clinical Support Division covers a diverse range of services and that there was some overlap in reporting with F&PE and Quality Committee. It was agreed to meet outside this meeting to shape future reporting. **ACTION: LH/LF**

The output of the round table being held in relation to the clinical systems issue regarding radiology electronic results needs to be brought back to a future meeting given this is a patient safety concern. **ACTION: LH**

HH made the committee aware that there has been a Regulation 28 around fragile services related to Worcester around dermatology. The Coroner saw no evidence of an effective process to manage staffing gaps which impact service delivery. It was noted that this is also a challenge for WVT.

9.	**Perinatal Safety Report**	**JJ/SP**	**Information**	**Enclosure 9**

Midwife to birth ratio was 1:17, indicating adequate staffing levels.

Birth numbers were average for the month with 125 deliveries. There were four category 1 C-section delays, but all were completed within 40 minutes and there was no harm to mothers or babies.

There was high acuity in month, leading to frequent staff redeployments and reliance on community midwives to support in-patient services. Some of this was driven by sickness which was slightly above trust target.

Mandatory training for CNST compliance is on track, with a cross-check of the training needs analysis against the core competency framework pending to ensure all safety actions are met.

Neonatal services reported a change in data collection to include a second supernumerary shift co-ordinator with QIS status, as per network requirements.

July saw a higher-than-usual admission rate to SCBU, with two cases identified as potentially avoidable. These were reviewed and action plans were implemented.

Sickness rates appeared high in July and August. This was due to one staff member's absence, which skewed the data given the small team size and assurance was given that the September data showed improvement.

The committee were informed of the intention to make changes to future reporting arrangements. The Perinatal safety report will continue monthly reporting to end of quarter two and will then move to quarterly reporting from quarter three which will mean an absence of reports until January 2026. We will introduce a monthly safe staffing

report and will introduce a perinatal incident report. CNST report will report separately and this will be a quarterly update.

10.	Infection Prevention Annual Report	LW	Information	Enclosure 10

The Trust successfully remained below the threshold for E. Coli Bacteraemia, reporting 46 cases against a target of 51. The Board Assurance Framework showed compliance in five key lines of inquiry, with five others requiring further support, particularly in antimicrobial stewardship, isolation practices, and out-of-hours patient management.

Clinical cleanliness compliance was below expected performance, despite improvements in domestic cleaning compliance. Performance overall was an improving trajectory given lower performance during the earlier part of the year.

Blood culture contamination rates remained below the national benchmark, with ongoing education and process improvements to further reduce contamination.

The team celebrated internal achievements, including the appointment of a Consultant Microbiologist and completion of the infection prevention degree module by a team nurse.

Most actions from the infection prevention improvement plan were completed, with remaining items addressed early in the current year.

COVID-19 hospital-onset cases decreased by 40 compared to the previous year, though outbreaks continued to challenge bed management.

The Trust implemented an in-house high-level cleaning process (HPV), replacing external contractors and contributing to significant savings and responsiveness.

Challenges included exceeding thresholds for Clostridium difficile and other gram-negative bacteraemias, Klebsiella and Pseudomonas, and are in collaboration with the ICB to review cases and refine internal reporting.

The Trust was flagged as an outlier for surgical site infections in knee replacements due to one infection among 118 procedures. This is not a concern but relates to small numbers impacting the percentage overall. All cases are reviewed to identify lessons learnt.

Additionally, three MRSA bacteraemia cases were reported, prompting policy reviews and coordination with district nursing teams.

Overall, the report highlighted considerable progress and ongoing efforts to improve infection prevention practices across the Trust.

11.	Trust Infection Prevention Committee Summary Report	LF	Information	Enclosure 11

The minutes included in the papers were of the Infection Prevention Committee meeting held on 22nd August remain in draft until the next meeting of the IPC, however, were an accurate reflection of that meeting as far as the Chair of that meeting was concerned.

Following insights from an NHSE inspection, a bed management pilot is taking place on Dinmore Ward, testing whether ward ownership of beds improves cleanliness.

The Trust's flu vaccination campaign is set to launch on 6th October, with peer vaccinators on the County site and District Nurse colleagues in the community setting. It is hoped to meet the national ask to increase uptake by staff of at least 5% compared to last year. We are currently working on the process to support eligible in patients to receive their flu vaccination as per the national ask.

Fit mask testing service is offered in and out of hours, though uptake of testing for high risk areas remains low and is a cause for concern.

Concerns were raised about water sampling in the Pathology lab. Mitigation measures including filters, flushing and testing are in place.

Four MRSA bacteraemia cases were reported last month prompting a review of screening practices, especially for patients colonised with MRSA who may fall between primary and community care and where responsibility for surveillance of that lies. This will be reviewed at the next Infection Prevention Committee.

Following a recent Inspection by NHSE and ICB colleagues, the Trust has moved from enhanced surveillance to routine monitoring for cleanliness and IPC practices, there will be a follow up meeting scheduled in three months to ensure ongoing momentum with estates and lifecycle work and a reinspection will be undertaken in six months to ensure that the improvements made have been sustained.

12.	**Patient Experience Committee Report**	**NO**	**Information**	**Enclosure 12**

The Friends and Family Test (FFT) service has undergone changes, including the introduction of QR codes and direct links to the website. Notably, the podiatric surgery team, previously not part of the text messaging service, achieved a 100% response rate on their first round of messages, which provided highly positive feedback and boosted staff morale.

There were some challenges within the Surgical Division in responding to complaints, particularly within the head, neck, and orthopaedics directorates. These complaints often relate to outpatient care, and staff expressed a strong desire to respond promptly despite facing high volumes. The emotional impact on staff and the operational difficulties was acknowledged, and a deep dive into complaints is planned for the next quarterly report to better understand themes and support staff.

LF raised a concern from the Children and Young People Committee, where paediatric services reported difficulty accessing FFT data. NO to investigate whether this was due to a time lag or an access issue and to arrange training if needed. ES added that the Surgical divisional team would also be reviewing the paediatric FFT data, suspecting that the issue might be due to a gap in recent data availability and offered support to ensure the data is accessible and used effectively. **ACTION: NO/ES**

LF informed the committee that she would be taking over the sign-off of complaint responses from the Managing Director.

13.	**Clinical Effectiveness and Audit Committee Summary Report**	**NO**	**Information**	**Enclosure 13**
All national audits are now mapped to relevant committees to ensure proper presentation and oversight. Between May and August, the audits reviewed did not contain any high-risk recommendations or concerns requiring escalation; all recommendations were low risk and are being actioned locally. The committee also addressed a previous issue regarding incomplete data submission to the National Joint Registry. The responsible team investigated the cause, adjusted their processes, and implemented a plan to ensure sustained and accurate data entry going forward. The registry has accepted the plan, and the remaining backlog is being addressed . **14. CONFIDENTIAL SECTION** **14.1 PSIRF Overview Report** — **NO** — **Discussion** — **Enclosure 14** **15. Any Other Business** — **All** — **Discussion** None. **16. Date of Next Meeting** **Thursday 30th October 2025 – 1300-1600pm** **MS Teams**			

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Patient Experience Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	Quality Committee
Appendices included with this report:	Report and appendix one – national inpatient survey
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The report provides an update on key metrics in relation to patient experience, an update against the quality priority for 2025/26 and the appendix includes a summary of the national inpatient survey results.

Recommended Actions required by Board or Committee

Board is asked to note;

- FFT service improvements made in line with quality priority objective, however response rate has declined.
- Overall the positive feedback from FFT far outweighs the negative. Utilising this for improvement may support the Trust to reduce the number of complaints and concerns received.
- Complaints comparison Q2 in 2024/24 and Q2 2025/26 shows an overall increase of 17% in new complaints received in the same period, with an increase of 11% for this financial year compared to the same period last year
- Comebacks continue to increase
- A new national Experience of Care Framework has been published. A gap analysis must be undertaken by the Trust and submitted to NHSE by March 2026.

Executive Director Opinion[1]

The data in this report is accurate at the time of completion. I remain concerned over the number of complaints received and the length of time it takes to respond. Whilst we do triangulate information to focus on areas for improvement there is still more work required in terms of local ownership and we need to explore alternative methods of collating meaningful feedback from our patients.

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

Patient Experience Report- November 2025

Introduction

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

Headlines

- FFT service improvements made in line with quality priority objective, however response rate has declined.
- Overall the positive feedback from FFT far outweighs the negative. Utilising this for improvement may support the Trust to reduce the number of complaints and concerns received.
- Complaints comparison Q2 in 2024/24 and Q2 2025/26 shows an overall increase of 17% in new complaints received in the same period, with an increase of 11% for this financial year compared to Q1 & Q2 2024/25.
- Comebacks continue to increase and if this continues, current trajectory will double figures seen in 2023/24.
- Concerns increased in Q2 but responsiveness has improved within the quarter.
- A new national Experience of Care Framework has been published. A gap analysis must be undertaken by the Trust and submitted to NHSE by March 2026.

Quality Priority- Improve responsiveness to patient experience data

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

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

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

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

Friends and Family Test (FFT)

The Trust has been using a text messaging service to receive feedback in line with the national Friends and Family test programme since October 2023.

One of the fundamental principles underpinning the FFT is 'all patients and people who use services have the right to provide anonymous feedback quickly and easily, when they want to'. To be able to achieve this principle and working with the provider of the text messaging service, during April – July 2025 we reviewed our system hierarchy and introduced a survey format that could be utilised via text messaging, QR code or a web link. No changes were made to the FFT questions asked, however the collection of demographics introduced to enable staff to follow up on feedback where patients wished for this.

The new survey went live 1st July 2025, rolling FFT out to all clinical areas across the Trust. Note there were no messages sent during Q1 due to the changes to the system.

Overview

Between 1st July 2025 – 30th September 2025;

- The Trust has sent 80298 messages for feedback
- 8564 responses were received (9% response rate overall).
- 92.66% of these responses are positive feedback.
- 8.54% of patients gave further comments regarding how they scored their experience.

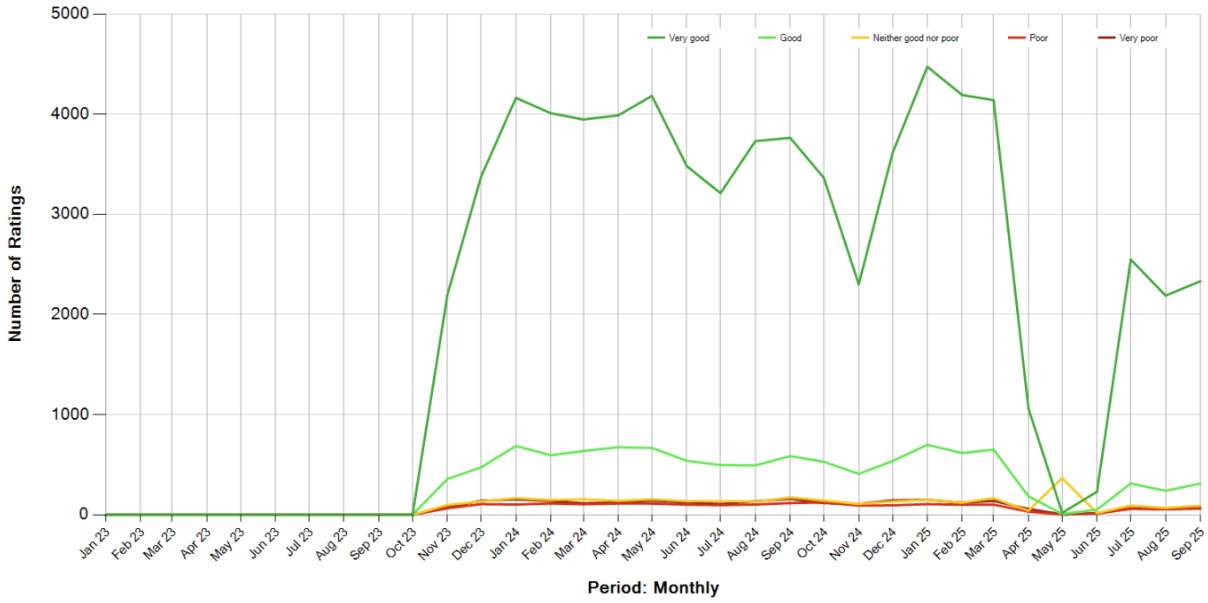
Quantitative data

Our latest results in the table and chart below, are the percentage of responses that scored their experience positively (recommendation rate).

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	June 25	July 25	Aug 25	Sept 25
Trust	92.27%	93.07%	91.66%	Paused	Paused	Paused	92.74%	93.06%	92.19%
Inpt	86.67%	87.13%	85.71%	Paused	Paused	Paused	90.00%	91.63%	93.94%
OP	93.87%	95.06%	94.20%	Paused	Paused	Paused	94.85%	95.81%	94.18%

Since 'Go Live' on 1st July, we continue to see the highest satisfaction ratings in outpatients. Inpatients have seen an increase in positive feedback since August bringing it to the same level as outpatients.

The chart below shows the actual response received by patients. The period April 2025 – June 2025 confirms the pause in requesting FFT whilst the project changes were being implemented. Since July 2025, whilst the number of ratings has reduced the most popular response continues to be 'very good'



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

The Trust's average response rate when introducing the text messaging service in January 2023 was 20%. From April 2024, we have continued to see the response rate decline reaching its lowest point in December 2024 at 12%, with a slight increase in January 2025 to 13%, since July 2025 'Go Live' our response rate has dropped further to 9%, despite requesting more FFT via text messaging, we have not witnessed the increase in responses we expected.

A breakdown by service type is shown in the table below.

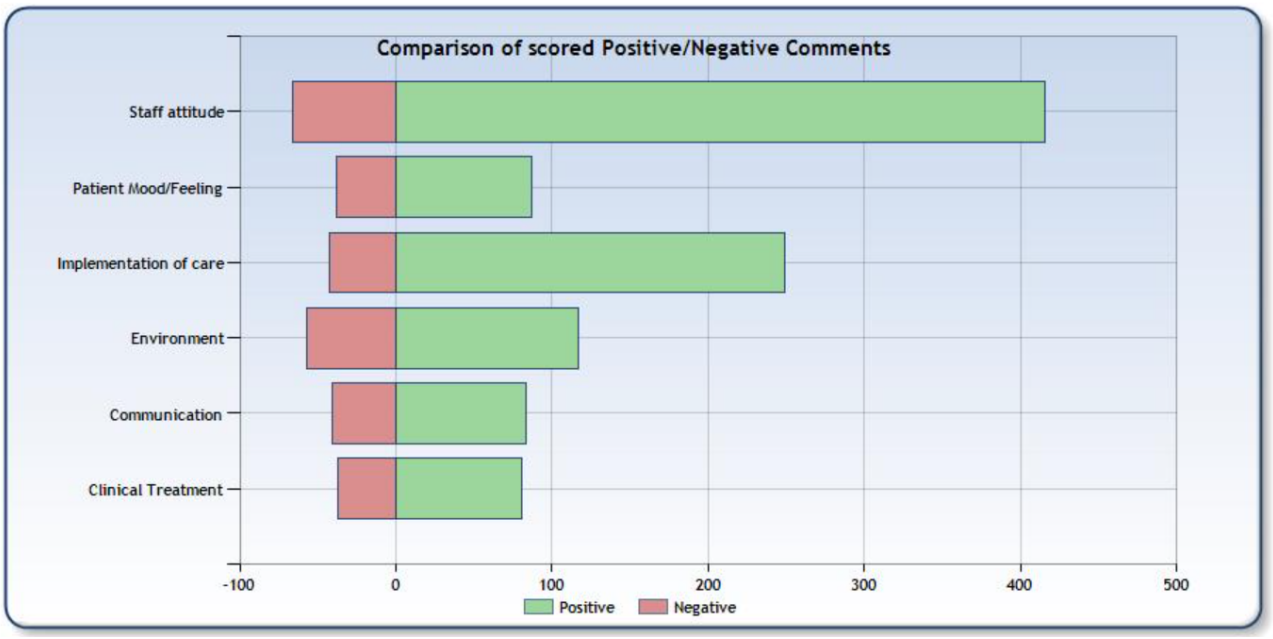
	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sep 25
Trust	13%	13%	15%	Paused	Paused	Paused	9%	9%	9%
Inpatient	15%	16%	15%	Paused	Paused	Paused	13%	14%	12%
Outpatient	12%	12%	14%	Paused	Paused	Paused	7%	8%	7%
Day case	20%	20%	20%	Paused	Paused	Paused	13%	11%	11%

Qualitative feedback

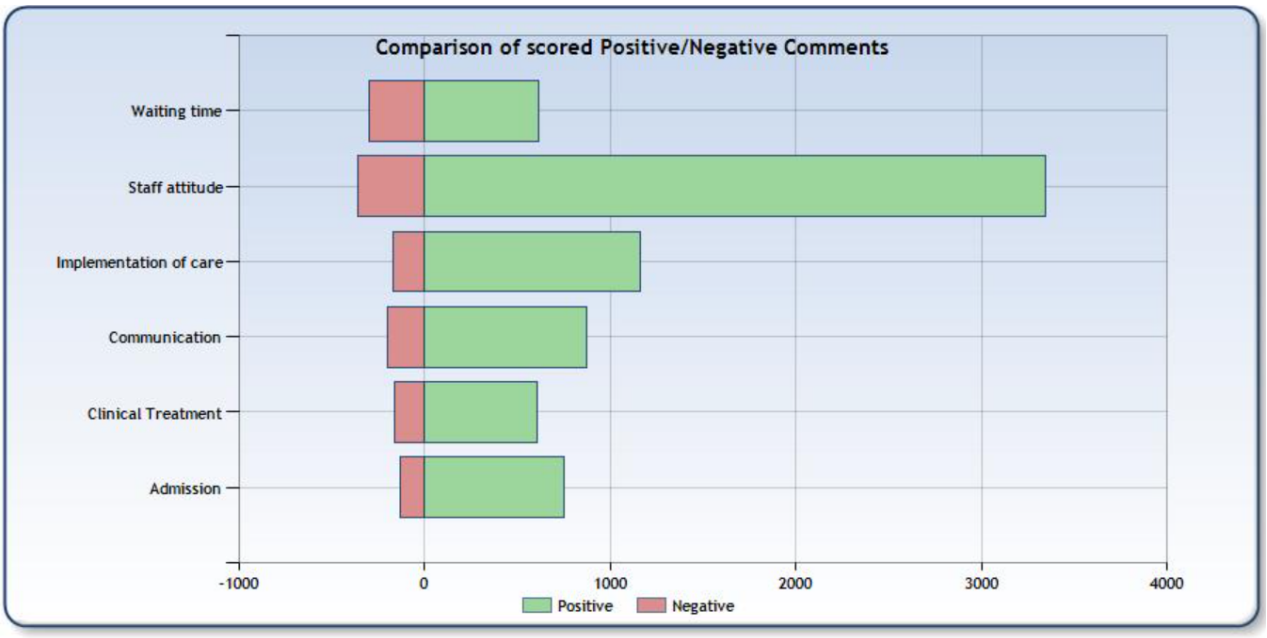
After patients have answered the initial FFT question, they are asked for comments. The free text comments message provides a wealth of qualitative data. The system allows themes to be identified and categorises the qualitative feedback thematically and by the negative or positive nature of the comment.

The charts below show the top 6 themes broken down by inpatient and outpatient responses for the previous quarter.

Inpatient responses Q2



Outpatient responses Q2



Both inpatient and outpatient areas, for all the themes, the positive feedback outweighs the negative

Complaints

This section of the report provides;

- KPI data update Q2 and trends
- Analysis of complaints position by Division
- PHSO cases update

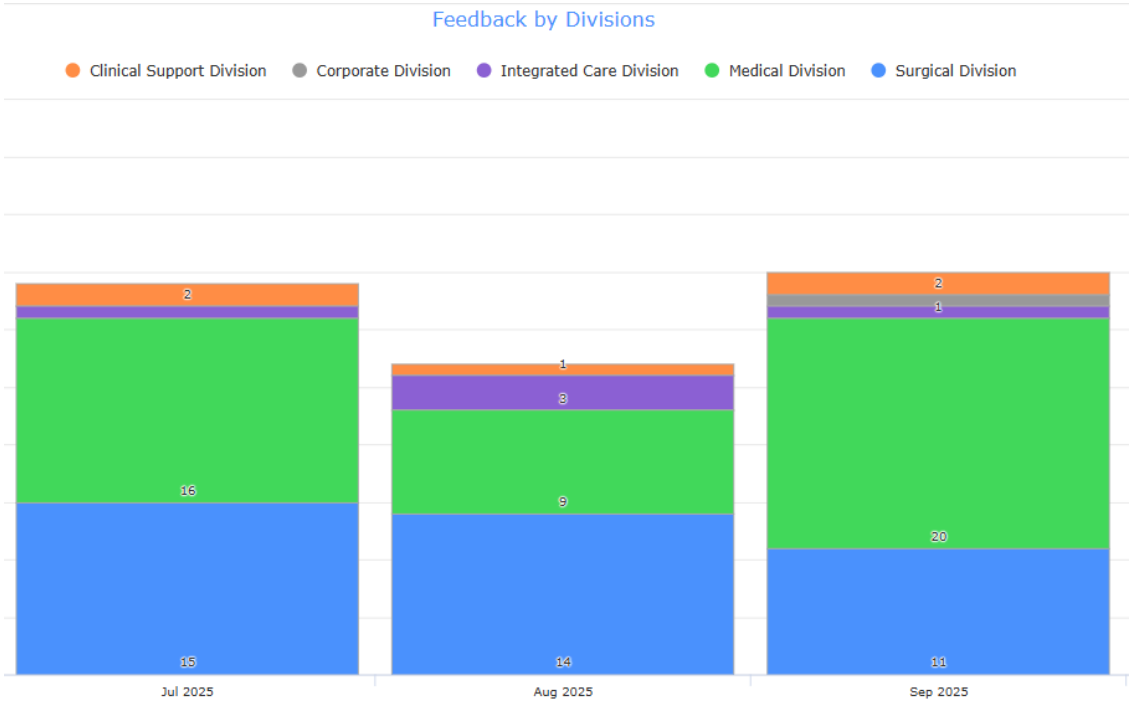
Complaints position

(New complaints only)

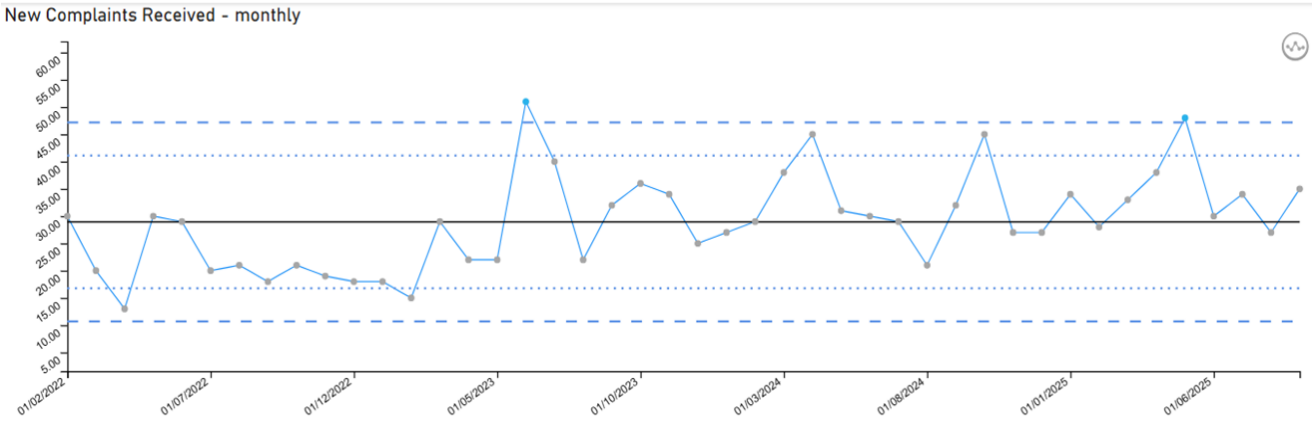
KPI	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Q1	Total Q2	Total Q3	Total Q4	Total Apr-Mar (inc)
Number of complaints **2024/25**	**46**	**31**	**30**	**29**	**21**	**32**	**46**	**27**	**27**	**34**	**28**	**35**	**107**	**82**	**100**	**97**	**386**
Number of complaints **2025/26**	**36**	**48**	**30**	**34**	**27**	**35**							**114** ↑6.5%	**96** ↑17%			

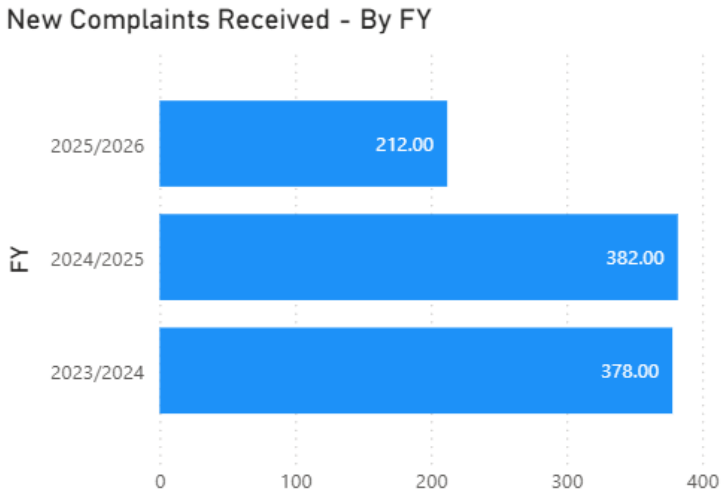
A comparison of data between Q2 in 2024/24 and 2025/26 shows an overall increase of 17% in new complaints received in the same period, with an increase of 11% for this financial year compared to Q1 & Q2 2024/25.

Q2 new complaints received by Division:



There has been an overall increasing trend in the total number of new complaints received since April 2023.





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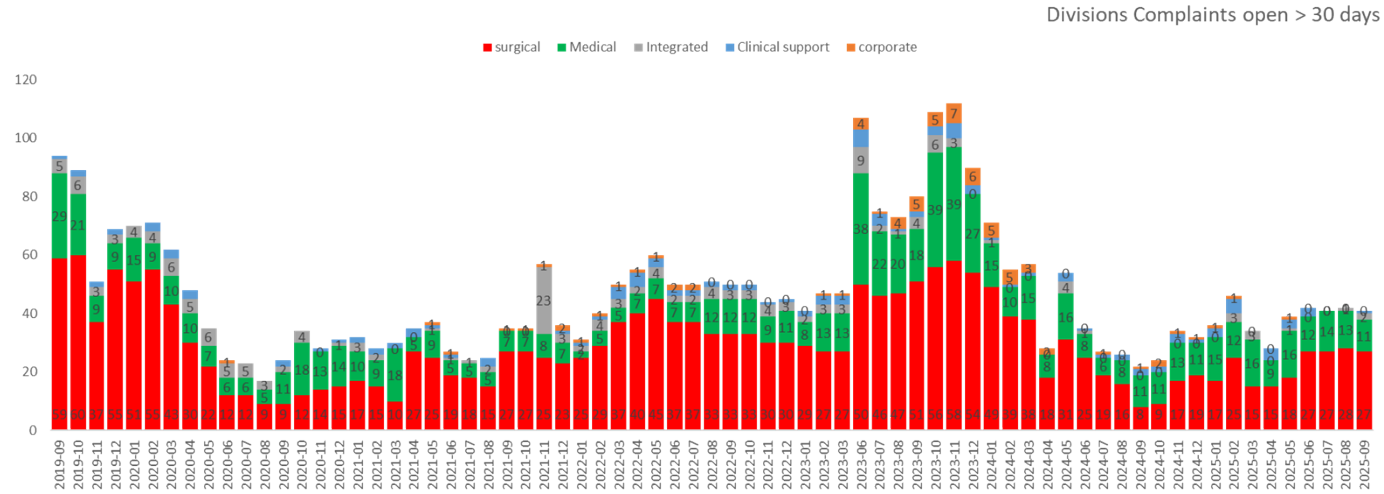
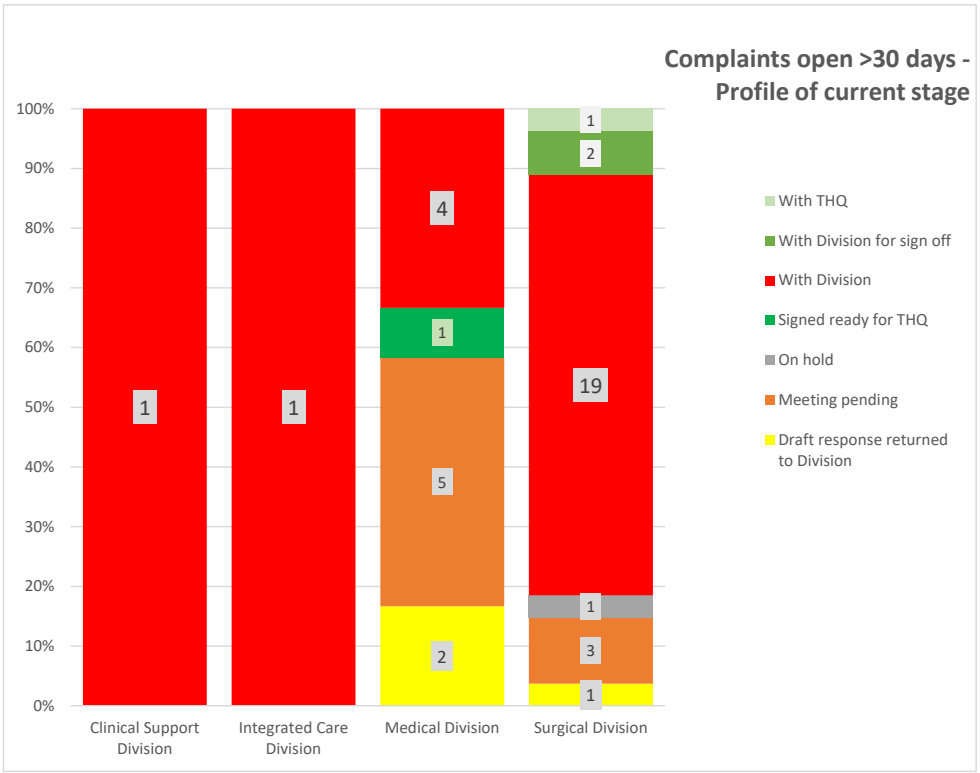
Complaint response times

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

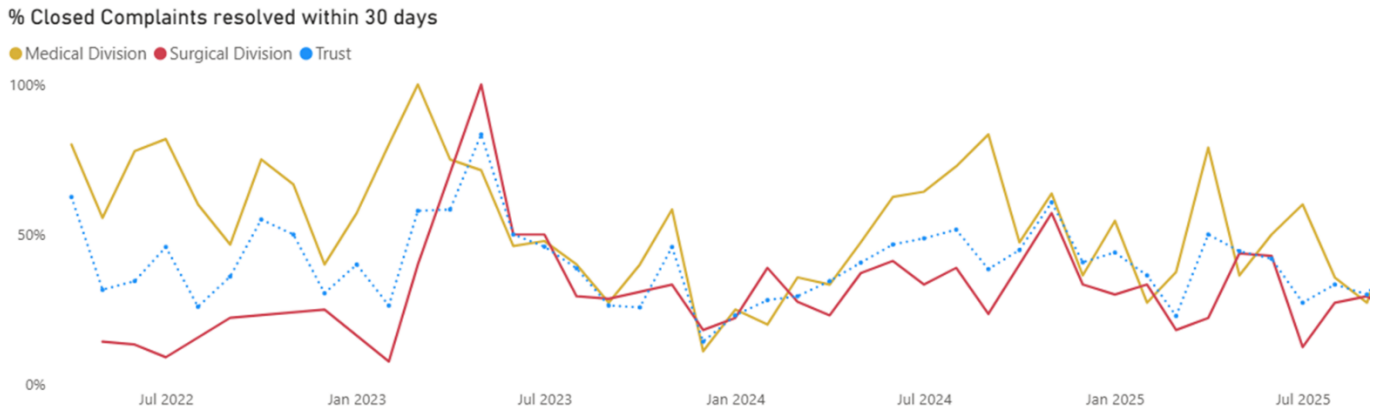


When reviewing the stage of current complaints open for more than 30 days, we can see that the majority are with the investigating officers to complete responses, or for the Medical Division, awaiting planned meetings to discuss the concerns raised in more detail.

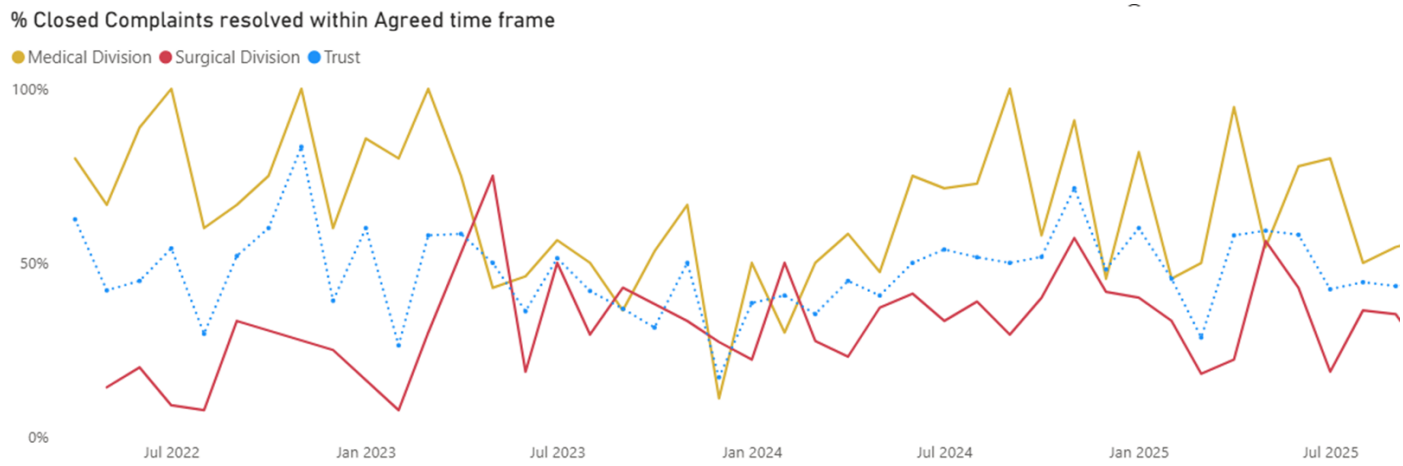


The chart below shows the percentage of complaints being resolved within the 30 day timeframe (rolling 3 month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers.

The Trust can demonstrate compliance with this KPI in only 30% of complaints in Q2.



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



These charts demonstrate that whilst there is some improvement when agreeing the timescale to respond with complainants, we are still only meeting any individually agreed deadlines 44% of the time in Q2.

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

Comebacks

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

Q2 has not shown a decrease in numbers, with an increased trajectory to 2024/5 if rates continue which is more than double 2023/4 numbers. Clinical support and medicine division have the highest proportion of comebacks in quarter 2.

Number of comebacks 2022	36
Number of comebacks 2023	25
Number of comebacks 2024	51
Number of comebacks 2025 (Q1 & Q2)	27

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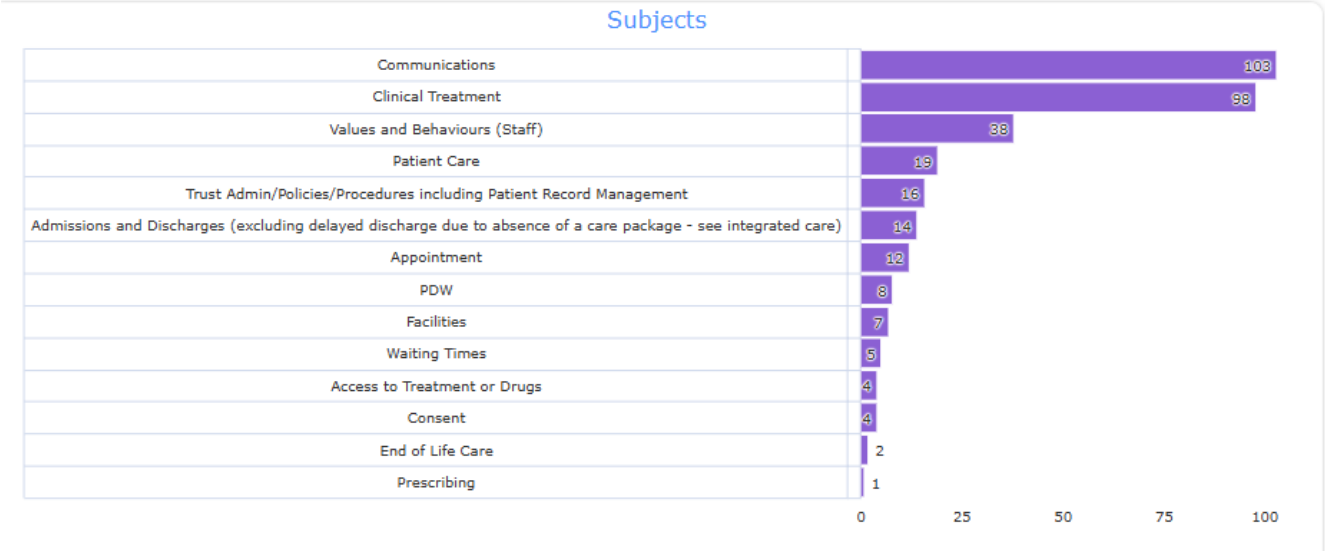
Complaint categories

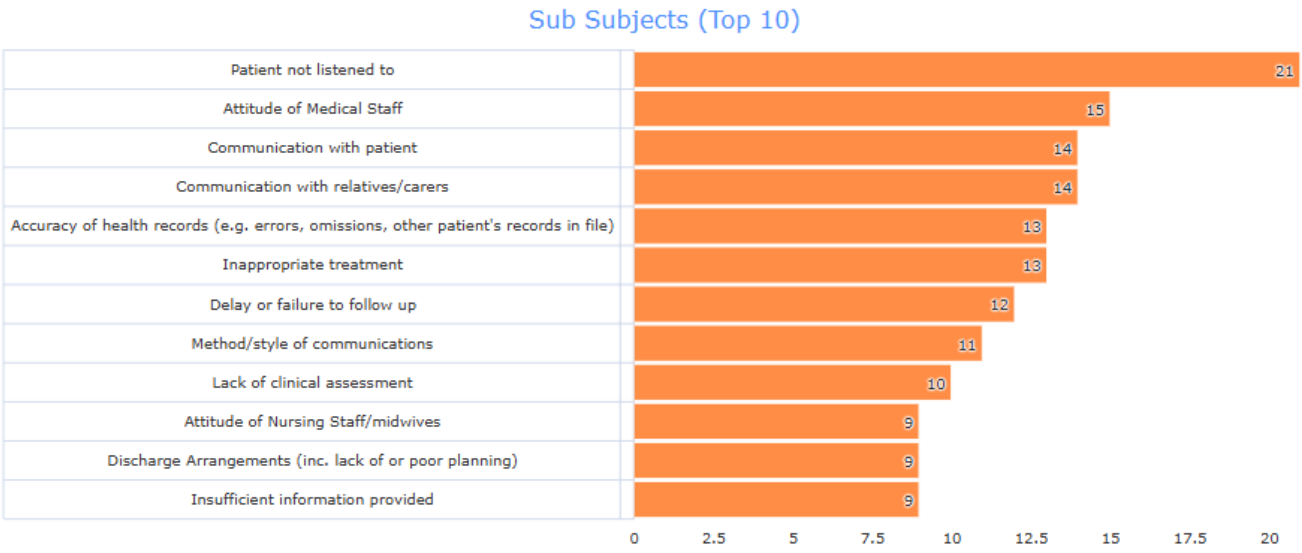
There can be multiple categories and sub categories identified in a complaint. These are analysed and recorded in a triage process by the complaints team based on the complainant's perception of the events, so reflect the patient/relatives experience.

The below chart shows the complaint categories for Q2



Within each overarching category, there can be multiple sub-categories assigned to a complaint.

The below chart shows the top 10 complaint sub-categories for Q2



Complaints regarding poor communication is our top complaint category, with the patient not being listened to featuring most often. A review of this was presented to Quality Committee in November and is a key focus for some specific services.

Parliamentary and Health Service Ombudsman (PHSO) update

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

Calendar Year	PHSO cases
2021	5
2022	1

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2023	2
2024	6
2025 (to date)	5

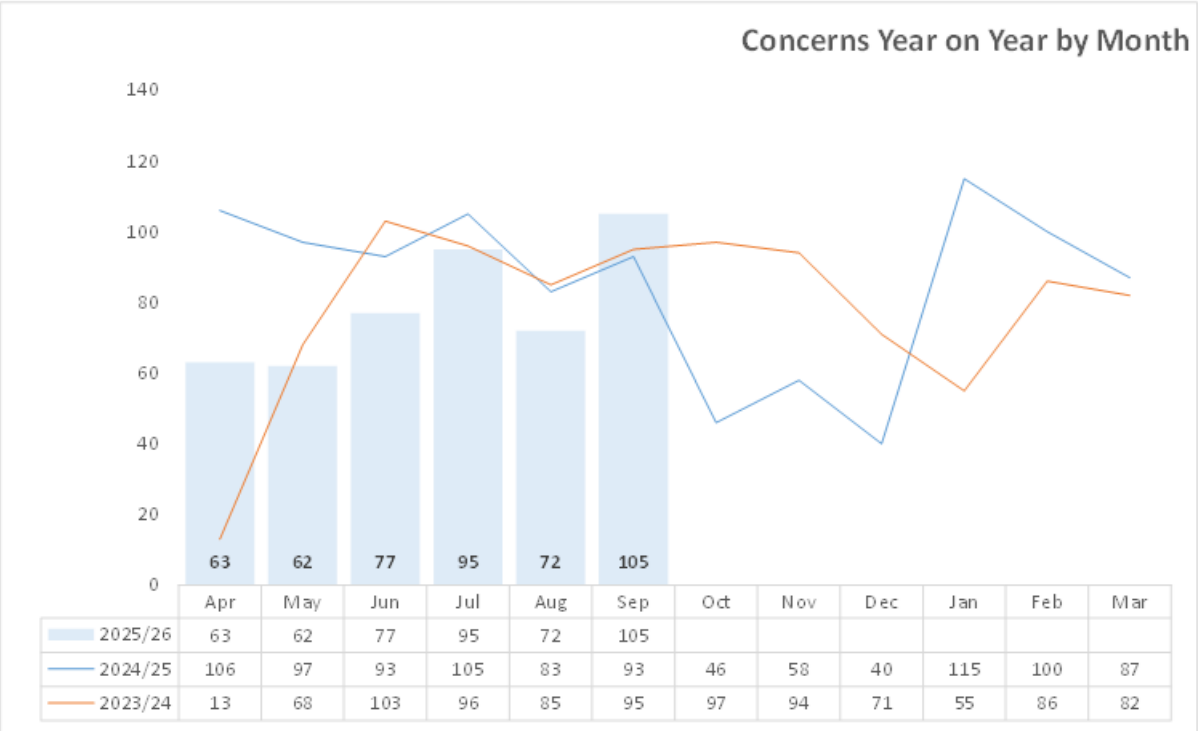
The PHSO have sent 2 letters to the Trust this year highlighting complaints that are over the statutory timeframes of 6 months and requesting the rationale for not responding and urging that response letters are provided. This is a new issue for the Trust and highlights the importance of responding to complaints in a timely manner.

Data on overdue complaints, stage of the complaints and highlighting any over 6 months is now being submitted for review at divisional F&PE meetings for increased oversight.

Concerns

Quarter 2 has seen an increase in the number of concerns recorded when compared to Q1. However, when compared to Q2, this is less than the previous two financial years. This will need to be monitored over the next quarter to establish if this represents an ongoing trend.

The chart below provides a month by month breakdown with comparative data for 2023/24 and 2024/25.

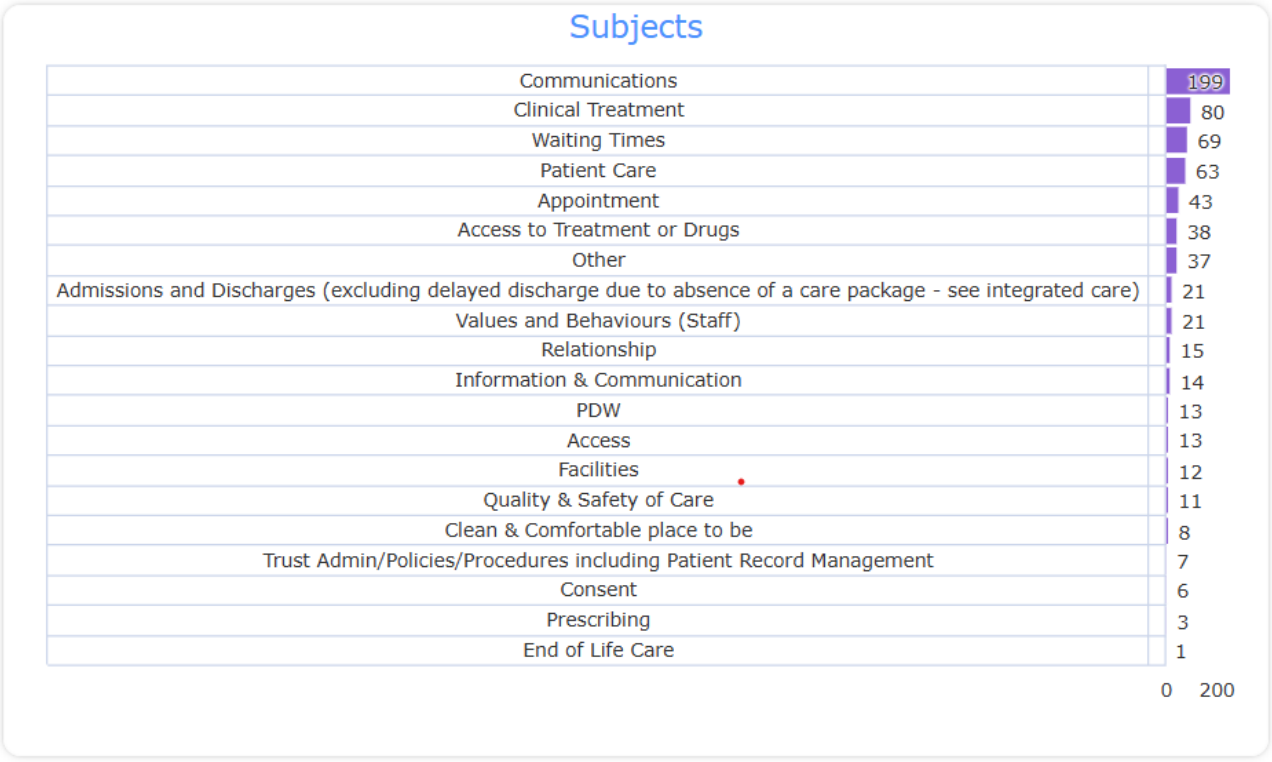


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/26	63	62	77	95	72	105						
2024/25	106	97	93	105	83	93	46	58	40	115	100	87
2023/24	13	68	103	96	85	95	97	94	71	55	86	82

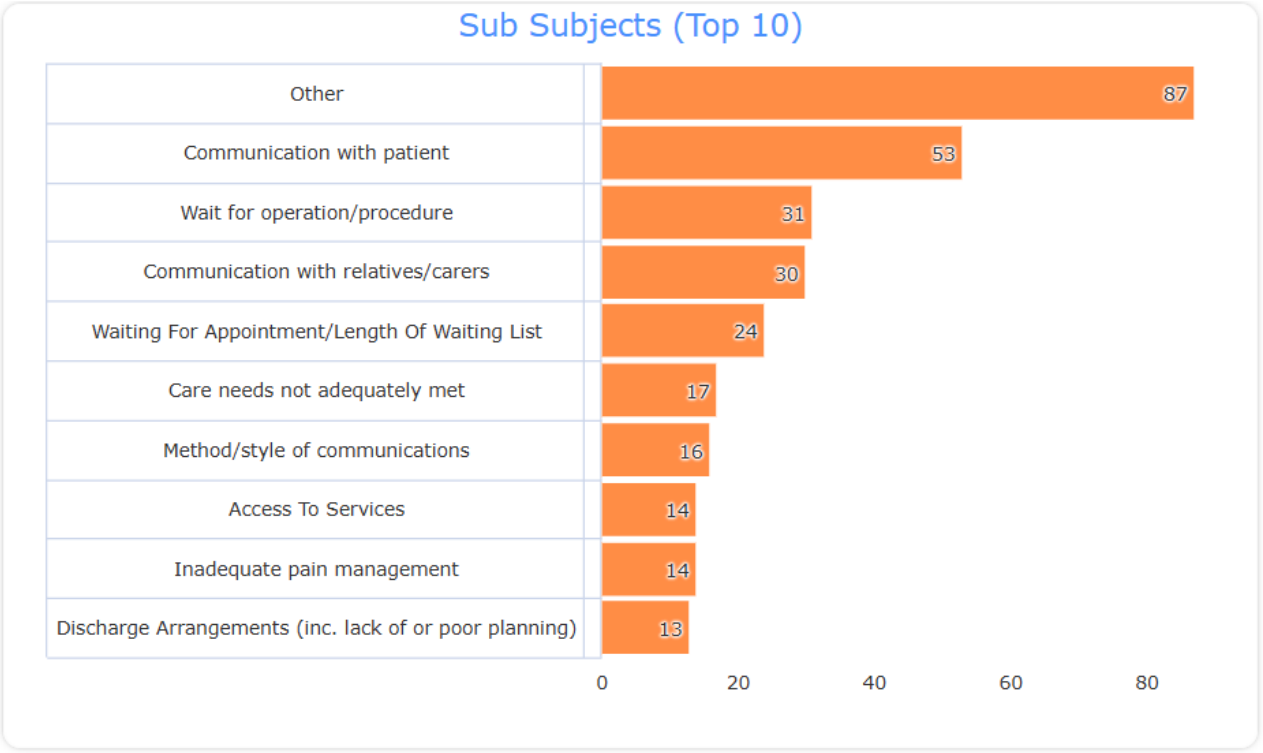
In addition PALS also logged 172 comments and enquiries during this time period. PALS aim to support early resolution of concerns within a 5 day timeframe. Despite increased activity, September did demonstrate an improvement in the percentage of concerns closed within 5 days. However, approximately a third of concerns are still open beyond 30 days. Work is ongoing with teams to support early resolution and timely closures of concerns records and will continue to be monitored over the next quarter.

The largest number of concerns, comments and enquiries continue to be logged for Surgical and Medical divisions, with the most commonly reported subject relating to communication, correlating with complaints.

The chart below indicates the subjects of both concerns and comments/enquiries.



Further breakdown of the top 10 sub-subjects gives further insight into some of the communication issues.



PALS service

Although, the PALS service had seen a brief return to full staffing levels, unfortunately upcoming vacancies will once again place the team in a fragile position whilst recruitment and onboarding is undertaken. In addition to managing concerns, enquiries and compliments PALS also support interpreting provision, patient engagement, surveys and patient information activities.

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Patient Experience Committee

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

Patient Engagement Forum

The patient engagement forum continues to meet monthly with many staff bringing projects to the group for input and support. During Q2 areas work that have been supported included:

- Worked to coproduce new concerns and complaints information for patients and carers
- Reviewed and updated Patient Engagement Charter
- Supported development patient information on Deprivation of liberties (DOLS) and Lasting Power of Attorney (LPA)
- Supported early conversations with the transformation team to improve inpatient information
- Supported the annual PLACE (Patient Led Assessment of the Care Environment) audits

Volunteer Steering Group

The group has oversight of the Trust Objective and Quality Priority for expanding our volunteer offering across our services. An update report was shared with Quality Committee in October.

Experience of Care Framework

NHS England have published a new Experience of Care Framework. This framework helps providers focus on the key areas (including supporting practice) that must be present to ensure continuous improvement in experience of care. It brings together the characteristics of organisations that consistently improve experience of care and enables boards to carry out an organisational diagnostic against a set of indicators.

There are 5 broad sections of the framework;

1. **Leadership**
   The strategic influence of communities, people using services and unpaid carers, leadership development, senior leadership influence and support, clinical, professional and volunteer engagement.
2. **Organisational culture**
   Organisational development, support for staff and volunteers' engagement, staffing levels, organisational values, communications and accessible information.
3. **Collecting feedback**
   Collecting both quantitative and qualitative feedback to understand experiences of care, including using data gathered from surveys, complaints and Patient Advice and Liaison Services (PALS).
4. **Analysis feedback**
   Analysis of qualitative and quantitative feedback, including using multiple datasets and analytical methods, as part of a comprehensive approach to provide robust evidence to inform change and improvement efforts.
5. **Learning for improvement**
   Care planning and shared decision-making, staff appraisal, service change, co-production and continuous quality improvement.

All Trusts are expected to undertake a gap analysis exercise to identify how well they are meeting the new standards and development plans to improve where there are gaps. This analysis is due in March 2026 and will be included in the February 2026 report to the committee for review.

Patient Surveys

The National Inpatient survey has been published and the summary report is attached at appendix 1. The maternity survey publication is delayed; a report on this will be presented to the December Quality Committee.

Report Ends

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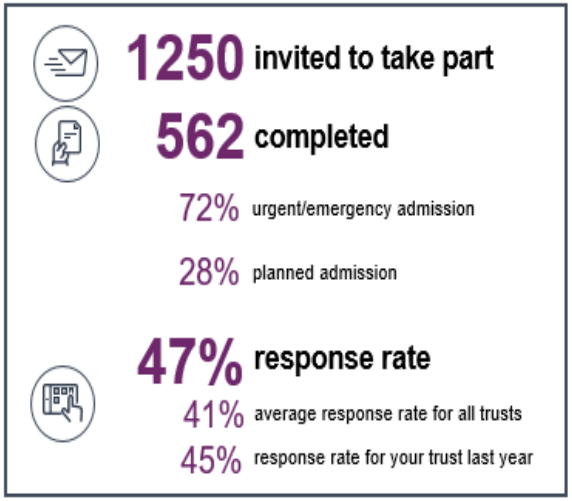
National Inpatient survey 2024 – Summary report

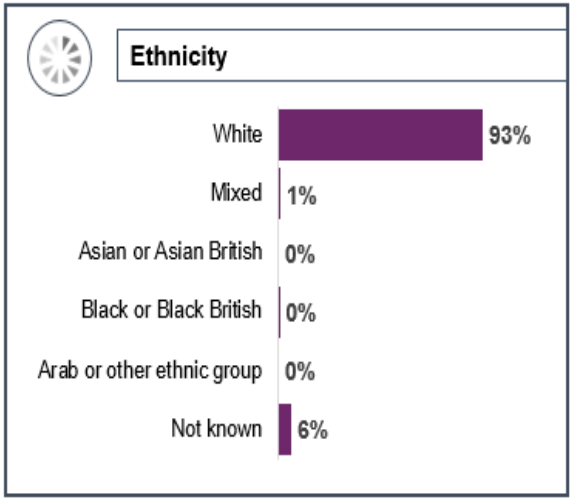
Published September 2025
Presented to Quality Committee November 2025
Presented to Board December 2025

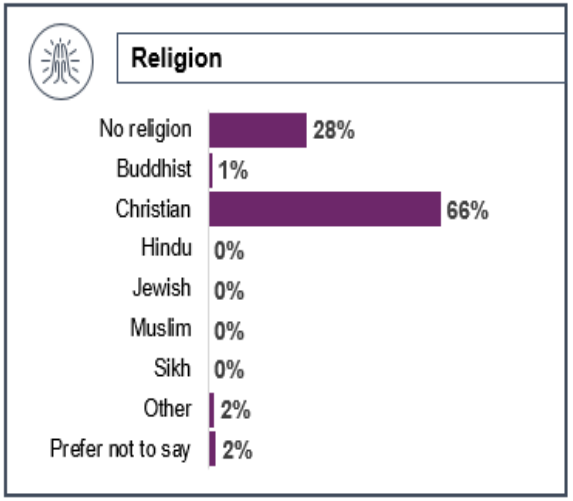
Background & Response rate

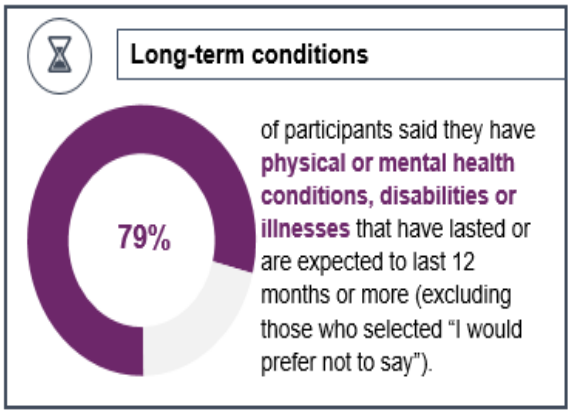
Who took part in the survey?

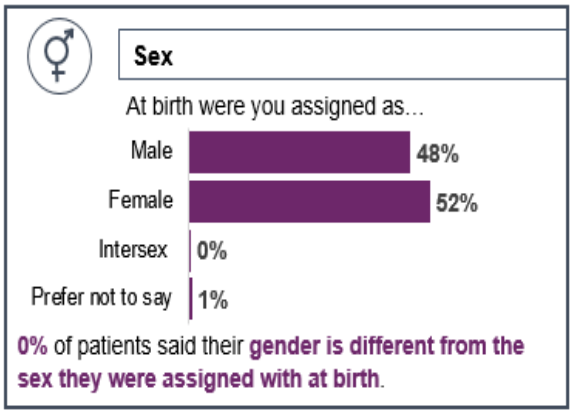
This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

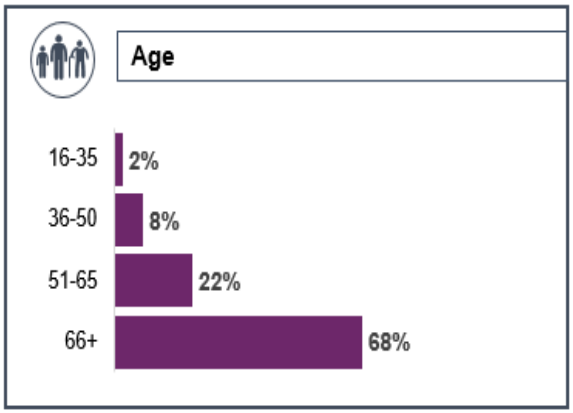








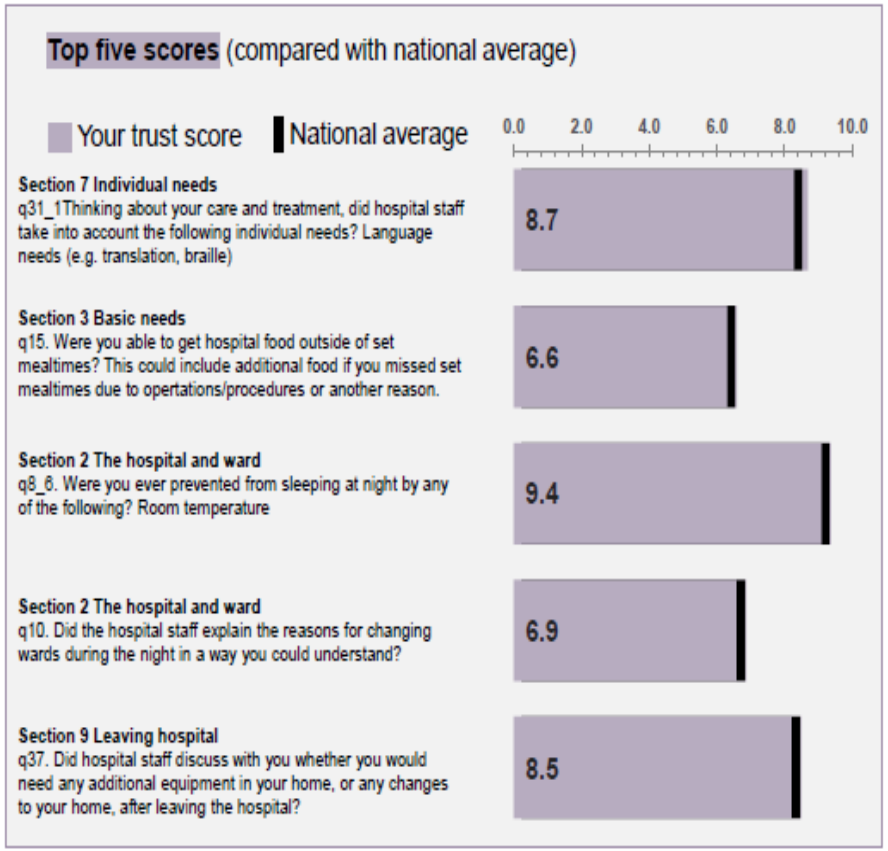


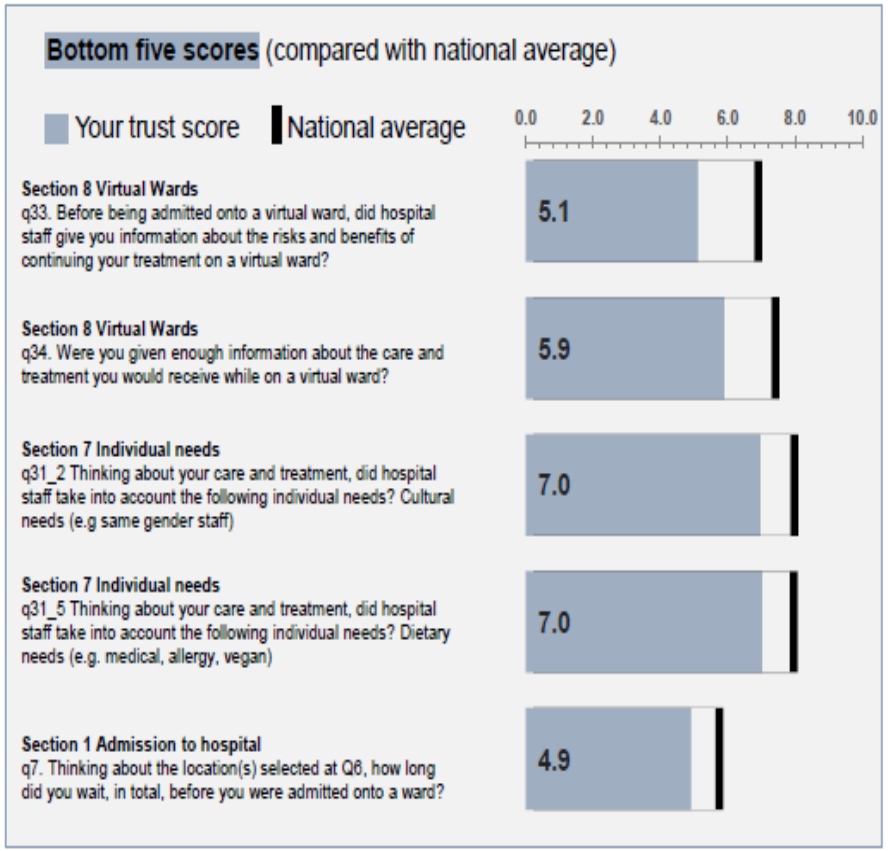


Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.



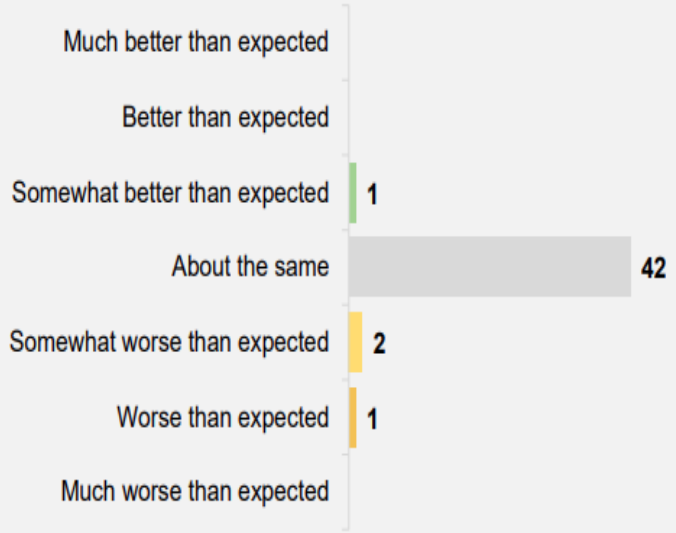


Summary of findings for WVT

Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

Summary of findings for WVT

Results for Wye Valley NHS Trust

Where patient experience is best

- ✓ **Individual needs:** Staff taking into account patients' individual needs: Language needs
- ✓ **Food:** Patients being able to get hospital food outside of set mealtimes
- ✓ **Sleeping:** Patients being prevented from sleeping at night due to room temperature
- ✓ **Explaining change of wards:** Reasons for changing wards explained in a way they can understand
- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving

Where patient experience could improve

- o **Information about virtual wards:** Patients getting information about risks & benefits of continuing treatment on virtual wards
- o **Information while on virtual wards:** Patients feeling they were given enough information about care and treatment on virtual ward
- o **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- o **Individual needs:** Staff taking into account patients' individual needs: Dietary needs
- o **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward

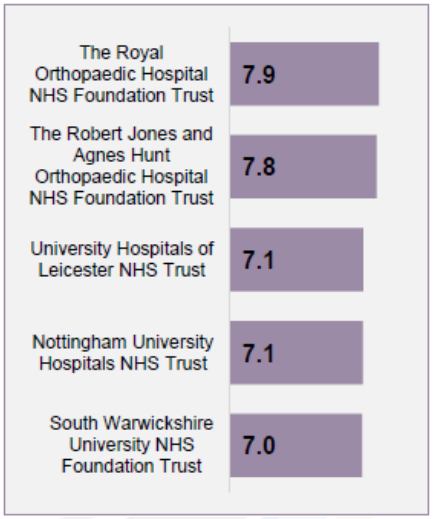
Section 1. Admission to hospital

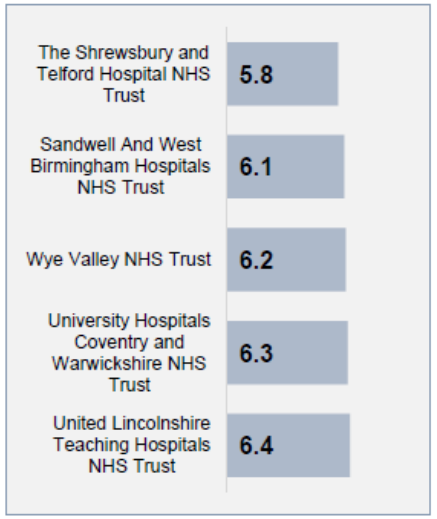
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.2 About the same

Comparison with other trusts within your region



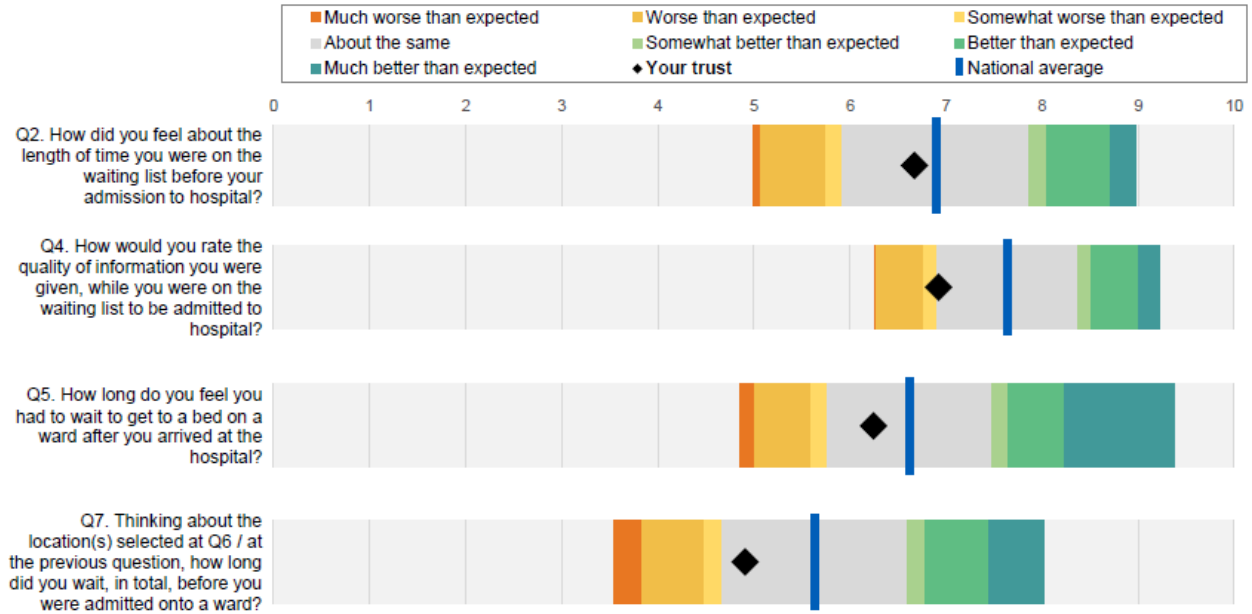


Overall for section 1 score 6.2- about the same as other Trusts

Bottom 5 Trusts in the region

Section 1. Admission to hospital (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 156	6.7	6.9	5.0	9.0
About the same: 162	6.9	7.6	6.3	9.2
About the same: 539	6.2	6.6	4.8	9.4
About the same: 311	4.9	5.6	3.6	8.0

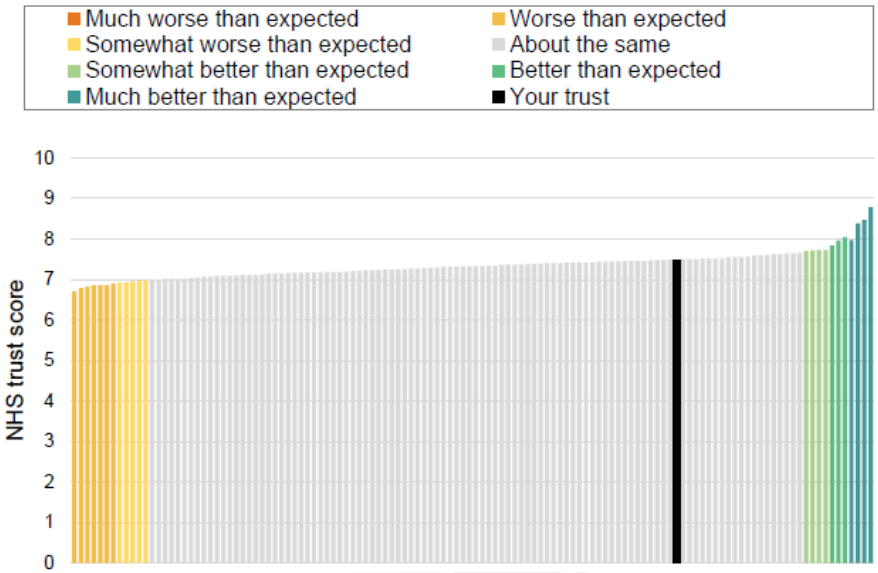
Q5 an area of focus for improvement and this section highlighted how we may benefit from learning and best practice across the foundation group

Section 2. The hospital and ward

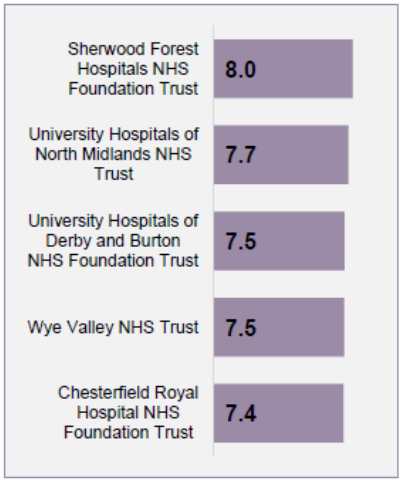
Section score

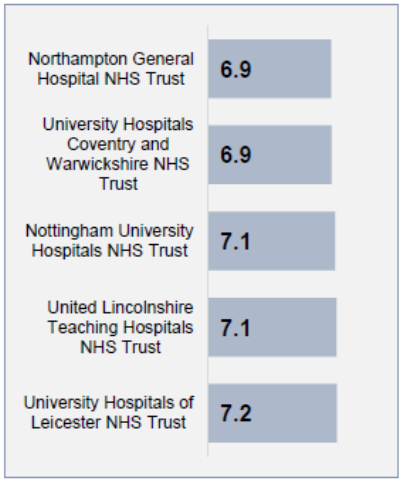
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.5 About the same



Comparison with other trusts within your region



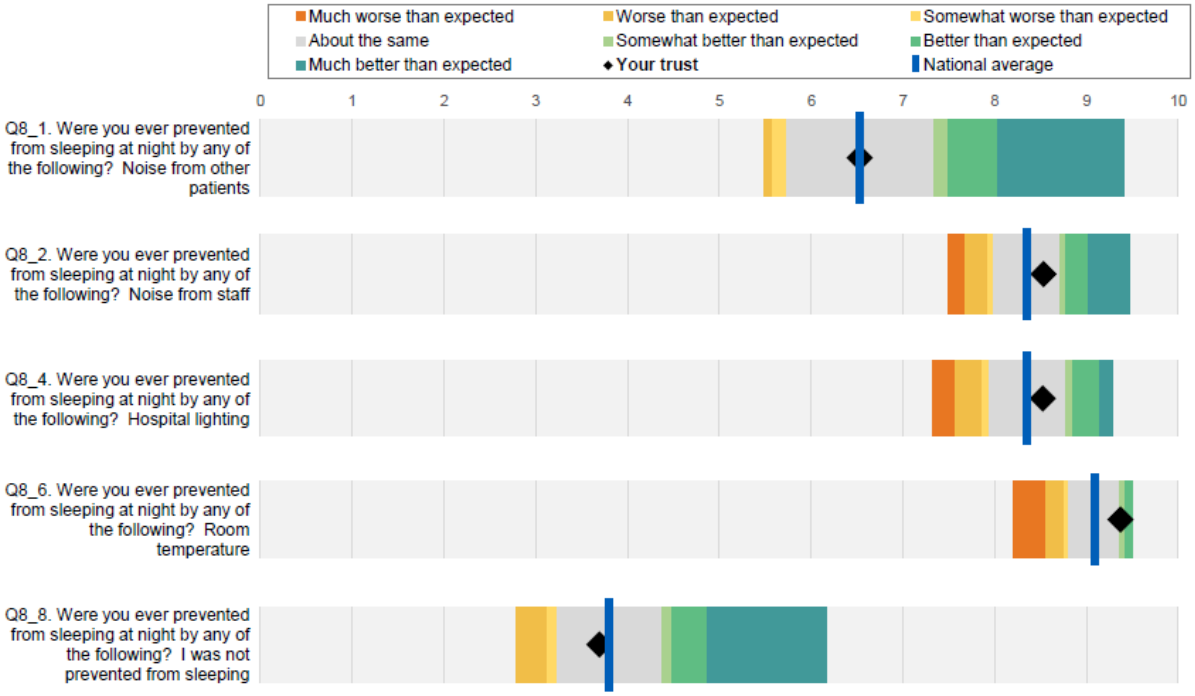


Overall for section 2 score 7.5- about the same as other Trusts

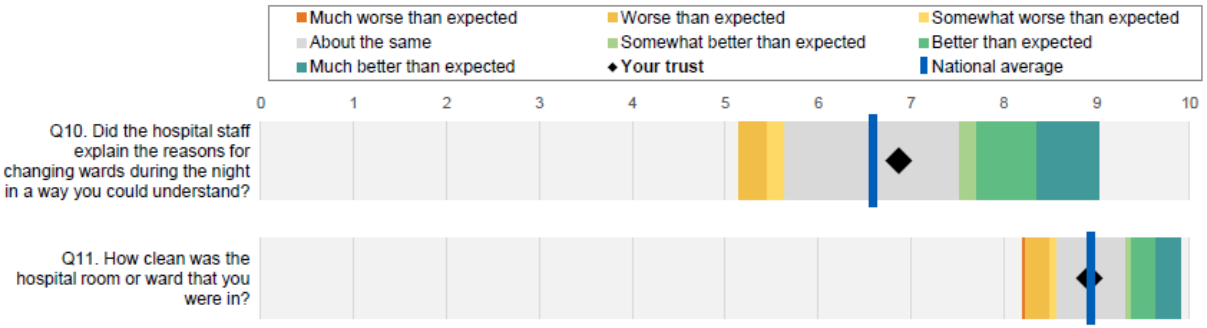
Top 5 Trusts in the region

Section 2. The hospital and ward (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	543	6.5	6.5	5.5	9.4
About the same	543	8.5	8.3	7.5	9.5
About the same	543	8.5	8.4	7.3	9.3
Somewhat better than expected	543	9.4	9.1	8.2	9.5
About the same	543	3.7	3.8	2.8	6.2



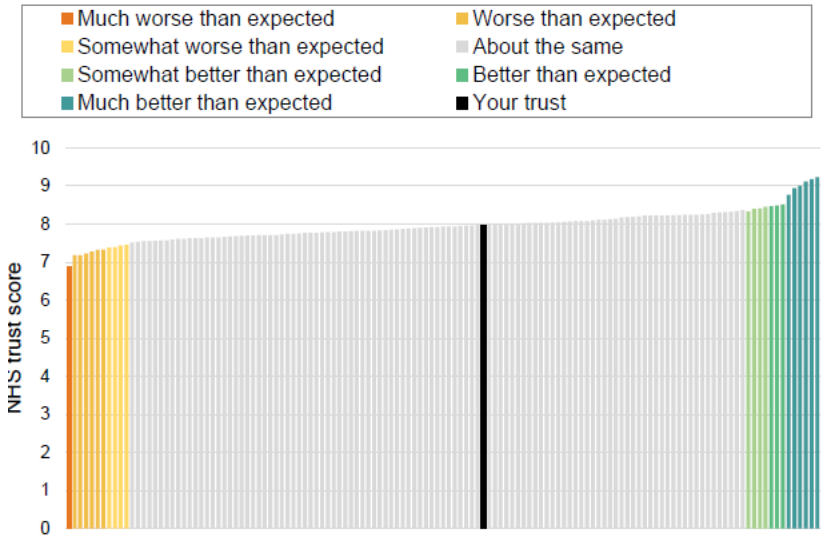
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	87	6.9	6.6	5.2	9.0
About the same	546	8.9	8.9	8.2	9.9

Section 3. Basic needs

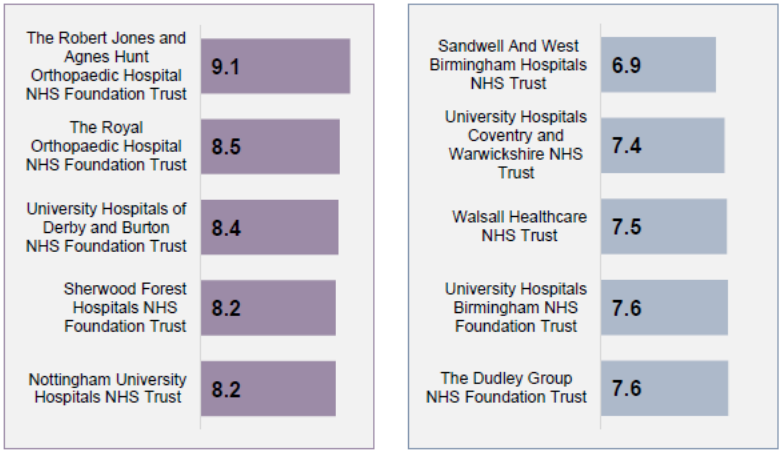
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 About the same



Comparison with other trusts within your region

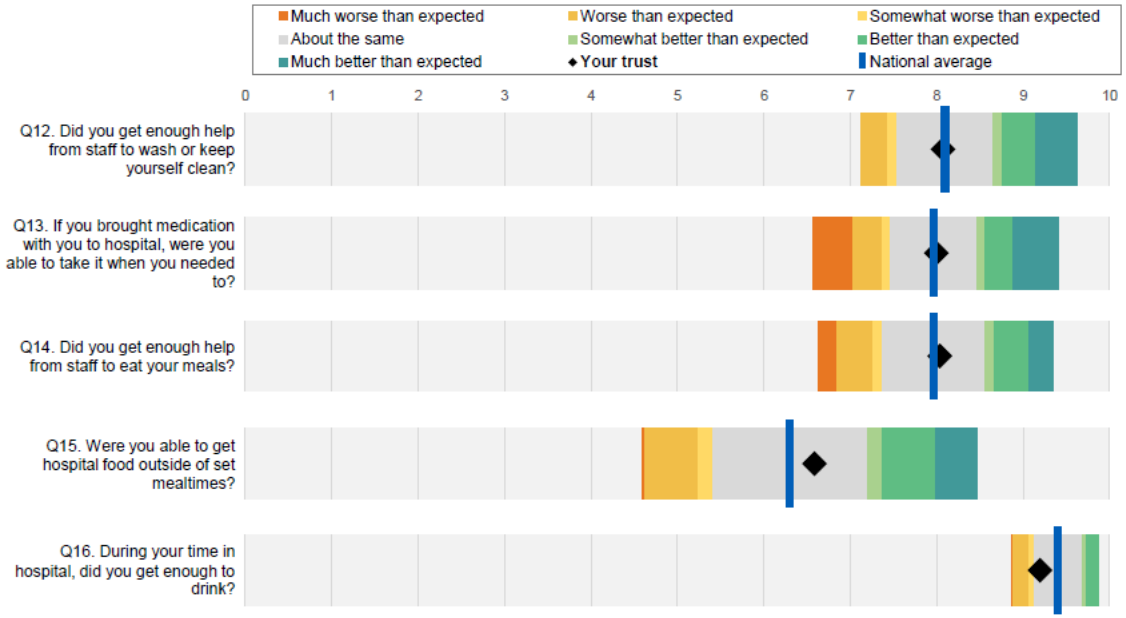


Overall for section 3 score 8.0- about the same as other Trusts

Score outside of top 5 in region by 0.2

Section 3. Basic needs (continued)

Question scores



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	372	8.1	8.1	7.1	9.6
About the same	317	8.0	8.0	6.6	9.4
About the same	158	8.0	8.0	6.6	9.3
About the same	230	6.6	6.3	4.6	8.5
About the same	511	9.2	9.4	8.9	9.9

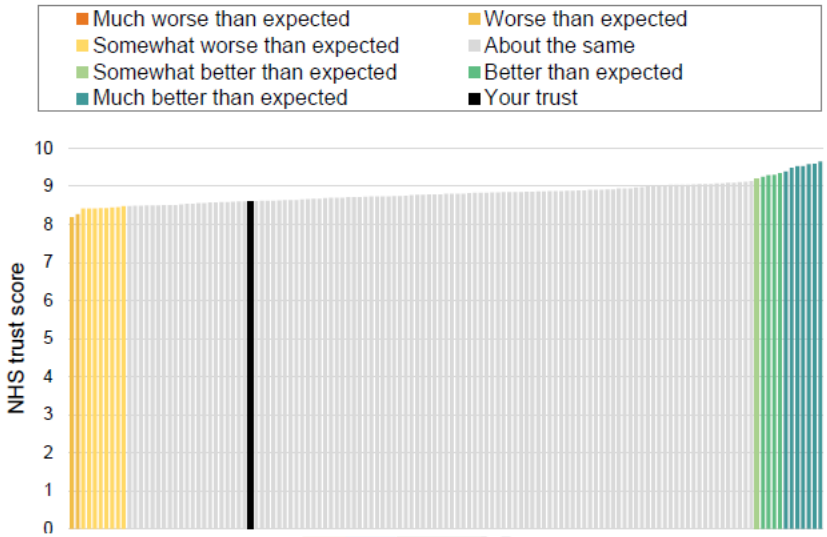
- Scores at national average or very close in this section for each question
- Possible area of focus- ensuring patients are getting enough to drink

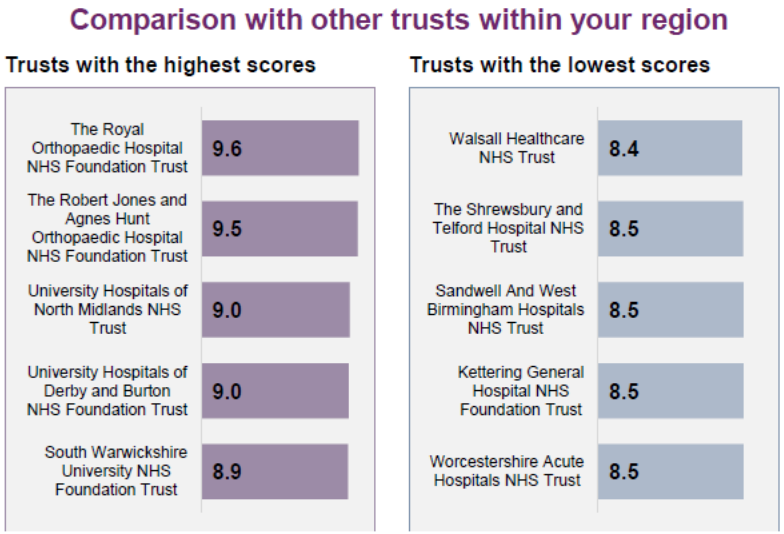
Section 4. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.6 About the same



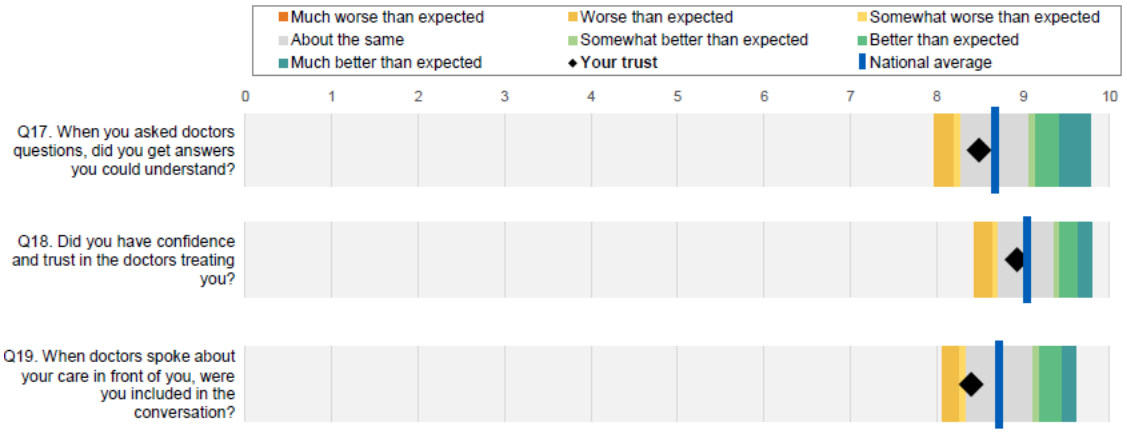


Overall for section 4 score 8.6- about the same as other Trusts

Score outside of top 5 in region by 0.3 and above bottom 5 by 0.1.

Section 4. Doctors (continued)

Question scores



		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	516	8.5	8.7	8.0	9.8
About the same	553	8.9	9.0	8.4	9.8
About the same	547	8.4	8.7	8.1	9.6

- Scores just below national average for questions in section 4
- This has been an area of concern in previous surveys, but results have improved

Section 5. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4 About the same

Overall for section 5 score 8.4- about the same as other Trusts

Score outside of top 5 in region by 0.3 and above bottom 5 by 0.5.

Section 5. Nurses (continued)

Question scores

		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	513	8.5	8.6	7.9	9.7
About the same	554	8.9	8.9	8.3	9.8
About the same	549	8.7	8.7	7.9	9.6
About the same	551	7.4	7.6	6.3	9.4

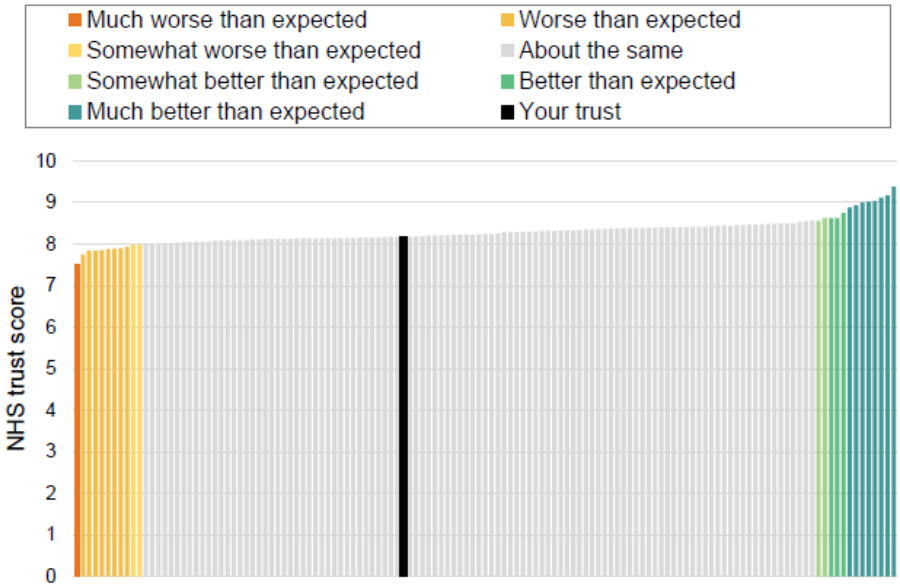
- Scores meet the national average with exception of Q23.
- Q23 response likely due to boarding and patient flow.

Section 6. Your care and treatment

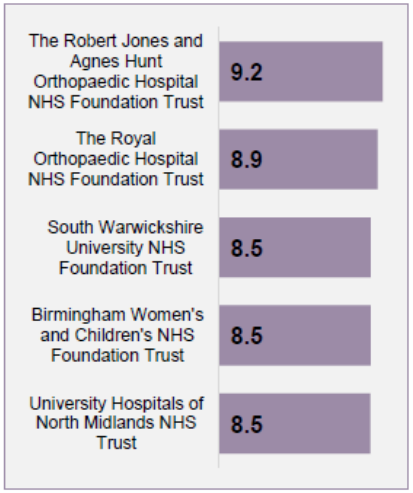
Section score

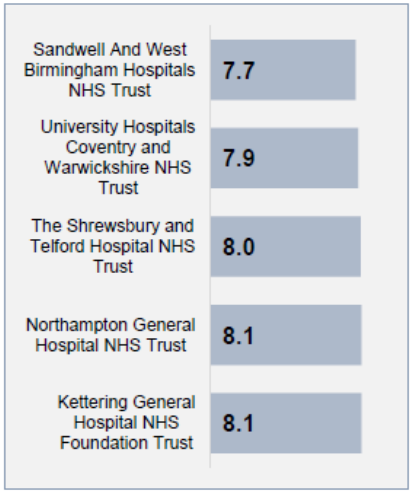
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.2 About the same



Comparison with other trusts within your region





Overall for section 6 score 8.2- about the same as other Trusts

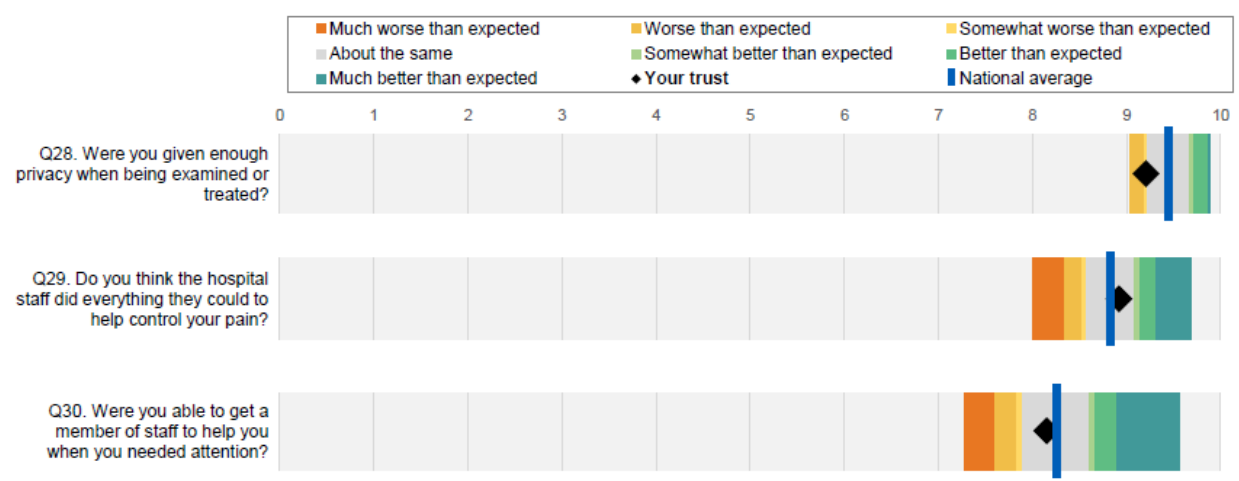
Score outside of top 5 in region by 0.3 and above bottom 5 by 0.5.

Section 6. Your care and treatment (continued)

Question scores

		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	505	7.6	7.7	6.8	9.1
About the same	536	7.0	7.2	6.3	8.5
About the same	534	8.5	8.9	8.3	9.8
About the same	462	7.7	7.7	6.6	9.2

Question scores



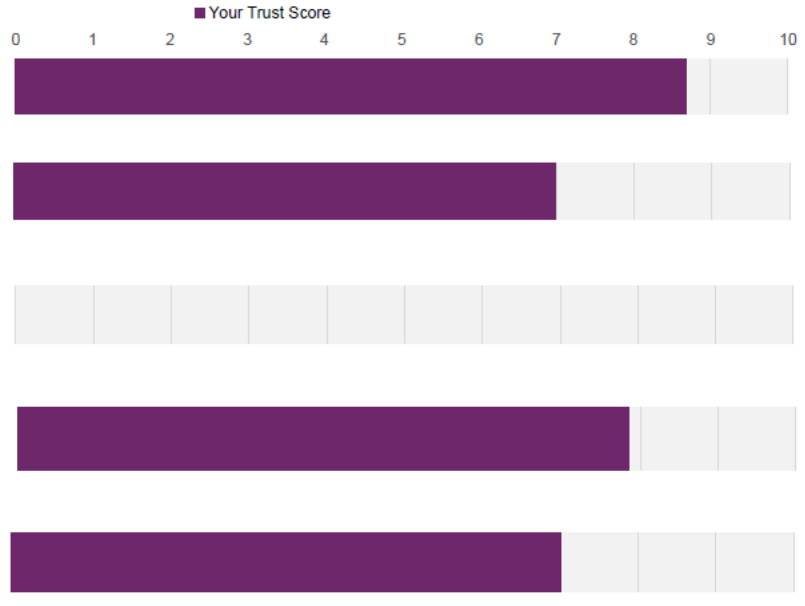
		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Somewhat worse than expected	548	9.2	9.4	9.0	9.9
About the same	447	8.9	8.8	8.0	9.7
About the same	499	8.2	8.2	7.3	9.6

Section 7. Individual needs

Benchmark data has not been provided for Q31 for the 2024 Adult Inpatient Survey due to data quality issues. However, a mean score has been produced to enable trusts to monitor their own performance internally. A section score has been provided at trust level below.

This data should not be used to compare or evaluate the performance of an individual trust against others within your region. Please note that this applies to all trusts included in the 2024 Adult Inpatient Survey.

Question scores



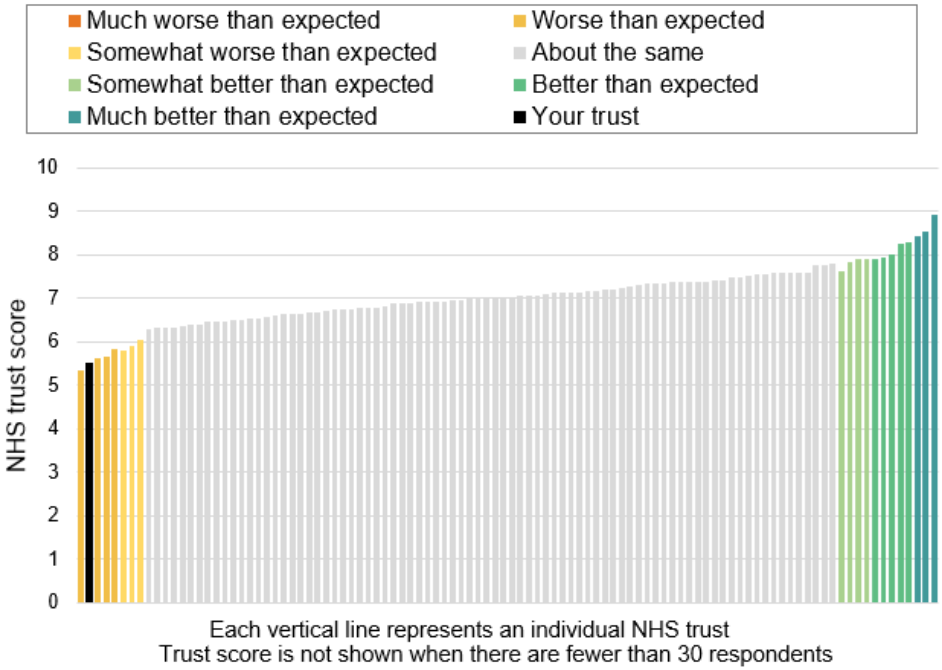
	Number of respondents	Your trust
Q31_1. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)	31	8.68
Q31_2. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Cultural needs (e.g. same gender staff)	41	6.97
Q31_3. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)	-	-
Q31_4. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)	91	7.85
Q31_5. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)	71	7.02

Section 8. Virtual wards

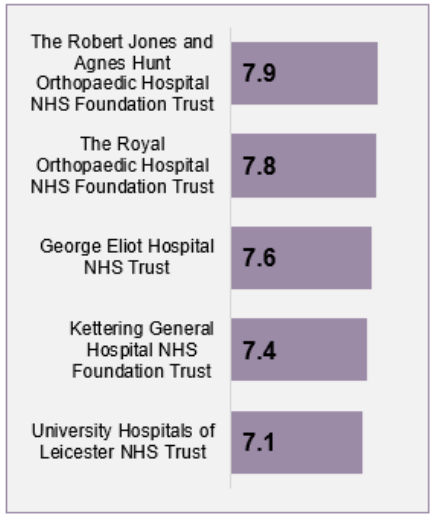
Section score

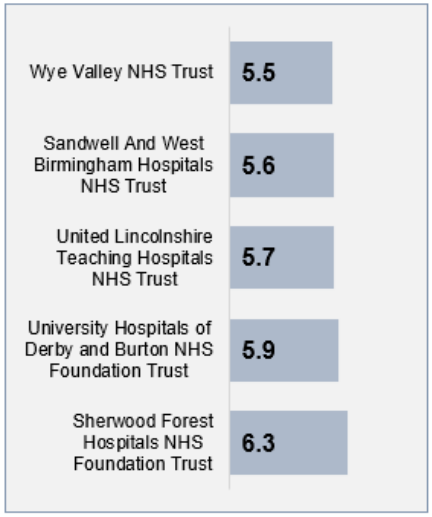
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 5.5 Worse than expected



Comparison with other trusts within your region

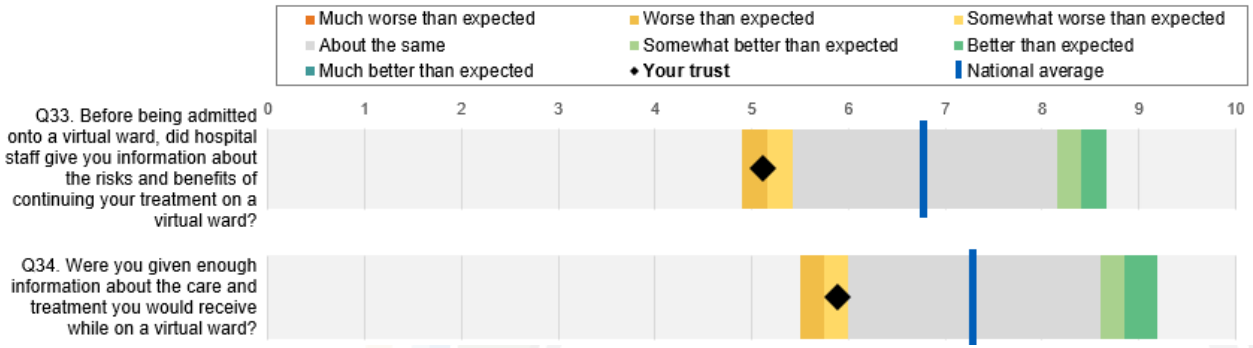




Trust scored worse than expected in this section- 5.5.
Lowest score in the region.

Section 8. Virtual wards (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Worse than expected: 37	5.1	6.8	4.9	8.7
Somewhat worse than expected: 38	5.9	7.3	5.5	9.2

Not only is the Trust score low for this section, we have seen a significant deterioration in response from 2023 to 2024.

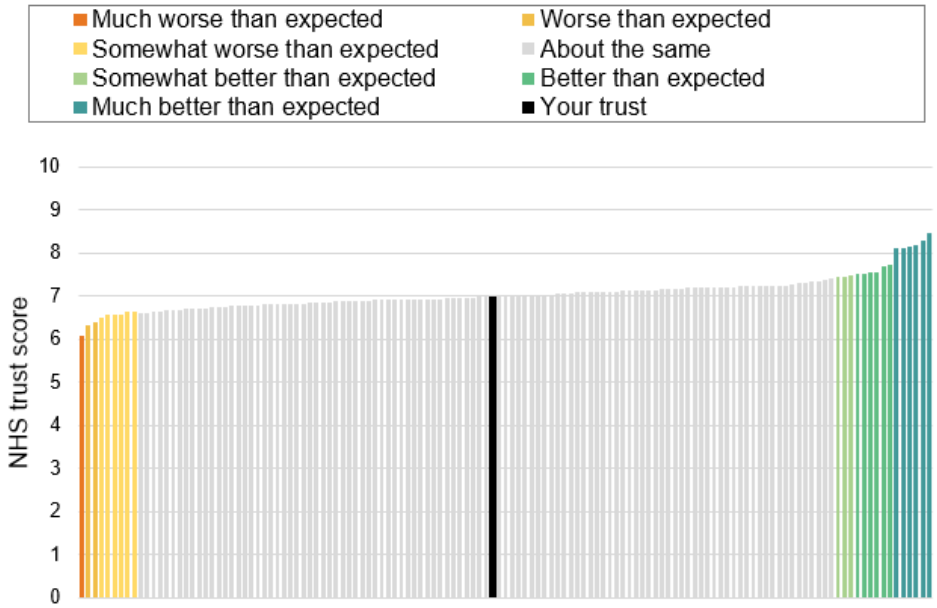
Results have been shared with Integrated Care Division to identify opportunities for improvement.

Section 9. Leaving hospital

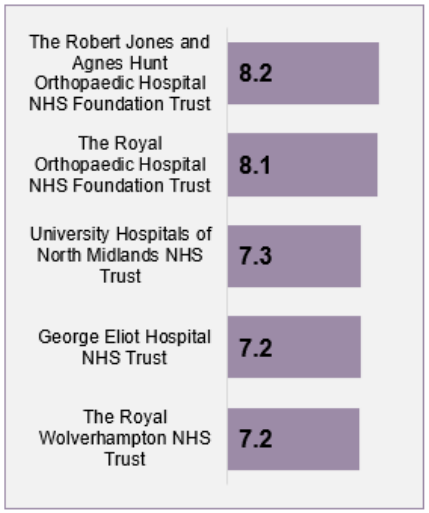
Section score

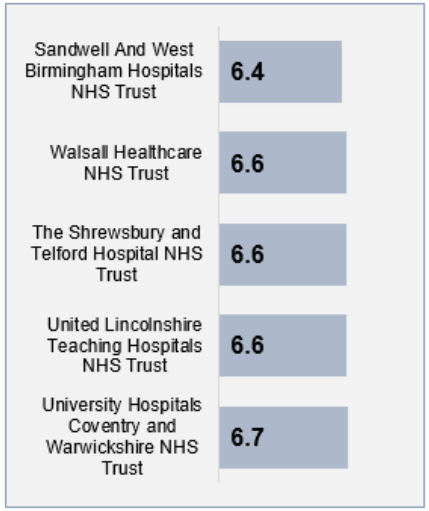
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.0 About the same



Comparison with other trusts within your region

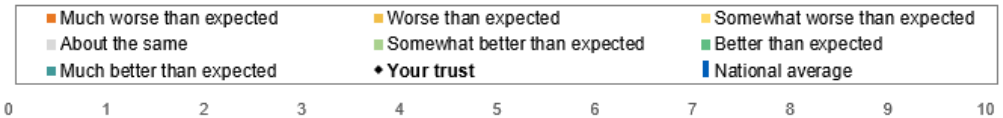




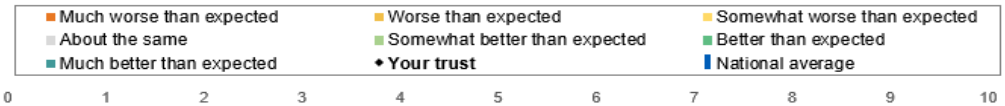
Score for this section 0.2 outside top 5 for region, about the same as all Trusts.

Section 9. Leaving hospital (continued)

Question scores



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q35. To what extent did hospital staff involve you in decisions about leaving the hospital?	538	6.5	6.7	5.8	8.1
Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving the hospital?	389	5.6	5.6	4.6	7.7
Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	198	8.5	8.2	5.8	9.6
Q38. Were you given enough notice about when you were going to leave hospital?	551	6.8	6.9	6.1	8.5



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q39. Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital?	523	7.9	7.9	6.9	9.6
Q40. To what extent did you understand the information you were given about what you should or should not do after leaving the hospital?	404	9.0	9.0	8.5	9.6
Q41. Thinking about any medicine you were to take at home, were you given any of the following?	406	4.7	4.5	3.5	6.0
Q42. Before you left the hospital, did you know what would happen next with your care?	478	6.4	6.7	5.6	8.8

			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	498	7.7	7.6	5.6	9.6
Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital?	254	7.7	8.1	6.9	9.4
Q45. After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition?	330	6.2	6.4	5.0	7.9

About the same

About the same

About the same

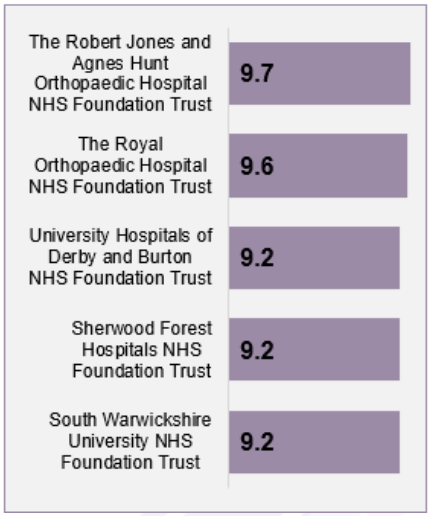
Section 10. Kindness and compassion

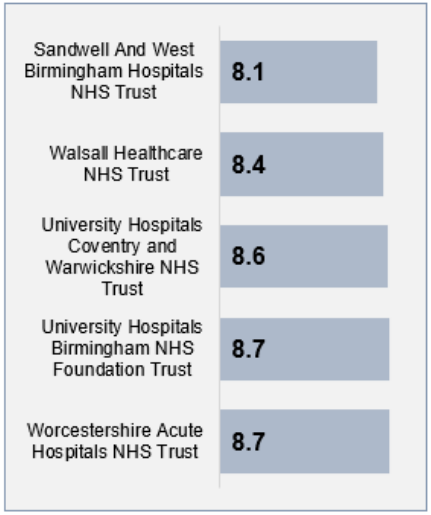
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.9 About the same

Comparison with other trusts within your region





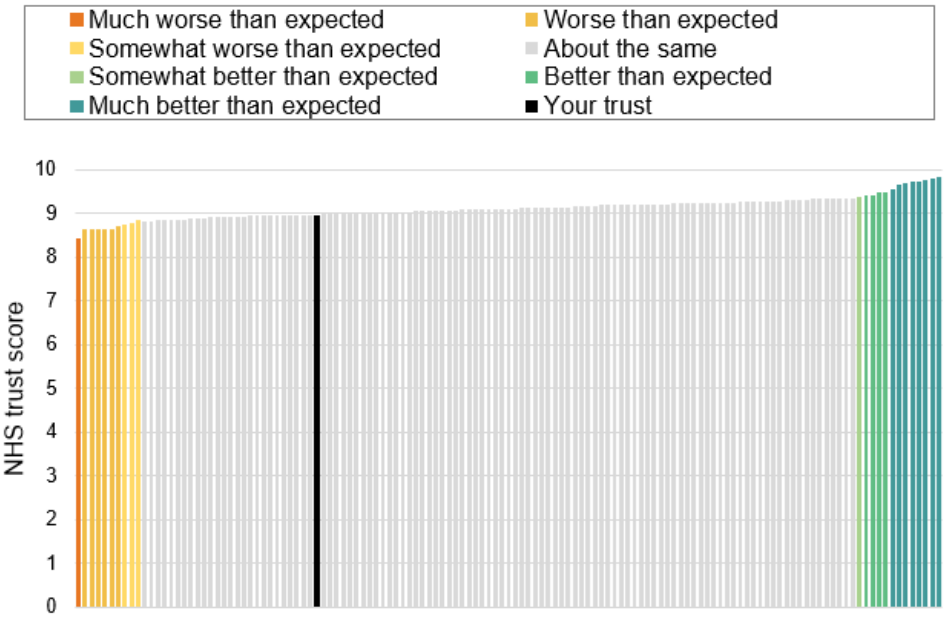
All trusts in England				
Number of respondents	Your trust	National average	Lowest score	Highest score
551	9.0	9.0	8.1	9.8

Section 11. Respect and dignity

Section score

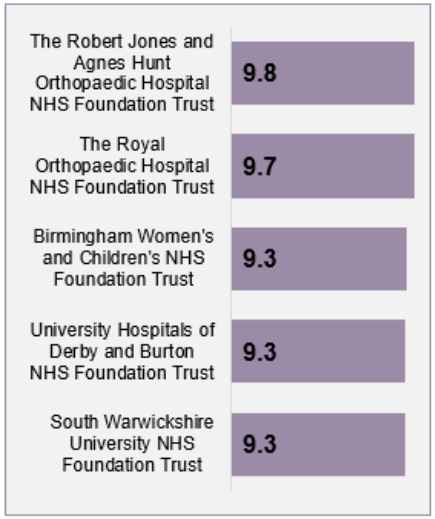
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.0 About the same

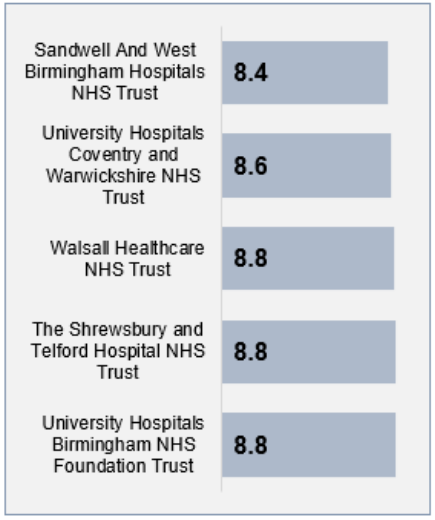


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



Trust score about the same as other Trusts - 9.0

	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
546	9.0	9.1	8.4	9.8

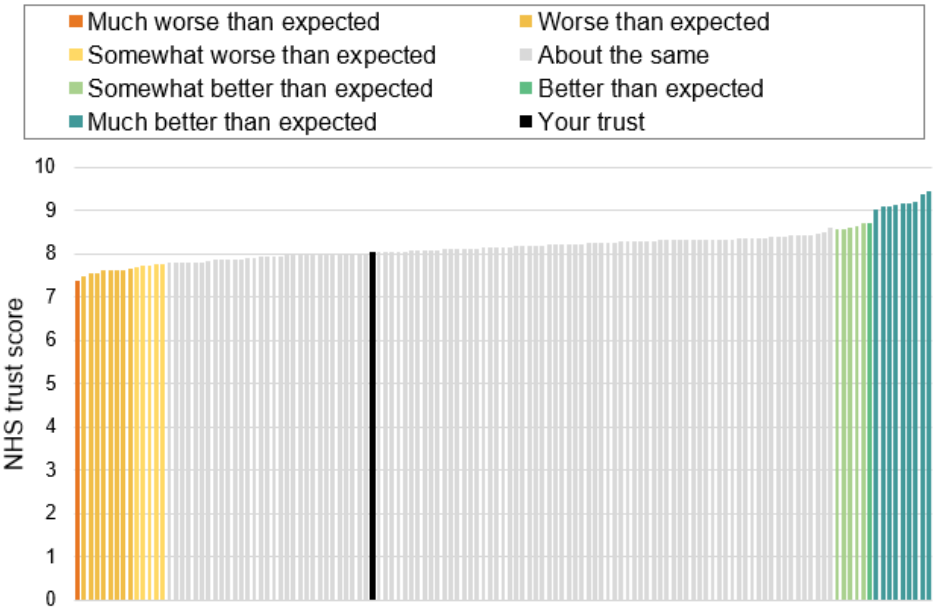
Slight deterioration from previous year score. Could be linked to use of boarding and TES beds. Some complaints and staff feedback have reported concerns in this area.

Section 12. Overall experience

Section score

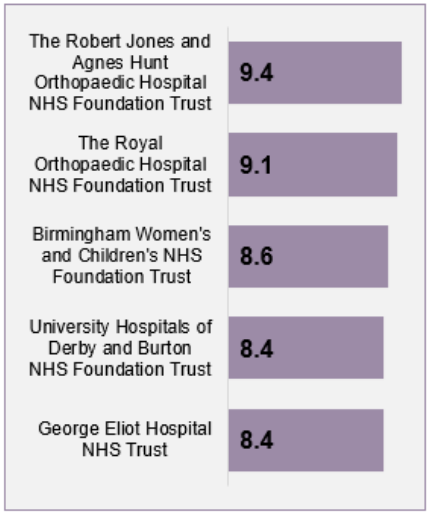
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 About the same

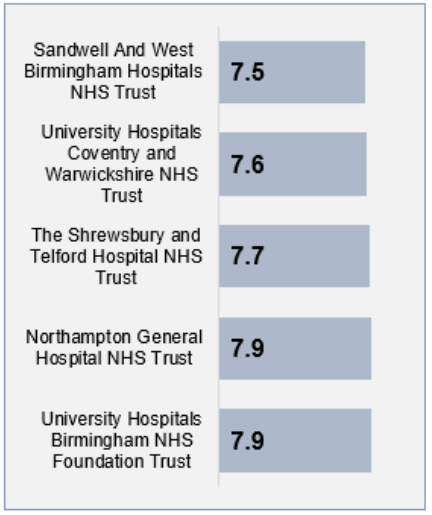


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



Overall for section score 8.0- about the same as other Trusts

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
548	8.0	8.2	7.4	9.4

Slight improvement on last year's result.

Potential areas to focus improvement

- Information whilst on waiting lists
- Verbal communication by doctors and nurses
- Information about condition and treatment
- Involving patients in decisions about care and treatment
- Individual needs
  - Dietary care
  - Cultural needs

Report to:	**Public Board**
Date of Meeting:	**04/12/2025**
Title of Report:	Use of the Trust Seal
Lead Executive Director:	**Managing Director**
Author:	Gwenny Scott, Associate Director of Corporate Governance & Company Secretary
Reporting Route:	N/A
Appendices included with this report:	N/A
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

The Board is asked to note the use of the Trust Seal as follows:

- 4 June 2025: Section 104 Water Agreement between WVT, Balfour Beatty and Dwr Cymru including plans (Holmer Road).
- 5 June 2025: Deed of Covenant and Indemnity relating to an agreement made under Section 104 of the Water Industry Act 1991 and other statutory provisions relating to sewers at HCDC Holmer Road, Hereford with Balfour Beatty Group Limited and Wye Valley NHS Trust.
- 23 June 2025: U80331 Agreement for Holmer Road Service Road between Wye Valley NHS Trust and Herefordshire Council.
- 26 September 2025: Amendment to scope of the original contract for the CDC to include refurbishment of the Lionel Green facility located at Lionel Green Building between Wye Valley NHS Trust and Speller Metcalfe. In line with the NHS ProCure23 process and the NEC4 Contract the use of the Trust Seal was required.

Recommended Actions required by Board or Committee

The Board is asked to note the use of the Trust Seal as described above.

Executive Director Opinion[1]

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.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT

Report to	**Public Board**
Date of Meeting	**04/12/2025**
Title of Report	Board Assurance Framework
Lead Executive Director	**Managing Director**
Author	Gwenny Scott, Company Secretary
Appendices included with this report	Board Assurance Framework
Purpose of report	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Board Assurance Framework provides a structure and process that enables the Board to focus on the risks that might compromise achievement of the Trust's strategic objectives. It includes the key controls in place to manages these risks and assurance as to the effectiveness of the controls.

The attached Board Assurance Framework (BAF) document comprises:

- A headline summary of all risks.
- A risk heat map of the risks, demonstrating the overall risk picture.
- The current Trust and relevant ICB objectives to which the BAF risks are aligned.
- The current risks rated Very High on the Trust's risk register which are aligned to the BAF risks
- separate summary of each BAF risk.

The heat map shows a generally high risk profile currently with little movement on risks in-year. However, the action plans indicate that several of these risks are likely to shift in a positive direction in the next quarter when actions become embedded or take effect.

Recommendation or action requested

The Board is asked to review the Board Assurance Framework, noting in particular the progress of actions to address gaps in control and identifying any areas where more information is required at Board or Committee level.

Executive Director Opinion[1]

The full executive team has reviewed the BAF documentation and support its presentation to the Board.

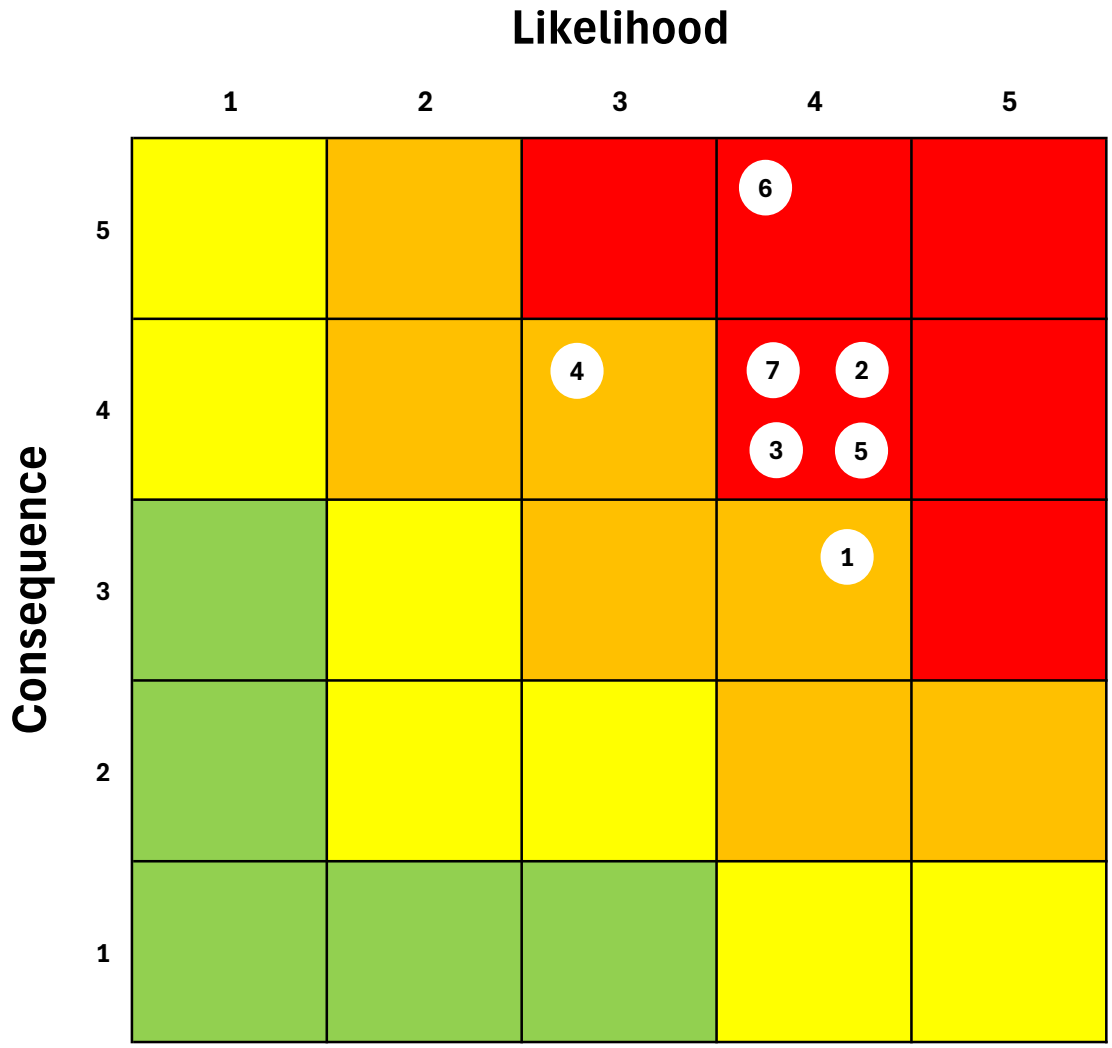
[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director has given their consent for the report to be released.

Board Assurance Framework Headlines November 2025

Ref #	Strategic Risk	Strategic Pillar(s)	Primary Strategic Objective(s)	Secondary Strategic Objective(s), Trust Priority or Big Move	Relevant ICS Corporate Objective(s)	Linked Trust Risks (very high)	Linked BAF Risks (interdependencies)	Entry Risk Score (LxC)	Current Risk Score (LxC)	Lead Chief Officer	Oversight
BAF01	Failure to improve patient experience in response to patient feedback	Quality	Improve inpatient experience by improving food quality	Quality Priority: Improve responsiveness to patient experience data	1g	n/a	n/a	4x3=12	4x3=12	CNO	Quality Committee
BAF02	Risk of failure to improve urgent and emergency care	Quality	Improve urgent and emergency care with One Herefordshire Partners	n/a	1b, 4b, 4c	789, 33, 2077, 2073	BAF03	4x4=16	4x4=16	COO	Valuing Patient Time Board
BAF03	Risk of a failure to deliver the financial plan and improve financial sustainability	Productivty	Improve financial sustainability by delivering a significant transformation programme	n/a	2a, 2b	1704	BAF03, 04	4x4=16	4x4=16	CFO	Financial Recovery Board
BAF04	Risk of failure to maintain a sustainable, available, effective workforce able to meet demand and patient need and deliver the highest quality services	Workorce	Improve staff attendance and wellbeing	Deliver and monitor job planning; Increase the number of opportunities to grow volunteer workforce	n/a	1927, 2080, 1288, 2198	BAF01, 02, 03	4x4=16	3x4=12	CPO	Trust Board
BAF05	Risk of non-delivery of full digital strategy	Digital	Improve functionality of existing systems	Test AI technology; Develop a plan for the future direction of electronic patient records	3d	2160	BAF06, 04	4x4=16	4x4-16	CFO	Trust Management Board
BAF06	Risk of a successful cyber attack	Digital	Improve functionality of existing systems	Test AI technology; Develop a plan for the future direction of electronic patient records	3d	n/a	BAF05	4x5=20	4x5=15	CFO	Trust Management Board
BAF07	Risk that we do not implement an effective transfer of responsibilities and a fully functioning, well maintained estate under the PFI expiry arrangements	Sustainability	n/a	PFI Exit Programme	n/a	n/a	BAF03	4x4=16	4x4=16	CSPO	PFI Expiry Committee

Board Assurance Framework Heat Map November 2025

Risk Ratings:	
Very high:	15-25
High:	8-12
Moderate:	4-6
Low:	1-3



Objectives

Trust Objectives

ICS Corporate Objectives and Priorities relevant to Trust

1 Quality and outcomes

1ai Quality and performance of maternity and neonatal care
1b Quality and performance of urgent care services
1d Quality and performance of elective, cancer and diagnostic care
1g Delivery of patient centred, safe, high quality care

2 Finance

2a Deliver the 2025/26 system financial plan
2b Develop a medium-term financial plan

3 System development

3a Deliver the Building a Sustainable Future priority programme on
3b Deliver the Building a Sustainable Future priority programme on sustainable elective services
3c Deliver the Building a Sustainable Future priority programme on thresholds and decommisioning
3d Deliver the Building a Sustainable Future priority programme on system enablers
3e Deliver the Building a Sustainable Future priority programme on Herefordshire Place plan

4 Prevention and health inequalities

4a Embed and maximise work to reduce health inequalities actoss all ICB programmes of work
4b Drive the shift from treatment to prevention through delivery of key prevention programmes, including implementation of the PHM framework
4c Drive the shift in acute to community through implementation of actions outlined in response to the Best Value Care in the Right Setting and Point Prevalence reports

Trust Very High Risks Linked to BAF Risks November 2025

BAF risk #	Headline	Trust Risk #	Headline	Risk Score
BAF02	Risk of failure to improve urgent and emergency care	789	Risk of adverse patient events due to long stay in ED and overcrowding	20
		33	Impact of quality when patients placed in temporary escalation spaces	16
		2077	Overcrowding in ED impacting resuscitation capacity	20
		2073	Use of clinical resource room for patient boarding	20
BAF03	Risk of a failure to deliver the financial plan and improve financial sustainability	1704	Delivery of financial plan and improving underlying financial position	16
BAF04	Risk of failure to maintain a sustainable, available, effective workforce able to meet demand and patient need and deliver the highest quality services	2169	Delivery of the 25/26 workforce plan	20
		1927	Consultant respiratory vacancies	16
		2080	SDEC consultant cover	15
		1288	Delays in typing clinical letters due to long-term sickness and vacancies	16
		2198	Risk of delays in antifibrotic pathway due to staffing issues in respiratory CNS team	16
		2204	Risk to patients caused by glaucoma pathway delays/capacity	16
		2228	Risk to patients caused by delays in surgical diabetes footcare pathway	15

Board Assurance Framework Risk Summary	
Risk Reference	BAF01
Strategic objectives and priorities	• Improve inpatient experience by improving food quality • Improve responsiveness to patient experience data

Date	**November 2025**
Risk Headline	**Patient Experience**
Risk owner	Chief Nursing Officer

Risk	**Cause**	**Result**
Risk of failure to improve patient experience in response to patient feedback.	Feedback from patients and families demonstrates that improvements are required in a number of areas that impact patient experience.	Poor patient experience impacting quality of care.

Initial Risk Score	**Risk Score History**		**Current Risk Score**	**Direction of travel**	**Target Risk Score**	**Risk Appetite**
4x3=12	April 25	4x3=12	4x3=12	↔	2x3=6	HIGH/OPEN

Current Controls and Mitigations	
1. Collection, analysis and reporting of patient feedback	2. Triangulation of feedback with other quality data
3. Engagement with Patient Engagement Forum	4. Monitoring by patient experience committee
5. Regular audits of food service	6.

Gaps in Control	**Related Actions**	**Lead**	**Due Date**	**Progress**
Poor feedback about inpatient food.	Deliver strategic priority to improve food quality.	CNO	Mar 26	Menu adjusted, training provided.
Insufficient capacity to support the best patient experience.	Deliver strategic objective to grow volunteer service.	CNO	Mar 26	See below performance (report to Quality Committee Oct 25)
Patient dissatisfaction with response to feedback	Expand reach of Friends and Family Test	CNO	Mar 26	FFT text messaging service now in place for all services.
	Implement updated complaint standards	CNO	Mar 26	In progress

Strategy Key Performance Indicators	**Date Reported**	**Performance**
National inpatient survey data	September 2025	See below
Meal service audit results	October 2025	Improvements demonstrated
PLACE results 2024	August 2025	Trust score for food improved overall but declined at 2 community hospitals.
Numbers of volunteers, volunteer hours and areas supported by volunteers.	October 2025	Reduction in volunteer numbers but growth in volunteer hours and areas supported.

Independent Assurance	**Date**	**Rating/Outcome**	**Previous rating (date)**	**Change**
Trust CQC rating: caring	Mar 20	Good	Good (2016)	↔
Urgent & emergency care CQC rating: caring	Feb 24	Good	Good (2020)	↔
Medical care CQC rating: caring	Dec 22	Good	Good (2020)	↔
CQC Adult inpatient survey 2024	Sept 25	8.0/10 overall	7.9/10 overall (2023)	↑
CQC Children and young people's survey 2024	May 25	8.5/10 overall	n/a	n/a
CQC Maternity Survey 2024	Nov 24	8.0/10 labour/birth 8.0/10 staff care 6.9/10 care after birth	8.6/10 labour/birth 8.7/10 staff care 7.7/10 care after birth (2023)	↓
CQC Urgent & emergency care survey 2024	Nov 24	7.2/10 overall	7.4/10 overall (2022)	↓
National cancer patient experience survey 24	July 25	All questions within expected range except 2 above and 2 below.	TBC	TBC

Summary Update:
Good progress is being made on implementation of improvement plans. Improvements in performance are anticipated once new arrangements are fully embedded.

Board Assurance Framework Risk Summary	
Risk Reference	BAF02
Strategic objectives and priorities	• Improve urgent and emergency care • Implement neighbourhood health model • Deliver secondary prevention initiatives • Deliver Diagnostic Centre

Date	**November 2025**
Risk Headline	**Urgent and Emergency Care**
Risk owner	Chief Operating Officer (COO)

Risk	**Cause**	**Result**
Risk of failure to improve urgent and emergency care (UEC)	• Increased demand in both volume and acuity for urgent and emergency care. • High demand for elective care. • High demand for diagnostic services. • Discharge pathway delays.	• Continued high demand for acute inpatient beds. • More care in the community • Longer waits in Emergency Department • Longer waits for elective care • Pressured working environments • Continued use of temporary escalation spaces • Failure to meet local and national targets. • Regulatory intervention.

Initial Risk Score	**Risk Score History**		**Current Risk Score**	**Direction of travel**	**Target Risk Score**	**Risk Appetite**
4x4=16	April 25	4x4=16	4x4-16	↔	3x4=12	High/open

Current Controls and Mitigations	
1. Single Point of Access/Community Referral Hub	2. Virtual Ward service
3. Urgent Community Response service	4. Discharge2Assess Service
5. Primary care interface	6. Falls Service
7. Valuing Patients Time initiatives/Programme Board	8. Partnership with West Midlands Ambulance
9. Additional oversight by NHS England through Tier 1 support	

Gaps in Control	**Related Actions**	**Lead**	**Due Date**	**Progress**
Continued high demand for UEC, Herefordshire	Enhance community based urgent care	COO	Mar 26	In progress
	Optimise pathways to avoid admissions	COO	Mar 26	In progress
	Enhance Single Point of Access	COO	Mar 26	In progress
	Neighbourhood Health Implementation Programme	MD	Mar 26	In progress
	Implement GIRFT recommendations	COO	March 26	Work with GIRFT team started Oct 25
Long waits in ED	Implement Test of Change programme	COO	Dec 25	In progress
	UEC Capital to increase SDEC capacity	COO	March 26	In progress
Delayed discharge, Herefordshire	Reduce 'over-staying' patients on Pathway 1 through Discharge to Assessment	COO	Dec 25	In progress
UEC management with Powys	Work with Powys partners to strengthen admission avoidance and discharge planning	COO	Mar 26	In progress
	Work with Powys partners to expedite discharges.	COO	Mar 26	In progress
Insufficient diagnostic capacity	Community Diagnostic Centre Project	CSCO	Dec 25	CDC opened end Sept 25.
Impact on patient flow across Trust	Increase use of Virtual Ward Service	COO	Mar 26	In progress
	Increase Therapy Resource through Better Care Fund	COO	Dec 25	In progress

Key Performance/Assurance Indicators	**Date Reported**	**Performance**	**Change**
4-hour emergency access standard	Oct 25	Target missed	↓
12-hour emergency department waits	Oct 25	Target missed	↓
Ambulance handover times	Oct 25	Target missed	↓
5% reduction in GP referrals - routine and urgent (on 24/25 outturn)	Oct 25	Decrease at week 24 of 1.7%	↑

Reduce acute admissions of patients aged over 65/ 100,000 population.	Oct 25	No reduction since 2024/25	↔
Reduce time from discharge ready date to discharge date.	Not yet reported	National data point not yet available	n/a
Reduce admission to long-term residential care	Oct 25	Admission numbers below the Better Care Fund Target.	↑

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHSE UEC support	Oct 25	Tier 1	n/a	n/a
NHS Oversight Framework Segmentation	Sept 25	Segment 3	n/a	n/a
Internal Audit: Data quality – ED pathways	2024/25	Reasonable assurance	n/a	n/a
Internal Audit: Elective Process Productivity (Pre-Op Theatres)	2024/25	Reasonable assurance	n/a	n/a
Internal Audit: Community Services	Dec 25	TBC	n/a	n/a
Provider Capability Assessment Rating	Jan 26	TBC	n/a	n/a

Summary Update:
While work programmes are progressing, very high urgent care demand has continued, resulting in a deterioration in performance on constitutional standards.

Board Assurance Framework Risk Summary	
Risk Reference	BAF03
Strategic Pillar/objective	Sustainability: Improve the financial sustainability of the organisation by delivering a significant transformation programme

Date	November 2025
Risk Headline	**Financial plan delivery**
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of failure to deliver the financial plan and improve financial sustainability.	The 2025/26 financial plan is to achieve financial balance which is dependent on delivery of a challenging cost and productivity improvement plan (CPIP) and addressing drivers of underlying deficit.	Regulatory intervention Inability to deliver other strategic priorities.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 25	4x4=16	4x4=16	↔	1x4=4	Moderate/ cautious

Current Controls and Mitigations	
1. Financial Recovery Board oversight	2. Enhanced financial controls
3. Enhanced vacancy controls	4. Enhanced controls of temporary staff usage
5. Adoption of national financial controls and toolkits	6. Strengthened forecasting
7. Divisional check and challenge meetings	8.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued use of temporary nursing staff in some areas	Implement Nursing Agency Reduction Plan (NARP)	CNO	March 26	See performance below
Continued use of temporary medical staff	Implement Medical Agency Reduction Plan (MARP)	CMO	March 26	See performance below
Fully developed CPIPs to meet target	Develop fully deliverable plans to meet CPIP target.	CFO	March 26	Parts of the plan remains under-developed or high-risk
Operational pressures challenging delivery of CPIP	See BAF02			

Key Performance/Assurance Indicators	Date Reported	Performance
Income and Expenditure YTD	October 2025	Better than plan
Nursing Agency Reduction Plan (NARP)	October 2025	General reduction YTD; a small increase in month 6 compared to month 5.
Medical Agency Reduction Plan (MARP)	October 2025	A reduction has been achieved but there was an increase in month 6 due to sickness and emergency demand
CPIP delivery overall	October 2025	Ahead of plan (non-recurrent); on plan (recurrent)
Productivity: Cost per weighted activity unit (WAU)	October 2025	Trend of improvement continues.

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
National Oversight Framework segmentation	Sept 25	Segment 3	n/a	n/a
Internal Audit: Key Financial Controls	2024/25	Reasonable assurance	Reasonable assurance (2023/24)	↔
Internal Audit: Key Financial Controls	Feb 26	TBC	Reasonable assurance	n/a
External Audit Value for Money assessment	2024/25	2 financial sustainability significant weaknesses	2 financial sustainability significant weaknesses	↔
Provider Capability Rating	Dec 25	TBC	n/a	n/a

Summary Update:
Although good progress on the annual financial plan is being made, the underlying financial position remains high risk.

Board Assurance Framework Risk Summary	
Risk Reference	BAF04
Strategic objectives and priorities	• Improve staff attendance and well being • Deliver and monitor job planning and e-rostering

Date	November 2025
Risk Headline	**Sustainable, available, effective workforce**
Risk owner	Chief People Officer

Risk	Cause	Result
Risk of failure to maintain a sustainable, available, effective and healthy workforce able to meet demand and patient need and deliver the highest quality services	• High patient demand and acuity creating pressures for staff • High vacancies/recruitment challenges in some teams • Industrial Action • Requirement to reduce workforce costs • Lack of electronic job planning and rostering across all areas to enable the most effective deployment of resource and productivity gains.	• High staff sickness • Poor morale and staff wellbeing • Poor staff retention • Impact on reputation/attraction • Over-reliance on temporary staffing • Failure to meet national and local workforce and operational targets • Fragile services • Impact on the quality of services

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	3x4=12	↑	1x4=4	Significant - seek
	October 2025	3x4=12				

Current Controls and Mitigations	
1. Strengthened sickness absence management policy	2. Occupational health service
3. Freedom to Speak Up Guardian	4. Staff wellbeing support and initiatives
5. Divisional recruitment and retention working groups	6. Centralised recruitment process for clinical support workers (CSW).
7. Inclusion programme	8. E-roster in all nursing areas
9. Electronic job planning partially in place	10. Staff networks

Gaps in Control	Related Actions	Lead	Due Date	Progress
E-Roster not in use in all areas	Implement E-Roster across Trust	CPO	Oct 26	All nursing areas implemented; review of resource to support wider implementation in progress.
Electronic job planning not fully implemented	Implement electronic job plans for all medical staff	CPO	March 26	80% complete
Winter infections impacting staff sickness	Flu vaccination campaign	CNO	Jan 26	Good progress - 43.7% by mid-November.
High turnover among CSWs	Implement central recruitment programme	CPO	Mar 26	Active programme with DWP engagement
Continued reliance on agency staff to fill gaps	Implement medical and nursing agency reduction plans	CMO/ CNO	Mar 26	See BAF03 Financial Delivery

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Sickness absence rate at 4% or lower	October 2025	4.2% (August data)	↓
100% compliance with e-job plans	October 2025	80%	↑
Staff turnover below 10%	October 2025	8.3% overall (August data)	↓
Staff vacancy rate below 7%	October 2025	6.9% (August data)	↓

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
National Staff Survey: we are safe and healthy	March 26	TBC	24/25: 6.20 (above average)	TBC
National Staff Survey: staff engagement	March 26	TBC	24/25: 7.03 (above average)	TBC
National Staff Survey: morale	March 26	TBC	24/25: 6.08 (above average)	
Internal Audit: Medical and surgical junior doctor rotas management	2024/25	Partial assurance	n/a	n/a
Internal Audit: Medical job planning	March 26	TBC	n/a	n/a
Internal Audit: Health Rostering	Jun 24	Reasonable assurance	n/a	n/a

Summary Update:
Good progress on actions and positive performance on indicators.

Board Assurance Framework Risk Summary	
Risk Reference	BAF05
Strategic objectives and priorities	• Improve the functionality of existing systems • Test artificial intelligence technology • Develop a plan that sets out the future direction for electronic patient records

Date	**November 2025**
Risk Headline	**Digital Strategy**
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of failure to deliver the Digital Strategy to support	• Multiple, simultaneous digital programme workstreams • Lack of clarity on central funding for digital strategy • High levels of staff engagement needed • Operational pressures • Limited resource to support business case development and procurement processes	• Full productivity not achieved • Cost savings targets not met • Quality improvements not made • Maximum digital maturity not achieved • Reputational impact

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=12	4x4=16	↔	1x4=4	Significant - seek

Current Controls and Mitigations	
1. Programme management structure in place with oversight by Digital Programme Board, reporting monthly to Trust Management Board	2. AI Working Group
3. All clinically agreed user improvements in EPR complete	4. Shared resource agreed to support linked Future EPR and Digital First projects
5. Use of electronic patient record systems is well-established within the Trust, providing a firm basis for further development.	6. Trust strategy aligned with ICB strategy

Gaps in Control	Related Actions	Lead	Due Date	Progress
AI implementation plan	Pilot AI technology	CFO	Oct 25	Pilots of ambient voice technology complete
	Ambient AI procurement	CFO	TBC	The procurement process has commenced based on the pilot outcome
Current EPR system contract coming to an end	Implement Future EPR project	CFO	TBC	OBC planned for completion by Feb 26
	Implement Digital First Project	CFO	TBC	Business case planned for quarter 3

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Reduce movement of patient notes by 65%	October 2025	55%	
Reduce postage costs	TBC	TBC	
Increase proportion of patients signed up to patient portal	TBC	TBC	
Increased proportion of clinicians utilising AI tools	TBC	TBC	

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Internal Audit: Digital Nurse Noting	May 25	Advisory/10 recommendations	n/a	n/a

Summary Update:
Steady progress is being demonstrated by the Digital Programme Board but the risk remains high due to the current status of the EPR strategy.

Board Assurance Framework Risk Summary	
Risk Reference	BAF06
Strategic objectives and priorities	Improve functionality of existing systems

Date	November 2025
Risk Headline	**Cyber security**
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of a successful cyber-attack on the Trust's systems	• Increasingly frequent and sophisticated attacks on internal and external digital systems containing critical Trust data. • High numbers of users with access to Trust's digital systems • Reliance on third party suppliers • Increasing reliance on digital systems	• Data security breaches • Loss or corruption of data • Lost or delayed access to patient care records • Business interruption • High cost of rectification

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x5=20	April 2025	4x5=20	4x5=20	↔	3x5=15	Significant/seek

Current Controls and Mitigations	
1. IT partner cyber security arrangements in place and overseen by partnership board (with Trust representation)	2. Mandatory information governance training for all Trust staff and cyber-security training for Board
3. IT partner cyber security expertise	4. Periodic phishing exercises
5. Annual penetration testing	6. Information Asset Register
7. Annual table-top exercise	8. Monitoring of and response to national alerts
9. Business Continuity Plan for IT Services	10. Dual data centre architecture provides resilience in the event of attack/failure of one centre.
11. Counter fraud training and awareness raising inc. cyber	12.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Gaps in compliance with CAF and DSPT (see assurance below)	Implement recommendations of Internal Auditor	CFO	Oct 25	11/13 actions complete by Sept 25; update to be reported to Audit Committee December 2025.

Key Performance/Assurance Indicators	Date Reported	Performance	Change
In development			

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) Independent Assessment (Internal Auditor)	Jun 25	Risk rating: very high Confidence rating: low	n/a	n/a

Summary Update:
The majority of recommendations from the independent assessment have now been addressed but the external threat, and therefore the risk, remain very high and the target score reflects this.

Board Assurance Framework Risk Summary	
Risk Reference	BAF07
Strategic objectives and priorities	Improve financial sustainability

Date	November 2025
Risk Headline	**PFI Expiry**
Risk owner	Chief Strategy & Planning Officer

Risk	Cause	Result
Risk that we do not implement an effective transfer of responsibilities and a fully functioning, well maintained estate under the Private Finance Initiative (PFI) expiry arrangements	• The Trust's Private Finance Initiative (PFI) contract will expire in July 2029. • The Trust is the first in the NHS to undergo PFI transition and to operationally interpret the national guidance to deliver the project • No national funding to support the process • Numerous stakeholders, contractors and workstreams requiring coordination • PFI estate has significant backlog of lifecycle maintenance works • Insufficient contractual levers relating to estate management	• Lack of continuity in provision of hard and soft facilities management (FM) • Loss of experienced FM staff • Lost opportunity to make anticipated financial savings • Lost opportunity to establish long-term high quality FM service arrangements

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	November 2025	4x4=16	4x4=16	↔	1x4=4	Moderate-cautious

Current Controls and Mitigations	
1. PFI expiry governance structure aligned with national guidance	2. Dedicated project management resource
3. Periodic Expiry Health Checks by National Infrastructure & Service Transformation Authority (NISTA)	4. Joint Expiry Working Group (with PFI partners)
5. Lifecycle Progress Committee oversees completion of maintenance plan	6. Representative from IPA engaged with PFI Expiry Committee
7. Separate and distinct governance structure for operational estate/PFI contract management	8. Joint working with Worcestershire Acute Hospitals NHS Trust to share support and learning on PFI expiry process
9. Project team participation in NISTA training	10. Clear project timeline in place

Gaps in Control	Related Actions	Lead	Due Date	Progress
Plan for future FM provision	Develop future FM options appraisal and recommendation	CSPO	July 26	PFI contract termination option agreed by Board in October 25; OBC planned for Board July 2026
Clarity on condition of estate	Complete a Joint Condition Survey	CSPO	July 26	The survey has been jointly commissioned and is in progress
Some asset maintenance requirements are outside the funded lifecycle plan	Strengthen oversight of all asset maintenance requirements through	CSPO	Dec 25	Plan agreed to widen scope of Lifecycle Progress Committee to include all asset maintenance needs
Detailed project plan aligned to NISTA guidance	Develop detailed project plan	CSPO	Dec 25	Project management team in place; detailed project timeline agreed; strengthened project governance arrangements agreed; detailed project plan in development.

Key Performance/Assurance Indicators	Date Reported	Performance
In development		

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Expiry Health Check, NISTA (previously IPA)	Nov 22	Amber: moderate additional work required	n/a	n/a
Expiry Health Check, NISTA (previously IPA)	Oct 24	Red/amber: major additional work required	Nov 22: amber	↓
Expiry Health Check, NISTA (previously IPA)	2026	TBC	Oct 24: red/amber	TBC

Summary Update:
New BAF risk, still in development in line with the rapidly progressing project management approach.

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