WVT Annual General Meeting and Trust Board Held in Public

Thursday 3 September 2026, 13:00 - 15:00

MS Teams

Agenda

Wye Valley NHS Trust Formal Annual Business

13:00 - 13:05
5 min

1. Welcome and Introduction - Annual General Meeting

Frances Martin

1.1. Apologies for Absence

Information *Frances Martin*

1.1.1. Quorum and Declarations of Interest

Information *Frances Martin*

1.2. Minutes of the Annual General Meeting - 25th September 2025

Approval *Frances Martin*

1.2 - Minutes - AGM 25th September 2025 ~v1.pdf (5 pages)

13:05 - 13:15
10 min

2. Presentation of Annual Report 2025/26

Information *Glen Burley*

2 - Annual Report Slides - Glen Burley - Final.pdf (7 pages)

13:15 - 13:25
10 min

3. Presentation of Annual Accounts 2025/26

Information *Katie Osmond*

3 - AGM 2526_finance extract final.pdf (4 pages)

13:25 - 13:27
2 min

4. Questions from Members of the Public

Information *Frances Martin*

Wye Valley NHS Trust Formal Board Business

13:27 - 13:34
7 min

5. Going the Extra Mile Quarterly Awards

Information *Frances Martin*

Employee of the Quarter Beverley Devey / Team of the Quarter - Delivery Suite

13:34 - 13:39
5 min

6. Apologies for Absence / Quorum / Declarations of Interest

Information *Frances Martin*

6.1. Minutes of the Meeting held on the 2nd July 2026

Approval *Frances Martin*

6.1 - Public Board Minutes 2nd July 2026~v1 LF FM.pdf (7 pages)

6.1.1. Foundation Group Board Workshop Meeting held on 5th August 2026

Information *Frances Martin*

6.1.1 - Foundation Group Board Workshop Report from the Meeting held on 5th August 2026.pdf (2 pages)

6.2. Matters Arising & Action Log

Discussion *Frances Martin*

6.2 - Public Board Action Log - Sept 2026.pdf (1 pages)

13:39 - 13:45
6 min

7. Managing Director's Report

Information *Sarah Shingler*

7 - MD Update Report Coversheet - September 2026 - SS.pdf (1 pages)
7a - MD Board Report - September 2026 - SS - Final.pdf (5 pages)

13:45 - 14:05
20 min

8. Integrated Performance Report

8 - WVT - IPR Board August 2026 - collated.pdf (21 pages)
8a - Board KPI Dashboard - July 2026.pdf (4 pages)

8.1. Quality

Lucy Flanagan / Chizo Agwu

8.2. Operational

Andrew Parker

8.3. Workforce

Geoffrey Etule

8.4. Finance

Katie Osmond

For Approval

14:05 - 14:10
5 min

9. Premises Assurance Model

Approval *Christian Homersley*

9 - Premises Assurance Model Board report on 2026- FINAL.pdf (6 pages)

14:10 - 14:15
5 min

10. Experts at Hand Business Case

Approval *Lucy Flanagan*

10 - Experts at hand frontsheet.pdf (1 pages)
10a - WVTBC0205-Experts at hand August 2026 v4.pdf (12 pages)
10b - EIA - impact-assessments-Experts at hand BC Aug 2026 - Final.pdf (4 pages)

14:15 - 14:20
5 min

11. Green Plan

Information *Alan Dawson*

- 11 - 2026_08_21 Green Plan Update & Metrics - Board - Coversheet.pdf (1 pages)
- 11a - 2026_08_21 Green Plan Update & Metrics - Board.pdf (29 pages)

Quality

14:20 - 14:20
0 min

12. Ockenden and Amos Board Briefing

Assurance *Lucy Flanagan*

- 12 - Ockenden- Amos- Board- Briefing Paper August 2026.pdf (3 pages)
- 12a - Ockenden-Amos - Appendix one- NHSE letter 12.08.26.pdf (6 pages)

14:20 - 14:25
5 min

13. Quality Committee Escalation & Assurance Reports - July / August

Assurance *Ian James*

- 13a - Quality Committee Escalation & Assurance Report 30 July 2026.pdf (4 pages)
- 13b - Quality Committee Escalation & Assurance Report August 2026.pdf (4 pages)

14:25 - 14:28
3 min

14. Perinatal Staffing Report

Assurance *Justine Jeffery*

- 14 - Midwifery and Neonatal Nurse Safe Staffing Report Q1.pdf (10 pages)

14:28 - 14:31
3 min

15. Perinatal Safety Report

Assurance *Justine Jeffery*

- 15 - Perinatal Safety Report Q for Board.pdf (12 pages)

14:31 - 14:34
3 min

16. Safeguarding Annual Report

Assurance *Lucy Flanagan*

- 16 - Safeguarding Annual reports Jan - Dec 2025 - full version.pdf (48 pages)

14:34 - 14:37
3 min

17. Patient Experience Quarterly Report

Assurance *Lucy Flanagan*

- 17 - Patient Experience Report Q1 data JUly 2026.pdf (13 pages)
- 17a - Appendix 1- PEF Annual Review.pdf (2 pages)

14:37 - 14:37
0 min

18. Infection Prevention and Control Annual Report 2025/26

Assurance *Lucy Flanagan*

- 18 - Front Sheet IPC annual report.pdf (1 pages)
- 18a - IPC Annual Report 2025.26 FINAL v1.pdf (48 pages)

Governance & Risk

14:37 - 14:40
3 min

19. Annual Review of Audit Committee Effectiveness

Approval *Nicola Twigg*

- 19 - Annual Review of Audit Committee Effectiveness 2025-26 coversheet TB.pdf (1 pages)
- 19a - Annual Audit Committee Report 2025-26.pdf (11 pages)
- 19b - WVT Audit Committee Terms of Reference_draft revisions June 26.pdf (7 pages)

14:40 - 14:43
3 min

20. Integrated Care Oversight and Assurance Committee Reports - June / August

Assurance *Ian James*

- 20a - ICOAC Escalation & Assurance Report June 2026.pdf (2 pages)
- 20b - ICOAC Escalation & Assurance Report August 2026.pdf (2 pages)

14:43 - 14:46
3 min

21. Executive Risk and Compliance Committee Escalation and Assurance Report

Assurance *Lucy Flanagan*

- 21 - ERCC Escalation & Assurance Report Aug 26.pdf (2 pages)

14:46 - 14:49
3 min

22. Charity Trustee Escalation and Assurance Reports - June 2026

Assurance *Grace Quantock*

To Follow

- 22 - Charity Trustee report to Trust Board June 2026.pdf (1 pages)

14:49 - 14:52
3 min

23. Children and Young People Committee Escalation and Assurance Report

Assurance *Joanne Rouse*

- 23 - CYP E&AR Aug 26.pdf (2 pages)

14:52 - 14:53
1 min

24. Any Other Business

Information *Frances Martin*

14:53 - 14:55
2 min

25. Questions from Members of the Public

Information *Frances Martin*

14:55 - 14:55
0 min

26. Acronyms

Information

- Acronyms - 2026.pdf (3 pages)

14:55 - 14:55
0 min

27. Date and Time of the Next Meeting - 1st October 2026 at 1.00 p.m.

WYE VALLEY NHS TRUST
Minutes of the Annual General Meeting
Held on 25th September 2025 at 6.00 p.m. – 7.30 p.m.
MS TEAMS

Present: Voting Board Members		
Russell Hardy MBE	RH	Chairman and Meeting Chair
Chizo Agwu	CA	Chief Medical Officer
Stephen Collman	SC	Acting Chief Executive
Jane Ives	JI	Managing Director
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Ian James	IJ	Non-Executive Director
Frances Martin	FM	Non-Executive Director and Deputy Chairman
Katie Osmond	KO	Chief Finance Officer / Deputy Managing Director
Grace Quantock	GQ	Non-Executive Director
Present: Non-Voting Board Members		
Eleanor Bulmer	EB	Associate Non-Executive Director
Glen Burley	GB	Foundation Group Chief Executive Officer
Alan Dawson	AD	Chief Strategy and Planning Officer
Geoffrey Etule	GE	Chief People Officer
Kieran Lappin	KL	Associate Non-Executive Director
Andy Parker	AP	Chief Operating Officer
In Attendance		
Jenny Connaughton	JC	General Manager, Theatre and Anaesthetics (For Improving Theatre Productivity presentation)
Fiona Gurney	FG	Communication Officer
Lydia Phillips	LP	Capital Projects Manager (For Chairman's Award)
Lou Robinson	LR	Deputy Company Secretary (for the minutes)
Gwenny Scott	GS	Associate Director of Corporate Governance / Company Secretary
Kim Smith	KS	Capital Projects Manager (For Chairman's Award)
Erin Tew	ET	Lead Rheumatology Pharmacist (Poster Winner)
Apologies		
Nicola Twigg	NT	Non-Executive Director (Voting)
Jo Rouse	JR	Associate Non-Executive Director (Non-Voting)

Ref	Item	Lead	Purpose	Format
1.	**Apologies for Absence**	**RH**	**Information**	**Verbal**
Noted as above				
1.1	**Minutes of the AGM – 26th September 2024**	**RH**	**Approval**	**Enclosure 1**
The Board approved the minutes from the 26th September 2024.				
FORMAL BUSINESS				
2.	**INTRODUCTION AND HIGHLIGHTS OF THE ANNUAL REPORT 2024/25**	**SC**	**Information**	**Enclosure 2**
The introduction and highlights of the Annual Report 2024/25 was presented for information. SC focused on reflecting the Trust's performance over the past year and setting the tone for future priorities emphasising that behind every statistic and technical term in the report are real people, our patients and staff whose experiences and wellbeing are central to the Trust's mission.				

SC noted that Wye Valley NHS Trust consistently delivered high-quality services despite its relatively small size. The summary highlighted areas of growth and concern, pointing out that while some metric, such as elective and cancer care, showed strong improvement, others like emergency admissions and A&E attendances had increased significantly, placing pressure on services. The Trust's response to these challenges included expanding elective care capacity and making strides in reducing waiting lists, particularly those exacerbated by the pandemic.

SC also discussed the Trust's strategic objectives, which revolve around sustainability and innovation. Sustainability was addressed not only in environmental terms but also in workforce development and service resilience. Innovation was evident in the adoption of AI to reduce administrative burdens and improve patient/clinician interactions, as well as in research and education initiatives.

SC praised the infrastructure developments, including the new Elective Surgical Hub and the Community Diagnostic Centre, which are expected to enhance service delivery and patient outcomes and also acknowledged the importance of addressing fragile services, those with limited staff or high demand, and the Trust's efforts to stabilise and retain these locally.

Staff engagement was another key theme and celebrating the Trust's role in providing meaningful employment in Herefordshire.

Finally, SC looked ahead to the Trust's involvement in the National Neighbourhood Implementation Programme, which positions Wye Valley as a leader in developing integrated community care models for older adults. SC expressing pride in the Trust's achievements and confidence in its direction for the coming year.

The Board accepted the Annual Report review.

3.	**PRESENTATION: IMPROVING THEATRE PRODUCTIVITY**	**JC**	**Information**	**Enclosure 2**

A review of improvements around Theatre Productivity was presented for information.

JC focused on the significant improvements in theatre productivity and the development of the Elective Surgical Hub over the past year. It was reported that theatre utilisation had increased from 77% in April 2024 to nearly 84% by August 2025, approaching the national target of 85%. This improvement has enabled the Trust to treat more patients more efficiently, reducing waiting times and improving patient experiences. Start-of-day delays were reduced from over 30 minutes to just 12 minutes, placing the Trust among the top performers nationally for theatre efficiency.

JC also highlighted the success of the Elective Surgical Hub, which opened in July 2024 and has seen an 80% increase in planned operations. The hub has enabled more patients to return home on the same day of their procedures. The average hospital stay for joint surgeries has been reduced by over a day, contributing to better patient outcomes and more efficient use of resources.

Looking ahead, JC outlined plans to further improve theatre scheduling, implement the federated data platform for better decision-making, pursue formal accreditation for the surgical hub, and introduce a digital pre-operative assessment system called MyPre-Op Plus. The presentation concluded by recognising the dedication of the surgical division's staff, whose efforts have been central to these achievements and will continue to drive future improvements.

The Board accepted the Theatre Productivity review.

4.	**PRESENTATION: DELIVERING MORE CARE IN THE COMMUNITY**	**SA**	**Information**	**Enclosure 2**

A review of delivering more care in the community was presented for information.

SA focused on the expansion and success of community-based healthcare services. It was highlighted that the Trust's commitment to delivering care in patients' homes, which aligns with the NHS's long term strategy, to move more services out of hospitals and into the community. Over the past year, the Trust introduced a dedicated GP working 12 hours a day, seven days a week within the community referral hub, supporting nurses and therapists to prevent unnecessary hospital admissions. Collaboration with West Midlands Ambulance Service has also strengthened, with paramedics now referring more patients directly to community services, aided by a simple pocket card outlining available support.

SA reported significant growth in referrals and impressive response times, with urgent cases consistently being seen within two hours. The Trust's virtual ward programme has expanded, allowing patients to receive hospital-level care at home, supported by a multidisciplinary team. Data showed a steady increase in avoided hospital admissions, demonstrating the effectiveness of these initiatives.

Looking ahead, the Trust plans to integrate its services more closely with the 111 pathway, enabling patients to be directed to community care rather than emergency departments when appropriate. They also aim to streamline access to the new Community Diagnostic Centre and Same-Day Emergency Care units, ensuring patients receive timely assessments and can return home quickly.

SA concluded by emphasising the importance of ongoing communication and engagement to raise awareness of these services and encourage further growth in demand.

The Board accepted the delivering more care in the community review.

5.	**EXTRACTS FROM THE ANNUAL ACCOUNTS 2024/25**	**KO**	**Information**	**Enclosure 2**

The Annual Accounts were presented to the Board for information.

KO reported that Wye Valley NHS Trust ended the 2024/25 financial year with a £5.6 million deficit, slightly worse than planned but in line with forecasts. The Trust faced operational and workforce pressures, which were partially mitigated through monitoring via a Financial Recovery Board and a £14m efficiency programme. Agency staff costs were reduced, and capital investment totalled £26m, supporting key projects like the Community Diagnostic Centre and Elective Surgical Hub.

The annual accounts were signed off with a clean audit, though concerns remain around the Trust's underlying deficit and cost improvement targets. A break-even plan is in place for 2025/26, with early signs of a stronger financial performance.

The Board accepted the Annual Accounts 2024/25.

6.	**INTRODUCTION TO THE QUALITY ACCOUNT 2024/25** **WE SHARE, WE LEARN POSTER COMPETITION WINNER 2024**	**LF** **CA / ET**	**Information**	**Enclosure 2**

The Quality Account was presented to the Board for approval.

LF provided a detailed overview of the Trust's efforts to ensure safe, effective, and patient-centred care throughout 2024 and into 2025. LF affirmed the role of the Quality Committee in overseeing safety and standards, noting that the Trust reported over 11,000 patient safety incidents, the vast majority of which were low or no harm. This high level of reporting reflects a strong safety culture, with staff confident in raising concerns.

LF outlined several priorities for 2025, including improving the timeliness of blood clot risk assessments, enhancing food quality through collaboration with Sodexo, and focusing on diabetes safety, particularly around insulin management and foot assessments. LF highlighted the success of last year's Parkinson's medication campaign, which has now been expanded to include epilepsy and insulin medications. Another key initiative was improving the transition of care for young people moving from paediatric to adult services.

LF showcased a range of new and improved services introduced in 2024, such as the Orthopaedic Enhanced Recovery Programme, which reduced hospital stays for joint surgery patients, and the expansion of the critical care outreach service to 24 hours. The Trust also implemented a revised pathway for femoral fracture patients, significantly reducing time spent in A&E, and launched a local PICC line service for cancer patients, saving time, travel, and reducing complications.

The quality account demonstrated the Trust's commitment to continuous improvement, innovation, and valuing patients' time, with a clear focus on safety, experience, and outcomes.

We share, We Learn Poster Competition – Erin Tew, Lead Pharmacist for Rheumatology

CA celebrated the success and growth of the "We Learn, We Share" poster competition, which showcases innovation, quality improvement, and learning across the Trust. The initiative began in 2024 with 26 entries and grew significantly in 2025 to 76 high-quality submissions, reflecting the enthusiasm and creativity of staff across departments. The competition highlights projects that improve patient care and staff experience, and it has become a platform for recognising and sharing best practices. CA introduced ET, whose team won the 2024 competition for their work on streamlining home care prescriptions, demonstrating the tangible impact of innovation on patient outcomes and service efficiency.

ET presented the project that transformed the Rheumatology home care prescription service at Wye Valley NHS Trust. Faced with rising patient numbers, staff turnover, and administrative overload, the team implemented a series of changes including longer prescription durations, streamlined processes, and improved clinical oversight. These efforts halved the number of prescriptions

processed annually and drastically reduced overdue renewals, all while maintaining patient safety and service quality. The project showcased the critical role of skilled administrative teams and has since gained regional and national recognition.

The Board congratulated ET and her team for their outstanding work in transforming the Rheumatology home care prescription service. Their project was praised for its innovative, solutions-focused approach, which significantly improved patient safety, reduced administrative burden, and enhanced service efficiency. The Board commended ET's leadership and the team's collaborative spirit, recognising their contribution as a model of improvement and excellence across the Trust.

The Board accepted the 2024 Poster winner and the Quality Account 2024/25

7.	QUESTIONS SUBMITTED FROM THE PUBLIC	RH	Information	Verbal

The following questions were submitted to the Board for discussion.

1) Following the Inpatient Survey results last year which said the Trust's inpatient food was worse than expected could the Trust answer the following questions
    a. Provide an update on what we have done since the survey to improve inpatient food.
    b. How is joint working with Sodexo, our catering company, enabling the Trust to hold them to account?
    c. What recent actions have been taken by the Nutrition Steering Group and Trust Lead for Nutrition?
    d. What impact has this had and how has it been measured?

LF provided a detailed response to the public question regarding the quality of inpatient food. Following the publication of the survey results, which highlighted concerns about food quality, the Trust established a joint working group involving frontline staff and Sodexo, the catering provider. This group has been active throughout 2024 and into 2025, implementing several improvements including enhanced menu choices, better nutritional value, increased snack availability outside of meal times, and the introduction of new crockery and cutlery, which has been positively received by patients.

It was acknowledged that food service needs to be tailored to different patient groups and ward types, such as paediatrics, maternity, surgery, and frailty, and that further work is needed in this area. LF also noted that Sodexo also provide meals in the Community Hospital sites, where patient satisfaction with food is higher, suggesting that the issue may lie in the final stage of food delivery, referred to as "the last 10 yards."

To address this, the Nutrition Steering Group has developed new routine audits focused on meal service and snack provision. These audits are now conducted jointly with Sodexo, clinical, and dietetic colleagues. Additionally, the group has created a new food and drink strategy centred on the concept of "food as medicine," led by an apprentice dietitian.

LF emphasised that the Trust uses multiple sources of feedback including family and friends' surveys, complaints, national surveys, and patient-led inspections to measure progress and inform performance monitoring. It was concluded that while the 2024 national patient survey has been published, many of the improvements were made after the survey was conducted, so their impact may not yet be reflected in the results.

8.	THANK YOU TO STAFF AND PARTNER ORGANISATIONS	JI	Information	Verbal

JI delivered a heartfelt thank you to all staff, partners, and volunteers, marking her final formal duty as Managing Director after nine years in the role and a 45-year NHS career. JI expressed deep gratitude for the dedication and hard work of everyone involved in patient care, both frontline and behind the scenes, highlighting the 350 different NHS careers that contribute to the Trust's success.

JI emphasised the importance of valuing patients' time, a principle embedded throughout the organisation, and praised the Foundation Group for its collaborative support in driving improvement. Special thanks was given to Glen Burley, Foundation Group CEO and Russell Hardy, Chairman for their leadership and mentorship, and to her Executive Team for their exceptional values, skills, and work ethic.

JI concluded by reflecting on the progress made during her tenure and the pride felt having worked with such a dedicated team to make a meaningful difference in the lives of patients and the community. Those staff who had been presented with Going the Extra Mile Awards in 2024/25 were celebrated.

9.	CHAIRMAN'S AWARD	RH	Information	Verbal

Lynne Kedward (Associate Chief Operating Officer Performance Improvement), Kim Smith and Lydia Phillips (Capital Projects Managers) were nominated for the Trust Chairman's Award for 2024/25 for the work on the opening of our Elective Surgical Hub on time, under budget and operating as planned on patients from day one.

This was a hugely successful scheme for the Trust, and LK, LP and KS formed a very effective core team that oversaw the building, fitting out and operational opening of the building. This was an extraordinary achievement given the complexity of capital projects. Their professionalism, energy, and humour were highlighted as key to the project's success, along with their ability to engage stakeholders and collaborate effectively across departments. RH noted the Elective Surgical Hub's immediate impact, including an 18% increase in elective activity, and commended the team as a model of excellence in project delivery. The Chairman and the Board congratulated the team for their exceptional work and were presented with the Chairman's Award for 2024/25.	
10.	**THANK YOU TO JANE IVES & MEETING CLOSE**
The Board paid tribute to JI as she stepped down from her role as Managing Director of Wye Valley NHS Trust. The Board praised her 45-year NHS career, highlighting her unwavering patient focus, energy, and innovation, and described her as a role model and inspirational leader. They commended her professionalism, determination, and the transformative impact she had on the Trust, including major infrastructure improvements and performance turnaround. The Board expressed deep gratitude and admiration, noting she will be greatly missed and leaves behind a legacy of excellence. RH thanked everyone for attending the Wye Valley NHS Trust Annual General Meeting. There was no further business.	

WVT Annual Report Highlights 2025/26

Sir Glen Burley
Chief Executive Officer

Performance highlights 2025/26

Delivering for patients and communities

- **Elective Care**

67.8% of patients treated within 18 weeks (target 65%)
52-week waits reduced to 0.7% (target <1%)

- **Cancer Care**

81.6% diagnosed or ruled out within 28 days (target 80%)
77.3% treated within 62 days (target 75%)

- **Diagnostics**

Patients waiting over six weeks fell from **21.4% to 11.8%**

- **Finance**

Delivered an adjusted surplus of **£2.7m**

Despite a challenging operating environment, we made significant progress reducing waits and improving access to care

Capital and service developments 2025/26

Investing in better care

Major developments

- **Community Diagnostic Centre**

Opened in January 2026. Means faster diagnostics and earlier diagnosis closer to home

- **Elective Surgical Hub**

This unit continues to improve productivity and reduce waiting times
Achieved national GIRFT accreditation

- **Urgent & Emergency Care Expansion**

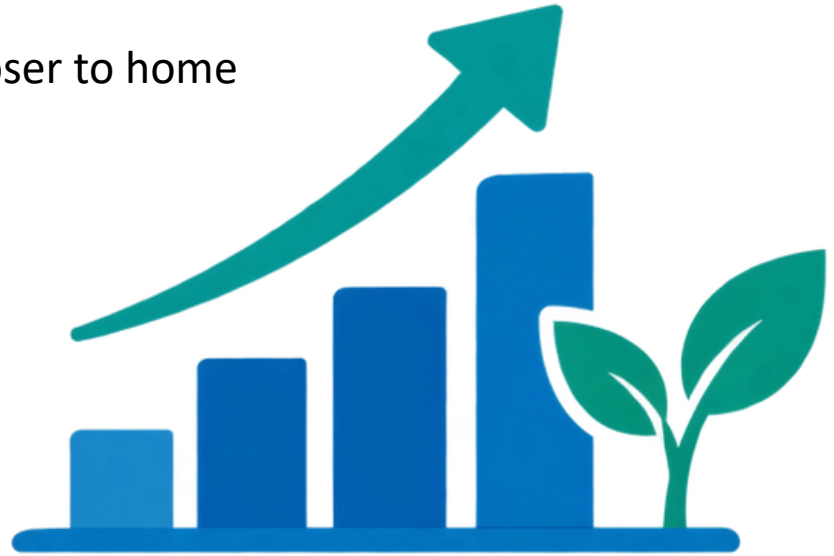
£4.3m investment in capacity improvements

- **Digital Transformation**

Continued expansion of electronic patient records.
Improved data sharing and virtual consultations

- **Sustainability**

Progress on Integrated Energy Scheme - moving towards a near fossil-fuel-free County Hospital site



Our people

A high-performing workforce

- **NHS staff survey**

Above average scores across all NHS Staff Survey themes

Staff engagement

Engagement score: 7.07/10. Above national average and represents continued year-on-year improvement

- **Speaking up**

Raising Concerns score improved to 6.57/10

- **Workforce improvements**

Sickness absence reduced to 4.3% from 5.0%

Staff turnover improved to 7.9% from 8.9%

Temporary staffing costs reduced significantly

- **Workforce diversity**

29% of staff from non-white British backgrounds

Quality headlines

Improving Quality and Patient Experience

- **Safety**

National VTE assessment target achieved
Sustained reduction in hospital-acquired VTEs
Improvements in diabetes safety pathways and self-management support

- **Effectiveness**

Improved administration of high-risk medicines including Parkinson's medication
New transition pathways from paediatric to adult services

- **Patient Experience**

Improved inpatient and maternity survey scores
Faster complaint responses
New Patient Engagement Forum established

- **National Oversight Framework**

People & Workforce: High Performing
Access, Safety, Experience and Finance: Above Average

But it’s not all been plain sailing…

We’ve faced significant system pressures during 25/26

Urgent and emergency care remained our greatest operational challenge during 2025/26, driven by rising demand, discharge delays and capacity constraints across the health and care system.

The key challenges

Emergency Department performance remained below the national standard

- **63.7%** of patients admitted, transferred or discharged within four hours (national standard 78%)

High bed occupancy and delayed discharges

- Patient flow was affected by discharge delays, infection pressures and ongoing capacity constraints.

Continued use of temporary escalation spaces

- Reflecting sustained pressure on urgent care pathways and inpatient capacity

Additional pressures

- Industrial action
- Severe weather
- Workforce challenges
- Building works
- Increasing complexity of patient needs

Thank you!

Together we make a difference

- **Thank you to:**

Our 4,500+ staff members
Our more than 70 volunteers (more than 1,000 volunteer hours every month!)
One Herefordshire partners:

- Herefordshire and Worcestershire Integrated Care Board
- Herefordshire Council
- Taurus Healthcare – Herefordshire General Practice
- Herefordshire & Worcestershire Health and Care NHS Trust
- Primary, community and social care colleagues

Wye Valley NHS Charity supporters and fundraisers
Businesses, community groups and voluntary organisations
Patients, carers and local communities

The progress we've made this year has only been possible because of the dedication of our staff, the support of our partners and volunteers, and the generosity of our communities. Thank you.

Overview

The Trust's financial performance against key metrics in 2025/26 was:

- Adjusted Financial Performance: £2,662k surplus (*better than plan*)
- Efficiencies delivered: £21.9m (5.4% of operating expenditure)
- Agency spend: 2.9% of total pay costs
- Better Payment Practice Code: >95% standard met
- Capital spend: £18.4m

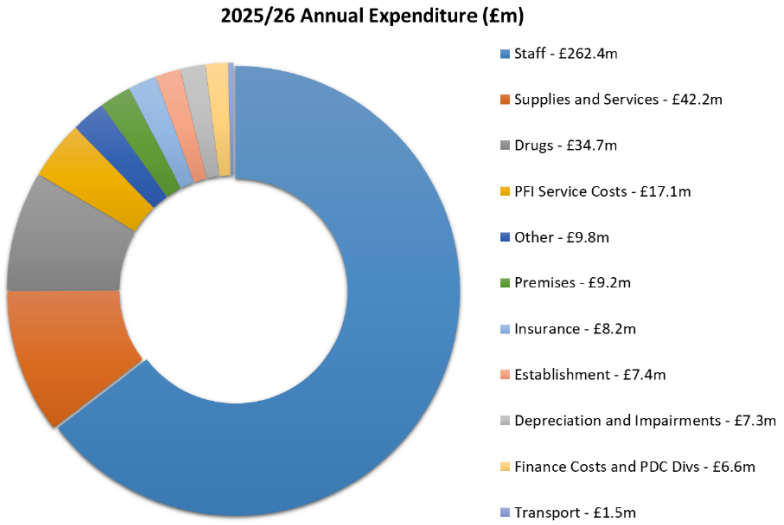
The financial landscape remains challenging moving into 2026/27.

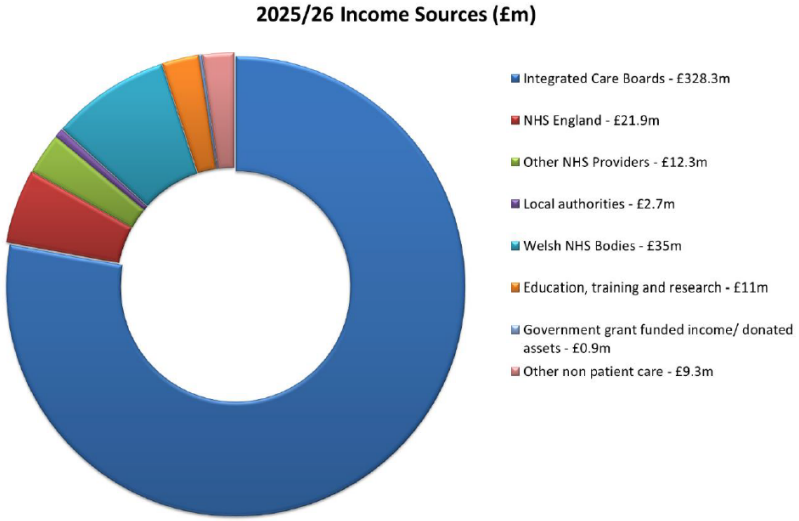
The Trust has set a break-even financial plan for 2026/27, including receipt of Deficit Support Funding.

Our 3-year medium term financial plan seeks to tackle the historic underlying deficit through a range of transformative schemes including Neighbourhood Health as a wave 1 pilot site, aligned to the 10-year Health plan ambitions.

Income & Expenditure 2025/26

The Trust receives most of its income from the Herefordshire and Worcestershire Integrated Care Board (ICB), neighbouring ICBs, NHS England and Welsh commissioners.





Most of the Trust's expenditure is on substantive and temporary staff costs, drugs and supplies and services for the delivery of healthcare.

Capital and Cash 2025/26

The Trust spent £18.4m on capital investments during 2025/26. The most significant elements within the capital programme were:

2025/26 Capital Expenditure	2025/26
	£k
Clinical Equipment	2,408
Estates Schemes	1,808
Community Diagnostic Centre	2,562
Decarbonisation funding -Solar	479
Digital (Systems and ICT)	1,594
Integrated Energy Scheme Phase 2	3,050
Modular Theatre	1,678
UEC Expansion	4,306
IFRS 16 Building Leases remeasurement	550
Total Capital Expenditure	**18,435**

The year end cash balance was £49m.

Despite a challenging financial position our cash balances remained well managed, and our percentage of invoices paid within target remained strong.

Annual Audit of Accounts 2025/26

Financial Statement Audit

- **Accounts**: give a true and fair view of the financial position and have been properly prepared.
- **Annual report** (including Annual Governance Statement and Remuneration and Staff report): meets reporting requirements and are consistent with accounts.
- **Audit Process:** Significant quality improvements sustained. No delays encountered and draft financial statements were of a good standard.

Quality Account:

- Not required to be audited in 2025/26. Approved by Trust Board June 2026.

Future considerations:

- Continuous Improvement Plan to deliver increasingly demanding and complex process.

Value for Money

- **Financial Sustainability**:
  - The existing significant weakness in relation to the breach of the break-even duty remained. No new recommendations made, existing recommendation to work with ICS to resolve historic underlying funding issues.
  - The existing significant weakness relating to the under-achievement of the CPIP target remained, as the full target was not achieved. No new recommendations made, existing recommendation that the Trust focuses on CPIP delivery, holding divisions to account and ensuring clear targets and plans are documented and regularly reviewed.
- **Governance**:
  - The previous significant weakness in the Trust's arrangements relating to the NHS Oversight Framework (NOF) has been removed.

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

Present (Voting):		
Frances Martin	FM	Chair
Chizo Agwu	CA	Chief Medical Officer
Sir Glen Burley	GB	Chief Executive Officer
Lucy Flanagan	LF	Chief Nursing Officer
Sharon Hill	SH	Non-Executive Director
Ian James	IJ	Non-Executive Director
Katie Osmond	KO	Chief Finance Officer
Grace Quantock	GQ	Non-Executive Director
Sarah Shingler	SS	Managing Director
Nicola Twigg	NT	Non-Executive Director / Deputy Chair
Present (Non-Voting):		
Ellie Bulmer	EB	Associate Non-Executive Director
Alan Dawson	AD	Chief Strategy and Planning Officer /Deputy Managing Director
Geoffrey Etule	GE	Chief People Officer
Kieran Lappin	KL	Associate Non-Executive Director
Andy Parker	AP	Chief Operating Officer
Jo Rouse	JR	Associate Non-Executive Director
In Attendance		
Lou Robinson	LR	Deputy Company Secretary for the minutes
Gwenny Scott	GS	Associate Director of Corporate Governance
Apologies:		
There were no apologies for absence.		

Ref	Item	Lead	Purpose	Format
1	**Apologies for Absence**	**FM**	**Information**	**Verbal**
Noted as above.				
2	**Quorum and Declarations of interest**	**FM**	**Information**	**Verbal**
The Board was quorate and there were no declarations of interest.				

Chair's Congratulations

FM opened the public board meeting by offering warm congratulations to Professor Sir Glen Burley, Chief Executive Officer, on his knighthood, which had been announced in the King's Birthday Honours. The Trust was immensely proud of his leadership of both Wye Valley NHS Trust and the wider Foundation Group. The Board wished to express its gratitude for his very significant and ongoing service to the NHS and the public sector in general.

3	**Minutes of meeting on 4th June 2026 / Foundation Group Strategy Committee Reports**	**FM**	**Approval**	**Enclosure 01 - 03**
Approved.				

3.1 – Foundation Group Strategy Committee (FGSC) Report – 18th June 2026
The paper was received and taken as read.

3.2 – Foundation Group Strategy Committee Annual Report
The paper was received and taken as read.

GB explained that the Foundation Group Strategy Committee demonstrated how Wye Valley NHS Trust, South Warwickshire University NHS Foundation Trust, Worcestershire Acute Hospitals NHS Trust and George Eliot Hospital NHS Trust collaborated across the Foundation Group. It was highlighted that, following the introduction of two Chairs within the group structure, there has been significant joint working and activity between the organisations.

The Strategy Committee and related subcommittees do not have delegated decision-making authority from the individual Trust Boards but instead, they provide a forum for collaboration, shared planning and developing recommendations.

GB noted that the reports reflected a substantial amount of collaborative work undertaken over the past year and indicated that there was much more joint work planned in the future. The annual report showed strong and increasing collaboration across the Foundation Group, with the Strategy Committee helping the Trusts work together on shared priorities while leaving formal decision-making with each Trust Board.

The Board accepted the FGSC Report for June and Annual Report.

4	**Matters Arising and Action Log**	**FM**	**Information**	

There were no matters arising for discussion.

5	**Chief Executive Officer's Report**	**SS**	**Assurance**	**Enclosures 04**

The paper was taken as read.

GB highlighted several significant national and local developments affecting the Trust and NHS including the recent publication of major maternity reviews and advised that the NHS had issued a 10-point action plan, with further discussion and implementation plans to follow.

GB welcomed the agreement reached with resident doctors, expressing hope that three years of industrial action had come to an end and noting that the deal included productivity measures, additional training posts and improved arrangements for locally employed doctors.

With regards to the NHS Oversight Framework, it was explained that while Wye Valley NHS Trust's overall rating remains constrained by its receipt of deficit support funding, performance across most operational measures was strong. The importance of delivering a long-term financial recovery plan was stressed, including progress on the Trust's PFI arrangements.

The Lord Mann review into antisemitism and racism in the NHS was referenced, confirming that the Trust would respond to the recommended actions.

There was positive progress in developing neighbourhood healthcare models and integrated care in Herefordshire, describing the county as well placed to lead improvements in care delivered closer to home through strong partnerships with primary care. NHS Online was an emerging model of care, creating opportunities for greater use of virtual clinics, digital pathways and community diagnostics. The strong performance of the Integrated Care Division was noted as integrated services would be a key area for future investment and development across the Trust and Foundation Group.

FM praised GB's leadership specifically thanking him for his proactive and effective work as NHSE Deputy Chief Executive in negotiations with the BMA resident doctors' committee. His contribution to securing an agreement that helped bring a prolonged period of industrial action to an end and expressed the Board's gratitude for that achievement.

FM strongly reinforced the message arising from the Lord Mann review, stating that there is no place in the NHS for antisemitism or any other form of racism. Such behaviours would not be tolerated from either staff or patients and reaffirmed the Trust's commitment to creating a safe, inclusive and respectful environment.

The Board accepted the Chief Executive Officer's Update Report.

6	**Integrated Performance Report**	**SS**	**Information**	**Enclosures 05-06**

The paper was taken as read.

SS summarised that the Trust's most significant challenge remains urgent and emergency care performance, with exceptionally high emergency department attendances reaching their highest level in more than two years. Despite these pressures, improvement work

was beginning to show positive results, including reductions in corridor care and patients waiting more than 24 hours in the emergency department, although these improvements were not yet consistently sustained. [

It was emphasised that quality remained the Trust's highest priority and highlighted the completion of a comprehensive review of the home birth service. This has led to strengthened governance arrangements, enhanced workforce capability and the purchase of additional equipment for home birth midwives. Performance in cancer services remained strong, with the Trust achieving key diagnostic and treatment standards, while elective activity is broadly on plan.

A positive workforce position was also reported, with low staff turnover, strong engagement, successful recruitment and sickness absence levels that compare favourably nationally. Financial performance was broadly in line with plan, although continued focus was required on the Trust's cost improvement programme to support long-term financial sustainability.

Overall, it was noted that while there were encouraging signs of improvement the Trust remained focused on delivering further progress.

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

LF updated the Board on the temporary suspension of the home birth service, explaining that this had enabled a full review of the service in light of the national prevention of future deaths notices and updated neonatal resuscitation guidance. As a result, additional equipment had been purchased, midwives had received further training, and local operating procedures have been strengthened. National guidance was awaited. A decision would be made in the confidential Board session on when the service would resume.

Progress relating to the national Special Educational Needs and Disabilities (SEND) reforms were outlined, including plans to establish an “Experts at Hand” model in Herefordshire. This would bring together health, education and local authority professionals to provide support for children and young people with additional needs, supported by a workforce plan and future business case.

LF noted that following a recent Board workshop on antimicrobial stewardship and antimicrobial resistance, three priority areas had been identified and that quarterly updates would be provided to monitor progress.

The outcomes of the Trust’s three-year Patient Safety Response Plan outlined the new patient safety priorities and quality improvement objectives for the coming year. These priorities had been reviewed and approved by the Quality Committee and would guide the Trust’s quality improvement work going forward.

<u>Mortality</u>

CA reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) remained within the expected range at 113, although it was higher than the organisation would wish. The Trust's crude mortality rate continued to remain low at 1.4%, equating to around 66 deaths during the month. Known coding issues, particularly relating to same-day emergency care data, were affecting the mortality metrics and were expected to fall out of the dataset over time.

There was continued improvement in mortality associated with fractured neck of femur, with a 20-point reduction in SHMI and evidence from the national hip fracture database showing that the Trust was no longer an outlier in this area. Further improvements were anticipated

CA also reported positive performance in maternity outcomes, with the extended perinatal mortality rate lower than average at 3.23 and the stillbirth rate significantly below the national average at 1.29 deaths per 1,000 live births.

Feedback gathered by Medical Examiners from bereaved families continued to identify examples of excellent care, particularly within the Acute Medical Unit, Coronary Care Unit, Redbrook and Leominster wards, providing further assurance on the quality of care being delivered.

FM noted that some of the higher SHMI figures have been influenced by coding issues rather than necessarily reflecting poorer patient outcomes. It was acknowledged that both local coding challenges and national inconsistencies in how trusts have recorded same-day emergency care activity have affected mortality reporting and made comparisons between organisations difficult. FM welcomed the fact that there was now a clear national timeline for addressing these coding inconsistencies so that all trusts will be reporting on a level playing field. The Board took reassurance from the crude mortality rate, which was improving and showed a positive trajectory, indicating that actual patient outcomes were better than the SHMI figure alone might suggest. FM thanked colleagues for their work on improving data quality and for providing a clear explanation of the position.

6.2	Activity and Performance	AP

AP reported that urgent and emergency care remained one of the Trust's most significant operational challenges, with Type 1 emergency department attendances increasing by 4% in May and 6.5% in June, reaching the highest levels seen in recent years. While some of this increase was linked to recent heatwaves, further work was underway to understand the underlying causes.

Despite these pressures, encouraging progress was highlighted in improving patient flow. The Trust had seen reductions in corridor care and a 50% reduction in patients waiting more than 24 hours in the emergency department since introducing clear operational "red lines." Delays associated with discharge pathways had also reduced, contributing to improved bed availability and flow through the hospital.

A range of improvement initiatives were noted that aligned to the Trust's urgent and emergency care transformation programme, including greater ward ownership of patient flow, digital flow management tools, 24/7 single point of access, expanded assessment capacity, improved community bed utilisation and strengthened collaboration with Powys and community services. Delivering sustainable improvement would require continued pace, focus and operational grip over the coming months to improve both patient experience and staff working conditions.

FM acknowledged the significant work underway and reinforced the Trust's commitment to improving urgent and emergency care. It was emphasised to follow NHS guidance during periods of extreme heat and thanked staff for continuing to provide compassionate care under increasingly challenging conditions. FM welcomed focus on eliminating corridor care and improving patient flow, noting that some NHS organisations, including George Eliot Hospital within the Foundation Group, had achieved significant improvements in this area. She encouraged teams to continue learning from these examples to support similar progress at Wye Valley NHS Trust.

6.3	Workforce	GE

GE reported that the Trust continued to perform well against workforce measures within the NHS Oversight Framework and remained focused on supporting staff while taking action to reduce sickness absence. It was confirmed that resident doctors had voted to accept the national pay deal and confirmed that they were working closely with the Chief Medical Officer to ensure the required local actions were implemented. Work was underway across the Foundation Group to respond to the Lord Mann review on antisemitism, with equality, diversity and inclusion leads and Freedom to Speak Up Guardians involved in ensuring the necessary actions were put in place.

The Trust's role as one of the largest employers in Herefordshire was highlighted and it was confirmed that the Trust had been working with local education providers and employers to create more opportunities for young people, following the publication of a report on young people and work. The forthcoming Wye Valley Family Fun Day was promoted, which was due to take place on 25th July 2026.

FM welcomed the work being undertaken to increase employment opportunities for young people, describing it as an important societal issue and a valuable contribution to the future workforce pipeline in Herefordshire.

6.4	Finance Performance	KO

KO reported that the Trust's financial position for the first two months of the year was broadly in line with expectations, with a planned deficit of £1m against an actual reported deficit of £1.2m. This was considered to be a reasonable position at that stage of the financial year but emphasised the need to remain mindful of the risks and underlying cost pressures facing the organisation.

It was noted that agency spending continued to improve as a result of workforce reduction initiatives and national requirements to reduce reliance on temporary staffing. However, financial performance had been adversely affected by industrial action during the first month of the year, which had generated around £200k of unplanned pay costs.

The Trust was behind plan in delivering its efficiency programme, having underachieved against its savings target by approximately £900k year-to-date, largely because some of the more transformational schemes were taking longer than anticipated to develop and implement. Around half of the Trust's planned efficiency savings were either already implemented or fully developed with a third remaining in the highest risk category. The importance of maintaining strong financial control while converting identified opportunities into deliverable schemes was emphasised. KO linked this work closely to improvements in operational performance and productivity, noting that the Trust needed to deliver planned activity levels and reduce waiting times as efficiently as possible.

There was no material concern relating to cash flow or capital expenditure at this stage of the year, although careful monitoring would be required given the risks within the financial plan. In response to a question from KL about national allocations of capital funding, KO explained that national capital funding arrangements were clearer than in previous years, allowing the Trust to prepare

schemes and business cases earlier, but stressed that maintaining momentum was essential to ensure allocated funding could be utilised within the current financial year

The Board accepted the Integrated Performance Report.

7	**QUALITY**			
7.1	**Board Briefing: Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust – June 2026**	**LF**	**Information**	**Enclosure 07**

The paper was taken as read.

The Board accepted the Board Briefing: Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust Report.

7.2	**Board Briefing: Independent Investigation into Maternity and Neonatal Services in England – Final Report and Recommendations (Amos Review)**	**LF**	**Information**	**Enclosure 08**

The paper was taken as read.

The Board accepted the Board briefing: Independent Investigation into Maternity and Neonatal Services in England – Final Report and Recommendations (Amos Review) Report.

LF provided an overview of both briefings.

LF described both reports as significant, sobering and important publications for the NHS. On behalf of the Trust Board, LF commenced her update by expressing condolences to the families affected by failures in maternity services, both those directly involved in the reviews and others who had experienced poor care elsewhere. The impact that the continued scrutiny of maternity services had on staff working in those services was also acknowledged.

LF explained that although the two reports had different scopes, they contained many common themes and demonstrated that maternity services across England still needed substantial improvement. It was noted that many of the recommendations in the latest Ockenden Review mirrored those issues that had been identified previously in the original Ockenden report published in 2020, indicating that some longstanding challenges remained unresolved. It was clear that the NHS was not getting everything right and that there was a collective responsibility to improve services and rebuild public confidence in maternity care.

In discussing the Ockenden Review, LF highlighted a number of immediate actions that organisations were being required to address. Particular attention was being given to post-death care, compliance with Human Tissue Authority requirements and mortuary arrangements. The importance of listening to women and families throughout their maternity journey was emphasised, especially when concerns were raised about care. The review reinforced the need for services to respond promptly and effectively to those concerns and to ensure that women's voices were heard and acted upon.

The Board were advised that NHS organisations had already been instructed to undertake immediate work in response to some of these findings, including providing assurance and evidence regarding Human Tissue Authority and mortuary arrangements by the end of July, and work had already commenced to meet that deadline. It was also reported that maternity and neonatal services had been identified as a priority area for the implementation of Martha's Rule. Although national guidance was still awaited, the Trust had already begun reviewing its local arrangements and identifying actions that could be implemented immediately to strengthen escalation routes for women and families with concerns.

With regards to the Baroness Amos Review, LF explained that while many of its findings aligned with those of Ockenden, it looked more broadly at maternity services across England and contained recommendations not only for provider organisations but also for national bodies and wider system partners. It was noted that the review proposed the introduction of a statutory Maternity and Neonatal Commissioner role and the development of a modern services framework designed to support long-term transformation and improvement in maternity and neonatal care. The review also identified funding to support estates and digital improvements, with both short-term and longer-term investment planned nationally.

LF highlighted several key areas where local action was expected over the next nine to twelve months. These included strengthening safety culture, teamwork and multidisciplinary working, addressing inequalities in care, tackling racism within services, improving maternity triage processes, and focusing on the management of births that occurred outside clinical guidance. It was emphasised that these were not issues that could be deferred and that organisations would be expected to demonstrate progress against them.

In summary LF confirmed that the Board needed to assure itself that governance and oversight arrangements were sufficiently robust to support implementation of the recommendations emerging from both reviews. Given the scale of the reports, the publication of a national 10-point plan was welcomed to aid organisations focus on the most immediate priorities. To coordinate the considerable volume of work required, a dedicated working group led by the Associate Director of Quality Governance had been established. The group would oversee all strands of work arising from the reviews and monitor delivery of the required actions.

LF explained that the Trust's first deadline was 31st July 2026, when assurances relating to Human Tissue Authority and mortuary requirements had to be submitted nationally. It was proposed that progress and compliance against these requirements be reviewed through the Quality Committee before submission and confirmed that further assurance reports would be brought back to the Board as implementation progressed. The Board stressed that they welcomed the reviews, recognised the need for change, and remained committed to learning from the findings in order to improve maternity services and restore public confidence.

GB welcomed the summary of the reports and was pleased that the Trust had moved quickly from reviewing the findings to implementing actions. Concern that maternity services had become subject to numerous reports and action plans over many years led to caution expressed to ensure focus not only on governance processes and action plans but also on improving culture. Cultural change was essential if meaningful improvements in maternity care were to be achieved. GB acknowledged that maternity services could never be entirely risk free and highlighted the Trust's discussions about the future of its homebirth service as an example of the difficult balance between managing clinical risk and preserving patient choice. The importance of ensuring women continued to have access to choice in how they give birth, while at the same time maintaining safe services was imperative and a decision would be made shortly on reopening the homebirth service.

The Board approved oversight of the national submissions to be undertaken through Quality Committee with updates being reported to Trust Board periodically.

7.3	**Quality Committee Escalation and Assurance Report**	**IJ**	**Assurance**	**Enclosure 09**

The paper was taken as read.

IJ provided assurance that the Quality Committee continued to maintain detailed and rigorous oversight across a broad quality and safety agenda, with improved reporting arrangements strengthening the Board's view going forward.

IJ drew particular attention to the Trust's priority of eliminating corridor care. It was noted that corridor care was not an issue in isolation but rather a symptom of wider challenges affecting both the Trust and the broader Herefordshire health and care system. These underlying issues had been referenced throughout the performance discussions and required action across multiple parts of the organisation and system.

While the Quality Committee could not directly oversee every contributing factor, it would continue to concentrate on the aspects within its remit, particularly patient safety and patient experience. IJ stressed that no one would consider corridor care acceptable for themselves, their families or their friends, and therefore the Committee's ongoing focus would be ensuring that patients received safe, dignified care despite operational pressures.

The Board accepted the Quality Committee Escalation and Assurance Report.

8	**Governance and Risk**			
8.1	**Board Assurance Framework (BAF) Report**	**NT**	**Assurance**	**Enclosure 10-12**

The paper was taken as read.

GS reported that the BAF had been updated to align with the Trust's new strategy and strategic objectives for the year. The revisions reflected matters discussed at the current Board meeting as well as issues scrutinised through supporting committees, with changes highlighted in the report for transparency.

Three key changes for approval.

1) It was proposed that the standalone patient experience risk should be absorbed into a broader quality risk because patient experience was no longer a separate strategic objective and the risk level had reduced.
2) The financial risk had been updated to reflect the current year's financial challenges. Although the risk rating had reduced at the end of the previous financial year due to improved performance, it had been increased again to acknowledge the financial pressures and risks facing the Trust during 2026/27.

3) The addition of a new strategic risk relating to partnerships, designated as BAF 8, which would be overseen through the Integrated Care Oversight and Assurance Committee. **The Board accepted the Board Assurance Framework Report and approved the proposed changes.**				
8.2	**Audit Committee Escalation and Assurance Report**	**NT**	**Assurance**	**Enclosure 13**
The paper was taken as read with no areas of escalation required. **The Board accepted the Audit Committee Escalation and Assurance Report.**				
8.3	**Executive Risk and Compliance Committee Escalation and Assurance Report**	**SS**	**Assurance**	**Enclosure 14**
The paper was taken as read with no areas of escalation required. **The Board accepted the Executive Risk and Compliance Committee Escalation and Assurance Report.**				
8.4	**Charity Trustee Escalation and Assurance Report**	**GQ**	**Assurance**	**Enclosure 15**
The paper was taken as read with no areas of escalation required. **The Board accepted the Charity Trustee Escalation and Assurance Report.**				
9.	**Any Other Business**			
There was no further business for discussion.				
10.	**Questions from Members of the Public**	**FM**	**Information**	**Verbal Update**
Ther were no questions provided by members of the public.				
DATE AND TIME OF THE NEXT MEETING – Thursday 3rd September 2026 1.00 p.m. to include the Annual General Meeting Formal Business				

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board Held in Public**
Date of Meeting:	**3rd September 2026**
Title of Report:	Foundation Group Board Workshop Report from the Meeting held on 5th August 2026
Lead Executive Director:	**Glen Burley, Chief Executive**
Author:	Chelsea Ireland, Foundation Group EA
Reporting Route:	Direct to Board
Enclosures included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
The purpose of this report is to provide the WVT Public Board with an overview of the Foundation Group Boards Workshop meeting held on the 5th August 2026.	
Recommended Actions required by Board or Committee	
To receive and note the report.	
Executive Director Opinion[1]	

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

Foundation Group Boards Workshop Report from the Meeting held on 5 August 2026

The third Foundation Group Boards Workshop was held on 5 August 2026, and the agenda was structured to provide both assurance and strategic insight across a range of priority areas for the Foundation Group.

The workshop opened with the usual governance items, including apologies, declarations of interest, and a review of matters arising and previous actions, providing oversight of progress since the May 2026 workshop. Members noted that succession planning and talent management work remained on track, with further proposals to be developed ahead of a future review.

The first part of the session focused on operational performance and service delivery across the Foundation Group. Through the Foundation Group Performance Report, Boards reviewed ongoing pressures within urgent and emergency care, elective recovery and cancer services, whilst also recognising areas of strong performance, including emergency care at GEH and cancer services at WVT. Discussion centred on rising referral demand, increasing out-of-area activity, workforce pressures and the need for stronger engagement with Integrated Care Boards around capacity planning and future demand forecasting. A detailed deep dive into outpatient transformation explored the relationship between new-to-follow-up ratios, Patient Initiated Follow Ups (PIFU) and discharge rates, emphasising the need to reduce unnecessary follow-up activity, improve patient experience and release clinical capacity through meaningful pathway redesign.

Attention then turned to service sustainability and strategic transformation. A review of fragile services examined workforce resilience, affordability and service dependency, identifying oncology, ophthalmology and oral surgery as common challenges across the Foundation Group. Discussion focused on the opportunities presented through greater collaboration, shared clinical leadership and alternative delivery models. This was followed by an update on the Foundation Group's Big Move ambition to Embed Prevention in Every Service, highlighting a range of prevention-focused initiatives across cardiac rehabilitation, cancer screening, physiotherapy and community-based care. The Boards explored how prevention could become a routine part of care delivery rather than a standalone programme, supported by partnership working across health and care systems.

The workshop also included a spotlight session from Wye Valley NHS Trust on sustaining and improving cancer performance. Members heard how strong clinical leadership, data-driven management, innovation and multidisciplinary collaboration had supported significant improvements in cancer pathways. Particular interest was shown in the use of Teledermatology, super clinics, cancer navigator roles and emerging AI technologies to improve access and reduce waiting times.

The latter part of the workshop focused on organisational resilience, culture and future readiness. Boards reviewed the Annual Foundation Group Equality Benchmarking Report, which demonstrated progress in workforce equality and inclusion while recognising ongoing challenges relating to bullying, harassment and the experience of minority staff groups. Cyber security was considered as a significant organisational and patient safety risk, with discussion centred on resilience, assurance arrangements, supplier risk management and the evolving threat landscape. Members also received an update on procurement transformation, including plans to establish a single Foundation Group procurement function and the implications of the Procurement Act 2023. The workshop concluded with a strategic update covering national NHS developments, future governance reforms, the emergence of NHS Online, prevention priorities and the need to refresh the Foundation Group strategy to reflect an evolving healthcare landscape.

The meeting closed with any other business and confirmation that the next Foundation Group Boards Workshop will take place on 4 November 2026 at Sixways Stadium, Worcester.

Chelsea Ireland
Foundation Group EA

WYE VALLEY NHS TRUST

ACTIONS UPDATE: Trust Board held in Public – 3rd September 2026

Month	Meeting Type	Ref	Item	Action	Due Date	Owner	Status
July	Public	Action 7.1/7.2	Ockenden and Amos Reports	The Board approved oversight of the national submissions to be undertaken through Quality Committee with updates being reported to Trust Board periodically.	Jul-26	Lucy Flanagan/Ian James	Closed

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board Held in Public**
Date of Meeting:	**3 September 2026**
Title of Report:	Managing Director report
Lead Executive Director:	**Managing Director**
Author:	Sarah Shingler, Managing Director
Reporting Route:	Direct to Board
Enclosures included with this report:	
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report provides an update on national policy developments, system transformation and an update from the Clinical Support Division.

Recommended Actions required by Board or Committee

The Board is invited to:

- **Note** the content of the report and;
- Receive **Assurance** that the organisation is well positioned to deliver against future system expectations, with continued oversight of neighbourhood delivery, operational and financial performance.

Executive Director Opinion[1]

National NHS reforms continue to reinforce a shift towards neighbourhood health, prevention, digital innovation and improved productivity. These priorities align closely with the strategic direction of the Trust and our wider system partnerships.

Locally, the Trust continues to demonstrate strong performance across a number of key areas, particularly cancer services, diagnostics and patient access.

Whilst challenges remain around UEC performance and financial sustainability, the Trust is well positioned to respond to both local needs and national priorities, supported by the continued commitment and innovation of our teams and wider Place partners.

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

Managing Director Report

1. NHS 10 Year Health Plan and Neighbourhood Health Service

The most significant national development remains implementation of the NHS 10 Year Health Plan, which sets out the Government's ambition to deliver three fundamental shifts across health and care:

- Hospital to community
- Analogue to digital
- Sickness to prevention

A core component of the plan is the development of a Neighbourhood Health Service, designed to bring services closer to people's homes and reduce reliance on hospital-based care. National policy now requires Integrated Care Systems (ICSs), providers and local authority partners to accelerate the development of Integrated Neighbourhood Teams and neighbourhood-based models of care

Alongside wider neighbourhood transformation, NHS England has published guidance supporting the development of Neighbourhood Health Centres as a key component of future service delivery.

The intention is to create integrated community-based facilities providing access to a broad range of health and care services closer to home. These centres are expected to support multidisciplinary teams, improve access to care, strengthen prevention programmes and reduce avoidable hospital utilisation.

Nationally, this programme represents one of the largest shifts in service configuration since the establishment of Integrated Care Systems and is likely to influence future estate strategies and capital investment plans across provider organisations and systems.

2. NHS Operating Model and NHS England Transformation

Nationally, NHS England continues to implement significant organisational reform following the publication of the new NHS operating model and the closer integration of NHS England and the Department of Health and Social Care.

There remains a strong national focus on reducing the layers, clarifying accountability and strengthening delivery against operational, financial and transformation objectives. NHS leaders are expected to take greater responsibility for system-wide performance, productivity improvement and financial sustainability while supporting delivery of the NHS 10 Year Health Plan.

The changing national architecture is expected to result in further simplification of oversight arrangements and increased emphasis on place-based delivery, neighbourhood care and measurable population health outcomes. The Board should anticipate continued evolution in

reporting requirements, performance management processes and system governance arrangements during 2026/27.

3. NHS Planning Priorities 2026/27

NHS England has reaffirmed a number of key priorities for systems during 2026/27, with particular emphasis on:

- Delivery of constitutional standards where possible
- Further reduction in elective waiting lists
- Improvement in urgent and emergency care performance
- Financial balance and productivity improvement
- Expansion of neighbourhood health models
- Increased use of digital solutions and technology-enabled care
- Reducing unwarranted variation in quality and outcomes

The national planning framework highlights the need for organisations to deliver both immediate operational improvements and long-term transformation simultaneously. Whilst encouraging progress has been made nationally in elective recovery and urgent care performance, NHS England has made clear that further improvement remains necessary, particularly in relation to patient access, flow and operational productivity.

Financial discipline continues to be a major national priority, with systems expected to operate within agreed resource allocations while maintaining quality and safety standards. Productivity improvement remains central to national planning assumptions across the NHS.

4. Digital Transformation and the NHS App

The Government's digital transformation agenda continues to gather momentum, with increasing emphasis on the NHS App as a primary digital gateway for patients accessing NHS services.

National expectations include enhanced patient access to appointments, communications, diagnostic results, care plans and self-management tools through digital platforms. The broader ambition is to improve patient experience, increase productivity and support more personalised models of care.

The digital agenda is recognised as a key enabler of wider neighbourhood health ambitions and is expected to remain a major area of national investment and transformation activity over the coming years.

Taken collectively, these developments signal continued national emphasis on delivering care closer to home, strengthening partnerships across organisational boundaries, utilising technology more effectively and improving productivity whilst maintaining high-quality patient care.

For our Trust, the national direction of travel aligns strongly with the ongoing development of One Herefordshire Partnership arrangements, neighbourhood health initiatives, integrated working with system partners and the continued focus on operational improvement, financial sustainability and patient experience.

5. More from our great teams – Clinical Services Division Update

The Clinical Support Division continues to make strong progress across a number of key service areas, supporting improvements in patient access, cancer performance, diagnostics and workforce sustainability.

Patient Access and Service Transformation - Significant progress has been made in streamlining outpatient and administrative services. A new GP Local Enhanced Service has enabled more wound care to be delivered closer to home, supporting the wider shift towards community-based care. The expansion of centralised reception services and approval of electronic patient check-in kiosks will further improve patient experience and operational efficiency. Improvements to health records management have also reduced historic backlogs and strengthened governance arrangements.

Bereavement and Mortuary Services - A new Trust-wide deceased patient handover process has been successfully implemented, improving safety, traceability and consistency of information transfer. Funding has also been secured to establish a network of Bereavement Champions across clinical areas, strengthening support for families and staff.

Cancer Services - Cancer performance remains a significant area of success for the Trust. Performance against the Faster Diagnosis Standard and 62-day standard continues to exceed national requirements, with WVT currently ranked as the highest performing organisation in the West Midlands for 62-day cancer performance. Permanent funding has also been secured to support the rollout of the Gold Standards Framework across Herefordshire, strengthening end-of-life care provision and coordination.

Diagnostic Services - Diagnostic services continue to deliver high levels of activity and performance, with the majority of patients receiving tests within six weeks despite ongoing workforce challenges within MRI. Successful recruitment campaigns and national funding awards for the Community Diagnostic Centre programme provide confidence in the sustainability and future development of services. Progress is also being made with several digital transformation initiatives, including implementation of AI-supported imaging referral tools.

Pharmacy and Pathology - Pharmacy has achieved its lowest pharmacist vacancy rate in recent years, enabling improvements in medicines reconciliation and patient safety. Pathology continues to strengthen service resilience through regional partnership working, investment in equipment and digital transformation, whilst also demonstrating significant improvement in quality management compliance standards.

Endoscopy - Endoscopy services continue to deliver strong cancer pathway performance and have significantly reduced long waiters following disruption associated with the temporary closure of Ross Community Hospital. Work continues to identify a sustainable solution for

future endoscopy estate requirements, with options under active consideration. Positive progress has also been made towards regaining JAG accreditation.

The Division continues to demonstrate strong performance in cancer services, diagnostics and patient access, whilst making tangible progress in workforce recruitment, service transformation and digital innovation. Estate capacity, particularly for Endoscopy, and maintaining diagnostic workforce resilience remain key strategic priorities.

6. Going the Extra Mile Awards

Employee of the Quarter: Beverley Devey

The Trust is delighted to recognise Beverley Devey as our Going the Extra Mile Employee of the Quarter.

Beverley has demonstrated exceptional commitment, initiative and leadership in transforming the outdoor environment at Coningsby Children's Centre. Driven by a genuine passion for improving opportunities for local children and families, she has gone far beyond the expectations of her role to create a vibrant, inclusive and inspiring community space.

Through her own determination and vision, Beverley secured support from Leominster in Bloom, arranged donated plants, engaged local businesses and developed strong community partnerships to bring the project to life. The garden now includes a range of creative and interactive features designed to support children's learning, communication and development, including sensory, imaginative play and literacy-focused areas.

What makes this achievement particularly remarkable is the significant amount of personal time Beverley devoted outside of her normal working hours. She also worked collaboratively with Speech and Language Therapy colleagues to ensure the space is accessible and inclusive for all children and families who will use it.

Beverley's actions embody our values of Compassion and Excellence. Her dedication will have a lasting positive impact on children, families, staff and the wider community, and she is a truly deserving recipient of this award.

The Board would like to thank Beverley for her outstanding contribution and congratulations on this well-deserved recognition.

Team of the Quarter: Delivery Suite

The Trust is delighted to recognise the Delivery Suite Team as our Going the Extra Mile Team of the Quarter.

The team was nominated for the exceptional care they provided to a mother and her baby during an extraordinarily difficult and high-risk birth. In a situation that demanded both outstanding clinical expertise and calm leadership, the team demonstrated the very highest standards of professional practice and compassionate care. Throughout the emergency, every member of the team communicated with clarity, honesty and reassurance, ensuring that the woman and her family felt informed, supported and involved, even during moments of significant uncertainty. Their ability to work together seamlessly while maintaining a calm and compassionate presence was truly remarkable.

When the clinical situation escalated, the team responded swiftly and decisively, recognising changes promptly, activating emergency pathways without delay, and working together with

complete trust, professionalism and accountability. Their smooth and effective response reflected exceptional preparation, expertise and teamwork.

Most importantly, despite the intense pressures of a time-critical emergency, the team never lost sight of the people at the centre of their care. They treated the woman, her baby and their family with dignity, kindness and compassion at every stage of their journey.

This team is an outstanding example of our values of Compassion, Accountability, Respect and Excellence. Their skill, professionalism and humanity made an immeasurable difference during one of the most critical moments in a family's life, and they are thoroughly deserving of this recognition.

The Board would like to thank the Delivery Suite Team for their exceptional care and congratulations on this well-deserved award.

Integrated Performance Report

August 2026

Managing Director – Executive Summary

Sarah Shingler
Managing Director

August has seen continued strong organisational performance, particularly in cancer services, patient experience and workforce stability, alongside financial performance remaining close to plan.

Key highlights:

- **Cancer performance remains outstanding**, with 86.4% achievement of the Faster Diagnosis Standard and 85.7% of patients starting treatment within 62 days, placing WVT amongst the highest-performing trusts nationally.
- **Patient experience has improved significantly**, with the Adult Inpatient Survey showing an overall score of 77% and top 20% national performance in 15 measures.
- The Neonatal Unit achieved **Baby Friendly Initiative Stage 2 accreditation**, recognising the quality of family-centred care and strong leadership.
- **Falls performance remains at historically low levels**, reflecting the impact of ongoing patient safety improvement work.
- Urgent and emergency care continues to face sustained demand and flow pressures, although over half of admissions are now managed through Same Day Emergency Care pathways.
- Workforce indicators remain positive with **sickness absence at 4.6%** and **turnover at 7.9%**, both comparing favourably across the NHS.
- Financial performance is broadly on track, with a **£2.4m year-to-date deficit against a £2.1m plan**, while maintaining a forecast breakeven position. Delivery of the Cost Improvement Programme remains a key focus.
- Planning for winter continues at pace, with a particular focus on urgent care flow, discharge improvement and neighbourhood health initiatives.

Overall, the Trust enters the autumn period with strong cancer performance, improving patient experience measures, stable workforce indicators and financial performance broadly in line with plan. Continued focus is required on mortality improvement, urgent and emergency care flow, and delivery of cost improvement programmes to maintain trajectory through winter.

Quality & Safety – Executive Summary

Chizo Agwu
Chief Medical Officer

Lucy Flanagan
Chief Nursing Officer

Baby Friendly Initiative stage 2 accreditation neonatal unit
The BFI stage 2 assessment of the neonatal service took place between 12-18 June. The unit achieved successful accreditation and are now working towards stage 3 accreditation. The visiting team noted the following in their summary report.

Wye Valley NHS Trust presents a positive approach towards implementing the Baby Friendly standards for neonatal units and consistently displayed enthusiasm and commitment towards providing an effective training programme. The assessment revealed the staff are equipped with the knowledge and skills to implement Baby Friendly standards to support parents (and siblings) to have close and loving relationships with their baby, promote the use of breastmilk and breastfeeding and encourage an environment where parents are involved as partners in care.

Staff demonstrated kindness and compassion and are to be commended for their support of families and babies. Wye Valley NHS Trust showed strong leadership and ambition for improving family outcomes and has begun implementing a range of supportive neonatal practices, including enhanced transitional care, a Family Integrated Care lead, and regular opportunities for families to contribute to unit developments.

Adult inpatient survey results publication – August 2026
The National Inpatient Survey results were published on 26th August. The results overall were positive with the average score being 77% (up by 2,7% from the previous year). The trust saw results improve by more than 5% for 7 questions, and no questions seeing results worsen by 5%. The Trust scored in the top 20% of Trusts for 15 questions. This is a vast improvement on the previous year. A detailed breakdown of the results will be presented to Quality Committee in September 2026.

Seasonal flu vaccination programme
There have been no changes to the eligible cohorts for this season's flu campaign. The programme commences in September for pregnant women and eligible cohorts of children and young people. The NHS staff vaccination programme will launch on the 28th September with a target delivery of 60-65%. Wye Valley will also support vaccination delivery for eligible patient cohorts who are inpatients in line with national requirements.

National Bowel Cancer Audit (NBOCA) State of the Nation Report 2025
Overall, the Trust demonstrated strong performance across most indicators;
Clinical Nurse Specialist involvement: 100% of patients were seen by a CNS, exceeding the >95% target.
Rectal cancer surgical volume: 21 cases annually, meeting the minimum threshold of ≥20 cases.
90-day mortality following major resection: 0%, significantly better than the national threshold of ≤6%.
30-day unplanned return to theatre: 6.8%, within the target of ≤10%.
Stage 3 colon cancer patients receiving adjuvant chemotherapy: 74%, well above the >50% benchmark.
Neoadjuvant treatment for rectal cancer: 18%, within the expected national range. Two-year survival following major resection: 82.8%, exceeding the target of >70%

Two standards were not met and action plans have been developed to address these with a particular focus on readmissions.

Quality & Safety Performance – Mortality

We are driving this measure because:

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

Data

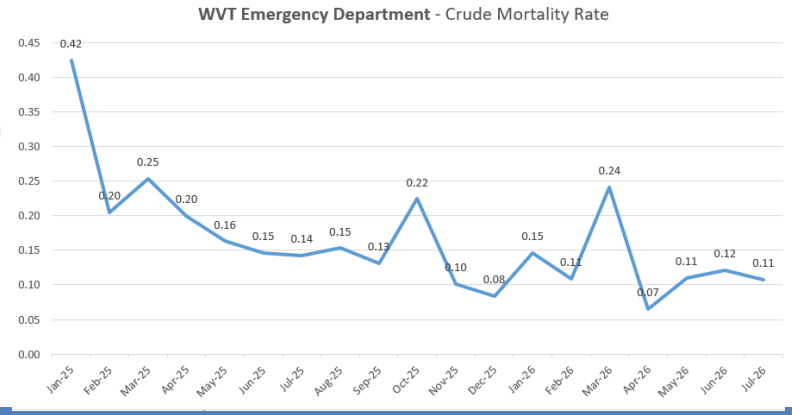
NHS England SHMI - ***April 2025 – March 2026***

Trust-level data

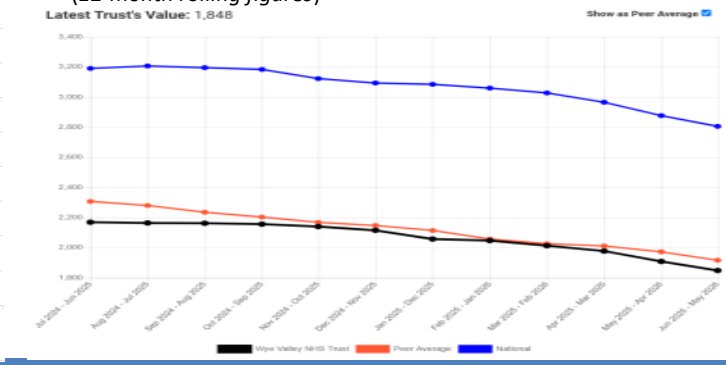
As expected SHMI

26,180 (-600)	1,305 (-15)	1,135 (-25)	1.1467 (+0.77)
Provider spells	Observed deaths	Expected deaths	SHMI value

Indicator - Latest Static	Description/Notes	Data month	Month Actual	Deaths in Month	Change (Rate %)
Crude Mortality - ***All***	*% of Deaths by Discharges*	Jul-26	1.24%	58	-0.15%
Crude Mortality - ***Emergency***	*% of Deaths by Emergency Discharges*		5.11%	57	-0.77%



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



Monthly Headlines

The latest 12-month rolling **SHMI** (*NHS England*) from April 2025 to March 2026 shows Wye Valley NHS Trust at **114.6**, which equates to 1305 observed deaths against 1135 expected.

*N.B. The provisional SHMI (HES-based) for May 2025 – April 2026 is reporting at **111.** Based on initial review, the re-inclusion of SDEC data appears to be having a positive impact on our local SHMI by increasing the number of spells and subsequently the level of expected deaths.*
Latest **crude mortality** rate for **July 2026** was **1.24%** for all admissions, which equates to 58 deaths with a further 7 deaths reported in the Emergency Department.

#NOF (Fractured Neck of Femur) Latest SHMI: 129 (-14) *Observed: 40 Expected: 30*
- The latest 12-month rolling SHMI (April 2025 – March 2026) has reported a further significant reduction of nearly 14 points to 129. The HES-based SHMI, which provides a provisional look ahead, shows a further reduction in the coming months ahead.
- NHFD (National Hip Fracture Database) clinical KPI's continue to report improved outcomes with key measures, notably the 7% increase in patients receiving appropriate bone medication.
- On-going discussions with key stakeholders to review the current pathway, regarding the rehab of #NOF patients in the acute setting, with a view to transitioning their care to the Community Hospital setting.

Pneumonia: Latest SHMI: 108 (-1) *Observed: 150 Expected: 140*
- As part of the Reducing HAP programme, there are planned clinical education and practice weeks on key wards. The education will focus primarily on the importance of mouthcare, mealtimes and positioning, and mobilisation with our nursing staff.
- As previously reported, there will a sample audit with a focus on the Antibiotic compliance audit to ensure that patients, who are identified as having HAP, receive the appropriate medications and in a timely fashion.
- There are plans for a Trust-wide HAP Campaign, which will aim to use a variety of media including an intranet page to promote key aspects of care for reducing the risk of hospital-acquired pneumonia.

Sepsis: Latest SHMI: 111 (+2) *Observed: 105 Expected: 95.* **Heart Failure**: Latest SHMI: 100 (-4) *Observed: 45 Expected: 45.*

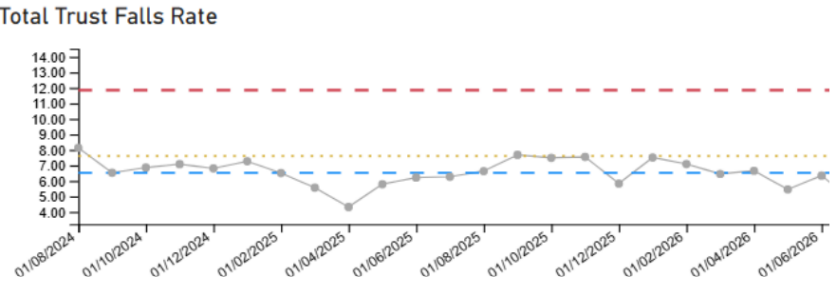
Clinical Coding:
- From April 2026, the SHMI dataset will start to include SDEC spells. Based on provisional data released for April 2026, the re-inclusion of this data will have a positive effect on reducing our overall Trust SHMI.
- Data Sharing Agreement is being finalised with primary care to allow access for our Clinical Coding team to access the EMIS records for patients. With this agreement in place, it will allow our Coders to ensure they capture all relevant co-morbidities that may not be captured in the latest spell.

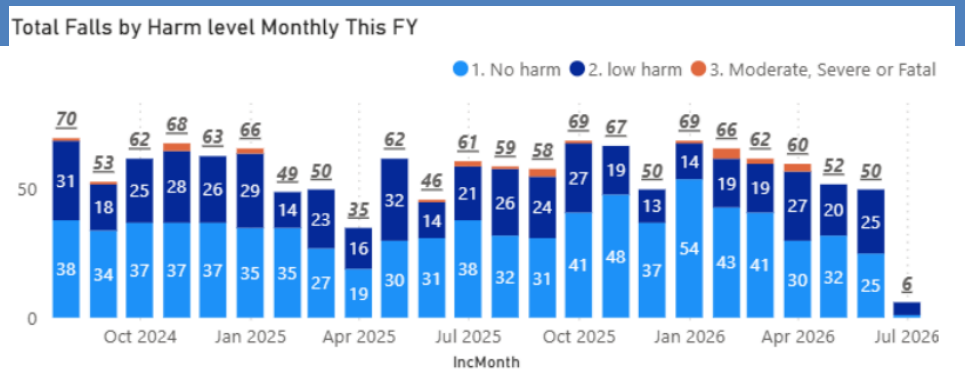
Quality & Safety Performance – Falls

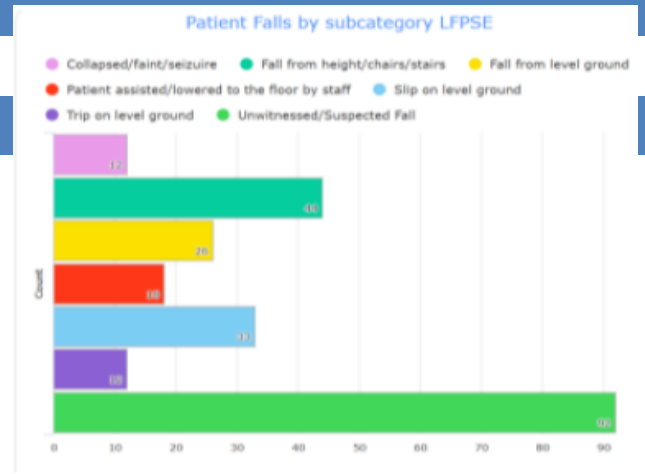
We are driving this measure because:

Reducing harm to patients through falls in our care is a key patient safety improvement priority.

Data







Monthly Headlines

Falls rates remaining lower than previous years and several indicators at historically low levels.

The Trust's year-to-date falls rate remains lower than the previous year, which was already the lowest rate recorded in four years. Q1 2026/27 recorded the second-lowest quarterly falls total since reporting began in this dataset (back to Q1 2023/24). The overall Q1 falls rate was 6.1 falls per 1,000 occupied bed days, the second lowest in the reporting period.

Unwitnessed falls, bathroom falls, and post-fall management remain key areas of focus.

A relatively high proportion of falls continue to be unwitnessed. Only 12% of unwitnessed falls occurred while patients were on higher levels of enhanced observation (Levels 3-4), improved from 18% in Q4 of the previous year. Most unwitnessed falls occurred among patients receiving Level 2 intermittent observations.

A small rise in bathroom falls has been identified and is being managed through local action plans.

Governance and Improvement

- Falls have been established as a Patient Safety Improvement Priority under PSIRF.
- Falls dashboards are now supporting performance monitoring.
- Falls panel terms of reference and processes have been reviewed and will encourage wider MDT engagement and local ownership
- Additional training, audit work, and assurance processes are being implemented, including National Audit of Inpatient Falls (NAIF) improvements and enhanced divisional oversight.
- Activities are being developed to support national falls week in September including funky footwear to enable visibility and engagement, local bite size training and awareness for clinical colleagues and activities for patients and the public to support falls awareness and prevention

Quality & Safety Performance – Staffing - July data

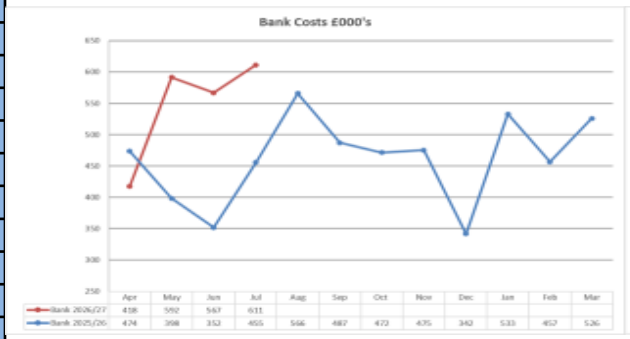
Fill Rate & CHPPD Data

	Day		Night		
	RN Fill	HCA Fill	RN Fill	HCA Fill	Overall (Actual) CHPPD
Primrose Unit	91%	92%	103%	152%	9.7
Maternity Ward	86%	89%	87%	82%	6.8
Children's Ward	108%	160%	123%	92%	23.6
Lugg Ward	139%	78%	131%	101%	6.9
Wye Ward	101%	90%	113%	94%	6.9
Cardiac Care Unit	100%	99%	100%	100%	12.0
Leominster Community Hospital	102%	100%	100%	119%	7.0
Bromyard Community Hospital	75%	106%	100%	162%	6.6
Ross Community Hospital	93%	90%	94%	99%	5.7
Teme Ward	138%	64%	99%	86%	11.7
Redbrook Ward	108%	104%	102%	133%	8.0
Special Baby Care Unit	103%	-	108%	-	15.1
Intensive Care Unit	107%	-	104%	-	26.5
Gilwern Ward	94%	128%	105%	108%	7.1
Acute Medical Unit	115%	92%	108%	128%	8.4
Ashgrove Ward	140%	96%	134%	122%	7.9
Dinmore Ward	129%	93%	116%	123%	8.1
Garway Ward	164%	82%	132%	123%	7.6
Frome Ward	121%	88%	102%	132%	7.0
Arrow Ward	129%	76%	148%	77%	7.5
Women's Health	87%	96%	100%	-	10.1

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

Paediatric Ward – Additional RN's and HCA required to support ED, and patients needing enhanced care - RMN support
Frome, Primrose, Dinmore, Garway and Ashgrove Wards – Additional staffing requirements for additional corridor care patients
AMU, Redbrook Wards – Due to patient acuity and dependency, additional staff needed to support individual care needs, including RMN support – these areas are subject to an establishment review due to case mix
Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV). Band 5 registered nurse backfilling Band 4 gap.
Gilwern Ward – alignment of roster needed for additional staffing needs
Bromyard – Due to additional D2A beds funded through BCF

Bank & Agency



- The agency expenditure limit set by NHS England has been applied to our Nurse Agency Reduction programme target for 26/27
- We have a cost productivity (CPIP) target of £1.2m
- CPIP delivery is ahead of plan in month 4
- 100% of all nursing shifts are cap compliant with the exception of off framework use detailed below
- 12 off framework shifts were used in month 4
- Bank costs have risen sharply since month 2 – driven in part by a deteriorating vacancy position
    - Additional weekly check and challenge meeting
    - Recruitment to substantive posts in high use areas – subject to business case process
    - Matron oversight
    - Optimising recruitment of newly qualified staff

Our Performance – Executive Summary

Andy Parker
Chief Operating Officer

This month I am starting with the excellent news regarding our strong performance for our cancer patients.

In June we were the highest performing Trust for the start of cancer treatment, within 62 days of referral, with over 85% of patients meeting this standard. Nationally we are the 7th best English Provider for the 62-day standard and 9th best English Provider for the Fast Diagnosis Standard, meaning that over 85% of patients urgently referred with suspected cancer have received a definitive diagnosis or have cancer ruled out within 28 days.

This is an impressive achievement and demonstrates all the hard work of our clinical and operational teams, supported by the Cancer Services team. Early indications is that we have maintained these high standards for July, which is under final validation. Our Cancer team is working with our colleagues across the Foundation Group to share best practice and are currently looking at four key cancer pathways to share best practice supported by the West Midlands Cancer Alliance.

In our Urgent and Emergency Care pathways we have been contending with pressures of extreme heat seen across the Nation and locally across Herefordshire, South Shropshire and Powys. This summer has seen surges and spikes in demand both during and within 48 – 72 hours after Heatwave conditions. Along with the challenges this bring to our staff, and the pressure on our estates, to maintain services the increased risks of these high temperatures has seen impacts on various patient groups across our local communities. On-going reviews are happening to collocate how we responded over the last few months are in progress to adapt our Adverse Weather plans as , no doubt, these increasing temperatures will be faced by our patients and staff on a more regular basis in the years to come.

Although we are still in the summer months, our teams have been working hard to get our ourselves “Winter Ready” and finalising the detail and modelling within our Winter Plans. Our Winter Plans are not new plans, but are fundamental workstreams within our Four Big Moves, our System plans with partners delivering Neighbourhood Health and partners across Powys.

Within our own plans each Division has key deliverables ahead of the winter period in order to ensure we can improve Urgent and Emergency Care [UEC] that delivers on ourRed Lines, reduces overnight admissions, Length of Stay for Emergency inpatients, increases Discharges by 6 per days and focus on Ward Based Processes.

As we finalise our modelling, our aim is to improve our bed occupancy, reliance on escalation beds and extremist measures over the, traditionally, busiest time of the year, and mirror some of the success in patient flow we have seen over the summer.

With our partners across Herefordshire our Neighbourhood Health schemes our key priorities, agreed with stakeholders and Senior Responsible Officers, are:

- Deliver our 24/7 Single Point of Access [SPoA], with a 24/7 Trusted Assessor Model
- Deliver our End of Life [EOL] pathway changes to prevent this cohort of patients been admitted to an Acute Hospital. By delivering the Gold Standard Framework for EOL care, linking our 24/7 SPoA to support improved pathways and make local improvements to Fast Track placements for EOL care
- Implement Integrated Neighbourhood Teams across our Primary Care Networks that focus on 3% of patients that are High Intensity User of UEC pathways, rapid re-design of Complex Patient pathways and development our proactive planning of frailty patients and those who have or are at high risk of falls.

Ensuring we have robust plans with partners across Powys is also key ahead of the Winter. Across both WVT and Powys Teaching Health Board we are working together with them on their “Working Better Together” Programme and have had joint meeting in order to support Powys with the development of their SPoA, improve the admission avoidance pathways available to our Acute Floor teams at WVT and join together to support Powys Adult Social Care on how we can reduce discharge delays.

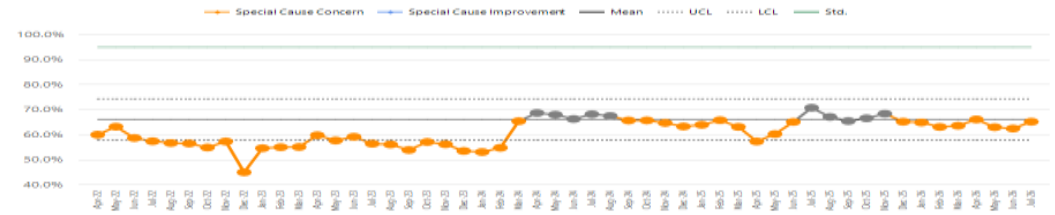
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

We are driving this measure because:

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

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

% Patients Spending less than 4hours In ED



% Patients Spending More Than 12 Hours In ED

% Admissions on Same Day Emergency Care (SDEC) Pathway

Risks

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

What the chart tells us

- April's 4 hour Emergency Access Standard [EAS] Performance was 65.3%.

Performance & actions

- 6,349 Type 1 patients attended ED in July which 246 less than the previous month yet similar activity levels to July-25 [6,307]. The range of all attendances varied from 178 to 270 with 204 daily average.
- 1,635 ambulances conveyed to the Trust in month which was 9 less than last month and 48 fewer than July-25. The range in month was 40 to 68 with a daily average of 52. This includes 11% from Powys [184].
- Ambulance handover delays over 1hr were 15% [220] of all conveyances with 78% [1,276] handed over within 45 minutes.
- Same Day Emergency Care [SDEC] treated 1,580 of all admissions [53.9% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 77th Type 1 Trust in England for July.
- 9.9% [740] of patients spent 12 or more hours in ED which was 167 [1.9%] fewer than last month.

Current Actions at part of our UEC Improvement plans:

- ➢ On-going action plan to increase medical Same Day Emergency Care [SDEC] pathways across the acute floor, including reviewing the Model ED guidance published by NHS Engl;and
- ➢ Increased Navigation to internal and external pathways including Primary care and Community services via our Single Point of Access [SPoA]. Internal pathways via our SDECs including the workforce model for Medical and Surgical along with a review of the operational hours.
- ➢ Non-admitted patients – focus on how we improve timeliness for non-admitted and not referred patients in ED and minor illness and injury.
- ➢ Establish a 24/7 Single Point of Access to support overnight Ambulance conveyances, provide coordination and senior clinical oversight overnight for virtual wards, Hospital@Home and scheduling of Urgent Community Response for management of overnight calls and ED re-direction patients that can be managed during daytime hours.
- ➢ Revised Speciality Doctors Roats from end of August and Consultants Rotas from October to more appropriately match demand

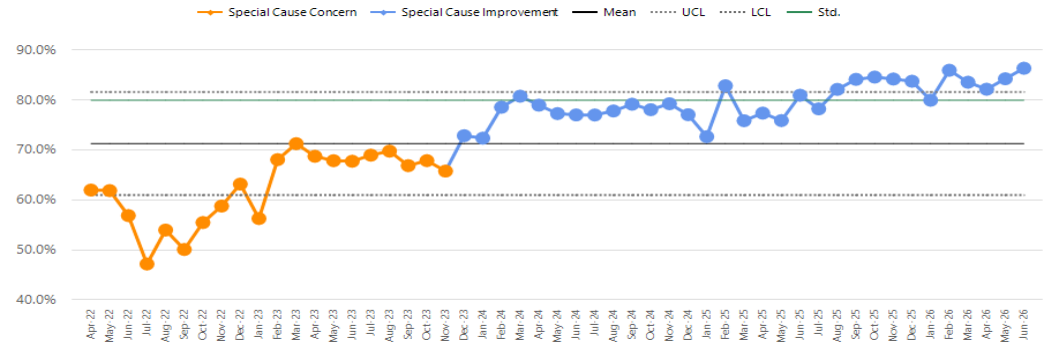
Operational Performance – Cancer Performance [June 26]

We are driving this measure because:

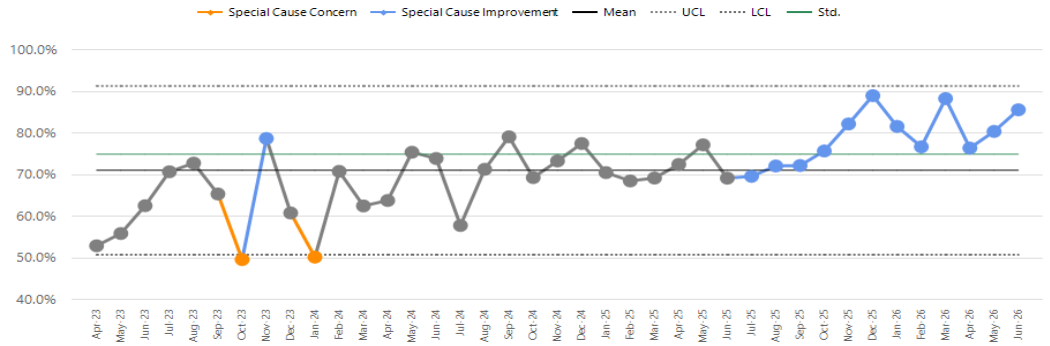
Cancer is one of the leading causes of mortality in the UK. There are nine main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway. Two of the key measures is 80% of patients getting a cancer diagnosis, or having cancer ruled out, within 28 days of being urgently referred by their GP for suspected cancer, known as the Faster Diagnosis Standard [FDS], and 80% start first treatment within 62 days to be achieved by March 2027.

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

28 Days Performance



62 Days Performance



Performance & actions

Referrals:
As of June 2026, urgent suspected cancer referrals have increased by 18% compared with the same period three years earlier. Breast, Skin and Lung pathways continue to experience the biggest increase with referrals rising by 38%, 37% and 50%.
Cancer Performance:
In June 2026, the Trust achieved the Faster Diagnosis Standard (FDS) of 86.4%, 5.8% ahead of trajectory. Eight specialties achieved the target, with Breast achieving 93.6%, Skin 98% and Head and Neck achieving 91.9%. Gynaecology did not meet the FDS target this month, achieving 69.3%, which represents a 4% improvement from April. Gynaecology received additional funding from the West Midlands Cancer Alliance, which is allocated from July. Enhanced navigation support remains in place within this speciality, as it continues to be the most vulnerable service at Wye Valley Trust (WVT). Discussions regarding the implementation of the GALEAS bladder pilot have commenced, this is a point of care/home usage genetic urine test that may remove the need for some cystoscopy referrals. The test is expected to improve the bladder cancer referral pathway by reducing the number of cystoscopies needed by around 50-60%.
WVT reported 96.7% compliance with the 31-day standard in June, which is an improved position in performance since May of 0.9% and 11.8% above trajectory. For the 62-day standard, WVT achieved 85.7% in June, exceeding the national target by 0.7 percentage points. This is the first month this year that performance has met or surpassed the national target and is 10.5 percentage points above trajectory. The Trust has experienced delays in the scheduling of Cobalt scans at Cheltenham. To address these issues, bi-monthly service review meetings have been established between the WVT General Manager for Cancer Services and the Director of Clinical Operations, with the first meeting taking place in August.

Developments update:

- All foundation group workshops facilitated by cancer alliance have been completed with numerous shared learning across trusts
- Continue to wait for outstanding West Midlands Cancer Alliance bids in relation to 26/27 to improve cancer performance
- We have now received National Cancer Patient Experience Survey 2025 where a full action plan will be devised of improvements needed and shared at WVT Cancer Board, WVT has shown a sustainable improvement compared to last report
- Initiating a 28 day patient tracking list meeting for more proactive escalation with management teams to prevent breaches, trialling in one speciality and then embedding across all specialties as business as usual

What the charts tell us

- 28 Day Faster Diagnosis performance for June 26 was 86.4%.
- 62 Days start of treatment target for June 26 was 85.7%.

Risks

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

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

We are driving this measure because:

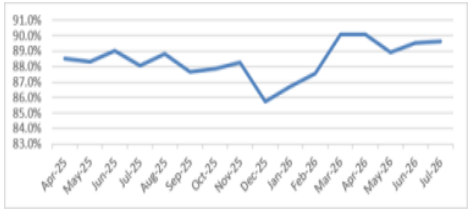
Referral to Treatment [RTT] aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. The maximum waiting time for non-urgent, consultant-led treatments is 18 weeks for English patients and 26 weeks for Welsh patients from when the referral is received by the Trust either booked through the NHS e-Referral Service, or when a referral letter received. Activity plans are measured against the Trust's agreed plans as part of the annual Business Planning process with commissioners, Diagnostics tests are ensuring patients receive their diagnostic test within 6 week. Less than 1% of patients should wait 6 weeks or more for a diagnostic test. For 2026/27 the Trust aims to achieve 92% of patients waiting less than 6 weeks for a diagnostic test by March 2027.

New/First Attendances			
Total vs Plan	This Year	Plan	Diff / Var
	28,561	29,786	-1225 / -4%
Vs 2025/26	This Year	2025/26	Diff / Var
	28,561	27,684	877 / 3%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	10.4	2.9	72.1%

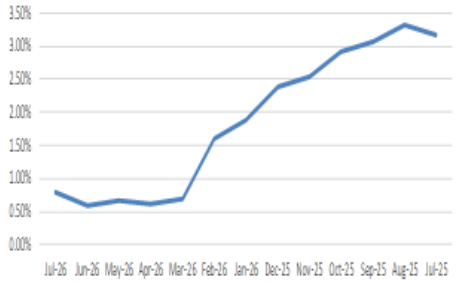
IP/DC Admissions (excl. Endoscopy)			
Total Vs Plan	This Year	Plan	Diff / Var
	10,495	9,801	694 / 7%
vs 2025/26	This Year	2025/26	Diff / Var
	10,495	10,096	399 / 4%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	15.6	8.2	47.7%

Follow Up Attendances			
Total Vs Plan	This Year	Plan	Diff / Var
	60,449	62,994	-2545 / -4%
Total vs 2025/26	This Year	2025/26	Diff / Var
	60,449	63,002	-2553 / -4%
Waitlist Clearance (wks)	Total	> See By Date (SBD)	% Past SBD
	18.4	6.4	63.5%

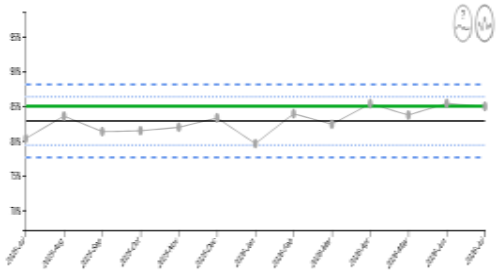
Outpatient Clinic Utilisation



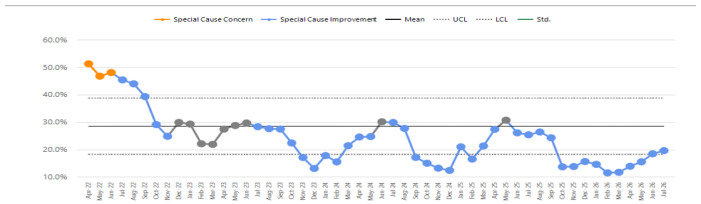
English % Patients on Waiting List over 52 weeks



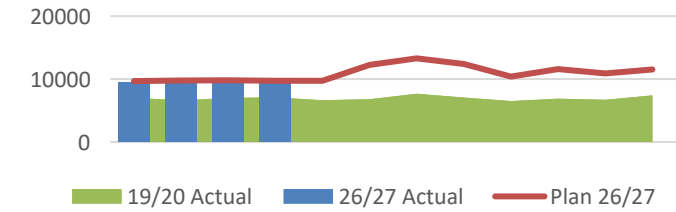
Theatres Utilisation (Uncapped)



Diagnostic Waits >6 weeks



Diagnostic Activity



Performance & actions

Theatres

Following steady improvement in capped theatre utilisation over the last 12 months, and having achieved the national standard of 85% for the first time in April, Divisional teams have worked hard to sustain this achievement with 3 of the last 4 months attaining 85%+ and the financial year to date position standing at 85.1% up to 31st July. Model Hospital data in July places the Trust 6th best nationally. Average cases per theatre list continues to perform well placing the Trust 8th best nationally. Following last year's success of reducing arthroplasty length of stay, the project has now begun focusing on achieving future milestones with the group is working up plans to implement a 23 hour stay / same day joint service. Cancellations 0-3 days prior to surgery continues perform well, being one of the best performing Trusts in the country.

Elective Activity

Overall elective inpatient and day care activity remains over plan by 7%, almost 700 patients, with a slight under delivery in New Outpatients activity, by 3%, and Follow up Outpatients is behind plan by 4%. The reason for the deterioration is mainly in some key medical specialties where we have had some workforce issues and increased in referrals.

Diagnostics

Overall Diagnostics is delivering 98% of 26/27 activity plan in M5 which is 143% compared with 19/20 activity. The Community Diagnostic Centre (CDC) is delivering approximately 4.5k tests per month. The patients waiting greater than 6 weeks for a Diagnostics test has increased driven by issues in Echocardiography, Respiratory sleep studies, Audiology and Non-Obstetric ultrasound.

Long waiting patients

- At the end of July, we had m 4 English patients were waiting 65 weeks.
- 147 English patients were waiting over 52 weeks for treatment at the end of May

What the charts tell us

- Performance against English RTT standard in July was 66% / 0.8 % of English patients on our Waiting List were waiting more than 52 weeks
- Performance against the Welsh RTT standard in July was 66.8%

Risks

- Workforce challenges to meet activity / Diagnostic plans due to recruitment of substantive and Locum staff, along with continued impact of high cancer referrals.
- Increased level of referrals from Primary Care and internal pathways. Year to Date 5% increase above predicted.

Our Workforce – Executive Summary

Geoffrey Etule
Chief People Officer

Sickness absence stands at 4.6% with Long Term Sickness at 2.58 %.and Short Term sickness at 2.06 %. The main reasons for sickness absence are mental health conditions, gastro conditions, colds and pregnancy related conditions. WVT is maintaining its position as having the lowest sickness absence rates in the Foundation Group and is still amongst acute trusts with the lowest % of sickness absence across the NHS.

Staff turnover has dropped to 7.9 % and HR teams will continue with their active engagements in divisional recruitment & retention working groups to ensure that local actions are being implemented to fill vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at 5.73% and turnover for band 2/3 hcsw staff has reduced from 19.61% (Aug 2025) to 14.53%. The centralised recruitment process, ongoing drop-in recruitment activity and active work with the DWP in filling our vacancies is having a positive impact.

The workforce optimisation and efficiency working group is now in place with representation across the Trust to look at expediting schemes to enhance workforce productivity and reduce costs over the next 6 to 12 months. A plan to rollout e-rostering to doctors and other clinical areas over the next year is being finalised as this is a key area to enhance workforce productivity.

New NHS Staff Standards aim to prioritise staff experience and ensure a consistent level of experience is felt by NHS staff. These standards set clear minimum expectations for employers, focusing on line management, health and wellbeing, violence prevention and reduction, tackling racism, championing sexual safety, and promoting flexible working. Working with our trade union representatives and staff networks we are implementing the standards at WVT through our HR processes and policies.

The new NHS Leadership and Management Framework supports leaders and managers working across organisational boundaries and emphasises collaboration with partners, communities and wider system stakeholders. A WVT plan to implement and embed the framework into local processes during 2026/27 is being progressed through the People & Organisational Development Committee.

WVT has been shortlisted as a finalist for the 2026 national HPMA Awards for excellence in people management for our health and wellbeing programmes.

As part of our health & wellbeing programme, we are working with Halo leisure and supporting their *Our Health Horizons* programme this September which is specifically tailored for individuals managing heart health, neurological conditions, or recovering from cancer. This four-week course is a holistic support system that combines expert-led education on fatigue management and mindfulness with gentle, supervised physical activity.

Performance appraisals remains low at 72.6% and this is being addressed at FPE meetings. WVT continues to perform well with mandatory training which now stands at 88.4%.

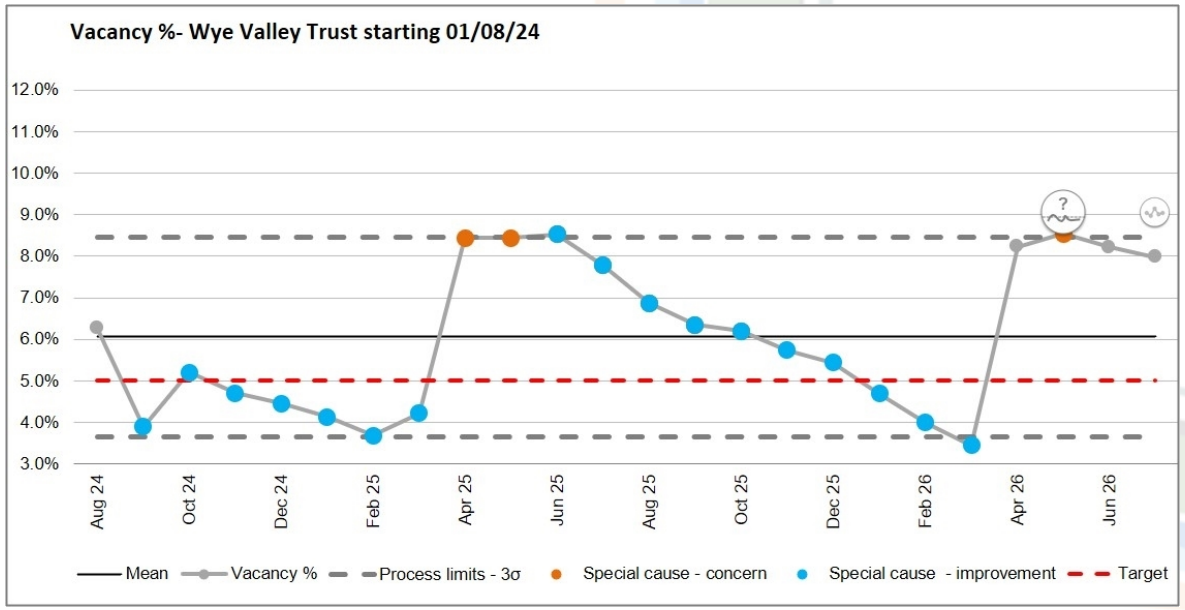
Workforce Performance – Vacancy

We are driving this measure because:

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

Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
7.8%	6.9%	6.3%	6.2%	5.7%	5.4%	4.7%	4.0%	3.4%	8.2%	8.5%	8.2%	8.0%

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



Performance & actions

HCSW – vacancies have fallen to 15.37 wte due to the centralised recruitment process and ongoing drop-in open recruitment sessions by the recruitment team. We are also working actively with the DWP to fill our vacancies.

N&M - since pausing international recruitment last year we are still seeing a good number of UK based applicants for our vacancies. We currently have 25.52wte vacancies on ESR.

M&D - we continue to work actively with a number of recruitment agencies in order to fill our vacancies. Regular meetings with CMO, CPO and Medical Staffing Manager to review progress with vacancies and cases of concern. We currently have 66.61wte vacancies on ESR.

We are continuing with our recruitment events and promoting our vacancies Herefordshire wide with a series of events supported by WVT Ambassadors including career events at schools, colleges and universities. We are also maintaining our presence at jobcentreplus offices and advertising our vacancies across local community organizations too.

Risks

Clinical vacancies , Band 2 HCSW vacancies

What the chart tells us

There is a large increase in the first month of 25/26, mainly related to an increase of substantive budget together with a bottom-up exercise and review of rostering areas. From month 4 onwards this has now decreased as budget has started to be moved to CIP codes and as a result of headcount reduction. Month 1 of 26/27 has shown a large increase, due to an increase in budget for the new financial year to cover usage, this has slightly increased in month 2 but come back down in month due to a decrease in budget, the trend continues in month 4 due to an increase in staff in post.

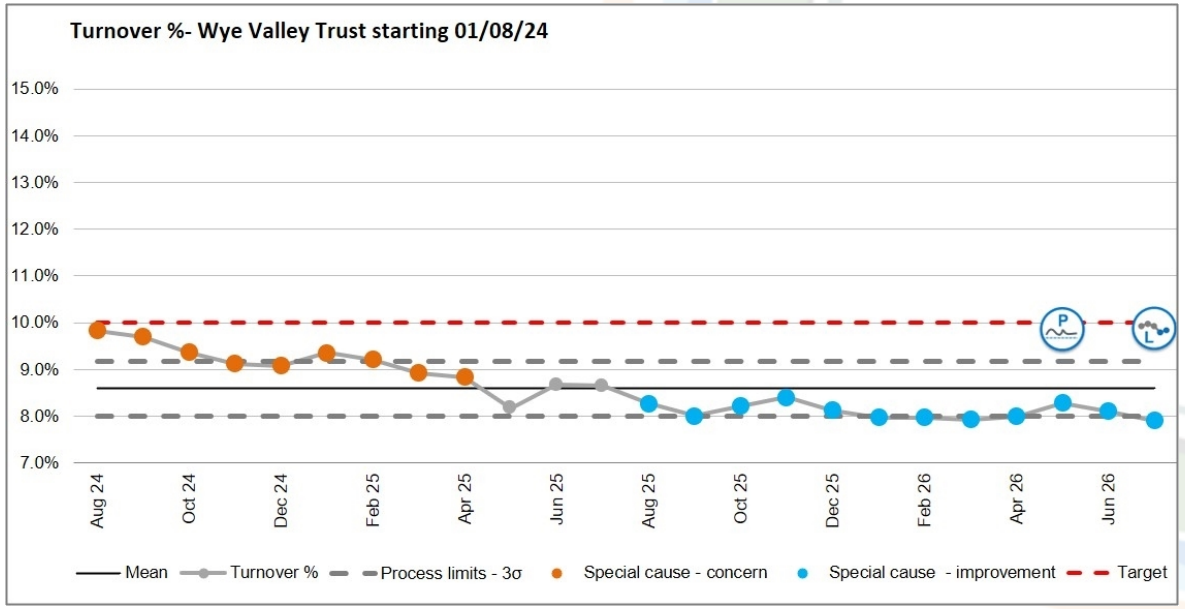
Workforce Performance – Turnover

We are driving this measure because:

To improve retention of staffing levels, maintaining standards to provide high quality care as well as reducing the reliance on temporary staffing, namely agency.

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

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



Performance & actions

Turnover at Trust level is at 7.9% and we are taking steps to ensure this stays below 10.0%.

Clinical support workers at band 2 level have the highest turnover rate at the Trust but this has fallen from a high of 19.61% to 14.53%. We have reintroduced the centralised recruitment process and enhanced the pastoral care support and training being provided. HR business partners are supporting line managers in areas of high turnover and highlighting career development opportunities through apprenticeships.

Turnover rates for qualified nurses remains low at 5.73% and divisional teams are using a variety of flexible working options and development opportunities to retain staff.

Through divisional recruitment & retention working groups, HR and line managers review and analyse new starter surveys and exit interview data so local actions can be implemented as appropriate. The WVT recruitment & retention working group continues to oversee exit interview surveys and recruitment & retention areas of concern to ensure actions are being progressed in a timely manner to aid recruitment & retention of staff across the trust.

Risks

Staff turnover for support workers

What the chart tells us

The rolling 24-month position shows an overall decreasing trend. A fluctuating pattern in 25/26 but continuing with an overall decreasing trend, remaining consistent in the last 8 months.

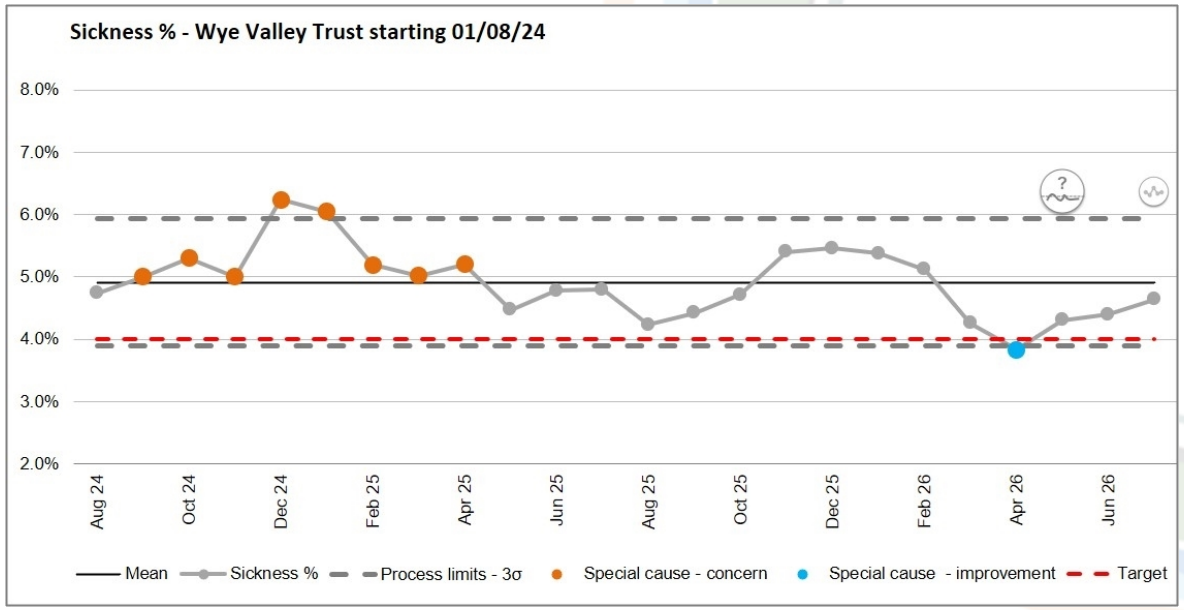
Workforce Performance – Sickness

We are driving this measure because:

We aim to reduce absence, so wards are appropriately staffed to provide high quality care as well as reducing the reliance on temporary staff.

Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
4.8%	4.2%	4.4%	4.7%	5.4%	5.5%	5.4%	5.1%	4.3%	3.8%	4.3%	4.4%	4.6%

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



Performance & actions

During this month, overall sickness at Trust level is at 4.6% and the main reasons for absence are gastro conditions, mental health issues, colds and long-term conditions.

At F&PE meetings, divisions will continue to present comprehensive data on sickness absence which includes heat maps, costs, no. of reviews and % of return-to-work interviews conducted. These reports are important to show concrete actions being taken to manage sickness absence effectively across WVT.

HR teams continue to sensitively support the management of long- and short-term sickness absence and considerable work continues to be done to enhance the wellbeing staff support offer including fast track OH referrals, wellbeing training, more psychological and team-based wellbeing support for staff. The wide range of health & wellbeing initiatives are still in place for staff.

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

Risks

What the chart tells us

There was a slight increase in the first month of 25/26 that peaked in December 25, then reducing slightly in the first 2 months of the year before a large decrease in March 26, followed by a further decrease in April 26, to our lowest levels of sickness. This increased in month 2 back to levels seen at the end of 25/26 and remained the constant in month 3, with a slight increase last month.

Our Finance – Executive Summary

Katie Osmond
Chief Finance Officer

Month 4 Income and Expenditure position

At the end of Month 4 we are slightly behind plan at (£2.4m) deficit against a (£2.1m) plan.

The plan includes a £24.7m efficiency challenge with the focus continuing on the identification and delivery of CPIP to achieve our breakeven plan and improve our underlying position. This includes schemes relating to transformational change and the left shift of care closer to the community which positively contributed to setting a balanced plan for the year. At the end of July, 59% of the targeted efficiency challenge had been assessed as fully developed or implemented, reflecting the lowest level of risk. Around one quarter of the target was within the highest risk categories reflecting the importance of continued grip and control measures and development of opportunities into actionable plans. The well-established Financial Recovery Board (FRB) maintains strong oversight of the risks and mitigations to support delivery of the plan and improvement in our underlying position, as well as our internal Check & Challenge meetings held with the Divisional teams maintaining accountability. Our focus in 2026/27 is building on the strong engagement in and ownership of the financial agenda as we seek to balance transactional and transformational financial improvements to ensure sustainability in the medium-term.

Significant focus is on developing our four big transformational schemes, Neighbourhood Health workstreams and associated assessment of financial benefits to underpin our medium-term financial plan and wherever possible support in year delivery.

Key headlines within the month / year to date:

- The net position for income is adverse by (£0.3m), mainly driven by an underperformance on variable activity
- Agency spend continues on a positive trend against plan linked to a range of actions within out medical and nursing agency reduction programmes, including a successful recruitment drive.
- Industrial action led to an unplanned pay cost of £0.2m in Month 1
- Planned efficiencies not fully delivered YTD (£1.2m) primarily due to slippage on the timing of implementation and working up of a complex transformation plan. Mitigated through timing of expenditure and non recurrent benefits.

Cash and Capital

Cash balances at the end of July are higher than planned, mainly driven by a higher closing balance as we exited 2025/26, a reduction in debtors and the national deficit support being received quarterly in advance.

Capital expenditure is less than planned at the end of July, largely due to the timing of the modular theatre development.

Finance Headlines

YTD Deficit
(£2.4m) against
(£2.1m) deficit plan

CPIP YTD **£4.9m** delivered
Against £6.0m YTD target

Agency YTD Spend
£1.4m against
£2.4m YTD Budget

Forecast Outturn
To Match plan
£0m – Break Even

Bank Spend
£6.2m against
£5.2m YTD Budget

Total Workforce (S/B/A)
4,009 WTE worked against
3,923 planned WTE

Finance Performance – Year to Date Income and Expenditure

We are driving this measure because:

The Income and Expenditure plan reflects the Trust's breakeven plan, operations and the resources available to the Trust to achieve its activity, workforce and financial objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

STATEMENT OF COMPREHENSIVE INCOME - To Month 4 - 31st July 2026 - 2026/27

	2026-27 ANNUAL BUDGET	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE CUMULATIVE VARIANCE	VARIANCE IN CURRENT MONTH
	£000	£000	£000	£000	£000
Operating income from patient care activities	374,395	123,573	122,872	(701)	348
Drugs Excluded	24,610	8,203	7,680	(523)	(507)
Other operating income	15,352	5,035	6,063	1,027	235
Donations from non current asets	240	80	0	(80)	(20)
Total Operating Income	**414,597**	**136,891**	**136,615**	**(277)**	**56**
Substantive Pay	(238,385)	(78,486)	(78,449)	38	275
Bank & WLI Pay	(14,507)	(5,235)	(6,197)	(962)	(428)
Agency pay	(5,638)	(2,439)	(1,377)	1,062	182
Subtotal Pay	***(258,529)***	***(86,160)***	***(86,023)***	***137***	***28***
Non Pay Expenditure	(100,621)	(34,395)	(36,000)	(1,605)	(452)
Excluded Drugs	(24,610)	(8,203)	(7,817)	387	291
Total Operating Expenditure	**(383,760)**	**(128,759)**	**(129,840)**	**(1,081)**	**(133)**
EBITDA	**30,837**	**8,133**	**6,775**	**(1,358)**	**(77)**
Depreciation	(15,604)	(5,204)	(4,621)	583	146
Impairment (CDC & PFI)	0	0	0	0	0
Interest Receivable	900	300	754	454	110
Interest Payable on Loans	(257)	(86)	(70)	16	(3)
Interest Payable on PFI	(3,030)	(420)	(420)	(0)	(0)
Dividends on PDC	(4,954)	(1,650)	(1,650)	0	0
Operating Surplus/ (Deficit)	**7,892**	**1,072**	**768**	**(305)**	**176**
Technical Adjustments					
Donated Assets Adjustment	742	248	238	(9)	(2)
Net impact of asset impairments	0	0	0	0	0
Impact of IFRS16 Implementation of PFI Contract	(8,634)	(3,460)	(3,421)	39	10
Adj. financial performance retained Surplus/ (Deficit)	**0**	**(2,140)**	**(2,414)**	**(275)**	**184**

Performance & actions

The position at the end of Month 4 (July) was a deficit of (£2,414k) YTD. This is performing slightly behind plan with an overall negative variance of (£275k) YTD, £184k favourable in month.

- Income shows an adverse variance of (£277k) YTD due to income for patient care activities being (£701k) behind plan largely in relation to depreciation offset in expenditure. The position includes at risk income in relation to Powys activity. Other operating income has a favourable variance of £1,027k. High-cost drugs income is (£523k) lower than planned YTD and largely aligns with expenditure.
- Pay is favourable by £137k YTD. The net position in month includes agency - 1.78% of total pay costs in month which is a slight increase from 1.76% in month 3. YTD bank (including WLI) and agency, as total temporary staff proportion, is 8.8% of overall pay, including costs for Industrial Action in M1 (c£150k). Nurse agency usage has remained low, with no spend on Healthcare Support Worker agency.
- Total Non-Pay (operating & non operating) is adverse by (£136k) YTD including technical adjustment benefits. The adverse variance is largely due to undelivered CPIP. The underspend on Depreciation/ Amortisation has led to a reduction in income (per income narrative above). Interest received is favourable due to higher cash balances than planned and timing of expenditure.
- Within Adjustments, there is a PFI £39k favourable variance driven by technical adjustments to the control total for historical accounting changes on PFI.

Risks

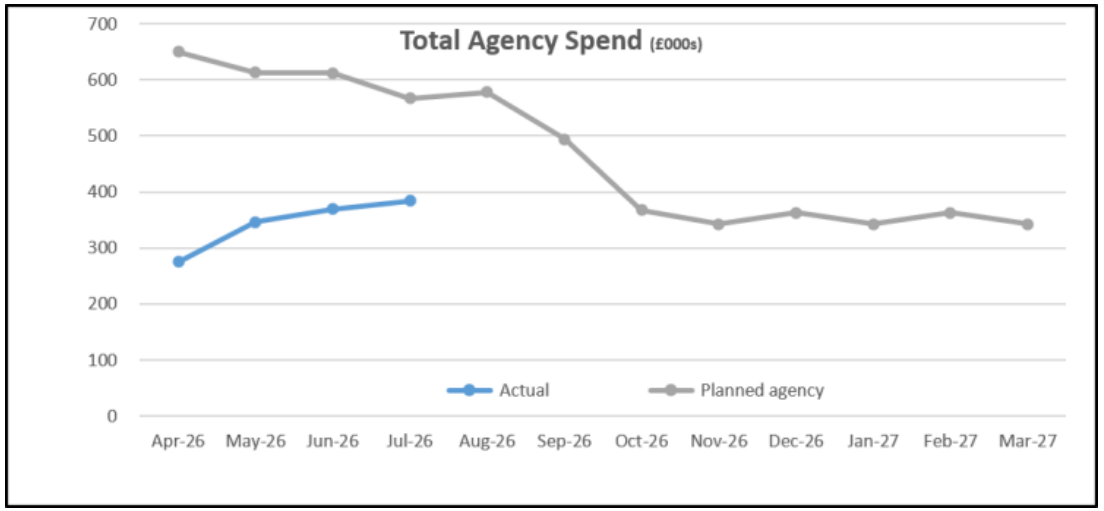
Key Financial risks mitigated throughout the year

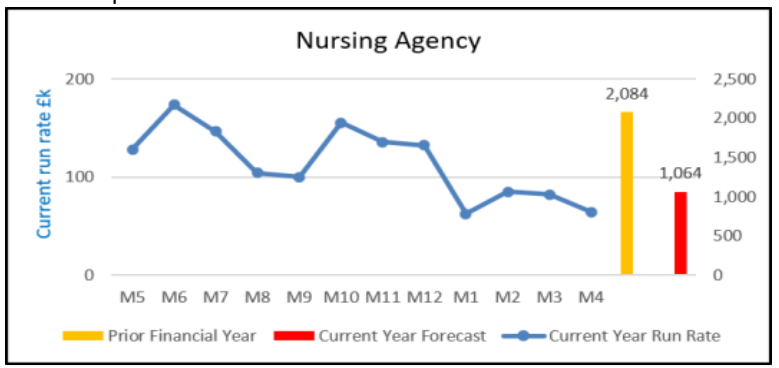
- Overall cost reduction needed to achieve breakeven by end of year and maturity status of programme
- CPIP Cost Efficiency delivery recurrently
- Level of Bank (as % of pay)
- Income risk around deficit support funding and Welsh parity
- Future cost pressures: e.g. Industrial Action / Winter impact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

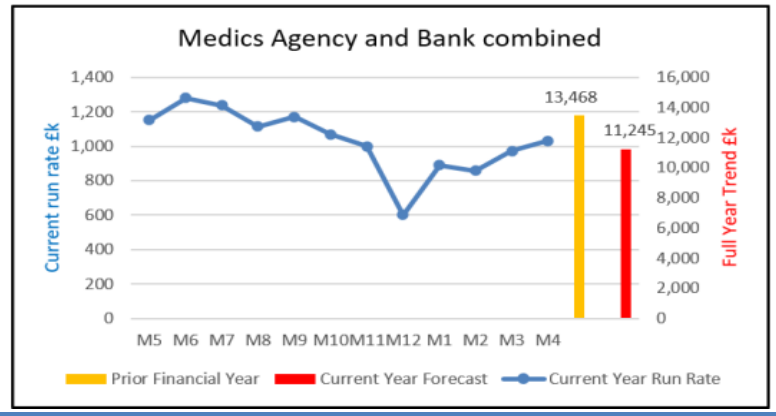
Finance Performance – Temporary Staffing Spend

We are driving this measure because:

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







Performance & actions

Agency represents 1.60% of total pay costs year to date, with an aim to reduce spending down to zero by 2029/30, in line with national guidance. Agency performed better than plan YTD by £1,062k, including non recurrent savings in month. Total agency spend year to date is £1,377k.

- **Nursing agency:** Total spend in 2025/26 was £2.1m, which was achieved through significant efficiencies through rate reduction changes and the elimination of HCSW agency spend. The planned spend in 2026/27 is £1.1m Nurse agency spend YTD is £294k.
- **Off framework Nurse Agency:** There have been 12 off framework shifts in July 2026 level with the 12 in June 2026 (37 YTD). The total shifts booked in 2025/26 was 64.
- **Medical staffing agency and bank:** The Trust spent £13.5m in 2025/26. The total spend YTD is £3,750k, which is on trend to meet the planned spend of £11.2m. M1 included Industrial action incurring a cost pressure of £150k.

Risks

Level of Agency reduction in latter half of financial year

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

Increase in emergency demand pressures

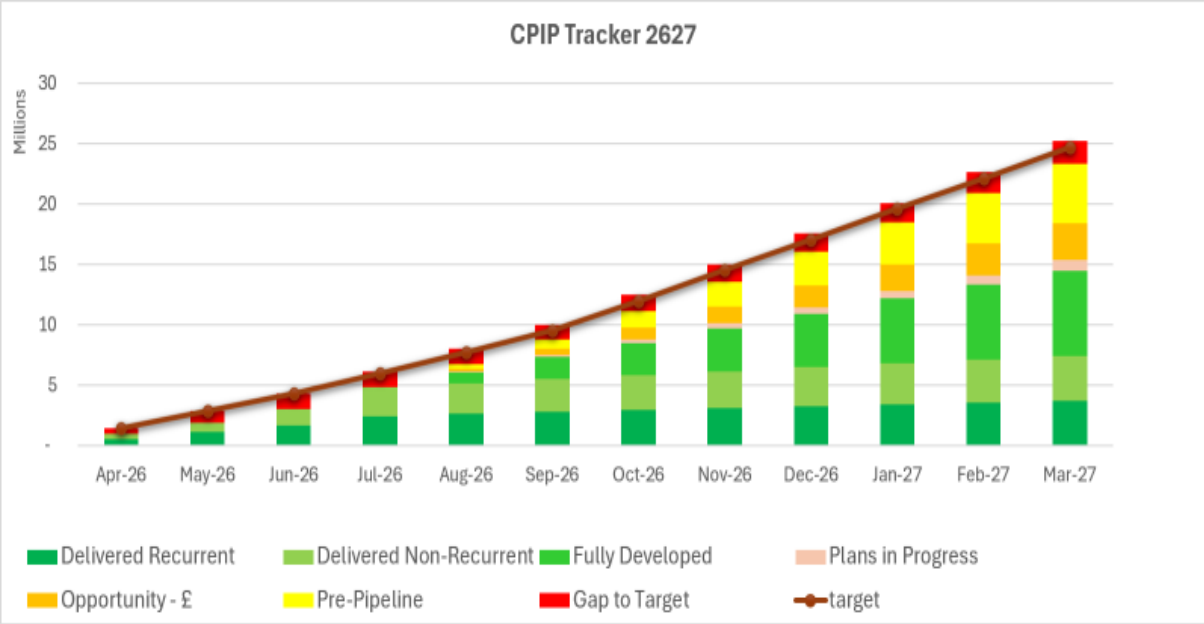
What the charts tell us

Agency performance is well within plan at Month 4 and will require a sustainable recurrent low level of spend to remain within target. Focus remains on high cost bank.

Finance Performance – Cost Improvement Programme

We are driving this measure because:

Delivering our cost efficiency programme is key to successfully mitigating financial risk and delivering the financial plan. Maximising recurrent efficiencies is critical to our financial sustainability and tackling our underlying deficit in the medium term.



Risks

Under achievement of Cost Improvement (CPIP)
Achievements relying on non recurrent delivery
Opportunity and Plans in Progress schemes not developing at pace needed for full delivery
Undelivered / non recurrent CPIP will impact 2027/28 requirement

What the charts tell us

Challenging CPIP target of £24.7m forecast to be delivered in 2026/27. Focus is on identifying and de-risking schemes as quickly as possible to move into deliverable schemes, in order to deliver a sustainable level of savings.

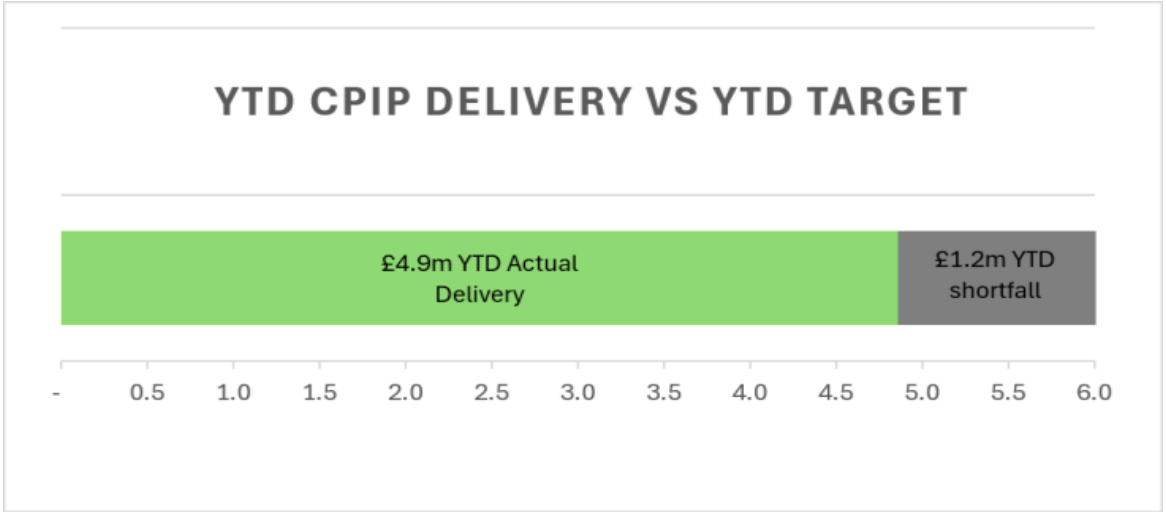
Performance & actions

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

The Trust efficiency delivery YTD at month 4 was £4.9m, £1.2m away from plan, mitigated through non recurrent benefits.

At the end of June, 59% of the targeted efficiency challenge had been assessed as fully developed or implemented, reflecting the lowest level of risk. Around one quarter of the target remains within the highest risk categories reflecting the importance of continued grip and control measures and development of opportunities into actionable plans. Recurrency levels are currently behind plan YTD with annual forecast remaining on plan.

The FRB will continue into 2026/27 focusing on the identification and delivery of CPIP to achieve our breakeven plan, including schemes relating to transformational change and the left shift into care closer to the community.



Finance Performance – Cash and Capital

We are driving this measure because:

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

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

Cash

Cash Balance				
Month	Performance	Target	Direction	Rating
May	50.8	39.1		
June	46.1	36.8		
July	49.2	35.7		
We started 26/27 with £6m more than planned, received £3.4m DSF in advance YTD and have seen a reduction in debtors. Cash is therefore £13m more than plan at month 4.				

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
May	99.1%	95.0%		
June	99.0%	95.0%		
July	98.9%	95.0%		
In July the Trust paid 98.9.0% of invoices within 30 days. This equates to 98.5% by invoice value. This is the fourteenth month, in a row, that we have achieved the 95% (by volume) target.				

Capital

To 31st July 2026, Month 4

Capital Scheme Type	Type of Capital	Full Year Plan £k	Year to Date - Month Budget £k	Actual £k	Variance £k	Full Year Forecast £k	Variance £k
Local CDEL funded	Owned	8,439	4,947	1,832	3,115	8,439	0
IFRS16 Leases	Leased	1,000	551	0	551	1,000	0
National PDC schemes	Owned	6,838	520	208	312	6,838	0
Grant funded and Donated	Owned	2,923	1,783	2,028	(245)	2,923	0
Total Capital Programme		19,200	7,801	4,098	3,703	19,200	0

What the charts tells us

Cash
The 2026/27 opening cash balance was £6m higher than planned. In 2026/27 we have benefited from a reduction in debtors and receipt of national deficit support quarterly in advance.

Capital
The capital expenditure for July 2026 was £4.1m, £3.7m lower than planned. The primary driver for this variance relates to the Modular Theatre development. The lease relating to this project will be fully capitalised upon completion, which is now forecast for the Autumn.

Performance & actions

Cash
Continued close management of the overall cash position will be necessary for 2026/27 with respect to CPIP delivery and receipt of deficit support funding.

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

Risks

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

Finance Performance – Statement of Financial Position

We are driving this measure because:

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

June 2026	2025/26	2026/27			2026/27 Full Year		
	Accounts £000s	M4 Plan £000s	M4 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	174,368	176,884	175,179	(1,705)	183,533	181,806	(1,727)
Intangible Assets	8,904	7,492	7,641	149	5,421	5,059	(362)
Trade and Other Receivables	1,410	1,197	1,454	257	1,197	1,410	213
TOTAL Non Current Assets	**184,682**	**185,573**	**184,274**	**(1,299)**	**190,151**	**188,275**	**(1,876)**
CURRENT ASSETS:							
Inventories	4,995	5,581	4,878	(703)	5,581	4,995	(586)
Trade and Other Receivables	29,505	33,293	27,206	(6,087)	38,493	37,305	(1,188)
Cash and Cash Equivalents	49,052	35,706	49,154	13,448	39,966	45,966	6,000
TOTAL Current Assets	**83,552**	**74,580**	**81,238**	**6,658**	**84,040**	**88,266**	**4,226**
TOTAL ASSETS	**268,234**	**260,153**	**265,512**	**5,359**	**274,191**	**276,541**	**2,350**
CURRENT LIABILITIES							
Trade and other payables	(46,261)	(42,593)	(47,820)	(5,227)	(40,943)	(44,117)	(3,174)
Borrowings - Loans, PFI and Finance Leases	(14,291)	(16,077)	(10,797)	5,280	(16,077)	(15,301)	776
Provisions	(185)	(49)	(46)	3	(49)	(185)	(136)
Total Current Liabilities	**(60,737)**	**(58,719)**	**(58,663)**	**56**	**(57,069)**	**(59,603)**	**(2,534)**
NET CURRENT ASSETS/(LIABILITIES)	**22,815**	**15,861**	**22,575**	**6,714**	**26,971**	**28,663**	**1,692**
TOTAL ASSETS LESS CURRENT LIABILITIES	**207,497**	**201,434**	**206,849**	**5,415**	**217,122**	**216,938**	**(184)**
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(30,565)	(26,828)	(29,167)	(2,339)	(18,719)	(19,699)	(980)
Provisions	(1,556)	(1,489)	(1,538)	(49)	(1,489)	(1,556)	(67)
Total Non-Current Liabilities	**(32,121)**	**(28,317)**	**(30,705)**	**(2,388)**	**(20,208)**	**(21,255)**	**(1,047)**
ASSETS LESS LIABILITIES	**175,376**	**173,117**	**176,144**	**3,027**	**196,914**	**195,683**	**(1,231)**
TAXPAYERS EQUITY							
Public dividend capital	339,856	339,817	339,856	39	356,794	352,271	(4,523)
Revaluation reserve	18,280	17,203	18,280	1,077	17,203	18,280	1,077
Income and expenditure reserve	(182,760)	(183,903)	(181,992)	1,911	(177,083)	(174,868)	2,215
TOTAL	**175,376**	**173,117**	**176,144**	**3,027**	**196,914**	**195,683**	**(1,231)**

Performance & actions

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

Non-Current Assets
Non-Current assets are £1.3m lower than plan at month 4 due to capital expenditure being lower than planned YTD combined with the opening balances from 2025/26 being greater than planned.

Working balances
Net working balances - receivables less payables - have decreased by £11m compared to plan, due to debtors being lower than plan and creditors being higher than planned.

Cash: We started 2026/27 with £6m more than planned and have benefited from other working capital changes impacting overall cash by £13m when compared to YTD plan.

Borrowings
Borrowings balances differ (plan versus actual) due to timing of split between current and non current but broadly off-set across both categories.

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

The income and expenditure reserve closing balance in 2025/26 was £2.2m better than the outturn used for the 2026/27 plan. This variance is reduced by the retained surplus being £0.3m behind plan at the end of July.

Risks

Delivery of the I&E plan and the cash forecast remain risks to the strength of the balance sheet which continue to be closely monitored.

What the chart tells us

Current assets outweigh current liabilities.

NHS
Wye Valley
NHS Trust

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

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

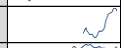
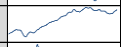
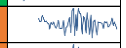
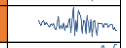
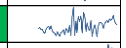
Type	Item	Description
Pass/Fail	F	The system is expected to consistently Fail the target
Pass/Fail	P	The system is expected to consistently Pass the target
Pass/Fail	?	The system may achieve or fail the target subject to random variation
Trend Variation	H	Special cause variation - cause for concern (indicator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

Example

Data Quality Assurance Questions

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

Quality of care, access and outcomes		Responsible Director	Standard	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Latest Month Numerator	Latest Month Denominator	Year to Date v Standard	Trend - Apr 2019 to date	Latest Available Monthly Position: WVT Latest month v benchmark	Latest Available Monthly Position: National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	**80%**	83.8%	80.0%	86.0%	83.6%	82.2%	84.3%	86.4%		918	1062	84.4%			79.0%	June	?	H	
	2 Week Wait all cancers	Chief Operating Officer	**93%**	83.6%	84.9%	80.1%	88.9%	86.2%	74.1%	86.4%		957	1107	82.4%			76.5%		?	~	
	Urgent referrals for breast symptoms	Chief Operating Officer	**93%**	38.1%	31.3%	53.3%	64.0%	69.2%	10.0%	53.3%		8	15	47.4%			62.9%		?	~	
	Cancer 31 Days Combined	Chief Operating Officer	**96%**	97.1%	90.2%	98.0%	96.4%	94.9%	95.8%	96.7%		147	152	95.8%			92.2%		?	H	
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Chief Operating Officer		2	4	6	4	9	6	4				19					?	L	
	Cancer 62 days Combined	Chief Operating Officer	**75%**	89.1%	81.7%	76.8%	88.4%	76.5%	80.5%	85.7%		105	122	80.8%			75.7%	Jun	?	H	
	Cancer: number of cancer patients waiting over 62 days	Chief Operating Officer	**Plan**	56	55	36	32	42	27	30	35								?	L	
Primary care and community services	Community Service Contacts - Total	Chief Operating Officer	**v 2025/26**	132%	134%	126%	121%	110%	104%	109%		36736	33683	108%					?	H	
	Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	**70%**	93%	90%	90%	95%	93%	91%	91%	93%	224	240	92.0%			86%	Jun	P	H	
	% emergency admissions discharged to usual place of residence	Chief Operating Officer	**90%**	87%	87%	88%	87%	92%	92%	92%	93%	3055	3301	92.2%			93%	Jun to May	?	L	
Urgent and emergency care	A&E Activity	Chief Operating Officer	**Plan**	95%	107%	96%	96%	104%	102%	107%	103%	6538	6330	104%					?	H	
	Ambulance handover within 30 minutes (WMAS Only)	Chief Operating Officer	**98%**	56.5%	39.9%	45.4%	45.8%	50.3%	55.7%	49.1%	65.5%	947	1445				73%	July	F	L	
	Ambulance handover within 45 minutes (WMAS Only)	Chief Operating Officer	**0%**	69.3%	51.7%	59.1%	59.0%	62.9%	67.5%	62.2%	76.4%	331	1445								
	Ambulance handover over 60 minutes (WMAS Only)	Chief Operating Officer	**0%**	24.8%	40.5%	32.7%	30.9%	27.8%	25.0%	28.5%	15.6%	226	1445	27.1%			12%		F	H	
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	**v 2025/26**	122%	128%	124%	126%					1639	1304	122%					?	H	
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	**45%**	48%	49%	50%	47%	48%	50%	52%	54%	1580	2933	51.3%			36%	Jun to May	?	H	
	A&E - % of patients seen within 4 hours	Chief Operating Officer	**78%**	65.3%	65.0%	63.2%	63.7%	66.2%	63.1%	62.6%	65.3%	4902	7511	64.3%			75%	Jul	F	H	
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		10.4%	13.9%	12.3%	12.3%	9.8%	11.2%	11.8%	9.9%	740	7511	10.9%			8%	June to May	F	H	
	A&E - Time to treatment	Chief Operating Officer		01:36	01:50	01:42	01:52	01:33	01:45	02:02	02:08						01:47			~	
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	**<15 minutes**	00:26	00:30	00:26	00:26	00:25	00:25	00:28	00:26						00:19		F	L	
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	**0**	202	274	234	234	161	174	176	126			511					F	~	
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	**3%**	8.7%	8.5%	8.7%	7.9%	8.7%	8.3%			107	5309	8.5%			10%	Jun to May	F	~	

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	**61%**	64.3%	65.2%	66.0%	67.8%	67.3%	66.9%	66.0%	66.0%	15017	22761				65.8%	Jun			
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	**TBC**	64.7%	64.3%	65.7%	66.8%	66.9%	65.2%	66.8%	66.7%	3158	4725								
	Referral to Treatment - Percentage of patients waiting no longer than 18 week for a first appointment - English Standard	Chief Operating Officer	**72%**	74.3%	74.5%	75.0%	75.1%	76.6%	76.9%	77.0%	75.8%	9318	12102							
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		26168	25888	26034	26031	26420	27140	27486	27798										
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	832	754	733	546	566	618	638	740						105711				
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	143	178	210	219	241	263	283	328						7831	June			
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	**0**	46	62	79	108	125	138	144	170						1099				
	GP Referrals	Chief Operating Officer	**2025/26**	113%	102%	99%	107%	104%	99%	115%	99%	4353	4393	**104%**							
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	**Plan**	94%	96%	99%	107%	95%	101%	97%	91%	7192	7915	**96%**							
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	**Plan**	100%	104%	106%	106%	96%	100%	94%	94%	22504	23850	**96%**							
	Proportion of Total Outpatient Appointments which are New or Follow Up Procedure	Chief Operating Officer	**46%**	47%	47%	46%	47%	46%	48%	48%	48%	12712	26513	48%			46.5%	Jun to May			
	Total Elective Activity (volume v plan)	Chief Operating Officer	**Plan**	102%	108%	106%	108%	114%	105%	100%	98%	3734	3823	**103%**							
	Elective Recovery Fund (ERF) Actual v Plan (£)	Chief Operating Officer	**Plan**	155%	137%	139%	147%							136%							
	BADS Daycase rates	Chief Operating Officer	**Actual**	80.4%	78.7%	78.7%	76.3%	82.8%						**82.8%**			79%	May to Apr			
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	**85%**	83.3%	79.6%	83.9%	82.4%	85.3%	83.7%	85.4%	85.0%			**84.9%**			81%	May			
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	**85%**	86.0%	82.4%	86.7%	85.9%	91.0%	86.7%	88.2%	88.4%			**88.6%**			85%	Feb			
	Cancelled Operations on day of Surgery for non clinical reasons	Chief Operating Officer	**10 per month**	26	56	34	41	14	26	10	13			50			22029	Apr to Mar			
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	**Plan**	90%	83%	86%	91%	107%	107%	114%	101%	3297	3256	**107%**							
	Diagnostic Activity - Endoscopy	Chief Operating Officer	**Plan**	126%	120%	107%	90%	92%	83%	79%	75%	762	1022	**81%**							
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	**Plan**	131%	101%	98%	111%	99%	98%	98%	92%	1751	1907	**97%**							
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	**<5%**	15.7%	14.7%	11.6%	11.8%	14.0%	15.6%	18.6%	19.7%	1301	6599				23.3%	Jun			
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	**90%**	93.9%	93.7%	94.4%	96.9%	95.0%	90.3%	94.9%	92.6%	125	135	**93.3%**							
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Chief Medical Officer	**<15%**	19.2%	20.0%	22.0%	22.0%	21.9%	24.0%	20.2%	16.0%	16	100	**16.0%**							
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Chief Medical Officer	**<34%**	67.6%	60.6%	56.7%	57.6%	59.0%	60.8%	62.5%	66.5%	121	182	**66.5%**							
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Chief Medical Officer	**<60%**	91.3%	89.5%	88.9%	89.8%	89.6%	90.3%	89.4%	90.8%	138	152	**90.8%**							
	Maternity Activity (Deliveries)	Chief Nursing Officer	**v 2024/25**	94%	101%	89%	98%	109%	101%	96%	109%	142	130	104%							
	Midwife to birth ratio	Chief Nursing Officer	**1:26**		1:32	1:32	1:27	1:25	1:24	1:25	1:28										
Outpatient transformation	DNA Rate (Acute Clinics)	Chief Operating Officer	**<4%**	5.9%	6.0%	5.8%	5.7%	5.9%	6.0%	6.1%	6.2%	2001	30047	**6.1%**			6.8%	Jun to May			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	**90%**	85.7%	86.7%	87.6%	90.1%	90.1%	88.9%	89.5%	89.6%	16897	18855	**89.5%**							
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	**Plan**	104%	108%	110%	106%	97%	100%	93%	96%	15312	15935	**96%**							
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	**25%**	21.9%	20.2%	19.7%	19.5%	20.2%	19.5%	18.7%	19.0%	4283	22504	**19.3%**			18%	Jun to May			
Prevention long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer		4.6%	4.0%	5.6%	3.9%	2.9%	4.9%	5.1%	10.4%	14	135								

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	**<92%**	98%	100%	100%	100%	100%	100%	100%	98%	310	315	**100%**			95%	Jul			
	Bed occupancy - Community Wards	Chief Operating Officer	**<92%**	99%	96%	97%	96%	95%	97%	97%	96%	81	84	**96%**							
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	**0**	94	133	85	71	51	69	106	118			**344**			4979	Jun			
	Patient ward moves emergency admissions (acute)	Chief Operating Officer	**4%**	6%	7%	7%	8%	7%	8%	7%	8%	97	1223	7%							
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	**4.5**	5.9	6.5	5.8	6.9	3.5	3.3	3.4	3.2	8957	2809	**3.3**			4.4	Jun to May			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	**2.5**	2.3	1.9	2.3	1.9	2.6	2.7	2.9	1.9	506	270	**2.4**			3.4	Jun to May			
	ALoS - General & Acute Adult (English)	Chief Operating Officer		5.2	5.6	4.9	5.6	3.2	3.1	3.0	3.0	7959	2677	3.1							
	ALoS - General & Acute Adult (Welsh)	Chief Operating Officer		6.4	6.3	6.6	7.3	4.6	4.3	5.2	3.5	1504	432	4.4							
	Medically fit for discharge - Acute	Chief Operating Officer	**5%**	16.8%	17.6%	19.0%	14.7%	14.5%	16.6%	17.0%	16.3%	1525	9354				23.1%	Dec			
	Medically fit for discharge - Community	Chief Operating Officer	**10%**	32.4%	29.5%	21.0%	22.9%	22.5%	25.5%	23.1%	29.2%	755	2587								
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	**5%**	5.1%	4.7%	4.6%						155	3373	**4.9%**			8.5%	May to Apr			
	Mortality SHMI - Rolling 12 months	Chief Medical Officer	**<100**	112.8	113.2	113.8	114.7					1305	1135				100				
	Never Events	Chief Nursing Officer	**0**	0	1	0	0	0	0	0	0			**0**							
	MRSA Bacteraemia	Chief Nursing Officer	**0**	0	0	0	0	0	0	1	0			**1**							
	MSSA Bacteraemia	Chief Nursing Officer		2	3	2	5	0	5	3	5			**4**							
	Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	**44**	1	4	6	4	7	5	3	5			20							
	Number of falls with moderate harm and above	Chief Nursing Officer	**2022/23 (30)**	0	4	5	3	4	0	1	1			6							
	VTE Risk Assessments	Chief Medical Officer	**95%**	91.8%	92.1%	94.1%	94.5%	94.4%	93.6%	93.8%	92.4%	3929	4254	**93.5%**							
	WHO Checklist	Chief Medical Officer	**100%**	99.4%			99.8%			100%											
	% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	**60%**	60.7%	63.3%	67.4%	62.9%	51.4%	54.3%	52.6%	64.4%	29	45	**56.0%**							
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	**90%**	54.5%	75.0%	91.7%	60.0%	62.5%	60.0%	100.0%	80.0%	4	5	**70.4%**							
	Stroke Indicator 80% patients = 90% stroke ward	Chief Medical Officer	**80%**	80.0%	83.3%	79.1%	70.7%	67.4%	86.7%	78.3%	83.3%	35	42	**79.0%**							
	Cleaning Standards: Acute (Very High Risk)	Chief Nursing Officer	**98%**	97.9%	97.1%	97.0%	97.3%	97.1%	97.3%	97.5%	97.0%			**97.2%**							
	Cleaning Standards: Community (Very High Risk)	Chief Nursing Officer	**98%**	98.5%	99.0%	99.0%	97.0%	97.4%	98.1%	98.9%	98.1%			**98.1%**							
	Number of complaints	Chief Nursing Officer	**2022/23 (253)**	33	24	28	27	30	27	28	53			138							
	Complaints resolved within policy timeframe	Chief Nursing Officer	**90%**	57.0%	44.0%	40.0%	51.0%	47.0%	65.4%	52.8%	53.6%	15	28	**54.7%**							

	Friends and Family Test - Response Rate (Community)	Chief Nursing Officer	**30%**								0	0	**0.0%**									
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Chief Nursing Officer	**95%**	83%	80%	82%				77%	76%						77%	June				
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	88%	92%	93%				90%	89%	175	198	**89.1%**			94%					
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	100%	100%	98%				96%	94%	17	18	**95.4%**			95%					
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Chief Nursing Officer	**95%**	93%	100%	100%				100%	88%	7		**96.5%**			91%					
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	**25%**	15%	16%	15%																
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	**30%**	12%	15%	13%						151	1194	**12.9%**								
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	**30%**	14%	21%	24%						14	59	**17.1%**								

People		Responsible Director	Standard	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Latest Month Numerator	Latest Month Denominator	Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position WVT Latest month v benchmark	Latest Available Monthly Position National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	**6.4%**	2.6%	2.4%	2.4%	1.4%	1.3%	1.6%	1.7%	1.8%			**2%**							
	Appraisals	Chief People Officer	**85%**	76.7%	75.1%	75.8%	75.6%	76.4%	76.0%	73.3%	72.6%	0	0	**75%**			76%	2021/22			
	Mandatory Training	Chief People Officer	**85%**	89.6%	89.0%	88.8%	88.9%	89.4%	85.5%	87.4%	88.4%	39031	44171	**88%**			88%				
	Overall Sickness	Chief People Officer	**4.0%**	5.5%	5.4%	5.1%	4.3%	3.8%	4.3%	4.4%	4.6%	5470	117899	**4%**			5%	Apr			
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	**10%**	8.1%	8.0%	8.0%	7.9%	8.0%	8.3%	8.1%	7.9%	298	3763	**8%**							
	Clinical WTE Establishment	Chief People Officer		3164	3166	3162	3163	3222	3222	3209	3211										
	Clinical WTE Actual	Chief People Officer		2926	2947	2958	2965	2966	2953	2955	2970										
	Non-Clinical WTE Establishment	Chief People Officer		819	805	791	778	923	923	921	920										
	Non-Clinical WTE Actual	Chief People Officer		841	838	838	840	838	839	836	832										
	Frozen Posts (where no agency or bank is being used)	Chief People Officer																			
	Vacancy Rate	Chief People Officer	**5%**	5.4%	4.7%	4.0%	3.4%	8.2%	8.5%	8.2%	8.0%	330	4132	**8%**							

Finance and Use of Resources		Responsible Director	Standard	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Latest Month Numerator	Latest Month Denominator	Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position WVT Latest month v benchmark	Latest Available Monthly Position National or Regional		Pass/ Fail	Trend Variation	DQ Mark
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	**≥0**	£552	£1,850	£365	£1,276	-£703	-£504	-£823	-£385			**-£2,415**							
	I&E - Margin (%)	Chief Finance Officer	**≥0%**	1.6%	5.4%	1.1%	2.5%	-2.1%	-1.5%	-2.4%	-1.1%	-£385	£34,612								
	I&E - Variance from plan (£k)	Chief Finance Officer	**≥0**	£477	£824	-£482	£417	-£184	-£6	-£268	£184			**-£274**							
	I&E - Variance from Plan (%)	Chief Finance Officer	**≥0%**	636.0%	80.3%	-56.9%	48.5%	-35.5%	-1.2%	-32.6%	32.3%	£184	-£569								
	CPIP - Variance from plan (£k)	Chief Finance Officer	**≥0**	-£655	-£861	-£1,081	-£1,023	-£404	-£525	-£327	£241			**-£1,015**							
	Agency - expenditure (£k)	Chief Finance Officer	**N/A**	£536	£506	£512	£502	£276	£346	£371	£384			£1,377							
	Agency - expenditure as % of total pay	Chief Finance Officer	**N/A**	2.5%	2.5%	2.4%	1.4%	1.3%	1.6%	1.7%	1.8%	£384	£21,626	1.6%							
	Capital - Variance to plan (£k)	Chief Finance Officer	**≥0**	£278	£272	£293	-£2,367	-£44	£37	£147	£3,306			**£3,446**							
	Cash - Balance at end of month (£m)	Chief Finance Officer	**As Per Plan**	£30	£32	£43	£49	£46	£51	£46	£49			£49							
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	**≥95%**	99.4%	92.6%	99.4%	98.7%	99.8%	92.1%	98.4%	98.5%	£23,407	£23,766	**97.7%**							
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	**≥95%**	99.4%	98.2%	98.9%	98.9%	99.0%	99.1%	99.0%	98.9%	£5,882	£5,949	**99.0%**							

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Trust Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	2026 Premises Assurance Model submission
Lead Executive Director:	**Chief Strategy and Planning Officer**
Author:	Christian Homersley
Reporting Route:	Health and Safety Committee
Enclosures included with this report:	
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

To inform the Board of the changes to the NHS Premises Assurance Model (PAM) for 2025/26, to explain the expected impact on the Trust's reported compliance position, and to seek the Board's endorsement of the proposed approach to completion, reporting and the associated costed action plans ahead of the national submission deadline of **Tuesday 8 September 2026**

Recommended Actions required by Board or Committee

The Board is asked to:

i. Note the change from an assurance-based to a compliance-based model with binary responses

ii. Endorse completion of the return in line with NHS England's stated expectation of pragmatic, honest answers, including where the Trust does not meet specified numerical requirements.

iii. Note the proposal for where actions will be monitored.

Executive Director Opinion[1]

The Trust has used the PAM for assurance on estates issues long before it was mandatory. The changes to the PAM are recent and, despite some quirks with a new format, the team has completed it to the best of its knowledge. As with any new documentation, it will be subject to change and I am confident that the areas highlighted will be addressed through existing governance.

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

1 Introduction: NHS Premises Assurance Model (PAM)

The NHS Premises Assurance Model (PAM) is the national framework used by provider organisations to assess, evidence and improve the safety, quality and compliance of their healthcare estate. PAM enables Trust Boards to gain clear, structured assurance that premises-related risks are being effectively identified, managed and monitored, and that statutory and regulatory obligations are being met.

PAM provides a consistent methodology across the NHS for evaluating performance in key domains including safety, patient experience, compliance, efficiency, and organisational governance. It supports Boards in understanding the condition and resilience of the estate, prioritising investment, and demonstrating due diligence to regulators such as the CQC.

Completion of PAM is now an established expectation within NHS England's wider assurance framework. It forms part of the Trust's evidence base for Safe and Well-Led domains, and supports strategic decision-making on capital planning, backlog maintenance, lifecycle replacement, and facilities management delivery models — particularly relevant as the Trust prepares for PFI expiry and future FM arrangements.

The FM Maturity questions within PAM assess how professionally, strategically and digitally mature the Trust's FM function is. They complement the traditional PAM domains by identifying the underlying organisational, data and governance factors that drive compliance performance. NHS England uses this data to benchmark Trusts, support national estates strategy and ensure alignment with Government Property Function standards. It should be noted that the Trust has completed and Estates and Facilities Digital maturity assessment and we benchmarked as the joint least mature in the NHS. This can be attributed to several factors but is primarily due to the size of the Trust and the proportion of service contracted through a first wave PFI project which was designed and built prior to many modern standards being implemented this century (e.g. the contract itself is effectively word processed and hard copy).

2 Process

The Trust has always completed the self-assessment even prior to it being mandated. The NHS Premises Assurance Model (PAM) has been an NHS England mandated assurance tool since 2016, forming part of the national Estates & Facilities Assurance Framework. PAM is now an established requirement for provider organisations, used by CQC within the Safe and Well-Led domains and referenced in national guidance relating to PFI expiry, statutory compliance and FM governance.

The assessment is completed as an internal estates review and following the best practise guidance evidence is provided or signposted wherever possible. There can be some anomalies where very different answers occur depending on whether services are provided within the PFI. For the avoidance of doubt the submission covers the whole estate and therefore answers are generally recorded as the lowest or least favourable.

The 2026 update to the NHS Premises Assurance Model (PAM) strengthens statutory compliance requirements, improves alignment with national datasets, and introduces clearer scoring criteria linked to CQC Safe and Well-Led domains. It places greater emphasis on estates resilience, FM governance and contract oversight, reflecting national priorities including PFI expiry readiness. PAM now requires annual Board review and more robust evidence to support assurance ratings, ensuring a more reliable and transparent assessment of estates-related risks.

2.1 NHS England view

NHS England has set out how it expects trusts to approach completion. Where a question asks whether the Trust is compliant, or specifies a numerical requirement the Trust does not meet, the expectation is that this is reported accurately. NHS England has stated:

> *"We do want a pragmatic approach where we are asking if you are compliant, but where our leads have requested a specific number and trusts are not in line, it is important for us to see this, so that we can either support trusts in achieving it or adjust our internal targets next year to make these more aligned to what is happening on the ground. We do understand concerns around looking non-compliant in areas, but please be assured trends will be picked up, especially where the majority of trusts are not compliant because the view is that the request is unreasonable or overly cautious. But we do need to see this rather than gloss over and have similar issues again next year."*

The implication for the Trust is that an accurate "no" serves a purpose both at local and national level: attracting support and/or correcting an unrealistic target in future years. Where a majority of trusts return the same non-compliance, NHS England has confirmed this will be read as a signal about the standard itself rather than a failing of individual organisations.

3 Domains

PAM is structured around **five core domains**, each assessing a different aspect of estates and facilities safety, compliance and governance. Together they provide a holistic picture of how effectively a Trust manages its premises-related risks.

1 Safety
Focuses on whether the estate is safe for patients, staff and visitors. Includes statutory compliance (e.g., fire safety, water safety, electrical systems), safe systems of work, incident reporting, and assurance that risks are identified, mitigated and monitored.

2 Patient Experience
Assesses how the physical environment supports dignity, comfort and accessibility. Covers cleanliness, wayfinding, privacy, noise, lighting, temperature, and the overall condition of spaces used by patients.

3 Efficiency
Examines whether estates and facilities resources are used effectively and represent value for money. Includes energy management, space utilisation, backlog maintenance planning, lifecycle management, and optimisation of FM delivery models.

4 Effectiveness
Looks at whether the estate supports clinical services and organisational performance. Covers resilience, business continuity, asset performance, planned preventative maintenance, and alignment of estate strategy with clinical need.

5 Organisational Governance

Assesses leadership, oversight and assurance mechanisms. Includes policy frameworks, reporting structures, risk registers, audit processes, training, and Board-level visibility of estates risks and compliance.

4 Draft responses

There are around 400 individual questions and many of the answers are yes or no. For some questions it is not clear how the ask is to be interpreted and, in this case, a prudent view has been taken and feedback will be given to the national team for future amendment/moderation. At this point it is not understood how to report specifically against the domains and so feedback is given in relation to the question themes.

For each section the following rating is given based on the answers provided:

Colour Key - Question Compliance
Outstanding (100%)
Good (85-99%)
Requires Minimal Improvement (41-84%)
Requires Moderate Improvement (21-40%)
Inadequate (0-20%)

The section score metrics are shown below:

Section	Score
Hard FM	79.67%
Soft FM	83.97%
Estates Competency	90.81%
Helipad Compliance	69.23%
Patient Experience	62.96%

4.1 Priority Actions

These are shown on the table overleaf in order of priority. An internal assessment of each has been provided in the Trust RAG Rating Column but this will be further ratified at the relevant committee moving forward. There are several items where the size of the Trust, the nature and date of the PFI agreement and service models mean that the rating are either skewed, not applicable or where we may accept the implied risks.

Where oversight of actions does not obviously site within a current governance committee with clear escalation to Board a proposal will be taken to Trust Management Board in the first instance to address this.

Theme (ref)	Priority (A High - E Low)	Key negative responses	Oversight of action plans	Trust RAG Rating	Comments
Asbestos Management (Safety Hard – SH5)	A. Statutory & Regulatory Compliance	Duty holder, appointed persons, surveys for pre-1999 buildings, asbestos register, updated plans, awareness training, R&D surveys, accredited contractor, updated register, site plans showing ACM's	Asbestos Management	5 (MOD)	Information which does exist was not made vailable to surveyors when assessing and most areas expected to be resolved within 3 months.
Medical Gas Systems (Safety Hard – SH6)	A. Statutory & Regulatory Compliance	AE audit, audit driven action plans, risk register entries, incident reporting	Medical Gas Committee	6 (MOD)	There is an authorising engineer (AE) appointed - cost benefit of audits and action plan to be undertaken. Committee to have risk register and incident report and standing agenda item.
Decontamination (Safety Soft – SS2)	A. Statutory & Regulatory Compliance	Training & development plan, annual resiliance/BCP testing	Decontamination Committee	6 (MOD)	Committee to consider training needs anaylisis. Resilience testing to be reccomended to relevent functions (e.g. sterile services/endoscopy)
Accommodation Standards (Patient Experience – P2.1)	A. Statutory & Regulatory Compliance	Not all accommodation meets published standards for privacy, dignity and same-sex accommodation.	Patient Experience	6 (MOD)	Direct CQC Safe & Effective domain exposure but recognised as a managed risk for significant time.
Car Parking Compliance (Patient Experience – P3.2 & P3.3)	A. Statutory & Regulatory Compliance	Non-compliance with HTM 07-03 and Car Parking Code of Practice	Sustainable Transport Committee	3 (LOW)	Significance of regulatory and reputational risk to be considered at commitee.
Helipad – CAP 1264 Compliance (H1.10)	A. Statutory & Regulatory Compliance	Partial compliance only, CEO SAR safety letter missing	Helipad Safety Group	10 (High)	Mandatory aviation safety requirement works still underway. Question on CEO letter does not allow n/a response (false negative caused by poor wording of question).
FM Data Maturity – Core Gaps	B. Digital, Data & Asset Information	Data specification not aligned to GPDS, Core asset fields incomplete, no regular sample surveys, limited change control, limited data quality checks, limited update assurance, informal governance, limited access to asset data, no common data platform, ad hoc reporting, limited insights for compliance/PPM/inestment, limited team capacity/capability/training	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	Trust rated joint lowest in NHS for Estates Digital Maturity - strategy is to use PFI Expiry as opportunity to address
FM Maturity – CAFM & Digital Integration	B. Digital, Data & Asset Information	CAFM maturity only Level 3, multiple systems, limited interoperability, limited real time access	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	Trust rated joint lowest in NHS for Estates Digital Maturity - strategy is to use PFI Expiry as opportunity to address
Estate Optimisation (C2.3)	C. Estates Strategy, Optimisation & Governance	No effective estate optimisation process, out of date 6-facet surveys	To be addressed by reccomendation to TMB for 26/27	8 (High)	Six facet survey for non-PFI estate planned before expiry (costing within Future FM Services OBC)
New Technology Adoption (C2.8)	C. Estates Strategy, Optimisation & Governance	No process to evaluate or adopt new estates technologies	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	Weak digital transformation capability.
Capital Procurement Cost Review (C3.6)	C. Estates Strategy, Optimisation & Governance	No ongoing cost review against baseline	Capital Planning and Equipment Committee	6 (MOD)	Control post PFI expiry will provide significant improvement in VFM on projects
Board Reporting (C4.5)	C. Estates Strategy, Optimisation & Governance	No dedicated estates Board report	Trust Board	6 (MOD)	Key areas of compliance are fed through subject matter focussed routes in governance to Board
Non-NHS Facilities Assurance (C7.13)	C. Estates Strategy, Optimisation & Governance	No policy ensuring NHS standards in external facilities	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Patient Information (P4.5)	C. Estates Strategy, Optimisation & Governance	No accessible information on meals, snacks, hydration.	Patient Experience	6 (MOD)	Different answers for non-PFI sites and will be addressed through PFI Expiry work
Allergen Awareness Training (SS1.28)	C. Estates Strategy, Optimisation & Governance	Ward/clinical staff not trained in allergen awareness.	Food Safety	6 (MOD)	Training is provided but not mandated and records sporadic - to be reviewed by committee
24/7 Food Provision (SS1.35–40)	C. Estates Strategy, Optimisation & Governance	No 24-hour restaurant, café, retail, cold vending or smart fridges.	To be addressed by reccomendation to TMB for 26/27	6 (MOD)	Service gap rather than statutory risk. Unclear on where staff welfare issue should be fed into governance.
Catering Policy (P4.1)	D. Catering, Information & Patient Experience	No MDT-reviewed catering policy aligned to national standards.	Food Safety/Patient Experience	6 (MOD)	Other policies cover key risks. Opportunity to standardise on PFI expiry.
Intelligent Client Function (Q18)	E. FM Governance, Intelligent Client Function & Supplier Relationships	Dispersed, not formally recognised.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Client Department (Q19)	E. FM Governance, Intelligent Client Function & Supplier Relationships	Not centralised; fragmented oversight.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Management Structure (Q21)	E. FM Governance, Intelligent Client Function & Supplier Relationships	No corporate landlord model.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Supplier Relationships (Q6)	E. FM Governance, Intelligent Client Function & Supplier Relationships	Transactional, not strategic.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Transparency (Q7)	E. FM Governance, Intelligent Client Function & Supplier Relationships	Limited real-time data access.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	
Cross-Government Collaboration (Q8)	E. FM Governance, Intelligent Client Function & Supplier Relationships	Minimal engagement.	To be addressed by reccomendation to TMB for 26/27	3 (LOW)	

5. Conclusion

Across the NHS Premises Assurance Model and Government FM Maturity assessments, the Trust demonstrates strong performance in many operational areas but faces significant challenges in statutory compliance, digital maturity, asset data quality, estates optimisation and governance.

The most critical risks relate to asbestos management, medical gas systems, decontamination, accommodation standards, car parking compliance and helipad CAP 1264 requirements. Strategic gaps include estate optimisation, digital transformation, costed action plans. The compliance risks will be added to the relevant agenda for ongoing monitoring at least quarterly.

FM data maturity is limited, with incomplete asset data, weak verification processes, informal governance and no common data platform. Addressing these issues will materially strengthen safety, compliance, strategic planning, digital capability and alignment with Government Property Function expectations.

Several of the higher risk actions are being addressed in part by the PFI Expiry process – for example the gaps in the asbestos assurance have partially been identified by the Asset Management and Compliance Review undertaken as part of the hand back surveys. However, a few of the strategic items will be picked up as part of the Future FM Services process for the end of PFI in 2029 as there is a huge opportunity at that point to make improvements.

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	WVTBC0205 – Business Case Experts at Hand – therapy staffing
Lead Executive Director:	**Chief Nursing Officer**
Author:	Susan Moody, Associate Chief AHP
Reporting Route:	Trust Management Board
Enclosures included with this report:	Business Case, Combined impact assessments
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

On 23 February 2026, the Department for Education (DfE) published the schools white paper 'Every child achieving and thriving' and the Special Educational Needs and Disabilities (SEND) consultation 'Putting Children and Young People First'.

This is a long-term (10-year) reform, subject to outcomes from the consultation, with any new legislation expected to come into effect from September 2029. Until then, current systems remain, while support is improved to help more children thrive.

In March 2026 the government set out high level guidance in the Local SEND reform plan to support local areas to begin their planning to set up an **Experts at Hand (EAH)** offer. The Experts at Hand offer will support mainstream school settings across early years, primary, secondary and post-16 to better identify and meet the needs of children and young people with SEND. Delivered through local area partnerships, it provides dedicated professional expertise to help more children and young people access support within their settings.

This business case seeks to recruit additional speech and language and occupational therapy professionals to implement experts at hand over the next 3 years in Herefordshire.

Recommended Actions required by Board or Committee

To accept the national funding provision and recruit the additional posts.

Executive Director Opinion[1]

This case is fully supported and a welcome service development to support Children and young people with SEND. Given the time critical nature of recruitment this case was considered and supported at Trust Management Board and is seeking formal retrospective approval through Board.

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

Wye Valley NHS Trust

BUSINESS CASE

Title:	Experts at Hand – Therapy staffing increases
Ref. No.	WVTBC0205
Author:	Sue Moody
Division:	Integrated Care
Finance Manager:	Jay Desai
Executive Sponsor:	Lucy Flanagan
Date:	12th August 2026

1. Introduction and Background Information

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

This is a long-term (10-year) reform, subject to outcomes from the consultation, with any new legislation expected to come into effect from September 2029. Until then, current systems remain, while support is improved to help more children thrive.

In March 2026 the government set out high level guidance in the Local SEND reform plan to support local areas to begin their planning to set up an **Experts at Hand (EAH)** offer (see Reference section). In April 2026 they published the Experts at Hand and local authority SEND transformation fund publication, which outlines the £429 million available for 2026 to2027 and its permitted use.

Overview of the Experts at Hand offer

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

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

The government is very clear that this new funding must not replace existing provision. It should be additional and strengthen local capacity, building on strong practice.

The Experts at Hand offer will provide support that is tailored to the needs of individual children and young people through observation, assessment and identifying appropriate targeted support. For example, recommending strategies or identifying the right group-based interventions. This support does not replace statutory provision set out in an EHCP. Rather, it enables needs to be identified and addressed earlier through evidence-based input. While the direct involvement of specialists is time-limited, their recommendations are intended to be embedded and sustained in practice by school staff, ensuring ongoing support at cohort or group level, with some one-to-one input where appropriate.

Experts at Hand is designed to transform how support for children and young people with SEND is delivered by bringing specialist expertise directly into mainstream settings. By embedding **speech and language therapists**, educational psychologists, **occupational therapists** and specialist teachers alongside school staff, the offer supports earlier identification of need, strengthens workforce confidence and capability, and provides timely, evidence-based support within everyday learning environments.

Through this approach, more children can be supported effectively without the need for escalation to specialist services, helping to reduce pressure on the system over time. Alongside stronger partnerships between education, health and families, this shift towards early intervention and inclusive practice will improve outcomes for children and young people while supporting a more sustainable, integrated SEND system.

TMB accepted WVTBJ0043 on 19/06/2026 with the outcome that the case would be converted to a Business Case for Board approval.

2. Current Position

The local authority (Herefordshire Council) through the SEND Assurance Board has asked WVT to provide the Speech and Language Therapists and Occupational Therapists within this SEND Reform Experts at Hand Offer using national funding from the DfE.

The Experts at Hand offer must be commissioned jointly by local authorities and integrated care boards within the local area SEND partnership joint commissioning arrangements. Local area partnerships must provide clear routes for mainstream education settings to access specialist support from a range of experts across education and health.

In establishing their offer, local area partnerships should start shifting local provision to focus on proactive and timely support for mainstream education settings, prioritising early identification and intervention so that staff are able to meet the needs of children more quickly and effectively within the setting.

Local partnerships can use evidence-based learning from local pilots such as:

- Change Programme
- Delivering Better Value (DBV)
- **partnerships for inclusion of neurodiversity in schools (PINS)**
- alternative provision specialist taskforces (APST)
- supported internships (SI)
- **Early Language Support for Every Child (ELSEC)**

WVT have demonstrated great outcomes from PINS and ELSEC pilots in our local schools, using Change Programme national funding over the past 2 years, this will help design this new offer over the next 6-12 months.

Current waiting times:

Below two tables are included to demonstrate the current waiting times for new assessments for SALT and OT children's teams. The development of the EAH team in schools is very likely to reduce demand for specialist assessments and interventions where it can be provided in a more timely way in schools.

Speech and Language Therapy

Waiting times	Apr-26				May-26				Jun-26			
	0-18	19-36	37-52	52+	0-18	19-36	37-52	52+	0-18	19-36	37-52	52+
Specialist Teams												
ASD - school age diagnostics	54	177	31	15	169	150	39	14	186	123	43	13
Complex Needs									5			
Feeding									19			
Hearing Impairment									2			
Spec Lang Impairment									0			
Stammering									8	1		
Community												
Bromyard	14				12				9	2		
City North	23	49	3		33	45	7		33	41	10	
City South	37	24	1		36	22	1		41	24	2	
~~Golden Valley~~												
Kington	10	5			11	5			8	6		
Ledbury	10	2			11	1			12	1		
Leominster	26	23	1	4	25	29	1		33	31	1	
Ross	19	5			18	8			17	11		
TOTAL	**193**	**285**	**36**	**19**	**315**	**260**	**48**	**14**	**373**	**240**	**56**	**13**

Occupational Therapy

	Measure	2025-26						
		Jan	Feb	Mar	Apr	May	Jun	July
Occupational Therapy	Total WL Position	82	90	83	88	97	80	
	0-18 week position	48	42	33	46	55	48	
	19-36 wk position	30	36	36	29	28	21	
	37-52 wk position	2	11	14	13	13	11	
	>52 weeks position	2	1	0	0	1	0	
	No. of referrals received (All children)	22	51	33	33	34		

3. Drivers for Change

The drivers for change are:

1. National SEND Reforms – Department for Education as detailed above
2. Long waiting times for specialist interventions across the country, and locally for speech and language therapy as detailed above.
3. New ways of working within education settings to embed the universal delivery of high-quality education for all children
4. WVT Strategy
    a. WHERE WE WANT TO GET TO - OUR VISION
        i. Together with our partners, we will shape the future of healthcare alongside our communities - ensuring everyone experiences outstanding, seamless care in our hospitals and closer to home.
    b. Treating people in the right place
        i. Enhancing our community and prevention services with partners

Core functions of the offer

The Experts at Hand offer must make available additional health professionals (including therapists, support workers, and assistants) and specialist education professionals (including trainees and assistants).

They will work with children and young people in their mainstream setting, delivering support alongside setting staff, including:

- supporting teachers to provide individualised support through observation, light touch assessment and advising on strategies for individual children and young people
- jointly delivering time-limited group or whole-class interventions, while ensuring that agreed strategies are consistently embedded in daily learning. In some cases, and by agreement with the setting, time-limited one-to-one support may also be provided (in addition to, not instead of, statutory responsibilities, which must continue as usual). This may be appropriate where needs are highly specific or where the geographic isolation of the setting makes group delivery impractical
- jointly developing resources and workshops for parents to help them understand and support their child's development
- They will work directly with mainstream education settings and their staff, providing support, advice and guidance, including:
    - building staff knowledge and skills through effective strategies, evidence-based interventions and targeted approaches to improve early identification of needs

- providing routes for staff to access advice, coaching and tailored guidance to overcome barriers to inclusion and better meet diverse needs
- supporting settings with the co-production of inclusive approaches, working in partnership with parents and carers to shape setting culture, practice and interventions, ensuring their voices inform decision-making and provision

National Funding limitations

The Experts at Hand grant must only fund experts from the following disciplines:

- **speech and language therapists – and support workers or assistants**
- **occupational therapists – and support workers or assistants**
- educational psychologists – and trainees
- specialist teachers – both local authority-based and those based in specialist or AP settings

Local area partnerships are expected to begin delivering their Experts at Hand offer in 2026 to 2027, with delivery starting from October 2026, and to develop and expand this over the next 3 years so it improves local SEND provision. This should be delivered through a phased approach, with local areas determining initial priorities based on need, while building an evidence base to refine and strengthen the offer over time.

Year 1 – limited to two school clusters, to be agreed, to allow the team to clarify the role themselves and with school partners.

Years 2-3 – full roll out across whole county, all mainstream schools.

We are on track to meet these time scales with early recruitment agreed at TMB in June.

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

4.1. Project Objectives

The objective of this project is to provide the necessary therapy staff to meet the Experts at Hand team requirements within the SEND reforms locally to our Herefordshire population by autumn 2026.

The staff must be **additional** to such existing statutory and one-to-one support, and specialist level pathways for services such as speech and language therapy and occupational therapy. This means that one-to-one support specified in an EHCP is not within the scope of the provision delivered through Experts at Hand. Local areas must demonstrate that the Experts at Hand offer increases overall capacity rather than displacing or replacing existing services.

4.2. Critical Success Factors (CSFs)

The Critical Success Factors for this project are

- Recruitment of specialist therapy and therapy support staff as requested by Herefordshire council education team

- Creation of the EAH team for Herefordshire, from across health and education
- Development of robust systems to support schools, parents and children, and meet professional requirements.

4.3. Benefits of the wider EAH team

1. Early identification and preventative support in mainstream schools

2. Functional assessment and analysis of a wide range of children and young people

3. Embedding strategies in everyday practice, across all mainstream schools

4. Intervention planning and review within school settings

5. Environmental adaptation and inclusion for all schools

6. Coaching and workforce development in schools for all staff

7. Collaborative problem solving as a team, especially during development

8. Inclusion policy development for mainstream settings

Health system benefits:

9. Reduction in demand and waiting times for therapy teams, predicted by year 2-3, where children receive earlier interventions within the school setting.

10. Reduced pressures on health-based therapy teams

11. Improved job satisfaction for staff where waits are reduced

National guidance, service specification, ways of working and job descriptions are being worked through currently.

Category	Description of Benefit	How benefit will be measured
Quality	1. Reduction in waiting times 2. Earlier interventions in schools 3. High-quality NHS service provision with good governance and staff development	Monthly information Reduced demand for specialist services
Operational	Reduction in waiting times	Monthly information
Accessibility	Provision of service within all schools settings, in local areas	Reduction in travel for CYP and families
Strategic intentions	Improved education for Herefordshire children with appropriate support at a local/school level	

Financial	Externally/Nationally funded initiative	
Prevention & Reducing inequalities	Local provision to the whole county	Reducing DNA rate and better engagement in schools

5. Options Appraisal

There are only 2 options.

Option 1 - Do Nothing and fail to support the local authority with these national developments

Option 2 – Accept the national funding and work closely to develop this EAH team for Herefordshire – **Preferred option**

6. Financial Analysis

LA and ICB Funding

The local authority leads, ICB children's commissioners and DfE advisors have confirmed this funding will be available from the end of June 2026 and is not dependent on the implementation plan approval. **Table 1 below** shows the funding we will receive and the breakdown of the therapy workforce we are being asked to recruit and provide, on a permanent basis. Funding is confirmed for 3 years as detailed below. Beyond that point a review of need will need to be done. The current position is that ICB colleagues support permanent recruitment, and National reforms indicate this is the long-term direction of travel.

The local authority will receive £1.2 million this financial year, and the details below are the WVT element of this for recruitment of the therapy staff required and agreed with the local authority.

Cost Type	**Cost Sub-Type** (Delete/Add rows as necessary)	**Description of Cost** (narrative not numbers)
Capital	None	
Revenue	Workforce	Detailed below
	IT equipment and licences	One-off for new staff
	Travel	Monthly

Table 1:

Experts at Hand	Year 1	Year 2	Year 3
Direct Delivery (WVT Allocation)	£296,333	£523,240	£538,937
Total WVT Funding	**£296,333**	**£523,240**	**£538,937**
Direct Delivery	**Year 1**	**Year 2**	**Year 3**
1SALT FTE BAND 7 (ICB)	£38,607	£66,183	£66,183
1SALT FTE BAND 6 (ICB)	£31,389	£53,810	£53,810
4SALT FTE BAND 4 (ICB)	£83,963	£143,936	£143,936
1 OT FTE BAND 7 (ICB)	£38,607	£66,183	£66,183
1OT FTE BAND 6 (ICB)	£31,389	£53,810	£53,810
2OT FTE BAND 4 (ICB)	£41,981	£71,968	£71,968
Inflation 3% Yr2		£13,677	£13,677
Inflation 3% Yr3			£14,087
Total Pay Costs	£265,936	£469,567	£483,654
IT equipment/mobiles	£12,500	£3,500	£0
Travel expenses/set up	£5,000	£20,000	£20,000
Contribution to Trust overheads	£12,897	£30,173	£35,283
Total non-pay costs	£30,397	£53,673	£55,283
Total Costs	**£296,333**	**£523,240**	**£538,937**
Funding less costs	**£0**	**£0**	**£0**

Funding after year 3 is not yet confirmed though Herefordshire Council finance teams have asked for the ongoing funding to be confirmed by the DfE national team. As the funding is from the Department of Education and relates to National Reforms that have been well received widely within education it is very likely permanent funding will be confirmed during this 3-year test phase.

Nine out of the ten staff have been recruited but are not in post, though have start dates of 1st October 2026.

Office space and administration staff will be provided by the local authority.

Current 2026 baseline pay inflation is 3.2% but for the duration of this project it is expected to drift down to 3%.

Contribution to Trust overheads is between 4.4% and 10.3% in year 3.

Travel expenses are expected to be low in year 1 due to set up time and limited travel only to 2 school sites.

Workforce increases:

Speech and Language Therapists:

1 wte x B7 (lead specialist); 1 wte x B6; 4 wte x B4 (assistant practitioners)

Occupational Therapists:

1 wte x B7; 1 wte x B6; 2 wte x B4(TSW)

7. Critical Assumptions and Risk Assessment

7.1. Critical Assumptions

The Trust will be able to fully recruit all staff, and any vacancies created within the teams. The recruitment of staff has been underway following TMB on 19/6/26 and has been largely very successful.

7.2. Risk Assessment

The long-term funding of the DfE reforms is likely to continue beyond the end of the first three years. The risk of the ongoing funding ceasing is low as the government reforms have been widely welcomed, however there is nothing in writing to confirm it will continue beyond 2029, despite the Local authority finance team requesting clarity and confirmation.

8. Impact Assessments

8.1. Equality Impact Assessment

Completed, and attached

8.2. Quality Impact Assessment

Not required

8.3. Sustainability Impact Assessment

Not required

8.4. Data Protection Impact Assessment

No DPIA indicated, records will be kept at school or local authority level, once agreed as the team develops

9. Impact on other areas of the trust

Impact on other areas of the trust and outcome of discussions (select all that apply)			
Clinical Support - Radiology	☐	Admin / management	☐
Clinical Support - Pathology	☐	Estates	☐
Clinical Support - Pharmacy	☐	Other Specialties / Pathways	☐
Clinical Support - Outpatients	☐	Other	☐
ICT Support – Application and/or infrastructure support	☐	No material impact	☒

Impact on internal WVT services is minimal at this early stage but may reduce demand to community paediatric services in the long term.

There will be a reduction in referral rates and demand for specialist SALT and OT provision by managing school casework earlier.

It is expected that **waiting times will benefit** during this three-year programme when we will be running both systems together, prior to full roll out of the SEND reforms.

The government will address long standing SEND financial pressures by covering 90% of local authorities' High Needs-related DSG deficits accrued up to the end of 2025–26 through the High Needs Stability Grant. This grant will be paid subject to each local authority securing the Secretary of State for Education's approval of their local area's Local SEND Reform Plan.

10.Implementation Timeline

Early recruitment is essential to start this new service in the autumn term of 2026-27.

Recruitment may be an issue across our teams, though the Band 4 assistant practitioners are in post currently doing the pilot work so will be easily recruitable to start in September. We have agreed that we will prioritise some staffing early in September so there can be a soft launch of the team as service development and school relationships will take time.

Recruitment has been successful with staff starting in role from 1/10/26.

An SLA will be developed with the local authority for quarterly invoices for workforce costs and non-pay.

11.Leadership and Project Management

Role	Name
Senior Responsible Officer (SRO)	Hilary Jones – Head of Additional Needs, Herefordshire Council (HC)
Project Lead	Tbc and employed by HC
WVT lead	Sue Moody

12. Workforce Plan

Additional workforce requirements					
Staff Group	**Position/Title**	**Permanent/ Fixed Term/ etc.**	**New post/skill-mix change/ etc.**	**Band**	**WTE**
Allied Health Professionals	SALT	Permanent	New position	7	1
Allied Health Professionals	SALT	Permanent	New position	6	1
Allied Health Professionals	Assistant practitioner (SALT)	Permanent	New position	4	4
Allied Health Professionals	OT	Permanent	New position	7	1
Allied Health Professionals	OT	Permanent	New position	6	1
Allied Health Professionals	Therapy Support Worker (OT)	Permanent	New position	4	2
				Total	**10**

This increased workforce has been directly agreed with the local authority leadership team, to fully staff the EAH team from year 1. The first year will be centred around setting up the team and working with two mainstream school clusters to design how the team functions to support school staff with provision of the universal offer of enhanced communication and improvement of inclusion in schools. Years two and three will roll the service out countywide in to all mainstream school settings including post-16 settings. The workforce is likely to be generous for year 1 but this will give time to develop systems and training resources which will be rolled out widely. Activity and data collection is unclear within the guidance currently but will be provided when this business is reviewed at the end of year 1.

13. Conclusions and Recommendations

Approval by WVT TMB was requested by the ICB (Mari Gay) to be able start the recruitment process ASAP and get ahead of the regional competition as all local authorities will be getting this funding during June and July. We expect significant advertising nationally relating to SALT and OT staffing this summer.

TMB accepted WVTBJ0043 on 19/06/2026 with the outcome that the case would be converted to a Business Case for Board approval.

TMB supported early recruitment to get ahead of local recruitment challenges as all local authorities have received this additional funding, and Children's SALT and OT staff are often hard to recruit.

Recruitment has proceeded well and the team will be starting in October 2026

Board is asked to formally endorse this development with Herefordshire council

14.Post-Implementation Evaluation Plan

The project will be evaluated at the end of year 1 of the 3-year programme and rolled out to all areas of the county in September 2027.

15.References

https://www.gov.uk/government/publications/every-child-achieving-and-thriving

https://www.gov.uk/government/consultations/send-reform-putting-children-and-youngpeople-first

https://www.gov.uk/government/publications/experts-at-hand-local-authority-send-transformationfund

Combined Impact Assessment Template

Project Name	Experts At Hand Therapy staffing BC
Project Lead	Sue Moody
Project Overview	The local authority (Herefordshire Council) through the SEND Assurance Board has asked WVT to provide the Speech and Language Therapists and Occupational Therapists within this SEND Reform Experts at Hand Offer using national funding from the DfE.

Equality Impact Assessment (EIA)	Has the EIA been completed?	YES	The EIA MUST be completed for all cases	
Quality Impact Assessment (QIA)	Has the QIA been completed?	NO	If NO then please give reasons	This project provides an improved quality of service provision to the CYP of Herefordshire
Sustainabillity Impact Assessment (SIA)	Has the SIA been completed?	NO	If NO then please give reasons	N/a
Data Protection Impact Assessment (DPIA)	Has the DPIA been completed?	NO	If NO then please give reasons	No new IT systems or data sharing indicated in this BC

Edit green cells only

Version 1.1
Nick Exon, Rachel Murray

Equality Impact Assessment

Project Name	Experts At Hand Therapy staffing BC
Completed by	Sue Moody
Date	17/08/2026

An EIA must be completed for all developments

Equality Impact Assessment is a tool for helping us to consider the potential impact that our activities (services, projects, strategies, policies etc.) might have on our community (staff, service users, patients, carers & others), from different equality perspectives. The assessment should be an open and honest assessment of potential impacts and effects.

For guidance see: https://wvt-intranet.wvt.nhs.uk/media/58475/equality-impact-assessment-guidance_wvt.pdf

Question	Answer		
Who will be affected by the development & implementation of this activity?	Service user	YES	
	Patient		
	Carers		
	Visitors		
	Staff		
	Communities	YES	
	Other	YES	Schools
Is this ..?	Review of an existing activity		
	New activity	YES	
	Planning to withdraw or reduce a service, activity or presence		
What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)	National guidance from Dept of Education (DfE); Local authority colleagues action planning documentat		
Summary of engagement or consultation undertaken (e.g. who, and how, have you engaged with, or why do you believe this is not required)	Engaged with SALT and OT staff - clinical leaders, and local authority colleagues when designing the imp		
Summary of relevant findings	This project will provide an improved service to schools and CYP in line with the governments proposed		

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. Please enter "Y" in one or more impact box below for each Equality Group and explain your rationale. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	YES			School age children positively impacted in schools

Disability	YES			SEND children and young people will benefit from early interventions
Gender Reassignment		YES		
Marriage & Civil Partnerships		YES		
Pregnancy & Maternity		YES		
Race including Traveling Communities		YES		
Religion & Belief		YES		
Sex		YES		
Sexual Orientation		YES		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities		YES		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	YES			Interventions in schools close to their home will benefit the CYP

What actions will you take to mitigate any potential negative impacts?			
Risk identified	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Time frame**
N/a			
How will you monitor these actions?			
n/a			

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)
At 12 months as full implementation is rolled out

Please read and agree to the following Equality Statement

Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. WVT will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carers etc. and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics

		Do you agree to the Equality Statement?
Person completing EIA:	Sue Moody	YES
Date signed:	17/08/2026	
Comments:	none	
Lead for this activity:	Lucy Flanagan	
Date signed:		
Comments:		

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	3rd September 2026
Title of Report:	Green Plan 2025-28 Annual Progress and Key Performance Indicator Update September 2026
Lead Executive Director:	Chief Strategy & Planning Officer
Author:	Nick Exon
Reporting Route:	Trust Sustainability Group
Enclosures included with this report:	Green Plan Annual Update & Metrics - Board
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report provides an update on progress made against the Trust's Green Plan 2025-2028 approved by the Board on 7th July 2025 and includes progress against Key Performance indicators.

Recommended Actions required by Board or Committee

That members note progress made on the Green Plan

Executive Director Opinion[1]

Overall, good progress has been made since the Board approved the refreshed Green Plan a year ago. Food waste, fleet decarbonisation and the removal of nitrous oxide infrastructure all stand out as highlights. There is a great deal of anticipation for the turn-on of the Integrated Energy Service (IES) next month, which will decarbonise the County Hospital site largely after years of engineering work. Two areas have seen little progress; national guidance says the Trust should have an overall clinical sustainability lead and the Trust has not been able to prioritise this role as yet, although there s a lead within one of the divisions. Secondly, minimal progress has been made on climate change adaptation, which will need capital investment to take it forward. Given the extraordinary heat of the summer this year and with the IES project concluding, this area will get renewed focus in the coming year.

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

Green Plan 2025-28

Annual Progress

and

Key Performance Indicator

Update

September 2026

Nick Exon

Head of Business Development

1. Introduction

This report provides an annual update on progress made against the Trust's Green Plan 2025-2028 approved by the Board on 7th July 2025 and includes progress against key performance indicators.

2. Green Plan Progress

2.1 Introduction

The Green Plan outlines projects, schemes and activities which will lead the Trust over the next three years towards its target of net zero, covering areas such as workforce and leadership, through to technical schemes aimed at reducing carbon emissions generated by the Trust's activity.

The Trust Green Plan is broken down into nine focus areas where for each area a number of SMART objectives were developed (see Appendix A)

2.2 Progress against objectives

A summary of progress to date for each focus area is shown below.

Focus Area	Delivered	In progress	Undelivered	Undeliverable	Not started	Total
Workforce and Leadership	2	1	0	0	0	3
Net Zero Clinical Transformation	0	2	1	0	1	4
Digital transformation	0	2	0	0	1	3
Medicines	1	2	0	0	7	10
Travel and transport	0	5	0	0	1	6
Supply chain and procurement	0	1	0	0	3	4
Adaptation	0	0	2	0	1	3
Food and nutrition	3	1	0	0	2	6
Estates, energy and waste	0	4	0	0	0	4
Total	**6**	**18**	**3**	**0**	**16**	**43**

Delivered

Six schemes have been delivered across three focus areas.

Workforce and Leadership	The above dashboard has been created and this report developed
Medicines	The Trust has removed Nitrous Oxide outlets in theatres and the main manifold system, thereby reducing greenhouse gas waste.

Food and nutrition	An inventory management is in place to measure the reduction in food waste across our sites. There is Improved patient experience of food at the County Hospital to reduce food waste by achieving better PLACE scores

In Progress

Sixteen schemes are in progress across eight focus areas.

Workforce and Leadership	Work has started with members of the Volunteer Steering Group to develop volunteering services for green space maintenance, transport and contact centre
Net Zero Clinical Transformation	Surgical Division have agreed that Rebecca Taylor-Smith will work on Surgical Division sustainability. There is still a requirement to find a Trust wide clinical lead.
Digital transformation	It is expected that the patient portal will go live from October 2026 which will reduce the use of paper. Various schemes have started that will consider how AI can automate functions and improve efficiency and productivity.
Medicines	Work is underway to install automated dispensing cabinets in clinical areas, which will reduce waste.
Travel and transport	In future only zero-emission vehicles will be offered through vehicle lease salary sacrifice scheme. The Trust is has converted its fleet to EVs. The Trust is working with Herefordshire Council on their transport plans for the city, including multi-storey car park discussions, in order that staff and patients can choose how they access services, by December 2026. A re-survey of staff travel is currently being undertaken to update the Trust travel plans. The Trust now has EV charging at community sites and the Community Diagnostic and Treatment Centre.

Supply chain and procurement	The Trust is working with Sodexo to implement a materials management system at the County Hospital by December 2026
Food and nutrition	Work has started to explore alternative food waste composting by March 2027
Estates, energy and waste	Recycling rates have increased at all sites, ensuring less waste goes for heat reclamation. It is expected that phase two of the Integrated Energy Solution, which will largely decarbonize the County Hospital estate will be completed by October 2026. A bid for funds to install solar panels to generate energy at community sites was successful. A session has been held with Sodexo to assess whether the Trust can specify the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption in the post PFI specification.

Undelivered

Three schemes have not yet delivered as planned.

Net Zero Clinical Transformation	Due to not having a Trustwide clinical lead a prioritised list of schemes in urgent and emergency care, diagnostics and medical pathways have not yet been agreed.
Adaptation	Very little progress has been made on the Trust's Climate Change Adaptation Plan due to competing demands but this is now being addressed.

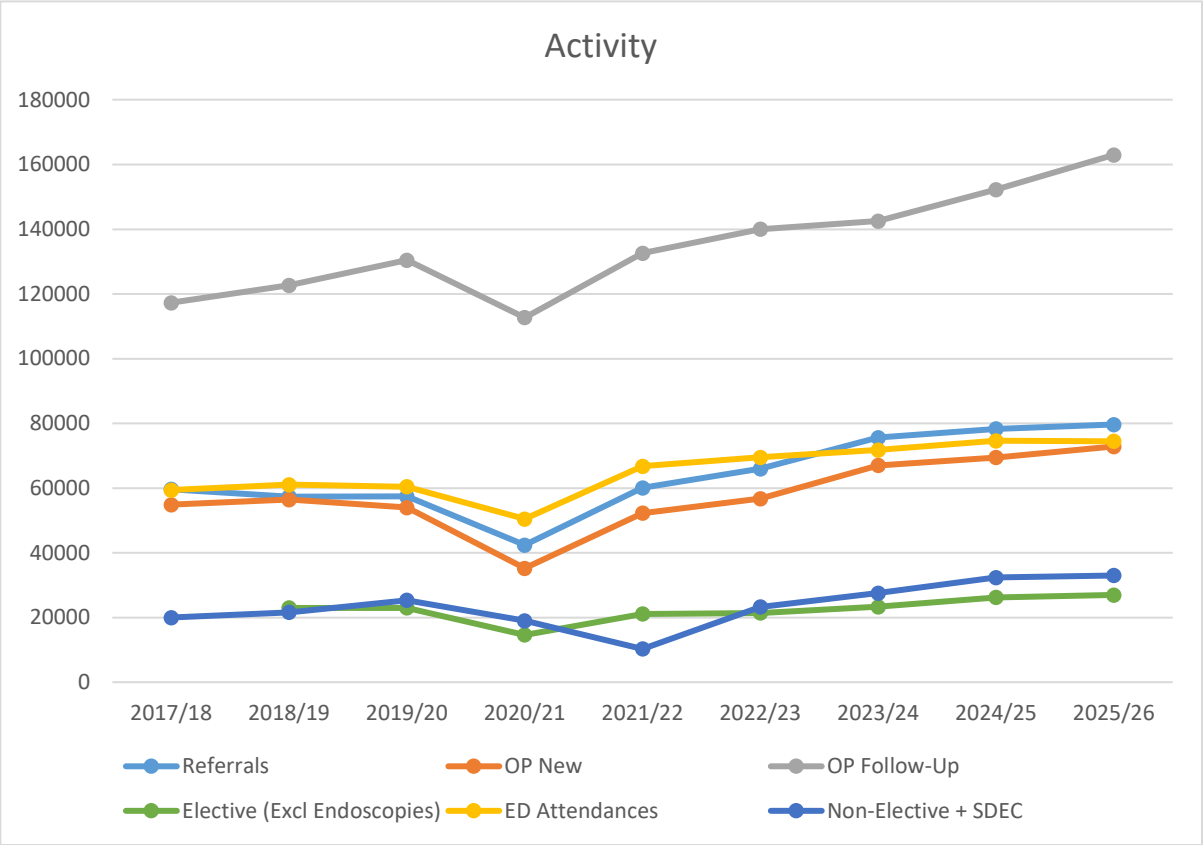
Not Started

The remaining sixteen objectives have not yet started as this is a three-year plan and a number of objectives are due to be delivered later.

3. Trust Activity and Gross Internal Floor Area

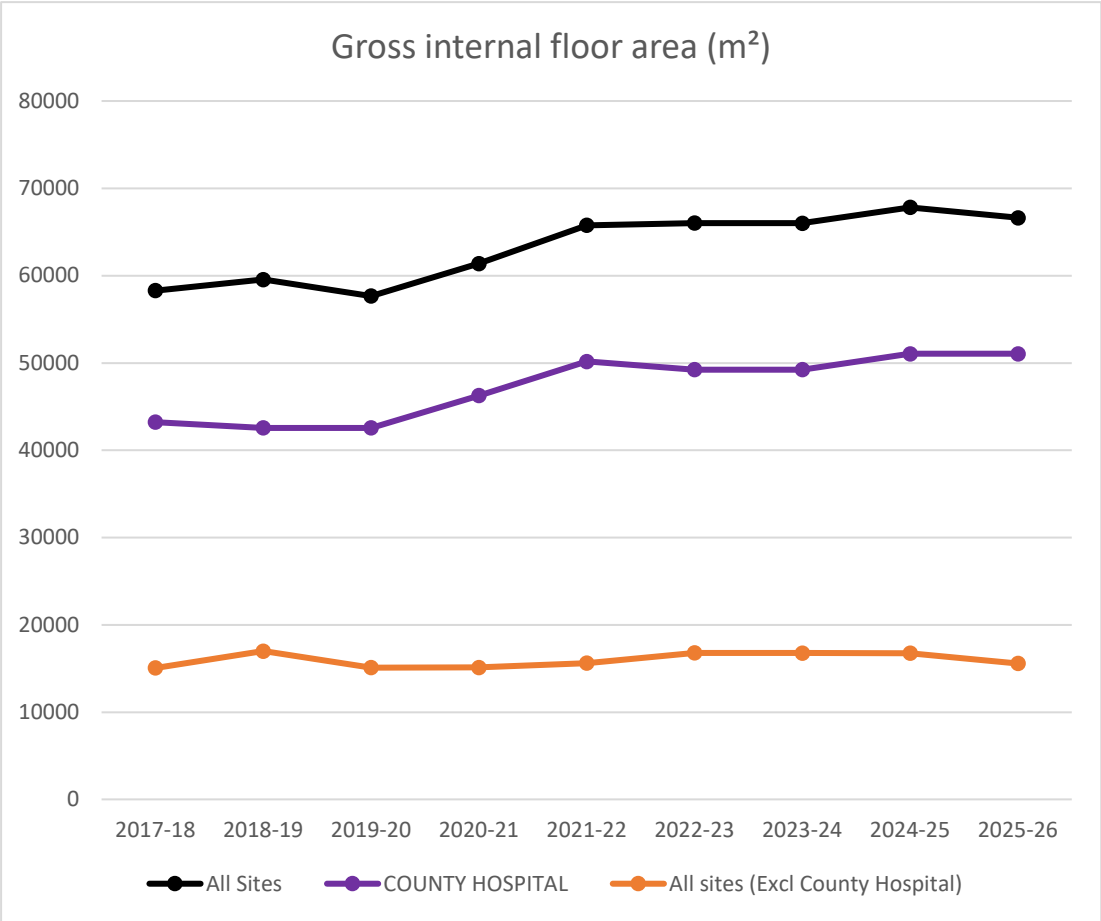
3.1 Activity

The Trust's use of resources is driven by activity. The chart below shows the historical activity where it can be seen that activity has steadily increased (excluding Covid) in all activity metrics.



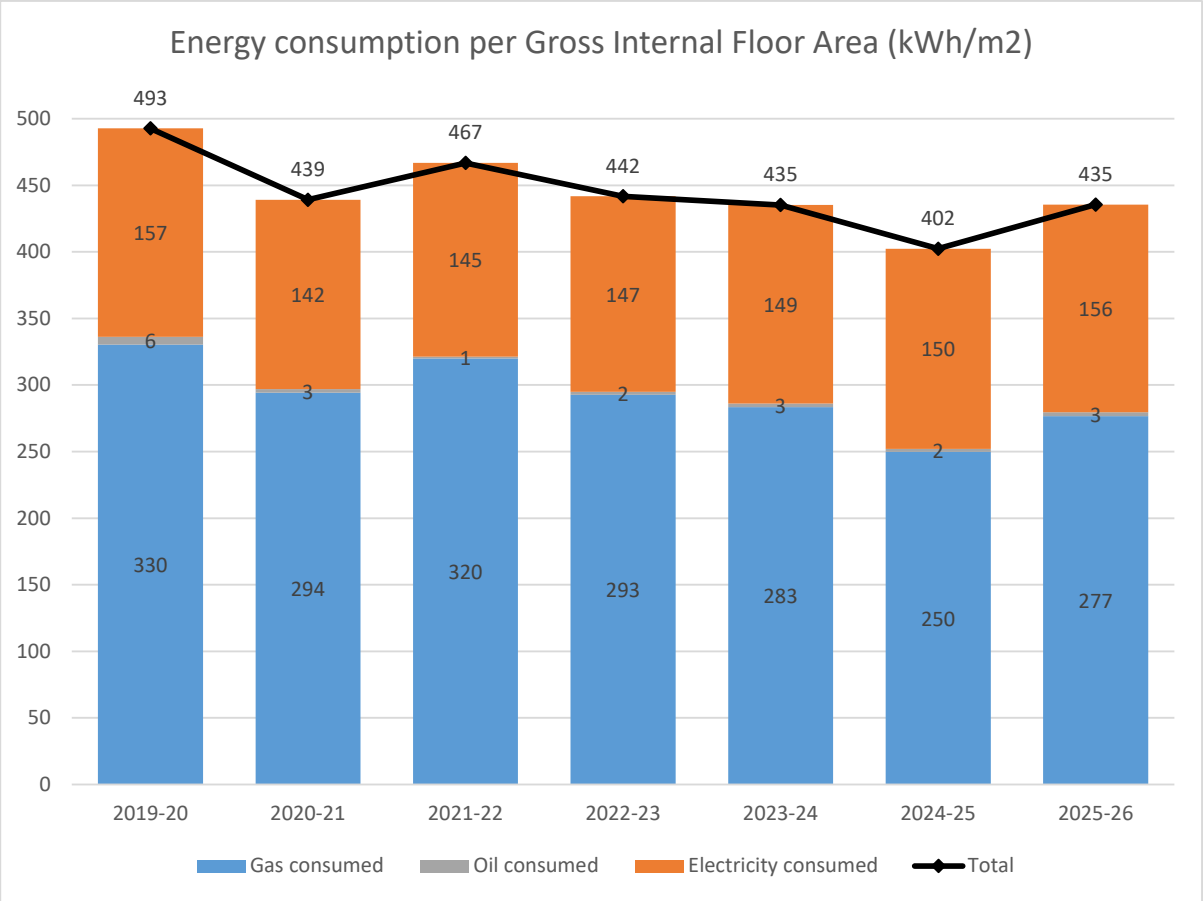
3.2 Gross Internal Floor Area

As activity has increased at the Trust there has been a corresponding increase in physical space required, measured by Gross Internal Floor Area (GIFA) (m^2), as shown below.



4. Key Local Metrics

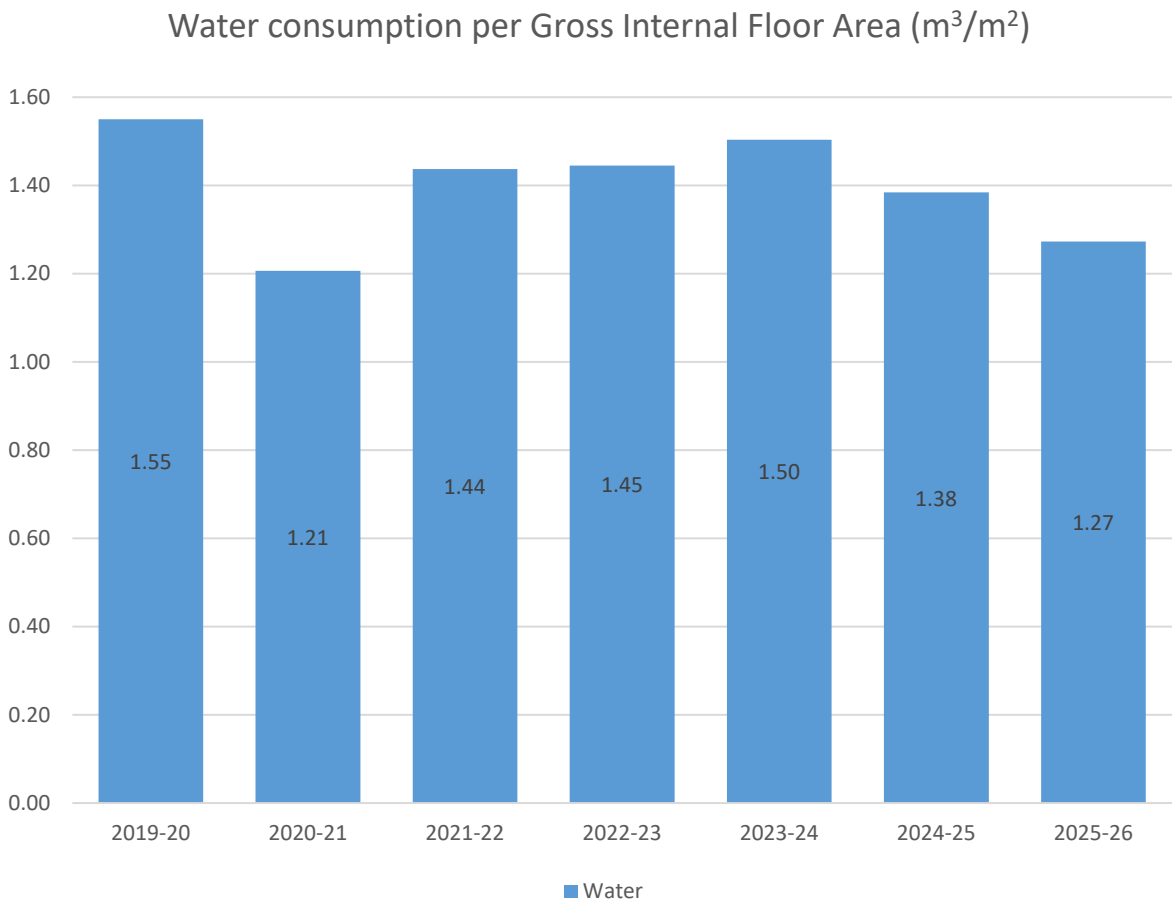
4.1 Energy consumption



Narrative:

- The overall energy consumption has generally been falling, mainly driven by a reduction in gas consumption due to the recent warmer winters, Phase 1 of the Integrated Energy Solution and improved energy efficiency. Electricity usage has remained broadly static.
- From the autumn of 2026 it is expected that there will be a significant shift from Gas to Electricity consumption as Phase 2 of the Integrated Energy Solution becomes operational

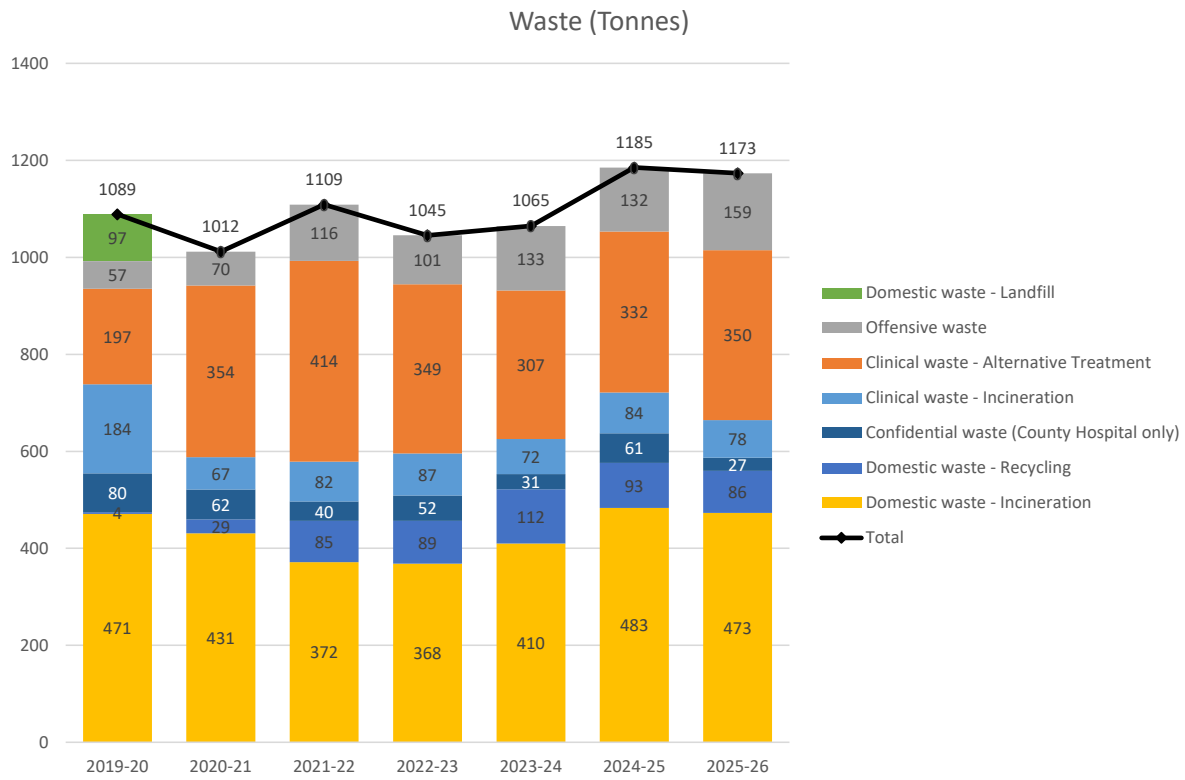
4.2 Water



Narrative:

- Water consumption had remained broadly static but has been falling over the last three years despite the underlying activity increases the Trust has seen

4.3 Waste

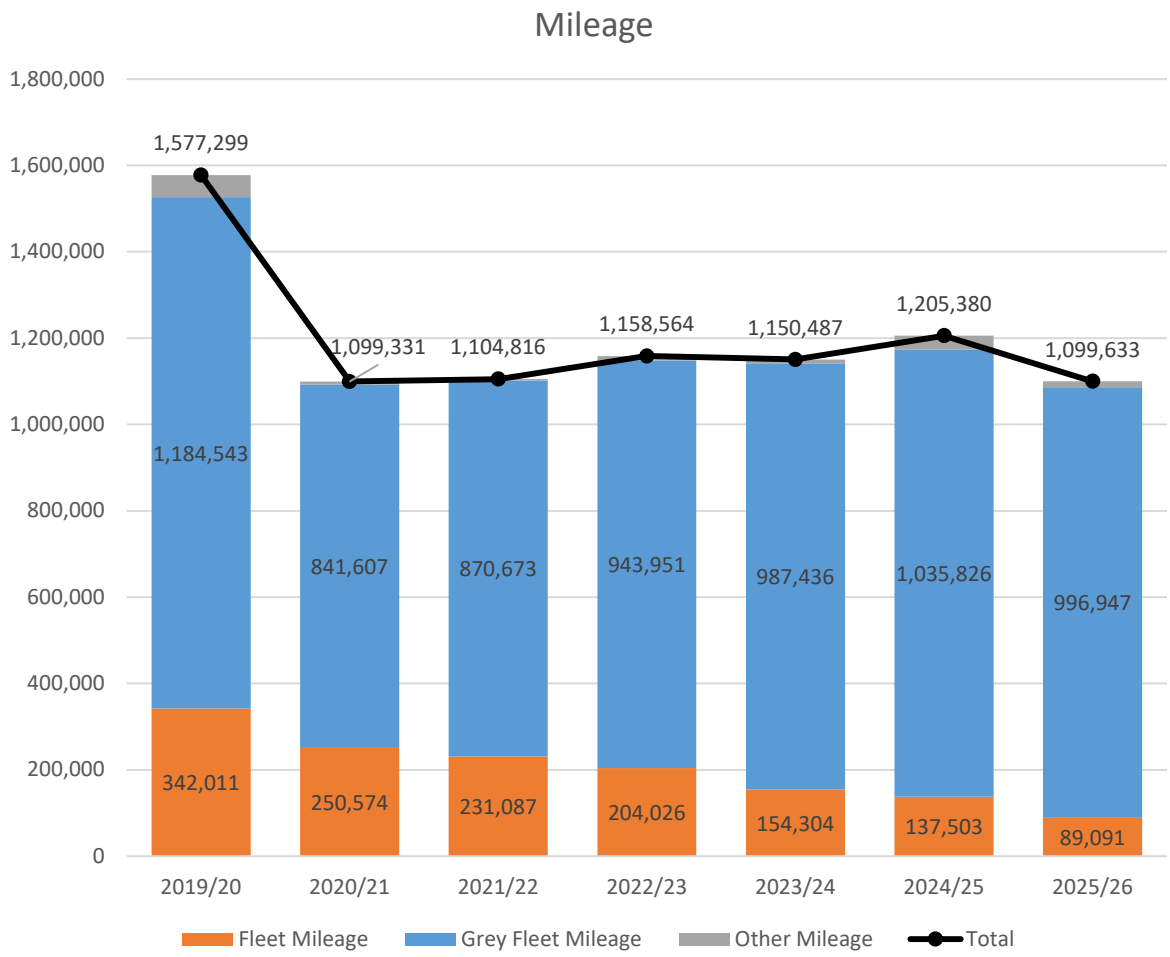


Narrative:

- Waste to landfill has been eliminated
- Clinical waste (incineration + alternative + offensive) has remained broadly static
- Confidential waste has reduced as a result of the use of electronic records
- Other waste has increased in line with activity increases

Note – This chart currently excludes food waste as the data was incomplete

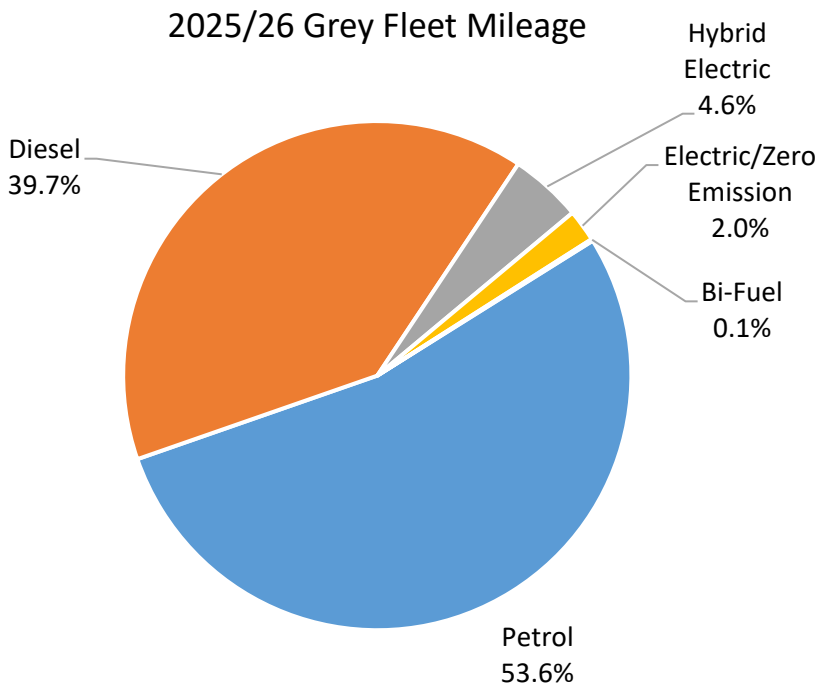
4.4 Mileage



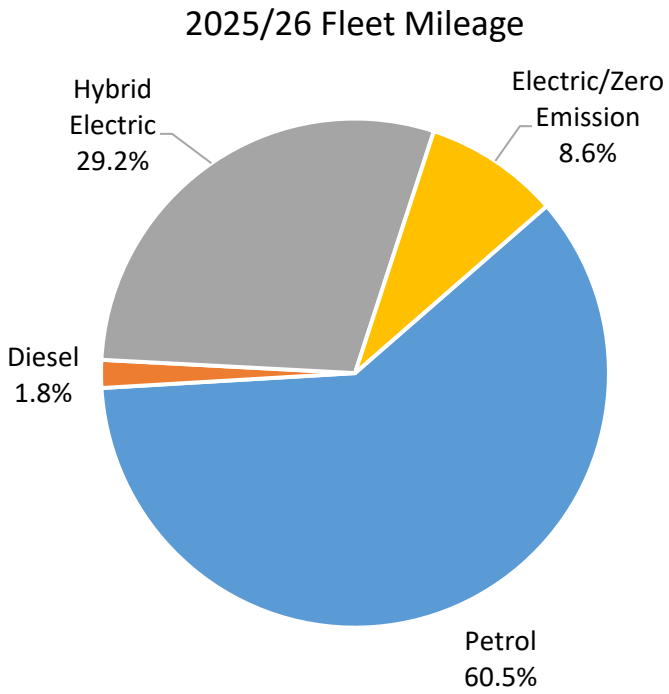
Narrative:

- Large reduction in mileage compared to pre-covid
- Steady reduction in (Trust owned vehicle) fleet mileage
- Grey fleet mileage (i.e. staff travel mileage claimed via expenses) had been increasing since covid but not up to pre-covid levels but has fallen again in 2025/26.

As of 2025/26 the mileage data is broken down by fuel type.



- Grey fleet mileage is dominated by Petrol and Diesel fuelled vehicles



- Fleet mileage is dominated by Petrol fuelled vehicles compared to Diesel
- There is now significant use of Hybrid Electric and Electric/Zero emission vehicles as the fleet is being switched

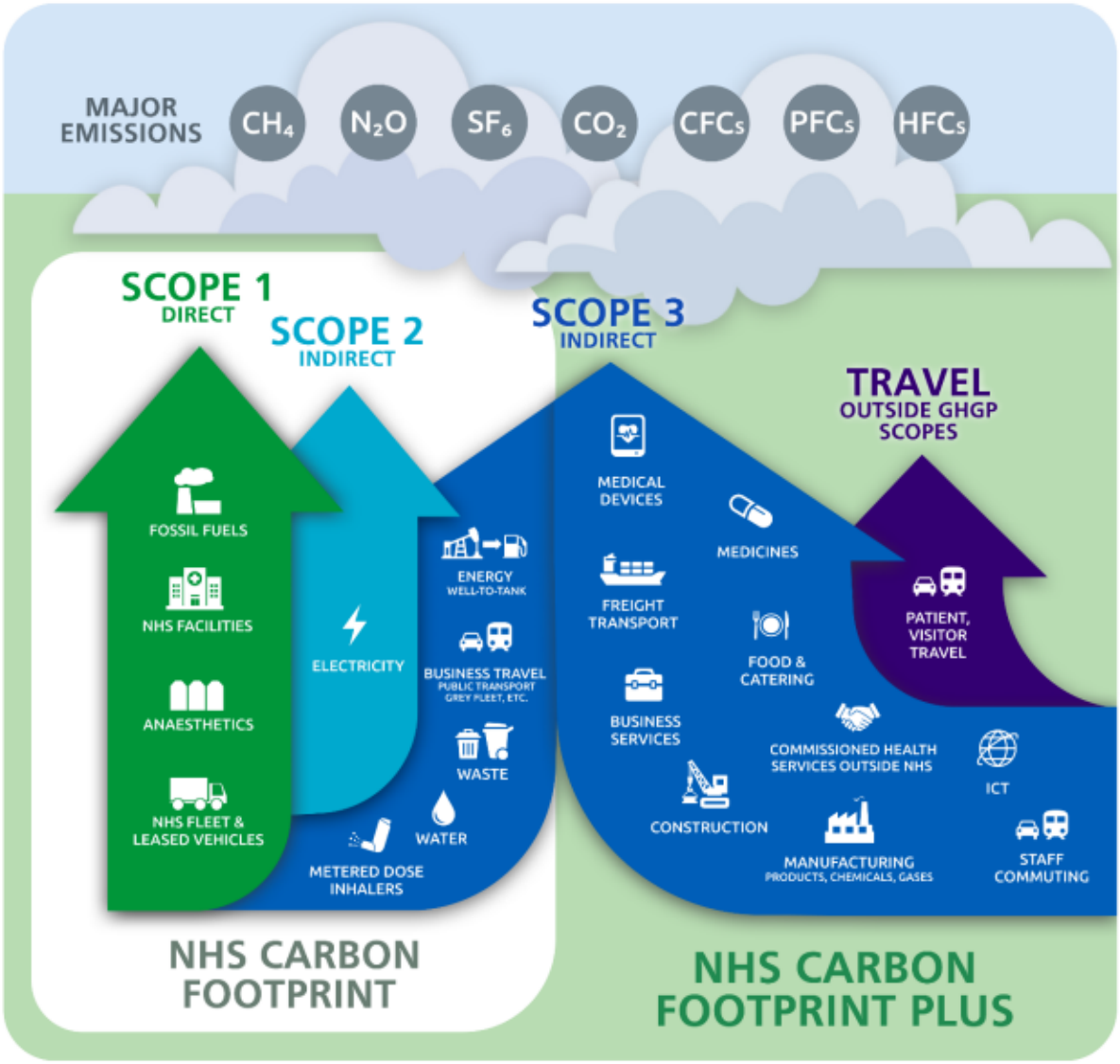
5. Green Plan Support Tool - Estimates of trust Carbon Footprint Plus emissions

5.1 Introduction

The Green Plan Support Tool (GPST) has been developed by the Greener NHS team to support Trusts and ICBs in further developing and implementing their green plans and targeting action to reduce carbon emissions.

Success against national targets is measured by national estimates for the NHS Carbon Footprint and NHS Carbon Footprint Plus and public assessments of national emissions.

The Greenhouse Gas Protocol (GHGP) scopes are shown in the Figure below.



In September 2025, the five-year progress review of the Greener NHS programme was published, including updated estimates for the NHS Carbon Footprint and NHS Carbon Footprint plus for 2019/20 to 2024/25, based on improved data and methodology.

In April 2026 the Green Plan Support Tool was updated with organisation-level data from the new NHS Carbon Footprint Plus model for Trusts, consistent with the updated data and methodology and providing a time series of NHS Carbon Footprint Plus estimates for the first time.

NHS emissions are calculated using a set of countable activities multiplied by the carbon intensity of each activity ('emissions factors') through the NHS Carbon Footprint Plus model. The model combines 'top-down' spend data with 'bottom-up' activity data (based on a range of inputs from NHS trusts, such as buildings energy use, medicines data, and fleet data collection). Carbon factors are applied to both spend (kgCO2e/£) and activity (kgCO2e/unit of activity).

Wherever possible, 'volume-based' estimates are used, where counts of emissions-sources are combined with specific emissions intensities where these estimates use data that is already collected at trust level and therefore easily attributable to individual organisations.

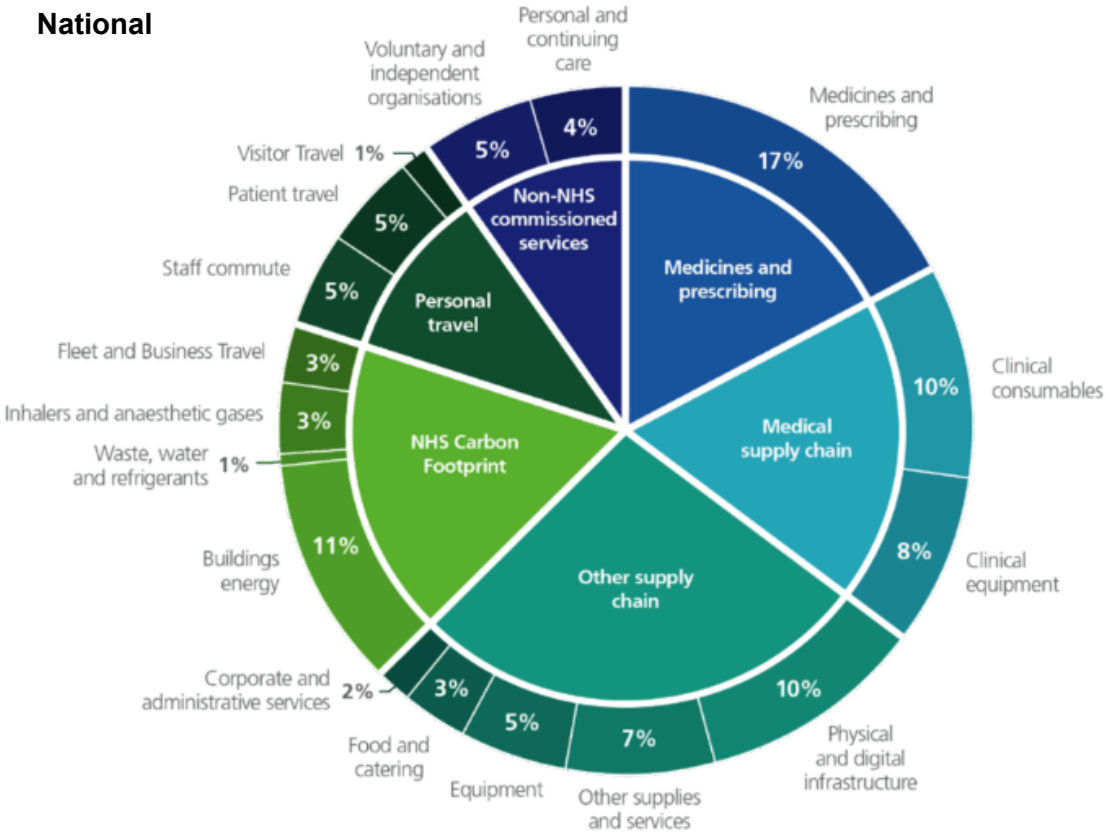
In other areas of the Carbon Footprint Plus model – particularly where estimates are associated with Scope 3 emissions embedded in the supply chain of goods and services – volumes and intensity factors for individual products and services are not generally available, and so an expenditure-based methodology is used.

The methodology employed converts the use of resources to equivalent tonnes of CO_2 which is written as tCO2e.

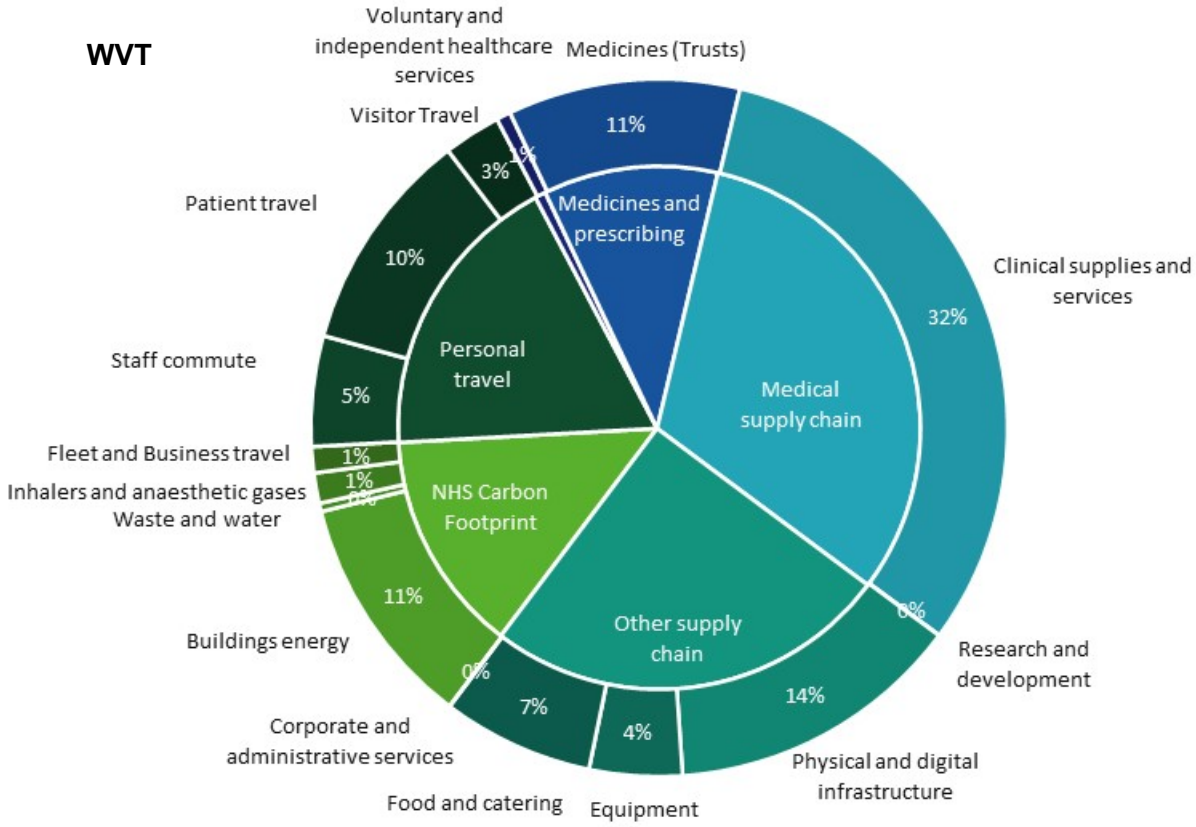
The initial WVT data is presented here.

5.2 WVT Carbon Footprint vs National picture (2024/25)

National



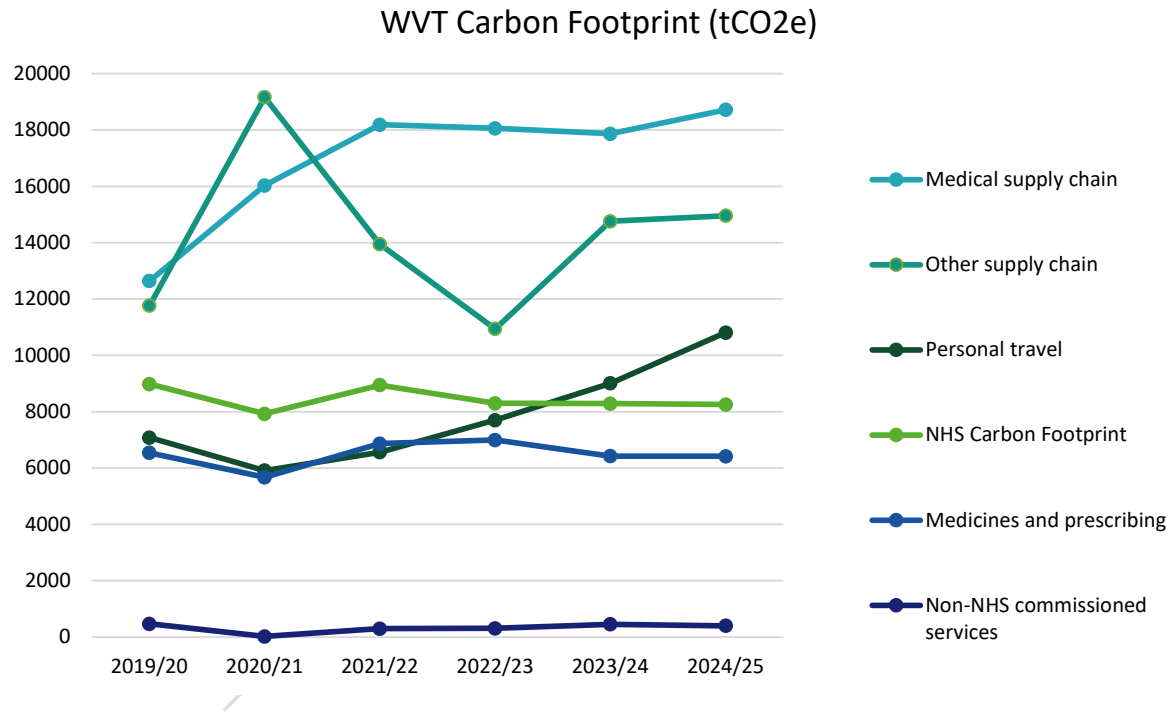
WVT



Narrative

- It should be noted that the categories do not fully match those used in the national picture
- At a high level the WVT breakdown is different from the overall national picture. This is likely to be because the national picture includes combined data from Acute Trusts, Community Trusts, Ambulance Trusts and Mental Health Trusts where the other Trust types will have very different profiles compared to Acute Trusts.
- The higher proportion for “Medical supply change” may reflect the higher intensity of medical resources employed in the Acute sector
- The higher proportion of “Personal travel” may reflect the rurality of WVT.

5.3 WVT Carbon Footprint – Time series

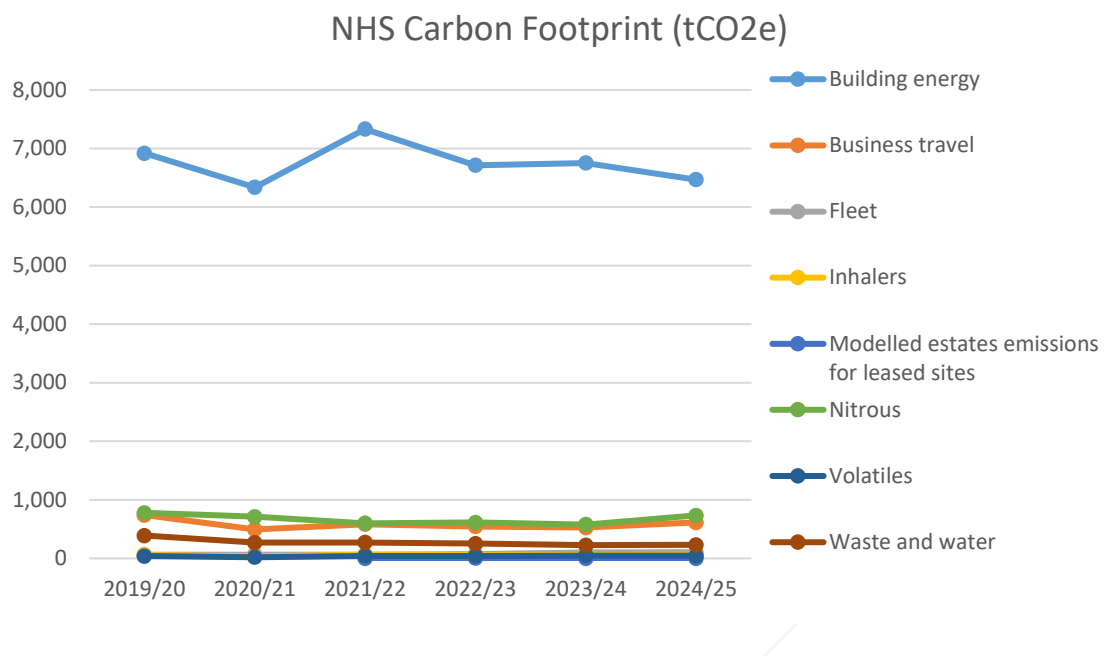


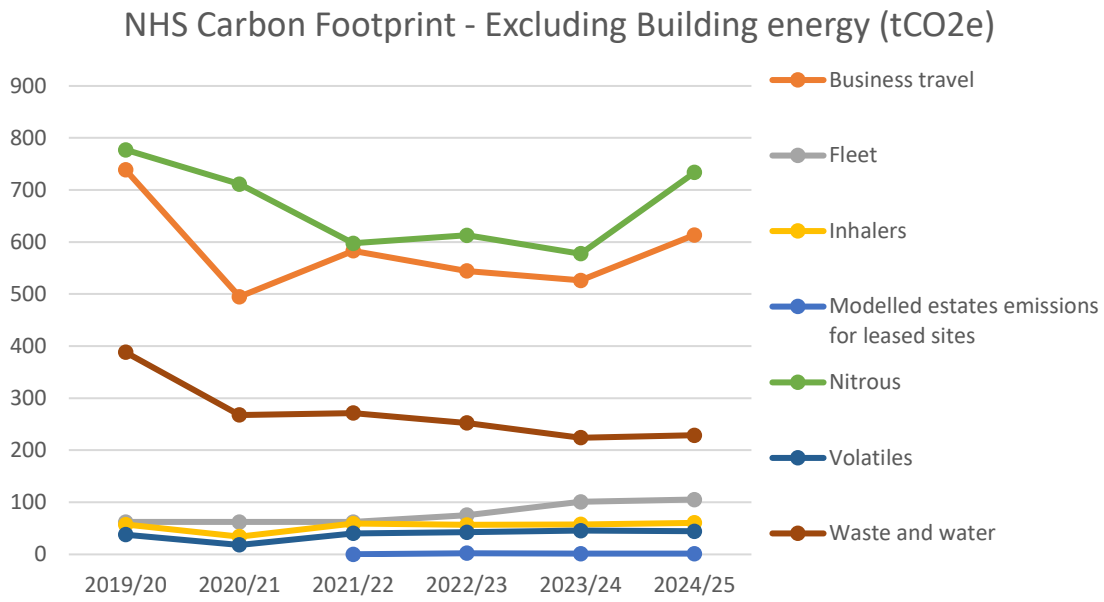
Narrative

- NHS Carbon Footprint, Medicines and prescribing and Non-NHS commissioned services have remained broadly static
- Personal travel has increased but with a rate higher than increased activity levels (see below)
- Medical supply chain is the largest contributor but has remained broadly static in recent years (see below)
- There is large variation in Other supply chain mainly due to the Trust’s recent construction projects (see below)

A more detailed analysis is presented below.

5.4 NHS Carbon Footprint

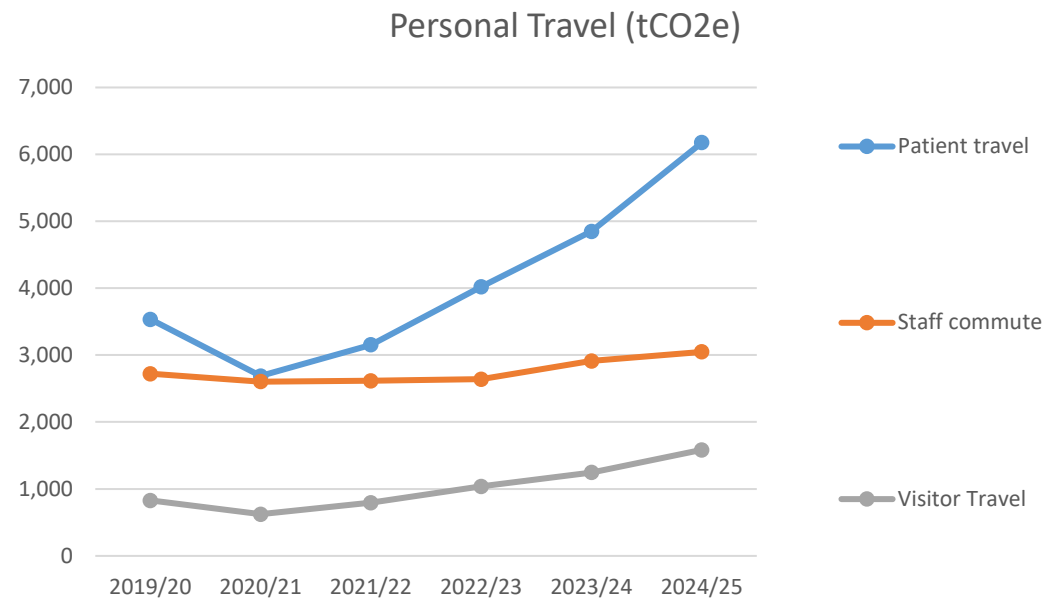




Narrative

- Business and Fleet travel is consistent with the local analysis presented above
- Waste and water combined gas reduced

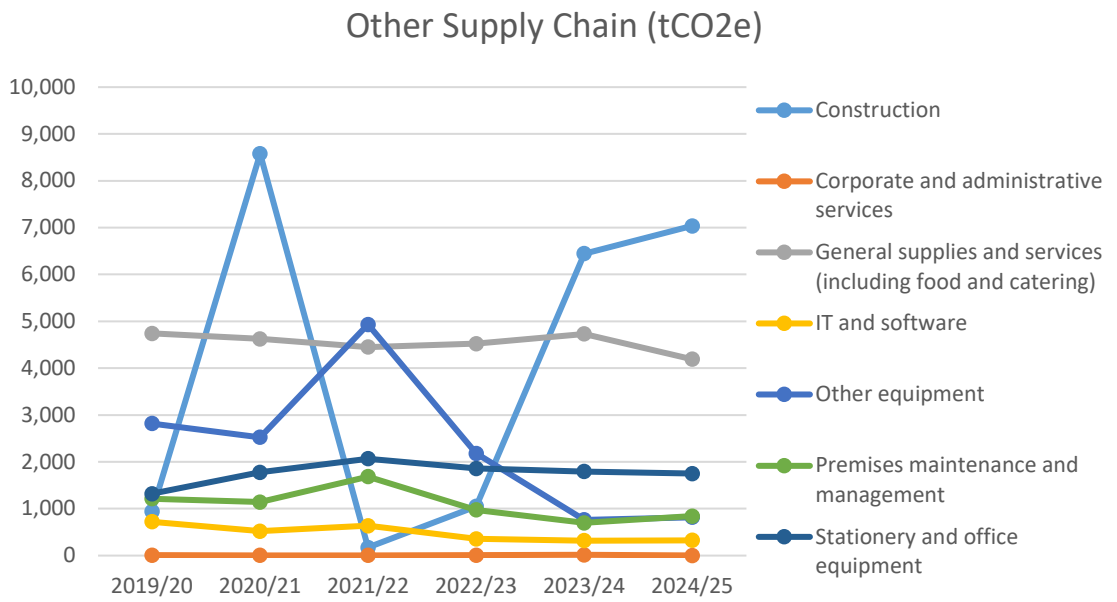
5.5 Personal Travel



Narrative

- The methodology employed is based on postcode analysis. There may be an issue with the methodology as the increases (since Covid) in patient and visitor travel are higher than activity increases shown above.

5.6 Other Supply Chain

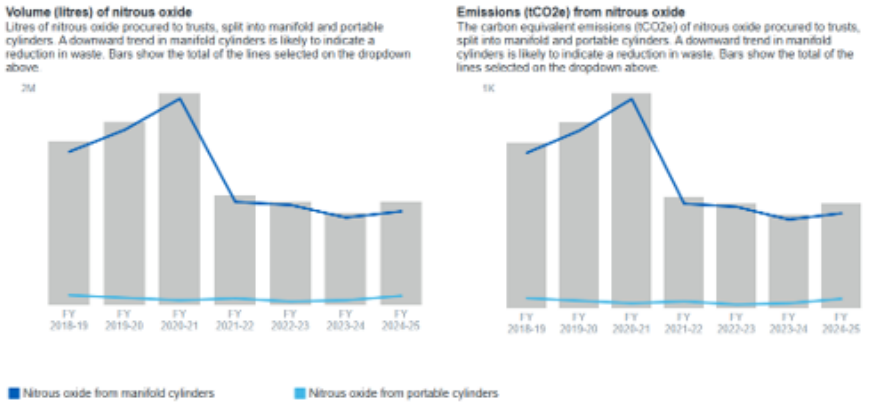
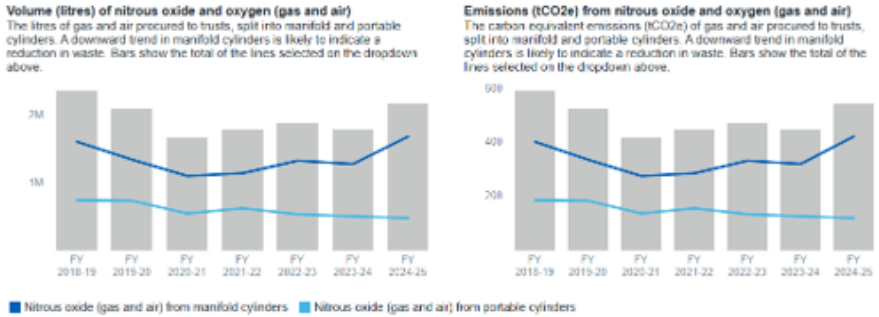


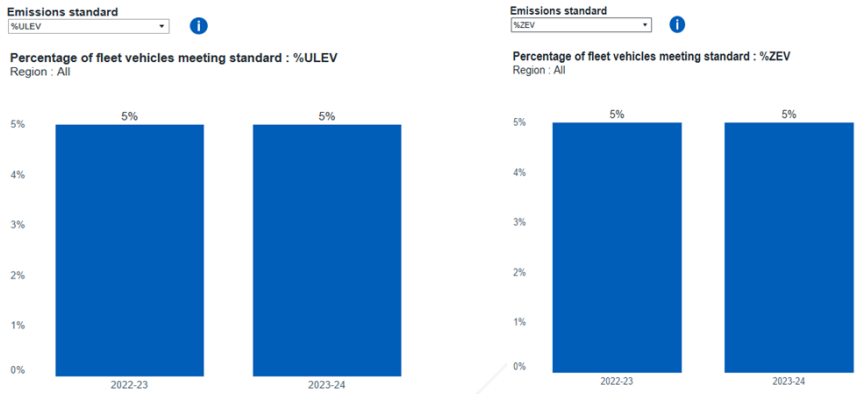
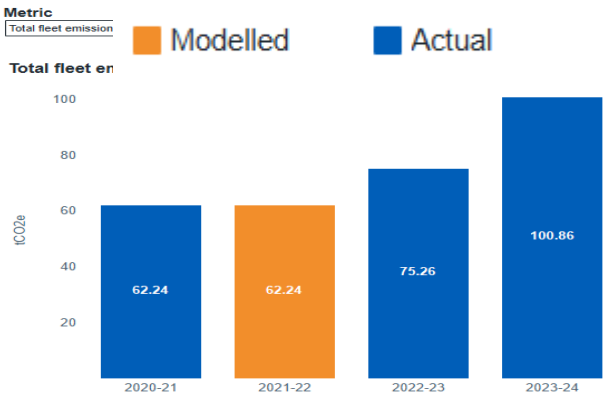
Narrative

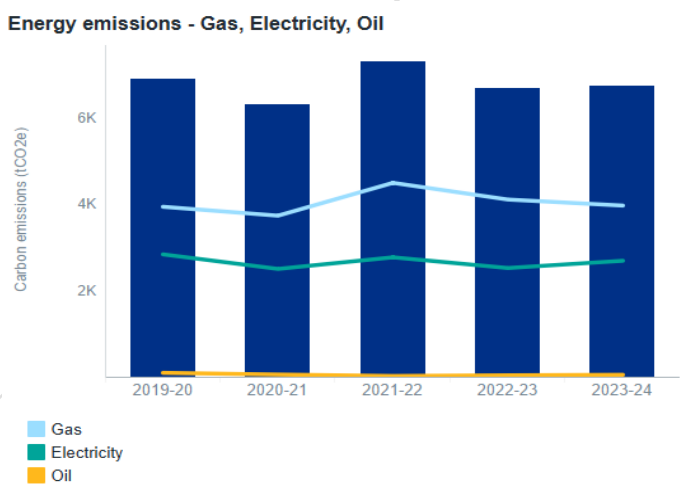
- The emissions for most sub-categories have stayed broadly static
- There is large variation for construction which likely to be linked to recent Trusts major capital schemes (Frailty Block, Elective Surgical Hub and Community Diagnostics Centre)

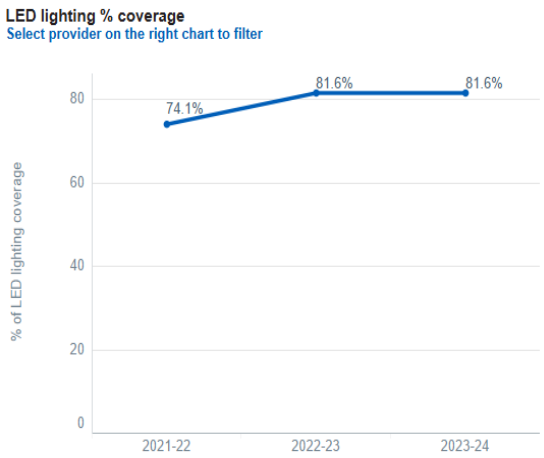
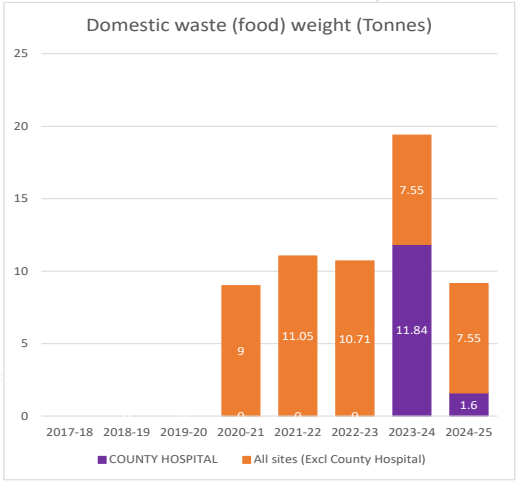
6. Other Supporting Metrics

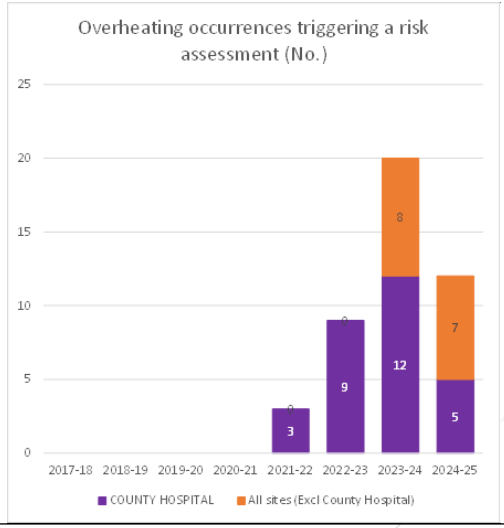
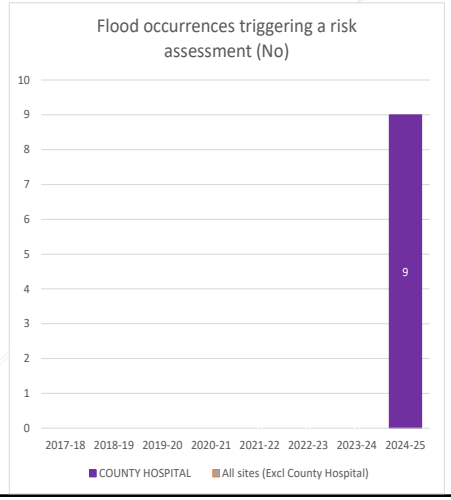
As suggested in the NHSE Green plan guidance (February 2025) additional metrics for tracking progress against green plan delivery are also shown below.

Focus area	Metric	Data source	Charts/Answer	Narrative
Medicines	Emissions (tCO2e) and volume (litres) of nitrous oxide by trust	Greener NHS dashboard		Large reduction in emissions since Covid. The Trust do not use the anaesthetic gases (such as Desflurane) that produce the highest emissions and are working on ways to reduce emissions from Nitrous Oxide. There are future plans to remove Nitrous Oxide outlets in theatres and then later the Nitrous Oxide manifold.
Medicines	Emissions (tCO2e) and volume (litres) of nitrous oxide and oxygen (gas and air) by trust	Greener NHS dashboard		This metric relates to Maternity activity.

Focus area	Metric	Data source	Charts/Answer	Narrative
Travel and transport	% of owned and leased fleet that is ultra-low emission vehicle (ULEV) or zero-emission vehicle (ZEV)	Greener NHS dashboard		The percentage is expected to increase in future years.
Travel and transport	Total fleet emissions	Greener NHS dashboard		See main travel metrics above.
Travel and transport	Does the organisation offer only ZEVs in its salary sacrifice scheme	Greener NHS dashboard	No, ULEV/ZEV are available alongside non ULEV/ZEV options	

Focus area	Metric	Data source	Charts/Answer	Narrative
Travel and transport	Does the organisation operate sustainable travel-related schemes for staff (for example, salary sacrifice cycle-to-work)	Greener NHS dashboard	Yes	Cycle to Work scheme - staff can now access brand new bikes with easy deductions through payroll at any time. "Park and Share" is promoted via the Trust intranet and actively via the car parking pass allocation process. Contract Hire and Salary Sacrifice Schemes are available to new and existing employees of the Trust who do Business Miles, Private Miles or a combination of both, subject to approval.
Estates and facilities	Emissions from fossil-fuel-led heating sources	Greener NHS dashboard		See main energy metrics above.
Estates and facilities	Number of oil-led heating systems	Estates Return Information Collection/Greener NHS dashboard (from Q4 24/25)	Zero	

Focus area	Metric	Data source	Charts/Answer	Narrative
Estates and facilities	% of gross internal area covered by LED lighting	Estates Return Information Collection/Greener NHS dashboard (from Q4 24/25)		The percentage is expected to increase in the future.
Food and nutrition	Weight (tonnes) of food waste, with further break down by spoilage, production, unserved and plate waste	Estates Return Information Collection		There is incomplete data for this metric. A segregated food waste bin scheme has recently been introduced.

Focus area	Metric	Data source	Charts/Answer	Narrative
Adaptation	Number of overheating occurrences triggering a risk assessment (in line with trust's "heatwave" plan)	Estates Return Information Collection		There is incomplete data for this metric. This is included in the Trust's Climate Adaptation Plan which was approved by the Trust Board on 07/03/2024.
Adaptation	Number of flood occurrences triggering a risk assessment	Estates Return Information Collection		There is incomplete data for this metric. This is included in the Trust's Climate Adaptation Plan which was approved by the Trust Board on 07/03/2024.

7. Appendix A – Green Plan SMART Objectives

Focus Area	"We will" statement	SMART Objective
Workforce and Leadership	Develop a dashboard and report key performance indicators to the Trust Board annually	Develop a dashboard from December 2025 and report key performance indicators to the Trust Board annually
Workforce and Leadership	Communicate our Green Plan and annual updates to staff, patients, visitors and the local community	Communicate our Green Plan and annual updates to staff (via TrustTalk), patients, visitors and the local community (via the Trust website) from December 2025
Workforce and Leadership	Work with volunteers and other members of our local community in the delivery of our Green plan	Work with members of the Volunteer Steering Group to develop volunteering services for green space maintenance, transport and contact centre by March 2026
Net Zero Clinical Transformation	Identify and appoint a clinical lead with oversight of net zero clinical transformation.	Identify and appoint a clinical lead with oversight of net zero clinical transformation by October 2025
Net Zero Clinical Transformation	Focus on critical and perioperative care pathways initially	Develop options for critical and perioperative care pathways initially by summer 2026
Net Zero Clinical Transformation	Move on to schemes in urgent and emergency care, diagnostics and medical pathways	Agree a prioritised list of schemes in urgent and emergency care, diagnostics and medical pathways by July 2026
Net Zero Clinical Transformation	Create a Trust-wide clinical network to improve staff engagement and support	Create a Trust-wide clinical network to improve staff engagement and support by July 2027
Digital transformation	Fully deliver the benefits of our digital ambitions by minimizing the use of paper notes and their transport	Reduce the use of paper notes and their transport by 80% by July 2028
Digital transformation	Consider how AI can automate functions and improve efficiency and productivity	Pilot and evaluate our AI Strategy by December 2026

Focus Area	"We will" statement	SMART Objective
Digital transformation	Explore how the Trust can minimize the carbon footprint of its Digital Strategy implementation, including AI roll-out	Undertake a sustainability impact assessment of the Digital Strategy by July 2027
Medicines	Reduce the use of metered dose inhalers (MDI)	Scheme launched to ensure that patients are not started on MDI or are switched to alternatives by July 2026
Medicines	Investigate measures to further reduce the ~~use~~ waste of nitrous oxide	Remove Nitrous Oxide outlets in theatres by March 2026
		Remove the Nitrous Oxide manifold by March 2027
		Review the use of Entonox as part of ICB-wide scheme by July 2028
Medicines	Further promote the use of the patient's own drugs whilst in hospital	Work with WMAS and Pre-Op assessment to encourage patients to bring their own medication into hospital by July 2026
		Implement a patient self-administration approach within the County Hospital by December 2026
Medicines	Reduce the amount of waste generated by Pharmacy	Monitor waste and implement dry recycling of Pharmacy packaging by July 2028
		Ensure that the most efficient and effective medicine choices are made, such as focusing on the oral route where possible
		Reducing polypharmacy and waste of medicines by proactive medicines reconciliation and specialty support
		Move to a paperless system in Pharmacy by July 2026
		Robot

Focus Area	"We will" statement	SMART Objective
Travel and transport	Offer only zero-emission vehicles through vehicle lease salary sacrifice schemes	Offer only zero-emission vehicles through vehicle lease salary sacrifice from December 2026
Travel and transport	Make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only	Purchase, or lease zero-emission vehicles only from December 2027 onwards
Travel and transport	Work with Herefordshire Council to improve transport links for staff and public	Work with Herefordshire Council on their transport plans for the city, including car parking, in order that staff and patients can choose how they access services, by December 2026
Travel and transport	Increase the number of staff that commute via active travel or public transport	Re-survey staff modes of transport in 2026 and 2028.
		Reduce the number of staff that commute via car to 82% from 85% by 2028
Travel and transport	Install EV charging points at the County Hospital for fleet vehicles and possibly staff/public	Undertake a needs assessment to establish potential demand for EV charging points at the County Hospital by March 2026
Supply chain and procurement	Adopt a whole life cycle approach to purchasing, embedding sustainability into all of our procurement processes.	Encourage suppliers to exceed minimum requirements by engaging with the Evergreen Sustainable Supplier Assessment for streamlined sustainability discussions by July 2028

Focus Area	"We will" statement	SMART Objective
		Review our sustainable procurement approach to find relevant links that enable our Green Plan and work closely with NHS Supply Chain and NHS Improvement to promote their sustainability programmes by July 2028
Supply chain and procurement	Work with suppliers to reduce the use of clinical single use plastics, and to support the procurement of sustainable PPE.	Investigate Clinical Product Reuse Schemes by July 2028
Supply chain and procurement	Implement materials management Trust-wide to reduce the amount of inventory and waste	Implement a material management system at the County Hospital by December 2026
Adaptation	Ensure that the organisation is prepared to deal with the effects of climate change, particularly extreme weather events.	Increase staff education, training and awareness on extreme weather events by March 2027
Adaptation	Deliver our Climate Change Adaptation Plan, focusing on dealing with the flooding and water ingress risk and cooling our buildings in the summer.	Report on delivery of our Climate Change Adaptation Plan in the annual Board report by December 2025
Adaptation	Review the NHSE climate change adaptation toolkit and update the Trust plan	Review the NHSE climate change adaptation toolkit and update the Trust plan by Dec 2025
Food and nutrition	Ensure inventory management is in place to measure the reduction in food waste across our sites	Ensure inventory management is in place to measure the reduction in food waste across our sites by March 2026
Food and nutrition	Improve the patients' experience of food at the County Hospital to reduce food waste	Improve the patient experience of food at the County Hospital to reduce food waste by achieving better than bottom quartile results in the Place & Inpatient surveys by March 2026

Focus Area	"We will" statement	SMART Objective
Food and nutrition	Ensure all food waste is segregated and consider composting alternatives	Ensure all food waste is segregated by March 2026
		Explore alternative food waste composting by March 2027
Food and nutrition	Consider opportunities to lower the carbon footprint of hospital food by providing seasonal menus high in fruits and vegetables and low in heavily processed foods	Work with PFI partners to lower the carbon footprint of hospital food by June 2028
		Assess whether the Trust can specify lower carbon menus in the post PFI specification by July 2027
Estates, energy and waste	Increase our recycling rates at all sites, ensuring less waste goes for heat reclamation	Increase our recycling rates to 20% by July 2028 at all sites, ensuring less waste goes for heat reclamation
Estates, energy and waste	Finalise Phase Two of our Integrated Energy Solution, which will decarbonize the County Hospital estate to 95%	Complete Phase Two of our Integrated Energy Solution, which will decarbonize the County Hospital estate by ~~March~~ ~~May~~ ~~August~~ Sept 2026
Estates, energy and waste	Bid for funds to complete the decarbonisation of the County Hospital sites and the community sites where possible	Bid for funds to complete the decarbonisation of the County Hospital sites and the community sites where possible by July 2028
Estates, energy and waste	Consider the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption	Assess whether the Trust can specify the use of intelligent building management systems to highlight issues pro-actively to continue to reduce energy and water consumption in the post PFI specification by 2028

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	Ockenden/Amos Briefing paper
Lead Executive Director:	**Chief Nursing Officer** **Chief Medical Officer**
Author:	Associate Director of Quality Governance
Reporting Route:	
Enclosures included with this report:	NHS England letter – 12th August 2026 included as appendix 1 10-point plan baseline assessment and maternity triage specification – circulated to Board members for reference
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

This paper sets out the next steps in responding to the Ockenden and Amos reports as published by NHS England on 12th August 2026.

Recommended Actions required by Board or Committee

The Board is asked to **note** the update and **approve** delegation to Quality Committee for a review of the baseline assessment and associated response in line with the 25th September deadline.

Executive Director Opinion[1]

Board is asked to note:

The Trust is on track to complete the baseline assessment and gap analysis as outlined in this report.

If Board is in agreement the assessment tools will be submitted to Quality Committee on 24th September for approval on behalf of the Board.

The longer-term governance arrangements and alignment across the foundation group will be developed over the coming months with a view to implementation by 31st December 2026, a preliminary report will be presented to Foundation group strategy committee in early September.

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

Ockenden- Amos Briefing Paper

1. Introduction

In June 2026, two key national reports were published relating to the quality and safety of maternity service at 13 NHS Trusts. The Ockenden report was published on 24th June 2026, followed by the Amos report on 30th June 2026. A briefing was presented to public board in July 2026 acknowledging the high-level summary and findings of both reports.

This paper sets out the evolving arrangements requested of Trusts in response to the reports and specific requests made by NHS England for all Trusts to respond to a defined ten-point plan.

2. Summary - July update

During July, Quality Committee were updated on the steps being taken to respond to the 10 point plan.

The Trust has convened a Task and Finish Group to coordinate the response and oversight of the ten-point plan. The Group has met weekly throughout July. The two key objectives for July were;

1. Develop detailed actions plans to address each section of the ten-point plan

2. Complete the most immediate action set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July 2026 in relation to care after death and the Human Tissue Authority requirements

3. August update

The submission relating to the Fuller Inquiry was approved by the Quality Committee on behalf of the Board on 30th July and submitted by the mandated 31st July deadline. Acknowledgement of submission was received.

Work has continued to develop comprehensive plans to deliver the ten-point plan under the current task and finish group arrangements.

Baseline assessment and gap analysis

On 12th August 2026, NHS England published a letter and a set of assessment tools, outlining the requirements for the 100-day response to the ten-point plan release. The letter is attached at appendix 1 and the assessment tools have been circulated for Board reference.

The Trust must complete and submit, with board approval, the baseline assessment and gap analysis documentation by 25th September. This will be followed by a progress update by 31st December.

Both submissions must be approved by the Trust Board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

As with the initial submission in July, due to the timing of this publication and deadline for submission, it has not been possible for the baseline assessment and gap analysis to have been undertaken in time for Board scrutiny today. Given this, Board is asked to delegate a review of the

self-assessment, gap analysis and associated evidence to the Quality Committee who are due to meet on 24th September. This will enable time for a robust assessment and allow the trust to meet the deadline of 25th September.

Longer term governance arrangements

In conjunction with Worcester Acute Hospital Trust and the wider foundation group it has been agreed to adopt aligned governance arrangements for the longer-term implementation, oversight and assurance of the Ockenden and Amos recommendations.

These arrangements will include;

- Agreeing the performance indicators and evidence requirements to assess compliance with the recommendations, and initially the ten point plan
- Implementing an assurance and evidence RAG rated methodology to demonstrate progress and evidence compliance
- Setting up a Perinatal Assurance Group (PAG)
- Development of local reporting arrangements of PAG which will, longer term, oversee the CNST process and related processes within Maternity and Neonates
- Overall strengthening our governance arrangements for maternity and neonatal services
- Foundation group support and peer review of evidence thus supporting objective/external scrutiny and enabling sharing of best practice

Next Steps

The Trust must action the ten-point plan within 100 days of the publication of the letter. The Trust are on track to do this with continued development of a comprehensive action plan and completion of the new assessment tools as outlined in this report.

The assessment tools will be submitted to Quality Committee on 24th September for approval on behalf of the Board.

The governance arrangements will be developed over the coming months with a view to implementation by 31st December 2026.

NHS England

To: NHS trust:

- chief executives
- chairs
- chief nursing officers
- medical directors
- chief operating officer
- communications directors

cc. Integrated care bard (ICB):

- chief executives
- chief nursing officers
- medical directors

NHS England:

- regional directors
- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 August 2026

Dear colleagues,

Maternity and Neonatal 10 Point Plan assurance process

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the assurance process and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.

Publication reference: PRN02631

The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with Maternity Incentive Scheme (MIS) Year 8 requirements, enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the standardised national template to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, ‘Amos into action’ will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out in his letter, this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a maternity

triage benchmarking tool to support implementation of the national maternity triage specification. You can find the full detail in the Appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Professor Frankie Swords
National Medical Director

Appendix: Maternity and Neonatal 10 Point Plan – support available

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the Model Board Report to support their reporting process.

Support will be available to help trusts and systems implement the 10 Point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided in the table below. For any queries relating to the reporting template, please contact england.maternitytransformation@nhs.net.

Action	National Support Available
Martha's Rule	Trusts should follow the implementation and reporting processes outlined by the Martha's Rule national team in NHS England. A webinar is scheduled for **Wednesday 12 August, 15:00–16:30hrs** to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication. The session will provide key information to support local implementation, including: • an overview of the three components of Martha's Rule • the national implementation approach • learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings • the implementation support, resources and tools available to local teams.

	The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team. The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email england.psimprovement@nhs.net
Maternity and Neonatal 10 Point Plan supporting webinar series	The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in **August.** The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on: 1. Listen to women and their families using real-time and transparently reported outcomes and experience, **Monday 17 August 2026, 11:30 – 12:00** 2. Clinical audit, **Wednesday 19 August 206, 15:30 – 16:00** 3. Ensuring 24/7 safety and responsiveness of services, **Wednesday 19 August 2026, 11:30 – 12:00** 4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, **Thursday 20 August 2026, 12:00 – 12:30** Further information will be shared soon.
Amos into Action staff listening exercise	This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services. Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that

	follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.
Safe and effective maternity triage	The triage benchmarking tool has been shared by NHS England to support implementation of the maternity triage specification. Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.
Post death care	Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry

Escalation and Assurance Report

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

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Quality Priorities 2026/27: Quarter 1 Overview**
Rating rationale	The report provided an update on the quality priorities, which included those in their second or third year, those linked to wider project work and priorities in the early stages of implementation.
Outcome	**Action:** Include reference in future reports on whether work is on track or not, using KPIs where appropriate.
Item/Topic	**Quality Priority Update: Transition of Care**
Rating rationale	• The first Young People's Transition Focus Group meeting provided valuable input to transition planning. • A Transition Passport and new Transition Pathway had been developed with engagement from departments including ED, SDEC, gastroenterology and community paediatrics. • Current challenges included IT systems integration and streamlining liaison with tertiary centres. • A Transition Working Group would be established to drive further work.
Outcome	The Committee welcomed progress and recommended ensuring the feedback loop is closed to build confidence in the engagement process **Action:** Include data in future reports to demonstrate progress.
Item/Topic	**Quality Priority Update: Frailty Assessments in Emergency Department**
Rating rationale	Good progress was being made with frailty screening in ED, which supported early identification of people who may benefit from comprehensive geriatric assessment. Audit findings indicated that frailty screening rates were good, but further improvement was required in post-screening activity. A test of change was planned, including implementation of delirium management care bundles.
Outcome	The Committee was assured about the pace of progress and supported the planned next steps. **Action:** Future updates should include agreed measures for screening, post-screening interventions, outcomes and impact on patient safety, experience and flow.
Item/Topic	**Clinical Support Division Monthly Report: Diagnostics**
Rating rationale	Positive highlights included reduced ENT waiting times, successful recruitment activity, progress in lung screening and positive feedback on the Community Diagnostic Centre (CDC). Workforce sustainability was an area of challenge, alongside increasing demand for EEG investigations. There were significant resource and infrastructure requirements to achieve future accreditation standards across physiological science services. Mitigation plans were being developed in relation to the risk of a major PACS network failure Staffing pressures largely reflected normal workforce turnover and recruitment cycles.
Outcome	The Committee took assurance from the report and oversight through divisional governance arrangements.
Item/Topic	**Divisional Quarterly Report: Surgical Division Q1**
Rating rationale	The report provided assurance on strong operational performance, including nationally recognised paediatric epilepsy services, improved theatre utilisation and cancellation rates, and achievement of all key urology cancer standards. A new Patient Safety Incident relating to delays in diabetic foot care was under review, alongside one remaining open Serious Incident in orthodontics nearing closure. There was a significant rise in complaints during July, largely related to waiting times and communication, although progress has continued in reducing the complaints backlog. There were ongoing concerns about VTE compliance and fit mask testing compliance, with improvement actions in place and ongoing monitoring through governance processes.
Outcome	The Committee took assurance from the report and oversight through divisional governance arrangements.

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

Escalation and Assurance Report

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

Item/Topic	Divisional Quarterly Report: Integrated Care Q1
Rating rationale	The report provided assurance on improvements in community service performance, including a significant reduction in pressure ulcers, improved patient flow from acute to community settings, and the continued success of the Bridging Team in supporting earlier discharge. Positive progress was noted in the development of neighbourhood health services, expanded community access arrangements and strong patient feedback across integrated services. A key challenge was increasing demand for community insulin administration, which was placing pressure on district nursing capacity. A longer-term workforce and service review is underway to address future demand and sustainability.
Outcome	The Committee took assurance from the report and oversight through divisional governance arrangements.
Item/Topic	**Safeguarding Quarterly Reports**
Rating rationale	• Adult safeguarding MCA and DoLS legislative changes would require updates to training and were expected to result in a temporary reduction in training rates. This would be added to the risk register. • Children's safeguarding Positive areas included training compliance above Trust standard. Areas requiring oversight included ED and PAU level 3 training compliance, safeguarding supervision for health visitors, increasing police safeguarding referrals, delayed children in care reporting and escalation around processes for suspected non-accidental injury. Government intervention in children's services in Herefordshire had closed following a positive review.
Outcome	The Committee noted the reports and requested continued oversight of safeguarding risks, training compliance and delayed reporting.
Item/Topic	**Mortality Report**
Rating rationale	SHMI remained elevated, although interpretation continued to be affected by national changes relating to SDEC data. The coding backlog had been cleared and resubmitted. Crude mortality remained low and ED mortality continued a downward trajectory. Fractured neck of femur mortality had improved. The Trust was no longer an outlier in the National Hip Fracture Database, with case-mix adjusted mortality returning to expected levels for the first time in around two and a half years. GIRFT recommendations were being implemented around enhanced recovery, including a review of the pain medication protocol.
Outcome	The Committee accepted the report for assurance and noted the continued focus on learning from mortality reviews.
Item/Topic	**Quarterly Perinatal Incident Report**
Rating rationale	The report provided an update on progress against actions from incidents and evidence of shared learning. Future reports would include the number of overdue actions and incidents, reflecting the national expectation that changes in practice arising from investigations should be evidenced within six months. A key concern was the number of outstanding actions from incidents. Recruitment to a governance vacancy was in progress and the leadership team was maintaining oversight. The next report would provide a position statement on this.
Outcome	The Committee accepted the report for assurance and noted progress with action delivery and learning.

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

Escalation and Assurance Report

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

Item/Topic	Nurse Staffing Report June 2026
Rating rationale	The Safer Nursing Care Tool study had been completed, with a further study planned for October 2026. NHSE was undertaking an independent review of the methodology in July and August. Agency usage continued to reduce but high numbers of ED attendances and ward admissions were creating additional staffing needs. Bank and agency usage increased in-month, driven particularly by demand for registered mental health nurses. Recruitment to the increased establishment, within existing budgets, was in progress and was expected to support a reduction in temporary staffing usage.
Outcome	The Committee noted the report and received assurance that safe staffing arrangements remain subject to appropriate oversight.
Item/Topic	**Patient Flow Report**
Rating rationale	The report provided assurance on urgent and emergency care, discharge and flow improvement activity. The amber rating reflected ongoing operational and quality risks linked to congestion, discharge delays and escalation capacity. Progress towards eliminating corridor care was slow, with volatile numbers driven by significant fluctuations in demand. It was acknowledged that maintaining safety was paramount and that the guiding principle must always be to do what is best for each patient.
Outcome	The Committee received the report for assurance
Item/Topic	**Infection Prevention and Control (IPC)**
Rating rationale	• **Trust IPC Committee Report** The post-mortem service had been paused during a period of extreme heat. From November, national reporting on fit mask testing would become mandatory • **IPC Annual Report** The report showed variable healthcare acquired infection (HCAI) performance in 2025/26, with C. difficile noted as a positive improvement story. Work on catheter care to reduce pseudomonas was in progress, alongside other programmes including antimicrobial stewardship, which were expected to support further improvement.
Outcome	The Committee received assurance from the reports and approved submission of the annual report to Board.
Item/Topic	**Patient Experience Committee and Quarterly Patient Experience Report**
Rating rationale	The Friends and Family Test position was expected to improve following implementation of the text message system. Complaints had reduced significantly compared with last year, and the number of complaint re-openings had also reduced, indicating improved complaint management. The total number of open complaints had also improved. Concerns had increased in Q1, although this may reflect a change to PHSO guidance encouraging earlier resolution rather than formal complaint processes. Patient engagement was developing, with increased opportunities for patients to engage. Although further work was required to develop a co-production approach, this represented a much improved position. The new virtual interpreting service was embedding well.
Outcome	The Committee welcomed the quarterly report and was assured regarding the continued focus on learning from patient experience.

Assure: Including assurance items rated green	
Item/Topic	**Clinical Effectiveness and Audit Committee (CEAC) Report**
Rating rationale	Key risks included a delayed update to the blood transfusion policy, heart failure specialist nurse capacity below national expectations and the sustainability of Emergency Laparotomy due to loss of nursing and administrative capacity. The national bowel cancer audit identified two outlier measures regarding high readmission rates and low ileostomy reversal rates, with improvement actions progressing.
Outcome	The Committee was assured that CEAC was appropriately overseeing clinical effectiveness and audit matters.

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

Escalation and Assurance Report

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

Item/Topic	Patient Safety Incident Response Framework (PSIRF) monthly report
Rating rationale	12 new incidents were discussed by the Patient Safety Panel in June and two PSIRF responses were requested. One serious incident relating to orthodontics from the previous incident framework remained outstanding. Three new patient safety priorities and four new improvement priorities had been agreed and were applicable from 1 July.
Outcome	The Committee was assured that PSIRF was well embedded and that it was helping address quality issues.

To Note: Items received for information or approval	
Item/Topic	**Ockenden and Amos Reports Briefing**
Rating rationale	The paper, together with Fuller Board Assurance Statement and gap analysis, highlighted implications for maternity and neonatal services, Board oversight, learning from harm, culture, equity and post-death care. Discussions with Worcestershire Acute Hospitals NHS Trust had commenced with a view to aligning governance arrangements.
Outcome	The Committee noted the reports and the requirement for continued oversight of Trust preparedness and implementation of national maternity recommendations.

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

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 27 August 2026
Report to: Trust Board

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Quality Priority: Time Critical Medications in ED**
Rating rationale	Good progress had been made with time-critical medicines in inpatient areas and the focus was now on ED. Work completed to date included the Trust guideline, pharmacy and ED engagement and awareness materials. Data analysis using Royal College audit data was in progress.
Outcome	The Committee was assured by progress, noting challenges regarding data extraction and analysis.
Item/Topic	**Quality Priority: Hospital-Acquired Pneumonia**
Rating rationale	The project aimed to reduce Hospital-acquired pneumonia by 20% through improved prevention, identification and management, including effective mouth care, mealtimes, mobility, nutrition and hydration. Ward guidance packs, online learning, standardised mouth-care boxes and training were being rolled out. The next phase would focus on timely chest X-ray and antimicrobial treatment. The number of cases in the last two months was below threshold, and the rolling average was reducing. Coding was a challenge due to no single national code for hospital-acquired pneumonia.
Outcome	The Committee was assured that early results suggested the programme was having an effect.
Item/Topic	**Clinical Support Division Monthly Report: Pathology and Endoscopy**
Rating rationale	**Pathology:** The outcome of a recent UKAS inspection was generally positive, with the number of findings reduced by half compared to last year. Improving governance and quality management were the focus areas of the action plan. Risks remained regarding quality manager cover, histopathology vacancies, Blood Sciences incidents and turnaround times, LIMS replacement by May 2028 and a new risk regarding a single point of failure in the laboratory power supply. Mitigation and remedial plans were in place. **Endoscopy:** JAG actions were progressing, with one final action close to completion. Use of the Recovery area as a hospital escalation space had reduced to 1% and was on trajectory to zero. Ventilation, decontamination, PAA alarms and longer-term accommodation remained under review.
Outcome	The Committee was assured by the improvement in UKAS and JAG performance, noting continuing infrastructure, workforce and system risks. The UKAS report would be circulated to members.
Item/Topic	**Medical Division Quarterly Report**
Rating rationale	Positive assurance included improved pharmacy audit compliance, a reduction in falls, new end-of-life dignity measures in ED, an ambulatory-care pilot and a 25% rise in compliments. Areas of ongoing focus included Duty of Candour compliance and a review of four clinical pathways. Key risks and concerns included: • Violence and aggression in ED persisted; a multi-disciplinary panel would be established to review. • Increased ED attendances of people in mental-health crisis, which required multi-agency support to resolve. • Medical staff mandatory training compliance required improvement.
Outcome	The Committee was assured by the focus on improvement and innovation and collaboration to resolve risks and challenges. **Action:** Provide more detail in the next report on: • plans to improve Duty of Candour compliance • analysis of complaints relating to behaviour/attitude
Item/Topic	**Very High Quality Risks**

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

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 27 August 2026
Report to: Trust Board

Rating rationale	The Committee received assurance on the progress of actions to mitigate or resolve quality risks scoring 15+ on the Trust risk register, the operational grip of the divisions and the continued oversight of the Executive through the Executive Risk and Compliance Committee.
Outcome	The report was accepted.

Item/Topic	**Mortality Report**
Rating rationale	Mortality remained broadly stable. The provisional data indicated the Trust SHMI had reduced following inclusion of SDEC data. Crude mortality remained low. Fractured neck-of-femur and pneumonia SHMI had also reduced but stroke and sepsis remained under focused review. Perinatal mortality continued to improve and medical examiner processes remained robust.
Outcome	The Committee was assured that mortality surveillance and learning arrangements remained robust.
Item/Topic	**Ward Accreditation – Baseline Review**
Rating rationale	All 17 baseline ward reviews were completed, with 15 achieving a good rating and the remaining two close to the standard. Feedback was positive and the methodology was considered reliable. The main challenge was sustainability within existing resources. A peer-review model was proposed to support learning and sharing of good practice moving forward. The two wards that missed a good rating would be revisited. Development of a modified process for non-bedded areas would be considered.
Outcome	The Committee was assured by the strong baseline results and supported continuation of the approach.
Item/Topic	**Children in Care Quarterly Report**
Rating rationale	Compliance with the access to a dentist standard had improved. Immunisation compliance had reduced due to absent parental consent and missed school-age vaccinations. Health assessment capacity had reduced during the absence within the team, which highlighted the fragility of a small team facing increasing local and out-of-area demand. An application for AI licences was being progressed, which could help by releasing administration hours for nursing staff.
Outcome	The Committee was assured by improvements, acknowledged the challenges and supported plans to release capacity.
Item/Topic	**Perinatal Safety Report – Quarter 1**
Rating rationale	During quarter 1 there was high activity and acuity and some staffing red flags, driven by a combination of complex cases and unexpected neonatal admissions. A revised major-obstetric-haemorrhage pathway showed clear benefit. Quality standards compliance was good overall. The home birth service had resumed.
Outcome	The Committee was assured that safety was maintained in Quarter 1 **Actions**: Incorporate in the next report narrative on trends and triangulation of data across the quality domains.
Item/Topic	**Perinatal Staffing Report – Quarter 1**
Rating rationale	Sickness remained broadly stable at 3–4% with no concerning common theme. However short-term sickness created some pressures and this, combined with training requirements and high acuity contributed to some induction delays and movement of staff. Five additional midwives were joining and two consultants were due to start in autumn. Further funding was being sought for additional midwifery capacity.
Outcome	The Committee was assured that recruitment and staffing oversight provided appropriate mitigation.
Item/Topic	**Nurse Staffing Report**
Rating rationale	Corridor care reduced by 30% from June to July and fewer escalation areas were required. Despite this, and while agency use fell, bank staff use increased, driven in part by an increase in sickness. Staffing incidents reduced with no reported harm. Overall vacancies marginally reduced, although registered-nurse vacancies increased in some services pending recruitment to revised establishments.
Outcome	The Committee was assured that safe nurse staffing was maintained.

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

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 27 August 2026
Report to: Trust Board

Item/Topic	Patient Flow Report
Rating rationale	The first complete data set showed improved ambulance handovers within 45 minutes, fewer ED stays over 24 hours and reduced corridor care. Handovers over 60 minutes had increased, however, and required analysis. A new incident theme concerned incomplete communication of needs for patients in boarding spaces, contributing to falls. Patients with dementia experienced more moves than other patients, contrary to the intended pathway. These issues were under review.
Outcome	The Committee was assured by improving headline flow measures, noting the concerns and plans for further analysis.
Item/Topic	**IPC Committee Summary – Cleanliness**
Rating rationale	The revised IPC Committee model separated cleanliness, performance and assurance meetings and had improved engagement. Overall compliance with national cleanliness standards was good. Clinical cleans remained the main area below target. Food-service audits were having a positive impact and preparation was under way for autumn PLACE inspections and the influenza programme.
Outcome	The Committee was assured by the revised governance model and overall cleanliness performance, noting continuing gaps in clinical-clean compliance.
Item/Topic	**IPC Quarterly Report – Quarter 1**
Rating rationale	One MRSA bacteraemia was reported against a zero threshold; a review found no care lapse or further learning. The Trust remained a surgical-site-infection outlier for historic hip and knee data, although performance was improving. Level 1 IPC training compliance fell after requirements expanded to all staff but had recovered substantially by the end of July. Mask fit-testing data and capacity were being strengthened ahead of new national requirements from November.
Outcome	The Committee was assured by sustained improvement and noted the risk relating to the pending mask fit-testing requirements.
Item/Topic	**Patient Safety Committee Summary Report**
Rating rationale	Falls performance continued to improve. Radiology demonstrated a strong learning culture, delivering 22 discrepancy-review sessions against a national expectation of six. New medical-engineering reporting increased visibility of equipment risks and opportunities for better working with clinical teams.
Outcome	The Committee was assured that the sub-committee was effectively overseeing matters within its terms of reference.
Item/Topic	**PSIRF Report**
Rating rationale	The revised report reflected the new safety improvement priorities. Future reporting would introduce new indicators covering responses, learning, actions and impact. One PSII was declared following a hypoxic event after total knee replacement. Maternity pathway learning would be triangulated through maternity and Patient Safety Committee reporting.
Outcome	The Committee welcomed the report and plans for further development.

Assure: Including assurance items rated green
None

To Note: Items received for information or approval

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

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 27 August 2026
Report to: Trust Board

Item/Topic	Safeguarding Annual Reports: Adults, Children and Children in Care
Rating rationale	The annual reports consolidated the quarterly assurance previously received by the Committee. A key theme noted was increased workload above capacity, particularly for learning disability liaison.
Outcome	The Committee approved submission of the reports to the Trust Board.
Item/Topic	**Ockenden / Amos 10-Point Plan**
Rating rationale	The Committee was briefed on a new requirement to submit two gap analyses by 25 September, with a progress update by 31 December. Formal delegation to the Committee was required as the Board timetable did not align with the submission deadline.
Outcome	Board delegation would be sought and the completed response returned to the September Committee for approval before submission.

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

WYE VALLEY NHS TRUST COVERING REPORT 2026/2027

Report to:	Public Board
Date of Meeting:	3rd September 2026
Title of Report:	Midwifery and Neonatal Nurse Safe Staffing Report Quarter 1
Lead Executive Director:	**Chief Nursing Officer**
Author:	Annette Arnold – Maternity Matron Elaine Evans – Ward Sister SCBU Justine Jeffery - Director of Midwifery
Reporting Route:	Quality Committee
Appendices included with this report:	None
Purpose of report:	☒ **Assurance** ☐ **Approval** ☒ **Information**
Brief Description of Report Purpose	
The purpose of this report is to provide assurance that midwifery and neonatal nurse staffing is monitored and to note actions taken to mitigate any shortfalls.	
Recommended Actions required by Board or Committee	
Board is asked to note how safe midwifery and neonatal nurse staffing is monitored in line with national guidance, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of staffing.	
Executive Director Opinion[1]	
The report offers assurance that there are robust processes in place to monitor midwifery and neonatal nurse staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur.	

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

Introduction/Background

Safe staffing is monitored monthly by the following actions:

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

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

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

Adherence to BAPM standards is monitored by:

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

The summary of the midwifery workforce KPIs for Q1 are as follows:

		May		June		July	
Sickness	MSW	3.06%		5.45%		3.57%	
	MW	3.17%		1.86%		4.24%	
Mat Leave (FTE)	MSW	0.92		0.92		0.92	
	MW	6.09		6.09		6.09	
Vacancy	MSW	(9.18%)		(7.62%)		3.79%	
	MW	(5.58%)		(2.77%)		1.69%	

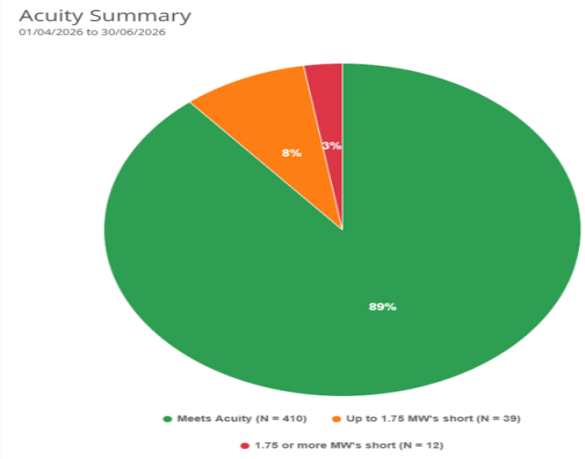
Metrics	Target	May	June	July
Midwife to birth ratio (in post)	1:24	1:25	1:24	1:25
1:1 care in labour	100 %	Achieved	Achieved	Achieved
Shift leader SN	100%	Achieved	Achieved	Achieved

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The diagram below presents when staffing met or did not meet the acuity. From the information available for Q1, the acuity was met in 89% of the time and recorded at 11% when the acuity was not met prior to any actions taken. Safe staffing levels were maintained on all shifts following mitigation.



The mitigations taken are presented in the diagram below and demonstrate the frequency (n=22) of when staff are reallocated from other areas of the inpatient service. On 55 occasions staff were required to be redeployed internally to maintain a safe skill mix. Other management actions taken to maintain a safe service was on 4 occasion the manager/matron was required to work clinically and on 14 occasions the situation was escalated to the manager on call. During Q1 there were 7 occasions where staff from community were required to be redeployed.

Number of Management Actions

01/04/2026 to 30/06/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	55	60%
MA2	Redeploy from community	7	8%
MA3	Redeploy staff from training	1	1%
MA4	Staff unable to take allocated breaks	5	5%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	2	2%
MA7	Manager/Matron working clinically	4	4%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	3	3%
MA10	Escalate to manager on call	14	15%
MA11	Maternity Unit on Divert	0	0%
TOTAL		91	

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

NICE recommended red flags are reported in the acuity app and are presented below. On 15 occasions there was over a one hours delay between admission and the beginning of the induction process this was due to acuity. The home birth service continues to be suspended. With a planned date to re-commence the homebirth service from the 27th June 2026.

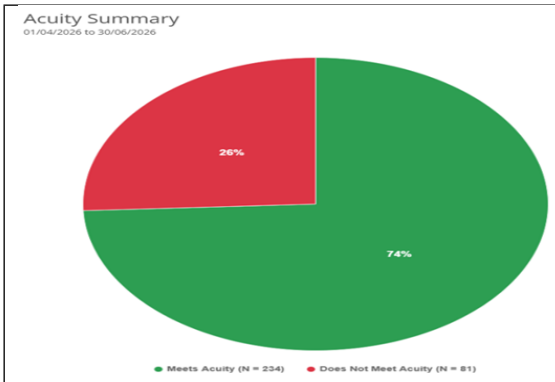
Number of Red Flags recorded

01/04/2026 to 30/06/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	5%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	2%
RF5	Delay between presentation and triage over 30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process more than 1hr	15	35%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite co-ordinator not supernumerary	0	0%
RF11	Suspension Home Birth Service	25	58%
TOTAL		43	

Antenatal/Postnatal Ward

The diagram below presents when staffing met or did not meet the acuity during Q1 for the maternity ward



Staff were redeployed internally on 4 occasions when acuity was not met.
There was one red flag reported for the maternity ward this was due to a delay between admission and commencement of an induction of labour.

Number of Management Actions

01/04/2026 to 30/06/2026

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	4	100%
MA2	Redeploy from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	0	0%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to manager on call	0	0%
MA11	Maternity Unit on Divert	0	0%
TOTAL		4	

Monitoring the midwife to birth ratio

The midwife to birth ratio was at 1:24 - 1:25 across the quarter.

Maternity SitRep

The local maternity SitRep pilot began in October 2025 and is recommended to be completed once per day. The report provides an overview of staffing, capacity and flow. Compliance with this is good. We are now submitting daily information to the new national maternity sitrep.

Unify Data

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

	Day RM %	Night RM %	Day MCA/MSW %	Night MCA/MSW %
Maternity Ward	86.02%	83.67%	95.35%	83.87%
Community Midwifery	N/A	N/A	N/A	N/A
SCBU	109.16%	1.1.08%	N/A	N/A

Daily staff safety huddle

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

Vacancy

Maternity have recruited 3.6wte band 5 midwives, hopefully all will have start date within the next 8 weeks. We have also successfully internally recruited 1.78wte Delivery Suite Coordinators. This will reinforce and stabilise the Delivery Suite Coordinator team further recruitment planned to meet requirement. This will mean there will be 2 AfC B7 midwives on duty 24/7. One in maternity triage and one in charge of the shift.

Sickness

Sickness above target for MWs and MSWs within the quarter. Work continues with HR to manage cases. Short term sickness driving some of the staffing challenges and bank usage.

Turnover

Staff turnover for Women & Children for June is 7.2% which is the lowest since January 2026.

Workforce – Neonatal

The Toolkit for High Quality Neonatal Services, the NCCR, getting it Right First Time (GIRFT) (2022) reports and other documents produced within the devolved nations describe the anticipated pattern of medical, nursing and allied health professional staff cover in different types of NNU. These recommendations have been further developed within the BPAM Service and Quality Standards for Provision of Neonatal Care in the UK (2022), the chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care.

Adherence to BAPM standards Nursing staffing standards is set by the British Association of Perinatal Medicine (BAPM) and these standards are endorsed by service specifications and national reports.

The following nurse patient ratios are expected to ensure compliance with BAPM standards.

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

Safe Staffing Standards – are monitored through:

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

Neonatal Clinical Staffing – Budgeted v Contracted Establishment Q1

Band	Budgeted WTE	Contracted WTE	Maternity Leave WTE	Gap +/-
Band 7	**2.2**	**2.0**	**0**	**-0.2**
Band 6	**5.4**	**5.84**	**0**	**+0.44**
Band 5/4	**13.57**	**10.87**	**0**	**-2.7**
Neonatal Outreach	**1.38**	**1.38**	**0**	**0**

Nurse Staffing (report lifted from BadgerNet) – Q1

	April 26	May 26	June 26	National Average
% of shifts staffed to BAPM recommendations	100%	100%	82.76%	89.34%
% of shifts QIS against Neonatal Toolkit standards	100%	100%	98.28%	95.68%
% of shifts with supernumerary shift lead	24.71%	8.2%	8.62%	24.5%
% of Nursing shifts covered by bank	5.27%	4.46%	6.91%	5.81%

Mitigation Q1

- During April and May all shifts were 100% BAPM Compliant and were 100% compliant for QIS against the Neonatal Toolkit Standards
- In June we were only BAPM compliant for 82.76% of shifts, this was due to high acuity with intensive care babies waiting for transfer for 3 shifts and increased capacity at the start of the month when 11 of our 12 cots were occupied.
- QIS compliance against Neonatal Toolkit standards was 98.28%, again this was because of increased acuity on unit, this was mitigated by senior staff from office providing clinical cover on the unit.
- There was an increase in Bank use in June 26, where we were above National Average, this was partially due to long term sickness within our QIS nurses.

Recruitment and Retention:

- We have had no leavers throughout Quarter 1
- We have successfully recruited to our 2.7wte Band 5 Vacancy with newly student nurses who are due to qualify in August 2026 and will commence employment in September 2026 dependent on successful completion of their course.

Supernumerary Shift Co-ordinator

In addition to the calculated number of nurses required to meet the neonatal nurse staffing levels for direct patient care, there should be a shift co-ordinator for all shifts. The day-to-day management of nursing care provision should be undertaken by a Senior Neonatal Nurse (Band 6) with no clinical commitment during the shift (often referred to as shift coordinator) This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time (BAPM 2022).

A Supernumerary shift co-ordinator is not included in our current establishment budget, and this is currently recognised as an acceptable risk by the Trust based on overall acuity and capacity. A risk assessment has been drafted to recognise the lack of speciality roles on Special Care Baby Unit, and this includes not being able to achieve having a supernumerary shift lead on all shifts. We assess whether we can achieve a supernumerary shift co-ordinator based on our daily acuity and capacity, however, if acuity or capacity changes during the shift then the supernumerary shift co-ordinator would be expected to step into the clinical numbers.

In April due to low activity on the unit we were able to achieve above National Average for supernumerary shift co-ordinator.

Daily Sit Rep Reporting

OPEL Reports – Q1

Daily Sit rep completed 7 days a week, report shared by Network Monday – Friday. Below compliance summary is based on Monday – Friday for March 2026. (NB Capacity Reports not shared during holiday period, OPEL Sit Rep continued to be submitted daily

April 26	OPEL 1 (Green)	OPEL 2 (Amber)	OPEL 3 (Red)	Opel 4 (Black)
Capacity	100%	0	0	
Staffing	96.6% (29)	0	3.4% (1)	

May 26	OPEL 1 (Green)	OPEL 2 (Amber)	OPEL 3 (Red)	Opel 4 (Black)
Capacity	100%	0	0	0
Staffing	84% (26)	0	16% (4)	0

June 26	OPEL 1 (Green)	OPEL 2 (Amber)	OPEL 3 (Red)	Opel 4 (Black)
Capacity	86%	10% (3)	4% (1)	
Staffing	86% (26)	0	14% (4)	

OPEL Report Summary – Mitigations – Q1

Capacity

We remained open to both internal and external admissions throughout April and May 2026 In June we were closed to external admissions for one day, due to high acuity on the unit. On three other days we were OPEL 2 'open with discussion to external admissions' this was because of high capacity.

Staffing

There were 9 shifts in Q1 where our staffing was reported as OPEL 3, as we were unable to roster two QIS nurses for these shifts. Mitigation was that second QIS cover was provided by the senior nurses from the office.

Qualified in Speciality Staffing Report

The Neonatal Toolkit (2009) defines that:

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

QIS Trajectory April 26 – October 26 (updated June 26)

Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
47%	47%	57%	60%	60%	52%	52%

- Two nurses have successfully completed the Speciality Training in Q1. The above trajectory takes these two nurses into consideration.
- There is an ongoing education plan – with another four nurses identified as ready to commence their training between September 26 and December 26 – and this has been reflected in our 2026/2027 education funding plan/request.
- Recruitment to our current vacancies will increase our overall establishment from September 26, these will all be newly qualified nurses; therefore, our QIS trajectory will decrease, but numbers of nurses with QIS qualification will not.

4.6.4 **Sickness and Maternity Leave SCBU – Q1**

	April 26	May 26	June 26
Sickness	9.43%	**9.58%**	**9.74%**
Maternity Leave	0	**0**	**0**

- Sickness remains above the Trust target of 4% throughout Q1. Staff on Long Term sick are being managed according to the Trust sickness and absence policy with HR and Occupational health support.

- We had one staff member on long term sickness return during Q1 but another then moved over into long-term sickness from short-term, which is why there is no decrease in the overall sickness across the Quarter.
- One staff member remains on indefinite long term sick leave and is being managed through the correct HR Processes.

Conclusion
Sickness remains high in neonatal nurses and midwives. Recruitment in all areas is positive with further leadership posts of note in maternity. The midwife: birth ratio was high in May and July due to acuity and sickness - staff redeployment remains high with support from community colleagues also required to maintain safety. Red flags reported – staff unable to take breaks and delays in IOL pathway noted. QIS meeting trajectory set and increased compliance with supernumerary status of the shift leader noted helped by lower acuity.
Recommendations
Board is asked to note the content of this report for information and assurance
Appendices
None

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	Perinatal Safety Report – Quarter 1 2026
Lead Executive Director:	**Chief Nursing Officer** **Chief Medical Officer**
Author:	Victoria Bailey – Patient Safety Midwife Elaine Evans - Neonatal Unit Sister Justine Jeffery - Director of Midwifery
Reporting Route:	Quality Committee
Enclosures included with this report:	None
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

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

The requirement to ensure the Trust Board and the ICB are informed of present or emerging safety concerns and activities being undertaken to ensure safety and two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team was initially outlined in the 2025 NHSEI document 'Implementing a revised perinatal oversight model.

Recommended Actions required by Board or Committee

Board is invited to:

- **Note** and discuss the content of the report,
- **Receive** Assurance that our maternity and neonatal services are meeting the national requirements outlined in the documents covered by this report.

Executive Director Opinion[1]

This report covers the national reporting requirements for perinatal safety. The number of red flag incidents, particularly delays in induction of labour are higher when compared to quarter 4. Special care activity is higher than in Q4 and the number of transfers out are much higher than in Q4.

As we review reporting across the services, we need to conduct further analysis from the safety metrics contained within this report to distil emerging safety concerns that need Board attention.

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

1. INTRODUCTION

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

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

2. PERFORMANCE

2.1 Red flags

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

Red Flags	WVT	Inphase	Delay in Induction >2hrs	2	8	5
	WVT	BadgerNet	Delay in Catagory 1 C-Section >30mins	2	4	0
	WVT	Birth Rate +	Delay in administering medication	0	0	0
	WVT	Inphase	Delay in starting syntocinon/ARM >30mins	0	0	0
	WVT	Birth Rate +	Delay in Suturing >60mins	0	0	0
	WVT/PQSM	Birth Rate +	Unable to provide 1:1 care in labour	0	0	0
	WVT	BadgerNet	Delay in Triage >15mins	0	0	0
	WVT	Birth Rate +	Community midwives on call covering maternity unit	2	3	0
	WVT	Birth Rate +	Delayed recognition of and action on abnormal vital signs	0	0	0
	WVT	Birth Rate +	DSC lost - supernumerary status	0	0	0
	WVT	Birth Rate +	Full clinical examination not carried out when presenting in labour	0	0	0
	WVT	Birth Rate +	Delay of more than 30 minutes in providing pain relief	0	0	1

In April, two delays in inductions over 2 hours were identified (recognising the national metrics is more than 6 hours), this was due to two triage midwives working on delivery suite providing 1:1 care. One delay in Category 1 C-Sections > 30 minutes was identified; this was due to the spinal anaesthetic taking 11 minutes to administer.

In May, on eight occasions, it was identified that inductions were delayed over 2 hours, this was due to high acuity, midwives on transfer duties and staff being redeployed internally.

On three occasions it was identified that there were delays in Category 1 C-Sections over 30 minutes, this was due differing opinions of CTG interpretation, a patient declining general anaesthesia and opting for a spinal anaesthetic, and two attempts to insert spinal anaesthetic on another patient.

In June, on five occasions, it was identified that inductions were delayed over 2 hours, this was due to unexpected staff sickness, unable to fill vacant shifts and high acuity. On one occasion it was identified that there was a delay of more than 30 minutes in providing pain relief, this was due to ongoing emergencies, escalation occurred to senior consultants however all unable to attend as clinically busy.

Delivery Suite co-ordinator supernumerary status

In April, May and June, the Delivery Suite Coordinator was supernumerary 100% of the time and all women received one to one care in labour. There were no exceptional events that required this for this quarter.

2.2 RCOG Obstetric attendance

There is an agreed RCOG list of instances when an Obstetric Consultant MUST attend delivery suite – in and out of hours. The performance in Quarter 1 is noted below.

Reason for attendance	No. of instances	Attendance %	Comments
Caesarean birth for major placenta previa / invasive placenta	0		
Caesarean birth for women with BMI>50	1	100%	
Caesarean birth <28/40	0		
Premature twins (<30/40)	0		
4th degree perineal tear repair	1	100%	
Unexpected intrapartum stillbirth	0		
Eclampsia	0		
Maternal collapse e.g. septic shock / MOH	0		
PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%	

2.3 SCBU Activity

Quarter 1 Neonatal Activity

The tables below outline the neonatal activity throughout Quarter 1.

Total Admissions to SCBU in Quarter 1 = 60.

Admission by Gestation @ Birth – Quarter 1 - 26/27				
Gestation	<26	26-30+6	31-36	>36
April 26	0	0	1	12
May 26	0	1	4	16
June 26	1	1	7	17

Mitigation/Exception to Pathways

April and May 26 – No Exceptions.

June 26

1. Pregnancy estimated gestation 23/40 – stabilised and transferred to Level 3 unit.

2. 30+6/40 delivered at Wye Valley NHS Trust, following current agreed pathway of care, transferred to a Level 2 unit, for nutritional support – requiring Total Parental Nutrition (TPN) which we are not commissioned to provide at WVT - repatriated on Day 8.

ITU & HDU Continuing number of cot days on SCBU other than day of admission Q1 26/27		
MONTH	INTENSIVE CARE	HIGH DEPENDENCY
April 26	0	3
May 26	1	19
June 26	1	19

BAPM 2011 Level of care on day of admission – Quarter 1 26/27				
Month	ITU	HDU	SCBU	TC
April 26	0	3	3	7
May 26	1	3	7	10
June 26	1	7	12	7

ITU Additional Care Days – Quarter 1

Neonatal Badger net data shows an additional two intensive care episodes other than on day of admission during quarter 1

One baby required 2 intensive care activity days.

There was one additional day of intensive care activity recorded, with baby needing an umbilical line to deliver IV fluids to treat hypoglycaemia, as unable to obtain venous access.

Two babies remained on additional respiratory support (High Flow) for >12hrs. One continued high flow for 48 hours and on was weaned off after 14 hrs.

HTU Additional Care Level Days – Quarter 1

Two babies remained on additional respiratory support (High Flow) for >12hrs. One continued high flow for 48 hours and on was weaned off after 14 hrs.

One baby required additional respiratory support (High Flow) for >12 hrs (15hrs in total). One baby recorded 18 days of additional HDU activity, this baby was born in network and was transferred to Hereford for continuing care.

Seven babies remained on additional respiratory support (High Flow/CPAP) for > 12hrs totalling an additional 10 days of HDU activity.

One baby was transferred back from a level 2 unit and needed to be isolated and barrier nursed for 9 days due to infection.

In-utero/Ex Utero Transfers – Quarter 1

Type of Transfer	Quarter 1 26/27		Comments
	In	Out	
IUT Transfer for clinical reasons as per network pathway		5	
IUT Transfer for non-clinical reasons		0	
IUT Transfers outside of the network		4	
Ex-utero Transfers for clinical reasons as per network pathway	3	3	
Ex-utero Transfers out of network	0	0	
Delays in Transfers in/out	0	0	
IUT or Ex-utero exceptions.		4	

3. SAFETY

3.1 Incidents

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

3.1.1 The maternity service in Wye Valley is one of the smallest in the region with circa 1650 births per year. Due to the small number of cases and the possibility of patient identification, to protect the privacy of our patients, the Minimum Data Set cannot be shared at the public section of Board. This is shared in full at Quality Committee, a forum where scrutiny and assurance are gained, and is restricted to the 'private' section of Board. The minimum data set for Q1 2026 can be found in APPENDIX 1.

3.1.2 There was one still birth and two neonatal deaths reported in Q1.

3.1.3 Minimum Data Set incident summary:

	No. of cases			Concern raised			
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28
April	2	0		0	0	0	0
May		1					
June		0					

3.2 Total Number of Incidents – SCBU – Quarter 1

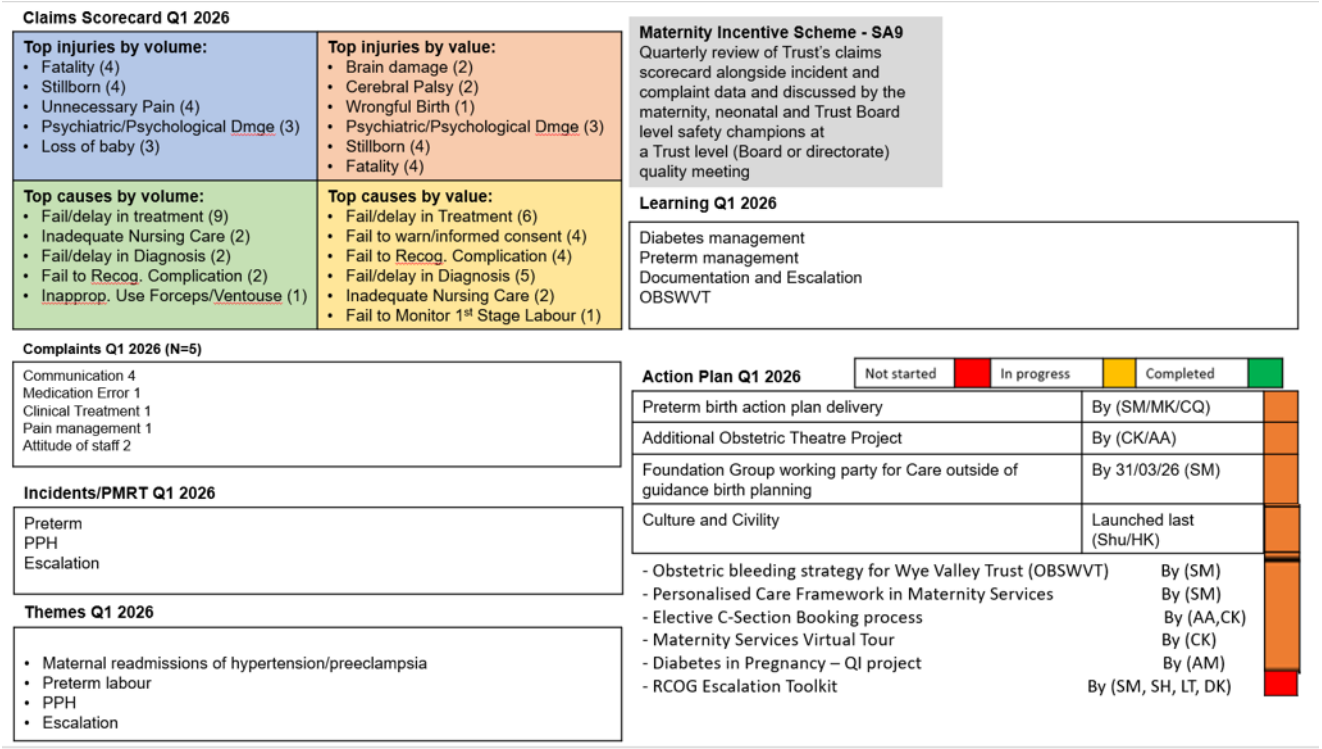
April 26	May 26	June 26
8	6	8

Incidents by Category

Unplanned admission/transfer to SCBU	18
Nutrition/Enteral feeding	1
Consent/Communication	1
Clinical Assessment/Screening	1
Labour/Delivery/Capacity transfer from PNW	1

3.3 TRIANGULATION

The NHS CNST Year schemes encourage services to review the data from the Claims Scorecard, alongside the Complaints / Incidents / PMRT to determine themes and identify relevant learning and subsequent actions. Below is the recommended national template which is reported quarterly. This covers Q1 (April-June 2026).



Claims Scorecard Q1 2026

Top injuries by volume:
- Fatality (4)
- Stillborn (4)
- Unnecessary Pain (4)
- Psychiatric/Psychological Dmge (3)
- Loss of baby (3)

Top injuries by value:
- Brain damage (2)
- Cerebral Palsy (2)
- Wrongful Birth (1)
- Psychiatric/Psychological Dmge (3)
- Stillborn (4)
- Fatality (4)

Top causes by volume:
- Fail/delay in treatment (9)
- Inadequate Nursing Care (2)
- Fail/delay in Diagnosis (2)
- Fail to Recog. Complication (2)
- Inapprop. Use Forceps/Ventouse (1)

Top causes by value:
- Fail/delay in Treatment (6)
- Fail to warn/informed consent (4)
- Fail to Recog. Complication (4)
- Fail/delay in Diagnosis (5)
- Inadequate Nursing Care (2)
- Fail to Monitor 1st Stage Labour (1)

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

Learning Q1 2026

Diabetes management
Preterm management
Documentation and Escalation
OBSWVT

Complaints Q1 2026 (N=5)

Communication 4
Medication Error 1
Clinical Treatment 1
Pain management 1
Attitude of staff 2

Incidents/PMRT Q1 2026

Preterm
PPH
Escalation

Themes Q1 2026

- Maternal readmissions of hypertension/preeclampsia
- Preterm labour
- PPH
- Escalation

Action Plan Q1 2026

Not started | In progress | Completed

Preterm birth action plan delivery	By (SM/MK/CQ)
Additional Obstetric Theatre Project	By (CK/AA)
Foundation Group working party for Care outside of guidance birth planning	By 31/03/26 (SM)
Culture and Civility	Launched last (Shu/HK)

- Obstetric bleeding strategy for Wye Valley Trust (OBSWVT) By (SM)
- Personalised Care Framework in Maternity Services By (SM)
- Elective C-Section Booking process By (AA,CK)
- Maternity Services Virtual Tour By (CK)
- Diabetes in Pregnancy – QI project By (AM)
- RCOG Escalation Toolkit By (SM, SH, LT, DK)

4. WORKFORCE

4.1 Safe Staffing – Midwifery & Neonatal Nursing

A report covering midwifery and neonatal nursing is presented to the Board on a quarterly basis.

4.2 Obstetric workforce

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

APRIL '26	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	170	200	85.00	0	200	0.00	30	200	15.00
Consultant: On Call	331.5	490	67.65	25	490	5.10	133.5	490	27.24
Consultant: Cold Week	80	120	66.67	16	120	13.33	24	120	20.00
Consultant: Antenatal Clinic	46.75	55.25	84.62	0	55.25	0.00	8.5	55.25	15.38
Middle Grade: delivery suite	112.5	180	62.50	67.5	180	37.50	0	180	0.00
Middle Grade: Antenatal Clinic	102	178.5	57.14	76.5	178.5	42.86	0	178.5	0.00

MAY '26	Substantive Fill			Substantive Extra fill			Locum Fill			Totals:
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	
Consultant: Hot Week	135	190	71.05	30	190	15.79	25	190	13.16	100.00
Consultant: On Call	319	525.5	60.70	109.5	525.5	20.84	97	525.5	18.46	100.00
Consultant: Cold Week	64	104	61.54	32	104	30.77	8	104	7.69	100.00
Consultant: Antenatal Clinic	42.5	55.25	76.92	0	55.25	0.00	12.75	55.25	23.08	100.00
Middle Grade: delivery suite	153	171	89.47	18	171	10.53	0	171	0.00	100.00
Middle Grade: Antenatal Clinic	102	127.5	80.00	25.5	127.5	20.00	0	127.5	0.00	100.00

JUNE '26	Substantive Fill			Substantive Extra fill			Locum Fill		
	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate	Filled Hrs	Total Hrs	Fill Rate
Consultant: Hot Week	130	220	59.09	30	220	13.64	60	220	27.27
Consultant: On Call	259.5	467	55.57	133.5	467	28.59	74	467	15.85
Consultant: Cold Week	80	104	76.92	0	104	0.00	24	104	23.08
Consultant: Antenatal Clinic	51	68	75.00	0	68	0.00	17	68	25.00
Middle Grade: delivery suite	180	198	90.91	18	198	9.09	0	198	0.00
Middle Grade: Antenatal Clinic	157.25	191.25	82.22	34	191.25	17.78	0	191.25	0.00

4.3 Neonatal Medical Workforce

4.3.1 The Neonatal Medical Workforce does not use locum support as they are fully funded and recruited to BAPM standards.

4.3.2 A review of the BAPM Standards for Medical Workforce has been undertaken, and changes are planned to meet the new requirements. This will enable the requirement for a dedicated Consultant/Registrar to be available for SCBU 4 hours a day (5 days a week).

4.4 Anaesthetic workforce

4.4.1 The anaesthetic rotas have been covered as outlined below. The rota gaps were filled by existing members of staff with cover provided 100% of the time.

April	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	30	90%	30	97%
Anaesthetist extra days	3	10%	1	3%

May	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	31	87%	31	94%
Anaesthetist extra days	4	13%	2	6%

June	Long Day	Fill rate%	Night	Fill rate%
Anaesthetist contracted hours	30		30	
Anaesthetist extra days				

The directorate team advise that the increase in extra shifts is due to paternity leave and long-term sickness.

4.5 MDT ward rounds

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

April 2026

	08:30	20:30
Anaesthetist	93%	100%
Obstetric Consultant	93%	100%

May 2026

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

June 2026

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

4.6 Neonatal Workforce

There is currently no additional funding to support recruitment to any additional Quality Nurse Roles or AHP positions. We currently have 0.7wte Practice Education Lead (B7) with 0.3wte Clinical working within role (=1.0wte) and 0.2wte Neonatal Governance Lead (B7) this is incorporated into the B7 Ward Manager Role and the 0.2wte B7 funding has been used to support a B6 Developmental Care 7.5hrs per week until end of March 2026.

NON DIRECT PATIENT CARE - *DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE*					COMMENTS
Role Title	Band	WTE Budget	WTE in post	Head Count in post	*e.g. no dedicated hours, data not available / not collected*
LEADERSHIP ROLES					
Consultant Nurse	0	0	0	0	
Senior/Lead Nurse	0	0	0	0	
Matron	8	1	1	1	covers paediatrics, neonates and womens health
Ward Manager	7	0.8	0.8	0.8	
Recruitment & Retention Lead	0	0	0	0	
Other Senior role (please specify)	0	0	0	0	
Subtotal - Leadership roles		**1.8**	**1.8**	**1.8**	
QUALITY ROLES					

Role Title	Band	WTE Budget	WTE in post	Head Count in post	COMMENTS	*Recommended WTE*	*Variance - in post against recommended WTE*
Governance Lead Nurse	7	0.2	0.2	1		**0.16**	**0.04**
Practice Development / Education Lead	7	0.7	0.7	1		**0.64**	**0.06**
Clinical Educator	0	0	0	0		**0.00**	**0.00**
Infant Feeding Lead	0	0	0	0			
Family Integrated Care Lead / equivalent	0	0	0	0		**0.33**	**#REF!**
Family Integrated Care Nurse / equivalent	0		0	0			
Family Integrated Care Link Nurse	0	0	0	0			
Other Family Care (please specify)	6	0.2	0.2	1	Developmental care		
Bereavement Lead	0	0	0	0		**0.20**	**-0.20**
Palliative Care Lead	0	0	0	0			
Professional Nurse Advocate (PNA)	7	0	0	1	included in WM hrs		
Discharge Co-ordinator	0	0	0	0			
Other (please specify)	0	0	0	0			
Other (please specify)	0	0	0	0			
Other (please specify)	0	0	0	0			
Subtotal - Quality roles		**1.1**	**1.1**	**4**			
TOTAL NON DIRECT PATIENT CARE		**2.9**	**2.9**	**5.8**			

5 TRAINING COMPLIANCE

CNST standards (Year 8) require compliance with training to be at 90% in all staff groups. The team is on track to meet the requirements for the two deadlines in October and November.

Dashboard	Framework	Indicator Description	Apr	May	Jun
PQSM	%	Training compliance in PROMPT: Midwives	83%	81%	75%
PQSM	%	Training compliance in PROMPT: Obstetric Consultants	75%	88%	75%
PQSM	%	Training compliance in PROMPT: Obstetric Middle Grades	90%	90%	80%
PQSM	%	Training compliance in PROMPT: Anaesthetic Consultants	80%	80%	80%
PQSM	%	Training compliance in PROMPT: Anaesthetic Middle Grades	73%	70%	70%
PQSM	%	Training compliance PROMPT: Maternity Support Workers	96%	92%	88%
PQSM	%	Annual NLS update compliance: Paediatric Consultants	73%	73%	50%
PQSM	%	Annual NLS update compliance: Paediatric Middle Grades	83%	100%	100%
PQSM	%	Annual NLS update compliance: Paediatric Juniors	100%	100%	100%
PQSM	%	Annual NLS update compliance: Midwives	96%	96%	96%
PQSM	%	Annual NLS update compliance: Neonatal Nurses	90%	85%	88%
PQSM	%	Fetal Wellbeing update day: Obstetrics	88%	90%	90%
PQSM	%	Fetal Wellbeing update day: Midwives	89%	93%	93%
PQSM	%	Midwifery update day (Core Competency): Midwives	88%	86%	88%
PQSM	%	Midwifery update day (Core Competency): Support Staff	92%	96%	96%

Mandatory Training – Neonatal – Nursing Quarter 1

Training	Expected Target	April 26	May 26	June 26
Mandatory (Core)	>90%	96.25%	95.08%	96.20%
Mandatory (Essential)	>90%	93.88%	96.10%	96%
Newborn Life Support	100%	90%	85%	85%
Maternity Breastfeeding Update	>90%	81.82%	95.65%	95.45%

PROMPT AND NLS Training in June was cancelled due to the extreme weather conditions.

6 CNST MIS Year 8

The MIS Year 8 scheme was launched on 19th February 2026. The scheme had undergone a significant redesign, with a clear shift from process-driven compliance to outcome-focused assurance.

The revised model introduces six safety actions, increased local flexibility, and a stronger emphasis on demonstrable improvements in safety outcomes for women and babies. There are enhanced expectations for Board oversight, including scrutiny of governance, workforce capacity, training compliance, and evidence of learning translated into improvement. The framework also strengthens requirements around service user voice, equity, and system-wide learning, with more explicit expectations for regular reporting and assurance to Trust Boards.

This report gives contains several elements to ensure that there is the recommended Sub – board and Board oversight of perinatal services.

A quarterly report is presented to Board to ensure that there is oversight of the current position, risks and actions that are being taken to meet the requirements of the scheme.

END OF REPORT

Appendix 1 Perinatal Dashboard

	Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar	Apr	May	Jun
ntenatal	Booking	LMNS	LMS	Total bookings	126	107	127	140	103	118
		LMNS	LMS	Women who were booked before 9+6 weeks	91	69	81	102	67	96
		LMNS	LMS	% Women who were booked before 9+6 weeks (target 90%)	72.2%	64.5%	63.8%	72.9%	65.0%	81.4%
		LMNS	LMS	Women who were booked after 9 + 6 weeks	35	38	46	38	36	22
		LMNS	LMS	% Women who were booked after 9 + 6 weeks	27.8%	35.5%	36.2%	27.1%	35.0%	18.6%
		LMNS	LMS	Women who were booked before 12 + 6 weeks	118	101	123	133	93	112
		LMNS	LMS	% Women who were booked before 12 + 6 weeks (target 90%)	93.7%	94.4%	96.9%	95.0%	90.3%	94.9%
		LMNS	LMS	Women who were booked after 12 + 6 weeks	8	6	4	7	10	6
		LMNS	LMS	% Women who were booked after 12 + 6 weeks	6.3%	5.6%	3.1%	5.0%	9.7%	5.1%
		LMNS	LMS	Midwife led care at booking	32	18	16	28	20	21
		LMNS	LMS	% Midwife led care at booking	25.4%	16.8%	12.6%	20.0%	19.4%	17.8%
	Risk Management	LMNS	LMS	Women with BMI of 30 and over at booking	40	35	36	42	22	40
		LMNS	LMS	% Women with BMI of 30 and over at booking	31.7%	32.7%	28.3%	30.0%	21.4%	33.9%
		LMNS	Better Births	% Antenatal Personalised Care Plan completed	100.0%	99.2%	99.2%	99.2%	99.3%	100.0%
		LMNS	Better Births	% Intrapartum Personalised Care Plan completed	56.9%	65.5%	58.3%	67.4%	70.6%	74.0%
		WVT		% Portal Access Consent	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%
		LMNS	LMS	% Portal Access - Women who registered and logged in	96.8%	87.9%	92.1%	92.9%	94.2%	95.7%
		LMNS	Ockenden	% Contacts were place of birth suitability was recorded	75.3%	76.6%	70.8%	74.7%	79.5%	78.1%
		LMNS	Ockenden	% High risk women assigned a named Consultant - within 7 days	79.7%	72.5%	83.8%	82.3%	83.0%	75.8%
		LMNS	Ockenden	% High risk women assigned a named Consultant - at any time	86.7%	77.1%	89.2%	91.1%	85.0%	86.2%
		LMNS	Ockenden	% Antenatal contacts with a reviewed / authorised risk assessment	90.1%	91.8%	82.3%	92.4%	90.4%	92.8%
		LMNS	Ockenden	% Antenatal contacts with a risk assessment form completed	95.3%	97.4%	95.9%	96.7%	96.0%	97.0%
	Smoking	WVT		Recorded Smoking Status at Booking - Yes	5	6	5	4	5	6
		WVT		Recorded Smoking Status at Booking - No	120	101	122	136	98	112
		WVT		Recorded Smoking Status at Booking - Unknown	1	0	0	0	0	0
		WVT		% of mothers with a recorded Smoking Status at Booking	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%
		LMNS	Saving Babies Lives	Women who were current smokers at booking	5	6	5	4	5	6
		LMNS	Saving Babies Lives	% Women who were current smokers at booking	4.0%	5.6%	3.9%	2.9%	4.9%	5.1%
		LMNS	Saving Babies Lives	Smokers who were referred to smoking cessation services	5	6	5	4	5	6
		LMNS	Saving Babies Lives	% Smokers who were referred to smoking cessation services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Carbon Monoxide	LMNS	Saving Babies Lives	Women who were screened for CO at booking	113	102	122	125	101	113
		LMNS	Saving Babies Lives	% Women who were screened for CO at booking (of total bookings)	89.7%	95.3%	96.1%	89.3%	98.1%	95.8%

	Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar	Apr	May	Jun
	Delivery Method	WVT		Home Births	2	0	0	0	0	0
		WVT		BBA's	1	3	1	1	1	3
		LMNS	Contractual	Vaginal births (deliveries)	53	46	57	50	56	54
		LMNS/PQS/M	LMS	% Vaginal births (deliveries)	36.3%	42.6%	44.2%	40.7%	42.4%	41.5%
		LMNS	LMS	Ventouse & forceps births (deliveries)	21	15	10	11	12	14
		LMNS/PQS/M	Contractual	% Ventouse & forceps births (deliveries)	14.4%	13.9%	7.8%	8.9%	9.1%	10.8%
	C-Section Deliveries	LMNS/PQS/M	LMS	RG*1 having a caesarean section with no previous births	5	3	3	3	5	1
		LMNS/PQS/M	LMS	RG*1 Deliveries	16	19	16	13	19	16
		LMNS/PQS/M	LMS	RG*1 % C-section deliveries	31.3%	15.8%	18.8%	23.1%	26.3%	6.3%
		LMNS/PQS/M	LMS	RG*2 having a caesarean section with no previous births	17	10	25	24	20	19
		LMNS/PQS/M	LMS	RG*2 Deliveries	38	25	36	30	27	28
		LMNS/PQS/M	LMS	RG*2 % C-section deliveries	44.7%	40.0%	69.4%	80.0%	74.1%	67.9%
		LMNS/PQS/M	LMS	RG*5 having a caesarean section with at least one previous birth	24	21	12	22	23	25
		LMNS/PQS/M	LMS	RG*5 Deliveries	27	24	12	24	27	28
		LMNS/PQS/M	LMS	RG*5 % C-section deliveries	88.9%	87.5%	100.0%	91.7%	85.2%	89.3%
		WVT		Total Elective C-Sections	33	28	35	33	24	25
		WVT		Total Emergency C-Sections	37	18	27	30	41	36
		LMNS	LMS	Total Caesarean births (deliveries)	70	46	62	63	65	61
		LMNS	LMS	% Total Caesarean births (deliveries)	47.9%	42.6%	48.1%	51.2%	49.2%	46.9%
		LMNS	LMS	% Grade 1 C-Sections within 30 minutes	25.0%	75.0%	44.4%	42.8%	77.0%	66.7%
		LMNS	LMS	% Grade 2 C-Sections within 75 minutes	86.7%	88.9%	93.8%	90.5%	92.3%	95.8%
	Midwife Led Care	LMNS	Contractual	Midwife led (low risk care) births	26	14	29	18	18	28
		LMNS	LMS	% Midwife led (low risk care) births	17.8%	13.0%	22.0%	14.4%	13.5%	21.4%
		LMNS	LMS	Home births (deliveries) - midwife led only	1	0	0	0	0	0
		LMNS	LMS	% Home births (deliveries)	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%
	Births	LMNS	Contractual	Total number of babies born	147	108	133	123	132	132
		LMNS	Saving Babies Lives	Babies born preterm (singletons born 36+6 or less)	12	7	12	1	5	9
		LMNS	Saving Babies Lives	% Babies born preterm (singletons born 36+6 or less)	8.16%	6.48%	8.89%	0.80%	3.76%	6.82%
		LMNS	LMS	Singleton babies born 26+6 or less	0	0	0	0	0	2
		LMNS	LMS	% Singleton babies born 26+6 or less	0%	0.0%	0.00%	0%	0%	2%
		LMNS	LMS	Babies (multiples) born 27+6 or less	0	0	0	0	0	0
		LMNS	LMS	% Babies (multiples) born 27+6 or less	0%	0%	0%	0%	0%	0%
		LMNS/PQS/M	LMS	Stillbirths	0	0	0	0	0	0
		WVT		No. of BAME stillbirths	0	0	0	0	0	0
		LMNS/PQS/M	LMS	% Stillbirths	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		LMNS	LMS	Stillbirths rate per 1,000	0.00	0.00	0.00	0.00	0.00	0.00

	Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar	Apr	May	Jun
	Smoking	WVT		Women who were current smokers at booking (delivered mothers)	7	8	2	10	10	6
		WVT		% Women who were current smokers at booking (delivered mothers)	4.8%	7.4%	1.5%	8.0%	7.5%	4.6%
		LMNS	Saving Babies Lives	Women who were current smokers at birth (delivery) All	6	8	1	9	7	4
		LMNS	Saving Babies Lives	% Women who were current smokers at birth (delivery) All	4.1%	7.4%	0.8%	7.2%	5.3%	3.1%
		LMNS	Saving Babies Lives	Women who were current smokers at birth (delivery) Hfds only	3	5	0	7	5	3
		LMNS	Saving Babies Lives	% Women who were current smokers at birth (delivery) Hfds only	2.4%	5.5%	0.0%	6.9%	4.5%	2.9%
		LMNS	Saving Babies Lives	% Women with CO measured at 36 weeks	100.0%	98.0%	98.3%	99.2%	99.2%	99.2%
	Risk Management	LMNS	Saving Babies Lives	Late pregnancy loss (singletons 16+0 - 23+6)	0	0	0	0	0	2
		LMNS	Saving Babies Lives	% (as a % of all singleton births)	0.00%	0.00%	0.00%	0.00%	0.00%	1.55%
		LMNS	Saving Babies Lives	% Detection rate for FGR (below 3rd centile)	0%	0%	33%	25%	0%	25%
		LMNS	Better Births	Women who had a PPH of 1,500ml or more	4	3	5	8	7	4
		LMNS	Better Births	% Women who had a PPH of 1,500ml or more	2.7%	2.8%	3.8%	6.4%	5.3%	3.1%
		LMNS	Better Births	Women who sustained a 3rd or 4th degree tear	1	0	1	2	0	2
		LMNS	Better Births	% Women who sustained a 3rd or 4th degree tear (of total vaginal births)	1.3%	0.0%	1.4%	3.2%	0.0%	2.9%
		LMNS	Better Births	Induction of labour	46	36	42	41	51	37
		LMNS	Better Births	% Induction of labour rate (of all births)	31.5%	33.3%	32.6%	33.3%	38.6%	28.5%
		WVT		Routine Enquiry Domestic Violence - Asked	134	102	121	116	126	124
		WVT		Routine Enquiry Domestic Violence - Unable to ask	11	6	10	9	7	5
		WVT		Routine Enquiry Domestic Violence - Unknown	1	0	0	0	0	1
		WVT		% Asked routine enquiry domestic violence	91.8%	94.4%	92.4%	92.8%	94.7%	95.4%
		WVT		Midwife to birth ratio	1:31	1:32	1:27	1:25	1:24	1:25

	Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar	Apr	May	Jun
Neonatal	Admissions	LMNS	Integer	Total admissions to neonatal care	16	4	8	7	10	19
		LMNS	Integer	Unexpected admissions of full-term babies to neonatal care	9	2	3	6	6	11
		LMNS	%	% Unexpected admissions of full-term babies to neonatal care	6.7%	2.0%	2.5%	4.9%	4.7%	8.9%
	SCBU admission temps	WVT	Born	Eligible Babies (<34 wks gestation)	3	0	1	0	2	2
		WVT		% taken within hour	66.7%	0.0%	100.0%	0.0%	100.0%	100.0%
		WVT		Adm temp <36.5 degrees	0	0	0	0	0	1
		WVT	All babies	Eligible Babies	18	10	11	6	7	21
		WVT		% taken within hour	84.0%	100.0%	100.0%	100.0%	100.0%	90.0%
		WVT		Adm temp <36.5 degrees	3	1	3	2	0	4
	Risk Management	LMNS	Integer	Babies born with an APGAR score between 0 and 6 (at 5 minutes)	2	1	2	1	2	6
		LMNS/PQSM	Integer	Neonatal deaths	1	0	0	0	0	2
		WVT		No. of BAME NND's	0	0	0	0	0	0
		LMNS/PQSM	%	% Neonatal deaths	0.7%	0.0%	0.0%	0.0%	0.0%	1.5%
		LMNS	Integer	Neonatal mortality per 1,000 births	6.80	0.00	0.00	0.00	0.00	15.15
		LMNS	Integer	Neonatal transfers for therapeutic hypothermia	0	0	0	0	0	0
		LMNS	%	% Neonatal transfers for therapeutic hypothermia	n/a	n/a	n/a	n/a	n/a	n/a
		LMNS/PQSM	Integer	Neonatal brain injuries	0	0	0	0	0	0
		LMNS/PQSM	%	% Neonatal brain injuries	n/a	n/a	n/a	n/a	n/a	n/a
		LMNS	Integer	Administration of antenatal steroids (to mothers of babies born 24+0 - 33+6 wks)	2	0	0	0	0	0
		LMNS	Integer	Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	3	0	1	0	2	2
		LMNS	%	% Mothers eligible for antenatal steroids (of babies born 24+0 - 33+6 wks)	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%
		LMNS	Integer	Administration of magnesium sulphate (to mothers of babies born 24+0 - 29+6)	0	0	0	0	0	0
		LMNS	Integer	Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	0	0	0	0	0	0
		LMNS	%	% Mothers eligible for magnesium sulphate (of babies born 24+0 - 29+6)	n/a	n/a	n/a	n/a	n/a	n/a

	Area	Dashboard	Framework	Indicator Description	Jan	Feb	Mar	Apr	May	Jun
Postnatal	Risk Management	LMNS	Local	Obstetrics admissions to ITU	0	0	0	0	1	1
		LMNS/PQSM	LMS	Maternal deaths	0	0	0	0	0	0
		WVT		BAME Maternal Deaths	0	0	0	0	0	0
		LMNS	Better Births	% Postnatal Personalised Care Plan completed	100.0%	96.0%	98.6%	99.3%	99.3%	97.8%
		LMNS	LMS	Postnatal readmissions within 28 days (mothers)	11	8	10	8	13	15
		LMNS	LMS	Postnatal readmissions within 28 days (babies)	3	6	8	2	7	5
	Suspended Access to Service	WVT		Number of times Maternity Services Suspended per month 0	0	0	0	0	0	0
		WVT		Number of hrs Maternity Services suspended	0	0	0	0	0	0
		WVT		Number of times Home Birth services suspended per month	0	17	14	8	15	2
		WVT		Number of hrs Home Birth services suspended	0	408	336	192	360	48
		WVT		Number of times SCBU suspended per month	0	0	0	0	0	0
		WVT		Number of hrs SCBU suspended per month	0	0	0	0	0	0
	Insight	PQSM	Integer	Number of inphase incidents graded as moderate or above/PSII reported (total)	0	0	1	0	0	3
		PQSM	Integer	New MNSI SI referrals accepted	0	0	1	0	1	0
		PQSM	Integer	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	1	0	0	0	0	0
		PQSM	Integer	Coroner Reg 28 made directly to Trust	0	0	0	0	0	0
	Workforce	PQSM	Hours	Minimum safe staffing in maternity services: Obstetric middle grade rota gaps (hours): Antenatal Clinic and Delivery Suite	68	97.5	30.75	144	43.5	69
		PQSM	Hours	Minimum safe staffing in maternity services: Obstetric Consultant rota gaps (hours): Antenatal clinic and Delivery Suite	12.5	126	164.5	237	314.25	390.5
		PQSM		Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	18%	27%	13%	13%	19%	17%
		PQSM		Vacancy rate for midwives (black = over establishment, red = under establishment	0.06wte	1.62wte	1.43wte	2.35wte	3.3wte	3.6wte
		PQSM	%	MDT ward rounds on CDS (minimum 2 per 24 hours)	95.00%	98.00%	91.00%	96.50%	98.50%	98.50%
	Involvement	PQSM		Service User feedback: Number of Compliments (formal)	0	1	0	0	0	0
		PQSM		Service User feedback: Number of Complaints (formal)	1	0	0	2	2	2
		PQSM		Staff feedback from frontline champions and walk-abouts (number of themes)	0	0	0	0	0	0

Version 1.1: February 2026

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	WVT Annual Safeguarding Reports Jan – Dec 2025
Lead Executive Director:	**Chief Nursing Officer**
Author:	Emma Lunn - Lead Nurse Adult Safeguarding Amy Tootell- Lead Nurses Children's Safeguarding Kirstie Gardner - Lead Nurse Children Looked After
Reporting Route:	Quality Committee
Enclosures included with this report:	
Purpose of report:	☒ **Assurance** ☒ **Approval** ☒ **Information**

Brief Description of Report Purpose

The purpose of this paper is to provide the Board with an annual report of the activities and progress made in relation to safeguarding adults, safeguarding children and children looked after during the period Jan – Dec 2025.

Recommended Actions required by Board or Committee

This annual report provides a high degree of assurance that the work of the Safeguarding teams ensures that the organisation is meeting its statutory duties in relation to safeguarding vulnerable children, young people and adults.

The following points should be noted:

- Significant increase in contacts to the Adult Safeguarding team for referral/advice
- Development of patient-centred Nightingale pathway to support patients with a learning disability with reasonable adjustments and proactive support for planned surgery
- Domestic Abuse focus – supplementary training opportunities provided
- Learning Disability Liaison Nurse provision – demand for support outstripping capacity currently
- All teams evidence effective interagency working to safeguard our most vulnerable patients
- Timely notifications of children coming into care have increased enabling more health assessments to be completed within statutory timescales.
- Although numbers of children in care in Herefordshire are above regional and national averages, the children in care team have successfully discharged their statutory responsibilities as corporate parents.

Executive Director Opinion[1]

These reports cover the activities of the teams that support vulnerable children, young people and adults in Herefordshire. The reports cover how we meet our statutory requirements to safeguard vulnerable individuals and demonstrate strong multiagency working and collaboration.

The demand for services and the rising complexity of caseloads is worthy of note.

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

Adult Safeguarding Annual Report 2025

This Adult Safeguarding annual report outlines the activity and work undertaken by Wye Valley NHS Trust (WVT) for the period 1st January 2025 – 31st December 2025. The report demonstrates the organisation's commitment to protecting adults at risk across all services and highlights how the Trust manages allegations of abuse and neglect and ensures that safeguarding is integral to everyday practice.

Adult Safeguarding

There remains a clear requirement that all commissioned services maintain within their workforce appropriately skilled staff who possess both the expertise and capacity to fulfil a safeguarding leadership role within their organisation. This includes the ability to provide leadership, professional guidance, advice, and supervision across the wider workforce in relation to adult safeguarding responsibilities and statutory obligations.

Despite facing another challenging year, the Adult Safeguarding Team has continued to deliver a consistently high standard of specialist advice, guidance, and support to staff working across both acute and community services. The team remains committed to ensuring safeguarding responsibilities are effectively embedded throughout the organisation, whilst supporting practitioners to respond appropriately to increasingly complex safeguarding concerns.

Maintaining visibility across inpatient wards and community services continues to present a significant challenge for the team. This is largely due to the substantial volume of daily requests for advice and guidance received from staff across the organisation. Whilst many enquiries relate directly to adult safeguarding concerns, the team also provides extensive support in relation to the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), and domestic abuse matters. It is encouraging that staff continue to recognise the safeguarding team as a key source of specialist expertise and seek advice appropriately; however, the increasing reliance on the team has inevitably placed additional operational pressure on an already stretched service, with each enquiry often generating further workstreams, case discussions, and follow-up actions.

Between 1 January and 31 December 2025, the Adult Safeguarding Team received a total of 711 safeguarding referrals. Referral numbers have continued to demonstrate a consistent year-on-year increase, reflecting both greater awareness of safeguarding responsibilities across the organisation and a growing complexity of need within the patient population.

As seen in previous reporting periods, the most common safeguarding concerns raised during 2025 related to self-neglect, domestic abuse, and omissions in care provision. However, beyond referral volume alone, the complexity of cases continues to increase significantly. Many cases now involve multiple intersecting factors requiring extensive involvement from the Adult Safeguarding Team, including co-existing learning disability needs, mental capacity considerations, mental health concerns, complex family dynamics, and domestic abuse.

This increasing complexity has resulted in safeguarding interventions becoming more resource intensive, often requiring prolonged involvement from the team, multi-agency collaboration, participation in safeguarding meetings, professional challenge with partner agencies, and ongoing support to frontline practitioners managing risk. Despite these pressures, the team has remained focused on ensuring that vulnerable adults receive appropriate protection, that statutory safeguarding duties are met, and that staff across the organisation feel supported and confident when managing safeguarding concerns.

The continued rise in both referral numbers and case complexity demonstrates the essential role of the Adult Safeguarding Team within the organisation and highlights the ongoing need to ensure sufficient

workforce capacity is maintained to enable the team to continue delivering effective safeguarding leadership, organisational oversight, staff support, and specialist safeguarding expertise across all services.

Position of Trust Concerns

Out of the total of 711 safeguarding referrals received in 2025, a total of 16 position of trust concerns were reported. The HR Safeguarding Allegation Against Staff policy was followed, with input from the Associate Chief Nursing Officer and Lead Nurse Adult Safeguarding, with oversight by the Chief Nursing Officer as Executive Lead for safeguarding.

Care at WVT

Out of the total of 711 safeguarding referrals received in 2025, 41 of these referrals were about concerns in regard to care at WVT. Most of these concerns were reviewed by the Local Authority and shared with WVT to apply the most appropriate pathway, some through a PSIRF response, some by individual ward managers. In all instances the Local Authority are updated regarding the progress or outcomes from WVT.

Pressure Damage

During 2023–2024, changes were implemented in relation to how pressure damage concerns are managed through Adult Safeguarding processes. Previously, all Grade 3, Grade 4, unstageable pressure ulcers, and cases involving multiple areas of pressure damage were automatically referred as adult safeguarding concerns. However, the Local Authority Adult Safeguarding Team were routinely closing these referrals and signposting them back to WVT for internal investigation, resulting in unnecessary duplication of work for both organisations. As a result, from late 2025, the Adult Safeguarding Practitioner (ASP) no longer attends the weekly Pressure Ulcer Expert Panel (PUEP). Where concerns are identified relating to care delivery, neglect, acts of omission, or poor practice, whether internally within WVT or involving external providers, a recommendation is made for a safeguarding concern to be raised via a prompt within the InPhase reporting system.

All other reports of pressure damage continue to be reviewed through the established governance process, with rapid reviews undertaken and learning identified and discussed at PUEP alongside the relevant divisions. The ASP continues to liaise with the Senior Practitioner within the Local Authority Safeguarding Team where needed to ensure transparency and maintain collaborative oversight.

Training

Safeguarding Level 2 training compliance remained consistently above the Trust minimum requirement of 85% throughout each quarter of 2025.

Level 3 training compliance fell below the minimum 85% target during the year due to factors outside of the Trust's control, including limited availability of training sessions and the cancellation of a scheduled session due to staff sickness.

In April 2025, the Children's and Adult Safeguarding Teams jointly delivered safeguarding training to the Trust Board. Since this session, a new Board member has joined the organisation, resulting in current Board compliance standing at 93.33%.

The Children's and Adult Safeguarding Teams have also worked collaboratively to deliver quarterly Think Family training sessions throughout 2025. This training was introduced in response to learning identified from a number of NHS England Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) now referred to as Domestic Abuse Related Death Reviews (DARDRs). Feedback from attendees has been consistently positive.

For the majority of 2024, the Adult Safeguarding Practitioner (ASP) was unable to provide supplementary safeguarding training due to capacity pressures within the team. Following the return of the Lead Nurse,

additional training provision has now recommenced. From 2026, the ASP will deliver monthly supplementary safeguarding sessions via Microsoft Teams to a range of staff cohorts across the Trust. A delivery plan is now in place, with sessions focusing on learning identified from recent Safeguarding Adult Reviews.

The current Intercollegiate Guidance recommends that all patient-facing staff groups should receive Level 3 safeguarding training. This is currently under review by the Education Team as part of the Statutory and Mandatory Training Project. At present, there is no internal Level 3 training provision available within the Trust, and the Adult Safeguarding Team continues to access this training through external providers. This remains part of an ongoing national programme of work, and further updates will be provided throughout 2026.

Current DHRs, SARs and scoping's open to WVT Adult Safeguarding Team

The Safeguarding Adults Review (SAR) process is undertaken when there has been multi-agency involvement in the care and support of an individual, and concerns arise that practice or service provision has not been effective or has not achieved the intended outcomes.

The purpose of a SAR is to:

(a) identify learning from past practice and improve future safeguarding practice and multi-agency working;
(b) engage frontline practitioners and first-line managers, alongside designated professionals and safeguarding leads, in reviewing practice. Involving operational staff and managers promotes ownership of the learning process and strengthens commitment to implementing and sharing lessons learned; and
(c) bring together practitioners, managers, and safeguarding leads at a structured learning event, independently chaired to encourage open discussion, reflection, and professional debate.

As part of the process, each agency involved is required to complete a chronology and/or an Individual Management Review (IMR), alongside an action plan. These individual reviews contribute to an overarching multi-agency action plan, which is monitored by the Herefordshire Safeguarding Adults Board (HSAB) Executive Committee, with progress reported through to the HSAB Strategic Board.

Domestic Homicide Reviews (DHRs), now referred to as Domestic Abuse Related Death Reviews (DARDRs), were originally established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. These reviews require a local multi-agency examination of the care, support, and services provided to both the victim and the alleged perpetrator when a death occurs in the context of domestic abuse. The review process runs alongside any criminal or legal proceedings. The purpose of a DARDR is not to apportion blame or determine liability, but rather to identify opportunities for learning and to improve policy, professional practice, and service delivery at both local and national levels.

Both SARs and DARDRs are complex, resource-intensive processes that often extend over a significant period of time. Partner agencies, including WVT who are involved are frequently required to attend multiple meetings and contribute substantial information throughout the review process.

Quarter	Identifier	Current status
Q1 23-24	HDHR10	DHR completed, awaiting sign off with the Home Office
Q1 24-25	HDHR12	Rapid review conducted, threshold met for DHR. Independent author commissioned
Q1 24-25	SAR LH/TH	IMR complete

		SAR has now been published
Q1 24-25	SAR RW	IMR complete Await IMR Panel meeting/final report
Q1 24-25	RR DS	Discretionary SAR – no IMR required
Q1 24-25	DARDR/SAR AH	IMR complete Await IMR Panel meeting (January 2026)
Q2 24-25	RR LW	Did not meet criteria for a SAR
Q2 24-25	RR DS	Did not meet criteria for a SAR
Q2 24-25	RR JB	Did not meet criteria for a SAR
Q3 24-25	DHR13 PH	RR completed, agreed meets criteria for full DHR – in progress
Q3 24-25	DHR14 AM	Did not meet criteria for full DHR
Q4 24-25	RR DJ	Did not meet criteria
Q1 25-26	DHR15 BE	Meets DHR criteria however HSAB are writing to the home Office to advise that it will not be commissioned as no history of DA identified
Q2 25-26	SAR NH	SAR criteria is not met, however agreement was reached for an independent author to undertake a discretionary SAR under section 44 (4) Care Act: discretionary review.
Q2 25-26	DARDR17 AMG	RR completed, agreed meets criteria for full DHR
Q3 25-26	RR SAR KC	RR completed. Did not meet threshold for SAR
Q3 25-26	RR SAR MH	In scoping process

Action plans from previously completed SARs and DARDRs are monitored regularly and reviewed at the Joint Case Review meeting. Review of action plans is also now included in WVT Overarching Safeguarding Committee.

Deprivation of Liberty Safeguards (DOLS) & Mental Capacity Act (MCA)

As highlighted in the previous three annual reports, and following a lengthy period of national review, the legislative framework underpinning the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was due to change. The final parliamentary stage of the Liberty Protection Safeguards (LPS) was completed on 24 April 2019, with Royal Assent granted on 16 May 2019, formally making LPS law. However, following changes in government and subsequent policy decisions, implementation of LPS has been postponed indefinitely, leaving the current DoLS framework in place for the foreseeable future.

Under the current DoLS legislation, staff are required to undertake a mental capacity assessment to determine whether a patient has capacity to consent to being accommodated in hospital for the purpose of receiving care and treatment. Where a patient is assessed as lacking capacity in relation to this specific

decision, a DoLS application is submitted. It is important to note that DoLS authorises only the deprivation of liberty itself and does not provide authority for care or treatment decisions. Any decisions relating to care and treatment must therefore be considered separately through additional Mental Capacity Act assessments, which remain both time and decision specific.

The Local Authority (LA) remains the responsible body for authorising DoLS applications. However, as has been the case nationally for a number of years, there continues to be a significant backlog of applications and delayed outcomes due to insufficient resources within Local Authorities to complete assessments within the required statutory timeframes. This ongoing challenge was one of the primary drivers behind the proposed introduction of LPS. With implementation now indefinitely delayed, these pressures continue to impact organisations operating under the existing framework. Within WVT, the MCA and DoLS Lead continues to review hospital applications and works closely with the Local Authority DoLS Team to support prioritisation of assessments according to risk and urgency.

There is also ongoing national interest in the forthcoming Northern Ireland legal judgment relating to deprivation of liberty arrangements, with a decision currently anticipated in Spring 2026. It is expected that the outcome of this judgment may have wider implications for the future direction of deprivation of liberty legislation across the UK and could significantly influence both the future of Liberty Protection Safeguards and the wider DoLS landscape for acute trusts. At present, the full impact remains unclear; however, developments will continue to be monitored closely and any significant changes or implications for practice will be reflected in the 2026 annual report.

Total breakdown of 2025 DoLs referrals are highlighted below:

Area Monitored	Number of Patients
DoLS approved (Standard Authorisation)	15
DoLS not approved	0
Discharged prior to being assessed by Local Authority	453
Regained capacity prior to being assessed	1
Died prior to being assessed	51
Other	86
	Total = 606

Under the DoLS process, where a patient remains in hospital beyond 7 days, an extension to the urgent authorisation should be requested, allowing lawful detention for up to a maximum of 14 days while awaiting a standard DoLS assessment by the local authority. Due to ongoing workload pressures, submitting extension requests within required timescales remains challenging. To improve compliance, the MCA and DoLS Lead has worked with the local authority to incorporate extension requests into the urgent DoLS paperwork, which has already led to improvement.

Training

Mental Capacity Act (MCA) training compliance has remained above the minimum target of 85% across all quarters in 2025. Deprivation of Liberty Safeguards (DoLS) training fell marginally below the 85% target in

one of the four quarters during 2025. However, the MCA and DoLS Lead has continued to provide supplementary training across all staff groups to support knowledge and practice development.

Although challenges remain in the practical application of MCA within clinical settings, there has been a significant improvement in the overall standard of DoLS practice throughout 2025. The MCA and DoLS Lead will continue to deliver bespoke training programmes throughout 2026/2027, and this will remain a key priority area for the team.

Mental Capacity Audits

Issues identified in Q2 in relation to obtaining necessary data for audits have now been resolved, and monthly MCA audits commenced in November 2025. Please refer to the appendix for the full report in Q3 report for a full analysis and breakdown.

In summary, whilst there is evidence of good practice, clinicians are not consistently completing best interest decision forms and checklists. The Advanced Practitioner will review this situation and determine the most effective approach to address the issue for 2026/2027.

Mental Health Act

Herefordshire and Worcestershire Health and Care NHS Trust continues to provide mental health services, Mental Health Act administration, and learning disability services to WVT through an established Service Level Agreement (SLA).

During 2025, a total of 25 patients were detained under the Mental Health Act at WVT.

Of these patients, 18 were detained under Section 2 of the Act, one patient was detained under Section 3, and two patients were detained under Section 5(2). Of the patients detained under Section 5(2), one was subsequently discharged, while the second was converted to a Section 2 detention.

In addition, two patients were transferred to WVT under Section 2, and a further two patients were transferred under Section 3 of the Mental Health Act.

All patients were appropriately managed and transferred to specialist mental health inpatient units, both within and outside of the local area, ensuring access to the most appropriate care and treatment pathways.

Domestic Abuse

2025 continued to see a busy and challenging year for the DA Lead for WVT.

The Hospital Independent Domestic Violence Advisor (HIDVA) role is now split between hospital-based working and home working, continuing to provide independent advice and advocacy for victims of domestic abuse. The HIDVA works closely with the WVT DA Lead to provide staff with information, awareness, and training to improve confidence in identifying and responding to domestic abuse, with joint training sessions receiving consistently positive feedback.

There has been an increase in referrals and calls into the domestic abuse service, reflecting improved awareness and engagement. The first Adult Safeguarding Study Day was successfully delivered for Emergency Department staff, specifically tailored to improve knowledge, confidence, and understanding of the importance of identifying domestic abuse and signposting patients to appropriate support. Referrals into the HIDVA service increased significantly during the final quarter following the appointment of a new HIDVA in autumn 2025, and the MARAC alert system continues to be effectively used across several digital patient record systems; MAXIMS, Symphony, and the Dental System.

Although progress remains positive overall, domestic abuse training is not mandatory for most staff groups, which limits attendance and opportunities to strengthen workforce knowledge, with the exception of District Nursing teams where managerial support has improved compliance. In addition, silo working and

inconsistent communication between services, including IDT, HIDVA, AST, Gynaecology, and ED, can at times impact collaborative working and effective safety planning. Work is underway to improve partnership working through planned meetings with relevant teams.

There remain several ongoing risks and areas requiring further development. There is currently no process for uploading police domestic abuse reports to adult patient records or flagging a history of domestic abuse across patient systems. This has been reviewed by safeguarding teams, however concerns remain regarding staffing capacity, the complexity of multiple IT systems, and the appropriateness of storing detailed police reports within adult records. In addition, there is currently no formal policy or standard operating procedure in place for responding to disclosures of sexual assault. Work is underway to review practice in other organisations, and specialist training for Emergency Department and Gynaecology staff has been arranged for 2026, delivered by RASASC, including referral pathways to The Glade SARC. Overall, domestic abuse services continue to strengthen across the Trust, although improvements are still needed in policy development, inter-service communication, and safeguarding record systems.

HIDVA referrals

WVT staff have made a total of 89 DA referrals to the HIDVA in 2025, and this can be further broken down:

Jan-March 15 referrals

April-June 20 referrals

July-Sept 22 referrals

Oct-Dec 32 referrals

Training

The Domestic Abuse (DA) Lead continues to provide bespoke training across all staff groups, and this programme will continue throughout 2026/2027. Although DA training is not currently mandatory within the Trust, the DA Lead has worked closely with the District Nursing Team Matron, who has supported District Nursing staff to attend training due to the high number of vulnerable patients they encounter within patients' own homes.

During 2025, the DA Lead delivered training sessions to Health Visiting, School Nursing, and Maternity Services, including two full-day training sessions, both of which were well attended. In addition, three training sessions were delivered to staff working on the Children's Ward.

Learning Disability Team

WVT has a Learning Disability Liaison Service for our most vulnerable patients as part of a Service Level Agreement (SLA) with Herefordshire and Worcestershire Health and Care Trust. The service promotes the rights and quality of care for people living with a learning disability to be the same as everyone else which includes reasonable adjustments. This includes ongoing efforts to identify people with a LD via an alert on the electronic record, developing pathways and reinforcing the need for good communication via the LD passport.

The Learning Disability Liaison Service has continued to demonstrate strong collaborative working across acute and community services, supporting improved care coordination and better patient outcomes for individuals with learning disabilities. Regular joint multidisciplinary meetings involving the liaison team, Community Learning Disability Teams, GPs, and specialist services including palliative care, epilepsy, and diabetes have enabled professionals to share information effectively, agree clear responsibilities, and work from a unified care plan, reducing fragmented care and avoiding duplication of interventions.

The team has strengthened support within specialist hospital services by providing joint visits alongside specialist nurses, offering expertise around communication needs, capacity assessments, and reasonable adjustments. In partnership with community Speech and Language Therapy services, the Learning Disability Liaison Team has also played a key role in establishing specialist ventilation clinics for patients with complex respiratory needs, working with acute respiratory consultants to ensure a holistic approach to care planning, including advance care planning and emergency protocols.

A significant development has been the introduction of the Nightingale surgical pathway designed to improve access to surgery for patients with complex learning disabilities. The pathway enables early multidisciplinary planning involving anaesthetics, pre-operative nursing and liaison services to ensure individualised care planning, identification of anaesthetic requirements, and implementation of reasonable adjustments, creating a more streamlined process and improving patient experience while reducing the risk of patients being unable to access necessary surgical procedures. Positive working relationships with community dental services have also supported improved preparation for complex surgical patients, ensuring wider health needs are addressed wherever possible. In addition, Learning Disability representation continues at both Mortality Forum and LeDeR processes, strengthening oversight, learning, and service improvement.

Despite these positive developments, increasing demand on the service continues to present a significant challenge. The service is currently delivered by two registered Learning Disability Nurses working in a job-share arrangement, with no resilience available during periods of sickness or annual leave. Demand currently exceeds service capacity, creating a potential risk to sustainability, and QuDoS workforce planning has now commenced in partnership with NHS Herefordshire and Worcestershire Integrated Care Board (ICB) to review future service requirements and support longer-term service planning.

Supervision

All staff within the Adult Safeguarding team receive regular supervision to support safe practice, professional development, and staff wellbeing. Informal supervision and peer support take place routinely on a daily basis, enabling discussion of complex cases, shared learning, and timely advice. In addition, every member of the team participates in formally recorded clinical supervision four times per year. These formal supervision sessions provide opportunities for reflection on practice, contribute to ongoing continuing professional development (CPD), and support staff in meeting their professional revalidation requirements.

Conclusion

Safeguarding and the protection of vulnerable adults remains everyone's responsibility. Practice across Safeguarding, Domestic Abuse, the Mental Health Act (MHA), Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and Learning Disability services continues to be complex and is constantly evolving both nationally and locally. As these areas develop, organisations must continue to adapt their processes to ensure the safety and wellbeing of vulnerable patients.

This Annual Report demonstrates that Safeguarding Adults, Domestic Abuse, MCA/DoLS, MHA, and Learning Disability support remain key priorities for the Trust. It provides assurance that Wye Valley NHS Trust continues to meet its statutory responsibilities whilst working collaboratively to improve outcomes for patients accessing services.

Throughout 2025, despite significant operational pressures and the challenges faced by a relatively small specialist team, the Trust has continued to provide effective safeguarding support and maintain robust systems to protect patients at risk. These challenges are expected to continue into 2026, however the Trust remains committed to strengthening partnership working, supporting staff, and continuing to develop services to ensure the protection of vulnerable adults remains central to the delivery of safe and effective care.

Wye Valley NHS Trust will continue to work collaboratively with the Herefordshire Safeguarding Adults Board and partner agencies both locally and out of county to ensure the best outcomes for vulnerable patients.

Adult Safeguarding – Annual Dataset January 2025 – December 2025

Adult Safeguarding Wye Valley NHS Trust					
Indicator	Target	Quarter 1 2025 Jan, Feb, Mar	Quarter 2 2025 Apr, May, June	Quarter 2 2025 July, Aug, Sept	Quarter 3 2025 Oct, Nov, Dec
WVT Board lead for adult safeguarding	Y/N	Chief Nursing Officer	Chief Nursing Officer	Chief Nursing Officer	Chief Nursing Officer
WVT Board (or sub committee) received a report on adult safeguarding	Y/N	Yes	Yes	Yes	Yes
WVT attendance at HSAB	Y/N	Yes	Yes	Yes	Yes
Adult Safeguarding L2 training	85%	90.50%	90.95%	90.44%	90.21%
Adult Safeguarding L3 training	85%	66.67%	75.00%	75.00%	87.50%
Adult Safeguarding Board Level	85%	23.08%	68.75%	100.00%	93.33%
Mental Capacity Training	85%	87.66%	88.29%	87.95%	86.24%
DOLS Training	85%	86.87%	87.77%	86.40%	84.81%
Prevent Level 1 & 2	85%	89.77%	92.26%	92.91%	92.62%
Prevent Level 3	85%	88.51%	88.58%	91.03%	90.44%
Position of Trust Concerns	Numbers	7	4	3	2
Concerns raised regarding care at WVT	Numbers	9	10	11	11
Number of DOLS applications made	Numbers	170	161	131	144
DOLS approved DOLS not approved Awaiting Assessment Discharged prior to being assessed Regained capacity Died prior to being assessed Other	Numbers	4 0 15 128 1 22 7 (MHA)	3 0 31 118 0 9 6 (MHA)	4 0 13 105 0 9 7 (MHA)	4 0 27 102 0 11 5 (MHA)
Numbers of new SAR/RR	Numbers	0	1	1	2
Number of SAR/RR open	Numbers	3	0	1	1
Number of DHR open	Numbers	1	1	1	1

Children & Young People Safeguarding Annual Report 2025

This report covers the period 1st January to 31st December 2025 and details how Wye Valley NHS Trust (WVT) is fulfilling its statutory duties to safeguard the welfare of children and young people. It sets out a summary of all activity and progress with safeguarding children. We have continued to be busy with both increasing activity and changes in the safeguarding children's agenda. This report highlights the drive for quality practice, which is effective, efficient, and continually improving.

It also provides.

- An overview of the national and local context including influences on safeguarding children.
- Assurance that WVT is compliant with its safeguarding responsibilities.
- An outline of priorities for 2025-2026

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. Two of these standards have relevance in safeguarding – regulation 11 (consent to care and treatment) and regulation 13 (safeguarding vulnerable people from abuse). Additionally, all NHS Trusts have statutory responsibilities under Section 11 of the Children Act (2004) to make arrangements that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of Children. Section 11 responsibilities are detailed in the Working Together statutory guidance; the latest version was published in March 2026.

These arrangements include.

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children.
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements.
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Herefordshire Safeguarding Children Partnership
- Named safeguarding children professionals – nurse, doctor, and midwife.
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check.
- appropriate supervision and support for staff
- employers being responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an

environment where staff feel able to raise concerns and feel supported in their safeguarding role.

- provision of safeguarding training for all staff including a mandatory induction, which familiarises staff with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare.
- clear policies in line with those from the HSCP for dealing with allegations against people who work with children.

In summary this means that WVT has a robust safeguarding children response to:

- Ensure that all children and young people are protected from significant harm.
- Ensure the welfare of the child is paramount, and the voice of the child is central to all interventions.
- Ensure compliance with the West Midlands Child Protection Procedures.
- Implement national and local guidance in relation to safeguarding.
- Play an integral part in Herefordshire Safeguarding Children Partnership and various sub and task groups.
- Promote best practice throughout the trust.
- To ensure that families and children who require early help interventions are identified and supported through multi agency partnerships.

The messages of 'Think Family' and that 'safeguarding is everyone's responsibility' has been at the forefront of all our work and will remain a central focus as we also look forward to the year ahead.

Safeguarding Children Team

Structure

The Chief Nursing Officer is the Executive Lead for Safeguarding Children and is supported by the Associate Chief Nursing Officer who oversees the management of, and the work undertaken by the team.

Role	Whole Time Equivalent
Named Nurse	1 W.T.E
Named Doctor	1.5 P.A.s
Named Midwife	1 W.T.E
Specialist Nurse Advisors (1 Specialist MASH Practitioner)	3 WTE
Safeguarding Practitioner (MASH)	1 WTE
Safeguarding Team Administrator	1 WTE

*WVT also employs the Sudden Unexpected Death in Infancy Consultant role (working 1 PA per week) for the NHS Herefordshire and Worcestershire under a contractual arrangement.

Roles

The work of the WVT Safeguarding Children Team is multi-faceted and relies heavily on partnership working, both internally and externally. We strive to deliver a seamless integrated service to safeguard children from abuse and neglect. The WVT Safeguarding Children 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,
    - A robust training and development strategy utilising Think Family safeguarding education forums, light bite sessions, as well as formal training.
    - Supervision
    - Coaching
- Support and advice on case management, 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 family and criminal court, (police) and if attendance at court is required.
- To undertake internal management reviews and contribute to multi-agency practice learning / Child Safeguarding Practice Reviews (CSPR) and ensure the shared learning is disseminated to practitioners.
- To support all NHS providers in relation to child safeguarding in respect of the role of the MASH Health Practitioner and the Specialist Nurse Advisor.
- Support the business of the multi-agency partnership.

Contribution to the work of Herefordshire Safeguarding Children Partnership (HSCP)

The Herefordshire Safeguarding Children Partnership (HSCP) is a statutory body established under arrangements within Working Together to Safeguard Children 2026 and is made up of the three statutory safeguarding partner organisations,

- West Mercia Police,
- Herefordshire and Worcestershire Integrated Care Board

- Herefordshire Council

The broader Safeguarding Partnership consists of relevant agencies that cooperate to safeguard children and promote their welfare. These agencies are engaged in the activity of the Partnership's subgroups, review and audit activity, Leadership Summits and Practitioner Forums. Wye Valley NHS Trust is a key agency.

During this period HSCP developed its Vision, Values and Principles. These were developed in collaboration with children, young people, and partners, through a variety of engagement activities.

Vision

'Children are safely cared for by their family because services work well together, and with families.'

The values and principles are for all children and young people in Herefordshire to grow up with their needs met well, that they are safe from harm and that our multi agency arrangements designed to support this will be of the highest quality with children at the heart of all we do.

Our values:

- Child Focused
- Collaboration
- Transparency
- Inclusivity

Our principles:

- Children are at the heart of what we do, and we will learn from the actions we take.
- We will make a difference to the lives of children and young people.
- We will focus on the difference our partnership makes to the lives of children & young people.
- We will ensure that children are at the heart of our discussions and the actions we take.
- We will share information and work together with openness, respect, trust, and confidence.
- We will challenge each other when this is needed and will welcome challenge in return, knowing this helps keep our system safe.

We will address the well-being needs of children and young people at the earliest opportunity and prevent the need for later child protection intervention whenever possible – providing the right help at the right time.

- Our role is to keep children safe and give them a voice.
- Our commitment is to make sure everything we do works for children.
- We will make sure that children are at the heart of what we do.

HSCP Strategic Priorities 2024-2025.

Safeguarding children is a multi-agency process, and the Trust collaborates closely with colleagues across Herefordshire to support the work of the HSCP ensuring that the Trust is represented at all its strategic and operational groups and contributes consistently to the work streams for the partnership's priorities. The Safeguarding Children Team also represent WVT within other multi-agency groups such as GET SAFE, Pre-Birth Panel, Multi-Agency Risk Assessment Conferences (MARAC) for high-risk domestic abuse cases; and on task and finish groups as required.

During this period HSCP had six strategic priorities

1. Vulnerable children leaving children's services
2. Think Family
3. Quality Assurance Programme – strengthening three key areas for effectiveness: data, audits, and feedback
4. Right Help, Right Time Levels of Need Document – joint development with Worcestershire
5. Restorative Practice
6. Multi-agency Response to Domestic Abuse and its Impact on Children

The Trust ensures work plans are aligned with the Partnership's priorities and has contributed to them during 2025 in several ways including.

Vulnerable children leaving children's services

- Joint participation with the WVT Children in Care Team and Adult Safeguarding teams with a multi-agency audit around transitions from child to adult services.
- Continued engagement with 'GET SAFE' process.

Think Family

- Development of the 'Think Family' Safeguarding Forums now run jointly with the Adult Safeguarding team, themes in 2025 included all age neglect, poverty, disabilities, professional curiosity, MCA, substance misuse & mental health.
- Think Family is promoted at all domestic abuse (DA) training provided by the Adult Safeguarding Team and has been a focus of training within the Emergency Department.

Quality Assurance Programme

- WVT has a robust governance structure and process as detailed below.
- WVT NHS Trust Safeguarding Children team provides appropriate representation and contribution to: Quality & Effectiveness Group, Development & Practice Group, Child Exploitation & Missing Group, and Joint Case Review Group. Additionally, the trust has supported the partnership at various task and finish and other groups such as: Performance Data and a variety of Multi-agency Audit working groups, pre-birth planning group, and more recently Joint Q&E and QUAPP meetings.
- The Trust disseminates key messages from the HSCP effectively and in a timely way to all our staff through the Trust briefing system and in a more targeted specific way via safeguarding children education forums, briefings training and newsletters.
- The Trust has engaged fully in all HCSP multi-agency audits in 2025 and has ensured that learning and changes in practice are disseminated to staff and policies, SOP's and processes are updated accordingly. In 2025 WVT safeguarding children team participated in all 2025 HSCP multi-agency audits
    - Neglect audit
    - Strategy Meetings and Initial/Review Child Protection Case Conferences
    - Electively home educated children
    - Assessment audit
    - Exploitation
    - Transitions from child to adult services

Right Help, Right Time Levels of Need Document

- A member of the safeguarding children team attends all the key groups that support this priority which include Quality and Effectiveness, Development and Practice, MASH operational group, and the Joint Case Review group.
- The internal Level 3 training offer includes specific training on Right Help Right Time to ensure; staff understand and can apply the Right Help Right Time levels of need guidance; can make appropriate and high-quality referrals to the appropriate safeguarding services and understand and adhere to the Partnership's Resolution of Professional Disagreement Policy.
- The team supports the development and delivery of training packages to a multi-agency audience on behalf of the HSCP (Level 2 & 3, GCP2 and multi-agency Briefings).
- When the new Joint Herefordshire & Worcestershire Threshold Document was launched without consultation or oversight from the Safeguarding Children's Team, errors within the document were immediately escalated to the HSCP Business Unit.

Restorative Practice

- During this period members of the safeguarding team attended the Launch of 'Family Formulations' in Herefordshire and became part of the 'Champions' Group that has led in the implementation of 'Family Formulations,' a process of restorative practice within safeguarding supervision and training.

Multi-agency Response to Domestic Abuse and its Impact on Children

- We continue to attend MARAC and feed into that process to reduce the risk to adult and child victims. MARAC alerts are placed on WVT systems for 12 months.
- We work closely with the HIDVA, and staff and patients have access to this specialist support. Referral numbers are variable – there have been between 15 and 33 referrals per quarter.
- The Domestic Abuse (DA) Lead has delivered training to many children-based services, i.e., HV's, SN's. M/W's, Children's Ward, ED. She has also delivered training to adult-based staff, promoting the Think Family approach and highlighting the impact of DA on children. The team are developing plans to reach more staff and make DA training essential to role.
- DA Lead has done a lot of work around organisational culture and ensuring we provide an effective response to both staff survivors and perpetrators to role model that, as an employer, we take DA seriously. Following a positive response to concerns from our own staff, the workforce will view identifying and responding to domestic abuse as their responsibility. Staff who have processed their own experiences and received effective support are also more likely to be able to have conversations with patients about domestic abuse without feeling triggered for example.
- Plans for 2026 include increasing data collection and planned WVT audits.

In addition to the strategic priorities discussed above, the development of a business plan aligned to the Children's Services Improvement Plan enabled improved working between HSCP and the Improvement Board.

Quality Assurance and Governance

Safeguarding is central to quality of care and patient safety. The Trust has a clear governance structure in place. The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms.

Wye Valley NHS Trust has an established safeguarding children quality framework which includes a safeguarding children performance dashboard (Appendix 1) and an annual audit plan. The dashboard and report are submitted on a quarterly basis through the governance structure to the Quality Committee and NHS Herefordshire and Worcestershire. Parts of the performance data are used to inform the Herefordshire Safeguarding Children Partnership's multi-agency data set. It has been recognised by HSCP Independent Scrutineer that the addition of data from WVT NHS Trust has helped to improve the robustness of the HSCP performance data set.

Learning, Development and Training

The provision and delivery of safeguarding children training remain a key priority for the team. Significant focus has been placed upon improving the trust's compliance to ensure that the staff have the required level of competency specified for their role.

During 2025 the safeguarding children team continued to provide updated training packages, taking into consideration; learning from case reviews, HSCP priorities, Working Together 2023 and current gaps in the training provided by HSCP (Neglect, Perplexing Presentations, Children with Disabilities and complex health needs, Get Safe and Right Help Right Time). Following a Training survey in November 2024, feedback from staff identified a clear need for a transition back to classroom-based learning to allow for richer discussions and greater learning. The team delivered classroom based safeguarding training but attendance by staff at these ½ day sessions was much lower than anticipated with rooms booked to accommodate up to 20 candidates but on average only 6 staff booking per session. Training arrangements for 2026 will be reviewed to try and ensure increased attendance.

Additional opportunities for learning have been provided by the quarterly, virtually delivered 'Think Family' Safeguarding Forum. These forums were previously only open to all staff who work with children but were re-branded in January from Safeguarding Children Forum to 'Think Family' Safeguarding Forum delivered jointly with the Adult safeguarding team and open to all WVT staff. These have been well attended and evaluated during the last year and provide a platform for staff to share and receive knowledge, ask questions, and request future topics. Attendance is monitored as the forum hours contribute to the Level 3 passport. There is a built-in evaluation process which allows for any future topics/themes to be included.

There is a multi-agency element to the forums with the inclusion of external speakers which adds an additional element to the learning. Themes for forums in the last year have been – All age neglect, hoarding and home safety, disabilities and complex health needs, substance misuse, mental health, and professional curiosity.

Additional bespoke training has been provided to individual teams within WVT as requested alongside the team providing bite sized teaching, updates on teams' social media pages and contributions to teams' newsletters.

The safeguarding team also contribute to the community paediatric monthly teaching, as well as providing safeguarding teaching sessions for the ED doctors and medical students.

The Training Log / Passport is being used to allow all staff a greater flexibility to complete their Level Three refresher requirements. This has been promoted by the team throughout this reporting period and is now much more widely used.

The safeguarding children team updates the intranet page with links to e-learning for all levels of training, as well as updating all safeguarding information on a regular basis.

WVT Safeguarding Children Training compliance data

Safeguarding Children Training	December 2023	December 2024	December 2025
% staff trained at level 1	90%	89%	91%
% staff trained at level 2	88%	87%	88%
% staff trained at level 3	84%	85%	86%
% Staff trained to level 4	100%	100%	100%
% Trust Board trained	86%	100%	93%

Audit

The Trust's safeguarding children team, together with key services, plan an annual audit programme which is monitored through the Trust's governance committees. Additionally, an overview of audit activity is provided within the Annual Safeguarding Children Report to Trust Board. Additional audits may be undertaken, which have not been included in the plan if a particular area is identified as needing further exploration. The WVT safeguarding children team have conducted several audits in 2025.

A MASH checks audit has been completed, assessing quality and application of practice standards. Several checks positively demonstrated comprehensive reviews of EMIS/MAXIMS and included the voice of the child

and a detailed analysis, highlighting safeguarding concerns and the impact on the child/children. Where concerns were identified, the senior MASH nurse was able to influence children's services to adapt local authority social worker practices to overcome some issues identified. Regular bespoke training sessions are being provided to the public health nursing teams, and a MASH check standardised operating process will be developed. Learning was disseminated through WVT systems detailed above and at MASH operational group. A repeat audit will be undertaken to review learning.

A child assault audit was conducted looking at the safeguarding actions of staff caring for children/young people attending the emergency department with inflicted injuries and the safeguarding actions of the public health nurses who are sent the discharge summaries to triage. This identified poor safeguarding actions, lack of professional curiosity and several missed opportunities to submit onward referrals to both police and children's social care. Several actions were identified, including mandatory MARF (multi-agency referral form) completion by Paediatric Assessment Unit staff into the MASH (multiagency safeguarding hub), strengthening protocols to ensure police reports are made, provision of training, all of which will be monitored through the children safeguarding operational group and will be reviewed at a repeat audit taking place imminently.

Special care baby unit (SCBU) conduct an **annual safeguarding audit** which assesses whether the SCBU multi-disciplinary team (MDT) are consistently and thoroughly fulfilling their safeguarding roles and responsibilities, specifically in clinical noting. The audit addresses safeguarding; documentation, communication, and actions. There were several examples of excellent practice with the following recommendations being identified and these will be monitored through the operational and overarching safeguarding groups. By completing an annual audit, the learning can be disseminated amongst the MDT, education provided to team members and time given to implement the systematic way of documenting.

The ICON audit looked at a small sample of health visiting and maternity records to identify whether health visitors, community nursery nurses, midwives and maternity support workers are having the discussion and sharing the advice and guidance regarding ICON and reducing abusive head trauma with parents following the birth of their newborn baby. A background of ICON and resources can be found at www.iconcope.org

From the small sample of cases sampled, it is evident that ICON is being discussed by 14 days and again at the 6–8-week Health visiting contact and this may be because of a prompt being available on EMIS for the new birth and 6-week contact. In addition, the practitioner will also provide the parent with a link to the ICON leaflet at these contacts which also prompts the discussion of ICON.

The sample identified that ICON is not being discussed at the light touch point at 3 weeks post birth. However, not all babies were seen at the 3-week light touch point in this sample and it is acknowledged that the service will not see all babies routinely between the new birth visit (10-14 days) and the 6 week contact only if they attend clinic or are receiving a targeted service which includes follow up visits usually during this time period.

The audit has identified that there is no evidence of ICON being discussed by midwives in pregnancy, within the 10 cases audited, the conversations in pregnancy tab was completed, however the ICON section was not completed. It is important to discuss ICON with parents and other care givers as early as possible to embed the message and instil confidence in coping with baby crying in preparation for birth and the postnatal period.

In 50% of the cases audited, the ICON discussion was completed during the first 10 days when the community midwife goes out to see the mother at home with a light touch reminder. This is an improvement from the previous audit. It would be recommended that a light touch reminder should be discussed on day 5 which is a standard visit for all families. In response to these findings the Named midwife will collaborate with Maternity managers around promoting the ICON message being discussed in pregnancy within 'conversations in pregnancy tab' and in the postnatal period as part of 'postnatal conversations tab'

Training has been provided to midwifery staff and support workers at the annual midwifery update day and monthly community midwives meeting.

ICON training/guidance to be provided to all new starters and midwives/staff transitioning to the community informing them of the required touch points.

Update and training to be provided to specialist midwives, co-ordinators, managers, and matrons to share and disseminate the message across their team.

The annual Named Safeguarding Midwife **audit of domestic abuse routine enquiry** has shown a significant increase in the enquiry being asked/form being completed in the postnatal period, a time where mothers are at an increased state of vulnerability and can often feel isolated. We know from research that victims of abuse may not disclose the abuse the first time they are asked. On average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help (Safe Lives (2015). Therefore, every opportunity to ask the routine enquiry is critical.

Research also shows that Healthcare professionals play a significant role supporting victims of domestic abuse. While only one in five survivors will call the police, 80% will seek help from health services. The cases audited were from booking up to the date of discharge from midwifery care to health visitor in 2025. The results show that during pregnancy, the routine enquiry is asked/form completed at least once in each trimester, where the question was asked, the form was completed appropriately.

There are some recommendations and actions for the Digital midwife to ensure patient electronic record systems are developed to support the processes, and additional training has been provided on how to ask routine enquiry and what midwives can do to support women who make disclosures.

The 2025 audit demonstrates how the number of women asked routine enquiry during their pregnancy has increased from 30% in 2024 to 100% in 2025.

Routine enquiry policy will be updated and promotion of the principles of the Domestic Abuse Bill (2021), Clare's law, and the support available to victims of domestic abuse. Trial of urine sample question packs for routine enquiry will also be evaluated.

An audit of Public Health Nurses attendance at Initial child protection conferences also took place in 2025. This provided assurance that expected processes detailed in the school nursing safeguarding SOP were followed.

All of the audit findings have been disseminated to practitioners through the safeguarding children education forum (Think Family Forum) and within training, team meetings, supervision, and briefings. Actions are monitored through the Safeguarding Children Operational Group and by exception to the Overarching Safeguarding Committee. Full reports of all the audits detailed can be accessed from the WVT Children's Safeguarding team.

Policy

The Trust's Safeguarding and Promoting Children's Health and Welfare Policy (MF35) was revised and approved in March 2025 to reflect the duty to report the death of a Care Leaver aged 18 years to 25 years *This guidance supports the HSCP multi - agency procedures
http://westmidlands.procedures.org.uk/page/contents

The Trust's Safeguarding Children Supervision Policy was revised and updated in August 2025 to reflect the introduction of restorative practice and family formulations processes.

Focus Upon Child Safeguarding in Maternity Services

Midwifery safeguarding services demonstrated consistently robust performance throughout 2025, underpinned by effective identification, escalation, and management of risk. A total of 124 MARFs were submitted, with 68 progressing to Level 4 statutory assessments, resulting in a conversion rate of 55%, notably higher than the wider health average of 32%. This indicates that referrals made by midwifery staff are appropriate, well-evidenced, and reflective of significant safeguarding concerns.

Monthly performance showed variation, with particularly strong conversion rates in March (88%) and September (86%), suggesting periods of highly effective decision-making and threshold application. In contrast, May (33%) reflected a lower conversion rate, which may indicate variation in referral thresholds or case complexity across the year.

Safeguarding outcomes highlight the high-risk nature of the caseload. There were 26 unborn babies subject to Child Protection Plans, alongside 13 removals into care, demonstrating the severity of concerns identified during pregnancy. In addition, 29 escalations to Children's Services were made and all were resolved, reflecting strong professional curiosity and effective multi-agency collaboration. Midwifery staff also contributed to nine court statements, further evidencing their role in formal safeguarding processes.

From an assurance perspective, compliance levels were consistently high. Community midwifery safeguarding supervision was maintained at 100%, and Level 3 safeguarding training compliance reached 95%, indicating that staff are appropriately trained and supported in managing safeguarding responsibilities.

However, despite strong mandatory compliance, engagement with additional safeguarding training was limited. Attendance at newly introduced training sessions was low, with some sessions receiving minimal or no participation. This suggests potential barriers such as capacity pressures, accessibility of training, or lack of engagement with optional development opportunities. As a result, key learning needs have been identified in adult safeguarding, learning disability, and mental capacity, which require targeted workforce development.

Considerable progress has been made in service development and quality improvement. A range of audits were completed (including routine enquiry, ICON, and discharge processes), supporting oversight and continuous improvement. Policies relating to substance use in pregnancy, domestic abuse, and FGM were reviewed and updated, ensuring practice remains aligned to current guidance. Importantly, a joint pre-birth protocol was implemented, strengthening partnership working and standardising processes across agencies.

Despite these strengths, several key challenges were identified. Most notably, the inconsistent submission of safeguarding caseload data by community midwives has limited the accuracy and completeness of reporting, particularly in relation to early help activity. In addition, low uptake of additional training and gaps in capturing preventative work (e.g., EHA/First Steps) highlight areas where further development is required to strengthen safeguarding oversight and early intervention.

Following a pause in 2024 and the subsequent escalation of concerns from WVT to Children's Services, the Pre-Birth Panel was reinstated in 2025 to ensure multi-agency oversight of all unborn babies subject to a pre-birth assessment and open to Children's Services. The panel meets weekly and has been consistently attended by the Named Midwife, facilitating effective communication, collaboration, and information sharing between agencies. In addition, the Pre-Birth Guidance was reviewed, updated, and streamlined to provide greater clarity and consistency for practitioners, supporting better understanding of the process and strengthening the safeguarding of unborn and newborn babies.

Looking ahead, priorities for 2026 focus on strengthening consistency, improving workforce engagement, and enhancing data quality. Planned actions include improving reporting systems, increasing accessibility and uptake of safeguarding training, introducing new Standard Operating Procedures (SOPs) (e.g., concealed pregnancy, toxicology, high-risk adults), and expanding the breadth of safeguarding data collected. Continued collaboration with local authority partners (e.g., Families First and restorative practice initiatives) will further support integrated safeguarding practice.

In summary, midwifery safeguarding services in 2025 were effective and well-performing, with strong statutory outcomes and high compliance. Sustained focus on data quality, training engagement, and early intervention recording will be essential to further enhance service quality and safeguarding outcomes for women and unborn babies.

Health within the Multi Agency Safeguarding Hub (MASH)

Since the implementation of the Specialist Nurse Advisor (Band 7) post, the postholder has had a wider remit, spanned the health economy working across children's social care, as well as providing support to the MASH Health Practitioner in managing the growing workload. This has resulted in:-

- Consistent WVT representation at the MASH Group, MASH team, and MASH audit meetings
- Liaison with wider Social Worker Teams to improve health contacts
- Regular meetings with CHAT team e.g. organisation of CAHMS question and answer sessions
- Monitoring of Performance Databases noted a significant increase in MASH checks resulting in an increased workload for WVT, GP and Mental Health services as well as the MASH nursing team. This was regularly queried at MASH Operational Meetings. The cause of this was found to be a change in policy within social care to send out on cases going for level 4 assessment. This was escalated to the ICB and has now been rectified.
- Also, from Monitoring of Performance Databases, it was noted that there was a significant increase in same day strategy meetings. This was also due to a change in policy within social care. This was also escalated and a process has now been agreed with School Nursing and Health Visiting regarding attendance.
- Providing support to the MASH Health Practitioner in managing the growing workload
- Standard Operating Protocol has been developed to clarify the process of attendance and documentation at the weekly Get Safe Multi agency meeting. The Band 7 attends this weekly alongside the Named Nurse for Children in Care. An alert has been developed which is added to the MAXIMS, EMIS and R4 records of those deemed at risk of exploitation.
- Wider training within the WVT remit including MARF and MASH check training for Band 5 public health nurses and Get Safe training which has been delivered to several WVT teams.
- Regular attendance at HSCB Child Exploitation Meetings and MACE2 meetings.
- Attendance at bi-weekly MASH Meetings

Workload in MASH has continued to grow as referrals into social care have been increasing.

Training	Audit	Policy	Other
Introduction of 'lunchtime learning' safeguarding children sessions	Monitor the annual safeguarding children audit plan and resultant actions	Review safeguarding supervision template to align itself with 'family formulation 'process	Set up planned 'group safeguarding supervision' for dermatology team.
Dissemination of 'family formulation' information/process to wider WVT teams' knowledge around this process.	Continue to play a key role in multi-agency audit group for the HSCP	Develop SOP for Get Safe processes including developing alerts for children at risk of exploitation	Amend quarterly data set collection to share with safeguarding partnership across Paediatrics, Public health nursing, ED & CLA teams
Think family training for ED teams delivered jointly by Adult and Child safeguarding teams. Introduce Think Family Safeguarding Education Forums in conjunction with Adult Safeguarding Team		Introduce CP-IS Phase 2 into Community Paediatrics, Dental Access, and Public Health Nursing. Develop SOP for processes and educate teams as required	Amend Peer Review processes for Paediatricians in line with new RCPCH guidance.
		Lead the development of the multi-agency Keep Me Safe When I am With Dogs strategy with support from the ICB.	Development of Safeguarding Children Template on Clinical Noting for team to use when providing staff with safeguarding information and advice around an inpatient

Conclusion

This annual report provides an overview of the key safeguarding issues, developments and initiatives relating to children and young people over the past 12 months. It offers assurance that the organisation continues to fulfil its statutory safeguarding duties and responsibilities.

The Trust's safeguarding team has continued to support key safeguarding priorities, respond to emerging themes and strengthen safeguarding practice across the organisation. Ongoing monitoring of service capacity will remain essential over the coming year to ensure the Trust continues to meet its Section 11 safeguarding responsibilities.

References/Links

1. Safeguarding children and young people: roles and competences for healthcare staff (2019) RCPCH.

2. HM Government (2026) Working Together to Safeguard Children 2023. A guide to multi-agency working to help, protect and promote the welfare of children https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf
3. Children and Social Work Act (2017) http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted
4. HSCP Regional Child Protection Procedures. (Multi –agency) https://westmidlands.procedures.org.uk/page/content

Dashboard - Child Safeguarding Wye Valley Trust 2025

Indicator	Jan-March	April-June	July-Sept	Oct-Dec
Early Intervention				
No of Early Help Assessment (EHA) initiated by School Nurse(SN) /Health Visitor(HV)	5	5	11	7
No of EHA SN/HV involved in	72	66	60	51
SN/HV acting as lead professional in EHA	10	Not Available	9	5
No of First Steps HV involved in	12	12	10	7
No of CiN SN/HV involved in	97	68	63	62
ED Alert & Cwilting Checks Completed (Target 100%)	100.00%	100.00%	100.00%	100%
Child Protection				
HV/SN attendance at Strategy Meetings	151	159	161	118
HV attendance at Initial and Review Child Protection Conferences (Target 100%)	100.0%	100.0%	100%	100%
Reports presented to CP conferences- HV (Target 100%)	100.0%	100.0%	100.0%	40%
SN Attendance at ICPC conferences (Target 100%)	100.0%	100.0%	100.0%	100%
Domestic Abuse (DA) notifications- numbers children	699	861	1197	1162
Midwifery routine enquiry question re DA	99%	99%	?	?
Domestic abuse disclosure (Midwifery)	1.0%	1.1%	?	?
Multi-Agency Risk Assessment Conference attendance	100%	100%	100.0%	100%
Number of children with a child protection plan	139	155	161	133
No of CP medicals / health assessments	14	9	15	25
Case Management Escalations resolved at Stage 1	7	13	5	5
Case Management Escalations resolved at Stage 2 and above	1	5	4	0
Number of Child Safeguarding Practice Reviews	0	0	0	0
Identified cases FGM -Women / Children	1	3	2	1
Training - Target 85%				
% staff trained at level 1	91%	92%	92%	91%

% staff trained at level 2	88%	88%	88%	88%
% staff trained at level 3	84%	85%	85%	86%
% PAU staff trained at level 3	87%	91%	90%	93%
% ED staff trained at Level 3	67%	71%	71%	70%
% staff trained at Level 4	100%	100%	100%	100%
% Board members training	23%	100%	100%	93%
Supervision - Target 80%				
% HV staff who have received supervision	96%	96%	76%	95%
% SN staff who have received supervision	100%	77%	92%	91%
% Community Midwives who have received supervision	100%	100%	100%	100%
Human Resources				
Staff Referrals To Local Authority Designated Officer	4	2	6	2
Health Visitor vacancies (wte)	2.6	2.8	1.00	1
School Nurse vacancies (wte)	0.2	0.2	0.7	0
Birth to midwife ratio	01:21	01:22	01:24	01:25
Complaints - Safeguarding Specific				
Tier 4 beds - number waiting during quarter and outcome	0	0	0	0
Number of complaints regarding the care of a child.	0	0	0	0
Serious Incidents - Child Safeguarding specific				
Number of SIRIs	0	0	0	0
ED & PAU Attendances for Children and YP				
Alleged Assault	8	11	12	13
Knife/Stab Injury	0	0	0	0
Drug/Alcohol Intoxication (including Overdoses)	10	29	26	23
Self-Harm	29	24	36	24
Suicidal Thoughts	13	14	20	24
MASH Health Data				

No of Immediate Strategy meetings attended	**19**	**36**	**32**	**63**
No of MASH checks	**115**	**156**	**248**	**256**
No of MASH contacts	**1307**	**1377**	**1659**	**1516**

Children in Care Annual Report 2025

The Children Looked After Annual report for 2025 provides assurance and performance data on how Wye Valley NHS Trust has met its statutory health responsibilities and supported the health needs of our Herefordshire Children Looked After.

The reporting period covers 1st January 2025 to 31st December 2025.

Breakdown of data is quarterly- Q4 January to March. Q1 April to June, Q2 July to September and Q3 October to December.

The annual report will cover

1. The Structure of the CLA Health Team.
2. Key roles and responsibilities of the children in care health team.
3. Profile of Herefordshire CLA during 2025.
4. Statutory IHA and KPI performance for Herefordshire CLA living in Herefordshire.
5. Statutory RHA and KPI Performance for Herefordshire CLA living in Herefordshire
6. Statutory IHA and KPI performance for Herefordshire CLA living out of County.
7. Statutory RHA and KPI Performance for Herefordshire CLA living out of County.
8. Clinical activity during 2025
9. Planned developments for 2026

1. Structure of Children in Care Health Team

The Chief Nursing Officer is the Executive Lead for Children in Care and is supported by the Associate Chief Nursing Officer who oversees the management of, and the work undertaken by the team.

- Job planning for the medical workforce (paediatricians) is subject to change.
- There has been no change to the nursing establishment of the Children in Care Health Team since 2019.
- In 2024 the administrator structure was reviewed and revised to incorporate a Band 2-4 Structure.

Role	Whole Time Equivalent
Named Nurse	1 W.T.E
Named Doctor	1 PA
Community Paediatrician	1 IHA Clinic per fortnight
Nurses for Children in Care	2.76 WTE
Administrator for Fostering and Adoption	0.8 WTE
Assistant Administrator Children in Care	0.76 WTE
Assistant Administrator Children in Care	0.35 WTE

2. Roles and responsibilities of Children in Care (CIC) Health Team

The Children in Care health team have a statutory responsibility to ensure that all Herefordshire Children in Care between 0-18 years living both in and out of Herefordshire have their health needs identified and met through statutory health assessments and that CLA are where possible compliant with CLA Key Performance indicators.

Children in care experience greater health inequalities and poorer health outcomes than peers who are brought up by biological parents. As Corporate Parents, the Children in Care team are central to ensuring general physical, social and emotional health is improved supporting children and young people's lifelong health outcomes ensuring that health care is neither delayed or disrupted due to circumstances beyond the child or young person's control. The team support children, young people, their primary carer and professionals around the child when there are concerns around emerging or new health needs.

Assurance that statutory health responsibility is being met is reported through the Governance Structure at Wye Valley NHS Trust and Herefordshire Council Corporate Parenting Board quarterly.

2.1 Statutory Health Assessments

WVT has a statutory health responsibility to ensure that all Children Looked After(CLA) are offered and have an

- Initial Health Assessment (IHA) with a Paediatrician within 20 working days of becoming looked after.
- Review Health Assessment (RHA) every six months when aged 0-4 years and annually for children and young people aged between 4 -17 years.

2.2 Key Performance Indicators (KPI)

KPIs are prioritised and recorded for every child or young person in care.

All children and young people in care:

- should be registered with a local GP
- should have a dental check every six months
- should have immunisations in line with the National Immunisation Programme.

2.3 Supporting the holistic health of children and young people in care.

The Children in Care team provides specialist support, advice and guidance to children and young people in care, as well as to the professionals involved in their care. The team responds to emerging, newly identified, and unmet health needs, offering support whenever a physical, emotional, mental, or social health concern arises. The service also provides oversight and intervention where there are changes to a child or young person's health status and/or concerns regarding delayed and disrupted healthcare.

Meeting the health needs of children and young people in care requires a flexible, responsive, and child-centred approach. The CIC heath team works collaboratively with a wide range of health providers and partner agencies, both within Herefordshire and across the United Kingdom, to ensure that children and young people receive timely and appropriate healthcare regardless of their placement location.

In addition to delivering Statutory Health Assessments, the CIC health team provides both direct and indirect health support tailored to the individual needs of children and young people. This support is delivered through multidisciplinary collaboration with social care professionals, carers, birth families, education providers, and specialist services. Interventions are provided across a range of settings, including clinics, foster homes, residential and specialist residential placements, and educational settings.

2.4 Safeguarding children and young people in care.

Children Looked After (CLA) Nurses play a vital statutory role in safeguarding children and young people in care and protecting them from exploitation. Through ongoing health assessments, direct engagement, and multi-agency working, CLA Nurses identify vulnerabilities, recognise early indicators of risk, and contribute to effective safeguarding and safety planning.

Children Looked After are disproportionately vulnerable to child sexual exploitation (CSE) and child criminal exploitation (CCE), including county lines activity, due to factors such as previous trauma, adverse childhood experiences, placement instability, and targeted grooming by perpetrators.

The CLA nurses attend all statutory safeguarding meetings for Herefordshire Children Looked After in accordance with local and national safeguarding policies, procedures, and Working Together to Safeguard Children guidance (March 2026). The stability and continuity within the CLA Nursing Team has enabled nurses to develop strong professional relationships and a comprehensive understanding of the children and young people on their caseloads. This ensures that the most appropriate nurse, with detailed knowledge of the child or young person's history, health needs, and current risks, can contribute effectively to safeguarding discussions and decision-making.

Attendance at safeguarding meetings is coordinated through a team duty rota, ensuring consistent representation and timely sharing of relevant health information. During the reporting period, the Children in Care Nursing Team achieved 100% attendance at safeguarding meetings for Children Looked After when invited, demonstrating the team's commitment to fulfilling its statutory safeguarding responsibilities and supporting the best possible outcomes for children and young people in care.

2.5 Quality Assurance

The CIC Health Team works with Herefordshire Children Looked After (CLA) and children looked after by other local authorities who are placed within Herefordshire. At the end of the reporting period, there were 332 Herefordshire children looked after.

The WVT Children in Care health team has robust processes in place to ensure that the health needs of children and young people living outside the county are identified, assessed, and supported through individualised comprehensive and effective health care plans.

To ensure that all health needs are identified and met, that robust health care plans are in place, and that compliance with key performance indicators (KPIs) is accurately recorded, all returned health assessments undergo a thorough quality assurance process. In 2025, the quality assurance template was updated to incorporate new and revised standards for health assessments. These changes place a greater emphasis on a trauma-informed approach to all health contacts and promote the use of compassionate, child-centred written and verbal communication that reflects a culture of care for children and young people.

3. Overview of Herefordshire Children Looked After 2025

The Children in Care health team continues to provide oversight and coordination of health for Herefordshire CLA, including those placed outside the county. Throughout 2025, the number of Herefordshire children in care remained relatively stable, with 332 children looked after at the end of Quarter 3 (95.2 CLA per 10,000 under 18 population). This is higher than the figure for England at 67 and the Midlands region at 87 CLA per 10,000 under 18 population.

A significant proportion of Herefordshire CLA live out of the county, reflecting the complexity of placement availability and individual care needs. The Children in Care health team has established robust systems and processes to ensure that children placed out of area receive their statutory health assessments, that health needs are identified and addressed promptly, and that comprehensive health care plans are in place regardless of placement location.

During Quarter 3, 110 children (33.1% of the total Herefordshire Children Looked After population) were living outside the county. The team maintains close working relationships with partner health providers and local authorities to ensure continuity of care, effective information sharing, and ongoing monitoring of health outcomes for these children and young people.

A total of 93 children and young people became Looked After during 2025 with 125 who stopped being looked after.

	Q4 2024 -2025	Q1 2025-26	Q2 2025-26	Q3 2025-26
Total number of Herefordshire Looked After Children	358	327	322	332
Number of Herefordshire Children Living out of area	112	107	115	110

3.2 New Children and Young People into Care 2025

Herefordshire supported 93 children who came into care during 2025. This represents an increase of 31 children compared with the same reporting period in 2024, reflecting a rise in new Herefordshire children becoming Looked and following the national trend.

26 (27.95%) of the new CLA during 2025 moved to live out of area at the time they became looked after. The primary reasons were risks of child exploitation, move to kinship carers and location of residential care support.

In addition to our new Herefordshire CLA, we had requests to complete an IHAs for 33 CLA on behalf of other Local Authorities for CLA living in Herefordshire.

3.4 Herefordshire CLA living out of county

At the end of the reporting period a total of 110 Herefordshire CLA were living out of Herefordshire. During 2025, Herefordshire CLA were living across 31 Counties. It remains the responsibility of WVT CIC health team to ensure statutory health reviews are requested and carried out and key performance indicators recorded for all our children and young people regardless of where they are living.

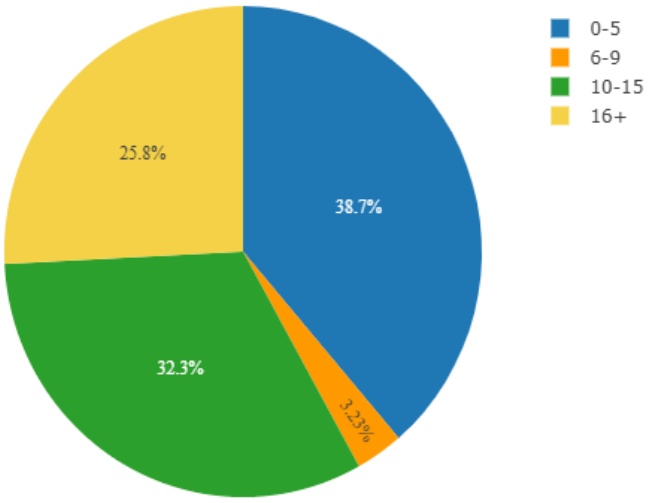
Statutory Health Assessment Data is reported on a separate dashboard for our out of county children and young people.

3.5 Gender and age profile of new children and young people into care 2025

The gender profile of these children and young people was generally evenly balanced, with 45 girls (48.38%) and 48 boys (51.6%), based on their gender assigned at birth. This balanced distribution indicates no significant gender-related variance in entry to care during the reporting period.

The age profile of children entering care highlights important considerations for health planning and service delivery. The largest proportion of children were aged 0–5 years, with 36 children (38.7%) entering care during early childhood.

Age profile of new Children into care 2025



This group of children typically presents with a high need for early health assessment, developmental screening, and targeted early intervention to support the impact of adverse childhood experience at a formative stage of life on health and development and for children coming into care there is a need to ensure readiness for school in line with their peers.

A further 30 children (32.3%) entered care between the ages of 10 and 15 years, and 24 young people (25.8%) were aged 16 years and over. These older age groups often present with more complex physical health, emotional wellbeing, and mental health needs, resulting from longer exposure to adverse childhood experiences, impact of trauma, neurodevelopmental concerns, safeguarding and child exploitation, with an often more complex health profile and need for support with transition to adulthood and adult services.

Only a small number of children (3; 3.2%) were aged 6–9 years at entry to care.

Overall children are entering care at both ends of the age spectrum, with notable concentrations in the early years and adolescence. This pattern underscores the need for a responsive and flexible health offer, support for delayed or disrupted health care, prioritising of timely statutory health assessments, coordinated multi-agency working, and age-appropriate interventions to support lifelong improved health outcomes for children and young people who are looked after whilst supporting children and young people to understand and place value on the importance of their own health and support age appropriate health literacy.

3.6 Separated Young People

Over the reporting period, Herefordshire provided care for 19 Separated Young People, representing 20.43% of the Herefordshire new children looked after population. 18 were male with one female separated young people. This reflects the local authority's continued commitment to support, and safeguard separated young people. WVT saw the most separated young people come into care.

Separated young people are allocated across the United Kingdom through the National Transfer Scheme (NTS), which aims to achieve a more equitable distribution of responsibility between local authorities. Allocation levels are determined using a national threshold of up to 0.1% of the local child population, helping to ensure that individual authorities are not disproportionately stretched.

The Local Authority assumes statutory responsibility for separated children and young people who become looked after, acting as the corporate parent until they reach the age of 18. Where young people meet the eligibility criteria for leaving care services, support continues until the age of 21. This may be extended to 25 years where they remain engaged in education, employment, or training.

Whilst the majority of Herefordshire separated young people are not living in county there is a small number of young people who are. A community Paediatrician at the Child Development Centre is taking a clinical lead for this group of young people and developing a specialist skill set to support the health of these young people.

Separated Young People are a unique group of young people who are likely to have experienced significant trauma, disruption to healthcare, with unmet physical and mental health needs often associated with being separated from families and their experience of travelling to the UK. The health response, as with all children and young people, therefore, requires timely initial health assessments, comprehensive screening (including immunisations, dental care and infectious disease screening), and access to specialist emotional wellbeing and mental health support. Close multi-agency working remains essential to ensure these young people receive culturally sensitive, trauma-informed health care required to achieve improved health and wellbeing outcomes.

Profile date for new Children into care for 2025 by quarter

	Q4 2024 -2025	**Q 1 2025-26**	**Q2 2025-26**	**Q3 2025-26**
Number of new children into care	**14**	**16**	**30**	**33**
Separated Young People	**2**	**1**	**11**	5
Number of new children in care living out of area	**5**	**5**	**10**	6
Number of Children stopped being a CLA before an IHA was completed.	0	2	1	1
Gender assigned at birth				
M	8	7	20	13
F	6	9	10	20
Age at time of becoming CLA in years.				
0-5	4	7	9	15
6-9	0	0	2	1
10-15	6	4	10	10
16 plus	4	5	8	7

3.7 Children and Young People leaving care

During 2025, a total of 125 children and young people left care**.** When a child or young person leaves care, the Child Looked After (CLA) alert is removed from their medical record. For those who are eligible, a Care Leaver alert is added and remains in place until their 25th birthday, at which point it is removed.

Notifications are received from Children's Social Care whenever there is a change in a child's legal status. This ensures that health records are updated promptly and accurately, maintaining the integrity of clinical information.

Reason for leaving care	Number of Children and young people.	Percentage of the cohort leaving care
Turned 18	**56**	
Returned home	**33**	
Adoption order granted	**19**	
Special Guardianship Order Granted	**13**	
Care transferred to another Local Authority	**3**	
Other	**1**	

4. Initial Health Assessments

Completion of an Initial Health Assessment (IHA) requires Children's Social Care to notify Wye Valley NHS Trust (WVT) Children Looked After (CLA) Health Team when a child becomes looked after and to ensure that the relevant medical consent documentation is completed and signed. For young people aged 16 years and over, consent may be provided by the young person where they are assessed as having the capacity to do so.

Historically, the CIC health team experienced challenges in receiving timely notifications of children entering care and in obtaining completed medical consent documentation. However, strengthened partnership working between Children's Social Care and the CIC health team, combined with a shared commitment to improving processes and outcomes, has resulted in ongoing improvements in both the timely notification of children becoming looked after and the improving timeliness of receipt of medical consent.

These improvements have enhanced the ability of the WVT CIC health team to fulfil its statutory responsibilities and support compliance with national timescales, ensuring that more Initial Health Assessments are completed within 20 working days of a child becoming looked after. Timely receipt of notifications and consent documentation also enables the early identification of health needs and supports children and young people to access appropriate healthcare interventions without unnecessary delay.

4.2 Notification of a child becoming Looked After

Notification performance for new Children Looked After (CLA) remained consistently good across the reporting period. The timely notification of children entering care to Wye Valley NHS Trust Children in Care health team is a statutory requirement and a critical component in ensuring that receipt of medical consent and initial health assessments appointments.

In Quarter 4, 11 notifications were received within the five-working-day timescale, achieving a compliance rate of 78.57%. Performance improved in Quarter 1 with 13 timely notifications recorded (82.35%). This upward trajectory continued into Quarter 2, during which 26 children were notified within five working days, corresponding to a compliance rate of 86.6%, the highest level achieved during the reporting cycle. In

Quarter 3 25 (80.64%) notifications were received within five working days of becoming CLA. The longest wait for notification of a new child into care was 20 working days.

Overall, the data demonstrates sustained and reliable adherence to notification requirements across all four quarters from Children's Social Care. This consistent performance provides assurance that operational processes remain effective, and that children entering care are identified promptly, enabling the timely commencement of health assessment pathways and supporting the wider safeguarding responsibilities for children looked after.

4.3 Medical consent received from Children's Social Care

There has been a notable improvement in the proportion of consents received within five working days compared with Quarter 4, reflecting strengthened processes between the CIC health team and Children's Social Care. Quarter 1 demonstrated the strongest performance, with over half of all consents received within five working days and no consents delayed beyond 20 working days.

Whilst performance remained good during Quarters 2 and 3, the proportion of consents received within five working days reduced, with most consents being received between 6 and 20 working days. A small number of cases continued to exceed 20 working days; however, the overall delays were significantly shorter than those experienced during the previous reporting year.

The CIC health team will continue to work collaboratively with Children's Social Care to ensure that consent is obtained at the earliest opportunity, minimising delays to health assessments and supporting timely access to healthcare services for children and young people entering care.

4.4 WVT Capacity to offer IHA's – working days from receiving medical consent to first IHA Offer

IHA Performance

Performance during Q4 and Q1 was strong, with all children being offered an Initial Health Assessment within 20 working days of receiving medical consent.

During Q2 and Q3 it was very challenging to offer an IHA without some delay, with a reduction in children offered an assessment in a timely manner. In Q2, 65% of children received an IHA appointment within 20 working days, decreasing further to 26.9% in Q3. Consequently, a greater number of children experienced delays, with the longest waiting times for a first IHA offer increasing to 49 working days in Q2 and 48 working days in Q3.

The challenges in offering a first IHA appointment were primarily attributable to increased demand on the service due to increasing numbers of new children into care and increased requests from other Local Authorities to complete IHA's, clinic capacity and the number of paediatricians completing IHA's. Despite these pressures, the CIC health team continued to prioritise our children and young people ensuring that safeguarding concerns and significant health issues were addressed promptly.

The CIC health team has continued to closely monitor performance and implement measures to improve compliance with statutory timescales. This includes ongoing review of service capacity and demand, optimisation of clinic utilisation. Escalation of this delay in capacity at times of increased demand has led to plans for increased clinical capacity that will be more responsive to increased demand for IHA appointments

with an additional two Paediatricians completing IHA's from April 2026 strengthening work force resilience and clinic capacity.

The CIC team remains committed to meeting statutory timescales for IHA and ensuring that children and young people entering care receive their Initial Health Assessment at the earliest opportunity. Early access to health assessments is essential in identifying unmet health needs, facilitating timely intervention, and promoting positive health outcomes for children and young people in care.

5. IHA and Key Performance Indicators for Herefordshire CLA

5.1 A total of 64 Initial Health Assessments were due for Herefordshire children living in Herefordshire during 2025. The number of children requiring an Initial Health Assessment increased steadily throughout the year, rising from 9 assessments in Q4 to 26 assessments in Q3. This represents a significant increase in demand placed upon the Children in Care health team.

Performance against statutory timescales for IHA declined over 2025. In Q4 77.8% of Initial Health Assessments were completed within statutory timescales. Compliance reduced to 50% in Q1 and 36.8% in Q2 2025/26, before falling further to 7.7% in Q3.

Correspondingly, the proportion of assessments completed outside the statutory timeframe increased throughout the year, from 22.2% in Q4 to 92.3% in Q3. This trend reflects the increasing demand on the service and the impact this had on the team's ability to deliver assessments within statutory timescales. All children and young people did have an IHA unless they refused.

Attendance at Initial Health Assessments remained generally high. There was one young person who did not attend in Q1 and one in Q3, with no appointments formally refused by children, young people, or those with parental responsibility throughout the reporting period. This demonstrates a continued commitment from children, carers, and professionals to engage with the statutory health assessment process.

The increase in the number of children becoming looked after during the year created significant additional demand on the service. Although the CIC health team continued to prioritise the delivery of statutory health assessments and safeguarding responsibilities, the increased volume of assessments required exceeded available clinical capacity at various points during the reporting period.

In addition to assessments required for Herefordshire children living within the county, WVT CLA Health Team also undertakes IHA's on behalf of other Local Authorities where children are placed within Herefordshire. During the reporting period, requests from other Local Authorities increased significantly, rising from 1 request in Q4 to 9 in Q1 14 Q2, in and 9 in Q3. This additional activity represents a further demand on the service and contributed to increased clinical workload during the year. Despite these pressures, the CIC health team continued to work collaboratively with partner Local Authorities to ensure that children placed within Herefordshire were able to access their statutory health assessments and receive appropriate health support in a timely manner.

5.2 Key Performance indicators Initial Health Assessment for Herefordshire Children living in Herefordshire

Initial Health Assessments provide an important opportunity to assess the health needs of children and young people entering care and to identify any gaps and unmet health needs and focus on Key performance indicators.

Throughout the reporting period, levels of GP registration remained consistently high, increasing from 88.9% in Q4 to 100% across all quarters of 2025.

Children seeing a dentist within the last six months was more variable. Children and young people who had attended a dental appointment within six months ranged from 22.2% in Q4 to 60% in Q1, before improving to 45.8% in Q3. All new CLA living in Herefordshire will be able to access a dentist and receive a dental examination and treatment to ensure they are dental fit.

Immunisation compliance was difficult to determine for some children due to incomplete or unavailable health records at IHA. Where information was available, between 23.1% and 50% of children were recorded as being up to date with the National Immunisation Programme. The CIC health team continues to work with primary care providers and community health services to obtain missing immunisation information and facilitate catch-up vaccinations where required.

Overall, the data demonstrates stronger engagement with primary healthcare services, highlighting the challenges in improving access to dental care and immunisation for vulnerable children and young people. The KPI data at IHA forms a baseline and it is encouraging that KPI performance at RHA shows a significant improvement.

6. RHA and KPI Performance for Herefordshire Children in Care living in Herefordshire

6.1 RHA compliance

Review Health Assessments (RHAs) are a statutory requirement for children and young people in care and provide an opportunity to review health needs, monitor progress against health plans, and ensure that appropriate healthcare interventions remain in place. The CIC health team continued to deliver RHAs throughout 2025, maintaining good levels of compliance with statutory timescales despite increasing service demand and challenges associated with appointment attendance and placement changes. A total of 308 RHA's were completed for CLA Living in Herefordshire.

During the reporting period, the number of RHAs due for Herefordshire children living in Herefordshire ranged from 47 to 63 per quarter. A total of 217 RHAs were completed across the four quarters reviewed, for Herefordshire CLA with between 77.7% and 84.7% completed within statutory timescales during 2025/26.

Performance improved significantly compared to Q4, when 66.6% of RHAs were completed within timescales. throughout 2025 achieving 84.5% in Q1, 77.7% in Q2, and 84.7% in Q3. This reflects the team's ongoing focus to ensure that children and young people receive an RHA within statutory timescales. All children due an RHA had an assessment completed unless they refused.

A small number of children and young people refused their Review Health Assessment reporting with refusals ranging from one to three children per quarter. In Q3, three young people stopped being CLA before their Review Health Assessment was due to be completed.

All RHA's are offered in statutory timescales with the CIC team having a robust allocation process. Where assessments were not completed within statutory timescales, most delays were related to factors outside the direct control of the team. The most common reason was appointment cancellation or limited availability of carers and young people to attend appointments. Delays were also associated with children not being

brought to appointments and placement moves. Seven assessments were delayed due to nursing capacity in Q4.

In addition to completing RHA's for Herefordshire CLA, a total of 91 RHA's were completed on behalf of other Local Authorities. As with IHA health reviews, the CIC health team continued to work collaboratively with partner Local Authorities to ensure that children placed within Herefordshire were able to access their statutory health assessments and receive appropriate health support in a timely manner.

Overall, the service has maintained strong performance in delivering statutory Review Health Assessments within timescales and continues to work collaboratively with carers and Children's Social Care to ensure timely RHA's whilst reviewing and supporting ongoing health needs.

6.2 Key Performance Indicators at RHA for Herefordshire Children Living in Herefordshire

RHAs KPI demonstrate positive health outcomes for Herefordshire children and young people living in Herefordshire. Access to a Local GP remained consistently high throughout 2025, with 100% of children reviewed being registered with a General Practitioner (GP) in every quarter.

Access to dental care continued to improve during the year. The proportion of children who had attended a dentist within the previous six months increased from 76.7% in Q4 25 to 93.6% in Q3 2025**,** reflects the ongoing commitment of carers, social workers, and health professionals to promoting good oral health and supporting regular dental attendance.

Immunisation rates also remained strong throughout the reporting period. Between 84.4% and 93.3**%** of children and young people were recorded as being immunised in line with the National Immunisation Programme, demonstrating effective monitoring of immunisation status and continued partnership working between the CLA Health Team, primary care services, and carers to ensure that children receive routine vaccinations and catch-up immunisations where required.

Recorded data indicates the majority of CLA living in Herefordshire can access dental care and immunisations. The consistently high levels of GP registration, improving dental attendance, and strong immunisation rates reflect the positive impact of collaborative working between healthcare professionals, carers, Children's Social Care, and partner agencies in promoting the health and wellbeing of Herefordshire's children and young people in care.

7. IHA and KPI Performance for Herefordshire Children in Care living out of county

7.1 Initial Health Assessments (IHAs) performance.

During the reporting period, a total of 25 Initial Health Assessments were due for Herefordshire CLA living out of county.

Of the 25 assessments due:

- 5 (20%) were completed within statutory timescales.
- 15 (60%) were completed outside statutory timescales.
- 3 children stopped being CLA before the IHA was completed
- No Initial Health Assessments were refused, demonstrating positive engagement from children, young people, carers, and professionals.

Performance varied across the reporting period. In Quarter 4, all five assessments due were completed; however, none were achieved within statutory timescales. Quarter 1 2025/26 showed a modest improvement, with one of four assessments completed within timescale. Quarter 2 experienced the highest demand, with ten assessments due. While two assessments were completed within statutory timescales, seven were completed late and one child stopped being a CLA before IHA assessment was completed.

Quarter 3 demonstrated continued improvement in timeliness and management of the assessment process. Of the six assessments due, two were completed within statutory timescales and there were no assessments completed outside statutory timescales. This improvement reflects strengthened oversight, effective case tracking, and close partnership working across health and social care services.

8. KPI data at IHA for Herefordshire CLA living out of county

8.1 GP Registration

GP registration rates were high throughout 2025 providing assurance that children entering care had access to primary healthcare services. In Quarter 4 and Quarter 1, all children assessed at IHA were registered with a GP (100%). In Quarter 2, seven children (77.7%) were registered with a GP at the time of assessment. For those not registered, actions were included within Health Care Plans to ensure prompt registration and access to primary care services.

8.2 Dental Attendance

Access to dental services remains an area of focus. In Quarter 4, 60% of children had attended a dentist within the previous six months, decreasing to 50% in Quarter 1 and 14.3% in Quarter 2. One child in Quarter 2 was under 12 months of age and therefore exempt from the dental KPI.

The lower rates of dental attendance are likely to reflect the circumstances of children entering care, including disrupted access to health services prior to becoming looked after, alongside wider challenges in accessing NHS dental provision. Where dental appointments were not up to date, referrals and recommendations were incorporated into individual Health Care Plans.

8.3 Immunisation Status

Immunisation status was reviewed for all children at their Initial Health Assessment. In Quarter 4, 40% of children were immunised in line with the National Immunisation Programme. This improved to 100% in Quarter 1 and remained comparatively high at 75% in Quarter 2. Two children assessed during Quarter 2 were under eight weeks of age and therefore exempt from the KPI.

Where a child was not fully immunised, appropriate recommendations were made to support catch-up vaccinations.

9. RHA and KPI Performance for Herefordshire Children in Care living out of county

9.1 RHA for Children and young people living out of area

A total of 102 Review Health Assessments were due for Herefordshire children living outside the county during 2025. Of these, 98 RHAs were completed and returned, representing a completion rate of 96.1%.

There were only two refusals during the year, and no children ceased to be looked after before their assessment was completed.

Throughout the reporting period, the CIC team maintained oversight of all assessments received from host health teams, ensuring that returned RHAs were quality assured and that recommendations were followed up appropriately. This process provides assurance that children placed out of area continue to receive effective healthcare support and that their health outcomes are closely monitored.

Performance against statutory timescales varied across the reporting period but remained above 50% in each quarter. During Quarter 4, 55.2% of assessments were completed within statutory timescales. Performance dipped slightly in Quarter 1 to 54.5%, before improving significantly in Quarter 2 to 68%. Quarter 3 maintained this improvement, with 64% of assessments completed within timescales.

9.2 KPI at RHA for children living out of county

GP Registration

Performance remained excellent throughout the reporting period, with 100% of children assessed being registered with a local GP in every quarter. This demonstrates that children placed outside Herefordshire continue to have access to primary healthcare services and appropriate medical support.

Dental Attendance

Dental attendance remained consistently high. The percentage of children who had attended a dentist within the previous six months ranged from 72.4% to 89.5% across the reporting period. Performance was strongest in Quarter 1, where almost nine out of ten children were up to date with dental attendance. While there was a slight reduction in Quarters 2 and 3, most children continued to receive regular dental care.

Immunisation Status

Immunisation rates remained positive throughout the year, ranging between 72% and 80%. Quarter 2 achieved the highest level of compliance, with 80% of children being immunised in line with the National Immunisation Programme. Where children were not fully immunised, recommendations for catch-up vaccinations were included within Health Care Plans and communicated to relevant health professionals and carers.

Challenges to meeting statutory time scales for Children living out of county

The Children in Care health team continues to face challenges in achieving statutory timescales, where children are placed out of county, where health information is required from multiple providers, or where there are delays in appointing RHA due to partner capacity and receiving completed assessment documentation. Despite these challenges, the team has maintained robust oversight of all children requiring RHA and ensures that assessments are quality assured and that health needs are incorporated into individualised health care plans.

The team has well-established processes for monitoring children who are placed outside Herefordshire and works proactively with partner health providers to obtain assessments and ensure that statutory responsibilities are met.

10. Planned Outcomes for 2026

Key Aims

- To ensure that children and young people remain at the centre of service delivery by actively listening to and acting upon their experiences, continuously shaping a responsive, high-quality health service that meets their individual needs, safeguards their wellbeing, and supports improved lifelong health outcomes.
- Continue to promote awareness of the health needs and challenges faced by Children Looked After across Herefordshire through meaningful written and verbal engagement with children and young people, ensuring that every contact is used as an opportunity to advocate for, support, and improve their health and wellbeing.
- To promote the corporate parenting responsibility that WVT holds for CLA living in Herefordshire.
- Secure full access to appropriate AI technology for the CIC Nursing Team to enhance service delivery, improve efficiency, and support a more engaging and positive experience for children and young people during lengthy and complex health assessments.
- Develop and implement a biannual forum for children and young people to provide feedback on health assessments and the wider service. This will ensure their views and experiences inform service development and continuous improvement.

Children in Care data sets for 2025

2025	Q4 2024 -2025	Q 1 2025-26	Q2 2025-26	Q3 2025-26	End of reporting period
Total number of Herefordshire Looked After Children	358	327	322	332	332
Number of Herefordshire Children Living out of area	112	107	115	110	110
Number of new children into care	14	16	30	33	93
Separated Young People	2	1	11	5	19
Number of new children in care living out of area	5	5	10	6	26
Number of Children who ceased being Children Looked After before an IHA was completed.	0	2	1	1	4
Number of requests for IHA from other Local Authorities	1	9	14	9	33
Number of requests for RHA from other Local authorities	19	23	28	21	91
Notification of new CLA within five working days of children becoming Looked after for all Herefordshire new CLA	11 (78.57%)	13 (82.35%)	26 (86.6%)	25 (80.64%)	
Delay in Health Team receiving notification of a Child being Looked After from Local Authority within 6-20 days of becoming CLA.	3 (21.42) %	3 (17.64%)	4 (13.3%	6 (19.35%)	
Number of new CLA with no formal Notification of being CLA	0	0	0	0	
Notification of new CLA over 20 working days of becoming CLA	0	0	0	0	
Longest Wait for notification of a C/YP new into care		6 Days	8 days	20 days	

Consent received for new Herefordshire CLA by CLA Health Team	**Q4 2024 -2025**	**Q 1 2025-26**	**Q2 2025-26**	**Q3 2025-26**	
Consent received within 5 working days of becoming a CLA by CLA Health Team	1 (7.14%)	8 (53%)	14 (46.66%)	8 (25.8%)	
Consent received within 6-20 days	12 (85.71%)	7 (46.66%)	15 (50%)	18 (58.06%)	
Consent received over 20 working days	1 (7.14%)	0	1 (3.33%)	1 (3.22%)	
Longest wait for medical consent	87 days	13 days	31 days	28 days	
WVT Capacity to offer IHA – working days from receiving medical consent to first IHA Offer.	**Q4 2024 -2025**	**Q1 2024 -2025**	**Q2 2024 -2025**	**Q3 2024 -2025**	
IHA offered within 20 working days offered Child becoming CLA.	9 (100%)	10 (100%)	13 (65%)	7 (26.92%)	
First IHA offered over 20 Working days from becoming a CLA	0	0	7 (35%)	19 (73.07%)	
Longest wait for first IHA in working days	12	19	49	48	
Number of IHA's due for Herefordshire children living in Herefordshire	**Q4 2024 -2025** 9	**Q 1 2025-26** 10	**Q2 2025-26** 19	**Q3 2025-26** 26	
IHA's completed in Statutory Timescale	7 (77.77%)	5 (50%)	7 (36.84%)	2 (7.69%)	
IHA's completed out of statutory time scales	2 (22.22%)	5 (50%)	12 (63.15%)	24 (92.30%)	
DNA First IHA's	0	1	0	1 (3.84%)	
IHA's Refused	0	0	0	0	

KPI Data at IHA FOR Herefordshire Children living in Herefordshire	Q4 2024-25	Q 1 2025-26	Q 2 2025-26	Q 3 2025-26	
Children registered with a local GP	8 (88.88%)	6 (100%)	4 (100%)	26 (100%)	
Children who have seen a dentist in the last six months	2 (22.22%)	6 (60%)	0	11 (45.8%) 2 children were not eligible under 12months	
Children immunised in line with National Immunisation Programme	3 (33.33%) Data unavailable for 7 children	5 (50%) Data available for 10 children	1 (50%)	6 (23.07%) Data was not available for 9 children.	

Statutory Review Health Assessments for Herefordshire children Living in Herefordshire

RHA for Herefordshire Children living in Herefordshire.	Q4 2024-25	Q 1 2025-26	Q 2 2025-26	Q3 2025-26
Total Number of RHA's due for all Children	91	82	74	85
RHA's due for Herefordshire Children living in Herefordshire	61	63	47	59
RHA's refused	1	3	1	2
Number of Children who ceased being Children Looked After before an RHA was completed	0	0	0	3
Total RHA's completed	60	60	45	52
RHA completed in Statutory Timescale	40 (66.6%)	49 (84.48%)	35 (77.7%)	44 (84.69%)
RHA's for children living in Herefordshire seen but outside of statutory timeframes. Delays were due to the following:	20 (33.66%)	11 (18.37%)	10 (22.2%)	8 (15.38%)
Appointments cancelled due to CLA -Nursing capacity	7 (35%)	0	0	0
RHA's completed out of timescales by the Health Visiting Service	4 (20%)	5 (45.45%)	1 (10%)	0

Was not brought to Health Review	3 (15%)	1	3 (30%)	0
RHA delayed due to a placement move	0	1	0	1
Young Person initially refused then wanted an RHA	1 (5%)	0	0	0
RHA Cancelled by Carer/availability	5 (25%)	4 (36.36%)	6 (60%)	7 (87.5%)
KPI Data at RHA Living in Herefordshire	**Q4** **2024-25**	**Q1** **2025-26**	**Q2** **2025-26**	**Q3** **2025-26**
Children registered with a local GP	60 (100%)	60 (100%)	45 (100%)	49 (100%)
Children who have seen a dentist in the last six months	46 (76.66%)	50 (83.33%)	41 (91%)	44 (93.61%)
Children immunised in line with National Immunisation Programme	54 (90%)	56 (93.33%)	38 (84.4%)	45 (91.83)

Statutory Heath Assessments for Herefordshire Children Living out of area

Statutory Heath Assessments for Herefordshire Children Living out of area	**Q4** **2024-25**	**Q1** **2025-26**	**Q2** **2025-26**	**Q3** **2025-26**
Number of Herefordshire children living Out of County due a statutory heath review.	35	23	36	30
IHA's due	5	4	10	6
IHAs seen in statutory timescales	0	1	2	2
IHA's completed but out of statutory Timescales	5(100%)	3	7	0
Children who ceased being a CLA before IHA was due	0	2	1	0
IHA's refused	0	0	0	0
KPI Data at IHA	**Q4** **2024-25**	**Q 1** **2025-26**	**Q 2** **2025-26**	**Q 3** **2025-26** **Data has not been returned**

Children registered with a local GP	5(100%)	4(100%)	7(77.7%)	xxx
Children who have seen a dentist in the last six months	3 (60%)	2 (50%)	1 (14.28%) 1 child was under 12 months so exempt from KPI	xxx
Children immunised in line with National Immunisation Programme	2 (40%)	4 (100%)	6 (75%) 2 children exempt from KPI Under 8 weeks of age.	
RHA's due for Herefordshire Children living out of area	30	19	27	26
Children living out of area who refused an RHA	1	0	1	0
Children who ceased being Looked After before RHA Completed	0	0	0	0
Total RHA completed and returned	29	19	25	25
RHA's completed in statutory timescales by Host Health Teams	16(55.17%)	6 (54.54%)	17(68%)	16(64%%)
Herefordshire children living out of area seen out of timescales	13(44.82%)	13(68.42%)	8(32%)	9(36%)
KPI Data at RHA	**Q4** **2024-25**	**Q 1** **2025-26**	**Q 2** **2025-26**	**Q 3** **2025-26**
Children registered with a local GP	29(100%)	19(100%)	25(100%)	25(100%)
Children who have seen a dentist in the last six months	21(72.41%)	17(89.47%)	21(84%)	19(76%)
Children immunised in line with National Immunisation Programme	21(72.41%)	14 (7.68%)	20(80%)	18(72%)

Statutory Health Assessments completed for Herefordshire Children Looked After living in Herefordshire

Statutory Assessment activity for CLA living in Herefordshire	**Q 4** **2025-26**	**Q 1** **2025-26**	**Q2** **2025-26**	**Q3** **2025-26**
Total assessments completed	83	100	113	114
IHA's for Herefordshire Children	6	9	26	25
IHA's completed for other local authorities	5	10	14	16
RHA's for Herefordshire Children	60	60	45	52
RHA's completed for other local authorities	19	23	28	21

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	Patient Experience Quarterly Report (Q1) 2026-27
Lead Executive Director:	**Chief Nursing Officer**
Author:	Associate Director of Quality Governance
Reporting Route:	Quality Committee – July 2026
Enclosures included with this report:	Appendix 1 – Patient Engagement Forum Annual Review Interpreting Service report – circulated to Board for information
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**

Brief Description of Report Purpose

The paper presents the Q1 update on patient experience and engagement services.

Recommended Actions required by Board or Committee

Board is asked to note the following;

- Patient experience remains a core component of the Trust's quality governance framework, with continued focus on responding effectively to patient feedback and improving services.
- The Trust has successfully implemented a new Friends and Family Test (FFT) platform, expanding opportunities for patients to provide feedback through multiple channels, including SMS, QR codes and online surveys.
- New complaints decreased by 25% in Quarter 1 compared with the same period in 2025/26, demonstrating a positive trend in patient experience and complaint management.
- The number of reopened complaints (comebacks) reduced by 31% compared with Quarter 1 last year, suggesting improvements in the quality and completeness of complaint responses.
- The overall position for open complaints has improved significantly since Quarter 4, reflecting sustained divisional focus on complaint management and timely responses.
- Communication remains a key theme within patient feedback, although complaints where communication is the primary issue have reduced during this quarter.
- Early indications suggest that increased use of concerns and informal resolution processes may be reducing the need for formal complaint investigations.
- The Trust remains committed to strengthening patient involvement in service design and quality improvement through increased engagement, co-design and co-production opportunities.
- Patient feedback has directly informed service improvements, including enhancements to patient information, signage, waiting areas and clinical pathways.

Executive Director Opinion[1]
The reducing number of complaints, timeliness of responses and completeness of responses is pleasing to note. The quality of responses has certainly improved during recent months. A focus on early resolution and communication must continue to be a focus. It was a pleasure to read the annual review of the patient engagement forum and demonstrates how meaningful engagement can lead to service change and improvement. We are eternally thankful to those patient representatives who offer their time to support this important agenda.

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

Patient Experience Report- July 2026 (Q1 2026-27)

Introduction

The report provides an update on patient experience and engagement, key metrics and areas of improvement.

Headlines

- Patient experience remains a core component of the Trust's quality governance framework, with continued focus on responding effectively to patient feedback and improving services.
- The Trust has successfully implemented a new Friends and Family Test (FFT) platform, expanding opportunities for patients to provide feedback through multiple channels, including SMS, QR codes and online surveys.
- New complaints decreased by 25% in Quarter 1 compared with the same period in 2025/26, demonstrating a positive trend in patient experience and complaint management.
- The number of reopened complaints (comebacks) reduced by 31% compared with Quarter 1 last year, suggesting improvements in the quality and completeness of complaint responses.
- The overall position for open complaints has improved significantly since Quarter 4, reflecting sustained divisional focus on complaint management and timely responses.
- Communication remains a key theme within patient feedback, although complaints where communication is the primary issue have reduced during this quarter.
  Early indications suggest that increased use of concerns and informal resolution processes may be reducing the need for formal complaint investigations.
- The Trust remains committed to strengthening patient involvement in service design and quality improvement through increased engagement, co-design and co-production opportunities.
- Patient feedback has directly informed service improvements, including enhancements to patient information, signage, waiting areas and clinical pathways.

Improve responsiveness to patient experience data

Patient experience and our response to patient feedback remains a core part of our Quality and Safety agenda, and is a key pillar of governance. Whilst we do not have the additional focus of a quality priority this year, this report will continue to provide assurance using the following metrics;

- FFT feedback and use to generate improvement to services
- Improvement in national patient survey results
- Evidence use of survey feedback to generate improvement (projects/ case studies)
- Reduction in complaints and concerns
- Improved response times to complaints and concerns
- Reduction in overdue responses to complaints and concerns
- Reduction in comebacks or re-opened complaints
- Implement the PHSO model complaints framework/ standards.
- Expand ability to leave feedback through improvement of the FFT system.

In addition, the report will focus on improving patient experience through engagement;

- Expand and improve patient engagement in service and quality improvement
- Expand and innovate our volunteer roles

Friends and Family Test (FFT)

One of the fundamental principles underpinning of the FFT is 'all patients and people who use services have the right to provide anonymous feedback quickly and easily, when they want to'.

The Trust has been using a text messaging service to receive feedback in line with the national Friends and Family test programme since October 2023.

In 2024-2025 the Trust expanded the breadth of the FFT system to capture all our services, and refreshed the reporting structure to ensure the data was seen by the right people at the right time, to use the feedback for meaningful improvement. This expanded service went live in July 2025 with data reported to Quality committee quarterly.

In October 2025 the Trust were given notice that our current provider was terminating their FFT service provision and we would need to procure a new provider by 31st March 2026. This was time pressured but achieved, with the Trust moving to 'I Want Great Care' (IWGC), a service used by GEH.

IWGC are able to provide multiple methods for leaving feedback. In addition to our text messaging service, there will be QR codes and link to service specific surveys on our website

In Q1 the focus of the Quality team was to build the new system with IWGC and roll out training to staff on the new reporting system. The new system went live in two stages in June 2026 and was fully live by end of Q1. Therefore there was no data collected in Q1 to report. The next report will include all data from 'go live' to end of quarter 2.

Complaints

This section of the report provides;

- Performance data update Q1 and trends
- Analysis of complaints position by Division
- PHSO cases update

Complaints position

(New complaints only)

KPI	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Q1	Total Q2	Total Q3	Total Q4	Total Apr-Mar (inc)
Number of complaints **2025/26**	36	48	30	34	27	35	30	40	33	24	28	27	114 ↑6.5%	96 ↑17%	103 ↑3%	79 ↓19%	392 ↑2%
Number of complaints **2026/27**	30	27	28										85 ↓25%				

A comparison of data between Q1 in 2025/26 and Q1 2026/27 shows ***an overall decrease of 25%*** in new complaints received in the same period.

Version 1 17/11/25

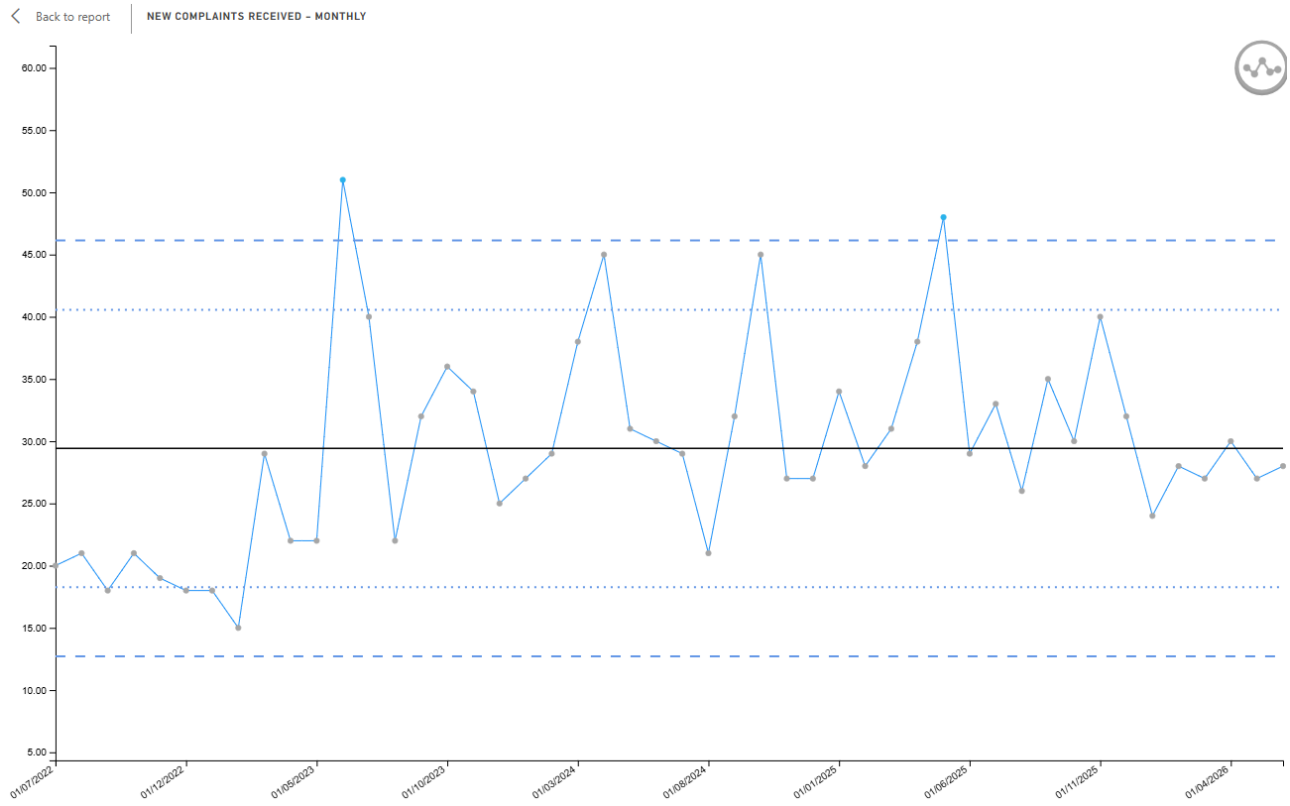
Q1 new complaints received by Division:

Open Complaint position by Directorate (as of 7th July 2026)

Surgical Division and Women and Children's directorate have the most open complaints.

Weekly reports are sent to Divisions by the Complaints team outlining all open complaints, highlighting those that are overdue or nearing the response deadline and requesting action as appropriate.

Trends since April 2023 shows new complaint numbers remain static and within control limits, with recurring peaks in April/May and October each year. Previous analysis of these spikes shows no predictable themes, with a number of complaints received in these peaks related to historic events. The predicted spike in complaints for April 2026 has not been significant.



Complaint response times

The chart below highlights the current number of complaints open over 30 days by division. These figures will include any complaints where an agreed timeframe has been applied. The position has improved significantly from Q4 reflecting a sustained focus on complaint management by the Divisions.

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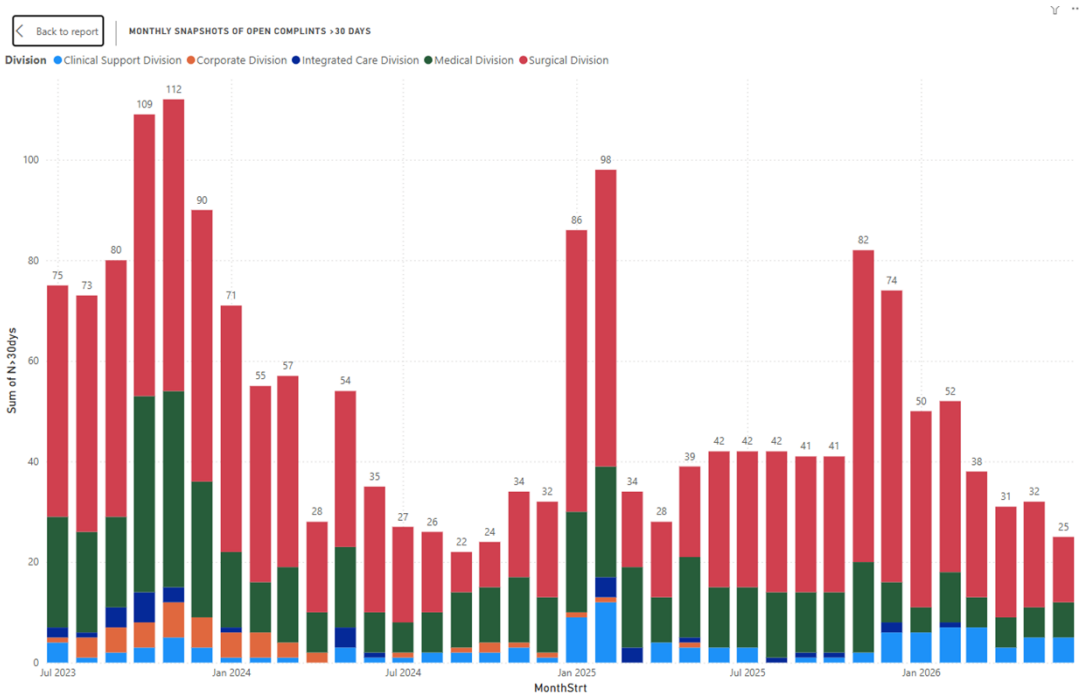
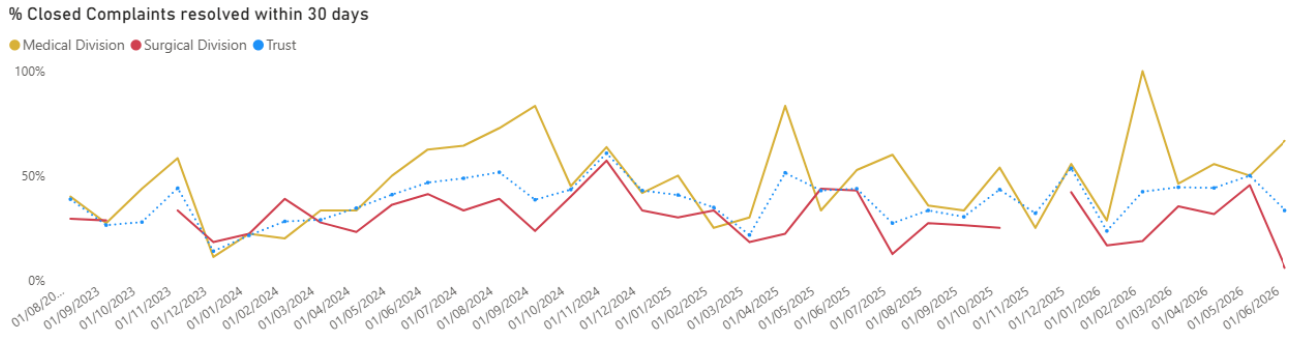
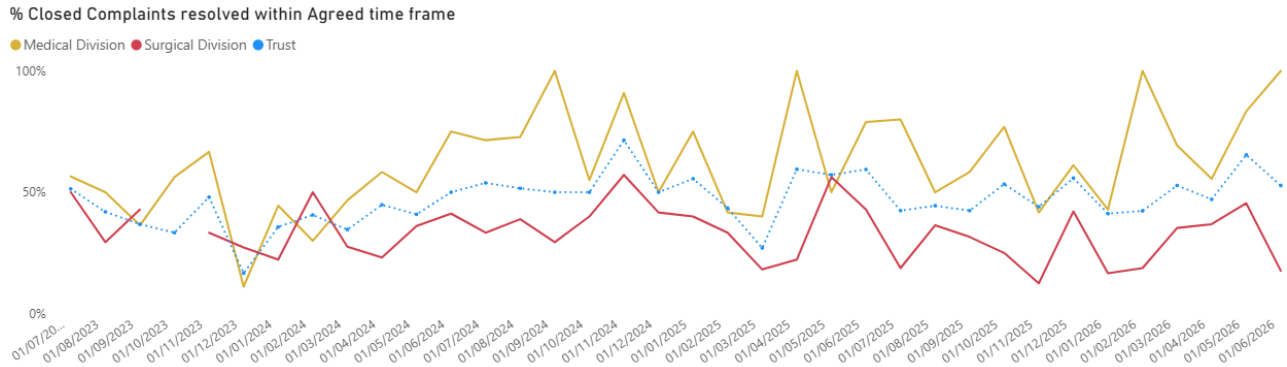


When reviewing the stage of current complaints open for more than 30 days, the majority are with the investigating officers to complete responses.

The chart below shows the percentage of complaints being resolved within the 30-day timeframe (rolling 3-month total). Clinical Support and Integrated Care Divisions excluded due to very small numbers. However, it should be noted that the number of overdue complaints in Clinical Support has increased, despite overall numbers not increasing.



Often complaints are complex in nature and require multiple services to input into the investigation and response. Where this is the case, early engagement with the complainant should be undertaken to agree a timeframe for the response to be provided. The chart below highlights performance for these cases where a timeframe is agreed that is perhaps greater than our specified 30-day target.



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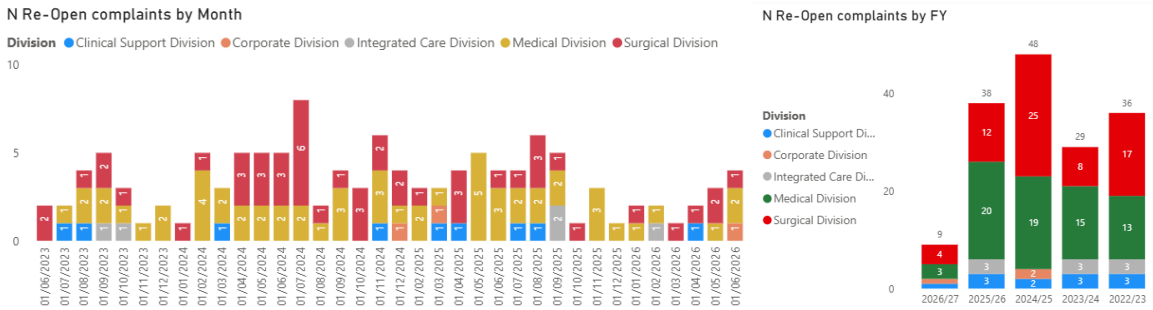
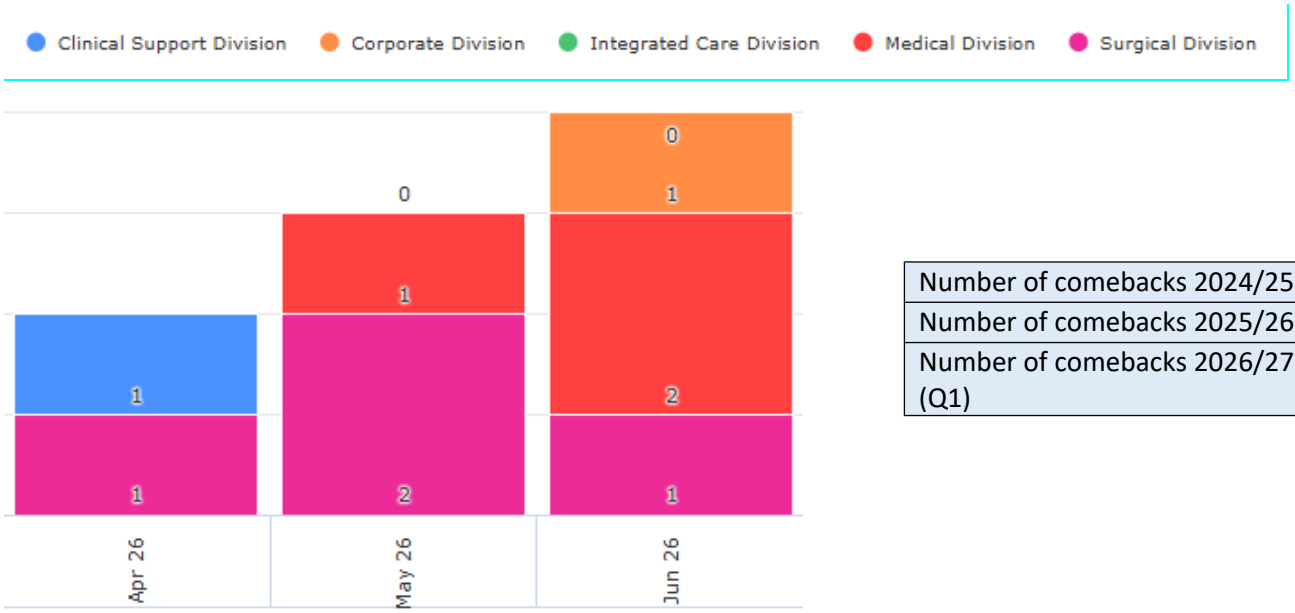
Dissatisfied with the original response (Comebacks)

When also considering the number of complaints that are reopened ('comebacks') that Divisions also need to respond to, this increases the total number of complaint responses required. The number of comebacks has reduced in 2025/26 by 21% (10) to 38. In Q1 there have been 9 comebacks compared to 13 in Q1 last year, a reduction of 31%.



Analysis shows that timely responses, improved accuracy and ensuring all questions asked are responded to supports a reduction in comebacks.

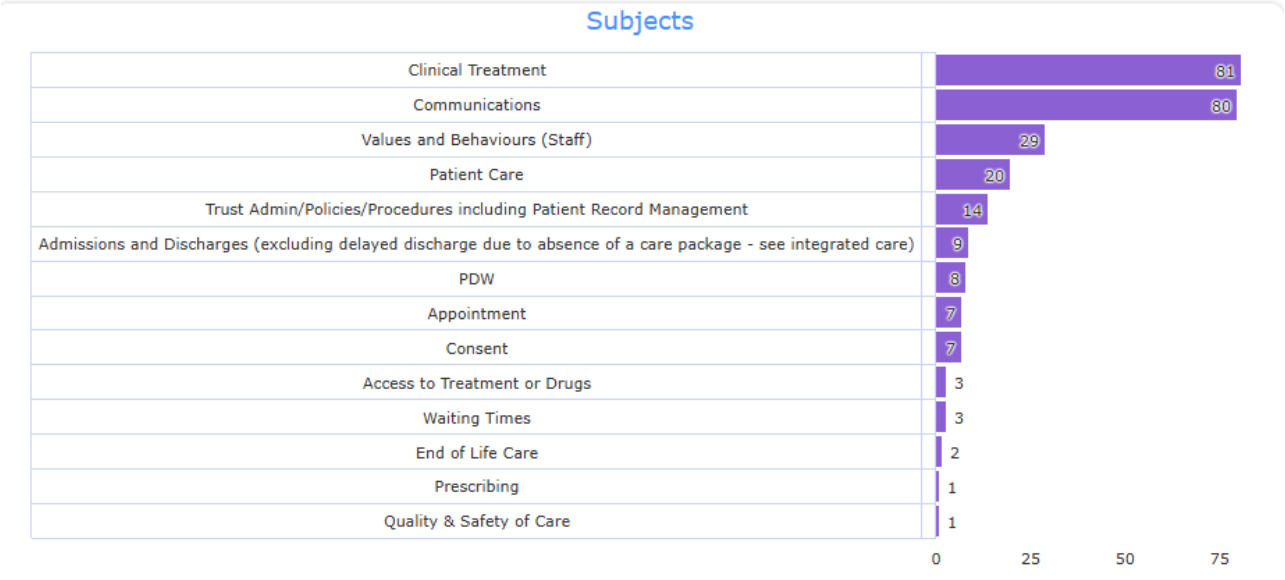


Number of comebacks 2024/25	51
Number of comebacks 2025/26	37
Number of comebacks 2026/27 (Q1)	9

Complaint categories

There can be multiple categories and subcategories identified in a complaint. These are analysed and recorded in a triage process by the complaints team based on the complainant's perception of the events, so reflect the patient/relative's experience.

The below chart shows the complaint categories for Q1. Communication has historically been the top complaint category. This quarter has seen this drop with Communication and Clinical Treatment being nearly equal in ranking collectively making over 60% of recorded subjects.



Parliamentary and Health Service Ombudsman (PHSO) update

Calendar Year	PHSO cases
2021	5
2022	1
2023	2
2024	6
2025	8
2026 (to date)	2

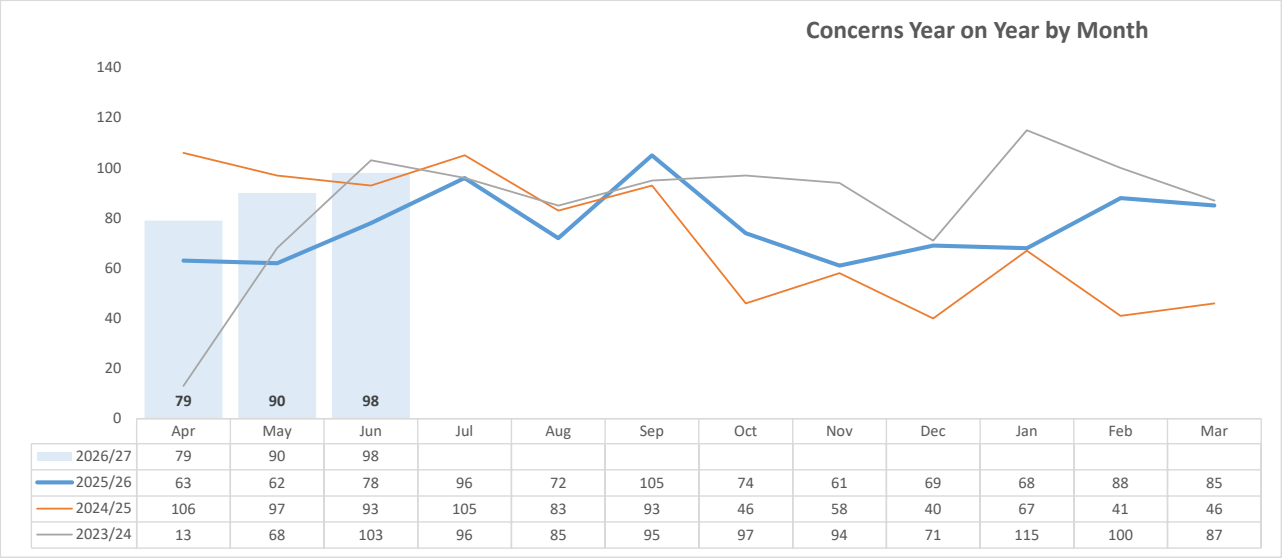
In some cases, the PHSO are now recommending financial remedy based on a severity of injustice scale. The premise is that this may reduce future litigation and claims, though claims can still be made. It is too early to determine if this has had an effect and analysis would likely need to be on a regional/national scale to determine impact.

There are currently 2 complaints over 6 months old, which breaches the statutory timeframes and work is ongoing with the Divisions to progress.

Data on overdue complaints, stage of the complaints and highlighting any over 6 months is now being submitted for review at divisional performance meetings for increased oversight.

Concerns

The chart below provides a month-by-month breakdown with comparative data from previous years and numbers of concerns received in Q1 2026-27. Overall numbers are similar comparatively each month over the previous 3 years. There are a small number of anomalies where numbers of concerns appear lower (eg. April 2023). These are attributed to staffing issues and change in system.



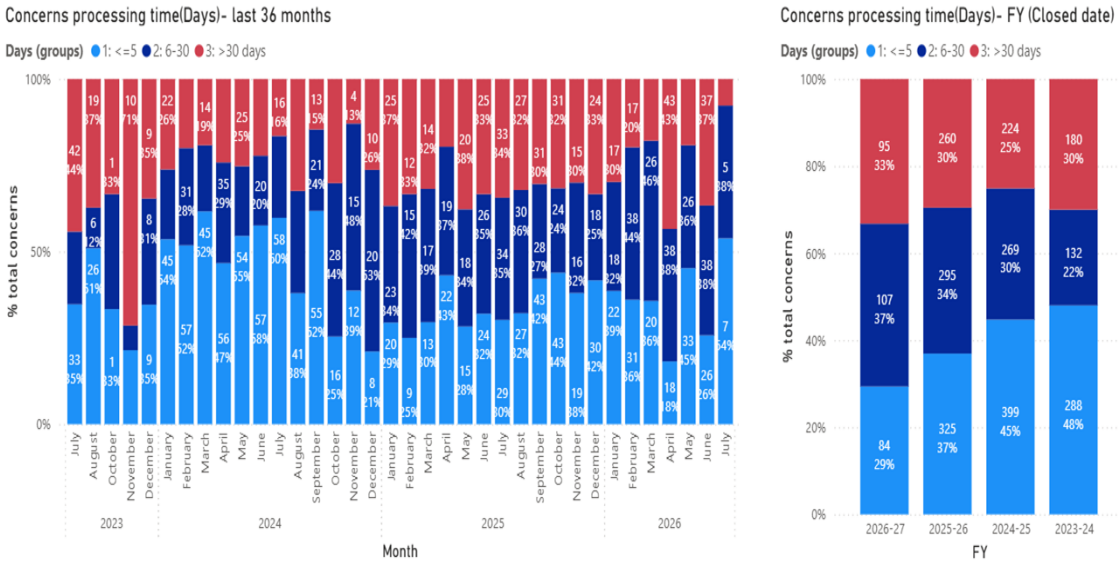
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	79	90	98									
2025/26	63	62	78	96	72	105	74	61	69	68	88	85
2024/25	106	97	93	105	83	93	46	58	40	67	41	46
2023/24	13	68	103	96	85	95	97	94	71	115	100	87

Complaint numbers during the Q1 period have decreased. This may represent a drive to increase opportunities for early resolution as part of the implementation of the PSHO Model Guidance for Complaint Handling. Therefore, an increase in concerns might indicate that patient feedback is being acted upon without the need for a full complaint investigation (with consent of the patient) and could be an early sign that the model guidance is embedding. The team will continue to monitor this.

In addition PALS logged 263 enquiries in Q1, a significant increase on the previous quarter. The largest number of concerns, comments and enquiries continue to be logged for Surgical and Medical divisions, with the most commonly reported subject relating to communication, with appointments now the second most common theme.

Concern response times

The internally agreed timeframe for responding to a concern is 5 working days. The chart below breaksdown concern response times into three categories; 5 days, 6-30 days and beyond 30 days.



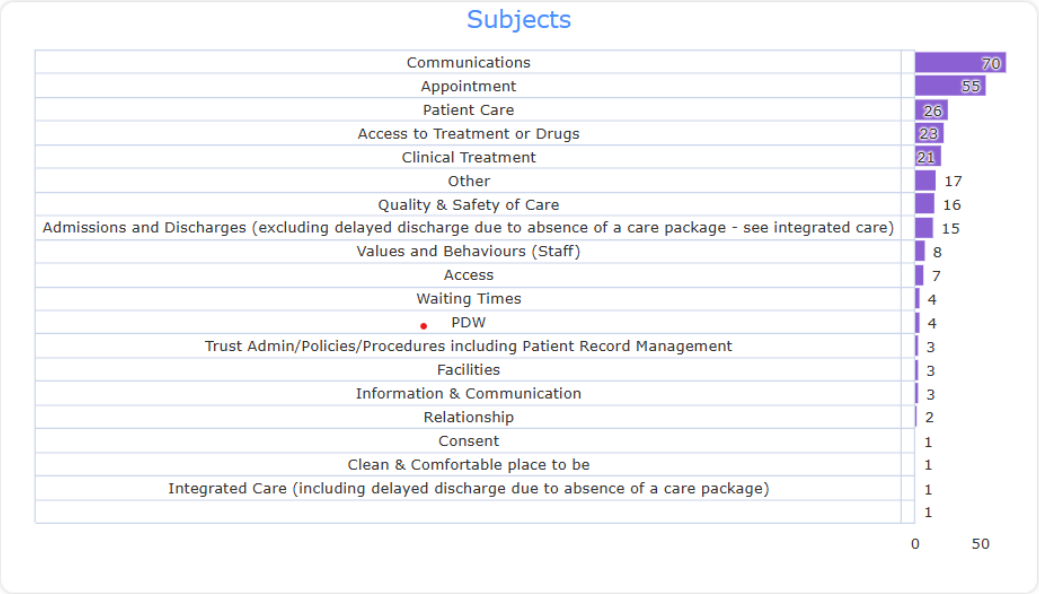
Numbers of concerns open between 6-30 days and also beyond 30 days both saw an increase this quarter, particularly in April and June.

Work with governance leads, matrons and managers is ongoing to support the handling of concerns with a particular focus on, assigning the concern handler correctly first time, monitor action taken, and

understand themes. These processes are under continual review, comparing current and historic levels of concerns and timeframes for resolution in order to assess the most efficient process, aiming to bring the Trust's average time to resolve concerns closer to the five working day goal.

Concern categories

The chart below idemonstrates the subjects of concerns based on main category.



Patient Surveys

- National Inpatient survey results are due for publication in August 2026. Results will be presented to the Committee in September 2026.
- National Maternity survey will be closing on 17 July 2026 with results expected to be published in Autumn 2026.
- Urgent and Emergency Care survey fieldwork ongoing with publication due later this year.
- Children & Young People Survey fieldwork to run from July to October 2026 with results expected to be published March 2027.

Patient Engagement

Interpreting service

The Trust Interpreting Service is managed by the PALS team. Last year, the Trust changed remote interpreting provider to increase use of remote interpreting and improve appropriate use of face-to-face interpreting. Prior to this, use of face-to-face interpreting was creating a significant overspend, with costs double to the budget. The previous remote service provider was unreliable and limited to telephone which increased the need for face-to-face interpreting.

The new provider (Word360) has both on demand and pre-book options for telephone and video interpreting. With improved oversight and scrutiny of face-to-face interpreting requests the Trust were able to reduce costs to within budget and realise a saving. The policy was updated to outline the 'remote first' approach and sets out criteria for face-to-face interpreting in scenarios where remote interpreting is not the best option for the patient and the clinician.

A report is presented quarterly to Patient Experience Committee providing an overview of the remote service provision. The report has been circulated to Board for information and was considered in full at Quality Committee in July.

Overall engagement with the service has increased quarter on quarter since implementation last year. Staff work closely with the team to ensure the right interpreting provision is provided to ensure patient engagement is effective when receiving clinical care.

Voluntary services

Last year the Trust had an objective and a quality priority focusing on the increased use of volunteers and role innovation, work continues to build on the achievements seen in 2025-26. The service reports quarterly to Patient Experience Committee.

Q1 Headlines

- 97 volunteers gave their time during Q1, and this is consistent with the previous quarter.
- Following a drop in volunteers in Q2 and Q3 last year, volunteer numbers have now returned to the level of Q1 (2025/26).
- This quarter, volunteer hours have increased by 1000 hours on the previous quarter, and overall significantly above the average quarterly hours for the last year. There have been marginal increases across the 4 key placement areas – Pharmacy, Meet & Greet, ED and Wards, and a significant increase for Hereford Hospital Radio (HHR). This is due to a development drive within the HHR team.
- There are 12 volunteer roles at the County site and 5 across the community sites. There is 1 new role in development which is gardening at the County site.

In Q2 there will be a focus on increasing volunteers in our Community Hospitals and confirming arrangements for volunteer gardeners at the County site. Role innovation remains a priority and working with staff to seek opportunities for volunteers to improve the patient experience across our services.

Volunteer training is under review with NHS England changing the provision of e-learning. The Trust is reviewing the current training matrix and how we can ensure volunteers still receive the correct level of training, for their role.

Patient Engagement Forum

The patient engagement forum continues to meet monthly with an increasing number of staff bringing projects to the group for input and support. During Q1 areas work that have been supported included:

- Co-produced Anaesthetic surgical follow up project continued in Q1. The poster for this project was shortlisted in WVT poster competition and accepted for presentation at a conference in Prague.
- Provided feedback on reception area developments including plans to introduce kiosks
- Provided feedback and suggestions for improvements to letter templates
- Provided feedback and suggestions for improvement on a number of patient information developments including; a follow up letter for NIV equipment return from bereaved families and a neuro OT leaflet for carers
- Provided feedback on a colposcopy and health inequalities project and questionnaire
- Raised concerns about and suggestions for improvements in relation to issues of wheelchair provision and seating provision for turning circle
- Raised concerns about signage, with one volunteer joining PFI partners on a walkabout to review signage

Positive change based on feedback:

- Benches are now in place under the turning circle canopy for those awaiting collection and have received much positive feedback

A summary of the forum's activity for 2025-26 is included in appendix 1.

Plans for the year ahead include increasing engagement through focus groups to support improvement projects and scoping how patients can be more involved in co-design and co-production.

Patient Feedback Initiated Improvement Activity

Patient Experience Committee now meets quarterly, with divisions presenting a quarterly report on patient feedback and resulting improvement initiatives.

Integrated Care

The division are increasing patient engagement through the Parent Carer Voice with regular SEND engagement sessions and close working with PCV and Herefordshire council in relation to the national SEND Reforms.

Medicine

Learning and actions taken from patient feedback include;

- Information Governance Training
- Improving Management of Cardiac Patients
- Nursing education for triage and pain management
- Feedback Friday – patient privacy & dignity
- Education – Patient property & importance of checklist completion

Surgery

Following a complaint in paediatrics, information on the Chaperoning Policy was provided trust wide through Safety Brief. The Chaperone Policy has recently been updated and approved in July 2026.

Conclusion

When reviewing the data against our measures we are seeing progress and improvement in a number of areas. Where measures are not progressing mitigations are highlighted.

Measure	Update November 2026	Update March 2026	Update July 2026
Evidence use of FFT feedback to generate improvement (projects/ case studies)	FFT service running again from 1st July 2025. Some evidence of data reviewed and reported at divisional level, no clear evidence of improvement projects. A number of services were new to the FFT system and may take some time to embed use of the feedback.	Response rate has consistently declined since full roll out, however overall feedback is positive. Move to new system is an opportunity to seek to increase response rate.	System go live in June 2026. No data to report for Q1.
Improvement in national patient survey results	Improvement seen in key areas in both inpatient and maternity surveys, in particular in relation to communication with patients.	No new results to report.	No new results to report.
Evidence use of survey feedback to generate	Continued work on feedback in relation to nutrition as	No new results to report.	No new results to report

improvement (projects/ case studies)	reported through quality priority. No new projects yet identified.		
Reduction in complaints and concerns	Both continue to increase, however concerns are not increasing at the same rate as previous years at time of reporting (Q2).	Complaints increasing for Q3 but anticipate lower figure for Q4.	Q1 saw a 25% reduction in complaints compared to the previous quarter. Concerns increasing however could be indicative of early resolution embedding and a positive indicator.
Improved response times to complaints and concerns	Response times to concerns is improving, however significant reduction in timeliness of response to complaints. At year end it was 50% of complaints, currently 30-40% of complaints.	Improved oversight of complaint response times through weekly reporting to divisions and scrutiny at F&PE.	
Reduction in overdue responses to complaints and concerns.	Increase in numbers of overdue complaints and a number of cases breaching the 6 month statutory timeframe. Concerns show some improvement however a proportion remain open after 30 days when should be closed in 5 days.	Improved oversight of complaint response times through weekly reporting to divisions and scrutiny at F&PE.	
Reduction in comebacks or re-opened cases.	Comebacks continue to increase.	Comeback numbers significantly reduced compared to previous years.	Comebacks continued to reduce in Q1.
Increased patient engagement and collaboration on improvement projects	Patient Engagement Group continues to thrive and support a number of projects.	Patient Engagement Group continues to thrive and support a number of projects.	Patient Engagement Group continues to thrive and support a number of projects. One project shortlisted in WVT poster competition and to be presented at a conference in Prague.

Patient Engagement Forum- Annual Summary

This year has been a genuinely positive and productive period for patient representation within the Patient Engagement Forum (PEF). One of our most significant achievements was the long-awaited review of the Patient Engagement Charter. After months of conversation, edits, reflection, and a fair bit of back-and-forth, we now have a charter that truly reflects who we are and what we value. It feels meaningful, practical, and ready to help welcome new members into the group as we continue to grow. Alongside this work, we've had ongoing discussions about how we can widen our reach into the community. Ideas have ranged from rethinking our recruitment approach to creating a short video that highlights our achievements and gives a clearer sense of the projects we're involved in. These early conversations have laid the groundwork for what we hope will be a much stronger recruitment drive in the coming year.

Practical involvement has been just as strong. Several of our members took part once again in PLACE, bringing an honest and grounded patient perspective to the assessment of hospital environments. Within our meetings, our AOB section continued to prove invaluable. What starts as a quick two-minute point often turns into the kind of thoughtful discussion that shapes future agendas. It's one of the things that defines this group: people noticing details, speaking up, and genuinely wanting to make things better.

We also spent considerable time this year focused on the patient portal and its value to the wider population. Two of our patient reps supported a stand at the hospital, talking directly with patients and families about how the portal can improve access to information and services. Their presence created a more approachable atmosphere for people who might not otherwise have felt comfortable asking questions. The feedback and engagement from the public were encouraging, and it highlighted just how effective patient-to-patient conversations can be in supporting digital developments.

In terms of technology, we also heard from the AI Steering Group, who demonstrated Heidi and gave us some space to raise concerns. The discussions were not always easy, but it remained important for us to be included in these conversations and to offer the perspective of those who will ultimately be using these systems. Even where the dialogue was challenging, it reinforced why patient involvement in digital transformation is necessary rather than optional.

Some of the most inspiring contributions this year came from our regular clinical guests. Dr Richard Gilpin has once again been a real champion of patient involvement in geriatric care. His team invited us to provide structured feedback on their service, and a smaller subgroup of our members worked to prepare a thoughtful presentation, which was very well received. The positive response has led to further requests for input across a few smaller projects, and Dr Gilpin continues to be one of our strongest advocates for co-production. Similarly, Dr Edward Bick has been working closely with the group on a new approach to collecting follow-up feedback in anaesthetic care. Together with one of our patient reps, he has developed a script and concept influenced by the Trust's contact-centre model. This pilot will run over the coming months, with the potential to expand if successful. It has been

refreshing to see clinicians not only asking for feedback but actively co-designing the methods to gather it.

We also saw several physical improvements around the Trust this year, and it would be impossible not to mention the beautiful new mural outside MRU. It has been widely admired and serves as a wonderful reminder of how art can soften clinical spaces and create moments of comfort or connection for those passing through.

Signage and wayfinding have long been recurring themes within our group, and this year brought a meaningful step forward. A patient representative who volunteers onsite most days, participated in a walkabout, in collaboration with Sodexo, to identify signage issues for review, thus providing day-to-day, practical insight into where people get lost, what causes confusion, and how real-world use differs from what is planned on paper. Their involvement has already proven valuable, and we've begun to explore the idea of developing wayfinding solutions that look beyond the main front-of-house areas and instead consider the hospital as a whole. This is a conversation with a lot of potential, and we hope it will continue to grow next year.

Another notable moment this year was having a patient rep sit on interview panels for the PALS team. Given the nature of the department, which works so closely with service users, having a lived-experience voice involved in recruitment was incredibly important. It also highlighted how patient perspectives can be unintentionally overlooked in busy departments where processes are well-established. Looking ahead, we hope to develop a trained subgroup of PEF members who can support interviews more regularly. By creating a simple sign-up system, we could ensure that patient involvement becomes a consistent element in recruitment where it makes a meaningful difference.

As we look towards next year, one message stands out clearly: we need to expand our membership. It is encouraging that conversations are already taking place with the Communications team, and we are lucky to have John Burnett, Comms manager, as a regular member helping us explore new approaches. Recruitment isn't simply about increasing numbers; it's about ensuring that our group reflects the diversity of experiences within the communities the Trust serves. More people, more perspectives, and more voices will only strengthen what the PEF can offer.

What continues to make the PEF special is its mix of staff, patient reps, volunteers, and community partners, all united by the shared goal of improving the Trust. It is a thoughtful, honest, sometimes lively group — and that's exactly what makes it work. We challenge, question, notice, support, and collaborate. Most importantly, we keep patient experience at the centre of every discussion. This year has demonstrated once again how powerful that can be, and how much more we are capable of as our group continues to grow.

Written by Patient Representative and approved by PEF

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	**Public Board**
Date of Meeting:	**3rd September 2026**
Title of Report:	Infection Prevention and Control Annual Report 2025-26
Lead Executive Director:	**Chief nursing officer/Director of Infection prevention and control**
Author:	Lead nurse for Infection prevention and control
Reporting Route:	Quality Committee – July 2026
Enclosures included with this report:	
Purpose of report:	☒ **Assurance** ☐ **Approval** ☐ **Information**
Brief Description of Report Purpose	
To present the Trust Infection Prevention and Control Annual Report	
Recommended Actions required by Board or Committee	
To **receive** and **approve** the annual report	
Executive Director Opinion[1]	
The Trust Infection prevention and control annual report has been reviewed at Trust Infection Prevention Committee and at Quality Committee, additionally the Quality Committee review and receive a quarterly infection prevention report focussing on key performance metrics. The report demonstrates how the Trust complies with the Health and Social Care Act code of Practice for Infection Control. The report includes our performance against those performance indicators as set out in the NHS standard contract. Where performance is off trajectory the report covers actions being taken. The infection prevention improvement plan is specifically focussed on improving performance and practice.	

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

NHS
Wye Valley
NHS Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2025/26

CONTENTS

EXECUTIVE SUMMARY

The Wye Valley NHS Trust (WVT) Infection Prevention and Control (IPC) annual report details the key clinical initiatives, governance activities, and safety outcomes from 1 April 2025 to 31 March 2026.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to improve the health and wellbeing of the people we serve in Herefordshire and the surrounding areas. The Quality Committee continued to scrutinise our infection prevention performance at quarterly intervals on behalf of the Board throughout 2025-26.

SECTION 1: KEY OUTCOMES OF 2025-26

- The Trust reported three Trust attributed Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias during the year 2025/26 against a threshold of zero.
- Seventy-three patients were identified with a Gram-negative blood stream infection (GNBSI). This included 46 Escherichia coli (E. coli) GNBSI, 21 Klebsiella species (Klebsiella spp.) GNBSI and 6 patients with a Pseudomonas *aeruginosa* (pseudomonas spp) GNBSI.
- Sixteen of the reported GNBSI were linked to the presence of an indwelling device. Areas of learning predominantly related to the completion of device documentation.
- The Trust reported 45 cases of hospital attributable *Clostridioides difficile* infection (CDI) against an NHS England set trajectory of no more than 38. Post infection reviews identified that 30 of these cases had learning opportunities
- There were 109 patients who were deemed to have probable or definite hospital onset COVID-19 infection.
- There were 58 infection outbreaks reported during the year. This included 17 outbreaks due to COVID-19, 29 due to Norovirus infection, 11 outbreaks of Influenza and 1 due to the bacteria Carbapenemase producing Enterobacteriaceae (CPE)
- The mean compliance score for hand hygiene practice was recorded as 96% and 99% for BBE compliance.

SECTION 2: INTRODUCTION

All NHS Trusts have a legal obligation under the Health and Social Care Act 2012 to produce an annual report and make this available to the public. It is essential for

demonstrating robust governance, alignment with Trust values, and public accountability. Its primary purpose is to assure that the Trust maintains high standards of compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance, last updated in December 2022. Accordingly, this annual report is structured around the ten compliance criteria outlined in the Code of Practice.

These criteria are used by the Care Quality Commission to judge a registered provider against the IPC requirements detailed in the legislation. It looks at all aspects of IPC, including monitoring and surveillance, environment, cleaning, staff, policies and laboratory provision.

Criterion Compliance	What the registered provider will need to demonstrate
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Criterion 4	Provide suitable accurate information on infections to service users and their visitors & any person concerned with providing further support or nursing/medical care in a timely fashion.
Criterion 5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide secure adequate isolation facilities.
Criterion 8	Secure adequate laboratory support as appropriate.
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Ensure, as far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

The Trust supports the principles that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection must be in place within the Trust.

The report sets out our priorities and plans to achieve further improvement and reductions in infection during 2026/27 as we continue to manage and move beyond the challenge of winter pressures.

WVT provides both acute and community healthcare services, including neighbourhood teams, maternity and children's services for Herefordshire. Acute and general services are provided from the Hereford County Hospital Site with 304 inpatient beds across 15 wards and departments. Community inpatient care is provided in three community hospitals Ross, Bromyard and Leominster with a core bed base of 76 beds.

The Hereford County Hospital site is a private finance initiative (PFI) site, and the NHS Trust partners are Mercia Healthcare and Sodexo. Estates and facilities services are provided in house at the community sites.

The term Infection Prevention Service is a collective term used throughout the report and includes the Infection Control Doctor and the IPC nursing team.

A list of abbreviations used throughout this report can be found in Appendix 1.

SECTION 3: COMPLIANCE

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

3.1 Infection Prevention Service & structure

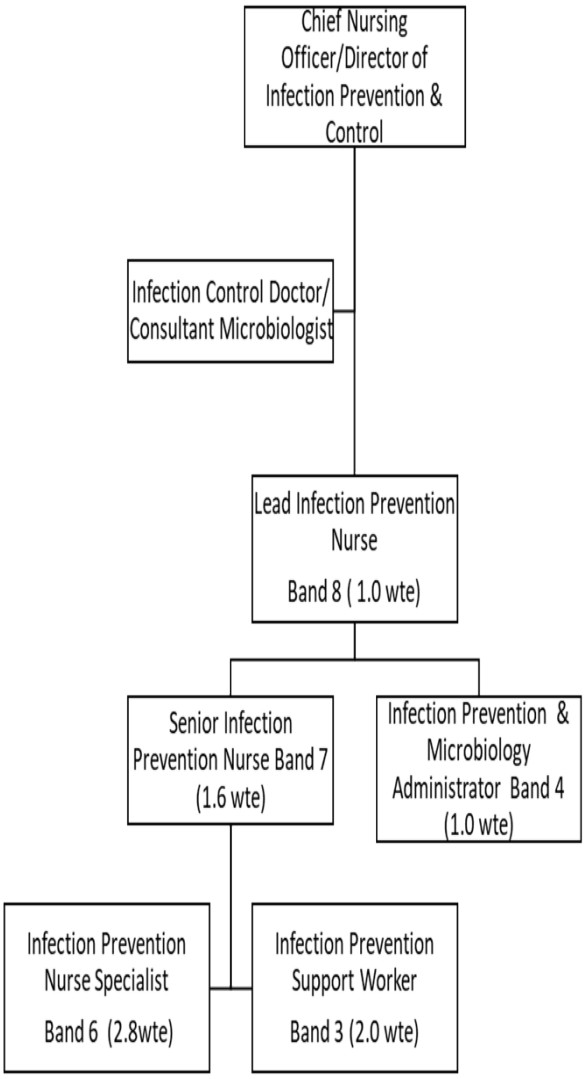
The Infection Prevention Service provide IPC advice and support to wards and departments. The IPC nursing service is provided five days a week between 07:00-17:00 between April to September; this increases to a seven-day week between October and March with weekend cover 08:00- 16:00. Out of hours Microbiologist cover is provided by the on-call Consultant Microbiologists from Hereford and Worcester.

The Chief Nursing Officer also holds the role of Director of Infection Prevention & Control (DIPC) and has overall responsibility for infection prevention and control.

A Consultant Microbiologist holds the role of Infection Control Doctor. This post is for 4 programmed activities. The role is supported by the Consultant Microbiologist team in their absence.

The approach to IPC across the organisation is based on a collaborative model across all Divisions, professions and with partner organisations with a clear focus on safety thus protecting patients, visitors and staff. The IPC nursing team remain in the corporate division directly line managed by the Chief Nursing Officer. Nursing team members have been allocated to each division to support infection prevention practice and governance within those divisions.

To ensure that IPC is at the forefront of divisional governance, information is disseminated to the Divisions via monthly infection prevention reports.



The IPC service continued to support frontline staff and prioritise urgent IPC issues during the waves of respiratory illnesses including influenza, resurgence in infections such as pertussis and during winter pressures. Any priorities that were not completed throughout the year have been reviewed and added to the Infection Prevention 2026/27 annual priorities plan as appropriate.

Changes to the IPC nursing team workforce throughout 2025/26 included the reduction in Infection Prevention & Microbiology administration whole time equivalent from 1.0 to 0.4. This has allowed the review of the team structure in 2026/27.

Any priorities that were not completed on this year's schedule have been added to 2026/27 schedules.

3.2 Committee structures and assurance processes

3.2.1 Trust board

The Code of practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive has overall responsibility for the control of infection at the Trust; the Trust designated DIPC is undertaken by the Chief Nursing Officer. The DIPC attends Trust Board meetings with detailed updates on IPC matters.

3.2.2 Quality committee

The Quality Committee is a sub- committee of the Trust Board and has overarching responsibility for managing organisational quality risks. This committee reviews high level infection prevention key performance data monthly and a detailed report is presented to the committee by the Lead Infection Prevention Nurse quarterly. This report outlines the Trust's compliance with statutory obligations and work streams, providing board assurance. The Chief Nursing Officer is a member of the Quality Committee.

3.2.3 Trust Infection Prevention & Control committee

The Trust Infection Prevention & Control Committee (TIPCC) is chaired by the DIPC and in their absence, by the Infection Control Doctor. The sub-committees of the Infection Prevention Committee are:

- Decontamination Committee
- Cleanliness Committee
- Water Management Group
- Ventilation Committee
- Surgical Site infection surveillance group
- Antimicrobial stewardship

TIPCC then reports directly to the Quality Committee.

3.2.4 Other meetings and committees attended by members of the Infection Prevention Service are as follows:

- Post infection reviews with appropriate clinical staff and colleagues from the Herefordshire and Worcestershire Integrated Care System (H&W ICS)
- Capital planning and equipment committee (CPEC)
- Health and Safety committee

- Estates and Facilities Performance meetings for acute and community
- Estates Projects and Operational meetings
- Countywide healthcare associated infection related forums chaired by H&W ICS
- Countywide *Clostridioides difficile infection* reduction forum chaired by H&W ICS
- Countywide Antimicrobial Stewardship forum chaired by H&W ICS
- New build and re-design meetings
- Incident meetings as they arise
- Infection Prevention service meetings
- Joint cleanliness monitoring with WVT and the private finance initiative partner.
- Patient Experience Forum & Committee
- Patient led assessment of the care environment (PLACE)

3.2.5 Antimicrobial Management Group

The Trust has an Antibiotic Stewardship Team consisting of an Antimicrobial Pharmacist and the Antimicrobial Stewardship lead / Associate Specialist in Microbiology. The group meets monthly and produce a quarterly report on antibiotic use and audit results which is presented at TIPCC. The Patient Safety Committee oversee prescribing practices and make recommendations for changes to formulary and practice.

3.2.6 External assurance reviews

Two external IPC assurance visits have been undertaken this year. Both were planned inspections and were arranged to review practices and seek assurances following findings from the inspections over the last 5 years.

Date	Representatives	Findings	Outcome
20/05/25	NHS England (NHSE), Hereford and Worcestershire ICB and UK Health Security Agency (UKHSA).	1. significant improvement in the ownership of IPC within the senior nursing leadership across the Trust 2. an improved understanding of the responsibilities of the team.	Trust de-escalated from Intensive Support to Enhanced support (NHSE IPC escalation matrix).
18/09/25	NHSE and Herefordshire and Worcestershire Integrated Care Board (H&W ICB)	1. Progress had been made with the management of estate processes 2. the sustained engagement of the senior leadership team.	Trust de-escalated from Enhanced support to Routine support on the (NHSE IPC escalation matrix).

A Sustainability Follow Up visit took place in May 2026 to ensure standards have been upheld/ improved.

The H&W ICS Infection Prevention Nurse has also undertaken regular assurance reviews throughout the year. Feedback is provided and reported to Department leads as appropriate.

Any areas for improvement noted throughout any inspection have been added to the IPC annual priorities action plan (Appendix 2) as appropriate and are monitored though the Trust Infection Prevention & Control committee (TIPCC). The IPC annual priorities action plan for 2026/27 will continue to focus on these elements to ensure IPC standards become embedded into Trust practices.

3.2.7 Board assurance Framework

NHSE issued a National Infection Prevention and Control Board Assurance Framework (BAF) in 2022, updated in November 2025. This BAF supports all healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control manual (NIPCM) and other related infection prevention and control guidance. The framework helps identify risks associated with infectious agents and provides an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability.

Compliance against the 10 Criterion has been regularly reviewed by the Infection Prevention service with the support of the Quality & Safety team and reported biannually to the Trust Infection Prevention & Control Committee. By year end, 4 of the 10 Criterion are fully compliant; 6 require additional evidence to ensure full assurance is achieved and 0 are non-complaint. Actions to support achieving compliance have been developed and included in the Trust's Infection Prevention Annual Priorities plan 2026/27.

3.3 Infection Surveillance

In June 2025, the NHS Standard Contract for 2025/26 was published. This stipulated that all Community Onset Healthcare Associated (CO-HA) and Hospital Onset Healthcare Associated (HO-HA) infections are to be included in Trust's data reporting.

Hospital onset healthcare associated: (>AD+1) - HO-HA	Cases that are detected in the hospital two or more days after admission (where day one is day of admission).
Community onset healthcare associated: (<AD+1) CO-HA	Cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (where day one is day of admission).

3.3.1 Healthcare Associated Infections Review Panel

All healthcare associated infections (HCAI) that occur within the organisation are appraised by the HCAI Review Panel. The review panel meets weekly with the primary objectives of providing a multidisciplinary review of all HCAI incidents, identifying areas of good practice/ improvement and ensuring that any HCAI that causes moderate harm are identified and escalated.

The panel consists of the Infection Control Doctor, Lead Infection Prevention Nurse, and Quality & Safety manager, H&W ICS Infection Prevention Nurse Specialist and Clinical Representatives.

All HCAIs are logged as incidents on the Trust incident reporting system.

3.3.2 Meticillin resistant Staphylococcus aureus (MRSA) bacteraemias

MRSA is a bacterium responsible for several difficult to treat infections in humans. The Department of Health continues to drive a Zero-tolerance approach to MRSA bacteraemia.

During 2025/26, three Trust appointed MRSA bacteraemia cases were reported. The cases were reviewed at the HCAI Review Panel, presented at TIPCC and discussed with the Trust Patient Safety Group to look for preventable causes and identify any future learning opportunities.

Outcome from the reviews have been shared with the Division.

No linked themes were identified between the 3 cases.

This increase in prevalence is also reflective in the national surveillance data.

3.3.3 Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemias

MSSA is the much commoner antibiotic sensitive version of *Staphylococcus aureus*. As a formal target for reduction of MSSA bacteraemia cases has not been defined in the NHS Standard Contract for 2025/26 it has been agreed in TIPCC to establish a local threshold for MSSA bacteraemias to support local monitoring and enable effective benchmarking. The calculation used to set the GNB threshold in the NHS Standard Contract 2024/25 was utilised to set the MSSA threshold; this was set at 12 cases for 2025/26

Nineteen MSSA bacteraemia cases were apportioned to the Trust for the period 2025/26 in comparison to 15 in 2024/25. The 2025/26 cases included 8 CO-HA and 11 HO-HA cases. All cases were reviewed to look for preventable causes when the source of infection was unknown or device related. Nine cases were identified as being linked to the patients underlying health concerns. Two patients were noted to have an indwelling invasive device such as Urinary catheters and/ or peripheral venous cannulas; Learning opportunities were noted in regarding the documentation of ongoing invasive device care and management, hand hygiene and clinical cleaning.

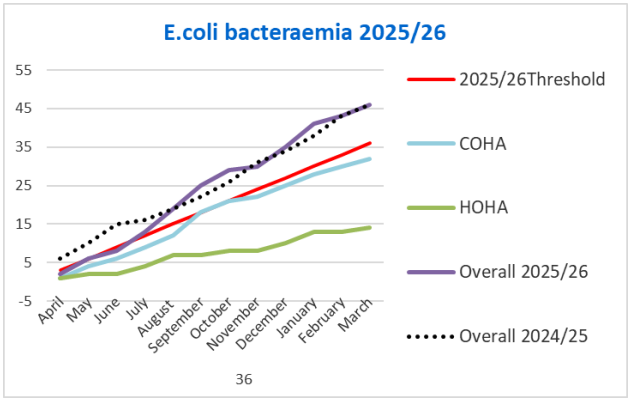
Work streams are already in place to improve hand hygiene and clinical cleaning practices. The Infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

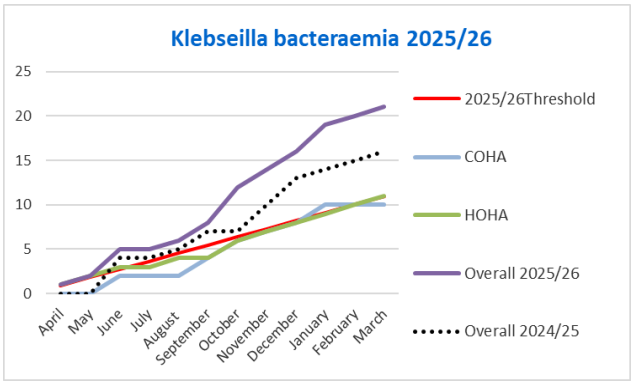
3.3.4 Gram negative blood stream infections

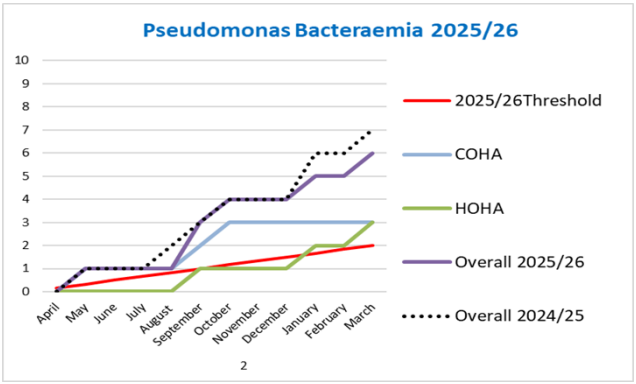
A healthcare associated Gram-negative blood stream infection (GNBSI) is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days. The top three GNBSI causative organisms which account for 72% of all Gram negative bacteraemias are: Escherichia coli (*E. coli)*, *Pseudomonas aeruginosa* (*Pseudomonas spp.*) and *Klebsiella* species (*Klebsiella spp*).

The focus is on the reduction of the top three GNBSIs and includes all CO-HA and HO-HA reported cases. In 2025/26 following cases of GNBSI were reported:

Bacteraemia	**Standard Contract Threshold for WVT**	**End of year tally**
E.coli	36	46
Klebsiella spp.	11	21
Pseudomonas	2	6







All cases were reviewed to look for preventable causes when the source of infection was unknown or device related.

Forty-seven of the cases were identified as being linked to the patients underlying health concerns. Sixteen of the reported GNBSI were noted to have an indwelling invasive device such as urinary catheters and/ or peripheral venous cannulas; Learning opportunities were noted in regarding the documentation of ongoing invasive device care and management, hand hygiene and clinical cleaning.

Work streams are already in place to improve hand hygiene and clinical cleaning

practices. The Infection Prevention service have been working with the Clinical Noting team to support accurate invasive device recording keeping.

3.3.5 Clostridioides difficile infection (CDI)

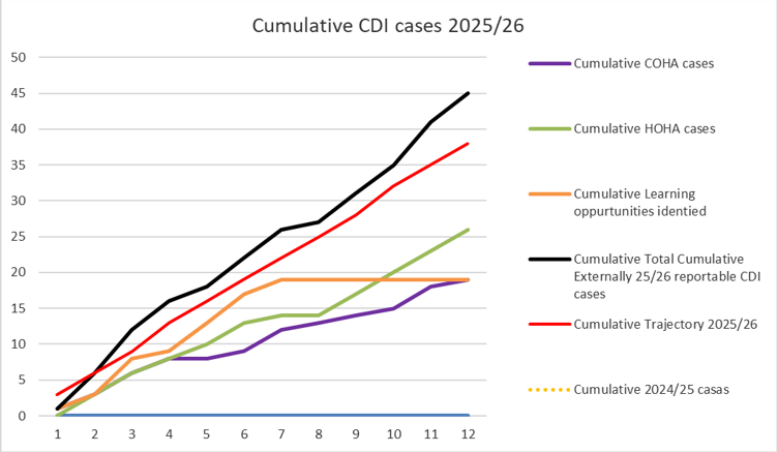
Clostridioides difficile (also known as C. difficile or C.diff) is a bacterium found in the gut which can cause diarrhoea after antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. It forms resistant spores which require very effective cleaning and disinfection to remove them from the environment.

C. difficile Infection (CDI) is nearly always preceded by antibiotic treatment but antibiotics may have been stopped up to 6 weeks before the patient presents with symptoms. Although most antibiotics have been implicated, broad-spectrum agents such as cephalosporins, quinolones and

carbapenems (e.g. meropenem) are most likely to cause it as they wipe out the “normal flora” of the gut which usually holds *C. difficile* in check.

The reportable cases of CDI are community onset healthcare associated CO-HA and Hospital onset healthcare associated HO-HA CDI cases that are positive by two tests, polymerase chain reaction (PCR) and enzyme-linked immunosorbent assay (EIA).

WVT was given an externally set trajectory of 38 cases of CDI this year. This included CO-HA and HO-HA cases. The Trust reported 45 CDI cases by the end of March 2026. This included 19 CO-HA cases and 26 HO-HA cases. This is a reduction of 26% from reported cases in 2024/25.



All reportable cases of CDI are investigated by the HCAI review panel. Learning opportunities were identified in 30 cases. Learning opportunities noted included:

• Hand Hygiene & Bare Below the Elbow practices	• Clinical equipment cleaning
• Documentation	• Stool sampling processes
• Prescribing and/or administrating antibiotics outside of guidelines	• Patient isolation practices

The Trusts CDI mortality rate at year end was 15.6% (7/45 patients). This is 2.9% above the national benchmark. Analysis on the 7 patient cases has been undertaken to identify any areas for learning and improvement. No additional learning has been identified at this time.

The Trust remain an outlier for CDI rates compared to other Trusts in the region and nationally. Some of the high rate but not all of it is explained by the fact that the denominator for the rate is taken from the NHSE quarterly

KH03 occupied overnight bed data and does not include the community hospital beds.

Action taken:

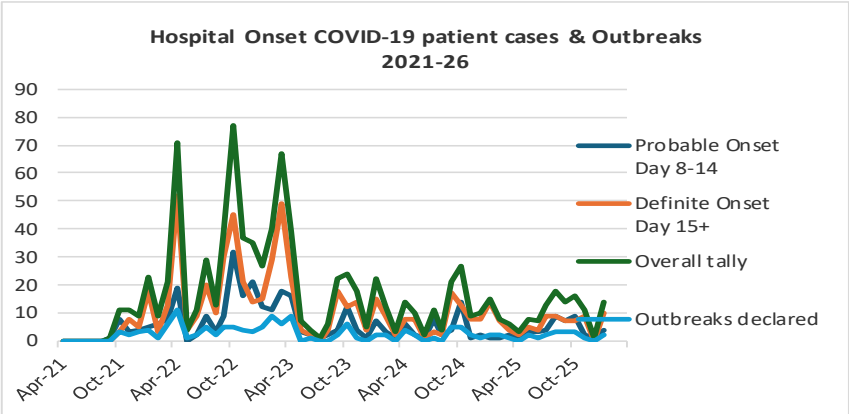
- A review of all Trust practices with diarrhoeal and CDI management is being undertaken;
- An IPC nurse is allocated to review all cases to ascertain any trends in demographics, infection acquisition and pre hospital care.
- Continued collaborative working with H&W ICB colleagues and sister organisations to monitor and understand relapsed cases.
- Review antibiotic therapy in the treatment of CDI

3.3.6 COVID-19

In total, 109 patients were deemed to have probable or definite hospital onset COVID-19 infection (See Appendix 3 for COVID-19 onset definition); this is a reduction from 139 reported patient cases in 2024/25.

The prevalence of COVID -19 infection both internally and within the Herefordshire community was regularly discussed in the Herefordshire & Worcestershire ICS led meetings to ensure a unified system approach to the peaks in reported cases.

Seventeen outbreaks were declared due to COVID-19 linked transmission. This is a reduction on the 24 reported in 2024/25.



National recommendations for COVID-19 management have been implemented by the Trust; Outbreak meetings were held as required and were attended by key stakeholders. The Infection Prevention Service continued to be heavily involved in planning and supporting patient pathways and providing staff education. The communications team issued key messages and updates for staff as required.

3.3.7 Carbapenemase-producing *Enterobacteriaceae* (CPE)

Carbapenemase – producing *Enterobacteriaceae* are bacteria that are very resistant to the last line of defence antibiotics, the carbapenems. They present a significant risk to healthcare. When isolated from a microbiological specimen, infection control measures are instigated to reduce the risk to other patients. The Trust has a CPE policy in place which reflects screening guidance recommended by UKHSA.

An outbreak of CPE was declared in November 2025 on AMU as two patients linked to time and place were identified as being CPE (Klebsiella pneumoniae carbapenemase- KPC) positive. Environmental screening of the ward environment also identified CPE KPC in 5 shower drainage pipes. Outbreak meetings were held and the IPC service had oversight of all actions undertaken including enhanced patient and environmental screening & monitoring, decontamination processes including drain disinfectant, reviewing standards and staff training. The outbreak incident was stepped down after a set period of negative screening results as per national and local guidance. The outbreak was contained and no additional spread was reported.

3.3.8 Measles

No cases of Measles were reported in Wye Valley NHS Trust.

UKHSA guidance and campaign materials were cascaded Trust wide to ensure staff awareness. Patient pathways have been developed to ensure safe management of patients attending Wye Valley NHS Trust.

3.3.9 M-POX

National and regional guidance on managing the virus m-pox (previously referred to as Monkeypox) has been published by NHSE and UKHSA; all organisations have been advised to have IPC measures in place to identify, manage and treat any patients presenting with suspected mpox.

No cases of Mpox were reported in Wye Valley NHS Trust.

3.3.10 Tuberculosis (TB)

There were no healthcare associated TB incidents reported in 2025/26.

3.3.11 Seasonal infections

- Norovirus
  All stool samples submitted to the laboratories are tested for Norovirus as routine. 205 patients were identified as having Norovirus whilst inpatients in Wye Valley NHS Trust.

  Twenty-nine norovirus outbreaks were declared during the financial year; This is an increase on the 2 cases reported in 2024/25. 23 outbreaks were reported between January – March 2026. All incidents were managed as per

Trust policy. Patient flow restrictions were applied to contain the spread of infection.

Outbreak meetings were held as required and were attended by key stakeholders.

See Appendix 3 for details on Norovirus associated outbreaks.

- Influenza
  413 patients were reported as having influenza by the Trust Microbiology department during September 2025-March 2026; 246 patients were admitted. The majority of these cases were recorded in the months of December and January. This was reflective of the national picture.

  The prominent strain reported: Influenza A 99.3% of positive cases.

  Eleven outbreaks due to Influenza were declared as per national and regional guidance; the majority of wards remained open as infection spread was contained. Three wards were closed to admission, discharges and transfers to enable the safe and effective management of patients who could not be isolated due to underlying clinical needs. See Appendix 3 for details on Influenza associated outbreaks.

  For the 2025/26 season, Wye Valley NHS Trust participated in the national inpatient flu vaccination plan. This plan focused on protecting high-risk individuals including patients over 65 years of age and those being admitted to or from a care home, with adult vaccination starting from October 1, 2025. Led by the IPC team, peer vaccinators in ward settings supported the assessment, prescribing (via prescription or Patient Group Directive) and administration of the vaccine.

  By the end of March 2026:

  Patients assessed for eligibility: 895

  Patients deemed eligible: 413

  Patients vaccinated: 63

  Rationale for not vaccinating:

  - 13 patients stated already received
  - 120 patients discharged pre offer
  - 120 patients were deemed not medically fit by doctors
  - 67 patients declined
  - 30 patients were unable to consent

Flu planning 2026/27 is underway and a meeting planned for April.

Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

2.1 Decontamination

There has not been a significant incident linked to Decontamination practices during this financial year. Incidents, if they do occur, are discussed at the Decontamination Committee.

Endoscopes continue to be processed at the County Hospital in Hereford and at Ross Community Hospital in their respective Endoscopy departments. Ear, nose and throat scopes are also processed in the Endoscopy Decontamination suite at the County Hospital, bringing a centralised process to the clinics within the trust.

Site wide reviews by the Trust appointed Authorising Engineer and the company Tristel have been carried out with no serious concerns identified.

All surgical instruments continue to be re-processed in the sterile services department at the Hereford County Hospital which is run by our PFI partner. Protein detection has been implemented, and it is effective in assisting Central Sterilising Services Department (CSSD) in managing their decontamination processes. CSSD routinely clean instruments from our surgical robot.

Local decontamination of dental instruments is undertaken in most of the Dental Access Centres (DAC). The Autoclaves and Washer Disinfectors at all sites were historically on a temporary loan. The Trust purchased these autoclaves and washer disinfectors 2.5 years ago following a tender process. The Trust has extended the service contract with the current service provider. A new service provider is being sought due to Trusts dissatisfaction with and underachievement of the incumbent.

The contracted laundry provider Elis provide a microbiology report to the Trust every month, which is reviewed, monitored and discussed at the Decontamination Committee. The last provider laundry assurance visit was undertaken in December 2024 and assurance gained. We are currently in a 6-month extension of the contract with the incumbent supplier however the Trust Estates team are working with Procurement to engage a new laundry service tender. Specifications are currently being re-written to accommodate our new laundry requirements and to align with the Department of Heath guidance Health Technical Memorandum (HTM) 01-04 Decontamination of linen for health and social care.

A review of the Decontamination Committee has been carried out during the financial year; Meetings moved from bimonthly to quarterly.

The Decontamination authorised person roles are still in the process of being appointed.

2.2 Cleanliness Monitoring

The Trust has now completed four full years of input to deliver the requirements set out under National Standards for Healthcare Cleanliness 2021 (NCS21). (Revised 2025)

Analysis of the 2025/26 scores show a sustained/continued improvement in Domestic Cleans and a small improvement in Clinical Clean scores from the previous year across both High risk (FR1) and General Ward areas (FR2) risk areas.

FR1 clinical areas continue to receive significant focus with local action plans receiving input from Clinical and Estates management. FR1 audits are completed weekly and scores have improved over 2025/26. FR2 areas receive audits on a monthly basis; FR2 audit scores have remained more consistent and very few action plans are required for Audits that receive a 3 star (*) rating or below.

See Appendix 4 for summary of FR1 & FR2 Cleaning scores from 2021 to date.

Enhanced environmental decontamination by hydrogen peroxide vapour (HPV) was bought in-house from February 2025. Previously undertaken by an external provider, this role has now been allocated to competency trained staff across all 4 inpatient sites. This has ensured decontamination can be completed in a timely and more cost-effective manner.

We therefore start 2026/27 aiming to improve our Clinical Cleaning scores. However clinical staffing levels with appropriate training and supervision would appear to be greatest challenges in achieving these improvements.

2.3 Ventilation

The Ventilation Safety Group (VSG) was set up in November 2022. The purpose of the group is to allow all duty holders to demonstrate that there are suitable governance, competence and accountability arrangements in place to provide safe ventilation systems and appropriate clinical environments in the Trust's healthcare premises.

The Group is a sub-committee of the TIPCC. Ventilation reports are presented quarterly at TIPCC or sooner if areas of concern have been identified.

There has not been a significant incident linked to Ventilation during this financial year. Incidents, if they occur, are discussed at VSG.

Air handling units (AHU's) continue to have their annual verifications and newly installed AHU's receive their validations before the area being served is used for clinical procedures. Where official verifications cannot be carried out due to access issues a local interim verification is carried out by on site engineers to provide assurance. Where access issues persist these are escalated through VSG and/or Access committee.

All new builds and developments have included consultation with the Authorising Engineer for Ventilation during both the design and build phases of construction for approval on Ventilation systems.

The main ventilation risk currently relates to overdue lifecycle of some of the air handling units. The risk is more of a business continuity risk but the VSG monitors risk mitigations relating to performance.

2.4 #WyeClean Quality Improvement campaign

#WyeClean has continued throughout 2025/26. Themed IPC roadshows have been held throughout the year focusing on key clinical cleaning responsibility's; The main emphasis in the 2025/26 training has been on the decontamination of patient beds, trolleys and mattresses. Support has also been provided on specific equipment cleaning, cleaning products and the standardization of practice.

#WyeClean will continue into 2026/27 promoting best practice and to embed learning and training

2.5 Patient Led Assessments of the Care Environment (PLACE)

The PLACE assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

The aim of PLACE assessments is to provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

Clinical facilities across all four Wye Valley Hospitals were inspected by PLACE assessors between September and October 2025

The results were published February 2026. Action plans addressing all issues highlighted by the assessment have been developed. This is being overseen via the Patient Experience Committee.

Individual sites	Cleanliness Score %	Food Score %	Privacy, dignity & wellbeing Score %	Condition, appearance & maintenance Score %	Dementia Score %	Disability Score %
Bromyard Hospital	**99.56**	**95.19**	**85.94**	**95.45**	**88.74**	**84.83**
Leominster Hospital	**98.48**	**93.52**	**85.48**	**94.40**	**93.48**	**88.59**
Ross Hospital	**98.92**	**89.78**	**87.06**	**98.57**	**81.60**	**83.40**
County Hospital	**99.61**	**92.99**	**90.20**	**99.26**	**81.68**	**82.33**
Trust average	**99.47**	**92.85**	**89.37**	**98.66**	**82.87**	**82.99**
National average	**98.55**	**92.13**	**80.52**	**97.26**	**85.68**	**87.12**

Overall, Wye Valley Trust scored higher than the national average in four areas: Cleanliness, Food, Privacy, dignity & wellbeing and Condition appearance & maintenance. Processes are already established in the trust that focus on these elements. Any areas noted for improvement in these domains will be addressed via these routes.

Despite improvements noted from 2024 results, the Trust scored below the national average in the following areas:

- Dementia
- Disability

Actions for improvement in these 2 domains are being monitored by the PLACE Working group and discussed quarterly in the Patient Experience Committee. PLACE 2026 inspections are planned to commence in September 2026.

Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

3.1 Antimicrobial stewardship 2025/26

Antimicrobial resistance (AMR) is a recognised threat to patient safety, the long-term effectiveness of antibiotics, and the sustainability of the NHS. Antimicrobial stewardship (AMS) refers to coordinated, evidence-based strategies to optimise antibiotic prescribing — ensuring patients receive the right antibiotic, at the right dose, by the right route, for the right duration.

The Trust continues to align its AMS programme with the UK 5-Year Action Plan for Antimicrobial Resistance 2024–2029 (NHS, 2024), collaborating with the Herefordshire and Worcestershire Integrated Care System's system-wide AMS group.

Our dedicated AMS specialist team consisting of an Infectious Diseases Specialist and an Antimicrobial Pharmacist, delivers this function by:

- Overseeing antibiotic prescribing practices across all Trust sites.
- Reviewing and maintaining evidence-based prescribing guidelines.
- Conducting clinical audits to ensure compliance.
- Providing direct education and clinical support to frontline ward teams

In November 2025, NHS England issued a formal letter to all Trust and Integrated Care Board chairs, chief executives, medical directors, and chief pharmacists under the heading ‘Act now: protect our present, secure our future.’ The letter set out the scale of the challenge: AMR causes twice as many deaths annually in the UK as breast cancer; secondary care antibiotic prescribing is rising counter to the national trend; and gram-negative bloodstream infections exceed the 2028/29 national targets in most areas. An NHS England compliance deadline of Quarter 1 2026 was set, requiring demonstrable action across all acute Trusts. Active workflows are currently underway across the Trust to ensure full compliance ahead of this deadline.

Detail on the Trust AMS compliance and additional information on the Trusts response to the NHS Act Now letter can be found in Appendix 5.

Criterion 4

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

4.1 Patient leaflets

The infection prevention related leaflets are available in hard copy or through the Trust intranet and public facing web sites. All leaflets are reviewed by the Trust reading group prior to publication.

4.2 Communication Team

Establishing a clear communication programme is a key requirement in the improvement of patient care, the instigation of IPC initiatives, public information and visitor safety, as the way we all worked had to change, often at short notice.

The Infection Prevention Service has worked closely with the Communications Team throughout the year. They have been instrumental in assisting with in ensuring the correct media information has been developed in a timely and clear manner.

The Communications Team attend incident and outbreak meetings to ensure that appropriate messages are delivered both to Trust staff and to the public. They have issued frequent Trust bulletins throughout 2025/26 with regular contributions from the Infection Prevention Service team members. Wider dissemination of current issues is also achieved by global emails and through the Trust weekly Team Brief newsletter.

4.3 Trust Intranet

The Trust website has a dedicated IPC site which provides pages on general IPC issues and guidance including link nurse information, information on specific HCAI management. Resources such as policies, audit tools and patient information leaflets can be accessed via this portal.

Criterion 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

5.1 Prompt identification

Notification of infections in a timely fashion is facilitated by laboratory reports directly to the Infection Prevention nurse team from the laboratory staff. These are also available electronically via the MAXIMS laboratory system. The ward area is then either telephoned or visited by their appointed IPC

nurse to ensure that the correct information is available for treatment and care of that patient.

If patients have been identified as having CDI, CPE or MRSA and they have been discharged, a letter is sent to their general practitioner.

The IPC nurses advise the Clinical Site Management team and ward staff regarding isolation and management of patients with known or suspected infections. The electronic patient record system, MAXIMS, has a notification flag on it so that patients with a history of alert organisms such as MRSA can be brought to the attention of nursing and medical staff when accessing the electronic patient record. The Infection Prevention nurse team also attend the daily bed meetings to advice on patients with known or suspected infections and on bay and ward closures.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

Compliance with screening for COVID-19, MRSA colonisation and CPE is also monitored. This information is reported to the Infection Prevention committee monthly.

5.2 Surveillance of Blood Culture Contamination (BCC) rates

Blood culture collection remains the gold standard to diagnose bacteraemia. The Emergency Department (ED) remains the frontline in identifying and initiating investigations for unwell patients where majority of blood cultures are generated.

Accurate blood culture results allow safe, timely, effective, efficient care for septic patients and those with serious infections, and the prevention of antimicrobial resistance. Higher BCC rates contribute to increased hospital length of stay, unnecessary or inappropriate antimicrobial treatment, negative impact on patient safety and an increased costs to the health care system.

The current recommendation by the Clinical and Laboratory Standards Institute and the UK Standards for Microbiology Investigations (Investigation of Blood Cultures) is to maintain a BCC rate of less than 3%.

However, reported figures vary significantly with literature from different countries including Australia, New Zealand and the United States of America identifying rates of between 3–12 %. Blood culture contamination rates in the UK typically range from 3% to 10% but can vary between hospitals and even within different units of the same hospital. The BCC rate at WVT as follow:

Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E - 2024/25	7.18%	5.50%	5.58%	7.07%	5.09%	7.20%	5.61%	8.53%	6.56%	6.70%	9.88%	6.99%
All Trust - 2024/25	6.24%	4.44%	4.96%	5.44%	4.21%	5.37%	4.40%	6.31%	5.11%	5.51%	7.28%	4.86%
A&E - 2025/26	4.82%	2.89%	6.20%	7.04%	6.91%	5.81%	5.12%	6.29%	4.94%	5.38	3.70	6.97
All Trust - 2025/26	3.60%	2.04%	4.19%	5.42%	5.72%	4.51%	4.38%	4.98%	4.34%	4.49	2.92	4.98

Action taken

- Roll out of updated Blood Culture training and competency assessment
- Implementation of training programmes to reduce BCC rates in ED.
- Blood culture collection product review

5.3 Mandatory surgical site infection surveillance (SSI)

During the financial year April 2025 – March 2026, 358 hips operations and a total of 491 knee operations took place in WVT.

The Trust has undertaken continuous data collection and has participated in all UKHSA mandated data collection periods during this timeframe. WVT has received the UKHSA collated analysis reports for 3 of the 4 data collection periods during this financial year. The UKHSA report for January- March 2026 is expected during Quarter 2 2026/27.

WVT received notification from UKHSA in March 2026, highlighting that data gathered during October – December 2025 deemed WVT as an outlier for hip SSI. The SSI rate in WVT Inpatient/Readmission post hip surgery (for Trusts who issue post discharge questionnaires) was 0.9% compared to the national SSI average rate of 0.2% for Trusts who issue post discharge questionnaires.

The Surgical division and the IPC service have launched a collaborative review to identify clinical trends and areas for improvement. This scope includes detailed patient case reviews alongside environmental and surgical process audits. A summary of these corrective actions has been shared with the UKHSA for external assurance.

Type of surgery	Apr- Jun 2024	Jul– Sep 2024	Oct– Dec 2024	Jan– Mar 2025	Apr- Jun 2025	Jul– Sep 2025	Oct– Dec 2025	Jan– Mar 2026
Knee replacement	0.0%	0.0%	0.0%	0.8%	1.0%	2.2%	1.3%	0.7%
National rate	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	*TBC*
Hip replacement	0.0%	0.0%	0.0%	0.0%	4.3%	3.0%	0.9%	0%
National rate	0.8%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	*TBC*

5.4 Outbreak and incident management

The Infection Prevention Service is involved in the management of outbreaks, periods of increased incidence and incidents.

The IPC nurse team monitor all alert organisms to identify trends and potential links between cases based on their location. If links are identified a meeting is convened to discuss potential cases. This is a manual process and completed without the aid of an automatic surveillance system.

All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC and lessons learnt are shared with the Trust and disseminated through communications such as Safety Bites bulletin.

Attendees at outbreak and incident meetings include the DIPC, Infection Control Doctor, and IPC nurses, Leads of the affected areas and Estates and Facilities colleagues. Colleagues in the H&W ICB, UKHSA and NHS England are informed and dial in to participate in the meeting if necessary.

A list of all outbreaks declared in 2025/26 can be found in Appendix 3.

Criterion 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 Wye Valley NHS Trust staff responsibilities

Each member of WVT staff has their responsibility for IPC within their job description. All staff are required to attend induction training before they work clinically and an annual refresher training session. This process is then monitored via the electronic staff record and is key to pay progression and revalidation. The block booked agency staff, have their in-house training as well as a local induction delivered by the area that they are working in. All contractors have IPC training which has been prepared by the IPC nurse team but is delivered by our estates team and our PFI partner.

Education resources on Personal Protective Equipment (PPE), Standard infection control precautions and hand hygiene have been developed to educate and support the Trust's Infection Prevention Champions.

6.2 Infection Prevention Team/Team Development

The Infection Prevention Service staff have attended regional & national infection prevention conferences held by the Infection Prevention Society.

The Infection Control Doctor completed the Trust Medical & Dental Leadership & Management Development Programme and the Water and

Wastewater Safety in Healthcare Course organised by the Healthcare Infection Society.

Criterion 7

Provide or secure adequate isolation facilities.

All wards have side rooms available to them. There are a total of 82 side rooms across the County Hospital site, 12 of these are specially ventilated rooms:

- Positive pressure: 3
- Negative pressure: 9

There are 12 isolation side rooms across the 3 inpatient wards in the Community hospitals. These all have neutral pressure.

The Infection Prevention nurse team monitor and prioritise the usage of side rooms for patients with known or suspected infections.

WVT staff have access to The Trusts Prioritisation Reference Guide, developed by the IPC team in line with the National Infection Prevention and Control Manual for England (NIPCM, NHS 2022) to support patient isolation decision making out of hours.

The Clinical Site Management team also receive regular updates from the IPC nurse team on the priority side rooms for environmental decontamination using the ultraviolet and hydrogen peroxide environmental decontamination equipment.

Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for WVT are located in the purpose-built Pathology Laboratory on-site at the County Hospital site. The Microbiology Laboratory has full UKAS accreditation. The Trust has declared microbiology as a fragile service due to limited substantive consultant cover. A grow our own workforce strategy continues with specialty doctors being supported by an experienced consultant microbiologist. The service is fully staffed although some of this is using locum staff. The department also has a trainee Consultant Clinical Scientist in post.

Despite these challenges, the Microbiology department were heavily involved in both the laboratory side of developing testing systems, providing IPC and antimicrobial stewardship advice and assisting with HCAI outbreak management.

The IPC nurse team work closely with the Microbiologists and laboratory staff to ensure prompt handover of alert organism data and management response.

Criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

9.1 Policies

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Policies are available for staff to view on the Trust intranet.

The Infection Prevention Service has a rolling programme of policies which require updating each year. In addition, policies are updated prior to review date if national guidance changes.

In 2025/26 the team updated the following IPC polices & Standard operation procedures:

- IC.08 Meticillin Sensitive Staphylococcus Aureus (MSSA) & Meticillin Resistant Staphylococcus Aureus (MRSA) Screening and Management Policy
- IC.24 – Glycopeptide Resistant Enterococci (GRE) policy
- IC.32 CPE management policy – addendum
- IC 36 – Laundry and Linen Management Policy
- IC. 41 High Consequence Infectious Diseases Policy for Initial Management and Investigation of Possible Cases- MERS, VHF
- IC. S 03 Standard Operating Procedure: Enhanced environmental decontamination by Ultraviolet (Ultra-V) and Hydrogen Peroxide Vapour (HPV) processes
- HS.33 Policy for the Prevention and Management of Occupational Dermatitis and Occupational Latex Allergy
- PR.S.66 Influenza vaccination for eligible hospital inpatients

All information regarding emerging organisms, infection management guidelines, protocols, pathways and practices have been available to Trust staff via a dedicated IPC page on the Trust Intranet. This was updated regularly throughout the year in line with changes to national and regional guidelines. Information has also been cascaded to staff via the email, Trust Talk and are available on the Trust staff myWVT app.

An IPC A-Z of Common Infections is available on the trust's intranet. This significantly enhances the quick location of key infection prevention guidance by our front-line staff in regard to common infections. Staff also have a direct link from the intranet to the Royal Marsden polices on nursing procedures.

9.2 Infection Prevention team audit program

The Trust have an IPC programme of audits in place, in order to demonstrate compliance with the Health and Social Care Act: Hygiene Code. The audits are undertaken by both clinical areas and the IPC nurse team, to ensure that areas are consistently complying with evidence-based practice and policies.

This year's programme of audit continued to concentrate on gaining assurance that standard infection control standards were being upheld across the Trust (Appendix 6). Any deferred audits have been added to the IPC audit plan for 2026/27.

All audit results are reported into the post infection reviews and reported to Divisions. Any issues identified were fed back to the divisions for action at the time of auditing. The audits provided a balanced picture of the wards involved.

In response to the audits undertaken, Divisions develop local action plans in response to the audit findings. These are reported by Division to the Infection Prevention Committee.

9.3 Hand Hygiene & BBE compliance

The Trust expected compliance for hand hygiene and BBE practices for staff working within clinical settings has been set locally as 100%. Compliance with this objective is monitored monthly by clinical areas. The IPC nursing team undertake validation audits of compliance monthly throughout the Trust. 6250 observations were completed in the year; a decrease on the 8941 observations reported in 2024/25. The overall annual scores:

- Hand Hygiene Compliance: 96%
- Bare below the Elbows compliance: 99%

9.4 Saving Lives: High Impact Intervention audits

Saving Lives: High Impact Intervention (HII) are audits that monitor compliance with best practice for a number of clinical interventions that will reduce the risk of healthcare associated infections in specific aspects of nursing care. The original audits were amended by NHS Improvement & the Infection Prevention Society in 2017. From April 2018, Wye Valley Trust has implemented modified audits which have been adapted by the Infection Prevention team to incorporate the stipulated care bundles and additional information that will support local initiatives.

The following audits are undertaken quarterly by each clinical area by point prevalence, and the results are collated by the Infection Prevention team.

- Preventing infection associated with peripheral vascular access devices

- Preventing infection associated with central venous access devices
- Preventing catheter associated urinary tract infection

The HII audit data is shared with clinical leads for action and learning. The results per division are displayed in the clinical settings on the IPC notice boards.

Three HII are not completed as a separate audit by the Infection Prevention nurse team as they duplicate work already undertaken within the organisation:

- Preventing infection in chronic wounds
- Preventing surgical site infection
- Stewardship in antimicrobial prescribing

Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

10.1 Personal Protective Equipment (PPE) including Filtering Face Piece protection level 3 (FFP3) mask fit testing

All clinical staff working within the organisation have been offered PPE training & FFP3 Fit mask testing.

The Trust Mask fit testing service has been managed by the Lead Infection Prevention Nurse from November 2022. The service runs Monday – Friday 08:00-16:00. However, additional sessions can be rostered based on clinical needs.

All training and testing records are stored centrally on the Trust electronic staff record system.

Training and fit testing will continue throughout the coming year and compliance with national recommendations for fit mask testing will be reported via TIPCC.

10.2 Staff mandatory infection prevention training

IPC remains a mandatory component of staff induction and update training across the Trust. All induction and annual updates are provided by recognised NHS Skills for Healthcare e-learning using the national IPC resources and placed on the Trust learning management system- ESR. All staff must attend Trust induction before commencing work within WVT.

Training compliance for Level 1 and Level 2 training is reported at the quarterly TIPCC, whilst breakdown compliance per area is reviewed locally monthly. The Trust threshold for mandatory compliance is 85%.

In 2025/26 Trust compliance with IPC mandatory refreshing training:

- Level 1 (Nonclinical) 93.55%
- Level 2 (Clinical) 83.15%

The IPC nurse team continues to work with the Education department to increase compliance plus provide local training in clinical departments as requested by Divisions including hand hygiene and areas of focused improvement such as the understanding of some organisms and management of CPE.

In addition, the IPC nursing team are working with the Education Department to align training in accordance with National Core Skills Training Framework (NCSTF) Training requirements from April 2026. This requires all trust staff to complete IPC Level 1 training, and those roles that previously required IPC Level 2 must now complete both Level 1 and Level 2.

10.3 The Occupational Health vaccination service.

The Occupational Health team have continued to provide a screening and vaccination service for occupational risks such as:

- Exposure Prone Procedures (for staff working in high-risk areas)
- MMR
- Pertussis
- Typhoid
- Hepatitis A & B
- Meningitis
- TB screening (IGRA)
- Varicella

From October 2025 to March 2026 Influenza vaccinations were offered to all Trust staff in line with national guidance; vaccinations were delivered in-house by the Occupational Health team and a small team of Peer Vaccinators.

2221 staff (44.38%) where vaccinated over winter 2025/26. This is an improvement from 29% during Winter 2024/25. Breakdown of staff take up this financial year:

Staff Type	Headcount
All other professionally qualified clinical staff	256
Clinical support	496
Doctor	259
Nonclinical	511
Qualified Nurse / Midwife	699
Grand Total	**2221**

The Influenza Peer Vaccinator programme will be expanded in 2026/27 to support vaccine delivery in the workplace with an aim to increase Trust compliance by 5% as per national recommendation.

10.4 Infection Prevention Champions

The WVT Infection Prevention Service is supported by over 80 Infection Prevention Champions across all divisions and professional groups. The Champions receive regular information which provides education on incidents that have occurred within the Trust with lessons learnt.

Infection Prevention Champions are expected to cascade information received to their teams.

SECTION 4: IPC AMIBITION FOR 2025/26

Wye Valley NHS Trust continues to prioritise and promote IPC across the organisation. Our key objectives for 2026/27 are to:

- Lower healthcare-associated infection (HCAI) rates.
- Strengthen communication with Primary Care and District Nurses to improve community HCAI management.
- Enhance decontamination protocols for clinical environments and shared equipment.
- Deliver High Consequence Infectious Disease (HCID) training to clinical staff, targeting ED and ITU.
- Expand the IPC Champions network through targeted educational sessions.

SECTION 5: CONCLUSION

Wye Valley NHS Trust remains dedicated to eliminating avoidable healthcare-associated infections (HCAIs) to safeguard patients, staff, and the community. Our Infection Prevention Service works across all teams to embed IPC practices into daily operations, ensuring compliance with the Hygiene Code as detailed in the Board Assurance Framework.

Looking ahead, our new IPC programme will focus on practical learning and quality improvement projects to make our wards safer and further reduce infection rates.

We extend our sincere thanks to all staff for their continued commitment and hard work throughout the year.

SECTION 6: REFERENCES

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-onthe-prevention-and-control-of-infections-and-related-guidance

NHS (2025) Infection prevention and control board assurance framework. Updated 13/09/24 Available online 01/05/25: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2022) National infection prevention and control manual (NIPCM) for England Version 2.10 Updated March 2025 Available online 01/05/25 https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

NHS (2024) UK 5-year action plan for antimicrobial resistance 2024 to 2029. Updated 08/05/2024 Available online 01/05/25: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029

NHS (2025) National Standards of Healthcare Cleanliness 2025. Available online 01/05/25: NHS England » National Standards of Healthcare Cleanliness 2025

APPENDIX 1: List of Abbreviations

AHU	Air Handling Unit
AMS	Antimicrobial Stewardship
BAF	Board Assurance Framework
BBE	Bare below the elbow
BCC	Blood Culture Contaminant
CDI	Clostridioides difficile infection
CO-HA	Community Onset- healthcare associated
CPE	Carbapenemase-producing Enterobacteriaceae
CPEC	Capital planning & equipment committee
CSSD	Central Sterile Services Department
DAC	Dental Access Centre
DDD	Defined Daily Dose
DIPC	Director of infection prevention and control
ED	Emergency Department
EIA	Enzyme-linked immunosorbent assay
E. coli	*Escherichia coli*
FFP3	Filtering face piece – protection level 3
FR	Function Risk
GNBSI	Gram negative blood stream infection
HCAI	Health care associated infection
HCID	High Consequence Infectious Disease
H&W ICS	Herefordshire & Worcestershire Integrated Care system
HO-HA	Hospital Onset- healthcare Acquired
HPV	Hydrogen Peroxide Vapour
HII	High Impact Intervention
IPC	Infection prevention and control
ITU	Intensive Therapy Unit
IV	Intravenous
IVOS	Intravenous-to-Oral Switch

JAG	Joint Advisory Group in GI Endoscopy
Klebsiella	*Klebsiella* species
KLOE	Key lines of enquiry
MHRA	Medicines and Healthcare products Regulatory Agency
MRSA	Meticillin-resistant *Staphylococcus aureus*
MSSA	Meticillin sensitive *Staphylococcus aureus*
NHS	National Health Service
NHSE	National Health Service for England
NIPCM	National Infection Prevention & Control Manual for England
NSC25	National Standards for Cleanliness in Healthcare 2021
OPAT	Out Patient Parenteral Antibiotic Therapy
PCR	Polymerase chain reaction
PFI	Private Finance Initiative
PLACE	Patient Led Experience of the Clinical Environment
PPE	Personal protective equipment
Pseudomonas spp	Pseudomonas aeruginosa
PSIRF	Patient safety incident review framework
UKAS	United Kingdom Accreditation Service
UKHSA	United Kingdom Health Security Agency
PLACE	Patient led assessments in the Clinical environment
SSI	Surgical site infection
TB	Tuberculosis
TIPCC	Trust Infection Prevention & Control Committee
VSG	Ventilation Safety Group
WTE	Whole time equivalent
WVT	Wye Valley NHS Trust

APPENDIX 2: Infection Prevention Improvement plan 2025/26

Priority	Link to H&S care Act 2012	Action	Rationale (Why)	RAG
1: AMS	Criterion 5	Undertake a training needs analysis on antimicrobial prescribing and stewardship across Trust and Staff roles undertaken	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	To progress through Act Now Priorities
1: AMS	Criterion 5	Explore local risk reduction strategies for high-risk patients such as patient information leaflets, going home leaflets, antibiotic (high risk) leaflets.	Support Gram Negative Bacteraemia reduction System working Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029	To progress through Act Now Priorities
1: AMS	Criterion 5	Update antibiotic prescribing guidelines	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	To progress through Act Now Priorities
1: AMS	Criterion 5	Consider initiatives for penicillin de-labelling	Support compliance with the UK 5-year action plan for antimicrobial resistance 2024 to 2029 To gain assurance of standardised practice	To progress through Act Now Priorities
2: Devices	Criterion 5	Promote and embed HOUDINI catheter management initiative; Monitor compliance with Urinary catheter care pathway	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction	Complete

2: Devices	Criterion 5	Support Trust roll out of updated Blood culture training; Monitor staff compliance through Blood Culture contamination surveillance	Assurance that best practices for blood culture collection is in place Trust wide Support Gram Negative Bacteraemia reduction Identify areas for improvement Participation in the Midlands AMR Programme Board Blood Culture Pathway Re-audit programme	Complete
2: Devices	Criterion 5	Review current documentation for the insertion and ongoing care of invasive devices; monitor compliance with document completion	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction Support a trained workforce	Complete
2: Devices	Criterion 5	Establish a Trust wide the invasive devices working group	Assurance that best practices for all invasive devices are in place Trust wide Support Gram Negative Bacteraemia reduction	Complete
3: Cleaning	Criterion 6	Refresh staff clinical staff knowledge on cleaning responsibilities. Including type terminology - Red, Violet, Amber & Green	Ensure the correct clean is requested/ undertaken post patient transfer/ discharge Strengthen governance and clarify role responsibility for clinical staff. Improve clinical cleaning standards	Complete
3: Cleaning	Criterion 2	Establish a programme for PLACE lite audits for 2025/26	Strengthen governance on clinical cleanliness To support the Trusts prompt identification of cleanliness & estates concerns in the clinical environment	Complete

3: Cleaning	Criterion 2	Promote staff responsibilities in undertaking clinical cleaning; to include methods, product use and frequency as contained within NSC25	Strengthen Trust Governance on Cleanliness Compliance with NSC25 Improve staff awareness on cleaning responsibilities	Complete
3: Cleaning	Criterion 2	Review current audit programme for mattresses, pressure cushions, beds, and cushions to ensure processes are embedded within the ward areas	Strengthen Trust Governance on Cleanliness	Complete
3: Cleaning	Criterion 2	Strengthen staff awareness and practices on mattress, bed / trolley frame and other soft furnishing cleanliness through a focused educational programme	Strengthen Trust Governance on Cleanliness	Complete
4: Surveillance	Criterion 1	Develop & embed local response plan to HCAI patient safety incidents	Processes in line with PSIRF	Complete
4: Surveillance	Criterion 1	Streamline the IPC audit programme for 2025-26	Streamline current process to provide timely rectification to issues raised and ensure key themes are recognised and acted upon	Complete
4: Surveillance	Criterion 2	Support Estates team in prioritising outstanding works across all Trust sites; Complete a full review of outstanding work per site to be reviewed to ensure that work can be prioritised	Improve fabric and maintenance across the Trust estate Establish full catalogue of outstanding works	Complete
4: Surveillance	Criterion 4	Review suitability of AI tools in supporting IPC service e.g. assisting in developing Patient & GP communication	Create efficient IPC work stream	On hold- under review
4: Surveillance	Criterion 4	Promote IPC organism alerts on Maxims Trust wide	To support patient management	Complete
4: Surveillance	Criterion 4	Review the uploading of infection Alerts on Maxims being transferred into EPMA & EMIS	Strengthen governance across the system	Complete
4: Surveillance	Criterion 9	Review and update Trust CDI policy in line with national guidance and reflective of local treatment pathways	Provide clear guidance to aid staff management of patients diagnosed with CDI (whether PCR only or PCR & EIA positive results)	Complete
4: Surveillance	Criterion 5	Review CDI ward round strategies	Improve patient care through MDT review	Complete
4: Surveillance	Criterion 8	Review CDI testing pathway in Microbiology labs to align with national guidance; to include review of lab testing platforms	Provide a research driven testing platform in line with national guidance	Complete

4: Surveillance	Criterion 5	Review of staff compliance with obtaining stool samples; Consider time to sample & Type 5-7 stool	Benchmarking against policy. Early identification of infection	Complete
4: Surveillance	Criterion 5	Review current practice/ management for Candida auris in line with national guidance https://www.gov.uk/government/publications/candida-auris-laboratory-investigation-management-and-infection-prevention-and-control	Benchmarking against policy. Early identification of infection	Complete
4: Surveillance	Criterion 5	Review current HCAI data capture system data input compliance with national requirements; streamline process to ensure efficient reliable data obtained	Benchmarking against policy. Support system learning	Complete
4: Surveillance	Criterion 5	appropriate timeliness in LFT testing for COVID/Flu/RSV at acute setting (ED/AMU) to support immediate isolation and bed management in the trust	Early identification of infection	Complete
5. Staff practices	Criterion 10	Identify Fit mask testing reporting systems to aid swift identification of staff FFP3 fitting	Support safe practices	Complete
5. Staff practices	Criterion 6	Educate the CSM team on patient management with specific infections	Support safe practices	Complete
5. Staff practices	Criterion 5	Deliver targeted education and training on PPE including Gloves Off campaign	Support Gram Negative Bacteraemia reduction Embed Hand hygiene and BBE best practice Trust wide	Complete
5. Staff practices	Criterion 6	Relaunch #StoolSmart trust wide promoting best practice in managing patients with diarrhoea	Support staff education To support patient management	Complete
5. Staff practices	Criterion 5	Launch annual hydration campaign for 2025.26	Support Gram Negative Bacteraemia reduction	Complete

APPENDIX 3: Hospital declared Infection outbreaks

COVID-19 infection onset definition

Community onset:	<= 2 days after admission to trust	**Day 0= Day of admission**
Hospital onset **indeterminate** healthcare associated	First positive specimen date 3- 7 days after admission to Trust .	
Hospital onset **PROBABLE** healthcare associated	First positive specimen date 8- 14 days after admission to Trust .	
Hospital onset **DEFINITE** healthcare associated	First positive specimen date 15 or more days after admission to Trust .	

COVID-19 Outbreaks – 17 Outbreaks declared

Location	Date outbreak declared	No. of affected patients	No. of affected staff
Wye	13/05/2025	3	0
Leominster	20/05/2025	2	0
Ashgrove	18/06/2025	5	0
Leominster	02/07/2025	2	0
Garway	03/07/2025	2	0
Garway	21/08/2025	4	0
Leominster	21/08/2025	7	5
Bromyard	26/08/2025	2	2
Arrow	01/09/2025	3	2
Lugg	15/09/2025	9	1
Redbrook	18/09/2025	8	5
Ross- Merlin	01/10/2025	3	1
Garway	07/10/2025	4	0
Arrow	23/10/2025	2	0
Bromyard	05/11/2025	3	0
Leominster	12/01/2026	6	4
Redbrook	09/01/2026	7	3

Norovirus Outbreaks- 29 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
AMU	01/04/2025	01/04/2025	3	0
Garway	02/04/2025	22/04/2025	13	0
Frome	04/04/2025	07/04/2025	2	0
Garway	13/05/2025	16/05/2025	2	1
Garway	20/05/2025	23/05/2025	3	0
Ross- Merlin	16/11/2025	19/11/2025	5	3
Bromyard	03/01/2026	09/01/2026	12	7
Garway	05/01/2026	12/01/2026	13	4
Gilwern	06/01/2026	12/01/2026	8	6
Redbrook	07/01/2026	09/01/2026	2	1
Leominster	09/01/2026	19/01/2026	9	4
Wye	12/01/2026	15/01/2026	9	0
Arrow	13/01/2026	14/01/2026	2	0
Redbrook	03/02/2026	06/02/26	7	0
Garway	06/02/2026	08/02/26	7	0
Redbrook	17/02/2026	20/02/26	3	2
Lugg	23/02/2026	27/02/26	3	2
Arrow	26/02/2026	02/03/26	2	2
Ashgrove	26/02/2026	29/02/26	4	0
Garway	26/02/2026	06/03/26	3	3
Ross	09/02/2026	24/02/2026	13	0
Arrow	01/03/2026	08/03/2026	4	2
Ashgrove	31/03/2026	08/04/2026	4	2
Dinmore	03/03/2026	10/03/2026	8	3
Bromyard	20/03/2026	23/03/2026	2	0
Arrow	26/03/2026	31/03/2026	3	0
Ross	05/03/2026	06/03/2026	4	3
Ross	20/03/2026	27/03/2026	3	0
Ashgrove	25/03/2026	08/04/2026	8	2

Influenza outbreaks- 11 outbreaks declared

Location	Date outbreak declared	Date Outbreak incident closed COVID-19 & Flu - 14 days from last positive case Noro- 3 days from last positive case	No. of affected patients	No. of affected staff
Garway	16/04/2025	30/04/2025	3	1
Ross -Merlin	20/04/2025	06/05/2025	4	0
Redbrook	22/04/2025	19/05/2025	8	5
Leominster	28/04/2025	11/05/2025	3	0
Lugg	04/11/2025	18/11/2025	3	1
Leominster	25/11/2025	11/12/2025	8	3
Wye	12/12/2025	24/12/2025	2	0
Lugg	15/12/2025	29/12/2025	6	0
Bromyard	22/12/2025	04/01/2026	2	1
Gilwern	10/01/2026	24/01/2026	2	0
Leominster	11/01/2026	27/01/2026	4	0

CPE outbreaks- 1 outbreak declared

Location	Date outbreak declared	Date Outbreak incident closed	No. of affected patients	No. of affected staff
AMU	26/11/2025	01/01/2026	2	0

APPENDIX 4: FR1 & FR2 Domestic and Clinical cleaning scores 2021-2026

Year	FR1 Domestic Cleans	FR1 Clinical Cleans	Star Rating	Combined Star Rating
2021/22	95.8%	94.3%	4* & 3*	N/A
2022/23	96.3%	94.25%	4* & 3*	4*
2023/24	98.2%	94.16%	5* & 3*	5*
2024/25	97.5%	94.4%	5* & 4*	4*
2025/26	98.80%	94.50%	5* & 4*	4*

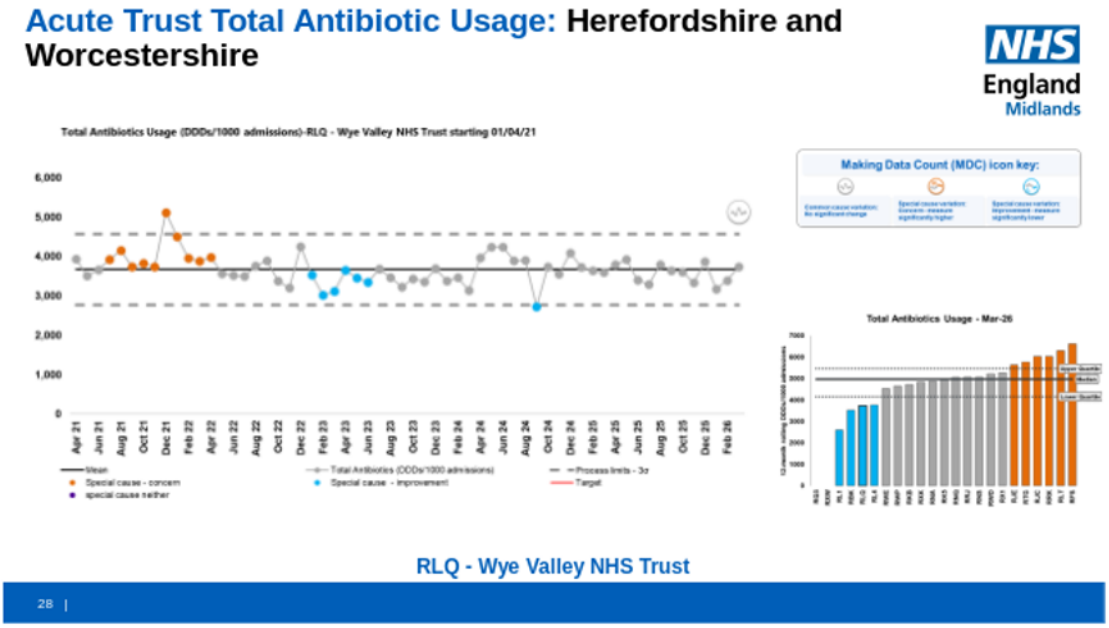
Year	FR2 Domestic Cleans	FR2 Clinical Cleans	Star Rating	
2021/22	93.7%	95.1%	4* & 5*	N/A
2022/23	93.9%	93.75%	4* & 4*	4*
2023/24	97.9%	92.4%	5* & 4*	5*
2024/25	97.5%	91.5%	5* & 3*	4*
2025/26	97.80%	93.20%	5* & 4*	5*

Appendix 5: Wye Valley NHS AMS monitoring & compliance

Antibiotic Usage 2025/26

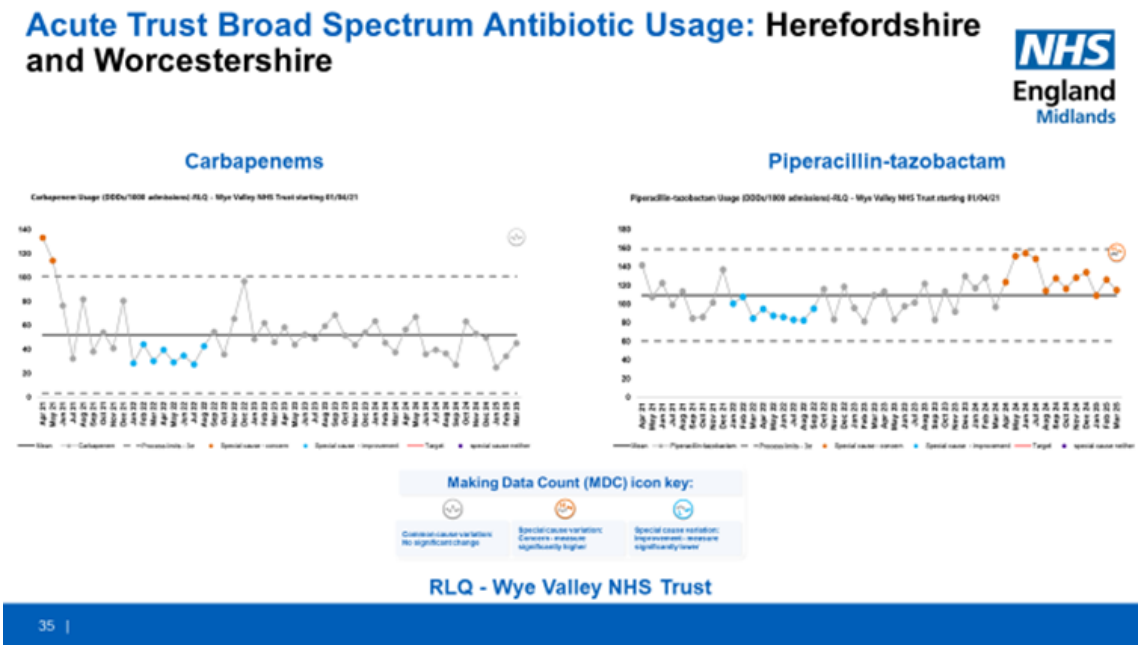
Antibiotic consumption is measured in Defined Daily Doses per 1,000 admissions (DDDs/1,000 admissions) and tracked using run chart methodology in line with NHS England Midlands regional reporting.

Total antibiotic usage, tracked from April 2021 to March 2026, has remained broadly stable over the period as a whole, with data points clustering around the process mean. The run chart does not demonstrate a sustained directional shift in total consumption during 2025/26. The regional comparative bar chart for March 2026 indicates that Wye Valley's total antibiotic usage sits in the upper range among acute trusts in Herefordshire and Worcestershire, representing a change from the position reported in 2024/25, when the Trust was recorded as having the fifth lowest usage rate in the region. This position warrants continued monitoring and forms part of the rationale for the quality improvement priorities outlined below

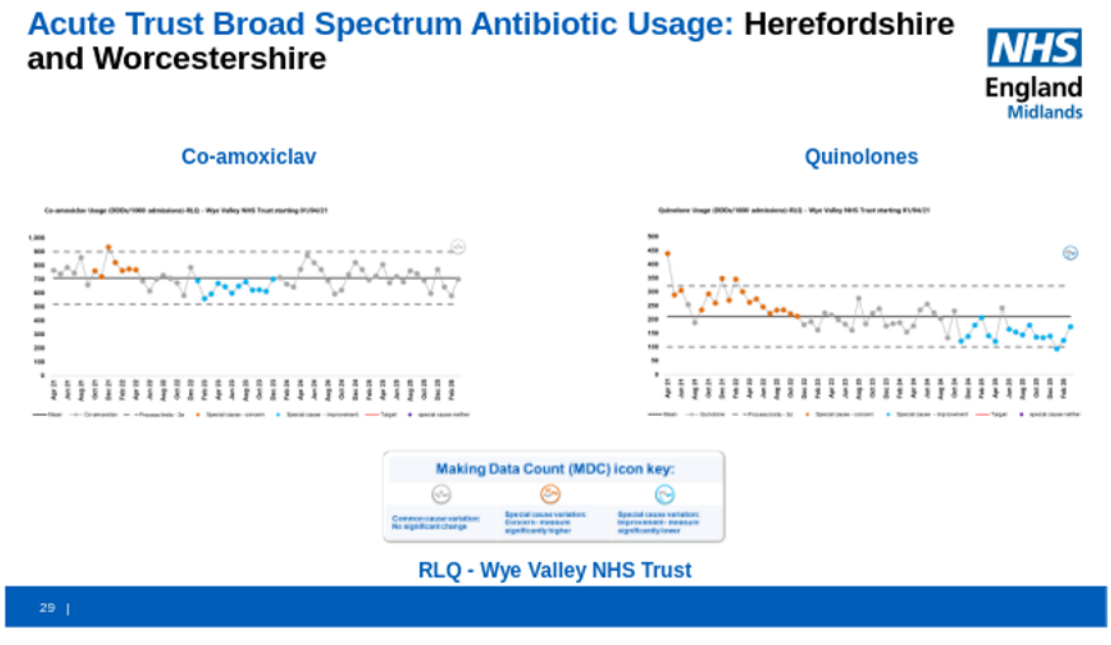


- Broad-Spectrum Antibiotic Use

Carbapenem usage remains low and broadly stable, with no evidence of a sustained upward shift. Piperacillin-tazobactam consumption is stable, although some isolated special cause variation data points have been recorded, which are kept under review.



Co-amoxiclav usage has remained within established control limits throughout the year. Quinolone use continues to show a sustained and statistically significant decline, with multiple consecutive data points recorded as special cause variation indicating improvement. This reflects the ongoing impact of the MHRA safety guidance issued in January 2024 and the Trust's active work to reduce quinolone prescribing across clinical areas



- Intravenous versus Oral Antibiotic Administration

The proportion of intravenous (IV) versus oral antibiotic administration is tracked at Trust level for both total antibiotics and a selected group of agents with established oral bioavailability — amoxicillin, co-amoxiclav, clarithromycin, clindamycin, ciprofloxacin, levofloxacin, metronidazole, and linezolid. Regional run chart data

from NHS England Midlands shows variation in the IV proportion over the monitoring period, including data points of both concern and improvement. This metric provides the baseline for the IV-to-oral switch improvement programme described below.

Quality Improvement Priorities for 2025/26

In response to the NHS England national call to action, the Trust has identified three priority improvement areas for 2025/26, each with defined targets, intended outcomes, and delivery timelines.

- Priority 1 — Intravenous-to-Oral Switch (IVOS)

The target is for 10% of eligible patients receiving IV antibiotics to switch to oral therapy within 48 hours. A timely IV-to-oral switch reduces inpatient length of stay, lowers the risk of IV line complications, and produces cost savings. The programme was targeted for launch in Q1 2026.

- Priority 2 — Reducing Broad-Spectrum Antibiotic Consumption

The aim is to align the Trust's broad-spectrum antibiotic consumption with national benchmarks published in the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) report. This will preserve antibiotic effectiveness for future patients and support the Trust in meeting national stewardship targets. Work is ongoing through a review of antimicrobial prescribing guidelines and plans to increase capacity for the Antimicrobial Stewardship Ward Round.

- Priority 3 — Digital Support and Monitoring

The objective is to establish real-time visibility of antibiotic consumption patterns across the Trust. This will enable more targeted EPMA-based interventions and support development of an advanced prescribing decision tool. A POWER BI dashboard is planned for delivery in Q1/Q2 2026.

- Outpatient Parenteral Antimicrobial Therapy (OPAT)

The Trust's OPAT service, which enables patients to receive parenteral antibiotics in an outpatient or domiciliary setting rather than requiring hospital admission, has continued to develop during 2025/26. The OPAT policy framework has now been finalised, providing the governance infrastructure required to support safe and consistent delivery of the service. A business case to secure dedicated funding for service expansion is currently being developed.

APPENDIX 6: Infection Prevention team audit plan 2025/26

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Progress
Hand hygiene & bare below the elbow (BBE) compliance	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquisition	Based on the Infection Prevention Society's hand hygiene observation tool	Trust IPC Committee	Completed
	Biannual in neighbourhood team				
Commode & toileting aid cleanliness compliance	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquisition	Locally developed tool focusing on the equipment's cleanliness	Trust IPC Committee	Completed
MRSA Screening compliance	Not applicable	Monthly in High-Risk areas	Surveillance data	Trust IPC Committee	Completed
		Monthly review of 28-day screening		Trust IPC Committee	
		Monthly monitoring of patients with known alert		Trust IPC Committee	
Infection Prevention Matrons Checklist	Monthly in all inpatient & outpatient clinical areas by Matrons	Monthly, supporting Matrons as per plan	Locally developed tool focusing on environmental cleanliness and clinical practices	Division Governance meetings	Completed
Audit of Diarrhoea & C. difficile infection management	Not applicable	Planned annual review	Locally developed tool reviewing the prevalence of patients with diarrhoea and their subsequent management	Trust IPC Committee	Completed

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Progress
Audit of Patient isolation and management documentation	Not applicable	Planned annual review	Locally developed tool reviewing the prevalence of patients with diarrhoea and their subsequent management	Trust IPC Committee	Completed
Audit use and completion of transfer documentation when patients are discharged to community hospitals and into district nurse care	Not applicable	Planned annual review	Locally developed tool monitoring communication between providers regarding a patient's infectious status & management	Trust IPC Committee	Pending; In Progress
High Impact Interventions	Quarterly	Following lapses in care being identified following HCAI Review panel	Based on the Infection Prevention Society's High Impact Intervention Care Bundles	Trust IPC Committee	Completed
- Urinary indwelling catheter		Completed as planned			
- Peripheral venous cannula					
- Central Venous Access Device					
- Ventilated patient					
NHSE Standard Infection Control Precautions SICP assurance audits	NA	Annual programme developed to ensure all clinical areas are audited	NHSE audit tool 2025	Trust IPC Committee	Completed

Audit	Clinical area self-audit frequency	Infection prevention team validation audit frequency	Audit tool	Reporting forum	Progress
National Standards for healthcare Cleanliness 2025: Efficacy audits:	Annually per clinical area	Planned annual review of all patients facing FR1,2,3 and 4 areas	National tool	Cleanliness committee	Completed
Mattress cleanliness and integrity audit	Monthly in all inpatient & outpatient clinical areas	Completed post HCAI acquisition & manage annual review	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Completed
		Annual programme supported by external suppliers	Locally developed tool reviewing the cleanliness and integrity of all mattresses	Cleanliness committee	Completed
PLACE	NA	Annual programme supported by patient representatives	National tool	Trust IPC Committee	Completed
One Together audits	Annually per Theatre / increased frequency on clinical need	Planned Annual review	National tool	Surgical Division	Completed

NHS Wye Valley NHS Trust

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board
Date of Meeting:	3 September 2026
Title of Report:	Annual Review of Audit Committee Effectiveness 2025/26
Lead Executive Director:	Managing Director
Author:	Gwenny Scott, Associate Director of Corporate Governance and Company Secretary
Reporting Route:	Audit Committee
Enclosures included with this report:	Revised Committee Terms of Reference
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

An annual review of the effectiveness of the Audit Committee is considered good governance and best practice to ensure the Committee is meeting its terms of reference, in particular its duties and responsibilities with regard to the oversight of a robust system of governance, risk management and control.

In addition to guidance and tools provided by the Healthcare Financial Management Association (HFMA), the report is informed by a set of measures and a member survey focused on Committee impact.

Recommended Actions required by Board or Committee

The Trust Board is asked to:

- Review the report and take assurance that the Committee met its duties during 2025/26.
- Note the plans approved by the Audit Committee to strengthen effectiveness in 2026/27.
- Approve the revised Terms of Reference.

Executive Director Opinion[1]

The report has been reviewed and approved by the Audit Committee.

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

Annual Review of Audit Committee Effectiveness 2025/26

Contents

1. Introduction

This report summarises the work of the Audit Committee during 2025-26 in discharging its duties as set out in its terms of reference.

The report should be read in conjunction with the Annual Governance Statement, which is part of the Trust's Annual Report.

The following documents are available as appendices to the report.

a) Review of compliance with terms of reference
b) Committee attendance record
c) Committee Process Checklist (HFMA)
d) Committee Effectiveness Checklists (HFMA)
e) Draft Revised Committee Terms of Reference
f) Record of Committee reporting

2. Meeting the Terms of Reference

a) Terms of Reference Compliance Review

The terms of reference are substantially aligned with the model published by the Healthcare Financial Management Association (HFMA).

The Committee met its terms of reference in full, with the following exceptions.

Term	Comment	Recommended Action
The Minutes of Audit Committee meetings shall be formally recorded and the approved Minutes will be submitted to the Board. Following each meeting, the Committee Chair will submit a formal report on the proceedings of the meeting, drawing the Board's attention to any issues that require disclosure to the full Board, or require executive action, to the next meeting of the Board	Only an escalation and assurance report is now presented to the Board, with minutes noted as available.	Change term of reference to align with practice.

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance, risk management and assurance of the organisation, to include IT security and information governance.	Limited focus in this area.	Strengthen focus on other assurance functions and linkages with other committees and avoid overlap/ duplication.
These will include, but will not be limited to, understanding the implications of working in an Integrated System, ensuring arrangements are aligned and any impact on the Trust's governance arrangements. Also any reviews by NHS England, Department of Health and Social Care arm's length bodies, Regulators/Inspectors (eg Care Quality Commission (CQC), NHS Resolution, etc), NHSCFA and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).	Much of this falls into the scope of the Quality Committee	Ensure this is included in the Committee's review of the work of the Quality Committee.
In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and the Executive Risk Management Committee.	Limited in-year to a review of the FRB terms of reference and the work of the Internal Auditor in relation to risk management arrangements.	Schedule reviews of the work of the other committees.
In reviewing the work of the Quality Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function including that the quality account presents accurate data and meets the reporting requirements as prescribed nationally.	Not included in-year. The expectations of the committee in relation to the quality account are now expressed differently in the HFMA handbook and example terms of reference*	• Consider the most effective way to meet this requirement. • Revise the term of reference to align with updated guidance.

b) Committee Meeting Attendance

The record shows good attendance from all members, a quorum at each meeting and good attendance and engagement from managers and auditors in line with the terms of reference.

c) HFMA Process Checklist and Effectiveness Checklist

Completion of the checklists has highlighted opportunities for improvement in similar areas to the terms of reference compliance review:

- Working with and assurance from other Board committees.
- Oversight of assurance from sources other than the auditors and LCFS.

d) Terms of Reference Revisions

Proposed revisions to the Terms of Reference are set out in the attached Appendix.

In addition to changes recommended in the review of compliance above, the following changes are proposed in line with the up to date HFMA model:

- More explicit confirmation that the Head of Internal Audit, External Audit representative and Local Counter Fraud Specialist (LCFS) have direct and unrestricted access to the Committee Chair and/or Committee as required.
- Updated terminology regarding internal audit.
- Extending the private meeting provision to include the LCFS alongside the internal and external auditors.
- Additional wording about the requirement for an annual committee effectiveness review.

3. Oversight of the system of governance, risk management and control

a) Committee Work Programme

An annual work programme was set at the start of the year based on the audit cycle, annual report and accounts, internal audit cycle and other key responsibilities within the Terms of Reference.

The work programme covered the following areas:

- Annual Accounts and Report
- Annual Governance Statement
- External Audit updates and annual report
- Work of the Internal Auditor in delivering the annual plan.
- Work of the local Counter Fraud Specialist (LCFS), both planned and reactive.
- Financial governance matters:
    - Single tender waivers
    - Losses and special payments/compensation
    - Contract management
    - Accounting policies
    - Invoicing error
- Governance and regulatory matters:
    - Manging conflicts of interest
    - Fit and Proper Person Test (FPPT)
    - Process for Raising concerns (freedom to speak up)
    - Annual review of compliance with Terms of Reference
    - Effectiveness review of Financial Recovery Board
- Risk management:
    - BAF process, format and controls
    - Financial accounting risks
- Other Assurance reports: management reports
    - Consultant job planning
    - Pre-operative improvements
    - Radiology Managed Equipment Service Business Case Evaluation

b) System of Risk Management

The Trust's system of risk management is described in detail in the Annual Governance Statement.

Each year, the Internal Audit Plan includes a review of risk management, with a particular focus on the Board Assurance Framework (BAF), as a core review pertinent to the Head of Internal Audit opinion. The outcome of each of the annual audits from 2022/23 is set out in section 6 of this report.

The BAF format and approach were revised in-year, with each strategic risk aligned to relevant annual strategic objectives and Trust priorities. The Audit Committee received regular reports on the new BAF during the second half of the year.

c) Internal Audit

The work of the Internal Auditor during the year is described in detail in the Annual Governance Statement. The outcome of each review from the 2025/26 Internal Audit Plan is set out below. Each report included management responses to the review recommendations. The Committee reviewed the responses and where it was not satisfied that these were sufficiently robust or realistic in terms of timescales, amendments were requested. Where appropriate, a detailed update on progress of management actions was requested. The Internal Auditor tracked completion of recommendations and provided a regular report, focused in particular on high and medium priority actions (see below).

Possible ratings:

Substantial assurance
Reasonable assurance
Partial assurance
Minimal assurance
Advisory/NHSE

Review	Rating
Fit and Proper Person Test	Substantial assurance
Risk management and Board Assurance Framework	Substantial assurance
Key Financial Controls: Contract management	Partial assurance
Community Services	Reasonable assurance
Theatre services productivity and utilisation	Reasonable assurance
Medical job planning	Reasonable assurance
Cyber Assessment Framework-aligned Data Security and Protection Toolkit (DPST)	Risk rating: Medium Confidence level: High

d) Other Assurance: Management Reports

In addition to routine governance matters and reports from the Auditor and LFCS, the Committee received management reports on three areas:

- Medical Consultant job planning

An internal audit on this subject was completed in 2022/23, with a rating of partial assurance. During the following years, the Committee received regular updates on management's progress in implementing improvements, with the last report in December 2025, which provided assurance that good progress was being made. An internal audit review was reported in March 2026, with an improved rating of reasonable assurance. The Committee was assured by the management response to the recommendations.

- Pre-Operative Improvements

The Committee received an update on progress with improvements following an internal audit in 2024/25, which was rated reasonable assurance. Although some progress was noted, the Committee was not assured that all recommendations had been implemented and requested a final report confirming completion of all recommendations to close the audit cycle.

- Radiology Managed Equipment Service (MES) Business Case Evaluation

The MES was set up in 2018. The Committee was assured that the evaluation demonstrated achievement of the business case objectives, with particularly strong evidence of operational and quality benefits.

e) Governance: Other Committees with Assurance Functions

- Quality Committee

During the year the Quality Committee increased its focus on divisional risk registers and added to its work programme a regular review of relevant risks in the BAF.

The Committee also adopted the escalation and assurance report format to enhance the focus on assurance in its reports to the Trust Board, directing attention to priority areas, which will support future internal audit planning.

- PFI Expiry Committee

Although not a strategic objective in 2025/26, the PFI expiry was viewed as a high priority for the Board during the year. The Committee oversaw a new BAF risk connected with the main programme workstream risks.

The Audit Committee agreed that sufficient independent assurance was incorporated within the PFI expiry programme and it was not therefore a priority area for Internal Audit focus in 2025/26 or 2026/27.

- Integrated Care Oversight and Assurance Committee

The new Committee was established in 2025/26 on the foundations of the Integrated Care Executive and has delegated authority from the Board to oversee the Trust's responsibilities within the One Herefordshire Partnership. The Partnership's work, particularly the Neighbourhood Health Programme, is key to mitigating several of the Trust's strategic risks, particularly those relating to patient flow. The new Committee agreed to oversee a strategic risk connected with its work, which was added to the BAF.

- Executive Risk and Compliance Committee

The terms of reference of the Executive Risk Management Committee were refreshed during the year and the name changed to reflect an enhanced focus on regulatory compliance and general risk management as well as the established detailed focus on individual high and very high risks. The Committee has no non-executive membership. Reports from the refreshed committee will be included alongside BAF reports to the Board from 2026/27.

- Financial Recovery Board

The FRB membership comprises all Board members and is not therefore truly a Board committee; however, this important forum provides a regular opportunity for more detailed scrutiny of and assurance about the delivery of the annual financial plan.

The terms of reference of the FRB and its work in its first year of operation were reviewed by the Committee during 2025/26.

- Relationships with other Assurance Committees

There is cross membership between the Audit Committee and all of the above committees, with the exception of the Executive Risk and Compliance Committee, in which case the link is provided by the Chief Finance Officer and the Associate Director of Corporate Governance.

Where appropriate, internal audit reports are referred by the Audit Committee to another relevant Board assurance committee for more detailed oversight.

The Audit Committee did not review the work of any committee other than the FRB during 2025/26.

f) Financial Reporting Systems

The Committee's assurance on the reliability and quality of the Trust's financial reporting systems comprised the following:

- Internal Audit Review: Financial Controls

A financial controls review based included in the annual plan, with a different focus each year, is a key source of assurance for the Head of Internal Audit Opinion. The 2025/26 review was focused on contract management and was rated partial assurance. The report was presented after the year-end.

- Counter Fraud Annual Report

The report includes an assessment of the Trust's compliance with the Counter Fraud Functional Standard. In 2025/26 the overall rating was green – fully compliant with requirements.

The Local Counter Fraud Specialist (LCFS) presented to the Committee an updated fraud risk register at the close of the year. This included one very high risk related to cyber security, which aligns with the Trust's risk assessment and BAF risk. All financial fraud risks were rated medium (score of 9) or lower.

During the year, the LCFS undertook a local proactive exercise, reviewing the Trust's processes to manage conflicts of interest. This resulted in a fraud risk rating of medium (9) and two medium and one low priority recommendations.

- External Audit:

The External Auditor highlights any areas of significant weakness in financial sustainability, governance or economy, efficiency and effectiveness. The number of weaknesses identified has reduced each year since 2023/24.

- Review of effectiveness of Financial Recovery Board

As described above.

- Financial governance reports
    - **Single tender waivers**: The Committee receive regular reports on single tender waivers containing sufficient detail to assure the Committee that the controls in place were robust and continued to develop. The LCFS risk assessment related to this scored medium (9).
    - **Single Tender Waivers - PFI Contract**: An additional report in September 2025 provided assurance to the Committee that, while there were separate arrangements, there were appropriate procedures in place to ensure that, within

the constraints of the PFI contract, value for money was obtained on the Trust's behalf.

- **Contract Management**: A report in September 2025 provided assurance that through the implementation of a new system, the Trust had strengthened its central control of contract management and that the approach continued to develop and improve.
- **Business Case Evaluation – Radiology Managed Equipment Service**: The Committee was assured that the benefits of the business case were realised.

- Review of Financial Statements

The Committee held a meeting in private dedicated to a detailed review of the unaudited financial statements and the draft Annual Governance Statements.

No significant issues related to the financial statements were highlighted.

No major weaknesses in governance systems were highlighted in the Annual Governance Statement.

4. Performance and Effectiveness of External Audit

The Auditor discussed the audit plan with the Committee at an early stage and the audit planning report was presented to the Committee before the start of the Audit.

There were reportedly positive relationships between the Auditor and management/the finance team.

The Committee received regular updates from the External Auditor on progress of all stages of the audit.

The External Auditor also provided additional information to the Committee on sector benchmarking and sector developments, which added value.

5. Performance and Effectiveness of Internal Audit

- **Delivery of the Internal Audit Annual Plan**

The annual Internal Audit Plan comprises mandatory reviews of topics which are core to the annual Head of Internal Audit Opinion and prioritised risk-based reviews of areas recommended by the Executive Team and agreed by the Committee.

The Committee received regular updates on delivery of the Internal Audit Plan, including performance on agreed KPIs for both the Internal Auditor and Trust management. The plan was largely complete by year-end, enabling the completion of the Head of Internal Audit Opinion in May 2026. One review remained outstanding.

- **Recommendation Tracking**

Recommendations made by the Internal Auditor are ranked according to priority: advisory, low, medium and high. Implementation of agreed recommendations was closely tracked and the position was regularly reported to the Committee during the year, with any due date revisions highlighted.

The reports provided assurance that management took internal audit and the need for assurance seriously and that actions were implemented in a timely way, reducing the duration of the Trust's exposure to risk.

The annual Head of Internal Audit Opinion provides an opinion on progress and in 2025/26 this was described as 'reasonable'.

6. Impact of the Audit Committee

As well as considering whether the Committee met its terms of reference and standards of best practice, this report considers the Committee's effectiveness in terms of its impact. Following Committee agreement, two sources of information were used as part of this assessment:

a) Key measures, with annual comparators where available, providing a picture of the Committee's impact or influence on its areas of oversight over time
b) Committee member Survey

Details of these two sources are provided below.

Audit Committee Impact Metrics

Indicator	2022/23	2023/24	2024/25	2025/26	Comment
External Audit: No. of financial sustainability weaknesses	1	2	2	2	Improvement in last 2 years but persistent issues
External Audit: No. of governance weaknesses	0	2	1	0	Improvement over time
Head of Internal Audit Annual Opinion (summarised)	An adequate and effective framework for risk management, governance and internal control. Further enhancements identified to ensure that it remains adequate and effective.	An adequate and effective framework for risk management, governance and internal control. Further enhancements identified to ensure that it remains adequate and effective.	An adequate and effective framework for risk management, governance and internal control. Further enhancements identified to ensure that it remains adequate and effective.	An adequate and effective framework for risk management, governance and internal control. Further enhancements identified to ensure that it remains adequate and effective.	Consistent every year
Internal Audit: Key Financial Controls	Reasonable assurance	Reasonable assurance	Reasonable assurance	TBC	Consistent every year
Internal Audit: BAF & Risk Management	Partial assurance	Reasonable assurance	Substantial assurance	Substantial assurance	Improvement over time
Internal Audit: Data security & protection toolkit*	Substantial assurance	n/a	Risk: very high Confidence: low	Risk: medium Confidence: high	Improvement over time
Internal Audit: Consultant/Medical Job Planning	Partial assurance	n/a	n/a	Reasonable assurance	Improvement over time
Internal Audit: Implementation of management actions	Not reported in annual opinion	16 overdue at year end plus 13 outstanding from previous years.	Reasonable progress	Reasonable progress	Improvement in 2024/25 sustained
LCFS: Counter fraud functional standard return	Green	Green	Green	Green	Consistent every year
Number of fraud referrals	6	20	12	14	Variable

**Change of scope in 2024/25*

Audit Committee Member Survey

Following consideration by the Committee earlier in the year, the Chair agreed a series of questions to include in a survey of Committee members with a view to assessing the impact of the Committee. The same survey was implemented at the Trust's partner trust, Worcestershire Acute Hospitals NHS Trust, which will provide opportunities for benchmarking and sharing.

Summary

Committee members answered 'agree' or 'strongly agree' in response to all questions:

- The Committee has added value to the Trust
- The Committee sought development and improvement of its own structure and approach
- There is evidence of tangible improvements to practice or compliance as a result of the work of the Committee
- The internal audit and counter fraud plans covered all the highest priority areas
- Where internal audits provided limited assurance, the Committee ensured it followed up on progress
- Progress reports on areas with limited assurance showed improvement
- The Committee received sufficient assurance from other sources on lower priority areas
- Managers were positive and transparent in responses to independent audits and reviews
- The outcome of independent audit and reviews have resulted in significant improvements to internal controls
- Areas reviewed annually by the Committee have shown improvement
- The Committee engaged well with the other Committees of the Trust Board

Key strengths are highlighted as follows:

- There is clear evidence of improved performance in a number of areas due to the focus of the Committee. Examples include consultant job planning, financial year-end reporting and governance reporting.
- Positive feedback from and good relationships with Internal and External Audit.
- Audit is generally seen as positive within the Trust.
- Internal controls have improved.
- Internal audit is used constructively, with the internal audit plan focused on areas requiring improvement.
- Non-executive and executive engagement in the work of the Committee.

Areas highlighted as opportunities for the Committee to be more effective:

- More regular reflection on progress and effectiveness.
- Identify and adopt best practice from other Foundation Group Audit Committees.
- Obtain manager feedback.

Suggested Committee Objectives

- Widen focus on assurance from other sources by scheduling a selection of local audit or self-assessment priorities within the Committee work programme.

7. Conclusions and recommendations

The report demonstrates overall good compliance with the terms of reference and current NHS guidance, with some areas for improvement to strengthen the Committee's oversight of the Trust's governance arrangements and internal controls.

Through its work during the year, the Committee was assured that:

- the Trust's system of risk management is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks.
- the assurance framework is fit for purpose and that the assurances and the reliability and integrity of the sources of assurance are sufficiently comprehensive to support the Board's decisions and declarations.
- there are no outstanding areas of significant duplication or omission in the Trust's systems of governance that have come to the Committee's attention.

Recommended actions

1.	Update terms of reference to align with updated HFMA model
2.	Add to each meeting agenda time to reflect on the Committee's effectiveness and impact
3.	Add to annual work programme reviews of the effectiveness of: • Quality Committee • Financial Recovery Board • Integrated Care Oversight and Assurance Committee • PFI Expiry Committee • Executive Risk and Compliance Committee
4.	Add to annual work programme an agreed schedule of local assurance reports on key internal control matters or areas of concern, guided by longlisted topics not included in the final internal audit plan.
5.	Share learning from this review with Foundation Group partner trusts and invite learning from their identified areas of good practice.

Wye Valley NHS Trust
Audit Committee
TERMS OF REFERENCE

Remit	The Committee is established by the Trust Board (hereafter referred to as the Board), in accordance with the Trust's Standing Orders, as an Audit Committee ~~in relation~~ to provid~~e~~ing assurance to the Board, specifically in relation to internal controls, risk management and the Trust's overarching governance framework.
Accountability Arrangements and Authority	The Committee is accountable to the Board in accordance with the following paragraphs of the Standing Orders: • The Trust shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate. The Committee has the full support of the Board and ~~the Board has~~is authorised ~~the Committee~~ to: • investigate any activity within its Terms of Reference. • seek any information it requires from any employees and all employees are directed to co-operate with any request made by the Committee. • to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Responsibilities	Governance, Risk Management and Internal Control The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ~~organisation's~~ Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of: • all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board. • the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of disclosure statements. • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence. • the policies and procedures for all work related to counter fraud, bribery and corruption as required by NHS Counter Fraud Authority (NHSCFA). In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of

	integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it. As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not undertake the Committee's role. <u>Internal Audit</u> The Committee shall ensure that there is an effective internal audit function that meets ~~public sector~~Global Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable/Accounting Officer and Board. This will be achieved by: • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal. • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. • consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between Internal and External Auditors to optimise the use of audit resources. • ensure a robust system is in place to follow up internal audit, external audit, value for money and any other audit reports presented to the Committee, based on agreed management action plans. • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. • monitor the effectiveness of internal audit by carrying out an annual effectiveness review. <u>External Audit</u> The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors, and consider the implications and management's responses to their work. This will be achieved by: • consideration of the appointment and performance of External Audit, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate). • discussion and agreement with External Audit, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy. • discussion with External Audit of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee. • review of all External Audit reports, including reports to those charged with governance and any work undertaken outside the annual audit plan,

	together with the appropriateness of management responses and also recommend the annual audit letter to the Board. • Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services. • Ensuring that the External Audit tenure of appointment conforms with the code of governance regarding rotation of key audit personnel and the provider as a whole. • The Committee shall ensure the cost effectiveness of External Audit. <u>Other Assurance Functions</u> The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance, risk management and assurance of the organisation, to include IT security and information governance. These will include, but will not be limited to, understanding the implications of working in an Integrated System, ensuring arrangements are aligned and any impact on the Trust's governance arrangements. Also any reviews by NHS England, Department of Health and Social Care arm's length bodies, Regulators/Inspectors (eg Care Quality Commission (CQC), NHS Resolution, etc), NHSCFA and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc). In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee and the Executive Risk Committee/Executive Risk Management Committee. In reviewing the work of the Quality Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and the robustness of processes behind the quality accounts. ~~including that the quality account presents accurate data and meets the reporting requirements as prescribed nationally.~~ <u>Counter Fraud</u> The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and shall review the outcomes of counter fraud, bribery and corruption work that meet NHSCFA's standards and shall review the outcomes of work in these areas. With regards to the local counter fraud specialist, it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports. <u>Management</u> The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

	It may also request specific reports from individual functions within the organisation (eg clinical audit, ICT, compliance reviews and accreditation reports) as they may be appropriate to the overall arrangements. Financial Reporting The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on: • the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee. • changes in, and compliance with, accounting policies, practices and estimation techniques. • Changes in, and compliance with guidance issued by NHS England. • unadjusted misstatements in the financial statements. • significant judgements in preparation of the financial statements. • significant adjustments resulting from the audit. • Letter of representation. • Explanations for significant variances. • Qualitative aspects of financial reporting.~~:~~ • The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. • The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. Suspension of Board Standing Orders The Committee shall review every Board decision to suspend the Board Standing Orders. System for Raising Concerns The Committee shall review the effectiveness of the arrangements in place for allowing staff ~~(~~and contractors~~)~~ to raise, ~~(~~in confidence,~~)~~ concerns about possible improprieties in any area of the organisation, including ~~(~~financial, clinical, safety or workforce matters.~~)~~ The Committee shall seek assurance ~~and ensure~~ that any such concerns are investigated proportionately and independently, and in line with the relevant policies. Governance Regulatory Compliance The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test. Conflicts of Interest The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, ~~(~~including gifts and hospitality and bribery~~)~~ are effective. This will includ~~e~~ing receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Membership / Attendance	The Members of the Committee are: • Not less than three Non-Executive Directors. • One of the members shall have recent and relevant financial experience. • A Non-Executive Director maybe coopted to attend a meeting to ensure the quorum of two Non-Executive members is met. The Chairperson of the Trust shall not be a member of the Committee. The Chief Finance Officer, ~~Trust~~ Company Secretary and appropriate Internal Auditor, External Auditor and Local Counter Fraud Specialist representatives shall normally attend meetings. At least once a year the Committee will meet privately with External Audit, ~~and~~ Internal Audit and the Local Counter Fraud Specialist, either separately or together, and may do so more frequently where required. The Head of Internal Audit, External Audit representative and Local Counter Fraud Specialist shall have direct and unrestricted access to the Committee Chair and/or Committee when required. This access is intended to support timely escalation of significant governance, risk, control, audit and counter fraud matters. The Chief Executive, Managing Director, Chief Officers and other Managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Chief Executive will attend at least annually, to discuss the process for assurance that supports the Annual Governance Statement and also when the Committee considers the annual accounts. The Managing Director will attend when the Committee considers the draft internal audit work plan. In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the Chair's approval. The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. The Audit Committee, supported by the Chief People Officer, will ensure that all members are suitably trained and have continuing appropriate training to enable them to be effective.
Chair	The Chair of the Committee shall be appointed by the Board from amongst the Non-Executive Directors. The Vice Chair or Senior Independent Director should not Chair the Audit Committee. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the Chair.
Quorum	A quorum shall be two Non-Executive members, to include the member with significant, recent and relevant financial experience/ Chair of the Committee (who will be a voting Non-Executive Director).

Reporting Arrangements	The Minutes of Audit Committee meetings shall be formally recorded and the approved Minutes will be made available for review by~~submitted to~~ the Board. Following each meeting, the Committee Chair will submit a formal report on the proceedings of the meeting, drawing the Board's attention to any issues that require disclosure to the full Board, or require executive action, to the next meeting of the Board. The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts. The Committee shall undertake an annual effectiveness review. The outcome of the review will be reported to the Committee and Boad and will inform any proposed amendments to these Terms of Reference.
Frequency of Meeting	The Committee will hold scheduled meetings not less than four times a year. The External Auditor or Head of Internal Audit may require a meeting if they consider that one is necessary~~. Therefore~~ and the Committee Chair may convene additional meetings as necessary. An annual work programme will be maintained to ensure that meeting dates and agendas are planned around the audit cycle, annual report and accounts, Annual Governance Statement, governance reporting, risk and assurance cycles, counter fraud reporting and other key responsibilities within these Terms of Reference.
Administration	The Trust Secretary will provide appropriate support to the Committee Chair and Committee members which will include: • Advising the Committee on pertinent areas relating to governance and risk management arrangements. • Supporting the Chief Executive as Accountable Officer on issues in relation to internal controls, governance and risk management particularly providing assurance on such systems through the drafting of the Annual Governance Statement. • The development of an annual programme of work for the Committee to approve. The Committee shall be supported by a nominated Executive Assistant/Board Administrator, whose duties will include: • Preparation of agenda in consultation with the Committee Chair and Chief Finance Officer. • Collation and publishing reports / presentations at least 5 working days in advance of the meeting. • Taking the Minutes, ensuring they are an accurate reflection of the business of the meeting and keeping an accurate record of matters arising and issues to be carried forward. • Ensuring the Minutes and actions are circulated to the Committee Chair for review within 5 working days of the meeting and circulated to the other members for information within 10 working days.

	• Keeping a record of matters arising and seeking updates on action points ready for the next meeting.
Date Approved	~~WVT Committee on 12 December 2024~~ ~~Foundation Group Boards on 5 February 2025~~By Audit Committee on: By Trust Board on:
~~**Date**~~ **Review**	~~To be reviewed annually.~~ These Terms of Reference will be reviewed annually, and more frequently if required. The annual review will take account of the Committee's effectiveness review, changes to national guidance, changes to Trust governance arrangements and any learning arising from internal audit, external audit, counter fraud or Board assurance processes.

Escalation and Assurance Report

Report from: Integrated Care Oversight and Assurance Committee
Date of meeting: 16 June 2026
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Finance Report: Herefordshire Better Care Fund (BCF)**
Rating rationale	The 2025/26 Outturn was revenue: £2.459m overspend, capital: £0.251m underspend. Based on partner budgets, funding reduction assumptions and cost pressures, the year was starting with a cost pressure of nearly £1.3m. Options to balance the BCF plan continued to be considered. Year to date financial performance information was not yet available due to the continued focus on developing a balanced plan.
Outcome	The Committee noted the significant financial risk and the ongoing work to address it.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**One Herefordshire Health and Care Partnership Board Assurance Report**
Rating rationale	The Committee was assured about progress in developing the neighbourhood health model but noted significant risks relating to the LICU operational and contractual position, financial pressures within the BCF and procurement and commissioning constraints that could slow the pace of transformation. Key escalations were: • The Partnership Board was focused in particular on a plan to mitigate and eliminate the LICU financial risk (£1m). • Procurement rules and commissioning arrangements were creating barriers and delays and a sustainable way forward was needed. • BCF budget as above • Neighbourhood Health capital funding uncertainty. The Partnership Leadership Team had been appointed, with the exception of the finance role, which would be covered by the Trust's CFO in the meantime.
Outcome	The Committee noted the report and was assured that the Partnership Board was appropriately managing the significant risks.
Item/Topic	**Discharge to Assess (D2A) Transformation Programme Update**

Summary	The Committee was assured that:
	• The revised model had been fully implemented.
	• Good progress was being made on all workstreams.
	• A comprehensive performance framework was in place.
	• There were clear governance and assurance arrangements.
	• Key risks were being actively managed, including:
	  ○ Workforce capacity constraints
	  ○ Provider sustainability
	  ○ Demand exceeding available capacity.
	The focus over the coming months would be:
	• Improving system flow and discharge performance.
	• Greater clarity and consistency in pathway delivery.
	• Enhanced partnership working and shared accountability

Outcome	The report was accepted.

To Note: Items received for information or approval	
Item/Topic	**Performance Dashboard Development**
Summary	A performance dashboard was in development to cover all services within the MOU. This would provide improved oversight of the areas covered by the BCF.
Outcome	The Committee supported the principles upon which the planned performance dashboard would be based. It was agreed that the dashboard would be reported monthly to the Partnership Board with an exception report to the Committee at each meeting, focused on the Trust's responsibilities.

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

Escalation and Assurance Report

Report from: Integrated Care Oversight and Assurance Committee
Date of meeting: 16 June 2026
Report to: Trust Board

Item/Topic	Board Assurance Framework Risk: Partnerships
Summary	The risk summary had been updated to reflect in particular the new Trust strategic objectives and the Big Moves Transformation Programme arrangements. Further updates would be made based on the Committee's discussions before submission to the Board.
Outcome	The Committee agreed that the risk score had not changed, accepted the updates and agreed the following additions: • 2025/26 BCF financial outturn (assurance) • 2026/27 BCF risk (gap in control)

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

Escalation and Assurance Report

Report from: Integrated Care Oversight and Assurance Committee
Date of meeting: 18 August 2026
Report to: Trust Board

Summary:
The Committee received assurance on continued progress with the One Herefordshire partnership and strong operational performance across Urgent Community Response, Virtual Ward and Falls Response, alongside early implementation of the revised Discharge to Assess (D2A) model. The principal matters for Board attention are the ongoing Ledbury Intermediate Care Unit (LICU) contractual, financial, operational and reputational risk; uncertainty over capital funding and asset arrangements for the Care Coordination Centre; reduced neighbourhood health programme capacity; and the forecast Better Care Fund (BCF) overspend. Mitigations are in progress but require continued integrated operational and financial oversight

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Finance Report**
Rating rationale	Month 3 reporting forecast a BCF overspend of £0.087 million. Pressures in Hillside and short-term care-home beds were partly offset by forecast underspends in community D2A services. The forecast relied on Home First and enablement activity, reduced pricing from October and average D2A length of stay reducing to 35 days from October. The continuing LICU commitment remained a material exposure. A more integrated report was in development to more clearly articulate operational performance and financial consequences together.
Outcome	**Actions planned and agreed:** • Maintain close monthly oversight of the BCF forecast and align each pressure with a clear operational mitigation and delivery trajectory. • Implement integrated finance and performance reporting, clarifying where reporting periods or national data lags differ. • Bring forward proposals for future commissioning of Home First and related bridging provision, including anticipated savings and service benefits.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**One Herefordshire Health and Care Partnership Board Assurance Report**
Rating rationale	Good progress continued on the Neighbourhood Health model, with stronger governance and more standardised programme reporting. Mobilisation planning was progressing for the 24/7 end-of-life telephone line and revised fast-track arrangements, pending finalisation of specification and confirmed start dates. Approximately £2 million of existing capital allocation had been identified for a Care Coordination Centre, with escalation through the ICB to NHSE to resolve asset ownership, change-control and governance arrangements. LICU remained unused. The loss of capacity created winter pressure, while the contractual position (running till July 2027) presented continuing financial, value-for-money and reputational risk. Temporary leadership capacity issues in the Neighbourhood Health programme were creating delivery pressures.
Outcome	**Actions planned and agreed:** Develop an alternative winter proposal to replace the lost LICU capacity and seek ICB funding through the Partnership Board. Progress escalations to secure decisions on capital funding, asset ownership and governance arrangements for the Care Coordination Centre. Maintain oversight of neighbourhood health programme capacity and confirm the arrangements required to sustain delivery and benefits realisation.

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

Escalation and Assurance Report

Report from: Integrated Care Oversight and Assurance Committee
Date of meeting: 18 August 2026
Report to: Trust Board

Item/Topic	Operational Performance Report and Discharge to Assess Update
Rating rationale	Urgent Community Response (UCR) demand remains significantly above 2025 levels. Of all urgent two-hour referrals, 91.3% were seen within two hours against the 70% national standard. Only 12.8% required escalation to ED and 36 patients were subsequently admitted. Development of a 24/7 service and stronger links with ED and same-day emergency care provided further opportunity to avoid admission and support earlier return home. Virtual Ward occupancy had improved and reconfiguration was focusing capacity on frail older people and step-up admission avoidance. The falls response service was benefiting from integration with the Single Point of Access, allowing immediate referral to therapy, nursing and prevention support. The revised D2A model launched in June and was supported by a system case tracker and strengthened escalation arrangements. The new model required time to embed. Development of the system D2A dashboard was well advanced, with completion expected in September. D2A discharge delay remained the principal performance concern. Key barriers were packages of care, community support assessment and therapy.
Outcome	**Actions planned and agreed:** • Provide further assurance on UCR acuity benchmarking. • Include total Virtual Ward bed numbers and overall occupancy in future reports. • Use the new D2A dashboard to report pathway-level activity, length of stay, overstay position, barriers to progression and delivery against agreed KPIs. • Consider whether patients with complex D2A delays should be linked more explicitly to Neighbourhood Health priority cohorts.

To Note: Items received for information or approval	
Item/Topic	**Risk Review: BAF08 Partnerships**
Summary	The risk remained scored 16 (4 × 4), with a target score of 8 and a static direction of travel. Controls had strengthened through the Alliance Agreement, revised D2A governance, the Neighbourhood Health Delivery Board and the Transformation Programme, but significant BCF financial risk remained.
Outcome	The next review should explicitly test whether controls and actions adequately address the continuing gaps: delivery capacity for the Neighbourhood Health programme, the LICU and wider BCF financial exposure, Virtual Ward alignment with demand, and sustained D2A demand affecting flow and cost.

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

Escalation and Assurance Report

Report from: Executive Risk and Compliance Committee
Date of meeting: 19 August 2026
Report to: Trust Board

Summary:
The Committee reviewed assurance reports from the Health and Safety, Information Governance and Emergency Planning Committees, the Trust-wide risk analysis and a deep dive into Corporate Division risks. No matters were rated red for assurance. The principal areas under continued monitoring were violence and aggression, moving and handling equipment, business continuity compliance and a number of longstanding corporate risks, particularly PFI expiry, corridor care, financial delivery and digital resilience. Positive assurance was provided on Information Governance compliance.

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

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Health and Safety Committee Escalation and Assurance Report**
Rating rationale	Violence and aggression remained a persistent concern across divisions, particularly in the Emergency Department and community services. A joint Foundation Group response was being developed alongside regional urgent and emergency care work, with further engagement planned with West Mercia Police. Sharps and exposure incidents remained high and required an improvement plan. Moving and handling Level 2 compliance was low in most divisions, and a risk had arisen from reduced availability of specialist equipment for retrieving patients from the floor. Extreme heat, lone-worker safety, corridor storage, mortuary cooling and estates-related matters also remained under active management.
Outcome	The Committee noted that plans and mitigations were in place. Work would continue on the violence and aggression response, procurement of replacement moving and handling equipment, improvement of training compliance, divisional health and safety audit completion and estates actions.
Item/Topic	**Emergency Planning Committee Escalation and Assurance Report**
Rating rationale	There were no red-rated matters. Assurance was assessed as amber on: • Implementation of the Terrorism (Protection of Premises) Act 2025 requirements • Completion and external audit of business continuity plans (though divisional and corporate planning and testing were stronger than last year) • Supplier and provider resilience assurance. EPRR documentation had been updated against the latest NHSE guidance and multi-agency arrangements. Training had been delivered across adverse weather, patient flow, communications, VIP and high-profile persons, lockdown, evacuation and shelter, with further specialist modules awaiting cascade. On-call certification was being proactively monitored. Work continued on the Trust security plan and risk assessment, completion of core standards evidence and identification of contract leads for supplier and provider assurance.
Outcome	The Committee welcomed the stronger position and expected this to support an improved annual core standards assessment.
Item/Topic	**Risk Analysis Report**
Rating rationale	The Trust had 25 very high risks, unchanged overall from May, with capacity and workforce remaining the most common theme. The Committee requested a stronger focus on aged high-scoring risks through future deep dives.
Outcome	The Committee was assured that active mitigations and review processes were in place but asked risk owners to update overdue entries and reassess scoring where controls had strengthened.

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

Escalation and Assurance Report

Report from: Executive Risk and Compliance Committee
Date of meeting: 19 August 2026
Report to: Trust Board

Item/Topic	Corporate Division Deep Dive
Rating rationale	Significant corporate risks remained: • Delivery of the financial plan • RTT tracking and worklist visibility • PFI handback, disputes and asset data • Corridor care • Multiple construction projects • Violence and aggression • Climate adaptation • Digital resilience • Future facilities management model. Several risk descriptions, review dates and scores required updating to reflect current controls and the latest operational position.
Outcome	Particular follow-up was requested on RTT risk, the Education Centre risk, elective waiting-list risk, digital risks, medical equipment servicing, defibrillator replacement, ligature hazards and corridor-care terminology.

Assure: Including assurance items rated green	
Item/Topic	**Information Governance Committee Escalation and Assurance Report**
Rating rationale	Mandatory training rates had increased following targeted reminders and face-to-face support and reached the Trust target of 85%. New NHSE guidance had been published on preventing unlawful access to patient records. Recent queries and investigations highlighted a need for clearer practical guidance on legitimate access and stronger staff awareness of the consequences of inappropriate access. The Information Governance Team and Caldicott Guardian would produce interim local guidance, aligned where possible across the Foundation Group, and develop a six-month awareness approach, including consideration of strengthened induction content. The Trust submitted the 2025/26 Data Security and Protection Toolkit at “Standards Met”, with high confidence in the self-assessment and all three audit actions complete. Freedom of Information responses achieved 100% compliance in June and Data Subject Access Requests achieved 98%, both within Information Commissioner thresholds. Five internally reported data incidents did not meet the threshold for reporting to the Information Commissioner.
Outcome	The Committee noted the positive assurance and continued targeted awareness work.

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

Escalation and Assurance Report

Report from: Charity Trustee
Date of meeting: 18 June 2026
Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	**Quarter 4 Charitable Funds Finance Report**
Summary	Income exceeded expenditure in Quarter 4 and in 2025/26 overall, increasing year-end fund balances. The active use of restricted funds was considered and the need to balance interest optimisation with administrative, compliance and audit costs.
Outcome	The report was accepted. Future reports would include information on monitoring cash balances, reviewing banking arrangements and transferring funds where proportionate to maximise returns.
Item/Topic	**Annual Accounts and Report Plan for 2025/26**
Summary	A clear timetable was in place to meet the Charity Commission filing deadline of 31 January 2027. The Annual Report was due by the end of July, independent examination by the end of September, and final approval by the Trustee in December. Any risk to milestones would be escalated promptly but there were no indications that the statutory filing deadline would not be achieved.
Outcome	The plan was accepted.
Item/Topic	**Fundraising Update**
Summary	Positive progress was reported on the Ross Community Hospital garden, community projects and dementia-friendly initiatives. Wider promotion of low-cost dementia support items was supported. Expansion of the successful staff lottery to wider public participation would be explored; any future business case should address staff engagement, procurement and provider due diligence, regulatory and reputational risks, benefit implications and relationships with local charity partners.
Outcome	The Fundraising Update was accepted. No decision was made on expanding the lottery; a detailed proposal would return to the Trustee for consideration. **Action**: Fundraising Manager to explore charitable funding for end-of-life care packs.

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

Escalation and Assurance Report

Report from: Children and Young People's Committee
Dates of meetings: April and June 2026
Report to: Trust Board

Summary
The Committee received assurance that most children and young people (CYP) services are delivering safe and effective care with evidence of improvement in surgical services, transition planning and specialty performance. However, significant concerns remain regarding therapy waiting times and autism assessment pathways.

Alert: Including assurance items rated red and matters requiring escalation	
Item/Topic	**Therapies Waiting Times and Autism Pathway Delays**
Rating rationale	• Speech and Language Therapy continues to experience significant demand pressures. • Data integrity issues exist between systems and administrative processes. • Eleven children were reported as waiting over 52 weeks. • More than 210 CYP remain on autism pathways beyond 18 weeks. • Upcoming SEND reforms may further increase demand.
Outcome	The Committee was not fully assured that sufficient progress has yet been made to reduce waiting lists and address data quality issues. A recovery plan has been requested, and performance will continue to receive close scrutiny.

Advise: Including assurance items rated amber, under monitoring and in development	
Item/Topic	**Transition from Children's to Adult Services**
Rating rationale	• Transition has become a Trust-wide quality priority. • Significant progress has been made with a standardised pathway, transition passport, education programme and governance arrangements. • Risks remain around adult specialty engagement, IT interoperability and oversight of disengaging young people.
Outcome	The Committee welcomed progress but requires further assurance regarding implementation across all specialties and safeguarding arrangements.
Item/Topic	**National Neonatal Audit Programme (NNAP)**
Rating rationale	Positive performance was demonstrated against several neonatal indicators. Performance relating to developmental follow-up of babies born under 32 weeks remains below expected standards.
Outcome	A revised pathway has been agreed, with dedicated clinics commencing in September 2026. Outcomes will continue to be monitored.
Item/Topic	**Children's Community Nursing Service**
Rating rationale	Service remains dependent on current Monday-Friday operating arrangements. Psychology provision remains an accepted risk within both Trust and ICB risk registers. End-of-life care arrangements remain vulnerable to capacity pressures
Outcome	Further assurance is required regarding funding discussions, virtual ward development and psychology support.
Item/Topic	**Children's Environment and Waiting Areas**
Rating rationale	Radiology and Oral Surgery identified concerns regarding child-friendly waiting environments. Some children continue to wait in adult clinical areas. National guidance is awaited.
Outcome	The Committee requested continued work to improve the patient experience and mitigate environmental concerns.
Item/Topic	**Looked After Children Audit**
Rating rationale	Documentation quality was generally good. Only 68% of Initial Health Assessments were completed within the statutory 28-day timescale. Delays were related to capacity, consent and attendance issues.
Outcome	Improvement activity is underway, with re-audit planned within 6-12 months.

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

Escalation and Assurance Report

Report from: Children and Young People's Committee
Dates of meetings: April and June 2026
Report to: Trust Board

Item/Topic	Emergency Department Attendances
Rating rationale	High numbers of paediatric attendances continue. Concerns were raised that some attendances could be managed through primary care. Existing redirection and navigation processes require strengthening.
Outcome	A multi-agency test of change is underway to improve patient navigation, triage and understanding of demand

Assure: Including assurance items rated green	
Item/Topic	**Radiology**
Rating rationale	• Stable performance. • Improved visibility of paediatric pathways. • Successful recruitment and improved MRI provision through sedation and GA pathways.
Outcome	The Committee was assured that the service remains safe and effective.
Item/Topic	**Anaesthesia and Critical Care**
Rating rationale	• Strong multidisciplinary working. • Effective peri-operative pathways. • Good prioritisation of children on theatre lists.
Outcome	The Committee was assured regarding quality and safety of care delivery.
Item/Topic	**Ear Nose and Throat**
Rating rationale	• Improved workforce capacity. • Reduced waiting times. • Good clinical outcomes and compliance with national benchmarks. • Paediatric endoscope funding secured.
Outcome	The Committee was assured regarding service quality, safety and accessibility.
Item/Topic	**General Surgery and Urology**
Rating rationale	• Consultant workforce strengthened. • Inpatient waiting list reduced from 47 patients to 10. • No post-operative complications or readmissions identified. • GIRFT compliance demonstrated.
Outcome	The Committee was assured regarding service performance and outcomes.
Item/Topic	**Circumcision Audit**
Rating rationale	• 74% of referrals managed conservatively. • Only 26% proceeded to circumcision. • Practice aligned with GIRFT guidance and national standards.
Outcome	The Committee was assured that practice is evidence-based and does not indicate over-treatment.
Item/Topic	**Oral Surgery**
Rating rationale	• Referral growth managed successfully. • Increased consultant capacity. • Improved local access reducing out-of-county travel. • Enhanced safeguarding arrangements.
Outcome	The Committee was assured regarding quality and safety, whilst continuing to monitor orthodontic workforce challenges.

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

Acronyms	
AAU	Acute Admissions Unit
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GEH	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council
GP	General Practitioner
HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HEE	Health Education England
HSE	Health & Safety Executive
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICB	Integrated Care Board
ICP	Integrated Care Provider
ICS	Integrated Care System

IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
LTP	Long Term Plan
MASD	Moisture Associated Skin Damage
MCA	Mental Capacity Act
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NEWS	National Early Warning Scores
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
NMC	Nursing Midwifery Council
OBC	Outlined Business Case
OOC	Out Of County
OHP	One Herefordshire Partnership
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RTT	Referral to Treatment
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SLA	Service Level Agreement

SOP	Standard Operating Procedure
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAHT	Worcestershire Acute Hospitals Trust
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur