WVT Trust Board Held in Public

Thu 02 July 2026, 13:00 - 14:30

MS Teams

Agenda

13:00 - 13:01
1 min

1. Apologies for Absence

Information *Frances Martin*

13:01 - 13:02
1 min

2. Quorum & Declarations of Interest

Information *Frances Martin*

13:02 - 13:07
5 min

3. Minutes of the Meeting held on the 4th June 2026

Approval *Frances Martin*

3 - Public Board Minutes - June 2026~Final.pdf (8 pages)

3.1. Foundation Group Strategy Committee Report - 18th June 2026

Information *Glen Burley*

3.1 - FGSC Report from the Meeting held on 18 June 2026.pdf (4 pages)

3.2. Foundation Group Strategy Committee Annual Report

Information *Glen Burley*

3.2 - FGSC Annual Report 2025-26.pdf (5 pages)

13:07 - 13:07
0 min

4. Matters Arising and Action Log

Discussion *Frances Martin*

There are no matters arising.

13:07 - 13:17
10 min

5. Chief Executive Officer's Report

Information *Glen Burley*

5 - WVT CEO Update Report and Coversheet - July 2026 Final~v1 SS.pdf (4 pages)

13:17 - 13:37
20 min

6. Integrated Performance Report

Information *Sarah Shingler*

6 - WVT - IPR Board Report - June 2026~v1 SS.pdf (27 pages)
6a - Board KPI Dashboard - May 2026.pdf (4 pages)

6.1. Quality

Lucy Flanagan / Chizo Agwu

6.2. Operational

Andrew Parker

6.3. Workforce

Geoffrey Etule

6.4. Finance

Katie Osmond

13:37 - 13:57
20 min

7. Quality

7.1. Board Briefing: Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust (June 2026)

Information *Lucy Flanagan*

7.1 - Ockenden Summary Report Public Board~v3- Final.pdf (3 pages)

7.2. Board Briefing: Independent Investigation into Maternity and Neonatal Services in England - Final report and recommendations (Amos Review)

Information *Lucy Flanagan*

7.2 - Amos Summary Report Public Board_LF Final.pdf (2 pages)

7.3. Quality Committee Escalation & Assurance Report

Assurance *Ian James*

7.3 - Quality Committee Escalation Assurance Report June 2026.pdf (2 pages)

13:57 - 14:17
20 min

8. Governance and Risk

8.1. Board Assurance Framework

Assurance *Gwenny Scott*

8.1 - BAF Report Coversheet - May 2026.pdf (2 pages)
8.1a - Board Assurance Framework Header June 2026.pdf (4 pages)
8.1b - BAF Risk Summaries June 2026.pdf (14 pages)

8.2. Audit Committee Escalation and Assurance Report

Assurance *Nicola Twigg*

8.2 - Audit Committee Escalation & Assurance Report 23 June 2026.pdf (2 pages)

8.3. Executive Risk and Compliance Committee Escalation and Assurance Report

Assurance *Sarah Shingler*

8.3 - ERCC Escalation & Assurance Report 17 June 2026.pdf (2 pages)

8.4. Charity Trustee Escalation and Assurance Report

Assurance *Grace Quantock*

8.4 - Charity Trustee Escalation & Assurance Report April 2026~Final.pdf (1 pages)

14:17 - 14:22
5 min

9. Any Other Business

Frances Martin

14:22 - 14:27
5 min

10. Questions from Members of the Public

Discussion *Frances Martin*

14:27 - 14:27
0 min

11. Acronyms

For Information

Acronyms - 2026.pdf (3 pages)

14:27 - 14:27
0 min

12. Date of Next Meeting: 3rd September 2026 at 1.00 p.m.

WYE VALLEY NHS TRUST
Minutes of the Trust Board Held in Public
Held on 4th June 2026 at 1.00 pm – 2.30 pm.
MS Teams

Present (Voting):		
Frances Martin	FM	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
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 /Deputy Managing Director
Geoffrey Etule	GE	Chief People Officer
Jo Rouse	JR	Associate Non-Executive Director
In Attendance		
Sarah Assinder	SA	Associate COO – representing Andy Parker, COO
Justine Jeffery	JJ	Director of Midwifery
Lou Robinson	LR	Deputy Company Secretary for the minutes
Jo Sandford	JS	FTSU Guardian (for Item 8)
Gwenny Scott	GS	Associate Director of Corporate Governance
Going the Extra Mile Awards Attendees		
Dorota Koim	DK	Senior Pharmacist Technician – Employee of the Quarter
Apologies:		
Andy Parker	AP	Chief Operating Officer (Non-Voting)
Kieran Lappin	KL	Associate Non-Executive Director (Non-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**
The Board was quorate and there were no declarations of interest.				
3	**Going the Extra Mile Awards (GEM)**	**FM**	**Information**	**Verbal**

The following summaries were presented to the Board.

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. Specialist and community palliative care consultants recognised their excellent multidisciplinary collaboration and communication, 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.

FM thanked DK for attending the Board and expressed strong gratitude recognising this contribution by awarding the Employee of the Quarter Award.

FM thanked the Oxygen Clinical Nurse Specialist team for delivering outstanding, compassionate and well-coordinated care in a complex situation and noted that this care exemplified excellent patient-centred care recognising their contribution by awarding the Team of the Quarter Award.

The Board congratulated both sets of Award winners for their exemplary work.

4	**Minutes of meeting on 2nd April 2026**	**FM**	**Approval**	**Enclosure 01**
Approved.				
5	**Matters Arising and Action Log**	**FM**	**Information**	**Enclosure 02**
The Action Log was noted.				
6	**Managing Director's Report**	**SS**	**Assurance**	**Enclosures 03-04**

The paper was taken as read.

SS highlighted generally strong operational performance alongside an emerging pressure from upcoming industrial action. A clarification was made noting a resident doctor strike had now been planned for 15-19th June 2026, with contingency planning underway.

Positively, surgical performance was strong, with the Trust now ranked 7th nationally for theatre utilisation, improved elective care performance, reduced short-notice cancellations, and high day case rates. The elective surgical hub had also achieved GIRFT accreditation, reflecting significant team effort.

Progress was outlined in broader system working, particularly the One Herefordshire Partnership, which was moving into delivery mode. This includes developing a 24/7 single point of access, improved system coordination, and a digital transformation hub, indicating a shift toward more integrated and accessible care services.

The Board accepted the Managing Director's Update Report.

7	**Integrated Performance Report**	**SS**	**Information**	**Enclosures 09-10**

The paper was taken as read.

SS summarised that while there are areas of strong performance, particularly in community care expansion, elective activity, and cancer standards, the Trust's main challenge remained the urgent and emergency care pathway. The need for significant improvement in patient flow and waiting times, alongside clear actions being implemented, including "red lines" such as eliminating long waits, reducing ambulance handover delays, and eradicating corridor care, was emphasised. Progress will depend on both system-wide work through neighbourhood health initiatives and internal improvements to capacity, navigation, and discharge processes.

7.1	***Quality (Including Mortality)***	***LF/CA***

LF reported strong progress in key quality areas, particularly achieving routine monitoring status following infection prevention inspections, reflecting improved collaboration across teams. It was noted that while Endoscopy accreditation had been deferred, positive practice was recognised and required actions were on track for completion. She also emphasised a key strategic focus on

tackling antimicrobial resistance and reducing hospital-acquired infections, including increasing delivery of antibiotic care at home, with this set as both a national and local quality improvement priority.

Mortality

CA reported that the Trust's mortality indicator (SHMI) for January to December 2025 remained stable at 112, keeping the organisation within the expected range, although slightly higher than desired. Key diagnostic groups such as sepsis, heart failure, stroke and pneumonia were stable or improving, while fracture neck of femur remained an area of concern despite slight improvement. It was noted that ongoing work to improve outcomes through structured initiatives such as enhanced recovery approaches and maintaining strong compliance with national hip fracture standards.

CA also provided an overview of the quality improvement priority to reduce the incidence of hospital acquired pneumonia.

FM welcomed the update and commended the progress in quality improvement, particularly the work on antimicrobial stewardship (a detailed presentation had been received at the Board Workshop), highlighting confidence that this would reduce reliance on intravenous antibiotics and promote safer, more targeted use. It was acknowledged there were continued ongoing concerns around mortality data and coding accuracy, but provided assurance that work was underway to improve data quality. Overall, it was reinforced that crude mortality figures were reassuring and emphasised continued scrutiny and use of data to understand performance and drive improvement.

7.2	***Activity and Performance***	***SA***

SA reported that urgent and emergency care continued to be the Trust's most significant operational challenge, with persistent pressures on waiting times, emergency department flow and ambulance handovers. It was emphasised that while some progress had been made, such as increased use of community services to care for patients at home and, improved navigation of patients away from emergency departments, there was still substantial improvement required.

A clear set of "red line" expectations was described to improve safety and flow, including eliminating long waits in emergency departments, avoiding inappropriate use of escalation areas, improving ambulance handover times, and working towards eradicating corridor care. Delivery of these improvements will rely on both system-wide approaches, particularly through neighbourhood health services, and internal changes such as better use of same-day emergency care, improved patient flow, and more proactive discharge processes.

A number of key improvement schemes were noted including maximising patient navigation to direct people away from emergency departments where appropriate, increasing use and occupancy of the same day emergency care (SDEC) service, and developing a ward pull model so inpatient areas proactively take patients rather than waiting. It was also referenced that work on the safer flow care bundle, which includes criteria-led discharge, standardised escalation processes and improving early patient flow through the hospital continued.

Alongside these challenges, SA highlighted strong performance in other areas, noting continued improvements in elective care, including high theatre utilisation, reduced waiting times and cancellations, and strong cancer performance. Overall, the update reflected a service under pressure in urgent care, but with clear plans in place and positive progress in planned care and community delivery models.

GQ asked how the Trust was communicating and promoting the benefits of "hospital at home" to both the public and staff, noting there may be misconceptions or lack of awareness about receiving care at home instead of in hospital and highlighting the importance of improving understanding to support uptake. SA responded that communication and engagement were key enablers to success, acknowledging the need to improve both internal and external awareness. It was noted that positive patient experiences were already helping to spread awareness but confirmed that a structured communication and engagement plan forms part of the neighbourhood health programme to support wider understanding and adoption.

7.3	***Workforce***	***GE***

GE reported positively on workforce progress, highlighting that the Trust now had one of the lowest sickness absence rates in the NHS, supported by strong health and wellbeing initiatives, with a continued focus on maintaining staff wellbeing while reducing absence levels. The organisation's commitment to equality and inclusion was reaffirmed, stressing a zero-tolerance approach to racism, discrimination and sexism, alongside further engagement with staff networks to ensure a supportive and compassionate working environment.

Ongoing work to improve efficiency was outlined, including completion of the first phase of a voluntary redundancy programme and the restart of a Workforce Optimisation Group to drive productivity improvements. In addition, significant progress in recruitment,

with over 30 consultants appointed over the past year to address longstanding vacancies was welcomed, helping to improve patient care and reduce reliance on agency staff.

GQ asked whether the Trust had received any specific feedback from staff on what additional support they would like to help address experiences of racism or discrimination and how the organisation could better demonstrate support and compassion. GE noted that this question had recently been put directly to staff through a staff network meeting, inviting feedback by mid-June. At that point, no significant concerns or specific requests had been raised, but it was emphasised that the Trust was actively seeking input and will review any feedback received to identify further actions to support staff.

FM reaffirmed the Trust's zero-tolerance approach to racism and any form of discrimination, making clear that it is not acceptable towards patients, staff or between colleagues. All staff were expected to treat others with respect and to act if they witness inappropriate behaviour and gave assurance that the organisation will fully support staff who experience discrimination. Wider societal tensions were acknowledged but stressed that the Trust was committed to ensuring a safe, inclusive and respectful environment for everyone.

7.4	***Finance Performance***	***KO***

KO reported that the Trust began the financial year with a £700k deficit, which was £200k worse than plan, largely due to unplanned industrial action costs. Despite this, there were positive trends, including continued reductions in agency spend and strong elective activity supporting income performance.

Delivery of efficiency savings was underway, with £1m achieved in the first month, though slightly behind the £1.4m target, requiring some short-term mitigation.

It was emphasised that the overall financial plan remained highly challenging, with a requirement to deliver around £25m in efficiencies, highlighted the need to focus on both immediate savings and longer-term transformational improvements to ensure sustainability. It was further noted the risks around income assumptions, particularly relating to contractual arrangements, and the importance of closely monitoring cash flow, which is currently stable but remained sensitive to performance against plan and ongoing receipt of national support funding.

FM emphasised that managing finances was a shared responsibility across the organisation, with every member of staff contributing through their day-to-day decisions. Colleagues were encouraged to be mindful of costs, consider the financial impact of their actions, and avoid unnecessary expenditure while continuing to provide appropriate care. It was stressed to be reminded of the importance of treating resources as if they were their own, identifying low-value or wasteful activities, and supporting the Trust's goal of using public money wisely to maintain financial balance and deliver services effectively.

The Board accepted the Integrated Performance Report.

8	**Freedom to Speak Up (FTSU) Annual Report**	**JS**	**Assurance**	**Enclosure 11**

The paper was taken as read.

JS highlighted that the service remained trusted and valued, with staff continuing to come forward to raise concerns, which was described as a positive sign. However, emerging patterns suggested some staff felt less psychologically safe, including increased requests for confidentiality and reassurance about speaking up, indicating that raising concerns can still feel difficult. It was emphasised that speaking up was often a personal and emotional experience, where staff value being listened to and supported as individuals rather than just through formal processes.

Three key areas where board support was needed included: continued visible leadership to reinforce that speaking up is safe and welcomed; strengthening the human and relational aspects of support so staff feel heard and cared for; and considering investment in early, person-centred interventions to improve wellbeing, retention and reduce escalation of concerns

IJ welcomed the report and thanked JS for the progress, noting improvements over time including a significant increase in speaking up champions. It was highlighted that while the service was strengthening, increasing confidence may also bring new challenges as more staff come forward. It was highlighted that the staff survey showed a positive increase in confidence to speak up within the Trust, with scores rising by around 1.5% compared to the previous year. This improvement stands against a national trend of declining confidence, reflecting well on the progress made locally in strengthening the speaking up culture.

JS explained plans with GE on actions to reduce the number of staff needing to escalate concerns directly to the Freedom to Speak Up service. This included strengthening alternative routes and signposting mechanisms so that issues can be addressed earlier and more locally where appropriate, while continuing to support staff and maintain confidence in the system.

The Board accepted the FTSU Annual Report.

9	**QUALITY**			
9.1	**Quality Committee Escalation and Assurance Report**	**IJ**	**Assurance**	**Enclosure 12**

The paper was taken as read.

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.

IJ drew particular attention to the priority on transition of care for children and young people moving from paediatric to adult services. It was explained that this transition was not always managed as well as it could be and was, therefore, a key focus area for improvement. The importance of co-production in this work, ensuring that children, young people and their families are directly involved in shaping how services are improved to deliver a better experience was key.

The Board accepted the Quality Committee Escalation and Assurance Report.

9.2	**Trust Quality Account**	**LF**	**Approval**	**Enclosure 13-14**

LF presented the Quality Account as the final draft, explaining that it was a nationally mandated report reviewing performance against the previous year's quality priorities and setting out priorities for the year ahead. It was confirmed it had been reviewed by the Quality Committee and was being brought to Board for approval, subject to final additions prior to publication on 30th June.

- ICB statement of assurance.
- Chief Executive overview.
- Final Quality Control check

Any material comments requiring Board attention will be escalated to Board in advance of the extraordinary meeting on 23rd June 2026 should these arise.

The Board approved the Draft Trust Quality Account subject to those caveats.

9.3	**Perinatal Safety Report**	**JJ**	**Assurance**	**Enclosure 15**

The report was taken as read.

JJ reported that overall perinatal safety performance remained stable, with no significant adverse outcomes despite some emerging pressures. A small number of delays in induction of labour and decision-to-delivery timings were noted but confirmed these were clinically justified and had not impacted patient outcomes.

The home birth service remained temporarily suspended although there has been positive progress on recovery actions and no significant increase in associated risks.

A small number of challenges were highlighted, including occasional patients being transferred long distances for care and a decline in early booking performance, which was being investigated. There were also some concerns around workforce pressures and service demand, but these were being actively managed.

There was confirmation of extremely strong progress in safety governance, including increased frontline engagement through safety champions and full compliance with CNST 10 - national maternity safety standards, which will result in additional funding for the Trust. Not all Trust's met this standard so there may be some additional funding for those who have.

The Board accepted the Perinatal Safety Report.

9.4	**Perinatal Staffing Reports – March and April**	**JJ**	**Assurance**	**Enclosure 16-17**

The reports were taken as read.

JJ reported that perinatal staffing had been broadly stable over the period, although sickness levels for midwives and neonatal nurses remained higher than desired, with expectations that these would improve by the end of the first quarter. Vacancy levels were being actively managed, with midwives in the recruitment pipeline and substantive recruitment helping to maintain safe staffing levels despite high maternity leave rates.

It was explained that some support worker vacancies were being held pending a wider staffing review, after which recruitment would proceed. There had been a reduction in staff redeployment, supported by improved skill mix and increased midwife presence in inpatient areas. However, challenges remained in the neonatal unit, where unplanned demand sometimes required the shift leader to take on a caseload, affecting supernumerary status. Overall, staffing pressures were being managed, with positive trends in some areas but ongoing challenges in others.

It was confirmed that reporting to the Board would move to quarterly with any escalations in between being reported via the IPR quality or the CNO safe staffing report.

The Board accepted the Perinatal Staffing Reports – March and April.

10	**Integrated Care Oversight and Assurance Committee (ICOAC) Report**	**EB**	**Assurance**	**Enclosure 18**

The report was taken as read.

It was clarified that FM had previously chaired the Integrated Care Oversight and Assurance Committee, but due to new responsibilities as Chair across two trusts, IJ had now taken on the role of committee chair. During the transition period, EB had been covering the chairing duties for recent meetings until IJ formally assumed the position. Both were thanked for their contributions.

The Board accepted the ICOAC Report.

10.1	**One Herefordshire Alliance Agreement**	**SS**	**Approved**	**Enclosure 19-20**

SS reported that the One Herefordshire Alliance Agreement established the formal framework for collaboration between health and care partners to improve population health, reduce inequalities and support long-term financial sustainability. It was noted that it aligned with national policy and local strategy and set out clear governance, accountability and data-sharing arrangements.

As the host organisation, the Trust would hold responsibility for any delegated funding and contractual requirements, supported by a defined risk management framework. While there were some associated risks, these were considered manageable, and the partnership would evolve over time, potentially moving towards more integrated arrangements. Decision-making would be managed through the partnership structure, with matters escalated through Trust Management Board and full Board where required. Board approval for the agreement was sought.

The Board approved the One Herefordshire Alliance Agreement.

11	**Children and Young People Committee (CYPC) Escalation and Assurance Report**	**JR**	**Assurance**	**Enclosure 21**

The paper was taken as read with no areas of escalation required.

The Board accepted the CYPC report.

12	**Governance and Risk**			
12.1	**Audit Committee Escalation and Assurance Report**	**NT**	**Assurance**	**Enclosure 22**

The paper was taken as read with no areas of escalation required.

The Board accepted the Audit Committee Escalation and Assurance Report Update.

12.2	**Revised Standing Financial Instructions (SFI's) / Scheme of Delegation**	**KO**	**Approval**	**Enclosure 23-25**

KO reported that the annual review of the Standing Financial Instructions had been completed and that only one amendment was proposed. This change introduced an additional delegated authority limit of £75k for the Deputy CFO, reflecting KO's dual role across organisations and ensuring approvals could continue efficiently without delays. It was confirmed that this amendment had been reviewed and supported by the Audit Committee

The Board approved the SFI's including the updated Scheme of Delegation.

12.3	Executive Risk and Compliance Committee Terms of Reference	SS	Approval	Enclosure 26-27

SS reported that the Trust had reviewed and updated the terms of reference for its newly named Executive Risk and Compliance Committee, to reflect an expanded remit. The changes strengthened the committee's focus to include regulatory compliance areas such as health and safety, emergency planning and information governance, and clarified its role in overseeing risk management on behalf of the Board.

The committee would place greater emphasis on working with divisions and corporate functions to ensure risks are accurately recorded, appropriately managed and consistently scored, and Board approval for the revised terms of reference was sought.

The Board approved the Executive Risk and Compliance Committee Terms of Reference.

12.4	Use of the Trust Seal – Biannual Report	GS	Information	Enclosure 28

The Seal was attached to documents where there was a legal requirement for sealing and the subject matter of the relevant documents had been approved in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation. The paper was presented for information.

The Board accepted the Use of Trust Seal report.

12.5	Foundation Group Board Workshop Report	FM	Information	Enclosure 29

The report was taken as read with no matters of escalation.

The Board accepted the FG Board Workshop Reports

12.6	Foundation Group Strategy Committee / Board Workshop March 2026	GB	Assurance	Enclosure 38-40

The report was taken as read with no matters of escalation.

The Board accepted the Committee Summary Report.

13.	Any Other Business

There was no further business for discussion.

14.	Questions from Members of the Public	FM	Information	Verbal Update

FM acknowledged that a number of detailed questions had been received from a member of the public.

Question 1. - *My last question to the Boards previous meeting I asked if the Board would conduct future Board meetings in a hybrid manner so that both online and face to face members the public could attend. The Chair seems to have overlooked this option and only considered online and face to face. It should be remembered that Herefordshire is an ageing population many of whom are not online! Would she reconsider?*

FM Response:
It was explained that the Chair had again considered the option of holding hybrid or in-person board meetings again but concluded that continuing with fully virtual meetings provided the most accessible approach for the public and staff. It was noted that virtual meetings allow people to join more flexibly or watch at a convenient time and highlighted that the Trust currently lacked the technology to support effective hybrid meetings. It was confirmed that meetings would remain online, with opportunities for the public to submit questions in advance.

Question 2. *Would the Board care to give details of hard to fill consultant posts and how long they have been vacant?*

GE Response:
There continues to be a national shortage occupation list for clinical positions and Wye Valley NHS Trust with many other organisations still face difficulties in filling medical vacancies. Over the past year, we have successfully recruited to many of our long-standing medical vacancies in Stroke, Haematology, Respiratory and Microbiology. It was noted that while vacancies had previously been covered by agency staff to maintain services, these were now increasingly being replaced by substantive appointments, which was better for both patient care and cost control.

Question 3.

- *How many WVT patients have died of sepsis in the last year, including those who have been transferred to other hospitals before death?*
- *How does this compare with other hospital trusts?*

CA Response:

In response to a public question, it was confirmed that 105 patients died from sepsis in the last year compared to 95 expected, giving a SHMI of 107, which was within the expected range and does not make the Trust an outlier. It was emphasised that sepsis remained a focus, with continuous quality improvement work underway to strengthen early detection and timely management through the sepsis care bundle.

Question 4.

- *How many ICU beds are there in Hereford Hospital?*
- *What is their percentage usage?*
- *How often does demand for these beds exceed supply?*
- *What happens when demand does exceed supply and is this acceptable?*

LF Response:

The Trust had an eight-bed critical care unit with flexible capacity, including main bed spaces, side rooms and an annex area. In practice, the Trust had been able to accommodate the vast majority of patients within this footprint, with only very rare occasions over the past two years where escalation outside the unit had been required. Patient flow was actively managed, with timely step-down arrangements to ensure capacity was available for new admissions.

DATE AND TIME OF THE NEXT MEETING – Thursday 2nd July 2026

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board Held in Public**
Date of Meeting:	**2nd July 2026**
Title of Report:	Foundation Group Strategy Committee (FGSC) report from the Meeting held on 18th June 2026 and Annual Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Chelsea Ireland, Foundation Group Executive Assistant (EA)
Reporting Route:	Direct to Board
Enclosures included with this report:	1. FGSC Report from 18th June 2026 2. FGSC Annual Report
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
The purpose of this report is to provide the Board with an overview of the FGSC meeting held on 18 June 2026 and to review the Annual Report.	
Recommended Actions required by Board or Committee	
The Board is asked to receive and note the report.	
Executive Director Opinion[1]	
n/a	

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

Report to WVT Trust Board Held in Public – 2nd July 2026

FGSC Report from the Meeting held on 18 June 2026

Matters of Concern or Key Risks to Escalate to the Board	Major Actions Commissioned and Work Underway
• The Aseptics Business Case remained complex and unresolved, with further discussions required with the national team regarding the transaction process. The Committee would continue to monitor progression. • The shared procurement model was discussed, and it was highlighted that it had not yet completed governance approval through all individual Trust Management Boards (TMBs). Delivery of the October 2026 implementation timeline was dependent upon successful approval through organisational governance and workforce consultation processes. • Information governance and data-sharing arrangements remained a barrier to creating a single Foundation Group-wide improvement repository. The Improvement Team continued to work through these a further update at the Committee was requested in due course. • Committee members highlighted a governance risk whereby matters discussed and agreed through the FGSC were not always clearly translated to TMBs or Trust Boards. The Managing Directors agreed to take this away as an action to find a solution. • Nationally, instability remained regarding NHS structural reform, Integrated Healthcare Organisation (IHO) development, workforce negotiations, resident doctor ballot outcomes and implementation of the new NHS Oversight Framework. These factors could impact organisational planning and delivery.	• Progression of the Foundation Group action learning network and lead provider learning programme, with the first network meeting being arranged. • Delivery of the National Job Planning Programme across the four organisations with national support secured. • Development of a Foundation Group-wide improvement repository, building on the Worcestershire Acute Hospitals NHS Trust (WAHT) portal and addressing information governance requirements. • Continued implementation of collaborative improvement activity, including communities of practice, improvement events, training review and shared improvement methodologies. • Procurement business cases to be progressed through individual TMBs during July 2026 in support of a consolidated procurement model, with the proposal of WAHT being the host provider. • Development of a three to five-year procurement and contract alignment plan to maximise scale opportunities across orthopaedics, pathology, trauma and other major contracts. • Development of a business case to support continuation and expansion of the Leading an Empowered Organisation (LEO) leadership programme across clinical and non-clinical staff groups. • Establishment of a small working group, led by Managing Directors, to progress proposals for a divisional autonomy and
Matters of Concern or Key Risks to Escalate to the Board (continued)	**Major Actions Commissioned and Work Underway (continued)**
• Discussion regarding divisional autonomy highlighted possible risks associated with reducing central control before organisations had sufficiently mature performance reporting, quality metrics and governance arrangements in place	incentivisation framework and undertake divisional engagement. • Comments to be feedback to the Committee Chairs and Chief Executive relating to any proposed changes to Foundation Group governance arrangements particularly the management of People agenda across the four trusts.

Positive Assurances to Provide the Board	Decisions Made by the Committee
• The Foundation Group Improvement Programme continued to mature, with common improvement principles established across all four organisations and positive feedback from the May 2026 improvement event. A total of 1,444 attendances were recorded. • The Committee received assurance that collaborative procurement arrangements had already delivered approximately £2.8 million in efficiencies, with further opportunities identified. Procurement collaboration was increasing through shared category management, contract alignment and joint procurement opportunities across the Foundation Group and wider partnerships. • More than 800 staff across the Foundation Group had completed the LEO leadership programme, with strong participant feedback and evidence of leadership and quality improvement benefits. The Committee received assurance that the programme was increasingly aligned with the national leadership and management framework and was being expanded to wider workforce groups. • Members agreed that collaborative working through the Foundation Group continued to deliver value through shared learning, scale benefits and collective improvement. Procurement and improvement activities were cited as strong examples of successful collaboration.	• Approved the previous minutes as an accurate record. • Agreed the principle of developing a Foundation Group-wide improvement repository, subject to resolution of information governance requirements. • Endorsed progression of the proposed shared procurement operating model through formal trust governance arrangements. • Approved the Foundation Group Annual Report for submission to individual Trust Boards. • Supported further development of a divisional autonomy and incentivisation framework, with additional work and consultation required before implementation. • Reaffirmed support for maintaining consistency of governance structures across the Foundation Group wherever possible.
Positive Assurances to Provide the Board (continued)	
• National updates indicated positive progression towards Foundation Trust freedoms, simplified transaction processes and development pathways for IHOs. • National recognition was noted for Wye Valley NHS Trust (WVT) improvement in elective care performance through participation in a Number 10 roundtable discussion.	
Comments on Effectiveness of the Meeting	**Recommendation**
• The Committee undertook a discussion on its own effectiveness and concluded that it continued to add value through collaborative working, sharing best practice and developing Group-wide opportunities.	• The Joint Board is asked to receive and note this report.

• Members recognised the strength of the Committee in accelerating improvement and procurement initiatives and supporting learning across organisations. • Feedback suggested the Committee should continue to increase pace and ambition while remaining focused on practical outcomes and avoiding duplication. • Members identified an opportunity to strengthen communication between the Committee and individual Trust Boards to ensure that actions, decisions and recommendations receive appropriate organisational consideration and approval	

Chelsea Ireland
Foundation Group EA

NHS South Warwickshire University NHS Foundation Trust

NHS Worcestershire Acute Hospitals NHS Trust

NHS George Eliot Hospital NHS Trust

NHS Wye Valley NHS Trust

Report to	Foundation Group Strategy Committee	**Agenda Item**	7.1
Date of Meeting	18 June 2026		
Title of Report	Foundation Group Strategy Committee Annual Report 2025/26		
Status of report: (Consideration, position statement, information, discussion)	For discussion		
Author:	Chelsea Ireland, Foundation Group Executive Assistant		
Lead Executive Director:	Sue Whelan, Chair George Eliot Hospital NHS Trust and South Warwickshire University NHS Foundation Trust, and Frances Martin, Chair Worcestershire Aute Hospitals NHS Trust and Wye Valley NHS Trust.		
1. Purpose of the Report	It is good governance for Board Committees to complete an Annual Report to demonstrate compliance with the requirements of its Terms of Reference and provide assurance that there are no matters the Committee is aware of at the time of reporting which have not been disclosed properly.		
2. Recommendations	The Foundation Group Strategy Committee is asked to consider its Annual Report for 2025/26, prior to submission to the Trust Boards in July 2026.		
3. Executive Director Assurance	The report provides an overview of the Committee's business during 2025/26. It also provides assurance that there are no matters the Committee is aware of, at the time of reporting, which have not been disclosed properly.		

South Warwickshire University NHS Foundation Trust
George Eliot Hospital NHS Trust
Worcestershire Acute Hospitals NHS Trust
Wye Valley NHS Trust

Report to Foundation Group Strategy Committee – 18 June 2026

Foundation Group Strategy Committee Annual Report 2025/26

1. Introduction

In 2017 the Foundation Group was formed when South Warwickshire University NHS Foundation Trust (SWFT) formalised its collaboration with Wye Valley NHS Trust (WVT). In June 2018, George Eliot Hospital NHS Trust (GEH) joined the Foundation Group. In 2022 Worcestershire Acute Hospitals NHS Trust (WAHT) joined the Foundation Group as an associate member and subsequently became a full member of the Foundation Group from August 2023.

The Foundation Group Strategy Committee (FGSC) is established under Board delegation of each Trust of the Foundation Group with approved Terms of Reference which are reviewed annually and any requests for amendment are made to the Board of each Trust.

During 2025/26, the Committee consisted of the Group Chairman, Group Chief Executive, a Non-Executive Director (NED) from each Trust, Managing Director/Acting Chief Executive from each Trust, Chief Medical Officer from each Trust, Chief Strategy Officer from each Trust, the Group Strategic Financial Advisor and Group Medical Advisor. Other officers from each Trust may be invited to attend for appropriate agenda items.

The Committee met on three occasions during 2025/26, due to the December 2025 meeting being cancelled. In August 2022 the Foundation Group Boards Workshop and Foundation Group Boards meeting replaced the previous twice yearly development sessions. These meetings brought together the full members within the Foundation Group to share best practice and performance data. During 2024/25 it was agreed that the FGSC would take ownership of the planning of the Foundation Group Boards agendas, these were taken to each meeting for approval and discussion. During 2025/26 the decision was made to move away from formal public Foundation Group Boards meetings and instead hold private Foundation Group Boards Workshops, with two of these held in person similar to the previous development sessions. The agenda for these workshops are no longer discussed at Foundation Group Strategy Committee but are instead agreed and developed by all three Managing Directors and the Group Chief Executive. The Committee continues to receive an important NHS Strategic Developments update to its standard agenda, which is provided by Foundation Group Chief Executive, Glen Burley. A schedule of attendance at the FGSC meetings during 2025/26 is attached (Appendix A).

The Chairman previously reported in writing to each Trust's Board via the Foundation Group Boards on key issues considered by the Committee following every meeting. This continues to be done by the new Chairs of the Trusts within the Foundation Group, but to individual Trust Board meetings. In addition to this, the approved minutes of the meetings are also submitted to the Foundation Group Boards Workshop for full Group oversight.

As part of the annual review of the Terms of Reference, amendments were approved by each Board in April 2026.

2. Principal Areas of Review

The Terms of Reference set out Strategic Financial and Operational Planning as the key duty for the Committee

which includes the following responsibilities:

- developing strategy and investment plans, including finance, IT, estates, and commercial development.
- overseeing processes which benchmark clinical outcomes and productivity across the Group supporting the implementation of best practice solutions.
- developing new working models for corporate functions.
- developing new business models to progress the development of integrated health and care.
- developing and executing a communications strategy.
- developing and maintaining business development capacity and capability across the Group.
- Determining the framework that supports each provider's organisational objectives and targets.
- developing and supporting achievement of operating, business, efficiency and delivery plans.
- identifying, reviewing and mitigating strategic risks.
- proposing and implementing joint working with partner organisations where collaborative approaches will yield tangible improvements and/or efficiencies.
- overseeing service transformation and pathway redesign.

3. FGSC – Review of Effectiveness

The FGSC has been active during the year in carrying out its duty in providing the Board of each Trust with assurance relating to the Foundation Group's strategic financial and operational planning. The Committee also advises the Boards of each Trust on all matters relevant to identifying and sharing best practice at pace.

The Committee has undertaken a formal review of its effectiveness during 2025/26, and a separate report has been submitted to the Committee on the responses received, which was subsequently submitted to Trust Boards in July 2026. It can be confirmed that the Committee met on three occasions during April 2025 to March 2026 and achieved an attendance rate of 87.9%. It should be noted that 80% is considered to be a good rate of attendance. The Committee's attendance average has improved during 2025/26 compared to last year's 85.34% attendance rate. It's important to note that whilst this is promising, this could be due to a number or role changes throughout the year and there was one less meeting in 2025/26.

Based on the feedback received from the Committee's review of effectiveness, it is evident that the Committee has achieved and improved on its effectiveness with a clear purpose and aim by delivering the duties set out in its Terms of Reference and improved. However, the self-assessment response rate was significantly lower than that in 2024/25, this will partly be due to committee membership figures being lower with the merging of GEH and SWFTs Share Leadership structure.

4. Areas of Particular Note

During the year the Committee has had the opportunity to consider strategic financial and operational planning opportunities as part of collaborative working across the Foundation Group. Examples of these are detailed below but it should be noted that the list is not exhaustive:

- Group Analytics Board
- Group Procurement
- Financial Reset
- Productivity
- Frailty
- Aseptics Services
- Clinical Teaching and Training
- Research
- NHS Strategic Developments

- Foundation Group Boards Planning
- Digital Updates
- Strategic Partnerships and Tertiary Services
- Improvement
- Operational Management Development Programme
- Warwickshire North
- Pathology Networks
- Job Planning
- One Herefordshire and Neighbourhood Health

Looking forward into 2026/27, the Committee continues to focus on development opportunities for strategic financial and operational planning. Also identifying and sharing best practice at pace across the Foundation Group and externally.

5. Conclusion

The Committee is of the opinion that this Annual Report demonstrates compliance with the requirements of its Terms of Reference and that there are no matters the Committee is aware of at this time which have not been disclosed properly.

6. Recommendation

The Foundation Group Strategy Committee is asked to consider its Annual Report for 2025/26, prior to submission to Trust Boards in July 2026.

Chelsea Ireland
Foundation Group EA

Appendix A

Foundation Group Strategy Committee Attendance 2025/26

	17 June 2025	18 September 2025	December 2026 (Cancelled)	11 February 2026
Members				
Russell Hardy (Group Chair)	✓	✓		✓
Chizo Agwu (Chief Medical Officer at WVT)	✓	✓		✓
Varadarajan Baskar (Chief Medical Officer at SWFT until September 2025 meeting)	✓	✓		
Jules Walton (Chief Medical Officer at WAHT)	✓			✓
Julian Berlet (Chief Clinical Strategy Officer at WAHT)	✓			✓
Glen Burley (Group Chief Executive)	✓	✓		✓
Adam Carson (Acting Chief Executive/Managing Director at GEH/SWFT)	✓	✓		✓
Stephen Collman (Acting Chief Executive/Managing Director at WAHT/WVT)	✓	✓		✓
Alan Dawson (Chief Strategy Officer at WVT)	✓			
Catherine Free (Managing Director at GEH until September 2025 meeting)	✓			
Phil Gilbert (NED representative at SWFT until December 2025 and then GEH/SWFT)	✓	✓		
Sophie Gilkes or Jennie Bannon (Chief Strategy Officer at GEH/SWFT/Deputy Chief Strategy Officer at SWFT)	✓	✓		✓
Jane Ives (Managing Director at WVT until September 2025 meeting)	✓	✓		
Frances Martin (NED representative at WVT)	✓	✓		✓
Adrian Stokes (Group Strategic Financial Advisor)	✓	✓		✓
David Mowbray (Group Medical Advisor)	✓	✓		✓
Simon Murphy (NED representative at WAHT)	✓	✓		✓
Jo Newton (Chief Strategy Officer at WHAT until September 2025 meeting)	✓	✓		
Jenni Northcote (Chief Strategy Officer at GEH until September 2025 meeting)	✓	✓		
Sarah Raistrick (NED representative at GEH until December 2026 meeting)		✓		
Naj Rashid (Chief Medical Officer at GEH/SWFT)	✓	✓		✓
Sarah Shingler (Managing Director at WVT from December 2025 meeting)				✓
Committee Attendance Rate	95.2%	81%	N/A	87.5%

It is important to note that when Chief Officers have been unable to attend a meeting, where possible, will always assign a deputy to attend on their behalf. This is not reflected in these figures.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board Held in Public**
Date of Meeting:	**2nd July 2026**
Title of Report:	Chief Executive Officer's Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Glen Burley, Chief Executive Officer
Reporting Route:	Direct to Board
Enclosures included with this report:	n/a
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

The Chief Executive's report provides an update on a number of significant national and local developments that will influence the Trust's operational performance, strategic direction and future regulatory position during 2026/27.

Recommended Actions required by Board or Committee

The Board is invited to Note the key messages from the report:

1. **The Resident Doctors dispute remains the most significant short-term external risk**, with potential implications for operational performance, workforce stability and patient care.
2. **The Trust's regulatory position continues to be constrained by deficit support funding**, despite improving operational performance and progress against key priorities.
3. **National NHS reforms are accelerating**, particularly in relation to provider autonomy, integrated care models and digital service delivery through NHS Online.
4. **The Integrated Care Division is delivering measurable improvements**, especially in discharge performance, community-based care and neighbourhood health, although workforce and demand pressures remain in several specialist services.
5. **Equality, inclusion and anti-racism initiatives are becoming a stronger element of NHS governance and oversight**, requiring visible Board leadership and organisational action.

Executive Director Opinion[1]

The Trust continues to make progress locally against a backdrop of significant national reform. While workforce pressures, financial constraints and service demand remain key challenges, the Trust continues to advance its integration agenda, improve patient flow and prepare for emerging NHS policy developments.

[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. **Resident Doctors Dispute**

A major focus remains the ongoing national dispute involving Resident Doctors. Considerable executive time has been dedicated to managing the consequences of industrial action and preparing for potential outcomes arising from the latest Government pay offer. At the time of writing, the offer was being considered by BMA members. The report notes that a rejection of the offer could result in further industrial action, continued disruption to patient care and a prolonged impasse between Government and the profession. Conversely, acceptance of the agreement would require substantial implementation work around pay, terms and conditions, while also providing an opportunity to strengthen the relationship between Resident Doctors and the organisations in which they work and train.

2. **The 2026/27 Oversight Framework**

As set out last year, at the start of each financial year NHSE will publish a new National Oversight Framework (NOF). The NOF is key to delivering quality and performance metrics within the agreed financial envelope. Each annual update will reflect any changes in priorities or policy and will support the delivery of the annual Planning Guidance. The new NOF for 2026/27 includes for the first time, a set of metrics which will lead to the segmentation of Integrated Care Boards based on their performance in their new Strategic Commissioning roles. As with the Trust NOF, each organisation will be placed into one of 4 segments, with segment 1 being the highest preforming. With segment 4 potentially leading to national intervention. We are taking every opportunity to link operational freedoms and incentives to the NOF with the ability to become an Advanced Foundation Trust being the most tangible benefit for high performing Trusts.

The Trust-level NOF builds on some of the themes of the 10-Year Plan and sets a higher performance improvement bar based on the positive results achieved in 2025/26. NHSE have decided to retain the Financial Override for at least one more year. The override ensures that any Trust in deficit or in receipt of deficit support funding cannot achieve more than a Segment 3 rating.

From a Group perspective, the override will apply to WAHT and WVT due to the Trusts being in receipt of Deficit Support funding. Without deficit support funding, WVT would currently be in the top half of the framework. Meanwhile SWFT and GEH should be able to attain Segment 1 or 2.

3. **Lord Mann Review of antisemitism and other forms of racism across the NHS and healthcare regulatory system**

Lord Mann was commissioned by the former Secretary of State for Health and Social Care to lead rapid review into antisemitism and other forms of racism across healthcare regulation and the NHS. As the largest employer in the country, the NHS can and should play a leading role in tackling antisemitism, racism and all forms of discrimination. At a time of heightened political tension at home and abroad, it is our duty to stand by our staff, patients and communities to ensure they have the protection and support they need to access or provide care effectively and safely.

The Lord Mann review provides an opportunity to state clearly: within the NHS, our professional values – care, compassion and clinical excellence – must always come first. The NHS is accepting Lord Mann's recommendations in full.

The actions we will take immediately are to:

- sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles

- set clear Staff Standards relating to experience of racism.
- support NHS improvement and assurance through the NHS Oversight Framework
- strengthen accountability for racial inclusion through our appraisals.
- consult on adding Jewish and Sikh to NHS protected characteristic datasets.
- develop bespoke eLearning for NHS PALS and complaints handlers.
- ensure all NHS boards and system leaders complete regular anti-racism training.

None of these steps are intended to limit any individuals' personal beliefs or prevent legitimate expression outside of work. But they do set clear expectations for a respectful working environment, where colleagues can collaborate effectively and patients can trust that their care will never be compromised by division.

NHSW have also set out immediate actions we are asking NHS organisations to take, including:

- Ensuring implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, monitored via the NHS Oversight Framework
- Prepare to implement the forthcoming NHS Staff Standards
- Adopting the new government definition of anti-Muslim hostility
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.
- Ensure that Boards and relevant committees fully understand your staff survey data on the experience of racism in their organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

4. Advanced Foundation Trusts (AFTs) and Integrated Healthcare Organisation (IHO) Contracts

The first 6 AFTs have recently been authorised. Having completed a consultation, NHSE has also now issued the full policy framework and Guide to Applicants (the Guide). The gateway to authorisation continues to be linked to strong performance in the NOF and the Guide sets out how the authorisation process will work in more detail including the Board self-certification processes.

Alongside this NHSE continues to work with pilot sites to develop an approach to allowing some providers to hold IHO contracts. The Group is also engaged in a national IHO network which is helping to develop best practice models to build IHO capability through integration and development of the lead provider model.

5. NHS Online

The NHS is setting up an 'online hospital' – NHS Online – in a significant reform to the way healthcare is delivered in England. The innovative new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. The first patients will be able to use the service from February 2027. Patients will be seen faster, as teams triage them through the NHS App and let them book in scans at times that suit them at Community Diagnostic Centres closer to home.

When a patient has an appointment with their GP, they will have the option of being referred to the online hospital for their specialist care. They will then be able to book directly through the NHS App and have the ability to see specialists from around the country online without leaving their home or having to wait longer for a face-to-face appointment. They will be able to track their prescriptions and get advice on managing their condition from the comfort of their home.

Initially the focus will be on a small number of planned treatment areas with the longest waits. Over time this will be expanded to more treatment areas. Treatment areas will only be offered if the NHS knows it is it is clinically safe to do so remotely. Online NHS Trust has held its first board meeting. Core policies and procedures and initial committee membership approved and a presentation of build progress was given to

the new Board. A Chair and Six non-execs took up post on 1 June, and they are currently recruiting a Chief Executive.

6. Integrated Care Division Update

Quarter 1 has seen the division progress with the implementation of relevant elements of the Neighbourhood Health agenda. Key elements have been the progress within our UCR service and our ability to provide more care at home through our wider community teams. We continue to support the system NNHIP programme, particularly in relation to our Integrated Neighbourhood Teams.
Key staff from the division have also been involved in the redesign of our Discharge to Assess pathways- with the aim to improve flow and prevent delays, but also to ensure patients receive the most appropriate services to support their recovery and to maximise independence. Pathway 1 has been recommissioned by the Local Authority, and we are working together as an integrated team to embed the redesign and pathway improvements.

Discharge delays for Herefordshire and Powys have seen sustained improvement over the last 3 months and we continue to support the improvements. Powys health colleagues have committed to working together to further reduce the waits that Powys patients experience for repatriation.

One of our objectives this year, is to review our District Nursing service, particularly around demand and capacity management- demand for this service has increased over recent years and the profile of core community nursing has changed. In 25/26 we were able to move unplanned care to be triaged and managed through our SPOA which has supported DN teams to focus on core DN work, however there is more to do in this space particularly around the levels of demand of insulin administration we are currently receiving.

Non RTT waits across our therapy services continues to show improvement with less people waiting over 18 weeks for treatment- though areas of concern are children awaiting SALT and OT support, and our leads are working with colleagues in the surgical division and Local Authority respectively, to reduce the waits. In addition, our children awaiting support with Autism from our SALT team, continues to see high demand, and recruitment is providing some challenge.

The division have been authorised to proceed with our plans to extend the current Single Point of Access to a 24-hour service providing coordination and a response overnight. In line with our One Herefordshire approach, this will ensure the team out of hours are integrated with our colleagues from primary care to ensure we deliver services as one team.
The division are also involved in The Experts at Hand programme which is an initiative designed to provide mainstream education settings (schools, colleges, and early years) with direct access to specialist health and education support. The division are currently working closely with the wider system to recruit into specialist therapy posts.

Quarter 2 will see progress across the 4 big moves, with particular focus on the Model of Care for Community Hospitals. Both the bedded and non-bedded elements are currently being reviewed to design a model that will support not only flow from the acute, but also how these valuable assets can support our system colleagues and communities for the future.
Our Associate Chief AHP is also working on a review of therapy staffing focusing on inpatients and community services and will be leading on our AHJP strategy which is a key objective for the division this year.

Glen Burley
Chief Executive Officer

Integrated Performance Report

June 2026

Managing Director – Executive Summary

Sarah Shingler
Managing Director

The Trust continues to make progress against its strategic priorities despite ongoing operational pressures. Urgent and Emergency Care demand remains high, with ED attendances reaching their highest level in over two years. Encouragingly, focused improvement work has delivered a reduction in corridor care, 24-hour waits, and delayed discharge bed days, demonstrating green shoots of improvements in patient flow and experience.

Quality and safety remain our foremost priorities. Following a comprehensive review, the Homebirth Service has undergone significant strengthening of governance, workforce capability, training, and equipment arrangements.

Performance across cancer services remains strong, with the Trust achieving the Faster Diagnosis Standard and meeting the 62-day treatment standard, while elective activity remains broadly on plan. Referral to Treatment performance continues to compare favourably across the Midlands, although increasing referral volumes and workforce pressures require ongoing attention.

Our workforce indicators remain positive, with low overall turnover, strong staff engagement, successful recruitment and sickness absence among the best-performing trusts nationally.

Financial performance is broadly in line with plan, although delivery of the Cost Improvement Programme remains critical to achieving long-term sustainability.

Overall, the Trust is maintaining performance and delivering improvements while managing increasing demand across services.

Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Homebirth Service

Following a local review of our service the Wye Valley Trust homebirth service was suspended in February 2026. This provided an opportunity to fully review the operational running of the service, personalised care and risk assessment and the governance and oversight arrangements, which has been a request from NHS England following a Prevention of Future Deaths Report – Jennifer Cahill and Agnes Cahill – Prevention of future deaths report – 2025-0559

Clearly the service suspension reduced the birth choices for our service users and certainly led to some disappointment and dissatisfaction, particularly for individuals who had imminent homebirth plans. These individuals were offered personalised communication to support them in planning for their birth.

During the service review we have developed a skills passport for our workforce, ordered new equipment as recommended by the resuscitation council for newborn life support, provided specific training in line with neonatal resuscitation requirements, rotated all community-based staff into the unit for further intrapartum experience and revised our local policies and processes.

NHS England have announced that they will produce a national set of standards for homebirth services in England. The WVT service will be benchmarked against these standards when they are published (due July 2026) and we believe the action we have taken to date will place us in strong position against the new standards.

Special Education Needs and Disabilities consultation and reforms

On 23 February 2026, the Department for Education (DfE) published the school white paper ‘Every child achieving and thriving’ and the Special Educational Needs and Disabilities consultation ‘Putting Children and Young People First’ . These outline a vision for a single, inclusive system with high-quality, local support, backed by plans to strengthen laws for evidence-based early help and increased investment to integrate education, health and care services for children and young people.

In preparation for and in anticipation of any legislative changes the high-level local SEND reform plan was published with a focus on the introduction of “Experts at hand”

The Experts at Hand offer will support mainstream settings across early years, primary, secondary and post-16 to better identify and meet the needs of children and young people with SEND. Delivered through local area partnerships, it provides dedicated professional expertise to help more children and young people access support within their settings.

The offer aims to remove barriers to access, enabling children and young people to achieve and thrive in education. It is designed to deliver responsive support to mainstream settings, and must be additional to, and not replace, support provided through an education, health and care plan (EHCP).

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.

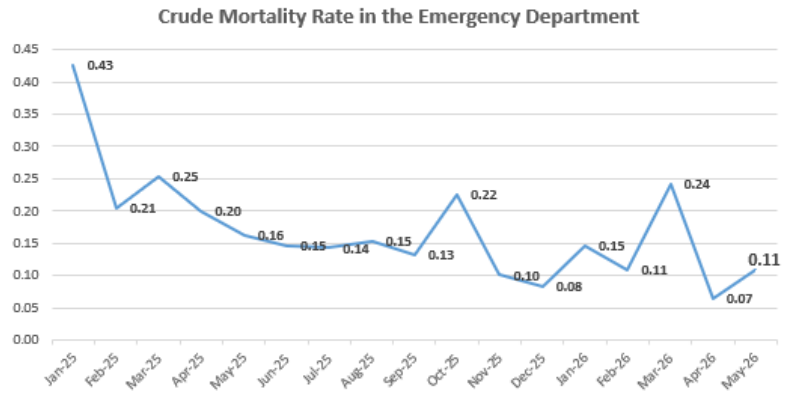
Data

Trust-level data ***(February 2025 – January 2026)***

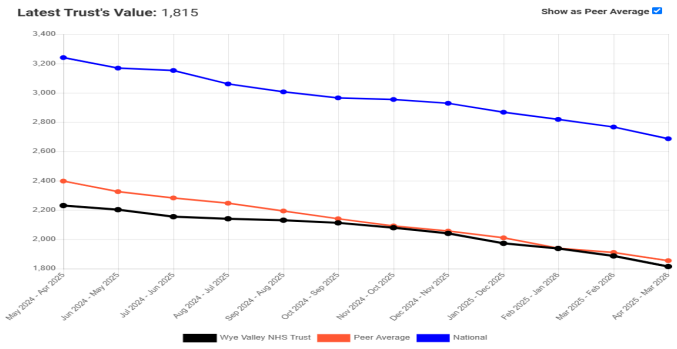
As expected SHMI

27,405 (-590)	1,340 (-5)	1,185 (-5)	1.1319 (+0.37)
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*	May-26	1.41%	66	-0.10%
Crude Mortality-Emergency	*% of Deaths by Emergency Discharges*		5.08%	63	-0.69%



A chart to show the number of mortalities at WVT: (*12-month rolling figures*)



Monthly Headlines

- The latest 12-month rolling **SHMI** (*NHS England*) from February 2025 to January 2026 shows Wye Valley NHS Trust at **113.2**, which equates to 1340 observed deaths against 1185 expected.

- Latest **crude mortality** rate for **May 2026** was **1.41%** for all admissions, which equates to 66 deaths with 6 reported in the Emergency Department. **ED** with the latest reported data remaining amongst some of the lowest rates at 0.11.

- **#NOF** has reported a significant reduction of nearly 20 points to 151 in the latest 12-month rolling SHMI (*February 2025 – January 2026*). The HES-based SHMI, which provides a provisional look ahead, shows a further reduction in the coming months ahead. In addition, the latest case-mix adjusted mortality rates on the National Hip Fracture Database have shown WVT as reducing back within expected ranges at 5.9% mortality rate compared to 5.0% as a national average.

- **Extended perinatal mortality rate** has remained at lower-than-average level at 3.23 deaths per 1000 live births in the latest unadjusted 12-month rolling (*June 2025 – May 2026*) period. In addition, the latest stillbirth is now reporting well below the local average at 1.29 deaths per 1000 live births.

- Based on **Medical Examiner** discussions with bereaved families and NOK, there were five cases where there was excellent care highlighted on our Acute Medical Unit, Coronary Care Unit, Redbrook and Leominster wards.

Quality and Safety Performance – Antimicrobial stewardship

We are driving this measure because :

The World Health Organisation has declared antimicrobial resistance(AMR) as one of the top global public health and development threats and priorities. All trusts have been asked to respond by agreeing 3 priority areas. The focus and priorities were presented to the board workshop in June 2026 and are included in this month's report for completeness. Quarterly updates will be provided against the priority areas.

Priority improvement areas

Priority 1
IV-to-Oral Switch (IVOS)

Target: 10% of eligible IV patients switch to oral within 48 hours

Impact: Shorter stays, fewer complications, cost savings

Deadline: Launch Q1 2026

Priority 2
Reduce Broad-Spectrum Use

Target: Align consumption with national benchmarks (ESPAUR report)

Impact: Preserve antibiotic effectiveness, meet national targets

Deadline: Ongoing – review of Antimicrobial guidelines and planning to increase capacity for Antimicrobial Stewardship Ward Round

Priority 3
Digital Support & Monitoring

Target: Real-time visibility of consumption patterns

Impact: Improve EPMA interventions and developing advanced prescribing decisions tool

Deadline: POWER BI dashboard Q1/Q2 2026

Priority 1 – IV to oral switch (IVOS)

Current Situation

- High IV antibiotic use in secondary care
- Limited awareness of switching criteria
- Inconsistent multidisciplinary decision-making
- No real-time oversight of eligible patients

Our Approach

- Clear switching criteria: No fever >24hrs, able to eat/drink, showing clinical improvement, stable
- Daily clinical reviews: AMS team flags eligible patients on ward rounds
- MDT decisions: Pharmacists, doctors, and nurses review together
- Track outcomes: % switched, time to switch, adverse events

Expected Impact

10% IV antibiotic patients switch to oral — reducing hospital stay by approximately 1 day per eligible patient, lowering medication costs, and reducing IV cannula-related infections.

Key Performance Metrics

- 10% of eligible IV patients switched within 48 hours
- Time from IV start to switch (hours)
- Length of stay comparison
- Adverse events post-switch

Priority 2 - Reduce Broad-Spectrum Antibiotic Use

The Challenge

- Excess broad-spectrum agent use visible in our data trends
- Antimicrobial guidelines — need refresh
- No real-time prescriber feedback mechanisms
- Consumption not aligned with national benchmarks

Measured Success

- Reduce broad-spectrum use to align with national benchmarks
- Increase narrow-spectrum prescribing where clinically appropriate
- Maintain or improve patient outcomes — reduce Gram-negative Blood stream infections

Guideline Review

Evidence-based update with pharmacy, microbiology, and clinical teams

Prescribing Campaigns

Target high-use antibiotics where narrower options exist

Enhanced Education

Quarterly dashboards showing department consumption vs trust average vs national targets

Feedback Loops

Regular audits and supportive conversations with clinicians

Priority 3 — Digital Support & Real-Time Monitoring

POWER BI Dashboard

Real-time consumption by ward, antibiotic, and indication

EPMA Template Redesign

Integrated guidance, IV-to-oral prompts, narrower-spectrum suggestions

Automated Alerts

Flag potentially inappropriate prescriptions in real time

Integrated Ordersets

Make IV-to-oral switching and narrow-spectrum options easier to select

Patient Safety Incident Response Plan

We are driving this measure because :

The Quality Committee, on behalf of the Board, approved the updated and revised Patient Safety Incident Response Plan (PSIRP) at its meeting in June. The priorities published in October 2023 were evaluated and the outcomes are described below.

Patient Safety Priority	Evaluation
Tissue Viability incidents- Deterioration of Moisture associated skin damage to G3/4 or unstageable pressure damage	↓54% decrease since 2024. Move to **improvement priority.**
Inpatient falls- Inpatient falls in patients with dementia, delirium or a known high risk of falls.	Proportionately similar rates of falls for those with high risk/dementia or delirium and low risk, but improvement seen in level of observation, risk screening and multifactorial assessment completion for high-risk groups. Move to **improvement priority.**
Delays in assessment, diagnosis or treatment- Responding well to clinically changing conditions	Incidents related to lack of clinical assessment decreased, reasons where timeliness of escalation of deteriorating patient well understood and no increase in patient harm – strong focus on deteriorating patient over past 2 years – **move to improvement priority** monitored via Deteriorating Patient Committee
Admissions and discharges- Incidents relating to the movement of patients, particularly delays to follow up	Previous priority was too broad in definition - Refine to '**Missed or Delayed Diagnosis due to issues with referral pathways**'
Medication incidents- Incidents relating to the failure of administration of critical medications	**Managed as quality priority during this time and this will continue.** Significant improvements in Parkinsons time critical medication delivery. Further time critical medications and a focus on ED time critical medications for future improvement activity
Emergent patient safety incidents- Incidents with extreme level of risk, and where there is significant potential for new learning and improvement	Divisions highlighting effectively and bringing to patient safety panel for discussion. Continue strengthening.

Patient Safety Incident Response Plan

We are driving this measure because :

The Quality Committee, on behalf of the Board, approved the updated and revised Patient Safety Incident Response Plan (PSIRP) at its meeting in June. The plan includes the following safety priorities and improvement priorities. Improvement priorities build on the learning from the previous safety priorities or relate to implementation of the national patient safety strategy standards, where the issues are known and the focus and resource is required for improvement moving forward.

Improvement Priority	Description
Reduction of hospital acquired MASD and pressure damage	Reduce incidence of hospital-acquired MASD and pressure damage by ensuring consistent early risk identification and delivery of evidence-based preventative interventions within the first 6 hours of admission and throughout care.
Reduction of in-patient falls and adverse outcomes	Reduce inpatient falls rate and falls with harm (moderate–severe) by ensuring early, continuous identification of falls risk and consistent delivery of personalised preventative interventions throughout the patient journey.
Reliable Early Recognition and Timely Escalation of Patient Deterioration	Reduce avoidable deterioration and unplanned ICU admissions by ensuring consistent early identification of deterioration and reliable, timely escalation and response across all inpatient and emergency care settings.
Embedding Compassionate Engagement and Involvement in Patient Safety Learning	To ensure that patients, families, and staff affected by patient safety incidents are consistently treated with compassion, openness, and respect, and are actively involved in the learning process, in line with PSIRF principles.
Iterative improvement focus	Continue to build improvement priorities as contributory factors understood.

Patient Safety Priority	Description
Missed or Delayed Diagnosis due to issues with referral pathways	Missed or delayed diagnosis that has impacted on patient outcomes. These may include but are not exclusive to: • Patient Pathway issues • Outpatient waiting lists
Communication	Patient safety events where there has been a failure to recognise, respond to or act on patient, parent or carer concern, including Martha's Rule.
Emergent patient safety incidents	Incidents with extreme level of risk, and where there is significant potential for new learning and improvement
Nationally mandated investigation responses	
Infection prevention annex	Hospital acquired infections meeting local/national criteria for investigation. These incidents will be subject to aggregated review which will inform the Trust Improvement Plan.
Maternity annex	Maternity / neonatal incidents meeting local/national criteria for investigation.

PSIRP Review – June 2026

What's changed and why it matters

Clearer focus: Fewer priorities
From 5 – 3 priorities

- Missed or delayed diagnosis due to issues with referral pathways
- Communication concerns – failure to act on patient, carer or family concerns including Martha's Rule
- Emerging risks

Shift from repeat investigations → improvement
Listening & acting

- Use time and resources to fix known problems rather than repeatedly analysing them
- Enables focus on the 'so what'
- Faster and more meaningful safety gains

Fewer investigations Better learning

- Higher quality investigations
- Focus on novel concerns
- Aggregated learning
- More time to make real improvement

Just Culture Approach
Just Culture & being Fair

- Learning not blame
- Promotes psychological safety
- Compassionate involvement of staff in the learning process

More proportionate response
Robust, timely, promotes teamwork

- Greater use of:
  - MDT Reviews
  - After Action Reviews
  - Thematic/Cluster learning

Stronger patient voice Compassionate engagement

- Prioritising effective communication
- Involving patients and families in investigation and learning processes
- Build a robust improvement plan

Faster safety actions

- Immediate action taken without waiting for reports

Stronger Governance

- Clearer priorities
- Clearer oversight and assurance
- Stronger focus on improvement assurance
- Strong alignment with national PSIRF approach

Key Takeaway	What this means	
We are moving from investigating similar incidents to improving systems • Fewer, better investigations on novel issues • More improvement activity and better improvement oversight	• More practical reviews (not just investigations) • Greater involvement in improvement • Safer culture to speak up	• Clearer accountability • Better assurance on impact • Better alignment with national PSIRF approach

Quality & Safety Performance – Staffing - data

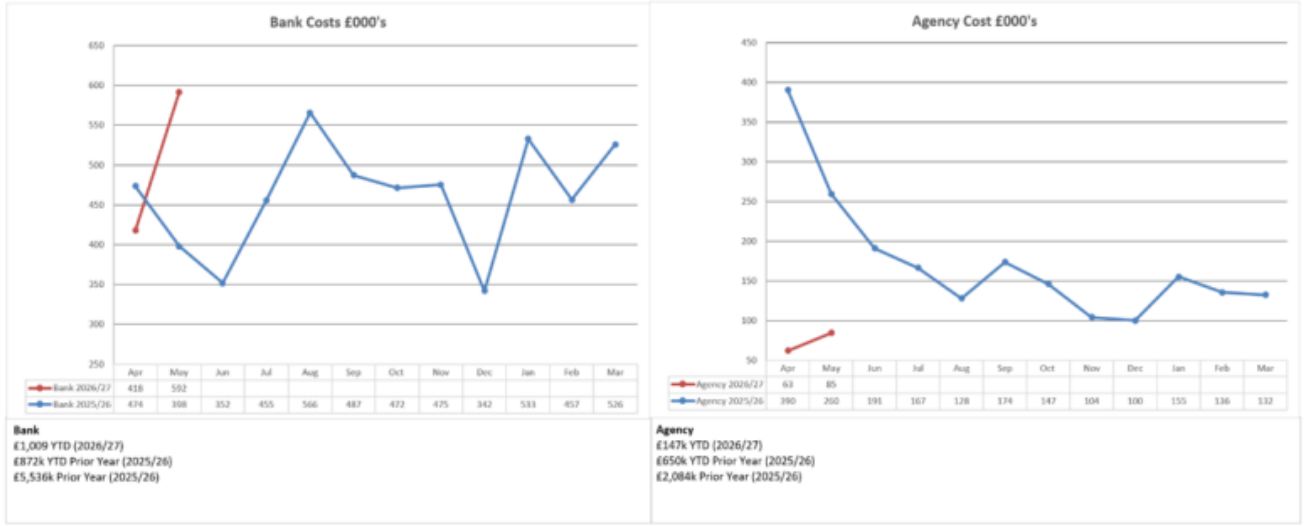
Fill Rate & CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	86%	91%	102%	142%	9.9
Maternity Ward	86%	94%	84%	84%	6.7
Children's Ward	115%	114%	143%	96%	21.5
Lugg Ward	132%	78%	105%	101%	6.7
Wye Ward	103%	82%	122%	88%	6.9
Cardiac Care Unit	99%	100%	100%	100%	12.0
Leominster Community Hospital	158%	77%	100%	106%	6.8
Bromyard Community Hospital	132%	91%	100%	97%	6.3
Ross Community Hospital	96%	102%	145%	104%	6.1
Teme Ward	134%	60%	94%	71%	15.8
Redbrook Ward	94%	108%	103%	121%	7.9
Special Baby Care Unit	109%	-	101%	-	50.7
Intensive Care Unit	103%	-	108%	-	26.1
Gilwern Ward	102%	120%	100%	104%	6.5
Acute Medical Unit	113%	96%	102%	136%	8.6
Ashgrove Ward	134%	87%	119%	115%	7.5
Dinmore Ward	125%	87%	105%	110%	7.4
Garway Ward	156%	83%	129%	113%	7.4
Frome Ward	124%	88%	100%	126%	7.1
Arrow Ward	139%	81%	141%	94%	8.2
Women's Health	89%	96%	100%	-	10.7

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
- Frome, Primrose, Dinmore, Garway and Ashgrove Wards – Additional staffing requirements for additional boarding patients
- AMU, Wye Ward, Redbrook Wards, Leominster and Ross Community Hospital– 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 needed for additional staffing needs
- Bromyard – Due to additional discharge to assess beds

Bank & Agency



- 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
- CPIP delivery is on plan in month 2
- 100% of all nursing shifts are cap compliant with the exception of some off framework use
- 12 off framework shifts were used in month 2 due to enhanced needs on our paediatric ward
- Bank costs have risen sharply in month 2 – this is in part due to significant operational pressures, a full analysis is underway to determine this increase

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

May was an operationally challenging month for our Urgent and Emergency Care [UEC] teams with our Type 1 Emergency Department [ED] attendances increasing by 4%, almost 250 more patients, which equated to over an additional day's worth of attendances. This is despite increased work via our Single Point of Access [SPoA] to support more admissions avoidance calls, more referrals for Urgent Community Response teams, increased utilisation of Virtual Ward step-up care and step-down care beds and more referrals from Ambulance colleagues to ensure patients are treated closer to home.

Over the last six weeks we have been socialising and working on our Operational focus and UEC delivery schemes for our UEC Red Lines:

- 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

During May we have seen a reduction in Corridor Care use, particularly in our ED. Compared with last May we have seen a 40% reduction in its use. We have seen a 50% reduction in the number of patients waiting in our ED over 24 hours from almost 200 patients to c.90 patients.
There has also been reduction in bed days lost for discharge pathway delays for patients waiting out of hospital care and support and are still residing in our Acute and Community beds. Overall, there has been a 300 bed days saved, roughly 25% less bed days lost, compared to May last year with April and May this year show a sustained reduction and a significant improvement on last three year.

This demonstrates the work our clinical and operational teams are making to improve quality and patient experience, despite the increased demand. However, we know there is a significant amount of work to do, internally and with system partners across Herefordshire and Powys, to improve our UEC delivery and improve flow across our pathways.

Our UEC Improvement Board heard this month the detailed schemes, as a result of the various workshops, the Clinical Divisions are undertaking to deliver the UEC changes required. These schemes reflect what is directly within their influence and control and what have been worked on locally within clinical areas with departmental teams that will see our position improve over the coming months. These schemes, along with those related to Elective Improvement, link directly to our Four Big Moves, are reported to our Trustwide Improvement Board each month for Governance and Assurance. There is also synergy and alignment with our Neighbourhood Health Programme to ensure joined up development of schemes and coproduced collaboration with our System partners.

Elsewhere, our overall elective activity remains our plan, despite a slight under delivery in outpatients, with cancer standards remains at, or above, national constitutional standards for 26/27. Our Referral To Treatment [RTT] performance has remained static over the last two month, although it remains one of the best in the Midlands Region, there is a concern that we are seeing an increase in RTT referrals greater than the same period last year. Operational and Informatics teams are currently undertaking a review, so we understand the drivers of this increase.

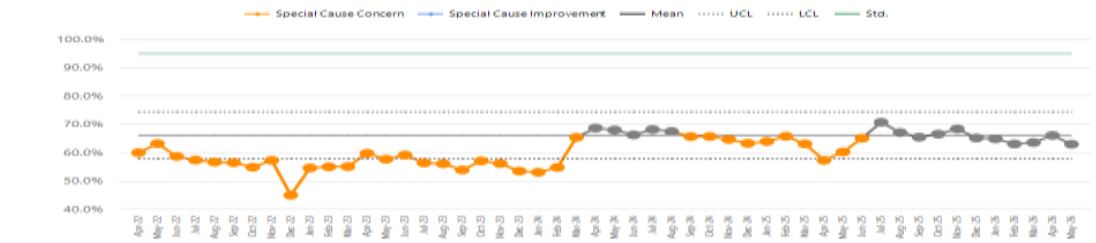
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

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

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 63.1%.

Performance & actions

- 6,375 Type 1 patients attended ED in May which 262 more than the previous month and similar increases over May-25. The range of all attendances varied from 178 to 243 with 205 daily average. Our Type 1 attendances in May this year was the busiest seen for over two years.
- 1,690 ambulances conveyed to the Trust in month which was 21 more than last month but 4 fewer than May-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 25% [378] of all conveyances with 68% [1,018] 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.
- 11.1% [821] of patients spent 12 or more hours in ED which was 120 [1.3%] more 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 [SPoA]. Internal pathways via our SDECs including the workforce model for Medical and Surgical along with a review of the operational hours.
- ➢ Non-admitted patients – focus on how we improve timeliness for non-admitted and not referred patients in ED and minor illness and injury.
- ➢ Establish a 24/7 SPoA to support overnight Ambulance conveyances, provide coordination and senior clinical oversight overnight for virtual wards, Hospital@Home and scheduling of Urgent Community Response for management of overnight calls and ED re-direction patients that can be managed during daytime hours.
- ➢ Deep dive into recovering our Paediatric ED performance to back above 95%

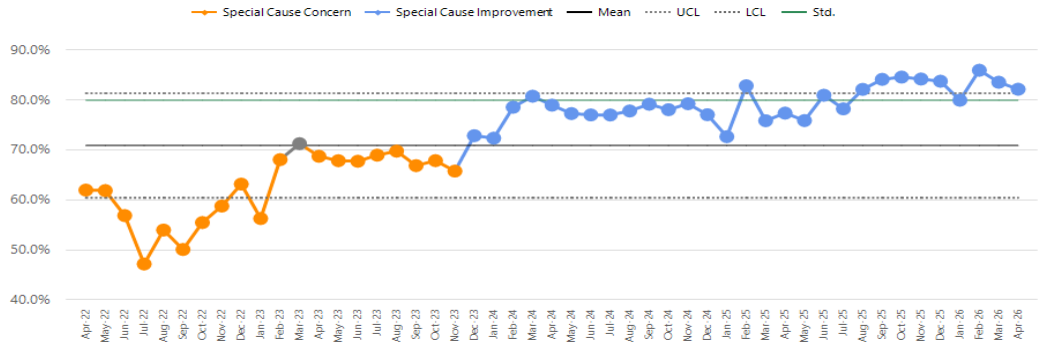
Operational Performance – Cancer Performance [April 26]

We are driving this measure because:

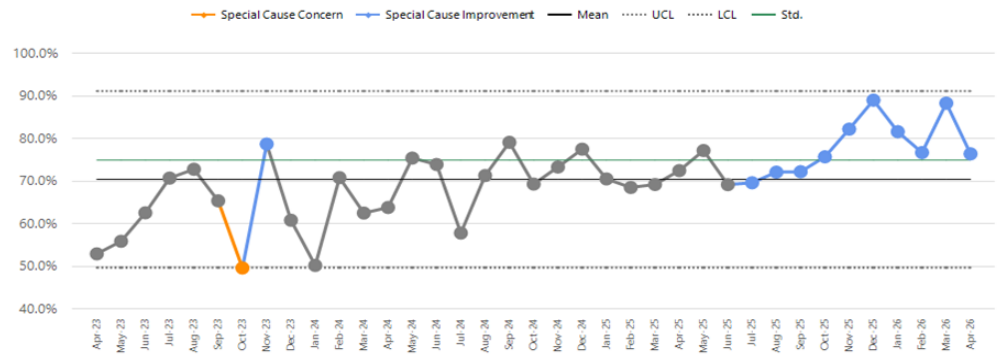
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or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

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

28 Days (Performance & Benchmark)



62 Days (Performance & Benchmark)



Performance & actions

Referrals:
As of April 2026, urgent suspected cancer referrals have increased by 20% compared with the same period three years earlier. Breast, Skin and Lung pathways continue to experience the biggest increase with referrals rising by 44%, 45% and 55%. Lower GI referrals have declined since the introduction of the Faecal Immunochemical Test (FIT) pathway, with a 10% reduction compared to three years ago. Wye Valley Trust is aligning with West Midlands Cancer Alliance guidance for urgent suspected cancer referrals from primary care, to ensure that all information received is of a consistently high quality.

Cancer Performance:
In April 2026, the Trust achieved the Faster Diagnosis Standard (FDS) of 82.1%, 1.1% ahead of trajectory. Seven specialties achieved the target, with Breast achieving 95.8%, Skin 99.5% and Haematology achieving 100%. Gynaecology did not meet the FDS target this month, achieving 65.8%, which represents a 3% improvement on the previous month. Bi-weekly improvement meetings remain in place, alongside enhanced cancer navigator support, and the specialty is anticipated to reach 70% in May. Partial funding has now been secured from the Cancer Alliance for additional gynaecology waiting list initiatives, which will be utilised over the next 12 months.
Wye Valley Trust (WVT) reported 96% compliance with the 31 day target in April, which is a maintained position to March performance and 11.4% above trajectory. WVT has been recognised as one of the top 10 Trusts nationally for the greatest improvement in 31-day performance, achieving a 5.5% increase over the past 12 months. The Trust also reached 80% compliance with the 62-day standard, exceeding its planned trajectory by 8.9%.

Developments update:
- Business justification for Genomics CNS is currently being prepared to be taken to the trust management board
- Equality, Diversity and Inclusion flags now live on Infoflex, cancer navigators alerted as soon as tracking to identify if patients require additional support
- Still awaiting approvals from West Midlands Cancer Alliance in relation to 26/27 bids to improve cancer performance
- Enhanced Power BI reports are now available, with further developments planned to improve visibility across the Trust, including clearer insight into current position and key bottlenecks for targeted focus.

What the charts tell us

- 28 Day Faster Diagnosis performance for April 26 was 82.1%.
- 62 Days start of treatment target for April 26 was 80%.

Risks

- Cancer referrals continuing to remain high compared to three years ago
- Gynaecology high risk areas that are being supported to improve with oversight at our Trust Cancer Board

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

We are driving this measure because:

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

New/First Attendances

Total vs Plan	This Year	Plan	Diff / Var
	15,556	15,873	-317 / -2%
Vs 2025/26	**This Year**	**2025/26**	**Diff / Var**
	15,556	14,856	700 / 5%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	10.1	**2.5**	**75.2%**

IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	5,654	5,115	539 / 11%
vs 2025/26	**This Year**	**2025/26**	**Diff / Var**
	5,654	5,383	271 / 5%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	15.5	**7.6**	**50.8%**

Follow Up Attendances

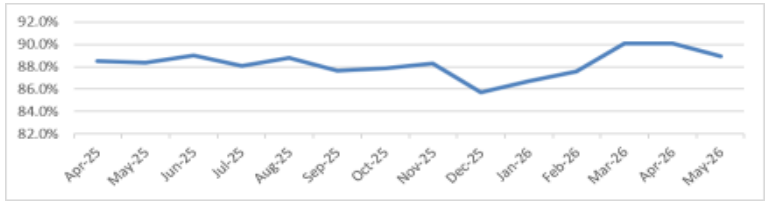
Total Vs Plan	This Year	Plan	Diff / Var
	32,191	33,883	-1692 / -5%
Total vs 2025/26	**This Year**	**2025/26**	**Diff / Var**
	32,191	33,894	-1703 / -5%
Waitlist Clearance (wks)	**Total**	**> See By Date (SBD)**	**% Past SBD**
	18.7	**6.6**	**66.4%**

Endoscopies

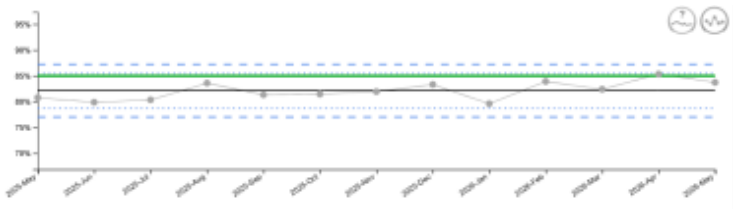
Total Vs Plan	This Year	Plan	Diff / Var
	2,144	2,122	22 / 1%
vs 2025/26	**This Year**	**2025/26**	**Diff / Var**
	2,144	1,936	208 / 11%
Waitlist Clearance (wks)	**Total**	**> 18 Wks**	**% <18 wks**
	14.6	**0.5**	**96.4%**

English Patients over 52 weeks on Incomplete Pathways Waiting List

Clinic Utilisation



Theatres Utilisation (Uncapped)



Performance & actions

Theatres and Pre-Operative Assessment
Theatre utilisation for May was 83.9%, with the Elective Surgical Hub at 84%. May also saw the Hub take part in the national GIRFT Hub Optimisation Week (HOW). This was a Surgical Division-wide initiative and resulted in utilisation of 89.3% for the week, the highest the Elective Surgical Hub has achieved to date.
Standby patients were used for the first time during HOW and there were a number of useful learnings. These will be shared at a HOW wash-up meeting, with the aim of taking forward some of the improvements, including the use of standby patients.
The main areas of underutilisation remain Oral and Dental. These are long-standing challenges due to the nature of the patients on these lists, however the specialties are working towards more realistic and achievable targets. Vascular also saw underutilisation, and work is underway within the specialty to increase list output.
Plastics, which has previously struggled with utilisation, showed a strong improvement in May with utilisation over 92%. Breast, colorectal, orthopaedics and urology all maintained utilisation above 85%.
My Pre-Op Plus is due for a soft launch in June, initially for patients already on waiting lists, with full rollout planned for July. This will help support the identification and use of standby patients across all lists.

Elective Activity
Overall elective activity remains on plan with a slight under delivery in New Outpatient activity, although 700 more than the first two months of 25/26, and Elective inpatients / day cases above plan and significantly more than last year.

Long waiting patients
- At the end of May, we had 8 English patients were waiting 65 weeks.
- 147 English patients were waiting over 52 weeks for treatment at the end of May

What the charts tell us

- Performance against English RTT standard in May was 67% / 0.6 % of English patients on our Waiting List were waiting more than 52 weeks
- Performance against the Welsh RTT standard in May was 65%

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.

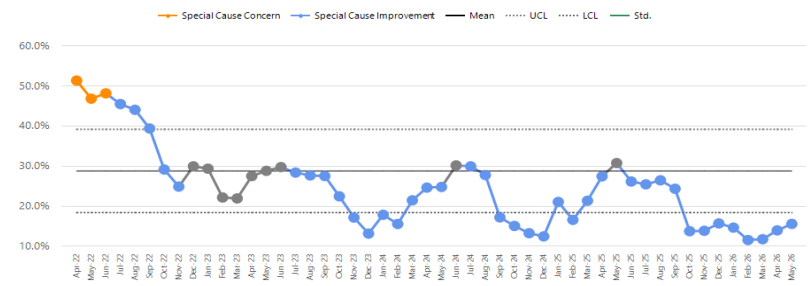
Operational Performance – Diagnostic Performance

We are driving this measure because:

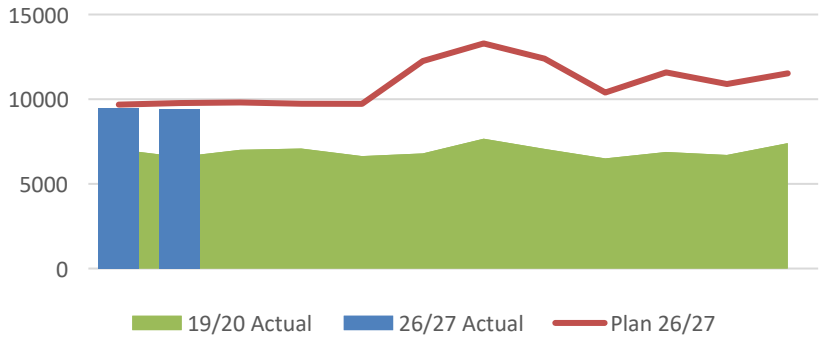
Diagnostic waiting times is a key part of the RTT waiting times measure. Referral to Treatment [RTT] may include a diagnostic test; therefore, ensuring patients receive their diagnostic test within 6 weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks/26 weeks. Less 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	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special cause variation – Cause for concern (where high is a concern)	Reasonable Assurance

Diagnostic Waits > 6 Weeks



Total Activity [all Modalities]



Performance & actions

Overall Diagnostics is delivering 97% of 26/27 activity plan in M2 which is 138% 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 May is 94.5% overall, with a deterioration in MRI performance experienced due to unplanned scanner downtime, increase in demand and persisting vacancies. 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 sustained 83%, because of successfully implanted productivity strategies. Notably, Paediatric Audiology has delivered a further 6 week performance improvement >80%

Endoscopy:
Waiting list position has improved in this period although progress is slow. The waiting list position overall position shows >6 weeks is 35% and >13 weeks is 12%. Work is ongoing to reduce this further with the planned appointment of additional clinical member of staff to deliver 5 lists per week and utilisation of these funds to increase through additional activity until appointment. However, the impact of sudden Ross closure is still being seen as well as the loss of a full time Clinical Endoscopist's activity.
Cancer wait times are under 7 days for all endoscopy procedures, position maintained and no delays seen across this pathway.
Validation of the diagnostic waiting is an ongoing process now implemented across the team on a weekly basis with several removals other than treatment expected due to patient choice.

Echocardiography (Echos):
Workforce challenges has impacted the department in the last 4-6 weeks and therefore despite the weekend insourcing, the 13 week and 6 week waiting list position has not improved as expected. Ongoing mitigation is being progressed whilst recruitment to posts and training for trainees continues, including extending insourcing and locum support.

Respiratory physiology (sleep studies)
Through additional activity the team are delivering additional sleep study appointments per week which has seen a consistent reduction each week since April of patients waiting >13 weeks and >6 weeks

Risks

Increased cancer referrals impacting on capacity of service particularly for MRI. Increase in UEC demand for Echocardiography (Echos) Audiology, MRI, Echocardiogram, Respiratory physiology and Endoscopy workforce challenges.

What the charts tell us

End of May 85% of patients waiting less than 6 weeks for a diagnostic test.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

The Trust continues to perform well in the NHS Oversight Framework and WVT is currently ranked 32 out of 134 in sickness absence and 37 out of 134 for its staff survey engagement theme; and overall the Trust is performing well in most HR KPI indicators.

Overall staff turnover stands at around 8.0 % and active work will continue on retention and recruitment to maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at around 6% but turnover for band 2/3 hcsw staff remains at 16.7% but we will continue to maintain the programme of work as described in the report.
In June, we have been 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. We are running our popular annual WVT Fun Day on 25th July at Halo Leisure Centre.

With the NHSE requirement to reduce our non-clinical headcount, we have completed phase one of the voluntary redundancy scheme and 8 non-clinical employees are exiting the Trust by the end of June. A second phase of voluntary redundancy is likely to be implemented by August. The first workforce optimization and efficiency working group commences in early July, in view of expediting schemes to enhance workforce productivity over the next 6 to 12 months.
Resident Doctors Deal – the national June strike action was called off and a revised deal is being balloted on with a closing date of 26th June. The offer has five main components:

- improved pay progression linked to training competencies and associated work delivered
- reimbursing Royal College membership, portfolio, and exam fees
- up to 4,500 additional training places over the next three years
- further action on the 10 Point Plan to improve resident doctors' working lives
- a new, improved contract for Locally Employed Doctors (LEDs)

The HR team are undertaking an early review of actions that will need to be put in place at local level.
The Lord Mann Review into antisemitism presents a clear and compelling picture: racism, including antisemitism, is persistent and in some cases normalised within NHS settings, affecting both staff experience and patient confidence. The review highlights that Jewish staff and patients continue to experience unacceptable discrimination, with variation in how organisations respond. Many NHS staff are also increasingly subject to racism, abuse and discrimination from the people they are trying to care for. Antisemitic behaviour and anti-Muslim hostility and racism have become more visible and must be addressed urgently and consistently, with employers acting as the first line of defence when this happens in the workplace. Working with our Staff Networks, HR, EDI leads and FTSU Guardians across the Foundation Group, we are reviewing our policies and protocols for raising concerns and developing clearer processes for reporting and investigating cases. Revised NHS mandatory training will also be implemented and closely monitored once this is available.
The Milburn Report on Young People and Work - at WVT we know we can make a difference here in our position as one of the largest employers in Herefordshire. Working closely with our line managers, DWP officers and One Herefordshire Partners we will be taking the following actions over the year:

- **Championing and promoting inclusive entry routes and apprenticeships and tracking progress**
- **Reform how we handle health and work conversations by influencing** the culture around fit notes and training managers and HR teams to ask, "what can you do?" rather than defaulting to exclusion.
- **Build genuine partnerships with local communities and schools by** collaborating with DWP, local authorities, further education colleges, and youth charities.
- **Humanise recruitment and reduce barriers by** reviewing our hiring practices to introduce more human touchpoints early on with skills-based assessments
- **Use data on employment of young people and** track internal metrics on young employee retention, progression, and health outcomes.

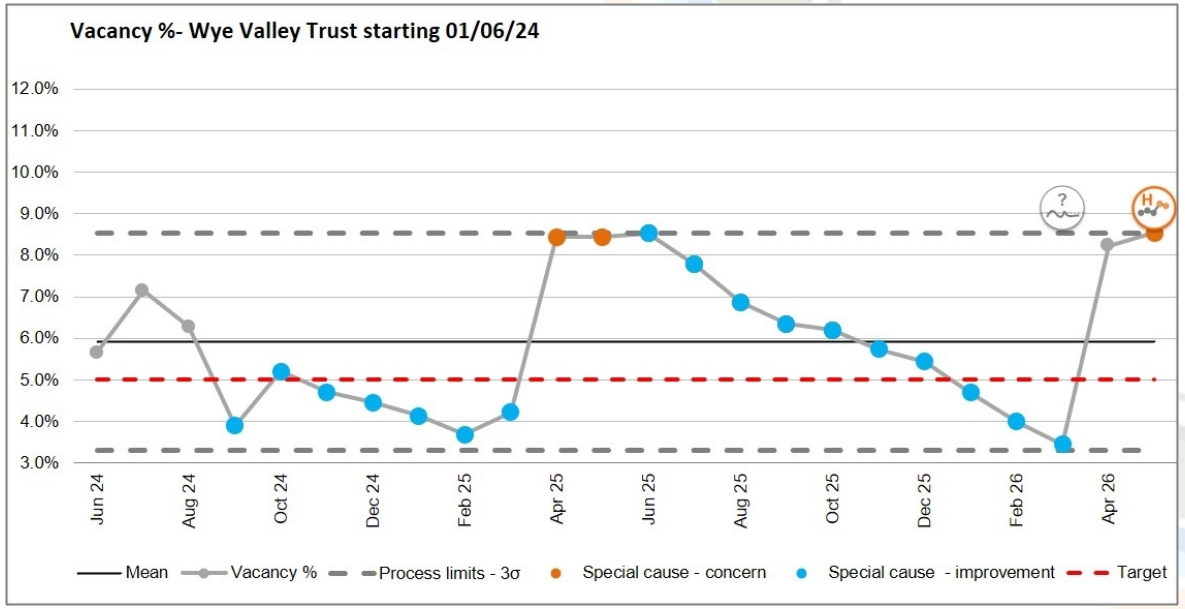
Workforce Performance – Vacancy

We are driving this measure because:

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

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

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



Performance & actions

HCSW – our current healthcare support worker vacancy gap is 27.30 wte (showing a positive reduction of 9.69wte vacancies that have been filled in the last month). The recruitment and nursing teams are working together pro-actively and the centralised recruitment process is demonstrating benefits. We continue working actively with the DWP through recruitment boot camps, monthly events and drop-in sessions.

N&M - We continue to see significant increase in applications from UK based applicants for nursing vacancies. We currently have 56.43 wte funded vacant positions which takes account of skill mix budget resets, however 19 of these vacancies are under offer.

M&D - We currently have 75.64wte funded vacant positions out of which 19 offers have been made in June, demonstrating continuing good progress working with recruitment agencies. Regular status reports and progress reviews continue to be held and any difficult areas to recruit are considered for different approaches.

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 and Month 2 of 26/27 has shown a large increase, due to an increase in budget for the new financial year to cover usage.

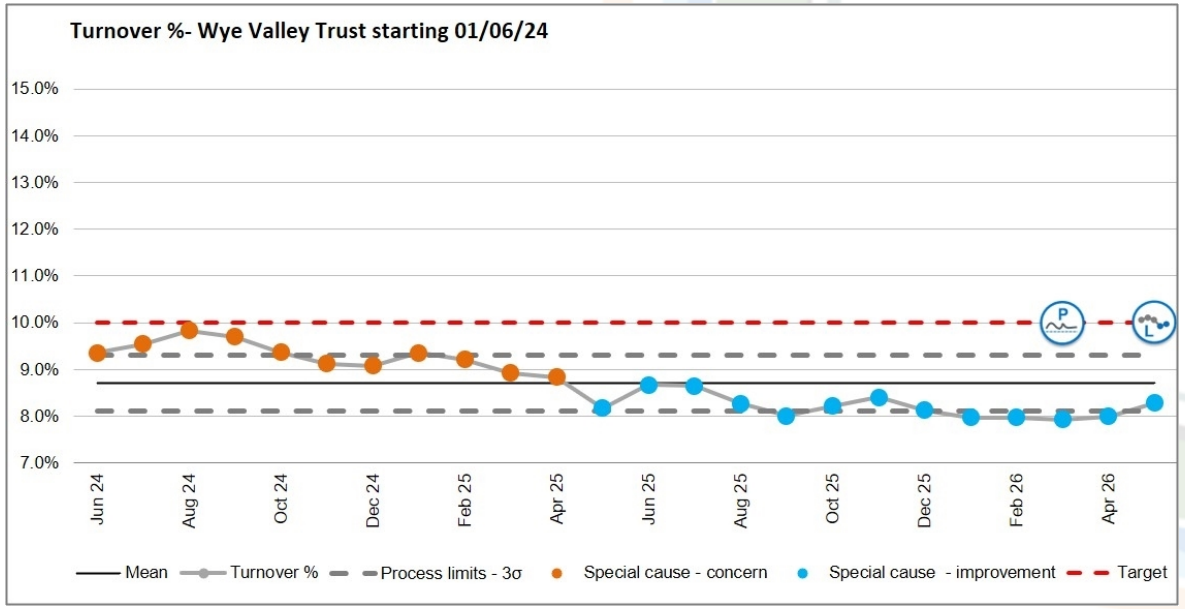
Workforce Performance – Turnover

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.

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

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



Performance & actions

The overall rolling 12-month turnover at Trust level is at 8.3% and continues to stay below the maximum KPI of 10.0%.
The turnover rate for clinical support workers at band 2&3 level continue to remain high at 16.72% however as described in the previous section, there is positive progress with recruitment to roles and part of the analysis is that a proportion of HCSWs move into further training. The HR team continues to work with line in areas of high turnover and highlighting career development opportunities through apprenticeships.
Turnover rates for qualified nurses remains in the region of 6% and divisional teams are using a variety of flexible working options and development opportunities to retain staff.

Risks

Staff turnover for band 2 support workers

What the chart tells us

A fluctuating pattern in 25/26 but continuing with an overall decreasing trend, remaining fairly consistent in the last 6 months.

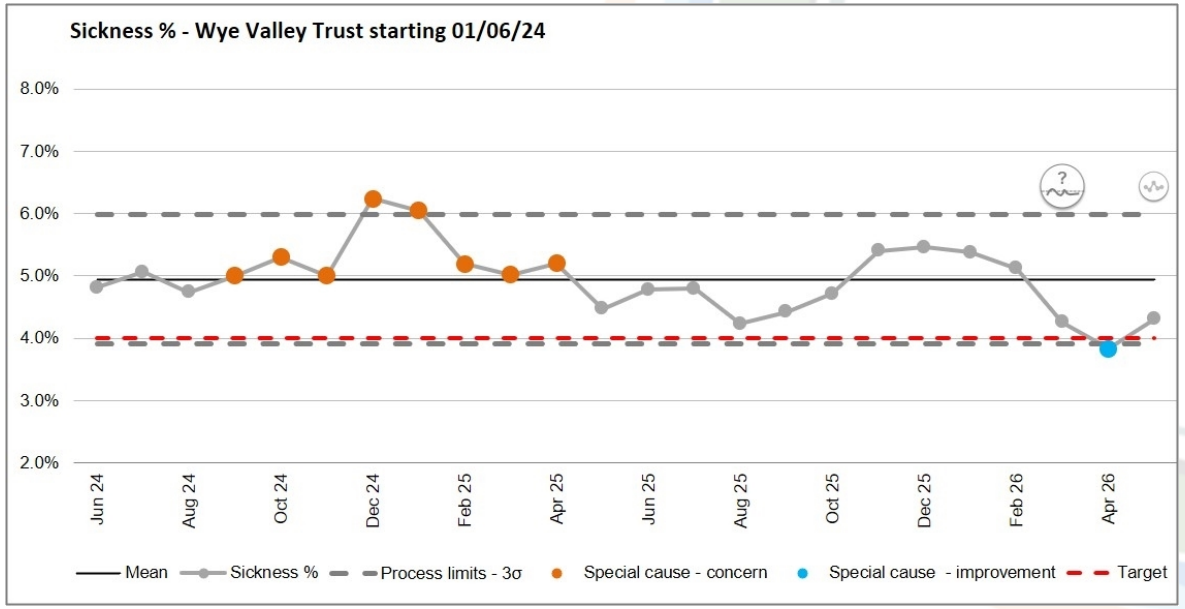
Workforce Performance – Sickness

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.

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

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



Performance & actions

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.
During this month, overall sickness at Trust level has increased slightly back to 4.3% and the main reasons for absence are colds/winter ailments, mental health/stress related, 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.

Risks

What the chart tells us

This was a slight increased in the first month of 25/26 but reduced in month 2 to the position from 12 months ago, with a slight uptick in month 3, maintained in month 4 reverting back down to the lowest position in the last 2 years in month 5, before 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 decrease in April 26, to our lowest levels of sickness but with a slight increase in May.

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 2 Income and Expenditure position

At the end of Month 2 we are slightly behind plan at (£1.2m) deficit against a (£1.0m) plan.

The plan includes a £24.7m efficiency challenge with the 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 and the left shift of care closer to the community which positively contributed to setting a balanced plan for the year. At the end of May, 46% of the targeted efficiency challenge had been assessed as fully developed or implemented, reflecting the lowest level of risk. Around one third of the target was within the highest risk categories reflecting the importance of continued grip and control measures and development of opportunities into actionable plans. The well-established Financial Recovery Board (FRB) maintains strong oversight of the risks and mitigations to support delivery of the plan and improvement in our underlying position, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability. 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.

Key headlines within the month / year to date:

- The net position for income is positive by £0.4m, mainly driven by one off income streams which offset in expenditure
- Agency spend continues on a positive trend linked to a range of actions within out medical and nursing agency reduction programmes, including a successful recruitment drive.
- Industrial action led to an unplanned pay cost of £0.2m in Month 1
- Planned efficiencies not fully delivered YTD (£0.9m) primarily due to slippage on the timing of implementation and working up of a complex transformation plan. Mitigated through timing of expenditure and non recurrent benefits.

Cash and Capital

Cash balances at the end of May are higher than planned, mainly driven by a higher closing balance as we exited 2025/26 and a £7m reduction in debtors year to date.

Capital expenditure is slightly less than planned at the end of May, 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 2 - 31st May 2026 - 2026/27

	2025-26 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Operating income from patient care activities	371,169	61,222	61,011	(210)	(4)
Drugs Excluded	24,610	4,102	4,256	154	8
Other operating income	15,798	2,633	3,107	474	333
Donations from non current asets	240	40	0	(40)	(20)
Total Operating Income	**411,817**	**67,997**	**68,374**	**377**	**317**
Substantive Pay	(236,447)	(38,827)	(39,414)	(588)	(194)
Bank & WLI Pay	(14,507)	(2,659)	(2,953)	(294)	(205)
Agency pay	(5,638)	(1,260)	(622)	638	265
Subtotal Pay	***(256,592)***	***(42,746)***	***(42,990)***	***(244)***	***(134)***
Non Pay Expenditure	(99,778)	(17,030)	(17,755)	(725)	(441)
Excluded Drugs	(24,610)	(4,102)	(4,233)	(132)	(31)
Total Operating Expenditure	**(380,980)**	**(63,878)**	**(64,978)**	**(1,100)**	**(606)**
EBITDA	**30,837**	**4,119**	**3,396**	**(723)**	**(289)**
Depreciation	(15,604)	(2,602)	(2,312)	290	147
Impairment (CDC & PFI)	0	0	0	0	0
Interest Receivable	900	150	370	220	112
Interest Payable on Loans	(257)	(43)	(38)	5	14
Interest Payable on PFI	(3,030)	(210)	(210)	(0)	(0)
Dividends on PDC	(4,954)	(824)	(824)	0	0
Operating Surplus/ (Deficit)	**7,892**	**590**	**382**	**(208)**	**(16)**
Technical Adjustments					
Donated Assets Adjustment	742	124	119	(5)	(2)
Net impact of asset impairments	0	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	(8,634)	(1,730)	(1,710)	20	10
Adj. financial performance retained Surplus/ (Deficit)	**0**	**(1,017)**	**(1,209)**	**(192)**	**(8)**

Performance & actions

The position at the end of Month 2 (May) was a deficit of (£1,209k) YTD. This is performing slightly behind plan with an overall negative variance of (£192k) YTD, (£8k) in month.

- Income shows a favourable variance of £0.4m. Of this £154k relates to drugs directly offset within expenditure . Operating income from patient care variance of (£210k) is largely related to depreciation which is also offset within expenditure. Other operating income of £474k over achievement is due to various one-off income benefits.
- Pay is adverse by (£244k) YTD. The net position in month includes agency - 1.45% of total pay costs in month which is an increase from 1.28% in month 1. Bank (including WLI) use further increases the total temporary staff proportion to 3.87% of overall pay, including costs for Industrial Action in M1 (c£150k). Nurse agency usage has remained low, with no spend on Healthcare Support Worker agency.
- Total Non Pay (operating & non operating) is adverse by (£326k) YTD including technical adjustment benefits. The adverse variance is largely due to undelivered CPIP and excluded drugs (offset by income). This is partly mitigated by an underspend on Depreciation/Amortisation, an over achievement of interest received due to higher cash balances than planned and timing of expenditure.
- Within Adjustments, there is a PFI £20k favourable variance driven by a one-off technical adjustment to the control total for historical accounting changes on PFI.

Risks

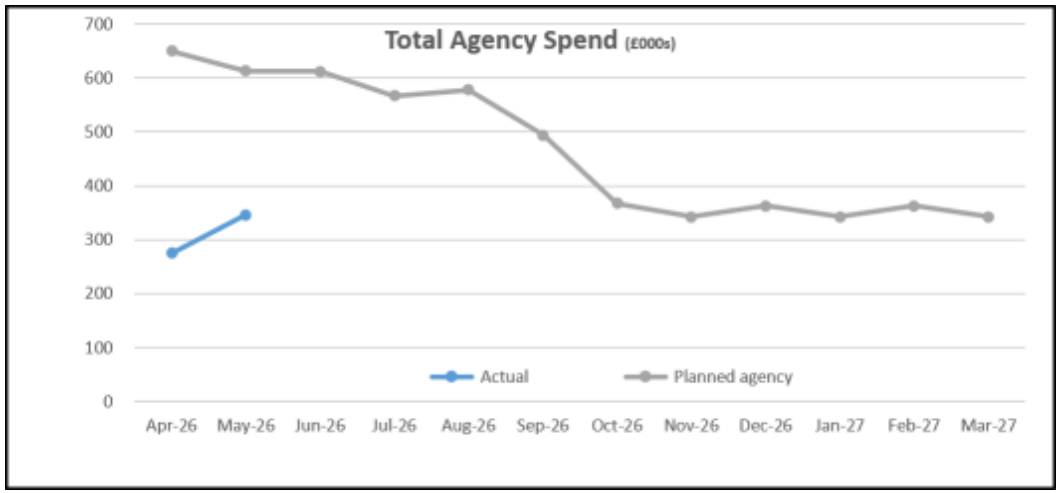
Key Financial risks mitigated throughout the year

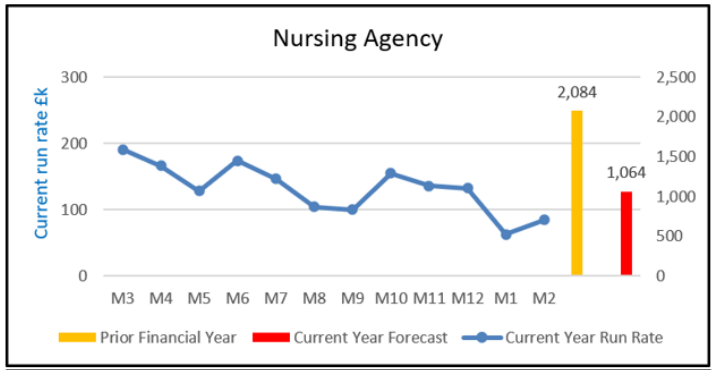
- Overall cost reduction needed to achieve breakeven by end of year and maturity status of programme
- CPIP Cost Efficiency delivery recurrently
- Level of Bank (as % of pay)
- Income risk around deficit support funding and Welsh parity
- Future cost pressures: e.g. Industrial Action / Winter impact on financial performance
- Marginal Cost of delivering activity

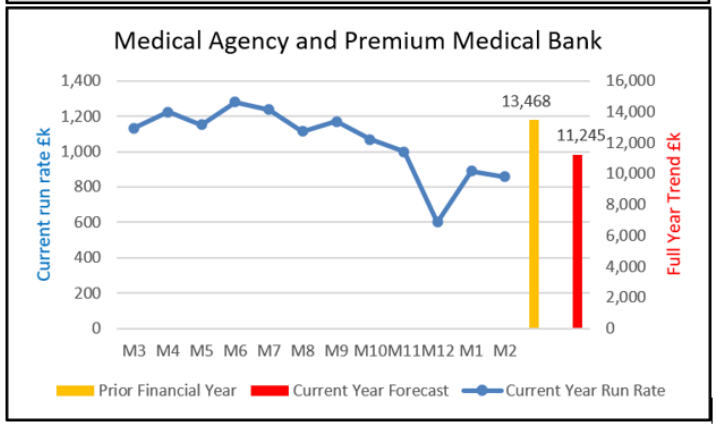
Finance Performance – Temporary Staffing Spend

We are driving this measure because:

Tackling our high agency and medical bank spend levels (volume and price) is key to successfully mitigating financial risk and delivering the financial plan.







Performance & actions

Agency represents 1.45% 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 £638k, including non recurrent savings in month. Total agency spend year to date is £622k.

- **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 Nurse agency spend YTD is £147k.
- **Off framework Nurse Agency:** There have been 12 off framework shifts in May 2026 compared to 1 in April 2026 (13 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 YTD is £1,747k, 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

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

Increase in emergency demand pressures

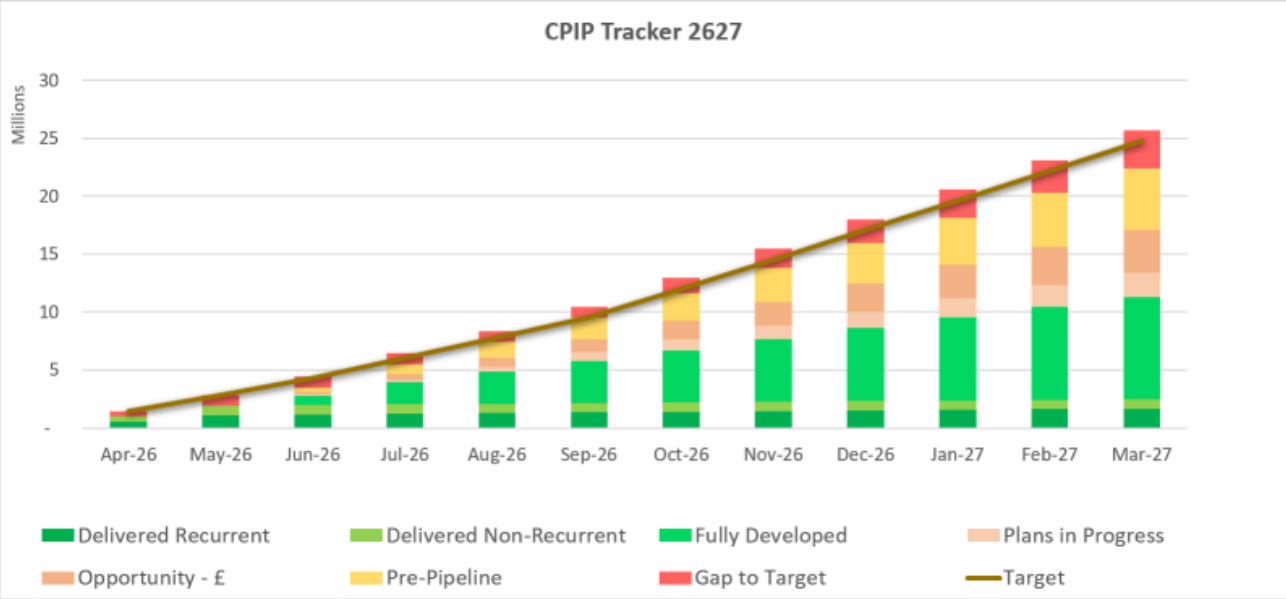
What the charts tell us

Agency performance is well withing plan at Month 1 and will require a sustainable recurrent low level of spend to remain within target. Focus remains on high cost bank.

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.



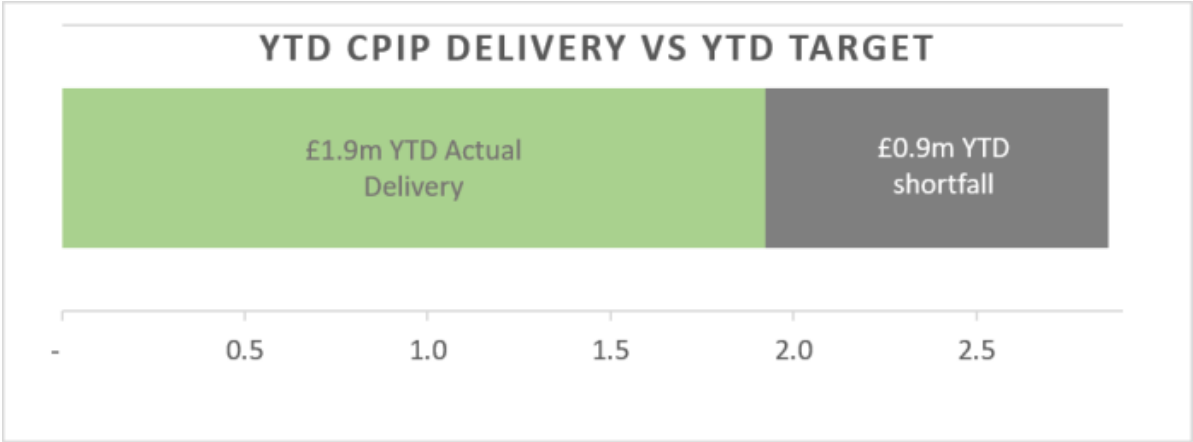
Performance & actions

The £24.7m target is planned to be delivered through Pay £7.5m & Non Pay £17.2m, which includes a recurrent assumption of £11.1m. The £24.7m represents a cost reduction in 2026/27, including notable schemes of Agency reduction, Bank reduction and WTE reduction. The programme includes a continued focus on reducing growth from pre Covid levels.

The Trust efficiency delivery YTD at month 2 was £1.9m, £0.9m away from plan, mitigated through non recurrent benefits.

At the end of May, 46% of the targeted efficiency challenge had been assessed as fully developed or implemented, reflecting the lowest level of risk. Around one third of the target was within the highest risk categories reflecting the importance of continued grip and control measures and development of opportunities into actionable plans.

The 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 care closer to the community.



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
March	49.1	46.0		
April	45.5	41.1		
May	50.8	39.1		
We started 26/27 with £6m more than planned, plus 1.7m DSF in advance and debtors have reduced by £7m and other working capital changes have reduced cash by £2m when compared to plan.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
March	98.9%	95.0%		
April	99.0%	95.0%		
May	99.1%	95.0%		
In May the Trust paid 99.1% of invoices within 30 days. This equates to 92.1% by invoice value. This is the twenty ninth month, in a row, that we have achieved the 95% (by volume) target.				

Capital

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month			Full Year	
			Budget £k	Actual £k	Variance £k	Forecast £k	Variance £k
Local CDEL funded	Owned	8,439	869	1,025	(156)	8,439	0
IFRS16 Leases	Leased	1,000	150	0	150	1,000	0
National PDC schemes	Owned	11,400	230	227	3	11,400	0
Grant funded and Donated	Owned	1,943	891	648	243	1,943	0
Total Capital Programme		22,782	2,140	1,900	240	22,782	0

What the charts tells us

Cash
The 2026/27 opening cash balance was £6m higher than planned. In 2026/27 we have received 1.7m DSF in advance, debtors have reduced by £7m which were partially off-set by other working capital changes reducing cash by £2m, compared to plan.

Capital
The capital expenditure for May 2026 was £1,900k, £240k lower thank planned. This is due to timing on the Integrated Energy Centre 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 planed 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.

Finance Performance – Statement of Financial Position

We are driving this measure because:

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

Statement of Financial Position

May 2026	2025/26	2026/27			2026/27 Full Year		
	Accounts £000s	M2 Plan £000s	M2 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	174,368	173,225	173,592	367	183,533	183,533	0
Intangible Assets	8,904	8,092	9,269	1,177	5,421	5,421	0
Trade and Other Receivables	1,410	1,197	1,432	235	1,197	1,197	0
TOTAL Non Current Assets	**184,682**	**182,514**	**184,293**	**1,779**	**190,151**	**190,151**	**0**
CURRENT ASSETS:							
Inventories	4,995	5,581	5,414	(167)	5,581	5,581	0
Trade and Other Receivables	29,505	31,993	22,656	(9,337)	38,493	32,532	(5,961)
Cash and Cash Equivalents	49,052	39,074	50,759	11,685	39,966	45,966	6,000
TOTAL Current Assets	**83,552**	**76,648**	**78,829**	**2,181**	**84,040**	**84,079**	**39**
TOTAL ASSETS	**268,234**	**259,162**	**263,122**	**3,960**	**274,191**	**274,230**	**39**
CURRENT LIABILITIES							
Trade and other payables	(46,261)	(42,767)	(43,247)	(480)	(40,943)	(40,943)	0
Borrowings - Loans, PFI and Finance	(14,291)	(16,077)	(13,107)	2,970	(16,077)	(16,077)	0
Provisions	(185)	(49)	(46)	3	(49)	(49)	0
Total Current Liabilities	**(60,737)**	**(58,893)**	**(56,400)**	**2,493**	**(57,069)**	**(57,069)**	**0**
NET CURRENT	**22,815**	**17,755**	**22,429**	**4,674**	**26,971**	**27,010**	**39**
TOTAL ASSETS LESS CURRENT	**207,497**	**200,269**	**206,722**	**6,453**	**217,122**	**217,161**	**39**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance	(30,565)	(26,145)	(29,278)	(3,133)	(18,719)	(18,719)	0
Provisions	(1,556)	(1,489)	(1,685)	(196)	(1,489)	(1,489)	0
Total Non-Current Liabilities	**(32,121)**	**(27,634)**	**(30,963)**	**(3,329)**	**(20,208)**	**(20,208)**	**0**
ASSETS LESS LIABILITIES	**175,376**	**172,635**	**175,759**	**3,124**	**196,914**	**196,953**	**39**
TAXPAYERS EQUITY							
Public dividend capital	339,856	339,817	339,856	39	356,794	356,833	39
Revaluation reserve	18,280	17,203	18,280	1,077	17,203	17,203	0
Income and expenditure reserve	(182,760)	(184,385)	(182,377)	2,008	(177,083)	(177,083)	(0)
TOTAL	**175,376**	**172,635**	**175,759**	**3,124**	**196,914**	**196,953**	**39**

Performance & actions

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

Non-Current Assets
Non-Current assets are higher than plan YTD due to the opening balances from 2025/26 being greater than planned, predominantly because of the year end revaluations.

Working balances
Net working balances - receivables less payables - have decreased by £10m compared to plan mainly driven by a reduction in debtors.
Cash: We started 2026/27 with £6m more than planned and have benefited from £1.7m DSF received in advance and English debtors reducing by £7m. This is partially off-set by other working capital changes adversely impacting cash by (£2m) when compared to plan.

Borrowings
Borrowings balances differ (plan versus actual) due to timing issues at plan formulation compared to year-end outturn but broadly off-set across current and non-current.

Taxpayers Equity
PDC and revaluation reserves differ from plan due to variances in the actual 2025/26 closing balances.

The income and expenditure reserve closing balance in 2025/26 was £2.2m better than the outturn used for the 2026/27 plan. This variance is reduced by the retained surplus being £0.2m behind plan at the end of May.

Risks

Risks identified in the year have been mitigated, resulting in a stronger balance sheet at year end than planned.

What the chart tells us

Current assets outweigh current liabilities.

NHS
Wye Valley
NHS Trust

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

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

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

Example

Data Quality Assurance Questions

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

Quality of care, access and outcomes		Responsible Director	Standard	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest Month Numerator	Latest Month Denominator	Year to Date v Standard	Trend - Apr 2019 to date	Latest Available Monthly Position: WVT Latest month v benchmark	Latest Available Monthly Position: National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	**80%**	84.6%	84.2%	83.8%	80.0%	86.0%	83.6%	82.2%		717	872	82.2%			75.9%				
	2 Week Wait all cancers	Chief Operating Officer	**93%**	92.3%	79.2%	83.6%	84.9%	80.1%	88.9%	86.2%		843	978	86.2%			74.4%				
	Urgent referrals for breast symptoms	Chief Operating Officer	**93%**	75.0%	0.0%	38.1%	31.3%	53.3%	64.0%	69.2%		9	13	69.2%			52.4%	April			
	Cancer 31 Days Combined	Chief Operating Officer	**96%**	93.7%	90.5%	97.1%	90.2%	98.0%	96.4%	94.9%		148	156	94.9%			91.5%				
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Chief Operating Officer		6	5	2	4	6	4	9				9							
	Cancer 62 days Combined	Chief Operating Officer	**75%**	75.8%	82.3%	89.1%	81.7%	76.8%	88.4%	76.5%		100	130	76.5%			75.7%	Apr			
	Cancer: number of cancer patients waiting over 62 days	Chief Operating Officer	**Plan**	67	32	56	55	36	32	42	27										
Primary care and community services	Community Service Contacts - Total	Chief Operating Officer	**v 2025/26**	140%	117%	132%	134%	126%	121%	110%	104%	33959	32698	107%							
	Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	**70%**	89%	89%	93%	90%	90%	95%	93%	91%	303	332	92.3%			87%	Apr			
	% emergency admissions discharged to usual place of residence	Chief Operating Officer	**90%**	87%	88%	87%	87%	88%	87%	92%	92%	2802	3044	92.1%			93%	Apr to Mar			
Urgent and emergency care	A&E Activity	Chief Operating Officer	**Plan**	97%	97%	95%	107%	96%	96%	104%	100%	6551	6451	102%							
	Ambulance handover within 30 minutes (WMAS Only)	Chief Operating Officer	**98%**	53.0%	61.7%	56.5%	39.9%	45.4%	45.8%	50.3%	55.7%	841	1509				73%				
	Ambulance handover within 45 minutes (WMAS Only)	Chief Operating Officer	**0%**	65.6%	77.4%	69.3%	51.7%	59.1%	59.0%	62.9%	67.5%	1018	1509					July			
	Ambulance handover over 60 minutes (WMAS Only)	Chief Operating Officer	**0%**	28.1%	17.5%	24.8%	40.5%	32.7%	30.9%	27.8%	25.0%	378	1509	23.8%			12%				
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	**v 2025/26**	123%	122%	122%	128%	124%	126%			1639	1304	122%							
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	**45%**	47%	50%	48%	49%	50%	47%	48%	50%	1394	2783	49.2%			36%	Apr to Mar			
	A&E - % of patients seen within 4 hours	Chief Operating Officer	**78%**	66.7%	68.5%	65.3%	65.0%	63.2%	63.7%	66.2%	63.1%	4646	7367	64.6%			76%	May			
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		11.9%	10.2%	10.4%	13.9%	12.3%	12.3%	9.8%	11.2%	822	7367	11.3%			8%				
	A&E - Time to treatment	Chief Operating Officer		01:32	01:33	01:36	01:50	01:42	01:52	01:33	01:45						01:48	Apr to Mar			
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	**<15 minutes**	00:24	00:22	00:26	00:30	00:26	00:26	00:25	00:25						00:19				
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	**0**	272	178	202	274	234	234	161				760							
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	**3%**	7.9%	8.4%	8.7%	8.5%	8.7%	7.9%			107	5309	8.4%			10%	Apr to Mar			

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	61%	63.5%	63.9%	64.3%	65.2%	66.0%	67.8%	67.3%	66.9%	14997	22402				65.0%	Apr			
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	TBC	67.7%	66.6%	64.7%	64.3%	65.7%	66.8%	66.9%	65.2%	3091	4738								
	Referral to Treatment - Percentage of patients waiting no longer than 18 week for a first appointment - English Standard	Chief Operating Officer	72%	71.1%	72.5%	74.3%	74.5%	75.0%	75.1%	76.6%	76.9%	9233	12000								
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		26991	26366	26168	25888	26034	26031	26420	27140										
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	925	852	832	754	733	546	566	618						99781	April			
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	121	118	143	178	210	219	241	263						5776				
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	28	33	46	62	79	108	125	138						1145				
	GP Referrals	Chief Operating Officer	2025/26	98%	94%	113%	102%	99%	107%	103%	99%	3947	4007	101%							
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	Plan	100%	101%	94%	96%	99%	107%	94%	94%	5817	6201	94%							
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	Plan	106%	108%	100%	104%	106%	106%	97%	92%	17485	19109	94%							
	Proportion of Total Outpatient Appointments which are New or Follow Up Procedure	Chief Operating Officer	46%	46%	46%	47%	47%	46%	47%	46%	48%	11078	23212	47%			46.4%	Apr to Mar			
	Total Elective Activity (volume v plan)	Chief Operating Officer	Plan	101%	106%	102%	108%	106%	108%	97%	95%	2893	3035	96%							
	Elective Recovery Fund (ERF) Actual v Plan (£)	Chief Operating Officer	Plan	143%	139%	155%	137%	139%	147%					136%							
	BADS Daycase rates	Chief Operating Officer	Actual	81.3%	78.4%	80.4%	78.7%	78.8%						81.3%			79%	Apr to Feb			
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	85%	81.5%	79.7%	83.3%	79.6%	83.9%	82.4%	85.3%	83.7%			84.5%			81%	May			
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	85%	84.4%	81.2%	86.0%	82.4%	86.7%	85.9%	91.0%	86.7%			88.9%			85%	Feb			
	Cancelled Operations on day of Surgery for non clinical reasons	Chief Operating Officer	10 per month	42	27	26	56	34	41	14	26			40			23056	Jan to Mar			
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	Plan	87%	85%	90%	83%	86%	91%	107%	108%	3329	3078	107%							
	Diagnostic Activity - Endoscopy	Chief Operating Officer	Plan	100%	103%	126%	120%	107%	90%	92%	83%	671	811	87%							
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	Plan	79%	75%	131%	101%	98%	111%	99%	99%	1750	1771	99%							
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	<5%	13.8%	13.9%	15.7%	14.7%	11.6%	11.8%	14.0%	15.6%	1096	7017				24.9%	Apr			
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	90%	99.2%	95.5%	93.9%	93.7%	94.4%	96.9%	95.0%	90.3%	93	103	93.0%							
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Chief Medical Officer	<15%	19.0%	16.8%	19.2%	20.0%	22.0%	22.0%	21.9%	24.0%	23	96	24.0%							
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Chief Medical Officer	<34%	67.1%	67.6%	67.6%	60.6%	56.7%	57.6%	59.0%	60.8%	118	194	60.8%							
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Chief Medical Officer	<60%	92.6%	91.7%	91.3%	89.5%	88.9%	89.8%	89.6%	90.3%	121	134	90.3%							
	Maternity Activity (Deliveries)	Chief Nursing Officer	v 2024/25	108%	91%	94%	101%	89%	98%	109%	101%	132	131	105%							
	Midwife to birth ratio	Chief Nursing Officer	1:26	1:30	1:25		1:32	1:32	1:27	1:25	1:24										
Outpatient transformation	DNA Rate (Acute Clinics)	Chief Operating Officer	<4%	5.6%	6.1%	5.9%	6.0%	5.8%	5.7%	5.9%	6.0%	1676	26158	6.0%			6.8%	Apr to Mar			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	90%	87.8%	88.3%	85.7%	86.7%	87.6%	90.1%	90.1%	88.9%	14080	15830	89.5%							
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	Plan	109%	111%	104%	108%	110%	106%	98%	90%	11668	12907	94%							
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	25%	19.8%	18.8%	21.9%	20.2%	19.7%	19.5%	20.8%	18.8%	3290	17485	19.8%			18%	Apr to Mar			
Prevention long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer		8.1%	6.3%	4.6%	4.0%	5.6%	3.9%	2.9%	4.9%	5	103								

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	100%	100%	98%	100%	100%	100%	100%	100%	315	316	**100%**			95%	May			
	Bed occupancy - Community Wards	Chief Operating Officer	**<92%**	96%	98%	99%	96%	97%	96%	95%	97%	80	83	**96%**							
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	100	100	94	133	85	71	51	69			**120**			4474	Apr			
	Patient ward moves emergency admissions (acute)	Chief Operating Officer	**4%**	6%	7%	6%	7%	7%	8%	7%		78	1134	7%							
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	6.1	6.1	5.9	6.5	5.8	6.9	3.4	3.3	8370	2532	**3.4**			4.4	Apr to Mar			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	2.2	2.3	2.3	1.9	2.3	2.4	2.3	2.4	687	284	**2.4**			3.4				
	ALoS - General & Acute Adult (English)	Chief Operating Officer		5.4	5.2	5.2	5.6	4.9	5.6	3.2	3.1	7599	2470	3.1							
	ALoS - General & Acute Adult (Welsh)	Chief Operating Officer		6.4	7.3	6.4	6.3	6.6	7.3	4.3	4.2	1458	346	4.3							
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	17.7%	19.1%	16.8%	17.6%	19.0%	14.7%	14.5%	16.6%	1613	9691				23.1%	Dec			
	Medically fit for discharge - Community	Chief Operating Officer	**10%**	37.7%	32.1%	32.4%	29.5%	21.0%	22.9%	22.5%	25.5%	674	2642								
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	4.9%	4.6%	5.1%	4.7%	4.6%				155	3373	**4.9%**			8.5%	Mar to Feb			
	Mortality SHMI - Rolling 12 months	Chief Medical Officer	**<100**	113.8	115.1	112.8	113.2					1340	1185				100				
	Never Events	Chief Nursing Officer	**0**	1	1	0	1	0	0	0	0			**0**							
	MRSA Bacteraemia	Chief Nursing Officer	**0**	0	0	0	0	0	0	0	0			**0**							
	MSSA Bacteraemia	Chief Nursing Officer		2	1	2	3	2	5	0	5			**1**							
	Number of external reportable >AD+1 clostridium difficule cases	Chief Nursing Officer	**44**	4	1	1	4	6	4	7	5			12							
	Number of falls with moderate harm and above	Chief Nursing Officer	**2022/23 (30)**	4	0	0	4	5	3	4	0			4							
	VTE Risk Assessments	Chief Medical Officer	**95%**	93.0%	92.8%	91.8%	92.1%	94.1%	94.5%	91.0%	90.8%	3460	3812	**90.9%**							
	WHO Checklist	Chief Medical Officer	**100%**			99.4%			99.8%												
	% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	**60%**	37.9%	67.9%	60.7%	63.3%	67.4%	62.9%	51.4%		19	37	**51.4%**							
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	50.0%	57.1%	54.5%	75.0%	91.7%	60.0%	62.5%		5	8	**62.5%**							
	Stroke Indicator 80% patients = 90% stroke ward	Chief Medical Officer	**80%**	79.6%	87.0%	80.0%	83.3%	79.1%	70.7%	67.4%		29	43	**67.4%**							
	Cleaning Standards: Acute (Very High Risk)	Chief Nursing Officer	**98%**	97.7%	97.8%	97.9%	97.1%	97.0%	97.3%	97.1%	97.3%			**97.2%**							
	Cleaning Standards: Community (Very High Risk)	Chief Nursing Officer	**98%**	97.7%	98.4%	98.5%	99.0%	99.0%	97.0%	97.4%	98.1%			**97.8%**							
	Number of complaints	Chief Nursing Officer	**2022/23 (253)**	30	40	33	24	28	27	30	27			57							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**90%**	52.0%	44.0%	57.0%	44.0%	40.0%	51.0%	47.0%	65.4%	17	26	**56.2%**							

	Friends and Family Test - Response Rate (Community)	Chief Nursing Officer	**30%**								0	0	**0.0%**								
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Chief Nursing Officer	**95%**	81%	87%	83%	80%	82%								80%					
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	90%	92%	88%	92%	93%			140	151	**90.1%**			95%	April				
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	70%	86%	100%	100%	98%			17	52	**92.0%**			95%					
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	100%	94%	93%	100%	100%			14		**96.5%**			92%					
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**25%**	15%	15%	15%	16%	15%													
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	13%	13%	12%	15%	13%			151	1194	**12.9%**								
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	12%	18%	14%	21%	24%			14	59	**17.1%**								

People		Responsible Director	Standard	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/ Fail	Trend Variation	DQ Mark
												Numerator	Denominator			WVT Latest month v benchmark	National or Regional				
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6.4%**	3.5%	2.6%	2.6%	2.4%	2.4%	1.4%	1.3%	1.6%			**1%**							
	Appraisals	Chief People Officer	**85%**	76.5%	76.7%	76.7%	75.1%	75.8%	75.6%	76.4%	76.0%	0	0	**76%**			76%	2021/22			
	Mandatory Training	Chief People Officer	**85%**	89.7%	89.7%	89.6%	89.0%	88.8%	88.9%	89.4%	85.5%	37777	44196	**87%**			88%				
	Overall Sickness	Chief People Officer	**4.0%**	4.7%	5.4%	5.5%	5.4%	5.1%	4.3%	3.8%	4.3%	5081	117894	**4%**			5%	Feb			
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**10%**	8.2%	8.4%	8.1%	8.0%	8.0%	7.9%	8.0%	8.3%	312	3768	**8%**							
	Clinical WTE Establishment	Chief People Officer		3165	3165	3164	3166	3162	3163	3222	3222										
	Clinical WTE Actual	Chief People Officer		2908	2919	2926	2947	2958	2965	2966	2953										
	Non-Clinical WTE Establishment	Chief People Officer		841	830	819	805	791	778	923	923										
	Non-Clinical WTE Actual	Chief People Officer		850	847	841	838	838	840	838	839										
	Frozen Posts (where no agency or bank is being used)	Chief People Officer																			
	Vacancy Rate	Chief People Officer	**5%**	6.2%	5.7%	5.4%	4.7%	4.0%	3.4%	8.2%	8.5%	354	4146	**8%**							

Finance and Use of Resources		Responsible Director	Standard	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/ Fail	Trend Variation	DQ Mark
												Numerator	Denominator			WVT Latest month v benchmark	National or Regional				
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	£407	£1,333	£552	£1,850	£365	£1,276	-£703	-£504			**-£1,207**							
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	1.6%	1.6%	1.6%	5.4%	1.1%	2.5%	-2.1%	-1.5%	-£504	£34,158								
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£289	£762	£477	£824	-£482	£417	-£184	-£6			**-£190**							
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	-41.5%	133.5%	636.0%	80.3%	-56.9%	48.5%	-35.5%	-1.2%	-£6	-£504								
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£396	-£404	-£655	-£861	-£1,081	-£1,023	-£404	-£525			**-£929**							
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	£718	£547	£536	£506	£512	£502	£276	£346			£622							
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	3.5%	2.6%	2.5%	2.5%	2.4%	1.4%	1.3%	1.6%	£346	£21,496	1.4%							
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£170	£231	£278	£272	£293	-£2,367	-£44	£37			**-£7**							
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£32	£30	£30	£32	£43	£49	£46	£51			£51							
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	99.8%	98.2%	99.4%	92.6%	99.4%	98.7%	99.8%	92.1%	£11,844	£12,855	**97.0%**							
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	97.7%	98.9%	99.4%	98.2%	98.9%	98.9%	99.0%	99.1%	£5,036	£5,084	**99.0%**							

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WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board Held in Public**
Date of Meeting:	**2nd July 2026**
Title of Report:	Board Briefing: Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust (June 2026)
Lead Executive Director:	**Chief Nursing Officer**
Author:	Sarah Shinger, Managing Director
Reporting Route:	Direct to Board
Enclosures included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide Board members with a concise summary of the principal findings, risks, and priority actions arising from the Ockenden Review of Maternity and Neonatal Services at Nottingham University Hospitals (NUH).

Executive Summary

The Ockenden Review concludes that significant and avoidable harm occurred to mothers and babies over many years as a result of systemic failures in leadership, governance, culture, workforce planning, clinical practice, and organisational learning. More than 2,500 families contributed evidence, making this the largest maternity inquiry in NHS history. The review found that many concerns had been known since at least 2010 but were not addressed effectively.

While evidence of improvement since 2021 was recognised, the report concludes that sustained action is required to embed change and restore public confidence.

Key Findings

Leadership, Culture and Governance Failures

- Known safety concerns were repeatedly overlooked, minimised, or insufficiently escalated.
- Board oversight lacked effective challenge and assurance.
- Incident investigations were delayed, poorly conducted, or failed to generate meaningful learning.
- A culture of reassurance rather than accountability prevailed.

Workforce and Staffing Pressures

- Chronic shortages of midwives, obstetricians, and governance staff affected safety and quality.
- Staff reported excessive workload, burnout, and inability to complete mandatory training.
- Only a small minority of staff felt staffing levels were sufficient.

Toxic Workplace Culture

- Bullying, intimidation, hierarchy and poor psychological safety were longstanding themes.
- Staff frequently reported concerns being ignored or not acted upon.
- Cultural issues undermined escalation, learning and patient safety.

Clinical Care Deficiencies

Recurring failures were identified across:

- Antenatal assessment and risk management.
- Triage and induction of labour.
- Fetal monitoring and CTG interpretation.

- Escalation of deteriorating mothers and babies.
- Postpartum haemorrhage management.
- Postnatal monitoring and discharge processes.

Family Experience and Psychological Harm

- Families consistently described:
- Not being listened to or believed.
- Poor communication and lack of informed consent.
- Delayed explanations following incidents.
- Additional trauma caused by defensive responses and poor investigations.

Health Inequalities

Women from ethnic minority and disadvantaged communities experienced:

- Communication barriers.
- Reduced ability to escalate concerns.
- Cultural misunderstandings.
- Lower confidence in services.

Recommended Actions required by Board or Committee

The Board is asked to **Note** the findings of the review and **seek Assurance** that relevant lessons continue to inform our maternity improvement programme, governance arrangements and quality assurance processes including the requirement for Boards to oversee the **Immediate (0–6 months) Priority Actions**:

- Ensure implementation of all Ockenden Immediate and Essential Actions.
- Review Board assurance mechanisms for maternity safety.
- Strengthen incident investigation and Duty of Candour compliance.
- Establish robust escalation routes for women, families and staff, including the implementation of Martha's Rule for maternity and neonatal services.

Executive Director Opinion[1]

The findings of the Ockenden Review highlight a number of strategic risks that require ongoing Board oversight.

The most significant relates to patient safety, where failures in recognising deterioration, escalating concerns and learning from incidents can result in avoidable harm to women and babies. The review also demonstrates the risks associated with weak governance and assurance arrangements, whereby known concerns may not be appropriately identified, escalated or acted upon, limiting the Board's ability to gain confidence in the quality and safety of services.

Workforce pressures, including staffing shortages, training compliance and staff wellbeing, present a continuing risk to the delivery of safe and effective care. The report further highlights the impact of poor organisational culture, including bullying, lack of psychological safety and barriers to speaking up, which can undermine both staff experience and patient outcomes. There are also significant reputational and regulatory risks associated with failure to demonstrate sustained improvement, transparency and compliance with national maternity safety requirements. Collectively, these risks reinforce the importance of strong leadership, robust assurance mechanisms and a culture of continuous learning and improvement.

As Chief Nursing Officer, I support the recommendations outlined in this report and consider ongoing scrutiny of maternity safety, workforce, culture and patient experience to be essential to sustaining improvement and maintaining public confidence.

[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.

Additionally, we are expecting the publication of the Baroness Amos investigation and associated recommendations.

We welcome both reports and will use this opportunity to review our local position against the recommendations and actions and bring back an assurance report to the next Board meeting.

NHS
Wye Valley
NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET 26/27

Report to:	**Public Trust Board**
Date of Meeting:	2 July 2026
Title of Report:	Independent Investigation into Maternity and Neonatal Services in England - Final report and recommendations (Amos Review)
Lead Executive Director:	**Chief Nursing Officer**
Author:	Managing Director
Reporting Route:	Direct to Board
Enclosures included with this report:	Report shared separately outside of board papers
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

To provide the Board with a summary of the findings and recommendations of the Amos National Maternity and Neonatal Investigation Final Report, highlighting the implications for Trust governance, maternity safety and quality assurance, and to support Board oversight of how relevant national learning will continue to inform local improvement.

Executive Summary

The Amos National Maternity and Neonatal Investigation Final Report presents the findings of a comprehensive national review of maternity and neonatal services across England. The report identifies recurring themes from previous national reviews, including the need to strengthen leadership, organisational culture, governance, workforce, patient safety and the consistent involvement of women and families in decision-making.

Key Findings

The Investigation concludes that, despite sustained national focus on improving maternity and neonatal services, many of the themes identified in previous national reviews remain evident. The report finds that improvement has not been consistently sustained and that systemic change is required across the NHS to improve safety, quality and experience.

The principal findings include:

- **Women and families are not consistently listened to**, with concerns sometimes dismissed or not acted upon promptly. The report identifies listening to women and families as a fundamental patient safety issue and a prerequisite for delivering safe, personalised care.
- **Persistent inequalities** continue to affect outcomes and experiences for women and babies, particularly those from ethnic minority communities and those experiencing deprivation. Racism, discrimination and health inequalities are recognised as significant patient safety risks.
- **Leadership, organisational culture and multidisciplinary working** remain inconsistent across maternity and neonatal services. Poor behaviours, bullying, lack of psychological safety and ineffective teamworking continue to undermine staff wellbeing and the delivery of safe care.
- **Workforce pressures**, including staffing shortages, increasing clinical complexity and insufficient time for education and multidisciplinary training, continue to impact service resilience and the ability to consistently deliver high-quality care.
- **Governance and organisational learning** require strengthening, with greater emphasis on effective incident investigation, learning from harm, transparency, accountability and Board oversight of maternity safety.

- **Infrastructure and digital systems** require significant investment to ensure maternity and neonatal services are supported by safe clinical environments, interoperable digital records and reliable data to inform quality improvement and patient safety.

The report concludes that sustainable improvement will require coordinated action nationally and locally, supported by strong organisational leadership, effective governance and continued Board oversight.

Recommended Actions required by Board or Committee

The Board is invited to N**ote** the findings of the Amos National Maternity and Neonatal Investigation and **seek Assurance** that the recommendations continue to inform the Trust's maternity improvement programme and governance arrangements.

In particular, the Board should receive assurance that:

1. Women, babies and families remain at the centre of service design, quality improvement and patient safety;
2. Maternity safety governance, incident investigation and organisational learning are robust, transparent and embedded across the Trust;
3. Workforce planning, education, multidisciplinary training and leadership arrangements support the delivery of safe, high-quality care;
4. Inequalities in maternity outcomes and experience are monitored and addressed through targeted improvement actions;
5. Organisational culture supports compassionate leadership, psychological safety and the confidence of staff to speak up;
6. Board assurance arrangements continue to provide effective oversight of maternity quality, safety and performance, including implementation of relevant national recommendations.

Executive Director Opinion[1]

I would like to acknowledge, with sincere sadness, the experiences of the women and families who have suffered avoidable harm or loss, and recognise the profound and lifelong impact this has had on them.

The recommendations from the National Maternity and Neonatal Investigation led by Baroness Amos reinforces the importance of strong leadership, effective governance, compassionate culture and listening to women and families in delivering safe maternity and neonatal care.

The report sets out 8 high level recommendations including the establishment of a statutory commissioner role and the development of a modern service framework that will redesign and transform maternity and neonatal services. There are local recommendations which must start with immediate effect and be delivered over the next 12 months. Funding will be provided in the short, medium and long term to support estates and digital transformation.

We will work through the recommendations and develop local actions to address any shortfalls and update Board at a future meeting.

[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: Quality Committee
Date of meeting: 25 June 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: Eliminate Corridor Care**
Rating rationale	The national deadline for eliminating corridor care was the end of September. The Trust quality priority was aligned with new national guidance and linked to the Trust's new Big Moves Transformation Programme. There were multiple project workstreams, involving medical, surgical and Integrated Care divisions, including Single Point of Access, Optimising UCR Pathways, Patient Navigation Improvements, Model ED, Ward Based Flow and Early Supported Discharge. Progress was generally positive and monitored by the UEC Improvement Board (reporting to Trust Improvement Board). Regular Committee oversight would continue via the monthly patient flow report. A quarterly update on the quality priority would focus on safety and patient experience The ongoing demand pressures meant that meeting the target was high risk.
Outcome	The Committee was assured by the dedication to achieving the priority aims and the comprehensive work programme but acknowledged the risks to achievement.
Item/Topic	**Clinical Support Division Quality Report: Cancer Services**
Rating rationale	Two risks were highlighted: 0423: Haematology recruitment and 2106: Gynaecology clinical nurse specialist single point of failure. 18 incidents were reported including non-patient incidents. FFT responses were 98.6% positive, with an 8% response rate. All incidents and complaints were monitored at the Cancer Services Directorate Governance meeting and if necessary, the Divisional Governance meeting. Performance on the 62 day standard remained consistently good. Any breaches were reviewed and themes were collated to identify common problems and learning. Radiology was a pinch point for all specialities. A capacity and demand analysis of SACT (systemic anti-cancer therapy) treatments was in progress, as there had been a substantial increase in activity over the last three years without additional capacity.
Outcome	The Committee acknowledged both the positives and challenges highlighted by the report.
Item/Topic	**Mortality Report**
Rating rationale	SHMI for the 12 months to January 26 was 113, which was higher than expected nationally. The rates of the 30 trusts who reported in same way all showed an increased rate the removal of SDEC mortality in line with national guidance. In April the data had been reintroduced following a change in guidance, which would result in a reduction to SHMI. The coding backlog had now been eradicated. The crude mortality rate for 2026 was low compared with the Trust average for the time of year. ED mortality is not included in SHMI. Internal analysis showed this had been on a general downward trajectory. benchmarking data would be sought. The Trust's key outlier group was fractured neck of femur (#NoF), which reduced significantly in May, which was likely to result in a reduction in the SHMI. GIRFT feedback on #NoF was being incorporated in an action plan to be reported in July. Perinatal mortality analysis showed a positive reduction for 2 months which was low for a Trust of this size. Mortality reviews highlighting potential avoidable elements were linked with Trust patient safety processes.
Outcome	The Committee welcomed the report and was assured by both the processes and the positive reduction in ED and perinatal mortality.
Item/Topic	**Nurse Staffing Report**
Rating rationale	There were no concerns about safe staffing levels on wards but they were challenging, particularly when corridor care and escalation spaces were used, which required temp staff or movement of staff. Although NARP agency and bank reductions were met last year, staffing was over-established. This had been adjusted following review, to align staff to the right places and the establishment was now met. Bank costs increased in May due to some coding issues which were being analysed.
Outcome	The report was noted

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

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 25 June 2026
Report to: Trust Board

Item/Topic	Patient Safety Committee (PSC) Report
Rating rationale	Risks and escalations included: • Basic life support training rates. Each division was focused on improvement. • The Resuscitation Committee was experiencing quorum/engagement issues. • Pharmacy workforce and aseptic unit capacity • Capacity constraints impacting the stroke pathway • Diabetes specialist workforce gaps • A functionality gap in the EPMA. • VTE assessment data capture issues (no solution identified).
Outcome	The Committee was satisfied that the PSC was appropriately overseeing matters within its terms of reference. **Action:** Provide an update on BSL training and Resuscitation Committee issues.

Assure: Including assurance items rated green	
Item/Topic	**Trust Infection, Prevention and Control (TIPCC) Committee**
Rating rationale	TIPCC was operating in a new format, which was successful but would take time to embed. Escalations and matters of note included: • Fit mask testing compliance required improvement and would shortly become subject to national performance reporting. A task and finish group would consider this. • Two IPC incidents had been well managed • The roll out of training on Specific High Consequence Infection Disease would allow an existing risk to be reduced and ultimately closed.
Outcome	The Committee was satisfied that the TIPCC was appropriately overseeing matters within its terms of reference and was seeking continuous improvement in its approach.

To Note: Items received for information or approval	
Item/Topic	**Patient Safety Incident Response Plan (PSIRP)**
Summary	The 2023 PSIRP had been updated in accordance with the National Patient Safety Strategy. The update included the Trust's new safety and improvement priorities (approved by the Committee in May) and reflected current internal and external governance requirements and practice. The PSIRP had been subject to stakeholder consultation and was supported by the ICB.
Outcome	Approved **Action:** Check the requirements to publish the PSIRP, noting the issues of compliance with the Accessible Information Standard.

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.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	2 July 2026
Title of Report:	Board Assurance Framework and Risk Report
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	Audit Committee and Executive Risk Management Committee
Enclosures included with this report:	Board Assurance Framework (including Trust Very High risk report)
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The Board Assurance Framework provides a structure and process that enables the Board to focus on the risks that might compromise achievement of the Trust's strategic objectives. It includes the key controls in place to manages these risks and assurance as to the effectiveness of the controls.

The attached Board Assurance Framework (BAF) document comprises:

- BAF Header providing headline information about each BAF risk, now also including the target risk scores.
- Heat Map showing the current degree of strategic risk
- Trust strategic objectives
- Trust Very High risks (linked to BAF risks)
- Separate summaries of each BAF risk

Updates to each BAF risk (shown in red) reflect information received by the Board and/or its Committees between April and June.

Each risk has been aligned to the relevant strategic pillar and objective/s.

Particular changes will be noted to BAF03: Urgent and Emergency Care, to reflect the new transformation and UEC programmes, and to BAF07: PFI expiry to reflect receipt of the 3-year independent programme health check.

Changes requiring Board approval are proposed as follows:

BAF01: Patient Experience: Absorb this risk into a new, broader quality risk aligned to the new Trust strategy.

BAF03: Increase the risk score from 12 to 16, reflecting the new, in-year financial risk.

BAF08: Partnerships: A new risk developed with the Integrated Care Oversight and Assurance Committee, aligned to areas of the Trust strategy dependent on strong partnership working.

Recommended Actions required by Board

The Board is asked to

1. Note and accept the BAF updates.
2. Approve the proposed changes to BAF01 and 03
3. Approve the new risk, BAF08: Partnerships

Executive Director Opinion[1]
The BAF risks have been reviewed by the individual executive risk owners.

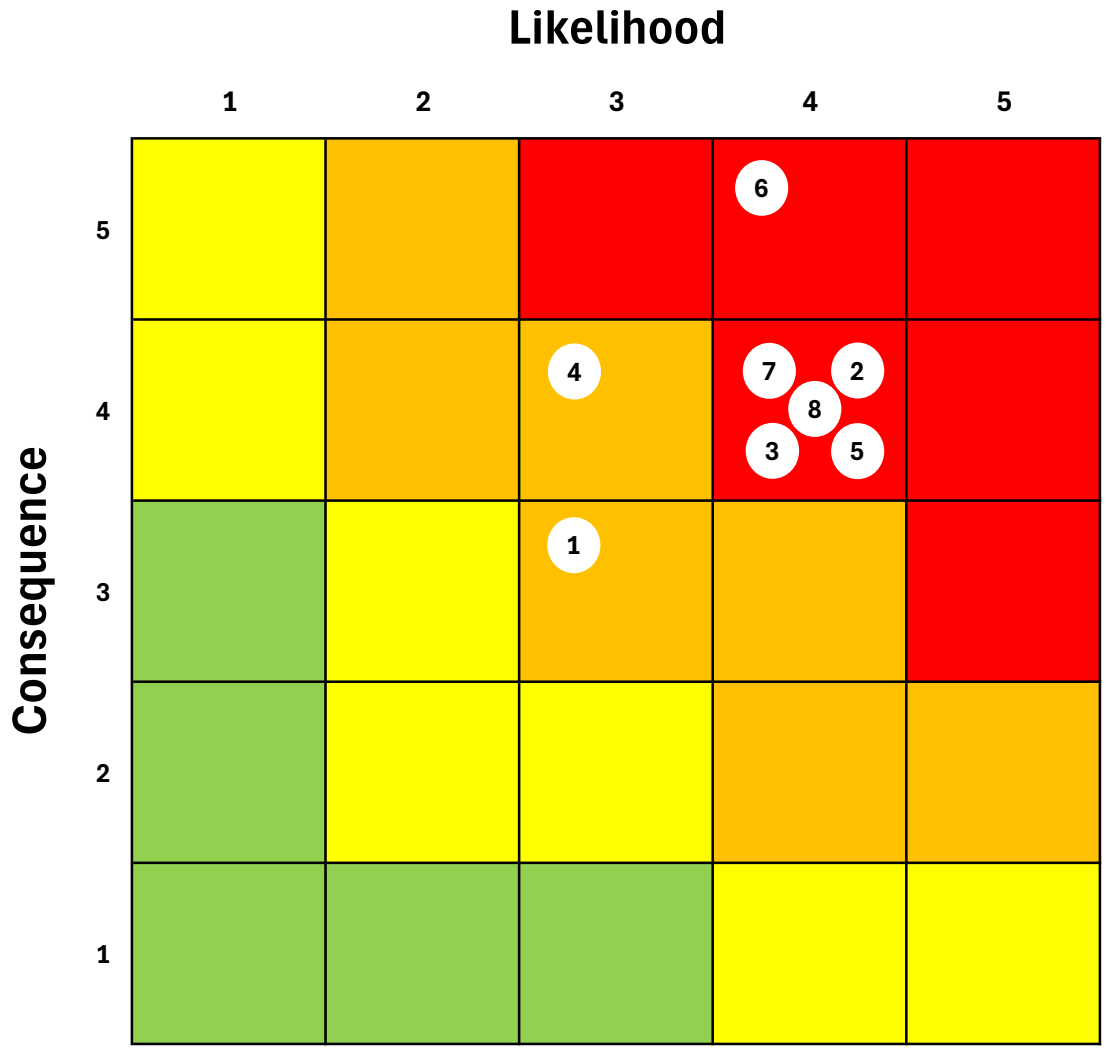
[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director has given their consent for the report to be released.

Board Assurance Framework Headlines June 2026

Ref #	Strategic Risk	Strategic Pillar(s)	Strategic Objective 2026/27	Linked BAF Risks (interdependencies)	Entry Risk Score (LxC)	Current Risk Score (LxC)	Target Risk Score (LXC)	Lead Chief Officer	Oversight	Quarterly Update
BAF01	Failure to improve patient experience in response to patient feedback	n/a	n/a	n/a	4x3=12	3x3=9	2X3=6	CNO	Quality Committee	Proposal to absorb risk into a new quality focused risk aligned to new strategy/objectives.
BAF02	Risk of failure to improve urgent and emergency care	Strengthening our services	Improve our urgent and emergency care pathway, increasing our capacity and navigating away from ED	BAF03	4x4=16	4x4=16	3X4=12	COO	Improvement Board	Aligned to new objectives and reflecting new programmes of work
BAF03	Risk of a failure to deliver the financial plan and improve financial sustainability	Delivering our Responsibilities	Improve our financial sustainability by delivering our transformation plans	BAF03, 04	4x4=16	4x4=16	1x4=4	CFO	Trust Board	Reviewed to reflect in-year risk
BAF04	Risk of failure to maintain a sustainable, available, effective workforce able to meet demand and patient need and deliver the highest quality services	Being a Supportive Employer	Develop and deliver a staff health and wellbeing programme Continue to reduce staff sickness levels	BAF02, 03	4x4=16	3x4=12	1x4=4	CPO	Trust Board	Aligned to new objectives.
BAF05	Risk of non-delivery of full digital strategy	Innovating to improve care	Continue to embed AI in our services to improve efficiency and reduce costs Deliver a business case for re-procuring an electronic patient record	BAF06, 04	4x4=16	4x4-16	1x4=4	CFO	Trust Management Board	Algned to new objectives
BAF06	Risk of a successful cyber attack	Innovating to improve care	n/a	All	4x5=20	4x5=20	3x5=15	CFO	Trust Management Board	General update.
BAF07	Risk that we do not implement an effective transfer of responsibilities and a fully functioning, well maintained estate under the PFI expiry arrangements	Delivering our Responsibilities	Develop a business case setting out the Trust's plan for the end of the PFI contract	BAF03	4x4=16	4x4=16	1x4=4	CSPO	PFI Expiry Committee	Aligned to new objective and reflecting recent independent assurance.
BAF08	Risk that partnership working arrangements do not support achievement of partnership-based strategies and plans	Treating People in the Right Place	Implement the Neighbourhood Health programme with our partners	BAF02, 03	4x4=16	4x4=16	2x4=8	MD	Integrated Care Oversight & Assurance Committee	New risk aligned to new strategy, developed with the newly established committee

Board Assurance Framework Heat Map June 2026

Risk Ratings:	
Very high:	15-25
High:	8-12
Moderate:	4-6
Low:	1-3



Trust Strategy from April 2026

Trust Strategic Objectives 2026/27

Being a supportive employer
- Develop and deliver a staff health and wellbeing programme
- Continue to reduce staff sickness levels

Innovating to improve care
- Continue to embed AI in our services to improve efficiency and reduce costs
- Deliver a business case for re-procuring an electronic patient record

Strengthening our services
- Improve our urgent and emergency care pathway, increasing our capacity and navigating away from ED
- Deliver an Outpatient Transformation Programme to reduce patient waiting times
- Build additional theatre capacity to reduce patient waiting times

Treating people in the right place
- Implement the Neighbourhood Health programme with our partners
- Develop a plan for the future of community hospital beds

Ensuring a sustainable future
- Improve our financial sustainability by delivering our transformation plans
- Develop a business case setting out the Trust's plan for the end of the PFI contract
- Deliver the final phase of Integrated Energy Scheme, reducing carbon emissions

Trust Very High Risks

Risk #	Division	Current score	Risk	Executive Risk and Compliance Committee Review April 2026	Link to BAF
2160	Clinical Support	15	PACS functionality	Mitigations in place and a solution near finalisation, though this needs to be expedited.	n/a
2211	Clinical Support	20	Aseptic services demand and capacity	Demand and capacity to be reviewed by Pharmacy Board and findings to be presented to Division.	BAF04
2227	Clinical Support	15	Ageing Bactalert machine	Good progress made on procurement and a collaborative solution. Risk expected to close end of April.	n/a
2251	Clinical Support	15	Aging microbiology equipment	Good progress made on procurement and a collaborative solution.	n/a
33	Corporate	16	Temporary Escalation Spaces	No change to the risk score but the recent risk assessment of boarding spaces is leading to a reduction of usage in a number of areas. Initiatives planned in May with the aim of eliminating boarding in ward areas.	BAF02
1070	Corporate	15	Ligature hazards	A new policy is in development and when in place should lead to a reduced risk score.	n/a
1704	Corporate	20	Financial plan	The score reflects both the new in-year risk and the underlying, longer term risk and would be reduced to 16 for the new financial year.	BAF03
1803	Corporate	15	Equipment maintenance backlog	Good progress made and risk score will likely reduce following review by Medical Devices Group.	n/a
2190	Corporate	20	Tracking and monitoring of RTT waiting list	Update required following data review.	BAF02
2234	Corporate	15	Management of number of capital projects	The risk was currently high but would reduce following completion of a number of projects. (June update - risk score reduced to target)	BAF03
2261	Corporate	15	Replacement of defibrillators	A phased replacement plan is now in place; risk score will reduce as the plan is implemented.	n/a
789	Medical	20	Long stays in ED	Although some positive changes had been made, they were not yet embedded and there was more work to do. Risk remains very high.	BAF02
1288	Medical	15	Letter typing backlog	Plan to outsource the backlog to mitigate the risk. Division to provide an update on the benefits of ambient AI on addressing this.	n/a
2077	Medical	16	Resuscitation space in ED	Work is in progress which will reduce the risk when complete.	BAF02
2185	Surgical	16	Psychiatric mediciation use in community paediatrics	June update: ICB has agreed to fund community nursing provision to address this.	n/a
2204	Surgical	16	Glaucoma waiting times.	The follow up backlog has reduced significantly but demand still outstrips capacity. Recruitment to fill the last vacant postion is in progress. EPR implementation is the long-term solution.	BAF02/04
2228	Surgical	15	Diabetic foot service	Full job plan and resilience plan now in place. Risk score will reduce.	BAF04
687	Surgical	16	Lack of Health Psychology for children	Categorised as an 'accepted' risks based on the mitigations in place and previous esclation to ICB.	n/a
2229	Medical	15	Lack of clinical nurse specialist support for patients with severe asthma.	New clinical leads addressing issues.	BAF04
2245	Surgical	16	Recruitment challenges and lack of clinical staff resilience in the corneal service.	Opportunities for joint working with another trust are being explored.	BAF04
2208	Corporate	16	Unquantified telephony costs to be transferred to Trust as part of PFI handover.	Costs have been assessed through an approved business case. The risk score will be reassessed and likely reduced.	BAF07
2284	Corporate	20	Failure to achieve PFI asset handback in contractual condition.	Engagement with PFI partners is progressing with legal advice.	BAF07
2267	Clinical Support	20	The laboratory information management system (APEX) support will be withdrawn in May 2027.	An options appraisal is underway, including potential collaboration with system partners.	n/a

Board Assurance Framework Risk Summary	
Risk Reference	BAF01
Strategic objectives and priorities	• Improve inpatient experience by improving food quality • Improve responsiveness to patient experience data

Date	**May 2026**
Risk Headline	**Patient Experience**
Risk owner	Chief Nursing Officer

Risk	Cause	Result
Risk of failure to improve patient experience in response to patient feedback.	Feedback from patients and families demonstrates that improvements are required in a number of areas that impact patient experience.	Poor patient experience impacting quality of care.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x3=12	April 25	4x3=12	3x3=9	↑	2x3=6	HIGH/OPEN
	February 26	3x3=9				

Current Controls and Mitigations	
1. Collection, analysis and reporting of patient feedback	2. Triangulation of feedback with other quality data
3. Engagement with Patient Engagement Forum	4. Monitoring by patient experience committee
5. Regular audits of food service	6. Updated policies in place to establish clear frameworks and clarify responsibilities – interpreting, patient information and volunteers)
7. Volunteer Steering Group oversight of volunteer service	8.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Poor feedback about inpatient food.	Deliver strategic priority to improve food quality.	CNO	Mar 26	Menu adjusted, training provided.
Insufficient capacity to support the best patient experience.	Deliver strategic objective to grow volunteer service.	CNO	Mar 26	See below performance (report to Quality Committee Oct 25)
Patient dissatisfaction with response to feedback	Expand reach of Friends and Family Test (FFT)	CNO	Mar 26	FFT text messaging service now in place for all services. New system launched 1 April 2026
	Implement updated complaint standards	CNO	Mar 26	Update due May 2026
Improvements required in Maternity (based on patient survey)	Develop and implement an action plan co-produced with MNVP.	CNO	March 26 (TBC)	

Key Assurance Indicators	Date Reported	Performance
Meal service audit results	October 2025	Improvements demonstrated
PLACE results 2024	August 2025	Trust score for food improved overall but declined at 2 community hospitals.
Numbers of volunteers, volunteer hours and areas supported by volunteers.	October 2025	Reduction in volunteer numbers but growth in volunteer hours and areas supported.
FFT results	April 2026	92.90% positive
FFT response rate	March 2026	8%
Complaints and concerns	March 2026	3% increase in Q3

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Trust CQC rating: caring	Mar 20	Good	Good (2016)	↔
Urgent & emergency care CQC rating: caring	Feb 24	Good	Good (2020)	↔
Medical care CQC rating: caring	Dec 22	Good	Good (2020)	↔
CQC Adult inpatient survey 2024	Sept 25	8.0/10 overall	7.9/10 overall (2023)	↑
CQC Children and young people's survey 2024	May 25	8.5/10 overall	n/a	n/a
CQC Maternity Survey 2024	Nov 24	8.0/10 labour/birth 8.0/10 staff care 6.9/10 care after birth	8.6/10 labour/birth 8.7/10 staff care 7.7/10 care after birth (2023)	↓
CQC Urgent & emergency care survey 2024	Nov 24	7.2/10 overall	7.4/10 overall (2022)	↓

National cancer patient experience survey 24	July 25	All questions within expected range except 2 above and 2 below.	TBC	TBC
National Inpatient Survey 2024	Sept 25	Overall experience score, slight improvement compared to 2024/ close to national average.	See above	↔
CQC Maternity Patient Survey 2025	Jan 26	Significantly better in 14 questions compared to 2024; worse than expected in 1 compared to all other trusts.	See above	↑
PLACE 2025	Feb 26	Majority of domains improved compared to 2024. All domains at or above national average.	n/a	

Summary Update:
Good progress being made in key areas. Propose absorbing this risk within new broad quality risk.

Board Assurance Framework Risk Summary	
Risk Reference	BAF02
Strategic objectives and priorities	Improve our urgent and emergency care pathway, increasing our capacity to reduce waiting times.

Date	**June 2026**
Risk Headline	**Urgent and Emergency Care**
Risk owner	Chief Operating Officer (COO)

Risk	**Cause**	**Result**
Risk of failure to improve urgent and emergency care pathway (UEC)	• Increased demand in both volume and acuity for urgent and emergency care. • High demand for elective care. • High demand for diagnostic services. • Discharge pathway delays.	• Continued high demand for acute inpatient beds. • More care in the community • Longer waits in Emergency Department • Longer waits for elective care • Pressured working environments • Continued use of temporary escalation spaces • Failure to meet local and national targets. • Regulatory intervention.

Initial Risk Score	**Risk Score History**		**Current Risk Score**	**Direction of travel**	**Target Risk Score**	**Risk Appetite**
4x4=16	April 25	4x4=16	4x4-16	↔	4x3=12	High/open

Current Controls and Mitigations	
1. Single Point of Access/Community Referral Hub	2. Virtual Ward service
3. Urgent Community Response service	4. Discharge2Assess Service
5. Primary care interface	6. Falls Service
7. Valuing Patients Time initiatives	8. Partnership with West Midlands Ambulance
9. Additional oversight by NHS England through Tier 1 support	10. Criteria to Admit to acute care approach and Criteria Led Discharge
11. Monitoring of live patient flow data	12. New Community Diagnostic Centre (accredited by GIRFT)
13. Improvement Board overseeing Urgent and Emergency Care Programme (UECP). High level workplans including: • Ward based flow improvements (medical & surgical) • Acute Surgical Unit design (aligned to estates work) • EEMAC design and test • Specimen process full automation • MRI digital vetting process • Patient navigation maximisation	14. Dedicated resource for Big Moves Transformation Programme in place for 2026/27 incorporating: • UEC improvement • Admission avoidance and early supported discharge • Model of care in community hospitals • Outpatient reform

Gaps in Control	**Related Actions**	**Lead**	**Due Date**	**Progress**
Continued high demand for UEC, Herefordshire	Enhance community based urgent care	COO	Mar 26	Close – part of UECP
	Optimise pathways to avoid admissions	COO	Mar 26	Close – part of UECP
	Enhance Single Point of Access	COO	Mar 26	Close – part of UECP
	Neighbourhood Health Implementation Programme	MD	-	See BAF08 Partnerships
	Implement GIRFT recommendations	COO	April 26	Close - integrated in UECP
	Implement UEC Programme	COO	April 27	Improvement Board workstream oversight (Jun 26): • Patient navigation (amber) • National guidance (amber) • Medical Division ward based flow (amber) • SDEC and Acute Surgical Unit (on track) • Surgical Division ward based flow (on track) • CDC pathways (on track)
	Implement Transformation Big Moves Programme workstream: Admission Avoidance & Early Supported Discharge	CSO	April 2027	To be reported to Board

Long waits in ED	Implement Test of Change programme	COO	Dec 25	Close – part of UECP
	UEC Capital to increase SDEC capacity	COO	March 26	Close – part of UECP
Delayed discharge, Herefordshire	Reduce 'over-staying' patients on Pathway 1 through Discharge to Assess	COO	Mar 26	Close: Revised model now implemented. Incorporated in Big Moves transformation programme.
	Implement Transformation Big Moves Programme workstream: Admission Avoidance & Early Supported Discharge (as above)	-	-	-
Impact on patient flow across Trust	Increase use of Virtual Ward Service	COO	Mar 26	Close – replaced by Big Moves transformation programme
	Increase Therapy Resource through Better Care Fund	COO	Dec 25	Close – replaced by Big Moves transformation programme
Industrial Action	Implement well-established response for each period of industrial action	COO	Mar 27	November and December 2025 actions were well managed with limited impact on delivery of services. No industrial action currently planned (Jun 26).
UEC management with Powys	Work with Powys partners to strengthen admission avoidance	COO	Mar 27	In progress
	Work with Powys partners to expedite discharges.	COO	Mar 27	In progress

Key Performance/Assurance Indicators	Date Reported	Performance	Change
% of people seen, treated or admitted within 4-hours in ED	June 26	April 26: 66.2%. Improved since Jan 26 (65.2%)ambulance handovers over 45min	↑
% of patients waiting over 12-hours in ED	June 26	April 26: 9.8%. Improved since Jan 26 (10.4%)	↑
% Ambulance handover times under 45mins	June 26	April 26: 62.9%. Improved since Jan 26 (61%	↑

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation	Mar 26	Segment 3 (quarter 3)	Segment 3 (quarter 2)	↔
NHS Oversight Framework Segmentation	June 26	Segment 3 (quarter 4)	Segment 3 (quarter 3)	↔
Internal Audit: Data quality – ED pathways	2024/25	Reasonable assurance	n/a	n/a
Internal Audit: Elective Process Productivity (Pre-Op Theatres)	2024/25	Reasonable assurance	n/a	n/a
Internal Audit: Community Services	Dec 25	Reasonable assurance	n/a	n/a
Provider Capability Assessment Rating	Feb 26	Amber/green	n/a	n/a
Getting it Right First Time (GIRFT) accreditation	Mar 26	Hub Accreditation – Community Diagnostic Centre	n/a	n/a

Summary Update:
Big Moves Transformation Programme, including UECP, are now in place to provide a strong governance framework and resource for delivering improvements to UEC and wider patient flow.

Board Assurance Framework Risk Summary	
Risk Reference	BAF03
Strategic objective	Improve our financial sustainability by delivering our transformation plans

Date	June 2026
Risk Headline	**Financial plan delivery**
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of failure to deliver the transformation and financial plans and improve financial sustainability.	The 2026/27 financial plan is to achieve financial balance which is dependent on delivery of a challenging cost and productivity improvement plan (CPIP). There remains an underlying deficit, driven partially by factors outside the Trust's control.	Regulatory intervention Detriment to reputation Inability to deliver other strategic priorities.

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 25	4x4=16	4x4=16	↑	1x4=4	High/open
	March 2026	2x4=8				
	June 2026	4x4=16				

Current Controls and Mitigations	
1. Financial Recovery Board oversight	2. Enhanced financial controls
3. Enhanced vacancy controls	4. Enhanced controls of temporary staff usage
5. Adoption of national financial controls and toolkits	6. Strengthened forecasting
7. Divisional check and challenge meetings	8. NHSE support in place to address issue of Welsh parity income
9. Medium term financial plan in place to tackle underlying deficit	10.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued use of temporary nursing staff in some areas	Implement Nursing Agency Reduction Plan (NARP)	CNO	March 26	Improvement has slowed but confidence in delivering target is high.
Continued use of temporary medical staff	Implement Medical Agency Reduction Plan (MARP)	CMO	March 26	Increased recruitment has resulted in improvements in some key areas and an improved forecast outturn.
Fully developed CPIPs to meet target	Develop fully deliverable plans to meet CPIP target.	CFO	March 26	CPIP assurance reviews have taken place with divisions. Further mitigations are being sought to reduce gap to target.
Operational pressures challenging delivery of CPIP	See BAF02			
Dispute between NHSE and NHS Wales on parity of funding resulting in delayed payments to WVT	Engage with NSHE on support for financial risk for the current year.	CFO	March 26	Close: NHSE support now in place (control)

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Income and Expenditure YTD	June 26	At month 2, performance slightly behind plan	n/a
Nursing Agency Reduction Plan (NARP)	June 26	On plan at month 2	n/a
Medical Agency Reduction Plan (MARP)	June 26	On plan at month 2	n/a
CPIP delivery YTD	June 26	Month 1 performance behind plan	n/a
Forecast financial outturn	TBC	TBC	n/a
Delivery of financial plan 2025/26	June 26	Surplus achieved against a breakeven plan (including deficit support funding)	↑
Delivery of annual CPIP 2025/26	June 26	£21.9m against plan of £25m	

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation	Mar 26	Segment 3 (quarter 3)	Segment 3 (quarter 2)	↔
NHS Oversight Framework Segmentation	Jun 26	Segment 3 (quarter 4)	Segment 3 (quarter 3)	↔
Internal Audit: Key Financial Controls	June 26	Partial assurance (draft)	Reasonable assurance (2024/2025)	↓
External Audit Value for Money Assessment	2025/26	2 financial sustainability significant weaknesses	2 financial sustainability significant weaknesses + 1 governance weakness	↑

		and no governance weakness		
Provider Capability Rating	Feb 26	Amber-green (2025/26)	n/a	n/a

Summary Update:
The risk has been updated for 2026/27. The risk score increased to reflect in-year risk of delivering annual financial plan. Internal year to date assurance indicators have been re-set.

Board Assurance Framework Risk Summary	
Risk Reference	BAF04
Strategic pillar/ objectives	Being a supportive employer • Develop and deliver a staff health and wellbeing programme • Continue to reduce staff sickness levels

Date	June 2026
Risk Headline	**Sustainable, available, effective workforce**
Risk owner	Chief People Officer

Risk	Cause	Result
Risk of failure to maintain a sustainable, available, effective and healthy workforce able to meet demand and patient need and deliver the highest quality services	• High patient demand and acuity creating pressures for staff • High vacancies/recruitment challenges in some teams • Industrial Action • Requirement to reduce workforce costs • Lack of electronic job planning and rostering across all areas to enable the most effective deployment of resource and productivity gains.	• High staff sickness • Poor morale and staff wellbeing • Poor staff retention • Impact on reputation/attraction • Over-reliance on temporary staffing • Failure to meet national and local workforce and operational targets • Fragile services • Impact on the quality of services

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	3x4=12	↑	1x4=4	Significant - seek
	October 2025	4x3=12				

Current Controls and Mitigations	
1. Strengthened sickness absence management policy	2. Occupational health service
3. Freedom to Speak Up Guardian	4. Staff wellbeing support and initiatives
5. Divisional recruitment and retention working groups	6. Centralised recruitment process for clinical support workers (CSW).
7. Inclusion programme	8. E-roster in all nursing areas
9. Electronic job planning and oversight by Job Planning Committee	10. Staff networks
11. Winter vaccine programme	12. Analysis of starter surveys and exit data by divisional Recruitment and Retention Working Groups

Gaps in Control	Related Actions	Lead	Due Date	Progress
E-Roster not in use in all areas	Implement E-Roster across Trust	CPO	Oct 26	All nursing areas implemented; review of resource to support wider implementation in progress.
Electronic job planning not fully implemented	Implement electronic job plans for all medical staff	CPO	March 26	82% reported in December 25.
High turnover among CSWs	Implement central recruitment programme	CPO	Mar 26	Close: controls in place.
Continued reliance on agency staff to fill gaps	Implement medical and nursing agency reduction plans	CMO/ CNO	Mar 27	See BAF03 Financial Delivery

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Staff sickness absence rate at 4% or lower	June 2026	Improved from 5.4% in January (average 4.9% 25/26) to 3.8% in April (better than target of 4%)	↑
Staff turnover	June 2026	Static performance at 8.0% (better than target of under 10%)	↔
Staff vacancy rate	June 2026	Reduced to a low 3.4% in March but increased to 8.2% in April due to increased budget in month 1	↑
100% compliance with e-job plans	December 2025	82% (an improvement)	↑

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
National Staff Survey: we are safe and healthy	Mar 26	25/26: 6.21 (above average)	24/25: 6.20 (above average)	↑
National Staff Survey: staff engagement	Mar 26	25/26: 7.07 (above average)	24/25: 7.03 (above average)	↑
National Staff Survey: morale	Mar 26	25/26: 6.13 (above average)	24/25: 6.08 (above average)	↑

Internal Audit: Medical and surgical junior doctor rotas management	2024/25	Partial assurance	n/a	n/a
Internal Audit: Medical job planning	Mar 26	Reasonable assurance	Partial assurance	↑
Internal Audit: Health Rostering	Jun 24	Reasonable assurance	n/a	n/a

Summary Update:
Aligned to new strategy. Good internal performance indicators and independent assurance.

Board Assurance Framework Risk Summary		Date	June 2026
Risk Reference	BAF05	**Risk Headline**	**Digital Strategy**
Strategic Pillar	Innovating to improve care	**Risk owner**	Chief Finance Officer

Risk	Cause	Result
Risk of failure to deliver the Digital Strategy	• Multiple, simultaneous digital programme workstreams • Lack of clarity on central funding for digital strategy • High levels of staff engagement needed • Operational pressures • Limited resource to support business case development and procurement processes	• Full productivity not achieved • Cost savings targets not met • Quality improvements not made • Maximum digital maturity not achieved • Reputational impact

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	April 2025	4x4=16	4x4=16	↔	1x4=4	Significant - seek

Current Controls and Mitigations	
1. Programme management structure in place with oversight by Digital Programme Board, reporting to Trust Management Board	2. AI Working Group
3. All clinically agreed user improvements in EPR complete	4. Shared resource agreed to support linked Future EPR and Digital First projects
5. Use of electronic patient record systems is well-established within the Trust, providing a firm basis for further development.	6. Trust strategy aligned with ICB strategy

Gaps in Control	Related Actions	Lead	Due Date	Progress
AI implementation plan	Ambient AI procurement	CFO	2028	The procurement process has commenced based on the pilot outcome
Current EPR system contract coming to an end	Implement Future EPR project	CFO	2028	Tender anticipated to launch summer 26
New patient portal required	Procure new patient portal	CFO	2027	A 3-month gap in service is anticipated

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Increase proportion of patients signed up to patient portal	TBC	TBC	
Increased proportion of clinicians utilising AI tools	TBC	TBC	

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Internal Audit: Digital Nurse Noting	May 25	Advisory/10 recommendations	n/a	n/a

Summary Update:
Steady progress is being demonstrated by the Digital Programme Board but the risk remains high due to the number and current status of key projects.

Board Assurance Framework Risk Summary	
Risk Reference	BAF06
Strategic pillar	Innovating to improve care

Date	**June 2026**
Risk Headline	**Cyber security**
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of a successful cyber-attack on the Trust's systems	• Increasingly frequent and sophisticated attacks on internal and external digital systems containing critical Trust data. • High numbers of users with access to Trust's digital systems • Reliance on third party suppliers • Increasing reliance on digital systems	• Data security breaches • Loss or corruption of data • Lost or delayed access to patient care records • Business interruption • High cost of rectification

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x5=20	April 2025	4x5=20	4x5=20	↔	3x5=15	Significant/seek

Current Controls and Mitigations	
1. IT partner cyber security arrangements in place and overseen by partnership board (with Trust representation)	2. Mandatory information governance training for all Trust staff and cyber-security training for Board
3. IT partner cyber security expertise	4. Periodic phishing exercises
5. Annual penetration testing	6. Information Asset Register
7. Annual table-top exercise	8. Monitoring of and response to national alerts
9. Business Continuity Plan for IT Services	10. Dual data centre architecture provides resilience in the event of attack/failure of one centre.
11. Counter fraud training and awareness raising inc. cyber	12.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Gaps in compliance with CAF and DSPT (see assurance below)	Implement recommendations of Internal Auditor 2024/25	CFO	Oct 25	Complete – one action carried forward into 2025/26 action plan
	Implement 1 medium and 2 low priority recommendations	CFO	Sep 26	To be monitored by Audit Committee

Key Performance/Assurance Indicators	Date Reported	Performance	Change
In development			

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Cyber Assessment Framework (including follow-up)	May 26	Risk rating: Medium Confidence level: High	Risk rating: very high Confidence rating: low	↑

Summary Update:
The majority of recommendations from the independent assessment have now been addressed but the external threat, and therefore the risk, remain very high and the target score reflects this.

Board Assurance Framework Risk Summary	
Risk Reference	BAF07
Strategic objectives and priorities	Improve financial sustainability

Date	June 2026
Risk Headline	**PFI Expiry**
Risk owner	Chief Strategy & Planning Officer

Risk	Cause	Result
Risk that we do not implement an effective transfer of responsibilities and a fully functioning, well maintained estate under the Private Finance Initiative (PFI) expiry arrangements	• The Trust's Private Finance Initiative (PFI) contract will expire in July 2029. • The Trust is the first in the NHS to undergo PFI transition and to operationally interpret the national guidance to deliver the project • No national funding to support the process • Numerous stakeholders, contractors and workstreams requiring coordination • PFI estate has significant backlog of lifecycle maintenance works • Insufficient contractual levers relating to estate management	• Lack of continuity in provision of hard and soft facilities management (FM) • Loss of experienced FM staff • Lost opportunity to make anticipated financial savings • Lost opportunity to establish long-term high quality FM service arrangements

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	November 2025	4x4=16	4x4=16	↔	1x4=4	Moderate-cautious

Current Controls and Mitigations	
1. PFI expiry governance structure aligned with national guidance	2. Dedicated project management resource
3. Periodic Expiry Health Checks by National Infrastructure & Service Transformation Authority (NISTA)	4. Joint Expiry Working Group (with PFI partners)
5. Lifecycle Progress Committee oversees asset maintenance needs	6. Representative from IPA engaged with PFI Expiry Committee
7. Separate and distinct governance structure for operational estate/PFI contract management	8. Joint working with Worcestershire Acute Hospitals NHS Trust to share support and learning on PFI expiry process
9. Project team participation in NISTA training	10. Project established with two clear workstreams

Gaps in Control	Related Actions	Lead	Due Date	Progress
Plan for future FM Service	Develop future FM options appraisal and recommendation	CSPO	~~July 26~~ Sept 26	PFI contract termination option agreed by Board in October 25; OBC planned for Board September 2026 following Board workshop in July.
Clarity on condition of estate	Complete a Joint Condition Survey	CSPO	July 26	Closed: survey complete
Completion of 5-year NISTA Health Check action plan	Implement all actions	CSPO	June 26	Full implementation delayed by protracted timescales in production of independent person survey.
Implementation of condition survey recommendations	Agree and deliver prioritised asset condition compliance works	CSPO	TBC	Triage complete. Items identified as requiring immediate attention formally submitted to helpdesk for action and tracking. Other items to be progressed through service improvement plans.
Implementation of asset management compliance assessment recommendations	Agree and deliver prioritised asset management compliance works	CSPO	TBC	Triage complete. High risk areas submitted to Sodexo helpdesk for action and tracking. Amber areas to be progressed through service improvement plans.
Agreed resources for next phase of programme	Develop a programme resource plan for final phase	CSPO	TBC	
Completion of – 3 year NISTA Health Check action plan	Implement all actions	CSPO	TBC	Action plan to be developed following receipt of EHC report

Enhance governance and assurance around Assets	Implement revised governance structure	CSPO	Aug 26	Paper outlining revised structure shared with PFI partners

Key Performance/Assurance Indicators	Date Reported	Performance
In development		

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Expiry Health Check, NISTA	Nov 22	Amber: moderate additional work required	n/a	n/a
Expiry Health Check, NISTA	Oct 24	Red/amber: major additional work required	Nov 22: amber	↓
Expiry Health Check, NISTA	Apr 26	Red/amber: major work required	Oct 24: red/amber	↔

Summary Update:
Good progress on project. Asset compliance and condition improvement plan remains high risk. NISTA health check outcome was red/amber overall for readiness indicating that major targeted work is required.

Board Assurance Framework Risk Summary	
Risk Reference	BAF08
Strategic objectives and priorities	• Improve urgent and emergency care pathway, increasing our capacity and navigating away from ED • Implement the Neighbourhood Health programme with our partners • Develop a plan for the future of community hospital beds

Date	**June 2026**
Risk Headline	**Partnerships**
Risk owner	Managing Director

Risk	Cause	Result
Partnership working arrangements do not support achievement of partnership-based strategies and plans	• Several strategic objectives depend on partnership working. • Multiple partners with competing priorities • Variation in standards, targets and expectations • Variation in funding models	• Strategic objectives not delivered • Unmanageable UEC demand • High bed occupancy • Slow discharge/long length of stay • National expectations and targets – operational and financial - not met

Initial Risk Score	Risk Score History		Current Risk Score	Direction of travel	Target Risk Score	Risk Appetite
4x4=16	February 2026	4x4=16	4x4=16	↔	2x4=8	High-open

Current Controls and Mitigations	
1. Strengthened One Herefordshire Partnership governance arrangements	2. Board oversight via new Integrated Care Oversight and Assurance Committee
3. Regular engagement with Powys Health Board to support improved discharge and reduced urgent care need.	4. Agreements in place with West Midlands Ambulance Service.
5. One Herefordshire Health and Care Partnership Alliance Agreement	6. Strengthened governance arrangements for Discharge to Assess (D2A) and Enhanced Health in Care Homes
7. Neighbourhood Health Delivery Board in place	8. Transformation Big Moves Programme
9. Improvement Board in place, to report to Trust Board	

Gaps in Control	Related Actions	Lead	Due Date	Progress
Limited control of Powys UEC flow and discharge	See BAF03 Financial delivery	-	-	-
Virtual ward bed model misaligned with demand profile	Reconfigure virtual bed allocation	MD	March 2027	Frailty model pilot in progress.
System capacity constraints for delivery of Neighbourhood Health programme	Implement Big Moves Transformation Programme with designated resource. The programme includes a number of workstreams aligned to the Neighbourhood Health Programme	AD	31 March 2027	New Improvement Board established. Transformation Programme in place. Project plans, KPIs and reporting arrangements to be finalised.
	Appoint senior partnership leadership team	MD	May 2026	Complete – move to controls
Significant cost pressures impacting ability to deliver a balanced plan	Agree options to create and implement a balanced financial plan	CFO	July 2026	In progress
Sustained growth in D2A demand, blocking flow and driving potential overspend	Implement D2A transformation programme	MD	March 2027	Revised model implemented and new performance and governance frameworks in place. Good progress reported on all workstreams.

Key Assurance Indicators	Date Reported	Performance	Change
BCF year to date financial delivery	TBC		
BCF Forecast Outturn	TBC		
BCF annual financial delivery (2025/26)	June 2026	Revenue: £2.459m overspend, capital: £0.251m underspend.	n/a

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
None to date				

Summary Update:
Partnership leadership team now in place. Transformation Programme arrangements agreed, which will support delivery in key areas. Significant BCF financial risk.

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 23 June 2026
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**Annual Report and Annual Governance Statement (AGS) 2025/26**
Summary	The report was prepared in accordance with the DHSC Group Accounting Manual. Some elements were subject to audit and the full report had been reviewed by the External Auditor.
Outcome	The Committee was satisfied that: • the AGS was consistent with its view on the Trust's system of internal control • the Annual Report gave a balanced review of 2025/26, including all significant matters and avoiding over-optimistic interpretation of results. The Committee endorsed the adoption of the Annual Report by the Trust Board.
Item/Topic	**Annual Accounts 2025/26**
Summary	The final audited Accounts were presented alongside a log of changes made since the Committee's detailed review of the draft accounts in April. Changes were minimal, demonstrating continuous improvement in the accounting process. The External Audit resulted in some differences in judgements which were explained in the Auditor's report (ISA260), the most significant of which related to the debt the Trust expected to recover relating to the Welsh parity income. The difference was below the materiality threshold, however, and therefore the accounts had not been altered. The Committee and the External Auditor commended the Finance Team on the production of the accounts, particularly the high quality of the draft accounts which were completed at an early stage of the timetable.
Outcome	The Committee: • was satisfied with the two changes made to the accounts since review of the draft. • endorsed the adoption of the Annual Accounts and the letter of representation by the 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	**External Audit**
Rating rationale	**1. Auditor Opinion (draft)** The opinion on the financial statements was unqualified. Two significant weaknesses were reported on the value for money (VFM) assessment, both on financial sustainability. These related to performance on CPIP and the failure to achieve a break even position. Improvements were seen in the finances this year and the opinion reflected that there were some issues outside the Trust's control. The Auditor was unable to certify the audit as complete at this stage due to a national instruction by the National Audit Office; the signed certificate would therefore be provided at a later date. **2. Management Letter of Representation** The letter was standard with nothing to flag. **3. ISA260 External Audit Report** The unqualified audit opinion would be issued subject to the conclusion of areas highlighted in the report. The majority of these were now finalised and the Auditor expected to issue the opinion ahead of the deadline. The report included an assessment of the significant audit risks highlighted at the start of the audit: • Management override of controls – no issues. • Validity of accruals and deferred income – there were some classification misstatements but these did not materially alter the usefulness of the financial statements or impact the audit opinion. The final review of the remuneration report following amendment was well progressed and no further changes were anticipated. As described above, there was one unadjusted misstatement related to the Welsh parity income. The report included a number of controls recommendations. None were material issues and the Auditor would support the Trust to address and close these and provide an update at interim audit stage. Several of the recommendations were best practice and low priority and would be addressed according to priority.
Outcome	The Committee welcomed and accepted the report.

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

Escalation and Assurance Report

Report from: Audit Committee
Date of meeting: 23 June 2026
Report to: Trust Board

Item/Topic	Financial Focus: Special Losses Report Quarter 4
Rating rationale	The value reported was higher than in the same period last year. The main driver of this was the continuation of high value expired drugs write off. This required challenge through the Finance and Performance Executive. A significant level of patient property losses also persisted. Joint working between finance and nursing teams was planned during autumn.
Outcome	The Committee noted the continuation of issues with patient property and expired drugs and was assured by plans to drive these down.

Assure: Including assurance items rated green	
Item/Topic	**Internal Audit Annual Report**
Summary	There had been minimal changes since the presentation of the draft opinion earlier in the year. The only material change was the addition of the draft partial assurance opinion on contract management - the final audit of the plan, which was near completion. The overall annual opinion was positive, that there was an adequate and effective framework for risk management, governance and internal control, with further enhancements identified. Most assurance outcomes were positive, with one partial assurance (as above). Progress on agreed actions was reasonable overall. The Committee thanked the Internal Auditor on the work completed to deliver the plan, which included a focus on some difficult issues at the Board's request.
Outcome	**Action:** Share final contract management audit with the other members of the Foundation Group for learning relevant to the joint procurement service
Item/Topic	**Annual Review of Audit Committee Effectiveness**
Rating rationale	The report was created to be read alongside the Annual Governance Statement and provided assurance that the Committee met its terms of reference in 2025/26. For the first time, the review included measures of the Committee's impact on the framework for risk management, governance and internal control. A series of actions were recommended for continuous improvement. The Committee welcomed the report and commended the use of metrics to assess the impact of the Committee, which demonstrated improvements in several areas. It was agreed that using the approach to assess the effectiveness of other Board committees would be beneficial.
Outcome	The Committee was assured that its terms of reference were met in 2025/26 and agreed the recommended actions set out in the report.
Item/Topic	**Annual Fit and Proper Person Test Compliance Report**
Summary	The report provided assurance that the Committee's procedures were compliant with the Trust policy and the national framework on which the policy was based. The Committee welcomed the report, including the actions identified by the local audit for continuous improvement.

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

Escalation and Assurance Report

Report from: Executive Risk and Compliance Committee
Date of meeting: 17 June 2026
Report to: Trust Board

Overview
The meeting was the first using the new terms of reference, which had a greater focus on key compliance areas and analysis of the risk register. Each alternate month, meetings would have the previous detailed focus on divisional risks rated high or very high.

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Health and Safety Committee (HSC) Escalation and Assurance Report: meeting 7 May 2026**
Rating rationale	Two items were rated red for assurance: • There was no report from the Clinical Support Services Division • The Waste Management Committee had not met since November due to a lack of engagement. It was agreed that relevant standards should be reviewed to ensure governance arrangements meet requirements and any further issues would be escalated. All other assurance items were rated amber for assurance. Key matters were: • Sharps incidents remained a concern and the Sharps Working Group had yet to be re-established. • An increase in occupational health referrals was sustained throughout 2025/26. • Work related stress and violence/aggression incidents remained high across divisions. Other matters noted: • The annual fire safety report demonstrated a good level of compliance. • Updates to the Lone Worker Policy and Electrical Safety Policy were approved.
Outcome	• HSC to recommend a round table discussion between multiple stakeholders about violence and aggression • Divisions to nominate a member of the divisional leadership triumvirate to attend every meeting of the HSC. • Repeat Trust-wide and divisional level communication about staff support options.
Item/Topic	**Emergency Planning, Resilience and Response (EPRR) Committee Escalation and Assurance Report, April 26**
Rating rationale	No items were rated red. Amber rated items were as follows, with clear plans and monitoring in place: • Gaps in divisional business continuity testing • Gaps in supplier and provider assurance All other items were rated green, including EPRR training and preparation for the annual EPRR core standards submission.
Outcome	The report was noted
Item/Topic	**Information Governance Committee Escalation and Assurance Report**
Rating rationale	There was one amber-rated item: information governance mandatory training, with an overall Trust completion rate of 83.52%. Targeted follow-up was in progress. Green rated items included: • Data Security and Protection Toolkit compliance actions • Compliance rates for responses to Freedom of Information and Data Subject Access requests There were 6 information governance incidents in March, none of which were reportable to the Information Commissioner.
Outcome	The report was noted.

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

Escalation and Assurance Report

Report from: Executive Risk and Compliance Committee
Date of meeting: 17 June 2026
Report to: Trust Board

Item/Topic	Risk Report
Rating rationale	The new report provided analysis of divisional very high scored risks and a baseline of information, which would allow more detailed assessment of the about use and health of the risk register in future reports. The Committee discussed two live risks: • 2185: good progress was being made on addressing this risk with the ICB. • 2234: the risk score had reduced to target but would remain on the register as it could increase again.
Outcome	The Committee welcomed the new report and was assured that the risk register was being used dynamically, with risks being regularly reviewed and progressed.

Assure: Including assurance items rated green	
Item/Topic	**Internal Audit: Risk Management and Board Assurance Framework**
Summary	The report, which had been reviewed by the Audit Committee, was rated substantial assurance, with one medium overarching recommendation and three low priority recommendations, all of which were now complete.
Outcome	The Committee welcomed the positive outcome and swift progress in completing actions.

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: Charity Trustee
Date of meeting: 9th April 2026
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**Quarter 3 Financial Position 2025/26**
Summary	At the end of Q3, total funds held remain stable at approximately £2.0m, with around £1.5m held in restricted funds. Commitments against funds remain relatively low at approximately £0.3m. While this position provides assurance, there is a recognised desire to increase utilisation of funds, particularly restricted funds. Planning activity is underway in key areas including Cancer and Ophthalmology, with proposals being developed alongside wider capital planning, which is expected to increase commitments over time.
Outcome	Noted
Item/Topic	**Schwartz Rounds Funding and Staff Wellbeing**
Summary	The Committee acknowledged the strong evidence base and value of Schwartz Rounds in supporting staff psychological wellbeing, particularly for multidisciplinary teams and resident doctors. It was noted that attendance levels are currently low and reliance on a small number of facilitators poses a sustainability risk. Plans are in place to expand the facilitator base, improve promotion, and schedule sessions further in advance to strengthen engagement and long-term resilience.
Outcome	Approval was given for £5,000 charitable funding to support Schwartz Rounds, including £3,600 for licence renewal and additional administrative support.
Item/Topic	**Staff Health and Wellbeing – Drinking Water Provision Discussion**
Summary	A detailed discussion took place regarding staff access to drinking water, particularly in clinical areas where staff work long shifts. This was recognised as an important physical wellbeing requirement. However, the cost of expanding provision Trust-wide would significantly exceed available charitable funding and it was acknowledged there is access to drinking water from sinks/taps.
Outcome	Consensus was reached that drinking water provision should not be considered an alternative to Schwartz Rounds funding and is more appropriately addressed as an operational responsibility. The Committee emphasised the importance of ensuring equitable access across all sites, including community and remote locations. **Action: Review drinking water provision across the Trust, including equity of access and organisational responsibility (GE)**
Item/Topic	**Independent Examiner Appointment 2025/26**
Summary	A market testing exercise was undertaken for appointment as Independent Examiner for 2025/26 accounts RD Accounting has been reappointed as Independent Examiner for the 2025/26 accounts at a cost of £1,860. This reflects best value and builds on a positive track record of delivery..
Outcome	Noted
Item/Topic	**Fundraising Update**
Summary	Fundraising activity continues to show positive impact, particularly through the targeted focus on Dementia care. This has contributed to improvements in PLACE scores relating to privacy, dignity and wellbeing. Community support remains strong, including donations to the Children's Ward. It was noted that the Fundraising Manager's role may be subject to change due to potential increased commitments elsewhere in the organisation.
Outcome	**Action: Bring forward proposal regarding future fundraising capacity (AD)**
Item/Topic	**Staff Lottery Scheme (Action Update)**
Summary	Work is ongoing to review use of external lottery providers and schemes such as NHS Together Charities.
Outcome	**Action: Develop proposal on staff lottery scheme and external provider options (KF/AD)**

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.

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