WVT Public Board Meeting

Thu 05 February 2026, 13:00 - 14:30

MS Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Information *Russell Hardy*

Jo Rouse.

13:01 - 13:02
1 min

2. Declarations of Interest

Information *Russell Hardy*

13:02 - 13:04
2 min

3. Minutes

3.1. Minutes of the Meeting held on the 4 December 2025

Approval *Russell Hardy*

3.1 PUBLIC BOARD MINUTES - DECEMBER 2025 LF, FM.pdf (9 pages)

13:04 - 13:05
1 min

4. Matters Arising and Actions Update Report

Discussion *Russell Hardy*

4. PUBLIC BOARD ACTION LOG - FEBRUARY 2026.pdf (1 pages)

13:05 - 14:10
65 min

5. Items for Review and Assurance

5.1. Chief Executive's Report

Assurance *Stephen Collman*

5.1 WVT CEO Report - February 2026 - SC.pdf (5 pages)

5.2. Integrated Performance Report

Assurance *Sarah Shingler*

5.2 WVT Full Pack - IPR_Board - SS.pdf (20 pages)
5.2a December KPIs.pdf (4 pages)
5.2b Resuscitation Committee PSC Report.pdf (7 pages)

5.2.1. Quality (including Mortality)

Assurance *Lucy Flanagan/Chizo Agwu*

5.2.2. Activity Performance

Assurance *Andy Parker*

5.2.3. Workforce

Assurance *Geoffrey Etule*

5.2.4. Finance Performance

Assurance *Katie Osmond*

5.3. Midwifery and Neonatal Staffing Report

Assurance *Justine Jeffery*

5.3 Midwifery and Neonatal Nurse Safe Staffing Report December 2025 WVT Public Board.pdf (9 pages)

5.4. CNST - Maternity Incentive Scheme (MIS) Final Evidence Submission and Formal Declaration

Assurance *Justine Jeffery*

5.4 CNST Board Exception Report 2026 updated LF final.pdf (4 pages)

5.5. Resident Doctor Ten Point Plan

Discussion *Chizo Agwu*

5.5 Resident doctors 10 point plan report to Trust Board_CA.pdf (4 pages)

5.6. Committee Summary Reports and Minutes

5.6.1. Audit Committee Escalation Report

Assurance *Nicola Twigg*

5.6.1 Audit Committee Escalation & Assurance Report 11.12.2025.pdf (3 pages)

5.6.2. Quality Committee Report and Minutes 30 October 2025 and 27 November 2025

Assurance *Ian James*

5.6.2 Quality Committee Summary Report October 2025 - public.pdf (2 pages)
5.6.2a October Minutes Quality Committee.pdf (11 pages)
5.6.2b Quality Committee Summary Report November 2025 - public.pdf (2 pages)
5.6.2c November Quality Committee minutes.pdf (9 pages)

5.6.3. Charity Trustee Report and Minutes

Assurance *Grace Quantock*

5.6.3 CT FRONT SHEET.pdf (1 pages)
5.6.3a CT REPORT.pdf (2 pages)

14:10 - 14:20
10 min

6. Items for Approval

6.1. Appointments and Remuneration Committee Terms of Reference

For Approval *Gwenny Scott*

6.1 - Appointments and Remuneration Committee TOR Covering Report Public Board February 2026.pdf (1 pages)
6.1a - WVT Appt and Rem Com Terms of Reference - January 2026.pdf (4 pages)
6.1b - WVT Appt and Rem Com Terms of Reference - January 2026_Clean.pdf (3 pages)

6.2. Integrated Care Oversight and Assurance Committee Terms of Reference

For Approval *Sarah Shingler*

6.2 Integrated Care Oversight and Assurance Committee ToR coversheet_Trust Board_Feb 2026.pdf (1 pages)
6.2a Integrated Care Oversight Assurance Committee Terms of Reference January 2026 v1.0 for TB.pdf (3 pages)

6.3. Additional Theatre on T10 Pad Business Case

Decision *Alan Dawson*

- 6.3 Full Business Case - Additional Theatre on T10 pad - Covering Report Board.pdf (2 pages)
- 6.3a Full Business Case - Additional Theatre on T10 pad 2026_01_22.pdf (37 pages)

14:20 - 14:25
5 min

7. Any Other Business

14:25 - 14:30
5 min

8. Questions from Members of the Public

Russell Hardy

14:30 - 14:30
0 min

9. Acronyms

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

14:30 - 14:30
0 min

10. Date of Next Meeting

The next meeting will be held on Thursday 2 April 2026 at 1.00 pm

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

Present (Voting):		
Russell Hardy, MBE	RH	Chairman and Meeting Chair
Chizo Agwu	CA	Chief Medical Officer
Stephen Collman	SC	Acting Chief Executive
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Ian James	IJ	Non-Executive Director
Frances Martin	FM	Non-Executive Director
Katie Osmond	KO	Chief Finance Officer/Deputy Managing Director
Grace Quantock	GQ	Non-Executive Director
Sarah Shingler	SS	Managing 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
Kieran Lappin	KL	Associate Non-Executive Director
Andy Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director
Gwenny Scott	GS	Associate Director of Corporate Governance
In Attendance:		
Val Jones	VJ	Executive Assistant for the minutes
Lou Robinson	LR	Deputy Company Secretary
Apologies		

Ref	Item	Lead	Purpose	Format
1.	**Going The Extra Mile Awards – Quarter 2**	**RH**	**Information**	**Verbal**
Team of the Quarter – Lugg Ward– RH read out the reasons why the Team were nominated for this award. Employee of the Quarter – Marrena Taylor-Johns, Neonatal Junior Sister - RH read out the reasons why Marrena was nominated for this award.				
2.	**Apologies for Absence**	**RH**	**Information**	**Verbal**
Noted as above.				
3.	**Quorum and Declarations of interest**	**RH**	**Information**	**Verbal**
The Board was quorate and there were no new declarations received.				

4.	**Minutes of meeting on 2 October 2025**	**RH**	**Approval**	**Enclosure 1**
The Board accepted the minutes of the meeting held on 2 October 2025.				
4.1	**Foundation Group Board Minutes and Action Log 5 November 2025**	**RH**	**Information**	**Enclosure 2**
The Board noted the minutes of the meeting and Action Log held on 5 November 2025.				
5.	**Matters Arising and Action Log**	**RH**	**Information**	**Enclosure 3**
The Board accepted the Action Log update.				
6.	**Chief Executive's Report**	**SC**	**Assurance**	**Enclosure 4**

This is a busy period operationally with significant activity ongoing. Regarding the Industrial Action expected in the week before Christmas, we are well-prepared to manage with minimal disruption and maintain elective activity targets. SC acknowledged the team's success in previous similar situations.

Resident Doctors' 10-Point Plan: Good progress on improving work-life balance and working conditions; updates to be shared with the Board.

Flu surge: Rising cases in the Midlands, mainly ages 5–15 and under-70s (especially unvaccinated). Impact on Primary Care and A&E anticipated. SC strongly encouraged everyone to have their flu vaccination to reduce symptoms and pressure on services. There is a risk of staff sickness affecting Clinical services during the pre-Christmas period.

Medium & Long-Term Planning – Initial draft of the Planning Framework due this month. The final draft will be presented to the Public Board in February.

There is a three-year numerical plan: Finance, Operational performance, Workforce (detailed first year, caveated later years).

Five-year strategic narrative: Vision for Herefordshire Health and Social Care System.

There has been a shift in accountability. There is now greater responsibility on Providers/Board for delivery, less at System level.

Efficiency and financial recovery: Exit from deficit funding and potential new payment mechanisms; transformation underpinning changes.

One Herefordshire & National Programme - Neighbourhood Health Pilot: Herefordshire selected as a wave-one pilot site. This reflects years of collaborative work and strong local leadership. This brings national attention and responsibility to deliver outcomes. Governance and integration with existing structures will be key.

RH advised that the Board are aware of ongoing issues with corridor care, particularly in A&E, where higher-than-desired numbers are partly due to delays in arranging discharge packages for medically fit patients. RH apologised to patients and families for any delays, along with thanks to staff for their resilience during periods of high demand. While frustration from patients is understood, abusive or impolite behaviour towards staff is unacceptable.

The Board accepted the Chief Executive's Report.

7.	**Integrated Performance Report**	**SS**	**Assurance**	**Enclosure 5**

The Trust continues to face operational and financial pressures but remains strongly committed to quality, patient safety, and performance recovery. Progress is being made across key strategic priorities, including Urgent Care, Elective Pathways, Cancer Services, and workforce initiatives, alongside ongoing work to strengthen winter resilience. SS thanked staff and System Partners for their efforts during recent industrial action, during which the Trust successfully maintained 95% of activity as required nationally.

Mortality indicators remain above expected levels (SHMI at 114.3), driven partly by coding backlogs and case mix, with Audits and Pathway Reviews underway under the Chief Medical Officer's oversight.

High demand continues in Urgent and Emergency Care, resulting in ongoing corridor care and 11.9% of Emergency Department (ED) patients waiting over 12 hours, which also affects ambulance offloading times—though improvements are being made.

Workforce performance shows improvement, with sickness absence reduced to 4.7% compared to 5.3% last year, and flu vaccination uptake now around 46%. Financially, the Trust is £700k favourable to plan for month 7, and our Cost Improvement delivery is ahead of target (£12.2m achieved versus £11.2m), although further progress is becoming increasingly challenging.

RH asked what is worrying SS most. The key concern for SS is patient experience in ED, particularly the ongoing use of corridor care and ward boarding—situations none of us would want for our own families. Another challenge is maintaining a safe balance between delivering the required cost improvements and efficiency targets while ensuring patient safety remains paramount. Despite these pressures, the Executive Team remains fully committed to doing the right thing for patients at every step.

The Board accepted the Integrated Performance Report.

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

The Flu Vaccination Campaign for both staff and patients has now been successfully launched, with staff uptake reaching 46%—exceeding the Regional target. This is particularly important as flu season has begun early across the country, and although rural areas like Wye Valley tend to lag behind urban trends, the Trust already has 12 positive cases and its first outbreak.

Progress against Quality Priorities continues, especially in ensuring timely, time-critical medications. Performance on Parkinson's medication remains strong, with over 90% delivered on time and no missed doses—placing the Trust in the top quartile nationally. A similar focus on epilepsy medication is showing positive early results. Appreciation is given to the Medicines Safety Officer for championing self-administration where appropriate.

The rollout of ED Safety Champions is now established, building on the successful Maternity Model. This initiative aims to strengthen safety amid ongoing pressures such as long ED waits, congestion, and corridor care. Recent discussions have centred on corridor care, escalation areas, and improving use of same-day emergency care to reduce unnecessary ED attendances and admissions. Quarterly updates will continue to be provided to the Board.

<u>Mortality</u>

The Trust's SHMI mortality index remains high despite there being 60 fewer deaths over the past 12 months compared with the previous period. Some of this rise is due to non-clinical factors, including the removal of Same Day Emergency Care (SDEC) from admissions—reducing the expected mortality denominator—and a coding backlog, with 21% of patient spells currently uncoded. Recruitment to the coding team has begun to address this.

Alongside resolving these data issues, the Trust remains strongly focused on improving clinical quality across both major and smaller Diagnostic Pathways. Sepsis deaths have fallen compared to last year, though delays in administering antibiotics persist in the ED, with ongoing quality improvement work underway.

Pneumonia deaths are also down by 50, supported by strengthened flu and Community vaccination efforts, and a Trust-wide initiative is planned to reduce hospital-acquired pneumonia. Stroke mortality remains stable and positive despite coding challenges. However, fractured neck of femur mortality has increased compared to last year. Although improvements have been made to the pathway and timeliness to Theatre, compliance with the Super Six Standards has not improved. Leadership and accountability are being strengthened, and an external Peer Review of the Pathway has been commissioned.

Mortality governance is robust, with strengthened dissemination of learning through Newsletters and Departmental Mortality Leads to ensure improvements are shared effectively across the organisation.

IJ, as Chair of the Quality Committee, highlighted ongoing frustration with the mortality data because SHMI comparisons depend on accurate coding of admitted patients. The current coding backlog means the SHMI figures are not truly reflective of performance. He acknowledged that additional Coders have now been recruited and emphasised the need for a clear trajectory to get coding back on track so mortality reporting can be accurate and meaningful.

KO acknowledged that the team have faced significant workforce shortages alongside rising activity levels, creating pressure on coding capacity. An early assessment suggests the coding backlog—including SDEC and core admissions—should be fully recovered by the end of March, aligning with the end of the financial year. Efforts will be made to accelerate this, if possible, as resolving the backlog is essential not only for accurate SHMI reporting but also for contract income and reimbursement.

The Board accepted the Quality (including Mortality) Report.

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

AP thanked staff for their hard work during recent industrial action and acknowledged further action planned later in the month. He apologised to the small number of patients whose appointments were postponed and encouraged the public to use alternatives such as Pharmacies, Primary Care and NHS 111 during strike periods.

He updated the Board on progress in Urgent and Emergency Care, including work on admission avoidance, improved streaming of 111 calls, the launch of the Geriatrician-led Virtual Ward, and development of Neighbourhood Health initiatives. Efforts are also underway to divert more patients away from ED at the front door, strengthen links with Primary Care, expand SDEC capacity for March, and reduce minor injury and minor illness breaches.

On the admitted pathway, teams are embedding criteria to admit only when necessary and improving digital patient-flow processes. A multidisciplinary approach is being used to support timely discharge before Christmas, reduce bed occupancy, and prepare for winter surges. Work continues with Partners to expand discharge-to-assess capacity and improve flow, particularly in Powys, where medically fit for discharge numbers and long stays remain a concern. The Trust remains under NHS England tier-one oversight and is benefitting from GIRFT support.

AP also highlighted strong improvements in RTT performance, including clearer waiting list validation, fewer internal referrals, and reductions in the 52-week cohort—nearly 200 patients removed in the last eight weeks, with a further 300 planned by March. Diagnostics performance has also improved significantly, with patients waiting over six weeks reduced from 900 to around 180, aided by the new Community Diagnostic Centre.

The Board accepted the Activity Performance Report.

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

GE reported continued improvement in sickness absence following updates to the Policy and added support measures. Work will continue with General Practice and external Partners to further strengthen staff attendance, recognising its importance for patient care.

On Equality, Diversity and Inclusion, the Trust marked Black History Month, Freedom to Speak Up Month and is now promoting Disability History Month. Line Managers are being encouraged to sign the Inclusive Leadership Pledge to reinforce the Trust's commitment to compassionate leadership.

The Consultation Programme for Admin and Clerical staff has been completed, and feedback will shape future local change processes. From January, these programmes will be driven by thorough quality impact assessments and well-defined implementation timelines agreed with Clinical Leaders.

Work continues on the National 10-Point Plan to improve the working lives of doctors, in collaboration with the Chief Medical Officer, with hopes for progress on issues linked to ongoing strike action.

The 2025 Staff Survey achieved its highest-ever response rate at 46%. Results will be published in March–April, after which the Trust will work closely with Unions, staff, and the Project Lead to develop actions that respond to staff feedback.

FM expressed gratitude to all staff for the excellent response rate to the Staff Survey. Although the results are not yet known, she emphasised that the Survey is the most reliable way to understand how staff are feeling and how equipped they feel to provide high-quality care. She thanked staff for taking the time to contribute, noting that their feedback is extremely valuable.

RH emphasised the importance of ensuring all staff feel safe and supported in the workplace, able to seek help with any issues they may face. He reinforced the Trust's aim to be the Employer of Choice in Herefordshire by responding to staff needs with empathy and understanding and helping them navigate life's challenges. He closed by thanking GE for his continued hard work in this area.

The Board accepted the Workforce Report.

11.	Finance	KO	Assurance	

KO reported a slight deterioration in financial performance in Month 7 (October), which had been expected due to higher efficiency targets in the second half of the year. Some planned savings schemes have not started as early as anticipated, leading to an adverse variance of just under £300k. Although the team were able to offset some pressures through one-off benefits (eg credit notes), this does not reflect a sustainable reduction in expenditure and creates concern about achieving a break-even year-end position.

While total efficiencies delivered remain ahead of plan overall, the Trust is now slightly behind target on recurrent savings for the first time this year and are relying more heavily on non-recurrent items. Ensuring sustainable cost reduction therefore remains a key focus.

Cash continues to be stable and well-managed despite the organisation's underlying deficit, and capital spend is slightly below plan but not a concern due to typical timing variations in major schemes. The main focus is now shifting towards developing Operational and Financial Plans for 2026/27 and the medium term. Initial national assumptions—such as lower-than-expected inflation uplifts—appear more challenging than anticipated, and the team is working through these to keep the board fully informed.

FM thanked the Executive Team for their strong leadership and their continued commitment to manage public money with the same care as if it were their own. She acknowledged the difficulty of maintaining tight daily financial control while also preparing for the significant transformational changes needed to meet the Trust's long-term financial goals. She emphasised that this disciplined, day-to-day focus is essential and expressed her appreciation and encouragement to the teams to keep going.

The Board accepted the Finance Report.

12.	Emergency Preparedness Resilience and Response (EPRR) Report	AP	Assurance	Enclosure 6

The annual EPRR Compliance Report shows that the Trust has achieved substantial compliance with NHS England's assurance process for the first time—an improvement of 14% over four years. This is a significant achievement given the rigorous standards and oversight involved, reflecting the importance of strong emergency preparedness for both patient and public safety.

Areas still requiring development include strengthening Business Continuity planning, increasing testing of continuity arrangements, and ensuring staff are well trained. The Trust's progress is particularly noteworthy given reliance on a part-time Emergency Planning Officer, whose diligent work has supported this success. The team is now working with the Local Health Resilience Forum and across the Foundation Group to reinforce support and maintain high compliance levels in future years.

On behalf of the Board, RH thanked the Emergency Planning Officer for his ongoing contribution and dedication to the organisation.

The Board accepted the Emergency Preparedness Resilience and Response Report.

13.	Midwifery Safe Staffing Report	JJ	Assurance	Enclosure 7

All shifts in October were safely staffed. Midwifery sickness absence was slightly above the Trust target, but a review provided strong assurance that this is being well managed locally. Most KPIs were on track, and Delivery Suite acuity was achieved around 85% of the time, supported by significant internal staff redeployment—also noted during a recent Insight Visit, with a full report to follow.

Most red flags were met, except for the supernumerary status of the Shift Leader; however, this still met CNST standards as the Shift Leader was rostered as supernumerary at the start of the shift. Some challenges remain with maintaining acuity on the Inpatient Ward, and work is underway to increase Midwifery staffing time there through roster adjustments.

The Birthrate Plus three-year Audit shows the service is currently funded at the required level. Further investment may be considered to increase headroom, which could help reduce current reliance on Bank staff.

SS queried why acuity on the Postnatal Ward was being met only 44% of the time when the Birthrate Plus Assessment shows the service is funded for the required 89 WTE Midwives. She questioned why staffing levels appeared insufficient despite being fully funded.

JJ explained that the issue is not the total number of staff but how staff hours are currently allocated within the Roster Templates. The Roster needs adjusting so that staffing is aligned to when and where it is needed. Once rostered hours are redistributed appropriately, acuity should be met more consistently on the Ward.

The Board accepted the Midwifery Safe Staffing Report.

14.	**Perinatal Safety Report**	**JJ**	**Assurance**	**Enclosure 8**

The Report highlights that Anaesthetic and Medical Staffing levels were where they needed to be, ensuring Consultant attendance when required. Neonatal QIS Nursing compliance remains challenging, although one staff member has now completed the training and another is due to start, which is positive given the difficulties all Neonatal Units face.

The period included one stillbirth and one neonatal death; both cases will undergo review through the Perinatal Mortality Review Tool, with any learning to be shared with the Board in due course. The dashboard now shows strong assurance around routine enquiry both antenatally and postnatally. There has been a rise in home birth suspensions, which reflects improved escalation and reporting processes to ensure the service is only offered when safe.

The Quality Committee discussed CNST compliance, and the team is confident that evidence is already in place for seven of the ten required safety actions, with work ongoing to gather the remaining evidence before the February declaration.

GQ asked whether there is any current concern or issue that JJ felt the Board should be made aware of at this moment.

JJ advised that the main concern is the delay in fully evidencing CNST requirements this year. Recent changes in leadership and the departure of the Governance Lead have caused a loss of organisational memory, making it harder to locate some required documentation. While the evidence is likely to exist, finding it is taking longer than hoped, and there is a risk of unintentionally misrepresenting the Trust's true position until everything is identified.

The Board accepted the Perinatal Safety Report.

15.	**Guardian Of Safe Working Report**	**CA**	**Assurance**	**Enclosure 9**

The Guardian Of Safe Working oversees compliance with safe working hours for Resident Doctors, ensuring both patient safety and staff wellbeing.

In the last quarter, 142 Resident Doctors submitted only five Exception Reports related to working hours—a reduction from the previous quarter and a positive trend. No reports indicated patient safety concerns or loss of educational opportunities.

The current Guardian's term ends this month, and recruitment for a successor is underway.

The Board accepted the Guardian Of Safe Working Report.

	COMMITTEE SUMMARY REPORTS AND MINUTES	**NT**	**Assurance**	**Enclosure 10**
16.	**Audit Committee Escalation Report**			

NT highlighted that it is the time of year to begin preparing the Internal Audit long list and shortlist, with meetings planned in the coming weeks.

External Audit continues to provide positive feedback on the strong working relationship with the Trust's team. They also praised GS and LR for achieving a Substantial Assurance rating on the first Internal Audit of the Fit and Proper Persons Test — a notable achievement, especially as the team typically selects challenging areas for Audit.

The Board accepted the Audit Committee Escalation Report.

17.	**Children and Young Peoples Escalation Report**	**JR**	**Assurance**	**Enclosure 11**

JR apologised for the delay in aligning governance processes necessary to report this Committee's work to the Board. Those processes are now in place, thanks to the leadership of LF and CA with support from GS.

As expected with any new Committee, it has taken time to embed expectations and clarify reporting requirements, and appreciation was also given to AP for helping develop a strong, reliable data set.

JR acknowledged the valuable contribution of Dr Vickers in her role as Children and Young People's Champion and in preparing the Report included in the Board papers. The Report outlines the current assurance around meeting quality standards for Children's and Young People's Services across the Trust.

AP: highlighted that improving emergency access for Children and Young People is a key planning priority for next year. He noted that Wye Valley is already performing strongly in this area, with 96% of Children and Young People seen and treated within four hours in ED — a performance level the organisation can be proud of within its Urgent and Emergency Care Pathway.

RH asked whether the Trust has an equivalent safeguarding mechanism for children—similar to the "Ask Angela" campaign used by adults who feel unsafe—to help children experiencing abuse at home or in their place of residence seek help when attending Trust services. He requested that the idea be taken forward for further development.

Action 17 – To review whether there is a child-focused safeguarding mechanism—modelled on the principles of the "Ask Angela" initiative—to enable children who feel unsafe or are experiencing abuse to discreetly seek help when attending Trust services - LF

The Board accepted the Children and Young Peoples Escalation Report.

18.	**Quality Committee Report and Minutes 28 August 2025 and 25 September 2025**	**IJ**	**Assurance**	**Enclosure 12**

RH asked IJ, as Chair of the Quality Committee, whether he would feel confident receiving care—or having a family member receive care—at Wye Valley. IJ responded that he would, noting that his wife recently received treatment there and that his personal experience aligns with his oversight of the Trust's quality work. He acknowledged the organisation faces challenges but emphasised that Wye Valley is firmly committed to providing high-quality care for people in Herefordshire and Wales.

The Board accepted the Quality Committee Report and Minutes 28 August 2025 and 25 September 2025.

19.	**Patient Experience Report**	**LF**	**Assurance**	**Enclosure 13**

LF expressed ongoing concern about the high volume of complaints, slow response times, and the number of Complainants who remain dissatisfied after receiving a response. Work is underway with Divisions to clear the backlog, improve timeliness, enhance the quality of responses, and encourage earlier resolution—often simply by picking up the phone.

LF highlighted key points from the National Inpatient Survey. The Survey covers patients who stayed at least one night in October 2024. The Trust scored in the top five Regionally on five questions and in the bottom five on another five. Positively, food-related feedback improved, with high scores for snack availability. Areas needing attention include the Virtual Ward, admission experience (linked to ED pressures and long waits), and particularly communication with patients across doctors, nurses, and overall care. The Trust performed well on Ward environment measures—sleep quality and cleanliness—aligning with NHS England's recent move from enhanced to routine Cleanliness Monitoring. Performance was average on basic care needs such as food, medicines, and personal hygiene. Scores for leaving hospital were better than last year, though communication again remained a weakness. Kindness and compassion improved, while privacy and dignity declined due to pressures causing corridor care and use of temporary spaces. Overall patient experience improved compared with the previous year.

The team now plans to introduce more frequent, targeted Patient Surveys to collect timely feedback, recognising that improvements made now may not influence National Survey results until 2026.

GE noted that the Ethnicity and Religion section of the Patient Experience Report shows several 0% response rates, which stood out as a concern. He highlighted that this links to previous discussions about the Trust's challenges in capturing patients' ethnicity and religious information and asked for clarification on why these zero values appear and what they indicate.

LF advised that the diversity seen in the patient group reflects the unique populations the Trust serves, which differ from other Trusts in the Group. While the workforce is very diverse, the patient population is generally less so, and the patient mix simply mirrors the characteristics of the local communities we support.

RH noted that Herefordshire's population is predominantly white (98%), while the workforce at Wye Valley is more diverse, with 80% of staff and about half of the Consultant body identifying as white. This diversity within the staff group is seen as one of Wye Valley's strengths, contributing to what makes it a special place to work in the county.
RH highlighted that the Board strongly values and recognises the strategic and moral importance of fostering an inclusive culture and embracing diversity across all staff groups. He believes society thrives when it benefits from a wide range of opinions, experiences, backgrounds, religions, and perspectives. Forgetting this is risky, and the organisation aims to continually celebrate its diversity and take pride in its inclusive ethos.

The Board accepted the Patient Experience Report.

	ITEMS FOR NOTING AND INFORMATION			
20.	**Use of Trust Seal - Biannual Report**	**GS**	**Information**	**Enclosure 20**
The Board accepted the Use of Trust Seal – Biannual Report.				
21.	**Board Assurance Framework**	**GS**	**Information**	**Enclosure 21**

The organisation has shifted from a traditional Risk-Register style Board Assurance Framework to a more narrative approach. Key headline risks are highlighted at the top, with many of them interconnected and linked both to high-rated risks on the main Risk Register and to the objectives of the ICB and the organisation's own goals. Each risk is owned by an Executive Director and aligned either to a Board Committee or directly to the Board, and much of the content should already be familiar to Board Members. All risks are brought together in this document, which will go to the Audit Committee for oversight of its format and process, ahead of an upcoming Internal Audit of the Board Assurance Framework.

RH advised that Wye Valley operates on a PFI (Private Finance Initiative) site, and significant work has been undertaken by AD, NT and others to prepare for the PFI's end. This ensures that long-term issues and risks are fully considered and incorporated into the work of the Board and its Subcommittees.

The Board accepted the Board Assurance Framework.

22.	**Any Other Business**			

There was no further business to discuss.

23.	**Questions from Members of the Public**

Q1. Does WVT Board have a plan to end long A&E waits, in particular, corridor waits? If not, why not? If yes, when will it be implemented and when is it likely that corridor care in Hereford County Hospital will cease?

A1. AP stressed the significant challenges the organisation continues to face with corridor care and made it clear that the Board does not accept the ongoing use of temporary Escalation spaces. He apologised to patients who experience this type of care and to staff working under such difficult conditions. While teams work hard to place only the most suitable patients in corridor areas and resolve these situations as quickly as possible, the continued reliance on corridor care remains a problem. He highlighted that the Escalation Policy and use of specific areas are being actively reviewed by LF and the Senior Nursing team ahead of the expected Christmas surge. The Board also heard about actions being taken with System Partners to reduce the need for temporary Escalation spaces; although performance has improved compared to last year, it remains far from acceptable. AP emphasised that corridor care is a symptom of wider pressures in the Urgent and Emergency Care System and remains a key priority for both the Trust and System Partners to address.

RH highlighted that despite efforts to improve medically fit-for-discharge processes, poor patient flow—both into and out of the hospital—is a major factor contributing to corridor care. He emphasised the need for a significant shift in Partnership working with Social Care Providers to create more capacity in the Community. He also urged the public to use ED only for genuinely urgent and emergency needs. By instead using GPs, Pharmacies, or NHS 111 for non-emergency issues, pressure on ED can be reduced, helping staff focus on patients who truly require urgent care.

FM added that the ongoing review of temporary Escalation spaces is closely linked to ensuring ambulances can be unloaded as quickly as possible. When someone in the community calls an ambulance, the organisation must make sure those vehicles can respond promptly, which sometimes results in higher numbers of patients in ED than ideal. This increased pressure can lead to the use of corridor care. She emphasised that frontline teams make these clinical prioritisation decisions daily to maintain patient safety and timely ambulance responses.

Q2. Herefordshire has a growing elderly population, with many elderly people retiring to the area. Many elderly people have eye problems and the number of people that attend the Victoria Eye Unit seems to have grown substantially in recent times. However much of the accommodation within the Unit is cramped, insufficient and inadequate to provide a quality service. What plans do WVT Board have to improve this situation?

A2. AD explained that capacity pressures are not unique to Ophthalmology and are affecting Outpatient Services across the site due to rising demand. In the short to medium term, the ongoing Outpatient Transformation Programme is working to improve Clinic and Room utilisation and reduce unnecessary activity. Additionally, the Capital Programme delivering the Urgent and Emergency Care scheme will create more space in ED and, as a positive knock-on effect, free up additional Outpatient Rooms. Looking ahead, AD noted that as the Trust develops its Operational Plan for the next few years, Outpatient transformation will likely remain a major strategic priority—focused both on managing demand and increasing capacity across the Trust.

RH praised high-street Opticians for significantly expanding the level of eye care they can provide in Primary Care over the past decade. He suggested that continuing to develop innovative partnerships with well-known Optical Retailers will be a valuable way forward for improving services.

Q3. A recent National Survey of nurses reported that 7 out of 10 nurses had worked in excess of their contracted hours at least once a week with 52% of them doing so unpaid. What steps have the WVT Board taken to ensure that their nurses are properly paid for any excess work that they undertake?

A3. LF explained that nurses are encouraged to finish their shifts on time because proper rest between shifts is essential. However, when staff do need to work beyond their contracted hours, the system records their actual finish time. Nurses can then choose how to be compensated: they can be paid for the extra time, take it back flexibly as time off, or accrue the hours and use them later, for example as a half-day off. This provides staff with several options for managing any additional hours worked.

RH reminded the public that the Executive Directors routinely work beyond their contracted hours, often having their evenings and weekends disrupted due to their responsibilities. He expressed his thanks to them for their professionalism, dedication, and commitment to delivering the best possible service for the people of Herefordshire.

The Board accepted the Questions from the Member of the Public.

DATE AND TIME OF THE NEXT MEETING – Thursday 5 February 2026 – 1.00 pm – 2.30 pm

WYE VALLEY NHS TRUST
ACTIONS UPDATE: PUBLIC BOARD MEETING – 5 FEBRUARY 2026

Public Board Reporting Action Log 2025/26							
Month	**Ref.**	**Item**	**Action**	**Lead**	**Due date**	**Status**	**Update**
December	Item 17	Children and Young Peoples Escalation Report	To review whether there is a child-focused safeguarding mechanism—modelled on the principles of the "Ask Angela" initiative—to enable children who feel unsafe or are experiencing abuse to discreetly seek help when attending Trust services.	Lucy Flanagan		**Closed**	From a Children and Young Peoples perspective there is not a similar system- families are encouraged to have safe words/phrases with their children if they find themselves feeling unsafe.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	Chief Executive Update Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Stephen Collman, Chief Executive
Reporting Route:	Direct to Board
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 assurance.	
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. <u>One Herefordshire</u>

The new Managing Director has worked with partners to review and refresh One Herefordshire partnership arrangements. This has resulted in increased governance and oversight by the establishment of a One Herefordshire Health and Care Partnership Board and Wye Valley NHS Trust being confirmed as the host organisation of the partnership. This board sub-committee responsible for providing oversight of the discharge of the Trust's responsibilities set out in the Memorandum of Understanding (MOU) between the One Herefordshire Health and Care Partnership and Herefordshire and Worcestershire Integrated Care Board (ICB) regarding services coordinated by the Partnership, has also been strengthened.

Immediate priorities for the Partnership include:

- Delegation of budgets from the Integrated Care Board to a place-based vehicle (hosted by Wye Valley Trust) for urgent and community services.
- Development of a joint business case for capital investment in a digital command centre, repurposed community hospitals, and Community Diagnostic Centre expansion.
- Exploration of new contracting models (IHO, MNP, SNP) and flexible funding flows to support integrated care delivery.

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

Risks include financial exposure, governance clarity, partnership dynamics, and capacity constraints. However, Herefordshire's mature partnerships, high-performing General Practice, and strong governance structures (One Herefordshire Partnership) provide a solid foundation for success.

2. Finance

We remain focused on delivering our break-even financial plan for the year. After the first nine months of the year, we are in a strong position, though there remains risk over the final quarter and a greater proportion than planned of our in-year delivery has been through one off measure which creates risk into 2026/27. We are particularly concerned about the ongoing funding dispute with Powys commissioners on which we are working closely with NHSE, and the potential risk to receipt of Deficit Support funding for the final quarter, linked to overall Herefordshire and Worcestershire System financial performance.

Our medium-term planning process continues; we held a transformation workshop with clinical, operational, and corporate leads, encouraging a shift in focus onto a smaller set of larger improvement opportunities linked to our strategic aims and medium-term sustainability. These will now be further developed into programmes. Operational, workforce and financial plans continue to be refined with a focus on ensuring triangulated plans that are ambitious yet deliverable.

3. Strategy and Planning

The Board held a workshop on the 15th January to consider the basis for a new organisational strategy for the next five to ten years, including our mission, vision and priorities. With further development meetings with board members and divisional teams, and some wider engagement to come, a new strategy document will be brought to the Board in April 2026.

In terms of capital planning, the last month has seen the formal opening of our Community Diagnostic and Treatment Centre in Hereford. Work on our improvement scheme for urgent and emergency care, centred around our Emergency Department, has just begun and should complete at the end of March 2026. The Trust Board has also just approved a scheme to develop an additional theatre adjacent to our existing theatre department that will provide much-needed additional capacity for our Maternity and Orthopaedic Teams. Work is just beginning and will complete in the summer of 2026.

4. Resident Doctor Ten-Point Plan

The 12-week progress survey is scoring 89%, and this represents a 25% improvement from the baseline. For the domains of our survey, we are now showing rapid and measurable improvement. The two areas we are focussed on are car parking and sorting safe locker and storage. The latter is now partially met. We have a full report on the Resident doctor Ten-Point Improvement Plan which will add more detail in the meeting.

5. Clinical Support Division Update

PATIENT ACCESS

Wound Service
The ICB have now given the Trust notice from the 31/03/26 that the Trust are no longer required to provide the wound service and it will be returning back to Primary Care. Outpatient Management are working through the plan to close down and ensure patients are handed over to their GP's. T&O and Outpatients are working through a plan to continue offering a cohort of wound clinics for their patients due to clinical needs.

SSDEC Moves
Outpatients are working through the plans for scheduling to support the SSDEC moves, the 6-4-2 process is temporarily being changed to support this. Currently clinic allocation is only being confirmed 2 weeks in advance however if the temporary process is followed by specialties cancelling in advance this should improve.

Referral Management Centre

e-RS roll out now at 17 specialities live. ENT is now live except for ENT/Audiology as pathways are being reviewed. Gynaecology is next to go live. Once Gynaecology is live this will be all surgical specialties now live.

Ophthalmology e-RS (Cinapsis) go live delayed due to a Maxims process issue found. We are working with the Clinical Systems Group and Cinapsis to resolve, currently no digital solutions, therefore may be a manual resource process for administration staff, concerns raised around resource/risks of manual processes.

Mortuary/Bereavement

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

Significant Improvement in Post-Mortem Turnaround Times

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

Investment in Staff Development – Trainee Anatomical Pathology Technologist (APT)

We have introduced our first Trainee APT role in over 20 years as part of a "grow your own" initiative. The trainee is on track to qualify in Spring 2026, strengthening our workforce sustainability and ensuring that we develop skilled professionals within our own department. This initiative not only addresses workforce challenges but also provides career progression opportunities within the organisation. Once qualified, the service will effectively double its technically competent workforce capacity, substantially improving service resilience, reducing single-point dependency, and supporting long-term operational stability.

A second Trainee APT has now been successfully appointed and is due to commence training on the same Level 3 RSPH APT programme in January 2026. This appointment fills the final technical vacancy within the service and further enhances resilience.

Premises Enhancements

A new privacy curtain has been installed within the viewing room to fully screen the gap between the viewing-room doors and the body store. This action directly addressed a security-related shortfall identified during the HTA inspection and has strengthened privacy arrangements. The curtain also creates a more welcoming and dignified environment, supporting bereaved families during viewings and enhancing the overall experience at a sensitive time.

CANCER SERVICES

Our Trust's Cancer performance continued to show significant improvement throughout 2025. In November 2025, we exceeded the 28-day Faster Diagnosis Standard by 9%, achieving 84%. We also delivered 81% against the 62-day standard, performing above our agreed trajectory of 73.3%. For November, WVT ranked 1st in the West Midlands for COSD, 2nd for 62-day performance, and 4th for the Faster Diagnosis Standard. In addition, we have participated in three NHSE meetings for Urology, UGI and Skin, where WVT was recognised for consistent performance and for meeting Cancer targets within these specialties. During these sessions, we shared details of our pathways to support other Trusts that are currently underperforming.

Best-practice timed pathway dashboards were implemented in October at WVT for Cancer which give a real time view of performance metrics for clinical and operational teams. These dashboards share consistent, visually accessible data on Cancer waiting time performance and include diagnostic activity metrics (such as DM01 waits). These are updated regular which provide the visibility of referral demand, diagnostics capacity, pathway bottlenecks, and compliance with the best practice timed pathways guided by NHS England. Having these identify to the Cancer Services Management Team areas that require more in depth deep dives to generate themes and therefore support in improving performance.

Cancer Services took over the Fred Bulmer Medical Day Case Unit in October 2025, and since then we have been exploring how a range of pathways can be effectively delivered through this area. To support this work, we have successfully appointed a Clinical Scheduler, ensuring the unit operates at full capacity.

We have also been working closely with colleagues in SDEC to identify and transfer appropriate clinical activity through FBMDC, helping to relieve operational pressures within the SDEC department.

Our Macmillan Renton Unit mural project was completed in August 2025, resulting in the installation of three stunning murals that transformed previously tired walls into vibrant art. The artwork has brought a sense of warmth and positivity to the unit, creating a more welcoming and comforting environment for our patients.

DIAGNOSTIC SERVICES

The Radiology team continues to deliver significantly increased capacity across all main modalities, including MRI (Magnetic Resonance Imaging), CT (Computed Tomography), NOUSS (Non-Obstetric Ultrasound Scan), and DEXA (Dual Energy X-ray Absorptiometry/bone density scanning). Year-to-date performance against the 2025/26 plan is 98%, 94%, 110% and 116% respectively. Across modalities, more than 96% of patients are being seen within six weeks of referral.

The Wye Valley Community Diagnostic Treatment Centre was officially opened on 15th January by Stephen Kinnock, Minister of State for Health and Social Care. After touring the facility and meeting staff and patients, Minister Kinnock cut the ribbon, accompanied by

Maritsa Crouse, WVT Operational Clinical Lead for the CDTC. Workforce recruitment currently stands at approximately 86% of plan, with active recruitment ongoing.

Digital transformation continues, with the rollout of i-Refer planned for February. I-Refer is an AI-enabled clinical decision support tool designed to improve the appropriateness of imaging requests. Progress also continues—although delayed—on implementing both Order Comms and i-Refer within General Practice.

Audiology waiting times continue to improve, with 76% of patients seen within six weeks in December 2025. Audiology faces ongoing workforce challenges. Insourcing support for Paediatric Audiology resumed in August 2025, and agency support is in place to cover a recent vacancy in Adult Audiology. Recruitment is underway to fill remaining posts and support the full withdrawal of premium temporary staffing. The new straight to Audiology pathway has embedded well and is effectively reducing the risk of 65-week breaching patients within the ENT service.

Neurophysiology performance is also improving, with zero patients now waiting over 13 weeks and 82% seen within six weeks. Succession planning for this team is a high priority, and apprenticeship pathways are being actively explored.

PHARMACY

Our Management of Change Consultation for the restructure of Medicines Procurement, Provision and Homecare services has now closed and we are currently undergoing phase 1 of the recruitment process.

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

Following Trust approval to proceed with the ADC (Automated Dispensing Cabinets) business case, the Pharmacy team has been working closely with the supplier to develop an implementation plan for deploying the cabinets across ward areas. The business case for the Dispensing Robot has been presented to SPB and is expected to be presented to TMB by the end of February. The additional space will facilitate the return of Pharmacy staff based over in St Owen's Chambers. The development of the aseptic unit at a regional ICS level is ongoing – the regional QA team have raised concerns based on the continual running of the Aseptic Unit over capacity. Regional audit due 10/02/26.

PATHOLOGY

Histology turnaround times (TATs) have been maintained with WVT achieving the highest TATs in the region for both 7-day and 10-day reporting specimens consistently since May 2025.

Digital Pathology is now live for end-to-end reporting, implemented 12/01/26. Training and troubleshooting ongoing but positive change and WVT are one of the first across the Network to go live. There are plans to increase its functionality and storage capacity to ensure compliant with recently updated regulatory requirements.

Histology Managed Laboratory Service Business Case was approved at TMB in December, with ROCHE agreed as the supplier for this project across the South Midlands Pathology

Network, despite the uncertainty of the Network the MLS contracts are hoped to progress within the individual Trusts.

Blood Sciences – The Managed Laboratory Services (MLS) works are ongoing with Chemistry due to go live on 12/02/26, despite recent issues with the water supply which whilst resolved did cause some delays with validation processes. The implementation plan is over a 9-month period and once fully implemented it is expected that there will be efficiency gains within Blood Sciences but also much improved TAT's for ED one-hour standard patients.

Microbiology MLS across the SMP has unfortunately stalled due to uncertainty of the Network. Microbiology has some of the oldest equipment and this is a high concern for Pathology. The current MLS is due to end in May 2026, and we will unlikely be able to extend this due to the age of the equipment and the limited maintenance available. There are plans to progress a business case to implement a new short term MLS contract to stabilise the at-risk equipment until we are able to progress with a Networked approach.

The APEX Hardware upgrade completed as planned on the 13/12/26 with limited downtime, this has stabilised the risk of APEX failure and ensures continuity of service in Pathology IT. The software upgrade will commence in early 2026 to bring WVT onto the most up to date version of APEX.

The Pan Pathology Quality Manager role maternity cover has successfully been recruited to with the new member of staff to commence 16/02/26 limiting the period without quality support across Pathology.

UKAS conducted a review visit, following the full inspection earlier in the year where there were 74 findings. The review visit was very successful, with only one minor finding outstanding regarding Microbiology audit schedule, which has now been resolved.

ENDOSCOPY

An Endoscopy workforce optimisation business case was approved in March 2025 and following successful recruitment this increased and stabilised workforce within Endoscopy. This has improved utilisation of Endoscopy lists and has increased capacity with Ross now running 5 days per week.

WVT is the top performing trust across the midlands for utilisation of planned endoscopy sessions. The endoscopy scheduler is extremely pro-active at filling sessions to cover leave, sickness or on call commitments.

Cancer performance has improved across Endoscopy with wait time reducing from an average of 9.12 days at the end of December to 5.75 days in January.

The over 13 week waiting list position has improved greatly with the number of patients awaiting Colonoscopies reducing from 98 to July to 10 in December.

Design work for a new Endoscopy unit has commenced with a view to seeking capital allocation in 26/27, aiming for completion of the new facility by the end of 2027 if funding is secured.

Integrated Performance Report

December 2025

Managing Director – Executive Summary

Sarah Shingler
Managing Director

Overall assurance: December saw significant pressure from early winter demand, industrial action and increased infection rates. Despite this, the Trust demonstrated strong leadership, operational grip and effective system working, delivering improved flow and maintaining performance in key areas.

Quality & safety: Winter infection outbreaks were effectively managed, however challenges remain with Noro-virus and Flu. December recorded the lowest crude mortality for many years, with improving performance across key mortality outlier pathways. Corridor care risks have been reviewed clinically, with further national guidance awaited.

Patient flow & UEC: The “Ho Ho Home for Christmas” initiative successfully reduced bed occupancy to 79.3% and eliminated corridor care. January pressures have returned due to IPC constraints and increased demand; NHS England has recognised the Trust’s escalation management as exemplary. Same Day Emergency Care remains a key strength, with expansion underway.

Elective & cancer performance: Elective recovery continues, with RTT performance among the top three Trusts in the Midlands and a continued reduction in long waiters. Cancer performance remains strong, with the Trust highly ranked regionally for Faster Diagnosis and 62-day standards.

Workforce: Workforce stability continues to improve, with reduced turnover (8.1%), lower sickness absence than last winter, and agency usage tightly controlled and compliant with national price caps

Finance: Finance performance remains strong. The Trust remains £1.9m better than plan year to date, with reduced agency spend and cost control. Key risks remain around recurrent efficiency delivery, Welsh parity funding and access to deficit support funding. Cash is below plan but under active management.
The Trust successfully submitted the initial 2-year activity, finance and workforce plans in line with the December deadline. At this stage the financial plan is non-compliant as it does not reflect a balanced position. Further work is underway to develop a comprehensive and fully worked up final plan for submission in mid-February.

Key risks & focus: Ongoing winter pressures, delivery of recurrent cost improvements, and sustained improvement in urgent and emergency care flow.

Overall, the Trust has demonstrated resilience and delivery during a challenging period. While pressures remain, performance provides assurance that the organisation is well positioned to continue delivering safe care and progress against its strategic priorities.

Our Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Outbreaks update
Winter has really taken its hold as we have seen rising cases of norovirus and respiratory viruses, since December we have had 14 outbreaks affecting over 83 patients and a number of staff. Since April 2025 we have seen 211 flu cases admitted, 89 if which presented during December and early January, norovirus affected 36 patients in the same period. Ward closures and bed losses were kept to an absolute minimum by cohorting patients, yet clearly when numbers are this high this can impact patient flow, increase length of stay and generally impact on the efficiency of the hospital overall. During the winter periods our infection prevention team cover a 7 day service to provide expert advice and support to clinical teams, all outbreaks are managed in line with national guidance and best practice. At the time of writing the report the overall numbers are reducing and we only have 25 patients (12 norovirus and 13 respiratory) admitted with these viruses and we have no declared outbreaks.

Flu vaccination update
The staff flu vaccination launched on 1st October 2025 and we have vaccinated 51.4 % of our workforce. Vaccination is still available for staff until February although we do know that uptake is much lower once the Christmas period is over.

NHSE/Infection prevention touch point meeting
Further to the inspection undertaken by NHSE in September when the Trust moved from enhanced to routine monitoring, it was agreed that a progress meeting would be held with NHSE in January; we have been able to demonstrate ongoing progress with help desk, estates back log work and general maintenance. At the time of writing we await formal notification/confirmation from NHSE that they are satisfied with our progress yet this was confirmed verbally on the day.

Corridor/ boarders assessment
There has been a clinically led review of all escalation areas and temporary escalation spaces applying a risk matrix across a number of areas including patient safety, patient experience, performance, finance and other measures, this has led to some recommendations and adjustments to our enabling flow policy. A self assessment against the national corridor care toolkit has also been completed. These will be presented to Quality Committee in February. We await the national definitions and guidance on corridor care and will review this when this is available – we are advised that this will be published shortly.

We remain committed to our longer term strategy to improve urgent and emergency care pathways with a view to significantly reducing/eliminating corridor care.

Resuscitation Committee Report
Appended to this report is the deep dive into our resuscitation service which is shared with Board to note the positive progress that has been made during the last 12 months. The Team had experienced resource issues over a sustained period limiting the availability of training courses for staff and we had been unable to participate in the National Cardiac Arrest Audit. Board will note the positive progress that has been made in this service during the last 12 months and this is to be commended.

Quality & Safety Performance – Mortality

We are driving this measure because:

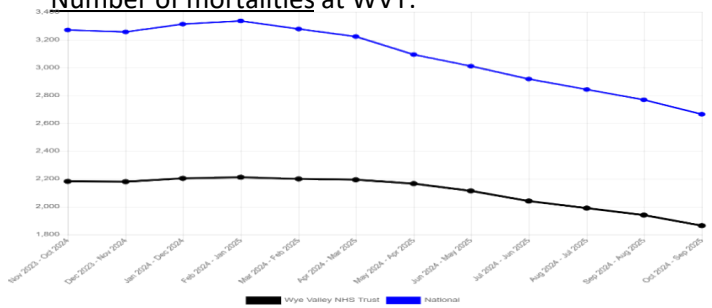
Mortality continues to report at 'higher than expected' levels for key national indicators, including SHMI.

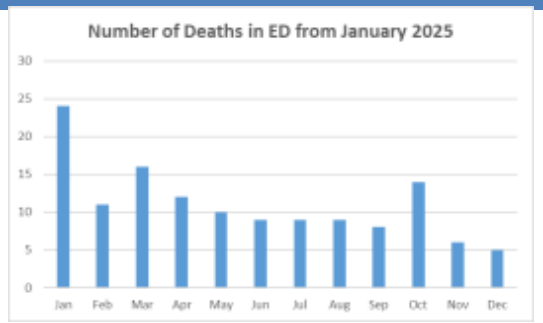
Data

Indicator	Description/Notes	Data month	Month Actual	Change
SHMI (NHS Digital)	*Rolling 12 month Standardised Hospital Mortality Indicator (inc. post 30 days discharge patients)*	Jul-25	113.3	*1.4*

Indicator - Latest Static	Description/Notes	Data month	Month Actual	Deaths in Month	Change (Rate %)
Crude Mortality-All	*% of Deaths by Discharges*	Dec-25	1.20%	58	-0.41%
Crude Mortality-Emergency	*% of Deaths by Emergency Discharges*		4.30%	56	-1.94%

Number of mortalities at WVT:





Monthly Headlines

- The latest **12 month rolling SHMI** (NHS England) from August 2024 to July 2025 shows Wye Valley NHS Trust at 113.3, which equates to 1406 observed deaths against 1240 expected. In comparison, for the 12-month rolling period from August 2023 to July 2024, WVT had a SHMI of 99, which equated to 1361 deaths versus 1362 expected deaths.
- Latest **crude mortality** rate for December 2025 was **1.20%** for all admissions, which equates to 58 deaths with only 5 reported in the Emergency Department. This is the lowest number of deaths reported in the month of December for many years.
- Continued efforts have been made by the **Clinical Coding** department to further reduce the growing backlog of un-coded patients within the SHMI reporting period. This improvement can be seen on the latest Clinical Coding charts shown, which highlight the rise in both Coding Depth and Co-morbidities. The new coded episodes are being re-submitted and will take some time to be refreshed into the SHMI dataset. This refresh should bring an increase in our level of expected deaths and ultimately a reduction in our current SHMI levels.
- Our key mortality outlier groups…
- **#NOF** – An external review by NHS England for the #NOF pathway is planned to take place in early March. This will offer further insight into our performance, data and identify potential opportunities for improvement. Currently, the latest NHS England SHMI is reporting at 158 for the 12-month rolling period from August 2024 to July 2025. This equates to 48 observed deaths against an expected 30 deaths. It is worth highlighting the consistent improvements being made in the National KPI's for #NOF patients. Over the past 12 months, the Trust has gone from 0% of #NOF patients reaching the specialist ward within 4 hours to the latest data showing 20%. The highlights the positive impact of the Fast Track Pathway in getting patients expedited from the Emergency Department promptly.
- **Pneumonia** – The latest SHMI period has reported an encouraging reduction to 107 with 166 observed deaths in the 12-month period. Although the SHMI remains slightly above the National average when compared to the same period for last year, there were 210 deaths, 44 more deaths than the current reporting period. There is a further planning meeting with key leads in February to discuss the next steps in the development of a 'Reducing Hospital-Acquired Pneumonia' strategy.
- **Sepsis** – Although this month has reported a slight increase in the rolling 12 month SHMI (*Aug 24 – Jul 25*) to 105.6, there has been a reduction in the number of actual deaths. When compared to the same period last year, the SHMI (*Aug 23 – July 24*) was at 118 with 137 reported deaths, which is 42 more deaths than the current reporting timeframe. The T&F group, which is aimed at reviewing and improving the current pathway, will be re-starting towards the end of January.
- **Stroke** – The latest SHMI (NHS England) data continues to show an encouraging position at 99, which sits below the National average and under the expected level of mortality for our population. There were 79 actual deaths against an expected 79 deaths for this period.
- At the **January LfD Committee**, there were presentations from Acute Medicine, General Medicine and Frailty on their learning from recent SJR's and mortality cases. There was a general theme highlighted from the SJR process by AMU around the escalation of deteriorating patients. A focussed audit of these patients is already underway, and the team have installed a large monitor on the ward to aid with the visibility of the patients on the ward and their latest NEWS score. There was a general theme, based on family and next of kin feedback, across all three presentations that highlighted excellent end of life care from the ward and clinical teams.

Quality & Safety Performance – Staffing - data

Fill Rate & CHPPD Data

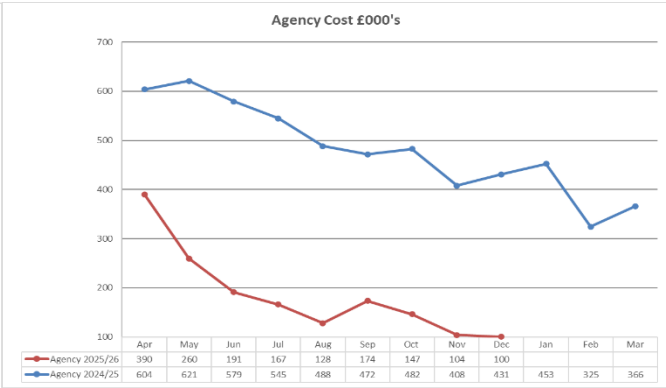
	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	81%	83%	98%	72%	12.1
Maternity Ward	67%	81%	71%	77%	5.3
Children's Ward	121%	125%	148%	82%	17.7
Lugg Ward	120%	72%	106%	97%	6.4
Wye Ward	118%	73%	114%	109%	7.2
Cardiac Care Unit	101%	94%	100%	100%	12.0
Leominster Community Hospital	152%	66%	103%	121%	6.6
Bromyard Community Hospital	132%	89%	100%	111%	6.5
Ross Community Hospital	98%	98%	147%	102%	5.8
Teme Ward	133%	52%	85%	64%	11.2
Redbrook Ward	95%	93%	103%	134%	7.7
Special Baby Care Unit	106%	-	111%	-	19.2
Intensive Care Unit	147%	-	151%	-	36.6
Gilwern Ward	101%	109%	100%	100%	6.6
Acute Medical Unit	126%	86%	100%	136%	8.2
Ashgrove Ward	128%	81%	116%	109%	7.1
Dinmore Ward	131%	76%	100%	101%	7.0
Garway Ward	132%	89%	118%	111%	7.3
Frome Ward	120%	83%	101%	115%	6.8
Arrow Ward	148%	76%	148%	89%	8.0
Women's Health	101%	94%	100%	-	12.3

There are several ward areas that are above the fill rate level:-

- Paediatric Ward – Additional RN's and HCA required to support ED, and patients needing enhanced care - RMN support
- Frome, Dinmore, Garway and Ashgrove Wards – Additional staffing requirements for additional boarding patients to maintain safety
- AMU, Lugg, Redbrook Wards – 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 – budget alignment required
- Bromyard – Due to additional beds

Bank & Agency

Bank
£2,245 YTD (2025/26)
£2,447k YTD Prior Year (2024/25)
£5,348k Prior Year (2024/25)



Agency
£1,136k YTD (2025/26)
£2,837k YTD Prior Year (2024/25)
£5,774k Prior Year (2024/25)

- 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 £1,535m YTD
- 100% of all shifts are NHSE price cap compliant
- 4 off framework shifts were required to maintain patient safety
- Agency health care support worker shifts have not been used since month 3

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

December`s challenges, before the festive period, started with a combination of Resident Doctors Industrial Action and the early onset of flu season. This led to significant challenges with Emergency Access Standards (EAS) and our ability to maintain flow. However, as part of our Winter Plan our operational and clinical teams developed local plans to reduce our bed occupancy ahead of the holiday period.

Starting from the 1st December our *"Ho Ho Home for Christmas"* workstreams focused on Criteria to Reside across all inpatient wards, acute floor support with discharge pathways and working with system partners on site across the acute and community hospitals to ensure as many patients as possible were discharged. This resulted in our bed occupancy reducing to **79.3%**, a position the Trust has not seen for a number of years, and one of the lowest bed occupancy's across the Midlands Region which ensured that, not only more patients were safely discharged home for Christmas and New Year, but we managed to eradicate patients boarding on our wards and corridor care. This reduced bed occupancy mitigated the challenges over the period and delivered improved flow into the first weekend of the new year period. The learning for this initiative in currently under evaluation and will be reviewed at our Valuing Patients Time Board and form part of our on-going improvement schemes for 2026.

A significant achievement by our operational and clinical teams – Thank You

Unfortunately, the new year has started with significant challenges across our Urgent and Emergency Care (UEC) pathways with Infection Prevention Control (IPC) issues being one of the main drivers for reduced flow and below target number of daily discharges. Multiple IPC issues have resulted in closed Community Hospitals, Acute Wards / Bays and reduced ability to move our patients to manage demand and discharge safely to other care providers. This peaked with almost 85 patients (approximately 27% of our General and Acute beds) during the second week in January being impacted. This has seen a return to high levels of escalation and increased congestion with additional patients across our Emergency Department and inpatient wards.

Despite these challenges NHS England, via our Tier 1 UEC assurance review, acknowledged that the Trust and System Partners management of flow and escalation during this period we exemplary under the circumstances.

Our improvements for UEC have not stood still over the winter period and we are focusing, with ongoing support from the Getting It Right First Time (GIRFT) team on three key areas:

- Same Day Emergency Care (SDEC). Working group focused on refreshing collaborative SDEC Operational Principles in line with with SDEC estate expansion work commencing on 26th January for an 8–10-week scheduled period to double the size of our clinical footprint. This is supported by GIRFT and the clinical team mapping for patient journeys and opportunities. This has identified process efficiencies which are aimed to be rectified including dedicated Ambulance access / off load space, increased streaming from our Community Referral Hub / Single Point of Access (SPoA) and access to same day diagnostics and blood test results.
- GIRFT Clinical Operational Standards across our Emergency Department, Specialities and Wards. Planning underway with improvement leads for next cultural change programme; new Clinically Vision for Flow, to embed and expand key schemes; linked to the rollout of our digital bed management; including GIRFT Clinical Operational Standards and Professor Time Briggs national drive to embed these standards.
- Developing our SPoA with System partners. Review and assessment of missed opportunities and pathway redesign based on GIRFT guidance and SPoA National Specification. Ongoing work with Ambulance colleagues to develop increased referrals through new Ambulance Computer Aid Dispatch functions and working together on access to alternative pathways through a review of our Directory of Services and developing 24/7 access and scheduling of Urgent Community Response support for overnight referrals.

Although we have much more to do and deliver on to make the improvements required for our patients requiring our UEC pathways all these schemes, not only support our current challenges, but are a foundation for the three-year operational plan and are key components to operationalise the Neighbourhood Health strategic plan.

Our Elective performance has maintained momentum over this reporting period with our activity delivering to plan, our Referral to Treatment (RTT) times for English patients' coutines to improve across New outpatient appointments and whole pathways. Our RTT performance is already delivering the 5% improvement required for this year with both standards being in the top three Trusts across the Midlands Region. We have also seen an almost 150 patient reduction in long waiting English patients waiting greater than 52 weeks in the last month.

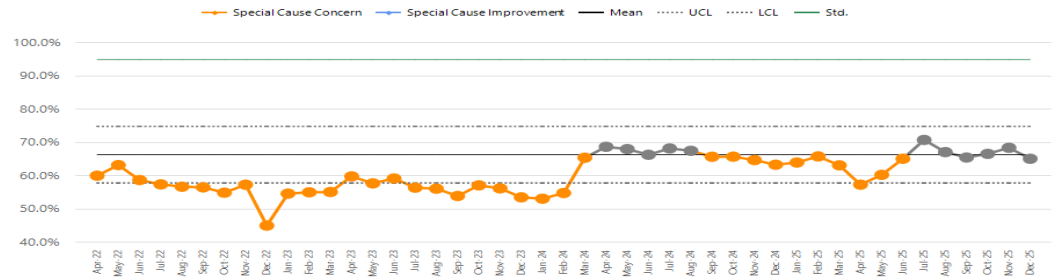
And finally, our Cancer performance is also one of the best in the Region in both 28 days faster diagnosis standard (FDS) and the start of first treatment within 62 days standard. The Trust was ranked 4th in the Midlands Region for FDS performance and 2nd in the Midlands Region for 62 day performance, and both delivering beyond the required delivery standard for 2025/26 . A fantastic achievement for our patients across Herefordshire and Powys.

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

We are driving this measure because:

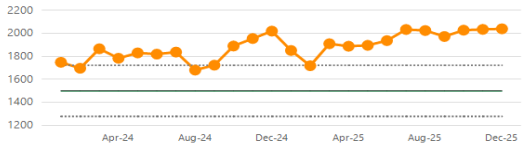
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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



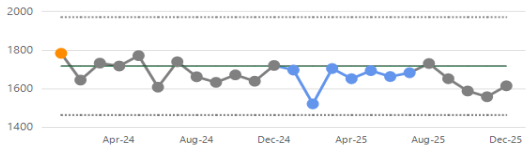
% Patients Spending More Than 12 Hours In ED

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

- Decembers 4 hour Emergency Access Standard [EAS] Performance was 65.2% Below our Trajectory of 70.2%
- 10.4% [686] of patients spent 12 or more hours in ED which was marginal deterioration against last month.

Performance & actions

- 5,987 Type 1 patients attended ED in December which 46 more than the previous month however it was 365 fewer than December-2024. The range of all attendances varied from 117 to 253 with 193 daily average.
- 1,615 ambulances conveyed to the Trust in month which was 57 more than last month. The range in month was 34 to 72 with a daily average of 52. This includes 9.1% from Powys [147] and marks the lowest percentage since January-2025.
- Ambulance handover delays over 1hr were 24.8% [367] of all conveyances with 30.7% [454] waiting over 45 minutes and 56.5% [834] having a handover within 30 minutes.
- Same Day Emergency Care [SDEC] treated 1,304 of all admissions [47.5% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 63 / 122 Type 1 Trust in England for December.
- Key actions being taken to recovery our 4hr EAS :

➢ 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. To be completed by March 2026.

➢ Developing our Single Point of Access in conjunction with our local System Partners. Including a community Geriatrician senior Doctor role to support admissions avoidance and Frailty led Virtual Ward within our Community Integrated Referral Hub, implemented from 1st December, for four months, as part of a successful bid NHS England funding from the Learning Improvement Network schemes.

➢ Increasing Call before Convey with Ambulance partners through SDEC pathways and changes to Ambulance Criteria and oversight to maximise opportunities

➢ 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.

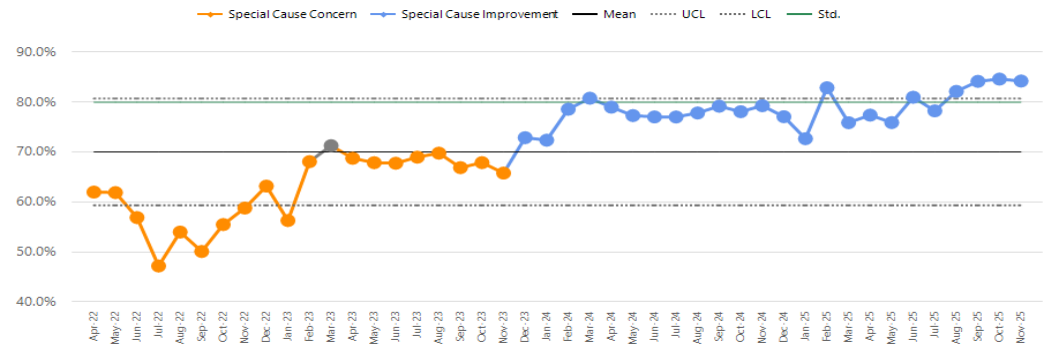
Operational Performance – Cancer Performance [September 25]

We are driving this measure because:

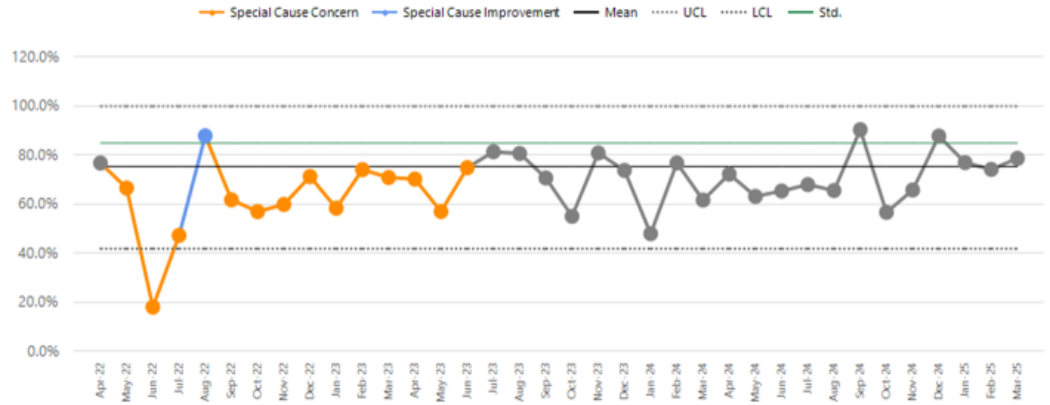
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or 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 November 2025, urgent suspected cancer referrals have risen by 20% compared to the same period two years ago. Referrals for Skin and Urology continue to see significant increases of 67% (1180 additional referrals) and 43% (513 additional referrals), over the same time period. WVT has presented an audit to the Integrated Care Board (ICB) highlighting opportunities to improve referral quality within primary care. A new Cancer Lead General Practitioner (GP) took up post in January 2026, and together with the General Manager for Cancer will lead the work to drive these improvements across primary care.

Cancer Performance:
In November 2025, the Trust met the Faster Diagnosis Standard (FDS), achieving a performance rate of 84%, which exceeded the trust trajectories target of 79%. We have seen eight specialities achieving higher than the target, Head and Neck (H+N) at 93%, Skin 98%, Lower Gastrointestinal (GI) 82%, Lung 79%, Haematology 100%, Non specific symptom 100% and Breast at 92%. Gynaecology did not meet the FDS target, achieving 64.2%. Additional recovery funding for Gynaecology was secured in October and implemented in November to support waiting list initiatives (WLI). This is expected to improve performance in this specialty over the coming months.

Compliance was achieved for current 62 day cancer treatment standards in November.
However, performance improved significantly compared with September, with a 10% increase for the 31 day standard and an 8% increase for the 62 day standard. The main contributing factors to underperformance in the 31 day standard were diagnostic and surgical delays. To help address these delays, additional finding has been secured through the West Midlands Cancer Alliance (WMCA) to support waiting list initiatives across Gynaecology, Radiology and Endoscopy. A new Programme Manager has also been appointed to strengthen diagnostic pathways, working closely with Cancer Services to implement a 7 day turnaround for Computed Tomography Colonography (CTCs) and 48 hour turnaround for Magnetic Resonance Imaging (MRI) prostate.

Developments updates
- New cancer clinical lead appointed at WVT
- New cancer GP leave appointed and started for Primary Care
- WVT were asked to meet NHSE (region) to share Skin, Upper GI and Urology pathways as specialties have been recognised as consistently performing high across the region, for shared learning at other trusts
- WVT were ranked 4th for FDS, 2nd for 62 day and 1st for COSD data for November performance across West Midlands

What the charts tell us

- 28 Day faster diagnosis performance this month was 84.2%.
- 62 Days start of treatment target was 82.3%

Risks

- Cancer referrals continuing to remain high compared to 2 years ago
- Gynaecology high 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
	56,484	57,055	-571 / -1%
Vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	56,484	46,308	10176 / 22%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	9.8	**2.7**	**72.4%**

IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	20,650	20,333	317 / 2%
vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	20,650	17,856	2794 / 16%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	14.7	**8.0**	**46.0%**

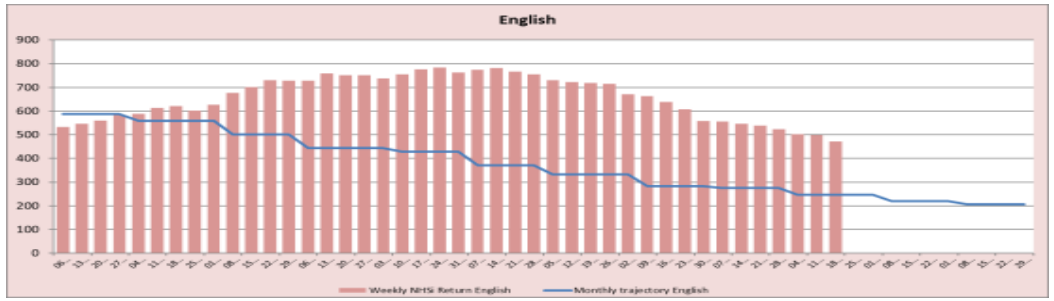
Follow Up Attendances

Total Vs Plan	This Year	Plan	Diff / Var
	127,304	115,853	11451 / 10%
Total vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	127,304	101,122	26182 / 26%
Waitlist Clearance (wks)	**Total**	**> See By Date (SBD)**	**% Past SBD**
	17.1	**5.7**	**63.0%**

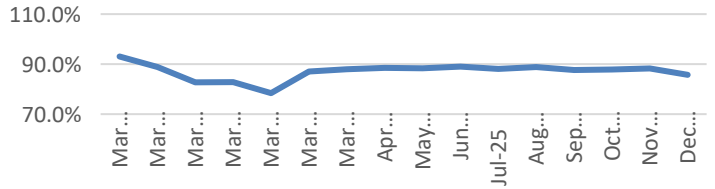
Endoscopies

Total Vs Plan	This Year	Plan	Diff / Var
	8,047	7,917	130 / 2%
vs 2019/20	**This Year**	**2019/20**	**Diff / Var**
	8,047	8,164	-117 / -1%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	13.7	**0.4**	**97.4%**

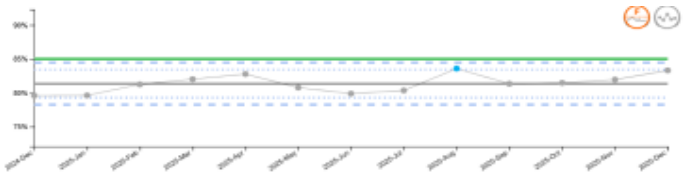
Patients over 52 weeks on Incomplete Pathways Waiting List- English only



Clinic Utilisation



Theatres Utilisation (Uncapped)



Performance & actions

Activity

- Overall elective activity remains on plan at the end of December. New appointments were 1% behind plan (460 contacts) but elective inpatients and day cases were 2% above plan (420 patients treated above plan)

Theatres and Pre-Operative Assessment:

- Theatre utilisation for the month of December was 82.8%, with the Elective Surgical Hub performance at 82.5%
- Podiatric surgery remains a key area for improvement, with ongoing transformational work taking place within the Specialty with key recommendations identified and to work through following support from the Theatre Operating Manager.
- Overall M9 was an impressive month for our Theatres team, with late starts also improving by an average of 7 minutes from the previous month.
- Model Hospital data also indicates a slight improvement in early finishes by around 2 minutes on average from M8, with WVT remaining in the highest quartile for this area.
- Pre-operative Assessment continues to achieve extremely impressive clinic utilisation, exceeding 96% yet again, with patients who Did Not Attend (DNA's) remaining below 4%.
- MyPreOp+ project implementation is ongoing, with recent site visits having been undertaken with Trusts who have already adopted this platform to support shared learning ahead of a March/April planned launch.

Long Waiting Patients

- 3 English patients were waiting longer than 65 weeks at the end of December. All 3 patients were treater within the first two weeks of January.
- 520 English patients were waiting over 52 weeks for treatment at the end of December, a decrease of almost 140 patients from the end of October

What the charts tell us

- Performance against English RTT standard in December was 64.3% / 2.4% of English patients on our Waiting List were waiting more than 52 weeks.
- Performance against the Welsh RTT standard in December was 64.7%.

Risks

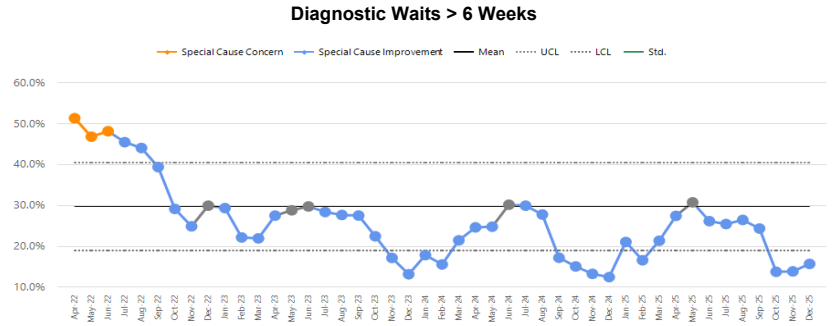
- Workforce challenges to meet activity plan due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.
- Urgent and Emergency Care demand impacting on the ability to maintain Elective activity.

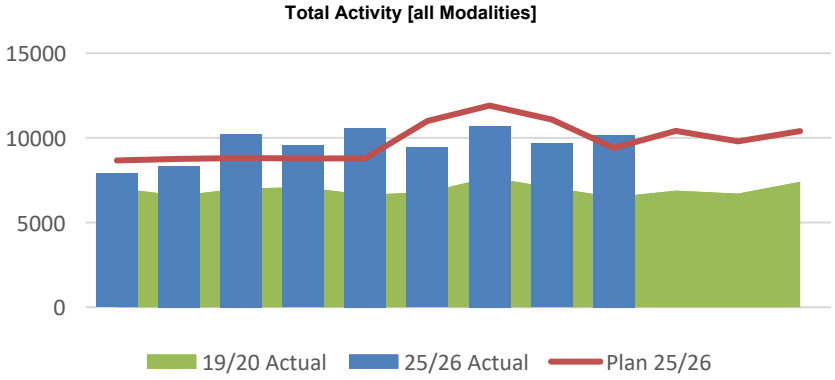
Operational Performance – Diagnostic Performance

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 99% of 25/26 activity plan which is 139% compared with 19/20 activity. The Community Diagnostic Centre (CDC) is delivering approximately 3,000 tests per month.

Imaging:
6 week wait position at the end of December has remained consistent at 96% overall, with high performance sustained across all modalities. Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and Computed Tomography (CT) Colonoscopy (CTC]) have both reduced to 5 days and 10.5 days respectively. MRI Prostate is planned as one of four priority pathways to improve access via the Community Diagnostic Centre (CDC).

Audiology:
Audiology Assessment 6 week wait position has improved by a further 0.8% to 76.4%, as a result of improved clinic utilisation, cross-service working with Ear Nose and Throat (ENT), waiting list validation.
Agreed insourcing solution for Paediatrics recommenced to help reduce the number of long waiting patients. Substantive B7 is re-advertised. NHSE Apprentice bids were successful however the funding does not align to national course intake dates and thus we are unable to proceed via this route. 2026 will provide renewed opportunities to access Apprentice funding

Neurophysiology:
<6weeks waiting has sustained at 82% for December. The number of patients waiting >13wks has reduced from 21 in March 25 to 0. A service review has been finalised for costing, which aims to improve service sustainability.

Endoscopy:
Waiting lists, >6 weeks is 33% of the current waiting list and >13 weeks has shown an increase to 7% of the current waiting list
The team are undertaking a detailed validation of the waiting list and profiling a reduction in the number of patients above >6 weeks further across coming quarter. To support this, we are utilising additional lists to cover current workforce gaps as well undertaking additional sessions at weekends where possible to ensure both cancer performance and improvements in waiting lists are maintained. Demand continues to increase overall across Endoscopy requests for 2025 by 18% YTD compared to our plan. A weekly forward look meeting as been established similar to the weekly Theatre Scheduling meeting as well as weekly validation and tracking of waiting lists is now in place and is helping to ensure timely removal or booking of patients.

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 December 84% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

With the ongoing NHS wide transition from paper-based systems to electronic platforms, we are working with local further education providers to develop a bespoke digital skills programme to upskill and foster a culture of confidence and inclusivity in technology adoption at WVT. This is in view of the new 10 Year Plan's focus on a shift from analogue to digital and the emphasis on building digital skills in the workforce.

To meet our workforce plan, we are running local management of change programmes which are informed by quality impact assessments with clinical engagement. We will be launching a WVT wide voluntary redundancy scheme in February but this will not be applicable to frontline clinical staff.

Sickness absence is at 5.5% compared to 6.2% (Dec 24) with Long Term Sickness at 3.14% and Short Term sickness at 2.32%. The main reasons for sickness absence are colds/flu. mental health conditions and gastro. We are taking appropriate management actions to reduce sickness in line with our revised absence policy and this remains a priority area for HR. The OH team are working closely with Taurus Healthcare and we have introduced the national Work Well programme which is aimed at supporting individuals stay in employment. We have also signed up for the Keep Britain Working programme to reduce sickness absence and support staff at work.

Staff turnover has dropped to 8.1 % and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill essential vacancies and maintain low staff turnover below 10% in order to reduce agency costs. Turnover for qualified nurses & midwives remains low at 6.11% and turnover for band 2/3 hcsw staff has reduced from a high of 20.34% (June 25) to 17.62%. We have restarted the centralised recruitment process and are running recruitment campaigns with the DWP to fill our vacancies. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments. Weekly drop-in recruitment screening sessions are also being facilitated by the HR department for support worker vacancies.

We are encouraging all line managers to complete the flexible online NHSE nurturing compassionate and inclusive cultures course as part of our EDI agenda. We supported the Holocaust Memorial Day and we will be supporting the LGBT+ month in February.

In support of our health and wellbeing programme for staff, we have submitted a bid to NHS charities seeking £50k to pilot an innovative programme for a clinician to support women's health at work working closely with OH, GPs and our consultants in obstetrics & gynaecology. We are also implementing actions from the new Men's Health Strategy for England launched in November.

On the 2025 NHS National Staff Survey, we had our highest response rate to-date of 46% and early indications are that we have made good progress in key areas of the survey. The national reports should be available by late February / March 2026.

Performance appraisals stands at 76.7% and this has been affected by winter pressures. WVT continues to perform well with mandatory training which now stands at 89.6%.

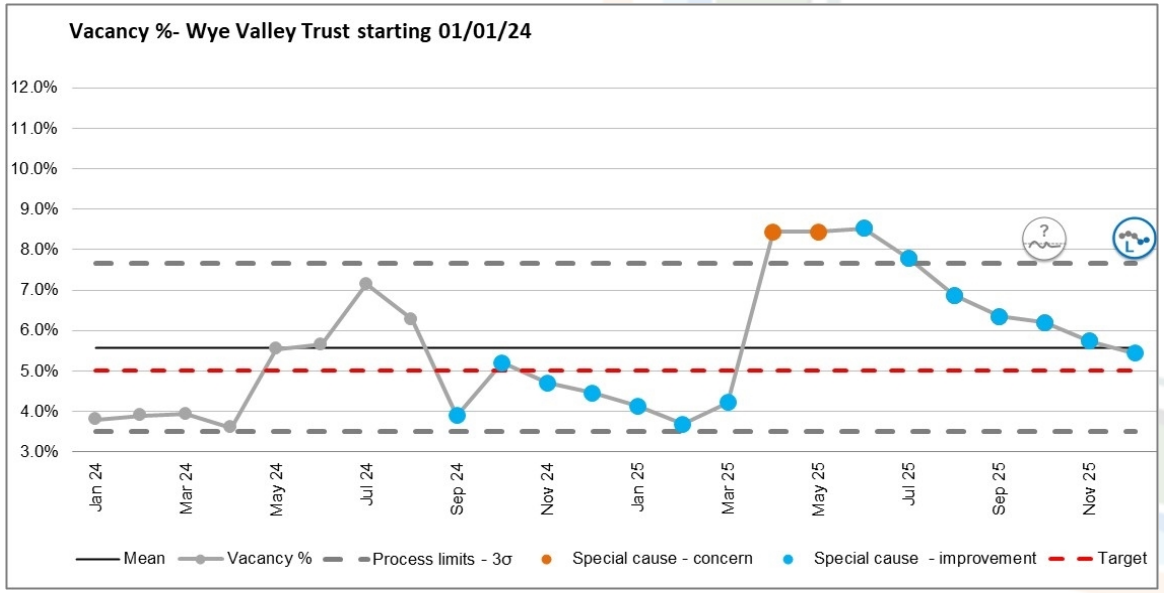
Workforce Performance – Vacancy

We are driving this measure because:

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

Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
4.5%	4.1%	3.7%	4.2%	8.4%	8.4%	8.5%	7.8%	6.9%	6.3%	6.2%	5.7%	5.4%

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



Performance & actions

HCSW – with 66.39 wte vacancies due to budget adjustments and turnover, we have re-introduced regular meetings with matrons and ward managers to ensure they support the centralised recruitment process. Active recruitment work continues with the DWP and recruitment drop-in sessions are ongoing at F Barnes. WVT recruitment open days will be held in Feb/March and social media is being used to promote career development pathways via apprenticeships.

N&M - we have low turnover and low vacancies for qualified nurses. We have suspended international recruitment for the foreseeable future.

CDC – recruitment activity is now closed and any future vacancies will be assessed by the WVT vacancy control panel.

M&D - we are working with over 70 agencies in view of filling our vacancies. Regular meetings with CMD, Medical Staffing Manager to review progress with vacancies and cases of concern. A project officer in medical HR is working with agencies in view of filling our vacancies. Overseas recruitment of medics where appropriate to continue over the coming year. We currently have 55.62wte vacancies on ESR.

HR continues to work closely with DWP officers in finding suitable job opportunities for unemployed people in Herefordshire. 48 WVT Ambassadors continue to support career events at schools, colleges and universities and we are engaging with the Hereford Youth Hub in finding work opportunities for young people.

Risks

Medical staff 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.

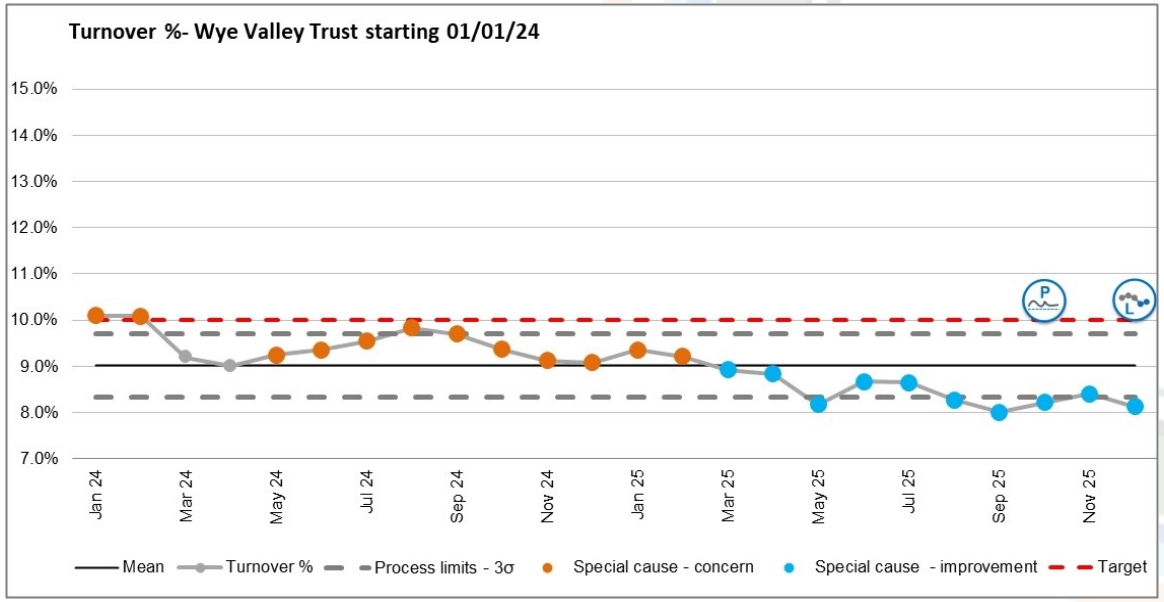
Workforce Performance – Turnover

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.

Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
9.1%	9.4%	9.2%	8.9%	8.8%	8.2%	8.7%	8.7%	8.3%	8.0%	8.2%	8.4%	8.1%

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



Performance & actions

Turnover at Trust level is at 8.1% and we are taking steps to retain essential clinical staff.

Clinical support workers at band 2 level have the highest turnover rate at the Trust (17.62%) and this is still the case across the NHS. We have reintroduced the centralised recruitment process and have pastoral care support and training for new starters. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships.

Turnover rates for qualified nurses remains low at 6.11% 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 support workers

What the chart tells us

The rolling 24-month position shows an overall decreasing trend. A fluctuating pattern in 25/26 but continuing with an overall decreasing trend.

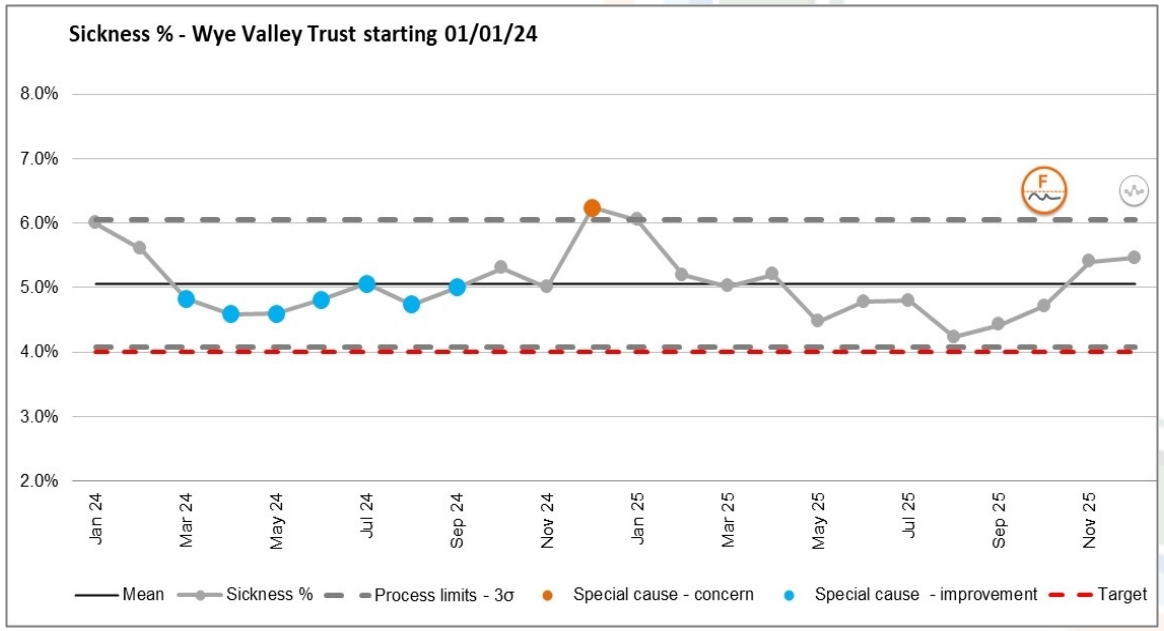
Workforce Performance – Sickness

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.

Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
6.2%	6.0%	5.2%	5.0%	5.2%	4.5%	4.8%	4.8%	4.2%	4.4%	4.7%	5.4%	5.5%

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



Performance & actions

During this month, sickness at Trust level stands at 5.5% compared to 6.2% (Dec 24). The main reasons for absence are colds/winter ailments, mental health issues and long-term 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 long- and short-term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team-based wellbeing support for staff. The 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 long-term sickness absence and short-term absence 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. We have also implemented Work Well at the Trust.

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 prewinter 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 4 months.

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 9 Income and Expenditure position

There has been an improvement in month of £0.5m, overall, we continue to perform better than plan YTD by £1.9m though the required run rate improvement over the remaining months remains a risk. The Trust set a breakeven plan for 2025/26, which includes a £25m CPIP challenge devolved to budget holders for delivery.

Agency spend in December was largely flat meaning 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 is near plan YTD, primarily through additional non recurrent benefits which does pose a risk into 2026/27. Continued focus remains on the rolling identification of opportunities and transition of these into fully developed schemes which have a positive and recurrent impact on the run rate. Substantive pay reported an overspend against plan in month though remains favourable YTD. We saw additional cost on bank in month due to the Industrial Action. Though elective activity levels were broadly in line with plan, overall contract income is behind plan driven by known timing issues and planned income and expenditure not yet realised. The forecast position has been reviewed across income, expenditure and efficiencies to understand remaining risk to delivery, and mitigating actions. Risks to delivery include:

- NHS England and NHS Wales are yet to conclude on the dispute around parity of funding with English commissioners in relation to population-based items (£13m across 24/25 and 25/26). Whilst we continue to escalate this through a variety of routes, we are assuming this will ultimately be paid.
- Our income plan includes £25.9m of deficit support funding (DSF). This is dependent on all parties in the ICS remaining on plan and is assessed quarterly by NHSE. At the end of Q3 NHSE assessed the ICS was not on plan and there was a high risk to full system plan delivery. Access to DSF in Q4 (£6.475m) is currently on hold pending re-assessment in February 2026.
- Identification and delivery of efficiencies to mitigate shortfalls in the increased step up required in the last quarter, and impact to exit run rate.

The well-established Financial Recovery Board (FRB) remains in place and will continue to maintain strong oversight of the risks and mitigations to support delivery of the plan and improvement in our underlying position, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability.

Cash and Capital

Cash balances at the end of December are lower than planned and have reduced in month. The balance remains at a satisfactory level. The risks above (Welsh parity, full achievement of CPIP and withholding of Q4 DSF) 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

The Trust successfully submitted the initial 2-year activity, finance and workforce plans in line with the December deadline. At this stage the financial plan is non-compliant as it does not reflect a balanced position. Further work is underway to develop a comprehensive and fully worked up final plan for submission in mid-February.

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 9 - 31st December 2025 - 2025/26

	2025-26 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Operating income from patient care activities	358,564	268,638	267,634	(1,004)	1,439
Drugs Excluded	26,098	19,574	20,129	555	17
Other operating income	16,833	12,579	13,008	429	99
Donations from non current asets	240	87	857	770	(20)
Total Operating Income	**401,735**	**300,879**	**301,627**	**749**	**1,535**
Substantive Pay	(221,590)	(166,939)	(166,756)	182	(451)
Bank & WLI Pay	(16,123)	(12,419)	(13,574)	(1,155)	(223)
Agency pay	(8,046)	(6,720)	(6,123)	597	43
Subtotal Pay	***(245,759)***	***(186,077)***	***(186,453)***	***(375)***	***(631)***
Non Pay Expenditure	(101,802)	(77,221)	(75,780)	1,441	4
Excluded Drugs	(25,795)	(19,346)	(20,292)	(946)	(749)
Total Operating Expenditure	**(373,356)**	**(282,644)**	**(282,525)**	**119**	**(1,376)**
EBITDA	**28,380**	**18,234**	**19,102**	**868**	**159**
Depreciation	(13,414)	(10,062)	(9,362)	700	59
Impairment (CDC & PFI)	(4,584)	(4,584)	3,712	8,296	0
Interest Receivable	527	395	1,477	1,082	104
Interest Payable on Loans	(180)	(135)	(120)	15	2
Interest Payable on PFI	(2,944)	(2,533)	(2,818)	(284)	0
Dividends on PDC	(4,296)	(3,222)	(3,096)	126	126
Operating Surplus/ (Deficit)	**3,489**	**(1,899)**	**8,895**	**10,802**	**449**
Technical Adjustments					
Donated Assets Adjustment	536	495	(271)	(766)	17
Net impact of asset impairments	4,584	4,584	(3,712)	(8,296)	0
Impact of IFRS16 Implementation of PFI Contract	(8,609)	(5,916)	(5,742)	174	13
Adj. financial performance retained Surplus/ (Deficit)	**0**	**(2,733)**	**(829)**	**1,915**	**480**

Performance & actions

The position at the end of Month 9 (December) was a deficit of £829k YTD. This is performing better than plan with an overall positive variance of £1,915k YTD.

- Income shows a favourable variance of £749k. Excluding the donated asset adjustment this is (£21k) below 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 offset by £900k of IA income from NHSE. Excluded drugs is overachieving YTD by £555k due to the increased cost of buying in drugs.
- Pay is adverse by (£375k) at month 9. The net position in month includes agency - 2.58% of total pay costs in month which is a small decrease from 2.63% in month 8. Bank use further increases the total temporary staff proportion to 8.60% of overall pay, including costs for a Critical Incident in Month 1, Industrial Action costs in Month 4, 8 and 9, and urgent & emergency demand related spend. Nurse agency usage has remained low, with zero spend on Healthcare Support Worker agency since Month 5.
- Total Non Pay (operating & non operating) is favourable by £1.5m 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, and a timing variance of £126k in PDC Dividends. 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 £174k favourable 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)
- Income risk around deficit support funding and Welsh parity
- Future cost pressures: e.g. Winter impact on financial performance
- Marginal Cost of delivering activity

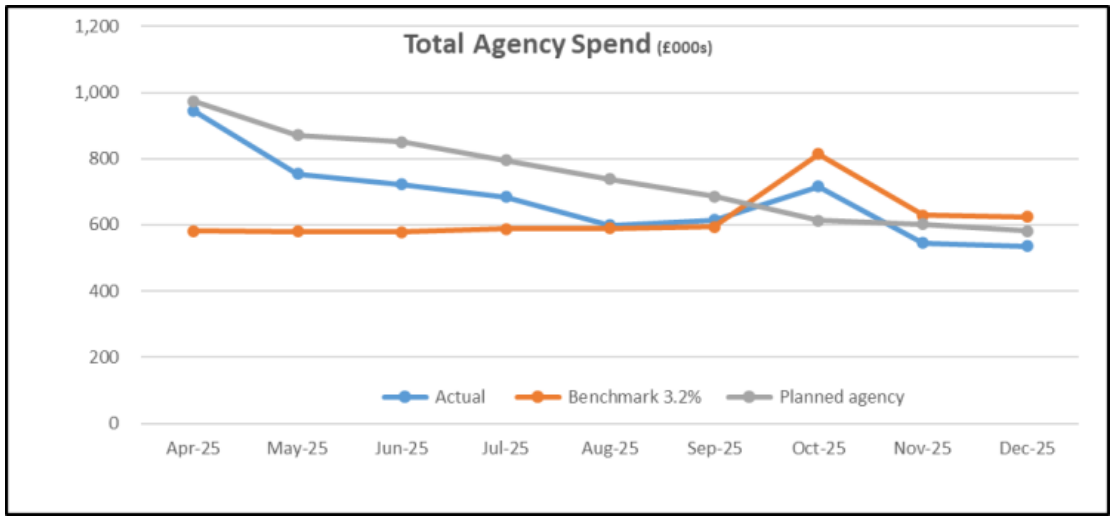
What the chart tells us

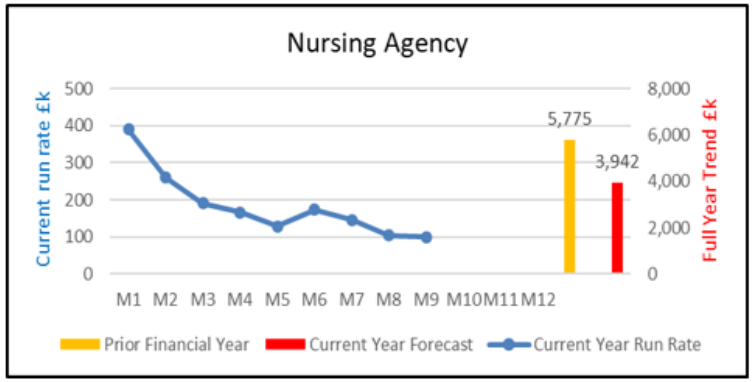
There are no material variances this month, outside of IA funding though the plan includes a number of known financial risks.

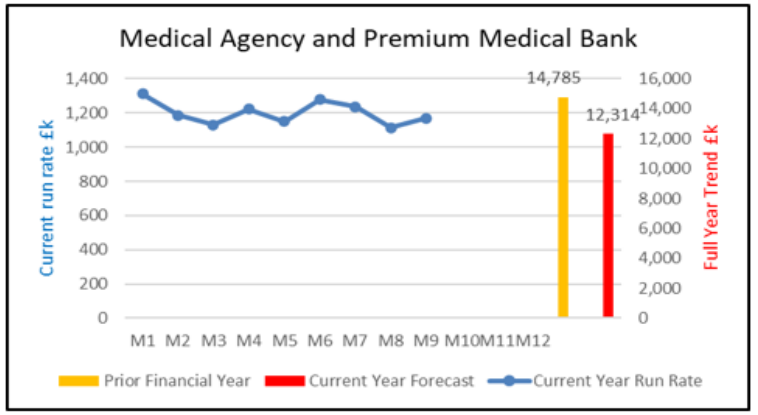
Finance Performance – Agency Spend

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 3.28% of total pay costs year to date. The Trust is now only 0.08% above the national target of 3.2% evidencing the commitment to sustainable temporary workforce reduction. Agency performance is currently better than plan YTD by £597k. Total agency spend year to date (excluding premium cost medical bank) is £6.1m.

- **Nursing agency:** Total spend in 2024/25 was £5.8m, which will be significantly reduced in 2025/26 through efficiencies. Rate reduction changes have significantly reduced agency costs over the last 12 months and the elimination of HCSW agency spend had been achieved from M4 (with a small spend in M5). The cost for nurse agency spend in December was £100k down from £104k in M8.

- **Off framework Nurse Agency:** There has been 4 off framework shifts in December compared to 1 in November (32 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 M9 is £1,169k, a small increase from £1,115k in M8. Industrial action happened in M4, M8 and M9..

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

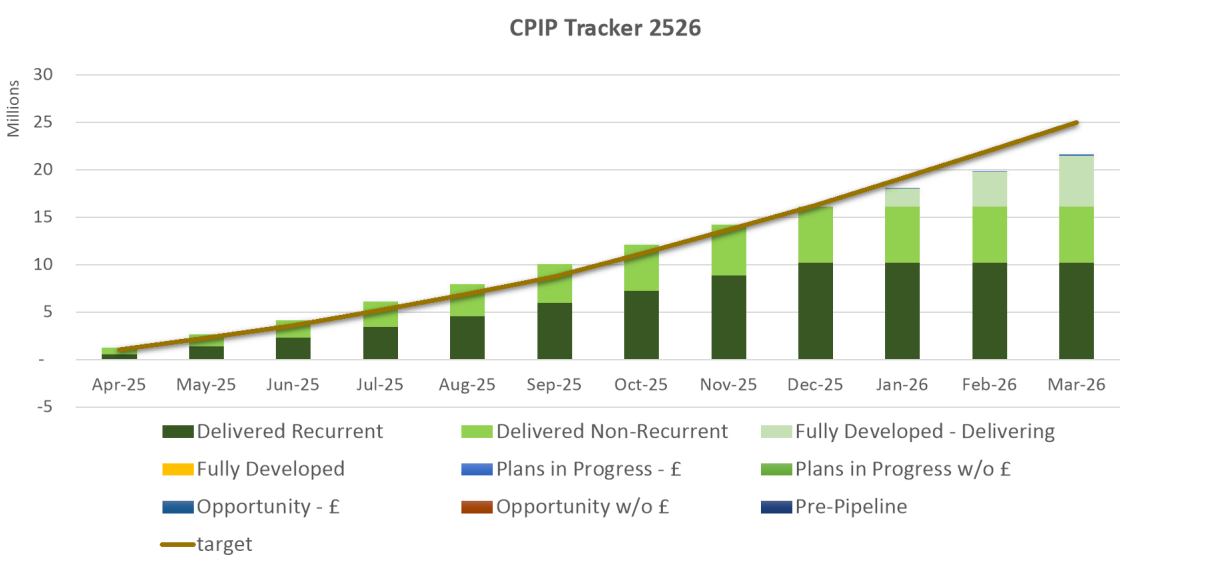
What the charts tell us

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 planned 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 £16.3m with a Trust delivery of £16.2m resulting in a £0.1m under-performance to plan. This does include £10.2m 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 Month 7 - 9, 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.

It is expected recurrent delivery will fall short of the £17.35m target by around £2m, which will rely on non recurrent solutions to fill the gap.

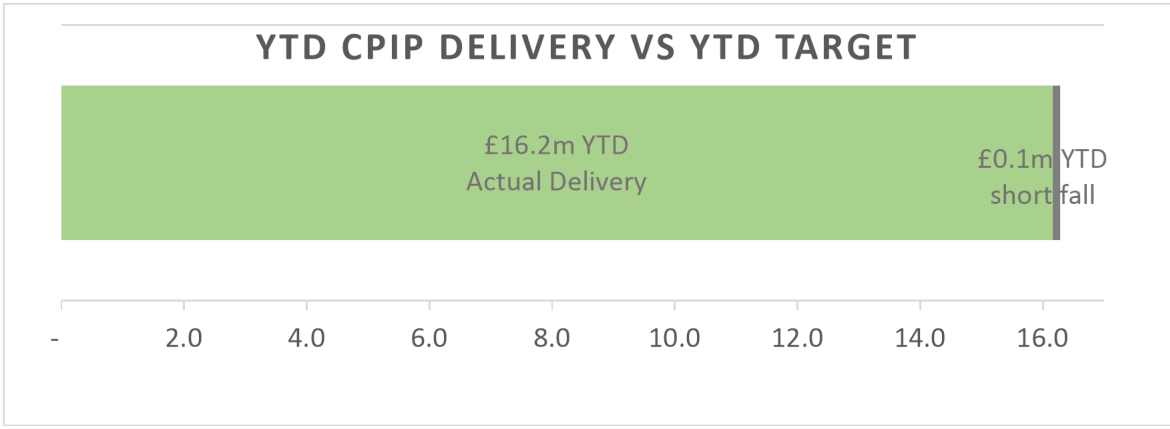
The FRB continues to focus on furthering identification and delivery of CPIP in order to achieve our breakeven plan. As part of the FRB, monthly Check and Challenge meetings with Divisions continue to place to specifically focus on identification and delivery of savings schemes. Schemes have progressed, 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 will impact 2026/27 requirement

What the charts tell us

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



Finance Performance – Cash and Capital

We are driving this measure because:

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

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

Cash

Cash Balance				
Month	Performance	Target	Direction	Rating
October	32.0	29.7		
November	30.2	36.3		
December	29.7	42.4		
Cash balances are £13m lower than plan, mainly due to increased debtors for Welsh parity of funding.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
October	99.3%	95.0%		
November	98.9%	95.0%		
December	99.4%	95.0%		
In December the Trust paid 98.9% of invoices within 30 days. This equates to 99.9% by invoice value. This is the twenty fourth month, in a row, that we have achieved the 95% (by volume) target.				

Capital

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month Budget £k	Year to Date - Month Actual £k	Year to Date - Month Variance £k	Full Year Forecast £k	Full Year Variance £k
Local CDEL funded	Owned	2,798	1,561	1,542	19	5,536	(2,738)
IFRS16 Leases	Leased	2,460	341	0	341	1,323	1,137
National PDC schemes	Owned	10,539	3,655	2,865	790	8,439	2,100
Grant funded and Donated	Owned	5,253	3,840	2,572	1,268	5,253	1
Total Capital Programme		21,050	9,397	6,979	2,418	20,550	500

What the charts tells us

Cash
Cash balances are £13m lower than plan, mainly due to increased debtors for Welsh parity of funding.

Capital
Locally funded capital (including IFRS16 leases) has increased by £1.6m to reflect an additional allocation. An underspend of £2.1m against nationally funded schemes has now been recognised.

Performance & actions

Cash
Performance is expected to remain below plan for the rest of the year. The main drivers are increased debtors for Welsh Parity dispute (with the national team) and withholding of Q4 national deficit support due to overall system performance. Both the working balances and overall cash positon continue to be closely managed.

Capital
Actions are being undertaken through CPEC identify expenditure to utilise slippage giving priority to expenditure that can be brought forward from 2026/27.

Risks

Cash
There remains 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. The Trust has had confirmation that the risk of access to Deficit Support funding in quarter 4 will now materialise in the form of reduced receipts in February and March.

Capital
Management of the local CDEL allocation remains a risk.

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.

December 2025	2024/25	2025/26			2025/26 Full Year		
	Accounts £000s	M9 Plan £000s	M9 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	159,386	166,871	165,088	(1,783)	175,402	175,196	(206)
Intangible Assets	11,572	9,466	7,410	(2,056)	8,766	8,766	0
Trade and Other Receivables	429	429	1,199	770	429	1,197	768
TOTAL Non Current Assets	**171,387**	**176,766**	**173,697**	**(3,069)**	**184,597**	**185,159**	**562**
CURRENT ASSETS:							
Inventories	5,087	5,087	5,542	455	5,087	5,087	0
Trade and Other Receivables	24,244	20,491	34,378	13,887	19,231	41,212	21,981
Cash and Cash Equivalents	37,906	42,376	29,711	(12,665)	45,995	24,103	(21,892)
TOTAL Current Assets	**67,237**	**67,954**	**69,631**	**1,677**	**70,313**	**70,402**	**89**
TOTAL ASSETS	**238,624**	**244,719**	**243,328**	**(1,391)**	**254,910**	**255,561**	**651**
CURRENT LIABILITIES							
Trade and other payables	(37,582)	(38,656)	(39,706)	(1,050)	(37,582)	(37,612)	(30)
Borrowings - Loans, PFI and Finance Leases	(15,067)	(15,067)	(14,493)	574	(15,067)	(15,067)	0
Provisions	(49)	(49)	(46)	3	(49)	(49)	0
Total Current Liabilities	**(52,698)**	**(53,772)**	**(54,245)**	**(473)**	**(52,698)**	**(52,728)**	**(30)**
NET CURRENT ASSETS/(LIABILITIES)	**14,539**	**14,182**	**15,386**	**1,204**	**17,615**	**17,674**	**59**
TOTAL ASSETS LESS CURRENT LIABILITIES	**185,926**	**190,947**	**189,083**	**(1,864)**	**202,212**	**202,833**	**621**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(40,822)	(32,028)	(32,831)	(803)	(28,985)	(28,985)	0
Provisions	(1,529)	(1,529)	(1,502)	27	(1,529)	(1,499)	30
Total Non-Current Liabilities	**(42,351)**	**(33,557)**	**(34,333)**	**(776)**	**(30,514)**	**(30,484)**	**30**
ASSETS LESS LIABILITIES	**143,575**	**157,390**	**154,750**	**(2,640)**	**171,698**	**172,349**	**651**
TAXPAYERS EQUITY							
Public dividend capital	325,841	331,088	327,916	(3,172)	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)	(201,875)	(190,369)	11,506	(196,486)	(184,692)	11,794
TOTAL	**143,575**	**157,390**	**154,750**	**(2,640)**	**171,698**	**172,349**	**651**

Performance & actions

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

Non-Current Assets
Non-Current assets are £3.0m lower than plan. This is mainly driven by the year-to-date underspend on capital (see capital section). Non-current debtors have increased due to reclassification of the debtor for the Gloucester radiotherapy building.

Working balances
Net working balances - receivables less payables - have increased by £12.8m compared to plan, mainly due to invoices to Powys for parity of funding and slower settling of invoices in neighbouring NHS Trusts. This has led to a corresponding cash balance decrease of c£12.7m 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
Capital PDC hasn't been drawn as early as planned. The revaluation reserve balances differ to plan due to the PFI revaluation impacting on the I&E reserve rather than the revaluation reserve.
The income and expenditure reserve balance for month 9 reflects the deficit for the year to date and differs slightly to plan due to timing issues at plan formulation

Risks

The level of risk included in the Income and Expenditure plan presents an ongoing risk to the strength of the SOFP, as does the higher than planned level of receivables at Month 9.

What the chart tells us

Current assets outweigh current liabilities.

NHS
Wye Valley
NHS Trust

Performance Against Target (Status)
- Meeting Target
- Not Meeting Target

Activity Performance Only
- Over 5% above Target
- 5% above to 2% below Target
- More than 2% below Target to 5% below Target
- Over 5% below Target

Type	Item	Description
Pass/Fail		The system is expected to consistently Fail the target
Pass/Fail		The system is expected to consistently Pass the target
Pass/Fail		The system may achieve or fail the target subject to random variation
Trend Variation		Special cause variation - cause for concern (indicator where HIGH is a concern)
Trend Variation		Special cause variation - cause for concern (indicator where LOW is a concern)
Trend Variation		Common cause variation
Trend Variation		Special cause variation - improvement (indicator where HIGH is GOOD)
Trend Variation		Special cause variation - improvement (indicator where LOW is GOOD)

Example

Data Quality Assurance Questions

		Overall KPI Rating Key
S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?	No Assurance
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?	Limited Assurance
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?	Reasonable Assurance
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?	Substantial Assurance

Quality of care, access and outcomes		Responsible Director	Standard	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date v Standard	Trend - Apr 2019 to date	Latest Available Monthly Position: WVT Latest month v benchmark	Latest Available Monthly Position: National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	80%	81.0%	78.3%	82.2%	84.2%	84.6%	84.2%		775	920	80.8%			76.5%	November			
	2 Week Wait all cancers	Chief Operating Officer	93%	72.3%	80.6%	81.5%	85.6%	92.3%	79.2%		734	927	82.2%			77.7%				
	Urgent referrals for breast symptoms	Chief Operating Officer	93%	16.7%	27.3%	18.8%	56.6%	75.0%	0.0%		0	11	22.9%			63.4%				
	Cancer 31 Days Combined	Chief Operating Officer	96%	82.9%	85.3%	85.0%	81.5%	93.7%	90.5%		143	158	86.8%			91.7%				
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Chief Operating Officer		8	9	3	7	6	5				55							
	Cancer 62 days Combined	Chief Operating Officer	75%	69.3%	69.7%	72.2%	72.3%	75.8%	82.3%		109	133	74.0%			75.7%	Nov			
	Cancer: number of cancer patients waiting over 62 days	Chief Operating Officer	Plan	66	50	74	58	67	32	56										
Primary care and community services	Community Service Contacts - Total	Chief Operating Officer	v 2023/24	117%	126%	120%	123%	140%	117%	131%	32141	24459	123%							
	Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	70%	85%	82%	88%	92%	89%	89%	93%	266	287	88.3%			85%	Nov			
	% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	88%	88%	88%	87%	87%	88%	88%	1576	1801	87.5%			92%	Nov to Oct			
Urgent and emergency care	A&E Activity	Chief Operating Officer	Plan	100%	100%	99%	101%	97%	97%	95%	6117	6445	98%							
	Ambulance handover within 30 minutes (WMAS Only)	Chief Operating Officer	98%	60.4%	69.6%	58.9%	50.9%	53.0%	61.7%	56.5%	834	1477				73%	July			
	Ambulance handover within 45 minutes (WMAS Only)	Chief Operating Officer	0%	26.6%	17.8%	28.7%	34.8%	34.4%	22.6%	30.7%	454	1477								
	Ambulance handover over 60 minutes (WMAS Only)	Chief Operating Officer	0%	18.9%	11.6%	21.4%	26.7%	28.1%	17.5%	24.8%	367	1477	23.8%			12%				
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	Plan	115%	124%	121%	125%	123%	122%	122%	1645	1350	121%							
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	45%	49%	47%	47%	49%	47%	50%	48%	1304	2743	47.9%			36%	Nov to Oct			
	A&E - % of patients seen within 4 hours	Chief Operating Officer	78%	65.2%	70.9%	67.2%	65.6%	66.7%	68.5%	65.2%	4591	7037	65.2%			74%	Dec			
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		11.6%	8.1%	10.9%	14.0%	13.3%	11.1%	11.5%	686	7037	11.8%			8%	Nov to Oct			
	A&E - Time to treatment	Chief Operating Officer		01:35	01:25	01:31	01:39	01:32	01:33	01:36						01:48				
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	<15 minutes	00:22	00:22	00:23	00:28	00:24	00:22	00:26						00:20				
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	0	234	182	207	283	272	178	202			760							
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	3%	9.4%	8.2%	8.0%	8.1%				107	5309	8.5%			10%	Nov to Oct			

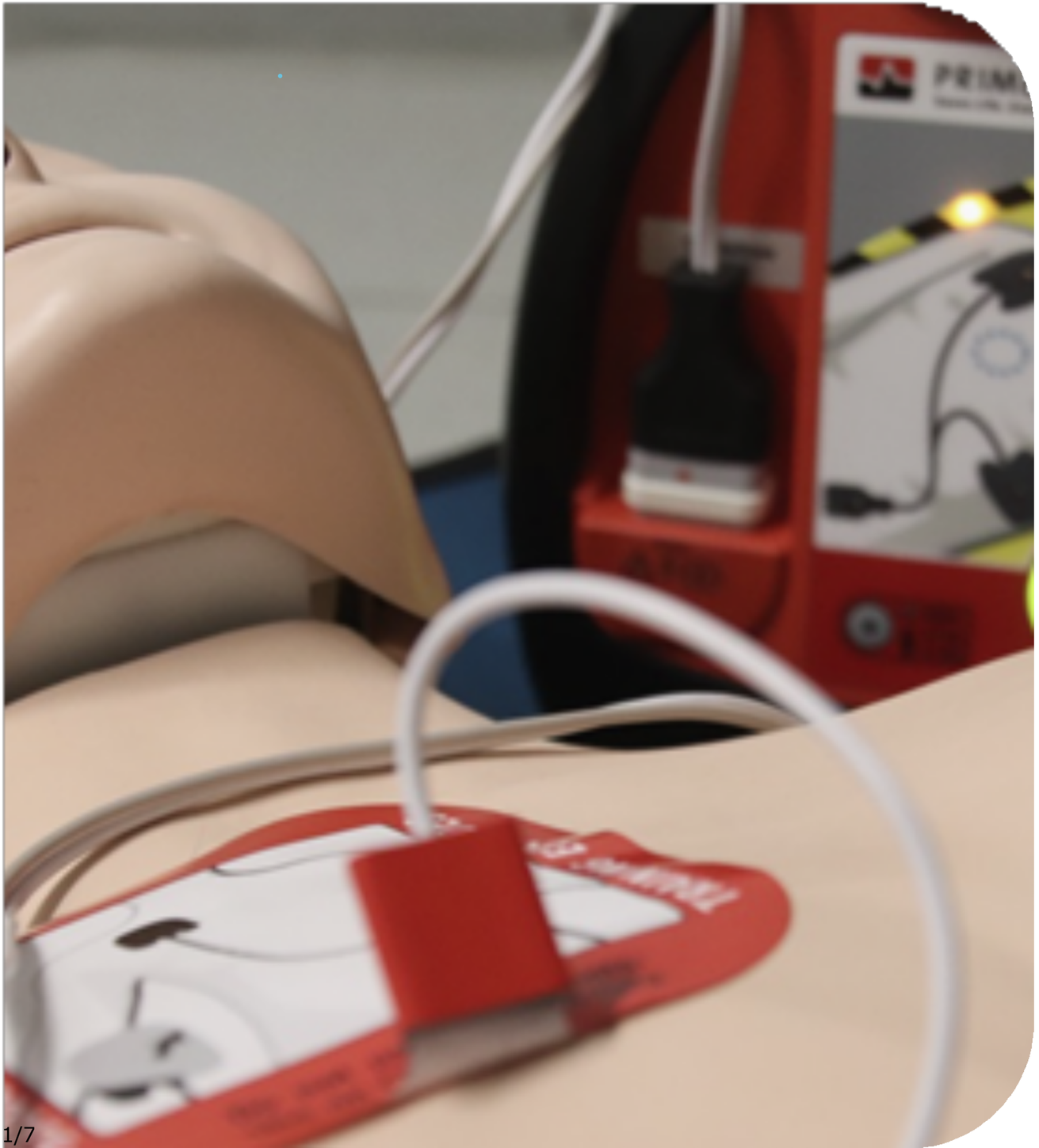
Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	**61%**	59.8%	61.4%	61.0%	62.7%	63.5%	63.9%	64.3%	13980	21753				61.8%	Nov			
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	**TBC**	70.1%	70.3%	68.8%	68.6%	67.7%	66.6%	64.7%	2855	4415								
	Referral to Treatment - Percentage of patients waiting no longer than 18 week for a first appointment - English Standard	Chief Operating Officer	**72%**	66.4%	66.8%	67.3%	68.4%	71.1%	72.5%	74.3%	8306	12925								
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		27296	27198	27294	27214	26991	26366	26168										
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	871	909	973	925	925	852	832						156483	November			
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	34	48	80	104	121	118	143						9521				
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	2	6	11	18	28	33	46						1500				
	GP Referrals	Chief Operating Officer	**2024/25**	102%	101%	98%	107%	98%	94%	110%	3736	3384	**100%**							
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	100%	100%	92%	102%	100%	101%	94%	5714	6094	**99%**							
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	108%	107%	100%	108%	106%	107%	99%	18416	18520	**106%**							
	Proportion of Total Outpatient Appointments which are New or Follow Up Procedure	Chief Operating Officer	**46%**	47%	47%	48%	47%	46%	46%	47%	11150	23917	47%			46.3%	Nov to Oct			
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	102%	100%	92%	101%	101%	105%	101%	3092	3060	**100%**							
	Elective Recovery Fund (ERF) Actual v Plan (£)	Chief Operating Officer	**Plan**	137%	129%	125%	143%	143%	138%	158%			135%							
	BADS Daycase rates	Chief Operating Officer	**Actual**	83.0%	83.6%	77.9%	84.8%						**82.8%**			79%	Oct to Sep			
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	81.6%	80.3%	83.6%	81.3%	81.5%	79.7%	83.3%			**81.7%**			81%	Nov			
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	**85%**	84.6%	85.2%	86.6%	83.9%	84.4%	81.2%	86.0%			**84.7%**			85%	Feb			
	Cancelled Operations on day of Surgery for non clinical reasons	Chief Operating Officer	**10 per month**	20	21	35	22	42	27	26			235			20189	Jul to Sep			
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	**Plan**	111%	109%	108%	79%	87%	85%	90%	3481	3856	**94%**							
	Diagnostic Activity - Endoscopy	Chief Operating Officer	**Plan**	89%	88%	135%	110%	100%	103%	126%	867	687	**103%**							
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	**Plan**	120%	99%	145%	78%	79%	75%	131%	1722	1316	**98%**							
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<5%**	26.2%	25.5%	26.5%	24.4%	13.8%	13.9%	15.7%	918	5837				21.7%	Nov			
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	98.0%	96.9%	94.8%	95.2%	99.2%	95.5%	93.9%	123	131	**96.6%**							
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Chief Medical Officer	**<15%**	19.8%	19.4%	15.2%	16.0%	19.0%	16.8%	19.2%	19	99	**19.2%**							
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Chief Medical Officer	**<34%**	62.1%	67.8%	69.2%	67.1%	67.1%	67.6%	67.6%	142	210	**67.6%**							
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Chief Medical Officer	**<60%**	87.7%	89.1%	89.5%	90.6%	92.6%	91.7%	91.3%	115	126	**91.3%**							
	Maternity Activity (Deliveries)	Chief Nursing Officer	**v 2024/25**	91%	102%	100%	93%	109%	91%	94%	121	129	96%							
	Midwife to birth ratio	Chief Nursing Officer	**1:26**	1:23	1:25	1:24	1:27	1:30	1:25											
Outpatient transformation	DNA Rate (Acute Clinics)	Chief Operating Officer	**<4%**	5.7%	5.7%	5.8%	5.8%	5.6%	6.0%	5.9%	1708	27462	**5.8%**			6.8%	Nov to Oct			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	89.0%	88.1%	88.8%	87.6%	87.8%	88.3%	85.7%	14426	16829	**88.0%**							
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	112%	110%	104%	111%	109%	110%	102%	12702	12426	**109%**							
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	20.3%	20.2%	20.5%	19.0%	19.8%	18.6%	21.4%	3936	18416	**19.8%**			18%	Nov to Oct			
Prevention long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer		7.4%	6.3%	4.3%	4.8%	8.1%	6.3%	4.6%	6	131								

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	100%	99%	98%	100%	100%	100%	98%	333	339	**99%**			94%	Dec			
	Bed occupancy - Community Wards	Chief Operating Officer	**<92%**	93%	97%	92%	98%	97%	98%	99%	82	83	**96%**							
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	146	105	46	119	100	100				**823**			4204	Nov			
	Patient ward moves emergency admissions (acute)	Chief Operating Officer	**4%**	6%	5%	6%	7%				79	1200	6%							
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	6.1	5.6	5.7	5.9	6.1	6.1	5.9	8274	1407	**6.0**			4.8	Nov to Oct			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	2.3	2.4	2.4	2.2	2.2	2.1	2.1	578	275	**2.2**			3.0	Nov to Oct			
	ALoS - General & Acute Adult (English)	Chief Operating Officer		5.5	5.1	5.0	5.2	5.3	5.1	5.1	7350	1448	5.3							
	ALoS - General & Acute Adult (Welsh)	Chief Operating Officer		5.9	5.5	6.4	6.5	6.4	7.1	6.4	1502	234	6.5							
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	17.5%	18.1%	16.7%	17.9%	17.7%	19.1%	16.8%	1567	9317				23.1%	Dec			
	Medically fit for discharge - Community	Chief Operating Officer	**10%**	39.3%	37.4%	39.6%	35.3%	37.7%	32.1%	32.4%	829	2560								
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	5.0%	5.3%	5.5%	4.7%	4.8%			182	3759	**4.9%**			8.3%	Oct to Sep			
	Mortality SHMI - Rolling 12 months	Chief Medical Officer	**<100**	111.9	113.3	115.0					1400	1220				100	Nov to Oct			
	Never Events	Chief Nursing Officer	**0**	0	1	0	0	1	1	0			**3**							
	MRSA Bacteraemia	Chief Nursing Officer	**0**	0	0	1	1	0	0	0			**3**							
	MSSA Bacteraemia	Chief Nursing Officer		1	2	0	2	2	1	2			**10**							
	Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	**44**	6	2	4	4	4	1	4			31							
	Number of falls with moderate harm and above	Chief Nursing Officer	**2022/23 (30)**	2	2	1	7	4	0	0			17							
	VTE Risk Assessments	Chief Medical Officer	**95%**	93.1%	90.6%	91.3%	93.4%	92.9%	92.5%	90.9%	3673	4042	**92.1%**							
	WHO Checklist	Chief Medical Officer	**100%**	99.4%			99.8%													
	% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	**60%**	71.7%	90.9%	85.7%	82.2%	37.9%	67.9%		11	29	**76.4%**							
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	75.0%	60.0%	70.0%	37.5%	50.0%	57.1%		4	7	**57.6%**							
	Stroke Indicator 80% patients = 90% stroke ward	Chief Medical Officer	**80%**	82.1%	92.0%	93.0%	76.8%	79.6%	87.0%		40	46	**83.6%**							
	Cleaning Standards: Acute (Very High Risk)	Chief Nursing Officer	**98%**	97.9%	97.7%	97.4%	97.5%	97.7%	97.8%	97.9%			**97.6%**							
	Cleaning Standards: Community (Very High Risk)	Chief Nursing Officer	**98%**	98.6%	99.2%	99.2%	98.5%	97.7%	98.4%	98.5%			**98.6%**							
	Number of complaints	Chief Nursing Officer	**2022/23 (253)**	29	34	26	35	30	40	34			314							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**90%**	56.3%	42.4%	44.4%	42.4%	51.6%	46.2%	52.3%	23	44	**49.5%**							

	Friends and Family Test - Response Rate (Community)	Chief Nursing Officer	**30%**							4	5023	**0.0%**							
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Chief Nursing Officer	**95%**		85%	85%	82%	81%	87%	83%					77%				
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Chief Nursing Officer	**95%**		90%	91%	94%	90%	92%	88%	169	192	**89.4%**		94%	October			
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Chief Nursing Officer	**95%**		81%	100%	100%	100%	94%	93%	14		**95.5%**		92%				
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**25%**		14%	13%	15%	15%	15%	15%									
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**		12%	13%	11%	13%	13%	12%	192	1623	**12.7%**						
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**		14%	14%	15%	12%	18%	14%	15	111	**15.7%**						

People		Responsible Director	Standard	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position WVT Latest month v benchmark	Latest Available Monthly Position National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6.4%**	3.5%	3.2%	2.9%	3.0%	3.5%	2.6%	2.6%			3%							
	Appraisals	Chief People Officer	**85%**	72.1%	75.2%	76.0%	77.3%	76.5%	76.7%	76.7%	0	0	**75%**			76%	2021/22			
	Mandatory Training	Chief People Officer	**85%**	89.6%	89.8%	90.4%	89.6%	89.7%	89.7%	89.6%	36911	41188	**90%**			88%				
	Overall Sickness	Chief People Officer	**4.0%**	4.8%	4.8%	4.2%	4.4%	4.7%	5.4%	5.5%	6390	117075	**5%**			5%	Aug			
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**10%**	8.7%	8.7%	8.3%	8.0%	8.2%	8.4%	8.1%	305	3757	**8%**							
	Clinical WTE Establishment	Chief People Officer		3169	3151	3161	3160	3165	3165	3164										
	Clinical WTE Actual	Chief People Officer		2855	2858	2894	2913	2908	2919	2926										
	Non-Clinical WTE Establishment	Chief People Officer		901	883	872	862	841	830	819										
	Non-Clinical WTE Actual	Chief People Officer		869	862	861	854	850	847	841										
	Frozen Posts (where no agency or bank is being used)	Chief People Officer																		
	Vacancy Rate	Chief People Officer	**5%**	8.5%	7.8%	6.9%	6.3%	6.2%	5.7%	5.4%	216	3983	**7%**							

Finance and Use of Resources		Responsible Director	Standard	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Latest Month Numerator	Latest Month Denominator	Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position WVT Latest month v benchmark	Latest Available Monthly Position National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	-£959	£223	-£209	-£503	£407	£1,333	£552			**-£829**							
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	-2.9%	0.7%	-0.6%	-1.5%	1.6%	1.6%	1.6%	£552	£34,604								
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	£31	£273	£653	-£22	-£289	£762	£477			**£1,905**							
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	3.1%	-546.0%	-75.8%	4.6%	-41.5%	133.5%	636.0%	£477	£75								
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	£157	£364	£110	£299	-£396	-£404	-£655			**-£125**							
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	£723	£685	£598	£616	£718	£547	£536			£6,124							
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	3.5%	3.2%	2.9%	2.9%	3.5%	2.6%	2.5%	£536	£21,100	3.3%							
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£199	£29	£56	£210	£170	£231	£278			**£292**							
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£30	£34	£31	£36	£32	£30	£30			£30							
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	94.4%	99.7%	97.9%	94.4%	99.8%	98.2%	99.4%	£10,222	£10,284	**98.8%**							
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	98.4%	98.7%	98.9%	98.4%	97.7%	98.9%	99.4%	£4,516	£4,545	**98.7%**							



NHS
Wye Valley
NHS Trust

Resuscitation Committee Report

Patient Safety Committee
December 2025

Rachel Jones
Practice Development Lead

Resuscitation Service Update

2.4wte staff members
supported by matrix working across
Education team and internal/external faculty

3 x WVT staff members supported to commence GIC course
to become internal faculty – further reducing single points of failure and upskilling workforce across the organisation
plan to support up to 5 more next year. In comparison only 1 staff member has been supported in the previous 5 years.

Education Clinicians Upskilled
7 members of Education team now competent to teach BLS
1 Education team member upskilled to join PILS Faulty

KPI's
0% sickness
100% appraisals
100% Mandatory Training

Development
B7 Resus Lead Development Post proving successful – completion and evaluation in March 2026
B6 Development meteoric – Within first 12 months has successfully completed GIC, ALS Instructor NLS and EPALS Instructor (given 6 yrs to complete) – focus now on consolidation

Regional and National Networking
Regular interaction at regional level and attendance at Annual RCUK Conference

AIM
Able to secure Educator to regularly support AIM programme – reducing temp staffing requirement

Course Offered	Hours training per session	2017	2024	2025	2026
BLS Adult (5 session/day)	1	47	35	38	36 (180)
BLS Induction (5 session/day)	1	N/A	22	24	24 (120)
BLS Induction HCSW (2 session/day)	1	N/A	N/A	24	24 (48)
BLS Paed (5 session/day)	1	12	7	8	6 (30)
BLS GPST (2 session/day)	1.5	N/A	11	14	14
BLS Maternal (2 session/day)	1	N/A	N/A	10	10 (20)
ILS Acute	7	12	21	24	28
ILS Acute Recert	3.5	N/A	23	29	58
ILS Community	7	12	12	12	N/A
ILS Community Recert	3.5	N/A	10	16	N/A
ILS/PILS Recert	7	N/A	13	13	17
PILS	7	4	13	17	16
PILS Recert	3.5	N/A	8	10	22
ALS	22	4	2	2	2
eALS	11	N/A	4	5	5
EPALS	22	2	3	3	3
NLS	10	4	4	5	4
Bespoke Training	1 – 3	N/A	N/A	10 (by Apr 2025)	10 planned so far
Total Courses		97	188	264	279 (677)

Productivity

- Upskilled Radiographers to ILS (from BLS) in view of CDC opening
- Upskilled Paeds Nurses in PBLS for covering Paeds ED
- Supporting Growth of Multi-professional Internal Faculty at all levels
- Increase in 'whole team' bespoke Updates – amazing feedback on this approach!

(i.e Gastro Team, Community Staff and CDC)

- BLS figures do not include use of Brayden

LEVEL 2: BLS COMPLIANCE
NOVEMBER 2024: 57%
NOVEMBER 2025: 67%

The brackets are the total sessions (i.e. BLS is 36 days x 5 sessions=180 total)

National Cardiac Arrest Audit

Summary of Key Indicators (Q1 2025–26)

Indicator	HCH Result	Expected / National	Comment
Cardiac arrest rate	0.60 / 1,000	National median ~0.7	Within expected range
ROSC >20 mins	88.9%	59.8%	Above expected
Survival to discharge	55.6%	33.6%	Above expected
Ward survival to discharge	0%	5.2%	Below expected (small n)
Witnessed arrests	100%	69%	Excellent
Capnography use	11%	37%	Below expected
Adrenaline use	22%	61%	Below expected
Data completeness	100%	100%	Excellent

Where we did well

- Excellent Survival and Recovery
- Fast Recognition and Response
- Good Care Planning
- Strong Aftercare
- Excellent Record Keeping

Areas to Improve

- 2 ward based cardiac arrests
- Medication during Resus attempts (ROSC achieved before useage)
- Early Defibrillation

National Cardiac Arrest Audit

At a Glance – Key Figures

Indicator	Q1 Result	Q2 Result
Cardiac arrest rate (per 1,000 admissions)	0.60	0.87
ROSC >20 mins	88.9%	61.5%
Survival to discharge	55.6%	46.2%
Ward survival to discharge	0%	0%
Witnessed arrests	100%	82.6%
Capnography use	11%	13%
Adrenaline use	22%	26%
Data completeness	100%	100%

Where we did well

- Survival remains well above national expectations in both quarters.
- ROSC (heartbeat restarted for >20 minutes) remained higher than expected nationally.
- High rate of witnessed arrests, indicating rapid staff response.
- Clear treatment plans in place for all patients before cardiac arrest.
- Excellent data completeness—every cardiac arrest was documented

Areas to Improve

- Cardiac arrest numbers increased in Quarter 2—this should be monitored.
- Ward outcomes remain low, although numbers are very small.
- Capnography use is significantly below national levels (Discussed poor documentation at DPC)
- Early defibrillation is limited—AED use could be improved on wards (>3mins)

Regional & National Initiatives

Digital Respect

- Phase 1 implementation due
- Safety, Access and IG concerns raised
- Awaiting feedback from National Team
- Internal plan to implement 2 x audits
  1) Quality
  2) Completion

Regional NLS Project

- Potential for regional funding to train up a bank of NLS Instructors
- Mutual Commitment across region
- Initial conversations to explore possibility but interested candidates at WVT

ATLS

- Interest from WVT colleagues
- Support offered from Merthyr and QE
- Observation completed by Resus Team
- Costing resources and scoping room availability and capacity

RCUK Conference

- Attendance at Conference from WVT
- Representatives from Resus Service, Maternity and SCBU
- CIP, productivity and efficiency ideas generated

NEW Resuscitation Guidelines launched at RCUK Conference end of November 2025

Changes to all courses to be implemented by January 2026

2026 plan:

- review Resuscitation Policy against new guidelines
- Review DNACPR Policy against new guidelines
- Re-assess Quality Standards against new guidelines

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	05/02/2026
Title of Report:	Midwifery and Neonatal Nurse Safe Staffing Report December 2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery, Director of Midwifery
Reporting Route:	Surgical Divisional Governance Quality Committee
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The purpose of this report is to provide assurance that midwifery and neonatal 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 staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of midwifery and neonatal staffing

Executive Director Opinion[1]

The report offers assurance to the Board that there are robust processes in place to monitor midwifery and neonatal staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur.

[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 in maternity 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.

Adherence to BAPM standards Nursing staffing standards is set by the British Association of Perinatal Medicine (BAPM) and these standards are endorsed by service specifications and national reports. The recommended minimum nurse: patient staffing ratios are 1:1 for intensive care, 1:2 for high dependency care and 1:4 for special care. Shift-by-shift cover must take account of these recommended minimum staffing levels based on an average unit occupancy of 80% (to allow for fluctuations in activity) and include a supernumerary shift coordinator and an appropriate skill mix to meet the care needs of the babies on the unit during each shift.

Adherence to BAPM standards is monitored by:

- Daily completion of safe staffing on BadgerNet (Morning and Evening)
- Monitoring nurse patient ratios as per BAPM Service and Quality standards for Provision of Neonatal Care in the UK.
- Representation/Attendance at MDT safety huddle 08:30 and 12:30
- Daily escalation depending on capacity and acuity - temporary bank and agency staff.
- Monitoring sickness and absence rates
- Monitor and review recruitment/vacancies.

The summary of the midwifery workforce KPIs are as follows:

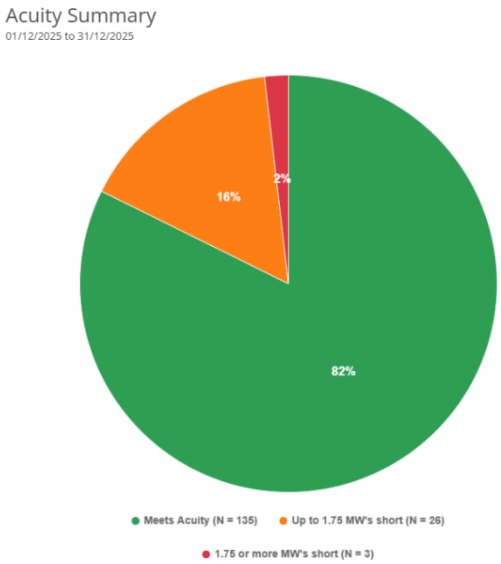
Metrics	Target	Current position (MW)	Current position (MSW/MCAs)
Sickness rate	4%	12.13%	4.34%
Turnover rate (rolling)	11.5%	n/a	n/a
Vacancy rate (MW)	7%	0.61%	0%
Maternity Leave	-	5.76WTE	2.15WTE
Midwife to birth ratio (in post)	1:24	1:24	
1:1 care in labour	100%	Achieved	
Shift leader SN	100%	Achieved	

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The diagram below presents when staffing met or did not meet the acuity. From the information available, the acuity was met in 82% of the time and recorded at 18% when the acuity was not met prior to any actions taken. Safe staffing levels were maintained on all shifts in December following mitigation.



*The % is rounded to nearest whole number

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=47) of when staff are reallocated from other areas of the inpatient service. The community teams were deployed to support the inpatient area on eleven occasions. There were two reports of staff not taking breaks and additional support provided by specialist midwives to maintain safe staffing levels. This is a considerable increase in the amount of staff deployment required to maintain safety across the inpatient area and likely driven by the increase in sickness absence in December.

Number of Management Actions
01/12/2025 to 31/12/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	47	59%
MA2	Redeploy from community	11	14%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	2	3%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	9	11%
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	10	13%
MA11	Maternity Unit on Divert	0	0%
TOTAL		79	

*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 10 delays in IOL care reported and one report of the Shift leader not being supernumerary during the shift however was initially rostered to be supernumerary.

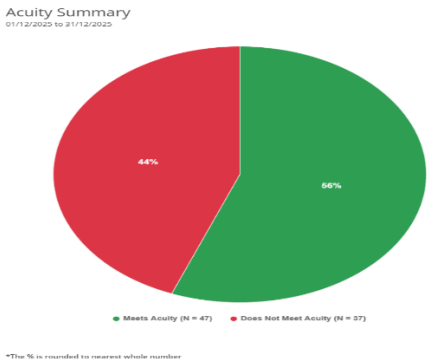
Number of Red Flags recorded
01/12/2025 to 31/12/2025

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	10	100%
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	0	0%
RF11	Suspension Home Birth Service	0	0%
TOTAL		10	

*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 56% of the time - this is a significant decreased from the previous month and is again likely to be driven by the increase in sickness absence.

Staffing incidents

There were three staffing incidents in December

1. Lack of available staff to provide 1:1 care
2. Lack of available staff impacting on IOL pathway (2)

Medication Incidents

There were no medication errors reported in December.

Monitoring the midwife to birth ratio

The ratio in December was 1:24. 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. Compliance with this is improving.

A regional OPEL SitRep is submitted daily and there is a plan to migrate to a national tool in February 2026.

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.

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Maternity Ward	71%	77%	67%	81%
Community Midwifery	n/a	n/a	n/a	n/a
SCBU	106%	111%		

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 - all posts offered in the most recent recruitment event.

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%.

Workforce – Neonatal

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

Neonatal Clinical Staffing – Budgeted v Contracted Establishment December 2025

Band	Budgeted WTE	Contracted WTE	Maternity Leave wte	Long Term Sickness wte	Gap +/-
Band 7	**2.0**	**2.0**	**0**	**0**	**0**
Band 6	**5.2**	**4.48**	**0**	**0**	**0**
Band 5	**13.5**	**11.82**	**1.0**	**2.1**	**-1.68**
Neonatal Outreach	**1.38**	**1.38**	**0**	**0**	**0**

BAPM Safe Staffing Standards (reported on BadgerNet) – December 2025:

	WVT Dec 25	Nat Av
% of shifts staffed to BAPM recommendations	100%%	85.6%
% of shifts QIS against Neonatal Toolkit standards	100%	94.98%
% of shifts with supernumerary shift lead	16.13%	24.89%
% of Nursing shifts covered by bank	1.95%	4.48%

- During December 2025 WVT SCBU was 100% compliant against BAPM staffing recommendations.
- We were 100% compliant in December for %QIS against Neonatal Toolkit

- We do not currently have an establishment to achieve a supernumerary shift leader on all shifts; this is currently recognised as an acceptable risk by the Trust for our capacity and acuity at WVT. Supernumerary shift lead is assessed daily against acuity and capacity and may be pulled into clinical numbers during a shift depending on acuity and capacity.
- We are below national average for number of shifts covered by bank, and this is lower than November when total bank and agency shifts covered was 3.96%. We continue to cover shifts with bank staff 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 which has helped to lower the bank/agency useage. This has been agreed as an acceptable mitigation by the WMPN

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 Reporting – December 2025

Daily Sit rep completed 7 days a week, only reported by Network Monday – Friday. Below summary is based on Monday – Friday for December 25. (NB Capacity Reports not shared during holiday period, OPEL Sit Rep continued to be submitted daily)

	OPEL 1 (Green)	OPEL 2 (Amber)	OPEL 3 (Red)	Opel 4 (Black)
Unit	100%	0	0	0
Staffing	80%	0	5%	15%

OPEL Report Summary – December 2025.

Staffing:

80% of shifts were OPEL 1 for staffing – with 2 staff members with neonatal specific qualification on duty.
5% of shifts were reported as OPEL 3 for staffing – with only 1 QIS rostered on duty and second QIS cover support facilitated through Senior Nurse(s) in office.
15% of shifts were reported as OPEL 4 (Black) for staffing – on further investigation two were incorrect data analysis reported on the Network report – these errors were escalated to Network and the report amended to reflect the correct QIS staffing. There was one other shift (Night 29/12) which was reported as Black on the daily submission of SIT REP form due to the Band 6 becoming unwell the previous night shift and unable to work the second night. This shift was covered later in the day with a 2nd QIS and therefore was Green by the time the shift started.

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 if 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.

Following the meeting with 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 always have a minimum of two registered nurses/midwives on duty, 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 always provided (some babies may require a higher staff-to-baby ratio for a period.
- 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 always provided (some babies may require a higher staff-to-baby ratio for a period).

QIS Trajectory October 25 – September 26 – Updated December 25

Octobe	Novembe	Decem	January	Februa	March	April	May	June	July	August	Septem
50.00%	44.00%	50.00%	48.00%	48.00%	48.00%	48.00%	55.00%	55.00%	58.00%	58.00%	58.00%

- There are currently 2 x Nurses completing the QIS course, one completing May 26 and one completing July 26. The above trajectory takes these two nurses into consideration.
- We have employed one additional staff nurse (Band 5) who will commence employment January 26, and has partially completed QIS training and will be supported to complete final module in September 26.
- A new Band 6 junior Sister will commence employment in January 26 and has a Neonatal Specific Qualification (QIS) this is reflected in the trajectory above.

4.6.4 **Sickness and Maternity Leave SCBU – December 2025.**

	November 25	**December 2025**
Sickness	7.59%	**8.78%**
Maternity Leave	1.0wte	**1.00wte**

- Sickness has increased from 7.59% in November to 8.78% in December. This is due to LT sickness and are being managed in line with the Trust sickness and Absence Policy.

Conclusion

To maintain midwifery safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts in November. The escalation policy was utilised on 47 occasions in the inpatient area. The community midwives were required to support the inpatient team on 11 occasions and specialist midwives were deployed to maintain safety.

There are two 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. Delays in the IOL pathway were noted.

Achieving the require compliance with QIS trained nurses remains challenging however there is a robust plan in place to address this – it is not possible to always maintain the supernumerary status of the shift leader in SCBU.

Sickness absence rates for midwives and neonatal nurses remains above the Trust target and are now expected to fall; 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 – successful recruitment.

Recommendations

The Committee is asked to note the content of this report for information and assurance.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	CNST Board Exception Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Justine Jeffery, Director of Midwife
Reporting Route:	Surgical Divisional Governance
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide the Board with an overview of performance against CNST Year 7 standards.

Recommended Actions required by Board or Committee

The Board is asked to note the current position 9/10 standards met and note that following further review of the evidence with the LMNS this position may change.

The return of the Board declaration is required by 12 noon on 3rd March 2026. Ongoing work between submission of this paper, LMNS review and external ODN feedback should have concluded by the time Board meets on 4th February. Given this the final position will be shared verbally at the Public Trust Board meeting on 4th February 2026.

Executive Director Opinion[1]

The report offers assurance to the Board that there is sufficient evidence to support compliance with 9/10 standards.

Our internal assessment is that we are confident we should be able to declare full compliance with all 10 standards.

[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

Maternity services are reporting to the Board the positon against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 7. The Board is asked to note progress against each of the 10 safety actions set out within the MIS standards.

A line by line review of the evidence has been undertaken with the Chief nursing officer to support the reporting of the current position and offer further assurance to the Board. The evidence will now be reviewed by the Local Maternity and Neonatal System (LMNS).

In order to comply with the scheme, and to be eligible for payment under the scheme, Trusts are required to submit their completed Board declaration form to NHSR by 12 noon on the 3rd March 2026. A quality assurance peer review will been undertaken by the LMNS and compliance against the standards confirmed. The Board declaration will then be prepared for sign off by the Trust Board and the AO at the ICB.

Issues and options

Safaty Action	External Validation	Summary of Evidence	Compliance Status	Oustanding actions
1	Yes - MBRRACE	PMRT is reported monthly/quarterly to Quality Committee and our position will be externally validated by MBRRACE	Compliant	None
2	Yes - NHS Digital	MSDS compliance summary shared with Quality Committee in Q3 report	Compliant	None
3	Yes - ODN	Quarterly transitional care audit reports have been shared with Quality Committee via the Safety report External validation is now required from the ODN	Partially compliant	Awaiting confirmation from the ODN that the additional information requested has provided the required level of assurance
4	Yes – action plans ODN	There are areas of non compliance within this standard but the MIS requirement to provide staffing updates against Board agreed action plans has been	Compliant	

		shared with Quality Committee in 2025.		
5.	No	The most recent Birthrate Plus audit was shared with Quality Committee in the October Safe staffing report. Monthly staffing is shared via the perinatal Safety report.	Compliant	
6.	Yes – LMNS/Region	Saving Babies Lives evidence is validated quarterly by the LMNS. It has been confirmed that compliance with the bundle has been achieved and this has been shared via monthly/quarterly safet reports with Quality Committee.	Compliant	
7.	No	Due to the challenges in recruiting MNVP members it has been recognised that compliance with this has been challenging. To mitigate this NHSR recommended that an action plan would be agreed with the LMNS and a risk would be placed on the Trust risk register. This was shared with Quality Committee in the last report.	Compliant	
8.	No	Training figures are shared with Quality Committee monthly/quarterly via the safety report. The training figures confirm compliance of 90% or above and was shared in the Q2 report.	Compliant	
9.	No	The Perinatal Surveillance Model	Compliant	

		requirements of monthly/quarterly reporting have been achieved via the submission of the PQSM and Safety reports to Quality Committee. It was agreed that this would be strengthened for 2026. Evidence is required that the Safety Champions have been active in terms of engagement with the Perinatal Leadership team and have had discussions around a number of items for example scoreclaims card, QI projects.		
10	Yes - NHSR	There were no MNSI reported cases during the notification period	Compliant	

Conclusion

There is good evidence to support compliance with 7 of the safety actions; current assessment is that there is sufficient evidence for standard 4 and 9 although overall a requirement to strengthen the administration of local meetings such as Safety Champions to ensure that the evidence required is more robust moving forwards. We await confirmation from the ODN with regards to Safety Action 3.

Recommendations

The Board is asked to note the current position 9/10 standards met and note that following further review of the evidence with the LMNS this position may change.

The return of the Board declaration is required by 12 noon on 3rd March 2026. Ongoing work between submission of this paper, LMNS review and external ODN feedback should have concluded by the time Board meets on 4th February. Given this, the final position will be shared verbally at the Public Trust Board meeting on 4th February 2026.

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	Resident Doctors 10-Point Plan (10PP)
Lead Executive Director:	**Chief Medical Officer**
Author:	Dr Jirayr Ajzajian, Dr Jayne Clarke & Dr Chizo Agwu
Reporting Route:	Public Board
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**
Brief Description of Report Purpose	
Provide Board assurance on delivery of the NHS England Resident Doctor 10 Point Plan Highlight key local achievements over 12 weeks Outline next steps and areas for continued focus	
Recommended Actions required by Board or Committee	
Note the contents of this report	
Executive Director Opinion[1]	
It is pleasing to note the 24% improvement in compliance over the 12 week period (from 65% to 89%).	

[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

Resident doctors form the backbone of the NHS workforce and are central to the delivery of safe, effective patient care. However, long-standing and avoidable issues relating to working conditions—such as payroll errors, rota management, access to rest facilities, and administrative burden during rotations—can adversely affect resident doctors' wellbeing, morale, and retention.

In August 2025, NHS England published the **10 Point Plan to Improve Resident Doctors' Working Lives**, with the explicit aim of addressing these fundamental issues and ensuring that basic employment standards are consistently met across all NHS organisations. The plan represents a focused, time-bound programme to "get the basics right" by setting clear expectations for trusts and introducing board-level accountability for the resident doctor experience.

The 10 Point Plan requires every NHS trust to take action across defined priority areas, including workplace wellbeing, rota and work schedule compliance, fair access to leave, elimination of payroll errors, reduction of unnecessary training duplication, and improved support during rotations. Central to the plan is the requirement for named executive and resident doctor leadership, routine monitoring, and formal reporting to trust boards.

This paper sets out the Trust's response to the NHS England Resident Doctors' 10 Point Plan, summarises current progress, highlights areas of risk and assurance, and outlines the actions required to ensure full compliance and sustained improvement in the working lives of resident doctors.

Summary of the NHS England Resident Doctors' 10 Point Plan

The 10 Point Plan requires NHS organisations to:

1. Improve the working environment and wellbeing of resident doctors, including access to rest facilities and basic amenities.
2. Provide work schedules and rotas in line with the resident doctors' rota code of practice, ensuring transparency and predictability.
3. Ensure fair and equitable access to annual leave, supporting wellbeing and work–life balance.
4. Appoint two named leads at trust level:
    - a senior executive responsible for resident doctor experience; and
    - a resident doctor peer lead,
      both reporting to the trust board.
5. Eliminate payroll errors associated with rotations, ensuring doctors are paid accurately and on time.
6. Prevent unnecessary repetition of statutory and mandatory training when doctors rotate between organisations.
7. Enable and encourage exception reporting to better identify and address work beyond contracted hours.
8. Ensure timely reimbursement of course-related and professional expenses.

9. Reduce the disruptive impact of rotations on resident doctors' personal and professional lives, while maintaining service delivery.
10. Minimise the administrative and practical burden of changing employers during rotations.

Current Trust Position

The Trust has made strong progress in implementing the NHS England Resident Doctors' 10 Point Plan, with overall compliance improving from 65% at baseline to 89% at the 12-week survey. This performance exceeds the Midlands average of 83% (see Figure 1) and demonstrates effective organisational focus and delivery within a short timeframe.

Governance and Accountability

Clear governance and accountability arrangements are in place, consistent with NHS England expectations for named leadership and board oversight:

- The Chief Medical Officer provides executive-level oversight of the resident doctor experience and compliance with the 10 Point Plan.
- A Resident Doctor Peer Lead, working closely with the Director of Medical Education, provides validation of reported compliance and supports assurance from a resident doctor perspective.

These arrangements support robust board reporting, transparency, and ongoing monitoring of progress.

Areas of Strong Performance

The Trust is performing particularly well in several areas that are recognised nationally as common drivers of dissatisfaction and escalation among resident doctors, including:

- Provision of hot and cold food 24/7
- Availability of appropriate rest facilities
- High-quality induction that meets the needs of resident doctors
- A positive and embedded exception reporting culture

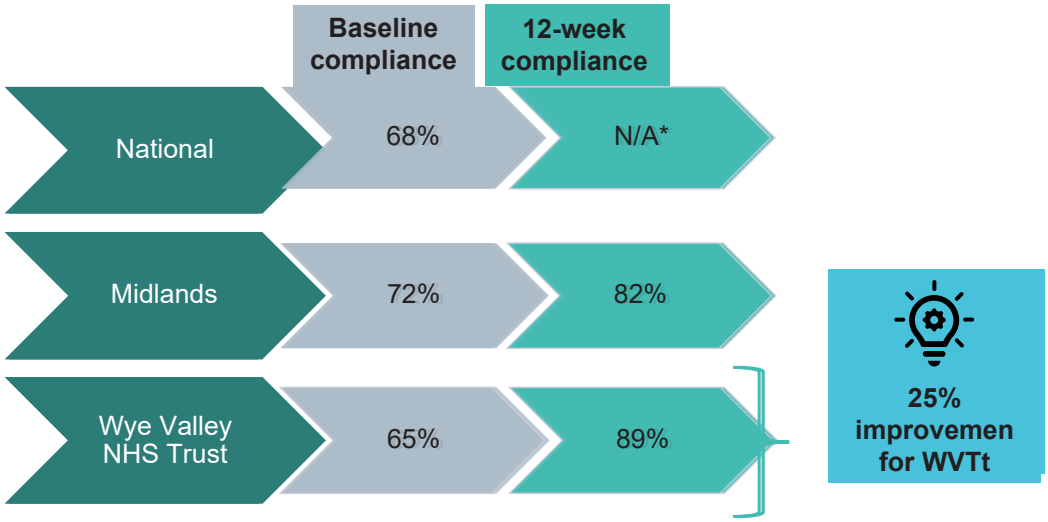
Performance in these areas reflects a strong focus on resident doctor wellbeing and supports both workforce retention and safe patient care.

Residual Operational Challenges

Some operational challenges remain and continue to require active management, notably:

a. Consistent access to lockers for all resident doctors
b. Self-rostering and ability to undertake self-development work from home requires more work to ensure we can offer this consistently.
c. Car parking constraints during core working hours. While mitigating actions are in place—such as adequate free parking availability out of hours—these issues require continued monitoring to ensure they do not undermine overall progress or resident doctor experience.

10-Point Plan (10PP) survey outcomes – an overview



*National comparison of compliance not undertaken at 12 weeks

Table 1

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: WYE VALLEY NHS TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, <50%
Rest facilities	Yes	Yes
Designated on-call parking access	No	Yes, >50%
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	No	Yes, <50%
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes, <50%	Yes
Protected breaks?	Yes, <50%	Yes, >50%
Do you promote the Safe Learning Environment Charter?	Yes, <50%	Yes
Sexual safety/harassment training and awareness?	Yes	Yes

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	No	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	No (consult with LNC/ equiv. bodies)	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	Executive Team	Executive Team
NETS survey	Executive Team	Executive Team
National Staff Survey		Executive Team
National Student Survey		None

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	No	Yes
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	No	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes	Yes
Changes in payroll errors over the last 12 months?	Decrease in errors	Decrease in errors
Processing of course related expenses?	After attendance, plan to change	After attendance, plan to change

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey | 89% | (Improvement of 25pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 11 December 2025
Report to: Trust Board

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Assurance Update: Pre-Operative Assessments**
Rating rationale	An internal audit of the pre-operative assessment process was reported in October 2024 (unrated) and highlighted several areas for improvement, with a focus on patient assessment processes and theatre utilisation. The report provided assurance that the majority of recommended actions had been implemented and enhanced processes were in place to embed and monitor improvements. Two actions were outstanding, with completion planned by the end of quarter 4.
Outcome	The Committee welcomed the progress demonstrated by the report. **Action**: Provide confirmation to the Committee when the final two recommended actions are complete.
Item/Topic	**Internal Audit: Community Services**
Rating rationale	The review was rated *Reasonable Assurance*, with five medium and four low propriety recommendations. The review was requested following significant investment in a number of schemes to improve admission avoidance and 'left shift' of care to the community. This included Call before Convey and Urgent Community Response Hubs. The main issue preventing a *substantial assurance* opinion was a lack of clear data to reinforce the soft intelligence regarding the positive impacts of the changes, including improved patient experience. The recommendations to strengthen the services related to policies and procedures, skill mix and training, access to equipment and accommodation. Management actions were planned to address all recommendations between January and the end of March 2026. The Committee encouraged a realistic approach to setting action deadlines.
Outcome	The Committee welcomed the helpful report in this critical area, which reinforced the importance of robust data to strengthen partnership working across the system. This would be particularly important as the Neighbourhood Health work progressed. **Action:** Remind management teams of the importance of meeting action deadlines and setting realistic timelines in response to internal audit reviews.
Item/Topic	**Internal Audit: Theatre Productivity and Utilisation**
Rating rationale	The review was rated *reasonable assurance* and noted a number of improvements since the previous review in 2019. Leadership and scheduling were particularly strong areas, with multi-speciality engagement. Opportunities for further improvement related to staffing issues, data validation and productivity. Ten recommendations were made, all with linked management actions agreed.
Outcome	The Committee welcomed the valuable report. **Action:** The Theatres Management Team to be invited to provide a progress update to the Committee in 6 months' time.
Item/Topic	**Financial Governance**
Rating rationale	• Payment to supplier to incorrect account The identification of this issue had led to the implementation of additional checks and balances. The majority of the payment had been recovered and receipt of the remainder was expected by the end of the month. • Losses and Special Payments – quarter 2 There had been a significant reduction in overall volume and value compared to the same period the previous year.
Outcome	The reports were accepted. **Action:** Provide losses and special payments trends over time in the next 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: 11 December 2025
Report to: Trust Board

Item/Topic	Job Planning Update
Rating rationale	89% of consultants now had signed off job plans for the rolling 12-month period. Those outstanding included newly recruited individuals and all were being followed up directly with the aim of achieving the target of 95%. All specialities now had embedded job planning after barriers in some areas were addressed. Due to improved job planning, Waiting List Initiative payments had reduced resulting in significant financial savings. The Committee commended the improvements, which enabled the next step of checks to ensure the job plans were being properly implemented. The Internal Audit follow up in this area was in progress.
Outcome	**Action**: Cross check gaps in job planning sign-off with gaps in declarations of interest to identify any overlap.

Assure: Including assurance items rated green	
Item/Topic	**Managing Conflicts of Interest Report**
Rating rationale	The report provided an update following the implementation of new processes to collate, record, monitor and manage staff declarations of interest. Compliance with the annual requirement for decision-making staff to submit a declaration was at 90.4%. The report also described processes to ensure compliance with the relevant counter fraud standard, including a new process to assess staff awareness of the policy and actions taken to improve awareness. The policy had been updated to reflect new NHS guidance and new internal processes and was presented to the Committee for approval. The Committee welcomed the improved process and high mandatory declaration return rate and requested an update on the process to check that actions to mitigate conflicts, particularly in relation to decision making.
Outcome	The Committee accepted the assurance provided by the report and approved the updated policy, for ratification by the Policy Review Group. **Action:** Provide an update at the next meeting on the process to check controls in place to manage actual or potential conflicts of interest.
Item/Topic	**Financial Recovery Board (FRB) Governance Review**
Rating rationale	A review had been undertaken of the Committee's work and compliance with its terms of reference in its first year of operation. This demonstrated full compliance, save in some areas where the terms of reference had now been amended to better reflect good governance and current practice. The Committee considered the extent to which the FRB had become a finance sub-committee of the Trust Board and accepted that this reflected a continued need for this level of scrutiny of the challenging financial plan delivery.
Outcome	The Committee was assured that the report demonstrated that FRB had effectively met its terms of reference in its first year of operation.
Item/Topic	**Board Assurance Framework (BAF)**
Rating rationale	The BAF had been aligned to the current strategic objectives and the relevant ICB objectives, and for each risk the link to Trust risks rated 'very high' on the risk register was described. The format focused on assurances – both local and independent – and actions linked to gaps in control. The Committee was assured that: • the format of the assurance framework was appropriate for the Trust • the way the framework was developed was robust and relevant • the objectives in the framework reflected the Trust's priorities • the key risks were identified and linked to the strategic objectives • the controls in place were sound • the assurances were reliable and of good quality, with all key sources identified • the underlying data on which assurances were based were reliable, accurate and timely • there was sufficient independent assurance over the more critical areas • there were actions in place to address gaps in control with appropriate timescales.
Outcome	The report was accepted. The BAF would be presented at each meeting going forward to provide contextual information in addition to assurance as above.

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: 11 December 2025
Report to: Trust Board

Item/Topic	Internal Audit Progress Report including Action Tracking
Rating rationale	Two reports had been finalised, three were in progress and two were planned to commence in quarter 4. The management action tracker demonstrated a generally good approach from management teams. Nine actions remained open with revised due dates, several relating to the DPST/CAF review that was in progress. Contextual information relating to each deferral provided reassurance that the issues were under control.
Outcome	The Committee was assured by progress, which was expected to ensure that the plan was complete by year end, and by oversight of management action implementation.
Item/Topic	**Local Counter Fraud Specialist Progress Report**
Rating rationale	Implementation was progressing according to the annual plan. Benchmarking showed the Trust's volumes of tender waivers were relatively low, with the main reason being single supplier, which was consistent with other organisations. Benchmarking also showed the Trust's mandatory declarations of interest compliance rate was relatively positive. Eight fraud referrals had been received in the reporting period, six of which remained under investigation. This increase in referrals was viewed as a positive reflection of staff awareness; however, it also highlighted the need for increased vigilance in areas such as email fraud. The Committee noted that last year's return rate on the counter fraud and bribery awareness survey was low and the Committee encouraged actions to improve the response this year.
Outcome	The report was accepted.

Items for Information or Approval	
Item/Topic	**Draft Internal Audit Plan 2026/27**
Comments	The plan would include three mandatory reviews that were core to the annual Head of Internal Audit Opinion: Board Assurance Framework, Cyber Assessment Framework and Key Financial Controls (specific area to be agreed). The Committee considered a long-list of other areas for review suggested by the executive directors.
Outcome	The Committee agreed support for the following areas in particular: • Complaints process • The patient pathway across providers, linked to the Neighbourhood Health work • Better Care Fund The Committee encouraged the Executive to take opportunities for shared reviews with the ICB. The comments would be incorporated into further development of the plan for approval at the next meeting.
Item/Topic	**External audit**
Comments	A new external audit partner had been appointed to lead the Trust's Audit. A detailed review of the draft audit plan was in progress ahead of presentation at the next meeting.
Outcome	Noted

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

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	**Quality Committee October 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, October 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 – Timely VTE Risk Assessments** – Overall performance remains at around 90% compared to the target of 95%. This is consistent with the national trend but a maxims upgrade is expected to help improve compliance. However the rate of hospital-acquired VTE has continued to reduce in-year, signalling reduced harm to patients, and is now the lowest in the Foundation Group.
2. **Quality Priority – Transition of Care** – the development of a transition "passport" has continued. This is intended to provide comprehensive information to support the transfer of care from children's to adults services. Work is also needed with adults services across the Trust to raise awareness and understanding. Committee emphasised the importance of coproduction with service users and families
3. **Quality Priority – Growing our Volunteer Workforce** – Committee commended the work since April to grow and to extend the range of support being provided by volunteers while noting the scope of further opportunities to bring us into line with other Trusts in the Foundation group.
4. **Quality Impact Assessments (QIAs)** – new national guidance for QIA's was published in June and in being used to review how we can strengthen our approach at WVT. A new reporting template supported by training is proposed. Committee stressed the importance of using the process to support quality improvement and outcomes.
5. **Mortality Report** – The headline SHMI remains above where it should be but the figure remains subject to uncertainty due to the ongoing work to clear the coding backlog. To provide an alternative measure of assurance Committee welcomed the evidence from actual deaths which showed reductions in most areas except for fractured neck of femur which remains the main area of focus and review and Committee will receive further updates.
6. **Safeguarding Quarterly Reports –** The Adult safeguarding Report highlighted the progress and continuing challenges associated with Deprivation of Liberty Safeguards and Mental Capacity Assessments with further training and awareness-raising and the outstanding audit work to commence in November. Children's Safeguarding report again highlighted concerns regarding ED attendances related to drug and alcohol use which are being discussed with wider children's services and with public health. For Looked After Children there have been improvements in initial health assessments and in access to dental care. More generally, concerns were expressed about increased numbers of children being received into care and in the number subject to child-protection plans – both of which need to be better understood.
7. **Staffing Report** – The general picture remains positive with agency use and sickness reducing. Of concern was the level of HCA vacancies and Committee asked for a deep dive in the next report.
8. **Divisional Quarterly Report – Surgery Division** – Committee acknowledged the significant improvements to support resilience in Community Paediatric services. Of concern was the fragility of breast services and capacity in Radiology.
9. **Divisional Quarterly Report – Integrated Care Division** – Committee noted the improvements in Leadership at Ross Hospital with acknowledgement of wider improvements from staff and visitors and through PLACE audits. Pressure Ulcers remain the main area of concern particularly in community nursing teams. .
10. **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 30th October 2025 at 1300 - 1600.

MS TEAMS

Present:		
Frances Martin	FM	Non-Executive Director (Chair)
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Eleanor Bulmer	EB	Non-Executive Director
Lynn Carpenter	LC	Quality and Safety Matron
Sharon Hill	SH	Non-Executive Director
Kieran Lappin	KL	Associate Non-Executive Director
Grace Quantock	GQ	Non-Executive Director
In Attendance:		
Hemantha Belehithlu	EB	Consultant Paediatrican (for item 5)
Jonathan Boulter	JB	Associate Chief Operating Officer Surgical Division
Hannah Duggan	HD	General Manager Women's and Children's (for item 5)
Kirstie Gardner	KG	Named Nurse Children in Care (for item 9)
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Helen Harris	HH	ICB Representative
Leah Hughes	LH	Operational Clinical Lead Radiographer, Clinical Support Division
Susan Hughes	SH	Deputy Director of Midwifery
Justine Jeffery	JJ	Director of Midwifery
Hamza Katali	HK	Associate Chief Medical Officer, Obstetrics and Gynaecology
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Tom Morgan-Jones	TMJ	Deputy Chief Medical Officer
Rachel Murray	RM	Clinical Quality and Improvement and CQUIN Manager (for item 7)
Nicola Read	NR	Voluntary Services Manager (for item 6)
Vicky Roberts	VR	Executive Assistant (for the minutes)
Caron Shelley	CS	Named Nurse Safeguarding Children (for item 9)
Emma Wales	EW	Associate Chief Medical Officer Medical Division
Gemma Woodford	GW	Lead for Domestic Abuse (for item 9)
Apologies:		
Rachael Hebbert	RH	Associate Director of Nursing
Jo Rouse	JR	Associate Non-Executive Director
Ian James	IJ	Non-Executive Director
Natasha Owen	NO	Associate Director Quality Governance
Hayley Pearson	HP	Clinical Director Pharmacy
Sarah Shingler	SS	Managing Director
Emma Smith	ES	Deputy Chief Nursing Officer
Nicola Twigg	NT	Non-Executive Director

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**FM**	**Information**	**Verbal**
Noted as above				
2.	**Declarations of interest**	**FM**	**Information**	**Verbal**
There were no new declarations.				
3.	**Minutes of meeting 25th September 2025**	**FM**	**Approval**	**Enclosure 3**
The minutes were 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.				

Midwifery – single point of failure. JJ – when first into post single point failure Safeguarding named midwife. When not around. Process in place with others to cover. In future planning to fund from unspent Ockenden monies, a specialist midwife for vulnerable women to work 3 days per week, under the guidance of named midwife. Also, some succession planning in place. Funds on annual basis will be added on to bottom line. LF – M&B forms sign off by safeguarding midwife - ssue now resolved with additional signatories in place.

4.	**BUSINESS SECTION**			
4.1	**Quality Priority Ensure patients receive a timely VTE risk assessment in with NICE guidelines**	**TMJ**	**Discussion**	**Enclosure 4**

Overall performance remains static, at around the 90% nationally. This is not unique to Wye Valley but reflects a broader trend across the UK. However, the Maxim's EPMA upgrade scheduled for 25th November, which will enforce VTE assessments as a prerequisite for prescribing post-admission and should help to improve compliance. To support this rollout, clinical teams are being provided with user guides, refresher training, and ward-based support during the implementation week.

The data showed a sustained reduction in hospital-acquired VTE rates at Wye Valley, continuing the positive trend observed in 2024. The Trust now has the lowest rate of hospital-acquired VTE within the foundation group, this is likely due to better awareness, improved prescribing practices, and enhanced data quality.

The Chair expressed optimism about the EPMA upgrade's potential to improve compliance and reduce harm. TMJ added is confident that improvements will be made following the software upgrade. There has been a lot of work on data quality and anomalies in maternity and front-door reporting have been identified and are being addressed.

CA added that while the Trust still struggles to reach the 95% target for VTE assessments, the reversal in hospital-acquired VTE rates compared to peers is a significant success. She emphasised that the Trust has moved from being worse than peers to outperforming them in terms of patient harm reduction.

LF raised a point about legacy incidents referenced in the report. Recalling a previous decision to draw a line under very historic cases due to limited value in pursuing them. TMJ confirmed that from next week, the Trust would be transitioning to a new process for handling legacy incidents. Common errors have been categorised and are developing targeted workstreams to address them.

The Committee also acknowledged that the new 12-hour assessment rule from NICE may initially cause a drop in reported performance. Despite this, the focus remains on reducing actual harm rather than simply meeting compliance targets.

5.	**Quality Priority Transition of Care**	**HB**	**Discussion**	**Enclosure 5**

The Trust's quality priority focused on improving the transition of care for children and young people with chronic medical conditions as they move from paediatric to adult services. The primary aim is to ensure that these transitions are safe, coordinated, and person-centred, involving all relevant stakeholders including adult services, community providers, mental health services, and primary care.

A central component of the initiative is the development of a Transition Passport, a document designed to capture essential medical information, specific needs, such as learning difficulties or safeguarding concerns, and details of professionals involved in the young person's care. This passport is intended to support continuity and clarity when young people present to emergency or inpatient services, especially when their conditions are complex or managed externally.

The document has undergone extensive feedback from paediatric colleagues and some adult clinicians, though engagement from adult services remains limited. There is some concern about the lack of a clear route to take the passport through adult governance structures and support is requested to navigate this.

The next steps include submitting the passport to the Paediatric Policy and Guidelines Committee on 26th November and identifying a pathway for approval within adult services.

Additionally, an alert system is being developed within Maxims to flag when a young person is approaching transition age. This alert will link to the Transition Passport, ensuring visibility and accessibility for clinicians. A Transition Register is also being established to track young people nearing transition, and clinicians will be invited to contribute names to this register.

CA emphasised the need for greater awareness and training among adult service providers, noting that some adult MDTs lack understanding of the family-centred approach typical in paediatrics. This can lead to misinterpretation of parental involvement, especially for 17-year-olds who may not be developmentally ready for full autonomy and suggested to expand training opportunities beyond grand rounds, which have had variable attendance, and agreed to explore other forums and to support with taking this through governance processes in divisions. **ACTION: CA**

LF asked whether there are national best practice standards that adult services could use for self-assessment. HB confirmed that NICE guidance and benchmarking documents exist and could be shared to support improvement efforts.

The committee agreed that transition is a shared responsibility and praised the work done so far, while acknowledging the need for broader ownership and cultural change across the Trust.

HB also clarified that the term 'transition' in this context refers specifically to the move from paediatric to adult services, to avoid confusion with other uses of the term and that our documentation would reflect this.

The committee encouraged continued collaboration and co-production with service users, particularly those who have experienced transition, to ensure the process is meaningful and effective.

Action: Explore forums to support governance processes regarding transition into adult services. CA

6.	**Quality Priority increase number of opportunities to grow our volunteer workforce**	**NR**	**Discussion**	**Enclosure 6**

Since April 2025, 118 volunteers have contributed over 1,000 hours monthly, with a peak of 1,220 hours in one month. Although Wye Valley Trust has the fewest volunteers among the Foundation Group, 107 compared to SWFT 604, its volunteers deliver the highest average hours per person at 33 hours per quarter. Reflecting a high level of commitment and integration within the Trust.

There have been several improvements made to existing roles. For example, reception volunteers now start earlier and finish later, with better coverage on busy days and access to clinic sheets to improve patient direction. In ED volunteer coverage has expanded to Sundays, with recruitment underway for Saturdays.

A significant milestone was the successful implementation of wheelchair support, with 17 trained volunteers now assisting patients which has received a lot of positive feedback. Volunteers have also received dementia training and now help complete "This is Me" documents for patients being admitted.

In terms of new roles, gardening initiatives have been launched at Bromyard and are ready to begin at Ross and the County site. The gardens have received positive feedback during PLACE visits. Additionally, the Trust has introduced a Pets as Therapy programme, with the first dog visit taking place recently, and plans to expand to other departments including frailty and children's services.

A volunteer management system is under development, which will streamline operations and reduce the administrative burden. The Trust is working with Worcester to adopt their system, pending funding approval for implementation from Hoople.

The Trust has partnered with Helpforce to develop a patient-led contact centre aimed at reducing DNAs through volunteer phone calls.

The committee commended the rapid progress and the quality of volunteer engagement. The committee also noted the potential for further innovation.

7.	QIA guidance and local process	RM	Discussion	Enclosure 7

The Trust's Quality Impact Assessment (QIA) process was first introduced in August 2023. Initially, engagement with the tool was positive, with regular submissions for approval by the Chief Nursing Officer and Chief Medical Officer. However, over time, the number of completed QIAs has declined. This prompted a review of the process following the publication of updated national guidance from NHS England in June 2025, which outlines a framework for assessing the impact of changes on the quality of care.

The new national framework outlines how QIAs can support decision-making and assess the impact of changes on care quality across various contexts. This guidance offered an opportunity to improve the trust's local processes and shift toward a 'think QIA' mindset across the organisation.

The quality team relies on divisions to notify them of QIAs. To improve visibility, divisions have been asked to include QIA as a standing item on governance board agendas. The quality team has also gained access to committee minutes to identify QIAs that may not have been formally submitted, yet have been completed and submitted as part of business plans and service changes.

The process works well for new or modified interventional procedures, largely because the quality team manages that agenda directly. Business cases often include a narrative overview of QIA considerations but sometimes the tool itself is not completed. When QIAs are requested after a change has already been approved, it is often difficult to obtain meaningful assessments.

To address these issues, several improvements are proposed:

- A revised QIA template aligned with the national framework is currently being piloted and the Standard Operating Procedure will be updated once the pilot is complete.
- A comprehensive engagement and education plan will be rolled out, including quick reference guides via the intranet, and communications via Trust Talk and screensavers.
- Training will be embedded in leadership development programs, as inclusion in the QSIR syllabus was not feasible.

LF supported the inclusion of QIA training in the GM leadership and ward leader development programs emphasising the value of using real life examples to demonstrate the value and importance of QIA. She also asked what the timelines are for piloting of the new documentation. RM confirmed that 2-3 completions of the document would be sufficient. LF also raised concerns about the visibility of QIAs, noting that more are likely completed than are captured centrally; and suggested tightening the business case process to require full QIA submission before approval.

HH asked whether the QIA process would be merged with Equality Impact Assessments. RM clarified that while both assessments are housed in the same Excel tool, they remain separate processes for now.

FM reinforced the importance of QIAs as a meaningful tool for improving outcomes, not just a bureaucratic exercise. She encouraged the team to focus on achieving real impact through the process.

8.	Mortality Report	CA	Discussion	Enclosure 8

Over the 12-month rolling period up to June 2025 SHMI remained largely unchanged, with 113 deaths reported compared to 112 in the previous period. To provide greater clarity, the report included actual number of deaths alongside SHMI figures, highlighting that, except for fractured neck of femur cases, which saw six additional deaths, most specialties showed a reduction in actual deaths despite higher SHMI scores. This discrepancy underscores ongoing challenges with coding accuracy and data completeness.

Work to resolve the backlog in clinical coding continues.

Governance around mortality remains robust, with regular mortality meetings and structured learning from deaths sessions. In the first nine months of 2025, three cases were identified as potentially avoidable and escalated for full patient safety investigations.

FM expressed optimism that once coding issues are resolved, at end of March, SHMI figures will better reflect actual performance and ask for clarity on when a real-time in-month figure will be reported. CA confirmed that Approximately 5,000 uncoded cases remain, though progress is being made, with the percentage of uncoded records dropping to 21%. Weekly updates are being received, and additional agency staff have been recruited to accelerate the catch-up. In parallel, IQVIA has been engaged to conduct quality audits, particularly focusing on comorbidity coding, which has been under-represented in recent submissions. The goal is to resubmit corrected data by the end of the financial year.

FM asked whether the fractured neck of femur death patients were following the new pathway to expediate admission on Dinmore. It was noted that the spike occurred primarily in January 2025, prior to the implementation of test of change. Structured judgment reviews did not identify any of these deaths as avoidable, though delays in meeting clinical timelines were acknowledged. An update to be included in the next medicine quarterly report in November. **ACTION: SH**

ACTIONS: An update on fractured neck of femur pathway to be included in the next Medical Division Quarterly Report. SH

9.	**Safeguarding Quarterly Reports**	**GW/C S/KG**	**Discussion**	**Enclosure 9**

9.1 Adult Safeguarding – Gemma Woolford

There has been a continued increase in referrals, particularly in cases involving self-neglect, domestic abuse, and individuals with complex needs. The Trust remains actively engaged with Herefordshire Council and other partners to ensure timely and appropriate safeguarding responses.

A key highlight was the delivery of supplementary training sessions focused on domestic abuse, mental capacity assessments, Deprivation of Liberty Safeguards (DoLS), and general adult safeguarding processes. These sessions have been well received and have led to an increase in referrals, indicating improved awareness and engagement among staff. The quality of referrals has also improved, helping ensure patients receive appropriate support in a timely manner.

Two staff members were recognised with the Going the Extra Mile award for their commitment to improving MCA and best interest decision-making practices, which has positively impacted patient care and team morale.

However, concerns remain. It has not been possible to obtain the necessary data to complete the MCA audit due to delays within the informatics team drawing data from Maxims for audit purposes. It was noted that the team has committed to providing this data by the end of November and will continue on a monthly basis. This will enable regular audits and will feed into the annual report.

Another significant issue is the inconsistent application of safeguarding referrals, particularly in cases involving domestic abuse. Staff do not always initiate appropriate referrals when patients disclose abuse, especially when the patient is temporarily away from the perpetrator during hospitalisation. This is a missed opportunity, as post-discharge contact may not be safe. The safeguarding team lacks capacity to be present on wards consistently, so ward staff must be empowered and trained to have these critical conversations.

Additionally, there is a backlog of referrals at the local authority's adult safeguarding team due to staffing shortages, sickness, and transitional changes under a new manager. The WVT safeguarding team continues to work closely with the local authority, flagging urgent cases to ensure timely prioritisation.

LF had been concerned about the inability to complete the MCA audit and welcomed the move to monthly data provision, which will improve intelligence and oversight. EW attended training provided by Weightmans on mental capacity. Which had been an extremely well received session with good engagement from both medical staff and Matrons.

SM praised the safeguarding team's support around MCA in community settings, especially for District Nurses and for attending pressure ulcer panel.

GQ raised a point about the heightened risk of domestic abuse during illness or recovery and noted that a lot of research had been done and that patients may become more vulnerable when reliant on a partner who may be abusive. This needs to be taken into account and considered when planning discharge and safeguarding interventions.

The Chair reinforced the importance of role specific training and encouraged divisions to work with safeguarding leads to tailor training appropriately.

9.2 Children's Safeguarding – Caron Shelly

There has been an increase in early help assessments, and the team maintained 100% attendance at initial child protection conferences. School nurse supervision rates have improved to 92%, and community midwifery supervision remains at 100%.

Most teams are meeting or exceeding the Trust's training standards and Health Visiting teams achieved 100% compliance in Level 3 safeguarding training.

The joint children and adult safeguarding forum received positive feedback, reinforcing the importance of a whole-family approach and continue collaboration between children's and adult safeguarding teams in training delivery.

Of concern is a mismatch between domestic abuse routine inquiry data on the maternity dashboard and manually collected data. A meeting is scheduled with maternity managers and the named midwife to resolve this.

Training compliance is mostly above trust standard, though there are still some challenges with ED L3 training compliance due to pressures. This risk is mitigated by provision of 24 hour paediatric assessment unit covered by paediatric trained staff whose compliance is high.

Health visitor supervision rates have declined. This has been escalated to the service lead for improvement.

The number of children subject to child protection plans continues to rise, despite fewer initial conferences. This suggests children are remaining on plans longer, possibly due to delays in assessments or ineffective plans.

There has been a 28% increase in high-risk domestic abuse notifications involving children this quarter.

The number of children subject to a child protection plan continues to rise, as children are not being stepped down from plans and will continue to monitor to identify the reasons for this.

There is concern regarding the rise in children and young people admitted to ED due to drug or alcohol intoxication, overdoses, stab injuries and self-harm. Data is now tracked quarterly and will also collect information from Worcestershire to look at cross-boarder trends.

There is currently no data on outcomes following CAMHS involvement for admitted children. Work is underway to address this gap.

MASH outcome letters. The decision by children's services to stop sending outcome letters for referrals has been escalated. These letters are vital for practitioner learning and case tracking. Meetings are ongoing to review and potentially reinstate the process.

SH noted some disturbing trends in the ED attendance data (alcohol, self harm etc) and asked if there is more to be done in wider child services to help support or escalate. CS agreed that this is needed and public health services are actively involved as far as they can be but will continue to be monitored.

JJ provided assurance around routine enquiry for domestic abuse data from Badgernet. Some manual cleansing has been done and the team are assured that women are asked at least once during the maternity pathway. There are some pre- determined reports in Badgernet and work will continue to ensure accuracy.

JJ also noted that regarding previous discussions regarding completion of M&B forms, that there are two trained B7 members of staff who will not be on leave at same time.

9.3 Children Looked after – Kirstie Gardner

Receipt of medical consent from the local authority is now timely and more consistent.

100% of initial health assessments were offered within statutory timescales although not all were completed on time, delays were due to external factors such as foster carer cancellations. There was also 100% attendance at statutory safeguarding meetings for children in care.

There is an increase in the number of separated young people which are now being considered at the Get Safe meetings to assess risks of exploitation.

91% of children have seen a dentist within six months, which is a significant achievement given national challenges in dental access.

The risk has been reduced regarding initial health assessments in terms of delays with local authority. Single point of failure risk in M&B form completion, required for adoption/fostering, is now closed with additional trained staff in place.

Of concern is an increase in the number of children entering care. 72 children were taken into care in 2024 whereas 53 children have entered care in the first two quarters of 2025. Additionally, 25 requests for initial health assessments were received from other local authorities placing children in Herefordshire. The longest wait was 44 days, exceeding the statutory 20-day requirement. 90% of missed review health assessments were due to foster carers cancelling or re-scheduling appointments. This has been escalated to the Local Authority Fostering Service to reinforce the importance of statutory health checks.

A change in policy regarding adult health assessments for foster carers and prospective adopters has significantly impacted the capacity of the medical advisor at Wye Valley. This issue has been escalated to the Women's and Children's Committee and the Integrated Care Board.

LF noted the rise in the number of protection plans and children entering care and questioned whether this reflects the previous Ofted concerns of too many children being in care or in receipt of a plan and asked if this is something we should be worried about? CS acknowledged the variability in numbers, noting that concerns had previously been raised about low numbers, now there is concern about high numbers of plans. It is thought that this is related to the high volume of MASH checks with low conversion rates to child protection conferences and was of concern, suggesting further multi-agency analysis is needed.

KG also noted that during the improvement phase with Leeds, a significant drop in new children into care was seen and since the end of that partnership, numbers have risen. Permanence planning is better but suggested that reduced early

help resources may be contributing. Also to highlight Herefordshire's historically high rates of children in care compared to national average.

LF – Suggested that this should be monitored closely and if remained a concern, should be escalated to the Children's Lead at ICB and Local Authority if remained a concerned. CS and KG agreed to monitor trends and provide more context in the next quarterly report. **ACTION CS/KG**

ACTION: The number of protection plans and children entering care has reduced and trends will be monitored over the next 3 months and more context provided in the next quarterly report. CS/KG

10.	Staffing Report	LF	Discussion	Enclosure 10

The Trust's vacancy position for registered nurses and midwives remains stable. While HCA vacancies remain higher, it was acknowledged that the data may not fully reflect the current reality on the ground and it would be subject to further review.

Agency usage continues to decline while there has been an increase in bank staff usage, partly due to the pay award but also as a strategic move to reduce reliance on agency staff. Bank staff are local, committed, and more cost-effective.

Sickness levels are improving. HCA sickness rates are higher but still relatively positive and among the best across the Foundation Group. The Trust has a higher-than-average maternity leave rate

SH raised a concern about the persistently high HCA vacancy rate despite recruitment efforts. LF agreed and committed to provide a deep dive into HCA vacancy and turnover rates in the next report. **ACTION ES**

ACTION: There remains a high HCA vacancy rate despite recruitment efforts. Next report to include a deep dive into HCA vacancies and turnover rates. LF

11.	Quarterly Report Surgery Division	ES	Discussion	Enclosure 11

There has been a slight improvement in complaints, which decreased from 55 in the April–June period to 46 in July–September. While communication remained the most common theme across complaints, a focused initiative supported by HR is underway to improve communication within all clinical settings.

Progress has been made in Community Paediatrics following the NHS England review in December 2023. Improvements in workforce stability, including the recruitment of a new consultant and clinical lead, as well as the addition of two locum consultants. The introduction of Clinical Nurse Specialists has supported multidisciplinary working, and job planning has become more robust, with increased clinic capacity and weekly MDTs and peer review sessions.

The next phase for community paediatrics will focus on pathway development, particularly for autism spectrum disorder and a nurse led phone line for ASDEC parents and carers.

The Acute Surgical Unit has launched as part of the Urgent and Emergency Care test of change. Services run within the surgical SDEC footprint using existing resource. The ASU has helped decompress ED by relocating surgical patients to a more appropriate setting, enabling earlier treatment and avoiding unnecessary admissions. Of the 50 patients seen during the pilot, 8% were discharged directly from ASU. Additionally, the time to specialty review for general surgery to outcome has decreased from 2 hours 5 minutes to 1 hour 37 minutes.

Another significant development was the trial of five-joint arthroplasty lists in the Elective Surgical Hub, exceeding the national average of four joints per list. Theatre turnaround time was reduced from 90 minutes to 4 minutes, resulting in increased productivity. Currently, 73% of all-day lists include four joints, up from 3.2 previously, placing the Trust 35th out of 108 nationally for joint replacements per list. The team is monitoring surgical site infections closely as volumes increase.

The arthroplasty length of stay project has been a particular success. The average length of stay has been reduced from 3.8 days to 2.2 days, with 83% of patients now mobilised on the same day and 66% discharged earlier than the national standard of 2.7 days.

The report also addressed challenges in the breast service. This is largely due to workforce fragility. Only one substantive consultant is currently in post and on leave; two NHS contracted locums who have a good vision for the service but are not yet on the specialist register. Other workstreams are in progress to improve pathways and develop nursing teams.

Radiology capacity remains a challenge due to national shifts in practice, and the team is working closely with radiology to address this.

A number of governance gaps were also identified, including incomplete audits.

Meetings are taking place fortnightly with Worcester clinical and operational colleagues who are providing guidance and support on process and pathways.

CA assured the committee that the executive team is well sighted on the issues and are supporting both the management and clinical teams to ensure quality and safety of the service are maintained.

Finally, the committee noted the ongoing discussions around neonatal cot reconfiguration. The Chair recognised the lack of strategic alignment and deferred further discussion to divisional leads, acknowledging the complexity of the issue.

12.	Quarterly Report Integrated Care Division	SM	Discussion	Enclosure 12

One of the long-standing issues addressed was the change in continence product supply from Abena to Tena. While Tena is generally preferred by staff and patients, the division has not yet seen clear evidence of improved outcomes. The issue may lie more in how continence is managed rather than the products themselves, and further evaluation is ongoing.

There has been a significant improvement at Ross Community Hospital. There has been praise of the leadership of the ward sister, whose efforts have led to noticeable improvements in cleanliness, organisation, and overall environment. This was supported by positive feedback from external visitors and unofficial PLACE results.

The dementia lead nurse has also contributed to improvements in dementia-friendly environments across community hospitals.

However, pressure ulcers remain a major concern. Despite targeted efforts, categorisation issues persist, particularly in district nursing teams, such as misclassification of pressure ulcers as moisture associated skin damage. A deep dive into documentation and practice is underway, and a new tissue viability lead nurse has been appointed. This role is expected to bring fresh perspective and drive improvements in both the pressure ulcer panel and the wider tissue viability service.

On a more positive note, The Stroke Association has put forward funding for a family support worker, who is now working across both Herefordshire and Worcestershire. This role has provided valuable emotional and practical support to stroke patients and their families, complementing the work of Herefordshire Headway.

SH questioned the effectiveness of the 2025 pressure damage action plan, noting that despite six months of implementation, improvements have not been evident. SM acknowledged the issue and explained that while some teams are performing well, others are still struggling with categorisation. There is commitment to continuing deep dives and documentation audits and it is hoped to see improvement in the next quarter.

13.	Trust Infection Prevention Committee summary report	LF	Discussion	Enclosure 13

The attached minutes were still in draft. The Infection Prevention Committee was scheduled to meet tomorrow for formal approval.

The recent NHS England inspection resulted in the Trust being moved into routine monitoring. The formal letter confirming this outcome has been received and will be shared at the next Quality Committee meeting in November. A follow-up session with Sodexo colleagues is scheduled for December 8th, and NHSE plans to revisit in March 2026 to assess sustained improvements.

The Trust has reported a recent cluster of MRSA bacteraemia cases with four cases in a short period. A cluster review was conducted and presented at the Infection Prevention Committee. The review found no direct links between the cases and no identifiable common cause. The findings were shared with the Integrated Care Board, which deemed the review robust. To note, MRSA cases have risen across the region, prompting a wider review by the ICB, the results of which will be brought back to both the Infection Prevention and Quality Committees in due course.

Another area of concern was a spike in surgical site infections related to hip and knee procedures. A meeting was scheduled to take place following this meeting with the SSI lead orthopaedic surgeon to investigate the cause of the increase and determine appropriate actions.

Staff flu vaccination rate was at 30%. While this placed the Trust at the top of the Foundation Group, it was still below national expectations. All staff are encouraged to get vaccinated. The Trust has also launched its inpatient flu vaccination programme, with six patients vaccinated in the previous week. A revised SOP had been implemented to support daily rollout going forward.

The Chair praised the team's efforts and encouraged divisional leaders to promote flu vaccination uptake. She also requested that uptake data be shared by team to help drive improvement and reiterated the availability of peer vaccinators to make access easier for staff.

KL asked whether staff who received their flu vaccinations externally, e.g., via GP or pharmacy, were included in the Trust's figures. LF clarified that staff are asked to self-report external vaccinations but acknowledged that the data is likely incomplete due to under reporting. The policy has also been amended to include volunteers, and the Trust now offers the appropriate vaccine for staff over 65, although they must attend occupational health due to cold chain requirements and limited supply.

14.	Patient Safety Committee Summary Report	TMJ	Discussion	Enclosure 14

The last meeting of the Patient Safety Committee reviewed and approved several policies, and performance in some areas are showing positive trends. The committee continues to monitor patient safety indicators and ensure that governance processes are robust.

One of the main issues discussed was poor attendance at the Hospital Transfusion Committee. This as an area off track and has been raised both at the Patient Safety Committee and in other forums. Also, potential solutions to improve attendance were being explored.

15.	Patient Experience Committee Summary Report	LC	Discussion	Enclosure 15

A new bereavement folder has been introduced, developed by the bereavement team and approved by the committee. This folder is designed to be user-friendly and supportive and has been distributed across relevant teams to assist families during difficult times.

Another positive development was the offer of free resources from the Royal National Institute of the Blind to support the implementation of the Accessible Information Standard. This includes assistance in developing a policy to ensure that patients with visual impairments or other communication needs receive information in formats they can understand. The offer is currently being explored and welcomed by the committee.

The Patient Engagement Group continues to grow in both size and influence, and the group has been actively involved in a number of projects and has provided valuable input into service improvements. Staff across the Trust are encouraged to engage with the group. Additionally, the committee reviewed the results of the National Inpatient Survey. These results are being shared with services across the Trust, including the Hospital at Home team, to allow teams to reflect on patient feedback and identify areas for improvement.				
CONFIDENTIAL SECTION				
16.	**PSIRF Report**	**LC**	**Discussion**	**Enclosure 16**
17.	**Patient Flow Report**	**SH**	**Discussion**	**Enclosure 17**
18.	**Any Other Business**	**All**	**Discussion**	
	None.			
Thursday 27th November 2025 – 1300-1600 **MS Teams**				

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	**Quality Committee November 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, November 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 – Timely Administration of High-Risk, Time-Critical Medications** – We continue to perform well on Parkinson's medication administration rates giving confidence that new processes have become embedded following the focussed work in 24/25. The current year sees a focus on epilepsy medication and support for self-administration. Work continues with wards to support both.
2. **Mortality Report** – Quality Committee continues to emphasise the need to resolve the coding backlog as understanding SHMI data is not possible with such a high level of uncoded admissions. Committee was assured that 4 additional coders were in post with an anticipated clearance of the backlog in 8 to 10 weeks. Some confidence can be taken from the actual number of deaths which continue to track at a level below the previous year. Notwithstanding data limitations, fractured neck of femur deaths are higher than they should be despite implementation of new processes and protocols. A peer review is planned to support further improvement.
3. **Quality Priority – Improving Responsiveness to Patient Experience** –Complaints and Concerns continue to be the main area of concern despite substantial efforts both to understand underlying issues and to respond better to individual complainants. Committee asked for renewed focus on thematic learning, on empowering staff to resolve issues as they arise and learning from Foundation Group partners.
4. **Quality Priority – Improving In-Patient Nutrition** – The annual in-patient survey remains the benchmark for satisfaction with food but the lag in data being available limits its usefulness and focus currently is to use local and regular feedback mechanism to support satisfaction. For those with particular nutritional needs, completion of risk assessments is now being monitored and focus is on assessment quality and follow-up.
5. **Patient Flow Report** – Committee noted the positive trend to reduce ward moves for patients with dementia, but overall concerns remain high at unacceptable patient experience due to high boarding levels. National standards are due to be published and the Trust will be using a self-assessment tool in advance of this.
6. **Staffing Report** – Nurse staffing rates, turnover and vacancy rates remain positive and committee commended the leadership that has supported significant improvements. Committee also received a deep-dive report on health care assistant vacancies.
7. **Divisional Quarterly Report – Medicine** – Committee heard about a number of concerns and challenges related to ED and care of patients in escalation area including end-of life patients, mental health safety and sepsis management. Positive developments included national awards for diabetes and for respiratory care, embedding the matron-of-the-day role and improvements in out-of-hours escalation capacity
8. **Perinatal Safety Report Quarter 2** – There were no major concerns reported though there have been some delays in in induction and this is subject to daily monitoring. CNST review is currently showing compliance with 7 of the 10 standards, with the other three subject to collation of further evidence.
9. **Inpatient Annual Survey Results** – Committee discussed the latest annual feedback from inpatients which is data collected in October 2024. Overall the results show similar scores to the previous year and are consistent broadly with other trusts. Areas for focus include the Virtual Ward service, communication to support hospital discharge, dementia care and its impact on other patients and food quality.
10. **Infection Prevention Quarterly Report** – The trust remains above trajectory in relation to prevalence of several key infections and Q2 shows a cumulative increase compared to Q1, though is not an outlier nationally. Cleanliness audits show good hand hygiene and bare-below-the-elbow compliance but a need for focus in some areas of equipment cleaning.

Matters for Escalation - None

WYE VALLEY NHS TRUST

Minutes of the Quality Committee

Held on 27th November 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
Sharon Hill	SH	Non-Executive Director
Rachael Hebbert	RH	Associate Director of Nursing
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
Sarah Shingler	SS	Managing Director
Emma Smith	ES	Deputy Chief Nursing Officer
Nicola Twigg	NT	Non-Executive Director
In Attendance:		
Annabell Cracknell-Jones	ACJ	Cancer Transformation Manager (for item 14)
Lucie Grisewood	LG	Infection Prevention Nuse (for item 16)
Sarah Holliehead	SH	Associate Chief Nurse Medical Division
Helen Harris	HH	ICB Representative
Susan Hughes	SH	Deputy Director of Midwifery
Justine Jeffery	JJ	Director of Midwifery
Susan Moody	SM	Associate Chief AHP, Integrated Care Division
Hayley Pearson	HP	Clinical Director Pharmacy – For Leah
Vicky Roberts	VR	Executive Assistant (for the minutes)
Sarah Seed	SS	Clinical Manager Dietetics (for item 7)
Emma Wales	EW	Associate Chief Medical Officer Medical Division
Raechael Wordsworth	RW	Medicines Safety Officer
Apologies:		
Jo Rouse	JR	Associate Non-Executive Director
Leah Hughes	LH	Operational Clinical Lead Radiographer, Clinical Support Division

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**IJ**	**Information**	**Verbal**
Noted as above				
2.	**Declarations of interest**	**IJ**	**Information**	**Verbal**
There were no new declarations.				
3.	**Minutes of meeting 30th October 2025**	**IJ**	**Approval**	**Enclosure 3**
The minutes were approved as correct record of the last meeting.				
3.1.	**Matters Arising and Action Log**	**IJ**	**Discussion**	**Enclosure 3.1**

All actions were reviewed and updated, and the following actions were closed.

September 2025, item 8. Clinical Support Division Quarterly report -The output of the round table being held in relation to the clinical systems issue regarding radiology results to be brought to a future meeting.
The theme identified through patient safety panel. Broader project has been established to agree a process for review of electronic radiology results. **CLOSED**

September 2025, item 12. Patient Experience Committee - Paediatric services reported difficulty accessing FFT data. To investigate whether this was due to a time lag or an access issue. 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 will ensure the data is accessible and used effectively.
Data now available and will be split by specialty going forward **CLOSED**

4.	**BUSINESS SECTION**			
4.1	**Quality priority - Target high-risk time critical medication as locally defined**	**RW**	**Discussion**	**Enclosure 4**

Parkinson's medication administration rates have reached their highest recorded level, with 90% delivered on time in October, which was a significant achievement. However, there was a slight increase in late doses and missed doses.

For epilepsy medications, although the volume of administrations is lower than Parkinson's, there has been a small rise in missed doses. This is partly due to operational pressures but requires renewed focus and ward-level engagement to maintain performance.

Progress on self-administration of medicines has been slow due to the absence of a dedicated function in the EPMA system. Currently, there is no 'self-administration' button, making data capture difficult; to mitigate this, communications have been issued to nursing staff to record self-administration in the EPMA comments field. Work is ongoing with the data and EPMA teams to extract this information, aiming to report meaningful insights by early next year.

A new initiative, the red bag system, is planned for December. This will involve pharmacy delivering urgently ordered time-critical medicines in distinctive red bags to wards, ensuring staff recognise their arrival promptly and avoid delays caused by unawareness of stock availability.

Benchmarking shows Parkinson's medication performance compares favourably at a national level, but no national benchmarks exist for epilepsy medication. Epilepsy Action have been contacted for guidance but there is limited comparative data available.

HH added that additional intelligence has been gathered from a system-wide epilepsy incident review and will be shared to support the improvement work.

Committee members commended Raechel's persistence and collaborative approach, noting the importance of sustaining improvements and avoiding reliance on system upgrades alone.

5.	**Mortality Report**	**CA**	**Discussion**	**Enclosure 5**

The mortality report was mainly focused on quality issues, though did provide an update on the coding backlog.

SHMI remains high at 114 for the 12-month period up to July, though the actual number of deaths has decreased by 60 compared to the previous year.

Persistent issues with SDEC data exclusion as well as uncoded admissions continue to limit assurance from SHMI figures, making crude mortality and learning-from-deaths processes the primary sources of confidence.

The backlog of uncoded admissions stands at 21%. Four additional coders have been appointed but full recovery may take 8–10 weeks. NHS Digital are considering reinstating SDEC data in future, which will require readiness for resubmission.

There are some concerns regarding fractured neck of femur cases, where mortality has increased despite implementation of the fast track protocol; pre-optimisation before transfer remains inconsistent, prompting plans for strengthened leadership accountability. ECIST have also been contacted to undertake an external peer review.

Other areas such as sepsis and pneumonia showed fewer deaths than last year, but ongoing quality improvement is needed, including a new trust-wide quality improvement initiative to reduce hospital-acquired pneumonia.

Stroke mortality remains relatively stable, though October figures require further analysis to distinguish true stroke cases from medical outliers.

Dissemination of learning continues through newsletters and mortality panel, and the medical examiner service remains robust.

The Chair expressed concern about limited assurance from SHMI until coding issues are resolved and requested a clear trajectory for backlog clearance. CA confirmed that four coders are now dedicated to clearing the backlog and suggested that this will take a further 8-10 weeks.

KL asked if uncoded work has an impact income. CA confirmed that focus on coding has been on electives which give most income, the remaining backlog is mainly in admissions. There is a potential financial consequence but is built into work to recover the position.

6.	**Quality Priority - Improve responsiveness to patient experience**	**NO**	**Discussion**	**Enclosure 6**

All services now have access to the Friends and Family Test following a major rollout earlier in the year, though response rates have declined due to the expanded implementation.

A new issue has arisen as the current FFT provider plans to withdraw next year. A business case is being work up to be presented to Trust Management Board and have engaged with the foundation group to benefit from shared procurement services to source a replacement.

Complaints have increased in both volume and complexity, with recurring themes around communication, staff values, and behaviours, previously concentrated in emergency care but now evident across multiple directorates. A deep dive revealed that most actions taken are localized and reactive rather than systemic, highlighting the opportunity for broader trust-wide interventions.

PALS concerns are also rising, though improved collaboration with divisional governance leads is helping streamline responses. Many complaints are complex and can sometimes involve unrealistic expectations or requests for care coordination, which can be challenging and time consuming for teams.

GQ asked for more information on comebacks as they appear to be on trajectory to double 2023-24 numbers. NO confirmed that a deep dive had taken place which showed that reasons varied, but that sometimes a particular question has not been answered or a patient has been offered a meeting where new questions may arise and are addressed at the time but have not been written into the final response.

The committee agreed that while current efforts are substantial, new strategies are needed to equip staff and empower them to be able to deal with a situation as it arises, in order to try to prevent a complaint or referral to PALS.

HH asked for clarity on the PHSO cases as there had been a blip in October. NO –Confirmed that the cases are historic or long standing, ongoing cases. PHSO have also raised two queries with regard to response time for complaints, being outside the statutory 6 months.

LF noted that the Trust has received three times the number of complaints than others in the Foundation group and would like to understand the reasons for this. NO has spoken to colleagues at Worcester regarding their de-registration process, whereby an investigator will speak with a complainant by telephone and provide a resolution, therefore de-registering the complaint. Following this discussion the complainant will receive a letter confirming the conversation and closure of the complaint. It was noted that the process works very well but is time consuming and only with the complainant's consent can the incident be de-registered.

7.	Quality Priority – Nutrition	RH/SS	Discussion	Enclosure 7

Overall patient feedback scores have remained stable compared to previous years, with no significant deterioration but limited improvement. To address timeliness of data, the team has been using the Sodexo Ambassador and feedback mechanisms alongside the annual inpatient survey.

A one-off audit in August showed positive progress, and plans are in place to make this a regular monthly process, tailored to different patient groups such as maternity and paediatrics for richer insights.

Nutritional risk assessments are being monitored through the Maxim's dashboard, which provides ward leaders with oversight of completion rates, though work continues to improve the quality of assessments and follow-up actions. Engagement with ward sisters is scheduled to identify any barriers.

Additional initiatives include reviewing portion sizes and menu options, particularly for community hospitals where recent PLACE audits indicated lower satisfaction with food quality.

8.	Patient Flow Report	NO	Discussion	Enclosure 8

Overall trends were similar to previous months, with no new themes identified. A notable positive development was a sharp reduction in ward moves for patients with dementia, reflecting recent improvement efforts.

While incident numbers have generally declined since January, three complaints received in the month were all linked to AMU. Boarding continues to feature prominently in complaints, even if not recorded as the primary concern, as patients often experience multiple moves and prolonged stays in corridors or escalation areas, leading to dissatisfaction.

National corridor care standards are expected to be published soon, which will provide clearer guidance, though the trust may need to adapt these locally. In the meantime, a draft framework for self-assessment is available, and the trust plans to conduct its own assessment while awaiting national definitions. Additionally, a Board Workshop will be taking place around patient stories and a review of all escalation and boarding spaces has taken place to assess risk and appropriateness, with findings expected to inform revisions to the escalation policy.

The committee noted the importance of maintaining focus on reducing corridor care and boarding, as these practices remain unacceptable despite operational pressures.

9.	Staffing Report	ES	Discussion	Enclosure 9

Nurse staffing levels remain largely stable despite ongoing operational pressures and the need to open escalation areas. Fill rates for registered nurses increased slightly during the day, and healthcare assistant coverage increased at night, with care hours per patient day remaining within safe limits.

Incidents linked to staffing were low, with 10 reported and 15 red flags mitigated through real-time adjustments using the Allocate SafeCare system.

Vacancy rates for registered nurses are stable, but healthcare assistant vacancies remain high at around 15–16% across ward areas, theatres, and ED, equating to 91 whole-time equivalents trust-wide. The highest vacancy rate is in the Hospital at Home team, 50%, attributed to recruitment challenges at Band 3 level. Plans are underway to revise job descriptions and strengthen recruitment through centralised processes and outreach. Vacancies and turn over also remain high in ED, Community hospitals and Frailty.

Some elective areas have intentionally delayed recruitment due to reduced weekend activity, though this will change with future elective pathway developments.

Positive progress was noted in reducing agency spend, with the lowest weekly agency shifts in five to six years, 51 shifts compared to over 600 two years ago, and no healthcare assistant agency use in October. Bank usage has also declined slightly, and supernumerary time for new staff is being prioritized to support retention.

The committee commended the significant improvement in workforce stability, particularly the deeper assessment around Health Care Assistants and the financial and quality benefits of reducing reliance on temporary staffing and recruitment of reliable, substantive staff.

10.	Divisional Quarterly Report - Medicine	SH	Discussion	Enclosure 10

A recent cluster review of five incidents involving potential missed cancer diagnoses revealed administrative process failures in respiratory and gastroenterology, referral handling and communication between MDTs. Improvements have been made across both specialties and none of the incidents resulted in any patient harm.

A complaint case was highlighted to reflect progress in out-of-hours escalation, supported by initiatives such as 24-hour Band 7 presence in ED, additional medical registrar cover, extended consultant hours, and the matron-of-the-day role. Also Mortality Panel and Learning from Deaths Committee; all promoting safety.

Ward accreditation has begun successfully, with CCU, Wye, Dinmore, and Arrow meeting standards. Other areas are awaiting review.

The division celebrated several achievements, including national awards for diabetes care and respiratory services and there had also been a compassionate example of staff facilitating a wedding for an end-of-life patient.

New initiatives include embedding the matron-of-the-day role for visible leadership and implementing the ED-to-ward handover SOP to improve patient transfers and reduce congestion.

Healthwatch Herefordshire engagement was discussed focusing on speaking to patients and understanding their rationale for coming to ED. The navigating nurse role was praised for diverting patients and reducing unnecessary ED attendance; in October an impressive 656 patients were navigated.

Areas of concern remain around sepsis management in ED, highlighted by a recent PSII. Work is ongoing focussed on pitstop and medical colleagues and the need for clearer pit-stop assessment processes.

Additional risks include complaints linked to end-of-life care in escalation spaces, management of patients with central venous access devices on medical wards, Redbook ward has been identified as the designated ward for these patients going forward. Training is underway, supported by nurses on Frome Ward, with a target of 75% of nurses trained by end December.

Concerns related to ED have been raised regarding inappropriate patients being assigned to fit-to-sit and discussion is underway regarding re-naming of escalation areas in ED.

There have been a cluster of incidents regarding mental health patient safety in ED, which is being addressed by the Practice Educator in ED band collaboration with the Police service and mental health liaison team.

The division also reported progress on establishing ED safety champions and reaffirmed its commitment to continuous quality improvement despite operational pressures.

The Chair asked for an update on the action regarding VTE assessment numbers in ED. A review of a list of patients who had not undergone VTE assessment on AMU, showed that these patients had been assessed in ED but could not be counted when they arrived at AMU. It is therefore confirmed as a data quality issue and has been highlighted to the Deputy Chief Medical Officer.

11.	Perinatal Safety Report Quarter 2	JJ	Discussion	Enclosure 11

The committee received the first of the new reports on perinatal safety.

Consultant attendance and anaesthetic cover were reported as compliant, while neonatal nursing remains challenged by shortages of QIS-trained staff, though one additional nurse has recently completed training.

The trust recorded one stillbirth and one neonatal death in the quarter; both cases will undergo review through the Perinatal Mortality Review Tool, with learning shared locally and system wide.

Following some previous concerns around routine enquiry around domestic abuse, data quality and collection it is now possible to provide assurance in what is reported on the dashboard and it is understood where the information can be found. Enquiry is made both in the antenatal period and post-natally.

Smoking at the time of birth continues to fall and has been recognised by the LMNS and is supported by the vaping incentive scheme. Noted of concern are some delays in induction of labour which is being monitored on a daily basis, and the home birth service has also been temporarily suspended due to staffing pressures.

The CNST safety actions were reviewed:

- Perinatal mortality tool - Both Q1 and Q2 reports were shared. Most importantly, all reviews were done in a timely manner and grading of outcomes for reviews, all graded either A or B and had not caused harm by actions taken. All learning shared system wide.
- Transition of care and avoidable admissions to neonatal unit - There is assurance that the right babies are transferred to transitional care and cared for in the correct way and any learning or outcomes taken that could inform changes.
- Medical and nursing workforce – All information is provided on a quarterly basis; however, some further evidence is needed for this action.
- Midwifery staffing – Safe staffing report is provided on a monthly basis.
- Special care bundle results are contained in report
- Interface and co-production with MNVP has been at risk this year due to recruitment at ICB. This has been entered on to the risk register and agreed with LMNS board as a future report.
- Role specific training confirmed achievement of 90% or above in all requirements and is compliant.
- Board reporting and Quality Committee - Additional reports are now being published to strengthen reporting and the role of Safety Champions.
- Serious incidents – Compliance is reported and confirm that there have not beenany cases requiring referral.

To summarise, seven of ten standards are currently compliant, with further evidence required for medical workforce, saving babies lives and safety champion board reporting.

LF observed that gold standard for compensatory rest would be very challenging for the Trust's small unit to achieve. It was noted that processes are already in place for individual consultants to make an assessment around tiredness and their safety to continue work. A risk assessment around this will be tightened with a clear action plan.

12.	Maternity Monthly Staffing Report	JJ	Discussion	Enclosure 12

All shifts were safely staffed during the month, despite some operational pressures.

Midwifery sickness rates increased slightly, attributed to seasonal illness, but overall KPIs remained below trust thresholds. Acuity was met for approximately 85% of the time before mitigations, with internal redeployment used frequently to maintain safety though this impacted staff well-being, particularly in triage.

Red flags were reported where shift leaders could not remain supernumerary, but these were managed appropriately and did not compromise safety.

The home birth service was temporarily suspended on several occasions due to staff sickness and have revised risk assessments to protect inpatient safety. Postnatal ward acuity was not consistently met, and medication incidents suggested staffing pressures in that area. To address this, unspent funding has been identified to add a third staff member to the postnatal ward.

Birthrate Plus audit confirmed the service requires 89 WTE midwives, which matches current funded establishment, but the uplift for training, currently 22%, may need review as other units have moved to 24% to support LMNS compliance.

Fill rates for midwives were above 90%, but slightly lower for support staff due to vacancies.

13.	**Inpatient CQC Survey Results**	**NO**	**Discussion**	**Enclosure 13**

The latest inpatient CQC survey results, which showed overall stability in patient experience scores compared to the previous year, with no major highlights or significant declines. For 38 questions, scores remained unchanged, and for 42 questions, the trust performed similarly to other hospitals nationally.

The response rate was strong, surpassing the national average and improving on last year. While quantitative data revealed few notable trends, qualitative feedback provided richer insights. A key area for improvement was virtual ward, where the score had deteriorated from last year. This was discussed at Patient Experience committee and is under review by divisions, and a plan is in progress to re-work Virtual ward to be geriatrician led hospital at home.

There are some smaller areas where a deeper dive is needed, and some learning has been taken from foundation group colleagues, however, of note, the difference in score to show a fall below standard, is extremely small.

Some common themes around lower scores included concerns about long waiting times in ED, delays in discharge after being informed, and extended stays in discharge lounges, suggesting a need for better communication and expectation management. A pattern emerged around patient distress when being cared for alongside individuals with dementia, often due to challenging behaviours, which will be shared with the dementia lead for review. Food quality also featured prominently in comments, despite the removal of the dedicated survey question, with issues around choice and taste persisting.

The committee agreed these findings should inform targeted improvement actions, particularly around discharge processes, dementia care environments, and catering standards.

14.	**Cancer Survey Deeper Dive**	**AC-J**	**Discussion**	**Enclosure 14**

The committee reviewed the latest Cancer Patient Experience Survey results, which provided comparative data over the past four years and highlighted areas for improvement.

Response rates have declined despite an increase in cancer referrals, a trend seen nationally, prompting the trust to join a regional working group to explore solutions.

Analysis showed 21 questions with improving trends, 36 with little change, and four with deterioration, mainly around clarity of diagnostic explanations, adequacy of information before hormone therapy, and perceived delays in receiving test results.

Health inequalities data revealed improvements in some areas, such as patients being allowed a family member present during diagnosis discussions, but persistent gaps remain, particularly in explaining long-term side effects.

Gender differences were noted, with men reporting poorer experiences overall, aligning with national findings.

Ethnicity data was limited, as 99% of respondents identified as White British or did not disclose ethnicity, suggesting a need to understand why patients avoid sharing this information.

Deprivation analysis showed mixed results, though the most deprived quintile reported the greatest improvement in overall care rating.

Action plans are being developed with specialties, focusing on targeted improvements such as better communication, reducing diagnostic delays, and enhancing patient information.

The committee acknowledged that while survey data is valuable, its timeliness and specificity remain challenges, and additional local surveys are being introduced to capture more actionable insights.

15.	Trust Infection Prevention Committee Summary Report	LF	Discussion	Enclosure 15

Flu vaccination uptake among staff has improved significantly, reaching 44.8%, compared to 30% last year, placing the trust 11th regionally and second within the foundation group. The regional target of 45% is close to being met, and the local ambition is 50%, with continued efforts to increase coverage.

The SOP for vaccinating eligible inpatients is now embedded, with 36 patients vaccinated so far, mainly in community hospitals where patients are more stable and well. Uptake on the County site remains lower due to clinical concerns about underlying conditions.

Two new risks were added to the risk register: the absence of UVD decontamination in community sites, mitigated by triple cleaning, and delays in submitting HCAI data to the national system, mitigated by internal processes and ICB oversight.

Areas requiring improvement include reducing unnecessary use of couch roll, which has crept up despite previous elimination efforts, and improving cleaning of bed frames, particularly in escalation areas where ownership and responsibility are unclear.

The quality improvement project for wards to retain their own beds to improve accountability is ongoing.

16.	Infection Prevention Quarterly Report	LG	Discussion	Enclosure 16

The quarter two report showed that the trust remains above trajectory for several key indicators, including Clostridium difficile, MRSA, and all three gram-negative bacteraemias (E. coli, Klebsiella, and Pseudomonas). Although the trust is not currently an outlier nationally, the cumulative figures indicate increased prevalence compared to quarter one.

Year-to-date, 22 C. diff cases have been reported against a trajectory of 38, with three patient deaths within 30 days of diagnosis, none of which listed C. diff on the death certificate, which is positive.

Gram-negative bacteraemia mortality rates were reviewed, with E. coli at 24% (national average 14.6%). Six of a total 25 patients had died within 30 days, with three having e-coli on part one of their death certificate, equating to 12%. Klebsiella at 25% (national average 18.9%). Two of a total of eight patients who died within 30 days, one patient had Klebsiella on part one of their certificate, also giving a total of 12.5%. Pseudomonas at 33% (national average 24.7%). One of three patients passed away within 30 days but did not have pseudomonas on part one death certificate giving a total of 0%.

Two community onsets of hospital acquired MRSA bacteremias were identified this quarter, breaching the zero target, and four MSSA cases were reported but remain within internal thresholds. Common contributory themes across infections include clinical cleaning, hand hygiene, and documentation.

MRSA screening showed a decrease in SCBU and Gilwern and also for known MRSA patients and 28 day screens. These are screens done within 24 hours of initial request.

COVID-19 outbreaks increased slightly, with eight outbreaks involving 25 patients with probable linked hospital onset and 20 definite hospital-onset cases, though all were managed according to trust guidance. There were also some confirmed cases of Covid for staff in August. No flu cases were reported.

Hand hygiene compliance was strong at 97%, and bare-below-the-elbow compliance at 99%, with the greatest percentage pass rate at moment 2 scoring 100% with the lowest scoring at moment 5 at 92%.

Equipment audits revealed a 93% overall pass rate, but high failure rates for Mobi frames and commodes, prompting targeted education. Actions include deploying an external trainer for clinical cleaning audits, reinforcing hand hygiene compliance, addressing equipment cleaning failures, and maintaining antimicrobial stewardship improvements.

The committee noted that C. diff remains the most significant risk and agreed to continue focused quality improvement work in this area.

LF added that there had been some MRSA cases in prior quarters and there has been a significant rise in cases both across the ICS and nationally. The trust is participating in a review, and no significant learnings have so far been identified. Some of the reportable infections are low numbers therefore making it easy to breach the trajectory. C-diff remains the most significant risk and will continue to be a focus of quality improvement work. SWFT colleagues shared their antimicrobial stewardship guidelines which was also shared with colleagues for a view.

17.	**Clinical Effectiveness and Audit Committee Summary Report**	**NO**	**Discussion**	**Enclosure 17**

The report focused on progress with NatSIPs2 implementation.

The Clinical Lead, supported by the quality team, is leading this work, and significant improvement has been shown compared to previous years, with clearer alignment to national standards and better structure in compliance monitoring. However, engagement with the NatSIPs2 Steering Group remains inconsistent, which has slowed progress in some areas, particularly around sharing learning and embedding best practice across divisions. To address this, the team is exploring alternative engagement strategies, such as proactive outreach to clinical teams rather than relying solely on meeting attendance.

The rest of the summary was taken as read.

18.	**Patient Experience Committee Summary Report**	**NO**	**Discussion**	**Enclosure 18**

PLACE audit results for community hospitals were generally positive, but concerns were raised about food quality, particularly meals being served cold, which has been fed back for action.

The surgical division's patient experience report identified a new trend of patient anxiety regarding the use of AI in clinics, with comments reflecting discomfort when clinicians were not seen writing or typing during consultations. This has prompted a need for clearer communication and reassurance that all information is accurately documented.

CONFIDENTIAL SECTION

19.	**PSIRF Report**	**NO**	**Discussion**	**Enclosure 19**
20.	**Any Other Business**	**All**	**Discussion**	

Thursday 18th December – 1300-1600pm

MS Teams

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	**Charity Trustee Escalation Report – 18 September 2025**
Lead Executive Director:	Choose an item.
Author:	**Grace Quantock, Non-Executive Director and Chair**
Reporting Route:	**Direct to Board**
Appendices included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**
Brief Description of Report Purpose	
To provide a summary of the Charity Trustee meeting and to escalate any matters of concern.	
Recommended Actions required by Board or Committee	
To consider the summary report 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.

Charitable Funds Committee Report - September 18, 2025

Matters for Noting

1. **Quarter 1 Financial Position 2025/26**: At the end of Quarter 1, total income of £66k was received with £148k of resources utilised, resulting in a net decrease in fund balances of £82k. The closing balance is just over £2m with £1.6m held in restricted funds. Overall commitments total £141k with an overall uncommitted fund balance of £1.9m. The creditor position shows the charity owes nearly £1m to the Trust, which is expected to be cleared shortly and will significantly reduce the creditor figure in the next report.
2. **Administration Recharge Review**: The administrative recharge review has been discussed with the finance team who are actively exploring areas to streamline processes and reduce the administrative burden. Process mapping has been undertaken. No significant cost saving measures have been identified yet. A proposal paper will be brought to the December committee meeting.
3. **Draft Annual Accounts/Draft Annual Report 2024/25**: The draft accounts are unchanged from the June meeting. The independent examination remains on track with the final accounts to be presented to Trustees at the December meeting, ahead of the January deadline. Minor discrepancies were noted in the balance sheet and income tables which will be corrected in future versions for clarity.
4. **Fundraising Updates**:
    - **Staff Lottery**: The staff lottery continues to be popular and successful. Due to its growing scale, outsourcing external management of the lottery is to be explored. Benchmarking will be carried out against others within the Foundation Group and expanded to non-NHS organisations.
    - **Education Centre**: Planning has now been secured but the funding position remains unchanged. The new fundraising strategy may target equipment funding as this is more appealing to donors than construction costs.
    - **Stroke Rehabilitation Gym**: A new stroke rehabilitation gym has been proposed as the next fundraising initiative, to be located on Wye Ward. The estimated cost will be around £100k. There is potential capital funding from underspent budgets as the UEC scheme has been allocated £4.3m capital and is currently looking under budget. The capital position should become clearer in the next few weeks and this will be brought back to the December meeting.
5. **Ethical Fundraising**: A draft Ethical Fundraising policy was introduced to guide decisions on accepting donations. There was support towards a principles-based policy rather than a fixed list of prohibited donors, allowing individual donation assessment. Ethical fundraising policies within the Foundation Group will be reviewed in order to align with best practice. This will be brought back to a future meeting for formal approval. Ethical investment was noted as a separate item to be addressed at a later date.
6. **Staff Health and Wellbeing**: A proposal was made to ring-fence part of the staff lottery income for wellbeing initiatives, aiming to support staff morale and reduce sickness absence. There was support for using lottery funds as this provides visibility to staff. A detailed breakdown of proposed initiatives and funding options will be developed for the December meeting.

7. **Other Business**: Concerns were raised about ensuring charitable fund investments are visible to staff and patients, as visibility can help boost engagement and attract further fundraising. It was clarified that most of the original Education Centre funding has been spent with only a small balance remaining. The vast majority of charitable funds are restricted and departments holding these funds need to provide clear spending plans. Discussion will continue offline around obtaining proposed spending and investment plans from departments holding restricted funds. Small, visible improvements across the estate were suggested.

Matters for Escalation

None.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	Appointments & Remuneration Committee Terms of Reference
Lead Executive Director:	**Trust Chairman**
Author:	Gwenny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	Appointments and Remuneration Committee
Appendices included with this report:	1) Amended Terms of Reference tracked version 2) Amended Terms of Reference clean version
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Appointments and Remuneration Committee reviewed its terms of reference and, alongside some minor amendments, four material changes are recommended:

1. The addition of a responsibility to consider and approve any retire and return plans for executives.
2. Removal of the responsibility to review the Trust's Fit and Proper Person Test (FPPT) arrangements. This responsibility has been adopted by the Audit Committee as part of its assurance responsibilities. The Appointments and Remuneration Committee will continue to receive information about the outcome of the FPPT.
3. Removal of a requirement for a formal report from each committee meeting to the Board. This has not been the practice of the committee due to the confidential nature of discussions. An annual summary of the Committee's decisions is included in the Annual Report.
4. A change to the quorum requiring two voting NEDs, in line with the Audit Committee.

Recommendation

The Trust Board is asked to approve the recommended changes to the terms of reference of the Appointments and Remuneration Committee.

Executive Director Opinion[1]

Not applicable. The proposed changes have been approved by the Appointments and Remuneration Committee.

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

Wye Valley NHS Trust
Appointments and Remuneration Committee

TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board) to perform the duties prescribed by ~~the Trust's Constitution[1] or~~ Standing Orders[2] in relation to the appointment and remuneration arrangements of the Chief Executive, Managing Director and Chief Officers (also referred to as Executive Directors). ~~It will also review the Trust's Fit and Proper Persons procedures and receive reports thereon.~~
Accountability Arrangements	The Committee is accountable to the Board of the Trust to perform the duties prescribed by the following paragraphs of the Trust's ~~Constitution or~~ Standing Orders: • *The non-executive directors shall appoint or remove the Chief Executive*[3] • *A committee consisting of the Chairperson, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors*[4] • *The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors*[5]
Responsibilities	The Committee will: • Review the structure, size and composition of the Board (including the mix of skills, knowledge and experience) in the light of the strategy and priorities of the Trust, and make recommendations to the Board with regard to any restructuring or development needs. • Give full consideration to continuity in the executive team, including the Chief Executive, taking into account the challenges and opportunities facing the Trust and the skills and expertise particularly needed on the Board in future. • Determine, and review from time to time, the terms and conditions of office of the Chief Executive, Managing Director and Chief Officers including the Trust's policies for the remuneration and allowances applicable to these positions. • Approve processes for the annual performance review of the Chief Executive, Managing Director and Chief Officers, and receive an annual report on the outcome of these reviews.

[1] ~~For SWFT~~
[2] ~~For WVT, GEH and WAHT~~
[3] ~~SWFT Constitution paragraph 27, WVT, GEH and WAHT Standing Order 3~~
[4] ~~SWFT Constitution paragraph 27.4, WVT, GEH and WAHT Standing Order 43~~
[5] ~~SWFT Constitution paragraph 33, WVT, GEH and WAHT Standing Order 43~~

	• Determine, and keep under review, the consolidated and non-consolidated remuneration of the Chief Executive, Managing Director and each Chief Officer. • Determine for all staff, under delegated powers, arrangements for any non-contractual payment, in line with Department of Health and Social Care and NHSE guidance. The Committee shall also sign-off the payment of contractual severance payments for individual Board level members of staff. • In the event of a vacancy for the Chief Executive, Managing Director or a Chief Officer position, approve the recruitment process, person specification and other particulars and instruct the Chief People Officer to undertake recruitment accordingly. • Identify a process for the short-listing and interview of candidates for the Chief Executive, Managing Director or a Chief Officer position. • To agree an interview panel and delegate authority to such a panel which shall be responsible for identifying and nominating for appointment candidates to fill posts for any Chief Executive~~6~~, Managing Director or Chief Officer vacancies as and when they arise provided that: ○ the appointment is within the parameters set by the Appointments and Remuneration Committee; ○ any proposed non-conformance to the parameters is referred back to the Appointments and Remuneration Committee for consideration and approval prior to any appointment being made; ○ a report confirming the appointment is submitted to the next Appointments and Remuneration Committee meeting. • Consider and decide upon any matter relating to the continuation in office of the Chief Executive, Managing Director and a Chief Officer, including suspension or termination of service in accordance with the terms and conditions of office. • Consider and approve any retire and return plans for ~~the Chief Executive, Managing Director and a Chief Officer~~executive directors. • Review succession planning and talent management for the positions of Chief Officers and recommend to the Chief Executive and Chief People Officer such development activities as may be needed to ensure the continued executive and senior management capability of the Trust. • Approve an annual statement of the Committee's processes and activities for the Chairperson to report to the Board, in a suitable form for inclusion in the Trust's Annual Report. ~~Receive Consider, approve and ratify amendments to the Trust's Fit and Proper Person Test Procedure as part of the review process or sooner if required.~~

~~6 For SWFT, the appointment of the Chief Executive is to be approved by the Council of Governors, in accordance with the Trust's Constitution.~~

	• Receive information on any concerns relating to the Chief Executive, Managing Director or Chief Officers identified as part of the Fit and Proper Persons Test checks. • Receive adhoc reports from the Chairperson, Chief Executive or Managing Director.
Membership / Attendance	The members of the Committee are: • The Trust Chair • The Non-Executive Directors (Voting, Non-Voting and Associate) The Chief Executive shall be invited to attend the Committee and will be: • excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. • a voting member for any decision related to the appointment or removal of the Managing Director or a Chief Officer except themselves. The Managing Director shall be invited to attend at least annually to discuss the performance of the Chief Officers. The Chief People Officer (or a deputy) will attend to advise the Committee but will be excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. The Managing Director, other officers of the Trust or external advisers may be invited to attend as the Committee considers necessary.
Chair	The Chair of the Trust shall be the Chair of the Committee. The Vice-Chair of the Trust will deputise in the Chair's absence.
Quorum	The Chair (or Vice Chair) and onetwo other voting NEDs, with at least one being a Voting NED, will constitute a quorum.
Reporting Arrangements	The Committee will undertake an annual self-assessment of its effectiveness which will be reported to the Board for information. Also an An Annual Report of the Committee's performance and compliance with theseagainst its Terms of Reference, which includes an annual register of attendance, will be produced and submitted to the Board for information.
Frequency of Meeting	The Committee will hold scheduled meetings at least twice a year, and the Chairperson may convene additional meetings as necessary.

Administration	The ~~Trust~~ Company Secretary (or a deputy) will attend to advise and support the Chair and ~~the Trust Secretary or nominated Executive Assistant to take the~~will be responsible for ensuring that ~~M~~minutes of the meeting are taken.
Date Approved	~~GEH Committee on 5 November 2024~~11 December 2025 ~~WAHT Vice Chair on behalf of the Committee on 29 January 2025 date to be confirmed~~ ~~SWFT Committee on 12 December 2024~~11 December 2025 ~~Foundation Group Boards on 5 February 2025~~4 March 2026
Date Review	To be reviewed annually. Next review due by January 2027. ~~Next Foundation Group Boards Review Date: February 2026~~March 2027

Wye Valley NHS Trust
Appointments and Remuneration Committee

TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board) to perform the duties prescribed by Standing Orders in relation to the appointment and remuneration arrangements of the Chief Executive, Managing Director and Chief Officers (also referred to as Executive Directors).
Accountability Arrangements	The Committee is accountable to the Board of the Trust to perform the duties prescribed by the following paragraphs of the Trust's Standing Orders: • *The non-executive directors shall appoint or remove the Chief Executive* • *A committee consisting of the Chairperson, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors* • *The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors*
Responsibilities	The Committee will: • Review the structure, size and composition of the Board (including the mix of skills, knowledge and experience) in the light of the strategy and priorities of the Trust, and make recommendations to the Board with regard to any restructuring or development needs. • Give full consideration to continuity in the executive team, including the Chief Executive, taking into account the challenges and opportunities facing the Trust and the skills and expertise particularly needed on the Board in future. • Determine, and review from time to time, the terms and conditions of office of the Chief Executive, Managing Director and Chief Officers including the Trust's policies for the remuneration and allowances applicable to these positions. • Approve processes for the annual performance review of the Chief Executive, Managing Director and Chief Officers, and receive an annual report on the outcome of these reviews. • Determine, and keep under review, the consolidated and non-consolidated remuneration of the Chief Executive, Managing Director and each Chief Officer. • Determine for all staff, under delegated powers, arrangements for any non-contractual payment, in line with Department of Health and Social Care and NHSE guidance. The Committee shall also sign-

	off the payment of contractual severance payments for individual Board level members of staff. • In the event of a vacancy for the Chief Executive, Managing Director or a Chief Officer position, approve the recruitment process, person specification and other particulars and instruct the Chief People Officer to undertake recruitment accordingly. • Identify a process for the short-listing and interview of candidates for the Chief Executive, Managing Director or a Chief Officer position. • To agree an interview panel and delegate authority to such a panel which shall be responsible for identifying and nominating for appointment candidates to fill posts for any Chief Executive, Managing Director or Chief Officer vacancies as and when they arise provided that: o the appointment is within the parameters set by the Appointments and Remuneration Committee; o any proposed non-conformance to the parameters is referred back to the Appointments and Remuneration Committee for consideration and approval prior to any appointment being made; o a report confirming the appointment is submitted to the next Appointments and Remuneration Committee meeting. • Consider and decide upon any matter relating to the continuation in office of the Chief Executive, Managing Director and a Chief Officer, including suspension or termination of service in accordance with the terms and conditions of office. • Consider and approve any retire and return plans for executive directors. • Review succession planning and talent management for the positions of Chief Officers and recommend to the Chief Executive and Chief People Officer such development activities as may be needed to ensure the continued executive and senior management capability of the Trust. • Approve an annual statement of the Committee's processes and activities for the Chairperson to report to the Board, in a suitable form for inclusion in the Trust's Annual Report. • Receive information on any concerns relating to the Chief Executive, Managing Director or Chief Officers identified as part of the Fit and Proper Persons Test checks. • Receive adhoc reports from the Chairperson, Chief Executive or Managing Director.
Membership / Attendance	The members of the Committee are: • The Trust Chair • The Non-Executive Directors (Voting, Non-Voting and Associate) The Chief Executive shall be invited to attend the Committee and will be:

	• excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. • a voting member for any decision related to the appointment or removal of the Managing Director or a Chief Officer except themselves. The Managing Director shall be invited to attend at least annually to discuss the performance of the Chief Officers. The Chief People Officer (or a deputy) will attend to advise the Committee but will be excluded from any discussion or decision relating to their own appointment, remuneration or terms of office. The Managing Director, other officers of the Trust or external advisers may be invited to attend as the Committee considers necessary.
Chair	The Chair of the Trust shall be the Chair of the Committee. The Vice-Chair of the Trust will deputise in the Chair's absence.
Quorum	The Chair (or Vice Chair) and one other voting NED will constitute a quorum.
Reporting Arrangements	An Annual Report of the Committee's compliance with these Terms of Reference, which includes an annual register of attendance, will be produced and submitted to the Board for information.
Frequency of Meeting	The Committee will hold scheduled meetings at least twice a year, and the Chairperson may convene additional meetings as necessary.
Administration	The Company Secretary (or a deputy) will attend to advise and support the Chair and will be responsible for ensuring that minutes of the meeting are taken.
Date Approved	
Date Review	To be reviewed annually. Next review due by January 2027.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	Public Board
Date of Meeting:	05/02/2026
Title of Report:	Integrated Care Oversight and Assurance Committee Terms of Reference
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	n/a
Appendices included with this report:	New Terms of Reference for an Integrated Care Oversight and Assurance Committee
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The governance arrangements supporting the Memorandum of Understanding (MOU) between the One Herefordshire Health and Care Partnership and Herefordshire and Worcestershire Integrated Care Board (ICB) have been refreshed.

Under the MOU, the Trust is Agent for the ICB in managing the Better Care Fund and Host for the One Herefordshire Health and Care Partnership. The Integrated Care Oversight and Assurance Committee will provide assurance to the Trust Board regarding the discharge of these responsibilities.

The new Committee, which replaces the Integrated Care Executive, is aligned to the MOU and will receive regular reports covering operational delivery and performance, financial performance and risk management, including reports from the One Herefordshire Health and Care Partnership Board regarding its decisions and activities.

Recommendation

The Trust Board is asked to approve these terms of reference.

Executive Director Opinion[1]

The Managing Director has engaged with key executive and non-executive Board members in the development of these terms of reference and recommends their approval by 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.

Wye Valley NHS Trust

Integrated Care Oversight and Assurance Committee

Terms of Reference

Chair	Non-Executive Director
Quorum:	One non-executive director Two chief officers
Meetings:	Monthly

1. Authority and Purpose

1.1. The Integrated Care Oversight and Assurance Committee ("the Committee") is established by the Wye Valley NHS Trust Board, in accordance with the Standing Orders, to provide oversight of the discharge of the Trust's responsibilities set out in the Memorandum of Understanding (MOU) between the One Herefordshire Health and Care Partnership and Herefordshire and Worcestershire Integrated Care Board (ICB) regarding services to be coordinated by the Partnership.

1.2. The Committee's decision-making powers shall be limited to those set out in these Terms of Reference, the MOU and the Trust's Standing Orders and Standing Financial Instructions.

1.3. The scope of the MOU is as follows:

a) The Better Care Fund (BCF)
b) Additional areas: Enhanced Care in Care Homes, Urgent Community Response, Virtual Wards, Falls Service.

1.4. The responsibilities of Wye Valley NHS Trust ("the Trust") under the MOU are, in summary, as follows:

a) As agent of the ICB:
   i. The day to day management of the Better Care Fund, including the management of financial risk.
   ii. Managing the utilisation of Better Care Fund resources.

b) As the Host for the One Herefordshire Health and Care Partnership in relation to the 'additional areas' described above:
   i. Integrated operational delivery.
   ii. Set objectives.
   iii. Service design, improvement and evaluation.
   iv. Monitor delivery and performance against indicators set out in the BCF service specifications.

2. Role and Duties

2.1. The Committee's role is to obtain and provide assurance to the Trust Board regarding the discharge of the Trust's responsibilities under the MOU.

2.2. In performing this role, the Committee shall:
   a) Receive regular reports from the One Herefordshire Health and Care Partnership Board.
   b) Require the attendance of individuals employed by the Trust and request the attendance of individuals employed by One Herefordshire Health and Care Partnership Partners to present reports.
   c) Set an annual schedule of reporting to include operational delivery and performance, financial performance and risk management.
   d) Agree the matters that require escalation to the Trust Board and/or to the ICB.

3. Membership and Quorum

3.1. The Committee's membership shall comprise:

- Non-executive director, who will be the Committee Chair.
- Managing Director.
- One Herefordshire Executive Operational Lead
- Chief Finance Officer.
- Chief Nursing Officer
- Chief Medical Officer.
- Chief Operating Officer.
- Chief Strategy and Planning Officer.

Attendees
Corporate Director Community Wellbeing (DASS) Herefordshire Council
Chair Herefordshire General Practice (Neighbourhood Health SRO)
Medical Director Herefordshire General Practice

3.2. In the absence of the non-executive Chair, the Managing Director shall chair the meeting.
3.3. A quorum shall include as a minimum:
   a) Chair/Managing Director
   b) Two Chief Officers members.
3.4. Should any Chief Officer be unable to attend a meeting they may send a deputy in their place but they will not contribute to the quorum.

4. Meetings

4.1. Meetings will take place approximately bi-monthly, at least 6 times per year, usually by means of video conferencing.
4.2. Additional meetings may be called at the discretion of the Chair.
4.3. Members are expected to attend every meeting. In the exceptional circumstances that attendance is not possible, apologies shall be submitted and, where appropriate, a Deputy shall be instructed to attend in their place.
4.4. The Committee Chair shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and shall ensure these are mitigated in accordance with the Trust's Managing Conflicts of Interest Policy.

5. Administration and Reporting

5.1. The Committee Chair will submit a written Escalation and Assurance report to the Trust Board on a quarterly basis.

5.2. The Company Secretary shall be responsible for ensuring that the Committee's meetings are properly administered.

5.3. All Committee reports shall be submitted to the Committee Secretary no later than 7 days prior to each meeting and meeting papers shall be circulated to Committee members no later than 5 days prior to each meeting.

6. Review

6.1. On an annual basis the Committee shall:

a) Review its compliance with these terms of reference.
b) Review and update as necessary these terms of reference.
c) Submit the outcome of these reviews to the Trust Board for assurance/approval.

7. Approval

7.1. These Terms of Reference were approved by the Trust Board on _

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**05/02/2026**
Title of Report:	Additional Theatre Business Case
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Nick Exon, Cand Kuegler, Jenny Connaughton, Jonathan Boulter, Liz Williams
Reporting Route:	Project Team
Appendices included with this report:	Full Business Case - Additional Theatre on T10 pad.docx
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

As detailed in Strategic Outline Case WVTBC0152 October 2025 the preferred option for increasing obstetric theatre capacity at the Trust was to provide a second obstetric theatre in the Women's Health department by 31st March 2026. This scheme has subsequently been discounted due to the risks of delivering the facility whilst maintaining current capacity and the likely programme for the works being unable to deliver before the end of the financial year.

The objective of this alternative proposal is to incorporate Elective Caesarean Section (ELCS) theatre sessions into main theatres and increase surgical capacity by procuring a single new theatre and locate this on the 'theatre 10 pad' which previously housed a mobile theatre connected to main theatres.

This proposal will partially resolve the Obstetric theatre capacity issues but will have the added benefit of providing much-needed additional theatre capacity that can be utilised by other specialties.

Recommended Actions required by Board or Committee

The Board are asked to approve the Business Case:

- To spend £5.7m project costs
- To sign the building contract with Darwin Group under an NHS Shared Business Servies (SBS) contract
- To commence the scheme and apply for planning permission in parallel.

Executive Director Opinion[1]

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

This scheme is unusual in that it began as a very different proposal and, even though this scheme is recommended for approval, there will still be a need for a second obstetric theatre in the Maternity Unit. Given this position it is worth stating clearly why it is worth considering this scheme.

Firstly, the scheme provides betterment for the Maternity Team in terms of the risk of emergencies occurring during ELCS lists. The team feel it improves the risk somewhat if the Obstetric Theatre was ringfenced for emergency activity only.

This scheme delivers six sessions of theatre capacity that can be utilised by the Trust to reduce long waiting times, increase activity, provide income and provide scheduled sessions for surgeons that do not have them. Through the current three year operational planning process the Trust understands it's demand and capacity and will absolutely have a requirement for additional theatre capacity in years two and three of the plan.

The scheme therefore improves but does not fully mitigate the original estates risk and provides crucial capacity that is a requirement for future years.

The case has been considered at the non-executive business case review meeting where risks around planning permission and commissioned levels of activity were discussed. The case was subsequently approved by the Board offline on the 29/01/2026. Offline approval was sought ahead of the Board meeting in order to maintain progress on the best timescale possible.

FULL BUSINESS CASE

Title:	Additional Theatre on T10 Pad
Ref. No.	WVTBC0178
Author:	Nick Exon, Cand Kuegler, Jenny Connaughton, Jonathan Boulter, Liz Williams, Christian Homersley
Division:	Corporate/Surgical
Finance Manager:	Clive Andrews, Julian Turner
Executive Sponsor:	Alan Dawson
Date:	21st January 2026

1. Introduction

As detailed in Strategic Outline Case WVTBC0152 October 2025 the preferred option for increasing obstetric theatre capacity at the Trust was to provide a second obstetric theatre in the Women's Health department by 31st March 2026. This scheme has subsequently been discounted due to the risks of delivering the facility whilst maintaining current capacity and the likely programme for the works being unable to deliver within the lifespan of NHSE Estates Compliance capital.

The objective of this alternative proposal is to incorporate Elective Caesarean Section (ELCS) theatre sessions into main theatres and, at the same time, increase surgical capacity by procuring a single new theatre and locate this on the 'Theatre 10 pad' which previously housed a mobile theatre connected to main theatres.

The effect of this scheme will be to partially mitigate the maternity theatre risk by freeing it up to run purely as an emergency theatre and will have the added benefit of providing much-needed additional theatre capacity that can be utilised by other specialties.

The intent of this Business Case is to seek approval:

- To spend £5.7m project costs
- To sign the building contract with Darwin Group under an NHS Shared Business Servies (SBS) contract
- To commence the scheme and apply for planning permission in parallel.

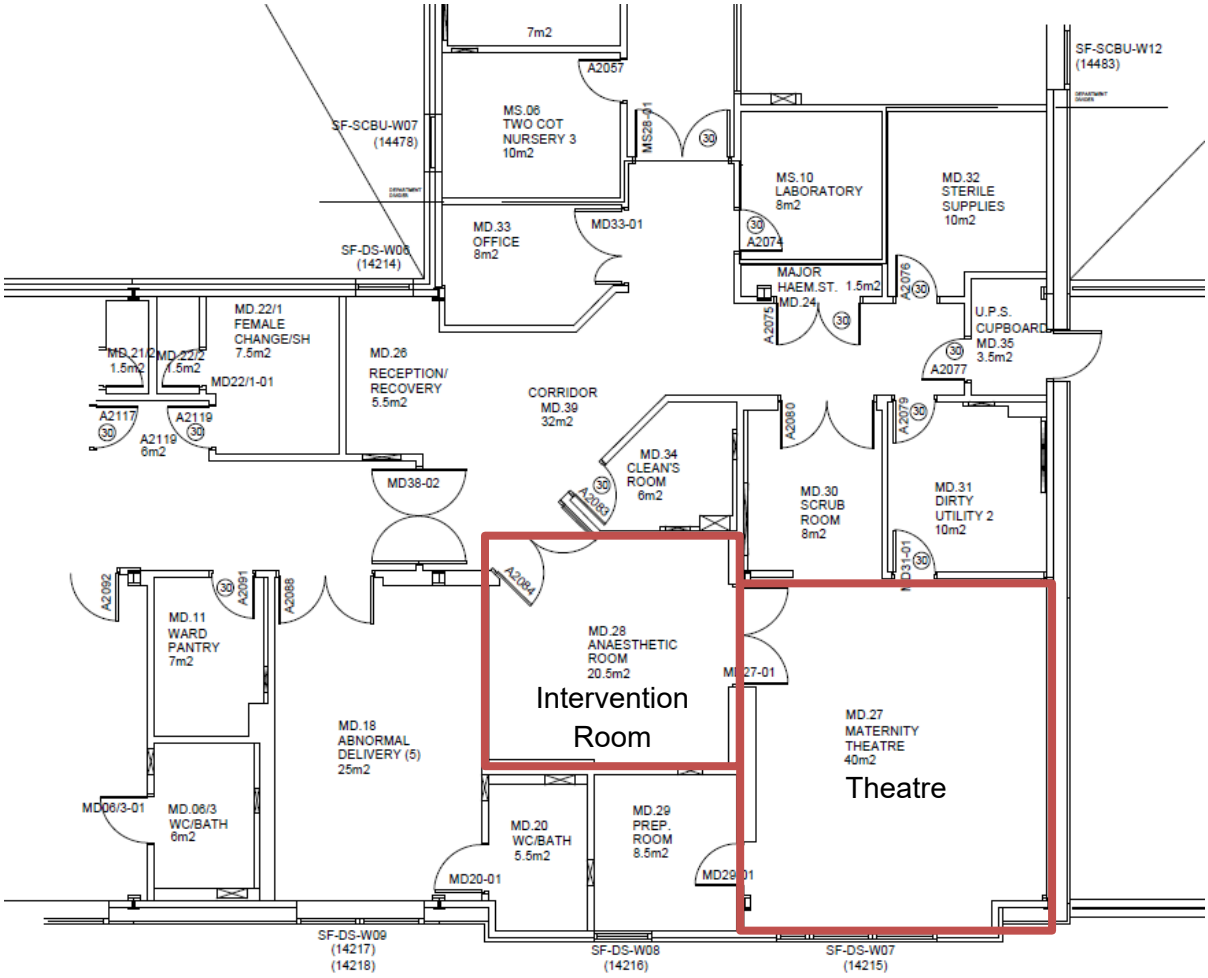
2. Background Information – Obstetrics

2.1. Current provision

The dedicated obstetric theatre on the second floor is located within the Maternity Unit, at the end of Delivery Suite. Its location and close proximity to Delivery Suite is paramount to the safe and efficient transfer of patients with time critical emergencies. The theatre is predominately used for elective and emergency caesarean sections, instrumental deliveries and management of obstetric haemorrhage with a number of other emergency procedures, as required.

The existing estate (see plan below) provides a single theatre of 40m^2 with an adjoining anaesthetic room. Additionally, there is some storage capacity, a dirty utility room and adjacent to the theatre is a small recovery bay. The adjoining anaesthetic room has been used as an 'interventions room' since approximately 2014. Its function is to provide an emergency theatre space in the event of an emergency arising whilst the main obstetric theatre is in use. At 20.5m^2, the space is restrictive and challenging to use and does not have the appropriate ventilation for a theatre, thus mitigated by only using in the event of an emergency. The Maternity team have added some mitigation to these challenges and rolled out skills drills to ensure staff are well versed in accessing and using this space.

The existing estate is identified in the floorplan below.



Being much smaller in size, the intervention room requires equipment and people to be manoeuvred in a particular order to enable the use of the space. For example, it is necessary to remove the bins from the environment; it is also necessary to catheterise from the scrub trolley as there is no space for the trolley that would be expected for catheterisation. This not only presents challenges for the staff to work effectively in this space but also presents Infection Prevention and Control (IPC) risks.

Furthermore, the resuscitaire (a large standing device used when a baby requires some additional support with their breathing) can only be moved into the space after the patient has been transferred into theatre, otherwise there is insufficient space for transfer of the patient. This requires a degree of precision and complete adherence to this process to ensure no unnecessary delays in care and treatment are caused.

Additionally, it should be noted that there is no space for the partner to accompany a woman into this environment which causes undue stress and compromises the woman's experience.

Despite the challenges presented, the SOP for use of the intervention room has been approved and in place for some time and did include consultation with Infection Prevention and Control (IPC) and related teams outside of maternity services.

In 2014, a breach of duty claim was made against the Trust following the death of a baby which occurred following a delay in an emergency caesarean section procedure due to the Obstetric theatre being occupied for another caesarean section. The claim was conceded by

the Trust and a substantial monetary sum paid to the claimants. The existing Intervention room was then subsequently created to mitigate the risk of this scenario reoccurring.

3. Drivers for Change – Obstetrics

3.1. National Strategic alignment

There are many national drivers to support the development of additional obstetric theatre capacity at the Trust, the focus of which being the importance of women being able to make choices about their care and the safety of the mother and baby. As outlined in the 'Better Births' report and the Maternity Transformation Programme, the additional theatre would support Wye Valley Trust (WVT) to:-

- improve safety and outcomes
- promote best practice within the theatre environment
- enhance patient choice and personalisation
- enable appropriate birth partner support, thus having a positive impact on both perinatal mental health, birth experience; and, in turn, reducing the risk of concerns, complaints and any subsequent post-birth grievances being raised.

Additionally, the Ockenden Report (2022) outlines 'Immediate and Essential Actions', within categories including: -

- Enhanced safety
- Listening to women and families
- Informed consent

3.2. Care Quality Commission (CQC)

The dedicated obstetric theatre on the second floor is predominately used for elective and emergency caesarean sections but the adjoining interventions room is also used as a second theatre in the event of an emergency.

CQC inspections of the Trust have highlighted that this "second obstetric theatre was not compliant with national standards" and has resulted in the following action that the Trust must take to improve:

> "*The trust MUST ensure the second obstetric theatre (the intervention room) is compliant with national standards and is regularly risk assessed."*

3.3 Trust

The delivery of additional obstetric theatre capacity at WVT would align to the Trust's vision by improving the health and wellbeing of the people of Herefordshire. It would provide an enabling strategy to a Trust Objective 2023/24; improving quality by delivering the best possible level of safe and effective care. It will ensure service sustainability and active participation in innovation, by enhancing our existing service and facilities to offer the best and safest care for our women and their families.

The heightened risk factors for birthing women resulting from increased comorbidities and other detrimental sociodemographic factors (smoking status, increased BMI, etc.) is reflected in the latest BirthRatePlus (2024) report, which demonstrates the additional risks and associated additional midwifery resource required to deliver safe, effective care to higher risk women.

Delays in elective procedures due to lack of suitable obstetric theatre space is a critical local driver. Unlike many elective procedures in other specialties, obstetric elective work is extremely time limited, with very little room for manoeuvre.

Additionally, existing delays in transfers to theatre for intrapartum and postpartum care (i.e. 3rd and 4th degree tears) due to lack of obstetric theatre availability have a detrimental impact on clinical outcomes and level of postnatal care and support subsequently required. This contributes to the additional Midwifery resource requirement, and an attributed financial cost, as outlined in the latest BirthRatePlus report.

Patient experience is also a major consideration. In the latest Annual CQC Patient survey (2024), the lowest overall score for WVT Maternity Services was for a question linked to having support whilst in hospital:-

> *"Thinking about your stay in hospital if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?"*

This scored 3.4 (out of 10) which is considerably lower than the national average score of 6.5. The psychological impact of women being unable to have their birth partner present for support can be extremely damaging, compounding birth trauma, and consequently can have a lasting effect on postnatal mental health and wellbeing. Recent research has identified that 40% of maternal deaths in the first postnatal year are attributed to mental health related causes (MMBRACE, 2022).

These factors, in conjunction with the continued emphasis on personalised care and birth choices, provides further justification for the requirement for an additional obstetric theatre. By introducing the additional single, modular theatre, this would allow all Elective caesarean procedures to be performed in a custom-built theatre which is fully compliant with national standards and located outside of the Maternity Unit, and fully supported by a dedicated, MDT team. This also enables any concurrent emergency procedures to be undertaken within the existing Obstetric Theatre in the Maternity Unit, supported by a separate, dedicated MDT team. Occasionally two emergencies take place at the same time and the Intervention Room will still need to be used, which is why this proposal only partially ameliorates the risk related to this scheme.

3.3. Trust Estates Strategy

This scheme is also aligned with the following Strategic Estates Objectives:

- Improve patient experience and care quality
- Provide a safe, fit for purpose and therapeutic environment to deliver healthcare
- Support the clinical/service strategy and business requirements of WVT
- Increase efficiency – better utilisation, lower overheads

4. Previous Work - Obstetrics

4.1. 2016 work

The Trust had accepted the risk associated with obstetric theatres and in 2016 explored options to expand the estate to accommodate a second theatre, however these were abandoned due to the costs being prohibitive as the designs then included an additional recovery room.

In the continued work to reduce and mitigate the risk, maternity services had been considered within the Elective Surgical Hub (ESH) plan. The plan had been that elective caesarean sections would be carried out in main theatres (using capacity freed up by activity moved to ESH) away from the main obstetric unit. As the plans were being realised, a number of concerns arose resulting in the plan being considered not practical and ultimately there was not the capacity to undertake elective C-sections in main theatres.

4.2. Strategic Outline Case WVTBC0152 October 2025

There is no longer a requirement for an additional recovery room as this will now be mitigated by transferring directly to a delivery room so a new proposed design became financially viable. The award under the scheme to mitigate maternity estate safety risks was therefore an opportunity for the Trust to revisit the reconfiguration of the existing estate.

A new proposal was developed to provide a second obstetric theatre adjacent to the existing theatre as detailed in Appendix A.

This was developed into a Strategic Outline Case (SOC) WVTBC0152 that was approved by the Trust Management Board (TMB) on 05/09/25 and Private Board on 02/10/25.

After the approval of the SOC, it became apparent that this new scheme was also not viable within the funding parameters as Sodexo has confirmed they could only meet the March 2026 deadline if given full access to the space which was not clinically viable. Giving up the entire Maternity Theatre space for the full duration of the works required a number of workarounds and was not deemed to be clinically suitable. This scheme has therefore been discounted (see Appendix A for more details).

5. Alternative Proposal

The proposal now is to procure a single additional laminar flow theatre and locate this on the ‘Theatre 10 pad’ which previously housed a mobile theatre connected to main theatres. This would be constructed rapidly using an offsite modular construction model.

This new theatre would be used for four elective C-section lists per week thereby ensuring that the existing obstetric theatre within the Maternity Unit is always available. In the event of two obstetric emergencies occurring at the same time then the Intervention room can be utilised as now.

The remaining six available sessions of the additional theatre will be utilised by other specialties.

6. Background Information – Surgical Specialties

Historically, the Trust has utilised the private sector to manage theatre capacity and demand gaps and to mitigate the impact of an increasing waiting list size. Over the last 18 months, reliance on the private sector has reduced, notably in General Surgery, Ophthalmology and Gynaecology. This has resulted in more elective activity being undertaken by the Trust with the associated tariff income being retained by the WVT in whole, rather than shared with, or given over to the private sector.

Despite repatriating such activity, a significant demand and capacity gap remains within elective Orthopaedics. Over the last three financial years, 225 patients per annum have been treated in the private sector, rather than at WVT.

7. Drivers for Change – Additional theatre capacity

A significant demand and capacity gap still exists within the higher tariff speciality of Orthopaedics. To this end, Orthopaedics uses a mixture of mutual aid with other Foundation Group Trusts and the private sector to treat patients.

During 2023/24 the Trust commissioned Nuffield Health to deliver over 200 procedures and the following year, 281 patients were treated at Nuffield Health via the ICB's contract with that organisation. This resulted in the Trust not receiving the tariff income for these procedures, while undertaking the outpatient elements of these patients' care at WVT, without receiving the associated income that was part of the elective 'bundle' awarded to Nuffield Health.

The demand and capacity gap for Orthopaedics has continued into the current financial year. In 2025/26, 180 Orthopaedic patients are being treated at WVT utilising an insourcing provider costing £1.6m for 4 months' worth of activity.

Use and cost of private sector for elective Orthopaedics:

Financial year	Provider	Volume	Cost of service
2025-26	Medinet (insourcing)	180	£1,311,507
2024-25	Nuffield Hereford	281	£1,368,279
2023-24	Nuffield Hospital SWFT	215 120	£1,755,155 £98,890

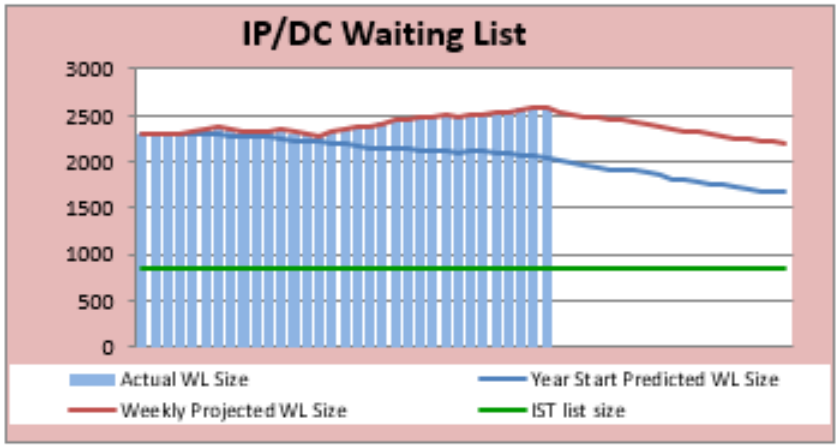
In addition, the speciality sends 120 patients per year to South Warwickshire University NHS Foundation Trust. For this cohort, WVT is invoiced by SWFT.

Funding for the first half of 2025–26 did not support continuation of the strategy of using the private sector, leading to a sustained increase in waiting list size. At present, the introduction of weekend insourcing from the end of November 2025 is the only identified solution capable of delivering a reduction in the waiting list by year end, as shown below

Both the SWFT arrangement and use of Nuffield Health allow for only ASA 1 (healthy patients) and ASA 2 (mild to moderate disease) patients to be treated. This has resulted in fewer ASA 1 and ASA 2 patients available to be added to lists at WVT and a greater proportion of the Trust's waiting list for treatment at WVT being made up of more complex patients. This makes

theatre list scheduling more challenging and attaining the most productive outcomes difficult. For example, while the speciality has made significant progress with the number of arthroplasty procedures per list, not all lists can run to the same productive levels as a result of case mix availability: all surgeons (apart from one) have transitioned to operating on four joint cases per list, in line with national averages and recommendations. However, due to waiting list composition (complexity, length of time on waiting lists and needing to treat within time order to meet elective backlog reduction targets), 25% of lists have run with fewer than four cases.

Increasing waiting list size for Orthopaedics



The below table summarises the patients added to waiting list versus patients treated for the last four months, showing the based on current capacity and additions, the waiting list is deteriorating by an average of 15 patients per week.

	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov	16-Nov	TOTAL
Actual treatment	31	27	54	42	41	59	57	53	64	48	65	36	51	55	49	49	781
DTA Current Year	85	46	75	75	63	93	75	97	72	76	94	80	63	90	89	69	1242
ROTT Current year	12	26	8	19	14	15	7	11	24	9	13	12	16	21	7	12	226
Variance	-42	7	-13	-14	-8	-19	-11	-33	16	-19	-16	-32	4	-14	-33	-8	-235

The Orthopaedic specialty is calculated to be six theatre lists per week and 500 cases per year short to meet elective demand and is therefore currently unable to maintain a reducing waiting list size to support backlog reduction, elective recovery targets and associated RTT performance requirements. In addition, some surgeons within the Orthopaedic speciality currently do not have any allocated theatre sessions and rely on using sessions handed back by colleagues or other specialities which does not guarantee the required volume. Furthermore, the specialty has, as a result, found recruiting to consultant posts without identified job planned theatre time challenging. Equally, the Royal College does not permit job plans and job adverts for posts that do not have dedicated operating time – i.e., job plans with only flexible theatre sessions and backfilling arrangements are not deemed appropriate to obtain approval for the vacant post to proceed to advert.

Productivity gains to use the existing orthopaedics theatre allocation have been made. All but one of the speciality surgeons operates on four joints per theatre list, in line with the national average. Some theatre sessions have been moved into the Elective Surgical Hub, with the support of, and upon the recommendation of the national NHSE Elective Surgical

Hub accreditation team. This has allowed some lists to operate with five joint procedures. Trials of lists of six arthroplasty procedures have also commenced.

Time between cases has also been improved through productivity-based projects. For lists that operate within the Elective Surgical Hub, the time between joint cases has averaged at four minutes, compared to 19 minutes for lists held in main theatres.

Furthermore, the speciality has significantly reduced the average length of stay of such patients on Teme ward: Average length of stay has reduced to a low of 2.2 days, down from 3.7 days 12 months ago, which is now below the national average of 2.7 days. In addition, over 80% of patients are now mobilised on the same day of procedure, up from 50% 12 months ago. This has increased the ward beds available to treat this cohort of patients.

8. Project Objectives, Critical Success Factors (CSFs) and Benefits

8.1. Project Objectives

The modified objective of this project is to incorporate elective C-section theatre sessions into main theatres and increase surgical capacity.

8.2. Critical Success Factors

The Critical Success Factors (CSFs) of this project are:

- CSF1 – Must provide dedicated ELCS capacity ensuring the current obstetric theatre is always available for obstetric emergencies.
- CSF2 – Must be delivered as soon as practicably possible in order to utilise national capital.
- CSF3 – Must not deteriorate the Trust's financial position.
- CSF4 – Must provide flexible theatre space for additional activity.

8.3. Benefits - Obstetrics

Category	Description of Benefit	How benefit will be measured
Quality	• Patient experience • Staff experience • Improved clinical outcomes. • Reducing risk of infection	• CQC Annual survey, Friends and family feedback • Staff survey, absence and retention rate • Reduction in emergency Caesarean Section rate and severe MOH rate
Operational	• Ability to manage concurrent emergencies. • Effective management of elective list which is extremely time limited	• Reduction in overtime/additional hours attributed to elective list delays. • Reduction in frequency of assembling an additional emergency team
Accessibility	• Health and safety risks to staff working in a confined environment	• Reduction in accidents at work / personal injury claims • Reduction in staff deregistration, breaches of

Category	Description of Benefit	How benefit will be measured
	• Reduction in manual handling risks (particularly for women with high BMI) • Breaches of professional standards of staff	professional standards or misconduct
Strategic intentions	• Meet expectations of CQC regulators and national standards (delivered against CQC action plan)	• Confirmation from CQC that new theatre meets national standards • Outcome of future CQC announced/unannounced visits to Maternity unit
Financial	• Reduction in the frequency that an additional Theatres Team (6 headcount - 2 qualified nurses, one ODP, Anaesthetist, 2 Support Workers) would be required to support the Elective Caesarean Section lists when they overrun and associated overtime/additional payment costs	• Actively tracked on Maternity Services' Governance Tracker, so volume of requests can be assessed within given periods of time
	• Ability to facilitate birth partner to support during birth will have a positive impact on women's mental health and wellbeing, potentially reducing postnatal mental health support required	• Improvement in CQC Annual Patient Survey score
	• Reducing adverse outcomes reduces the risk of claims against the Trust and attributed financial costs	• Reduction in requests / length of postnatal mental health support requests
Prevention & Reducing inequalities	• Women with higher BMI at greater risk due to environmental constraints of Intervention room	• Monitor outcomes for women with BMI>25 via Maternity dashboard for a 12-month period post implementation and make comparison with baseline data for this population group

8.4. Benefits – Other Surgical Specialties

Category	Description of Benefit	How benefit will be measured
Financial	• Removal of regular ongoing expenditure within the private sector for Orthopaedics	• Reduction in private sector expenditure
Operational	• Creation of a sustainable waiting list size for orthopaedics	• Weekly monitoring of ops tool showing reducing waiting list size

Category	Description of Benefit	How benefit will be measured

	• Improved T&O RTT performance over 3 years (in line with 3 year planning guidance) and supports national requirement to return to constitutional standards (92% RTT)
	  ○ Yr 1 end: 63.0%
	  ○ Yr 2 end: 81.0%
	  ○ Yr 3 end: 97.9%
		• Weekly RTT monitoring
		• Trust removed from 'tiering' for elective performance monitoring

	• Increase in average cases per list to 5+ for arthroplasty	• Increase in local and national data relating to average cases per list – including GIRFT metrics
	• Improved recruitment and retention and able to recruit to existing unfilled posts due to lack of available scheduled theatre time in Orthopaedics	• Fully recruited consultant team with full allocation of DCCs
	• Increase in orthopaedics activity by 561 cases per annum	• Total throughput monitored week through ops tool
	• Improved theatre utilisation in the Elective Surgical Hub through six full day arthroplasty lists per week and reduced time between cases	• Weekly internal theatre monitoring • Improvement in national / GIRFT theatre utilisation metrics
	• Delivery of long wait / elective recovery targets	• Improvement in Trust position in national league tables
Quality and accessibility	• Improved and more timely access to treatment for orthopaedic patients	• Reduction in long waiting patients, increase in 18 week referral to treatment % compliance
	• Improved patient experience for orthopaedic patients due to shorter waits to treatment	• Friends and family survey rates • Reduction in complaints and concerns relating to treatment times

9. Options Appraisal

9.1. Option 1 – Business as Usual/Do nothing

Description

No increase in theatre capacity for obstetrics or other surgical specialties.

Costs

No additional costs incurred

Pros

- No financial outlay
- Theatre facilities remain the same

Cons - Obstetrics

- Fails to address the CQC action for the Trust to ensure that the second obstetric theatre is compliant with national standards
- Continued risk of poor clinical outcomes
- No improvement in patient and family experience
- Reputational damage – WVT will be less attractive for women who can elect to receive their intrapartum care elsewhere and for recruitment of new staff
- Staff retention – staff are currently having to work in a pressurised, stressful environment when undertaking emergency procedures in the Intervention room
- Health and safety risks – for women and staff
- Manual handling risks in confined space
- Non achievement of benefits outlined above.
- Care delivery, patient and staff risks remain the same

Cons – Surgical Specialties

- Does not address waiting list issues
- Continues to rely on expensive insourcing and continued use of the private sector
- Long waits to treatment in Orthopaedics continue
- Nationally required return to constitutional standards for RTT (92%) will not be delivered for Orthopaedics
- Orthopaedic consultant posts remain unfilled due to undesirable job plans (no allocated theatre sessions)

9.2. Option 2 – Do minimum - Extend working hours of existing theatres

Description

Extend theatre working hours through more evening and weekend working.

Pros

- Does not require building additional capacity

Cons

- Not able to guarantee daytime elective caesarean section lists - evening lists not clinically supported
- Requires more than six sessions to deliver the same level of activity for Orthopaedics as the modular theatre option due to evening sessions being shorter in length (1 hour shorter than daytime sessions)
- Unable to specify in job plans that weekend theatre sessions be mandated: all Royal Colleges do not routinely allow for weekend sessions in consultant job plans
- Relies upon volunteers coming forward to routinely work weekends
- Weekend working will not deliver the same number of weekday sessions - unable to schedule six additional lists every weekend for orthopaedics due to the unpalatable nature of such job plans with regular weekend working requirements
- On call commitments reduces weekend elective opportunities and creates unpalatable job plans containing both regular on call and weekend elective weekend working
- Total cases treated per year will be reduced compared to the modular theatre option due to weekend and evening theatre sessions unable to treat the most complex ASA categories. This will also impact theatre utilisation and the ability to treat 5+ joint cases per list

9.3. Option 3 – Develop a second obstetric theatre as originally planned in SOC WVTBC0152

Description

An additional obstetric theatre, located within the Delivery Suite in the Maternity Unit.

Pros - Obstetrics

- Will address the CQC action for the Trust to ensure that the second obstetric theatre is compliant with national standards
- Will reduce the risk of poor clinical outcomes
- Will assist in addressing healthcare inequalities within Herefordshire by enhancing facilities available to women most at risk of requiring interventions/emergency procedures
- Will reduce risk posed to high-risk women, particularly those with a high BMI, in a confined emergency room environment

- Will reduce manual handling risks, particularly for women with a high BMI
- Will enable effective management of the elective caesarean section list
- Will reduce likelihood/severity of birth trauma, and associated postnatal mental health and wellbeing support
- Will improve patient flow
- Will facilitate improved patient and family experience
- Will enable greater birth choice and enhance personalised care
- Will improve the working environment and increase job satisfaction of Obstetric, theatres and midwifery staff which may result in an overall reduction in turnover, sickness and absence rate

Cons - Obstetrics

- As culture shifts towards utilising theatre appropriately, there is a risk that the theatre workforce may need to increase in line with increased demand
- As theatre begins to be used appropriately to manage Major Obstetric Haemorrhages (MOHs) and instrumental delivery (these are currently frequently managed in the Delivery rooms), there is a risk that the theatre workforce may need to increase in line with increased demand
- The percentage of women with increased medical comorbidities and subsequently the complexity of their care is increasing, resulting in an increase of deliveries requiring interventions i.e. instrumental deliveries, emergency caesarean sections
- National standards may change in future which may impact on future requirements
- Whilst building work is undertaken, there will be an operational impact on main theatres as their facilities will be required for obstetric emergencies, a large geographical distance from the Delivery Suite
- Decrease in available changing space, but this is mitigated with the increase of the staff changing facilities on second floor
- Loss of recovery space - this will be mitigated by transferring directly to the delivery room

Cons – Surgical specialties

- Does not address current surgical capacity and waiting list issues
- Continues to rely on expensive insourcing and continued use of the private sector
- Long waits to treatment in Orthopaedics continue
- Nationally required return to constitutional standards for RTT (92%) will not be delivered for Orthopaedics
- Orthopaedic consultant posts remain unfilled due to undesirable job plans (no allocated theatre sessions)

9.4. Option 4 – Procurement of an additional laminar flow theatre connected to the main Theatre Department

Description

This new theatre would be used for the four ELCS lists per week, where having a dedicated ELCS theatre would ensure that the emergency obstetric theatre is always available. In the event of two obstetric emergencies occurring at the same time then the Intervention room can be utilised as now.

The additional proposal is that the remaining capacity of the additional theatre would be used by other specialties.

Pros - Obstetrics

- Will partially address the CQC action for the Trust to ensure that there is a dedicated emergency obstetric theatre fully compliant to national standards
- Will enable effective management of the elective caesarean section list by a dedicated team
- Will facilitate improved patient and family experience
- Will allow two concurrent Obstetric emergencies to be managed within the Maternity Unit without impacting on the ELCS list

Cons – Obstetrics

- Does not fully address the risk of two obstetric emergencies occurring simultaneously as the Intervention room will remain non-compliant
- Requirement for an additional Midwife to enable continuous patient flow
- Does not remove the need for a second obstetric theatre within the Maternity Dept.

Pros – Surgical specialties

- Increased theatre capacity, flexibility and resilience
- Ability to increase average cases per list for joint procedures to above the national average
- Ability to work to NHSE Elective Surgical Hub accreditation team's recommendation to utilise the Elective Surgical Hub for arthroplasty and increased arthroplasty productivity gains
- Supports Orthopaedics managing a sustainable waiting list
- Reduces spend in and reliance on the private sector to deliver treatments for WVT
- Supports return to constitutional standards for Referral to Treatment (RTT) 92%

Cons – Surgical specialties

- Loss of T10 pad for use by mobile facilities

9.5. Analysis of the Options

Although the original preferred option for Obstetrics is Option 3 this option is discounted as detailed above.

The **preferred option is therefore now Option 4 to procure an additional theatre** which will partially resolve the Obstetric issues (four ELCS sessions) but will provide alternative benefits via additional theatre capacity that could be utilised by other specialties.

The proposal recommends using the six additional elective sessions that are generated as part of the proposed obstetrics theatre to support more elective orthopaedic activity to address the drivers for change. The proposal also uses budgeted orthopaedic surgeon DCCs (Direct Clinical Care) and will support improved recruitment and retention to these current gaps.

These six sessions will not be based in the new theatre. To ensure maximised gains, a theatre schedule has been devised that:

- Provides significantly more Elective Surgical Hub capacity to orthopaedics for arthroplasty procedures. In the new theatre template, orthopaedics will be allocated six additional sessions in the Hub
- This will allow Orthopaedics to harness the benefits seen of utilising the Elective Surgical Hub for joints, allowing for lists of 5 / 6 procedures per list – in excess of the national average, as well as significantly reduced time between cases
- Allocation of additional Elective Surgical Hub lists to Orthopaedics has been recommended, and is supported by, the NHSE Elective Surgical Hub team
- The high utilisation specialities of Urology and Breast will also be retained within the Elective Surgical Hub
- The new modular theatre will house four elective caesarean section sessions. These will, following the advice of the clinical team, be rescheduled to two all day sessions to improve efficiency / cases per list
- Gynaecology will have four lists within the new theatre, with two Breast and one General Surgery session. For clarity, these sessions are lists reallocated from other theatres and are best suited to the new theatre from a utilisation perspective

10. Engagement

There has been strong clinical engagement in the development of the plans and designs for this case including by:

- Obstetricians
- Midwives
- Clinical Lead and Associate Medical Director (AMD)
- Theatres
- Anaesthetics
- Neonatal Team
- Surgical specialties
- Operational management

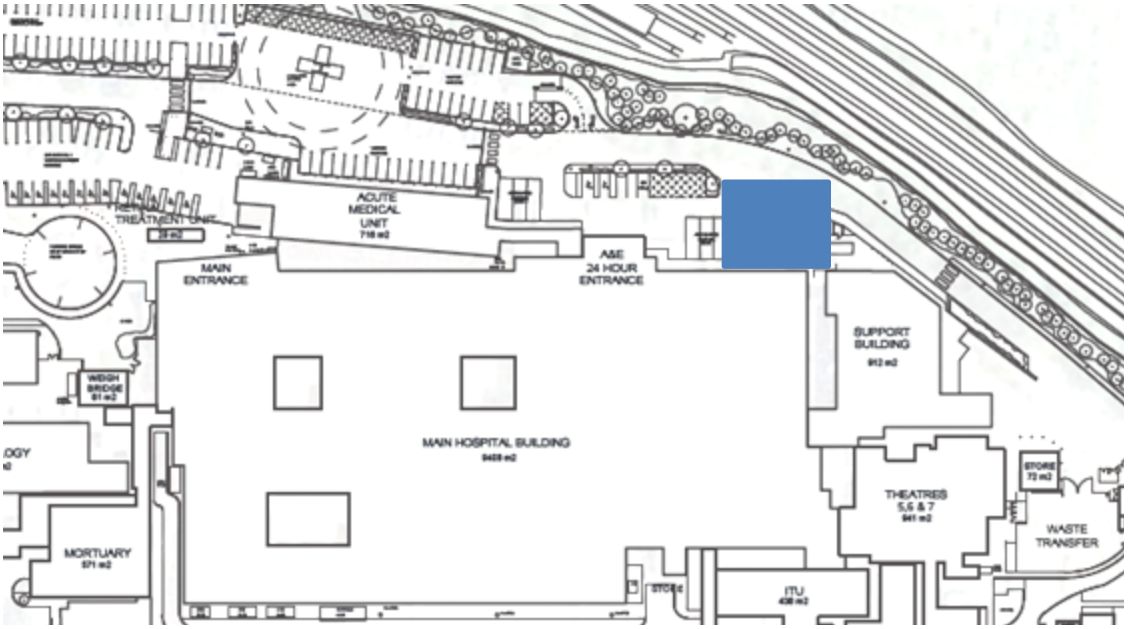
11. Design Specification and Drawings

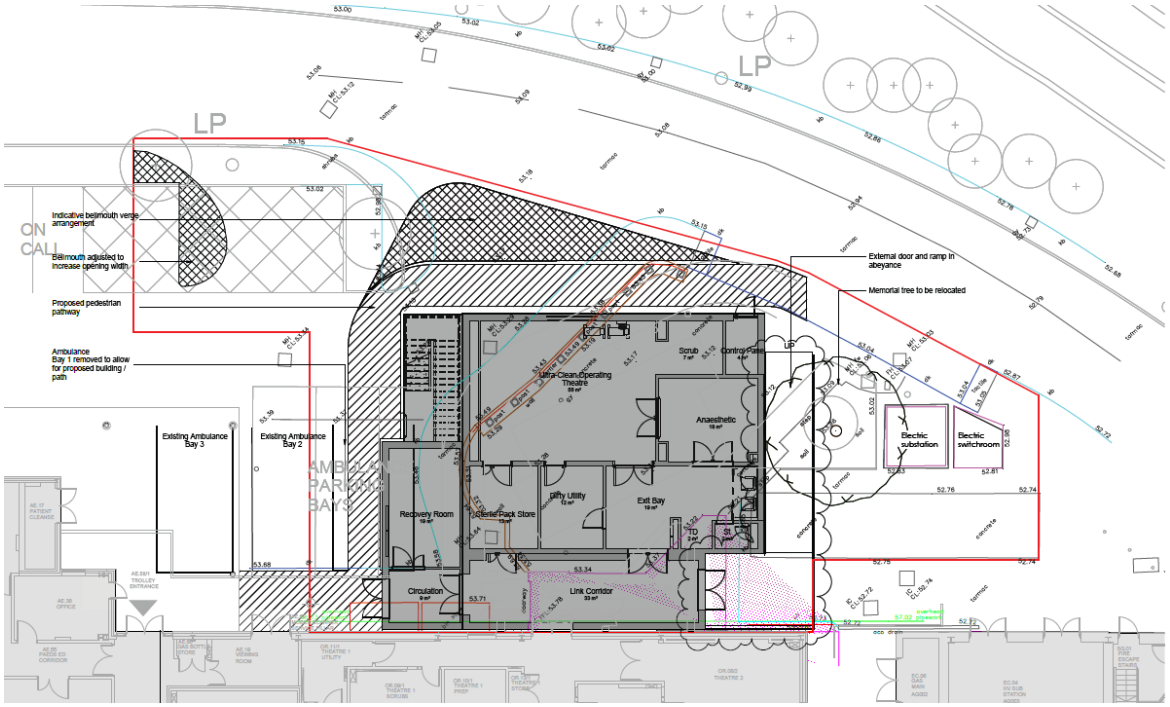
11.1. Theatre Specification

Ultra-Clean Single Operating Theatres: HBN 03-01 compliant

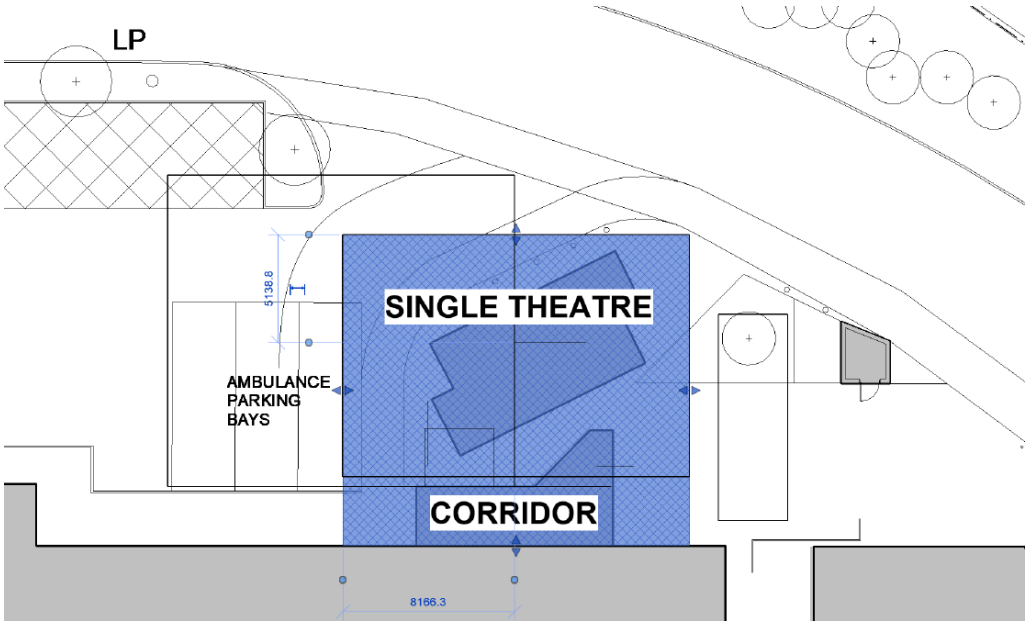
- 1 x Ultra Clean Operating Theatres
- 1 x Anaesthetic Rooms
- 1 x Scrub Rooms
- 1 x Recovery room
- 1 x Dirty Utility
- 1 x Disposal Hold
- 1 x Trolley Bays
- Touchdown area
- Roof Top Plant Space for AHU`s etc
- Re-provided storeroom

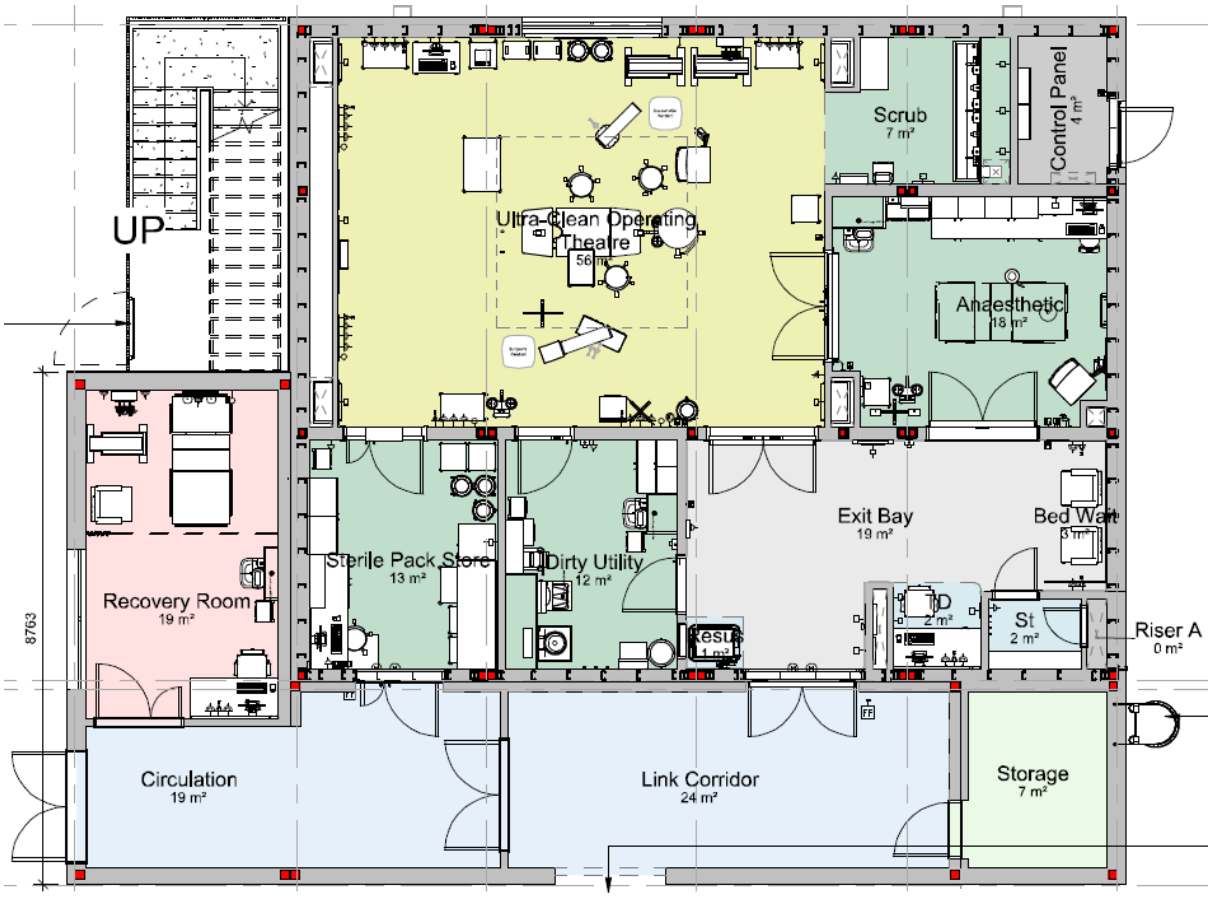
11.2. Draft site location plan





11.3. Proposed layout





12. Financial Analysis

The means of procuring the unit would be via a lease for five years with the option to purchase at the end of the concession period.

The costs related to various financial options open to the Trust regarding the procurement of the theatre are detailed within this section and are split into capital and revenue costs.

12.1. Introduction

The proposal identified in this business case is to procure an operating theatre on an initial 5-year lease. The case identifies both capital and revenue costs associated with the development. In addition, three financial options in relation to the lease of the theatre have been identified which result in different cost structures. These will be reviewed.

12.2. Capital

The capital costs relating to the project consist of:

- Right of use asset value derived from lease information
- Construction costs incurred in design, preparation and costs relating to linking it to the main Hospital
- Cost of capital equipment identified
- Appendix B1 identifies the cash impact of the capital cost for three financial options which are as follows:

Option A Lease over 5 years and hand back at contract end

Option B Lease for initial 5 years and extend for a further 5 years at a lower annual charge

Option C Lease for 5 years and activate option to purchase at the end of the lease period and operate for a further five years

The costs of each option are identified in attached Appendices B1 to 4.

Total cash outlay identified in Appendix B1 over 5 years is £3,840,955 including VAT. In addition, Options B and C, include additional capital costs relating to a reduced lease cost for a further 5-year period (Option C) and a buyout price at the end of Year 5 (Option C)

Appendix B2 identifies the total capital cost for each option and calculates depreciation charges for the period covered by each option.

Appendix B3 identifies the impact of capital expenditure for each option on future years revenue costs taking account of depreciation, interest charges, PDC dividends and accounting for VAT on the lease.

Appendix B4 compares the capital cost for each option against the national funding available to identify the value of the potential shortfall to be funded.

12.3. Findings

Based on the information utilised to compare options, the following was deduced:

Option A is the lowest cost option as it covers only 5-years and does not enable the option to purchase at the end of the contract. As a result, the capital costs incurred are lower than the other two options. However, the impact on revenue on a cost per annum basis is greater due to the asset being depreciated over only 5-years. However, this option does minimise the capital funding shortfall within the current financial year.

Option B is based on an operating period of 10-years and extends the lease for a further 5-years at a reduced cost of £330,200 pa plus VAT. The capital cost of Option B in 2025/26 is the same as Option A but requires a further capital investment of £1,477k in Year 6 to reflect the ROU asset value of the renewed lease. The revenue cost of the capital investment is less than Option A when measured on an average cost per annum basis which reflects the extension of the asset life and lease to 10-years. The capital shortfall in 2025/26 is the same as Option A.

Option C also extends the operating period to 10-years but rather than entering a further 5-year lease, the trust buys the asset for a fixed price at the end of 5 years. This increases the value of the ROU asset compared to Option A as it takes account of the additional payment for the assets at the end of the contract. The revenue impact of the capital outlay is the lowest in terms of the average cost per annum. Finally, affordability against 2025/26 capital resource is greater than in the first two options due to the impact of the agreed purchase value at the end of the lease.

To summarise from a capital perspective, Options A and B give the lowest immediate capital spend although Option A is for 5-years only and Option B requires further capital investment in Year 6. Although Option C increases the capital sum by £652k, the benefits in relation to lower average revenue costs outweigh the increased capital requirement. Further work is required to review the capital programme due to this and the increase in costs relating to preparatory works. This is being reviewed as part of the 2026/27 capital prioritisation exercise.

12.4. Timing of Expenditure

The trust has sought to utilise monies awarded from the Estates Safety Fund in 2025/26 to meet as much of the cost as possible. It was initially envisaged that the modular theatre development would be completed by 31 March 2026. This would enable the trust to account for the Right of Use value of the theatre within the 2025/26 financial year. However, it is recognised that the timescale for completion in the current financial year is too challenging and therefore the decision has been taken to account for the costs over two financial years.

This has implications for utilisation of Estates Safety funding of £2.9m in the current year. It is estimated that the project will utilise a maximum of £1.6m of expenditure in 2025/26 relating to preparation costs and the purchase of some equipment. This will leave an estimated £4.05m of expenditure to manage in 2026/27.

The trust will apply for further national funding in 2026/27 in respect of the projected cost, however there is no guarantee that any funding will be forthcoming. It's therefore proposed

to cover the additional costs from the Trust's local CDEL funding. This is made possible due to an increase in CDEL funding to £9.4m compared to £5.3m in the current financial year.

The table below analyses the cost breakdown into financial years:

Section 13.4 - Project expenditure timing

AJT assessment on work done	*% Complete*	25/26	26/27	Total
Complete by 31st March 2026	100%	225,100	0	225,100
70% complete by 31st March 2026	50%	94,875	94,875	189,750
Complete by 31st March 2026	100%	565,800	0	565,800
Complete by 31st March 2026	40%	91,080	136,620	227,700
95% complete by 31st March 2026 but testing and commissioning still t	0%	0	293,231	293,231
90% complete by 31st March 2026	25%	0	0	0
Complete by 31st March 2026	100%	0	0	0
95% complete by 31st March 2026 but testing and commissioning still t	0%	0	0	0
95% Complete by 31st March 2026	50%	15,000	15,000	30,000
Planning management	75%	11,481	3,827	15,308
Generator (Hire costs)	80%	441,600	110,400	552,000
Reduced spec of pendant	100%	-24,840	0	-24,840
95% complete by 31st March 2026	75%	181,493	60,498	241,991
Sub Total		**1,601,590**	**714,451**	**2,316,041**
VAT recovery estimate		-32,640	-14,560	-47,200
Revised Sub Total - One off capital costs		**1,568,950**	**699,891**	**2,268,841**
Trust equipment into building - start installation 22nd April 2026	20%	120,000	480,000	600,000
Sub Total		**1,688,950**	**1,179,891**	**2,868,841**
Modular Theatre - ROU asset cost		**0**	**2,868,336**	**2,868,336**
Total by Financial Year		**1,688,950**	**4,048,227**	**5,737,177**

12.5. Revenue costs

The preferred option produces a recurrent contribution to the Trust as shown in the following table.

		2026/27		2027/28		2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/26
Activity Increases	Lower limb		348		418	418	418	418	418	418	418	418	418
	Foot and ankle		120		144	144	144	144	144	144	144	144	144
	O&G		80		96	96	96	96	96	96	96	96	96
Total Activity Changes			**548**		**658**	**658**	**552**	**552**	**552**	**552**	**552**	**552**	**552**

		2026/27		2027/28		2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/26
		WTE	£000's	WTE	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Contracted Income	H&W ICB		3,588		4,309	4,309	4,309	4,309	4,309	4,309	4,309	4,309	4,309
Excess Depreciation - Pass Through	H&W ICB		189		265	265	265	265	265	265	265	265	265
Total Income			**3,778**		**4,575**	**4,575**	**4,575**	**4,575**	**4,575**	**4,575**	**4,575**	**4,575**	**4,575**
Pay Costs	Anaesthetics	1.19	197	1.19	210	210	210	210	210	210	210	210	210
	Pre-Op	0.61	18	0.61	24	24	24	24	24	24	24	24	24
	T&O	0.60	98	0.00	0	0	0	0	0	0	0	0	0
	O&G	0.13	15	0.13	21	21	21	21	21	21	21	21	21
	Maternity	0.74	36	0.74	48	48	48	48	48	48	48	48	48
	Theatres	6.78	264	6.78	352	352	352	352	352	352	352	352	352
Total Pay Costs		**10.04**	**627**	**9.44**	**654**	**654**	**654**	**654**	**654**	**654**	**654**	**654**	**654**
Non Pay Costs	MSSE		265		318	318	318	318	318	318	318	318	318
	Implants		1,425		1,710	1,710	1,710	1,710	1,710	1,710	1,710	1,710	1,710
	Drugs		19		22	22	22	22	22	22	22	22	22
	Radiology/Pathology/Pharmacy		100		120	120	120	120	120	120	120	120	120
	Energy		65		65	65	65	65	65	65	65	65	65
	SSD		21		21	21	21	21	21	21	21	21	21
	Business Rates		16		16	16	16	16	16	16	16	16	16
	Soft FM Costs		26		26	26	26	26	26	26	26	26	26
Capital impact on revenue costs	Depreciation		189		265	265	265	265	265	265	265	265	265
	Interest		125		107	88	68	47	0	0	0	0	0
	PDC Dividends		83		111	118	126	135	151	159	153	147	140
	VAT on Lease		99		99	99	99	99	165	0	0	0	0
Total Non Pay Costs			**2,434**		**2,881**	**2,869**	**2,858**	**2,846**	**2,880**	**2,723**	**2,717**	**2,710**	**2,704**
Total Expenditure		**10.04**	**3,061**	**9.44**	**3,535**	**3,523**	**3,512**	**3,500**	**3,534**	**3,377**	**3,371**	**3,364**	**3,358**
Contribution			**717**		**1,040**	**1,051**	**1,063**	**1,075**	**1,041**	**1,197**	**1,204**	**1,210**	**1,217**

The table above shows the full financial position for this option over a ten-year period due to the changes in the capital impact on revenue costs. The average annual contribution over the ten-year period amounts to £1.08m.

In the 2026/27 financial year, the modular theatre is expected to be operational from the start of June 2026. Activity is anticipated to increase by 548 cases in year 1 with an increase in contracted income of £3.6m and revenue costs of £3.06m giving a contribution of £0.7m. 10.04wte of additional posts are required in Year 1 in order to achieve this income. Of the 10.04wte, there is 0.60wte fixed term Trauma & Orthopaedics consultant to complete activity to clear 52 week wait backlogs. Due to the part year effect, the contribution in Year 1 is lower than the recurrent position.

From the 2027/28 financial year, the activity is anticipated to increase by 658 cases compared to the current position with an increase in contracted income of £4.3m and costs of £3.5m giving a contribution of approximately £1.1m over the following 9 year period. The recurrent substantive requirement is 9.44wte in order to meet the activity performance.

This option requires an increase to the headcount and run rates over and above the Trust's current financial position. However, there will be a reduction in private sector spending amounting to, on average, £1.5m per annum as shown in the below table.

Use and cost of private sector for elective Orthopaedics:

Financial year	Provider	Volume	Cost of service
2025-26	Medinet (insourcing)	180	£1,311,507
2024-25	Nuffield Hereford	281	£1,368,279
2023-24	Nuffield Hospital SWFT	215 120	£1,755,155 £98,890

Financial Assumptions

- The increase in activity numbers have been provided by the service with an assumption on lower limb activity of 40% Knees and 60% Hips.
- Recurrent staffing is based on substantive in post and costs have been calculated based on 2025/26 pay scales. Year 1 requires an uplift of 10.04wte including 0.60wte fixed term consultant and 1.19wte Bank reducing to 9.44wte substantive staffing from Year 2 onwards.
- Non recurrent staffing (2026/27) assumes substantive for all areas apart from Anaesthetics which is based on Bank and Trauma & Orthopaedics which assumes a 12 month fixed term post.
- Non recurrent staffing and operation costs are based on 10 months with Estates costs based on full year.
- The capital impact on revenue costs is based on Option C as described in the capital costs section above.
- Within the income section, Excess Depreciation has been included per the capital guidance from NHS England.
- Within the non pay costs; MSSE, Implants, Drugs and Radiology, Pathology and Pharmacy costs have been calculated from 2025/26 Quarters 1 and 2 Patient Level Information Costing System (PLICS) data.

Financial Risks

- Contracted Income has been calculated based on Tariff Herefordshire and Worcestershire ICB may not be able to afford the increase in activity
- Pay costs assume substantive costs for most of the posts needed – there is a risk that if substantive are not recruited in time with increased spending needed on bank and agency.

Capital impact on revenue costs

As identified in the options review above, the revenue costs relating to capital for each option over 5 or 10 years vary in accordance with the duration of the assets operation and the costs incurred to extend the lease. The table below identifies the average cost per annum for each option as taken from Appendix B

Option	Duration	Cost/annum
A – 5-year lease	5 years	£1,150,525
B – 5-year lease plus further 5-year lease	10 years	£793,441
C – 5-years lease then purchase	10 years	£499,953

From the table it is shown that Option C is the best value in revenue terms.

12.6. Income

The following table shows the breakdown of additional activity and income.

Specialty	Activity Type	2026/27		Full Year (2027/28 onwards)	
		Additional Activity	Additional Income £000's	Additional Activity	Additional Income £000's
Orthopaedics	Lower Limb	348	2,694	418	3,236
Orthopaedics	Foot and Ankle	120	840	144	1,009
Obstetrics & Gynaecology		80	54	96	64
Total		**548**	**3,588**	**658**	**4,309**

The recurrent annual activity increase amounts to 658 patients with an additional income to the Trust amounting to £4.3m. The 2026/27 activity amounts to £3.6m due to the anticipated operational start date of the beginning of June 2026.

The table above assumes the Trust will be paid at tariff for this additional activity. The elective activity element of our contract is variable, and this is therefore a reasonable assumption. However, the ICB has a finite level or resources and payment for this additional activity. This needs to be formally agreed with the ICB, in the context of our overall elective activity and that of the system as a whole. There is therefore a risk that we are agreeing to a cost pressure of £4.3m.

12.7. Financial Summary

The tables below summarises the financial position for this option.

	2026/27		2027/28		2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/26
	WTE	£000's	WTE	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Total Income		3,778		4,575	4,575	4,575	4,575	4,575	4,575	4,575	4,575	4,575
Total Expenditure	10.04	3,061	9.44	3,535	3,523	3,512	3,500	3,534	3,377	3,371	3,364	3,358
Contribution		**717**		**1,040**	**1,051**	**1,063**	**1,075**	**1,041**	**1,197**	**1,204**	**1,210**	**1,217**

This option produces a contribution to the Trust of £1.1m per annum on an increasing basis.

13. Key Risks & mitigations

13.1. Capital availability

Section 13.4 on capital above identifies the impact of the preferred option on capital in both 2025/26 and 2026/27. Due to the programme being unable to deliver the theatre in full in 2025/26, not all the Estates Safety funds awarded can be utilised. In addition, costs will need to be managed in 2026/27 within local CDEL funding.

13.2. Programme

Timescales are tight and there are several unknown elements at this stage, largely due to the detailed groundworks required. However, the main contractor does have a good track record on delivering rapid construction both with the Trust and elsewhere. To ensure best chance of delivery it is proposed to go at risk with the first stage of the works under letter of intent with a view to finalising a decision on or around 4th December 2025.

There are three main construction risks:

a) Planning permission

Once agreement has been reached to proceed an application will be submitted but it is unlikely to be granted before intended use. It is considered low risk that planning will not be achieved and the planning department will be consulted as soon as we are sure the project is going ahead to keep them appraised on the plans.

b) Network rail consent

Due to the required cranage and proximity to the track consent will be required and an application has already been submitted. All surveys have been commissioned in order to be able to answer the questions usually asked in anticipation.

c) Service connections

To operate the facility various services (e.g. power and data) will need to be linked to the building and this will require delivery from partner organisations including under the PFI which can be slow.

13.3. Revenue costs

At this point there is a working assumption that additional elective income can be targeted to fund the increased overhead as around 70% of the additional capacity could be utilised to address current demand/waiting lists outside of maternity.

13.4. Quality

The solution proposed has been worked up to meet general required standards. Since the Trust used Darwin (for AMU) thy have been subsumed into the Portakabin group and have delivered a significant number of health facilities nationally and are also on some lots within the Procure 23 Framework. That said there were some concerned over some areas of quality in AMU (which was delivered in less than 4 months without a preset design) and this would need to be closely monitored. Lessons from that project include having a sensible snagging

period which may have picked up the key quality issues arising from working at breakneck speed noting AMU was handed over and patients moved in within a couple of hours.

13.5. Procurement

The proposal from Darwin has been assessed as they have a predesigned model and have existing information on the site. Whilst no formal market testing has been carried out it is highly unlikely that another provider would be able to deliver in time given the tight programme. It is proposed that the trust utilises the NHS Shared Business Services Framework for this project and this allows for direct award and is compliant with procurement rules.

13.6. Accounting treatment

There are a number of issues relating to accounting treatment that have been addressed in arriving at the cost enclosed in the business case.

IFRS 16 has been applied to the lease proposal for the Theatre and a Right of Use Asset value calculated for each option. There is a question mark regarding the inclusion of an optional right to purchase the asset within the lease. Option three assumes that the right to purchase the asset for a pre-determined price should be reflected in the Right of Use Asset value. Guidance indicates that if the lessee is reasonably certain to exercise the right to purchase then the ROU asset value should reflect the purchase price. IFRS16 does not allow a flexibility of approach, and the “reasonably certain” test should apply. Judgement is key and in this and in this instance, Option 3 specifically reflects the option to purchase and therefore the purchase cost within the calculation includes the purchase price.

A further issue has been addressed relating to the application of VAT on the lease cost. The issue of whether VAT should be included within costs when calculating ROU asset is subject to differing interpretations, however most accounting firms advise that VAT should be excluded from the Right of Use asset calculation and instead accounted for as an annual expense on an ongoing basis. This is consistent with the Trust’s current practice and has been adopted in the business case for all options.

Finally, there is the issue of when a ROU asset relating to a lease should be recognised. The Business case is predicated on the lease commencing in 2025/26 to allow the ROU asset to be recognised in the current year. Any inability to meet this requirement will prevent the business case from delivering its required goals within the funding timeframe. The assumption has been made that the asset lease will commence when the facility is delivered on-site prior to 31 March 2026. This assumption needs to be confirmed.

13.7. Site location

As the site location is larger than the existing ‘pad’, detailed design work is needed to understand the precise details for additional enabling works and for any service impact. For example the working assumption is that the ED drop off will not be affected but there could be a loss of one ambulance parking bay.

14. Impact Assessments

14.1. Equality Impact Assessment

The assessment indicates that the ‘Pregnancy and Maternity’ equality group will be impacted positively as a result of the introduction of a second Obstetric Theatre for reasons previously outlined in this paper.

14.2. Quality Impact Assessment

The area where the quality will potentially have the greatest improvements are ‘Clinical standards’ and ‘Productivity/Targets/Performance’ as an additional, fully functional and equipped second obstetric theatre will enable consistent adhesion to 'decision to delivery' intervals and concurrent procedures to be undertaken.

Patient safety, staff safety and experience will also be expected to dramatically improve as a result.

14.3. Sustainability Impact Assessment

This will be carried out as part of the detailed design process.

14.4. Data Protection Impact Assessment

No impact identified from a Data Protection perspective.

15. Impact on other areas of the trust

Impact on other areas of the trust and outcome of discussions (select all that apply)			
Clinical Support - Radiology	☐	Admin / management	☐
Clinical Support - Pathology	☐	Estates	☐
Clinical Support - Pharmacy	☐	Other Specialties / Pathways	☒
Clinical Support - Outpatients	☐	Other	☐
ICT Support – Application and/or infrastructure support	☐	No material impact	☐

There is also an expectation that the proposal will have a positive impact on the main theatre team once the second obstetric theatre is operational, as two procedures will be able to be managed simultaneously, increasing staff efficiency and productivity.

16. Implementation Timeline

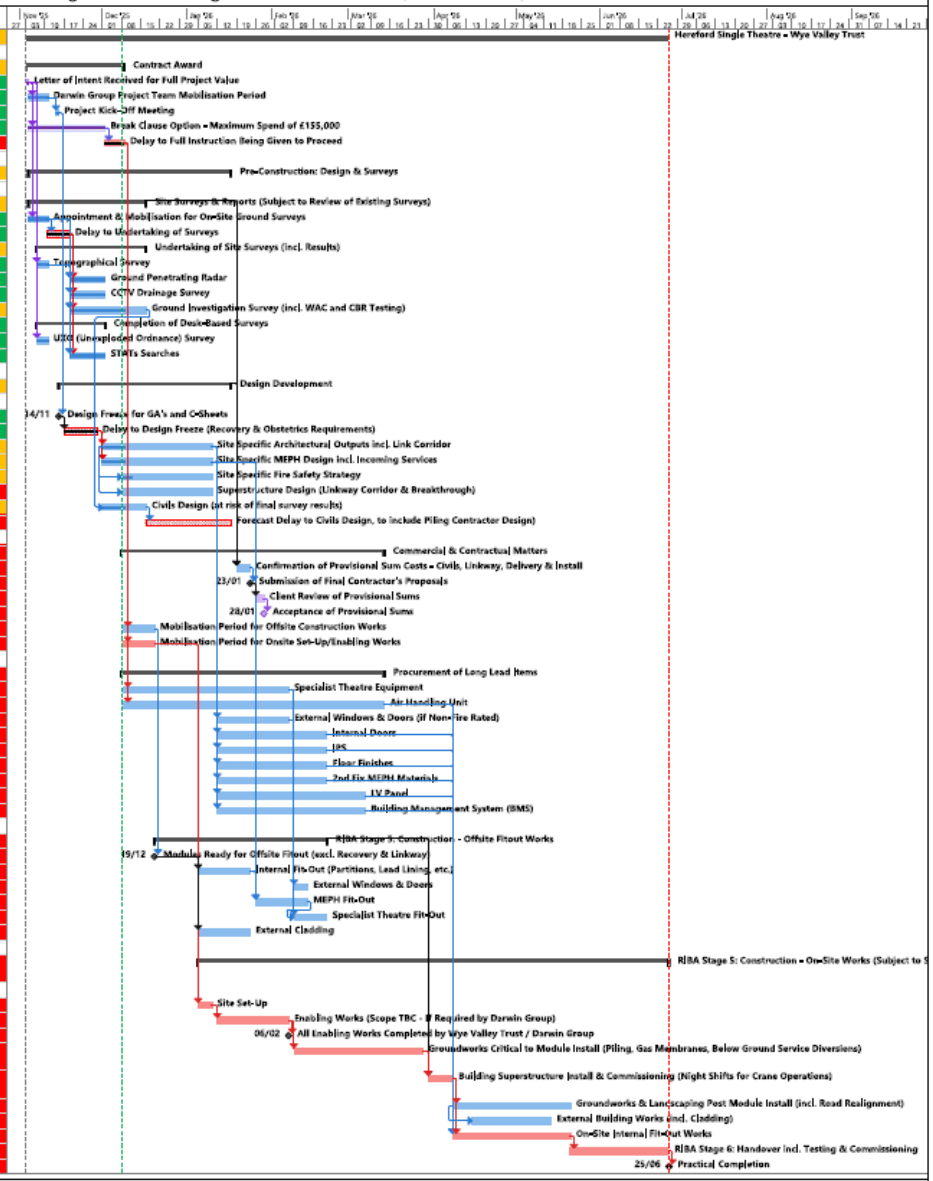
The current proposed programme is shown overleaf. The majority of works will be completed by early July 2026 and the planned go live date is 20th July 2026.

Milestones:

Letter of Intent for design	03/11/25
FBC Approval	05/02/26
Delivery of modules on site	15/04/26
Practical Completion	09/07/26
Anticipated patient activity	20/07/26

OPP1384163-DG-PR-W0001(P04)_Hereford Hospital Single Theatre_Programme_08.12.2025 (FOR REVIEW)

ID	Task Name	Duration	Start	Finish	Predecessors	Task Owner	% Complete
1	**Hereford Single Theatre - Wye Valley Trust**	**155 days**	**Mon 03/11/25**	**Thu 25/06/26**			**15%**
2							
3	**Contract Award**	**26 days**	**Mon 03/11/25**	**Mon 08/12/25**			**98%**
4	**Letter of Intent Received for Full Project Value**	1 day	Mon 03/11/25	Mon 03/11/25		Wye Valley Trust	100%
5	Darwin Group Project Team Mobilisation Period	5 days	Mon 03/11/25	Mon 10/11/25	4	Darwin Group	100%
6	Project Kick-Off Meeting	1 day	Fri 14/11/25	Fri 14/11/25	5FS+3 days	Darwin Group	100%
7	**Break Clause Option - Maximum Spend of £155,000**	20 days	Tue 04/11/25	Mon 01/12/25	4	Wye Valley Trust	100%
8	**Delay to Full Instruction Being Given to Proceed**	**5 days**	**Tue 02/12/25**	**Mon 08/12/25**	**7**	**Wye Valley Trust**	**90%**
9							
10	**Pre-Construction: Design & Surveys**	**44 days**	**Tue 04/11/25**	**Fri 16/01/26**			**53%**
11							
12	**Site Surveys & Reports (Subject to Review of Existing Surveys)**	**31 days**	**Tue 04/11/25**	**Tue 16/12/25**			**90%**
13	Appointment & Mobilisation for On-Site Ground Surveys	5 days	Tue 04/11/25	Mon 10/11/25	4	Darwin Group	100%
14	**Delay to Undertaking of Surveys**	**5 days**	**Tue 11/11/25**	**Tue 18/11/25**	**13**	**Wye Valley Trust**	100%
15	**Undertaking of Site Surveys (incl. Results)**	**28 days**	**Fri 07/11/25**	**Tue 16/12/25**			**85%**
16	Topographical Survey	2 days	Fri 07/11/25	Mon 10/11/25	4FS+3 days	Darwin Group	100%
17	Ground Penetrating Radar	9 days	Wed 19/11/25	Mon 01/12/25	13,14,16	Civils Engineer	100%
18	CCTV Drainage Survey	9 days	Wed 19/11/25	Mon 01/12/25	13,14,16	Civils Engineer	100%
19	Ground Investigation Survey (Incl. WAC and CBR Testing)	20 days	Wed 19/11/25	Tue 16/12/25	13,14,16	Civils Engineer	70%
20	**Completion of Desk-based Surveys**	**17 days**	**Fri 07/11/25**	**Mon 01/12/25**			100%
21	UXO (Unexploded Ordnance) Survey	2 days	Fri 07/11/25	Mon 10/11/25	4FS+3 days	Darwin Group	100%
22	STATs Searches	9 days	Wed 19/11/25	Mon 01/12/25	13,14,16	Civils Engineer	100%
23							
24	**Design Development**	**35 days**	**Fri 14/11/25**	**Fri 16/01/26**			**30%**
25							
26	**Design Freeze for GA's and C-Sheets**	0 days	Fri 14/11/25	Fri 14/11/25	6	Wye Valley Trust	100%
27	**Delay to Design Freeze (Recovery & Obstetrics Requirements)**	**30 days**	**Mon 17/11/25**	**Fri 28/11/25**	**26**	**Wye Valley Trust**	100%
28	Site Specific Architectural Outputs incl. Link Corridor	20 days	Mon 01/12/25	Fri 09/01/26	27	Darwin Group	30%
29	Site Specific MEPH Design incl. Incoming Services	20 days	Mon 01/12/25	Fri 09/01/26	27	MEPH Contractor	30%
30	Site Specific Fire Safety Strategy	15 days	Mon 08/12/25	Fri 09/01/26	28SS+5 days	Fire Officer	25%
31	Superstructure Design (Linkway Corridor & Breakthrough)	15 days	Mon 08/12/25	Fri 09/01/26	28SS+5 days	Darwin Group	0%
32	Civils Design (at risk of final survey results)	12 days	Mon 01/12/25	Tue 16/12/25	19FS-12 days	Civils Engineer	50%
33	**Forecast Delay to Civils Design, to include Piling Contractor Design)**	**13 days**	**Wed 17/12/25**	**Fri 16/01/26**	**32**	**Piling Contractor**	0%
34							
35	**Commercial & Contractual Matters**	**60 days**	**Mon 08/12/25**	**Fri 13/03/26**		ALL	0%
36	Confirmation of Provisional Sum Costs - Civils, Linkway, Delivery & Install	5 days	Mon 19/01/26	Fri 23/01/26	12,24	Darwin Group	0%
37	Submission of Final Contractor's Proposals	0 days	Fri 23/01/26	Fri 23/01/26	36	Darwin Group	0%
38	**Client Review of Provisional Sums**	3 days	Mon 26/01/26	Wed 28/01/26	37	Wye Valley Trust	0%
39	**Acceptance of Provisional Sums**	0 days	Wed 28/01/26	Wed 28/01/26	38	Wye Valley Trust	0%
40	Mobilisation Period for Offsite Construction Works	10 days	Mon 08/12/25	Fri 19/12/25	8FS-1 day	Darwin Group	0%
41	*Mobilisation Period for Onsite Set-Up/Enabling Works*	10 days	Mon 08/12/25	Fri 19/12/25	8FS-1 day	Darwin Group	0%
42							
43	**Procurement of Long Lead Items**	**60 days**	**Mon 08/12/25**	**Fri 13/03/26**		Darwin Group	0%
44	Specialist Theatre Equipment	35 days	Mon 08/12/25	Fri 06/02/26	8FS-1 day	MEPH Contractor	0%
45	Air Handling Unit	60 days	Mon 08/12/25	Fri 13/03/26	8FS-1 day	MEPH Contractor	0%
46	External Windows & Doors (If Non-Fire Rated)	20 days	Mon 12/01/26	Fri 06/02/26	28	Window & Door Contractor	0%
47	Internal Doors	30 days	Mon 12/01/26	Fri 20/02/26	28	Internals Contractor	0%
48	IPS	30 days	Mon 12/01/26	Fri 20/02/26	28	Internals Contractor	0%
49	Floor Finishes	30 days	Mon 12/01/26	Fri 20/02/26	28	Internals Contractor	0%
50	2nd Fix MEPH Materials	30 days	Mon 12/01/26	Fri 20/02/26	29	MEPH Contractor	0%
51	LV Panel	40 days	Mon 12/01/26	Fri 06/03/26	29	MEPH Contractor	0%
52	Building Management System (BMS)	40 days	Mon 12/01/26	Fri 06/03/26	29	MEPH Contractor	0%
53							
54	**RIBA Stage 5: Construction - Offsite Fitout Works**	**35 days**	**Fri 19/12/25**	**Fri 20/02/26**		Darwin Group	0%
55	Modules Ready for Offsite Fitout (excl. Recovery & Linkway)	0 days	Fri 19/12/25	Fri 19/12/25	40	Darwin Group	0%
56	Internal Fit-Out (Partitions, Lead Lining, etc.)	15 days	Mon 05/01/26	Fri 23/01/26	55	Internals Contractor	0%
57	External Windows & Doors	5 days	Mon 09/02/26	Fri 13/02/26	46	Window & Door Contractor	0%
58	MEPH Fit-Out	15 days	Mon 26/01/26	Fri 13/02/26	29,56	Internals Contractor	0%
59	Specialist Theatre Fit-Out	10 days	Mon 09/02/26	Fri 20/02/26	44,58FS-10 days	MAT	0%
60	External Cladding	15 days	Mon 05/01/26	Fri 23/01/26	55	Externals Contractor	0%
61							
62	**RIBA Stage 5: Construction - On-Site Works (Subject to Surveys and Final Design)**	**120 days**	**Mon 05/01/26**	**Thu 25/06/26**		Darwin Group	0%
63							
64	*Site Set-Up*	5 days	Mon 05/01/26	Fri 09/01/26	41	Darwin Group	0%
65	*Enabling Works (Scope TBC - if Required by Darwin Group)*	20 days	Mon 12/01/26	Fri 06/02/26	64	Darwin Group	0%
66	**All Enabling Works Completed by Wye Valley Trust / Darwin Group**	0 days	Fri 06/02/26	Fri 06/02/26	65	Wye Valley Trust	0%
67	*Groundworks Critical to Module Install (Piling, Gas Membranes, Below Ground Service Diversions)*	35 days	Mon 09/02/26	Fri 27/03/26	65	Darwin Group	0%
68	*Building Superstructure Install & Commissioning (Night Shifts for Crane Operations)*	5 days	Mon 30/03/26	Tue 07/04/26	54,67	Darwin Group	0%
69	Groundworks & Landscaping Post Module Install (incl. Road Realignment)	30 days	Wed 08/04/26	Wed 20/05/26	68	Darwin Group	0%
70	External Building Works (incl. Cladding)	20 days	Wed 15/04/26	Wed 13/05/26	69SS+5 days	Darwin Group	0%
71	*On-Site Internal Fit-Out Works*	30 days	Wed 08/04/26	Wed 20/05/26	47,48,49,50,45FS-10 da	Darwin Group	0%
72	*RIBA Stage 6: Handover incl. Testing & Commissioning*	25 days	Thu 21/05/26	Thu 25/06/26	71	Darwin Group	0%
73	**Practical Completion**	0 days	Thu 25/06/26	Thu 25/06/26	72	Wye Valley Trust	0%



Mon 08/12/25 | Page 1 | Client Owned Tasks / *Critical Path Activities*

17. Leadership and Project Management

Role	Name
Senior Responsible Officer (SRO)	Alan Dawson - Chief Strategy and Planning Officer
Obstetrics	Justine Jeffery - Director of Midwifery Susan Hughes - Deputy Director of Midwifery Hamza Katali, Consultant - Obstetrics Clinical Director Duncan Cochrane, Consultant – Anaesthetics Clinical Lead Obstetrics Julie Vickers, Consultant - Paediatrician Hannah Duggan - General Manager - Project support Candida Kuegler -Service Delivery and Programme Manager – Project Support
Surgical & Theatres	Jonathan Boulter – Associate Chief Operating Officer - Surgical Division Jenny Connaughton – General Manager, Theatres & Anaesthetics Directorate Liz Williams – General Manager, Head, Neck & Orthopaedics David Stoten, Theatres Manager Emma Woolley - Theatre Team Leader
Estates	Christian Homersley - Associate Chief Estates and Capital Planning Officer Tony Guerri - Estates adviser Lydia Phillips -Estates Project Manager Allan Taylor - Estates Project Manager
Other	Lynne Kedward, Associate Chief Operating Officer - Performance Improvement Operational Project Support Laura Weston, Lead Nurse Infection, Prevention and Control

18. Workforce Plan

18.1. Obstetrics

To enable the additional laminar flow theatre option to be delivered, an enhancement to the existing midwifery workforce will be required. Currently, one dedicated Midwife supports the elective c-sections which are performed within the Maternity Unit, with Midwifery support provided, if required, from rostered, Inpatient Team Midwives. However, with the laminar flow theatre being located away from the Maternity Unit on the ground floor of the hospital, and with the design plans containing separate preparation and recovery areas for the women, to ensure 1-2-1 care and continuous patient flow, an additional Midwife will be required to support with all elective c-sections.

Currently, the elective c-sections are undertaken in the mornings only, on three days per week (Mondays, Wednesdays and Fridays, with the exception of Bank Holidays). However, once the new theatre is completed, the theatre schedule will change to full day lists, delivered over two days per week (Tuesdays and Fridays). This new schedule would require a Midwifery staffing uplift to ensure the elective c-section lists are fully staffed by two dedicated Midwives.

18.2. Other Surgical Specialties

To deliver the majority of the additional surgical sessions, existing fully funded clinical posts within the current core establishment of Orthopaedics department will be utilised. Additionally, a 0.6WTE consultant will be required. This is driven by backlog reduction and return to constitutional standard requirements. This consultant post will be recruited on a 12 month fixed term contract basis. Anaesthetist cover of 1.19WTE consultants is required based on the split of maternity activity over two theatres and the additional surgical elective activity. A small amount of Obstetrics & Gynaecology consultant time (0.13WTE) is required to deliver elective c-section within the new theatre.

Theatre staffing requirements are detailed within section 19.3. These posts will support the operation of the new theatre. Elective c-section patients will be recovered within the recovery room based in the new theatre, as per clinical recommendation for this cohort of patients. Specialties using the remaining six sessions will recover patients in the main theatre recovery unit, ensuring additional recovery staff are not required for these six sessions.

The Senior Management Team of the Surgical Division have undertaken a 'check and challenge' review of the theatre staffing requirements.

18.3. Summary

Additional workforce requirements					
Staff Group	**Position/Title**	**Permanent/Fixed Term/ etc.**	**New post/skill-mix change/ etc.**	**Band**	**WTE**
Medical & Dental	Anaesthetics	Permanent	New position	Cons	1.19
Nursing & Maternity	Pre-Op	Permanent	New position	2	0.61
Medical & Dental	T&O Consultant	Fixed Term Temp	New position	Cons	0.60
Nursing & Maternity	Obstetrics & Gynaecology	Permanent	New position	Cons	0.13
Additional Clinical Services	Theatres	Permanent	New position	2-5	6.78
				Total	**10.04**

19. Conclusions and Recommendations

The objective of this project is to incorporate ELCS theatre sessions into main theatres and increase surgical capacity.

The proposed solution is (Option 4) to incorporate Elective Caesarean Section (ELCS) theatre sessions into main theatres and increase surgical capacity by procuring a single new theatre and locate this on the 'theatre 10 pad' which previously housed a mobile theatre connected to main theatres.

This proposal will partially resolve the Obstetric theatre capacity issues so the Trust will continue to pursue in the future the discounted Option 3 - Second obstetric theatre on the second floor (as detailed in the SOC WVTBC0152).

20. Post-Implementation Evaluation Plan

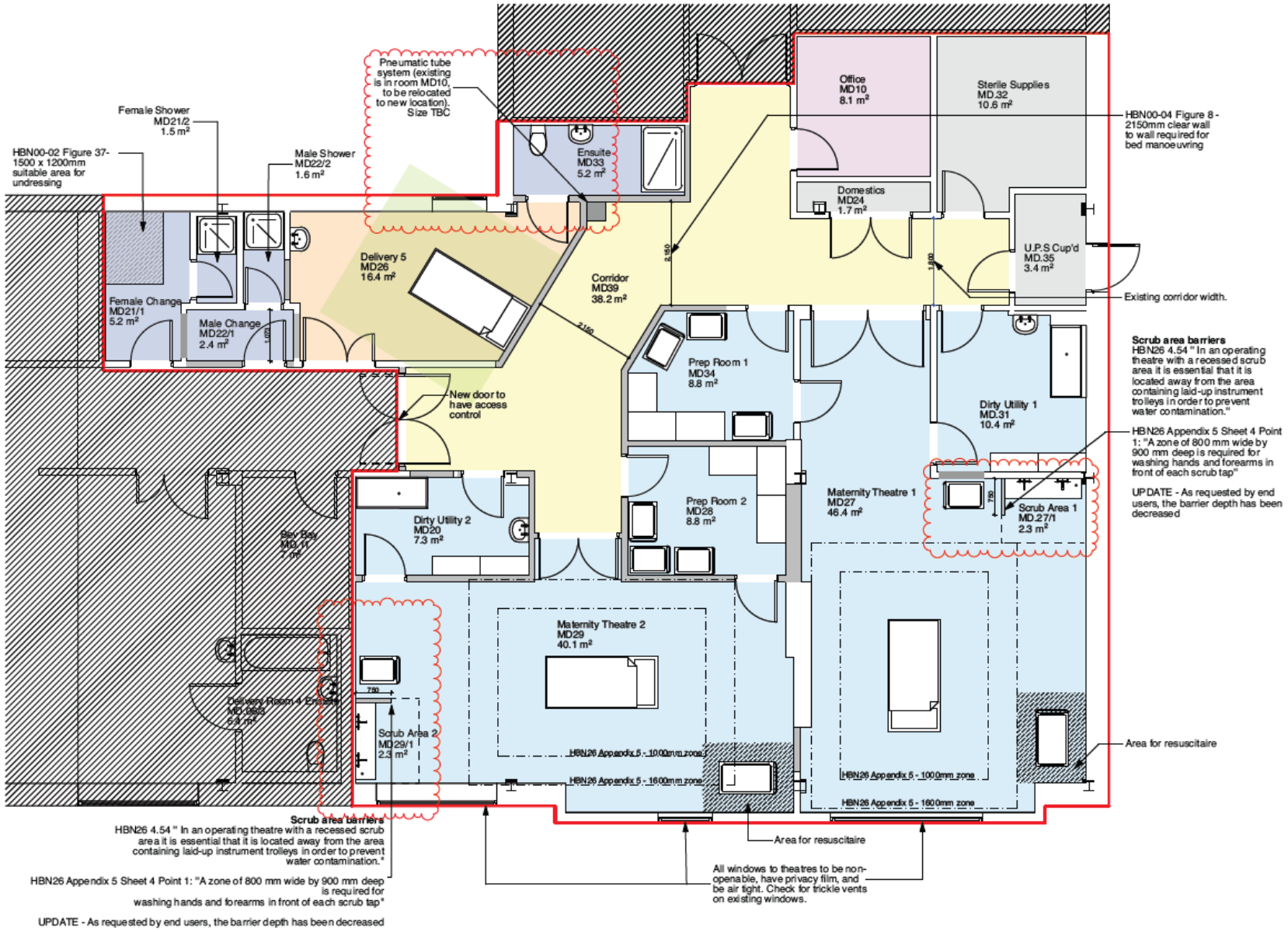
The project will be evaluated by closely monitoring the agreed measures linked to outcomes, and undertaking a benefits realisation evaluation to identify demonstrable positive impacts on outcomes.

21. Appendix A – Strategic Outline Case WVTBC0152 October 2025

A new proposal was developed to provide a second obstetric theatre adjacent to the existing theatre. This was developed into a Strategic Outline Case (SOC) WVTBC0152 that was approved by the Trust Management Board (TMB) on 05/09/25 and private Board on 02/10/25.

Subsequent to the approval of the SOC it has become apparent that this new scheme was also not viable as Sodexo has confirmed they can only meet the March deadline if given full access to the space. A phased approach would delay completion to July 2025 and push 50% of costs into the next financial year, for which there is no funding cover.

Full details are given below.


Pneumatic tube system (existing is in room MD10, to be relocated to new location). Size TBC
Female Shower MD21/2 1.5 m²
Male Shower MD22/2 1.6 m²
HBN00-02 Figure 37- 1500 x 1200mm suitable area for undressing
Ensuite MD33 5.2 m²
Office MD10 8.1 m²
Sterile Supplies MD.32 10.6 m²
HBN00-04 Figure 8 - 2150mm clear wall to wall required for bed manoeuvring
Domestics MD24 1.7 m²
U.P.S Cup'd MD.35 3.4 m²
Existing corridor width.
Delivery 5 MD26 16.4 m²
Corridor MD39 38.2 m²
Female Change MD21/1 5.2 m²
Male Change MD22/1 2.4 m²
Prep Room 1 MD34 8.8 m²
New door to have access control
Dirty Utility 1 MD.31 10.4 m²
Scrub area barriers
HBN26 4.54 " In an operating theatre with a recessed scrub area it is essential that it is located away from the area containing laid-up instrument trolleys in order to prevent water contamination."
HBN26 Appendix 5 Sheet 4 Point 1: "A zone of 800 mm wide by 900 mm deep is required for washing hands and forearms in front of each scrub tap"
UPDATE - As requested by end users, the barrier depth has been decreased
Dirty Utility 2 MD20 7.3 m²
Prep Room 2 MD28 8.8 m²
Maternity Theatre 1 MD27 46.4 m²
Scrub Area 1 MD.27/1 2.3 m²
Bay Bay MD.11 7 m²
Maternity Theatre 2 MD29 40.1 m²
Delivery Room 4 Ensuite MD.09/3 6.4 m²
Scrub Area 2 MD29/1 2.3 m²
HBN26 Appendix 5 - 1000mm zone
HBN26 Appendix 5 - 1600mm zone
Area for resuscitaire
Scrub area barriers
HBN26 4.54 " In an operating theatre with a recessed scrub area it is essential that it is located away from the area containing laid-up instrument trolleys in order to prevent water contamination."
HBN26 Appendix 5 Sheet 4 Point 1: "A zone of 800 mm wide by 900 mm deep is required for washing hands and forearms in front of each scrub tap"
UPDATE - As requested by end users, the barrier depth has been decreased
All windows to theatres to be non-openable, have privacy film, and be air tight. Check for trickle vents on existing windows.

This was developed into a Strategic Outline Case (SOC) WVTBC0152 that was approved by the Trust Management Board (TMB) on 05/09/25 and private Board on 02/10/25.

Subsequent to the approval of the SOC it has become apparent that this new scheme was also not viable.

Timescale risks

As highlighted in the SOC one of the main risks was not being able to complete the project by 31st March 2026 to meet the funding requirements.

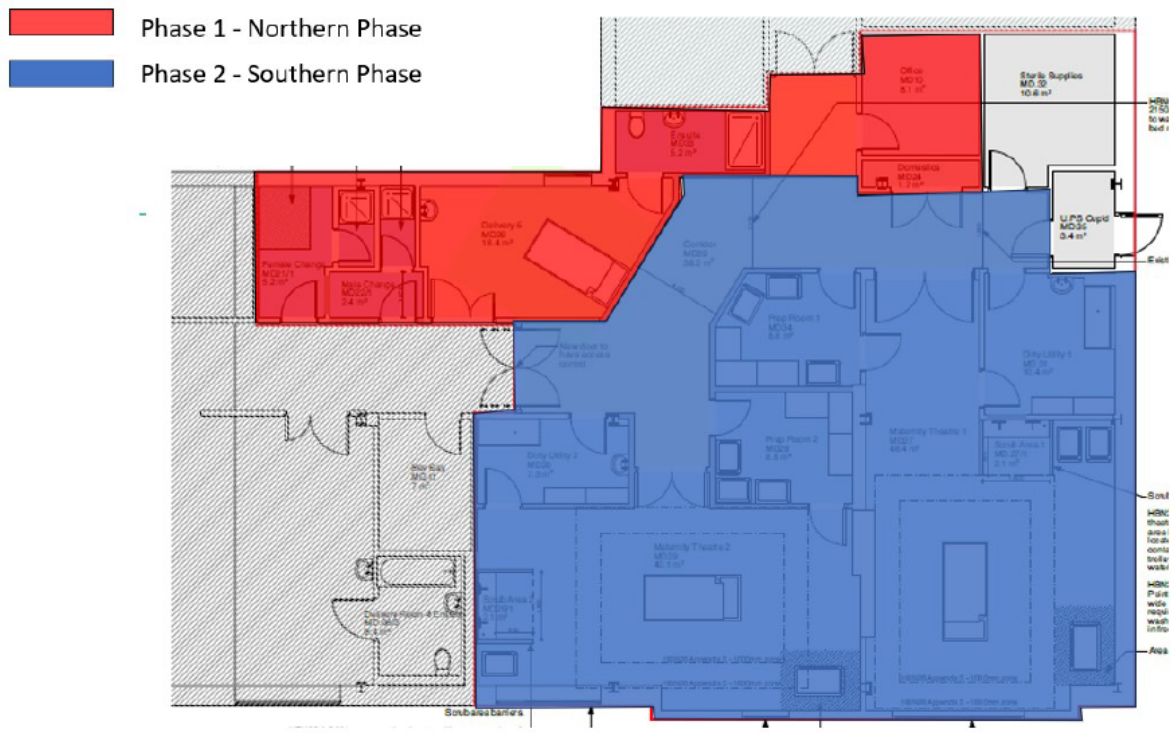
The originally proposed programme was itself challenging but all stakeholders were fully aware of these timescales. Subsequently it became apparent that lead times on key equipment meant the project timescales could not be met.

Clinical risks

The SOC proposed that the building work would be undertaken in four phases but working with key stakeholders it was established that this would also not actually meet the timescales and it would not be possible to undertake this four-phase build work in the live environment and therefore would not meet two of the original SOC Critical Success Factors (CSFs)

- SOC CSF3 – Must have minimal impact on the existing theatre
- SOC CSF4 – Must have minimal impact on the other existing clinical and support space

An alternative two phase approach was subsequently proposed (as detailed below) that required vacation of the unit during the build works.



Proposed Phasing Plan

For this approach alternative temporary provision of obstetric theatre capacity would therefore be required (for both elective and emergency activity) but it has not been possible to find a solution that is clinically safe as the emergency obstetric theatre needs to be in close proximity to paediatric and neonatal teams in the event of a newborn emergency.

22. Appendix B – Financial Analysis

See separate attachment.

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