

WVT Trust Board Held in Public

Thu 04 June 2026, 13:00 - 14:30

MS Teams

Agenda

13:00 - 13:05 **1. Going the Extra Mile Awards**

5 min

Frances Martin

Employee: Dorota Koim

Team: Oxygen CNS Team: Represented by Laura Lucas, Claire Sweeney, Lisa-Marie Long

13:05 - 13:06 **2. Apologies for Absence**

1 min

Information Frances Martin

13:06 - 13:06 **3. Quorum & Declarations of Interest**


0 min

Information Frances Martin

13:06 - 13:08 **4. Minutes of the Meeting held on the 2nd April 2026**

2 min

Approval Frances Martin

 4 - Public Board Minutes - April 2026 - Draft for approval~v1 FM.pdf (8 pages)

13:08 - 13:09 **5. Matters Arising and Action Log**

1 min

Discussion Frances Martin

 5 - Public Board Action Log - June 2026.pdf (1 pages)

13:09 - 13:14 **6. Managing Director's Report**

5 min

Information Sarah Shingler

 6 - MD Update Report Coversheet - June 2026 - SS.pdf (1 pages)

 6a - MD Board Report - June 2026 - SS - Final.pdf (5 pages)

13:14 - 13:26 **7. Integrated Performance Report**

12 min

Information Sarah Shingler

 7 - WVT - IPR Board May 2026 final.pdf (21 pages)

7.1. Quality

Lucy Flanagan / Chizo Agwu

7.2. Operational

Andrew Parker

7.3. Workforce

Geoffrey Etule

7.4. Finance

Katie Osmond

13:26 - 13:31 **8. Freedom to Speak Up Annual Report**

5 min

Assurance Jo Sandford

📄 8 - FTSU Annual Report 2025-26 ~FINAL.pdf (8 pages)

13:31 - 13:46 **9. Quality**

15 min

9.1. Quality Committee Escalation & Assurance Report

Assurance Ian James

📄 9.1 - Quality Committee Escalation Assurance Report April 2026 v1.1 - Final.pdf (3 pages)

9.2. Trust Quality Account 2025/26

For Approval Lucy Flanagan

📄 9.2 - Coversheet Trust Quality Account 25-26.pdf (1 pages)

📄 9.2a - WVT Quality Account 25.26 draft.V6 270526.pdf (97 pages)

9.3. Perinatal Safety Report

Assurance Justine Jeffery

📄 9.3 - Perinatal Safety Report Q4 Board version - final.pdf (19 pages)

9.4. Perinatal Staffing Reports - March & April 2026

Assurance Justine Jeffery

📄 9.4a - Midwifery and Neonatal Staffing Report March 2026.pdf (9 pages)

📄 9.4b - Midwifery and Neonatal Nurse Staffing Report April 2026.pdf (9 pages)

13:46 - 13:54 **10. Integrated Care Oversight and Assurance Committee Report**

8 min

Assurance Eleanor Bulmer

📄 10 - ICOAC Escalation Assurance Report 21.04.26.pdf (2 pages)

10.1. One Herefordshire Alliance Agreement

For Approval Sarah Shingler

📄 10.1a - Public Board Front Sheet Alliance Agreement.pdf (3 pages)

📄 10.1b - One Herefordshire Health and Care Partnership Alliance Agreement FINAL DRAFT SS2.pdf (25 pages)

13:54 - 13:59 **11. Children and Young People Committee Escalation and Assurance Report**

5 min

Assurance Jo Rouse

📄 11 - CYP Committee Escalation Assurance Report May 2026.pdf (5 pages)

13:59 - 14:10 **12. Governance and Risk**

11 min

12.1. Audit Committee Escalation and Assurance Report


Assurance Nicola Twigg

 12.1 - Audit Committee Escalation & Assurance Report 13.5.2026.pdf (2 pages)

12.2. Revised Standing Financial Instructions

For Approval *Katie Osmond*


 12.2a - SFI and Scheme of Delegation Update - covering paper.pdf (1 pages)

 12.2b - WVT SFIs 2025-26.pdf (37 pages)

 12.2c - Scheme of Delegation May26.pdf (1 pages)

12.3. Executive Risk and Compliance Committee Terms of Reference

For Approval *Sarah Shingler*

 12.3 - ERCC TOR Cover sheet June 2026.pdf (1 pages)

 12.3a - Executive Risk and Compliance Committee Terms of Reference v2.pdf (3 pages)

12.4. Use of the Trust Seal Biannual Report

Information *Gwenny Scott*

 12.4 - Biannual Report for June Board - Use of Trust Seal~v1.pdf (1 pages)

12.5. Foundation Group Board Workshop Report - 6th May 2026

Information *Frances Martin*

 12.5 - FG Board Workshop Report - 6th May 2026.pdf (2 pages)

14:10 - 14:10 **13. Any Other Business**

0 min

Frances Martin

14:10 - 14:15 **14. Questions from Members of the Public**


5 min

Discussion *Frances Martin*

14:15 - 14:15 **15. Acronyms**

0 min

For Information

 15 - Acronyms - 2026.pdf (3 pages)

14:15 - 14:15 **16. Date of Next Meeting: 2nd July 2026 at 1.00 p.m.**

0 min

WYE VALLEY NHS TRUST
Minutes of the Trust Board Held in Public
Held on 2nd April 2026 at 1.00 pm – 2.30 pm
MS Teams

Present (Voting):		
Frances Martin	FM	Chair / Meeting Chair
Chizo Agwu	CA	Chief Medical Officer
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Ian James	IJ	Non-Executive Director
Katie Osmond	KO	Chief Finance Officer/Deputy Managing Director
Grace Quantock	GQ	Non-Executive Director
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
Kieran Lappin	KL	Associate Non-Executive Director
Andy Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director
In Attendance		
Justine Jeffery	JJ	Director of Midwifery
Lou Robinson	LR	Deputy Company Secretary for the minutes
Gweny Scott	GS	Associate Director of Corporate Governance
Apologies:		
Glen Burley	GB	Chief Executive Officer (Voting)

Ref	Item	Lead	Purpose	Format
1	Apologies for Absence	FM	Information	Verbal
Noted as above.				
2	Quorum and Declarations of interest	FM	Information	Verbal
<p>The Board was quorate.</p> <p>FM made a declaration regarding the recent appointment as Chair for Wye Valley NHS Trust and for Worcestershire Acute Hospitals NHS Trust. This additional interest has been recorded on the Trust Board Register of Interests.</p> <p><u>Chair's Introduction</u></p> <p>FM noted that Russell Hardy's tenure as Chair had now ended but he had now been appointed Regional Chair for NHSE. FM expressed that the Trust was delighted by his appointment and looked forward to his continued interest and encouragement for Wye Valley and the wider Foundation Group.</p> <p>FM welcomed GB's return from secondment as the substantive Chief Executive for the Group. GB will continue to support NHSE in a partial national role.</p> <p>FM finally offered thanks to Stephen Collman, who served as Acting Chief Executive during GB's secondment. He had now returned to his substantive role as Managing Director at Worcestershire Acute Hospitals NHS Trust.</p> <p>FM summarised that the Board workshop undertaken that morning had focused on the frailty virtual ward, illustrating how partnership working with primary care and community services enables people to be cared for at home, avoiding unnecessary</p>				

admissions and supporting earlier discharge. This provided a strong, practical example of the Trust’s ambitions in action. The Board then heard a thought-provoking presentation from the Director of Public Health for Herefordshire on health inequalities, population needs, and how services and resources should be targeted to support healthy, fulfilling lives and prevent ill health. This reinforced the Trust’s role in neighbourhood health and its responsibilities as a major anchor institution and employer.

The workshop concluded with a presentation from surgical division colleagues highlighting significant improvements in productivity and utilisation of the elective surgical hub, which has now received national recognition under the ‘Getting It Right First Time’ programme. The discussion emphasised the importance of ambition, culture and preparedness in enabling the Trust to secure resources and deliver timely elective care.

3	Minutes of meeting on 5th February 2026	FM	Approval	Enclosure 01
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Approved.

4	Matters Arising and Action Log	FM	Information	Enclosure 02
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The Action Log was noted.

5	Medium Term Plan 2026/27 to 2027/28 - including Financial Plan and Budgets for 2026/27	KO	Approval	Enclosures 03-04
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KO explained that the Trust submitted its Medium-Term Plan covering 2026/27 to 2028/29, with particular focus on the 2026/27 financial plan, activity, performance, workforce and finance. The 2026/27 plan was compliant, delivering a planned £20.1m deficit that was fully supported by national deficit funding, resulting in a balanced submitted position. Achieving this requires just under £25m of efficiencies, equivalent to around 6% of total expenditure, which was significantly above national expectations and reflects the Trust’s continued reliance on deficit support. Around £16m of these efficiencies had been identified at the time of submission, with approximately £14m assessed as higher risk, and £4m of additional financial risk had been accepted to enable submission of a compliant plan.

Years two and three of the plan were currently around £7m short of compliance in each year and will require further work to close those gaps. Key risks highlighted included delivery of the efficiency programme and contractual risks, particularly around unfunded activity growth and ongoing discussions with Welsh commissioners. The plan also set out delegated divisional budgets, workforce establishments, and the Trust’s capital and cash position, with a strong focus on accelerating transformation to support longer-term sustainability.

NT questioned whether the reset of the urgent and emergency care payment mechanism would be better or harder for the Trust financially. KO explained that the change moves the Trust away from a fixed-envelope payment system, where increases in activity were not funded, towards a variable mechanism that resets the baseline to reflect current demand. Under the new approach, if activity increases, the Trust would receive additional funding at a marginal rate, and if demand falls, funding would reduce, also at a marginal rate. She emphasised that while the Trust ultimately wanted to see reduced demand and improved flow, the revised mechanism provided protection in both directions, making it a more balanced and responsive system.

AD explained that the medium-term plan and five-year integrated delivery plan were presented for information, bringing together activity, workforce, financial and performance plans in one coherent narrative. It was noted that the plan aligned closely with the Trust’s strategy, reflected the latest ICB priorities, and set out how the Trust will work in partnership at both place and system level. The plan clearly articulated the Trust’s transformation approach, showing how strategic ambitions, operational delivery and partnership working were integrated to support sustainable improvement over the medium term.

The Board approved the Final Operational / Financial Plan and Budgets.

6	Trust Strategy and Objectives 2026/27	AD	Approval	Enclosures 05-07
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AD explained that the Trust had developed a refreshed, single-page strategy that brought together its purpose, mission and a newly articulated vision. The vision signals a clear intent for the organisation not only to deliver high-quality care but also to take a stronger role in shaping future health services for Herefordshire alongside partners. The strategy sets out five areas that will underpin delivery, including being a good employer, driving innovation, strengthening key services, ensuring people receive care in the right place, and fulfilling the Trust’s wider responsibilities as a major local organisation.

The Board has been heavily involved in shaping the strategy and that the next step would be to allocate themes to executive leads so detailed plans can be developed. The draft objectives for the coming year were presented, which align closely with the strategic

themes. These objectives may need some refinement in wording, but together they set out the core priorities the Trust aimed to deliver, with further work to follow to finalise and communicate them across the organisation.

The Board agreed the importance of the objectives being sharp, understandable and actionable noting the wording and framing would need further refinement to ensure they clearly conveyed priorities and supported effective execution, reaffirming that this was part of an ongoing process rather than a finalised position.

The Board approved the Trust Strategy and Objectives 2026/27.

7	Chief Executive's Report	SS	Information	Enclosures 08
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The report was taken as read.

There had been strong overall performance and staff engagement despite the ongoing system pressures and all four Trusts performed above average across every People Promise theme in the NHS staff survey. WVT's engagement score being the best in region receiving national recognition for our top rankings and most improved scores across the foundation group, which just proved the great culture and the leadership in each of the four Trusts.

Urgent and emergency care remained the main operational risk with four-hour performance below target at 63% with sustained pressure from high demand, acuity and a temporary estate constraint due to building work being done to increase assessment capacity. This had resulted in a 35% loss of our acute floor space.

The Trust was noted as top national improver in cancer and elective care.

Financially, the biggest challenge was around the ongoing conversations with Wales around parity funding and ongoing cost of care, but the Trust would continue to have those conversations in the coming months.

The Board accepted the Chief Executive's Report.

8	Integrated Performance Report	SS	Information	Enclosures 09-10
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The paper was taken as read.

SS introduced the Integrated Performance Report and acknowledged the considerable effort of the executive and divisional teams in driving performance improvement and managing significant operational change. It was noted that colleagues were working extremely hard to deliver improvement across performance, quality and productivity, while also planning for forthcoming industrial action after Easter. SS highlighted the importance of maintaining safe services and clear plans during this challenging period and expressed her thanks to the executive team for their leadership and resilience in sustaining delivery under ongoing pressure.

8.1	Quality (Including Mortality)	LF/CA
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LF reported that corridor care and the use of temporary escalation spaces remained the Trust's most significant quality concern, following receipt of the national guidance on definitions and oversight. A clinically led review of all escalation areas had resulted in agreement to reduce the number of spaces deemed inappropriate for patient care, to clarify the order in which remaining spaces were used, and to explore options to convert some temporary beds into substantive capacity. Alongside this risk, it was highlighted the Trust achievement of the UNICEF Baby Friendly Gold Award for maternity services, sustained improvement in the timely administration of Parkinson's medications with over 90% compliance and national recognition, and the extension of this work to other time-critical medicines. LF further reported very positive results from the Patient-Led Assessments of the Care Environment, with notable improvements in privacy and dignity, and in dementia and disability domains, bringing the Trust close to or above national averages in most areas.

Mortality

CA reported a significant improvement in mortality for February, with the crude mortality rate falling markedly and the total number of deaths almost halving compared with January. Improvements were seen across several major diagnostic groups, including sepsis, pneumonia and heart failure. However, fracture neck of femur continues to show higher than expected mortality despite improvements to pathways and performance that were above the national average for best-practice tariff metrics. In response, the Trust voluntarily invited a GIRFT peer review of the fracture neck of femur pathway, which provided reassurance on progress made and identified further opportunities to embed enhanced recovery and review post-operative analgesia. While awaiting the final report, work had commenced on these areas. CA also confirmed that mortality governance remained strong, with services regularly presenting learning and improvement actions through the Learning from Deaths processes.

8.2	Activity and Performance	AP		
<p>AP reported strong progress in elective care, highlighting a significant reduction in the waiting list of almost 10% over the year, delivery of the NHS requirement to reduce 52-week waits to below 1% of the list, and the Trust achieving the second-best referral-to-treatment performance in the region. It was noted that the elective surgical hub was now fully accredited, reflecting improved theatre utilisation, increased cases per list and sustained productivity gains driven by clinical and operational leadership.</p> <p>Cancer performance had also improved, with consistent delivery against the 28-day faster diagnosis standard and sustained achievement of the 62-day treatment standard above national thresholds, supported by local implementation of the national cancer plan and partnership working within One Herefordshire.</p> <p>AP acknowledged that urgent and emergency care remained challenging, with congestion, reduced flow and corridor care continuing to impact performance, although estate works expanding same-day emergency care capacity was going live. AP outlined focused recovery actions, including GIRFT support, strengthened ambulatory pathways, improved front-door navigation, targeted reductions in short length-of-stay admissions and closer collaboration with partners to develop neighbourhood health alternatives to hospital care.</p>				
8.3	Workforce	GE		
<p>GE reported that workforce performance remained broadly positive, with most key workforce indicators showing improvement following a particularly challenging winter period. Sickness absence was beginning to reduce, reflecting targeted management actions and continued support for staff wellbeing, which remains a core priority.</p> <p>To ensure alignment with the medium-term service and financial plans, the Trust has introduced a voluntary redundancy programme limited to non-clinical roles, with applications considered on a case-by-case basis to ensure service sustainability and affordability. Strong progress in workforce development, highlighting the Trust's success in winning the Herefordshire Large Employer Apprenticeship Award, recognised effective use of the apprenticeship levy to grow and develop the workforce. GE emphasised that staff engagement and wellbeing continued to underpin performance delivery, with further discussion on staff survey results scheduled later in the agenda.</p>				
8.4	Finance Performance	KO		
<p>KO reported that at month 11 the Trust delivered a year-to-date surplus of around £1.4m, which was slightly worse in February but still £2.2m ahead of plan overall. Agency expenditure continued to reduce and remained just over 3% of the pay bill, staying below the national ceiling. Delivery of the efficiency programme was behind plan by around £2.1m at this point in the year, creating a small element of recurrent risk moving into 2026/27 that will need mitigation.</p> <p>Despite this, the Trust was confident of achieving its break-even position for the year, with a potential small upside currently being worked through as part of the accounts process. It was also confirmed that receipt of additional deficit support funding linked to compliant financial performance had provided a cash benefit. Cash levels remain stable and capital spend was forecast to undershoot plan by approximately £0.9m due to an agreed extension to the integrated energy centre scheme, which does not raise concern.</p> <p>The focus had now shifted fully to delivery in the new financial year.</p> <p>The Board accepted the Integrated Performance Report.</p>				
9	Quality Priority Proposal 2026/27	LF	Assurance	Enclosure 11-12
<p>LF explained that the draft quality priorities for the coming year had been reviewed in detail by the Quality Committee and were broadly supported, subject to further refinement of the measures and supporting information. It was noted that the proposed priorities were informed by multiple sources, including patient experience, staff feedback and performance data, and built on progress made against the previous year's priorities, with some areas now moving into business-as-usual oversight.</p> <p>LF outlined that further work was underway to strengthen the clarity of metrics and evidence sources, after which the final priorities would be brought forward for formal sign-off ahead of publication in the Trust's Quality Account in June. It was proposed, with committee support, that final approval be delegated to the Quality Committee to enable timely completion without returning the paper to the Board.</p> <p>The Board accepted the Quality Priority Proposal 2026/27 and agreed for delegated approval to the Quality Committee.</p>				

10	Quality Committee Terms of Reference and Forward Planner 2026/27	LF	Assurance	Enclosure 13-15
<p>The paper covered the annual review of the Quality Committee’s Terms of Reference and the proposed forward work plan for the coming year, both of which had been considered by the Quality Committee and recommended for Board approval.</p> <p>LF highlighted that the changes to the Terms of Reference were minor and focused on clarifying reporting requirements and making a small adjustment to the sub-committee structure, rather than altering the Committee’s core purpose. The forward planner sets out the planned quality agenda for the year ahead, acknowledging that it will remain flexible to respond to emerging risks, safety concerns or new priorities. LF noted that once the Trust’s quality priorities for the year are finalised, these will be incorporated into both the Terms of Reference and the work plan to ensure clear alignment and oversight.</p> <p>The Board approved the Quality Committee Terms of Reference and Forward Planner 2026/27.</p>				
11	Midwifery and Neonatal Nurse Safe Staffing Reports - January and February 2026	JJ	Assurance	Enclosure 16
<p>JJ reported that for both January and February the maternity and neonatal services were staffed safely on all shifts, although there were ongoing challenges in fully meeting acuity at times. These pressures were driven by a small number of vacancies and an increase in sickness absence, particularly evident over the winter period. It was explained that a detailed piece of work was underway to better understand staff health and wellbeing, with a focus on supporting staff back to work in a timely and compassionate way.</p> <p>JJ further provided reassurance that recruitment activity had been positive and that the outstanding vacancies had now been filled, which should ease pressure going forward.</p> <p>SH added assurance that sickness levels within midwifery had been subject to strong challenge and scrutiny and were being actively addressed rather than simply accepted as an outlier. The Board took reassurance from this triangulation, noting that while the reports highlighted pressures, there was clear management, appropriate escalation and concrete action in place to support staff and maintain safety.</p> <p>The Board accepted the Midwifery and Neonatal Nurse Safe Staffing Reports - January and February 2026.</p>				
12	Perinatal Safety Report – Quarter 3 - 25/26	JJ	Assurance	Enclosure 17
<p>JJ reported that during the quarter there had been one stillbirth and one neonatal death, which she acknowledged sadness. She explained that both cases would be reviewed through the Perinatal Mortality Review Tool, with family involvement fully supported, and that any learning would be shared with the Board once the reviews were completed.</p> <p>The Trust had declared compliance with all ten CNST safety actions and was awaiting formal confirmation of this achievement, with the newly published Year 8 CNST scheme to be reviewed and reported on in due course. JJ also highlighted ongoing work to strengthen perinatal safety leadership, noting plans to redesign the safety champion model to include more clinically focused roles, refreshed Terms of Reference and a clearer agenda, with updates on impact to follow.</p> <p>The Board received the report with no additional challenge, noting the clarity of assurance and the strength of the governance processes in place. FM took the opportunity to thank SH for taking on the Non-Executive maternity and neonatal safety champion role more fully following FM’s new Chair role, providing continuity of oversight, and reinforced the Board’s commitment to maintaining close scrutiny of perinatal safety while supporting learning, transparency and compassionate engagement with families.</p> <p>The Board accepted the Perinatal Safety Report – Quarter 3 - 25/26.</p>				
13	Patient Experience Quarterly Report (Q3)- March 2026	LF	Assurance	Enclosure 18
<p>The discussion acknowledged ongoing challenges with patient feedback, particularly the continued low response rates for the Friends and Family Test, despite efforts to pause, reset and relaunch the approach. LF explained that this was not unique to WVT and is reflected across the wider Foundation Group, and new actions were outlined including the move to a new feedback provider, expanded digital options such as QR codes, and renewed use of volunteers to support patients to give feedback while in hospital.</p> <p>The Board welcomed early reassurance that overall complaint numbers were likely to be similar to last year rather than increasing and noted significant improvement in the timeliness and quality of complaint responses within medicine, alongside a reduction in the number of complainants returning dissatisfied, indicating better resolution first time.</p> <p>The Board noted that such feedback should be seen as a gift and a learning opportunity, encouraging staff to resolve concerns in the moment wherever possible rather than relying on formal complaints. The discussion reinforced the importance of openness, listening</p>				

and compassionate responses, recognising that not every patient experience will be perfect but that the Trust was committed to learning from feedback to improve care. Overall, the Board took assurance from the report while encouraging continued focus on proactive engagement with patients and families to shape services and reduce the need for formal complaints.

The Board accepted the Patient Experience Quarterly Report (Q3)- March 2026.

14	Board Assurance Framework Report	GS	Assurance	Enclosure 19-21
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The BAF had been reviewed by both the Audit Committee and the Executive Risk Management Committee, with no major changes proposed overall. Two specific recommendations were highlighted: a reduction in the risk score for patient experience from 12 to 9, reflecting increased assurance from progress against actions, and a reduction in the in-year financial plan delivery risk score from 16 to 12, while noting that the longer-term future financial risk remains high.

FM welcomed these changes, emphasising the importance of a dynamic risk framework that reflects active management rather than static reporting.

SS added that further work was underway to develop an additional BAF risk focused on neighbourhood health and the Trust’s evolving role in integration and partnership working, including clarifying the Board’s risk appetite in this area, with a view to bringing this to the Board at a future meeting. The Board noted the need for the BAF to continue evolving in line with strategic ambition and system leadership. Overall, the Board was assured by the clarity of the framework, the appropriateness of the score changes, and the strengthened alignment between strategic priorities, risk appetite and assurance.

The Board accepted the Board Assurance Framework Report.

15	Annual Risk Appetite Review	GS	Approved	Enclosure 22-23
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The Trust’s risk appetite statement had been in place for several years and had previously been adjusted to reflect a more ambitious approach to workforce risks. Following discussion at the Executive Risk Management Committee, there was a proposal to move the Trust’s appetite one step further to the right in relation to reputation, recognising that successful delivery of the strategy depended on closer engagement with partners and stakeholders and therefore carried greater inherent risk. It was also highlighted a more nuanced debate about financial risk appetite had taken place, questioning whether the statement should better reflect the organisation’s increasing exposure as it pursues transformation and longer-term sustainability.

KO reflected that the appropriate financial risk appetite depended on the time horizon, noting that in the short term the Trust remained relatively cautious and disciplined, while over the medium to long term the ambition to act as a place-based host provider and deliver significant transformation inevitably required greater openness to risk. It was emphasising that strengthened governance, oversight and risk management processes provided greater confidence to take bolder decisions without losing control, and that transformation at pace cannot be achieved without accepting some additional risk.

FM stressed that the Trust’s strategic ambition to become sustainable, shift care towards prevention and neighbourhood health, and live within its means required decisive change and a willingness to take measured risks. It was reinforced that while in-year financial control remained essential, the Board must be honest about the level of ambition required to secure long-term quality and sustainability for the population it served. The Board broadly supported this balanced approach, agreeing that the risk appetite statement should appropriately reflect both short-term caution and longer-term strategic ambition, with further refinement delegated to the executive team.

The Board approved the Annual Risk Appetite Review.

16	Revised Standing Orders	GS	Approved	Enclosure 24-25
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It was noted that the Audit Committee had reviewed the document and that the proposed changes were limited and largely technical.

One substantive amendment shared across all Trusts in the Foundation Group, was to extend emergency decision-making powers to include the Deputy Chair for practical and resilience reasons. No concerns or questions were raised by Board members, and the proposal was viewed as sensible and proportionate.

The Board approved the Revised Standing Orders.

17	Staff Survey	GE	Assurance	Enclosure 26-28
<p>The Board welcomed the staff survey results, recognising them as the product of sustained effort over several years rather than a single-year improvement. Members congratulated GE and the wider leadership team on achieving the Trust’s highest response rate to date and on maintaining strong performance across the People Promise themes, with particular pride expressed in WVT achieving the highest staff engagement scores in the region and moving above the NHS average for both recommending the Trust as a place to work and confidence in the quality of care provided.</p> <p>The importance of translating these results into tangible action at divisional and staff-group level was discussed, with interest in how teams will use local data to drive further improvement.</p> <p>There was an opportunity to use the positive results externally, both to support recruitment and to give confidence to the public about the culture and quality of services. There was also a focus on continuing to increase participation, particularly among harder-to-reach staff groups, and on learning from other large employers to further boost response rates. GE reflected that strong and visible commitment from the full executive team had been key. It was reinforced that listening to staff was a shared responsibility for all staff groups and that the survey should be seen as an ongoing dialogue rather than an end point, with ambition to continue improving both engagement and experience year on year.</p> <p>The Board accepted the Staff Survey Update.</p>				
18	Committee Summary Reports			
18.1	Quality Committee Reports – December 2025/January/Feb/March 2026	IJ	Assurance	Enclosure 29-34
<p>The Board received several months of Quality Committee reports, noting a transition to a new summary reporting format that aligns with other Board sub-committees. This change will enable more timely escalation and assurance, replacing the previous approach of bringing full minutes.</p> <p>IJ highlighted that recent Quality Committee discussions had focused on the Trust’s proposed quality priorities for the coming year, which had been considered in detail in advance of Board discussion and delegated approval.</p> <p>IJ further noted a robust discussion at the most recent meeting on maternity services, specifically a new standard operating procedure for women giving birth outside clinical guidelines. The Committee had supported the direction of travel but requested further refinement in how risk, choice and informed consent were presented, particularly for complex cases. This item will return to the Quality Committee for further consideration.</p> <p>IJ provided assurance that the Quality Committee continued to maintain detailed and rigorous oversight across a broad quality and safety agenda, with improved reporting arrangements strengthening the Board’s view going forward.</p> <p>The Board accepted the Committee Summary Reports.</p>				
18.2	Audit Committee Escalation Report	NT	Assurance	Enclosure 35
<p>The report was taken as read.</p> <p>NT highlighting several areas of positive assurance and commended the significant progress made on medical job planning, noting that this had been a long-running area of focus and that the re-audit demonstrated the impact of sustained effort, particularly in supporting productivity improvements referenced elsewhere in the meeting. NT also reported early confidence in a positive year-end audit position, explaining that strong performance during the year and the final external audit conclusions were unlikely to be adversely affected by the remaining reviews, which reflected well on the organisation’s overall control environment.</p> <p>The Audit Committee continued to focus on more challenging and higher risk areas and noted that the quality of audit outcomes this year was a source of pride. The Committee was beginning a period of reflection on its own effectiveness, with work underway to identify how it can continue to evolve and better support the Trust as it delivers an ambitious transformation agenda.</p> <p>The Board welcomed the update and reinforced the critical role of the Audit Committee in providing assurance on governance, financial stewardship and risk management.</p> <p>The Board accepted the Committee Summary Reports.</p>				

18.3	Charitable Funds Committee Report	GQ	Assurance	Enclosure 36
<p>There were no matters of escalation to the Board the report was taken as read.</p> <p>The positive impact of charitable funds and the staff lottery was noted with strong participation and support from staff. A key decision taken by the Committee was to direct charitable funds, including proceeds from the staff lottery, towards renewing the Halo Leisure contract to continue providing wellbeing and support services for staff. This was a timely and targeted use of funds in response to increased pressure, stress and anxiety across the workforce.</p> <p>The Board welcomed the update recognised the value of charitable contributions in supporting staff wellbeing and patient care.</p> <p>The Board accepted the Committee Summary Reports.</p>				
18.4	Integrated Care Oversight and Assurance Committee Report	SS	Assurance	Enclosure 37
<p>The report was taken as read with no matters of escalation.</p> <p>The Board accepted the Committee Summary Reports.</p>				
18.5	Foundation Group Strategy Committee / Board Workshop March 2026	GB	Assurance	Enclosure 38-40
<p>The report was taken as read with no matters of escalation.</p> <p>The workshop had been undertaken in person and was particularly valuable in strengthening relationships, shared understanding and collective challenge across the group. The session provided space to reflect on shared strategic ambitions, system context and the responsibilities of Boards within an increasingly complex and financially constrained NHS environment.</p> <p>Contributions from external speakers, including Integrated Care Board leaders and Sir David Nicholson, were thought-provoking and grounding, especially in reinforcing the role of Boards in setting ambition, maintaining control of delivery and stewarding public resources. Overall, the workshop and strategy discussion were seen as reaffirming the value of the group model, the benefits of collaboration at scale and the need for Boards to remain confident, aligned and purposeful as system leadership and integration matures.</p> <p>The Board accepted the Committee Summary Reports.</p>				
19.	Any Other Business			
<p>There was no further business for discussion.</p>				
20.	Questions from Members of the Public	FM	Information	Verbal Update
<p>FM acknowledged that a number of detailed questions had been received from a member of the public shortly before the meeting, covering issues including corridor care, wound services, pressure damage, staffing data clarity and the format of Board meetings.</p> <p>The Board welcomed public questions but noted that some of the questions were too complex to answer fully within the available time. A response in writing would be undertaken after the meeting.</p> <p>Addressing the question about Board meetings being held virtually, FM explained that the decision to remain online reflected a desire to maximise public access and engagement. Experience had shown that significantly more people were able to observe meetings via live stream or recordings than were able to attend in person, particularly given the challenges of travel and timing. This approach supported openness and accessibility.</p>				
<p>DATE AND TIME OF THE NEXT MEETING – Thursday 4th June 2026</p>				

WYE VALLEY NHS TRUST
ACTIONS UPDATE: PUBLIC BOARD MEETING – 4 JUNE 2026

Month	Meeting Type	Ref	Item	Action	Due Date	Owner	Status	Update
February	Public	Action 11	Midwifery and Neonatal Staffing Report	To consider and propose additional support measures for Maternity staff during the ongoing period of national scrutiny and bring options back for future discussion.	Jun-26	Geoffrey Etule/Justine Jeffery	Closed	It was confirmed that a survey was undertaken with relevant staff. The request from staff was that they would prefer to receive information via the staff FB group and via newsletters.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	4th June 2026
Title of Report:	Managing Director report
Lead Executive Director:	Managing Director
Author:	Sarah Shingler, Managing Director
Reporting Route:	Direct to Board
Enclosures included with this report:	
Purpose of report:	<input type="checkbox"/> Assurance <input type="checkbox"/> Approval <input checked="" type="checkbox"/> Information
Brief Description of Report Purpose	
<p>This report provides an update on national policy developments, system transformation and Trust operational performance. It demonstrates strong alignment with NHS strategic direction, particularly the shift towards neighbourhood health, prevention and integrated care delivery.</p>	
Recommended Actions required by Board or Committee	
<p>The Board is invited to:</p> <ul style="list-style-type: none"> • Note the content of the report and; • Receive Assurance that the organisation is well positioned to deliver against future system expectations, with continued oversight of neighbourhood delivery, urgent care performance and workforce risks. 	
Executive Director Opinion¹	
<p>The Trust remains well aligned with national direction, with strong progress in system integration, neighbourhood health development and partnership working. Operational performance is particularly strong in elective recovery and productivity, with marked improvements in utilisation, length of stay and long waits.</p> <p>Neighbourhood delivery models are now moving into implementation, supported by system investment and strengthened place-based collaboration. However, challenges remain in urgent and emergency care performance and these will receive continued targeted focus.</p>	

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.

Managing Director Report

1. DHSC / NHS England Executive Leadership Integration

Nationally, work continues to integrate leadership arrangements between the Department of Health and Social Care (DHSC) and NHS England through the establishment of a joint executive leadership structure. The revised model is intended to strengthen alignment between policy, operational delivery, transformation and performance management, while reducing duplication and improving accountability.

Senior appointments confirmed within the emerging structure include:

- Sir Jim Mackey – Chief Executive Officer, NHS England
- Samantha Jones – DHSC Permanent Secretary
- Professor Chris Whitty – Chief Medical Officer
- Tom Riordan – Chief Operating Officer / Second Permanent Secretary
- Duncan Burton – Chief Nursing Officer for England
- Professor Lucy Chappell – Chief Scientific Adviser and Director General for Science and Research
- Elizabeth O’Mahony – Director General, Finance / Chief Financial Officer
- Danny Mortimer – Director General, People
- Paul Dinkin – Director General, Strategy and Healthcare Policy

The evolving leadership structure is expected to support delivery of NHS operating model reforms, neighbourhood health priorities, productivity improvement and financial sustainability objectives.

2. Coventry and Warwickshire / Herefordshire and Worcestershire Cluster Update

The Coventry and Warwickshire / Herefordshire and Worcestershire (CWHW) Cluster continues to strengthen collaboration across organisational boundaries, with increasing alignment between the Integrated Care Board (ICB), providers and place-based partnerships. The system is now moving into the next phase of transformation focused on prevention, neighbourhood health, integrated care delivery, population health management and long-term financial sustainability.

Four place-based collaboratives are now established across Coventry, Warwickshire, Herefordshire and Worcestershire, with host providers operating with delegated authority and greater accountability for local population outcomes and service performance. The longer-term ambition remains the development of Integrated Health Organisation-style models with shared accountability between commissioners and providers.

The Cluster has identified five core strategic programme areas:

- Neighbourhood health
- Urgent and emergency care
- Elective care, cancer and diagnostics

- Mental health and learning disabilities
- Children, young people and perinatal services

A key strategic priority remains the development of neighbourhood health models, supporting a continued shift from hospital-based care towards proactive, preventative and community-based services. Integrated neighbourhood teams are being expanded across primary care, community services, mental health, social care, pharmacy and VCSE partners.

Investment has been agreed to support local “left shift” transformation programmes, including £3m per place and £1.5m for Herefordshire. Providers continue to lead work on outpatient redesign, Advice and Guidance, virtual care models, discharge improvement and digitally enabled productivity initiatives.

3. One Herefordshire Health and Care Partnership Update

Updated National Neighbourhood Health guidance has reinforced priorities relating to reducing non-elective admissions and system pressure, improving urgent and emergency care, improving planned care and access to general practice, improving outcomes for people with long-term conditions and maintaining focus on children and high-priority cohorts.

The Herefordshire system continues to be recognised as comparatively advanced in its neighbourhood health development due to existing Neighbourhood Health Integrated Partnership arrangements.

The Neighbourhood Health Delivery Board has now moved into delivery phase, with agreed priorities including:

- 24/7 Single Point of Access (SPOA)
- System coordination hub
- Digital transformation priorities

Senior Responsible Officers are finalising KPIs, milestones and outcome frameworks to support delivery and accountability.

Partnership Alliance Agreement formally approved and progressing through statutory organisations for final sign-off. The Partnership has discussed the benefits of moving to a Joint Venture arrangement, with the consensus being that it is premature to establish a formal JV structure ahead of national neighbourhood contracting frameworks.

Organisational development work continues across the partnership, including development of a Partnership Charter and strengthening of system leadership and partnership maturity arrangements.

Senior partnership leadership posts have now been appointed, including Chief Operating Advisor, Chief Nursing Advisor and Chief Medical Advisor roles.

4. Resident Doctor Industrial Action Update

National discussions between NHS England, DHSC and the British Medical Association (BMA) resident doctors committee continue regarding pay, contractual reform and workforce conditions.

At the time of reporting, no formal industrial action dates have been confirmed locally; however, systems remain on a heightened state of operational preparedness given the potential for further national action during 2026.

The Trust continues to work closely with regional NHS England colleagues and system partners to maintain robust contingency arrangements, including:

- Maintenance of safe staffing levels
- Protection of urgent and emergency care services
- Prioritisation of clinically urgent elective activity
- Mutual aid and escalation arrangements where required
- Ongoing communication and engagement with resident doctors and clinical teams

Operational planning assumptions continue to be reviewed in line with emerging national guidance to minimise disruption to patient care, elective recovery and operational performance should further industrial action be announced.

5. More from our great teams - Surgical Division Update

In the period since the last Surgical Divisional update within this report, the Division has been focused on continuing on its quality and productivity improvement journey. To this end, our teams have been able to 'turn the dial' further in a number of key areas that have in turn supported improved utilisation of our resources, increased volumes of patients being treated and improvements in how long elective patients spend in our hospital. Most significantly, operating theatre utilisation has continued its improving trajectory, with the Division attaining the national standard of 85%+ for the first time in April. Focused work has also seen notable improvements in how our theatre lists are used: all specialties have realised gains in the number of cases per 4 hour theatre session compared to 10 months ago, with all but one speciality starting April 2026 ahead of the national average for their service. Notably, Orthopaedics and Gynaecology have seen significant improvement in GIRFT national rankings for cases per session: at the start of April, the specialties were ranked 6th and 7th respectively in the country. This has contributed to the Trust rising to 7th of 145 Trusts nationally overall for average cases per 4 hour session. Orthopaedics have also focused on reducing time between theatre cases, saving 15 minutes on average on arthroplasty lists in the Elective Surgical Hub compared to main theatre lists.

Directorate teams have also worked hard to improve the patient experience and reduce short notice cancellations. The last year has seen the percentage of cancellations 0-3 days prior to surgery fall from 3.9% in April 2025 to 1.6% at the end of March 2026. This places the Trust 5th best of 145 Trusts nationally in GIRFT league tables and is significantly below the national average. Furthermore, undertaking more procedures as day case surgery rather than with inpatient stays has been a focus, with over 88% of procedures now being undertaken as day cases. Projects in Gynaecology, Breast and Orthopaedics have reduced length of stay for elective patients and supported the growth in day case rates. Overall, elective length of stay has consistently reduced over the last 2 years, falling from 4.0 days to 2.2 days. A specific workstream for patients undergoing hip and knee replacement surgery has also improved the experience for our patients, reducing the average length of stay from 3.9 days in April 2025 (a national outlier) to 2.4 days in March 2026 (below the national average), with a low of 1.9 days in January. The clinical teams have also focused in improving early mobilisation post surgery: 53% of patients were mobilised on day 0 in April 2025, increasing to 98% in March 2026 which has contributed to getting patients home sooner.

Central to this progress over the last 12 months has been our Elective Surgical Hub, which has been nationally recognised for delivering high-quality clinical care and high operational standards. Being awarded NHS England's Getting it Right First Time (GIRFT) accredited Hub status in March not only recognises the hard work of our clinical and operational teams in attaining accredited status, but also the underlying changes that they have driven to shift some long-standing challenges that has in turn allowed them to move ahead with improving quality and care offered to our patients. These underlying improvements have enabled the Division to reduce the number of patients waiting longer than a year for treatment. The total 52 week wait cohort size for surgical exception specialities decreased from 4,902 in August 2025 to fewer than 100 at the end of the financial year, with the Referral to Treat (RTT) position increasing for these specialties by 11%. While progress has been made, some patients still do experience long waits to surgery and there is still a huge amount more to do to continue to sustain these improvements and deliver further gains in the coming months. The Division is focused on delivering further quality and productivity improvement gains and focusing on reducing long waits to 40 weeks by the end of March 2027 and attaining national expectations regarding RTT performance.

The Surgical Division has also been focused on working closely with the other clinical Divisions to improve urgent and emergency care access and performance. Focus has been on reducing the time for speciality reviews by surgical teams in the Emergency Department with General Surgery and Trauma & Orthopaedics seeing a reduction in the time patients wait in ED for a speciality review. However, waits are still longer than we would like and much more improvement work is required by the Division over the coming months. Paediatrics 4 hour emergency access standard performance has also become challenged in recent months and the speciality is working closely with the ED team and Medical Division to collectively address this issue. Focus for the next 6 months is also on implementing a dedicated Acute Surgical Unit. Last year, the surgical teams implemented a trial of an assessment unit that enables appropriate General Surgical patients who are waiting to be admitted from ED to move out of the Emergency Department sooner and commence treatment earlier in ASU, while a ward bed is being prepared. Equally, the unit will support admission avoidance.

6. Going the Extra Mile Awards – Quarter 3 2025/26

EMPLOYEE OF THE QUARTER - Dorota Koim (Dot), Senior Pharmacist Technician

Nominated by Shaun Jones – Lead Pharmacist

Dorota Koim (Dot) was nominated for her exceptional compassion and professionalism in stepping in at very short notice to act as a Polish interpreter during a highly sensitive clinical consultation. Dot ensured the patient fully understood the difficult diagnosis and subsequent treatment plans. This was despite this not being part of her role as a Senior Pharmacist Technician. Dot then returned to her duties afterward. The award has been given to Dot as she demonstrated her exceptional commitment and compassion to both colleagues and patients. Dot is an exceptionally caring and committed member of the Pharmacy team, and an ambassador for the Trust as whole and it was agreed that this should be acknowledged and recognised.

TEAM OF THE QUARTER - Oxygen CNS Team

Nominated by Felicity Archer – Matron

The Oxygen CNS Team was nominated for their outstanding, compassionate, and highly coordinated care in supporting a gentleman at the end of his life to remain at home, in line with his wishes. The team responded rapidly in a fast-moving and complex situation, reviewing the patient at home,

arranging district nursing and community palliative care support, and securing timely delivery of an oxygen concentrator. Their excellent multidisciplinary collaboration and communication were recognised by specialist and community palliative care consultants, and the patient's family expressed their gratitude for the care and support provided. Their actions enabled a peaceful death at home, surrounded by family, demonstrating exceptional teamwork and commitment to patient-centred care.



Compassion • Accountability • Respect • Excellence



Integrated Performance Report

May 2026





Sarah Shingler
Managing Director

The Trust has made strong progress against its strategic priorities, with impressive performance in elective care, workforce metrics, and quality and safety metrics.

Elective care, productivity, and cancer performance remain key strengths. Theatre utilisation has reached a record 85.6%, and the Trust is now ranked 11th in England for RTT performance. Performance against cancer standards is particularly strong, with Faster Diagnosis and 62-day treatment targets exceeded. Performance across 25/26 saw the Trust ranked as the third best performer nationally for the 62-day treatment standard.

The Trust received a positive outcome following the NHSE infection prevention and cleanliness inspection. Additionally, full compliance with all 10 maternity safety standards has been achieved under the Maternity Incentive Scheme.

Urgent and Emergency Care remains the Trust's primary operational risk. Four-hour performance is currently 66.2%, significantly below national expectations. This is largely driven by high demand, increased patient acuity, and delayed discharges. Improvement workstreams from the UEC programme must continue to progress at pace to reduce pressure on the Emergency Department and improve performance against national standards.

Workforce indicators remain strong. Sickness absence has reduced further to 3.8%, now close to the NHS target. Recruitment and retention continue to perform well across most staff groups.

Financially, the Trust is slightly off plan, reporting a £0.2m adverse variance in Month 1. This reflects the impact of industrial action and prior-year non-recurrent cost pressures. Efficiency delivery is £0.4m below plan but has been partially offset by non-recurrent income and timing benefits.

Key financial risks include delivery of efficiency targets, Welsh income assumptions, and access to deficit support funding. Cash performance is currently ahead of plan, supported by a favourable year-end position in 2025/26.

Overall, the Trust continues to perform strongly in elective care and quality measures. However, sustained focus is required to address urgent care pressures and ensure financial sustainability.



Chizo Agwu
Chief Medical Officer



Lucy Flanagan
Chief Nursing Officer

Cleanliness inspection outcome

NHS England carried out a follow up Infection prevention and cleanliness inspection on 13th May 2026, after being placed on routine monitoring last year. The inspection team reported seeing continued and sustained improvements in the areas visited. They witnessed good patient care and interactions, and could see the positive relationships between clinical, housekeeping, estates and Sodexo colleagues, with a commitment to work together.

The result of this inspection means that the Trust has retained routine monitoring for two consecutive visits, this is the best level we can achieve on the NHSE framework.

Joint Advisory Group on Endoscopy (JAG) – visit outcome

Following the on-site assessment at Wye Valley NHS Trust in April (County hospital and Ross community hospital endoscopy), the assessment outcome is deferral of JAG accreditation for up to 6 months to allow the trust to focus on 5 actions which must be completed to be awarded full accreditation. The visiting team offered congratulations to the team on their achievements to date, and the full report highlighted many areas of excellence including a dedicated team, who deliver high quality procedures, with impressive performance measures, with patients being at the heart of the service. The full report and associated action plan has been presented to Quality Committee, and the 5 mandated actions are highlighted below:

1. Recovery - The use of endoscopy recovery for inpatients needs to cease
2. Standard operating procedure to be developed due to the positioning of the drying cabinets in the corridor – in development
3. Adjustments to ventilation in the Decontamination Room – work ongoing
4. Final report from Authorising engineer for the 2025 IHEEM audit – now submitted
5. Trajectory and recovery plan for waiting times – in progress

Antimicrobial Stewardship

In response to NHS England's "Act Now: Protect Our Present, Secure Our Future" letter, the Trust have developed a quality priority to strengthen antimicrobial stewardship with an aim to combat antimicrobial resistance. A full workshop was held with Board today and the following priorities have been established

1. Intravenous to oral switch
2. Reduce the use of broad-spectrum antibiotics by aligning local consumption with national benchmarks
3. Utilising digital solutions to aid prescribing decision making and increasing visibility of consumption patterns

Maternity (Perinatal) Incentive Scheme (MIS) Year 7 results

Since the last board meeting the year 7 results have been officially published (13th April 2026) and we are pleased that the Trust has achieved compliance with 10/10 safety standards.



Quality & Safety Performance – Mortality

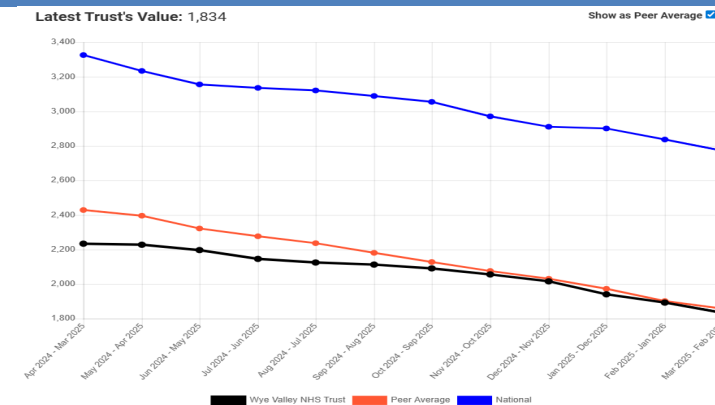
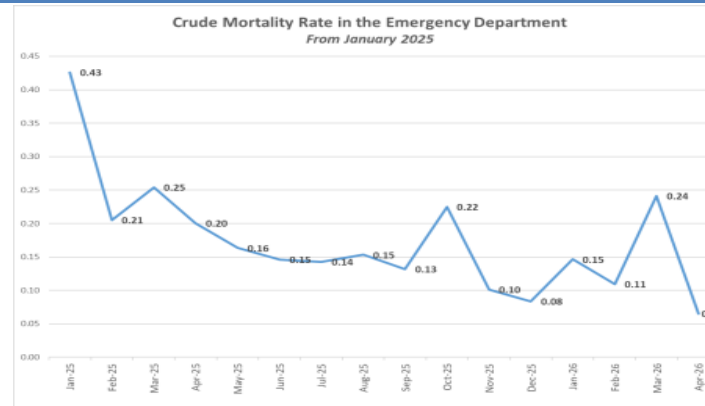
We are driving this measure because:

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

Data

Trust-level data <i>January 2025 – December 2025</i>					
As expected SHMI					
27,995	1,345	1,190	1.1282		
Provider spells	Observed deaths	Expected deaths	SHMI value		

Indicator - Latest Static	Description/Notes	Data month	Month Actual	Deaths in Month	Change (Rate %)
Crude Mortality-All	% of Deaths by Discharges	Apr-26	1.52%	72	0.12%
Crude Mortality-Emergency	% of Deaths by Emergency Discharges		5.75%	71	0.23%



Monthly Headlines

- The latest 12-month rolling **SHMI (NHS England)** from January 2025 to December 2025 shows Wye Valley NHS Trust at **112.8**, which equates to 1345 observed deaths against 1190 expected.
- Latest **crude mortality** rate for **April 2026** was **1.52%** for all admissions, which equates to 72 deaths with 4 reported in the Emergency Department. This is the lowest rate of ED mortality for over 18 months.
- #NOF** Latest 12-month rolling SHMI: **169 (-2)**
- There is a planned GIRFT Feedback Session, following the recent visit, on the 16th June.
- Progress on the implementation of the DREAMS bundle with a focus on building in the key steps into the documentation and pathway. Nursing-led physio on the wards to increase mobilisation of patients, particularly during out of hours and weekends.
- On review of the latest SHMI HES-based data, which reports the 12-month period from *March 2025 to February 2026*, shows a significant reduction in the SHMI following removal of January 25 month where the Trust reported 12 deaths in one month.
- A full coding audit was completed by the IQVIA team, which reviewed the 50 deaths within the latest SHMI. Each case was reviewed in-depth and any additional coding was re-submitted before the cut-off period.

Pneumonia Latest 12-month rolling SHMI: **102 (-1)**

- There has been continued progress on the reducing HAP programme with the current focus aiming to bring together the on-going improvement work around the Trust and build into the plan. Encouragingly, there is already a significant amount of improvement being undertaken by therapy and nursing teams across the Trust. A full progress update will be reported through this month's Trust Quality Committee.

Heart Failure Latest 12-month rolling SHMI: **100 (-)**

Sepsis Latest 12-month rolling SHMI: **107 (-)**

Stroke Latest 12-month rolling SHMI: **104 (+4)**

- Local **SJR training** was held during May, which has significantly increased our numbers of trained staff. There was a good attendance and engagement by a wide range of staff including nursing and medical staff.

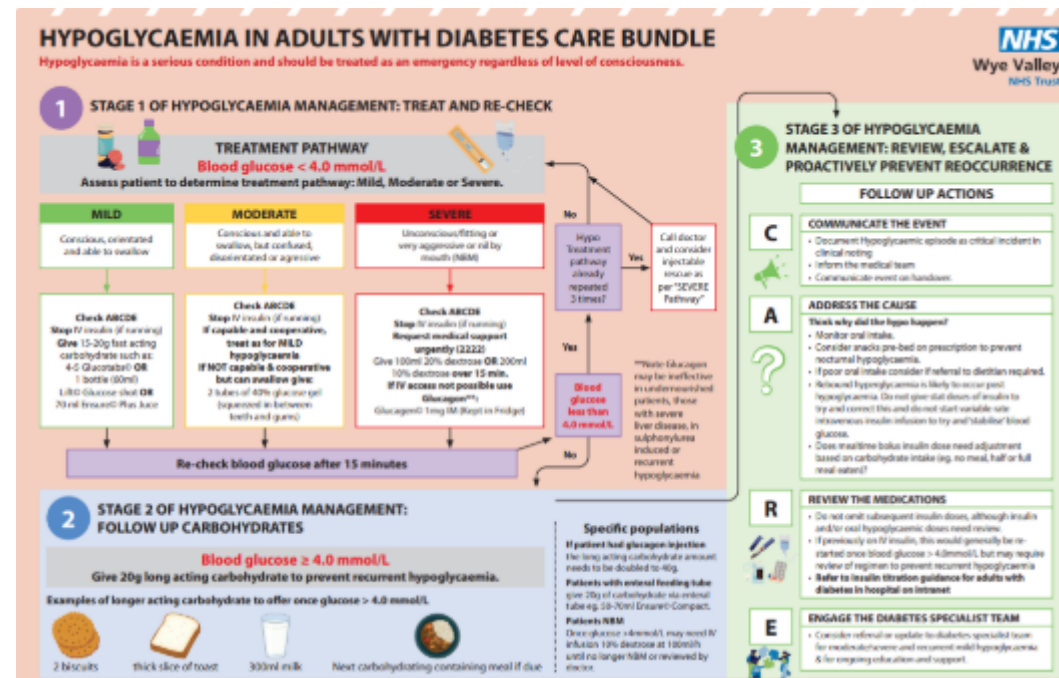
We are driving this measure because :

Project aim is to Improve the safety of inpatient care for patients with diabetes. The 25/26 priority focussed on foot assessment, safe management of insulin, patient empowerment and safe hypoglycaemia management. This remains a priority in 2026-27 to build on the improvements seen in 2025-26 recognising there is more work to do.

Focus for 2026/2027

Improving Diabetes inpatient care to continue as a quality priority 2026/2027

- ◆ Roll out Self Administration and Management of Insulin (SAMI) beyond the 2 pilot wards
- ◆ Embed Hypoglycaemia Dashboard & accountability
- ◆ Start diabetic foot assessment embedded into nursing Waterlow assessment/SKIIN bundle – to enable audit and oversight
- ◆ Continue patient empowerment across perioperative pathway (Periop passports / future digital)
- ◆ NEW project: Safe discharge/avoidance of errors at transitions of care
- ◆ Self-assess, track and work towards meeting some of the Diabetes inpatient care accreditation by RCP 2023-06 21 - DCAP accreditation standards 2023



We are driving this measure because :

The Trust aims to reduce the incidence of Non-Ventilated Hospital Acquired Pneumonia (HAP). As one of the most common and preventable hospital-acquired conditions, evidence suggests that simple bedside interventions—particularly improved oral care, upright positioning, appropriate swallow screening, and early mobilisation can significantly reduce incidence of HAP in non-ventilated patients

Quality Priority plans

- Trust Mortality Data – 146 deaths with 150 deaths expected over a year period.
- Review of local data indicates opportunities to strengthen early recognition, prevention, clinical documentation, and surveillance across adult inpatient wards.

AIM- To reduce Hospital-Acquired Pneumonia incidence across Wye Valley NHS Trust by at least 5-10% within 6 months, through the implementation of a standardised HAP prevention bundle, strengthened clinical pathways, improved oral care protocols, and enhanced surveillance.

A number of workstreams are being set up to achieve this;

Early Identification & Risk Assessment
 Infection Prevention & Bedside Care
 Oral Care
 Positioning & Mobility
 Antimicrobial Stewardship
 Communications – Patient & Staff
 IT Systems & Reporting

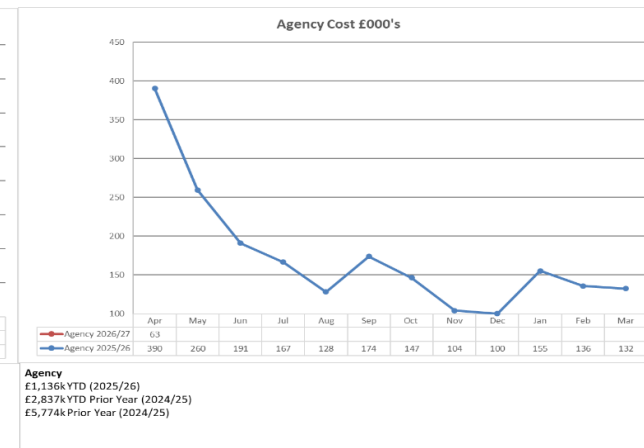
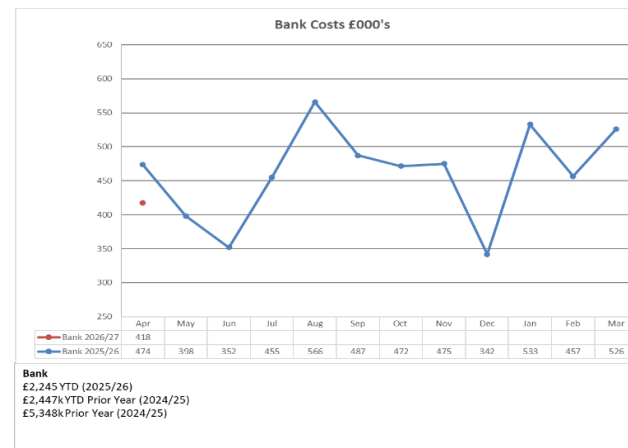
Outcome measures	Process measures
≥25% reduction in HAP incidence by Month 12	Oral care compliance ≥90%
Reduction in length of stay for patients with HAP	Upright positioning documentation ≥85%
Reduction in HAP-associated mortality, 5-10% within six months	Swallow screening ≥90% for at-risk patients
	48-hour antibiotic review ≥95%
	Chest x-ray performed < 24 hours of diagnosis
	Sputum sample collected

Quality & Safety Performance – Staffing - April data

Fill Rate & CHPPD Data

Bank & Agency

	Day		Night		Overall (Actual) CHPPD
	RN Fill	HCA Fill	RN Fill	HCA Fill	
Primrose Unit	85%	92%	102%	121%	10.4
Maternity Ward	97%	88%	92%	88%	7.6
Children's Ward	111%	125%	135%	97%	18.7
Lugg Ward	126%	80%	106%	97%	6.4
Wye Ward	112%	85%	123%	78%	6.8
Cardiac Care Unit	100%	101%	99%	100%	12.2
Leominster Community Hospital	153%	79%	102%	98%	6.7
Bromyard Community Hospital	130%	94%	100%	112%	6.9
Ross Community Hospital	98%	102%	147%	105%	6.2
Teme Ward	133%	63%	95%	78%	13.4
Redbrook Ward	99%	115%	98%	141%	8.3
Special Baby Care Unit	106%	-	101%	-	61.5
Intensive Care Unit	115%	-	110%	-	27.4
Gilwern Ward	100%	115%	100%	88%	6.9
Acute Medical Unit	116%	93%	97%	135%	8.5
Ashgrove Ward	117%	89%	109%	115%	7.3
Dinmore Ward	123%	82%	101%	98%	6.9
Garway Ward	136%	92%	109%	121%	7.5
Frome Ward	119%	98%	99%	143%	7.4
Arrow Ward	135%	75%	141%	91%	8.0
Women's Health	87%	89%	100%	-	10.5



- The agency expenditure limit set by NHS England has been applied to our Nurse Agency Reduction programme target for 26/27
- We have a cost productivity (CPIP) target of £1.2m
- For CPIP delivery we have a favourable variance of £12k in month 1
- 100% of all shifts were NHSE price cap compliant
- We used 1 off framework shifts in month 1 to maintain patient safety in ED

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, Primrose, Dinmore, Garway and Ashgrove Wards – Additional staffing requirements for additional boarding patients

AMU, Wye Ward, Redbrook Wards – Due to patient acuity and dependency, additional staff needed to support individual care needs, including RMN support.

Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV).

Leominster and Ross Community Hospitals – alignment of roster required following business case approval

Bromyard – Due to additional D2A beds



Andy Parker
Chief Operating
Officer

Urgent and Emergency Care [UEC] remains the key operational area of focus and our biggest challenge to resolve as an Acute and Community Trust but also a priority at Place in Herefordshire, with System partners, and with System partners in Powys.

We have seen our Community Integrated Referral Hub [CIRH] receiving almost 25% more referrals with 10% more referral being managed by our community teams than last year and our Emergency Department front door navigation signposting more and more patients to the most appropriate internal and external pathways than every before.

Our Medical Same Day Emergency Care [SDEC] facility opened in April, and we are seeing an increase in the number of patients being managed through this expanded space, but there is much more work to do to increase the patient cohorts through an increased patient acuity being cared for via this pathway.

But there is significantly much more to do order to improve our 4-hour Emergency Access Standard ,reduce the number of patients waiting greater than 12 hours in our ED and eradicated Corridor Care across our acute Trust both the inpatient wards and our ED.

In order to meet this requirement a number of UEC workshops have taken place as part of developing our Big Move Plans around valuing our patients time / UEC improvement schemes ahead of Winter 26. Aligned with the Getting It Right First Time [GIRFT] work, along with peer reviews and revised National best practice guidance, that have taken place across our Trust over the last eight months we have set our own red lines, timeframes and challenges as high level principles we should be aiming for as a minimum. These are:

- *No patients waiting in our ED greater than 24 hours with immediate effect*
- *No inpatients waiting in our Surgical and Medical SDECs overnight with immediate effect*
- *When inpatient escalation areas are utilised these areas are for clinically appropriate “step down of care” patients only with immediate effect*
- *No Ambulance handover waits over 45 minutes by August 2026*
- *Eradicate Corridor Care by September 2026*

Based on where we are currently with UEC flow achieving these objectives will be challenging. We need to develop our own transformation plans that compliment our ambition around our schemes within Neighbourhood health, including interdependencies with Urgent Neighbourhood Services, Integrated Neighbourhood Teams and Integrated Intermediate Care, and other transformational schemes in development are part of the Trust Big Moves including our model of care of Community Hospitals.

There is much within our organisation that is within our influence to improve on. The challenge that has been set over the summer and early autumn is “how do we increase our daily discharges by an average of 6 per day?” as this would resolve Corridor Care, reduce ED congestion, improve Ambulance Handover and delivery a 0.7 reduction in Length of Stay.

These schemes are focused around:

- Maximising Navigation
- Maximising all SDECs
- ‘My Next patient (ward pull from ED model)
- SAFER flow Care Bundle (including earlier flow, Criteria led Discharges, Standardisation and Escalation)

Outside of UEC our Elective Activity, despite the challenges in April of Industrial Actions, remains on plan with ongoing productivity developments across our Theatres, who delivered, for the first time, utilisation above 85%. We have recently undertaken work as part of the national drive to increase productivity in Elective Surgical Hubs which has seen a focus on “standby” patients to fill short notice, a focus on starting on time and list utilisation, as part of the implementation of the Elective In-patient Federated Data Platform functionality . A full evaluation of the Hub Optimisation Week is ongoing.




Our Referral to Treatment performance for 25/26 made an almost 11% improvement in the number of English patients being treated in 18 weeks, the 11th best English Trust in the Country.

In March we saw our Cancer performance also improve with 28-day Faster Diagnosis Standard [FDS] consistently above 80% and our 62-day first treatment started at over 88% for March. When looking across 25/26 WVT was the 15th most improved English Trust for FDS and the 3rd most improved English Trust for 62-day first start of treatment.

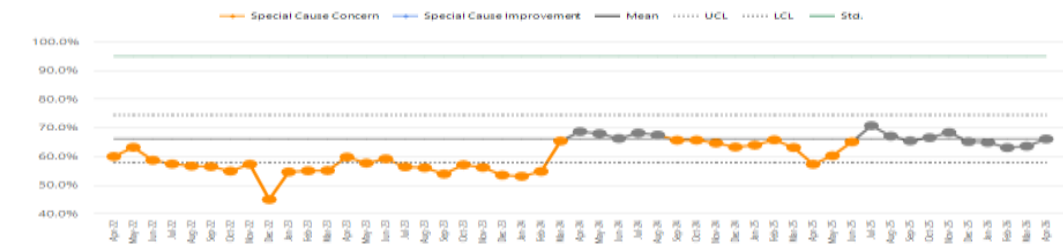
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

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, along with challenges with acute and community flow due to internal and external system constraints

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 less than 4hours In ED



% Patients Spending More Than 12 Hours In ED



% Admissions on Same Day Emergency Care (SDEC) Pathway



Performance & actions

- 6,113 Type 1 patients attended ED in April which 120 less than the previous month however it was 98 more than April-25. The range of all attendances varied from 163 to 248 with 203 daily average.
- 1,669 ambulances conveyed to the Trust in month which was 55 more than last month and 17 more than April-25. The range in month was 42 to 75 with a daily average of 55. This includes 11% from Powys [184].
- Ambulance handover delays over 1hr were 27.8% [416] of all conveyances with 62.9% [941] handed over within 45 minutes.
- Same Day Emergency Care [SDEC] treated 1,291 of all admissions [48.3% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 79th Type 1 Trust in England for April.
- 9.8% [641] of patients spent 12 or more hours in ED which was 209 [3.1%] fewer than last month.

Current Actions at part of our UEC Improvement plans:

- On-going action plan to increase medical Same Day Emergency Care [SDEC] pathways across the acute floor through supported by the completion of a large estates footprint.
- Increased Navigation to internal and external pathways including Primary care and Community services via our Single Point of Access. Internal pathways via our SDECs including the workforce model for Medical and Surgical along with a review of the operational hours.
- Developing a Surgical Assessment Unit on the acute floor to support earlier flow for Surgical patients along with increased acuity linked to the workforce model for the Surgical SDEC
- Non-admitted patients – focus on how we improve timeliness for non-admitted and not referred patients in ED and minor illness and injury.
- Deep dive into recovering our Paediatric ED performance to back above 95%
- Admitted Performance – schemes linked to our UEC Improvement plans and our requirement to increase emergency discharges >0 days length of stay by 6 additional each and every day.

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.
- System patient flow constraints. Including delayed discharges for patients no longer requiring acute or community hospital care.

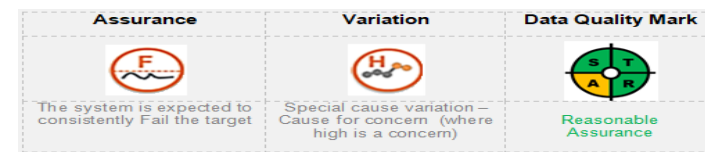
What the chart tells us

- April's 4 hour Emergency Access Standard [EAS] Performance was 66.2%.

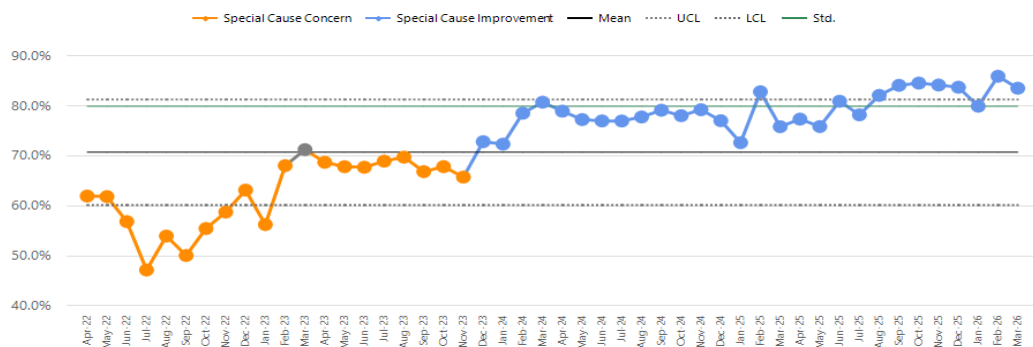
Operational Performance – Cancer Performance [March 26]

We are driving this measure because:

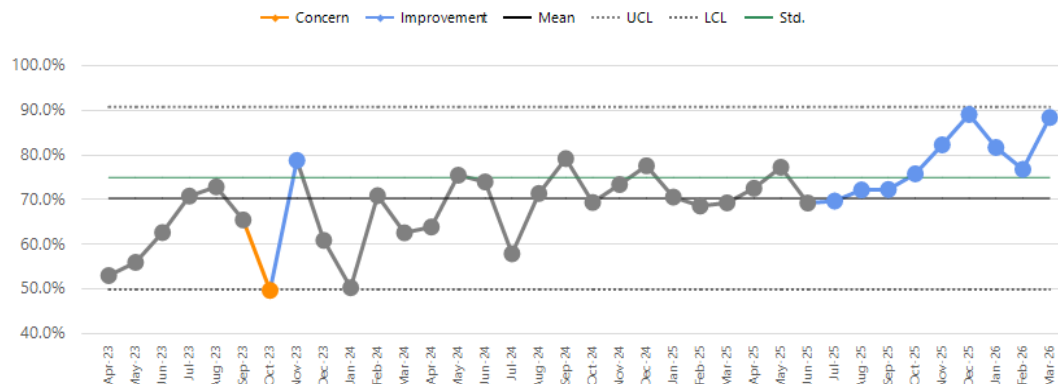
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or 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 80% start first treatment within 62 days to be achieved by March 2027.



28 Days (Performance & Benchmark)



62 Days (Performance & Benchmark)



Performance & actions

Referrals:

As of March 2026, urgent suspected cancer referrals have increased by 23.5% compared with the same period three years earlier. Breast, Skin and Lung pathways continue to experience the biggest increase with referrals rising by 48.2%, 51.1% and 57.5%. Wye Valley Trust (WVT) has undertaken an Urgent Suspected Cancer (USC) audit that highlighted areas of incomplete or non-compliant referrals from primary care. The results have been shared with the Integrated Care Board (ICB), and a joint meeting with WVT, the ICB and primary care has been scheduled to agree actions around support and training.

Cancer Performance:

In March 2026, the Trust achieved the Faster Diagnosis Standard (FDS) of 83.5%, 1.2% ahead of trajectory. Six specialties achieved the target, with Skin achieving 98%, Head and Neck 96.2% and Breast achieving 93.4% despite seeing some significant pressures over the last few months. Gynaecology did not meet the FDS threshold (62.8%). Bi-weekly improvement meetings and a detailed action plan are in place, supported by cancer administration huddles to reduce delays. We are awaiting confirmation from the West Midlands Cancer Alliance on funding for additional waiting list initiatives for 2026/27.

Wye Valley Trust (WVT) reported 96.4% compliance with the 31 day target in March, representing an improvement compared with performance in earlier months of the financial year. This improvement has been supported by improved data validation with tertiary centres, proactive tracking and escalation by cancer navigators, and improved Power BI dashboards. WVT also achieved 88.4% compliance against the 62 day standard, which is 13% above the Trust's planned trajectory and a 12% improvement compared with February performance.

Developments update:

- Work is underway on a patient education video for USC pathway which they will receive at point of referral
- Patient Stratified follow up live in 4 sites with a further 2 being worked through
- WVT's backlog on the cancer PTL of patients that have surpassed 62 days, as of March 2026, averaged at 35 patients remaining below the national target of 5%.
- Business justification being completed for Genomics
- All diagnostics are being booked within 7 days and Magnetic Resonance Imaging Prostate within 4 days

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

What the charts tell us

- 28 Day Faster Diagnosis performance for March 26 was 83.5%.
- 62 Days start of treatment target for March 26 was 88.4%.

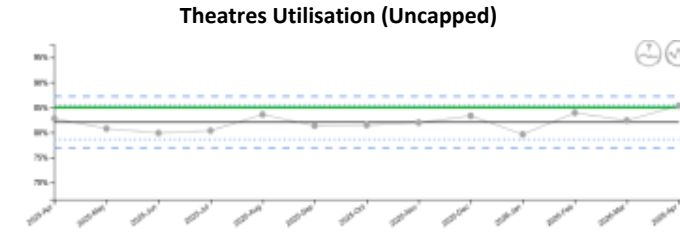
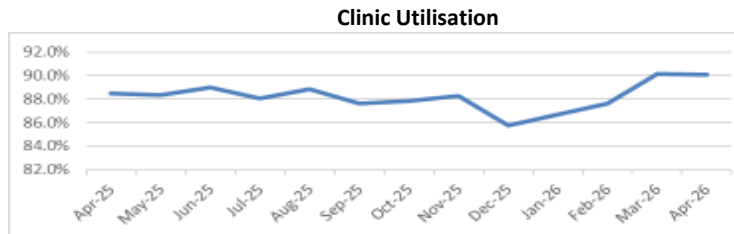
Operational Performance – Elective Activity / Productivity / Referral To Treatment Performance

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
	9,851	9,836	15 / 0%
Vs 2025/26	This Year	2025/26	Diff / Var
	9,851	9,524	327 / 3%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	9.9	2.4	75.6%

IP/DC Admissions (excl. Endoscopy)			
Total Vs Plan	This Year	Plan	Diff / Var
	3,576	3,093	483 / 16%
vs 2025/26	This Year	2025/26	Diff / Var
	3,576	3,399	177 / 5%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	15.2	7.3	52.2%



Follow Up Attendances			
Total Vs Plan	This Year	Plan	Diff / Var
	20,746	21,263	-517 / -2%
Total vs 2025/26	This Year	2025/26	Diff / Var
	20,746	21,404	-658 / -3%
Waitlist Clearance (wks)	Total	> See By Date (SBD)	% Past SBD
	18.3	6.2	67.3%

Endoscopies			
Total Vs Plan	This Year	Plan	Diff / Var
	1,325	1,211	114 / 9%
vs 2025/26	This Year	2025/26	Diff / Var
	1,325	1,210	115 / 10%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	15.0	0.3	97.8%

Performance & actions

Theatres and Pre-Operative Assessment

April saw our highest theatre utilisation to date, with overall utilisation reaching 85.6% and 84.2% within the Elective Surgical Hub. Since the launch of the Federated Data Platform, we have seen a consistent improvement in utilisation across the pilot cohort. This is particularly evident within ENT and gynaecology, both of which have seen strong gains, achieving utilisation rates of 86.6% and 90.4% respectively.

Podiatric surgery has also demonstrated a notable improvement, reaching 86.6% utilisation in April, which reflects the positive impact of improved visibility and planning.

The only area remaining within the red range for April is Dental. This is historically a challenging specialty in terms of utilisation due to the nature of the lists and patient pathways. However, work is ongoing within the specialty to agree a realistic and clinically appropriate utilisation benchmark and to identify opportunities for improvement.

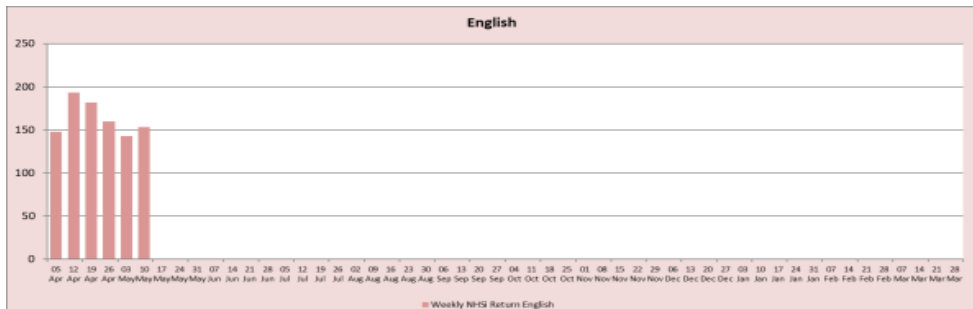
Looking ahead, MyPreOp+ is expected to go live from mid-June. Once fully implemented, this is anticipated to reduce the number of pre-operative appointments required for ASA 1 patients and, importantly, will support the introduction of standby patients across the majority of lists. This should help maximise utilisation further and reduce any unused capacity on the day.

Learnings from the Hub Optimisation Week will be finalised and shared in May, and will help inform the next phase of improvements across theatres.

Long waiting patients

- At the end of February, we had 7 English patients were waiting 65 weeks. These patients were three cornea transplant patients, two patients waiting for diagnostics in other provider Trusts, two patients who require outpatients after validation of the waiting list.
- 132 English patients were waiting over 52 weeks for treatment at the end of April

English Patients over 52 weeks on Incomplete Pathways Waiting List



What the charts tell us

- Performance against English RTT standard in April was 67.3% / 0.6 % of English patients on our Waiting List were waiting more than 52 weeks
- Performance against the Welsh RTT standard in April was 69.9%




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 2026/27 the Trust aims to achieve 92% of patients waiting less than 6 weeks for a diagnostic test by March 2025.

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

Overall Diagnostics is delivering 97% of 26/27 activity plan in M1 which is 135% compared with 19/20 activity. The Community Diagnostic Centre (CDC) is delivering approximately 3,000 tests per month.

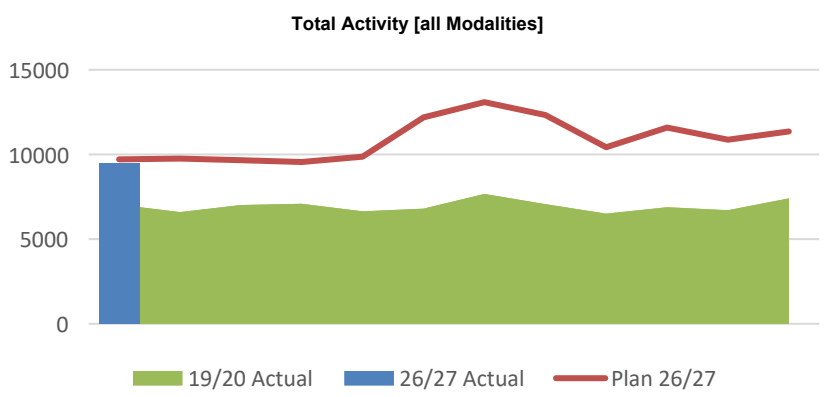
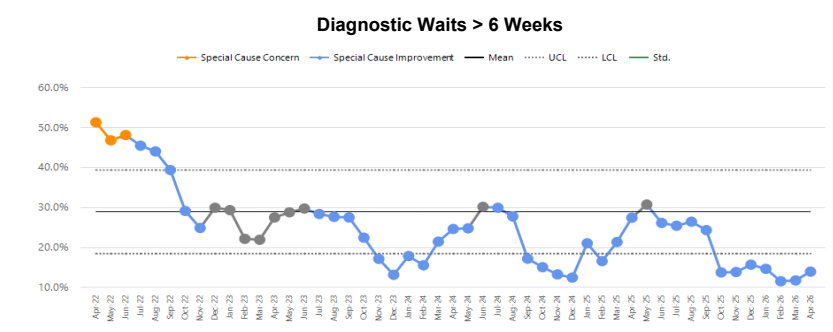
Imaging:
 6 week wait position at the end of April has achieved 98% overall, with high performance sustained across all modalities. Average appointment wait times for Magnetic Resonance Imaging (MRI) prostate and Computed Tomography Colonography (CTC) access are 4 days and 11 days respectively.

Audiology:
 Audiology Assessment 6 week wait position has improved by a further 4% to 83%, because of successfully implanted productivity strategies. Notably, Paediatric Audiology has delivered >70% 6 week performance for the first time in over 2 years.

Endoscopy:
 Waiting list improvements have declined during this period due to Ross closure, >6 weeks is 33.1% of the current waiting list and >13 weeks is 9.1% of the overall current waiting list. Work ongoing to reduce this further now activity has restarted at Ross. Cancer wait times are under 10 days for all endoscopy procedures, position maintained and no delays seen across this pathway, aiming for a further reduction to under 7 days for all procedure types over coming month. Validation of the diagnostic waiting is an ongoing process now implemented across the team on a weekly basis. Productivity of lists now also reviewed at recently implemented 6-4-2 meeting and productivity board

Echocardiography (Echos):
 Short term insourcing commences this month. Our plan and trajectory included a continuation of weekend insourcing for three month of the financial year. Our vacancy position has improved significantly with two trainees recently qualifying and progressing into Band 7 qualified posts in June and successful recruitment to a practice facilitator that will deliver both clinical activity and support training and development of the service.

Respiratory physiology (sleep studies)
 Waiting list validated has commenced with nin the waiting lists along with 100 additional tests planned for May and June. The deterioration in the waiting list position has been due to long term sickness, and capacity expected to worsen from June when our Lead Respiratory Physiologist commences maternity leave. We are recruiting to cover this vacancy and currently out for locum cover to support bridging the gap and to stabilise the position.



Risks

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

What the charts tell us

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



Geoffrey Etule
Chief People Officer

Resident doctors in England are to stage a fresh round of strikes from 15th to 19th June and this will be the 16th strike in the long-running dispute over pay. The Trust has developed a strong resilience working group with divisional leaders over the past year and actions will be taken to provide a safe and efficient service to patients during the strike.

Sickness absence has dropped to 3.8% with Long Term Sickness at 1.98%.and Short Term sickness at 1.85%. The main reasons for sickness absence are colds/flu, mental health conditions, gastro and msk. With the significant reduction in sickness absence, we will continue taking appropriate management actions to maintain low sickness in line with our absence policy. This remains a priority area for HR and WVT has been invited to publish a case study with NHS Employers on reducing sickness absence and supporting employees at work.

Staff turnover stands at 8.0 % 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 clinical vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at 5.77% but turnover for band 2/3 hcsw staff is still high at 16.71%. We are working actively with the DWP to fill our support worker vacancies with monthly recruitment boot camp events and drop-in sessions. Managers with increased staff turnover have been identified and active steps are being taken to reduce staff turnover in these departments through centralised recruitment.

In May we supported the national walking month to enhance the health & wellbeing of our employees. In June, we will be promoting men's health month working closely with our senior clinicians and Halo leisure in view of encouraging men to take more ownership of their health.

A recent RCN article on racism in the NHS called on NHS trusts to do more to tackle racism. We have provided reassurance to our staff that WVT does not tolerate any form of discrimination, sexism or racism in the workplace. We have a zero-tolerance approach to any form of discrimination and we are working closely with our staff networks to maintain a compassionate and inclusive working environment for everyone.

With the NHSE requirement to reduce our non-clinical headcount, we have completed phase one of the voluntary redundancy scheme and up to 11 non-clinical employees will be exiting the Trust by the end of June. A second phase of voluntary redundancy is likely to be implemented by August. We are also restarting the workforce optimization and efficiency working group in view of expediting schemes to enhance workforce productivity. E-rostering has been implemented in acute nursing areas and is having a positive impact on cost avoidance. We will be rolling out e-rostering to other clinical areas in 2026/27 as this is one key area to enhance workforce productivity.

To-date, we have supported 618 apprentices at the Trust with 157 employees currently undertaking apprenticeships in a variety of clinical and non-clinical areas. We now have our first trainee anatomical pathology technologist at the Trust and more are being developed to support future workforce resilience.

Since April 2025 we have recruited 30 consultants and are filling longstanding vacancies in areas such as stroke, haematology, microbiology and respiratory. The active recruitment of consultants will continue as this plays a major part in reducing agency costs.

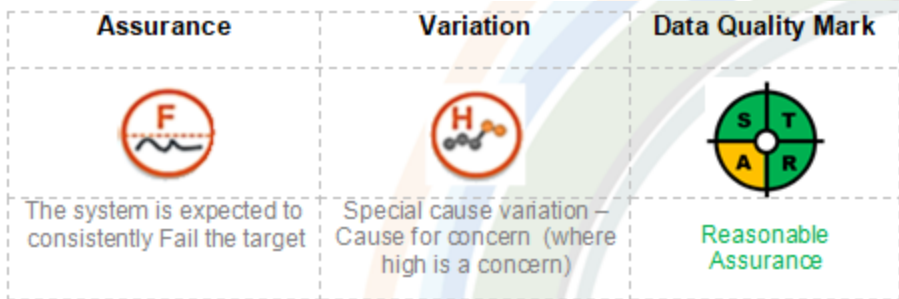
Following the dismissal of a number of staff at Nottingham University Hospitals Trust for inappropriately accessing patient records, we are reminding all staff about the importance of not breaching patient confidentiality as the consequences could be very severe including dismissal. Information governance training is mandatory for all staff and we monitor compliance on a monthly basis with any areas of concern highlighted to line managers for prompt actions.

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

Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
8.4%	8.4%	8.5%	7.8%	6.9%	6.3%	6.2%	5.7%	5.4%	4.7%	4.0%	3.4%	8.2%



Performance & actions

HCSW – with 36.99 wte vacancies we have re-introduced the centralised recruitment process and we are working actively with the DWP to fill our vacancies through recruitment boot camps and the use of work coaches. Recruitment officers hold monthly events at DWP offices and regular run drop-in sessions. We are exploring the feasibility of offering work experience for job seekers with the DWP.

N&M - since pausing international recruitment in 2025 we have seen a significant increase in applications from UK based applicants for nursing vacancies. We currently have 46.83 wte funded vacant positions.

M&D - we have successfully recruited 30 consultants over the past year using a combination of incentives and close working with over 50 recruitment agencies. Regular meetings continues with the CMD, Medical Staffing Manager & Medical HR Officer to review progress with vacancies and cases of concern. The active recruitment of medics to continue over the coming year. We currently have 73.41wte funded vacant positions.

Throughout 2026/27, we will continue promoting our support worker and clinical vacancies Herefordshire wide with a series of events. We will also be extending WVT presence at regional fairs to promote our job opportunities.

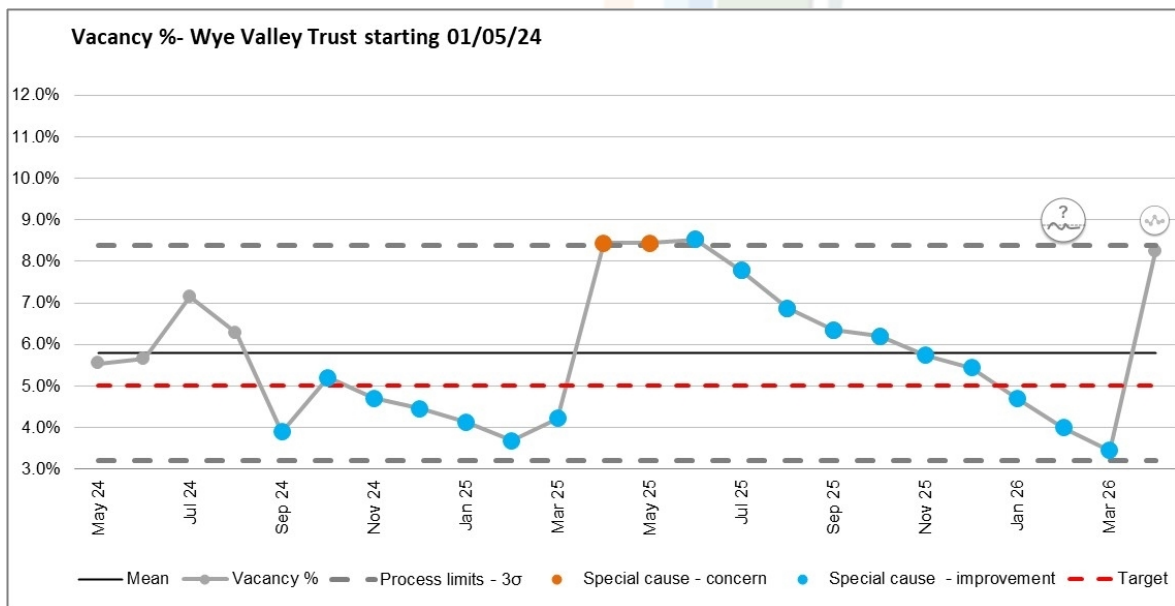
Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

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 as a result of headcount reduction. Month 1 of 26/27 has shown a large increase, due to an increase in budget for the new financial year to cover usage.

Vacancy %- Wye Valley Trust starting 01/05/24






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.

Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
8.8%	8.2%	8.7%	8.7%	8.3%	8.0%	8.2%	8.4%	8.1%	8.0%	8.0%	7.9%	8.0%

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

The overall rolling 12-month turnover at Trust level is at 8.0% and we are taking steps to ensure this stays below 10.0%. Clinical support workers at band 2 level have the highest turnover rate at the Trust (16.71%) and this is still the case across the NHS. We have reintroduced the centralised recruitment process and are strengthening the pastoral care support and training being provided. HR business partners are supporting line managers in organising stay at WVT informal meetings in areas of high turnover and highlighting career development opportunities through apprenticeships. Turnover rates for qualified nurses remains low at 5.77% 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.

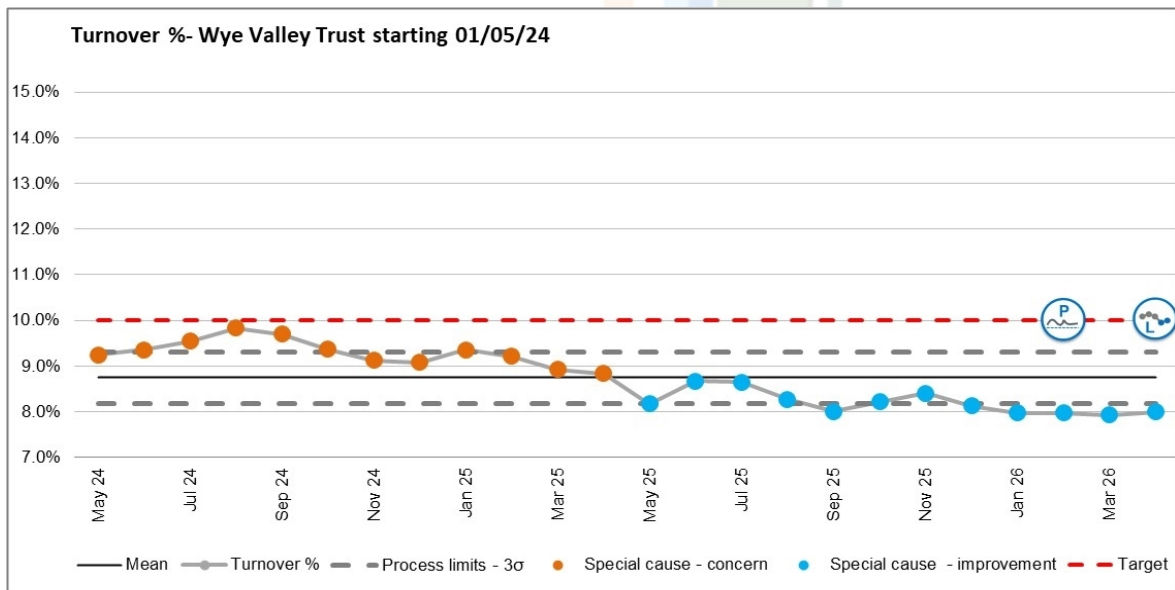
Risks

Staff turnover for band 2 support workers

What the chart tells us

The rolling 24-month position shows an overall decreasing trend. An improved position present from March and April 24 due to now removing retire and returnees. A fluctuating pattern in 25/26 but continuing with an overall decreasing trend, remaining consistent in the last 5 months.

Turnover %- Wye Valley Trust starting 01/05/24

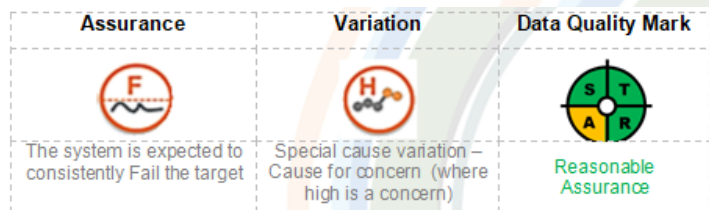


Workforce Performance – Sickness

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.

Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
5.2%	4.5%	4.8%	4.8%	4.2%	4.4%	4.7%	5.4%	5.5%	5.4%	5.1%	4.3%	3.8%



Performance & actions

During this month, overall sickness at Trust level has dropped to 3.8 % and the main reasons for absence are colds/winter ailments, mental health issues, msk 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.

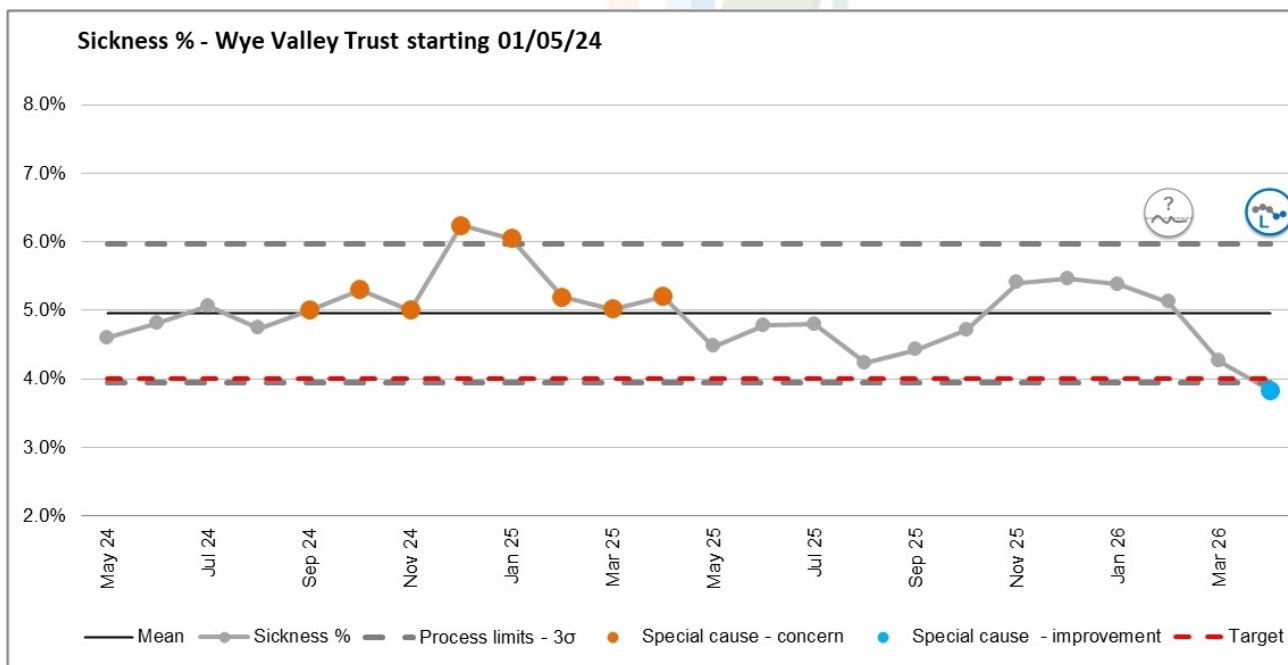
The management of absence remains a key priority area for HR and case by case reviews are undertaken by HRBPs and OH for all long-term sickness absence and short-term absence cases of concern to ensure the absence process is being managed appropriately. The HR team are also following NHSE Improving Attendance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

Risks

What the chart tells us

This was a slight increase 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 steadily increasing over the winter months, peaking in December 25, then reducing slightly in the first 2 months of the year before a large decrease in March 26, followed by a further decrease in April 26, to our lowest levels of sickness.

Sickness % - Wye Valley Trust starting 01/05/24





Katie Osmond
Chief Finance Officer

Month 1 Income and Expenditure position

Month 1 has ended slightly behind plan at (£0.2m) variance against a (£0.5m) plan.

The current year plan includes a £24.7m efficiency challenge with focus continuing on the identification and delivery of CPIP to achieve our breakeven plan and improve our underlying position. This includes schemes relating to transformational change, continuing to improve patient experience and delivering community-based care. We are actively de-risking our plan by progressing into fully developed efficiency schemes which will have a positive and recurrent impact on the run rate in year.

Month 1 Highlights:

- Agency spend was considerably better than plan in April continuing the positive trend seen last year linked to the range of actions within our medical and nursing agency reduction programmes.
- Industrial action led to an unplanned pay cost of £0.2m in month, partly mitigated in Pay by strong agency performance
- The net position for income is positive by £0.6m including a strong elective performance in month
- A £1m successful delivery of efficiencies – a shortfall of £0.4m in planned efficiency delivery, mitigated with non recurrent benefits in income and through timing of payments

We will continue to use our well-established Financial Recovery Board (FRB) to maintain strong oversight of the risks and mitigations to support delivery of the plan and improve our underlying position, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability. Our focus in 2026/27 is building on the strong engagement in and ownership of the financial agenda as we seek to balance transactional and transformational financial improvements to ensure sustainability in the medium-term.

Cash and Capital

Cash balances at the end of April are higher than planned, mainly driven by a higher closing balance as we exited 2025/26. The timing of receiving national deficit support funding has netted down the benefit from the opening cash position.

Capital expenditure is slightly less than planned at the end of April, mainly due to timing differences in the Integrated Energy Centre Scheme.



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 1 - 30th April 2026 - 2026/27			
	2025-26 ANNUAL BUDGET	YEAR TO DATE			VARIANCE IN CURRENT MONTH
		BUDGET	ACTUAL	CUMULATIVE VARIANCE	
	£000	£000	£000	£000	£000
Operating income from patient care activities	371,169	30,780	30,573	(207)	↓ (207)
Drugs Excluded	24,610	2,051	2,197	146	↑ 146
Other operating income	15,798	1,317	1,457	141	↑ 141
Donations from non current assets	240	20	0	(20)	↓ (20)
Total Operating Income	411,817	34,167	34,227	60	60
Substantive Pay	(236,447)	(19,393)	(19,787)	(394)	↓ (394)
Bank & WLI Pay	(14,507)	(1,343)	(1,432)	(89)	↓ (89)
Agency pay	(5,638)	(648)	(276)	373	↑ 373
Subtotal Pay	(256,592)	(21,384)	(21,494)	(110)	↓ (110)
Non Pay Expenditure	(99,778)	(8,684)	(8,968)	(284)	↓ (284)
Excluded Drugs	(24,610)	(2,051)	(2,151)	(100)	↓ (100)
Total Operating Expenditure	(380,980)	(32,119)	(32,613)	(494)	↓ (494)
EBITDA	30,837	2,048	1,614	(434)	↓ (434)
Depreciation	(15,604)	(1,301)	(1,158)	143	↑ 143
Impairment (CDC & PFI)	0	0	0	0	→ 0
Interest Receivable	900	75	183	108	↑ 108
Interest Payable on Loans	(257)	(21)	(31)	(9)	↓ (9)
Interest Payable on PFI	(3,030)	(105)	(105)	(0)	→ (0)
Dividends on PDC	(4,954)	(412)	(412)	0	→ 0
Operating Surplus/ (Deficit)	7,892	284	92	(192)	↓ (192)
Technical Adjustments					
Donated Assets Adjustment	742	62	59	(2)	↓ (2)
Net impact of asset impairments	0	0	0	0	→ 0
Impact of IFRS16 Implementation of PFI Contract	(8,634)	(865)	(855)	10	↑ 10
Adj. financial performance retained Surplus/ (Deficit)	0	(519)	(704)	(184)	↓ (184)

Performance & actions

The position at the end of Month 1 (April) was a deficit of £704k YTD, performing slightly behind plan with an overall negative variance of £184k YTD.

- Income shows a favourable variance of £60k. Of this (£20k) relates to donated assets and £146k relates to drugs which are directly offset by expenditure. Of the (£207k) variance in operating income from patient care, (£115k) is related to depreciation which is also matched with an expenditure positive variance.
- Pay is adverse by (£110k) YTD. The net position in month includes agency - 1.28% of total pay costs in month which is a decrease from 1.42% in month 12 in the prior year. Bank (excluding WLI) use further increases the total temporary staff proportion to 7.19% of overall pay, including costs for Industrial Action in M1 of (c£150k). Following successful recruitment earlier than planned, Medic agency costs have reduced in month. Nurse agency usage has remained low, with no spend on Healthcare Support Worker agency.
- Total Non Pay (operating & non operating) is adverse by £135k YTD including technical adjustment benefits. The adverse variance is largely due to excluded drugs (offset with income) a prior year non recurrent cost pressure in month and a shortfall in CPIP delivery. This is mitigated through non recurrent benefits including an over achievement of interest received due to higher cash balances than planned and timing of payments.
- Within Adjustments, there is a PFI £10k favourable variance driven by a one-off technical adjustment.

Risks

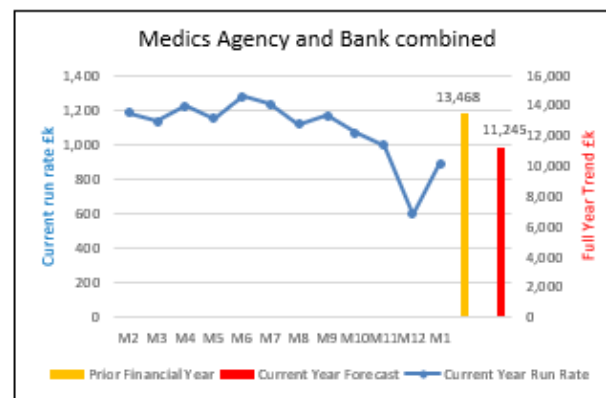
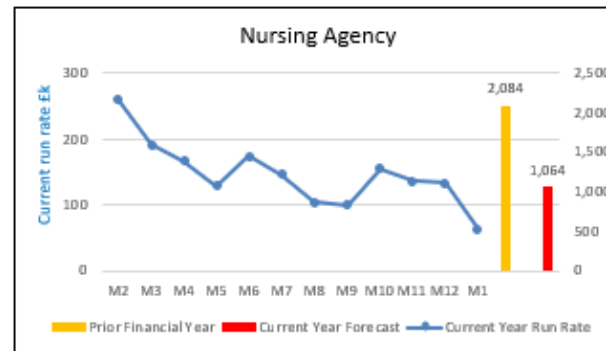
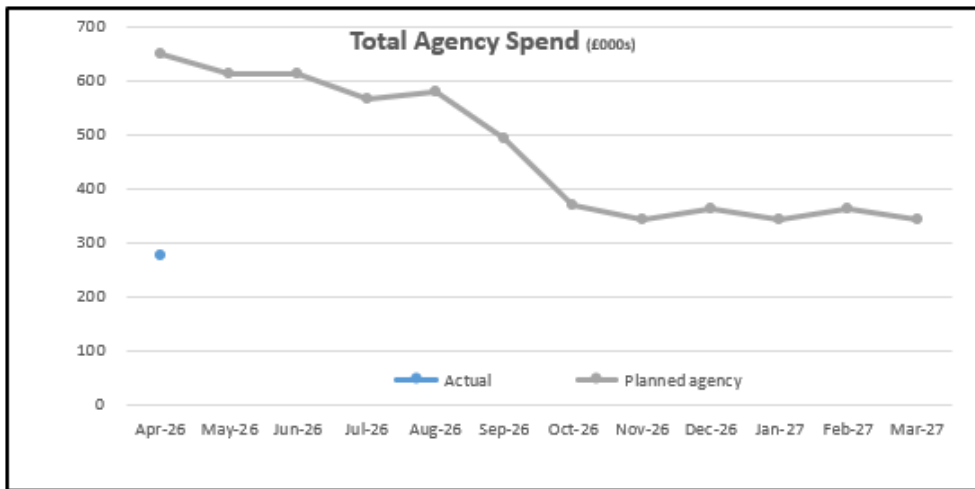
Key Financial risks within plan throughout the year

- CPIP Cost Efficiency delivery recurrently
- Level of Bank and Agency usage
- Income risk around deficit support funding and Welsh
- Future cost pressures: e.g. Industrial Action / Winter impact on financial performance
- Cost of delivering activity and the move into more community-based patient care

Finance Performance – Agency Spend

We are driving this measure because:

Tackling our 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 1.28% of total pay costs year to date, with an aim to reduce spending down to zero by 2029/30, as per national guidance. Agency performed better than plan YTD by £373k, including non recurrent savings in month. Total agency spend year to date is £276k.

- **Nursing agency:** Total spend in 2025/26 was £2.1m, which was achieved through significant efficiencies through rate reduction changes and the elimination of HCSW agency spend. The planned spend in 2026/27 is £1.1m. The cost for nurse agency spend in April was £63k.
- **Off framework Nurse Agency:** There has been 1 off framework shifts in April 2026 compared to 15 in March 2026 (1 YTD). The total shifts booked in 2025/26 was 64.
- **Medical staffing agency and bank:** The Trust spent £13.5m in 2025/26. The total spend in M1 is £888k, which is on trend to meet the planned spend of £11.2m. M1 included Industrial action incurring a cost pressure of £150k.

Risks

- Level of Agency reduction in latter half of financial year, dependent on successful recruitment
- Unplanned workforce gaps (e.g. sickness, UEC, industrial action, winter) resulting in greater requirement for temporary workforce.
- Increase in emergency demand pressures

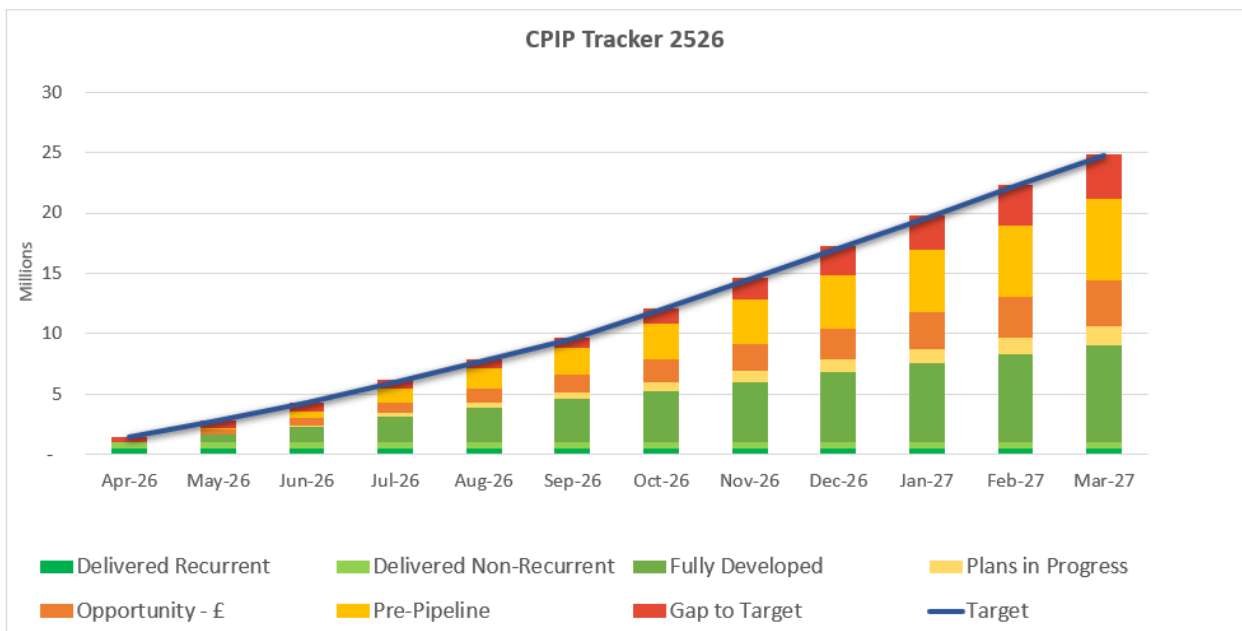
What the charts tell us

Agency performance is well within plan at Month 1 and will require a sustainable recurrent low level of spend to remain within target.

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 £24.7m target is planned to be delivered through Pay £7.5m & Non Pay £17.2m, the total includes a recurrent assumption of £20.3m. The £24.7m represents a cost reduction in 2026/27, including notable schemes of Agency, Bank and WTE reduction, reducing agency levels to zero by 2029/30.

The Trust efficiency delivery for Month 1 was £1.0m, £0.4m away from plan. Recurrent delivery was £0.5m behind plan, with a partial mitigation of £0.1m through non recurrent delivery. Any recurrent shortfall would be taken forward into the next financial year, the forecast is to deliver the planned recurrent target.

We are continuing to de-risk our plan by identifying deliverable schemes and progressing schemes into a Fully Developed status, recognising there is more work to do to reach full maturity across this category.

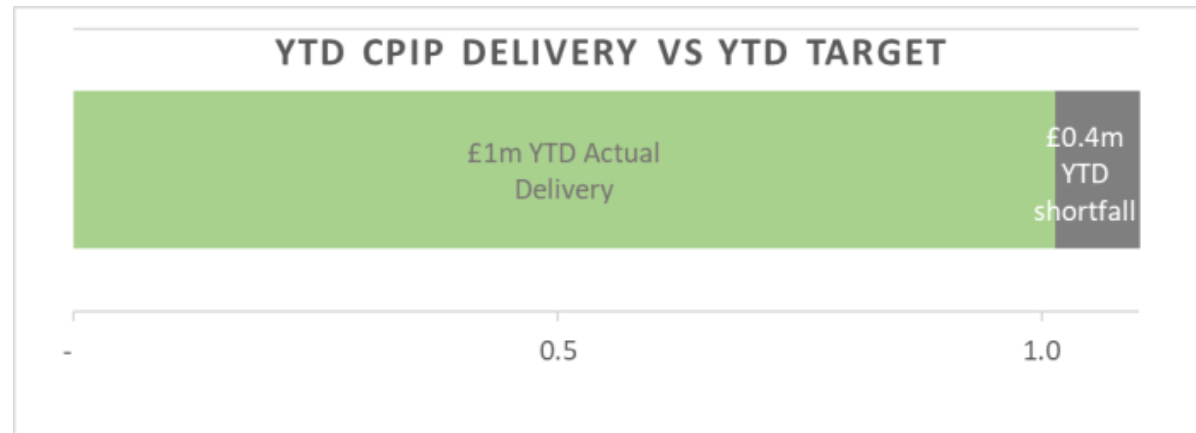
The well-established Financial Recovery Board (FRB) will continue into 2026/27 focusing on the identification and delivery of CPIP to achieve our breakeven plan, including schemes relating to transformational change and the left shift into community care. We will also continue our internal Check & Challenge meetings held with the Divisional teams maintaining accountability and pace.

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 2027/28 requirement

What the charts tell us

Challenging CPIP target of £24.7m forecast to be delivered in 2026/27. 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
February	42.9	41.1		
March	49.1	46.0		
April	45.5	41.1		
Cash balances are greater than planned due to the closing balance in 2025/26 being £6m greater than plan, netted down with M1 Deficit Support Funding not yet received				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
February	98.9%	95.0%		
March	98.9%	95.0%		
April	99.0%	95.0%		
In April the Trust paid 99% of invoices within 30 days. This equates to 99.8% by invoice value. This is the twenty eighth month, in a row, that we have achieved the 95% (by volume) target.				

Capital

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month		
			Budget £k	Actual £k	Variance £k
Local CDEL funded	Owned	8,439	469	276	193
IFRS16 Leases	Leased	1,000	0	0	0
National PDC schemes	Owned	11,400	0	164	(164)
Grant funded and Donated	Owned	1,943	446	293	153
Total Capital Programme		22,782	915	733	182

What the charts tells us

Cash

Cash balances are greater than planned due to the closing balance in 2025/26 being £6m greater than plan, netted down with M1 Deficit Support Funding not yet received.

Capital

The capital expenditure for April 2026 was £733k, £182k lower than planned. This is due to timing, predominantly of the IES scheme.

Performance & actions

Cash

Continued close management of the overall cash position will be necessary for 2026/27 with respect to CPIP delivery and receipt of deficit support funding (which is dependent on the overall system position).

Capital

Refinement of prioritisation for locally funded schemes continues through the Capital and Planning and Equipment Committee. Development of schemes related to provisional national allocations are in progress, including preparing bids to secure the funding.

Risks

Cash

Ending 2025/26 with a higher cash balance than planned helped the cash position going into the first quarter of 2026/27. However, there are several risks in 2026/27 which will impact cash and therefore cash will continue to be tightly managed.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	4th June 2026
Title of Report:	Freedom to Speak Up (FTSU) Annual Report 2025/26
Lead Executive Director:	Chief People Officer
Author:	Jo Sandford, FTSU Guardian
Reporting Route:	Direct to Board
Enclosures included with this report:	n/a
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
<p>This report provides broad details of Speaking Up events for the year 2025/2026. It provides an up-date from the Trust’s Freedom to Speak Up Guardian (FTSUG) on progress, exceptions, any themes and learning and on-going plans to continue strengthening arrangements for staff to Speak Up and raise their concerns.</p> <p>It also informs the board and public of National FTSU and Local developments that will influence WVT strategy and development and where FTSU objectives contribute to Trust objectives</p>	
Recommended Actions required by Board or Committee	
<p>Leaders to continue to promote :-</p> <ul style="list-style-type: none"> • Speaking up FTSU training within all departments. We do have a high percentage at 93.4% which is steadily increasing and an excellent percentage for mandatory training. Please contact ftsug@wvt.nhs.uk if you would like a breakdown provided for your area. • E-Learning for line managers, Listen Up training as part of the appraisal process. 196 staff in the trust have completed Listen Up training to date. <p>The Organisation to :-</p> <ul style="list-style-type: none"> • Promote that senior staff do listen, are very supportive of FTSU and will take all speaking up seriously. • To provide more training for managers to ensure that any bad behaviours within a team are tackled promptly. • 	
Executive Director Opinion¹	
FTSU Guardian has ongoing approval from CPO to release the report following a review.	

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

1. Executive Summary

This paper summarises Freedom to Speak Up (FTSU) activity and the key themes of concerns raised with the Freedom to Speak Up Guardian (FTSUG) and FTSU Champions at WVT during 2025/26.

It outlines FTSUG activity, alongside developments and actions taken to further embed the FTSU role and promote a culture of openness. As an example of WVT's commitment to FTSU, the hours allocated to the FTSUG role were increased to three full days per week from April 2023. However, due to the growing volume of cases and the continued development of the role, the Guardian has been working full-time hours since November 2023. This arrangement was made permanent in November 2025, as while WVT is delivering a strong and effective speaking-up service, sustained investment is needed to maintain this level of support.

The FTSUG role spans multiple areas of the CQC Well-Led Framework. The Care Quality Commission (CQC) evaluates a Trust's speaking-up culture during inspections under Key Line of Enquiry (KLOE) 3 within the Well-Led domain.

2. Summary of Speaking Up in 2025/26

The speaking up service has had a highly successful year. Extensive promotional activity, alongside a strong network of Champions across the Trust, has led to a significant increase in both case numbers and overall awareness of the service. As a relatively small Trust, this has been further supported by positive word of mouth, with many staff approaching the Guardian based on the experiences of their colleagues.

Cases are managed promptly and resolved more quickly, reducing stress and uncertainty for those who speak up. This timely and supportive approach has contributed to a strong and positive reputation for the FTSU service across the Trust.

2.1. Speaking up data in 2024/25

There were a total of 187 cases in 2024/5. Only three of these still remain open. This is an increase of 49.6% on last financial year and an increase of 159.7% since commencing in the Guardian role on 1/4/23

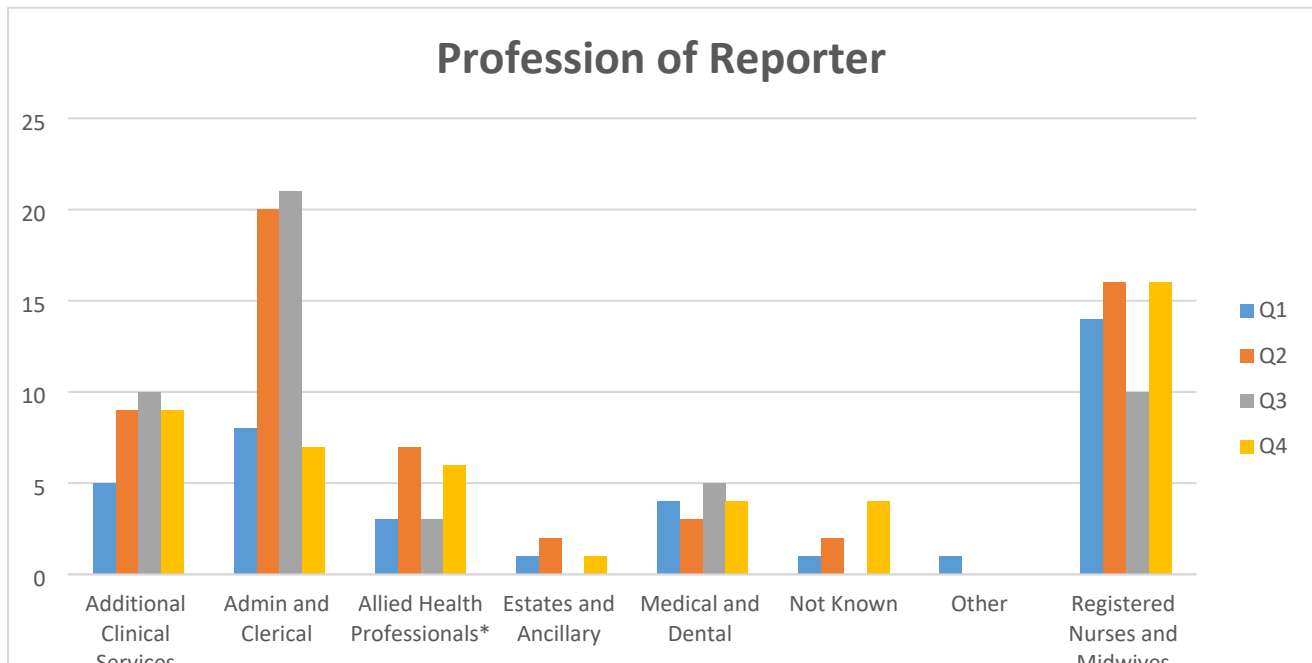
Financial Year	Number of Cases
2018/19	24
2019/20	73
2020/21	70
2021/22	74
2022/23	72
2023/24	125
2024/25	187
2025/26	192

2.2 Speaking up Identified by Staff Group.

Administration and clerical staff, along with registered nurses and midwives, were the primary groups raising concerns over the year, consistent with previous trends.

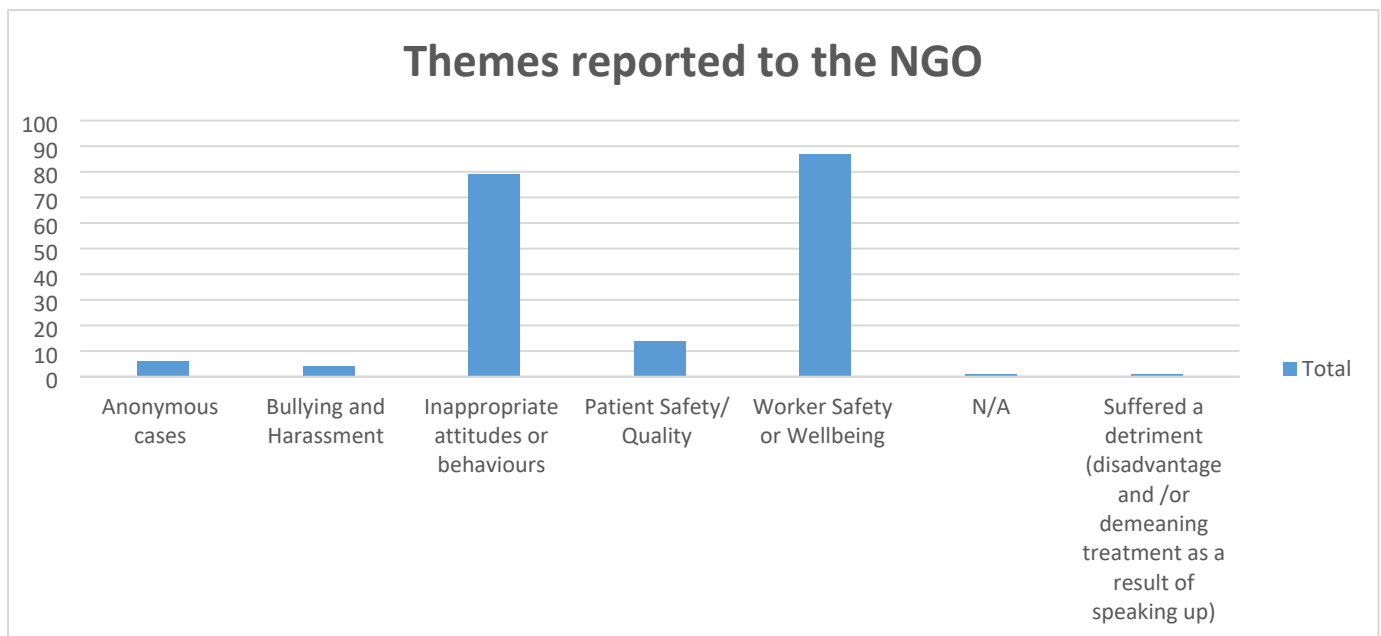
There has been a notable reduction in cases recorded as anonymous compared to prior years. Previously, anonymous cases included individuals who chose not to share their identity with the Guardian, queries or comments submitted anonymously via the Trust's Rumour Mill that required a response from the FTSU Guardian, or concerns raised through an intermediary such as an FTSU Champion.

The reduction in anonymous reporting is a positive development and is likely linked to increased promotional activity and communication, reinforcing that concerns are acted upon and that WVT provides a safe and supportive environment for staff to speak up.



2.3 Data returns to National Guardian Office (NGO)

The six categories that are required within the NGO quarterly report are shown in the graph below.



Speaking up cases are categorised from the perspective of the individual raising the concern, or, where necessary, based on the Guardian’s interpretation of the information received. These categories must be reported to the National Guardian’s Office (NGO) on a quarterly basis. However, the current categorisation framework can be broad and, at times, lacks specificity. Where concerns relating to staff do not clearly fit into other categories, they are often recorded under “worker safety or wellbeing.” There have been ongoing requests from Guardian Networks for the NGO to expand the category set to better reflect themes such as non-adherence to Trust policies and procedures.

Behavioural concerns—across the related categories of detriment, bullying and harassment, and inappropriate behaviours—represent the most significant area of concern, accounting for 53% of cases, as illustrated in the chart above. Worker safety and wellbeing also includes cases where staff are experiencing stress or anxiety as a result of workplace issues. This pattern is consistent with the wider national picture. The NGO FTSU Annual Report 2023/24 highlights that poor behaviour remains a key concern, with 32.3% of cases including elements such as bullying or harassment, an increase from 30.1% the previous year. While the 2025/26 report is not due until July 2026, discussions within the Midlands FTSU Network suggest that this trend is likely to continue.

As highlighted by Tim Keogh in *A Kind Life*, workplace bullying can have significant psychological impacts, with 75% of affected individuals reporting loss of concentration, memory issues, and heightened anxiety, and over 80% experiencing ongoing stress linked to anticipating further negative events.

While high-quality clinical services are central to WVT's success, maintaining these standards depends on prioritising staff wellbeing. It is essential that when concerns are raised, there is clear and demonstrable action taken in response. However, achieving timely action can be challenging in the current operating environment, which may in turn impact the wellbeing of those who speak up. To sustain an effective FTSU service and maintain confidence that concerns are both heard and acted upon, improvements in response times are required.

Feedback to staff who speak up is consistently timely and thorough, and the FTSUG continues to work alongside the HR team to support staff wellbeing initiatives and promote awareness across the Trust.

2.4 Civility Saves Lives

Over the past 3 years, Civility Saves Lives (CSL) training has been delivered to 870 WVT staff. The Guardian has also facilitated “train the trainer” sessions, establishing a cohort of 10 trained facilitators. This has enabled the introduction of both monthly virtual sessions and monthly face-to-face sessions via the Education and Development Centre (EDC). In addition, bespoke sessions can be arranged for individual teams on request.

CSL training is also embedded within a range of development programmes, including the preceptorship programme, leadership and management courses, as well as sessions for junior doctors and student nurses.

What is Civility Saves Lives?

- It focuses on developing and sustaining a positive, open culture, fostering psychological safety so that staff feel confident to speak up.
- It promotes civility in the workplace, which is widely recognised as critical to patient safety. It also supports staff wellbeing by addressing poor behaviours, including bullying, harassment, and microaggressions that may reflect bias.
- It encourages individuals to move away from defensiveness and instead respond with curiosity and openness when concerns or challenges are raised.
- At its core, it is about treating colleagues with kindness and respect to strengthen teamwork and improve patient outcomes.

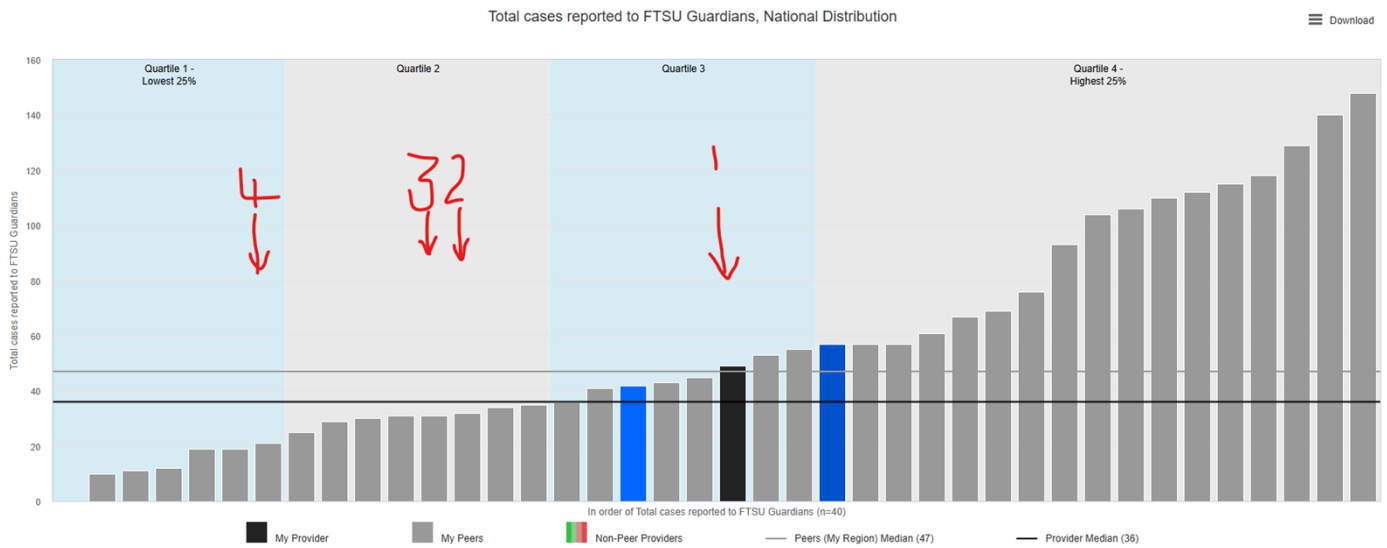
“We are a collective voice for the importance of respect, professional courtesy and valuing each other. We aim to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can understand the impact of our behaviours” Dr Chris Turner, Consultant in Emergency Medicine

2.5 National Comparisons

Model Hospital's reporting for cases reported to FTSU Guardians is for Quarter Three of 24/25 showing WVT into quartile 3 with 47 cases.

1. George Eliot Hospital – 18 cases

- 2. Worcester Acute Trust – 31 cases
- 3. South Warwickshire Foundation Trust – 36 cases
- 4. Wye Valley Trust – 47 cases



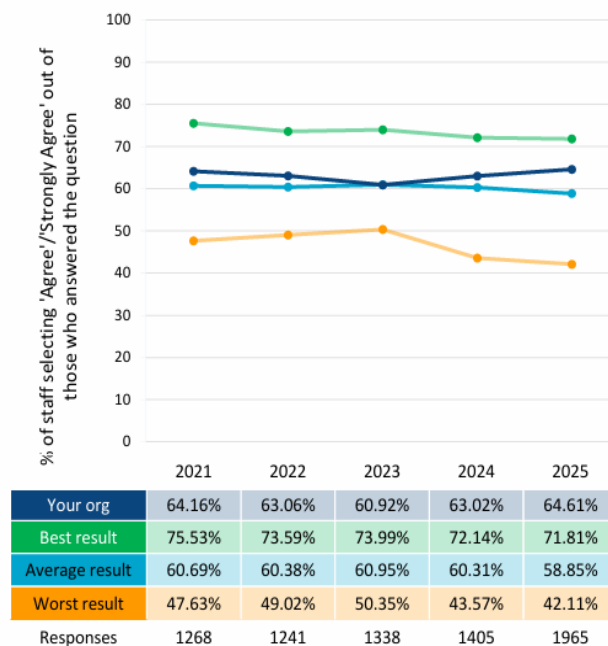
This does not mean that WVT have more issues than other hospitals. It means we have a speak up service that is trusted. Staff feel listened to and have faith that action will be taken as a result of them speaking up.

2.6 NHS National Staff Survey 2023

The questions that make up the People Promise section, we all have a voice that counts, raising concerns, is reviewed every year locally, regionally and nationally by all FTSU Guardians. This compares the Trust’s performance nationally and is an indicator how safe staff feel to Speak Up and how confident they are the Trust will act. The 2025 Staff Survey published in March 2026 show that for feeling safe to speak up there was an increase of 2.1% which is a reflection on the promotional work around the trust, an increase in Champions and a high success rate for resolving issues and concerns.



Q25e I feel safe to speak up about anything that concerns me in this organisation.



2.7 Lessons Learnt

1. Use of the English Language in the Workplace

A number of concerns have been raised over the past year regarding the use of the English language in the workplace. This has been addressed through targeted presentations delivered to Medical Matrons, Sisters, and teams within Theatres and the Surgical Directorate. The presentation will also be made available for managers to use locally when similar issues arise. The aim is to raise awareness of the Trust's position, which reflects three distinct workplace settings, and to support staff in understanding the sensitivities and challenges associated with this topic. Staff are encouraged to adopt a compassionate and inclusive approach by considering different perspectives. In clinical areas, the use of English is essential to ensure clear communication and inclusion for both colleagues and patients. In non-clinical or communal areas, a more flexible "read the room" approach is encouraged to ensure all staff feel included and respected. This approach has already had a positive impact, particularly within Theatres, where initial concerns arose after staff were advised that speaking languages other than English was not permitted anywhere in the department. The revised, balanced guidance has helped address concerns and promote a more inclusive environment.

2. Responding to Speak Up Barriers

A recurring theme identified through speaking up cases is the perception among some staff that managers and the Executive team may not listen to, or act upon, concerns that are raised. To address this, "Listen Up" training has been made mandatory for all staff with line management responsibilities and is now embedded within the appraisal process. This training reinforces the importance of active listening, appropriate responses, and creating a culture where speaking up is encouraged and valued. In addition, a locally produced film has been developed to demonstrate the Executive team's commitment to the speaking up agenda. The film highlights that concerns are taken seriously and reinforces that speaking up at WVT is supported. Feedback has been very positive and has helped build confidence in leadership commitment.

3. Feedback to Staff

Maintaining regular and effective communication with staff is essential to delivering a high-quality speaking up service. Those responsible for investigating concerns must respond promptly, as individuals who speak up are often experiencing significant stress and anxiety. Speaking up can, in some cases, contribute to sickness absence, which impacts both the individual and the organisation. Encouragingly, more timely resolution of cases over the past year has contributed to a reduction in sickness absence among those who have raised concerns.

4. Support and Development for Leaders

A key theme this year has been concerns relating to inconsistent management practice in some departments, including not following established policies and procedures or not treating staff fairly.

Further review suggests that some staff—particularly within administrative and clerical roles—are progressing quickly into management positions without sufficient leadership experience. While the Trust offers a range of development opportunities, including a three-day leadership and management course, these are not always being accessed consistently.

The Guardian has recommended the development of a structured preceptorship or support programme for new managers to strengthen leadership capability. This would support new leaders in their roles and is likely to have a positive impact on staff experience and confidence.

5. Psychological Safety

A key concern identified through speaking up activity this year is the perceived lack of psychological safety within some areas of the Trust. Feedback from staff indicates that some individuals feel unable, or reluctant, to raise concerns with their line managers due to fear of negative consequences or not being taken seriously. This highlights the need for continued focus on strengthening a culture where all staff feel safe, supported, and confident to speak up without fear of detriment. Addressing this will require consistent leadership behaviours, visible commitment from managers at all levels, and ongoing reinforcement that raising concerns is both valued and essential to improving staff experience and patient care.

These areas represent a selection of the learning identified through speaking up cases. The Guardian will continue to review themes and provide recommendations to support ongoing improvement across the Trust.

3.1 Exception Reports

For the year 2025/26 there were no cases open for more than 3 months. Only 5 cases from this financial year still remain open

3.2 Mandatory Training for FTSU

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	131	131	126	96.18%
Additional Clinical Services	802	802	762	95.01%
Administrative and Clerical	875	875	833	95.20%
Allied Health Professionals	350	350	333	95.14%
Estates and Ancillary	131	131	121	92.37%
Healthcare Scientists	92	92	85	92.39%
Medical and Dental	447	447	360	80.54%
Nursing and Midwifery Registered	1,223	1,223	1,165	95.26%
Students	4	4	4	100.00%
Total	4,055	4,055	3,789	93.44%

WVT was one of the first Trusts in the Midlands to mandate module one, Speak Up via eLearning. It still remains one of the few trusts within the region that has made the training mandatory. The aim for all mandatory training is for the percentage is 85% or higher to be compliant. At the end of March 2025 FTSU was 93.44%. Only Medical and Dental are not achieving the required 85%. The National Guardian Office is calling for all three modules of FTSU eLearning to be mandated following on from the results of the 2022 Annual Staff Survey.

"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters" Jayne Chidgey-Clark National Guardian

The Guardian has reported to TMB that staff feel that some managers will not listen or act upon their concerns. It has been agreed to mandate module two, Listen Up training for anyone who line manages another staff member.

4. The WVT FTSU Team

The Guardian has been contracted for 37.5 hours per week since 1 November 2025. At the start of 2023/24, there were only 22 Champions across the Trust, which did not adequately reflect the diversity and scale of the workforce. As a result, a target of 100 Champions was set within the FTSU Five-Year Plan.

This target was successfully achieved by May 2024, and there are now 112 trained Champions in place. The ongoing aim is to ensure that every department across the Trust has access to a Champion.

Work continues to enhance the visibility of Champions. Initiatives include the introduction of lanyards and badges, publishing a Champion directory on the intranet, and displaying posters across the Trust identifying the Champion for each area.

5. Breaking down Barriers

As part of this year's promotional work, I have focused on engaging with groups who may be less likely to speak up. The BAME community is one such group, despite representing more than a quarter of our workforce. I have actively supported engagement by recruiting additional Champions and attending monthly BAME meetings. This has led to an increase in BAME Champions from 7 last year to 15 this year.

I am also part of a WhatsApp group for Indian staff, alongside the Chief People Officer. There are plans to expand this approach over the coming year to include other nationality-based groups that have formed through shared heritage. In addition, I act as an ally to both the LGBTQ+ community and the disability awareness group within the Trust. It is essential that all staff feel confident to speak up in a safe and supportive environment.

A dedicated Freedom to Speak Up (FTSU) office is now in place. Given the sensitive nature of these conversations, it is vital that a private and confidential space is available for staff who wish to raise concerns.

6. The Future of FTSU within WVT

The case load rose by 4% last financial and although a smaller increase it still continues to do so. To maintain the successful Speak up Service that has been developed over the last 3 years consideration to enhancing the service with extra admin support needs to be addressed. I am looking forward to continually reviewing, improving and developing the FTSU Service within Wye Valley Trust over the next financial year.

Jo Sandford

Freedom to Speak Up Guardian

Wye Valley Trust

End of report

Escalation and Assurance Report

Report from: Quality Committee
 Date of meeting: 30 April 2026
 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	Quality Priority: Transition of Care
Rating rationale	The priority related to the transition of care of young people with chronic medical conditions from paediatric to adult services. Progress included consultation with stakeholders on the development of a passport and a transition pathway, focus groups with young people, education sessions with specialities and engagement with the ICB Transition Network. A Transition Working Group and Young Ambassadors Forum would be set up to support the coproduction of a Transition of Healthcare for Young People Strategy and would potentially be made permanent.
Outcome	The Committee welcomed the progress and the planned coproduction approach. Action: Provide detail on planned actions and timescales in the next report.
Item/Topic	Quality Priority: Diabetes Safety Improvement
Rating rationale	There were four workstreams, each with associated KPIs, related to foot assessment on admission, safe management of insulin, patient empowerment and safe hypoglycaemia management. Each workstream was progressing well, with key achievements including launch of a new hypoglycaemia care bundle and a self-administration pilot. An action plan would drive further improvements in 2026/27.
Outcome	The Committee welcomed the report and the progress demonstrated.
Item/Topic	Mortality Report
Rating rationale	The latest 12 month rolling SHMI (to October 2025) was similar to preceding months and therefore stable. The latest crude mortality rate (March 2026) was 1.41% of all admissions. At a speciality level there had been SHMI reductions in stroke and pneumonia related deaths but an increase in fractured Neck of Femur (#NOF). Compliance with best practice standards for #NOF was good and had improved. Several workstreams were in progress to better understand the data and further improvements needed. A peer review had taken place and feedback was awaited. More work was needed on coding to provide detailed understanding of issues such as comorbidities.
Outcome	The mortality data was noted. The Committee welcomed plans for further improvements on #NoF. Action: Report on #NoF peer review feedback at the next possible meeting.
Item/Topic	Surgical Division Quarterly Report
Rating rationale	The number of incidents for the year was down 9% compared to the previous year. Analysis indicated this related to improved safety rather than under-reporting. The number of complaints in March was typical and for 2025/26 similar to the previous year. The top 2 themes were clinical treatment and communication, particularly 'patient not listened to'. Staff were encouraged to take part in advanced communication and customer care training. Work continued to reduce the complaints backlog through strengthened processes, including ensuring learning was identified at an early stage. Two PSIs were declared, including one for maternity and one relating to T&O requested by the Coroner. There were five very high scored risks (15+). Positive areas included: <ul style="list-style-type: none"> • Additional enhanced care beds had opened to help reduce length of stay. • The GIRFT Team visit to the Elective Surgical Hub was very positive and resulted in accreditation. • Theatre productivity, cancellations and RTT performance had all significantly improved. Areas of concern included an increase in surgical site infections.
Outcome	The report was accepted.

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: Quality Committee
 Date of meeting: 30 April 2026
 Report to: Trust Board

Item/Topic	Integrated Care Division Quarterly Report
Rating rationale	<p>The number of overdue incidents was high, though significantly reduced since December. The oldest now dated back to October 2025. Plans were in place to address this.</p> <p>Falls incidents were up 5% on the previous year but there had been a downward trajectory since October supported by dementia management training.</p> <p>Tissue viability continued to be an area of concern, particularly for patients in the community. A Pressure Ulcer Panel had been established to oversee this at divisional level.</p> <p>The number of complaints had reduced.</p> <p>Key areas of progress included the expansion of projects to support Trust-wide flow improvements, including hospital avoidance, virtual ward and Call Before you Convey.</p>
Outcome	The report was accepted.
Item/Topic	Clinical Support Division Quarterly Report: Pharmacy
Rating rationale	<p>A department restructure was in progress which would support important improvements. An independent cultural review was complete and an action plan had been developed.</p> <p>The number of incidents related to expired medicines in Pharmacy had increased; a new process was in place to reduce this.</p> <p>An ICS Aseptic Review highlighted some issues that would benefit from a dedicated Quality Manager role.</p> <p>There was one very high risk (20) regarding aseptic unit demand and capacity.</p>
Outcome	<p>Actions</p> <ul style="list-style-type: none"> • Board members were invited to attend a walkaround to the Pharmacy Department. • Provide an update report in October.
Item/Topic	Perinatal Incident Quarterly Report
Rating rationale	<p>There was one stillbirth and one neonatal death in Q4 which would both have a PMRT review.</p> <p>There were two incidents of moderate harm. The duty of candour had been followed in one and the other was awaiting PMRT.</p> <p>One MNSI report was completed, highlighting opportunities for improvement in routine urinalysis and use of family members for interpretation.</p> <p>The patient safety action tracker showed some delays in implementation; actions would be transferred to the Trust incident system.</p>
Outcome	The report was noted.
Item/Topic	Midwifery and Neonatal Nurse Safe Staffing Report
Rating rationale	<p>The position was stable overall. Sickness was reducing and was below target for support staff but above for midwives and neonatal nurses.</p> <p>The midwife to birth ratio was not met but was improving due to recruitment to vacancies and reduced sickness.</p> <p>Birthrate+ acuity levels were not met all of the time, with mitigations taken to ensure safety was maintained through movement of staff.</p> <p>There were no staffing incidents.</p>
Outcome	The Committee was assured that robust processes were in place to monitor staffing levels and to mitigate risks when staffing gaps occurred.
Item/Topic	Nurse Staffing Report March 2026
Rating rationale	<p>Fill rates remained stable for nurses and health care assistants.</p> <p>Nine incidents were reported (a reduction), all no harm, and there were 19 red flags (a reduction).</p> <p>Registered nurse vacancies had reduced and recruitment over-establishment continued in line with the rate of turnover and maternity leave.</p> <p>Sickness rates had improved.</p> <p>Escalation areas remained open and continued to require additional staffing. A revised corridor care model was now in place based on a risk assessment of all corridor care and temporary escalation spaces.</p> <p>The need for mental health nursing support meant a continued reliance on agency nursing off-framework.</p>
Outcome	The Committee welcomed the overall positive performance in some challenging circumstances.

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: Quality Committee
 Date of meeting: 30 April 2026
 Report to: Trust Board

Item/Topic	Safeguarding Quarterly Report
Rating rationale	<ul style="list-style-type: none"> • Adults <p>There were 189 safeguarding referrals and an increase in requests for advice and support from staff. The increase in domestic abuse support referrals last quarter had reduced again. Training rates for medical staff had dipped overall, particularly for Mental Capacity Act and DOLs training.</p> <ul style="list-style-type: none"> • Children <p>There was an increase in early help assessments. Training compliance was good except in ED for level 3 safeguarding.</p> <ul style="list-style-type: none"> • Looked After Children <p>Generally it was a positive quarter Timely completion of statutory Review Health Assessments would be a focus during the year.</p>
Outcome	The Committee accepted the report, noting improvement actions planned where required.

Assure: Including assurance items rated green	
Item/Topic	Patient Safety Committee (PSC) Summary Report
Rating rationale	Red-rated areas (with actions in place): <ul style="list-style-type: none"> • Planned preventative maintenance • Gaps in transfusion governance • VTE assessment rates below target, with data quality issues affecting reporting accuracy.
Outcome	The report was noted.
Item/Topic	Infection Prevention and Control Committee Report
Rating rationale	Key messages: <ul style="list-style-type: none"> • NHSE has asked all trusts to take actions to reduce the consumption of broad spectrum antibiotics and thereby reduce gram negative infections. This would be a topic for the Board workshop in June. • Fit mask testing compliance was a concern; FPE would monitor improvements.
Outcome	The report was noted.
Item/Topic	Patient Experience Committee Report
Rating rationale	Red-rated areas: <ul style="list-style-type: none"> • FFT response rates remained low across the Trust (7-10%) • There were high numbers of complaints in Gynaecology • There was a downward trend in complaints response performance in the Medical Division. • The complaints process would be subject to Internal Audit this year.
Outcome	The Committee welcomed the planned focus on complaints management.
Item/Topic	Patient Safety Incident Response Framework (PSIRF) Report
Rating rationale	5 PSIRs remained opened beyond the original target date for completion.
Outcome	The report was noted.

To Note: Items received for information or approval	
Item/Topic	Quality Priorities 2026/27
Summary	Additional detail was provided about the proposed quality priorities considered at the previous meeting.
Outcome	Actions: <ul style="list-style-type: none"> • Next year provide more detail at an earlier stage about the process of selecting the priorities, the intersection with patient feedback, incidents and national priorities, and a longlist. • Standardise the approach to presenting progress reports on each priority. • Provide a regular overarching summary report on progress of all priorities.

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.

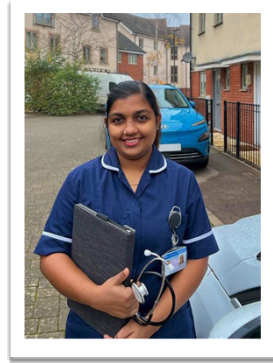
WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Public Board
Date of Meeting:	4th June 2026
Title of Report:	Trust Quality Account 2025-26
Lead Executive Director:	Chief Nursing Officer
Author:	Natasha Owen, Associate Director of Quality Governance
Reporting Route:	Quality Committee
Enclosures included with this report:	
Purpose of report:	<input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
The Trust Quality Account details the progress against the 2025-26 quality priorities and sets out the priorities for 26-27. The account includes all statutory information in relation to the quality and safety of our services.	
Recommended Actions required by Board or Committee	
The Board is asked to approve the Quality Account subject to those matters listed below.	
Executive Director Opinion¹	
<p>The quality account has been prepared in line with national guidance; the account is no longer subject to an audit opinion. Given the year end data requirements and the June deadline it is impossible to produce a final account in advance of the Board meeting.</p> <p>The Quality Account will be subject to the following additions and review prior to publication on 30th June.</p> <ul style="list-style-type: none"> • ICB statement of assurance, any material comments requiring Board attention will be escalated to Board in advance of the extraordinary meeting on 23rd June • Chief Executive overview • Final Quality Control check 	

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



NHS
Wye Valley
NHS Trust



Quality Account 2025-26



Compassion • Accountability • Respect • Excellence

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Wye Valley Trust Quality Accounts 2025/26

Introduction to Quality Accounts



Wye Valley Trust Quality Accounts 2025/26

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Quality Account for Wye Valley NHS Trust (the Trust) reflects on the achievements made in the past year against the goals set. It also looks forward to the year ahead and defines what the priorities for quality improvements will be and how the Trust expects to achieve and monitor them.

How will the Quality Account be published?

In line with legal requirements, all NHS healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30th June 2026. The Trust also makes the Quality Account available on the Trust website.

About the Trust

The Trust is an acute and community service provider, with a wide range of services provided to people of all ages living in Herefordshire and some of the population of mid-Powys. The Trust employs over 4000 staff who operate from the County Hospital, many community sites and in people's homes.

Wye Valley NHS Trust was established in 2011 and provides healthcare services at Hereford County Hospital in Hereford and at community hospitals in Ross-on-Wye, Leominster and Bromyard.

The Trust provides community and hospital care to a population of approximately 195,000 people in Herefordshire and a population of more than 40,000 people in mid-Powys, Wales.

The Trust has four clinical divisions: Surgical, Medical, Integrated Care and Clinical Support.

The Trust delivers joined up services, helping people to remain independent at home for as long as possible by providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, the Trust offer a wide range of services to keep you and your family well.

The Trust is part of a Foundation Group with South Warwickshire NHS Foundation Trust, George Eliot Hospitals NHS Trust and Worcestershire Acute Hospitals NHS Trust with a single Chief Executive Officer and Chairman (to end of March 2026). Wye Valley and Worcestershire Acute Hospitals NHS Trust had a new Chair appointed in April 2026. All four organisations face similar challenges and have a common strategic vision for how these can be solved. The Foundation Group model retains the identity of each individual trust whilst strengthening the opportunities available to secure a sustainable future for local health services and providing a platform to share best practice and improve whole system patient pathways.

Having been rated as 'Requires Improvement' by the Care Quality Commission the journey to 'Good' is continuing and the Quality Account illustrates what the Trust is doing to achieve this.



Wye Valley NHS Trust Mission and Values

Vision, mission and values



Our vision

"To improve the health and well being of the people we serve in Herefordshire and the surrounding areas".

Our mission

"To provide a quality of care we would want for ourselves, our families and friends".

Which means:-



Our values

Compassion

Accountability

Respect

Excellence

Our Trust's values are so important to the way we work every day, we're really keen to hear from candidates who share our values and will demonstrate them when joining our team.

Compassion

- We will support patients and ensure that they are cared for with compassion

Accountability

- We will act with integrity, assuming responsibility for our actions and decisions

Respect

- We will treat every individual in a non-judgemental manner, ensuring privacy, fairness and confidentiality

Excellence

- We will challenge ourselves to do better and strive for excellence



Introduction from the Chief Executive

Account this year.



Glen Burley, Chief Executive



Commented [RM2]: NO to draft

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CELEBRATING EXTERNAL RECOGNITION

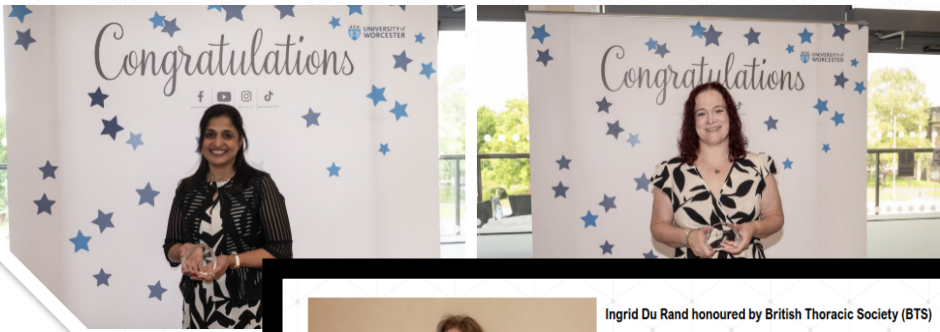
University of Worcester's Excellence in Practice Awards

Last month representatives from the Trust were invited to celebrate the University of Worcester's Excellence in Practice Awards, an event that aims to recognise and celebrate some of the outstanding work undertaken by staff in practice who support students and apprentices completing their work placements.

We are thrilled to share that **Emma Colegate** (District Nurse) won the award for 'Outstanding Practice Supervisor/Assessor of Nursing Associate Students/Apprentices' and **Vijo Boban** (Physiotherapist) won the 'College of Health and Science Award for Excellence in Practice Learning – Individual'

We want to congratulate them both on this fantastic achievement. Their success is a powerful reminder of the importance of strong role models in practice.

Well done and thank you for making a difference!



Ingrid Du Rand honoured by British Thoracic Society (BTS)

Ingrid Du Rand, our respiratory and acute medicine consultant, has been presented with the BTS Award for Meritorious Service.

The award is presented for "an exceptional service to the Society far above that which would normally be expected for their position/role; provided an exceptional service to the Society over a far longer period than would normally be the case; provided a service to the Society in particularly difficult or delicate or trying circumstances."

In her nomination, the society said Ingrid has delivered exceptional service and care in respiratory medicine and that she is recognised internationally for her contribution to respiratory medicine over the years.

Ingrid was also recognised for writing and co-chairing five guidelines, four Quality standards for the BTS, serviced on BTS standards of care committee and Quality Committee and is associate editor for Thorax.

If that wasn't enough, Ingrid has also developed guideline guidance for the BTS to

Andrea Johnson receives prestigious award

A huge congratulations to Andrea Johnson our Histopathology and Microbiology Laboratory Manager who won the Biomedical Science Leader award at the IBMS Awards 2025 on Friday 4th July. The pathology department at Wye Valley was shortlisted for four awards including Team of the Year (Blood Sciences), Best Use of Research, Innovation or Technology (Microbiology) and Harvey's Lab Tour of the Year. We were shortlisted in more categories than any other organisation and we are incredibly proud to be a part of the Wye Valley Pathology team. To be nominated and shortlisted recognises our colleagues dedication, hard work and professionalism which is exemplified every day to deliver high quality, critical clinical services for patients across Herefordshire and surrounding areas.

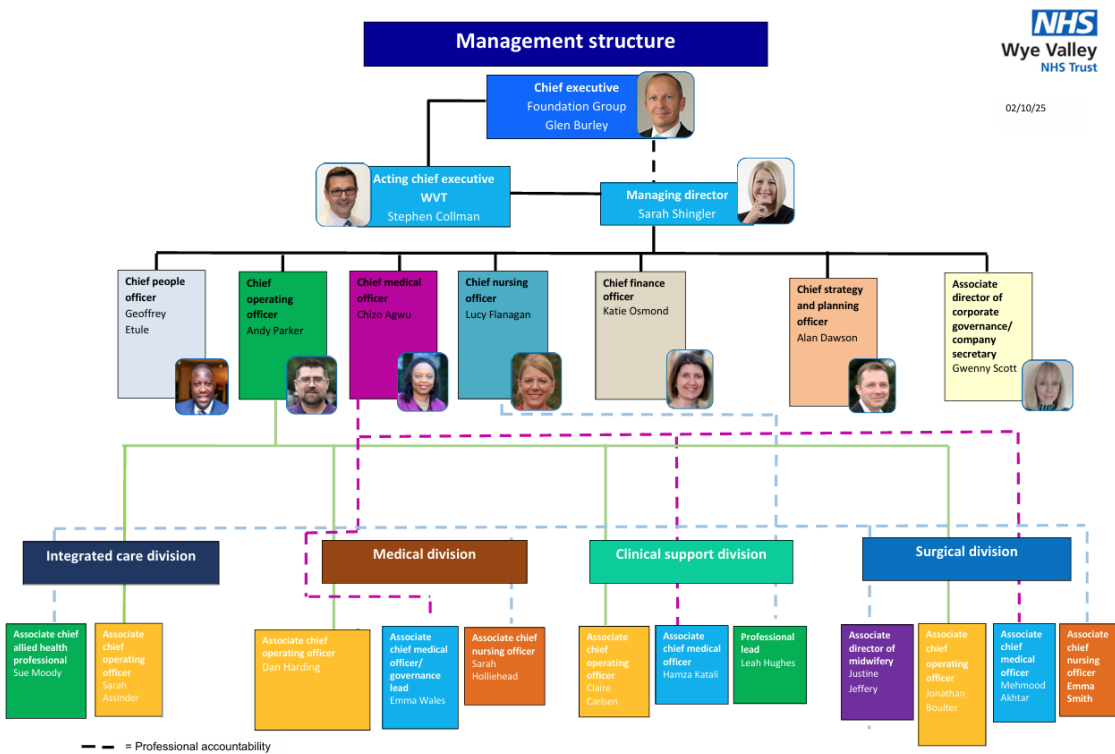


Organisational Change

Wye Valley NHS Trust is part of the Foundation Group that includes South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and Worcestershire Acute Hospitals NHS Trust.

The Foundation Group enables the Trust to strengthen opportunities available to help secure a sustainable future for all four organisations and allows each Trust to maintain its own governance while benefitting from scale and learning across the wider group.

In September 2025, our managing director Jane Ives retired, 45 years after joining the NHS, and 9 years after becoming managing director at the Trust. Our new managing director Sarah Shingler joined the Trust in October 2025.



NHS
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02/10/25

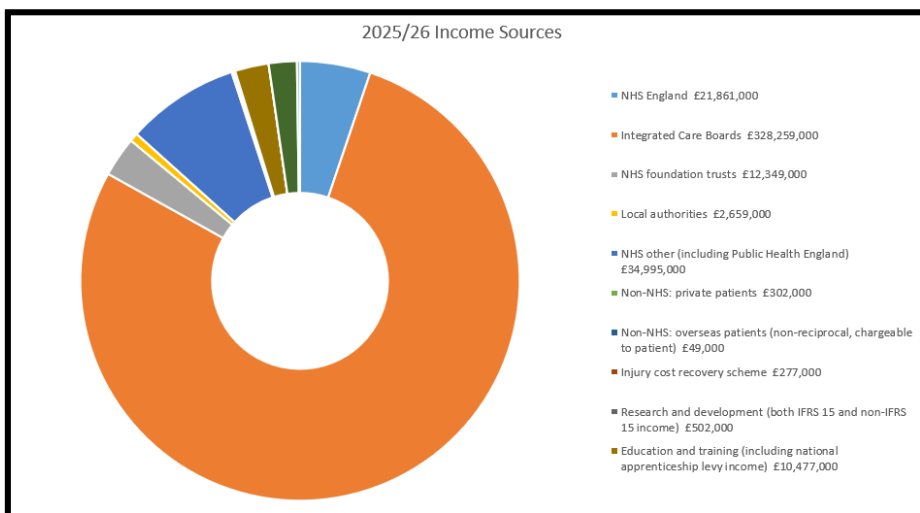
Statement of Assurance

The Trust provided and/or subcontracted 62 acute and community services for the population of Herefordshire, bordering English counties, and mid- Powys (details on these services is provided in Appendix 5). The Trust has reviewed all the data available on the quality of care in all of these services.

More detail on the income of the Trust can be found in the Annual Report 2025-26.

The income generated by Wye Valley NHS Trust for services reviewed in 2025-26 represents 100% of the total income generated from the provision of relevant health services.

A breakdown of income received from each body for 2025-26 is illustrated below.



Care Quality Commission (CQC) Overview of Progress



The Trust had no official CQC inspections during 2025-26.

Three national survey reports were released by the CQC in 2025-26 for inpatients, maternity and urgent and emergency care further detail can be found on pg.44.

The County hospital's overall rating remains requires improvement. For the full breakdown

of service ratings see Appendix 1.

The Trust is currently registered with the Care Quality Commission without any compliance conditions and is licensed to provide services.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Mar 2020	Requires improvement ↔ Mar 2020	Good ↔ Mar 2020	Requires improvement ↔ Mar 2020	Requires improvement ↔ Mar 2020	Requires improvement ↔ Mar 2020

CELEBRATING CHANGE

Winner of the annual Poster competition

Commented [LF4]: For insertion when winner announced - do just need to check which year's poster this account covers - can we please check

Core Areas of Assurance

National Audit and National Confidential Enquiries (NCEPOD)

High participation in National Audits (98%) and 100% completion of National Confidential Enquiries

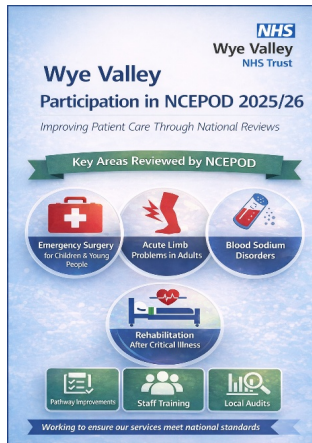
46 National Clinical Audit and 7 National Confidential Enquiry reports were published & reviewed

Audit findings and improvement actions are presented at Committee Meetings

During 2025-26, the Trust was eligible to participate in 61 national clinical audits, based on the services it provides, and participated in 60 (98%). The Trust also participated in 100% of National Confidential Enquiries.

Further detail is provided in Appendix 2.

*National Audit Participation Exception (2025-26)
The Trust did not participate the National Ophthalmology Database audit as this required electronic data submission and functionality is not yet available within local systems. Digital development is planned to support future participation.*



Learning from Audit

In 2025-26, the Trust's Clinical Audit Programme included 299 projects (national and local). Progress is monitored monthly through divisional and directorate governance groups, with oversight provided by the Clinical Effectiveness and Audit Committee. Audit results are reviewed by clinical teams at specialty level. Where improvement is required, action plans are developed and monitored within divisions.

Highlights from National Audit Reports (2025-26)

During 2025-26, 46 national clinical audit reports and 7 National Confidential Enquiry reports were published. Relevant specialties reviewed the findings and developed action plans where required. Two projects are highlighted below to demonstrate areas of good practice and actions being taken where standards were not fully met.

National Data opt-out

The National Data Opt-Out allows patients to choose not to have their confidential information used for purposes beyond their individual care, such as research and service planning.

Before submitting information to national clinical audits, the Trust checks for and removes records for patients who have registered a National Data Opt-Out. As a result, a small number of patients may not be included in audit submissions. In services with low patient numbers, this may influence reported results. This is considered when interpreting findings and planning improvements.



ORAL HYDRATION IN THE OLDER ADULT INPATIENT QUALITY IMPROVEMENT PROJECT

N. Pettit, B. Jordan, K. Lwin, M. Zon, T. Banerjee, R. Gilpin



BACKGROUND

Older adult inpatients are at high risk of dehydration due to frailty, cognitive impairment, reduced thirst perception and dependency on staff for basic care¹.

Suboptimal oral hydration can lead to:

- Hospital-acquired acute kidney injury²
- Delirium and confusion³
- Prolonged length of stay and morbidity⁴



THE METHOD

A two-cycle retrospective audit:

1st Cycle (baseline): reviewed 21 patients on Garway (Geriatric ward), October-December 2024.

2nd Cycle (post-intervention): reviewed 15 patients on Dinmore (Geriatric ward) after implementations.

THE AIM

To ensure that 100% of inpatients who are safe to drink receive adequate oral hydration with accurate, personalised hydration documentation.

Measures assessed:

- Availability and accessibility of cups/jugs
- Balance of oral vs IV hydration
- Mouthcare support
- Nursing hydration care plans
- Fluid balance documentation accuracy
- Patient risk factors (e.g. confusion, mobility, side room isolation)

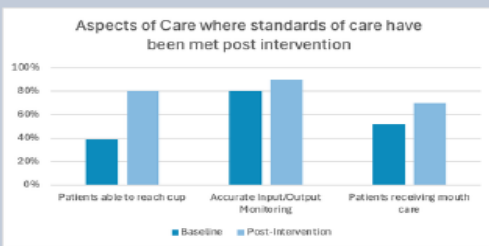
INTERVENTIONS IMPLEMENTED

- Ward-based teaching & presentation at M&M
- Educational posters placed on wards
- Planned use of a hydration identifier emblem
- Shortlisted in Trust-wide QI Poster Competition
- Encouraged hydration review in ward handover
- Induction teaching for new staff
- Mouthcare awareness incorporated into training

EMPOWER RECOVERY ONE SIP AT A TIME



RESULTS



⚠ Key Issue: Over half of patients had drinks out of reach, significantly increasing dehydration risk.

ANALYSIS

What Improved?

- ✓ More patients with drinks within reach
- ✓ More accurate fluid balance documentation
- ✓ Improved mouthcare support
- ✓ Increased use of hydration care plans
- ✓ Lower reliance on avoidable IV fluids

our educational poster

CONCLUSIONS

We demonstrated that a simple intervention improved patient hydration. However, variation in outcomes across different patient areas highlighted the importance of engaging all staff groups and considering wider system changes to support consistent improvements in patient care. We also believe that focused staff education improved documentation, as it helped teams link hydration assessments more clearly to tangible benefits for patients.

RECOMMENDATIONS

- Implement hydration emblem
- Standardised hydration prompts in care plans
- Include hydration update in verbal handovers
- Ongoing training for all staff
- Work with S< and Dieticians
- Monitor hydration in side rooms
- Implementing colour coded drinking jugs



REFERENCES

1. McCrow, J. et al. (2016) 'Associations between dehydration, cognitive impairment, and frailty in older hospitalised patients: an exploratory study', *Journal of Gerontological Nursing*, 42(5), pp. 19-27.
2. Wolff, A. et al. (2020) 'Hyperosmolar dehydration: a predictor of kidney injury and outcome in hospitalised older adults', *Clinical Nutrition*, 39(6), pp. 1737-1743.
3. Inouye, S.K. et al. (2014) 'Delirium in hospitalised older patients', *New England Journal of Medicine*, 371(14), pp. 1327-1337.
4. Siervo, M. et al. (2014) 'Hydration and outcome in older patients admitted to hospital (The HOOP prospective cohort study)', *Age and Ageing*, 43(6), pp. 943-949.



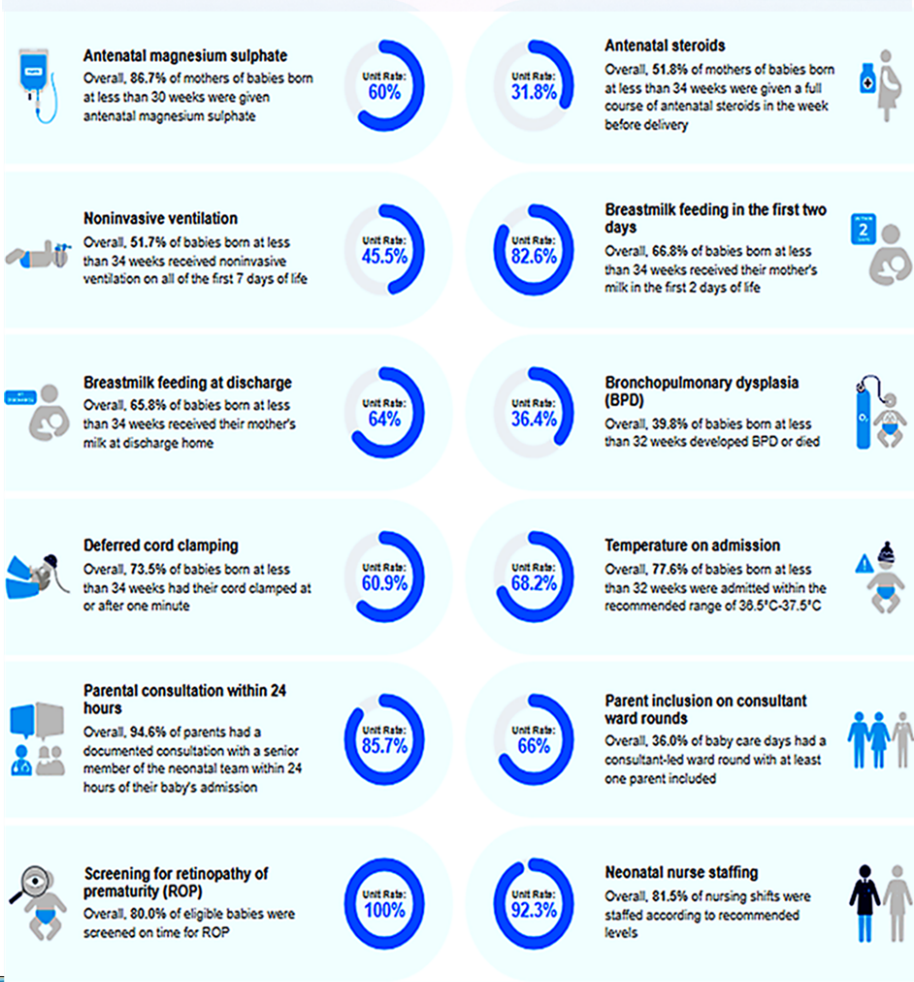
Your baby's care

Measuring standards and improving neonatal care

NNAP
National Neonatal Audit Programme

How our unit did across 12 NNAP measures:

Hereford County Hospital takes part in the National Neonatal Audit Programme (NNAP) which reports on aspects of care given to babies on neonatal units. This poster shows how selected 2024 results for this hospital compared with overall (England, Scotland, Wales, and the Isle of Man) performance.



What we have done in response to our NNAP 2024 data results



Working together around very premature birth

We are implementing the national PERIPrem programme so maternity and neonatal teams provide the same evidence-based care before and immediately after birth.



Improved electronic records now in place

We now use an updated electronic patient record to document conversations with parents and treatments given before birth and after delivery.



Keeping babies warm at birth

We introduced daily delivery-room temperature checks to reduce babies becoming cold after birth.



Regular review and learning

We routinely review outcomes using national dashboards and local review processes to improve care.



Our current areas of quality improvement in 2025/26



Improving reliability of protective treatments for very premature babies

We are working to ensure all eligible mothers receive magnesium sulphate and antenatal steroids before early delivery and babies receive delayed cord clamping where possible.



Care immediately after birth

We are improving breathing support and maintaining normal temperature on admission to reduce complications of prematurity.



Early communication with families

We are working to ensure parents meet the neonatal team as early as possible to support shared decision-making and preparation.



Consistent delivery of the preterm care bundle

Our aim is that every eligible baby receives every recommended treatment every time.



Trust Research Participation Overview 2025-2026

CLINICAL RESEARCH TEAM

ACADEMIC RESEARCH PROGRAM | RESEARCH DEVELOPMENT | NHS Wye Valley NHS Trust

Meet the Team ...

Associate Chief Medical Officer & Clinical Lead of Research & Development

Clinical Research Fellow

Research Nurses & Clinical Research Practitioners

Research & Development

Clinical Trials Data Officer

We are proud to be a Research Active Hospital

The Clinical Research and Development Strategy remains a cornerstone of the trusts ambition to improve the health and well-being of the communities we serve across Herefordshire and the surrounding areas. Guided by our CARE values, the strategy strengthens our commitment to delivering high-quality research, enhancing patient experience, and aligning our work with wider NHS priorities.

We continue to ensure that research participants receive exceptional care while maximising the value of resources provided by the National Institute for Health and Care Research (NIHR), research funders and charitable partners. Engagement across all levels of the organisation- from Trust Board to our frontline teams remains central to our approach as we work and drive to:

- Increase staff participation in clinical research
- Expand opportunities for patient involvement
- Align research activity with local population health needs
- Achieve financial sustainability in research delivery

Achievements in 2025-2026

In 2025-26, the trust made substantial progress in strengthening its research portfolio expanding opportunities for patients and staff and embedding research more deeply into clinical practise. This year saw significant growth in recruitment capability development and academic engagement reflecting the impact of strengthened research leadership and improved organisational readiness.

Exceptional Growth in Research Recruitment

Formats reached its highest level to date with 1,024 participants recruited by the end of February 2026 compared with 271 at the same point last year. This represents 278% year on year increase demonstrating the trust growing research culture and improved operational delivery. Weighted recruitment also increased markedly reflecting a shift toward higher value interventional studies. Interventional research accounted for 83.9% of all recruitment activity with observational studies representing 16.1%.

Expansion of Research Portfolio

18 actively recruiting studies across a broad range of specialties including:

- Ageing
- Anaesthesia & Pain
- Cancer
- Critical Care
- Dermatology
- Gastroenterology & Hepatology
- Infection
- Renal
- Respiratory
- Surgery

Demonstrating a maturing diverse research portfolio that offers more patients access to innovative care pathways.

Non-commercial Research Growth

Show research activity increased significantly with 1007 participants recruited to 23 non-commercial studies compared with 269 and 2,425. This reflects strong engagement with the NIHR portfolio studies and improved integration of research into routine clinical pathways.

Strengthening Research Leadership and Workforce Capability

Research leadership continued to grow with Principal Investigators active across 11 specialties and a sustained increase in associate principal investigators. The number of associated principal investigators rose to 9 in 25-26 with the continued study upward trajectory from three in 22-23. This growth reflects increasing clinician engagement and the success of structured development pathways.

Delivery of the Research Academic Programme

The Trust delivered Part 1 of the research academic programme led by the R&D team. This programme provides structured development for clinicians AHP's nurses and students supporting the Trust's ambition to build a confident research active workforce

Achievements include delivery Part 1 with strong multidisciplinary attendants, positive participant feedback demonstrating increased focus and confidence in the research pathways

Programme dates confirmed for 2026 planning underway for Part 2.



CPD research skills programme

Scoping began on CPD research skills programme in partnership with the university of Worcester. This early-stage work proposes a flexible menu of online and in person workshops covering research methods, ethics, evaluation. This alliance brings us closer to meet the trusts ambition to strengthen research capability across health social care and education.

Challenges and Lessons Learned

While 2025-26 brought many successes, we continued to face challenges such as recruitment hurdles and resource constraints.

Research Priorities for 2026-27

Our focus in 2026-27 is to continue strengthening research impact, improve accessibility, and drive financial sustainability.

Key priorities continue to include:

- Expanding Commercial Research to Increase Financial Value and Reinvestment
- Aligning Research with Local Health Needs & Improving Access for Rural Populations
- Raising Awareness & Engagement through a Trust-Wide Clinical Trials Day
- Enhancing Clinician Involvement through Training & Education Principal Investigator and Principal Investigator pathways
- Academic Programme & Pathway to University Status.



Safety Alerts

Safety alerts are issued when a specific concern is identified that requires urgent action to prevent the risk of serious harm or death. They set out the steps that health and care organisations must take to reduce risk and improve patient safety.

During 2025–26, the Trust continued to receive alerts through the Central Alerting System (CAS) and the Medicines and Healthcare products Regulatory Agency (MHRA). All alerts were managed through the Trust’s established process, which includes reviewing each alert for relevance, coordinating the required actions, and recording evidence of completion.

To strengthen assurance and improve oversight, the Trust uses an alert

management system that provides centralised monitoring of all alerts. This system enables alerts to be linked to relevant incidents and risks, supporting a more comprehensive and triangulated view of the Trust’s safety profile.

Field Safety Notices (FSNs) are issued by medical device manufacturers or their representatives when a potential safety concern has been identified with a device. To support a coordinated response to FSNs, the Trust has a dedicated email address, published on the Trust website, for manufacturers to use when sending notifications. This ensures that all FSNs are received promptly and managed consistently

Best Practice

Since its establishment in 1999, the National Institute for Health and Care Excellence (NICE) has continued to provide evidence-based recommendations across health and social care, using independent committees comprising healthcare professionals, methodologists, and lay members. These recommendations guide safe, effective, and high-quality care provision across the NHS.

During 2025–26, the Trust has sustained strong performance in the oversight and implementation of NICE guidance through continued use of the organisation’s Standard Operating Procedure, *PR.S.21 — Implementation of NICE Guidance*. Originally ratified in 2022, this SOP continues to provide a robust and well-functioning framework for managing



Guidance

guidance across WVT, supporting timely allocation, review, and evidence submission. Engagement across divisions remains strong, with each new piece of NICE guidance assigned a named clinical or managerial lead.

During the 2025–26 reporting year, NICE has continued to evolve the way it issues recommendations within its guidance portfolio, including the introduction of guidance reviews (NR-type documents).

These NR-labelled reviews are not NICE guidelines and do not contain NICE recommendations. Instead, they provide:

- An external guideline covering a topic where NICE does not currently have its own guidance – with a rationale for



- why NICE is signposting to external guideline
- NICE assesses whether the external guideline is methodologically sound and useful.
 - NICE publishes to support healthcare professionals but does not take responsibility for the content and clarifies that clinical teams must exercise their own judgement and consider local policy

- No NICE recommendations are produced; NICE instead offers commentary to support improved care.

For 2026-27, the Trust will be developing processes that allow us to have strong performance not only for oversight and implementation of NICE but for ongoing monitoring of completed baseline assessment tools.

The table below shows the guidance’s published by type within the last financial year (25-26)

Type of guidance	Total number
NICE Guidance (NG)	26
Clinical Guidance (CG)	22
Quality Standard (QS)	11
Technical Appraisal Guidance (TA)	101
NICE recommendation/advice (NR)	2
Interventional Procedure Guidance (IPG)	10
Highly Technologies Guidance (HTG/HTE)	27
Highly-Specialised Technology Guidance (HST)	6
TOTAL =	205

(Figures correct as of 23rd March 2026)

Information Governance

Information Governance is how an organisation handles patient and staff information, which may be of a sensitive nature. This includes ensuring all information, especially personal, is held legally, securely and confidentially.

The Data Security Protection Toolkit (DSPT) was introduced in 2018-19 and replaces the Information Governance Toolkit (IGT).

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the Cyber Assessment Framework.

Last year, the Trust achieved Standards Met following initially being “approaching standards” with an improvement plan. This plan was completed and submitted in December making the Trust “Standards met” The Trust’s year-to-date position is shown in the table below:



Progress Dashboard	
Mandatory Reporting -	Baseline Submission Provided December 2025 Current Position: Standards Met Final submission due – 30/06/26
Outcomes 24/47	Confirmed
Standards Met: December 2025	

Baseline submission was provided in December 2025 with 24 of the 47 requirements provided.

At January 2026, 24 of the 47 requirements have been provided. The Trust is having an internal audit conducted by RSM in February/March 2026 for compliance with the DSPT, and any recommendations will assist the Trust with the final submission of the DSPT in June 2026.

Clinical Coding and Error Rate

Clinical coding is the translation of medical terminology (written by the clinicians) that describes a patient’s complaint, problem, diagnosis, treatment or other reason for seeking medical attention into standard codes that can then be easily tabulated, aggregated and sorted for statistical and financial analysis, in an efficient and meaningful manner.

The figures for 2025-26 shows an achievement of meeting the Mandatory Clinical Coding percentage target.

Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip operation) so that indicators of quality can be produced to help improvement processes.

The Trust has a constant focus on data quality and the need to meet the organisation’s reporting requirements against the National Data Security and Protection Toolkit.

Data Quality Standard 1. The Trust uses a variety of systems and processes to ensure poor data quality does not undermine the information being reported. Data quality (DQ) checks are performed on all main reporting domains (including quality, finance, operational performance, and workforce). The Trust makes use of internal and external benchmarks to highlight areas potentially requiring improvement to data quality.

As part of the Foundation Group, the Trust has developed some key principles for data quality, and these will be adopted across all trusts within the group. Further work on developing Information strategy across the group is ongoing and projects and work streams being finalised. The Trust uses a Data Quality Kite mark within its main Trust Board KPIs as an indicator of the level of assurance of the quality of the data which supports each indicator.



	Level of attainment mandatory	Level of attainment advisory	Trust % correct
Primary Diagnosis	>=90.0%	>=95.0%	90.60%
Secondary Diagnosis	>=80.0%	>=90.0%	95.10%
Primary Procedure	>=90.0%	>=95.0%	94.00%
Secondary Procedure	>=80.0%	>=90.0%	91.60%

Illustration of the percentage coding accuracy at Wye Valley NHS Trust in 2025-26 of which all mandated standards were met as set by NHS Digital.

The Trust is committed to ensuring staff are aware of their responsibility for data quality and the accurate recording of data on Trust electronic systems and paper held records. The Trust have included this responsibility in all job descriptions and regular audits are undertaken. We work closely with our partner IMS Maxims who are supporting with electronic patient record development. The Trust's commitment to data quality is demonstrated by implementing the following principles:

- The aim is that all staff should be fully trained in the use and recording of data on electronic systems – where possible access should not be given until training has taken place.
- All managers are responsible for data quality within their services.
- Staff are aware of the reporting mechanisms for data quality issues and complaints.
- The Trust has a dedicated team for each electronic system that sits with the CSG, for managing data quality issues, system management, system configuration in line with national standards and advising staff on managing data quality issues. For other systems used within specific departments there may be a single administrator providing support and advice.
- Regular reports are sent out for managers to ensure missing data and errors are actioned and regular meetings are held to discuss and report actions of the same.
- Summary data quality dashboard produced weekly and discussed at weekly Trust wide patient tracking list (PTL) meeting.
- Additional steps added to commissioning data sets processing to identify incorrectly recorded data and passed to the Electronic Patient Record Support Team to correct for the IMS MAXIMS system.

The Patient's NHS number

The patient's NHS number is a key identifier for patient records, and the National Patient Safety Agency has found that the largest single source of nationally reported patient safety incidents relates to the misidentification of patients.

The Trust submitted records during 2025-26 to the Secondary Uses Service (SUS), for inclusion in the Hospital Episodes Statistics (HES), which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number for the period April 2025 to March 2026, is detailed below.

	NHS Number 25/26			%
	Has NHS	No Number	Total	
IP	68288	49	68337	99.9%
OP	513671	247	513918	100.0%
AE	83790	479	84269	99.4%

The Patient's Registered GP Practice Code

Accurate recording of the patient's GP practice is essential to enable the transfer of clinical information from the Trust to their GP.

The Trust submitted records during 2025-26 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records, which included the patients valid General Medical Practice Code, was highest at 100% for Outpatients.

	GP Code 25/26			
	Gp code	No Number	Total	%
IP	67738	599	68337	99.1%
OP	513769	149	513918	100.0%
AE	84022	247	84269	99.7%

Walle

Commissioning for Quality and Innovations (CQUINs) 2025-26

The Commissioning for Quality and Innovation (CQUIN) is a framework within the NHS that supports improvements in the quality of services and the creation of new, improved patterns of care including transformational change.

For 2025-26, NHS England paused the mandatory CQUIN scheme.



CELEBRATING CHANGE

Commented [RM5]: I have requested an improved version

Celebrating working together at Wye Valley NHS Trust: Preventing Inpatient Falls and Improving Outcomes

Aligning NICE NG249 and NAIF Standards with Patient Safety

At Wye Valley NHS Trust, we are proud to celebrate a sustained four-year reduction in inpatient falls - an achievement driven by strong multidisciplinary teamwork and our commitment to national standards such as NICE NG249 and NAIF.



Spine injury



Head injury



Hip injury



Other fracture

Aim: To strengthen the Trust's approach to preventing inpatient falls by improving adherence to NICE NG249 and NAIF standards - ensuring timely pain relief, thorough injury checks, high-quality assessments, and consistent post-fall management to reduce harm and improve outcomes for patients.

Inpatient falls remain one of the most frequently reported patient safety incidents within NHS hospitals

4 YEAR
REDUCTION
IN FALLS

Key Improvements and Achievements:

- Strengthened Compliance with NICE NG249**
 - Updated clinical noting to ensure all risk assessments and reviews meet NICE NG249 standards.
 - Reinforced documentation of individualised risk-factors and personalised safety plans.
- Implementation of NAIF Recommendations**
 - Annual NAIF audit findings have informed Trust wide action planning.
 - Introduction of a consistent post fall management framework, including assessment for head injury or suspected fracture within 30 minutes.
- New Post Fall Assessment Template (Maxims)**
 - A dedicated post fall medical assessment template was developed and launched on Maxims in 2025.
 - Helps improve timely documentation, communication, and oversight of clinical reviews.
- Rapid Pain Relief Standard**
 - Pharmacy developed a new Post-Fall Analgesia Guide, including out of hours support, to ensure patients are offered pain relief within 30 minutes of a fall.
 - Supports NAIF goals and enhances patient assessment, comfort and safety.
- Enhanced Patient Safety Culture**
 - Introduction of the red falling man icon on ward whiteboards to support rapid visual identification of at risk patients.
 - Development of patient information leaflets and QR coded posters (NAIF aligned) promoting better understanding of fall risks and prevention.
- Supporting Staff Through Education**
 - Monthly ADAPT training for nursing teams includes a dedicated falls prevention session - delivered by the Falls Lead.
 - Simulation training provides scenario-based practice for managing falls, delivered by the education department for Community Teams.
 - Manual Handling & Health (M&H) support correct use of flat lifting devices for safe post fall care.

Ongoing Challenges and Focus Areas

- Despite strong improvements, the Trust continues to focus on:
- Unwitnessed falls, particularly among patients identified as high risk - addressed through enhanced care and personalised safety interventions.
 - Bathroom falls, balancing patient privacy and dignity with appropriate supervision.
 - Ensuring timely assessments and analgesia in the community and during out of hours periods, where responsiveness can vary.

Summary: WVT demonstrates strong, sustained progress in aligning with both NICE NG249 (falls assessment, prevention, and post-fall management) and NAIF expectations for systematic inpatient falls care. The Trust has shown continuous reduction in falls over a four-year period, with Q3 2025/26 achieving the lowest fall rate to date, at 75% of the previous year's rate. This indicates a sustained positive trend and is consistent with the NG249 focus on reducing recurrent falls through structured assessment and targeted interventions.



Patient Safety Team Physiotherapists Pharmacy



Who was involved?



Community & Frailty Teams Falls Panel & Integrated Care

Quality of Services - Key Areas

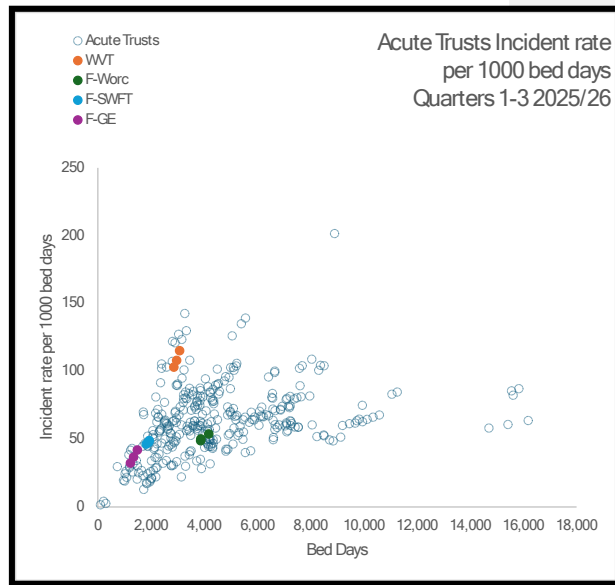
Incident Reporting

The Trust promotes a culture of safety where staff are encouraged to report actual or near miss incidents.

National comparison data is only available for the first three quarters of 2025/26.

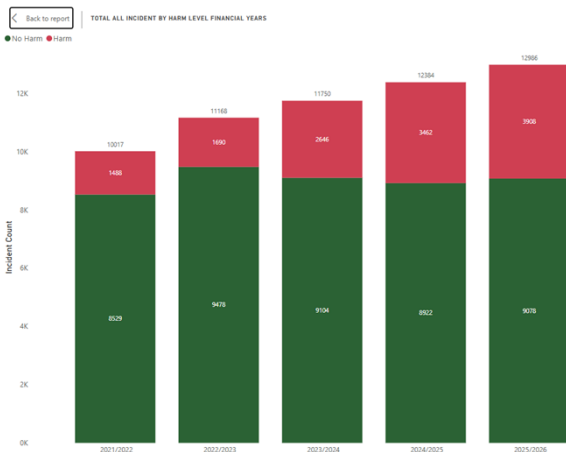
The chart adjacent shows all Acute Trusts in England, plotting an incident rate per 1000 bed days against the number of bed days occurring in the Trust, in each of the three quarters, thus there are plots per Trust one for each quarter.

Wye Valley is plotted in orange, and the foundation Trust members Worcester, George Elliot and South Warwickshire are the other filled colour plots. This shows that Wye valley is one of the highest reporters of incidents amongst Trusts in England. In quarter three and four the Trust was ranked fourth amongst Acute Trusts and in Quarter one seventh.



[Statistics » Patient safety data 2025-26](#)

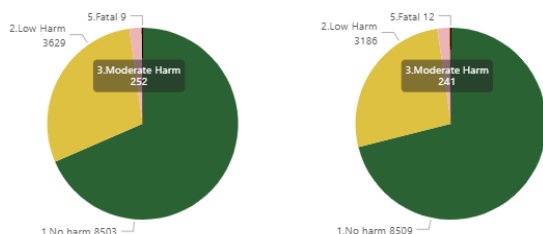
For patient safety incidents we now collect both physical and psychological harm but to provide a comparison with previous years the following graphs only relate to physical harm. The reason we now record psychological harm is because it is vital to understand the impact an incident has on a patient and we are able to have a more complete picture of the event. We will be able to compare psychological harm in future reports.



The charts adjacent and below shows all incidents reported by the Trust on the incident reporting system. The incidents reported are 5% more than last year. This also shows No harm incidents account for 70% of all incidents.



Total all incident by Harm level 2025/26 Total all incident by Harm level 2024/25



The proportion of patient safety incidents resulting in harm has increased marginally to 30%, compared to 29% in the previous year. Out of all patient safety incidents that caused harm, 2% resulted in moderate or more serious harm. This means that 7% of the incidents that had a harmful outcome were in the moderate or higher harm category.

The top five categories of all incidents reported in 2025-26 are shown in the next table. The top five remain the same as the previous year

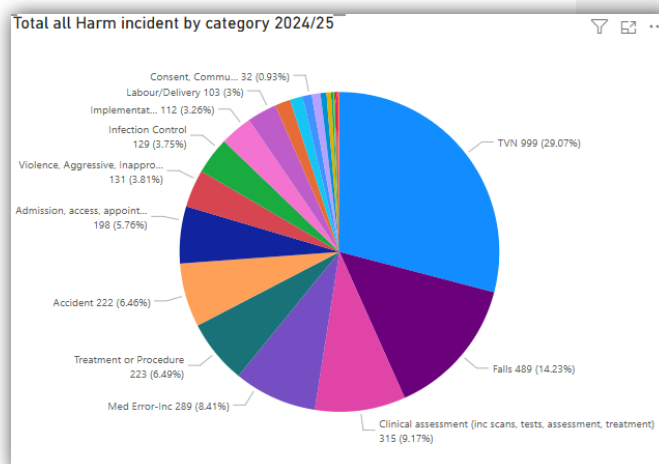
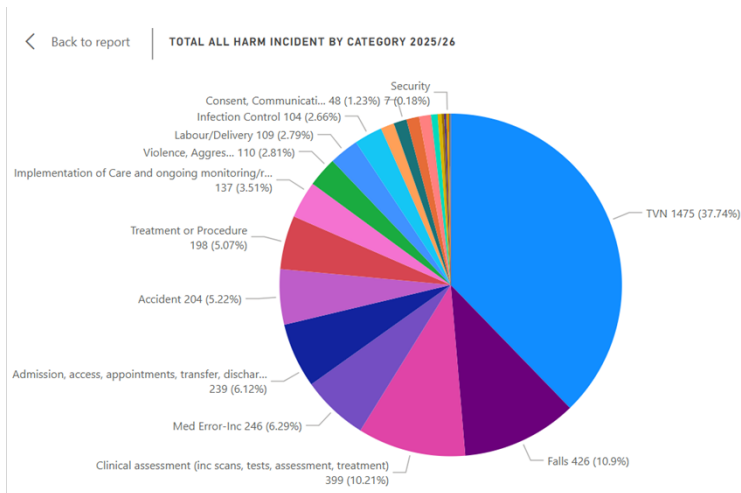
Category	2024/25	2025/26	% of total	% change
Tissue Viability	2784	3309	25.51%	19%
Admission, access, appointments, transfer, discharge	1317	1319	10.17%	<1%
Infrastructure (incl. staff, facilities, environment)	1262	1230	9.48%	-3%
Falls	1067	1058	8.16%	-1%
Clinical assessment (incl. scans, tests, assessment, treatment)	1043	1049	8.09%	<1%

The top five incidents with harm are comparable to the total incidents, with the addition of treatment or procedure.

Category	2024/25	2025/26	Grand Total	% Change
Tissue Viability	995	1475	37.74%	48%
Falls	489	426	10.9%	-13%
Clinical assessment (incl. scans, tests, assessment, treatment)	324	399	10.21%	23%
Admission, access, appointments, transfer, discharge	201	239	6.12%	19%
Medication Error-Incidents	289	246	6.29%	-15%

The following three charts illustrate incidents resulting in harm by category, compared with the previous year. Tissue Viability incidents, specifically those related to pressure damage, account for both the highest number of reported incidents and the highest number of incidents resulting in harm. The overall distribution of incident categories associated with harm has remained largely unchanged year on year. However, there has been a reduction in both medication-related incidents and treatment or procedure-related incidents resulting in harm. This demonstrates stability in the overall harm profile and identifies specific categories where reduction in harm has been achieved.



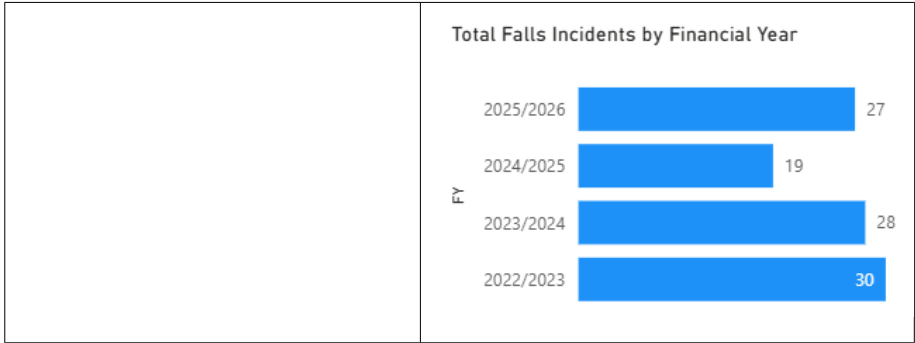


The Trust continues to apply the Patient Safety Incident Response Framework (PSIRF) to ensure learning from incidents and a proportionate, consistent response. Incidents are reviewed through the Patient Safety Panel, with a focus on identifying new learning and opportunities for improvement.

Reducing Harm to Patients

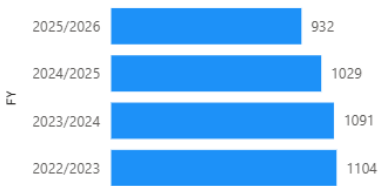
The charts below show comparisons by financial year for Total Falls and those with Moderate Severe or fatal falls:





In 2025-26 we saw the following changes:

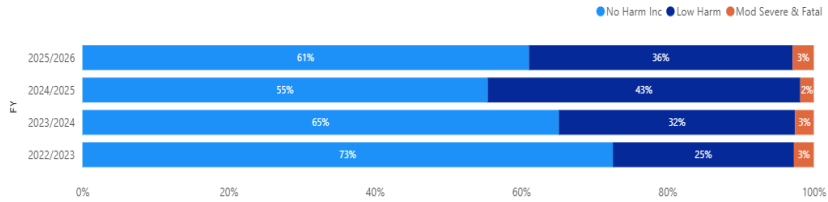
Total Falls Incidents by Financial Year



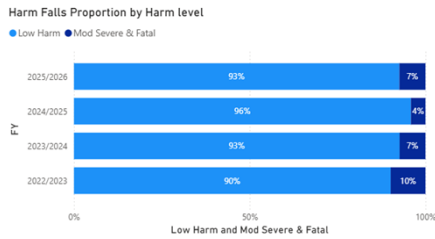
Total falls in the Trust are very similar to last year around 1000 falls (932 until end of February 2026)

Total falls of moderate harm or more severe have increased on last year but are like 2023-24 and 2022-23. In 2025-26 these represent 2.9% of all falls up from the 1.85% seen last year

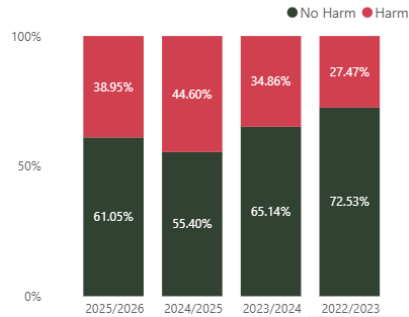
Total Falls by Harm level Proportion by harm category by FY



Proportion of harmful falls as a percentage of total falls has reduced from 45% to 38%. The harm falls are largely low harm which account for 93% of all incidents with Harm.



Total Falls Incidents Proportion of Harm & No Harm falls by Financial Year

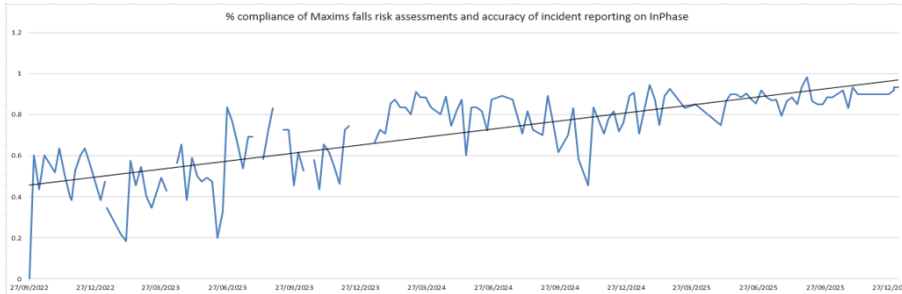


Falls are classed as low harm according to LFPSE guidance if a patient undergoes a scan/x-ray even if there is no fracture/harm.

The Trust has undertaken several actions over the previous 12 months, these include:

- Patient safety priority introduced in April 2024 to monitor falls in patients with dementia, delirium or known high risk of falls.
- Strengthened Trust compliance of NICE guidelines NG249 2025 baseline assessment completed.
- Continued monitoring of appropriate bed rails assessment and use via audit and incident review.
- Continuing ultra-low bed base review across Acute and community hospital sites
- Continued use of yellow socks/ wristbands to identify inpatients at risk of falls
- Post fall medical assessment template in place supporting NAIF (National Audit Inpatient Falls) recommendations of a timely post fall medical review
- Supporting patients to move safely in hospital – enhanced observation tool in place supporting falls risk; mobility assessment is part of the nursing admission assessment; walking aid SOP in place
- Improved patient safety culture – falls risk icon available on ward digital whiteboards to improve risk oversight
- Shared learning from incidents across Integrated Care Division sites via ward safety huddle in place.
- Extremis bed space patient criteria in place for Frailty and Community Hospital sites.
- Creation of FORMIC audit tool (roll out due to commence April 2026) to improve senior nursing oversight of bed rails compliance; bed space environment; nursing falls risk assessment compliance.
- Continued audit of safe manual handling practice post fall with use of appropriate flat lifting equipment for injurious falls. Trust compliance remains consistent with National Average.
- Continuing training relating to falls prevention via the ADAPT program
- Snapshot weekly audit of completion of nursing risk assessment for patients who have fallen. The chart below shows an improving trend.





2026-27 will see the Trust continue to build on the progress made in 2025-26, with the introduction of the following:

- Joint working between Falls Lead and newly appointed Dementia Lead to support patient care; staff training – Ross community hospital site has received support as a targeted area in 2026.
- Reinstate Falls/Dementia/Frailty steering group or similar to drive improvements
- Falls policy due for review
- Audit of bed rails/ bed space environment /nursing risk assessments to be rolled out Trust wide April 2026
- Continued training via ADAPT program/ Fall prevention resources support by Falls Lead for the ward staff.
- Post fall retrieval flat lifting device training continuing to be provided via Moving and Handling.
- Falls dashboard in place providing data relating to falls for Wye Valley Trust increasing Divisional oversight of incidents relating to falls, providing reporting data.
- Improvement project in 'Frailty/Community Hospitals improving the amount of ward-based activity for patients to support safe mobility and prevent deconditioning.
- Patient Group Directive for morphine administration post fall awaiting sign off to support Community Hospital falls out of hours. This will improve compliance with National Audit of Inpatient Falls (NAIF) recommendation that analgesia is to be offered within 30 minutes of a fall with harm. Continued audit of analgesia being offered via NAIF audit.
- Review of post fall medical assessment template compliance. Continued audit of medical assessment within 30 minutes of a falls with harm via NAIF audit (NAIF recommendation 2025).

Duty of Candour

The Duty of Candour is a statutory requirement for all health and social care providers, ensuring openness, honesty, and transparency with people using healthcare services. In line with this duty, the Trust actively engages with individuals affected by patient safety events and encourages their involvement throughout the review and investigation process. This may include co-producing Terms of

Reference for learning responses, participating in face-to-face meetings, or contributing through telephone discussions.

For any incident that meets the statutory threshold, the incident management system provides prompts and a dedicated section for staff to document Duty of Candour actions. However, all staff are



expected to demonstrate openness and honesty in relation to any incident, as part of their overarching professional duty.

Compliance with the Duty of Candour is monitored through monthly divisional and corporate reporting and is included within submissions to the Quality Committee through Key Performance Indicators (KPI). Additionally, patient and family

engagement is undertaken when a complaint relates to a patient safety incident. This approach ensures that individuals have a clear point of contact and are offered the opportunity to be involved in the investigative process, should they wish to do so.

Never Events

A **Never Event** is defined within the NHS as a **serious, largely preventable patient safety incident that should not occur if healthcare providers have implemented existing national guidance and safety recommendations**. These events are considered **“wholly preventable** because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should already be in place within all healthcare settings.” NHS England.

The NHS maintains a nationally defined list of Never Events, which includes incidents such as wrong site surgery, retained foreign objects post-procedure,

mis-selection of medication, and transfusion of incompatible blood components. These events are subject to mandatory reporting, thorough investigation, and organisational learning to identify and understand contributory factors and implement safeguards to prevent recurrence.

Wye Valley NHS Trust reported in 2025-26 period 3 Never Events:

- Wrong site surgery - nerve block catheter inserted into wrong side
- Wrong site surgery – injection in wrong joint
- Wrong site surgery – nerve block administered to wrong side

Adult Safeguarding

Adult Safeguarding means protecting a person’s right to live in safety and free from abuse and neglect and is everybody’s business. This remains a high priority for the Trust, and we continue to work with partner agencies across Herefordshire and beyond to ensure best practice.

The Trust ensures the principles of empowerment, prevention, proportionality, protection; partnership working and accountability have been applied

preserving the individual’s wellbeing at its core. The outcomes being that people are:

- Safe and able to protect themselves from abuse and neglect.
- Treated fairly and with dignity and respect.
- Protected when they need to be
- Able to easily get the support, protection and services that they need.

Making Safeguarding Personal (MSP) continues to remain a high priority and the



Trust have endeavoured to ensure the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible.

WVT has a Lead for Domestic Abuse who works as part of the Adult Safeguarding team but also integrally with the Children's Safeguarding Team. The Lead is responsible for coordinating the Trusts response to domestic abuse. The Domestic Abuse Act was passed in 2021 and puts clear responsibilities on all agencies to ensure that they are asking about domestic abuse and providing an effective response for all victim-survivors.

The Lead works very closely with the Hospital Independent Domestic Violence Advisor (HIDVA) (employed by West Mercia Women's Aid but working within the Trust). The HIDVA provides independent advice and support for all patients and staff. The Lead for Domestic Abuse and HIDVA jointly deliver training across the Trust, and a large focus of their roles is to raise awareness about domestic abuse and to build staff confidence so that more victims are identified and receive the support that they need.

The Trust maintains its commitment to Herefordshire Multiagency Risk

Assessment Conference (MARAC) and Domestic Abuse Perpetrator Panel and is an active member of the Domestic Abuse Operational Group and MARAC Governance Group.

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests process in everyday practice. This has continued to be a quality priority for WVT. The Trust has an adult safeguarding performance dashboard, which is monitored and discussed at the Trust's Overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Quality Committee, with a report produced for the Trust Board annually.

The Trust has maintained its commitment to be an active member of the Herefordshire Safeguarding Adult Board and associated sub-groups, contributing to multi-agency audit, Safeguarding Adult Reviews and Domestic Abuse Related Death Review (DARDR) previously known as Domestic Homicide Reviews (DHR's).

The Trust has equally maintained their commitment to work collaboratively with out of county safeguarding board.

Children Safeguarding

A child and/or young person is defined as anyone who has not yet reached their 18th birthday.

Safeguarding children and young people is central to the quality of care provided to patients by the Trust. The Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people.

The Trust recognises the importance of

partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in Working Together to Safeguard Children and their Families, 2023. All NHS trusts are required to have effective arrangements in place to safeguard vulnerable children and to assure themselves, regulators and their commissioners that these are working. All health providers must be registered with the Care Quality Commission (CQC) and are expected to be compliant with the fundamental standards of quality and safety.



The Chief Nursing Officer is the Trust's Executive Lead for Safeguarding Children, and the Associate Chief Nursing Officer oversees the management of, and the work undertaken by the Child

Safeguarding team. The Trust has maintained a robust focus on Safeguarding Children through the governance arrangements depicted below.



The work of the safeguarding team is multi-faceted and relies heavily on partnership working, both internally and externally. The Trust strives to deliver a seamless integrated service to safeguard children from abuse and neglect. The Child Safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

The core functions of the team are to:

- Provide clinical leadership in respect of safeguarding to support high quality safeguarding practice.
- Offer support for practice development through:
 - Providing a robust training and development strategy utilising education forums, light bite sessions as well as formal training.
 - Supervision.
 - Coaching.
 - Share learning from safeguarding practice reviews.
 - Support and advice on case management, including attendance at complex meetings.
 - Provide oversight and assurance regarding how the Trust is meeting its obligations in respect of Safeguarding Children.
 - To provide oversight and

- development of policy and procedures.
- To provide challenge and scrutiny of safeguarding practice internally and externally.
- To support staff to provide high quality statements for court, the police and if attendance at court is required.
- To undertake internal management reviews and contribute to multi-agency practice learning / CSPRs (Child Safeguarding Practice Reviews.)
- Support the business of the, HSCP (Herefordshire Safeguarding Children Partnership)
- The Trust has an established safeguarding children quality framework, which includes a safeguarding children performance dashboard and an annual audit plan. The Trust's Overarching Safeguarding Committee monitors this framework. A report summarising activity and priorities is produced for the Trust Board annually. Learning from single and multi-agency audits, child safeguarding practice reviews and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

Ensuring staff receive the required safeguarding children training continues to be a priority and compliance rates for Levels 1, 2, 3, 4 and Board level, are shown in the table below.

Level of training	December 2024	December 2025	WVT expected level
Level 1	89%	91%	85%
Level 2	87%	88%	85%
Level 3	85%	86%	85%
Level 4	100%	100%	100%
Board level	100%	100%	100%

The Trust continues to support the business of the Herefordshire Safeguarding Children Partnership in a number of ways for example;

- By aligning safeguarding children’s priorities to those of the Partnership; contributing to the work of the various subgroups and task and finish groups and by providing trainers for various learning and educational events.
- The multi-agency work extends to contributing to the Local Authority Improvement Plan which is in response to the Ofsted inspections. To support this in response to looking to improve multi-agency working we now have a Specialist Safeguarding Children Practitioner within the MASH (B7) to strengthen collaborative working. The Trust already provides the health practitioner within the multi-agency safeguarding hub (MASH) which is often the first point of contact for professionals, family members or the public when they have concerns about a child’s welfare or safety.
- Support the Children and Young Peoples partnership for Herefordshire (CYPP)

Keeping children and young people safe – **BE SAFE FROM HARM**

(Supporting children and young people with our public health services discussing healthy relationships and professionals being trained to recognise safeguarding thresholds – the safeguarding team contributing to wider partnership training on this) The safeguarding team are key contributors to the Get Safe programme to prevent CE (child/criminal exploitation)

Improving children and young people’s health and wellbeing – **BE HEALTHY**

(NHS services working on priorities of obesity, mental health support and access to dental health)

Helping ALL children and young people succeed – **BE AMAZING**

Ensuring that children and young people are influential in our communities – **FEEL PART OF THE COMMUNITY**

As a safeguarding team we will support the mission of the CYPP to improve safeguarding in children’s services.



Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records for:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases
- certain 'dangerous occurrences' (near miss – incidents with a high potential to cause death or serious injury)

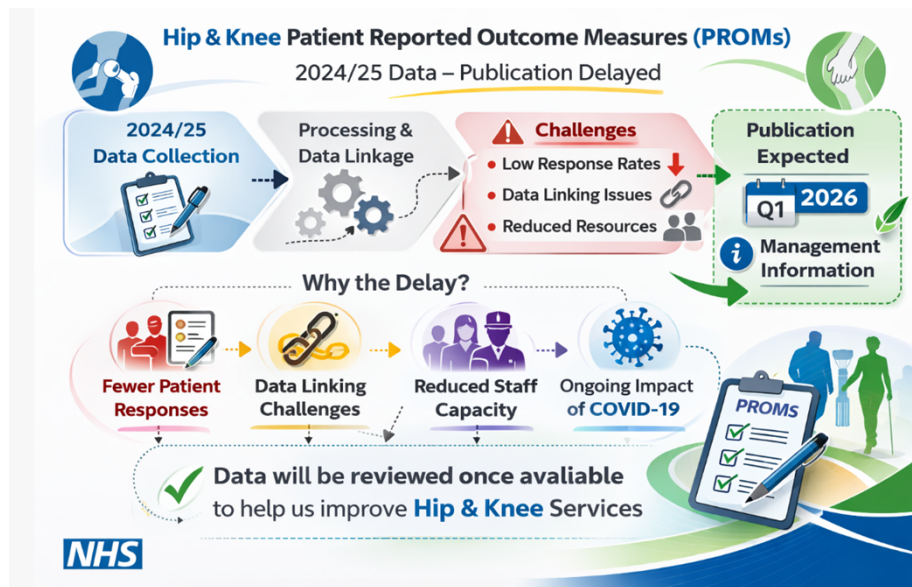
The Trust has a legal duty to report all RIDDOR reportable incidents in a timely manner. Work related accidents which lead to a member of staff unable to work or are unable to perform their normal duties for a period of more than seven days need to be reported within 15 days of the incident. More serious incidents including deaths, fractures, need to be reported within 48hrs.

During 2025-26 there were a total of 5 RIDDOR reportable incidents, a decrease in one compared to 2024-25. Of these incidents, 1 was patient related and 4 were staff incidents. The detail below provides an outline of these incidents:

Patient incidents : Injuries included	Staff incidents : Injuries included
<ul style="list-style-type: none"> • A witnessed patient fall resulting in a fracture of the right femur 	<ul style="list-style-type: none"> • Fracture of wrist/facial • Dislocation/fracture of hip • Dislocation of left shoulder • Possible Hep B exposure incident



Patient Reported Outcome Measures (PROMS)



Improving Patient Engagement

This year has been a genuinely positive and productive period for patient representation within the Patient Engagement Forum (PEF).

PATIENT ENGAGEMENT FORUM (PEF)

IMPACT SUMMARY 2025–2026

□ AT A GLANCE





- ✓ Strengthened patient voice
- ✓ Expanded digital engagement
- ✓ Increased clinical collaboration
- ✓ Focus on inclusion & future growth

📄 KEY ACHIEVEMENT


Patient Engagement Charter

- ✓ Fully reviewed and refreshed
- ✓ Clear values and shared purpose
- ✓ Supports onboarding and growth

GROWING OUR REACH

-  **Goal: More diverse membership**
-  Promotional video in development
-  Improved recruitment approach
-  Stronger community links

DIGITAL INNOVATION


-  **Patient Portal**
- Public engagement stand
- Improved awareness and access

AI & Technology (Heidi)

- Input through AI Steering Group
- Patient-focused discussions

✓ Technology shaped with patient voice

CO-PRODUCTION IN ACTION



-  **Geriatric Care (Dr Gilpin)**
- Patient-led feedback influencing services

Anaesthetic Care (Dr Bick)

- Co-designed follow-up pilot

 From feedback → partnership


PATIENT INVOLVEMENT

-  PLACE assessments completed
-  AOB discussions shaping priorities



 **Real voices driving meaningful change**

 **ENVIRONMENT IMPROVEMENTS**


-  MRU mural enhancement
 - ✓ Supports wellbeing
 - ✓ Creates welcoming spaces
-




 **RECRUITMENT & INCLUSION**

- ✓ Patient rep on PALS interviews

Next steps:

- Train patient interview panel members
- Introduce sign-up system

 **WAYFINDING IMPROVEMENTS**

-  Walkabout with Sodexo
 -  Real-world navigation insights
 -  Moving towards whole-site solutions
-

 **LOOKING AHEAD**


Top Priority: Grow Membership

- ✓ Communications collaboration
 - ✓ Broader representation
 - ✓ Diverse patient voices
-

 **WHAT MAKES PEF UNIQUE**

  Staff |   Patients |  Volunteers |  Community

- ✓ Challenge
- ✓ Collaborate
- ✓ Improve

 **Patient experience is at the heart of everything we do**

 **IMPACT STATEMENT**

Stronger patient voices are shaping better care, better environments, and better experiences across the Trust.

Prepared by Patient Representative | Approved by PEF



Wye Valley Trust Quality Accounts 2025-26

Formatted by AI



Wye Valley Trust Quality Accounts 2025-26

Wye Valley NHS Trust

Patient engagement: our promise to you

“ We engage, include, and improve - embedding patient voices at every level to shape services, drive equity, and deliver care that truly reflects the communities we serve ”

OUR AIMS

- ACTIVE ENGAGEMENT**
We aim to embed Trust-wide patient engagement structures at all levels of service delivery ✓
- INCLUSIVE AND EQUITABLE**
We aim to provide services that are a reflection of the communities we are here to serve ✓
- BETTER OUTCOMES**
We aim to ensure better outcomes for patients - patients involved in their care have better outcomes. When communication is good, care is good ✓

We will...

OUR ACTIONS

- Create a culture where feedback is welcomed, heard, acknowledged and communicated back to patients
- Use feedback to take action and improve services
- Ensure that all patient information is up to date, accessible and produced in collaboration with patients
- Encourage the use of creative and accessible methods to capture feedback

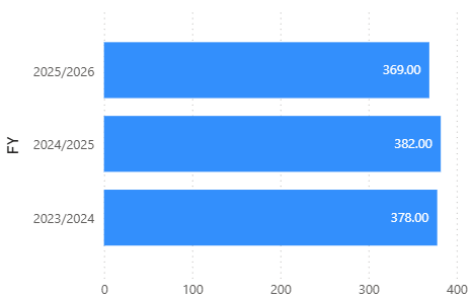


Complaints

The Complaints team are structured within the patient safety workstream which supports alignment with the patient safety strategy and has enabled effective oversight and triangulation of data, recognising that patient safety incidents are being raised by patients and families via the complaints route.

The risk management system implemented in 2024 for complaints, has supported identification of themes and has benefitted the effective triangulation of multiple sources of patient safety information which improves our understanding of safety, our patient safety culture as well as patient experience.

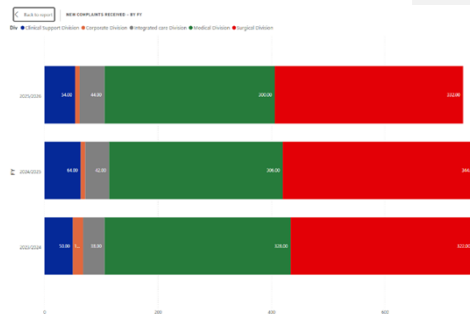
New Complaints Received - By FY



The overall number of complaints received during 2025-26 has shown a small decrease but is largely similar to previous years.

The surgical and medical divisions received the highest proportion of complaints, consistently accounting for more than 85% all complaints, with a similar proportion received by these divisions.

- Clinical Support- Blue
- Medical – Green
- Corporate – Orange
- Integrated Care – Grey
- Surgical - Red



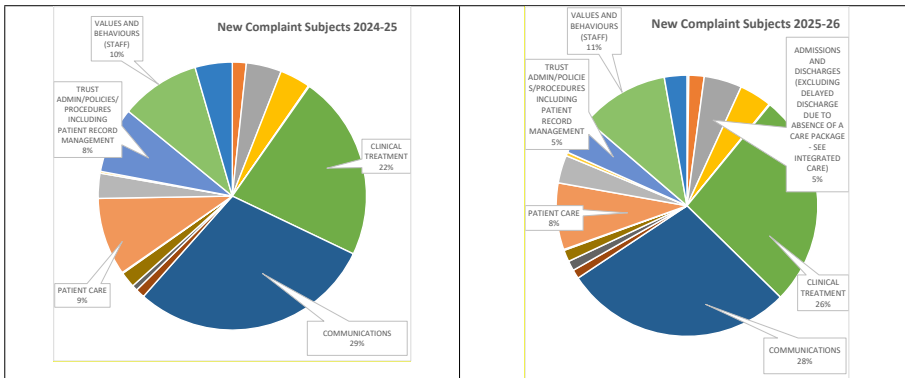
There has been a drop in the number of complaints re-opened, with 37 in 2025-26, compared to 49 in 2024-25.

There have been 6 preliminary enquiries made by the Parliamentary and Health Service Ombudsman (PHSO) in 2025-26, 4 of which, were not progressed with the remaining 2 awaiting outcome decisions

Complaint categories

65% of the complaints received related to perceived issues with the following categories by complainants. These are largely the same as last year.

- Communications down 1%
- Clinical treatment up 4%
- Values and behaviour up 1%



1. Communication:

The main sub-categories identified within communication are concerned with patients, relatives and carers and patients not feeling listened to.

Communication Sub-category	% of total	2024/25	2025/26	% of total
Communication with patient	46%	120	44	17%
Communication with relatives/carers	27%	72	49	19%
Conflicting information	13%	35	35	14%
Insufficient information provided	14%	36	32	13%
Method/style of communications	2%	6	28	11%
Patient not listened to	10%	25	59	23%

The table shows:

Reductions in the number of complaints associated with “Communication with patient or relative/career” but increases in “patient not listened to” and “method of communication”.

2. Clinical Treatment:

A review of complaints shows the following sub-categories accounted for 67% of complaints in this category. Overall numbers in these sub-categories have improved by 19%. Delay or failure in treatment or procedure was proportionately the greatest issue last year 23% but this year this improved to 13% of the category total.

Also improving are:



- Delay or failure to diagnose (incl. e.g. missed fracture) improved by 6%
- Inadequate pain management improved by 5%
- Lack of clinical assessment improved by 5%.

Those increasing are:

- Delay or failure to follow up, increased by 6%
- Delay or failure to undertake scan/x-ray etc., increased by 4%
- Failure to follow up on observations / recognise deteriorating patient, increased by 6%
- Inappropriate treatment, increased by 6%
- Missed or incorrect diagnosis, increased by 3%.

Other categories are largely the same.

Communication Sub-category	% of total	2024/25	2025/26	% of total
Delay or failure in treatment or procedure	23%	46	30	13%
Delay or failure to diagnose (inc e.g. missed fracture)	14%	28	20	8%
Delay or failure to follow up	7%	13	30	13%
Delay or failure to undertake scan/x-ray etc.	6%	12	23	10%
Failure to follow up on observations / recognise deteriorating patient	5%	10	26	11%
Inadequate pain management	16%	31	27	11%
Inappropriate treatment	8%	16	33	14%
Lack of clinical assessment	18%	36	31	13%
Missed or incorrect diagnosis	6%	12	21	9%
Post-treatment complications	13%	26	28	12%

3. Values and Behaviour:

There may be more than one issue identified relating to values and behaviour within a single complaint e.g. attitude of staff, rudeness or failure to act in a professional manner. These complaints have increased by 14% on last year. The two main categories are Attitude of medical staff or Nursing staff accounting for 72% of this category.

Learning from a detailed review of complaints has been systematically shared across the organisation. Divisions are actively monitoring emerging themes and trends, using these insights to strengthen understanding of the concerns raised by our patients and their families.

Targeted development opportunities in advanced communication and customer care are being promoted, alongside a renewed emphasis on early, proactive engagement with complainants. This approach is designed to improve experience, build trust, and support timely resolution.

Over the coming year, the Trust will prioritise improvement initiatives that enhance compassionate engagement, ensuring that patient and family perspectives are consistently at the centre of care delivery.

These are added to the complaint at the triage process and are based on the complainant's perception of their experience.

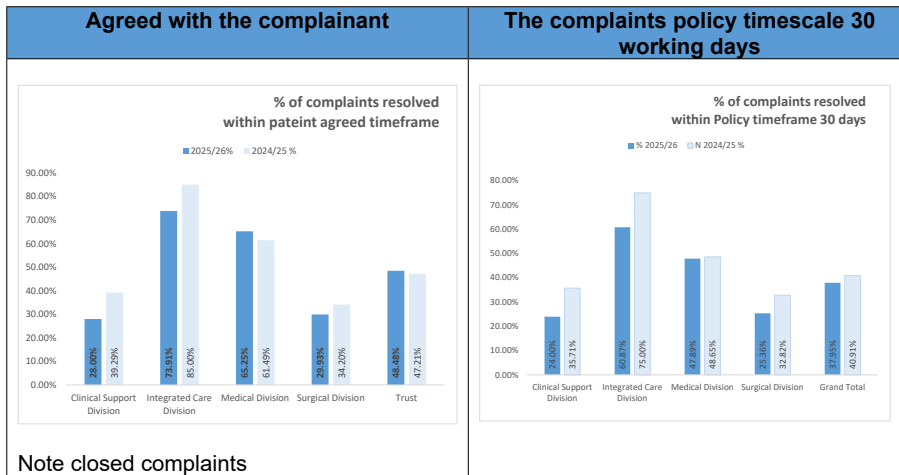


Complaint response times:

There are two measures:

- Individually agreed with the complainant
- The complaints policy timescale 30 working days

The chart below compares closed complaints



Note closed complaints

Overall, the time to process complaints has remained relatively stable year on year.

- The number of complaint responses that are completed within the agreed 30-day timeframe is improved from 47% to 48%.
- Within complainant’s timeframe shows a slight drop from 41% to 38%.

National Surveys 2025-26

Inpatient and National Surveys

Three national survey reports were published by the CQC in 2025-26 for inpatients, maternity and children & young people. In addition, the National Cancer Patient Experience Survey was once again hosted by Picker on behalf of NHS England.

A brief overview of the survey results is outlined below. The results relate to patient experiences of care in 2024-25. All results have been shared with the relevant teams for review and development of improvement plans and this year we have chosen to focus a spotlight on the National Inpatient Survey.

- Five national surveys have been commissioned by Care Quality Commission (CQC), and data collection carried out during 2025-26.
- The **annual National Inpatient Survey, Maternity survey and Urgent and Emergency Care Survey**, results will be received later in 2026.
- The Trust is participating in the new **Neonatal Care Experience Survey**, hosted by Picker on behalf of NHS England. Expected publication date summer 2026
- Picker is, once again, hosting the **National Cancer Patient Experience Survey**. The results of this are expected to be published later in 2026.



Children & Young People's Survey 2024 (Published May 25)

Patients who had been admitted to hospital, aged between 15 days and 15 years old and discharged between the 1 March 2024 and 31 May 2024 were eligible to participate. Three versions of the questionnaire tailored to three age groups were utilised. These covered 0-7 years old, 8-11 years old and 12 -15 years old. The 0-7 questionnaire was designed to be completed entirely by parents/carers. The other two were designed for responses from both parents/carers and the child.

574 patients/ carers of WVT were invited to take part with 152 completed responses returned. This represented a 27% response rate, which was above the national average.

When compared to other Trusts, WVT scored about the same for the majority of questions, with 4 questions scoring on the better-than-expected range and one question in the worse than expected range. Results identified written information at discharge as an area for improvement.

National Inpatient Survey 2024 (Published July 2025)

A total of 1250 patients who had an overnight stay in an acute bed in the hospital during November 2024 were given the opportunity to participate in the survey. A total of 562 responses were received, representing a 47% response rate (a 2% increase on the previous survey).

Compared to the previous year, the scores for responses remained about the same for the majority of questions. Three questions identified areas for potential improvement – two relating to patient information, the other to privacy when being examined or treated.

In addition to the quantitative data, a coded thematic analysis of the patient comments was undertaken, the results of which were generally reflective of the quantitative data. The patient comments provide a rich source of qualitative data, overall, more positive comments are received than negative comments.

Maternity Survey 2025 (published December 2025)

Women and other pregnant people who gave birth between 1 and 28 February 2025 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey.

At WVT 257, participants were invited to complete the survey and 118 responded representing a 46% response rate which is higher than the national average.

The survey demonstrated a significant improvement in overall score and highlighted multiple areas of excellence, with WVT falling in the top 5 highest scoring Trusts in the region for antenatal care and care at home after the birth.

An area identified for improvement was the provision for partners being able to stay as much as they wanted. A solution to allow partners to stay overnight has been implemented to address this.

National Cancer Patient Experience Survey (NCPES) (published July 2025)



The National Cancer Patient Experience Survey 2024 was sent to adult (ages 16 and over) NHS patients with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2024. 301 patients responded out of a total of 500 patients locally, resulting in a response rate of 60%.

In national benchmarking, the Trust scored above the expected range on two questions with two questions falling below the expected range. Where enough responses have been received to allow for robust data reporting, the results are broken down by speciality and actions down for each respective area.

Patients gave overall care an average rating of 9 out of 10.

Friends and Family Test (FFT) – National Data Collection

The NHS Friends and Family test (FFT) was launched in 2013 and was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving NHS care or treatment. In July 2022, the Trust introduced a new system for receiving feedback from patients for the Friends and Family test sending a text message to patients to receive their feedback. Whilst Trusts are no longer monitored on response rate, we know that the more feedback we receive the more

opportunity we have to improve patient experience.

The Trust experienced highs and lows over the previous 12 months, the project to allow individuals to leave feedback at any time and be fully rolled out FFT across the Trust was successfully implemented in June 2025, enabling areas that had never been able to obtain FFT feedback the opportunity to hear directly from patients using their services. Unfortunately, in October that same year our provider issued notice after deciding to move away from providing FFT services to focus resources elsewhere.

Work has commenced with our new provider to build our FFT survey, the project is due to 'Go Live' in May 2026.

Freedom to Speak Up (FTSU)



The requirement for Trusts to have a FTSU Guardian, as a mandated post in NHS Trusts continues as an outcome of the public enquiry in 2016 chaired by Sir

Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust. More recently, the importance of the Guardian role has been highlighted by the Lucy Letby case. There are now over 1200 FTSU Guardians in over 500 NHS primary and secondary care, independent sector organisations and national bodies. According to the



latest data from the National Guardian's Office, FTSU guardians have handled 171,814 cases since their establishment, with the most recent year, 2024/25, seeing over 38,000 cases reported to them, representing a significant increase from previous years. In 2025-26, WVT had 192

cases with each providing an opportunity to learn and make improvements that benefit the wellbeing of our colleagues and the care we provide to our service users. Research and data show that an open culture in a Trust provides the safety needed for staff to speak up in the confidence that their voice will be heard.

FTSU and Civility Saves Lives

The Guardian alongside a team of ten trainers continue to work together to deliver the Civility Saves Lives training.

The Guardian leads on this by promoting FTSU, Civility Saves Lives (CSL) and the need for teams to create a space of physiological safety. This has all been promoted across the Trust in a number of ways both virtually and face to face:

- Mandated eLearning for Speaking Up for all WVT staff. This is one of the KPIs for measuring staff awareness of how to raise concerns and what they can expect.
- Listen Up Training is now part of all managers appraisal after feedback that managers do not listen. Also 'Listen Up' was the theme of this year's speak up month. Highlighting that being able to listen to staff is equally as important as them speaking up.
- Delivering CSL sessions to 420 staff both Trust wide and bespoke to teams.
- We now have a strong team of 112 FTSU Champions in the Trust. The aim is to have at least one Champion in each area and recruitment is ongoing
- Continuing to provide a new way of speaking up via a QR code and confidential Microsoft Teams online form

National Speaking Up Week

In the National Speaking up Week, October 2025, the FTSU team contributed to Staff Wellbeing week and attended the Foundation Group FTSU conference hosted by South Warwickshire Foundation Trust as well as promoting FTSU via Trust Talk (the global weekly newsletter for staff). There was a stand in the staff canteen each week to both promote speaking up and to recruit Champions. This included a free Tombola with prizes that encouraged engagement and helped boost morale. Several Champions were available to talk to staff considering the role. It was very successful.

FTSU Quality Indicators

Delivering awareness of FTSU and Civility Saves Lives (CSL) at every Corporate Induction as well as other bespoke training. This includes timetabled sessions with foundation doctors, doctors in training, preceptorship, student and newly recruited nurses.

FTSU quality indicators include the response to the question, "I feel safe to speak up about what concerns me in my Trust". This is calculated from the responses to the staff survey.



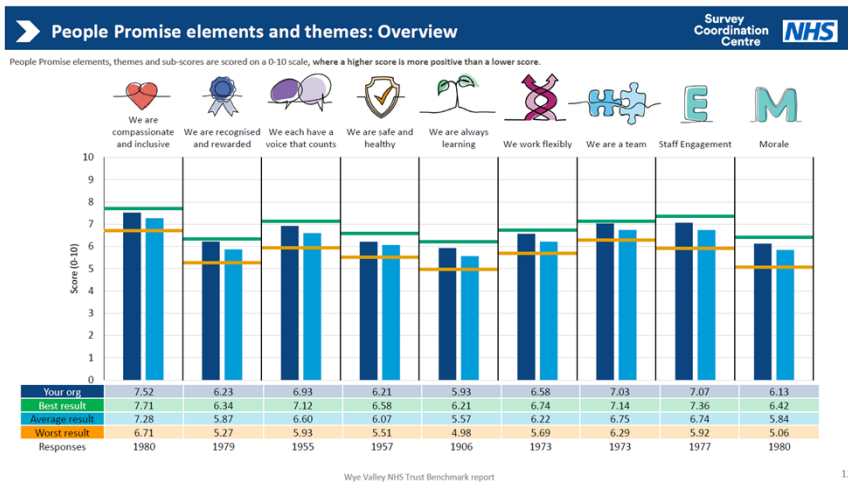
Year of the Survey	WVT Score	National/Sector score	Position Nationally
2024 staff survey	62.98%	60.29%	Top 25% of Quartile 3

NHS Staff Survey 2025

The 2025 NHS Staff Survey was conducted between early October and end of November 2025, with results published in March 2026.

46%, almost 2,000 Trust staff participated in the survey, compared to 34% in 2024. This compares well with the median response rate of 47% across the benchmark comparator group and is a positive shift in engagement across the organisation. Furthermore, the results for Wye Valley NHS Trust continue to show improvements with scores above the average ratings of benchmark comparators across all 9 themes.

The following chart details the Trust's performance against each of the People Promise elements:



Flexible working scores remain broadly static with 57 per cent of employees being satisfied with flexible working opportunities. Bullying, harassment and violence remain at high levels, though reporting rates have improved.

Progress is being made with positive scores recorded in many key areas, including compassionate leadership, support from line management and some aspects of violence and sexual safety.

WVT scores are reflective of the national position, but we have seen improvements in some key questions including overall willingness to recommend the Trust as a place to work and receive care.

The 2025 data for WVT does not show any negative changes and is reflective of the ongoing concerted efforts and investments we have made in order to improve the staff experience.

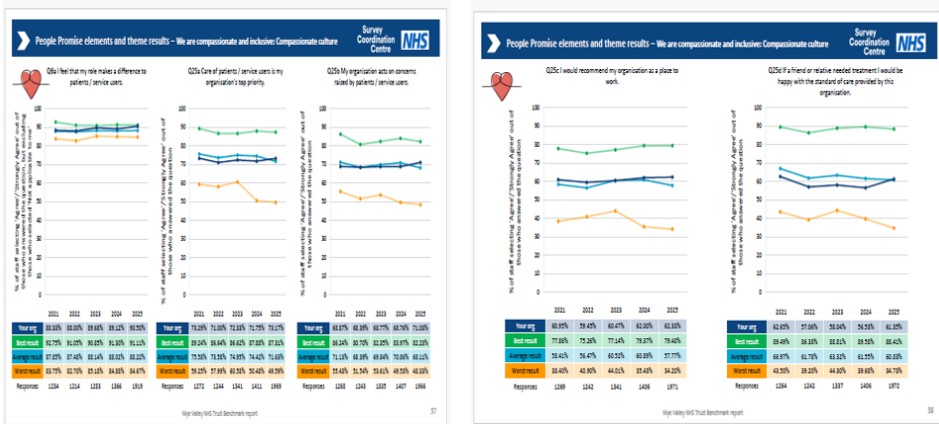


This is attributable to a number of leadership, staff wellbeing, workforce and OD initiatives that have been implemented and are still in place at the Trust over the past few years.

On the questions relating to the care of patients and staff recommending WVT to friends and relatives as a place to receive care, we are now above the NHS average scores in most areas for the first time since 2021.

Care of patients (Q6a, Q25a, Q25b, Q25c, Q25d)

- Significant progress made with above NHS average results in key questions on care of patients and recommending WVT to friends and relatives as a place to receive care



WVT has seen improvements in the key areas of the 2025 survey and no area is rated as being amongst the worst NHS organisations in the survey. In terms of violence and aggression which was a major area of concern in previous surveys, actions implemented at WVT since 2021 continue to have a positive impact.

Overall, the results continue to show positive progress at WVT over the past few years and we are still amongst the top 5 high performing Trusts in the Midlands.

Health & Wellbeing

WVT Health & Wellbeing Strategy (helping you to help yourself)

Working closely with members of the WVT health & wellbeing group, a comprehensive Health and Wellbeing Strategy (*helping you to help yourself*) was introduced in 2024. The aim of the strategy is to help staff integrate health and wellbeing into their daily activities so they can optimise their wellbeing in order to create a positive and healthy environment for patients and service users.

The strategy acknowledges that there is strong NHS evidence which indicates that patient care is dependent on staff who are well at work and trusts need concentrated focus on staff health and wellbeing. WVT recognises that focusing on staff health and wellbeing delivers benefits for NHS organisations, their staff and ultimately patients.



Using the NHS Health & Wellbeing Framework, a range of inter-related domains of employee wellbeing were identified and these have informed the development of health & wellbeing programmes at WVT.

The table below shows the work that has been undertaken in this last year:

2025-2026	
Promotion of national wellbeing initiatives	Promotion of key wellbeing initiatives
Annual health & wellbeing week	Annual wellbeing week for staff in October
Employee Assistance Programme (EAP)	24/7 online counselling support to staff via HapiCo
Sleeping pods	Sleeping pods in place for resident doctors
WVT health & wellbeing brochure	Promoting NHS wellbeing Apps, guidance documents, videos – all on WVT intranet for staff
WVT health & wellbeing group	Bi-monthly meetings chaired by CPO and membership includes trade union rep, service managers, HRBPs, OH and clinicians
Schwartz Rounds / Team Time	Schwartz rounds and Team Time facilitated sessions providing emotional and psychological support to staff
Halo Leisure onsite wellbeing programmes	Onsite wellbeing programmes - personal coaching, individual goal setting plans, onsite exercise classes, wellbeing support, walking group, annual fun day at Halo leisure grounds, discounted gym membership
Staff physiotherapist in OH	Physio department rotational programme with physios in OH supporting staff
Connecting staff with nature	University of Derby programme encouraging staff to enhance their wellbeing by connecting with nature
NHS sickness absence study	WVT participating in a research study on sickness absence by Kings College
Work Well programme	Herefordshire GP practice & Taurus DWP/DHSC scheme to support people stay at work

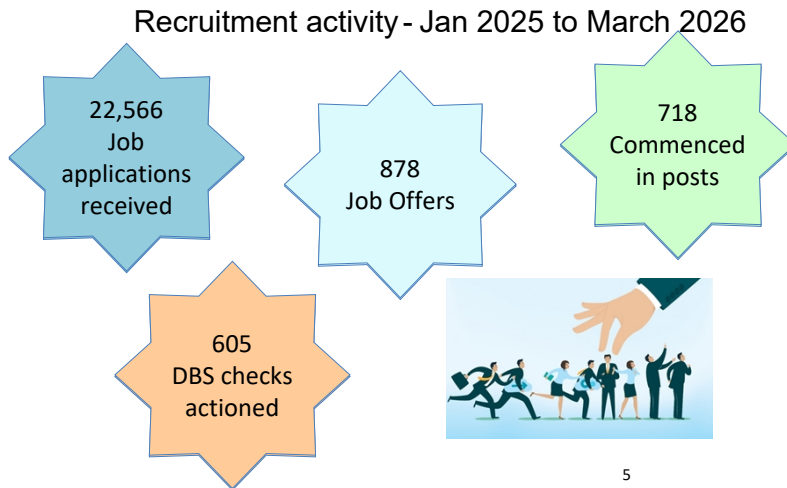
Appraisals and Mandatory Training

The table below shows the Trust's performance against statutory and mandatory training and appraisal as at end of March 2026. Monitoring reports are issued monthly for departments to review and enable targeted action in areas that are below compliance level.

	Target	Actual March 2026
Core Skills (Statutory and Mandatory) Training	85%	88.4%
Appraisals	85%	75.6%



Recruitment and Retention



5

Wye Valley continues to work closely in partnership with the Department for Works and Pensions (DWP), Hoople and Hereford & Ludlow College, supporting individuals into employment.

The Trust also works closely with DWP supporting job seekers into employment into a number of roles across the trust which include administration, Pharmacy, Health Care Support Worker and Soft Facilities. In the last 12 months the recruitment team have engaged with 94 job seekers and 12% of job seekers have found employment with us.

Care Leaver Programme 2025 – the Trust has been a key partner across the ICS, participating in a pilot scheme for young care leavers in conjunction with the ICS and Spectra the agency supporting care leavers back into employment. It has been a system partnership to get young people into vacancies, to improve their life chances and enable them to live independently

We have 46 WVT Ambassadors who are supporting with career events at schools, colleges and universities; this reflects on our aim to support young people within the county and neighbouring counties. In the last 12 months we have attended 42 events promoting careers across the NHS.

We have continued to make good progress throughout the year. During 2025-26, we have again seen a further improvement in turnover which as at March 2026 is 8% and below the 10% performance target.

Linked to our 'Grown our Own' strategy, this year we provided opportunities for 201 apprentices, bringing the to date figure to 705 apprenticeships within Wye Valley NHS Trust Care Leaver Programme 2025.

We have worked on a pilot scheme for young care leavers in conjunction with the ICS and Spectra the agency supporting care leavers back into employment. It has been a system partnership to get young people into vacancies, to improve their life chances and enable them to live independently.



CELEBRATING CHANGE

Surgical Division

Orthopaedic team – Outstanding results and Patient impact

COLLABORATION

Strong partnership across surgical, nursing, AHP, theatres, anaesthetics, pharmacy & therapies

TEAMWORK

Achievements reflect dedication and collaboration across teams driving continuous improvement



PRODUCTIVITY IMPROVEMENTS

Reduced LOS from 3.8 to 1.9 days
Increased ward capacity
Higher theatre activity

SERVICE IMPACT

Kenee replacements increased (4 →8/day)
Increased efficiency across service
Reduced waiting pressures

KEY RESULTS

Length of stay reduced by 34% (to 2.2days)
Earlier mobilisation (+30%)
Same-day mobilisation increased to 83%



INNOVATION

New pathways developed
High-productivity weekend lists
Best practice embedded into standard working

PATIENT IMPACT

Faster recovery times
Timelier mobilisation
Improved patient experience on wards

CONCLUSION

A highly successful transformation programme delivering measurable improvements in quality, productivity, and patient care

Quality Priorities: Review of the Previous Twelve Months

Quality Priorities for 2025-26

The Trust identified seven quality priorities for 2025-26, which are detailed below. This section explains the progress made for each priority over the previous 12 months.

Safe	Effective	Experience
<ol style="list-style-type: none"> 1. Ensure patients receive a timely VTE risk assessment in line with NICE guidance. 2. Diabetes inpatient safety improvement project 3. Improvement in food safety and quality – support delivery of Trust objective. 	<ol style="list-style-type: none"> 4. Implement Quality Improvement project to target high-risk time critical medication as locally defined. 5. Transition of care 	<ol style="list-style-type: none"> 6. Improve responsiveness to patient experience data 7. Increase the number of opportunities to grow our volunteer workforce, in numbers and reach.



Quality Priorities - Safe

1. Ensure patients receive a timely VTE risk assessment in line with NICE guidance

In 2024, VTE risks assessment returned to the NHS standard contract, and it was announced that patients were expected to be assessed within 14 hours of admission, rather than 24 hours.

To allow the trust to continue to improve and meet the new changes, VTE risk assessment compliance continued as a quality priority for 2025-26. The following actions were planned to be undertaken:

- Strategy is revised with changes to healthcare-associated venous thromboembolism (HAVTE) reporting
- The use of historical HAVTE event records to provide evidence for improvement work
- MAXIMS/ EPMA upgrade to 'Go Live'
- Continue to work towards meeting the national 95% target

An improvement plan has been implemented and the following changes completed:

- Continuation of working with divisions to improve activity and review the elective pathway.
- Data logic has been revised and applied which has improved reported performance through improved data accuracy.
- NICE guidance was updated in September 2025, with a VTE assessment now being expected for those patients that have not been admitted within 12 hours of their arrival to the accident and emergency department. The information team have supported in understanding how this will work in practice and recorded.
- Work has continued on the dashboard with issues surrounding maternity records (Badgernet) being resolved to reflect their strong performance (96% seen in December for admission assessments).
- The EPMA/Maxims upgrade went live in February 2026; this change prevents the use of EPMA to prescribe medications until a risk assessment is complete on Maxims. Our Clinical Support Group (CSG) team provided support with the changes to the system in the form of providing awareness, user guides, refresher training and ward-based support during implementation week.
- Continuation of education and training to raise awareness across multiple groups.
- Continued learning from trends and themes.
- Our performance remains strong for hospital acquired VTE with lower-than-average incidence.
- Two potential research studies were identified by the research team with participation meetings booked.

Our data

The Trust has continued to try to meet the national 95% target for undertaking VTE assessments; however, are aware its performance is below the national average with improvement work continuing. Data collection at a national level showed that performance across NHSE is lower than pre 2020 (see diagram 1 below, which is labelled figure 2, from NHSE website). Additionally, only 14 of the 42 ICBs met the 95% target in Q3 of 25/26.



The introduction to reporting assessments within 14 hours is the likely reason to this lower performance across NHSE in the whole.

Diagram 1:

Figure 2: Percentage of hospital admissions (aged 16 and over at the time of admission) risk assessed for VTE in previous collections

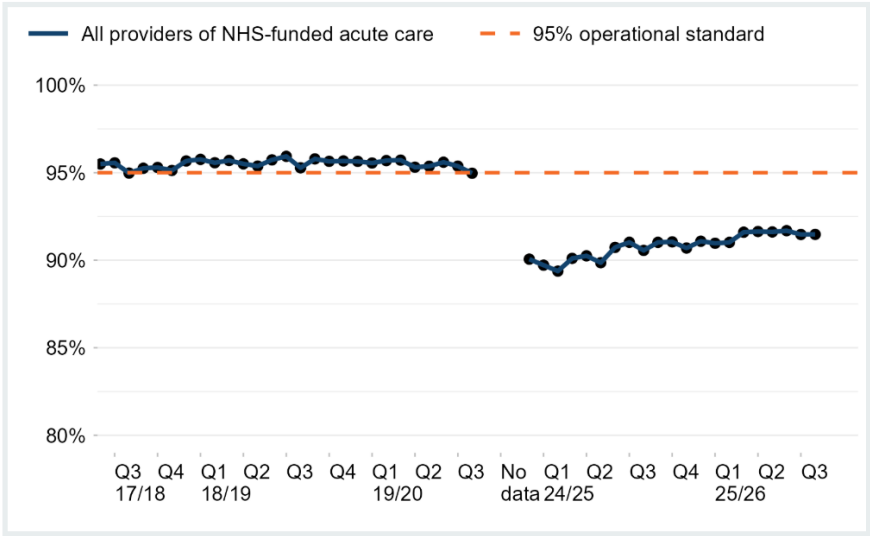
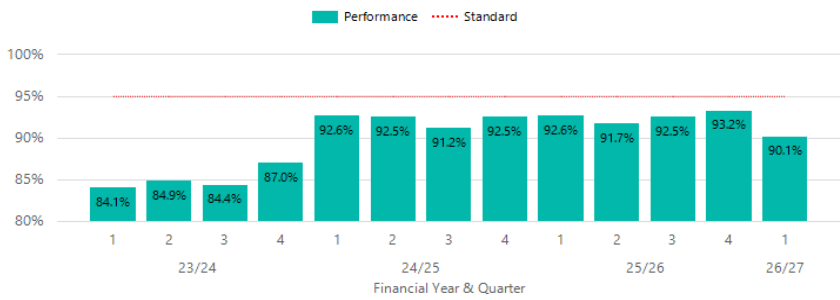


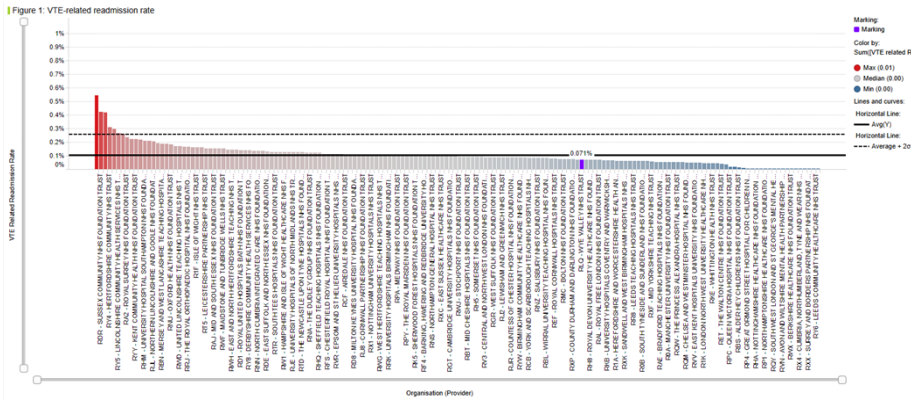
Diagram 2 demonstrates WVT is not achieving the 95% target for VTE assessment. However, it is above historic levels and is maintaining its performance.

Diagram 2:



Data showed a sustained reduction in hospital-acquired VTE rates, 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. Below shows the trust hospital acquired VTE readmission rate in comparison to other sites and demonstrates WVT has above average performance (note this is the most recent whole year December 24 to November 25).





The Trust remains confident that the 24-hour VTE assessment target is achievable in the near term through further improvement work, though the more challenging 14-hour target will require greater focus.

2. Diabetes inpatient safety improvement project

To focus the quality priority four projects on areas of clinical care for diabetes where improvement can be made were identified:

- Foot assessment – ensure all inpatients with diabetes receive a foot assessment within 24 hours of admission and inspection daily thereafter
- Insulin safety – reduce inappropriate insulin omissions in the first 24 hours and to improve timing of meal-time insulin administration
- Hypoglycaemia management – ensure prompt and appropriate treatment
- Patient empowerment with an emphasis on enabling patients to manage their insulin safely while in hospital

What we achieved

Governance arrangements

To aid this improvement journey the Diabetes Safety Improvement Board was re-established.

- Meet quarterly
- Terms of reference approved by Patient Safety Committee

Diabetic foot assessment

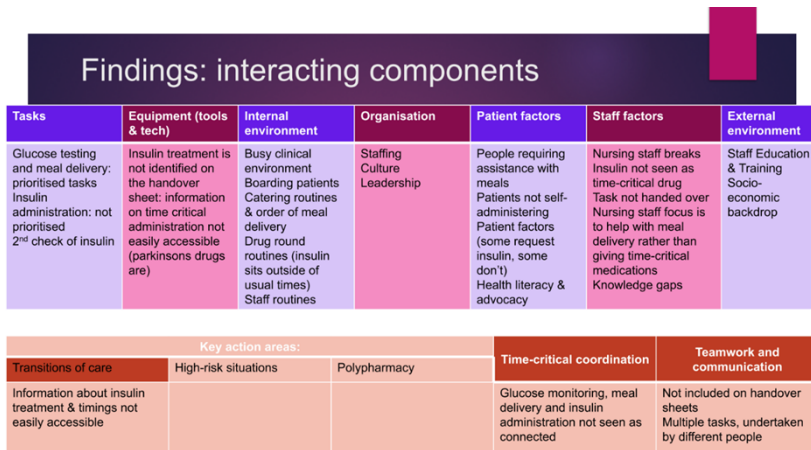
The goal to achieve was for all patients to have a foot assessment within 24 hours of admission. A spot audit undertaken in May 2025 showed very poor completion of this care process at 5.3% (total number of people with diabetes in hospital on the day n=75).

The assessment is important as foot complications are the largest single Diabetes related reason for hospital admission among those with diabetes. All patients should be checked for diabetic foot emergency as soon as possible on admission, if one is found then the diabetic active foot pathway is urgently followed, enabling the identification of risk and to put in place preventative measures. Collaborating with the clinical manager for Podiatry services we worked on the following:

- Working with our IM&T team to develop a template linked to the Waterlow assessment (risk assessment tool for skin assessment) in our electronic nursing documentation
- Trust nursing leadership agreement to embed this new workflow into existing nursing processes and documentation
- Standard Operating procedure drafted to support nursing and midwifery staff to undertake foot screening, care planning and escalation as appropriate.
- Education plan being developed to roll out across the county and community hospital sites.
- Worked with the pressure ulcer panel to understand why diabetic foot ulcers are under reported. Process is now place that identifies them correctly.
- Initial data collection for baseline audit undertaken in May, to re-run following roll out.

Safe use of insulin: timing of mealtime insulin administration

Observational work on timely mealtime insulin administration was carried out on different wards between October and November 2025 by student nurses and dietitians. The observations demonstrated significant variation in the coordination of glucose testing, meal delivery and insulin administration. The findings of these observations identified the following, see diagram below.



To address these findings, the trust required system changes through senior nursing engagement and leadership. The following were suggested:

- Nursing handover sheet changes: to identify people who are on insulin therapy and the timings of their insulin regimen – this is being piloted on at least 2 wards, and encouraged through Self administration of Insulin (SAMI) initiative also
- A 'Time critical drug round' (benefit all time critical drugs, not only insulin) - however it was felt this was too complex to address imminently; a first step would be the changes to the handover sheets

Promoting self-administration and management of insulin (SAMI project below)

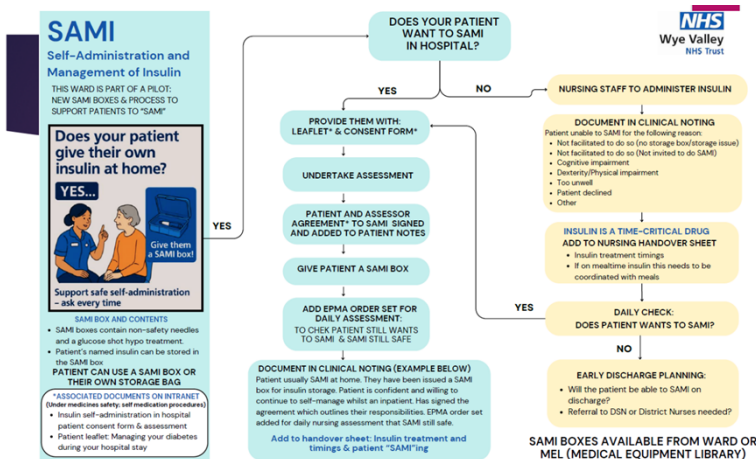
Safe use of insulin: inappropriate omission in first 24 hours

- Training medical and nursing/midwifery staff: multiple opportunities facilitated by clinical fellow in diabetes and new diabetes study day for nursing staff
- Emphasising/training staff on key procedures: Medicine Related Guideline: MSC:24.83.11.3 Emergency alternatives to unavailable insulin preparations; Standard Operating Procedure: PR.S.50 - Management of Reusable Insulin Pen Devices in Hospital; Variable rate intravenous insulin infusion

Patient empowerment

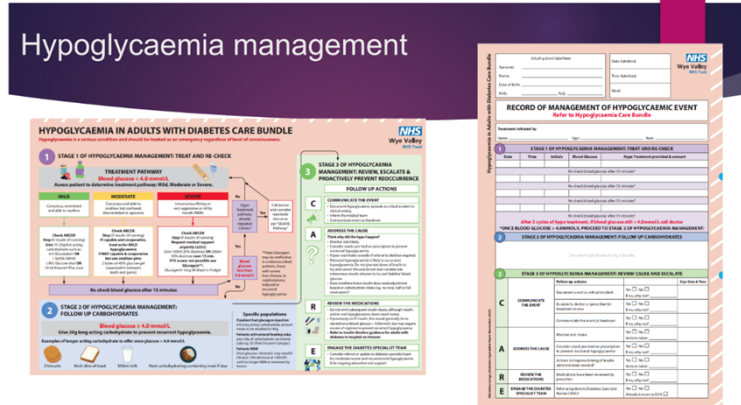
What we achieved:

- 'My diabetes Perioperative passport' successfully launched October 2025: this includes information to empower and support patients prepare for their hospital admission including information about the possibility to self-manage insulin in hospital
- Education to practice nurse champions in Herefordshire to promote Perioperative passport and key safety netting advice to patients
- Self-management and administration of insulin (SAMI) in hospital pilot started on 2 wards in March 2026 (aligned with the GIRFT challenge to SAMI in hospital).



In-patient management of hypoglycaemia

57 episodes of hypoglycaemia, concerning 29 people were audited during August 2025, more than half of the incidents occurred in patients over the age of 80 and the vast majority occurred out of hours and on a weekend. The audit findings were shared at the Diabetes Safety Board and presented at ward sister meetings. What we also achieved: New hypoglycaemia care bundle launched February 2026. This emphasises areas requiring improvement: glucose recheck, provision of long-acting carbohydrates post hypo resolution & preventative measures to avoid reoccurrence.



- For National Hypoglycaemia Awareness Week 6-12 October: walkaround education emphasised, screensavers etc.
- Snacks pre-bed available on prescription for at risk patients treated with insulin and Sulfonylurea medication.
 - o Job logged with electronic prescribing team to make this available as patient group directive to facilitate its prescribing
- Continued rolling audit
- Longer-term ambitions include developing a dashboard with local level data for areas to access & promote accountability and ownership.

Next Steps

- Continue developing workstreams and projects linked to performance indicators
- Continue Diabetes Safety Board, encouraging ownership and accountability with teams presenting on their local area findings and actions.
- Continue navigating the system challenges
- Improving Diabetes inpatient care to continue as a quality priority 2026/27.

The Trust has agreed that this quality priority will continue for 2026-27, continuing to build on the significant progress that has been made in 2025-26 across all workstreams with continued cross-divisional collaboration.

3.Improvement in food safety and quality – support delivery of Trust objective

Nutrition and quality of patient food continued to feature negatively in a variety of patient experience feedback formats, despite the previous quality priority improvement undertaken in 2023-24 and 2024-25, showing we had still not got things right.

A number of objectives were compiled to promote this quality priority for 2025-26.

Objectives: Improvement in food quality and nutritional risk

1. Focus on our Food and Drink Strategy
2. Develop targeted meal service audits using a ward team approach involving our Sodexo colleagues, Lead Dietician & ward staff
3. Include the meal service audit as part of our Nutritional Care Group meetings in our Nutritional Governance Structure
4. Use patient feedback to inform improvements.
5. Focus on nutritional risk assessments.

Measurement: Triangulation between patient food experience evaluation data:-

- Annual Patient Survey
- Patient-Led Assessments of the Care Environment (PLACE) audit
- Sodexo/ward team audit of meal service

Measurement : Nutritional Risk Assessment

- Ward Dashboard available on Maxims with real time data re. MUST (Malnutrition Universal Screening Tool) assessment completion
- Annual audit of MUST compliance and quality by Lead Dietitian

Over the past 12 months the Trust has worked tirelessly to implement the following:

➤ **Focus on our Food and Drink Strategy**

- Embedded the strategy within our meeting governance structure
- Referred to in Nutrition Steering Group (NSG) meetings for ongoing focus and initiatives
- Sodexo leading on improving snack provision at the County Hospital
- Incidents related to nutrition reviewed at NSG for identification of themes and action planning
- Provided training around MUST
- Promotion of recycling/waste reduction on wards and ensuring ward teams have access to correct equipment

➤ **Develop targeted meal service audits using a ward team approach involving our Sodexo colleagues, Lead Dietician & ward staff**

- These audits take place monthly and provide a rich source of information to inform ongoing improvements with results reported into the Nutritional Steering Group.
- Multiple data sources available pertaining to patient feedback re. food and drink.
- The Sodexo Patient Ambassador additionally undertakes monthly patient experience audits, the nutritional steering group requested that these audits included specific questions lifted from the National Annual In-Patient survey. Given we have



introduced many changes since the last national survey was undertaken, we wanted to gather more current intelligence.

➤ **Include the meal service audit as part of our Nutritional Care Group (NCG) meetings in our Nutritional Governance Structure**

The meal service audits, remain the focus of discussion at the Nutrition Care Group meetings. These are multi-disciplinary meetings including operational ward staff, nursing and housekeepers, alongside dietetics and Sodexo colleagues. Format of the NCG meetings was reviewed in December 2025 and it was agreed that these were very valuable and proving beneficial in improving relationships between colleagues.

➤ **Use patient feedback to inform improvements**

Intelligence from patient feedback is utilised to inform improvements in our meal service and food and drink offer.

Measurement: Triangulation between patient food experience evaluation data.

➤ **Annual In-Patient Survey**

Results from the annual Wye Valley NHS Trust National Inpatient Survey are used to help inform our performance along with the use of more timely data and intelligence.

➤ **PLACE audit**

The annual Patient-Led Assessment of the Care Environment (PLACE) audits continue to be completed, with results used to support our decisions for quality improvement. The diagrams below show the results from the 2025 audit which show a positive picture for the Trust overall and improvements on the 2024 results in 6/8 food scores.

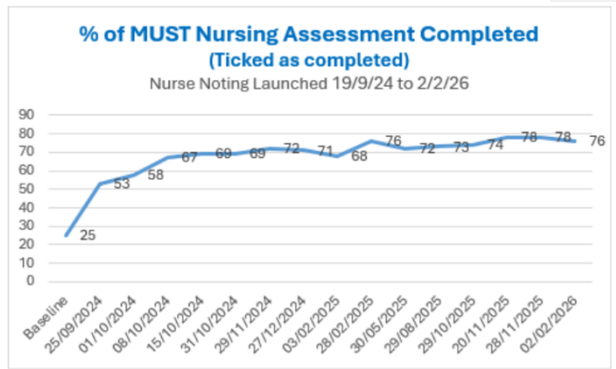
Site Name	year of audit	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
COUNTY HOSPITAL	2025	99.61%	92.99%	94.62%	92.27%	90.20%	99.26%	81.68%	82.33%
	2024	98.23%	90.75%	94.62%	89.13%	81.20%	98.20%	71.52%	73.39%
BROMYARD COMMUNITY HOSPITAL	2025	99.56%	95.19%	92.01%	98.81%	85.94%	95.45%	88.74%	84.83%
	2024 00%	100.00%	91.39%	88.02%	95.24%	83.93%	97.85%	75.00%	77.81%
LEOMINSTER COMMUNITY HOSPITAL	2025	98.48%	93.52%	92.01%	95.24%	85.48%	94.40%	93.48%	88.59%
	2024	98.81%	87.90%	93.06%	81.58%	77.05%	90.91%	81.87%	76.62%
ROSS COMMUNITY HOSPITAL	2025	98.92%	89.78%	92.53%	86.11%	87.06%	98.57%	81.60%	83.40%
	2024	95.96%	93.45%	92.01%	95.12%	75.34%	93.64%	65.63%	65.42%
Overall organisation		99.47%	92.85%			89.37%	98.66%	82.87%	82.99%
national average 2025		98.55%	92.13%			89.37%	97.00%	85.68%	87.12%



Measurement: Nutritional Risk Assessment

➤ **Ward Dashboard available on Maxims with real time data re. MUST assessment completion**

The ward dashboard provides an overview for the nurse in charge of completed assessments for patients in their care thereby highlighting any gaps or omissions. Our clinical noting team were able to audit and provide an overview of completed assessments see adjacent diagram.



Following an initial poor start prior to the implementation of the dashboard and focus of work on improving MUST assessment completion, performance is much improved and has continued to be consistently high.

The nursing documentation audit of MUST also provide data related to completion and associated actions. The data from this audit feeds into the annual audit completed by the Lead Dietician to avoid duplication of effort.

➤ **Annual audit of MUST compliance & quality by Lead Dietitian**

The annual audit of MUST data for the County Hospital site has recently been completed in January 2026. Due to limited staff resource, the community hospital sites have not yet been audited but this is planned to be completed shortly. This focussed audit is a snap-shot deep dive review of the quality of MUST completion and associated actions.

Thanks to improved digital reporting through Maxims, ward leaders have real-time visibility of MUST completion rates. The annual audit provides a deep review of whether scores were completed and acted on appropriately.

The Trust are pleased with the progress made over the past 12 months for this quality priority, this good news story and the triangulation of evidence indicates an improvement with patient experience of food quality.



Quality Priorities - Effective

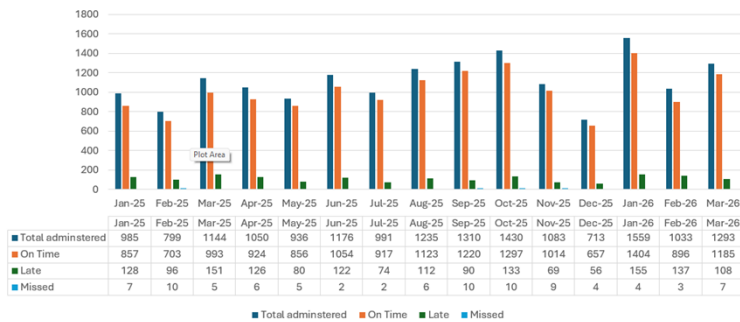
4. Implement Quality Improvement project to target high-risk time critical medication as locally defined

2025-26 would see the medicines safety and quality improvement teams continue to monitor data for Parkinsons and epilepsy medications targeting high risk time critical medication ensuring they are administered within correct times for patients. In addition, the priority would see the introduction of looking into self-administration and understanding the reasons behind this not being used as widely as it could be, breaking down any barriers to promote this across the trust for staff to use for our patients.

Our data

The overall % of Parkinson's medications "on time every time" shows a positive picture with the majority of medication being prescribed on time. Work continues to monitor missed doses and understand the reasons recorded on EPMA.

Parkinsons Medications Data as a Trust Quality Priority

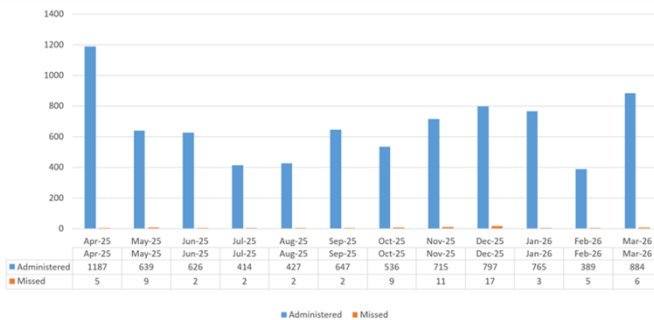


Epilepsy medication was reviewed, as just one missed dose can cause a seizure and therefore these are time critical for our patients (Epilepsy Action UK 2025).

Epilepsy medications from April 2025 show very low doses of missed medications, work continues with ward staff to ensure epilepsy medications are prioritised on ward rounds.

Self-administration

Epilepsy medications from April 2025- End March 2026.



The plan for the 2025-26 quality priority was to explore the use and process of self-administration to ease pressures at ward level and ensure our patients are empowered to self-administer. This would include:

- Review the policy at Trust level and understand what is used at Foundation Group. Update in line with the Foundation Group.
- Ensure Electronic prescribing system functions are usable and updated.
- Roll the new policy out Trust wide.
- Ensure staff training and engagement is continued
- Review use on wards and any barriers that can be removed.
- Obtain staff feedback.
- Review and streamline at regular intervals.
- Collect data to give reassurance the self-administration for our patients is being implemented.

The results of an audit carried out in July 2025 identified only 2 wards out of 10 were using self-administration.

Whilst the 'go live' for using the self-administration button with EPMA, the team identified steps could be taken to promote the use of paperwork and writing comments within EPMA/nurse noting.

What we have achieved over the past 12 months

Screensaver for medicines safety week November 2025, continuing to promote Parkinson's.



Red bags.

January 2026 witnessed the launch of the Red Bags system. These red bags allow pharmacy staff to flag critical medications and dispatch them rapidly to the wards, ensuring that these medications are prioritised immediately upon arrival.

Early indications suggest the initiative is already improving timeliness.



Additional actions implemented



- Medicine safety officer and team constantly working with nurses to support staff on wards to realise the importance of time critical medication, sharing data with ward sisters.
- Provided wipeable laminated clock faces on wards to help with the precise timing required for Parkinson's medications.
- Relunched the critical medication medicine related guidelines (MRG) January 2026 and continued to promote all time critical meds MRG's across the trust.
- Updated staff on the importance of using the correct button and adding comments into EPMA stating reasons for delays or not administering.
- Discussion to enable the correct paperwork for self-administration to be available on nurse clinical noting allowing improved accessibility for nursing staff.
- Review and update of the self-administration policy, providing a user-friendly version.

Moving forward

- Continue to monitor Parkinsons and Epilepsy data to keep up momentum
- Visit wards to ensure staff are aware of correct EPMA procedure until EPMA self-administration button is restored.
- Continue links with Parkinsons Nurses and Parkinson's UK as well as being part of the national Parkinson's Excellence Network.
- Continue to promote all time critical meds MRGs trust wide.
- Continue using the red bags to see for improvements in all missed medication including critical. SOP to be created following full roll out across the Trust.

The Trust has agreed that this quality priority will continue for 2026-27, shifting the focus to improve administration of critical medication in the Emergency Department.

6. Transition of care.

The aim of this quality priority was to:

- Ensure best possible Transition care pathways for children and young people with chronic medical conditions in the journey from paediatric to adult services.
- Ensure participation of all the stakeholders across services including adult services, community providers, mental health services and primary care.
- Address challenges and barriers affecting the Transition process for young people and parents.

Status of Transition at the beginning of the year

Whilst improvement work was needed for this quality priority, it was also acknowledged that there was already good practice adopted across the Trust. This included:

- Pathways in place for Transition in well-established specialities including Diabetes, Epilepsy, Respiratory Medicine, Cystic Fibrosis and Rheumatology.
- Improved awareness about Transition through teaching and training
- Involvement of Youth worker team in facilitating Transition work in Diabetes and Epilepsy as well as collecting feedback on patient experience

The main challenge was for children with complex medical conditions who need specific transition pathways.



What was achieved

Whilst progress with implementing change was slower than expected for this quality priority, the following was achieved:

- Transition passport drafted receiving paediatric and adult clinician's feedback
- Transition alert has been developed and is live on Maxims. Next steps are to create guidelines/instructions to follow for HCPs on how to set up alerts
- Focus groups being set up for feedback on Transition related experience with a view to co-production with young people
- Education session being delivered to various specialties
- Working closely with the ICB transition network to develop shared good practices.

Moving forward:

There are a number of projects in the work plan for the coming year:

- Setting up a Transition working group,
- Setting up a young ambassador's forum,
- Appraisal of NICE guidelines
- Provide training on Transition for health care practitioners,
- Develop a Transition of Healthcare for young people strategy document
- Develop Transition related resources.

To allow the continuation of the improvement work already completed, this quality priority will continue into 2026-27, allowing for continued collaboration and co-production with service users, particularly those who have experienced transition to ensure the process is meaningful and effective.



Quality Priorities - Experience

7. Improve responsiveness to patient experience data.

Significant progress has been made in strengthening responsiveness to patient experience data, with clear improvements in feedback handling, learning, and patient engagement.

Friends and Family Test- Strong patient satisfaction despite lower response rates

The Trust received 8,403 FFT responses from 83,764 requests (8% response rate). Whilst this is a reduced response rate, it does compare to the national average.

Importantly, 92.9% of patients reported a positive experience, demonstrating consistently high satisfaction levels.

Improved quality and effectiveness of complaints handling

Although complaints increased in year, the number of complaint “comebacks” has reduced significantly, with year-end figures much improved compared to 2024/25.

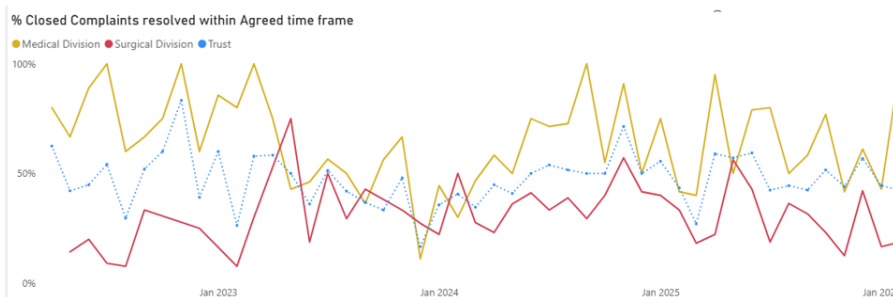
- 2024-25: 51 comebacks
- 2025-26: 36 comebacks

This demonstrates better quality, accuracy, and completeness of responses, reducing the need for re-investigation.

Clear improvements in responsiveness and communication

There has been a notable improvement in agreed response timeframes and communication with complainants, particularly in the Medical Division.

Weekly oversight and governance processes in the division have strengthened monitoring and accountability for both complaints and concerns. This reflects a more responsive, transparent, and patient-focused complaints and concerns handling process.



Measurable improvements in patient experience themes

Communication-related complaints have reduced as a top category. Specific improvements include; reduction in concerns about staff attitude and decreased issues relating to discharge and clinical assessment.

Growth in patient engagement and co-production

The Patient Engagement Group is now fully embedded and actively supporting multiple improvement projects including;

- Improving the anaesthetic care pathway
- Enhancing hospital signage
- Improving diabetes inpatient experience

This demonstrates a shift towards co-production and involving patients directly in service design.

Continuous improvement culture and system development

A new FFT provider has been secured, with go-live planned for April 2026, creating opportunities to increase response rates and enhance insight and reporting capability to improve the focus on actions to create more positive patient experiences of our services.

Oversight processes (e.g. weekly reporting and divisional scrutiny) are now driving more consistent performance management of complaints and concerns.

The Trust has made meaningful and measurable progress in responding to patient experience data. Key successes include;

- High levels of patient satisfaction with FFT (92.9%)
- Significant reduction in complaint comebacks
- Improved timeliness and quality of responses in Medical Division
- Demonstrable service improvements from feedback
- Stronger patient involvement in shaping services

Together, these improvements reflect a more responsive, learning-focused, and patient-centred culture, with strong foundations in place for continued progress in 2026-27.



8. Increase the number of opportunities to grow our volunteer workforce, in numbers and reach.

This quality priority was closely linked to the Trust's 2025-26 objectives for volunteering.

Our volunteer vision is:

- We are committed to improving patient experience through the contribution made by volunteers that adds value to our services.
- We aspire to increase the contributions that volunteers can make through innovation of volunteer roles and working with the voluntary sector to provide a diverse range of experiences for volunteers across Herefordshire within a healthcare setting.

Trust Objective – “Increase the number of opportunities to grow our volunteer workforce, in numbers and reach”

Key performance indicators identified to monitor our progress with this objective are:

- Number of volunteer hours contributing to services
- Number of volunteers recruited
- Number of roles offered
- Number of areas supported by volunteers

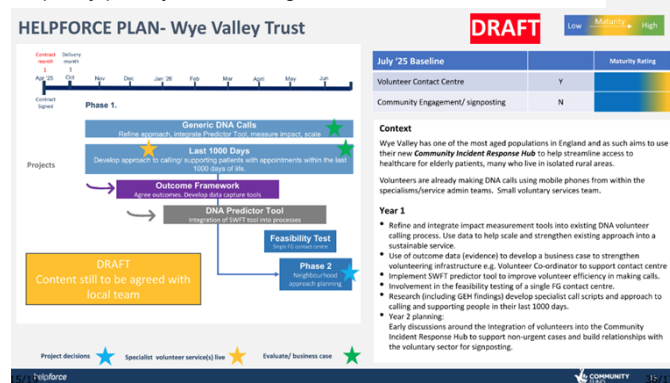
Trust Objective – “There’s growing evidence to suggest that not only can volunteering help NHS providers meet some of the most stubborn challenges – it can also be transformational when expert programmes are designed to meet specific needs”

The key drivers for this objective were identified as:

- Identify areas in need (new or existing roles)
- Opportunity for volunteer-led service innovations
- Maintain network with the Group and expand
- Streamline management and support for volunteers (VMS, recruitment, training)

To support the Trust objectives and quality priority the Trust agreed to:

- Partake in the national pilot project adopting and implementing a contact centre model aimed at reducing Do not attends for outpatient appointments through volunteer phone calls
- Expand the type of



roles volunteers undertake, reaching more services and more patients

- Streamline processes
 - Recruitment
 - Training
 - Volunteer Management System

Our headlines on the past 12 month

- Overall, our volunteers consistently give in excess of 1000 hours every month, delivered by 70 or more individuals.
- Volunteer training was streamlined with support from the education team to ensure safety and efficiency.
- Wye Valley adopted and implemented the Worcester's Volunteer Management system (VMS) to improve processes and free up resources for recruitment and innovation.
- The Trust worked closely with Helpforce as part of the Foundation Group programme to reduce DNA's via the contact centre. Roll out of the model continues, targetting the services where DNA's are highest to establish reasons for patients not attending.
- Increased ward support and developed more innovative ways for volunteers to provide support.
- Continued with opportunities to increase volunteer support by working more closely with VCSE organisations.

Whilst this objective will not continue as a quality priority for 2025-26 the Trust is aware of the significant progress made and is fully supportive to continue the projects and build on what has already been achieved through business as usual. The Trust is aware its exciting future opportunities lie in neighbourhood health and community-based volunteer support, networking with key stakeholders has already been initiated.



Quality Priorities: The Year Ahead



2026-27 Trust Objectives

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QUALITY PRIORITIES 2026-27

The Trust has identified 8 new quality priorities for 2026-27.

SAFE		
Diabetes Safety	Time critical medications	Reducing the prevalence for Hospital Acquired Pneumonia

EFFECTIVE		
Frailty assessments in ED	Timeliness and Quality of Electronic Discharge Summaries	Antimicrobial stewardship

EXPERIENCE		
Seek to eliminate Corridor Care	Transition of care	

SAFE

Diabetes Safety

Time critical medication

Reducing the prevalence for Hospital Acquired Pneumonia

EFFECTIVE

Frailty assessment in the Emergency department

Timeliness and Quality of Electronic Discharge Summaries (EDS)

Antimicrobial stewardship

EXPERIENCE

Seek to eliminate Corridor Care

Transition of care



External Statements of Assurance





Statement of Assurance

Kirkham House
John Comyn Drive
WORCESTER
WR3 7NS

0330 053 4356
hw.enquiries@nhs.net

Reference: HWICB feedback Quality Account 2024/25

Yours sincerely

A handwritten signature in black ink, appearing to read "Kathryn Cobain", positioned above a horizontal line.

Kathryn Cobain



Wye Valley Trust Quality Accounts 2025-26

Appendix 1 – CQC Ratings Tables

Acute Site ratings

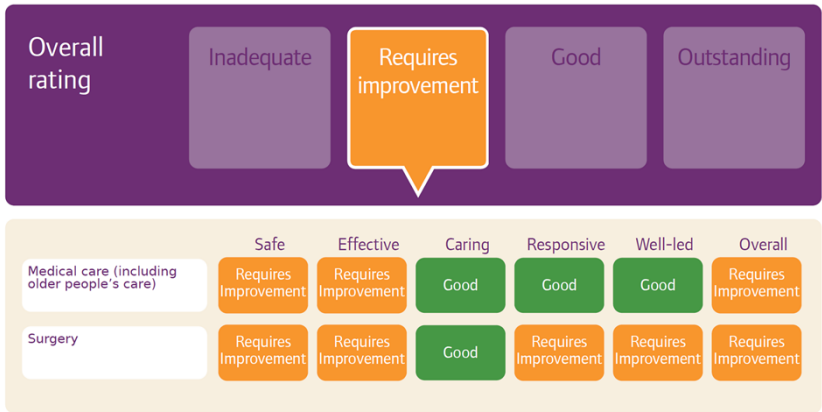


Are services



Most recent inspection rating changes

The County Hospital



Community Services

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↓ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Requires improvement ↔ Mar 2020	Requires improvement ↔ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Requires improvement ↔ Mar 2020
Community end of life care	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020
Community dental services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020	Good ↔ Mar 2020	Good ↑ Mar 2020

Appendix 2 – National Audit & NCEPOD Compliance

Eligible National Audits	WVT participation in 2025-2026	Cases submitted (where applicable)	Comments
Royal College of Emergency Medicine (RCEM) Care of older people	✓	N/A	Report not yet due to be published (interim data only)
Royal College of Emergency Medicine (RCEM) Adolescent Mental Health	✓	N/A	Report not yet due to be published (interim data only)
Royal College of Emergency Medicine (RCEM) Mental Health Self Harm	✓	N/A	Report not yet due to be published (interim data only)
Royal College of Emergency Medicine (RCEM) Time Critical Medications	✓	N/A	Report not yet due to be published (interim data only)
The National Major Trauma Registry (NMTR)	✓	All eligible cases submitted	Report not yet due to be published
Case Mix Programme (CMP)	✓	All eligible cases submitted	Case Mix Programme (CMP) Public Report 2023-24 (data) was published mid-2025
National Audit of Metastatic Breast Cancer (NAoMe)	✓	All eligible cases submitted	National Audit of Metastatic Breast Cancer – State of the Nation Report 2025 - published 9 th October 2025



National Audit of Primary Breast Cancer (NAoPri)	✓	All eligible cases submitted	National Audit of Primary Breast Cancer – State of the Nation Report 2025 - published 9 th October 2025
National Bowel Cancer Audit (NBOCA)	✓	N/A	National Bowel Cancer Audit – State of the Nation Report 2025 - published 9 th October 2025
National Kidney Cancer Audit (NKCA)	✓	N/A	National Kidney Cancer Audit – State of the Nation Report 2025 - published 9 th October 2025
National Lung Cancer Audit (NLCA)	✓	All eligible cases submitted	National Lung Cancer Audit – State of the Nation Report 2025 -- published 9 th October 2025 Lung cancer State of the Nation 2026 (NLCA/NATCAN) - published 12 th February 2026
National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	All eligible cases submitted	National Non-Hodgkin Lymphoma Audit – State of the Nation Report 2025 - published 9 th October 2025
National Oesophago-Gastric Cancer Audit (NOGCA)	✓	All eligible cases submitted	Oesophago-gastric cancer report (NOGCA / NATCAN) State of the Nation Report 2025- published 11 th September 2025
National Ovarian Cancer Audit (NOCA)	✓	All eligible cases submitted	National Ovarian Cancer Audit – State of the Nation Report 2025 - published 9 th October 2025
National Pancreatic Cancer Audit (NPaCA)	✓	All eligible cases submitted	National Pancreatic Cancer Audit – State of the Nation Report 2025 - published 9 th October 2025
National Prostate Cancer Audit (NPCA)	✓	All eligible cases submitted	National Prostate Cancer Audit – State of the Nation Report 2025 - published 9 th October 2025



National Audit of Cardiac Rhythm Management (CRM)	✓	All eligible cases submitted	National Heart Failure Audit (NHFA) 2025 Annual Report (2nd Edition) - published 18 th December 2025
National Audit of Cardiac Rehabilitation	✓	All eligible cases submitted	National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2024 - published April 2025
Myocardial Ischaemia National Audit Project (MINAP)	✓	25%	Myocardial Ischaemia National Audit Project (MINAP) 2025 Annual Report (2nd Edition) - published 18 th December 2025
National Heart Failure Audit (NHFA)	✓	93.1%	National Heart Failure Audit (NHFA) 2025 Annual Report (2nd Edition) - published 18 th December 2025
National Diabetes Audit - CORE	✓	All eligible cases submitted	Annual report not yet published but quarterly reports available online
Diabetes Prevention Programme (DPP) Audit	✓	All eligible cases submitted	Diabetes Prevention Programme: Non-Diabetic Hyperglycaemia, April 2025 – September 2025 - published 8 th January 2026
National Diabetes Foot Care Audit (NDFA)	✓	N/A	National Diabetes Foot Care Audit 2020–2025 – published 13 th November 2025
National Diabetes Inpatient Safety Audit (NDISA)	✓	All eligible cases submitted	Report not yet due to be published
National Pregnancy in Diabetes Audit (NPID)	✓	All eligible cases submitted	NPID Dashboard 2024 (pregnancies ending 1 Jan 2022 – 31 Dec 2024) - published 9 th October 2025
Transition (Adolescents and Young Adults) and Young Type 2 Audit	✓	N/A	National Diabetes Audit, Adolescents and Young Adults with Type 1 Diabetes 2017–24 – published 11 th September 2025



Gestational Diabetes Audit	✓	N/A	National Gestational Diabetes Mellitus (GDM) Audit, 2024–25 – published 13 th November 2025
National Audit of Dementia	✓	N/A	Report not yet due to be published
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	All eligible cases submitted	2024 Annual SHOT report - published August 2025
National Maternity and Perinatal Audit (NMPA)	✓	All eligible cases submitted	NMPA – State of the Nation Report (based on 2023 births) - published 11 th September 2025 Maternity services – multiple births (NMPA) – published 12 th March 2026
National Hip Fracture Database	✓	All eligible cases submitted	National 2025 Report: Room for improvement: hip fracture care in 2024 - published September 2025
Fracture Liaison Database	✓	N/A	Fracture Liaison Service Database report (FFFAP) Ninth Annual Report published 8 th January 2026
National Inpatient Falls Audit	✓	All eligible cases included	National Audit of Inpatient Falls (NAIF) annual report 2025 – published 9 th October 2025
UK Parkinson's Audit	✓	All eligible cases included	Report not yet due to be published
National Joint Registry (NJR)	✓	N/A	NJR 22nd Annual Report – published October 2025
National PROMS Programme	✓	N/A	Report not yet due to be published
NPDA National Paediatric Diabetes	✓	All eligible cases included	National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2024/25 – published 12 th March 2026



National Neonatal Audit Programme (NNAP)	✓	All eligible cases included	National Neonatal Audit Programme – Summary report on 2024 data - published 8 th October 2025
National Audit of Seizures and Epilepsies in Children and Young People	✓	All eligible cases included	Epilepsy 12 State of the Nation Report - published 11 th July 2025
UK Cystic Fibrosis Registry (Adults & Children)	✓	Data only collected on Children	UK CF Registry Annual Data Report for 2024 – published October 2025
National Child Mortality Database	✓	N/A	Child Death Review Data Release 2025 - published 13 th November 2025 Children with Life-Limiting Conditions and Palliative and End-of-Life Care Needs - published 10 th July 2025 Understanding consanguinity related child deaths (NCMD) - published 12 th February 2026
Cleft Registry and Audit Network (CRANE)	✓	All eligible cases included	Cleft Registry and Audit Network (CRANE) 2025 Annual Report published 9 th December 2025
National Respiratory Audit Programme (NRAP) COPD Secondary Care	✓	N/A	Catching our breath: Time for change in respiratory care – published 12 th June 2025
National Respiratory Audit Programme (NRAP) Pulmonary Rehabilitation	✓	N/A	Catching our breath: Time for change in respiratory care – published 12 th June 2025
National Respiratory Audit Programme (NRAP) Adult Asthma Secondary Care	✓	N/A	Catching our breath: Time for change in respiratory care – published 12 th June 2025
National Respiratory Audit Programme (NRAP) Children and Young People's Asthma Secondary Care	✓	N/A	Catching our breath: Time for change in respiratory care – published 12 th June 2025



National Early Inflammatory Arthritis Audit (NEIAA)	✓	All eligible cases included	State of the Nation 2025 (National Early Inflammatory Arthritis Audit) – published 9 th October 2025
Sentinel Stroke National Audit programme (SSNAP)	✓	All eligible cases included	Stroke Care – State of the Nation Report 2025 (Sentinel Stroke National Audit Programme) -published 13 th November 2025
National Emergency Laparotomy Audit (NELA)	✓	All eligible cases included	Emergency laparotomy – Tenth Patient Report of the National Emergency Laparotomy Audit - published 9 th October 2025
National Emergency Laparotomy Audit (NELA) No-Lap Audit	✓	N/A	Report not yet due to be published
Perioperative Quality Improvement Programme (PQIP)	✓	All eligible cases included	Perioperative Quality Improvement Programme (PQIP): 6th Cohort Report (March 2024 – March 2025) – published July 2025
Breast and cosmetic implant registry	✓	All eligible cases included	BCIR is a patient safety and traceability registry (for recall and surveillance) and does not routinely publish annual “State of the Nation” or outcomes reports.
British Hernia Society Registry	✓	N/A	Report not yet due to be published
Society for Acute Medicines Benchmarking Audit (SAMBA)	✓	All eligible cases included	SAMBA 2025 National Report - published December 2025
BAUS Urology Audits – British audit Of the Investigation and referral of Women with Recurrent Urinary Tract infection using recent Guidance (BOOMERANG)	✓	N/A	Report not yet due to be published



BAUS Urology Audits – Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✓	N/A	Report not yet due to be published
National Audit of Care at the End of Life (NACEL)	✓	All eligible cases included	End of life care – 2024 State of the Nations Report (NACEL) – published 14 th August 2025
UK Renal Registry Chronic Kidney Disease Audit	✓		Report not yet due to be published
UK Renal Registry National Acute Kidney Injury Audit	✓	All eligible cases included	Report not yet due to be published
National Cardiac Arrest Audit (NCAA)	✓	N/A	Annual Report not yet due to be published (quarterly report data discussed)
National Ophthalmology Database Audit	✗	N/A	At present, the Trust is unable to participate in the National Ophthalmology Database as the electronic data submission systems required are not yet available locally. We are exploring future participation as part of our ongoing digital development.



Child Health Clinical Outcome Review Programme	NCEPOD	N/A	Emergency Procedures in Children and Young People – Right Place, Right Time, Right Team - published 11 December 2025
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Appendix 3 – NHS Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps

Our Medical and Surgical Divisions maintain detailed rotas identifying gaps. Detailed improvement plans are in place to address gaps.

**Table A – 3rd rotation 02/04/2025 – 05/08/2025
Surgical Resident Doctors**

Grade	Entitled To	Filled	Gap	
Surgical FY1	16	12	4	1 x LAS, 3 unfilled
Surgical FY2	13	11	2	1 x LAS, 1 unfilled
GPST	8	7	1	1 x LAS
CTs	5	5	0	
ST	7	6	1	1 x LAS
ST3+	16	13	3	2 x LAS, 1 unfilled

**1st rotation 06/08/2025 – 02/12/2025
Surgical Resident Doctors**

Grade	Entitled To	Filled	Gap	
Surgical FY1	16	16	0	
Surgical FY2	14	13	1	1 unfilled
GPST	7	6	1	1 x LAS



CTs	5	5	0	
ST	7	6	1	1 x LAS
ST3+	17	10	7	3 x LAS, 4 uncovered



**2nd rotation 03/12/2025 – 31/03/2026
Surgical Resident Doctors**

Grade	Entitled To	Filled	Gap	
Surgical FY1	16	14	2	2 x LAS
Surgical FY2	14	12	2	2 x LAS
GPST	7	6	1	1 x LAS
CTs	5	5	0	
ST	7	6	1	1 x LAS
ST3+	17	12	5	1 x LAS, 4 unfilled

**Table A – 3rd rotation 02/04/2025 – 05/08/2025
Medical Resident Doctors**

Grade	Entitled To	Filled	Gap	
Medical FY1	26	22	4	4 x LAS
Medical FY2	19	15	4	3 x LAS, 1 unfilled
GPST	8	7	1	1 unfilled
CTs/IMT	5	5	0	
ST3+/ IMT3	16	12	4	4 unfilled

**1st rotation 06/08/2025 – 02/12/2025
Medical Resident Doctors**

Grade	Entitled To	Filled	Gap	
Medical FY1	26	23	3	3 x LAS
Medical FY2	22	18	4	3 x LAS, 1 unfilled
GPST	9	9	0	
CTs/IMT	5	5	0	
ST3+/ IMT3	16	13	3	1 x LAS, 2 unfilled



2nd rotation 03/12/2025 – 31/03/2026
Medical Resident Doctors

Grade	Entitled To	Filled	Gap	
Medical FY1	26	22	4	3 x LAS, 1 unfilled
Medical FY2	22	16	6	3 x LAS, 3 unfilled
GPST	9	8	1	1 unfilled
CTs/IMT	5	5	0	
ST3+/ IMT3	16	10	6	3 x LAS, 3 unfilled



Appendix 4 - Comparable data summary from data available to the Trust from NHS Digital – martin updating

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. Wye Valley NHS Trust considers that this data in the table below is as described for the following reasons:

<https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts>

Performance information is consistently gathered and reported on monthly to the Trust

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2021/22)	0	0	3	20	0	Hospital Onset cases. Latest 2023-2024 Previous 2022-23 (09/2024 release)
<u>MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)</u>						
Wye Valley NHS Trust is taking the following actions to reduce incidence of MRSA and so the quality of services, by ensuring its strict cleaning, hygiene, hand-washing regimes, and bare below the elbows practice is adhered to. The trust also has a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.						
NHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile	37	42	77.4	326	0	Hospital & Community onset, Healthcare associated. Latest 2023-24 Previous 2022-23 (17/05/2024 release)
<u>Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)</u>						
Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and the quality of services, by learning lessons from these investigations, sharing with the clinical area and presenting at the Trust's Quality Committee meetings.						
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported						No new release of data due to the change to the new Patient Safety Incident Reporting framework
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported Severe or death						No new release of data due to the change to the new Patient Safety Incident Reporting framework
Note: No new release of data since 19/20 due to the change to the new Patient Safety Incident Reporting Framework						
Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents and the outcome of investigations are shared throughout Divisional and Directorate governance meetings. Incident reviews that identify a new emerging risk or new learning are shared in a variety of forums and in the trust Safety Bites newsletter.						



Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level (Current Dec 2023 – Nov 2024) Band 2 (Previous Dec 2022 – Nov 2023) Band 2	1.028	1.0212	1.0	1.29	0.70	Data is banded 1-3 high to low Previous period Dec 2023 - Nov 2024
Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the (Current Nov 2023 – Oct 2024) (Previous Nov 2022 – Oct 2024)	24%	24%	45%	65%	17%	Reported as a percentage of all deaths.
SHMI data at trust level, Dec22-Nov23 (xls).xls (live.com)						
SHMI data - NHS England Digital						
Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by maintaining the implementation of the Mortality strategy and supporting quality improvement work in relation to mortality alerts and learning from deaths.						
Limited submissions for current year . Numbers not sufficient for the benchmarking tool to use						Using EQ-5D Index score (a combination of five key criteria concerning general health) This year Measuring Health gain Note for Hip sample small for accurate National comparison. Note last year updated to 2022-23 More info in link below
Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	
PROMS Total Hip Replacement (latest 2023-24) (Previous latest 2022-23)	0.498	0.495	0.453	0.60	0.36	
PROMS Total Knee Replacement Latest 2023-24 Previous 2022-23	0.292	0.34	0.323	0.40	0.23	
Patient Reported Outcome Measures (PROMs) - NHS Digital						
Wye Valley NHS Trust is taking the following actions to improve PROMs outcomes and so the quality of services, by continuing to look at the issues with the PROM outcome scores in greater detail, in particular those patients who have had a negative outcome and analysing patient level information to look at the outliers and their impact on the overall scores. This analysis is undertaken by the surgical teams to understand how we can improve.						



Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Section 5 Your care & treatment NHS Outcomes Framework - Indicator 4b Patient experience of hospital care Statistic: verall how was you experience.....in Hospital	7.90	7.98	8.14	9.34	7.47	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to 2023 survey Nov sent Jan – April 2024 Published Sept 2024
Adult inpatient survey 2023 - Care Quality Commission						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement						
d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d – 2024)	57	58	62	90	40	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 Previous December 2023
Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work (Q25c-2024)	62	61	61	79	35	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 survey latest available
NHS Staff Survey 2024 Benchmark Report						
Local results for every organisation NHS Staff Survey (nhsstaffsurveys.com)						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.						
Friend and Family Inpatient services latest Jan 2025 Previous December 2023	88	84	95	100	72	Figures expressed as percentage who would recommend. Current Jan 2025 previous December 2023
Friend and Family Accident and Emergency services Jan 2025 Previous December 2023	80	72	80	97	56	
https://www.england.nhs.uk/fft/friends-and-family-test-data/						
NHS England » Friends and Family Test data – January 2025						
friends-and-family-test-inpatient-data--january-2025.xlsm						



Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
VTE risk assessed						Expressed as a percentage of patients requiring assessment
Current October to December Q3 2024-25	91%	92.2%	91%	99.6%	14%	
Previous VTE risk assessed Quarter 3 (October to December Q3 2019-20)						
Statistics » Quarter 3 2024/25 (October to December 2024)						
https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/						
Wye Valley NHS Trust is taking the following actions to improve the number of patients who are risk assessed for VTE and so the quality of services by maintaining a focus on achieving the national target through the quality priority set for 2024-5 and continued audit of practice.						
2025 latest published national data see VTE section for latest quarterly data. There was a National data suspension during the Pandemic.						



Appendix 5 - Contracted Services 2024-25 - Contract Monitoring Services

Surgical	Medical	Integrated Care	Clinical Support
General Surgery	Plastic Surgery	Physiotherapy	Palliative Medicine
Urology	Accident & Emergency	Occupational Therapy	Anti Coagulant
Breast Surgery	General Medicine	Dietetics	Chemical Pathology
Colorectal Surgery	Gastroenterology	Orthotics	Haematology
Upper GI	Endocrinology	Speech & Language	Radiology
Vascular Surgery	Hepatology	Podiatry	Audiology
Trauma & Orthopaedics	Diabetic Medicine	Medical Inpatient (Community Beds)	Pathology
ENT	Cardiology	Community Nursing Inc. Specialist Com. Nursing	Clinical Neurophysiology
Ophthalmology	Transient Ischaemic Attack	Community ACPs	Endoscopy
Oral Surgery	Dermatology	Community Referral Hub	
Orthodontics	Respiratory Medicine	Virtual Ward	
Anaesthetics	Respiratory Physiology		
Paediatrics	Stroke		
NeoNatology	Nephrology		
Gynaecology	Neurology		
Obstetrics	Rheumatology		
Midwifery	Geriatric Medicine		
ITU			
SCBU			
Community Child Health			
Community Dental			
Podiatric Surgery			
Public Health Nursing			
Health Visiting			
School Nursing			



WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	4th June 2026
Title of Report:	Perinatal Safety Report – Quarter 4 2026
Lead Executive Director:	Chief Nursing Officer
Author:	Elaine Evans - Neonatal Unit Sister Justine Jeffery - Director of Midwifery Susan Hughes – Deputy Director of Midwifery Victoria Bailey – Patient Safety Midwife
Reporting Route:	Surgical Divisional Governance Quality Committee
Enclosures included with this report:	Appendix 1: SCBU Dashboard Appendix 2: PQSM Dashboard
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
<p>The purpose of the paper is to provide a quarterly update on key maternity and neonatal safety initiatives which will support the Trust to achieve the national ambition. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety.</p> <p>The requirement to ensure the Trust Board and the ICB are informed of present or emerging safety concerns and activities being undertaken to ensure safety and two-way reflection of ‘ward to board’ insight across the multi-disciplinary, multi-professional maternity services team was initially outlined in the 2025 NHSEI document ‘Implementing a revised perinatal oversight model.</p>	
Recommended Actions required by Board or Committee	
<p>Board is invited to:</p> <ul style="list-style-type: none"> • Note and discuss the content of the report, • Receive Assurance that our maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report. 	
Executive Director Opinion¹	
The CNO offers assurance to the Board that the maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.	

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

1. INTRODUCTION

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

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

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

2. PERFORMANCE

2.1 Activity

Below shows the total number of births for the months January, February and March (Quarter 4) and the Midwife to Birth ratio.

Area	Dashboard	Framework	Indicator Description	January	February	March
Deliveries	LMNS/PQS M	Contractual	Total births (deliveries)	146	108	129
WVT		Midwife to birth ratio		1:31	1:32	1:27

2.2 Red flags

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

The red flags for Quarter 4 are recorded as:

Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar
Red Flags	WVT	Inphase	Delay in Induction >2hrs	0	0	2
	WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	1	1	3
	WVT	Birth Rate +	Delay in administering medication	0	0	0
	WVT	Inphase	Delay in starting syntocinon/ARM >30mins	0	1	0
	WVT	Birth Rate +	Delay in Suturing >60mins	0	0	0
	WVT/PQSM	Birth Rate +	Unable to provide 1:1 care in labour	0	0	0
	WVT	BadgerNet	Delay in Triage >15mins	1	0	0
	WVT	Birth Rate +	Community midwives on call covering maternity unit	3	4	1
	WVT	Birth Rate +	Delayed recognition of and action on abnormal vital signs	0	0	0
	WVT	Birth Rate +	DSC lost - supernumerary status	0	1	0
	WVT	Birth Rate +	Full clinical examination not carried out when presenting in labour	0	0	0
WVT	Birth Rate +	Delay of more than 30 minutes in providing pain relief	0	0	0	

In January, one delay was identified in Triage > 15 minutes, one delay in category 1 cesarean sections and on 3 occasions, a community midwife was called in to cover the maternity unit. One case was escalated from Category 2 to Category 1 due to a pathological CTG classification. In January, there was a high level of staff sickness, therefore, the on call community midwives were utilised to cover the maternity unit.

In February, one delay was identified in delay in starting syntocinon/ARM > 30 minutes, this was due to high acuity and was deemed appropriate to delay, in this circumstance. The on call community midwives were called in 4 times in February due to high acuity and staff sickness.

The Trust has made the difficult decision to temporarily suspend the homebirth service due to a national request for all Trusts to review their homebirth services. This pause has enabled us to carefully review our service so that, in the future, it can be provided in a safe, robust, and sustainable way. A paper has been previously shared with the Board and following the completion of agreed actions a recommendation will be made to the Board to reinstate the service.

In March, on two occasions there was a delay in induction > 2 hours, on three occasions, there was a delay in Category 1 C-Sections > 30 minutes. One delay in induction was due to acuity and the second delay was due to staff sickness and assessing the priority of the unit at that time. One Cesarean section was delayed due to a patient being reluctant to proceed with the operation. The other two occasions, the themes were consistent including delayed team brief and increasing the severity of the C-Section from a category 2 to a category 1.

Delivery Suite co-ordinator supernumerary status

In February 2026, on one occasion, the delivery suite co-ordinator lost supernumerary status and was providing care to a postnatal patient due to acuity and staffing. This was escalated through the appropriate channels and the on call community midwife was utilised appropriately.

In January and March, the Delivery Suite Coordinator was supernumerary 100% of the time and all women received one to one care in labour. NHS Resolution's CNST Maternity Incentive Scheme Year 7 guidance recognises that isolated, exceptional events may occur. Compliance is maintained where the incident is well documented, escalation is immediate, and there is evidence of mitigation and review. There were no exceptional events that required this for this quarter.

2.3 RCOG Obstetric attendance

CNST requires compliance with the RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. Our performance in Quarter 4 is noted below.

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0	100%	
Caesarean birth for women with BMI > 50	0	100%	
Caesarean birth < 28/40	0	100%	

Premature twins (<30/40)	0	100%	
4 th degree perineal tear repair	0	100%	
Unexpected intrapartum stillbirth	0	100%	
Eclampsia	0	100%	
Maternal collapse e.g. septic shock / MOH	0	100%	
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	50%	In one case, the Consultant was informed but did not attend. This is being audited. The MOH Guideline has been updated this Quarter to comply with CNST requirements.

2.4 SCBU Activity

Quarter 4 SCBU Activity

The table below details the number of admissions (Activity) for SCBU throughout Quarter 4.

There was a total of 59 admissions to SCBU during Quarter 4, a slight decrease on Quarter 3 activity where there were 65 admissions. The three babies that were admitted with a gestation lower than 30 weeks gestation were all ex-utero transfers, all being delivered in a Level 3 unit and only accepted for transfer back to SCBU when they met the admission criteria.

BAPM 2011 Level of Care on day of admission – Quarter 4				
Month	ITU	HDU	SCBU	TC
January 26	0	4	13	9
February 26	0	1	3	10
March 26	1*	6	7	11
Quarter 4 Total	1*	11	23	30
February 26	1*	0	5	8
March 26	0	0	5	14

ITU & HDU Continuing number of cot days on SCBU other than day of admission Q4		
MONTH	INTENSIVE CARE	HIGH DEPENDENCY
January 26	1*	7
February 26	0	4
March 26	0	10
Quarter 4 Total	1*	21

ITU Additional Care Level Days Quarter 4

One baby initially received High Flow and SVIA however required further support and sadly died at a tertiary centre.

HDU Additional Care Level Days – Quarter 4

Four babies initially required nasal CPAP as additional respiratory support and both were weaned from respiratory support within 24 hours.

Five babies, both needing High Flow O2 therapy were weaned from respiratory support between 12 and 48 hours and two babies remained on High Flow O2 for >36 hours.

One baby returned to SCBU on High Flow O2 therapy and was weaned to low flow nasal prong oxygen after 4 days.

In-utero/Ex Utero Transfers – Quarter 4

Type of Transfer	Quarter 4		Comments
	In	Out	
IUT Transfer for clinical reasons as per network pathway	0	4	2 to WRH 2 to BWH
IUT Transfer for non-clinical reasons	0	0	
IUT Transfers outside of the network	0	2	1 to Gloucester Royal (28 +4) 1 to Cardiff University hospital (26+3)
Ex-utero Transfers for clinical reasons as per network pathway	4	1	
Ex-utero Transfers out of network	0	0	
Delays in Transfers in/out	0	0	
IUT or Ex-utero exceptions.	0	0	

3. SAFETY

3.1 Incidents

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

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the details of the cases cannot be shared at the public section of Board, and a separate detailed Incident Report is shared at Private Board following a detailed discussion at Quality Committee.

3.1.2 There was one intrapartum stillbirth and three neonatal deaths reported in Q4.

3.1.3 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
January	2	0	0	0	0	0	0
February	1	0	1	0	0	0	0
March	1 (died at external trust)	1 (external trust)	0	0	0	0	0

Total Number of Incidents – SCBU – Quarter 4

January 26	February 26	March 26
5	4	10

Incidents by Category

Admissions, access, appointments, transfer, discharge	10
Clinical Assessment (inc scans, tests, assessment, treatment.	4
Medication Incidents	2
Documentation	1
Falls*	1
Medical devices/equipment	1

Moderate Incident

One incident resulted in moderate physical harm. In Q4 a baby drop was reported, a fracture was identified.

3.4.1 Triangulation

A review the data from the Claims Scorecard, alongside the Complaints / Incidents PMRT is undertaken to determine themes and identify relevant learning and subsequent actions.

Below is the recommended national template which is reported quarterly. This covers Q4 (January-March 2026).

Claims Scorecard Q4 2026		Maternity Incentive Scheme - SA9 Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting																								
Top injuries by volume: <ul style="list-style-type: none"> Fatality (4) Stillborn (4) Unnecessary Pain (4) Psychiatric/Psychological Dmge (3) Loss of baby (3) 	Top injuries by value: <ul style="list-style-type: none"> Brain damage (2) Cerebral Palsy (2) Wrongful Birth (1) Psychiatric/Psychological Dmge (3) Stillborn (4) Fatality (4) 																									
Top causes by volume: <ul style="list-style-type: none"> Fail/delay in treatment (9) Inadequate Nursing Care (2) Fail/delay in Diagnosis (2) Fail to Recog. Complication (2) Inapprop. Use Forceps/Ventouse (1) 	Top causes by value: <ul style="list-style-type: none"> Fail/delay in Treatment (6) Fail to warn/informed consent (4) Fail to Recog. Complication (4) Fail/delay in Diagnosis (5) Inadequate Nursing Care (2) Fail to Monitor 1st Stage Labour (1) 																									
Complaints Q4 2026 (N=1) Communication (1) Clinical Treatment (1) Pain management (1) Attitude of staff (1)		Learning Q4 2026 Diabetes management Preterm management Documentation PPH learning Cross boundary working																								
Incidents/PMRT Q4 2026 Cross boundary patients Preterm		Action Plan Q4 2026 <table border="1"> <thead> <tr> <th></th> <th>Not started</th> <th>In progress</th> <th>Completed</th> </tr> </thead> <tbody> <tr> <td>Preterm birth action plan delivery</td> <td></td> <td></td> <td>By (SM/MK/CQ)</td> </tr> <tr> <td>Maternal haemorrhage action plan delivery</td> <td></td> <td></td> <td>Completed</td> </tr> <tr> <td>Foundation Group working party for Care outside of guidance birth planning</td> <td></td> <td></td> <td>By 31/03/26 (SM)</td> </tr> <tr> <td>Culture and Civility</td> <td></td> <td></td> <td>Launched last month (Shu/HK)</td> </tr> <tr> <td>Home birth Suspension</td> <td></td> <td></td> <td>(AM/SJ)</td> </tr> </tbody> </table>		Not started	In progress	Completed	Preterm birth action plan delivery			By (SM/MK/CQ)	Maternal haemorrhage action plan delivery			Completed	Foundation Group working party for Care outside of guidance birth planning			By 31/03/26 (SM)	Culture and Civility			Launched last month (Shu/HK)	Home birth Suspension			(AM/SJ)
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Home birth Suspension			(AM/SJ)																							
Themes Q4 2026 <ul style="list-style-type: none"> Failure to act on abnormal CTG/Monitor CTG Maternal readmissions of hypertension/preeclampsia Diabetes Management Preterm labour 																										

4. WORKFORCE

4.1 Safe Staffing – Midwifery & Neonatal Nursing

To provide assurance a monthly submission to Board outlining how safe staffing in maternity and neonatal nursing is monitored.

4.2 Obstetric workforce

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

JANUARY '26	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	210	/ 210	100.00	0	/ 210	0.00	0	/ 210	0.00
Consultant: On Call	490	/ 502.5	97.51	12.5	/ 502.5	2.49	0	/ 502.5	0.00
Consultant: Cold Week	104	/ 104	100.00	0	/ 104	0.00	0	/ 104	0.00
Consultant: Antenatal Clinic	59.5	/ 68	87.50	0	/ 68	0.00	8.5	/ 68	12.50
Middle Grade: delivery suite	189	/ 189	100.00	0	/ 189	0.00	0	/ 189	0.00
Middle Grade: Antenatal Clinic	72.25	/ 140.25	51.52	68	/ 140.25	48.48	0	/ 140.25	0.00

FEBRUARY '26	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	120	/ 200.00	60.00	20	/ 200	10.00	60	/ 200	30.00
Consultant: On Call	404.5	/ 442.00	91.52	0	/ 442	0.00	37.5	/ 442	8.48
Consultant: Cold Week	96	/ 96.00	100.00	0	/ 96	0.00	0	/ 96	0.00
Consultant: Antenatal Clinic	51	/ 59.50	85.71	0	/ 59.5	0.00	8.5	/ 59.5	14.29
Middle Grade: delivery suite	108	/ 180.00	60.00	72	/ 180	40.00	0	/ 180	0.00
Middle Grade: Antenatal Clinic	131.75	/ 157.25	83.78	25.5	/ 157.25	16.22	0	/ 157.25	0.00

MARCH '26	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	180	/ 230	78.26	30	/ 230	13.04	20	/ 230	8.70
Consultant: On Call	430.5	/ 491	87.68	60.5	/ 491	12.32	0	/ 491	0.00
Consultant: Cold Week	84	/ 104	80.77	20	/ 104	19.23	0	/ 104	0.00
Consultant: Antenatal Clinic	68	/ 102	66.67	0	/ 102	0.00	34	/ 102	33.33
Middle Grade: delivery suite	180	/ 198	90.91	18	/ 198	9.09	0	/ 198	0.00
Middle Grade: Antenatal Clinic	131.75	/ 144.5	91.18	12.75	/ 144.5	8.82	0	/ 144.5	0.00

Compensatory rest

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

4.3 Neonatal Medical Workforce

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

4.4 Anaesthetic workforce

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

January 2026

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	31	74%	31	90%
Anaesthetist extra days	8	26%	3	10%

February 2026

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	28	68%	28	78%
Anaesthetist extra days	9	32%	6	22%

March 2026

	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	31	87%	31	87%
Anaesthetist extra days	4	13%	4	13%

The directorate team advise that the increase in extra shifts is due to paternity leave and long-term sickness.

MDT ward rounds

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

January 2026

	08:30	20:30
Anaesthetist	97%	90%
Obstetric Consultant	100%	93%

February 2026

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

March 2026

	08:30	20:30
Anaesthetist	97%	87%
Obstetric Consultant	97%	84%

During March 2026, compliance with the 20:30 handover fell below 90% for Anaesthetist and Consultant attendance. No causal factors have been identified at this stage; however, this will be subject to ongoing monitoring. Staff have been asked to document instances where these professionals are not present to facilitate a formal audit process going forward.

4.5 Neonatal Workforce.

4.5.4 Quality nurse Roles and AHP Provision

There is no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7wte Practice Education Lead (B7) with 0.3wte Clinical working within role (=1.0wte) and 0.2wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2wte B7 funding has been used to support a B6 Developmental Care 7.5hrs per week until end of March 2026.

Non Direct Patient Care Roles are included in the Quarterly Neonatal Staffing Audit submission to the WMPN – Quarter 4 data submission below.

NON DIRECT PATIENT CARE - DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE					COMMENTS
Role Title	Band	WTE Budget	WTE in post	Head Count in post	e.g. no dedicated hours, data r
LEADERSHIP ROLES					
Consultant Nurse	0	0	0	0	
Senior/Lead Nurse	0	0	0	0	
Matron	8a	0	0	1	Paediatric Matron across paed
Ward Manager	7	1	0.8	1	
Recruitment & Retention Lead	0	0	0	0	
Other Senior role (please specify)	0	0	0	0	
Subtotal - Leadership roles		1	0.8	2	
QUALITY ROLES					
Governance Lead Nurse - Band 7	7	0.2	0.2	1	included in WM hrs
Practice Development / Education Lead - Band 7	7	1	0.7	1	0.3wte clinical
Clinical Educator	0	0	0	0	
Infant Feeding Lead	0	0	0	0	
Family Integrated Care Lead / equivalent	0	0	0	0	
Family Integrated care Nurse / equivalent	0	0	0	0	
Family Integrated Care Link Nurse	0	0	0	0	
Other Family Care (please specify)	0	0	0	0	
Bereavement Lead	0	0	0	0	
Palliative Care Lead	0	0	0	0	
Professional nurse advocate (PNA)	7	0	0	1	Both Matron & WMPNA
Other (please specify)	6	0.2	0.2	1	developmental care lead
Other (please specify)	0	0	0	0	
Other (please specify)	0	0	0	0	
Subtotal - Quality roles		1.4	1.1	4	
TOTAL NON DIRECT PATIENT CARE		2.4	1.9	6	

5 TRAINING COMPLIANCE

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

Improvement	PQSM		Progress in achievement of CNST /10	9	10	10
	PQSM	%	Training compliance in PROMPT: Midwives	90%	89%	87%
	PQSM	%	Training compliance in PROMPT: Obstetric Consultants	90%	90%	90%
	PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	90%	80%	80%
	PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%
	PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	73%	80%	80%
	PQSM	%	Training compliance PROMPT: Maternity Support Workers	93%	89%	89%
	PQSM	%	Annual NLS update compliance: Paediatric Consultants	90%	70%	80%
	PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	60%	40%	50%
	PQSM	%	Annual NLS update compliance: Paediatric Juniors	82%	63%	90%
	PQSM	%	Annual NLS update compliance: Midwives	98%	96%	96%
	PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	100%	95%
	PQSM	%	Fetal Wellbeing update day: Obstetrics	100%	100%	90%
	PQSM	%	Fetal Wellbeing update day: Midwives	97%	97%	89%
	PQSM	%	Midwifery update day (Core Competency): Midwives	96%	92%	86%
PQSM	%	Midwifery update day (Core Competency): Support Staff	86%	89%	89%	

5.1.3 Mandatory Training – Neonatal – Nursing Quarter 4.

Training	Expected Target	January 26	February 26	March 26
Mandatory (Core)	>90%	95.45%	92.5%	94.17%
Mandatory (Essential)	>90%	93.28%	90.90%	90.09%
Newborn Life Support (Annual Update)	100%	95%	100%	100%
Maternity Breastfeeding Update	>90%	90%	75.86%	81.82%

*There have been 3 new members of staff joined in February and March, who will complete their mandatory Breastfeeding Study Day in May 26.

6 CNST MIS Year 7

MIS Year 7 was published in April. The final declaration was submitted to NHS Resolution in March declaring full compliance with all safety actions. We await confirmation of external validation of the scheme.

The year 8 scheme is expected in April/May 2026 when a review of the standards and evidence required will be shared with the Committee.

END OF REPORT

APPENDIX 1 SCBU DASHBOARD

SCBU DASHBOARD 2025- 2026													
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Comments
Staffing: Vacancy Gaps, Attrition Rate, Sickness													
Band 7 Vacancy Gap (2.2wte)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
Band 6 Vacancy Gap (5.49wte)	0	0	0	0.5	0.5	1	1	1	1	0	0	0	
Band 5 Vacancy Gap (13.5)	2	3.1		4.47	4.47	1.02	2	0.87	1.75	2.39	1.64	1.7	
Band 4 Support Worker/RNDA (0.66) Vacancy Gap	0	0	0	0	0	0	0	0	0	0	0	0	
Band 2 Vacancy Gap (1.0wte)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
Neonatal Outreach Team B6 Vacancy Gap (1.3wte)	0	0	0	0	0	0	0	0	0	0	0	0	
Attrition Rate (WTE)	0	0	0.62	0	0	1	0	0	0	1.84	0	0	
Maternity Leave (WTE)	1	1	1	1	1	1	1	1	1	0	0	0	
Sickness (<3.5%)	1.09%	1.39%	4.12%	5.63%	4.88%	4.32%	2.42%	7.59%	8.78%	9.80%	7.59%	8.38%	
Safe Staffing													
% Shifts staffed to BAPM Standards	92%	84%	100%	100.00%	100.00%	98.18%	96.77%	96.61%	100%	100%	98.21%	100%	
QIS % (standard = 70% of registered workforce)	44.4%	44.4%	52.5%	57.60%	57.60%	41.36%	50%	44%	50.00%	48.00%	49%	46.44%	
% of shifts QIS to toolkit	98.31%	100%	100%	100.00%	100.00%	100%	96.77%	100.00%	100%	100%	100%	100%	
% Shifts with supernumerary shift co-ordinator	3.39%	3%	26.67%	5.17%	3.28%	10.91%	14.52%	18.64%	16.13%	6.45%	1.79%	9.68%	
% Shifts covered with Bank	1.1%	1.4%	5.7%	3.70%	7.00%	1.18%	3.38%	3.96%	1.95%	2.05%	6.15%	2.91%	
Appraisal Rate	85%	67%	94.74%	100%	88.89%	70%	77.0%	95.00%	90%	85.00%	94.74%	100%	
Mandatory Training Core	98.75%	97.50%	97.83%	96.67%	98.64%	98.18%	91.60%	90.87%	94.00%	95.45%	92.50%	94.17%	
Mandatory Training Essential	89.8%	92.14%	94.78%	94.26%	95.32%	93.56%	88.24%	92.07%	97.39%	93.28%	90.90%	90.09%	
Basic Life Support	43%		86.36%	90.00%	90%	95%	95%	91.30%	91%	95.24%	100.00%	91.30%	
Newborn Life Support >90%	96%	95%	95%	95.00%	94.4%	85%	100%	100%	100%	95.00%	100%	100%	
Maternity Breastfeeding update.	77.27%	77.27%	90.48%	94.74%	95%	75%	66.00%	90.91%	90.48%	90.00%	75.86%	81.82%	
Safeguarding Level 3	100%	100%	100%	100%	95%	95%	95%	95%	100%	100.00%	86.36%	100.00%	
Compliments/Concerns/Concerns													
Complaints/Concerns	0	0	0	0	0	0	0	0	0	0	0	0	
Infection Prevention													
Overall - Star rating.	4	5	5	5	5	5	5	5	5	5	5	5	
Ward Assurance Audit	82%	100%	88%	92%				97.00%	100%	100%	93.00%		
Hand Hygiene	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Bare Below the Elbow	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
MRSA Screening Compliance	73%	100%	100%	75%	100%	60%	100%	100%	TBC	TBC	TBC		
Incident and Exception Reporting													
Number of Incidents (Inphase)	5	4	2	12	6	9	5	2	5	5	4	10	
Medication Errors	0	1	0	1	1	1	0	0	0	0	1	0	
Staffing	0	0	0	1	1	1	2	1	2	0	1	0	
Service Escalation (OPEL RED/BLACK)	0	Red x 4	0	Red x 1	Red x 2	1 x amber, 1 x red	1 x Amber	0	0	1 x Amber	1 x Amber	1 x Amber	
WMPN Staffing Escalation Red/Black						2 x Red 1 x Black	2 x Red 2 x Black	4 x Red 2 x Black	1 red 2 black	2 x Red 3 x Black	2 x Red	2 Red 1 Black	
Exception reports - ex-utero outside of care pathway	0	0	0	0	2	0	0	1	0	0	0	0	
Exception reports - in utero transfers outside of pathway/network	1	1	1	2	1	1	1	1	0	0	0	0	

Audits													
Quarterly CD Audit		96%			100%			90%			95%		
IV Fluid Prescription - Target 90% Compliance	97%			97%				90%				94%	
Clinical Notes Audit - Correct Completion target 90%	57%												
Cannula Care Plan (Peripheral Cannula) Target 90%	89%			95%				89%				89%	
Gentamicin Clinical Audit	96%			100%				100%				96%	
NGT Misplacement NPSA Safety Alert 2016 Target 90%	86%			70%				81%				88%	
Pain Audit Tool Completed Correctly Target 80%	60%			77%				74%				76%	
IVAB administered within 1 hr of decision to give								74%				70%	
Growth parameters Audit	82%			76%				92%				88%	
Transitional Care and Term Admissions													
% Unexpected admissions of full-term babies to neonatal care (of all live term births) m(National Average 5% Best Practice <3%)	3.47%	1.49%	2.2%	4.58%	3.12%	4.50%	0.7%	1.73%	3.22%	TBC	TBC	TBC	
TC Bed occupancy rate on SCBU % including parent bedroom	40.0%	54.00%	40%	52.3%	65%	62%	55%	48%	57%	38%	TBC	TBC	
Total number of live births 34-36 weeks	4	10	4	5	6	3	4	1	4	3	TBC	TBC	
Number of babies born between 34-36 wks gestation and admitted to SCBU	3	7	4	3	6	3	2	1	3	3	TBC	TBC	
Number of TC Babies 34-36 wks gestation not admitted to SCBU remaining on PNW	1	3	0	2	0	0	2	0	1	0	TBC	TBC	
Neonatal Outreach Team													
Total Patients	11	19	20	10	13	13	13	15	15	14	8	12	
NewReferrals	4	12	8	4	11	7	7	5	6	3	5	7	
Existing Patients continuing care	7	7	12	6	2	6	6	10	9	11	3	5	
No. NGT Feeding in the community	8	5	3	4	8	1	5	7	5	5	4	5	
Receiving EBM on discharge from SCBU	5	10	13	7	10	10	9	8	10	9	5	10	
Receiving EBM on discharge from O/R	3	1	9	5	3	4	3	4	1	5	1	2	
Numbers Discharged from outreach	5	2	9	7	3	7	3	6	4	11	3	3	
Number of Incidents (Inphase)	0	0	0	0	0	0	1	0	0	0	0	1	
Home Phototherapy	1	1	1	0	0	0	0	0	0	0	0	0	
Prolonged Jaundice Screening Referrals	27	24	34	34	32	33	35	21	32	41	31	33	
Prolonged Jaundice Screening - Total Number of Referrals meeting criteria for Screening	21	22	32	30	28	33	27	15	27	27	24	29	
Prolonged Jaundice Screens - Outreach	18	22	20	25	26	27	22	13	19	27	17	17	
Prolonged Jaundice Screens - RAC	5	2	6	5	5	7	12	8	8	12	7	11	

APPENDIX 2 – PQSM DASHBOARD

Area	Dashbo	Framew	Indicator Description	Jan	Fel	Ma
Booking	LMNS	LMS	Total bookings	126	107	127
	LMNS	LMS	Women who were booked before 9+6 weeks	91	69	81
	LMNS	LMS	% Women who were booked before 9+6 weeks (target 90%)	72.2%	64.5%	63.8%
	LMNS	LMS	Women who were booked after 9 + 6 weeks	35	38	46
	LMNS	LMS	% Women who were booked after 9 + 6 weeks	27.8%	35.5%	36.2%
	LMNS	LMS	Women who were booked before 12 + 6 weeks	118	101	123
	LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	93.7%	94.4%	96.9%
	LMNS	LMS	Women who were booked after 12 + 6 weeks	8	6	4
	LMNS	LMS	% Women who were booked after 12 + 6 weeks	6.3%	5.6%	3.1%
	LMNS	LMS	Midwife led care at booking	32	18	16
LMNS	LMS	% Midwife led care at booking	25.4%	16.8%	12.6%	
Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	40	35	36
	LMNS	LMS	% Women with BMI of 30 and over at booking	31.7%	32.7%	28.3%
	LMNS	Better	% Antenatal Personalised Care Plan completed	100.0%	99.2%	99.2%
	LMNS	Better	% Intrapartum Personalised Care Plan completed	56.9%	65.5%	58.3%
	WVT		% Portal Access Consent	100.0%	100.0%	100.0%
	LMNS	LMS	% Portal Access - Women who registered and logged in	96.8%	87.9%	92.1%
	LMNS	Ockenden	% Contacts where place of birth suitability was recorded	75.3%	76.6%	70.8%
	LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	79.7%	72.5%	83.8%
	LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	86.7%	77.1%	89.2%
Smoking	LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	90.1%	91.8%	82.3%
	LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	95.3%	97.4%	95.9%
	WVT		Recorded Smoking Status at Booking - Yes	5	6	5
	WVT		Recorded Smoking Status at Booking - No	120	101	122
	WVT		Recorded Smoking Status at Booking - Unknown	1	0	0
	WVT		% of mothers with a recorded Smoking Status at Booking	99.2%	100.0%	100.0%
	LMNS	Saving	Women who were current smokers at booking	5	6	5
	LMNS	Saving	% Women who were current smokers at booking	4.0%	5.6%	3.9%
	LMNS	Saving	Smokers who were referred to smoking cessation services	5	6	5
Carbon Monoxide	LMNS	Saving	% Smokers who were referred to smoking cessation services	100.0%	100.0%	100.0%
	LMNS	Saving	Women who were screened for CO at booking	113	102	122
	LMNS	Saving	% Women who were screened for CO at booking (of total bookings)	89.7%	95.3%	96.1%

Area	Dashboard	Framework	Indicator Description	January	February	March
Deliveries	LMNS/PU SM	Contractual	Total births (deliveries)	146	108	129
Delivery Method	WVT		Home Births	2	0	0
	WVT		BBA's	1	3	1
	LMNS	Contractual	Vaginal births (deliveries)	53	46	57
	LMNS/PU CM	LMS	% Vaginal births (deliveries)	36.3%	42.6%	44.2%
	LMNS	LMS	Ventouse & forceps births (deliveries)	21	15	10
C-Section Deliveries	LMNS/PU CM	Contractual	% Ventouse & forceps births (deliveries)	14.4%	13.9%	7.8%
	LMNS/PU CM	LMS	RG*1 having a caesarean section with no previous births	5	3	3
	LMNS/PU CM	LMS	RG*1 Deliveries	16	19	16
	LMNS/PU CM	LMS	RG*1 % C-section deliveries	31.3%	15.8%	18.8%
	LMNS/PU CM	LMS	RG*2 having a caesarean section with no previous births	17	10	25
	LMNS/PU CM	LMS	RG*2 Deliveries	38	25	36
	LMNS/PU CM	LMS	RG*2 % C-section deliveries	44.7%	40.0%	69.4%
	LMNS/PU CM	LMS	RG*5 having a caesarean section with at least one previous birth	24	21	12
	LMNS/PU CM	LMS	RG*5 Deliveries	27	24	12
	LMNS/PU CM	LMS	RG*5 % C-section deliveries	88.9%	87.5%	100.0%
	WVT		Total Elective C-Sections	33	28	35
	WVT		Total Emergency C-Sections	37	18	27
	LMNS	LMS	Total Caesarean births (deliveries)	70	46	62
	LMNS	LMS	% Total Caesarean births (deliveries)	47.9%	42.6%	48.1%
	LMNS	LMS	% Grade 1 C-Sections within 30 minutes	25.0%	75.0%	44.4%
	LMNS	LMS	% Grade 2 C-Sections within 75 minutes	86.7%	88.9%	93.8%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	26	14
LMNS		LMS	% Midwife led (low risk care) births	17.8%	13.0%	22.0%
LMNS		LMS	Home births (deliveries) - midwife led only	1	0	0
LMNS		LMS	% Home births (deliveries)	0.7%	0.0%	0.0%
Births	LMNS	Contractual	Total number of babies born	147	108	133
	LMNS	Saving Babies	Babies born preterm (singletons born 36+6 or less)	12	7	12
	LMNS	Saving Babies	% Babies born preterm (singletons born 36+6 or less)	8.16%	6.48%	8.89%
	LMNS	LMS	Singleton babies born 26+6 or less	0	0	0
LMNS	LMS	% Singleton babies born 26+6 or less	0%	0.0%	0.00%	

LMNS	LMS	Babies (multiples) born 27+6 or less	0	0	0
LMNS	LMS	% Babies (multiples) born 27+6 or less	0%	0%	0%
LMNS	LMS	Stillbirths	0	0	0
WVT		No. of BAME stillbirths	0	0	0
LMNS	LMS	% Stillbirths	0.0%	0.0%	0.0%
LMNS	LMS	Stillbirths rate per 1,000	0.00	0.00	0.00
LMNS	National	Live births where breastfeeding initiated (first feed = breastmilk)	123	81	108
LMNS	National	% Live births where breastfeeding initiated (first feed = breastmilk)	84.8%	75.0%	82.4%
WVT		Women who were current smokers at booking (delivered mothers)	7	8	2
WVT		% Women who were current smokers at booking (delivered mothers)	4.8%	7.4%	1.5%
LMNS	Saving Babies	Women who were current smokers at birth (delivery) All	6	8	1
WVT		Women who were current smokers at birth (delivery) Hfds only	3	5	0
LMNS	Saving Babies	% Women who were current smokers at birth (delivery)	4.1%	7.4%	0.8%
LMNS	Saving Babies	% Women with CO measured at 36 weeks	100.0%	98.0%	98.3%
LMNS	Saving Babies	Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0
LMNS	Saving Babies	% (as a % of all singleton births)	0.00%	0.00%	0.00%
LMNS	Saving Babies	% Detection rate for FGR (below 3rd centile)	0%	0%	33%
LMNS	Better Births	Women who had a PPH of 1,500ml or more	4	3	5
LMNS	Better Births	% Women who had a PPH of 1,500ml or more	2.7%	2.8%	3.8%
LMNS	Better Births	Women who sustained a 3rd or 4th degree tear	1	0	1
LMNS	Better Births	% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.3%	0.0%	1.4%
LMNS	Better Births	Induction of labour	46	36	42
LMNS	Better Births	% Induction of labour rate (of all births)	31.5%	33.3%	32.6%
WVT		Routine Enquiry Domestic Violence - Asked	134	102	121
WVT		Routine Enquiry Domestic Violence - Unable to ask	11	6	10
WVT		Routine Enquiry Domestic Violence - Unknown	1	0	0
WVT		% Asked routine enquiry domestic violence	91.8%	94.4%	92.4%
WVT		Midwife to birth ratio	1:31	1:32	1:27

Reduced Fetal Movements	WVT		Number of women presenting to service with reduced fetal movements	233	195	205
	WVT		Number of women presenting with RFM who are recorded as having a CTG	229	195	204
	WVT		% of women presenting with RFM who received CTG	98.28%	100.00%	99.51%
Area	Dashboard	Type	Indicator Description	January	February	March
Admission s	LMNS	Integer	Total admissions to neonatal care	16	4	8
	LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	9	2	3
	LMNS	%	% Unexpected admissions of full-term babies to neonatal care	6.7%	2.0%	2.5%
SCBU admission temps	WVT	Born <34wks	Eligible Babies (<34 wks gestation)	3	0	1
	WVT		% taken within hour	66.7%	0.0%	100.0%
	WVT		Adm temp <36.5 degrees	0	0	0
	WVT	All babies	Eligible Babies	18	10	11
	WVT		% taken within hour	84.0%	100.0%	100.0%
	WVT		Adm temp <36.5 degrees	3	1	3
Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	2	1	2
	LMNS	Integer	Neonatal deaths	1	0	0
	WVT		No. of BAME NND's	0	0	0
	LMNS	%	% Neonatal deaths	0.7%	0.0%	0.0%
	LMNS	Integer	Neonatal mortality per 1,000 births	6.80	0.00	0.00
	LMNS	Integer	Neonatal transfers for therapeutic hypothermia	0	0	0
	LMNS	%	% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a
	LMNS	Integer	Neonatal brain injuries	0	0	0
	LMNS	%	% Neonatal brain injuries	n/a	n/a	n/a
	LMNS	Integer	Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	2	0	0
	LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	3	0	1
LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	66.7%	0.0%	0.0%	

LMNS	Integer	Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0
LMNS	Integer	Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0
LMNS	%	% mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a
Dashboard	Framework	Indicator Description	January	February	March
LMNS	Local	Obstetrics admissions to ITU	0	0	0
LMNS	LMS	Maternal deaths	0	0	0
WVT		BAME Maternal Deaths	0	0	0
LMNS	Better Births	% Postnatal Personalised Care Plan completed	100.0%	96.0%	98.6%
LMNS	LMS	Postnatal readmissions within 28 days (mothers)	15	9	10
LMNS	LMS	Postnatal readmissions within 28 days (babies)	3	6	8
WVT		Number of times Maternity Services Suspended per month 0	0	0	0
WVT		Number of hrs Maternity Services suspended	0	0	0
WVT		Number of times Home Birth services suspended per month	0	17	14
WVT		Number of hrs Home Birth services suspended	0	408	336
WVT		Number of times SCBU suspended per month	0	0	0
WVT		Number of hrs SCBU suspended per month	0	0	0
PQSM	Integer	reported (total)	0	0	1
PQSM	Integer	New MNSI SI referrals accepted	0	0	1
PQSM	Integer	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	1	0	0
PQSM	Integer	Coroner Reg 28 made directly to Trust	0	0	0
PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	68	97.5	30.75
PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	12.5	126	164.5
PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	18%	27%	13%
PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment)	0.06wte	1.62wte	1.43wte

PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	95.00%	98.00%	91.00%
PQSM		Service User feedback: Number of Compliments (formal)	0	1	0
PQSM		Service User feedback: Number of Complaints (formal)	1	0	0
PQSM		Staff feedback from frontline champions and walk-about (number of	0	0	0
PQSM		Progress in achievement of CNST #10	9	10	10
PQSM	%	Training compliance in PROMPT: Midwives	90%	89%	87%
PQSM	%	Training compliance in PROMPT: Obstetric Consultants	90%	90%	90%
PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	90%	80%	80%
PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	100%	100%	100%
PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	73%	80%	80%
PQSM	%	Training compliance PROMPT: Maternity Support Workers	93%	89%	89%
PQSM	%	Annual NLS update compliance: Paediatric Consultants	90%	70%	80%
PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	60%	40%	50%
PQSM	%	Annual NLS update compliance: Paediatric Juniors	82%	63%	90%
PQSM	%	Annual NLS update compliance: Midwives	98%	96%	96%
PQSM	%	Annual NLS update compliance: Neonatal Nurses	95%	100%	95%
PQSM	%	Fetal Wellbeing update day: Obstetrics	100%	100%	90%
PQSM	%	Fetal Wellbeing update day: Midwives	97%	97%	89%
PQSM	%	Midwifery update day (Core Competency): Midwives	96%	92%	87%
PQSM	%	Midwifery update day (Core Competency): Support Staff	86%	89%	89%

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Public Board
Date of Meeting:	4th June 2026
Title of Report:	Midwifery and Neonatal Nurse Staffing Report (March 2026)
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery, Director of Midwifery
Reporting Route:	Surgical Divisional Governance Quality Committee
Enclosures included with this report:	
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> 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	
Board is asked to note how midwifery and neonatal nurse staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of staffing.	
Executive Director Opinion¹	
The report offers assurance that there are robust processes in place to monitor midwifery and neonatal nurse 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 workforce KPIs are as follows:

Metrics	Target	Midwives	MSW/ MCA	Neonatal Nurse
Sickness Rate	4%	5.27%	3.62%	7.59%
Turnover	11.5%	n/a	n/a	n/a
Vacancy Rate	7%	0.07%	1.74%	
Maternity Leave	-	8.2WTE	0.61WTE	0
Midwife to Birth Ratio	1:24	1:27		
1:1 care in labour	100%	Achieved		
SN status of Delivery Suite Shift leader	100%	Achieved		

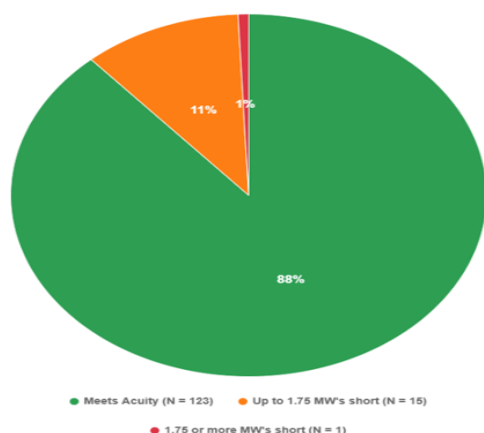
Issues and options

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 88% 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 February following mitigation.

Acuity Summary
01/02/2026 to 28/02/2026



The mitigations taken are presented in the diagram below and demonstrate the frequency (n=22) of when staff are reallocated from other areas of the inpatient service. The community teams were deployed to support the inpatient area on five occasions. There was one report of staff not taking breaks and additional support provided by specialist midwives to maintain safe staffing levels. This is a decrease in the amount of staff deployment required to maintain safety across the inpatient area.

Number of Management Actions

01/02/2026 to 28/02/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	22	59%
MA2	Redeploy from community	5	14%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	3%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	3	8%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	1	3%
MA10	Escalate to manager on call	5	14%
MA11	Maternity Unit on Divert	0	0%
TOTAL		37	

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 was one report of the Shift leader not being supernumerary during the shift however was initially rostered to be supernumerary

Number of Red Flags recorded

01/02/2026 to 28/02/2026

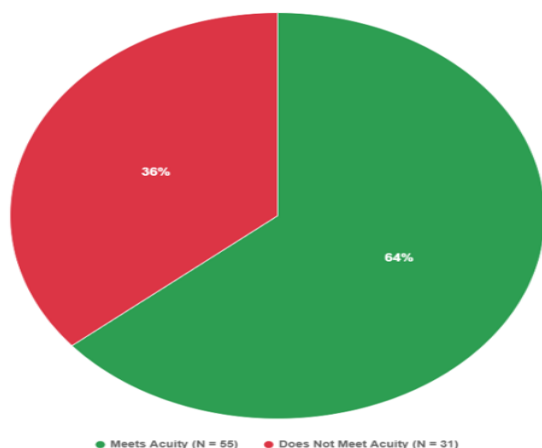
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage over 30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process more than 1hr	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite co-ordinator not supernumerary	1	6%
RF11	Suspension Home Birth Service	17	94%
TOTAL		18	

Antenatal/Postnatal Ward

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

Acuity Summary

1/02/2026 to 28/02/2026



The acuity was met in 64% of the time - this is an increase from the previous month.

Staffing incidents

There were no staffing incidents via Inphase.

There was one medication incident relating to the inappropriate discontinuation of a VRII during the caesarean section pathway – no harm identified.

Monitoring the midwife to birth ratio

The ratio in March was 1:27. The midwife to birth ratio was not compliant with the recommended ratio from the Birth Rate Plus Audit, 2024 (1:24) – this is likely to be driven by the high rate of sickness and onboarding of supernumerary staff in March.

Maternity SitRep

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.

We are now submitting daily information to the new national maternity sitrep.

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	70%	96%	96%	68%
Community Midwifery	n/a	n/a	n/a	n/a
SCBU	102%	100%		

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 – no additional huddles were held in February.

Vacancy

There are minimal unfilled midwifery hours. A review of support staff requirements is in progress and vacancies will be advertised when the review is complete.

Sickness

Sickness absence rates for midwives and neonatal nurses are reported above the Trust target however rates are improving and midwifery sickness is projected to be at target by end May.

Turnover

The turnover rate is not currently available for midwives and support workers however for Obstetrics it is 9.7% (Feb data) and is below the Trust target.

Workforce – Neonatal

The following nurse patient ratios are expected to ensure compliance with 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 February 2026

Band	Budgeted WTE	Contracted WTE	Maternity Leave wte	Long Term Sickness wte	Gap +/-
Band 7	2.2	2.0	0	0	-0.2
Band 6	5.49	5.48	0	0	0
Band 5	13.57	11.93	0	1.62	-1.64
Neonatal Outreach	1.38	1.38	0	0	0

Nurse Staffing (report lifted from BadgerNet) – February 2026

	WVT Jan 26	Nat Av
% of shifts staffed to BAPM recommendations	98.21%	87.74%
% of shifts QIS against Neonatal Toolkit standards	100%	94.95%
% of shifts with supernumerary shift lead	1.79%	22.53%
% of Nursing shifts covered by bank	6.15%	6.37%

- We were 98.21% compliant for percentage of shifts staffed to BAPM recommendations and 100% compliant with percentage of shifts staffed with QIS against neonatal toolkit standards – this is measured against the acuity and capacity data recorded on Neonatal Badger Net.
- We continue to use bank staff to provide two qualified in speciality nurses on duty across all shifts with emphasis on weekend and night cover. Where there are not 2 x Qualified in Speciality on the day shifts Monday – Friday additional QIS cover is provided by the senior staff in the office, to minimise bank and agency usage. This has been agreed as an acceptable mitigation by the WMPN.

Supernumerary Shift Co-ordinator

In addition to the calculated number of nurses required to meet the neonatal nurse staffing levels for direct patient care, there should also be a supernumerary shift co-ordinator rostered for each shift. The day-to-day management of nursing care provision should be undertaken by a senior neonatal nurse (Band 6) with no clinical commitment during the shift (often referred to as shift coordinator) This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time (BAPM 2022).

Our current budgeted establishment does not allow for a supernumerary shift co-ordinator on all shifts and the status may change throughout the shift according to capacity and acuity.

This risk is reported on the Trust risk register with mitigations and controls in place

Daily Sit Rep Reporting

OPEL Reports – February 2026

Daily Sit rep completed 7 days a week, report shared by Network Monday – Friday. Below compliance summary is based on Monday – Friday for February 2026. (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)
Capacity	90%	8%	0	0
Staffing	90%	0	10%	10%

OPEL Report Summary – Mitigations - February 2026.

Capacity

We were closed to external admissions on one day, due to high capacity and acuity on unit, and staffing would not meet BAPM standards.

On 3 other days we were OPEL 1 but declaring open to external admissions with discussion this was due to high capacity on unit.

Staffing

There were 2 shifts where staffing was OPEL 3, this was because second QIS cover was provided by the senior staff in the office. There were 2 shifts where staffing was OPEL 4, with only one QIS on shift, and no senior nurse cover in office, on both occasions this was due to staff sickness within QIS members of staff. The one shift was during the day, and the senior nurse was already on clinical duties, there was 1 x Band 7 QIS, one Band 5 (Currently completing QIS nurse training), 1 additional Band 5 staff nurse and a Band 4 HCA on duty. The second was a Night duty which was reported as only 1 x QIS available when daily report was submitted but additional bank cover was found for the night duty during the day. Patient safety was not compromised at any time.

Qualified in Speciality Staffing Report

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 March 26

October	November	December	January	February	March	April	May	June	July	August	September
50.00%	44.00%	50.00%	50.00%	49.00%	46.44%	46.44%	46.44%	52.40%	52.40%	56.20%	56.20%

- There are currently 2 x Nurses completing the QIS course, one completing end of May 26 and one completing end of July 26. The above trajectory takes these two nurses into consideration.
- There is an ongoing education plan – with another four nurses identified as ready to commence their training between September 26 and December 26 – and this has been reflected in our 2026/2027 education funding plan.

4.6.4 Sickness and Maternity Leave SCBU – January – February 2026.

	January 2026	February 2026
Sickness	9.8%	7.59%
Maternity Leave	0	0

- Sickness remains above the Trust target of 4% and is predominantly long term sickness with 1.62wte Band 5 on long term sickness. These staff members are being managed according to the Trust sickness and absence policy with HR and Occupational health support.
- 4 Staff Members with short-term sickness episodes have triggered stage 1 review meetings. These have all been completed.

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 February. The escalation policy was utilised on 22 occasions in the inpatient area. The community midwives were required to support the inpatient team on 5 occasions and specialist midwives were deployed to maintain safety.

There was one report of staff not being able to take a break and 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. No delays in care were reported.

Achieving the require compliance with QIS trained nurses remains challenging but achieved in month – it is not possible to maintain the supernumerary status of the shift leader in SCBU.

Sickness absence rates for midwives and neonatal nurses remains above the Trust target but are reducing slowly.

The vacancy rate for midwives is low and after successful recruitment will fall to 0%. Work in the support staff group is ongoing.

Appendices

None

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Public Board
Date of Meeting:	4th June 2026
Title of Report:	Midwifery and Neonatal Nurse Safe Staffing Report April 2026
Lead Executive Director:	Chief Nursing Officer
Author:	Elaine Evans – Neonatal Unit Sister Annette Arnold – Inpatient Matron Justine Jeffery – Director of Midwifery
Reporting Route:	Surgical Divisional Governance Quality Committee
Enclosures included with this report:	
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
The purpose of this report is to provide assurance that midwifery staffing is monitored and to note actions taken to mitigate any shortfalls.	
Recommended Actions required by Board or Committee	
The Board is asked to note how safe midwifery and neonatal nurse staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of staffing.	
Executive Director Opinion¹	
The report offers assurance to the Board that there are robust processes in place to monitor midwifery and neonatal nurse staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur.	

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- Sickness absence, vacancy and turnover rates
- Recruitment & retention rates
- 3 yearly Birthrate Plus audit
- Monthly report to Board

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 KPI's are:

Metrics	Target	Midwives	MSW/ MCA	Neonatal Nurse
Sickness Rate	4%	5.36%	3.12%	9.43%
Turnover	11.5%	n/a	n/a	n/a
Vacancy Rate	7%	6.2%	4.32%	19.8%
Maternity Leave	-	8.2WTE	0.61WTE	0
Midwife to Birth Ratio	1:24	1:27		
1:1 care in labour	100%	Achieved		
SN status of Delivery Suite Shift leader	100%	Achieved		

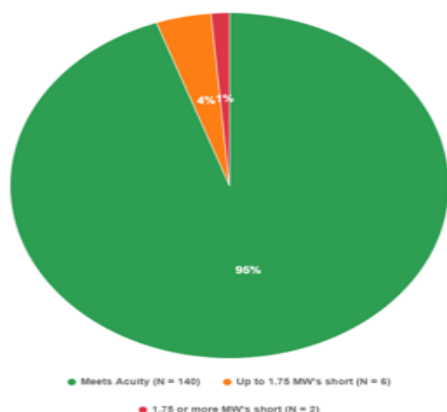
Issues and options

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 95% of the time and recorded at 5% when the acuity was not met prior to any actions taken. Safe staffing levels were maintained on all shifts in April following mitigation.

Acuity Summary
01/04/2026 to 30/04/2026



The mitigations taken are presented in the diagram below and demonstrate the frequency (n=15) of when staff are reallocated from other areas of the inpatient service. On 15 occasions staff were required to be redeployed internally to maintain a safe skill mix. Other management actions taken to maintain a safe service was on 3 occasions the manager/matron was required to work clinically and on 1 occasion the situation was escalated to the manager on call. In April there were no occasions where staff from community were required to be redeployed.

Number of Management Actions
01/04/2026 to 30/04/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	15	79%
MA2	Redeploy from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	3	16%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	1	5%
MA11	Maternity Unit on Divert	0	0%
TOTAL		19	

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. On 2 occasions there was over a one hours delay between admission and the beginning of the induction process this was due to acuity. The home birth service remains suspended.

Number of Red Flags recorded

01/04/2026 to 30/04/2026

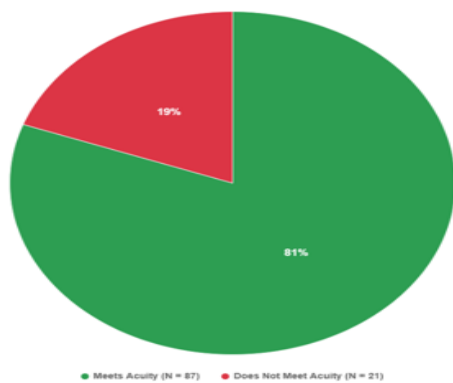
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, 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	2	20%
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	8	80%
TOTAL		10	

Antenatal/Postnatal Ward

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

Acuity Summary

01/04/2026 to 30/04/2026



The acuity was met in 81% of the time in April - this is a huge increase from 48% of the time in March.

Staffing incidents

In April 2026, two medication errors were reported through Ideagen Healthcare Guardian. Neither incident resulted in physical harm to the patients involved. One incident concerned a patient being discharged without their TTO medication, while the second involved a patient receiving Enoxaparin in error. Both incidents were investigated by the inpatient manager. Staff reflections were completed, key

learning points were identified, and the findings were shared with the multidisciplinary team to support ongoing learning and improvement.

There were no reported staffing incidents for April.

Monitoring the midwife to birth ratio

The ratio in April was 1:27. The midwife to birth ratio was not compliant with the recommended ratio from the Birth Rate Plus Audit, 2024 (1:24).

Maternity SitRep

The local maternity SitRep pilot began in October 2025 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.

We are now submitting daily information to the new national maternity sitrep.

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	97%	92%	88%	88%
Community Midwifery	n/a	n/a	n/a	n/a
SCBU	106%	101%		

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the midwife in charge, the consultant obstetrician 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 is current vacancy for band 5/6 midwives of 2.35wte (6.2%). This vacancy has been authorised on TRAC and will be advertised shortly.

Sickness

Sickness rates remained above the Trust target for midwives and neonatal nurses. A reduction in LTS will be noted in next month's midwifery sickness report.

Turnover

The turnover rate is not currently available for midwives and support workers as this information is currently reported for ‘obstetrics’ and remains below the Trust target.

Workforce – Neonatal

The Toolkit for High Quality Neonatal Services, the NCCR, getting it Right First Time (GIRFT) (2022) reports and other documents produced within the devolved nations describe the anticipated pattern of medical, nursing and allied health professional staff cover in different types of NNU. These recommendations have been further developed within the BPAM Service and Quality Standards for Provision of Neonatal Care in the UK (2022), The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care.

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 following nurse patient ratios are expected to ensure compliance with BAPM standards.

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

Safe Staffing Standards – are monitored through:

- Daily completion of safe staffing report on Badger Net (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 following nurse patient ratios are expected to ensure compliance with 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 April 2026

Band	Budgeted WTE	Contracted WTE	Maternity Leave wte	Long Term Sickness wte	Gap +/-
Band 7	2.2	2.0	0	0	-0.2
Band 6	5.49	5.67	0	0	+ .27
Band 5	13.57	11.87	0	1.62	-1.7
Neonatal Outreach	1.38	1.38	0	0	0

Nurse Staffing (report lifted from BadgerNet) – April 2026

	WVT April 26	Nat Av
% of shifts staffed to BAPM recommendations	100%	90.82%
% of shifts QIS against Neonatal Toolkit standards	100%	95.55%
% of shifts with supernumerary shift lead	16.39%	24.71%
% of Nursing shifts covered by bank	4.33%	5.27%

- We were 100% compliant for percentage of shifts staffed to BAPM recommendations and 100% percentage of shifts staffed with QIS against neonatal toolkit standards – this is measured against the acuity and capacity data recorded on Neonatal Badger Net.
- We continue to use bank staff to provide two qualified in speciality nurses on duty across all shifts with emphasis on weekend and night cover. Where there are not 2 x Qualified in Speciality on the day shifts Monday – Friday additional QIS cover is provided by the senior staff in the office, to minimise bank and agency usage. This has been agreed as an acceptable mitigation by the WMPN

Supernumerary Shift Co-ordinator

In addition to the calculated number of nurses required to meet the neonatal nurse staffing levels for direct patient care, there should be a shift co-ordinator for all shifts. The day to day management of nursing care provision should be undertaken by a Senior Neonatal Nurse (Band 6) with no clinical commitment during the shift (often referred to as shift coordinator) This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time (BAPM 2022).

Our current budgeted establishment does not include uplift for a supernumerary shift co-ordinator on all shifts. This has been recognised as an acceptable risk by The Trust based on our overall acuity and capacity. We assess whether we can achieve a supernumerary shift co-ordinator based on our daily acuity and capacity which is reported daily. However, if acuity or capacity changes during the shift then the supernumerary shift co-ordinator would be expected to step into the clinical numbers.

A risk assessment has been drafted and is waiting speciality review and approval to support this mitigation.

Daily Sit Rep Reporting

OPEL Reports – April 2026

Daily Sit rep completed 7 days a week, report shared by Network Monday – Friday. Below compliance summary is based on Monday – Friday for March 2026. (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)
Capacity	100%	0	0	
Staffing	96.6%	0	3.4% (once)	

OPEL Report Summary – Mitigations - April 2026.

Capacity.

We remained open to both internal and external admissions throughout April 2026.

Staffing

There was one shift where staffing was OPEL 3, this was because we were unable to achieve two QIS nurses in the clinical numbers, therefore second QIS cover was provided by the senior staff in the office

Qualified in Speciality Staffing Report

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 speciality (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 April 26 – September 26 (updated May 26)

Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
47%	47%	53%	56%	56%	53%

- We have one nurse who has just successfully completed the Neonatal and High Dependency speciality course and a second one will complete the course at the end of June 2026. The above trajectory takes these two nurses into consideration.
- There is an ongoing education plan – with another four nurses identified as ready to commence their training between September 26 and December 26 – and this has been reflected in our 2026/2027 education funding plan/request.

4.6.4 Sickness and Maternity Leave SCBU – March-April 2026.

	March 26	April 2026
Sickness	8.38%	9.43%
Maternity Leave	0	0

- Overall sickness increased in April 23 this was due to a small increase in short-term sickness with no concerning patterns – mainly gastro and respiratory viruses.
- Sickness remains above the Trust target of 4% with two staff members remaining on Long Term Sickness. Both are being managed according to the Trust sickness and absence policy with HR and Occupational health support, with one likely to return during April on a phased return to work

Conclusion
<p>To maintain midwifery safe staffing levels internal staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts in April. The escalation policy was utilised on 1 occasion in the inpatient area. The community midwives were not required to support the inpatient team during April other than on call requirements.</p> <p>There were two IOL delays to maintain patient safety due to acuity.</p> <p>Achieving the require compliance with QIS trained nurses remains challenging but achieved in month – challenges continue to maintain the supernumerary status of the shift leader in SCBU.</p> <p>Sickness absence rates for midwives and neonatal nurses remains above the Trust target – slight further increase in nurses and maintained in midwives</p> <p>All midwifery vacancies will be advertised imminently. This includes the additional 0.74 wte for the EL LCS project. Neonatal nurse recruitment underway.</p>
Appendices
None

Escalation and Assurance Report

Report from: Integrated Care Oversight and Assurance Committee
 Date of meeting: 21 April 2026
 Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	Better Care Fund (BCF) Finance Report
Rating rationale	<p>There was a forecast overspend of £1.168m (after mitigation) for 2026/26, a deterioration of £0.098m since month 9. The Trust was responsible for 50% of this. The key driver was D2A services, as previously reported, where there was an overspend due to increased length of stay and a sustained increase in expenditure on spot purchased care.</p> <p>An urgent recovery plan was in place with strengthened oversight arrangements.</p> <p>The report format would be reviewed to ensure it provided the specific information needed by the Committee.</p>
Outcome	<p>Action:</p> <ul style="list-style-type: none"> • Provide more detail on mitigations in future reports. • Add risk appetite to the agenda of the next Partnership Board meeting.
Item/Topic	Better Care Fund Performance Report
Summary	<p>Monthly local reporting remained unavailable due to system access issues; a resolution was being developed with partners. National data was available up to November 2025, which demonstrated stability or modest/seasonal variation across all performance indicators.</p> <p>Changes planned to strengthen BCF delivery in 2026/27 included the revised D2A model and development of a 24/7 single point of access for UEC.</p> <p>New metrics had been agreed for 2026/27 to strengthen oversight.</p> <p>All providers would be required to undertake a service review.</p> <p>There would be a particular focus on developing a more in-depth suite of data and information to enable future service prioritisation.</p> <p>Future reports would include a detailed dashboard.</p>
Outcome	<p>Action:</p> <ul style="list-style-type: none"> • Add benchmarking data to the report, including model hospital. • Where possible, break down the performance data to Welsh/English patients to strengthen understanding of how variation could be mitigated or addressed.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	One Herefordshire Health and Care Partnership Board Assurance Report
Rating rationale	<p>The report provided positive assurance on governance and partnership development and implementation of the Neighbourhood Health programme.</p> <p>The following areas were highlighted as high risks:</p> <ul style="list-style-type: none"> • BCF financial position • Intermediate care capacity in LICU due to reduced medical cover, resulting in the need to close 7 beds and a potential financial impact of £1m. A task and finish group had been set up to implement urgent actions. • System performance and flow pressures. <p>There were also emerging risks relating to the Trust's role as host provider, including delivery responsibility in the absence of full control. There were plans in place to increase transparency of the Trust's pressures with other members of the Partnership.</p>
Outcome	<p>Action: Consider additional ways to increase transparency of the internal pressures at WVT with other members of the Partnership to improve visibility and understanding of the Trust's risk as host provider.</p>

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: Integrated Care Oversight and Assurance Committee

Date of meeting: 21 April 2026

Report to: Trust Board

Item/Topic	D2A Performance Report/Strategic Plan update
Summary	<p>Pathway allocation performance continued to improve and data showed that when pathway decisions were made early and consistently service users had a smoother experience with fewer delays. There was a focus on reducing variation between providers, with strengthened clinical oversight.</p> <p>Operational flow continued to be challenged by extended lengths of stay.</p> <p>The pathway 1A tender had commenced.</p> <p>There was a shift towards outcomes-based commissioning.</p> <p>The Bromyard pilot had achieved a shorter length of stay.</p>
Outcome	The report was accepted.

Assure: Including assurance items rated green

None

To Note: Items received for information or approval

Item/Topic	One Herefordshire Health and Care Partnership Alliance Agreement
Summary	<p>The agreement established a formal framework for collaboration between health and care organisations in Herefordshire, setting out how partners would work together to improve population health and wellbeing outcomes, reduce inequalities, enhance quality of care and ensure long-term financial stability.</p> <p>The Agreement had been reviewed by the Partnership Board and each partner was seeking approval from their respective Boards.</p> <p>The WVT Board members on the Committee confirmed support for the Agreement.</p>
Outcome	<p>The Committee endorsed the Alliance Agreement for Trust Board approval.</p> <p>Action: Present the Alliance Agreement to the Trust Board for approval in June.</p>

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 REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	4 th June 2026
Title of Report:	One Herefordshire Health and Care Partnership Alliance Agreement
Lead Executive Director:	Sarah Shingler, Managing Director
Author:	Sarah Shingler, Managing Director
Reporting Route:	One Herefordshire Health and Care Partnership Board and Integrated Care Oversight and Assurance Committee
Enclosures included with this report:	N/A
Purpose of report:	<input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
<p>The One Herefordshire Health and Care Partnership Alliance Agreement establishes a formal framework for collaboration between statutory and non-statutory health and care organisations across Herefordshire. It sets out how partners will work together to improve population health and wellbeing outcomes, reduce inequalities, enhance quality of care, and ensure long-term financial sustainability.</p> <p>The Agreement is endorsed for approval by the Integrated Care Oversight and Assurance Committee.</p>	
Main Report	
<p>Purpose and Vision</p> <p>The Alliance supports the development of integrated, community-based models of care aligned to national policy and the local Health and Wellbeing Strategy. It promotes a “left shift” toward prevention, early intervention, and neighbourhood-based services, with a strong emphasis on tackling wider determinants of health such as housing, employment, and transport.</p> <p>Strategic Alignment</p> <p>The Agreement is clearly aligned to national policy direction under the Health and Care Act 2022 and to the ambitions of the local Health and Wellbeing Strategy and Integrated Care System. It appropriately emphasises prevention, neighbourhood health models, population health management, and the wider determinants of health. The focus on a “Best for Herefordshire” principle is particularly important in a system with finite resources and increasing demand pressures.</p> <p>Governance and Accountability</p> <p>The governance architecture is comprehensive and proportionate for the current level of integration. The Host Provider model, with Wye Valley NHS Trust as host, provides clarity of accountability while preserving the sovereignty of each partner organisation.</p> <p>The establishment of:</p>	

- The One Herefordshire Health and Care Partnership Board for strategic direction and transformation oversight
- The Integrated Care Oversight and Assurance Committee for quality and assurance
- A defined risk management framework
- creates an appropriate balance between collaboration and statutory compliance.

However, successful implementation will depend on:

- Clear schemes of delegation within each organisation
- Timely decision-making authority at Board level
- Transparent reporting and escalation processes
- Consistent attendance and executive-level engagement

Risk and Financial Sustainability

The Agreement recognises the need to operate within a defined financial envelope and manage risk collectively where partnership mitigation adds value. This is essential given system-wide financial constraints.

The shared Risk Management Framework is pragmatic and appropriately aligned to the Host's policy. That said, cultural maturity around risk-sharing will be critical. Partners must be prepared to move beyond observational collaboration toward genuine shared ownership of transformation risks.

Workforce and Culture

The emphasis on culture, workforce retention, and integrated neighbourhood teams is a significant strength. Delivery of integrated care depends not only on structures but on behaviours and trust.

The behavioural commitments outlined in the Agreement are well articulated; however, they must be actively reinforced through leadership modelling, joint development sessions, and consistent communication.

Data Sharing and Information Governance

The data sharing principles are robust and compliant with DPA18 and UK GDPR requirements. Implementation will require operational clarity through transaction-specific Data Sharing Agreements and strong information governance oversight.

Maturity and Future Development

Importantly, the Agreement acknowledges that if deeper delegation, funding flow changes, or significant service integration occur, a more formal Joint Venture arrangement may be required. This demonstrates strategic foresight.

The Alliance Agreement is appropriate for the current stage of partnership maturity. It enables progress without prematurely creating legal or financial exposure.

The Agreement provides a structured yet flexible mechanism for partners to collaborate in good faith, while recognising that each organisation remains sovereign and retains its statutory and regulatory responsibilities.

Conclusion

This Alliance Agreement provides the governance and behavioural foundation for a maturing, place-based integrated care partnership in Herefordshire.

Recommended Actions required by Board or Committee

Board members are invited to:

1. Confirm that WVT Scheme of Delegation enables timely decisions at Partnership Board level;
2. Define financial and operational thresholds requiring escalation to individual Boards.
3. Approve the Alliance Agreement

Executive Director Opinion¹

This Alliance Agreement offers a credible and proportionate framework to support the next phase of integrated health and care delivery in Herefordshire. It enables partners to work collaboratively within existing statutory frameworks, supports transformation toward neighbourhood health models, and strengthens collective accountability for improving outcomes and reducing inequalities across the system.

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.



One team One system

ne Herefordshire

ALLIANCE AGREEMENT

ONE HEREFORDSHIRE HEALTH AND CARE PARTNERSHIP

February 2026



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ONE HEREFORDSHIRE HEALTH AND CARE PARTNERSHIP ALLIANCE AGREEMENT made on the day of 2026 BETWEEN the parties listed in item 2..

1. INTRODUCTION

- 1.1. The One Herefordshire Health and Care Partnership is developing new integrated ways of working to improve the health and wellbeing outcomes of our population, increase the quality of care provided and provide long term financial sustainability for the system.
- 1.2. This agreement is an integral part of the vision to promote integrated services that deliver personalised care, and it is anticipated that this agreement will facilitate the objectives of One Herefordshire as more fully described in this agreement.
- 1.3. All Partners agree that at the point of significant delegation, reworking funding flows and driving the left shift, a more formal Joint Venture agreement will be required. This would provide the required protections whilst enabling all partners to feel assured and support collaborative decision making across all Partners.
- 1.4. The Partnership provides a mechanism through which to plan, manage and deliver integrated care. The wider Place Governance infrastructure provides the contractual environment to further develop and strengthen the role and responsibility of the One Herefordshire Health and Care partnership as this matures over the coming years.
- 1.5. Over the period of this agreement, the partners will work together positively and in good faith in accordance with the partnership behaviours to achieve the partnership objectives. The partners also envisage that this agreement will endeavour to provide flexibility to their relationship as may be required, from time to time, to implement the changes required either nationally or any subsequent changes to the Health or Social Care functions.

2. THE PARTNERS

Membership of the partnership will comprise:

- 2.1. statutory commissioners and providers of health and care services
- 2.2. strategic representation from non-statutory health, care or wellbeing organisations.
 - Wye Valley NHS Trust
 - Herefordshire Council
 - Herefordshire General Practice
 - Herefordshire and Worcestershire Health and Care NHS Trust
 - St Michaels Hospice
 - Chief Officer Herefordshire Healthwatch (Community anchors representative)
 - Herefordshire and Worcestershire Integrated Care Board.

3. PURPOSE

- 3.1. The partners have agreed to form an alliance with a primary aim to improve the health and wellbeing outcomes for the population of Herefordshire. In addition, the alliance will work to improve the financial, governance and contractual framework for the delivery of the services within the One Herefordshire scope.

3.2. We recognise that the successful implementation of the alliance will require strong relationships and the creation of an environment of trust, collaboration, and innovation. This agreement provides a formal mechanism in which the partners will work together to deliver the agreed governance arrangements and objectives of One Herefordshire Health and Care Partnership through a set of behaviours that are described in this agreement.

3.3. This Alliance Agreement supports the wider Health and Wellbeing Strategy and the Herefordshire and Worcestershire Integrated Care System Strategy.

3.4. This agreement will be subject to annual review.

4. EXCLUSIONS

All partners agree that:

- Each one of the partners is a sovereign organisation
- The alliance is not a separate legal entity and as such is unable to take decisions separately from or that bind the partners.

4.1. This agreement is the overarching agreement that sets out how the partners will work together in a collaborative and integrated way and the Service Contracts, the Service Operations Manual and Third Party Service Contracts respectively set out how services will be provided.

4.2. We recognise that each partner has its own regulatory and statutory responsibilities and that there will be some decisions that will need to be reserved for consideration and determination by individual Boards. The limits of that authority will be recorded in partners' respective Schemes of Delegation.

4.3. The partners shall support each other to achieve compliance with each of their statutory responsibilities. Accordingly, nothing in this agreement will require any of the partners to do anything which is in breach of legal obligations (including procurement and competition law), or which breaches any regulatory or provider licence requirements.

5. AIMS AND OBJECTIVES

5.1. The Partnership will deliver services within the financial envelope allocated in accordance with the appropriate funding formula to deliver increased sustainable, effective and efficient services with improvements in outcomes over the term of the agreement. The partners have agreed to work collaboratively to:

5.2. Improve the health and wellbeing outcomes for the population of Herefordshire;

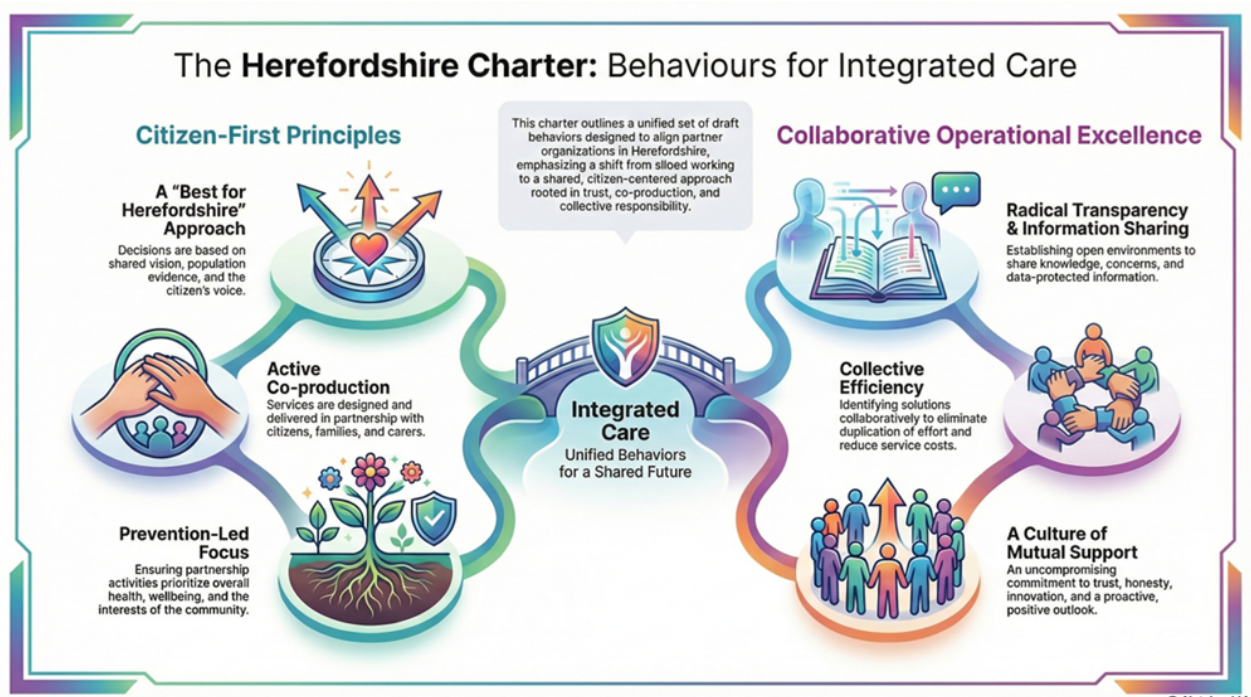
5.3. Align local efforts with both the Neighbourhood Health Implementation Programme and local initiatives to create a unified focus on community-based care;

5.4. Prioritise culture and retention across all organisations, linking these efforts to create dedicated neighbourhood health teams that 'work for all' partners to increase capacity and foster a collaborative environment;

5.5. Utilise a 'community paradigm' approach to enable local voluntary and community assets to strengthen resilience, prevention, and self-management for residents

- 5.6. Make prevention a visible thread by acting jointly on non-clinical factors including housing, transport, employment, and children's life chances to improve long-term outcomes.
- 5.7. Make best use of partnership resources.
- 5.8. The alliance objectives will support commissioning functions in the planning and design of local services, for example to meet demand from changing levels of need, changing funding levels, new legislation and/or policy imperatives.
- 5.9. One Herefordshire Partnership vision supports our population health journey, increasing the focus on wider determinants of health, the places and communities in which we live and our health behaviours and lifestyles whilst maintaining our focus on our integrated health and care system. The vision reflects the national and local ambition and incorporates the voice of Herefordshire residents. Partner strategies and operating plans will describe the anticipated impact on activity shifts across the system.
- 5.10. Partners agree to support shared learning, work together to deliver continuous improvement for the people of Herefordshire that will reduce inequalities, improve population health and collectively achieve the outcomes identified in the Health and Well Being Board Strategy and the Neighbourhood Health National Programme.

6. BEHAVIOURS



- 6.1. Partners have agreed a set of behaviours that the partners will work to in delivering the alliance objectives:
- 6.2. Work towards a shared vision of integrated service provision;
- 6.3. Commit to delivery of population health and wellbeing outcomes derived jointly from the evidence base and citizen voice;



- 6.4. Commit to common processes, protocols and other partner inputs for those in-scope services;
- 6.5. Take responsibility to make decisions on a 'Best for Herefordshire' basis, understanding population needs and predicting demand;
- 6.6. Always demonstrate that the best interests are at the heart of our activities, ensuring the partnership promotes prevention and overall health and wellbeing;
- 6.7. Adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;
- 6.8. Establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, whilst complying with data protection laws;
- 6.9. Co-produce with others, especially citizens, families and carers, in designing and delivering the services
- 6.10. Communicate openly about major concerns, issues or opportunities relating to the programme and the achievement of the outcomes;
- 6.11. Share appropriate information, experience and knowledge so as to learn from each other and develop effective working practices;
- 6.12. Work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
- 6.13. Adopt a positive outlook by behaving in a positive, proactive manner.

7. DELEGATED AUTHORITY

- 7.1. We shall strive to give as much advance notice of One Herefordshire Health and Care Partnership Board business as is reasonably possible in order to allow each partner to seek views and any necessary approvals or authority from the individual organisations.
- 7.2. We shall seek to ensure that partners have appropriate levels of delegated authority in order to consider and determine issues at meetings of the Partnership Board.
- 7.3. Where there are limits on the delegated authority of partners (as confirmed in the relevant Scheme of Delegation), each partner shall advise the other partners of those limits and what additional approvals or authorisations will be required to participate in and make decisions at meetings of the Partnership Board.

8. WORKFORCE

- 8.1. All partners understand that we each have certain responsibilities to each other in the way we deal with staff and employment law issues. For example, we need to manage the risk that some staff could transfer from one partner to another under the Transfer Regulations contained in the relevant Service Contract.
- 8.2. We agree that we will each have responsibility for our own staff and that, where internal reorganisation or redeployment of staff is needed, each partner shall be individually responsible for any costs of that reorganisation or redeployment.

8.3. In respect of staff and volunteers that manage and run services pursuant to this Agreement, each partner commits to each of the others that we shall co-operate and negotiate, acting reasonably and in good faith, to agree how we will manage the financial, operational, legal and other consequences of such staff transfers.

9. PROCESSES

- 9.1. Any partner that becomes aware of any actual or potential conflict of interest, which is likely to have an adverse effect on the partners' ability to properly perform the obligations under this agreement, must immediately notify the One Herefordshire Health and Care Partnership Board. The Partnership Board shall determine how best to manage any actual or potential conflict of interest.
- 9.2. The One Herefordshire Health and Care Partnership Board may resolve to terminate this agreement if circumstances render the continuation of the agreement impossible.
- 9.3. New partners shall be admitted on terms which are fair, reasonable and non-discriminatory. Where a partner or partners wish to admit a new organisation to be a partner under this agreement, such a proposal shall be considered at the One Herefordshire Health and Care Partnership Board.
- 9.4. A Partner may be removed by submitting its resignation to the One Herefordshire Health and Care Partnership Board.
- 9.5. Subject to or as otherwise specifically provided for in this Agreement, any Dispute arising out of or in connection with this Agreement will be resolved in accordance with Dispute Resolution Procedure (Appendix 1).
- 9.6. The provisions of this agreement may be varied at any time by a partner submitting a Notice of Variation to the One Herefordshire Health and Care Partnership Board. All Variations must be agreed by all partners.

10. STRUCTURE

- 10.1. It is agreed that Wye Valley NHS Trust shall be the Host Partner.
- 10.2. As Host Partner, Wye Valley NHS Trust will engage with partners in a coordinated and integrated way, establishing an environment that encourages collaboration and integration.
- 10.3. Partners agree to establish the One Herefordshire Health and Care Partnership (OHHCP) Board. The position of the OHHCP Board in relation to the wider Herefordshire Place governance arrangements is described in Appendix 2.
- 10.4. The OHHCP Board will have additional accountability to the Health and Wellbeing Board for delivery of improved health and wellbeing outcomes for the population of Herefordshire.
- 10.5. The OHHCP Board will have reciprocal accountability to the ICB Integrated Commissioning Committee (ICC) for the operational performance of services contractually in scope and for the transformation of services in line with the model of health care and wellbeing. The OHHCP Board and ICC will agree an Integrated Commissioning & Transformation Delivery Plan.

- 10.6. The OHHCP Board will be responsible for decision making and strategic direction, including responsibility for the delivery of the National Neighbourhood Health Strategy.
- 10.7. The OHHCP Board will have responsibility for setting and overseeing the implementation of the One Herefordshire Alliance response to reducing health inequalities, aligned to the strategic ambition set by the Health & Well Being Board (HWBB).
- 10.8. The OHHCP Board will have other duties and the authority and accountability as defined in its Terms of Reference (Appendix 3).

11. INTEGRATED CARE OVERSIGHT AND ASSURANCE (ICOA) COMMITTEE

- 11.1. Partners agree to establish the ICOA Committee as a sub-committee of the host partner's Trust Board. The position of the Wye Valley NHS Trust Board in relation to the wider Herefordshire place governance arrangements is described in Appendix 2.
- 11.2. The ICOA Committee will 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.
- 11.3. The ICOA Committee on behalf of the Host's Trust Board will have reciprocal accountability to the ICB Integrated Commissioning Committee (ICC) for the operational performance of services contractually in scope and for the transformation of services in line with the model of health care and wellbeing.
- 11.4. The ICOA Committee will oversee the quality standards of services in scope, monitoring risks to the quality and safety of service provision and provide quality-based assurance to the Host's Board on the provision of services in scope.
- 11.5. The ICOA Committee will have responsibility for the oversight of service integration contractually in scope for the system integration and transformation.

12. INTEGRATED GOVERNANCE STRUCTURE

- 12.1. Partners agree to establish a series of sub-groups that will have a range of duties, authority and accountability as defined in their terms of reference as approved by the OHHCP Board. The integrated governance structure is described in Appendix 2.
- 12.2. Although the duties and accountability of the sub-groups will include oversight of the partnership's contractual obligations, partnership working will be embedded in all sub-groups and the remit will not be contractually bound.

13. RISK MANAGEMENT

- 13.1. Risk implications of the partnership arrangements will be managed according to the host's Risk Management Policy.
- 13.2. Where relevant, each partner will transfer all or part of a risk that is identified on the partnership Risk Register to individual organisations' risk registers in accordance with individual risk management policies.

13.3. Clinical and operational risks for the services in scope will continue to be reported and managed by the individual service providers and in accordance with the obligations under the Services Contracts. Where there is opportunity for a partnership response that would add value, all or part of a risk that is identified on individual organisation risk registers, may be transferred to the partnership Risk Register in accordance with the framework outlined in Appendix 4.

14. DATA SHARING

14.1. An overarching agreement will be put into place to help support the legitimate sharing of information between Partner Organisations. It constitutes an organisational agreement to work in partnership and ensure that there are adequate safeguards in place to protect all personal confidential data (PCD) that may be processed as outlined in legislation or linked to national requirements.

14.2. Organisations that provide services to the public have a legal responsibility to ensure that the use of PCD is lawful, properly controlled and that individuals' rights are respected.

14.3. All personal and anonymised information as defined in the Data Protection Act 2018 (DPA18) is covered by this agreement:

14.4. Personal information (service user, staff, individuals providing support to service users) processed by the Partner Organisations including electronically (e.g. computer systems, Audio etc.), or in manual records, or in the provision of virtual/remote support.

14.5. Anonymised, including aggregated, personal data. The considerations, though less stringent, must take into account factors such as commercial or business sensitive data, and the effect of many data sets being combined. Data is only truly anonymised if the DPA18 can no longer be used to govern its use.

14.6. Special Category Information as defined under the UK General Data Protection Regulations 2018, such as health or social care information for specified purposes in line with an appropriate lawful basis as defined within the Data Protection Regulations and or relevant Legislation.

14.7. The specific purpose for using and sharing information will be defined in the Data Sharing Agreement (DSA) that will be established in accordance with the legislation and best practice for each transaction. These will be specific to the Partner Organisations' purpose for processing and the legal basis should be outlined for each.

15. Purposes for Sharing Information

15.1. Information should only be shared for a specific, lawful purpose, on a need to know basis or where appropriate consent has been obtained.

15.2. Staff should only have access to personal information on a justifiable need to know basis, in order for them to perform their duties in connection with the services they are there to deliver.

15.3. Having this agreement in place does not give license for unrestricted access to information another Partner Organisation may hold and does not imply that information can be shared. It does set the parameters for the safe and secure sharing of information for a justifiable need to know purpose.

16. Personal Information

- 16.1. The term 'personal information' refers to any information held as either manual or electronic records, or records held by means of audio and/or visual technology, about an individual who can be personally identified from that information.
- 16.2. The term is further defined in the DPA18 as:
- 16.2.1. Data relating to a living individual who can be identified from those data, or
- 16.2.2. Any other information which is in the possession of, or is likely to come into the possession of, the data controller (person or organisation collecting that information).
- 16.3. The DPA18 also defines certain classes of personal information as 'sensitive data' known as "Special Category" information, where additional conditions must be met for that information to be used and disclosed lawfully.
- 16.4. An individual may consider certain information about themselves to be particularly 'sensitive' and may request other data items to be kept especially confidential, e.g. any use of a pseudonym where their true identity needs to be withheld to protect them.
- 16.5. All medical data is deemed to be sensitive personal data and is held under a duty of confidence.

17. Sensitive data is defined as:

- 17.1. The racial or ethnic origin of the data subject;
- 17.2. The data subject's political beliefs;
- 17.3. The data subject's religious beliefs or other beliefs of a similar nature;
- 17.4. Whether the data subject is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992);
- 17.5. The data subject's physical or mental health or condition
- 17.6. The data subject's sexual life;
- 17.7. The commission or alleged commission by the data subject of any offence; or
- 17.8. Any proceedings for any offence committed or alleged to have been committed by the data subject, the disposal of such proceedings or the sentence of any court in such proceedings;
- 17.9. Genetic or biometric data.

18. Anonymised Data

- 18.1. Partners must ensure anonymised data, especially when combined with other information from other organisations, does not identify an individual, either directly or by summation.

18.2. Anonymised data about an individual can be shared without consent (subject to certain restrictions regarding health / social care records), in a form where the identity of the individual cannot be recognised i.e. when:

18.2.1. Reference to any data item that could lead to an individual being identified has been removed;

18.2.2. The data cannot be combined with any data sources held by a Partner to produce personal identifiable data.

18.3. All NHS or health care organisations must ensure that they abide by the NHS guidance linked to National Data opt Out.

19. Organisational Responsibilities

19.1. Each Partner Organisation is responsible for ensuring that their organisational and security measures protect the lawful use of information shared under this Agreement.

19.2. Every organisation should make it a condition of employment that employees will abide by their agreed rules and policies in relation to the protection and use of confidential information. This condition should be written into employment contracts and any failure by an individual to follow the policy should be dealt with in accordance with that organisation's disciplinary procedures.

19.3. Every organisation should ensure that their contracts with external service providers abide by their rules and policies in relation to the protection and use of confidential information.

19.4. Partner Organisations accept responsibility for independently or jointly auditing compliance with any individual Data Sharing Agreements in which they are involved, within reasonable timescales.

19.5. The Partner Organisation originally supplying the information should be notified of any breach of confidentiality or incident involving a risk or breach of the security of information. Reporting and management of such incidents for NHS organisations or health care providers should be via the Data Security & Protection Toolkit.

19.6. Partner Organisations should have documented policies for retention, weeding and secure waste destruction.

APPENDIX 1 - DISPUTE RESOLUTION PROCEDURE

Avoiding and Solving Disputes

We commit to working cooperatively to identify and resolve issues to our mutual satisfaction to avoid all forms of dispute or conflict in performing our obligations under this Agreement.

We believe that by focusing on our agreed Partnership Outcomes and Partnership Behaviours we can reinforce our commitment to avoiding disputes and conflicts arising out of or in connection with Our Partnership.

We shall promptly notify each other of any dispute or claim in relation to this Agreement or the operation of Our Partnership (each a 'dispute') when it arises.

In the first instance the Chair of the OHHCP Board shall seek to work with senior officers within the respective partner organisations to resolve any dispute to the mutual satisfaction of each of the Partners within 3 calendar months unless otherwise agreed. If the dispute cannot be resolved, the dispute shall be referred to the ICOA Committee.

The ICOA Committee will deal proactively with any dispute in accordance with this Agreement so as to seek to reach a unanimous decision. If a decision is reached that resolves, or otherwise concludes a dispute, it will advise the relevant parties of its decision by written notice.

We agree that the ICAO Committee may determine whatever action it believes is necessary, including the following:

- (a) If the ICAO Committee cannot resolve a dispute, it will refer to Health and Wellbeing Board to assist with resolving the dispute; and
- (b) The Health and Wellbeing Board shall:
 - (i) be provided with any information they request about the dispute;
 - (ii) assist the Partnership to work towards a consensus decision in respect of the dispute.
- (c) If the Health and Wellbeing Board cannot facilitate the resolution of the dispute, the Health and Wellbeing Board may recommend:
 - (i) Termination of the Alliance agreement; or
 - (ii) removal of a partner. The proposal shall outline the reasons for removal. Any removal will be considered on terms which are fair, reasonable and non-discriminatory; or
 - (iii) agree that the Dispute need not be resolved.

The Health and Wellbeing Board shall use its best endeavours to reach its decision within 3 months of the date the matter was first referred to it.

APPENDIX 2 – ONE HEREFORDSHIRE PARTNERSHIP GOVERNANCE ARRANGEMENTS

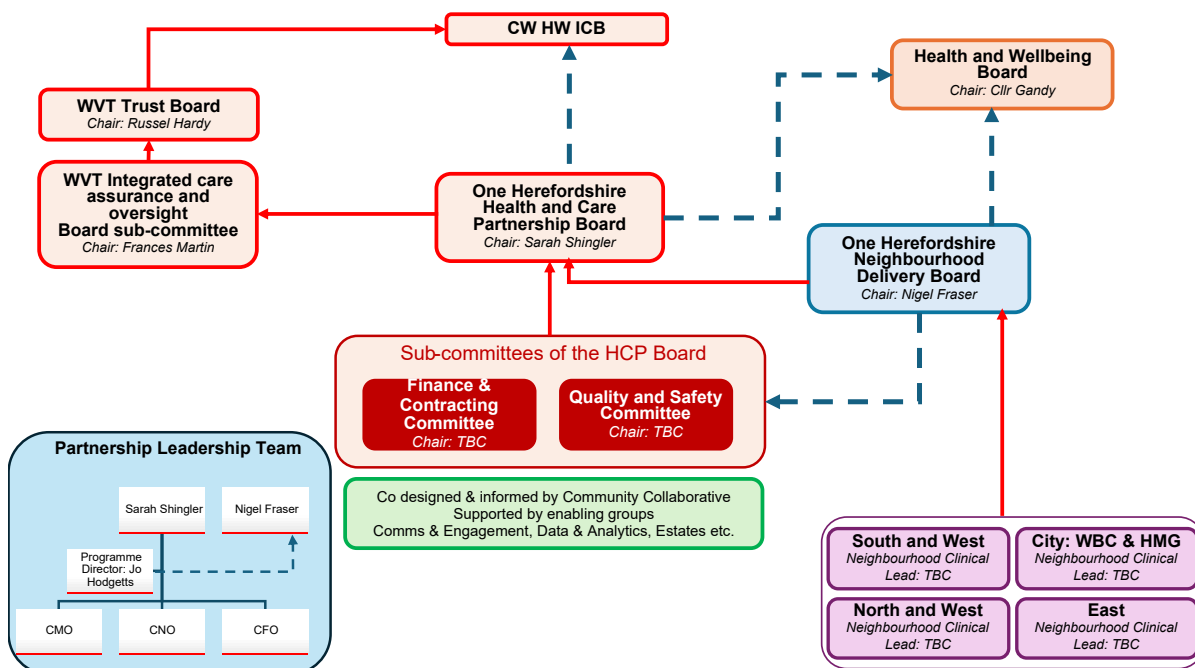
The partnership governance operates under a Host Provider model, which is a specific variation on a Lead Provider model. Wye Valley NHS Trust acts as the host organisation. There is an established Partnership Board, which reports into a formal sub-committee of the Wye Valley NHS Trust Board.

The Health & Care Act 2022 and associated policy guidance is designed to increase collaboration and integration across all health and care organisations. It involves the integration of planning, commissioning and delivery, facilitated by the aligning and pooling of resources, digital transformation and changes to regulation.

We continue to lead the way from a governance perspective in building on existing arrangements and are seeking to increase the level of collaboration on both strategic planning and delivery of integrated health and care through delegation of responsibilities. This will be done through the ICB Integrated Commissioning Committee (ICC) as well as Wye Valley NHS Trust who will take commissioning responsibilities for services agreed to be in scope for the partnership.

Statutory commissioning responsibilities will be retained by the ICC, however, greater collaboration on processes traditionally undertaken by commissioning will be formally transferred to the One Herefordshire Partnership. This will include shaping service models, managing delivery and redistribution of system-allocated resources at place.

One Herefordshire Health and Care Partnership Governance structure



APPENDIX 3 – TERMS OF REFERENCE FOR PARTNERSHIP BOARD AND OVERSIGHT BOARD SUB COMMITTEE

One Herefordshire Health & Care Partnership Board

DRAFT Herefordshire Health and Care Partnership Board (V2)

TERMS OF REFERENCE

Chair: Host Trust Managing Director

Frequency of Meetings: A minimum of 10 per annum

Location of Meetings: Meetings will rotate across Neighbourhood base sites

Quorum: At least one representative from each Partner Organisation

1 Aim

1.1 The One Herefordshire Partnership is a collaboration of local health, social care, and public bodies working to provide integrated, resident-focused care, aiming to keep people healthy at home, reduce hospital admissions, and tackle health inequalities through joined-up services, delivering more personalised and efficient local support in Herefordshire.

2 Constitution

2.1 The Herefordshire Health and Care Partnership Board (**'the HHCP BOARD'**) is the formal means by which our aim is.

2.2 Specifically, the HHCP Board is responsible for exercising all the powers delegated to it by the Herefordshire and Worcestershire Integrated Care Board (**'ICB'**) via the Host organisation, Wye Valley NHS Trust (**'WVT'**).

2.3 The Partnership Organisations of the HHCP Board are:

2.3.1 Wye Valley NHS Trust

2.3.2 Herefordshire Council

2.3.3 Herefordshire General Practice

2.3.4 Herefordshire and Worcestershire Health and Care Trust

2.3.5 St Michaels Hospice

2.3.6 Chief Officer Herefordshire Healthwatch (Community anchors representation)

- 2.4 With the approval of the Board of WVT and in line with its Standing Orders, Scheme of Delegation and Standing Financial Instructions, the HHCP Board may establish subgroups to which it may delegate powers.
- 2.5 These Terms of Reference (ToR) will be published on the websites of the ICB and WVT. Changes to the membership, remit, responsibilities and reporting arrangements of the HHCP Board may only be changed with the approval of the HHCP Board and WVT Board.
- 2.6 For the avoidance of doubt, in the event of any conflict, WVT's Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference, insofar as they relate to the delegations exercised to it.

3 Purpose

The purpose of the HHCP Board is to:

- 3.1 Provide the multi-agency, system leadership to the HHCP. It will be responsible for commissioning services that have been fully delegated to the HHCP (i.e. services that the HHCP are responsible for). The HHCP Board is the vehicle by which Herefordshire Place partners work together at strategic level.
- 3.2 Promote and encourage commitment to the Partnership Principles and Partnership Objectives amongst all Participants.
- 3.3 Provide direction on the options for pursuing greater authority and responsibility for decision by the HHCP.
- 3.4 The Delegation Framework document, which provides a detailed outline of the purpose and role of the HHCP Board should be read alongside these Terms of Reference.

4 Membership

- 4.1 Each partner organisation will nominate up to three representatives of appropriate seniority as members of the HHCP Board.
- 4.2 The membership and list of required attendees are set out in Annex 1 to these terms of reference.
- 4.3 Members of the HHCP Board will operate with the individual delegated responsibility from their employing organisation to enable the HHCP to carry out its responsibilities and functions. It is recognised that each of the partner organisations has its own regulatory and statutory responsibilities and internal governance arrangements. Where individual HHCP Board members do not have the appropriate levels of delegated authority to make decisions at meetings of the HHCP Board, some

decisions may need to be considered by partners' individual Boards/Governing Bodies before final resolution by the HHCP Board.

- 4.4 The WVT Managing Director will be the Chair of the HHCP Board.
- 4.5 A member of the HHCP Board will be the Vice Chair and act in the absence of the Chair. The Vice Chair will be nominated by the HHCP Board.
- 4.6 If the Chair of the HHCP Board is unable to attend a meeting, the Deputy Managing Director may attend the meeting in their place and will contribute to the quorum but they will not act as Chair unless they are a member of the HHCP.
- 4.7 A meeting will have a quorum if at least one representative of each Partner Organisation is present.
- 4.8 If a member is unable to attend a meeting they may nominate another representative of appropriate seniority to attend in their place and they will count towards the quorum.
- 4.9 In the absence of a quorum, meetings may at the discretion of the Chair continue to be held and any decisions made will be ratified at the next quorate meeting of the HHCP Board.

Voting

- 4.9 The HHCP Board will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 4.10 Only members of the HHCP Board may vote. Each organisation is allowed one vote and a majority will be conclusive on any matter.
- 4.11 Where there is a split vote, with no clear majority, the Chair of the HHCP Board will hold the casting vote.
- 4.12 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of email or other electronic communication. Such virtual decisions will be recorded in the minutes of the next meeting.

5 Duties

5.1 The HHCP Board is authorised to:

- 5.1.1 Convene and support all partners across the HHCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services.

- 5.1.2 Develop the partnership arrangements to support new system archetypes including shadow Integrated Health Organisation status and neighbourhood provider contracts.
 - 5.1.3 Agree and oversee contractual agreements at Place, such as the Better Care Fund and other contracts delegated by the ICB.
 - 5.1.4 Develop and deliver the HHCP's delivery plan, including relevant national priorities/targets.
 - 5.1.5 Assure and drive the performance and delivery of National neighbourhood health development and transformation work undertaken within Herefordshire neighbourhoods.
 - 5.1.6 Utilise population health management approaches, to identify and develop evidence based pathways and models of preventive and proactive care.
 - 5.1.7 Drive a fundamentally different model of care and services that support people at or closer-to-home, to improve experience and outcomes and provide better value for money.
 - 5.1.8 Be accountable for delivering the HHCP's strategy and priorities, including the delivery of relevant aspects of the ICB's strategy and priorities in relation to services delivered within and on behalf of the population of Herefordshire that have not been fully delegated to the HHCP (i.e. services that the HHCP have oversight or influence over).
 - 5.1.9 Ensuring effective engagement and co-production with the public, patients and service users in designing service changes in planning for the future.
 - 5.1.10 Be accountable for balancing specified delegated budgets.
- 5.2 The HHCP Board shall be responsible for transacting the HHCP's core business and leading strategic thinking on behalf of the HHCP. **In discharging these key responsibilities, the HHCP Board will:**
- 5.2.1 Take accountability for the development and delivery of the overall financial plan for Herefordshire within the specified delegated budgets of the HHCP.
 - 5.2.2 Scrutinise and approve proposed recommendations through the model of managing these responsibilities agreed by the HHCP. This will include investment, capital and spending decisions within the specified delegated budgets of the HHCP.
 - 5.2.3 Approve recommendations for activity/interventions arising from the HHCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.

5.2.4 Receive updates from the Neighbourhood Health Delivery Board including exception reporting if off plan and identified risks that require HHCP Board support or approval.

5.3 In taking Strategic Leadership the HHCP Board will:

5.3.1 Develop a place based health and care strategy for Herefordshire, in collaboration with the ICB and the Health and Wellbeing Board.

5.3.2 Participate in the development of strategy across the Integrated Care System.

5.3.3 Take accountability for the development and implementation of plans to transform the delivery of health and care in Herefordshire.

5.3.4 Maintain oversight, understanding and alignment of individual organisation strategies and plans.

5.3.5 Bring together activity, finance, operations, and quality intelligence from all providers in order to drive whole-system planning and prioritisation.

5.3.6 Lead the resolution of strategic challenges, issues and risks between partners.

6 Required Attendance

6.1 HHCP Board members should aim to attend all scheduled meetings where possible.

6.2 If any member of the Board has been prevented from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

6.3 Named deputies are permitted to attend meetings where specified individuals are unable to attend.

7 Frequency of Meetings

7.1 The Board will meet approximately monthly, a minimum of ten times a year, or as otherwise agreed by the Partners. Additional meetings may be called at the request of HHCP Board members and at the discretion of the HCCP Board Chair.

7.2 Meeting dates and times shall be set in advance and communicated to all members via email.

7.3 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8 Reporting Arrangements

- 8.1 The minutes of all meetings will be formally recorded by a Secretary appointed by WVT.
- 8.2 The Chair of the HHCP Board will submit a written assurance report to the to the WVT Board's Integrated Care Assurance and Oversight committee on a quarterly basis.
- 8.3 The Chair of the HHCP Board will on behalf of the Partnership provide a highlight report from each meeting to the Board of each of the Partner organisations outlining key actions, key risks identified and key levels of assurance given.
- 8.4 The Chair of the HHCP Board will on behalf of the Partnership provide a quarterly report to the Health and Wellbeing Board reporting progress on development and delivery of Neighbourhood Health Model and specific objectives delegated to the HHCP Board.

9 Monitoring Effectiveness and Compliance with Terms of Reference

- 9.1 The HHCP Board will carry out an annual review of its effectiveness and compliance with these terms of reference.

Terms of reference ratified by: Integrated Care Oversight and Assurance Committee

Date of ratification: February 2026

Date of next review:

One Herefordshire Health & Care Partnership Board

Membership:

HHCP Board Members will have the authority to act and make decisions on behalf of their organisation. Membership of the Board will be up to three representatives from each of the following Partner organisations.

- Herefordshire Council
- Herefordshire General Practice (to include Chair of the Neighbourhood Health Delivery Board)
- Herefordshire and Worcestershire Health and Care Trust
- Wye Valley NHS Trust
- Healthwatch
- St Michaels Hospice

The following roles are required to attend and will be recorded as 'in attendance':

- Director of the Herefordshire and Worcestershire Integrated Care Board
- Chief Officer Strategy and Transformation (WVT)
- Representatives of the Care Home sector (as required)

Professional Representation:

- Operational lead for in-scope hospital services
- Operational lead for mental health
- Professional lead for nursing and AHPs
- Professional lead for Adult Social Care
- Professional lead for Children's Services

Attendees:

Required attendees will be notified of meetings in advance and informed whether attendance is required for the whole agenda or specific items only.

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) – Health component only. Herefordshire Council have responsibility for overseeing the local authority contributions into the 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, through a BCF Manager reporting jointly into the Trust and the Council.
 - 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 5 February 2026

APPENDIX 4 - RISK MANAGEMENT PROCESS

1. Risk Management Framework Purpose

- 1.1. The One Herefordshire Health and Care Partnership Board has 2 broad areas of responsibility:
 - 1.1.1. oversight of operational services in scope.
 - 1.1.2. oversight of the programme of transformation.
- 1.2. To ensure the Partnership Board can take assurance on its areas of responsibility, a risk management framework is required. This framework will be aligned to Wye Valley NHS Trust as host provider and will enable the sharing of relevant information across partner organisations, whilst ensuring that each individual organisation maintains its statutory obligations, as referenced in the Alliance Agreement.
- 1.3. The process of developing a risk management framework has been an iterative one to adapt to maturing levels of appetite for risk sharing across the partnership. It has been reflected in the Alliance Agreement, in the context of the Health & Social Care Act (2022) and ongoing discussions regarding delegation of responsibilities from the Integrated Care Board.
- 1.4. This document is intended to provide a framework for shared risk management, to enable the joint management of risks within the partnership and support an appropriate level of assurance reporting to the One Herefordshire Health and Care Partnership Board.

2. Principles of Shared Risk Management

- 2.1. Each individual organisation retains its statutory obligations, as described in the Alliance Agreement
- 2.2. Risk scoring criteria, adoption of a 5x5 matrix, escalation criteria, and management processes are aligned to Wye Valley NHS Trust (WVT) Risk Management Policy (as Host Provider for the Partnership)
- 2.3. Risks will be entered onto the agreed partnership risk register, maintained by the Programme Office.
- 2.4. The Partnership Risk Register is equivalent to a Corporate-level risk register and should directly support and align to the risks associated with the strategic objectives of the Partnership.
- 2.5. Risks identified by partner organisations and operational services are included where there is added value from having a partnership approach to mitigation; this does not replace the management of risks within individual partner organisations and the entry on the Partnership
- 2.6. Risk Register will need to clearly articulate the extent to which the partnership has ownership for resolution.
- 2.7. Risk owners are One Herefordshire Health and Care Partnership Board members and can be external to WVT.
- 2.8. Risk Assessors and Action Owners will be identified as appropriate for each individual action.

3. Alliance Agreement

- 3.1. Risk implications of the partnership arrangements will be managed in line with the host's Risk Management Policy.
- 3.2. Where relevant, each partner will transfer all or part of a risk that is identified on the Partnership Risk Register to individual organisation Risk Registers in accordance with individual Risk Management Policies.
- 3.3. Clinical and operational risks for the services in scope will continue to be reported and managed by the individual service providers and in accordance with the obligations under the Services Contracts.

4. Definition

- 4.1. The Risk Register contains risks to delivery of the transformation programme, risks to delivery of the Partnership's strategic objectives and operational risks that have been escalated to the Partnership Board due to there being opportunity for a partnership response that would add value.

5. Escalation/Adding New Risks

- 5.1. Operational and transformation programme risks are only escalated to the Partnership Risk Register in instances when a partnership mitigation response would add value, when action is required outside the control of the current owner and is no longer manageable, and when the risk affects the achievement of the Partnership's strategic objectives. It is expected that these risks would remain and/or be duplicated on one or more Partner organisation risk registers,.

6. Process

- 6.1. Partner organisations and operational services in scope will share any risks that could have an impact on other partners or the wider system
- 6.2. Risks are presented from the perspective of the individual organisation or service for information and discussion on a quarterly basis to the Quality and Safety Group (QSG) which is a subgroup of the Partnership Board.
- 6.3. The QSG will agree whether to:
 - 6.3.1. Continue with current risk management within the individual organisation or service, potentially with observation or review at a later date; or
 - 6.3.2. Create a new, corresponding entry on the Partnership Board Risk Register that describes the risk from a partnership perspective and where there are mitigating actions that will add value.
 - 6.3.3. Newly added risks will be presented to the Partnership Board for approval, on the recommendation of QSG.

7. Monitoring

- 7.1. The One Herefordshire Programme Office will support regular review of all open risks in a timely manner, according to the WVT Risk Management Policy. Oversight will be provided by the One Herefordshire Quality and Safety Group and the Partnership Board. Where appropriate risks will be shared with ICC.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	4th June 2026
Title of Report:	Children and Young People’s Committee Escalation and Assurance Report
Lead Executive Director:	Jo Rouse
Author:	Julie Vickers
Reporting Route:	Director to Board
Enclosures included with this report:	Escalation and Assurance Report
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
Summary of Children and Young People’s Committee meetings.	
Recommended Actions required by Board or Committee	
For the Board to note the report.	
Executive Director Opinion¹	
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.

Escalation and Assurance Report

Report from: Children and Young People's Committee
Date of meeting: 4th June 2026
Report to: Trust Board

Introduction

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

Now in its second year, the committee has gained improved oversight of the services provided for CYP, particularly of the smaller specialities. The committee acknowledges that the specialty service updates now contain more information in relation to performance against quality standards, but in some areas further information is required to provide assurance that standards are being met.

There was no meeting in December due to the festive period and the January meeting was cancelled due to service pressures. This report summarises the meetings from February to April 2026.

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	Lack of specialist behavioural support for CYP with learning disability
Rating rationale	There is a lack of specialist behavioural support for CYP with ASD and learning disability in Herefordshire and Worcestershire, with ongoing concerns regarding the prescribing of antipsychotics, such as risperidone, for a small number of these patients. This is a recognised system-level risk requiring agreement across Community Paediatrics, CAMHS, Pharmacy, and Commissioners. The issue has been escalated to the ICB Lead, who has proposed convening a multi-disciplinary panel, including a Learning Disability Psychiatrist.
Outcome	The committee require further assurance that there will be system-wide resolution to ensure appropriate governance around prescribing of antipsychotics and availability of non-pharmacological intervention and support for CYP with learning disability and challenging behaviour.

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

Escalation and Assurance Report

Report from: Children and Young People's Committee
 Date of meeting: 4th June 2026
 Report to: Trust Board

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	National Neonatal Audit Programme (NNAP)
Rating rationale	NNAP data shows improved performance and/or above national average for breastmilk feeding within the first 2 days, documented parental consultation within 24 hours of admission, parent inclusion on consultant ward rounds, neonatal nurse staffing as per recommended levels and temperature on admission. There is improvement in deferred cord clamping from 57% to 74% but still just below the national average (78%). However, data highlighted a decrease in formal developmental assessment of preterm babies at 2 years of age to 60%, below the national average of 77%.
Outcome	It was acknowledged that improvements are required to meet targets, with changes to follow up pathways and training in formal developmental assessment planned. The annual audit data will be reviewed again with next publication.
Item/Topic	Long waiting times for autism assessment
Rating rationale	Considerable waiting time for completion of multidisciplinary autism assessment. Currently 29 patients waiting over 40 weeks for first consultant appointment and further significant waiting time for SaLT diagnostic assessment. Despite these pressures, waiting times remain shorter than in neighbouring Trusts.
Outcome	The committee will continue to monitor ASD waiting times as part of its review of all SEND data. It was encouraging to hear that service redesign and pathway standardisation have ensured more appropriate use of specialist clinical capacity and recruitment of an additional consultant and specialty doctor will increase capacity. ASD waiting times
Item/Topic	Community Paediatrics typing backlog
Rating rationale	Due to increased vacancies and sickness within the admin and clerical team, there are significant delays in typing clinic letters, 13.5 weeks at time of report. The A&C team at the Child Development Centre also currently manage all appointment booking. Typing delays and the impact of reduced admin and clerical support were a consistent theme across all specialities.
Outcome	The committee was encouraged to hear that the typing delay had reduced to 5 weeks in community paediatrics, the introduction of Heidi has been a factor in the reduction of workload. Heidi has also been used successfully in school nursing, allowing the team to see more CYP.
Item/Topic	Paediatric phlebotomy within primary care
Rating rationale	Changes to the GP contract from April 2026 may result in primary care no longer being able to perform blood tests in CYP under 16. This would have a significant impact on the WVT paediatric phlebotomy service which is already struggling due to increased demand and reduced capacity within the team due to sickness. Any changes in the primary care provision have been delayed until July 2026.
Outcome	Clarification has been requested from the ICB with a further update to committee in May.
Item/Topic	Paediatric audiology
Rating rationale	A Peer Review was conducted following earlier concerns, reviewing 67 ABR cases; 12 children were recalled; of which 3 cases were assessed as moderate harm risk; 5 cases assessed as low harm risk and 4 cases were assessed as no harm. An action plan is in progress, changes have been made to testing protocols, advanced training has been completed and there has been successful recruitment of a band 7 paediatric audiologist.
Outcome	A follow up report will be provided during the scheduled paediatric audiology update in July, to include progress against the action plan.
Item/Topic	Therapies
Rating rationale	Across all three teams there is an additional focus on SEND reforms and forthcoming implementation plans. SaLT demand continues to rise with increasing referrals. There are ongoing data integrity issues between IT systems and admin pathways, with long waits particularly for ASD diagnostic assessment (11 children waiting over 52 weeks). Occupational Therapy (OT) performance has improved following pathway redesign, with no children waiting over 52 weeks. Physiotherapy experiences some pressures from sickness and vacancies but no significant concerns with only a few children waiting over 18 weeks. Innovative drop in and group sessions, providing advice and support for parents have reduced referrals.

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

Escalation and Assurance Report

Report from: Children and Young People’s Committee
 Date of meeting: 4th June 2026
 Report to: Trust Board

Outcome	Work is ongoing to resolve pathway and data issues and clear backlogs in SaLT, the committee will review monthly along with SEND data.
Item/Topic	Dietetics
Rating rationale	The paediatric dietetics service meets most of the quality standards embedded in disease specific guidance. There is no commissioned ARFID service within CAMHS and no commissioned multidisciplinary obesity management service locally, leading to increased pressures on services. Recruitment difficulties have led to increased waiting times and the temporary suspension of some services. The increase in demand within paediatric diabetes was noted.
Outcome	The impact of reduced staffing with continue to be monitored. The introduction of electronic growth charts will allow for more effective remote monitoring.
Item/Topic	Children’s Community Nursing
Rating rationale	There is significant national and regional variation in how children’s community nursing services are commissioned and delivered. The service currently operates Monday to Friday 9-5. Joint working with Worcester has supported the provision of end of life care but this is reliant on goodwill and available capacity. The service is working with the ICB to secure funding to extend operating hours, which would reduce gaps in support, allow increased provision of home IV antibiotics and allow the development of a paediatric virtual ward.
Outcome	The committee acknowledges the challenges in benchmarking and performance comparison and will await the outcome of ICB funding discussions.

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

Escalation and Assurance Report

Report from: Children and Young People's Committee
 Date of meeting: 4th June 2026
 Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	Autism assessment
Rating rationale	Multidisciplinary autism assessments for pre-school and school age children are delivered using recognised diagnostic frameworks in line with NICE guidance. Standardised assessment processes and documentation have been implemented, improving consistency and reducing unwarranted variation.
Outcome	Committee was assured that autism assessments are of high quality and steps being taken to improve long waiting times.
Item/Topic	Paediatric podiatry
Rating rationale	WVT is one of a few Trusts in the country to provide a specialist paediatric podiatry service. The service is compliant with the Royal College of Podiatry Paediatric Podiatry Framework. The service is fragile as, at present, there is a single MSK podiatrist, training is underway for an additional staff member but is anticipated to take 12 months.
Outcome	The committee was assured that although this is a small, potentially fragile specialist service, succession plans are in progress and the service receives peer support and review from Gloucester.
Item/Topic	Public health nursing
Rating rationale	The health visiting and school nursing services are consistently meeting key performance indicators with 100% of eligible children receiving a timely 2-2½ review and 99% of children in reception and year 6 taking up the offer of the National Child Measurement Programme. Both services have developed innovative ways of working, such as working in partnership with early years providers, attendance at a range of community events, successful use of social media and implementing the provision of emergency hormonal contraception.
Outcome	The committee was assured about the quality and effectiveness of the service and impressed by the innovative practice.
Item/Topic	Paediatric and Young Adult Diabetes GIRFT Review
Rating rationale	The first system-wide review, looking at adult and paediatric services, noted a number of areas of good practice: High technology usage with 100% of paediatric patients using CGM (continuous glucose monitoring) and 71% on HCL (hybrid closed loop systems), good collaboration between paediatric and adult services around transition and the NHSE funded youth worker pilot interventions which have improved service engagement resulted in a reduction in avoidable admissions. Recommendations include a workforce review to ensure the service will be able to meet future demands; this work is already underway.
Outcome	The committee was assured about the quality of the service and collaboration with the ICB but recognises that there needs to be improved communication around diabetes funding, particularly Best Practice Tariff.

To Note: Items received for information or approval	
Item/Topic	
Summary	
Outcome	

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

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

Escalation and Assurance Report

Report from: Audit Committee
 Date of meeting: 13 May 2026
 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	Effectiveness of Processes for Raising Concerns
Rating rationale	<p>The review of the effectiveness of arrangements, including Freedom to Speak Up (FTSU), highlighted the range of established good practice and identified areas for further development.</p> <p>Areas for improvement included the approach to triangulating data and sharing intelligence. A working group would review this as well as developing simple communication for staff regarding the various reporting routes for concerns, which could include fraud, patient safety incidents or grievances for example.</p> <p>An executive-led People and Culture Committee would shortly be established and would provide strengthened oversight of these arrangements.</p> <p>The Committee considered the raising concerns culture in light of the report, noting the broader role that had developed for the FTSU beyond dealing with concerns about patient safety and the potential for people to default to the FTSU Guardian or champions rather than discussing with their manager.</p>
Outcome	<p>The Committee was assured that the arrangements for raising concerns were broadly compliant and effective and that the plans for further development were appropriate.</p> <p>Actions:</p> <ul style="list-style-type: none"> • Future reports to provide more detail on the activities of the FTSU Champions and the reasons people raised concerns through the FTSU route rather than via the management route. • Clarify governance in this area in light of the planned new People and Culture Committee.
Item/Topic	Internal Audit: 2025/26 Plan Progress Report
Rating rationale	<ul style="list-style-type: none"> • Progress <p>One further audit had been completed since the last report (see below) and one was in progress (key financial controls: contract management). This would complete the 2025/26 plan.</p> <p>Work had started on the 2026/27 plan, with the audit of complaints management now in progress.</p> <ul style="list-style-type: none"> • Head of Internal Audit Opinion (HoIAO) 2025/26 <p>The draft opinion (presented at the last meeting) had been updated to reflect the above progress and a final version would be presented when the last review of the 2025/26 plan was complete.</p> <ul style="list-style-type: none"> • Recommendation tracker <p>Of the 43 management actions on the tracker, 15 were beyond the original due date and revised dates had been requested (7 medium and 8 low priority). The CFO had reviewed and was challenging where appropriate with relevant teams. It was recognised that some of the original actions were broad and could be clearer on end points.</p>
Outcome	<p>The Committee was assured by progress on the plan and noted the positive draft HoIAO.</p> <p>The Committee agreed the importance of setting more clearly defined actions in response to improvement recommendations.</p>
Item/Topic	Internal Audit: Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DPST)
Rating rationale	<p>The review was positive overall and benchmarked well. The overall risk rating across all five CAF objectives was Medium with one area that did not meet the criteria. The confidence level of the independent assessor in the veracity of the self-assessment was High. This was a significant improvement on the first review the previous year, though it focused on a different set of criteria.</p> <p>Three recommendations were made, one of medium and two of low priority. The medium recommendation was almost complete.</p> <p>Eight of the nine recommendations from the previous year were implemented with one still in progress. The External Auditor advised that the helpful report would be reviewed as part of the Audit.</p>
Outcome	<p>The Committee was assured by the positive report and the plans in place to address the recommendations, which was important assurance for the Board Assurance Framework cyber security risk.</p>

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: 13 May 2026
 Report to: Trust Board

Item/Topic	Local Counter Fraud Specialist (LCFS) Annual Report 2025/26
Rating rationale	The report provided a summary of work undertaken by the LCFS team during the year. Assessment of compliance with government functional standard was green overall, with one area assessed as amber relating to the fraud, bribery and corruption risk assessment. This was connected with work required regarding the new Failure to Prevent Fraud offence. Plans were in place to ensure full compliance.
Outcome	The Committee accepted the report and was assured by the assessment of compliance and the reason for the one non-compliant area.

Assure: Including assurance items rated green
None

Items for Information or Approval	
Item/Topic	Annual Review of Standing Financial Instructions and Scheme of Delegation
Comments	One change was proposed, providing an additional level of delegated authority for the Deputy Chief Finance Officer (CFO) to respond to the current shared CFO role with Worcestershire Acute Hospitals NHS Trust.
Outcome	Approved
Item/Topic	External Audit Progress Update
Comments	Good progress was being made on the Audit. All levels of review were complete, with no significant issues highlighted to date. Feedback on the VFM assessment was expected to take place next week.
Outcome	Noted
Item/Topic	Pre-Operative Assessment update
Comments	The paper provided an update on one element of a previous review, focused on implementation of the new digital solution (MyPreOp+) to support preoperative improvements and productivity.
Outcome	Noted Action: Add a wider update to the schedule for a future meeting.

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 REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	04/06/2026
Title of Report:	Update to SFIs - Scheme of Delegation
Lead Executive Director:	Chief Finance Officer
Author:	Heather Moreton – Associate Chief Finance Officer
Reporting Route:	Via Audit Committee
Enclosures included with this report:	SFIs Scheme of Delegation May 26
Purpose of report:	<input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
<p>The scheme of delegation within the SFIs has been updated to reflect an additional level of delegated authority for the Board Deputy CFO, in response to the CFO’s current dual role with Worcestershire Acute Hospital Trust.</p> <p>An additional level of delegation, for both authorisation limits and tendering and contract procedures, has been added whereby the Board Deputy CFO has a limit of up to £75k.</p> <p>There are no other changes to the SFIs since the version approved by Trust Board on 3rd April 2025.</p>	
Recommended Actions required by Board or Committee	
Board members are requested to approve the full SFI’s and updated Scheme of Delegation.	
Executive Director Opinion¹	
This has been reviewed by the Chief Finance Officer.	

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 STANDING FINANCIAL
INSTRUCTIONS 2025/26**

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STANDING FINANCIAL INSTRUCTIONS

1 *Interpretation*

- 1.1. The **Chair** of the Trust is the final authority in the interpretation of SO on which the **Chief Executive Officer** shall advise him. In the case of the SFIs, he will be advised by the **Chief Finance Officer**.
- 1.2. The definitions applied to the SO apply also for these SFIs. The following additional definitions apply:

Legislation definitions:

No additional legislation

Other definitions:

- **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.
 - **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
 - **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
 - **Assistant Chief Operating Officers** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.
- 1.3. Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

2 *Introduction*

- 2.1. These SFIs are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.
- 2.2. The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
- 2.3. They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board (Appendix 1) and the Scheme of Delegated Authorities (Appendix 3) which both also form part of the Trust's SOs.
- 2.4. Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

- 2.5 These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the **Chief Finance Officer**, prior to action.
- 2.6 The SFIs apply to all staff, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs could lead to disciplinary action, up to and including dismissal.

3 *Compliance with these SFIs*

- 3.1 These SFIs prevail over any division and service guidance or procedural documents. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. All staff should notify the **Chief Finance Officer** of any conflicts between the local guidance and instruction and the SFIs, if the conflict cannot be resolved satisfactorily locally.
- 3.2 **All staff** have a duty to disclose, as soon as possible, to the **Chief Finance Officer** or the **Company Secretary**, any failure to comply with these SFIs. Full details of the non-compliance including an assessment of the potential impact; and any mitigating factors shall be reported by the **Chief Finance Officer** to the next formal meeting of the Audit Committee for referring action or ratification.
- 3.3 Changes to or variations from these SFIs will be subject to a specific resolution of the Trust Board or be consequent upon further directions from the Secretary of State.
- 3.4 There shall be a periodic review, normally annually, but no more than every two years of all financial limits contained in these SFIs.

4 *Responsibilities and delegations*

- 4.1 These SFIs have been compiled under the authority of the Trust Board. They are reviewed by the **Audit Committee** and approved by the Trust Board.
- 4.2 **The Trust Board** exercises financial supervision and control by:
- a. approving the financial strategy
 - b. requiring the submission and approval of budgets that deliver the financial targets set for the Trust within approved allocations and overall income
 - c. approving specific responsibilities placed on directors and employees as indicated in the Scheme of Delegated Authorities
 - d. approving the method of providing financial services.
- 4.3 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions Reserved to the Trust Board ([Appendix 1](#)). All other powers have been delegated to the Board's appointed committees; and the directors and officers of the Trust.
- 4.4 **The Chief Executive Officer** is the Accountable Officer of the Trust and:
- a. is legally accountable to Parliament for all of the actions of the Trust

- b. is accountable to the Trust Board for ensuring that the Board of Directors meets its obligation to perform the Trust's functions within the available financial resources
 - c. holds overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met
 - d. is responsible overall for the maintenance of the Trust's systems of internal control
 - e. is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs
- 4.5 Save for the decisions and actions reserved to the Trust Board, the **Chief Executive Officer** has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The **Chief Executive Officer** will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegated Authorities (appendices 1 and 2).
- 4.6 The **Chief Finance Officer** is responsible for:
- a. maintaining and implementing the Trust's financial policies
 - b. maintaining an effective system of internal financial control including ensuring that adequate and effective financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained
 - c. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time
- 4.7 **All staff**, including Board members, severally and collectively, are responsible for:
- a. the security of the property of the Trust;
 - b. avoiding loss;
 - c. exercising economy and efficiency in the use of resources;
 - d. conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.
 - e. considering the legality of all transactions
- 4.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.
- 4.9 All officers shall make available any relevant records or information to the Chief Finance Officer in connection with the carrying out of their duties of supervision regarding the implementation of the Trust's financial policies and systems of financial control whether by internal audit or otherwise.
- 4.10 Contractors and their employees, who are empowered by the Trust to commit the Trust to expenditure or who are authorised to obtain income shall be covered by these instructions. It is the responsibility of the **Managing Director** to ensure that such persons are made aware of this.

Part 1 – Allocation, planning, budgets, budgetary control and monitoring

5 *Financial and budget plans*

- 5.1 The **Chief Executive Officer** shall submit to the Board and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board. These plans will include an annual financial plan, which takes into account financial targets and forecast limits of available resources. The plans will include:
- a. description of the significant assumptions on which planning is based
 - b. details of major changes in workload, delivery of services or resources required to achieve the plans.
- 5.2 Prior to the start of each financial year, the **Chief Finance Officer** shall prepare and submit budgets for approval by the Board. Such budgets will:
- a. be in accordance with and reconcilable, at a summary level, to the aims and objectives set out in the annual Business Plan
 - b. reconcile the financial plans to be provided to relevant external regulators, such as NHSE
 - c. reflect resource plans, including workload and workforce plans
 - d. be prepared within the limits of available funds
 - e. show how the plans will deliver against the financial targets and obligations set externally by the Secretary of State and relevant regulatory bodies; and set internally by the Trust
 - f. provide a forecast of the Trust's performance over the year against key financial indicators, as determined by the Trust and by relevant regulatory bodies
 - g. include summary financial projections for the longer term
 - h. identify and assess significant financial risks.
- 5.3 **All staff** who have been given delegated authority to manage and administer budgets shall be expected to contribute to the preparation of the annual budget.
- 5.4 All **Associate Chief Operating Officers** will sign up to their allocated budgets at the commencement of each financial year.
- 5.5 The **Chief Finance Officer** has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

6 *Management of the financial resource*

- 6.1 The **Chief Executive Officer** shall require directors and authorised budget managers to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.
- 6.2 The **Chief Executive Officer** may change the financial outturn targets of any divisions, or services.
- 6.3 **Directors** and **authorised budget holders** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them.

Financial and other resources shall only be used for the purposes for which they are provided, as approved by the **Chief Executive Officer** and the Board.

7 *Setting the annual financial plan*

- 7.1 The **Chief Executive Officer** shall be responsible for providing the Trust Board with the annual financial plan, taking into account financial targets and forecast income and service developments. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health.
- 7.2 The **Chief Finance Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.
- 7.3 All **Chief Officers** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.
- 7.4 **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the **Chief Finance Officer** to enable budgets to be compiled.
- 7.5 All **budget managers** should sign up to their allocated budgets at the start of each financial year.

8 *Managing and reporting the financial position during the year*

- 8.1 The **Chief Finance Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:
 - a. identifying the level of earned income directly attributable to each budget area
 - b. identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target
 - c. updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.
 - d. monitoring and reporting financial performance against plans and forecasts
 - e. delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and Performance Executive and the Trust Board in a form approved by the Board.
- 8.2 All **Chief Officers** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.
- 8.3 **All staff** to whom responsibility is delegated to incur expenditure, or generate income shall comply with the requirements of those systems.
- 8.4 Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

- 8.5 Designated **budget holders** shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:
- a. progress towards delivering the required financial position for the budget area
 - b. the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans
 - c. trends and projections
 - d. where relevant, plans and proposals to recover adverse performance
- 8.6 The **Chief Finance Officer** shall ensure that **budget holders** are provided with advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.
- 8.7 The **Chief Finance Officer** shall be required to compile and submit to the Trust Board such financial estimates and forecasts, on both revenue and capital account, as may be required from time to time.
- 8.8 The **Chief Finance Officer** shall keep the Trust Board informed of:
- a. significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance
 - b. financial consequences of changes in Trust policy
 - c. financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services
- 8.9 The **Chief Finance Officer** shall:
- a. ensure that **budget managers** receive adequate training on an on-going basis to help them comply with expectations and to manage successfully
 - b. issue timely, accurate and comprehensible advice and financial reports to each **budget manager**, covering the areas for which they are responsible

9 Annual accounts, reports and returns

- 9.1 The **Chief Finance Officer** shall:
- a. prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DH) and the Treasury, the Trust's accounting policies, and accounting practice as determined by the accounting bodies in the UK.
 - b. prepare and submit annual financial reports to NHS England (NHSE) certified in accordance with current guidelines
 - c. submit financial returns to the DH for each financial year in accordance with the timetable prescribed by the DH
 - d. submit periodic monitoring and financial returns to external organisations, such as NHSE, in accordance with the timetables set by those organisations
- 9.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DH.

- 9.3 The **Chief Executive Officer** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DH requirements and guidance.

10 *Budgetary Delegation*

- 10.1 The **Chief Executive Officer** may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
- a. the amount of the budget;
 - b. the purpose(s) of each budget heading;
 - c. individual and group responsibilities;
 - d. authority to exercise virement;
 - e. achievement of planned levels of service;
 - f. the provision of regular reports.
- 10.2 The **Chief Executive Officer** and delegated **budget holders** must not exceed the budgetary total or virement (administrative transfer of funds from one part of a budget to another) limits set by the Trust Board.
- 10.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the **Chief Executive Officer**, subject to any authorised use of virement.
- 10.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the **Chief Executive Officer**, as advised by the **Chief Finance Officer**.

11 *Budgetary Control and Reporting*

- 11.1 The **Chief Finance Officer** will devise and maintain systems of budgetary control. These will include:
- a. monthly financial reports to the Board in a form approved by the Board containing:
 - income and expenditure to date showing trends and forecast year-end position;
 - movements in working capital;
 - movements in cash and capital;
 - capital project spend and projected outturn against plan;
 - explanations of any material variances from plan;
 - details of any corrective action where necessary and the **Chief Executive Officer's** and/or **Chief Finance Officer's** view of whether such actions are sufficient to correct the situation.
 - b. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
 - c. investigation and reporting of variances from financial, workload and manpower budgets;
 - d. monitoring of management action to correct variances; and
 - e. arrangements for the authorisation of budget transfers.
- 11.2 Each **budget holder** is responsible for ensuring that:

- a. any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Board;
- b. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- c. no permanent employees are appointed without the approval of the **Managing Director** other than those provided for within the available resources and manpower establishment as approved by the Board.

11.3 The **Managing Director** is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Financial Plan and a balanced budget.

12 Capital expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure.

13 Monitoring returns

The **Chief Executive Officer** is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

Part 2 – Audit

14 Audit Committee

14.1 In accordance with SO, the Board shall formally establish an Audit Committee, with clearly defined terms of reference in line with the Code of Governance for NHS Providers (2022) and following guidance from the most recent NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

- a. overseeing Internal and External Audit services;
- b. reviewing financial, information systems, monitoring the integrity of the financial statements, and reviewing significant financial reporting judgments;
- c. review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
- d. monitoring compliance with SOs and SFIs;
- e. reviewing schedules of losses and compensations and making recommendations to the Board;
- f. reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans;
- g. Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

14.2 Where the Audit Committee considers there is evidence of ultra vires (beyond authority) transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the NHSE. (To the Chief Finance Officer in the first instance.)

- 14.3 It is the responsibility of the **Chief Finance Officer** to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

15 *Chief Finance Officer*

- 15.1 The **Chief Finance Officer** is responsible for:
- a. ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
 - b. ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;
 - c. deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
 - d. ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:
 - a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
 - major internal financial control weaknesses discovered;
 - progress on the implementation of internal audit recommendations;
 - progress against plan over the previous year;
 - strategic audit plan covering the coming three years;
 - a detailed plan for the coming year.
- 15.2 The **Chief Finance Officer** or designated auditors are entitled without necessarily giving prior notice to require and receive:
- a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
 - b. access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
 - c. the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
 - d. explanations concerning any matter under investigation.

16 *Role of Internal Audit*

- 16.1 Internal Audit will review, appraise and report upon:
- a. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
 - b. the adequacy and application of financial and other related management controls;
 - c. the suitability of financial and other related management data;
 - d. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - fraud and other offences;
 - waste, extravagance, inefficient administration;
 - poor value for money or other causes.

- e. Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the National Audit Office.
- 16.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the **Chief Finance Officer** must be notified immediately.
- 16.3 The **Chief Internal Auditor** will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the **Chair** and **Chief Executive Officer** of the Trust.
- 16.4 The **Chief Internal Auditor** shall be accountable to the **Chief Finance Officer**. The reporting system for internal audit shall be agreed between the **Chief Finance Officer**, the Audit Committee and the **Chief Internal Auditor**. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.
- 16.5 Designated Chief Officers and non-executive directors must carry out audit recommendations within the timescale agreed for action. Failure to do so will be reported to the Audit Committee.

17 External Audit

Under the [Local Audit and Accountability Act 2014](#), NHS Trusts must select and appoint their own auditors and directly manage their contracts for the audits for the financial year. Local appointment increases local accountability and moves NHS Trusts into line with NHS Foundation Trusts.

18 Fraud and corruption

- 18.1 In line with their responsibilities, the **Chief Executive Officer** and **Chief Finance Officer** shall monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on fraud and corruption.
- 18.2 The Trust shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.
- 18.3 The Local Counter Fraud Specialist shall report to the **Chief Finance Officer** and shall work with staff in NHS Protect and the Regional Anti-Fraud Specialist in accordance with the [NHS Counter Fraud Standards 2018](#).
- 18.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

19 Security Management

- 19.1 In line with their responsibilities, the **Managing Director** will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

- 19.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.
- 19.3 The **Managing Director** has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

Part 3 – Bank and Government Banking Service (GBS) Accounts

20 General

- 20.1 The **Chief Finance Officer** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using the GBS accounts, or any successor organisations, for all banking services.
- 20.2 The Board shall approve the banking arrangements.

21 Bank and GBS Accounts

The **Chief Finance Officer** is responsible for:

- a. bank accounts and the accounts of the GBS or any successor organisations;
- b. establishing separate bank accounts for the Trust's non-exchequer funds;
- c. ensuring payments made from bank or GBS (or successor) accounts do not exceed the amount credited to the account except where arrangements have been made;
- d. reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
- e. monitoring compliance with DH guidance on the level of cleared funds.

22 Banking Procedures

- 22.1 The **Chief Finance Officer** will prepare detailed instructions on the operation of bank and GBS (or successor) accounts, which must include:
- a. the conditions under which each bank and GBS (or successor) account is to be operated;
 - b. those authorised to sign cheques or other orders drawn on the Trust's accounts.
 - c. those authorised to undertake electronic banking transactions.
- 22.2 The **Chief Finance Officer** must advise the Trust's bankers in writing of the conditions under which each account will be operated.

23 Tendering and Review

- 23.1 The **Chief Finance Officer** will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

- 23.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS (or successor) accounts.

Part 4 – Income, fees and charges and security of cash, cheques and other negotiable instruments

24 *Income Systems*

- 24.1 The **Chief Finance Officer** is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
- 24.2 The **Chief Finance Officer** is also responsible for the prompt banking of all monies received.

25 *Fees and charges*

- 25.1 The Trust shall follow the Department of Health's Payment by Results guidance in charging commissioners for healthcare services, based on the national tariff. Where prices outside of the national tariff are used, they should be calculated in accordance with the "Costing" Manual.
- 25.2 The **Chief Finance Officer** is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.
- 25.3 All employees must inform the **Chief Finance Officer** promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

26 *Debt recovery*

- 26.1 The **Chief Finance Officer** is responsible for the appropriate recovery action on all outstanding debts.
- 26.2 Income not received should be dealt with in accordance with losses procedures.
- 26.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

27 *Security of cash, cheques and other negotiable instruments*

- 27.1 The **Chief Finance Officer** is responsible for:
- a. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
 - b. ordering and securely controlling any such stationery;

- c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
 - d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
- 27.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.
- 27.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the **Chief Finance Officer**.
- 27.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

Part 5 – NHS Agreement for provision of services ([see also Section C, Paragraph 37](#))

28 Service Level Agreements

The **Chief Executive Officer**, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services. All SLAs should aim to implement the agreed priorities contained within the Financial Plan) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the **Chief Executive Officer** should take into account:

- a. the standards of service quality expected;
- b. the relevant national service framework (if any);
- c. the provision of reliable information on cost and volume of services;
- d. the NHS Commissioning and contracting guidelines;
- e. that SLAs are based on integrated care pathways.

29 Involving partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the **Chief Executive Officer** to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way, the Trust can jointly manage risk with all interested parties.

30 Reports to Board on SLAs

The **Chief Executive Officer**, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

31 *Commissioning*

The Trust's main activity is to provide healthcare services. Guidance should be sought from the **Chief Finance Officer** where commissioning activities are necessary.

Part 6 – Terms of service, allowances and payment of employees

32 *Funded Establishment*

- 32.1 The manpower plans incorporated within the annual budget will form the funded establishment.
- 32.2 The funded establishment of any department may only be varied in accordance with delegated limits.

33 *Staff Appointments*

- 33.1 No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, on a permanent or temporary nature, hire agency staff, or agree to changes in any aspect of remuneration:
 - a. unless authorised to do so by the **Managing Director**;
 - b. within the limit of their approved budget and funded establishment.
 - c. in accordance with Trust approved human resource policies and agreements
- 33.2 The Board will approve procedures presented by the **Managing Director** for the determination of commencing pay rates, condition of service etc, for employees.

34 *Processing Payroll*

- 34.1 The **Chief Finance Officer** will be responsible for liaison with the Trust's payroll and **Chief People Officer** in order to:
 - a. specify timetables for submission of properly authorised time records and other notifications;
 - b. determine final pay and allowances;
 - c. make payment on agreed dates;
 - d. agree methods of payment.
- 34.2 The **Chief Finance Officer** will liaise with the Trust's payroll and **Chief People Officer** to issue instructions regarding:
 - a. verification and documentation of data;
 - b. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
 - c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
 - d. security and confidentiality of payroll information;
 - e. checks to be applied to completed payroll before and after payment;
 - f. authority to release payroll data under the provisions of the Data Protection Act;
 - g. methods of payment available to various categories of employee and officers;

- h. procedures for payment by cheque, bank credit, or cash to employees and officers;
- i. procedures for the recall of cheques and bank credits;
- j. pay advances and their recovery;
- k. maintenance of regular and independent reconciliation of pay control accounts;
- l. separation of duties of preparing records and handling cash;
- m. a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

34.3 Appropriately nominated **managers** have delegated responsibility for:

- a. submitting time records, and other notifications in accordance with agreed timetables;
- b. completing time records and other notifications within 3 months of the date of the claim in accordance with the **Chief Finance Officer's** instructions and in the form prescribed by the **Chief People Officer**;
- c. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the **Chief Finance Officer** must be informed immediately.

34.4 Regardless of the arrangements for providing the payroll service, the **Chief Finance Officer** shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

35 *Contracts of Employment*

The Board shall delegate responsibility to authorised **managers** for:

- a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
- b. dealing with variations to, or termination of, contracts of employment.

Part 7 – Non-pay expenditure

36 *Delegation of Authority*

36.1 The Board will approve the level of non-pay expenditure on an annual basis and the **Chief Executive Officer** will determine the level of delegation to budget managers.

36.2 The **Chief Executive Officer** will set out:

- a. the list of managers who are authorised to place requisitions for the supply of goods and services;
- b. the maximum level of each requisition and the system for authorisation above that level.

36.3 The **Managing Director** shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Part 8 – Choice, requisitioning, ordering, receipt and payment for goods and services

37 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the **Chief Finance Officer** and/or the **Chief Executive Officer** shall be consulted.

38 System of Payment and Payment Verification

38.1 The **Chief Finance Officer** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

38.2 The **Chief Finance Officer** will:

- a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed;
- b. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;
- c. be responsible for the prompt payment of all properly authorised accounts and claims;
- d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - (i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.
 - (ii) Certification that:
 - goods have been duly received, examined and are in accordance with specification and the prices are correct;
 - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
 - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
 - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
 - the account is arithmetically correct;
 - the account is in order for payment.
 - (iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
 - (iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

- e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in [SFI 40](#) below.

39 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

- a. Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to net present value (NPV) using the National Loans Fund (NLF) rate plus 2%).
- b. The appropriate executive director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
- c. The **Chief Finance Officer** will need to be satisfied with the proposed arrangements before approving the contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
- d. The **budget holder** is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate **director** or **Chief Executive Officer** if problems are encountered.

40 Official orders

Official Orders must:

- a. be consecutively numbered;
- b. be in a form approved by the **Chief Finance Officer**;
- c. state the Trust's terms and conditions of trade;
- d. only be issued to, and used by, those duly authorised by the **Chief Executive Officer**.

41 Duties of managers and officers

41.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the **Chief Finance Officer** and that:

- a. all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements, letters of intent and other commitments which may result in a liability are notified to the **Chief Finance Officer** in advance of any commitment being made;
- b. contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;
- c. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
- d. no order shall be issued for any item or items to any firm, which has made an offer of gifts, reward or benefit to directors or employees, other than:
 - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
 - conventional hospitality, such as lunches in the course of working visits;**This provision needs to be read in conjunction with [Section B, Part 3 Standards of Business Conduct](#);**

- e. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the **Chief Finance Officer** on behalf of the **Managing Director**;
- f. all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
- g. verbal orders must only be issued very exceptionally - by an employee designated by the **Managing Director** and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
- h. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- i. goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- j. changes to the list of employees and officers authorised to certify invoices are notified to the **Chief Finance Officer**;
- k. purchases from petty cash and procurement card are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
- l. petty cash and procurement card records are maintained in a form as determined by the **Chief Finance Officer**.

41.2 The **Managing Director** and **Chief Finance Officer** shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant guidance. The technical audit of these contracts shall be the responsibility of the relevant director.

42 Joint Finance Arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under the powers of [Section 75 of the NHS Act 2006](#) shall comply with procedures laid down by the **Chief Finance Officer**, which shall be in accordance with these Acts.

43 External borrowing

43.1 The **Chief Finance Officer** will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The **Chief Finance Officer** is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

43.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the **Chief Executive Officer** and the **Chief Finance Officer**.

43.3 The **Chief Finance Officer** must prepare detailed procedural instructions concerning applications for loans and overdrafts.

43.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

43.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the **Chief Executive Officer** or the **Chief Finance Officer**.

Officer. The Board must be made aware of all short term borrowings at the next Board meeting. All long-term borrowing must be consistent with the plans outlined in the current Financial Plan and be approved by the Trust Board.

44 *Investment*

- 44.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.
- 44.2 The **Chief Finance Officer** is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.
- 44.3 The **Chief Finance Officer** will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

45 *Financial framework*

The **Chief Finance Officer** should ensure that members of the Board are aware of the Financial Framework. This document contains directions, which the Trust must follow. It also contains directions to Clinical Commissioning Groups regarding resource and capital allocation and funding to Trusts. The **Chief Finance Officer** should also ensure that the direction and guidance in the framework is followed by the Trust.

Part 9 – Capital investment, private financing, fixed asset registers and security of assets

46 *Capital Investment*

- 46.1 The **Chief Executive Officer**:
- a. shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
 - b. is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
 - c. shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.
- 46.2 For every capital expenditure proposal the **Managing Director** shall ensure:
- a. that a business case (in line with the guidance contained within the “Capital Investment Manual”) is produced setting out:
 - an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
 - the involvement of appropriate Trust personnel and external agencies;
 - appropriate project management and control arrangements;
 - b. that the **Chief Finance Officer** certified professionally to the costs and revenue consequences detailed in the business case.

- 46.3 For capital schemes where the contracts stipulate stage payments, the **Chief Executive Officer** or **Managing Director** will issue procedures for their management.
- 46.4 The **Chief Finance Officer** shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.
- 46.5 The **Chief Finance Officer** shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
- 46.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.
- 46.7 The **Managing Director** shall issue to the manager responsible for any scheme:
- a. specific authority to commit expenditure;
 - b. authority to proceed to tender;
 - c. approval to accept a successful tender.
- 46.8 The **Chief Executive Officer** will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.
- 46.9 The **Chief Finance Officer** shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as notified to the Trust by the Department of Health/NHSE.
- 46.10 The **Chief Finance Officer** shall issue procedures for the rare occasions where there may be a requirement to commence work in advance of contracts being signed based on a Letter of Intent. Authorisation should be sought from the CFO and/or **Managing Director** in accordance with the scheme of delegation.

47 *Asset registers*

- 47.1 The **Managing Director** is responsible for the maintenance of registers of assets, taking account of the advice of the **Chief Finance Officer** concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling basis.
- 47.2 The Trust shall maintain an asset register recording fixed assets with sufficient detail to enable the asset's identification, valuation, type of asset, location and relevant manager.
- 47.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
- a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

- b. stores, requisitions and wages records for own materials and labour including appropriate overheads;
 - c. lease agreements in respect of assets held under a finance lease and capitalised.
- 47.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 47.5 The **Chief Finance Officer** shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 47.6 The value of each asset shall be held at fair value as determined by the Trust's accounting policies.
- 47.7 The value of each asset shall be depreciated using methods and rates as specified within the Trust's accounting policies.
- 47.8 The **Chief Finance Officer** shall calculate and pay capital charges as specified in the NHS Finance Manual issued by the Department of Health.

48 **Security of Assets**

- 48.1 The overall control of fixed assets is the responsibility of the **Chief Executive Officer**.
- 48.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the **Chief Finance Officer**. This procedure shall make provision for:
- a. recording managerial responsibility for each asset;
 - b. identification of additions and disposals;
 - c. identification of all repairs and maintenance expenses;
 - d. physical security of assets;
 - e. periodic verification of the existence of, condition of, and title to, assets recorded;
 - f. identification and reporting of all costs associated with the retention of an asset;
 - g. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 48.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the **Chief Finance Officer**.
- 48.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.
- 48.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.
- 48.6 Where practical, assets should be marked as Trust property.

Part 10 – Stores and receipt of goods

49 General position

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- a. kept to a minimum;
- b. subjected to annual stock take;
- c. valued at the lower of cost and net realisable value.

50 Control of stores, stocktaking, condemnations and disposal

- 50.1 Subject to the responsibility of the **Chief Finance Officer** for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the **Chief Executive Officer**. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the **Chief Finance Officer**. The control of any pharmaceutical stocks shall be the responsibility of a designated **pharmaceutical officer**; the control of any fuel oil and coal of a designated **estates manager**.
- 50.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the **designated manager/pharmaceutical officer**. Wherever practicable, stocks should be marked as health service property.
- 50.3 The **Chief Finance Officer** shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
- 50.4 Stocktaking arrangements shall be agreed with the **Chief Finance Officer** and there shall be a physical check covering all items in store at least once a year.
- 50.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the **Chief Finance Officer**.
- 50.6 The designated **manager/pharmaceutical officer** shall be responsible for a system approved by the **Chief Finance Officer** for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the **Chief Finance Officer** any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

51 Goods supplied by NHS Supply Chain

For goods supplied via the NHS Supply Chain, the **Chief Executive Officer** shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the **Chief Finance Officer** who shall satisfy himself that the goods have been received before accepting the recharge.

Part 11 – Disposals and condemnations, losses and specials payments

52 *Disposals and condemnation procedures*

- 52.1 The **Chief Finance Officer** must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.
- 52.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the **Chief Finance Officer** of the estimated market value of the item, taking account of professional advice where appropriate.
- 52.3 All unserviceable articles shall be:
- a. condemned or otherwise disposed of by an employee authorised for that purpose by the **Chief Finance Officer**;
 - b. recorded by the Condemning Officer in a form approved by the **Chief Finance Officer**, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the **Chief Finance Officer**.
- 52.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the **Chief Finance Officer** who will take the appropriate action.

53 *Losses and special payments*

- 53.1 The **Chief Finance Officer** must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
- 53.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform **Managing Director** and the **Chief Finance Officer** or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the **Chief Finance Officer** and/or **Managing Director**. Where a criminal offence is suspected, the **Chief Finance Officer** must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies, which may indicate fraud or corruption, the **Chief Finance Officer** must inform the relevant LCFS and NHS Protect regional team in accordance with Secretary of State for Health and Social Care's Directions. The **Chief Finance Officer** must notify NHS Protect and the External Auditor of all suspected frauds.
- 53.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the **Chief Finance Officer** must immediately notify:
- a. the Board (via the Audit Committee),
 - b. the External Auditor.
- 53.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.
- 53.5 The **Chief Finance Officer** shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

- 53.6 For any loss, the **Chief Finance Officer** should consider whether any insurance claim can be made.
- 53.7 The **Chief Finance Officer** shall maintain a Losses and Special Payments Register in which write-off action is recorded.
- 53.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.
- 53.9 All losses and special payments must be reported to the Audit Committee at every meeting.

Part 12 – Information Technology

54 *Responsibilities and duties of the Chief Finance Officer*

- 54.1 The **Chief Finance Officer**, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
- a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
 - b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
 - c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
 - d. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as they may consider necessary are being carried out.
- 54.2 The **Chief Finance Officer** shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
- 54.3 The **Chief Finance Officer** shall publish and maintain a Freedom of Information Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority and describes the classes or types of information about our Trust that we make publicly available.

55 *Responsibilities and duties of other directors and officers in relation to computer systems of a general application*

In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the **Chief Finance Officer**:

- a. details of the outline design of the system;
- b. in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

56 *Contracts for computer services with other health bodies or outside agencies*

- 56.1 The **Chief Finance Officer** shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
- 56.2 Where another health organisation or any other agency provides a computer service for financial applications, the **Chief Finance Officer** shall periodically seek assurances that adequate controls are in operation.

57 *IT risk assessments*

The **Chief Finance Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

58 *Requirements for computer systems, which have an impact on corporate financial systems*

Where computer systems have an impact on corporate financial systems, the **Chief Finance Officer** shall need to be satisfied that:

- a. systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
- b. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- c. **Chief Finance Officer** staff have access to such data;
- d. such computer audit reviews as are considered necessary are being carried out.

Part 13 – Patient Property

59 *Patient property*

- 59.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.
- 59.2 The **Chief Operating Officer** and **Chief Finance Officer**, on behalf of the **Chief Executive Officer** are responsible for ensuring that patients or their guardians, as appropriate, are given information and advice on patient property which includes two key messages:
- a. Patients should keep as little property as possible on Trust premises, and this particularly applies to valuables. They should hand any item they do not need to a relative/carer to take home

- b. The Trust will not accept liability for loss of or damage to the patient's property unless it is handed over for safekeeping and a copy of the Patient Property Record is obtained as a receipt.

This information and the process for handing in property will be provided in writing, by notices and other written information material including admission documentation and property records, and orally through the advice of staff responsible for admission.

- 59.3 The **Chief Finance Officer** must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.
- 59.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the **Chief Finance Officer**.
- 59.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the [Administration of Estates \(Small Payments\) Act 1965](#)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 59.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 59.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

Part 14 – Funds Held on Trust

60 *Corporate Trustee*

- 60.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.
- 60.2 The **Chief Finance Officer** shall ensure that each trust fund, which the Trust is responsible for managing, is managed appropriately with regard to its purpose and to its requirements.

61 *Accountability to Charity Commission and Secretary of State for Health and Social Care*

- 61.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.
- 61.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

62 *Applicability of SFIs to funds held on Trust*

- 62.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held in trust.
- 62.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

Part 15 – Retention of Records

- 63.1 The **Managing Director** shall be responsible for maintaining archives for all records required to be retained in accordance with the [Records Management Code of Practice for Health and Social Care 2021 \(updated 2023\)](#).
- 63.2 The records held in archives shall be capable of retrieval by authorised persons.
- 63.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the **Managing Director**. Detail shall be maintained of records so destroyed.

Part 16 – Risk Management and Insurance

64 *Programme of risk management*

- 64.1 The **Managing Director** shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board. The programme of risk management shall include:
- a. a process for identifying and quantifying risks and potential liabilities;
 - b. engendering among all levels of staff a positive attitude towards the control of risk;
 - c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
 - d. contingency plans to offset the impact of adverse events;
 - e. audit arrangements including; Internal Audit, clinical audit, health and safety review;
 - f. a clear indication of which risks shall be insured;
 - g. arrangements to review the Risk Management programme.

64.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

65 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme, this decision shall be reviewed annually.

66 Insurance arrangements with commercial insurers

There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

- a. Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
- b. where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
- c. where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the **Chief Finance Officer** should consult the Department of Health.

67 Arrangements to be followed by the Board in agreeing insurance cover

67.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution, the **Chief Finance Officer** shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The **Chief Finance Officer** shall ensure that documented procedures cover these arrangements.

67.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the **Chief Finance Officer** shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The **Chief Finance Officer** will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses, which will not be reimbursed.

67.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The **Chief Finance Officer** should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendices 1 and 2 – Schedule of Reservation, Delegation of Powers and Financial Delegation Limits

Introduction

Standing Order 1 provides that “the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session.” These powers and decisions are set out in this Schedule.

1 Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1 Approve, including variations to:

- Standing Orders for the regulation of its proceedings and business (Section B, Part 4).
- this Schedule of matters reserved to the Trust Board (Section B, Part 4, SO 40).
- Standing Financial Instructions (SO 43, SO 44, SFI 2)
- Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (Section B, Part 4).
- suspension of Standing Orders (SO 27)

1.2 Determine the frequency and function of Trust Board meetings (SO 8), including:

- administration of public and private agendas of Board meetings (SO 8)
- calling extra-ordinary meetings of the Board (SO 9)

1.3 Ratify the exercise of emergency powers by the Chair and **Chief Executive Officer** (SO 37)

1.4 Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation (Section B, Part 4); and:

- delegate functions from the Board to the committees
- delegate functions from the Board to a director or officer of the Trust
- approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies
- receive reports from Board committees and take appropriate action in response to those reports
- confirm the recommendations of the committees which do not have executive decision-making powers

1.4.1. approve terms of reference and reporting arrangements of committees (SO 42).

1.4.2. approve delegation of powers from Board committees to sub-committees (SO 42)

1.5 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and modifications thereto.

- Appoint the **Chief Executive Officer** (SO 3)

- Appoint the Chief Officers (SO 3)
- 1.6 Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests (Section B, Part 3).
 - 1.7 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.
 - 1.8 Approve the disciplinary procedure for officers of the Trust.
 - 1.9 Approve arrangements for dealing with and responding to complaints.
 - 1.10 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust
 - 1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2 Determination of strategy and policy

- 2.1 Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.
- 2.2 Approve the Trust's strategic direction:
 - 2.2.1 annual budget, strategy and business plans
 - 2.2.2 definition of the strategic aims and objectives of the Trust.
 - 2.2.3 clinical and service development strategy
 - 2.2.4 overall, programmes of investment to guide the letting of contracts for the supply of clinical services.
- 2.3 Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3 Direct operational decisions

- 3.1 Approve capital investment plans:
 - 3.2.1 the annual capital programme
 - 3.2.2 all variations to approved capital plans in accordance with authorization levels.
 - 3.2.3 to acquire, dispose of, or change of use of land and/or buildings
 - 3.2.4 capital investment in accordance with authorization levels, supported by a business case and in line with the approval guidance issued by NHS England & Improvement.
- 3.1 Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in accordance with the financial delegations.
- 3.2 Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £500K:

- 3.2.1 Tenders and quotations over the lifetime of the contract
 - 3.2.2 Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement
 - 3.2.3 Orders processed through approved supply arrangements
 - 3.2.4 Orders processed through non-approved supply arrangements
 - 3.2.5 Receipt of loans and trials equipment and materials
 - 3.2.6 Prepayment agreements for services received
- 3.3 Decide the need to subject services to market testing (Section C, Part 1)

4 Quality, financial and performance reporting


- 4.1 Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.
- 4.2 Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:
 - 4.2.1 The Care Quality Commission
 - 4.2.2 NHS England
- 4.3 Consider and approve the Trust's Annual Report including the annual accounts.
- 4.4 Approve the Annual report(s) and accounts for funds held on trust.
- 4.5 Approve the Quality Account.

5 Audit arrangements

- 5.1 Approve audit arrangements recommended by the Audit Committee (including arrangements for the separate audit of funds held on trust).
- 5.2 Receive reports of the Audit Committee meetings and take appropriate action.
- 5.3 Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts.
- 5.4 Receive the annual management letter from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.
- 5.5

6 Management of revenue budgets and authorization levels

Appendices 3 – Exemption to Contract Procedure Rules Approval Form

EXEMPTION TO STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS (CONTRACT PROCEDURE RULES)	 Wye Valley NHS Trust
<i>Staff are responsible for ensuring that exemptions to the rules are approved in advance of any action undertaken in all instances where contract procedures rules cannot be complied with. An exemption is a permission to let a contract without complying with one or more of the rules within standing orders and standing financial instructions.</i>	
Section 1 Details	
Scheme Name	
Description of Services, Works or Supplies	
Provider	
Section 2 Contract Values and Duration	
Total Contract Value	
Contract Duration	
Approx Start Date	
Please 'check' the box which covers the contract value:	
<input type="checkbox"/>	Up to £10,000
<input type="checkbox"/>	Up to £100,000
<input type="checkbox"/>	Up to £250,000
<input type="checkbox"/>	Up to £500,000
<input type="checkbox"/>	Over £500,000
Section 3 Why is the exemption requested?	
<i>Not limited to: no quotations have been sought or the purchase cannot be made via a compliant framework agreement. If an application to let a contract without genuine competition is granted, the officer responsible for the contract must demonstrate that the price obtained is not in excess of the market price and that the contract represents best value. A lack of time caused by inadequate forward planning is not a cogent reason and will not permit an exemption to the rules.</i>	
Section 4 Has the matter been agreed with the relevant technical expert	
<i>Has the relevant experts(s) in your service agreed that the goods, services or works to be purchased are required and will be fit for purpose, that the supplier's prices are reasonable and good value for money and the suitability of the proposed provider has been established.</i>	
Section 5 What is the impact of non-approval?	

Section 6 Why has the proposed provider been selected?					
Section 7 What will happen when the exemption period expires?					
<i>What will be in place to prevent the need for a future exemption request?</i>					
Section 8 Has Procurement advice been sought?					
<i>Has procurement advice been sought in arriving at the decision to seek a waiver?</i>					
Section 9 Approvals (to be finalised after completion of Sections 1 to 8)					
Originating Officer					
Name		Signature		Date	
Authorising Officer (as defined in the financial delegation limits: up to £10,000 - Associate COO/Executive Director/Associate or Deputy Director; Up to £50,000 –Chief Finance Officer or Deputy CFO; Up to £100,000—Managing Director OR Chief Finance Officer; Up to £500,000 – Managing Director AND CFO Over £500,000 – Board)					
Name		Signature		Date	
Chief Finance Officer or Nominated Deputy					
Name		Signature		Date	

Management of revenue budgets

Responsibility for maintaining expenditure within approved budget	Authority delegated to
Individual budget level (Pay and Non Pay)	Designated Budget Holder
Divisional/department budgets	Associate COO/Executive Director/Associate or Deputy Director
Financial reserves and provisions	Chief Finance Officer
Hosted services	Appropriate Budget Holder
Virement of budgets WITHIN Cost Centre	Budget Holder/General Manager/Associate COO/Assoc or Deputy Director
Virement of budgets BETWEEN Cost Centres (excluding those affecting reserves):	
<£10k	Designated Budget Holder
£10k-£25k	General Manager
£25k-£50k	Associate COO/Executive Director/Associate or Deputy Director
£50k-£75k	Managing Director OR CFO OR Board Deputy CFO
£75k-£100k	Managing Director OR CFO
£100k-£500k	Managing Director AND CFO
>£500k	Trust Board

Authorisation Levels - Trust

These limits represent the maximum limits to be applied to Groups of Officers (Levels 1-4) operating within their available budgetary provision. Actual limits applied to individual officers may be set at a lower level to reflect the level of delegated budgetary authority. The Chief Finance Officer will maintain an Authorised Signatory List specifying individual officer limits – this list shall have effect as if incorporated in this Scheme of Delegation.

Limits	Auth'n of Non Stock req's and payments	PFI related Exp	Capital Schemes	Finance Leases and MES's
£0k-£10k	Level 4: Designated Budget Holder	Head of Estates	Desig. Capital Project Manager	Level 4: Designated Budget Holder
£10k-£25k	Level 3: General Manager / Associate Directors / Heads of Dept	Head of Estates	Desig. Capital Project Manager	Level 3: General Manager / Associate Directors / Heads of Dept
£25k-£50k	Level 2: Associate COO/Executive Director/ Deputy CFO	Head of Estates	Desig. Capital Project Director	Level 2: Associate COO/Executive Director/ Deputy CFO
£50k-£75k	Level 1b: Managing Director OR CFO OR Board Deputy CFO	Managing Director OR CFO OR Board Deputy CFO	Managing Director OR CFO OR Board Deputy CFO	Level 1b: Managing Director OR CFO OR Board Deputy CFO
£75k-£100k	Level 1: Managing Director OR CFO	Managing Director OR CFO	Managing Director OR CFO	Level 1: Managing Director OR CFO
£100k-£500k	Managing Director AND CFO	Managing Director AND CFO	Managing Director AND CFO	Managing Director AND CFO
>£500k	Trust Board*	Trust Board*	Trust Board*	Trust Board*

* NB: where authority is reserved to the Trust Board, once approved, it shall be enacted on the relevant Trust system by the Managing Director AND the CFO

Authorisation Levels - Charitable Funds

Limits	Charitable Funds	Charitable Funds	Role Titles	Lease and MES Value
<£2k	Fund Manager	Charitable Funds No changes proposed to sign-off limits or rights	Role Titles Associate COO and General Manager are designated roles within the organisational hierarchy relating to operating Divisions. Associate Director roles in corporate functions will be designated as equivalent roles for the purpose of the scheme of	Lease and MES Value Authorisation limits applicable to Leases and MES's will apply to the whole life cost of lease or MES charges.
£2k-£10k	Managing Director OR CFO			
£10k-£25k	Managing Director AND CFO			
£25k-£50k	Managing Director AND CFO AND Chairman/NED			
>£50k	Trust Board or Charity Trustee			

Non Pay Expenditure - requirements to enforce competition

Limits	Requirements	Application of competition requirements based on value of procurement (Left)	Tendering and Contract Procedures (Below)	Delegated Authority
£0k - £9.999k	No Quotations required though VFM to be evidenced	The limits are applicable to all requisitions. Values are based on the full contract life. Values exclude VAT	These limits govern processes relating to the managing and award of tenders and subsequent amendments to contract terms. They also identify the limits applicable to the application of waivers to procurement requirements as set out in SFI's and the level at which waivers must be approved. All waivers are reported on to the Audit Committee on a retrospective basis.	Where either the Managing Director or Chief Finance Officer are unavailable due to annual or sick leave, delegated authority for authorisation of goods and services and/or contract awards and application of waivers is delegated to the Chief Executive or an Executive Director in the case of the Managing Director or to one of the Deputy CFOs in place of the Chief Finance Officer.
£10k-£49.999k	Minimum of 3 formal written quotations received			
£50k - Find a Tender Limit	See advice of CFO or Head of Procurement - formal procurement			
> Find a Tender Limit	All potential contracts over this value must comply with the Procurement Act 2023. Thresholds subject to amendment and differ according to type of expenditure. Contact Head of Procurement for advice/guidance			

Tendering and Contract Procedures (including Leases and MES's)

Limits	Application of Waivers to avoid requirements to obtain Quotations/Tenders (subject to SFIs)	Opening Tenders	Awarding Tenders and Signing of Contracts on behalf of the Trust	Variation to existing contracts (including PFI scheme and MES's)
<£10k	Associate COO/Executive Director/Associate or Deputy Director		Designated Budget Holder	Designated Budget Holder
£10k-£50k	CFO / Deputy CFO		Associate COO/Executive Director/Associate or Deputy Director	Associate COO/Executive Director/Associate or Deputy Director
£50k-£75k	Managing Director OR CFO OR Board Deputy CFO		Managing Director OR CFO OR Board Deputy CFO	Managing Director OR CFO OR Board Deputy CFO
£75k-£100k	Managing Director OR CFO		Managing Director OR CFO	Managing Director OR CFO
£100k-£500k	Managing Director AND CFO		Managing Director AND CFO	Trust Board*
>£500k	Trust Board*		Trust Board*	Trust Board*
<£1m		Two Senior Managers/Officers as nominated by Managing Director		
>£1m		One Senior Manager/Officer and one Board member		

* NB: where authority is reserved to the Trust Board, once approved, it shall be enacted on the relevant Trust system by the Managing Director AND the CFO

Where the total value of the contract (being the value over the contract period) is > £100k a Contract Adjudication Report must be completed to document that the relevant approval routes have been followed.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board in Public
Date of Meeting:	04/06/2026
Title of Report:	Executive Risk and Compliance Committee Terms of Reference
Lead Executive Director:	Managing Director
Author:	Gweny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	Executive Risk and Compliance Committee
Enclosures included with this report:	Terms of Reference
Purpose of report:	<input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
<p>The terms of reference for the Executive Risk Management Committee have been reviewed and revised and are presented to the Board for approval. Material changes are:</p> <ul style="list-style-type: none"> • Strengthening and extending the Committee’s focus on regulatory compliance (including health and safety, emergency planning and information governance). • Clarifying the Committee’s role on behalf of the Board regarding risk management. • Enhancing the Committee’s focus on risk register housekeeping and divisional risk management process and governance. • Renaming the Committee to reflect these changes to Executive Risk and Compliance Committee <p>The output from the Committee will be included with each Board Assurance Framework report to the Board.</p>	
Recommended Actions required by Board or Committee	
The Board is asked to approve the revised terms of reference for the Executive Risk and Compliance Committee.	
Executive Director Opinion¹	
The terms of reference were approved by the Managing Director and Executive Team before formal approval by the 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.

Executive Risk and Compliance Committee

TERMS OF REFERENCE

Remit	<p>Constitution In accordance with the Standing Orders, the Executive Risk and Compliance Committee (“the Committee”) is established by the Trust Board.</p> <p>The Committee has no executive powers other than those specified in these terms of reference or the Scheme of Delegation.</p> <p>The Committee is authorised by the Trust Board to investigate any activity within its terms of reference and to seek any information it requires from any Trust employee. All employees are instructed to cooperate with any request made by the Committee.</p> <p>Role The role of the Committee is to assist the Trust Board in fulfilling its responsibilities by reviewing and monitoring:</p> <ul style="list-style-type: none"> • The Trust’s attitude to and appetite for risk. • The effectiveness of the Trust’s risk management framework, including its policies, procedures and tools. • The Trust’s compliance with legislation and regulations in relation to: <ul style="list-style-type: none"> ○ Health and safety ○ Information governance ○ Emergency planning, resilience and response ○ Any other topic as delegated to the Committee by the Trust Board
Accountability Arrangements	The meeting is accountable to <i>Trust Board</i>
Responsibilities	<p>The <i>Executive Risk and Compliance Committee</i> will:</p> <p>Risk management</p> <ul style="list-style-type: none"> • Regularly review the Trust’s Risk Management Framework and associated documentation, ensuring they remain fit for purpose and accessible to all staff. • Ensure that an up to date, complete and effective risk register is maintained. • Maintain an overview of the key risks identified across the Trust, obtaining assurance from divisional risk owners regarding their management. • Review independent assurance regarding the effectiveness of risk management arrangements and oversee actions taken to make any improvements required. • Regularly review the Board Assurance Framework to ensure clear alignment to the Trust’s strategic objectives and a link to the Trust’s key operational risks and issues. <p>Risk Appetite</p> <ul style="list-style-type: none"> • Consider the appropriate risk appetite for the Trust across all major activities, taking into account the overall strategy of the Trust, its future plans and other internal information as well as the external environment, including economic, political and sector information. • Regularly review the Trust’s Risk Appetite Statement, making recommendations to the Trust Board on any changes required.

	<p>Regulatory Compliance</p> <ul style="list-style-type: none"> • Maintain oversight of the work of the sub-committees or other functions responsible for monitoring compliance with key statutory and regulatory compliance, including: <ul style="list-style-type: none"> ○ Health and Safety ○ Information Governance ○ Emergency Planning, Resilience and Response • Obtain and provide assurance to the Trust Board on the effectiveness of the sub-committees arrangements. • Receive regular updates on significant risks to regulatory compliance and the implementation of improvement plans. • Receive regular updates on any significant outcomes arising from external reviews by regulatory bodies regarding matters within these terms of reference. <p>Policies</p> <ul style="list-style-type: none"> • To review and approve updates to key policies, including: <ul style="list-style-type: none"> ○ Risk Policy ○ Health and Safety Policy ○ Information Governance Policy
<p>Membership / Attendance</p>	<p>The membership of the <i>Executive Risk and Compliance Committee</i> shall comprise of:</p> <p>Membership and Quorum The Committee membership shall comprise:</p> <ul style="list-style-type: none"> • All executive directors. • A named, senior representative from each clinical division. • The Associate Director of Corporate Governance/Company Secretary <p>The Managing Director shall be the Chair of the Committee. In the absence of the Managing Director, one of the other Executive Directors shall chair a meeting. A quorum shall comprise four members including a minimum of two executive directors.</p> <p>Meetings and Attendance Meetings will usually take place on a monthly basis. Additional meetings may be called if necessary, at the discretion of the Chair.</p> <p>Meetings will usually take place by means of video conference.</p> <p>Members are expected to attend every meeting, issuing apologies to the meeting secretary in advance of meetings where necessary.</p> <p>Deputies may attend meetings in the place of a Committee member but will not count towards a quorum in the case of executive directors.</p> <p>Other members of staff will be expected to regularly attend meetings to present reports and/or contribute to discussions. These shall include:</p> <ul style="list-style-type: none"> • Health, Safety and Risk Manager. • The chairs of relevant sub-committees. • Heads of corporate departments. <p>Other members of staff or external observers or contributors may attend meetings at the discretion of the Chair.</p>
<p>Chair</p>	<p>The Chair of the <i>Executive Risk and Compliance Committee</i> shall be the <i>Managing Director</i> or in their absence a nominated Executive.</p>
<p>Quorum</p>	<p>The quorum for the <i>Executive Risk and Compliance Committee</i> meetings shall be <i>four members</i> of which at least <i>two executive directors</i> are present.</p>

Reporting Arrangements	As appropriate to <i>Executive Risk and Compliance Committee</i>
Frequency of Meeting	The <i>Executive Risk and Compliance Committee]</i> will meet monthly.
Administration	<p>The Associate Director of Corporate Governance/Company Secretary shall be responsible for ensuring the appropriate administration of the Committee.</p> <p>The Committee shall provide a regular report to the Trust Board to provide assurance on the performance of its functions.</p>
Date Approved	
Date Review	These terms of reference shall be reviewed annually and any revisions submitted to the Trust Board for approval.

Report to:	Public Board
Date of Meeting:	04/06/2026
Title of Report:	Use of the Trust Seal
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Associate Director of Corporate Governance & Company Secretary
Reporting Route:	N/A
Appendices included with this report:	N/A
Purpose of report:	<input type="checkbox"/> Assurance <input type="checkbox"/> Approval <input checked="" type="checkbox"/> Information
Brief Description of Report Purpose	
<p>The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.</p> <p>The Board is asked to note the use of the Trust Seal as follows:</p> <ul style="list-style-type: none"> • 22 December 2025: Lease for Vaughan and Benet Buildings / Stamp Duty and Land Tax • 18 May 2026: Lease - Vaughan and Benet Buildings, Belmont Abbey Replacement Land Registry compliant lease plan 	
Recommended Actions required by Board or Committee	
The Board is asked to note the use of the Trust Seal as described above.	
Executive Director Opinion¹	
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.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	4th June 2026
Title of Report:	Foundation Group Boards Workshop – 6 th May 2026
Lead Executive Director:	Glen Burley, Chief Executive Officer
Author:	Chelsea Ireland, Foundation Group EA
Reporting Route:	Direct to Board
Enclosures included with this report:	Foundation Group Board Workshop Report
Purpose of report:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information
Brief Description of Report Purpose	
To provide the Board with an overview of the Foundation Group Boards Workshop held on 6 th May 2026	
Recommended Actions required by Board or Committee	
To note the report.	
Executive Director Opinion¹	
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.

Foundation Group Boards Workshop Report from the Meeting held on 6 May 2026

The second Foundation Group Boards Workshop was held on 6 May 2026, and the agenda was structured to provide both assurance and strategic insight across a range of priority areas for the Foundation Group.

The workshop opened with standard governance items, including apologies, declarations of interest, and a review of matters arising and previous actions, ensuring continuity and oversight from earlier meetings. This was followed by our mandatory Board level Cyber Security Training. Board members are required to complete this training every two years, and this year it highlighted the importance placed on digital resilience and organisational awareness in light of ongoing system risks.

The mid-morning agenda focused on operational performance and service quality. The Foundation Group Performance Report provided an overview of organisational delivery, followed by a dedicated deep dive into Children and Young People Services, indicating a targeted focus on this patient cohort. This was complemented by a Safe Staffing overview, including nurse-to-bed ratios, demonstrating the Board's continued scrutiny of workforce capacity and patient safety metrics across the Foundation Group.

In the latter part of the session, attention shifted towards strategic transformation programmes, particularly the "Big Move" initiatives. Updates were provided on 'Home First' - specifically on the New Hospital Programme Demand Model, and on 'Being a Very Flexible Employer', reflecting system-wide ambitions to modernise care delivery and workforce practices. The agenda also included discussions on succession planning and talent management, reinforcing the importance of leadership sustainability and future workforce capability.

The workshop concluded with a strategic update and discussion on shared Foundation Group objectives, alongside a spotlight session on improving outcomes through research. This reinforced the Group's commitment to innovation and evidence-based improvement. The meeting closed with standard governance items, including any other business and confirmation of the next workshop date which is the 5th August 2026.

Chelsea Ireland
Foundation Group EA

Acronyms	
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