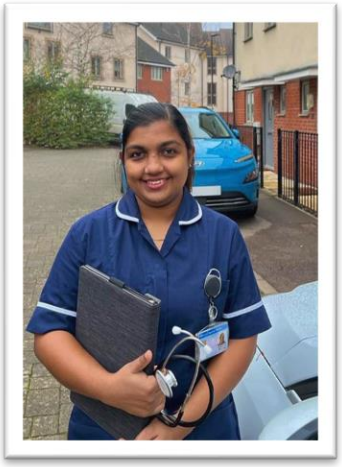
NHS
Wye Valley
NHS Trust



Quality Account 2025-26

Compassion • Accountability • Respect • Excellence

Contents

Introduction to Quality Accounts

What is a Quality Account?

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

How will the Quality Account be published?

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

About the Trust

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

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

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

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

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

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

Having been rated as 'Requires Improvement' by the Care Quality Commission at our last inspection in 2019, the journey to 'Good' is continuing and the Quality Account illustrates what the Trust is doing to achieve this.

Wye Valley NHS Trust Mission and Values

Vision, mission and values

The county hospital

Our vision

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

Our mission

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

Which means:-

Right care, right place, right time....every time

Our values

Compassion | Accountability | Respect | Excellence

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

Compassion

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

Accountability

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

Respect

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

Excellence

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

Introduction from the Chief Executive

I am proud to present this year's Quality Account, which reflects a period of strong progress, innovation, and continued commitment to delivering high-quality care for our communities in Herefordshire.

Over the past year, Wye Valley NHS Trust has demonstrated clear and measurable improvement across a wide range of areas. Despite ongoing pressures across the NHS, our teams have remained focused on what matters most – providing safe, effective, and compassionate care to the populations we serve.

One of our most significant achievements has been the strengthening of our culture of learning and improvement. We remain one of the highest reporting trusts for patient safety incidents in England, which is a positive reflection of our open and transparent safety culture. Alongside this, we have embedded the Patient Safety Incident Response Framework, ensuring learning is translated into improvement for the safety of our services.

Innovation and research have been a major success story this year. We have seen a remarkable 278% increase in research recruitment, with over 1,000 participants involved in studies. This reflects a growing research culture across the Trust, improving access to cutting-edge care for our patients and strengthening our academic profile.

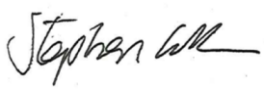
Patient experience has also improved significantly. Over 92% of patients reported a positive experience through the Friends and Family Test, with strong results across national surveys including maternity services, where we ranked among the highest-performing trusts regionally. We have seen a reduction in complaint "comebacks", improved response quality, and a growing role for co-production through our Patient Engagement Forum.

Our workforce remains at the heart of everything we do. This year saw a marked increase in staff survey participation and improvements across all nine themes, with scores above comparator averages. We continue to invest in staff wellbeing, leadership, and development, and we are proud to be among the top-performing trusts in our region.

We have delivered tangible improvements in key clinical priorities. These include reducing hospital-acquired VTE rates to the lowest within our Foundation Group, enhancing diabetes inpatient care, improving food and nutrition standards, and strengthening the management of time-critical medications through initiatives such as the 'Red Bags' system.

The Trust has invested in significant changes to how we deliver services to improve the safety and quality of care through the opening of the Community Diagnostic Centre and achieving accreditation of our Elective Surgical Hub.

I would like to thank all our staff, volunteers, patients, and partners for their continued dedication and support. The progress outlined in this report is a testament to their commitment and professionalism. I am confident that, together, we will continue to build on this momentum and deliver even better outcomes for our communities in the year ahead.



Stephen Collman, Acting Chief Executive 2025-26

CELEBRATING EXTERNAL RECOGNITION

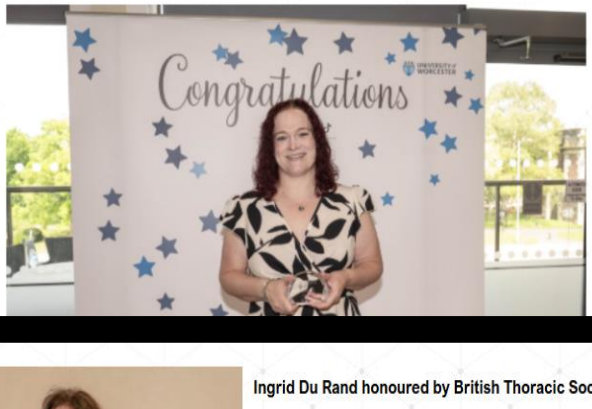
University of Worcester's Excellence in Practice Awards

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

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

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

Well done and thank you for making a difference!



Ingrid Du Rand honoured by British Thoracic Society (BTS)

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

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

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

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

If that wasn't enough, Ingrid has also developed guideline guidance for the BTS to include GRADE methodology and a website to write guidelines with.

Andrea Johnson receives prestigious award

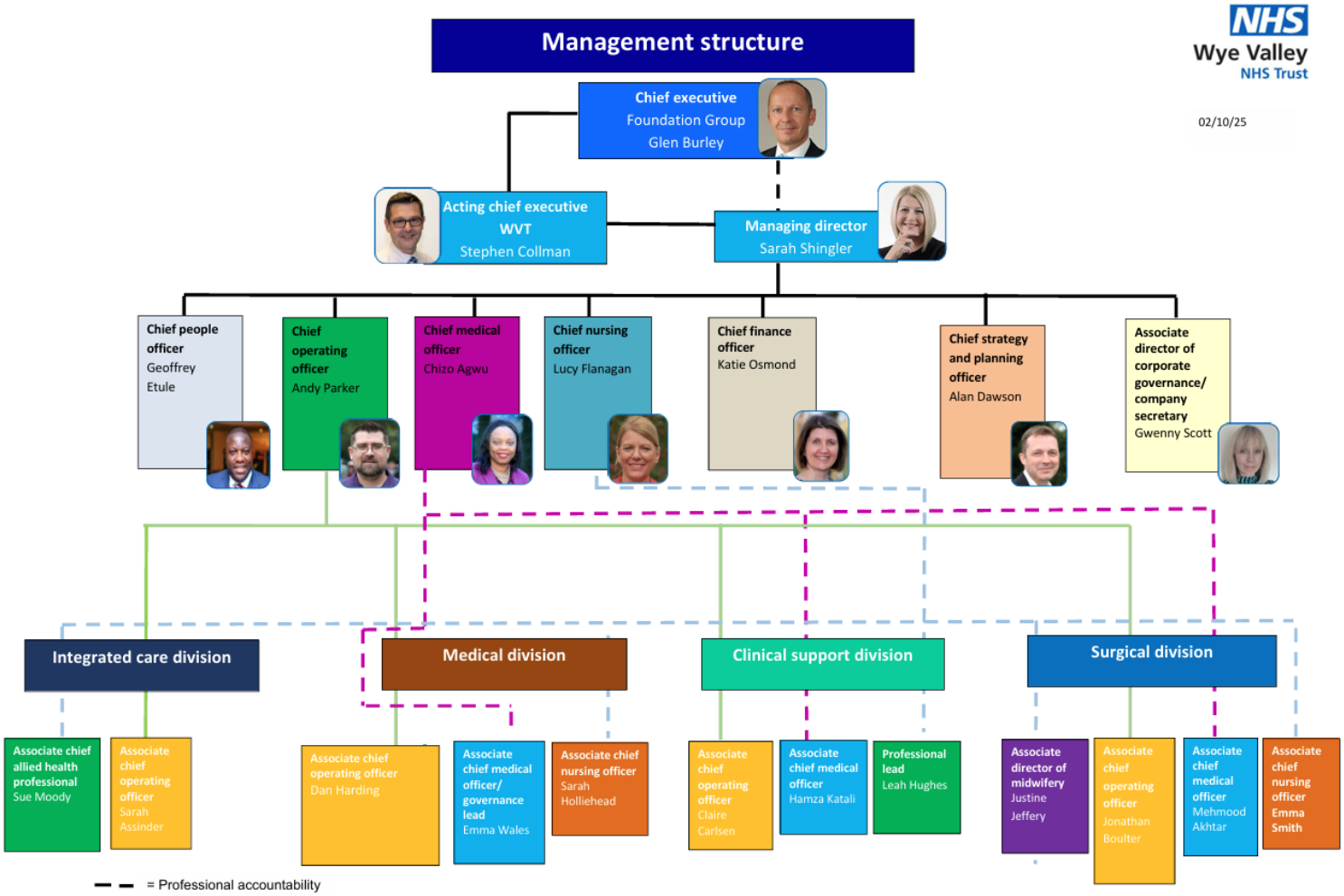
A huge congratulations to Andrea Johnson our Histopathology and Microbiology Laboratory Manager who won the Biomedical Science Leader award at the IBMS Awards 2025 on Friday 4th July. The pathology department at Wye Valley was shortlisted for four awards including Team of the Year (Blood Sciences), Best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

Organisational Change

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

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

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



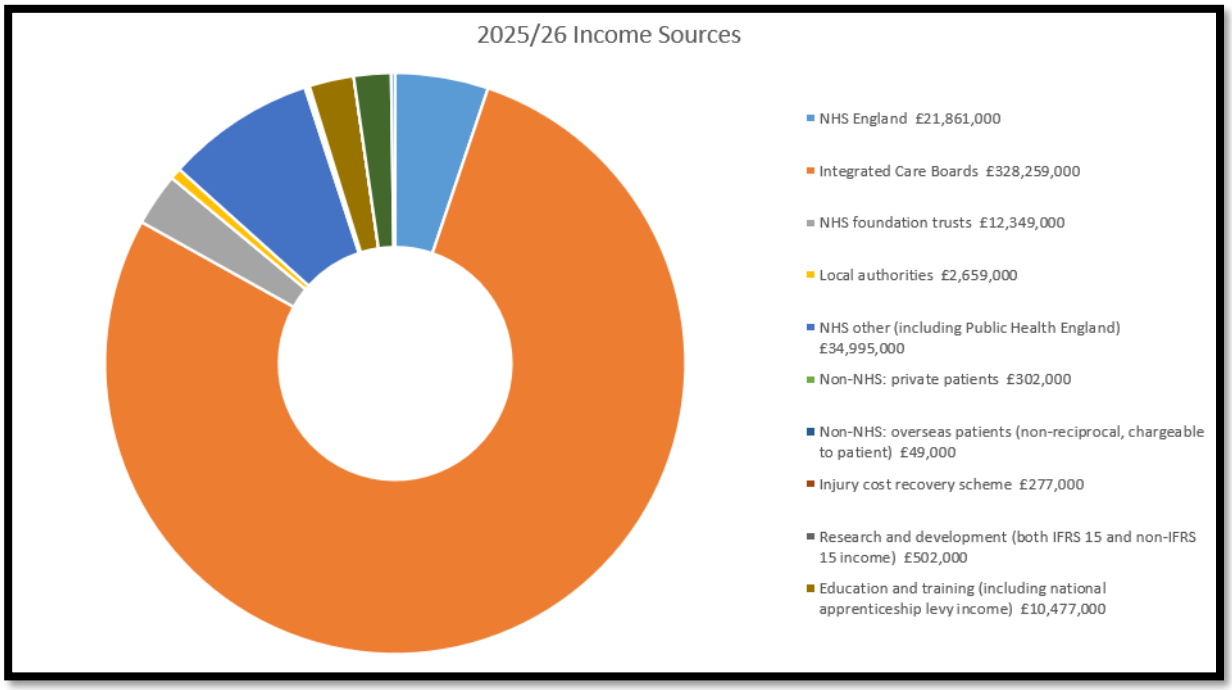
Statement of Assurance

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

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

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

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



Care Quality Commission (CQC) Overview of Progress

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

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

The County hospital's overall rating remains requires improvement following the last inspection in 2019. For the full breakdown of service ratings see Appendix 1.

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

Ratings for the whole trust

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

CELEBRATING CHANGE
Winner of the Poster competition 2025

This project showcases the collaborative work of our Upper GI team in developing a streamlined pathway for patients requiring emergency laparoscopic cholecystectomy. By implementing clear criteria, fast rack diagnostics, and CNS-led co-ordination, we significantly reduced wait times, hospital stays and readmissions; while improving patient experience.

UPPER GASTRO-INTESTINAL DEPARTMENT

HOT CHOLECYSTECTOMY:
HELPING PATIENTS, SAVING MONEY

CNS Lara Fieldhouse
Mr M Abduljabbar
Mr R Shetty
Mr M Bhandari
Mr T MacGregor

Smart Surgery, Leaner Spending - Invest in the Hot Lap Chole Pathway

PROJECT AIM

Develop, implement, and assess an efficient 'Hot Lap Chole' pathway to streamline the surgical management of patients in Herefordshire with acute gallbladder conditions. The goal is to reduce time to surgery, decrease hospital length of stay, and optimise resource utilisation while maintaining high standards of patient safety and care outcomes.

RATIONALE

Current practices often involve delaying or scheduling interval cholecystectomy, which can result in multiple hospital admissions, extended patient discomfort, increased risk of complications, and inefficient utilisation of healthcare resources. National and international guidelines (e.g., NICE, WSES) advocate for early laparoscopic cholecystectomy within 7 days of symptom onset; however, adherence to these recommendations remains variable due to logistical and operational challenges.

The establishment of a specialised Hot Lap Chole pathway seeks to address these challenges by facilitating timely surgical intervention for appropriate patients during their initial admission. This service model is anticipated to improve clinical outcomes, decrease readmission rates, reduce healthcare costs, and enhance the overall patient experience through prompt and effective care.

PRE-IMPLEMENTATION

- Repeated emergency readmissions due to recurrent pain or complications.
- Non-compliance with NICE and WSES guidelines advocating for early surgical intervention.
- Extended hospital stays and increased demand on emergency bed capacity.
- Patient dissatisfaction resulting from delays and uncertainty in care.
- Suboptimal utilisation of surgical theatres and redundant investigations during readmissions.

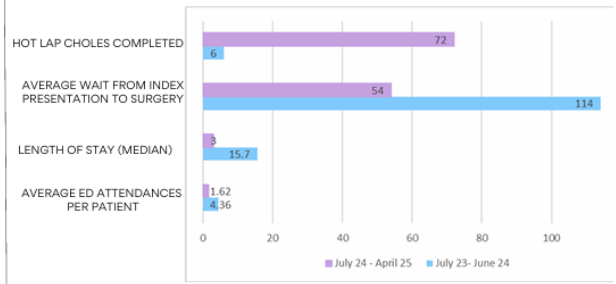
DURING IMPLEMENTATION

- Eligibility criteria have been established to ensure patient suitability, including fitness for general anesthesia, imaging confirmation of gallstones or cholecystitis, and low surgical risk.
- The use of SSDEC is implemented for laparoscopic cholecystectomy workup.
- The CEPOD list is utilised for urgent "Hot" laparoscopic cholecystectomy cases.
- A rapid diagnostic pathway is in place, with ultrasound and surgical review scheduled within 24 hours for inpatients, forming part of the fast-track biliary colic pathway.
- A Standard Operating Procedure (SOP) has been developed to promote consistency among clinicians.
- Early identification by the UGI CNS is prioritised to select appropriate patients, and streamline diagnostics imaging quickly and ensure reports are readily available for review
- Data collection has commenced using a standardised audit tool.

POST IMPLEMENTATION

- The number of hot lap procedures increased from 6 to 72.
- The average time to surgery decreased in nine months from 114 days to approximately 54 days.
- The readmission rate shortened from a median of 4.36 days to 1.62 days.
- Length of stay was reduced from a median of 15.7 days to 3 days.
- Patient satisfaction notably improved, reflected in positive feedback and a reduction in repeat visits.
- Theatre utilisation enhanced through improved planning and a decrease in cancellations.

COMPARISON BEFORE & AFTER IMPLEMENTATION OF HOT LAP CHOLE PATHWAY



COST SAVINGS

- Between July 2024 and April 2025, a total of 72 patients underwent Hot Lap Chole procedures. The final estimated cost savings, after accounting for deductions, amount to **£4,700 per patient**. This results in total savings of **£338,400** for WVT over the nine-month period.
- The initiative has led to the equivalent activity of 36 extra theatre sessions and a reduction in clinic waiting times from 15 weeks to 9 weeks.
- Surgical waiting times for elective procedures in UGI have also decreased, with patients now waiting an average of 17 weeks compared to 36 weeks last year. Currently, UGI has no surgical urgent breaches.

RECOGNITION

- The success of this project is attributed to the collaborative efforts of the multidisciplinary team listed below, each contributing to the development of a cohesive pathway and effectively overcoming challenges through a streamlined service.
- Subsequently, similar pathways have been adopted by WVT's colorectal and urology departments to manage patients requiring an acute colectomy and treatment for acute management of renal calculi, respectively.
- Worcester Acute Hospital has expressed interest in adapting our pathway for implementation within their organisation.

NEXT STEPS

- Allow direct GP access to SSDEC for assessment and surgical listing, thereby reducing emergency department visits and enhancing clinical capacity.
- Maintain the Hot Lap Chole Pathway and continue to celebrate its achievements.

The results would not have been achieved without the support of these individuals. I sincerely thank each and every one of you:
Rose Davies, Ellie Clarke, Sarah Anderson, Kaylee Lee, Rebecca Stone. Jo Hill, Robert Dawes, David Stoten, Gemma Maddy, Jonathan Boulter, Claire Griffin, Beki Tandy, Amanda James, Amdad Ahmed, Nicholas Cross, Linda Saunders, Shona Chandler, Dawn Moore and Scarlett Morgan.

Core Areas of Assurance

National Audit and National Confidential Enquiries (NCEPOD)

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

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

Audit findings and improvement actions are presented at Committee Meetings

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

Further detail is provided in Appendix 2.

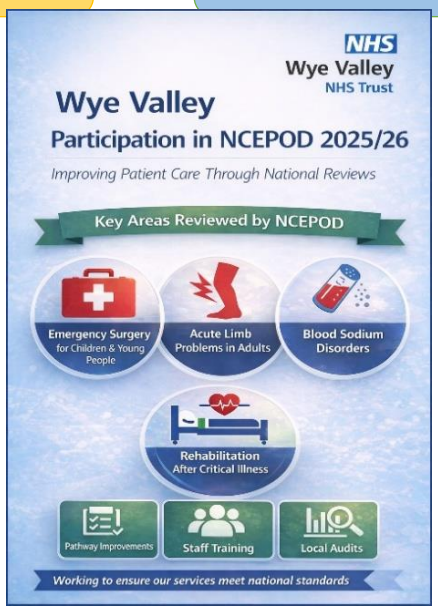
National Audit Participation Exception (2025-26)
The Trust did not participate the National Ophthalmology Database audit as this required electronic data submission and functionality is not yet available within local systems. Digital development is planned to support future participation.

National Data opt-out

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

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

Learning from Audit



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

Highlights from National Audit Reports (2025-26)

During 2025-26, 46 national clinical audit reports and 7 National Confidential Enquiry reports were published. Relevant specialties reviewed the findings and developed action plans where required.

Two projects are highlighted below to demonstrate areas of good practice and actions being taken where standards were not fully met.

ORAL HYDRATION IN THE OLDER ADULT INPATIENT
QUALITY IMPROVEMENT PROJECT

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

NHS Wye Valley NHS Trust

BACKGROUND

Older adult inpatients are at high risk of dehydration due to frailty, cognitive impairment, reduced thirst perception and dependency on staff for basic care[1].

Suboptimal oral hydration can lead to:

- Hospital-acquired acute kidney injury[2]
- Delirium and confusion[3]
- Prolonged length of stay and morbidity[4]

THE METHOD

A two-cycle retrospective audit:

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

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

THE AIM

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

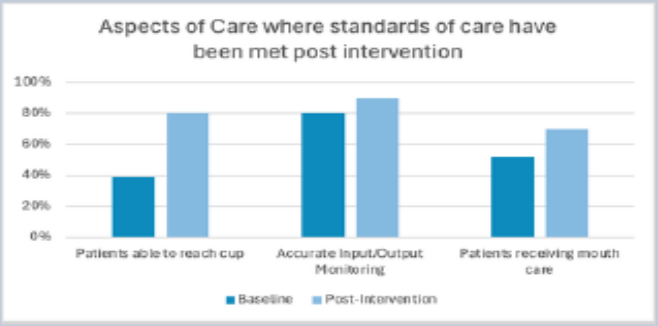
Measures assessed:

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

INTERVENTIONS IMPLEMENTED

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

RESULTS



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

ANALYSIS

our educational poster

What Improved?

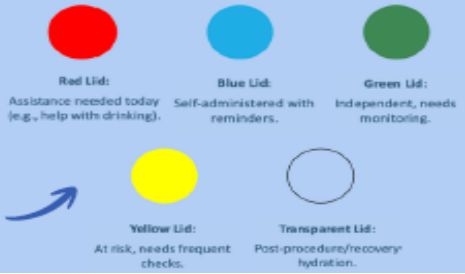
- ✓ More patients with drinks within reach
- ✓ More accurate fluid balance documentation
- ✓ Improved mouthcare support
- ✓ Increased use of hydration care plans
- ✓ Lower reliance on avoidable IV fluids

CONCLUSIONS

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

RECOMMENDATIONS

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



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2. Wolff, A. et al. (2020) 'Hyperosmolar dehydration: a predictor of kidney injury and outcome in hospitalised older adults', Clinical Nutrition, 39(6), pp. 1737–1743.
3. Inouye, S.K. et al. (2014) 'Delirium in hospitalized older patients', New England Journal of Medicine, 371(14), pp. 1327–1337.
4. Siervo, M. et al. (2014) 'Hydration and outcome in older patients admitted to hospital (The HOOP prospective cohort study)', Age and Ageing, 43(6), pp. 943–949.

How our unit did across 12 NNAP measures:

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

Antenatal magnesium sulphate

Overall, 86.7% of mothers of babies born at less than 30 weeks were given antenatal magnesium sulphate

Antenatal steroids

Overall, 51.8% of mothers of babies born at less than 34 weeks were given a full course of antenatal steroids in the week before delivery

Noninvasive ventilation

Overall, 51.7% of babies born at less than 34 weeks received noninvasive ventilation on all of the first 7 days of life

Breastmilk feeding in the first two days

Overall, 66.8% of babies born at less than 34 weeks received their mother's milk in the first 2 days of life

Breastmilk feeding at discharge

Overall, 65.8% of babies born at less than 34 weeks received their mother's milk at discharge home

Bronchopulmonary dysplasia (BPD)

Overall, 39.8% of babies born at less than 32 weeks developed BPD or died

Deferred cord clamping

Overall, 73.5% of babies born at less than 34 weeks had their cord clamped at or after one minute

Temperature on admission

Overall, 77.6% of babies born at less than 32 weeks were admitted within the recommended range of 36.5°C-37.5°C

Parental consultation within 24 hours

Overall, 94.6% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission

Parent inclusion on consultant ward rounds

Overall, 36.0% of baby care days had a consultant-led ward round with at least one parent included

Screening for retinopathy of prematurity (ROP)

Overall, 80.0% of eligible babies were screened on time for ROP

Neonatal nurse staffing

Overall, 81.5% of nursing shifts were staffed according to recommended levels

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

Working together around very premature birth

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

Improved electronic records now in place

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

Keeping babies warm at birth

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

Regular review and learning

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

Our current areas of quality improvement in 2025/26

Improving reliability of protective treatments for very premature babies

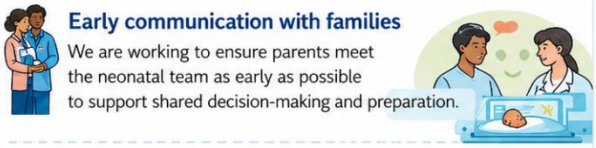
We are working to ensure all eligible mothers receive magnesium sulphate and antenatal steroids before early delivery and babies receive delayed cord clamping where possible.

Care immediately after birth

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

Early communication with families

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



Consistent delivery of the preterm care bundle

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

Trust Research Participation Overview 2025-2026

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

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

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

Achievements in 2025-2026

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

Exceptional Growth in Research Recruitment

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

Expansion of Research Portfolio

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

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

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

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

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

Delivery of the Research Academic Programme
The Trust delivered Part 1 of the research academic programme led by the R&D team. This programme provides structured development for clinicians AHP's nurses and students supporting the Trust's ambition to build a confident research active workforce
Achievements include delivery Part 1 with strong multidisciplinary attendants, positive participant feedback demonstrating increased focus and confidence in the research pathways Programme dates confirmed for 2026 planning underway for Part 2.

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

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

Research Priorities for 2026-27
Our focus in 2026-27 is to continue strengthening research impact, improve accessibility, and drive financial sustainability.
Key priorities continue to include:

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

Safety Alerts

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

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

To strengthen assurance and improve oversight, the Trust uses an alert management system that provides centralised monitoring of all alerts. This system enables alerts to be linked to relevant incidents and risks, supporting a more comprehensive and triangulated view of the Trust's safety profile.

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

Best Practice Guidance

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

During 2025–26, the Trust has sustained strong performance in the oversight and implementation of NICE guidance through continued use of the organisation's Standard Operating Procedure, *PR.S.21 — Implementation of NICE Guidance*. Originally ratified in 2022, this SOP continues to provide a robust and well-functioning framework for managing guidance across WVT, supporting timely allocation, review, and evidence submission. Engagement across divisions remains strong, with each new piece of NICE guidance assigned a named clinical or managerial lead.

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

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

- An external guideline covering a topic where NICE does not currently have its own guidance – with a rationale for why NICE is signposting to external guideline
- NICE assesses whether the external guideline is methodologically sound and useful.

- NICE publishes to support healthcare professionals but does not take responsibility for the content and clarifies that clinical teams must exercise their own judgement and consider local policy
- No NICE recommendations are produced; NICE instead offers commentary to support improved care.

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

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

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

(Figures correct as of 23rd March 2026)

Information Governance

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

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

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

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

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

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

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

Clinical Coding and Error Rate

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

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

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

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

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

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

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

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

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

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

The Patient's NHS number

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

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

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

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

The Patient's Registered GP Practice Code

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

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

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

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

Commissioning for Quality and Innovations (CQUINs) 2025-26

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

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

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

Aligning NICE NG249 and NAIF Standards with Patient Safety

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

Spine injury

Head injury

Hip injury

Other fracture

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

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

4 YEAR REDUCTION IN FALLS

Ongoing Challenges and Focus Areas

Despite strong improvements, the Trust continues to focus on:.

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

Summary: WVT demonstrates strong, sustained progress in aligning with both NICE NG249 (falls assessment, prevention, and post-fall management) and NAIF expectations for systematic inpatient falls care. The Trust has shown continuous reduction in falls over a four-year period, with Q3 2025/26 achieving the lowest fall rate to date, at 72% of the previous year's rate. This indicates a sustained positive trend and is consistent with the NG249 focus on reducing recurrent falls through structured assessment and targeted interventions.

Key Improvements and Achievements:

1. Strengthened Compliance with NICE NG249

- Updated clinical noting to ensure all risk assessments and reviews meet NICE NG249 standards.
- Reinforced documentation of individualised risk factors and personalised safety plans.

2. Implementation of NAIF Recommendations

- Annual NAIF audit findings have informed Trust wide action planning.
- Introduction of a consistent post fall management framework, including assessment for head injury or suspected fracture within 30 minutes.

3. New Post Fall Assessment Template (Maxims)

- A dedicated post fall medical assessment template was developed and launched on Maxims in 2025.
- Helps improve timely documentation, communication, and oversight of clinical reviews.

4. Rapid Pain Relief Standard

- Pharmacy developed a new Post-Fall Analgesia Guide, including out of hours support, to ensure patients are offered pain relief within 30 minutes of a fall.
- Supports NAIF goals and enhances patient assessment, comfort and safety.

5. Enhanced Patient Safety Culture

- Introduction of the red falling man icon on ward whiteboards to support rapid visual identification of at risk patients.
- Development of patient information leaflets and QR coded posters (NAIF aligned) promoting better understanding of fall risks and prevention.

6. Supporting Staff Through Education

- Monthly ADAPT training for nursing teams includes a dedicated falls prevention session – delivered by the Falls Lead.
- Simulation training provides scenario-based practice for managing falls, delivered by the education department for Community Teams.
- Manual Handling & Health (M&H) support correct use of flat lifting devices for safe post fall care.

Patient Safety Team | Physiotherapists | Pharmacy

NHS Wye Valley NHS Trust

Who was involved?

Community & Frailty Teams | Falls Panel & Integrated Care

Quality of Services - Key Areas

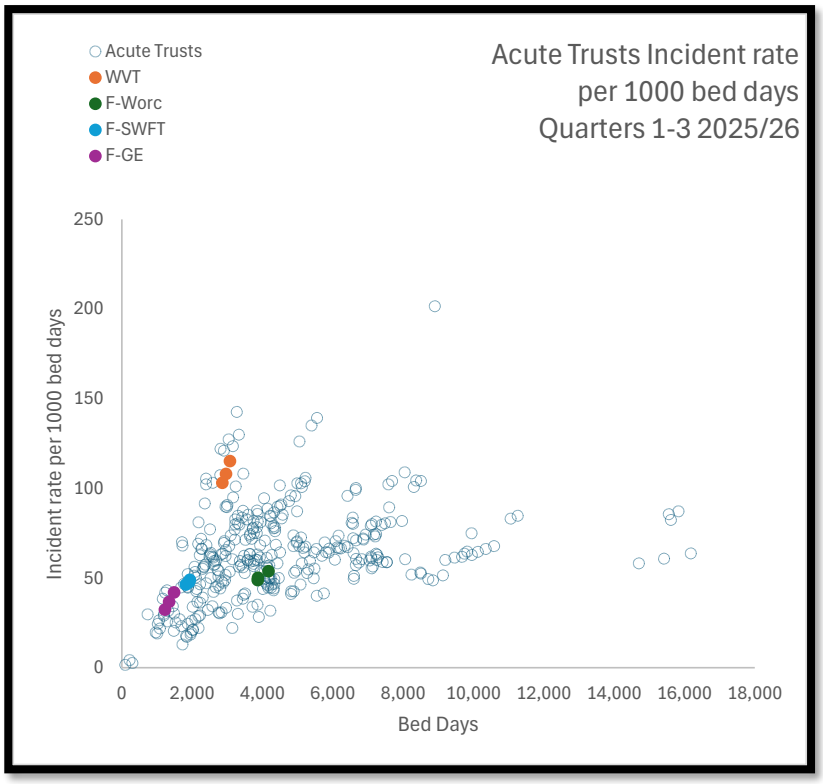
Incident Reporting

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

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

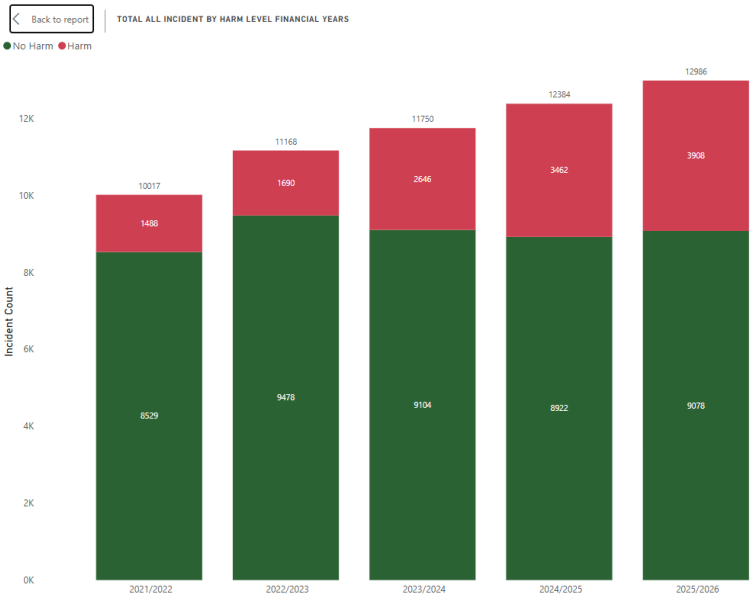
The chart adjacent shows all Acute Trusts in England, plotting an incident rate per 1000 bed days against the number of bed days occurring in the Trust, in each of the three quarters, thus there are plots per Trust one for each quarter.

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

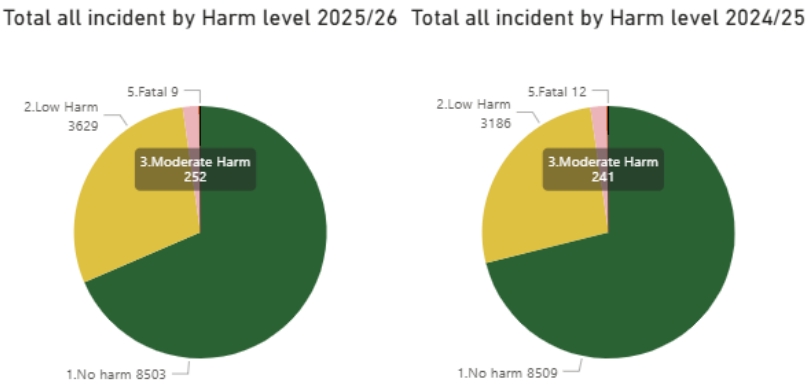


[Statistics » Patient safety data 2025-26]

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



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



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

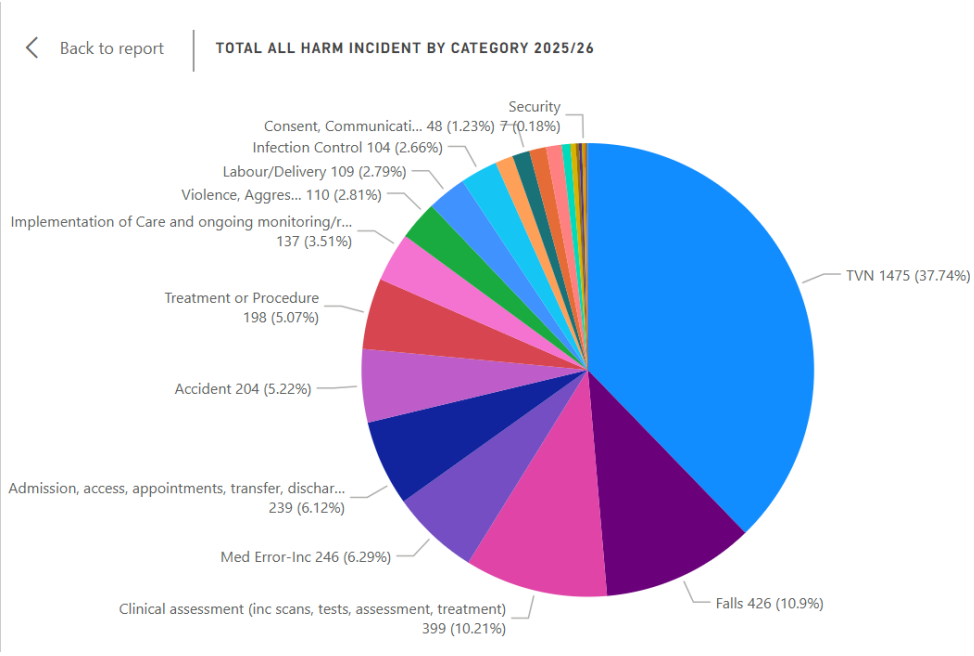
The top five categories of all incidents reported in 2025-26 are shown in the next table. The top five remain the same as the previous year

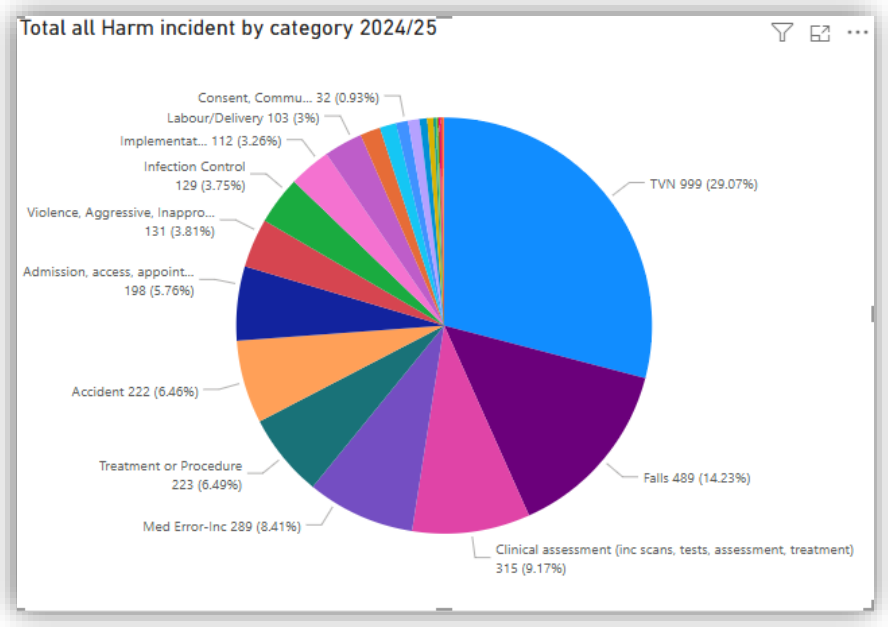
Category	2024/25	2025/26	% of total	% change
Tissue Viability	2784	3309	25.51%	19%
Admission, access, appointments, transfer, discharge	1317	1319	10.17%	<1%
Infrastructure (incl. staff, facilities, environment)	1262	1230	9.48%	-3%
Falls	1067	1058	8.16%	-1%
Clinical assessment (incl. scans, tests, assessment,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

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

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

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

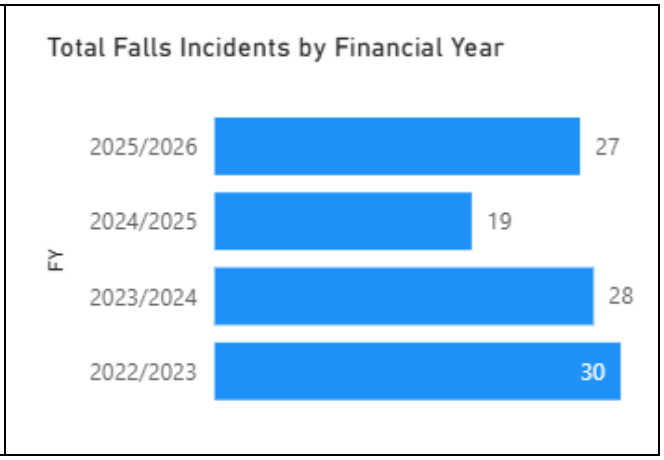




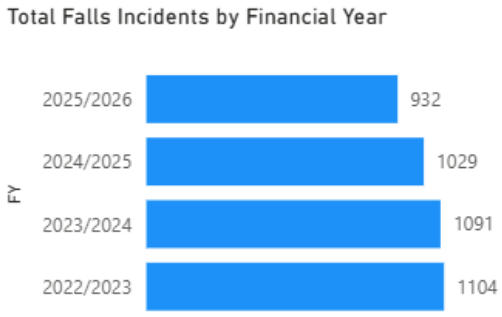
The Trust continues to apply the Patient Safety Incident Response Framework (PSIRF) to ensure learning from incidents and a proportionate, consistent response. Incidents are reviewed through the Patient Safety Panel, with a focus on identifying new learning and opportunities for improvement.

Reducing Harm to Patients

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

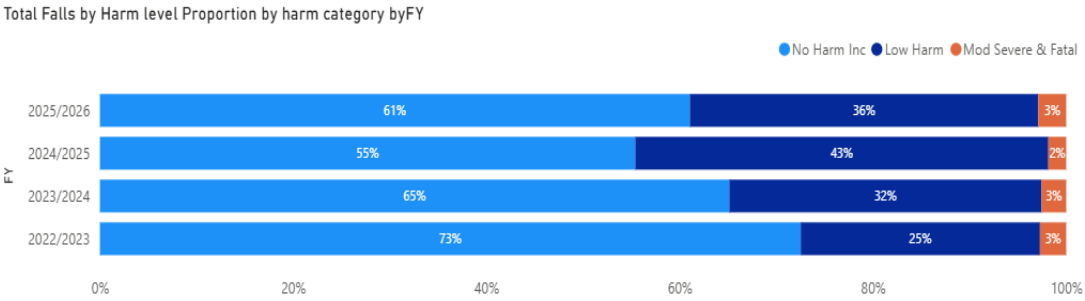


In 2025-26 we saw the following changes:

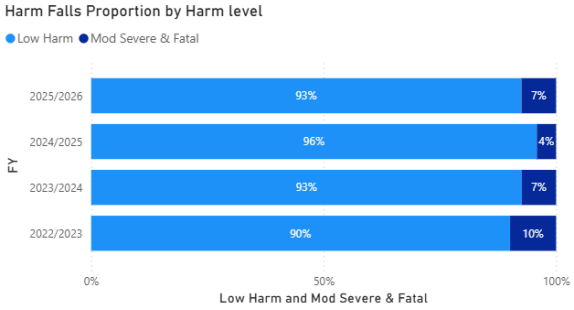


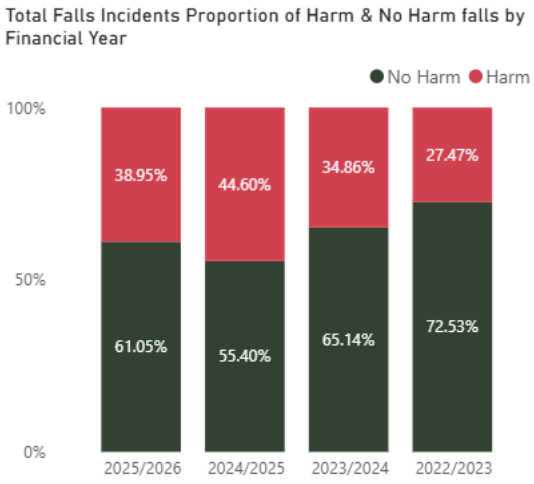
Total falls in the Trust are very similar to last year around 1000 falls (932 until end of February 2026)

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



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

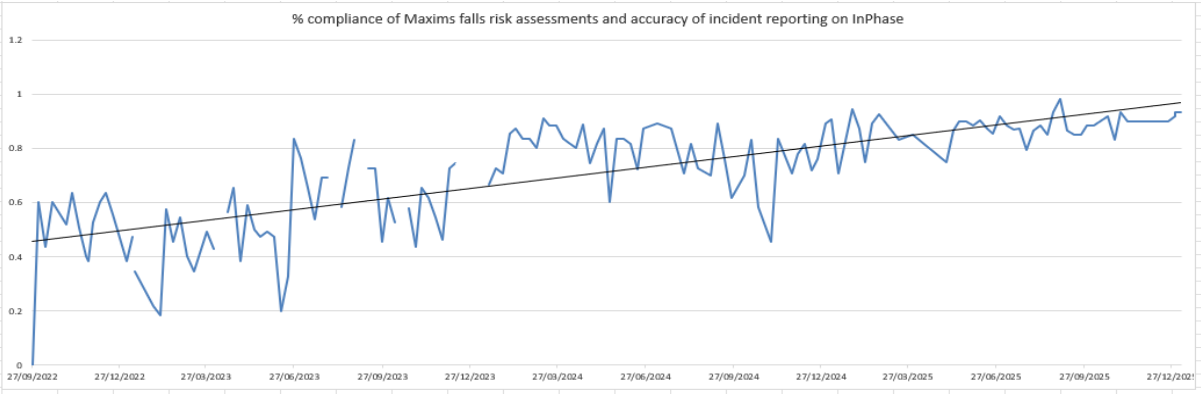




Falls are classed as low harm according to LFPSE guidance if a patient undergoes a scan/x-ray even if there is no fracture/harm.

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

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



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

- Joint working between Falls Lead and newly appointed Dementia Lead to support patient care; staff training – Ross community hospital site has received support as a targeted area in 2026.
- Reinstate Falls/Dementia/Frailty steering group or similar to drive improvements
- Falls policy due for review

- Audit of bed rails/ bed space environment /nursing risk assessments to be rolled out Trust wide April 2026
- Continued training via ADAPT program/ Fall prevention resources support by Falls Lead for the ward staff.
- Post fall retrieval flat lifting device training continuing to be provided via Moving and Handling.
- Falls dashboard in place providing data relating to falls for Wye Valley Trust increasing Divisional oversight of incidents relating to falls, providing reporting data.
- Improvement project in 'Frailty/Community Hospitals improving the amount of ward-based activity for patients to support safe mobility and prevent deconditioning.
- Patient Group Directive for morphine administration post fall awaiting sign off to support Community Hospital falls out of hours. This will improve compliance with National Audit of Inpatient Falls (NAIF)recommendation that analgesia is to be offered within 30 minutes of a fall with harm. Continued audit of analgesia being offered via NAIF audit.
- Review of post fall medical assessment template compliance. Continued audit of medical assessment within 30 minutes of a falls with harm via NAIF audit (NAIF recommendation 2025).

Duty of Candour

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

For any incident that meets the statutory threshold, the incident management system provides prompts and a dedicated section for staff to document Duty of Candour actions. However, all staff are expected to demonstrate openness and honesty in relation to any incident, as part of their overarching professional duty.

Compliance with the Duty of Candour is monitored through monthly divisional and corporate reporting and is included within submissions to the Quality Committee through Key Performance Indicators (KPI). Additionally, patient and family engagement is undertaken when a complaint relates to a patient safety incident. This approach ensures that individuals have a clear point of contact and are offered the opportunity to be involved in the investigative process, should they wish to do so.

Never Events

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

The NHS maintains a nationally defined list of Never Events, which includes incidents such as wrong site surgery, retained foreign objects post-procedure, mis-selection of medication, and transfusion of incompatible blood components. These events are subject to mandatory reporting, thorough investigation, and organisational learning to identify and understand contributory factors and implement safeguards to prevent recurrence.

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

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

Adult Safeguarding

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

The Trust ensures the principles of empowerment, prevention, proportionality, protection; partnership working and accountability have been applied preserving the individual's wellbeing at its core. The outcomes being that people are:

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

Making Safeguarding Personal (MSP) continues to remain a high priority and the Trust have endeavoured to ensure the adult, their wishes, choices and desired outcomes have remained at the centre of the safeguarding process as much as possible.

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

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

The Trust maintains its commitment to Herefordshire Multiagency Risk Assessment Conference (MARAC) and Domestic Abuse Perpetrator Panel and is an active member of the Domestic Abuse Operational Group and MARAC Governance Group.

Staff are supported in all aspects of safeguarding and in understanding and applying the Mental Capacity Act and Best Interests process in everyday practice. This has continued to be a quality priority for WVT. The Trust has an adult safeguarding performance dashboard,

which is monitored and discussed at the Trust's Overarching Safeguarding Committee. Adult Safeguarding reports are produced quarterly for the Trust Quality Committee, with a report produced for the Trust Board annually.

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

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

Children Safeguarding

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

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

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

The Chief Nursing Officer is the Trust's Executive Lead for Safeguarding Children, and the Associate Chief Nursing Officer oversees the management of, and the work undertaken by the Child Safeguarding team. The Trust has maintained a robust focus on Safeguarding Children through the governance arrangements depicted below.

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

The core functions of the team are to:

- Provide clinical leadership in respect of safeguarding to support high quality safeguarding practice.

- Offer support for practice development through:
  - Providing a robust training and development strategy utilising education forums, light bite sessions as well as formal training.
  - Supervision.
  - Coaching.
  - Share learning from safeguarding practice reviews.
  - Support and advice on case management, including attendance at complex meetings.
  - Provide oversight and assurance regarding how the Trust is meeting its obligations in respect of Safeguarding Children.
  - To provide oversight and development of policy and procedures.
  - To provide challenge and scrutiny of safeguarding practice internally and externally.
  - To support staff to provide high quality statements for court, the police and if attendance at court is required.
  - To undertake internal management reviews and contribute to multi-agency practice learning / CSPRs (Child Safeguarding Practice Reviews.)
  - Support the business of the, HSCP (Herefordshire Safeguarding Children Partnership)
  - The Trust has an established safeguarding children quality framework, which includes a safeguarding children performance dashboard and an annual audit plan. The Trust's Overarching Safeguarding Committee monitors this framework. A report summarising activity and priorities is produced for the Trust Board annually. Learning from single and multi-agency audits, child safeguarding practice reviews and practice learning reviews is embedded into practice in a number of ways, including supervision and education.

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

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

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

- By aligning safeguarding children's priorities to those of the Partnership; contributing to the work of the various subgroups and task and finish groups and by providing trainers for various learning and educational events.
- The multi-agency work extends to contributing to the Local Authority Improvement Plan which is in response to the Ofsted inspections. To support this in response to looking to improve multi-agency working we now have a Specialist Safeguarding Children Practitioner within the MASH

(B7) to strengthen collaborative working. The Trust already provides the health practitioner within the multi-agency safeguarding hub (MASH) which is often the first point of contact for professionals, family members or the public when they have concerns about a child's welfare or safety.

- Support the Children and Young Peoples partnership for Herefordshire (CYPP)

  Keeping children and young people safe – BE SAFE FROM HARM

  (Supporting children and young people with our public health services discussing healthy relationships and professionals being trained to recognise safeguarding thresholds – the safeguarding team contributing to wider partnership training on this)

  The safeguarding team are key contributors to the Get Safe programme to prevent CE (child/criminal exploitation)

  Improving children and young people's health and wellbeing – BE HEALTHY

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

  Helping ALL children and young people succeed – BE AMAZING

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

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

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

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

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

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

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

Patient incidents : Injuries included	Staff incidents : Injuries included
• A witnessed patient fall resulting in a fracture of the right femur	• Fracture of wrist/facial • Dislocation/fracture of hip • Dislocation of left shoulder • Possible Hep B exposure incident

Patient Reported Outcome Measures (PROMS)

Improving Patient Engagement

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

PATIENT ENGAGEMENT FORUM (PEF)

IMPACT SUMMARY 2025–2026

AT A GLANCE

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

KEY ACHIEVEMENT

Patient Engagement Charter

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

GROWING OUR REACH

Goal: More diverse membership

Promotional video in development
Improved recruitment approach
Stronger community links

DIGITAL INNOVATION

Patient Portal
- Public engagement stand
- Improved awareness and access

AI & Technology (Heidi)
- Input through AI Steering Group
- Patient-focused discussions

✓ Technology shaped with patient voice

CO-PRODUCTION IN ACTION

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

Anaesthetic Care (Dr Bick)
- Co-designed follow-up pilot

➡ From feedback → partnership

PATIENT INVOLVEMENT

PLACE assessments completed
AOB discussions shaping priorities

Real voices driving meaningful change

🎨 ENVIRONMENT IMPROVEMENTS

🌟 MRU mural enhancement

✓ Supports wellbeing

✓ Creates welcoming spaces

👥 RECRUITMENT & INCLUSION

✅ Patient rep on PALS interviews

Next steps:

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

🧭 WAYFINDING IMPROVEMENTS

🚶 Walkabout with Sodexo

🔍 Real-world navigation insights

➡️ Moving towards whole-site solutions

🚀 LOOKING AHEAD

Top Priority: Grow Membership

✓ Communications collaboration

✓ Broader representation

✓ Diverse patient voices

💡 WHAT MAKES PEF UNIQUE

👩‍⚕️ Staff | 👫 Patients | 🙋 Volunteers | 🌐 Community

✓ Challenge

✓ Collaborate

✓ Improve

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

🟢 IMPACT STATEMENT

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

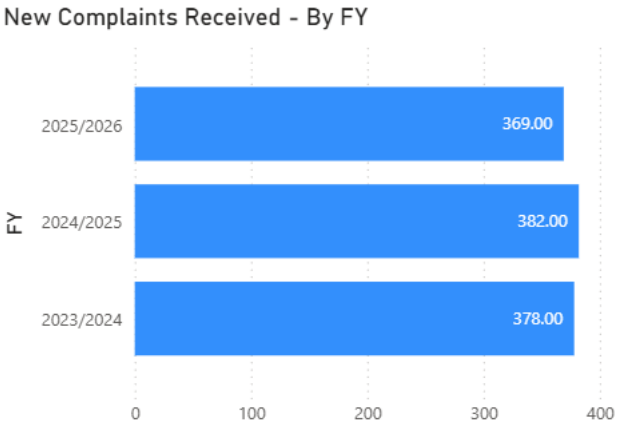
Prepared by Patient Representative | Approved by PEF
Formatted by AI

Patient Engagement Charter

Complaints

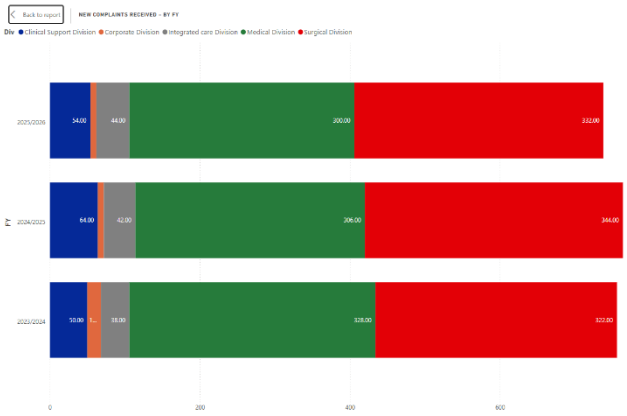
The Complaints team are structured within the patient safety workstream which supports alignment with the patient safety strategy and has enabled effective oversight and triangulation of data, recognising that patient safety incidents are being raised by patients and families via the complaints route.

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



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

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



Clinical Support- Blue

Corporate – Orange

Integrated Care – Grey

Medical – Green

Surgical - Red

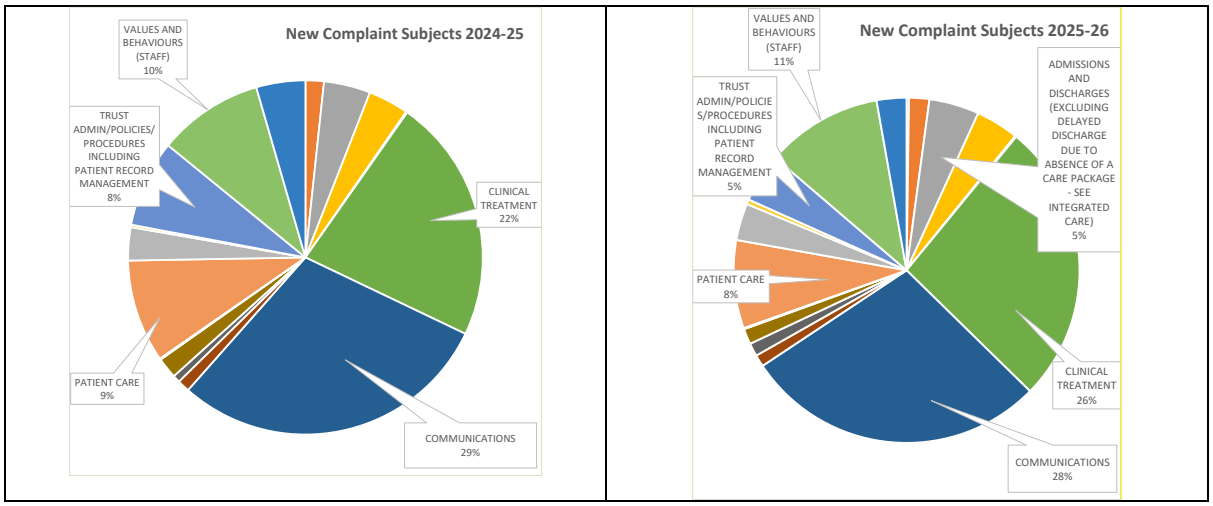
There has been a drop in the number of complaints re-opened, with 37 in 2025-26, compared to 49 in 2024-25.

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

Complaint categories

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

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



1. Communication:

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

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

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

2. Clinical Treatment:

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

Also improving are:

- Delay or failure to diagnose (incl. e.g. missed fracture) improved by 6%

- Inadequate pain management improved by 5%
- Lack of clinical assessment improved by 5%.

Those increasing are:

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

Other categories are largely the same.

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

3. Values and Behaviour:

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

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

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

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

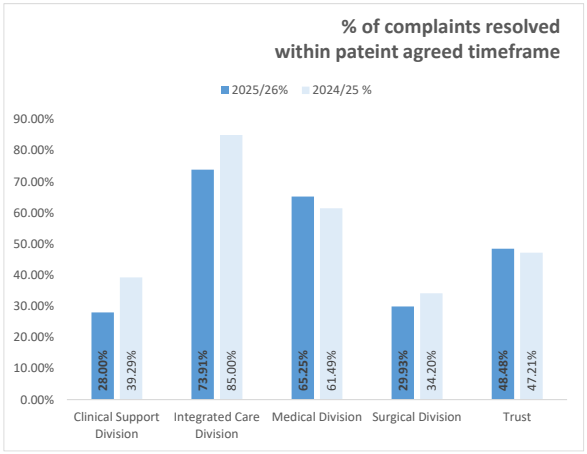
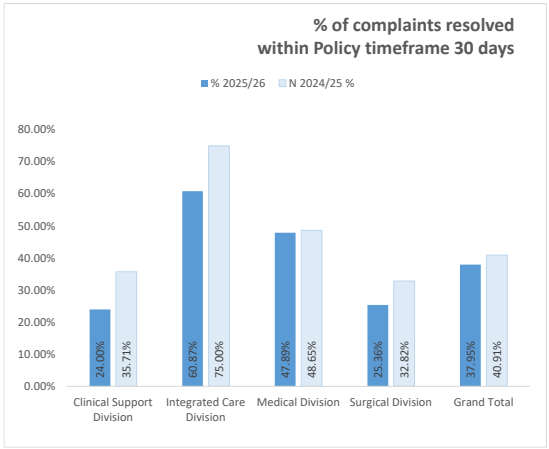
These are added to the complaint at the triage process and are based on the complainant's perception of their experience.

Complaint response times:

There are two measures:

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

The chart below compares closed complaints

Agreed with the complainant	The complaints policy timescale 30 working days
	
Note closed complaints	

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

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

Inpatient and National Surveys

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

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

National Surveys 2025-26

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

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

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

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

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

National Inpatient Survey 2024 (Published July 2025)

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

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

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

Maternity Survey 2025 (published December 2025)

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

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

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

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

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

The National Cancer Patient Experience Survey 2024 was sent to adult (ages 16 and over) NHS patients with a confirmed primary diagnosis of cancer, discharged from an NHS Trust

after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2024. 301 patients responded out of a total of 500 patients locally, resulting in a response rate of 60%.

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

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

Friends and Family Test (FFT) – National Data Collection

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

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

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

Freedom to Speak Up (FTSU)

The requirement for Trusts to have a FTSU Guardian, as a mandated post in NHS Trusts continues as an outcome of the public enquiry in 2016 chaired by Sir Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust. More recently, the importance of the Guardian role has been highlighted by the Lucy Letby case.

There are now over 1200 FTSU Guardians in over 500 NHS primary and secondary care, independent sector organisations and national bodies. According to the latest data from the National Guardian's Office, FTSU guardians have handled 171,814 cases since their establishment, with the most recent year, 2024/25, seeing over 38,000 cases reported to them, representing a significant increase from previous years. In 2025-26, WVT had 192 cases with each providing an opportunity to learn and make improvements that benefit the wellbeing of our colleagues

and the care we provide to our service users. Research and data show that an open culture in a Trust provides the safety needed for staff to speak up in the confidence that their voice will be heard.

FTSU and Civility Saves Lives

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

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

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

National Speaking Up Week

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

FTSU Quality Indicators

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

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

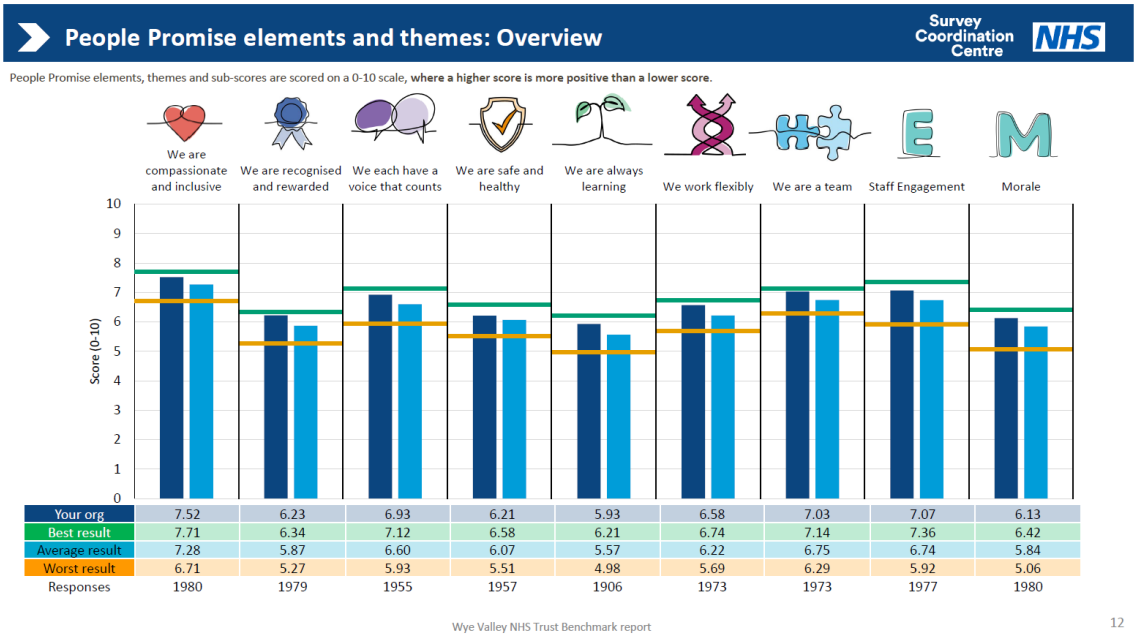
Year of the Survey	WVT Score	National/Sector score	Position Nationally
2024 staff survey	62.98%	60.29%	Top 25% of Quartile 3

NHS Staff Survey 2025

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

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

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



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

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

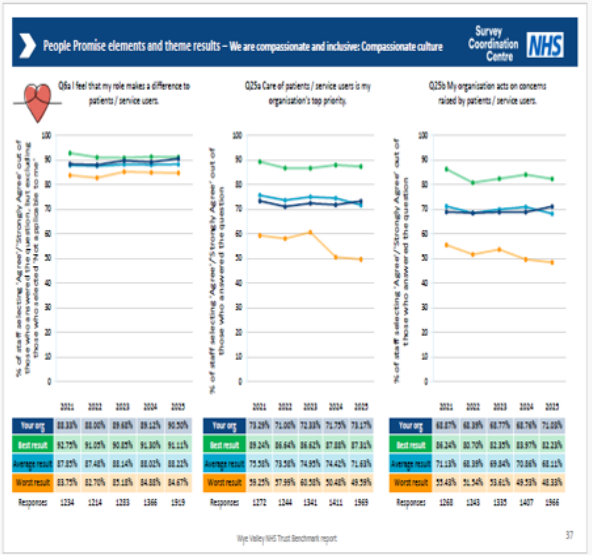
WVT scores are reflective of the national position, but we have seen improvements in some key questions including overall willingness to recommend the Trust as a place to work and receive care.

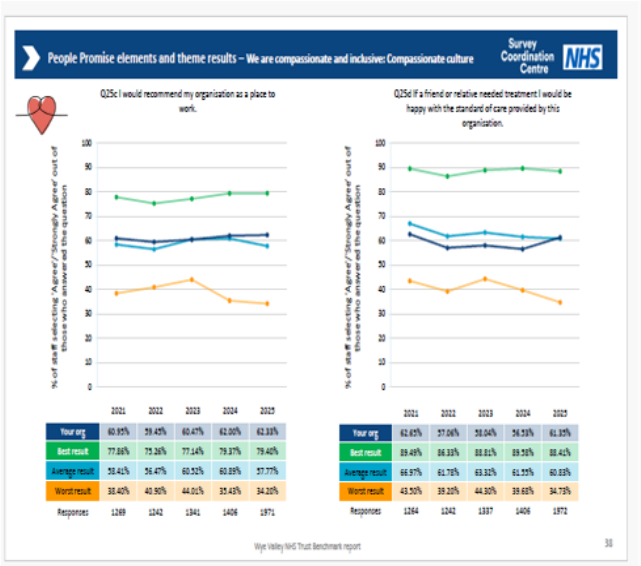
The 2025 data for WVT does not show any negative changes and is reflective of the ongoing concerted efforts and investments we have made in order to improve the staff experience. This is attributable to a number of leadership, staff wellbeing, workforce and OD initiatives that have been implemented and are still in place at the Trust over the past few years.

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

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

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





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

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

Health & Wellbeing

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

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

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

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

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

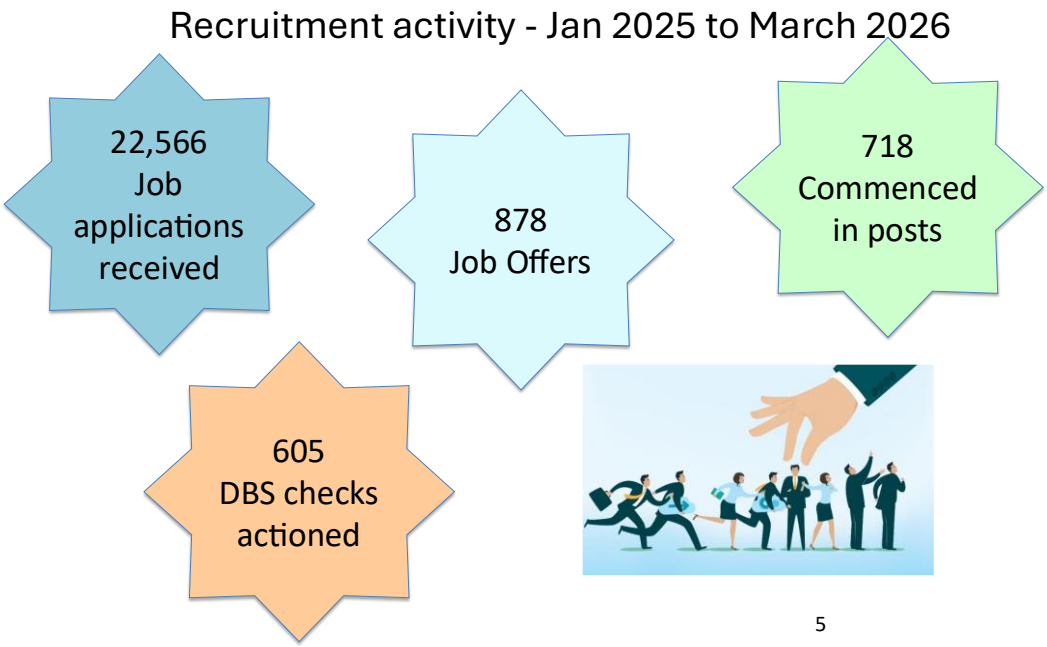
2025-2026	
Promotion of national wellbeing initiatives	Promotion of key wellbeing initiatives
Annual health & wellbeing week	Annual wellbeing week for staff in October
Employee Assistance Programme (EAP)	24/7 online counselling support to staff via HapiCo
Sleeping pods	Sleeping pods in place for resident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

Appraisals and Mandatory Training

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

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

Recruitment and Retention



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

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

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

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

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

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

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

CELEBRATING CHANGE

Surgical Division

Orthopaedic team – Outstanding results and Patient impact

COLLABORATION

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

TEAMWORK

Achievements reflect dedication and collaboration across teams driving continuous improvement

PRODUCTIVITY IMPROVEMENTS

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

SERVICE IMPACT

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

KEY RESULTS

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

INNOVATION

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

PATIENT IMPACT

Faster recovery times
Timelier mobilisation
Improved patient experience on wards

CONCLUSION

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

Quality Priorities: Review of the Previous Twelve Months

Quality Priorities for 2025-26

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

Safe	Effective	Experience
1. Ensure patients receive a timely VTE risk assessment in line with NICE guidance. 2. Diabetes inpatient safety improvement project 3. Improvement in food safety and quality – support delivery of Trust objective.	4. Implement Quality Improvement project to target high-risk time critical medication as locally defined. 5. Transition of care	6. Improve responsiveness to patient experience data 7. Increase the number of opportunities to grow our volunteer workforce, in numbers and reach.

Quality Priorities - Safe

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

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

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

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

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

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

Our data

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

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

Diagram 1:

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

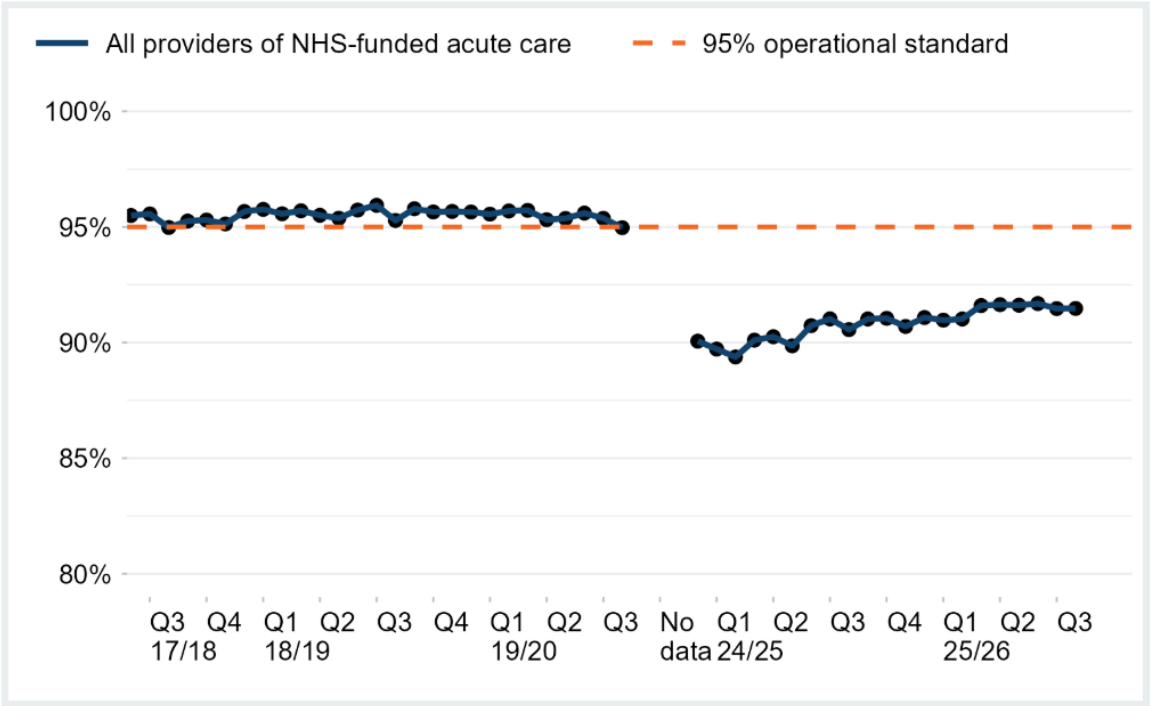
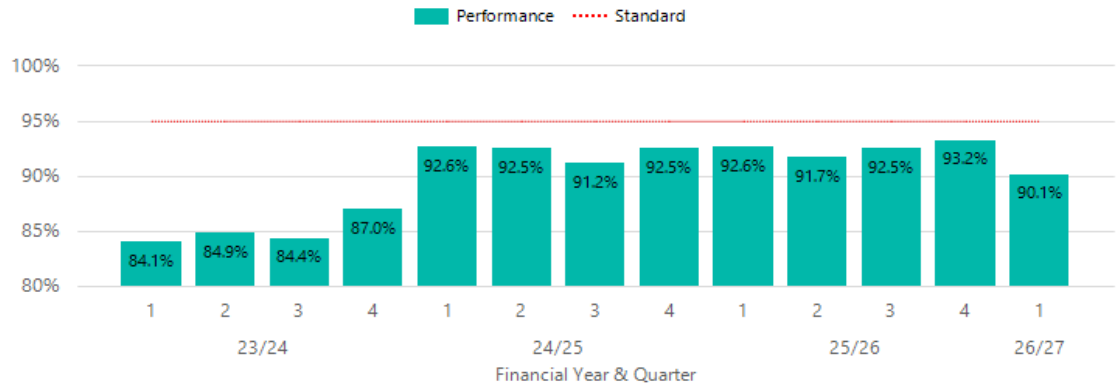
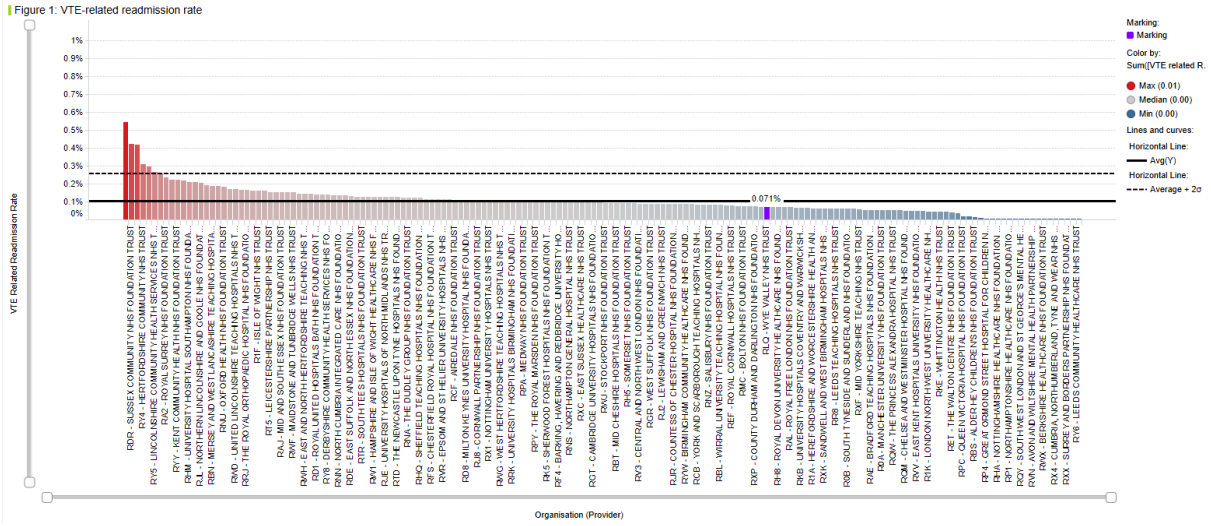


Diagram 2 demonstrates WVT is not achieving the 95% target for VTE assessment. However, it is above historic levels and is maintaining its performance.

Diagram 2:



Data showed a sustained reduction in hospital-acquired VTE rates, continuing the positive trend observed in 2024. The Trust now has the lowest rate of hospital-acquired VTE within the foundation group, this is likely due to better awareness, improved prescribing practices, and enhanced data quality. Below shows the trust hospital acquired VTE readmission rate in comparison to other sites and demonstrates WVT has above average performance (note this is the most recent whole year December 24 to November 25).



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

2.Diabetes inpatient safety improvement project

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

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

What we achieved

Governance arrangements

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

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

Diabetic foot assessment

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

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

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

Safe use of insulin: timing of mealtime insulin administration

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

Findings: interacting components

Tasks	Equipment (tools & tech)	Internal environment	Organisation	Patient factors	Staff factors	External environment
Glucose testing and meal delivery: prioritised tasks Insulin administration: not prioritised 2nd check of insulin	Insulin treatment is not identified on the handover sheet: information on time critical administration not easily accessible (parkinsons drugs are)	Busy clinical environment Boarding patients Catering routines & order of meal delivery Drug round routines (insulin sits outside of usual times) Staff routines	Staffing Culture Leadership	People requiring assistance with meals Patients not self-administering Patient factors (some request insulin, some don't) Health literacy & advocacy	Nursing staff breaks Insulin not seen as time-critical drug Task not handed over Nursing staff focus is to help with meal delivery rather than giving time-critical medications Knowledge gaps	Staff Education & Training Socio-economic backdrop

Key action areas:			Time-critical coordination	Teamwork and communication
Transitions of care	High-risk situations	Polypharmacy		
Information about insulin treatment & timings not easily accessible			Glucose monitoring, meal delivery and insulin administration not seen as connected	Not included on handover sheets Multiple tasks, undertaken by different people

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

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

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

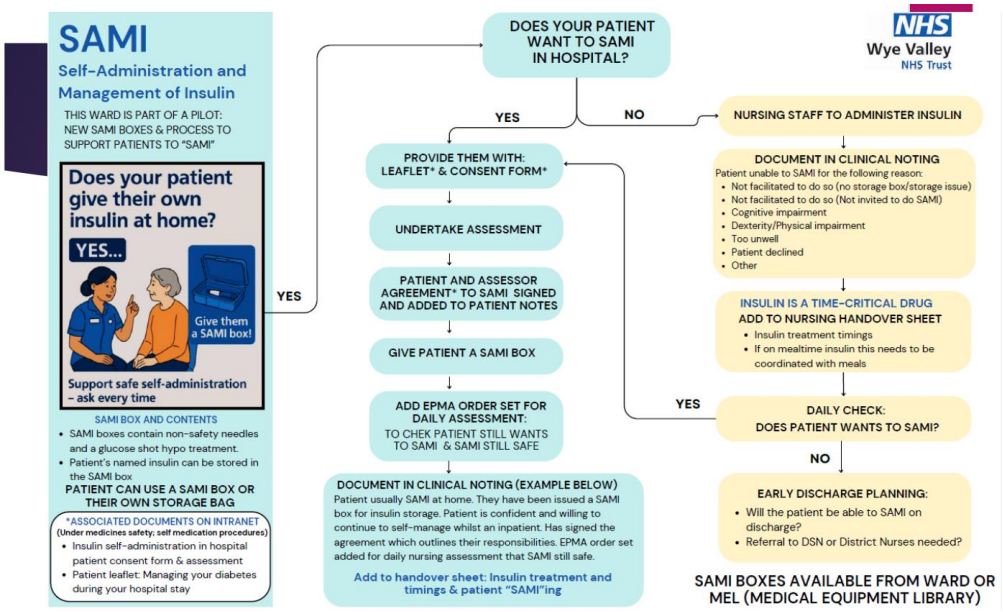
Safe use of insulin: inappropriate omission in first 24 hours

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

Patient empowerment

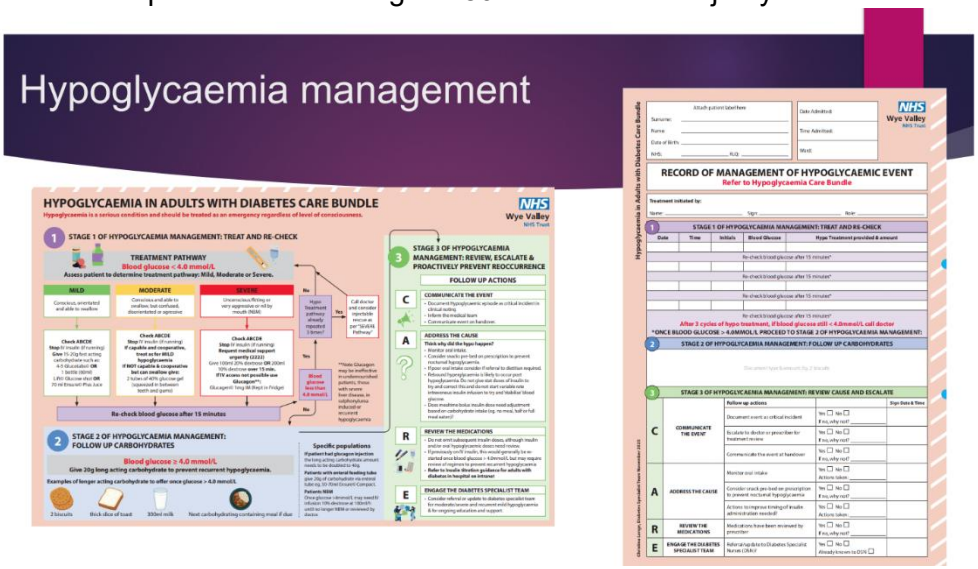
What we achieved:

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



In-patient management of hypoglycaemia

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



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

Next Steps

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

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

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

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

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

Objectives: Improvement in food quality and nutritional risk

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

Measurement: Triangulation between patient food experience evaluation data:-

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

Measurement : Nutritional Risk Assessment

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

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

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

- **Develop targeted meal service audits using a ward team approach involving our Sodexo colleagues, Lead Dietician & ward staff**
  - These audits take place monthly and provide a rich source of information to inform ongoing improvements with results reported into the Nutritional Steering Group.
  - Multiple data sources available pertaining to patient feedback re. food and drink.
  - The Sodexo Patient Ambassador additionally undertakes monthly patient experience audits, the nutritional steering group requested that these audits included specific questions lifted from the National Annual In-Patient survey. Given we have introduced many changes since the last national survey was undertaken, we wanted to gather more current intelligence.

- **Include the meal service audit as part of our Nutritional Care Group (NCG) meetings in our Nutritional Governance Structure**
  The meal service audits, remain the focus of discussion at the Nutrition Care Group meetings. These are multi-disciplinary meetings including operational ward staff, nursing and housekeepers, alongside dietetics and Sodexo colleagues. Format of the NCG

meetings was reviewed in December 2025 and it was agreed that these were very valuable and proving beneficial in improving relationships between colleagues.

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

Measurement: Triangulation between patient food experience evaluation data.

- **Annual In-Patient Survey**

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

- **PLACE audit**

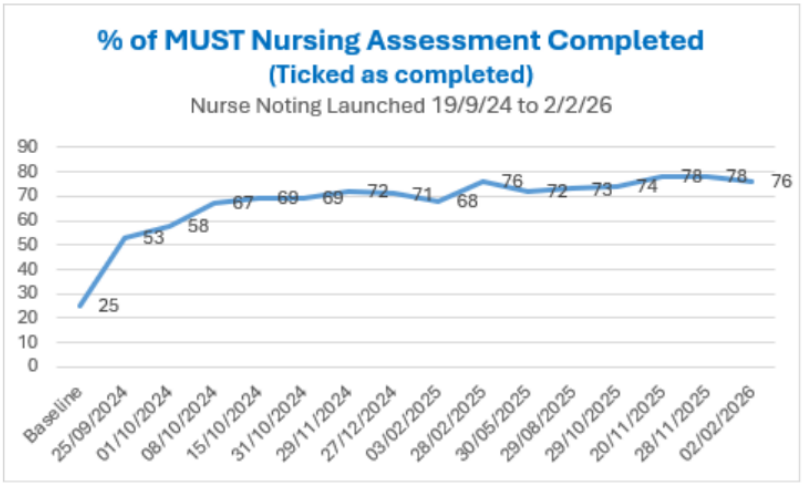
The annual Patient-Led Assessment of the Care Environment (PLACE) audits continue to be completed, with results used to support our decisions for quality improvement. The diagrams below show the results from the 2025 audit which show a positive picture for the Trust overall and improvements on the 2024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

Site Name	year of audit	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
COUNTY HOSPITAL	2025	99.61%	92.99%	94.62%	92.27%	90.20%	99.26%	81.68%	82.33%
	2024	98.23%	90.75%	94.62%	89.13%	81.20%	98.20%	71.52%	73.39%
BROMYARD COMMUNITY HOSPITAL	2025	99.56%	95.19%	92.01%	98.81%	85.94%	95.45%	88.74%	84.83%
	2024.00%	100.00%	91.39%	88.02%	95.24%	83.93%	97.85%	75.00%	77.81%
LEOMINSTER COMMUNITY HOSPITAL	2025	98.48%	93.52%	92.01%	95.24%	85.48%	94.40%	93.48%	88.59%
	2024	98.81%	87.98%	93.06%	81.58%	77.05%	90.91%	81.87%	76.62%
ROSS COMMUNITY HOSPITAL	2025	98.92%	89.78%	92.53%	86.11%	87.06%	98.57%	81.60%	83.40%
	2024	95.96%	93.45%	92.01%	95.12%	75.34%	93.64%	65.63%	65.42%
Overall organisation		99.47%	92.85%			89.37%	98.66%	82.87%	82.99%
national average 2025		98.55%	92.13%			89.37%	97.00%	85.68%	87.12%

Measurement: Nutritional Risk Assessment

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

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



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

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

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

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

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

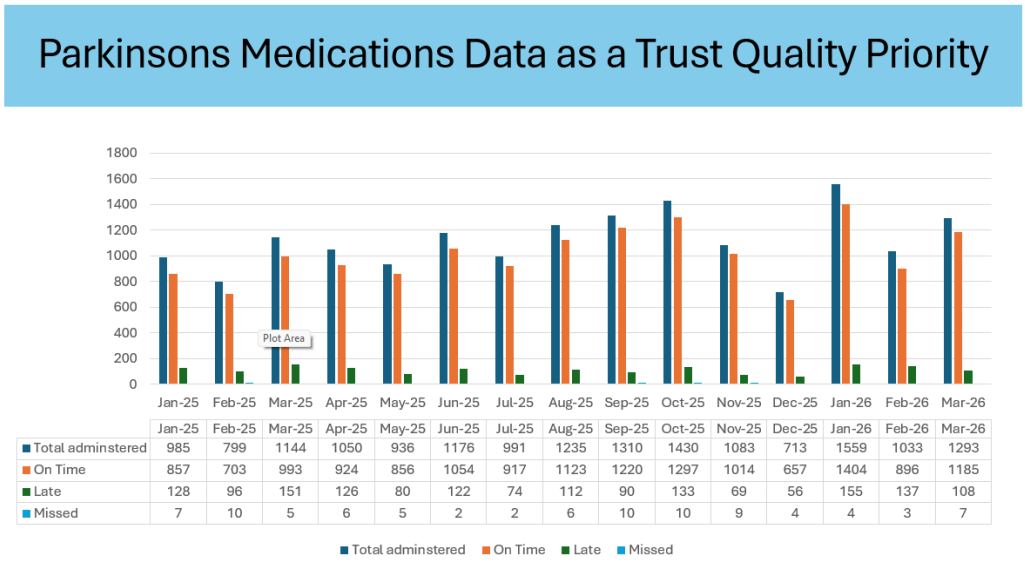
The Trust are pleased with the progress made over the past 12 months for this quality priority, this good news story and the triangulation of evidence indicates an improvement with patient experience of food quality.

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

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

Our data

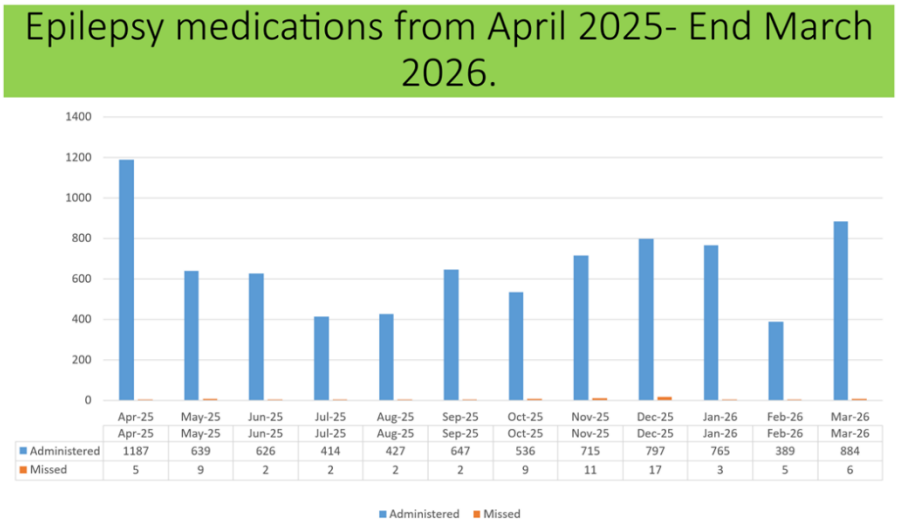
The overall % of Parkinson's medications "on time every time" shows a positive picture with the majority of medication being prescribed on time. Work continues to monitor missed doses and understand the reasons recorded on EPMA.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total adminstered	985	799	1144	1050	936	1176	991	1235	1310	1430	1083	713	1559	1033	1293
On Time	857	703	993	924	856	1054	917	1123	1220	1297	1014	657	1404	896	1185
Late	128	96	151	126	80	122	74	112	90	133	69	56	155	137	108
Missed	7	10	5	6	5	2	2	6	10	10	9	4	4	3	7

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

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



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Administered	1187	639	626	414	427	647	536	715	797	765	389	884
Missed	5	9	2	2	2	2	9	11	17	3	5	6

Self-administration

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

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

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

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

What we have achieved over the past 12 months

Screensaver for medicines safety week November 2025, continuing to promote Parkinsons.

Red bags.

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

Early indications suggest the initiative is already improving timeliness.

Additional actions implemented

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

Moving forward

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

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

5.Transition of care.

The aim of this quality priority was to:

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

Status of Transition at the beginning of the year

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

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

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

What was achieved

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

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

Moving forward:

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

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

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

6.Improve responsiveness to patient experience data.

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

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

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

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

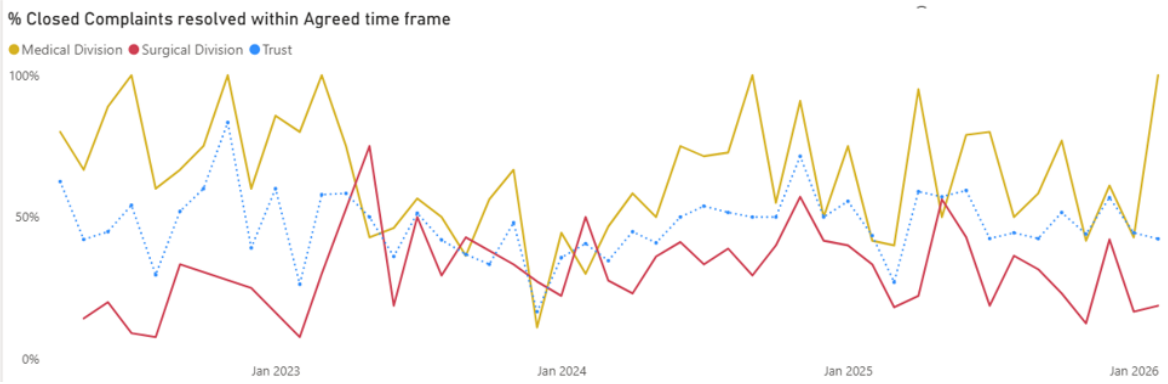
Improved quality and effectiveness of complaints handling

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

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

This demonstrates better quality, accuracy, and completeness of responses, reducing the need for re-investigation. Clear improvements in responsiveness and communication. There has been a notable improvement in agreed response timeframes and communication with complainants, particularly in the Medical Division.

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



Measurable improvements in patient experience themes

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

Growth in patient engagement and co-production

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

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

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

Continuous improvement culture and system development

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

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

The Trust has made meaningful and measurable progress in responding to patient expeience date. Key sucesses include;

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

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

7.Increase the number of opportunitites to grow our volunteer workforce, in numbers nd reach.

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

Our volunteer vision is:

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

Trust Objectve – "Increase the number of opportunities to grow our volunteer workforce, in numbers and reach"

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

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

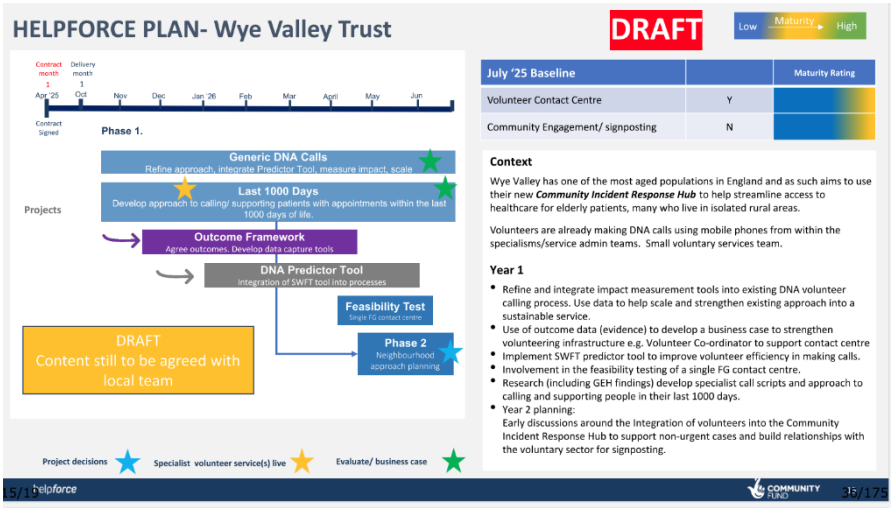
Trust Objective – "There's growing evidence to suggest that not only can volunteering help NHS providers meet some of the most stubborn challenges – it can also be transformational when expert programmes are designed to meet specific needs"

The key drivers for this objective were identified as:

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

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

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



- Expand the type of roles volunteers undertake, reaching more services and more patients
- Streamline processes
  - Recruitment
  - Training
  - Volunteer Management System

Our headlines on the past 12 month

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

Whilst this objective will not continue as a quality priority for 2025-26 the Trust is aware of

the significant progress made and is fully supportive to continue the projects and build on what has already been achieved through business as usual. The Trust is aware its exciting future opportunities lie in neighbourhood health and community-based volunteer support, networking with key stakeholders has already been initiated.

Quality Priorities: The Year Ahead

QUALITY PRIORITIES 2026-27

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

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

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

EXPERIENCE		
Seek to eliminate Corridor Care	**Transition of care**	

SAFE

Diabetes Safety – Improving inpatient care for diabetic patients

Time critical medication – continuing to build on the positive work over the last two years to ensure patients get their medication on time every time in our care

Reducing the prevalence for Hospital Acquired Pneumonia (HAP) – implementing the caring principles in the HAP care bundle.

EFFECTIVE

Frailty assessment in the Emergency department – improving frailty assessments in ED to support timely care in the right place for the elderly

Timeliness and Quality of Electronic Discharge Summaries (EDS) – ensuring patient information on discharge is communicated with healthcare professionals in a timely way to support effective ongoing care

Antimicrobial stewardship – implementing the national standards for improving use of antibiotics for inpatient care

EXPERIENCE

Seek to eliminate Corridor Care – following publication of national guidance and aiming to cease use of corridor spaces for inpatinets and improve patient flow

Transition of care – improving the change from paediatric to adult services for children and young people to support their ongoing care needs in line with NICE guidance

External Statements of Assurance

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Statement of Assurance

Kirkham House
John Comyn Drive
WORCESTER
WR3 7NS

0330 053 4356
hw.enquiries@nhs.net

June 2026

Reference: Herefordshire and Worcestershire ICB (HWICB) feedback Quality Account 2025/26

HWICB welcomes the opportunity to comment on the draft Wye Valley Trust (WVT) Quality Account for 2025/26. The ICB recognises the Trust's ongoing efforts and thanks staff for their commitment to delivering services and supporting the wider health and care system. The Quality Account provides a valuable opportunity to reflect on progress, recognise achievements and set out priorities to address ongoing challenges.

HWICB considers the draft Quality Account to be an open and balanced assessment of performance against the Trust's 2025/26 priorities, demonstrating a strong commitment to patient safety, clinical effectiveness, and patient experience. The ICB acknowledges several positive developments during 2025/26, including strong participation in national audits and confidential enquiries, increased research activity, high levels of patient satisfaction, and improved staff engagement and wellbeing. We also welcome the Trust's ongoing implementation of PSIRF, high levels of incident reporting, and improved responsiveness to patient experience concerns, including fewer complaint re-openings and strengthened governance.

We also recognise focused improvement work across key quality priorities, including diabetes inpatient safety through strengthened governance and care processes improvements in time-critical medications with initiatives such as "red bags" and enhanced oversight, and nutrition and food quality supported by improved audit and governance,

HWICB supports the quality priorities identified for 2026/27. These reflect local challenges and national priorities and build on progress made to date. HWICB particularly welcomes continued focus on improving discharge processes and whole-system patient flow, recognising the critical role that timely, safe and well-coordinated discharge plays in reducing delays, improving patient experience and supporting urgent and emergency care capacity. This includes sustained action to eliminate corridor care, ensuring patients are cared for in appropriate settings with privacy, dignity and clinical oversight. Alongside this, strengthening antimicrobial stewardship remains essential to support safe prescribing, minimise avoidable harm and tackle antimicrobial resistance, underpinned by clear governance, clinical leadership and effective use of data to drive improvement across care pathways. The ICB also looks forward to continued progress on national patient safety initiatives, including

embedding PSIRF and strengthening the early identification and escalation of deteriorating patients.

HWICB recognises the Trust's contribution to partnership working across Herefordshire & Worcestershire. Collaboration remains essential to address shared challenges in urgent and emergency care, patient flow, workforce, and quality improvement.

We acknowledge the progress made by Wye Valley Trust during 2025/26 and its commitment to addressing areas for improvement. The Quality Account reflects a strong focus on learning, transparency and quality improvement. We support the Trust's priorities for the year ahead and look forward to continued partnership working to deliver sustained improvements in the quality and safety of care.

Yours sincerely

Simon Trickett
Chief Executive

Appendices

Appendix 1 – CQC Ratings Tables

Last Inspection: 12 November to 19 December 2019

Acute Site ratings

Are services

Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Good
Responsive?	Requires improvement
Well-led?	Requires improvement

Most recent inspection rating changes

The County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Community Services

Ratings for community health services

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

Appendix 2 – National Audit & NCEPOD Compliance

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

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

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

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

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

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

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

National Confidential Enquiries (NCEPOD)			
Eligible National Audits	**WVT participation in 2025-2026**	**Cases submitted**	**Eligible National Audits**
Maternal, Newborn and Infant Clinical Outcome Review Programme	NCEPOD	N/A	MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2023 – State of the Nation Report – published 8 May 2025 Maternity care – Confidential Enquiries 2021-23 (MBRRACE-UK) "Saving Lives, Improving Mothers' Care: State of the Nation Report" – published 11 September 2025
Medical & Surgical Clinical Outcome Review Programme	NCEPOD	N/A	Rehabilitation Following Critical Illness – Recovery Beyond Survival -Published: 12 June 2025 Blood Sodium Disorders – A Balanced Solution - published: 9 October 2025 Acute Limb Ischaemia – Risking Life and Limb - published 13 November 2025
Mental Health Clinical Outcome Review Programme	NCEPOD	N/A	The Trust contributes to Mental Health Clinical Review Programme when required Suicide annual report, data 2013-2023 (NCISH) published 12 February 2026
Child Health Clinical Outcome Review Programme	NCEPOD	N/A	Emergency Procedures in Children and Young People – Right Place, Right Time, Right Team - published 11 December 2025

Appendix 3 – NHS Doctors and Dentists in Training

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

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

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

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

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

Grade	Entitled To	Filled	Gap	
Surgical FY1	16	16	0	
Surgical FY2	14	13	1	1 unfilled
GPST	7	6	1	1 x LAS
CTs	5	5	0	
ST	7	6	1	1 x LAS
ST3+	17	10	7	3 x LAS, 4 uncovered

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

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

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

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

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

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

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

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

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

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

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

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

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
NHS Outcomes Framework - Indicator 5.2.i - Incidence of healthcare associated infection (HCAI) - MRSA (2021/22)	0	0	3	20	0	Hospital Onset cases. Latest 2023-2024 Previous 2022-23 (09/2024 release)
MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to reduce incidence of MRSA and so the quality of services, by ensuring its strict cleaning, hygiene, hand-washing regimes, and bare below the elbows practice is adhered to. The trust also has a robust antibiotic prescribing policy and ongoing screening of all people that we admit to hospital.						
NHS Outcomes Framework - Indicator 5.2.ii - Incidence of healthcare associated infection (HCAI) - C. difficile	61	37	88.25	389	1	Hospital & Community onset, Healthcare associated. Latest 2024-25 Previous 2023-24
Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)						
Wye Valley NHS Trust is taking the following actions to improve the rate of C.Diff infection and the quality of services, by learning lessons from these investigations, sharing with the clinical area and presenting at the Trust's Quality Committee meetings.						
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents Latest Q3 2025/26 Previous Q1 2025/26	115.3	103.1	61.45	201.6	1.6	Reported as per 1,000 bed days. Latest Q3 2025/26 Previous Q1 2025/26
NHS Outcomes Framework - Indicator 5.6 Patient safety incidents reported Severe or death October 2019 - March 2020 Harm currently not reported	0.20	0.18	0.10	0.50	0.00	Reported as per1000 bed days. Previous period October 2018 - March 2019
Wye Valley NHS Trust is taking the following actions to improve the rate of patient safety incidents (including those that result in severe harm or death) and so the quality of services, by organisational learning from incidents and the outcome of investigations are shared throughout Divisional and Directorate governance meetings. Incident reviews that identify a new emerging risk or new learning are shared in a variety of forums and in the trust Safety Bites newsletter.						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Summary Hospital-level Mortality Indicator (SHMI) - SHMI data at Trust level (Current Jan 2025 – Dec 2025) Band 2 (Previous Nov 2024 – Oct 2025) Band 2	1.1282	1.1380	1.0	1.33	0.71	Data is banded 1-3 high to Jan 2025 – Dec 2025) Band 2
Summary Hospital-level Mortality Indicator (SHMI) - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the (Current Jan 2025 – Dec 2025) (Previous Nov 2024 – Oct 2025)	26%	27%	45%	70%	17%	Reported as a percentage of all deaths.
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, January 2025 - December 2025 - NHS England Digital						
Wye Valley NHS Trust is taking the following actions to improve its mortality rates and so the quality of services, by maintaining the implementation of the Mortality strategy and supporting quality improvement work in relation to mortality alerts and learning from deaths.						

Limited submissions for current year . Numbers not sufficient for the benchmarking tool to use

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	
PROMS Total HIP Replacement (latest 2024-25) (Previous latest 2023-24)	0.439	0.498	0.45	0.54	0.27	Using EQ-5D Index score (a combination of five key criteria concerning general health) ***This year Measuring Health gain*** Note for Hip sample small for accurate National comparison. Note last year updated to 2022-23 More info in link below
PROMS Total Knee Replacement Latest 2024-25 Previous 2023-24	0.31	0.292	0.323	0.51	0.23	

Patient Reported Outcome Measures (PROMs) - NHS Digital
Wye Valley NHS Trust is taking the following actions to improve PROMs outcomes and so the quality of services, by continuing to look at the issues with the PROM outcome scores in greater detail, in particular those patients who have had a negative outcome and analysing patient level information to look at the outliers and their impact on the overall scores. This analysis is undertaken by the surgical teams to understand how we can improve.

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Section 6 Your care & treatment NHS Outcomes	**8.17**	7.56	8.29	9.38	7.52	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to 2024 survey Nov sent Jan – April 2025 ***Published Sept 2025***
Framework - Indicator 4b Patient experience of hospital care Statistic: overall how was your experience….in Hospital	**8.03**	7.90	8.14	9.44	7.38	NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions relating to 2024 survey Nov sent Jan – April 2025 ***Published Sept 2025***
Adult inpatient survey 2024 - Care Quality Commission						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement						
d) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Q25d – 2024)	61	57	61	88	35	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 Previous December 2023
Staff recommendation: Key Finding 1. Staff recommendation of the organisation as a place to work (Q25c-2024)	62	62	57	79	34	Percentage of staff taking part in the survey. Selection of Community & Acute Trusts Current data 2024 survey latest available
NHS Staff Survey dashboard Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)						
Wye Valley NHS Trust is taking the following actions to improve the score and so the quality of services by developing local action plans which will focus on areas identified as requiring for improvement.						
Friend and Family Inpatient services latest Jan 2026	93	88	95	100	77	Figures expressed as percentage.
Friend and Family Accident and Emergency services Jan 2026	80	80	78	100	55	
https://www.england.nhs.uk/fft/friends-and-family-test-data/						

Indicator	WVT latest available	WVT previous	NHS E Ave	NHS E max	NHS E min	Remarks
Current October to December Q3 2025-26 Previous VTE risk assessed Quarter 4 (October to December Q4 2024-25)	91%	91%	91%	99.8%	14%	Expressed as a percentage of patients requiring assessment
Statistics » Venous thromboembolism (VTE) risk assessment						
Wye Valley NHS Trust is taking the following actions to improve the number of patients who are risk assessed for VTE and so the quality of services by maintaining a focus on achieving the national target through the quality priority set for 2024-5 and continued audit of practice. **2025 latest published national data see VTE section for latest quarterly data. There was a National data suspension during the Pandemic**.						

Appendix 5 - Contracted Services 2025-26 - Contract Monitoring Services

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

Appendix 6 - A-Z INDEX – NHS TERMINOLOGY USER GUIDE

AHPs (Allied Health Professionals) – Healthcare staff such as physiotherapists, occupational therapists, and radiographers

CAS (Central Alerting System) – a system that sends urgent safety alerts to healthcare organisations

CLINICAL DIVISIONS – groups within a hospital that organise services by specialist area (e.g. surgery or medicine)

CQC (Care Quality Commission) – the independent regulator that checks and rates the quality and safety of NHS services

CQUIN (Commission for Quality and Innovation) – a system that links NHS funding to improvements in the quality of care

DETERIORATING PATIENT – a patient whose condition is getting worse and needs urgent attention

DSPT (Data Security and Protection Toolkit) – a system used by NHS organisations to check they are keeping patient information safe

DUTY OF CANDOUR – a legal duty for healthcare staff to be open and honest with patients if something goes wrong

EDS (Electronic Discharge Summary) – a digital record sent to a GP when a patient leaves hospital

EPMA (Electronic Prescribing and Medicines Administration) – a system used by clinicians to prescribe and manage medicines electronically

EPR (Electronic Patient Record) – a digital version of a patient's medical information

FFT (Friends and Family Test) – a quick survey asking patients to rate the service they have received and provide feedback

FOUNDATION TRUST/FOUNDATION GROUP – NHS organisations with greater independence that often work together to improve services

FSNs (Field Safety Notices) – safety messages about medical equipment issued by manufacturers

FTSU (Freedom to Speak Up) – a system that supports staff to safely raise concerns about patient care or workplace issues

HES (Hospital Episode Statistics) – information about patient care in hospitals across England

HYPOGLYCAEMIA – when a person's blood sugar levels drop too low

ICB (Integrated Care Board) – the organisation that plans and pays for NHS services in a local area

KPI (Key Performance Indicator) – a measure used to track how well a service or organisation is performing

MARAC (Multi-agency Risk Assessment Conference) – a meeting where organisations work together to protect people at risk of harm

MASH (Multi-agency Safeguarding Hub) – a team that shares information across services to protect vulnerable people

MHRA (Medicines and Healthcare Products Regulatory Agency) – the UK regulator for medicines and medical devices

MUST (Malnutrition Universal Screening Tool) – a tool used to check if patients are at risk of poor nutrition

NAIF (National Audit of Inpatient Falls) – a national review of how well hospitals prevent and manage patient falls

NATIONAL CLINICAL AUDIT – a process of reviewing clinical practice against agreed standards to improve patient care

NCEPOD (National Confidential Enquiry into Patient Outcome and Death) – a programme that reviews patient care to identify improvements

NEVER EVENTS – serious patient safety incidents that should not happen if proper safety processes are followed

NICE (National Institute for Health and Care Excellence) – a national body that produces Guidance on best practice for treating and caring for patients

NIHR (National Institute for Health and Care Research) – the organisation that funds and supports health research in England

NMPA (National Maternity and Perinatal Audit) – a national review of maternity care to improve outcomes for mothers and babies

PALS (Patient Advice and Liaison Service) – a service that provides help, advice, and support to patients and families

PEF (Patient Engagement Forum) – a group that brings patients and staff together to improve services based on feedback

PHSO (Parliamentary and Health Service Ombudsman) – an organisation that investigates complaints about NHS services in England

PROMS (Patient Reported Outcome Measures) – information provided by patients about how their health has improved after treatment

PSIRF (Patient Safety Incident Response Framework) - a new way of looking at patient safety incidents to learn from them and improve care rather than assign blame

RIDDOR – a legal requirement for reporting workplace injuries, illnesses, or dangerous incidents

SAFEGUARDING (Adult & Children) – protecting people from abuse, neglect, or harm

SEPSIS – a life-threatening condition caused by the body's extreme response to an infection

SHIMI (Summary Hospital-Level Mortality Indicator) – a measure comparing how many patients die in hospital compared to what would be expected

SOP (Standard Operating Procedure) – a step-by-step guide for staff to follow to ensure safe and consistent practice

SUS (Secondary Uses Service) – a national system that collects NHS data for planning and research

TIME-CRITICAL MEDICATION – medicines that must be given at the right time to be safe and effective

VTE (Venous Thromboembolism) – a blood clot in a vein that can be dangerous if not identified and treated quickly