

WVT Trust Board Held in Public

Thursday 1 October 2026, 13:00 - 14:30

MS Teams

Agenda

Wye Valley NHS Trust Formal Board Business

13:00 - 13:03
3 min

1. Apologies for Absence / Quorum / Declarations of Interest

Information Frances Martin

1.1. AGM and Public Minutes of the Meeting held on the 3rd September 2026

Approval Frances Martin

📄 1.1 - AGM and Public Board Minutes 3rd September 2026~v1.pdf (17 pages)

1.2. Foundation Group Strategy Committee Report from 17th September 2026

Information Professor Sir Glen Burley

📄 1.2a - Foundation Group Strategy Committee (FGSC) report from the Meeting held on 17 September 2026.pdf (4 pages)

1.3. Matters Arising & Action Log

Discussion Frances Martin

📄 1.3 - Public Board Action Log - Oct 2026.pdf (1 pages)

13:03 - 13:09
6 min

2. Chief Executive's Report

Information Professor Sir Glen Burley

📄 2 - WVT CEO Update Report and Coversheet - October 2026 Final~v1 FINAL.pdf (5 pages)

13:09 - 13:29
20 min

3. Integrated Performance Report

Including KPI Dashboard

📄 3 - WVT - IPR Board - August 2026.pdf (53 pages)

📄 3a - KPI Dashboard - October Board.pdf (4 pages)

3.1. Quality

Lucy Flanagan / Chizo Agwu

3.1.1. National Inpatient Survey 2025 Summary report

Lucy Flanagan

3.2. Operational

Andrew Parker

3.3. Workforce

Geoffrey Etule

3.4. Finance

Katie Osmond

For Approval

13:29 - 13:39 10 min **4. Winter Plan 2026 and Winter Planning 2026/27 Board Assurance Sign Off**

Approval Andrew Parker

-  4 - Winter Planning 2026 Public Board Cover sheet.pdf (2 pages)
-  4a - WVT Winter 2627 V3 Sept 26.pdf (20 pages)
-  4b - 2026_27_WVT BAS Self Assessment.pdf (9 pages)

13:39 - 13:44 5 min **5. Financial Recovery Board Terms of Reference**

Approval Frances Martin

-  5 - FRB Terms of Reference Cover Sheet - Oct 2026.pdf (1 pages)
-  5a - WVT FRB Terms of Reference v1 - FINAL September 2026.pdf (3 pages)

Quality

13:44 - 13:44 0 min **6. Thirlwall Inquiry Board Update**

Information Chizo Agwu

-  6 - Thirlwall Inquiry Coversheet and Update - CA.pdf (4 pages)

13:44 - 13:44 0 min **7. Maternity Incentive Scheme (CNST) Quarterly Report**

Assurance Lucy Flanagan

-  7 - CNST Quarter 1 2026-27 v0.8 - FINAL.pdf (10 pages)
-  7a - 20260219 MIS Year 8 letter to trusts.pdf (6 pages)

13:44 - 13:49 5 min **8. Quality Committee Escalation & Assurance Reports - September**

Assurance Ian James

-  8 - Quality Committee Escalation & Assurance Report September 2026_draft.pdf (3 pages)

Governance & Risk

13:49 - 13:59 10 min **9. Gender Pay Gap Annual Report**

Assurance Geoffrey Etule

-  9 - Gender Pay Gap Coversheet - October 2026 - GE.pdf (1 pages)
-  9a - GPG Presentation for 25-26.pdf (6 pages)

13:59 - 14:04 5 min **10. Board Assurance Framework Report**

Assurance Gwenny Scott

-  10 - BAF Report Coversheet - October 2026.pdf (1 pages)
-  10a - BAF Header Oct 26.pdf (5 pages)
-  10b - BAF Risks Combined October 26 TB.pdf (12 pages)

14:04 - 14:09 11. Audit Committee Escalation and Assurance Report - September

5 min

Nicola Twigg

 11 - Audit Committee Escalation Assurance Report 9 Sept 26.pdf (3 pages)

14:09 - 14:14 12. Charity Trustee Escalation and Assurance Reports - September 2026

5 min

Assurance

Grace Quantock

 12 - Charity Trustee report to Trust Board September 2026.pdf (1 pages)

14:14 - 14:15 13. Any Other Business

1 min

Information

Frances Martin

14:15 - 14:20 14. Questions from Members of the Public

5 min

Information

Frances Martin

14:20 - 14:20 15. Acronyms

0 min

Information

 Acronyms - 2026.pdf (3 pages)

14:20 - 14:20 16. Date and Time of the Next Meeting - 3rd December 2026 at 1.00 p.m.

0 min

WYE VALLEY NHS TRUST
Minutes of the AGM and Trust Board Held in Public
Held on 3rd September 2026 at 1.00 pm – 3.00 pm.
MS Teams – Live Streamed

Present (Voting):

Frances Martin	FM	Chair
Chizo Agwu	CA	Chief Medical Officer
Ellie Bulmer	EB	Non-Executive Director
Professor Sir Glen Burley	GB	Chief Executive Officer (left at conclusion of Annual General Meeting)
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):

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

Christian Homersley	CH	Associate Chief Estates and Capital Planning Officer (for Item 9)
Justine Jeffery	JJ	Director of Midwifery (for Items 14 and 15)
Lou Robinson	LR	Deputy Company Secretary for the minutes
Gweny Scott	GS	Associate Director of Corporate Governance

Apologies:

There were no apologies for absence.

Annual General Meeting – Formal Annual Business

1. Chair's Welcome and Introduction

FM welcomed attendees and noted her new role as Chair of both Wye Valley NHS Trust and Worcestershire Acute Hospitals NHS Trust, a role she had held since 1 April 2026.

FM paid tribute to her predecessor, Russell Hardy MBE, thanking him for his leadership of the Trust over recent years and noting that he had remained within the NHS family as Chair of NHSE Midlands. FM also congratulated Professor Sir Glen Burley on receiving a knighthood in the King's Birthday Honours, expressing the Trust's gratitude for his leadership and pride in the national recognition he had received.

FM further welcomed Eleanor Bulmer to her new role as a substantive Non-Executive Director, recognising the valuable contribution she had already made as an Associate Non-Executive Director and thanked Sharon Hill, Non-Executive Director, who was due to leave the Board at the end of the month after three years of service, acknowledging her significant contribution and wishing her well for the future.

Ref	Item	Lead	Purpose	Format
1.1	Apologies for Absence	FM	Information	Verbal

Noted as above.

1.1.1	Quorum and Declarations of interest	FM	Information	Verbal
The Board was quorate GQ declared two new interests: • Commencement of a PhD by Publication at the University of Reading. • Commencement of the Doikayt Fellowship EB declared a new interest: • ANED at Herefordshire & Worcestershire Health & Care NHS Trust				
1.2	Minutes of meeting on 25th September 2025	FM	Approval	Enclosure 01
Approved.				
2	Presentation of Annual Report 2025/26	GB	Information	Enclosure 02
The Annual Report review presentation was presented for information. The following key points were noted. GB presented the Annual Report by reflecting on a highly successful year for Wye Valley NHS Trust, highlighting significant improvements in performance, quality, workforce engagement and financial sustainability. Members of the public were encouraged to read the full Annual Report, which was included on the website, noting that his presentation focused on key achievements from what was an extensive and positive account of the Trust's work during 2025/26. GB reported that the Trust had delivered strong operational performance across a number of national measures. Elective care waiting times had exceeded the standards set for the organisation, with the Trust performing better than its targets for patients waiting more than 18 weeks and more than 52 weeks for treatment. Cancer performance had also been strong, with the Trust surpassing targets for diagnosis within 28 days and treatment within 62 days. Diagnostic waiting times had improved considerably, with the number of patients waiting longer than six weeks for diagnostic tests having been halved. The Trust had delivered a financial surplus during the year, demonstrating both operational and financial success. It was noted that these achievements were particularly significant given the organisation's historical challenges and pointed out that Wye Valley had moved from having longer waiting times than many NHS organisations to becoming one of the best-performing Trusts in the country. It was noted that due to the performance, SS had been invited to Number 10 Downing Street to discuss the Trust's success in reducing waiting times. Much of the Trust's success had been achieved through a long-term strategy to expand and protect elective capacity. The development of the elective surgical hub had played a major role in improving performance by increasing theatre capacity and ensuring elective activity could continue despite pressures elsewhere in the hospital. During the year the surgical hub had achieved national "Getting It Right First Time" accreditation, recognising the quality of the Trust's approach to elective care. The opening of the Community Diagnostic Centre in January was highlighted, noting that some benefits had already been realised by year end, with further improvements expected during the current year. Alongside this, the Trust had continued to invest in urgent care services, digital transformation programmes and environmental sustainability initiatives, including progress towards creating a fully decarbonised County Hospital site. Wye Valley NHS Trust was among the most advanced NHS organisations in reducing carbon emissions and was leading other organisations within the wider group in this area. GB noted the staff as the greatest asset of the organisation and expressed particular satisfaction with the latest NHS Staff Survey results. The staff engagement scores had improved again, with Trusts across the Foundation Group holding the top three staff survey positions in the Midlands. These results demonstrated that staff understood and supported the organisation's strategy and were actively involved in delivering it. Improvements had also been seen in Freedom to Speak Up (FTSU) scores, indicating that staff felt increasingly confident in raising concerns and contributing ideas to improve safety and quality. Workforce indicators had strengthened, with sickness absence falling at a time when NHS sickness rates nationally had risen. Staff turnover had improved by approximately one percentage point, while reduced reliance on temporary staffing had helped both financial performance and organisational stability. Nearly 29% of the workforce came from non-white British backgrounds, reflecting the diversity of the community served by the Trust.				

With regards to quality and safety, GB highlighted reductions in hospital-acquired venous thromboembolism and improvements in diabetes safety pathways. Noted were advances in medicines management, particularly around the administration of high-risk medications such as treatments for Parkinson’s disease, and improvements in paediatric transition pathways into adult services. Patient experience had also improved, with stronger maternity and inpatient survey results and quicker responses to complaints without compromising quality. The introduction of a new Patient Engagement Forum had strengthened opportunities for patients to influence service improvements. The Trust had performed well under the new NHS National Oversight Framework, achieving positive ratings across workforce, access, safety and patient experience measures. Clarity was provided that were it not for the Trust’s historical need to receive deficit support funding, its overall position in the national framework would have been significantly higher.

Despite these successes, GB acknowledged that urgent and emergency care remained a challenge. Performance against the four-hour emergency care standard had reached 63.7%, below the national expectation of 78%. Although the Trust had invested in additional urgent care capacity and introduced measures to improve patient flow, demand continued to grow, particularly among older patients with increasingly complex health needs. Clarity was given around the challenges created by industrial action, adverse weather conditions, workforce pressures and major building works throughout the year. While recognising the progress already achieved, it was stressed that the organisation remained committed to further improving urgent and emergency care performance and would continue monitoring progress through monthly Board reports.

GB concluded the presentation by expressing his gratitude to everyone who had contributed to the Trust’s achievements and thanked the Trust’s approximately 4,500 staff, recognising the contribution made by both clinical and non-clinical colleagues across hospital and community services. A particular thank you was provided by acknowledging the Trust’s amazing volunteers, who collectively contributed more than 1,000 hours of support each month, and thanked partner organisations including Herefordshire Council, Taurus Healthcare, the Integrated Care Board, local GP practices, the Health and Care Trust, and voluntary sector organisations. The support provided through charitable fundraising and community partnerships and praised the collaborative relationships that existed across Herefordshire’s health and care system was acknowledged. GB concluded by extending his thanks to the Executive and Non-Executive Directors for their leadership and governance, describing the year as an impressive one and noting that the Trust was well placed to deliver on its ambitious plans for the future.

The Board accepted the Annual Report Review.

3	Presentation of Annual Accounts 2025/26	KO	Information	Enclosures 03
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The Annual Accounts review presentation was presented for information. The following key points were noted.

The Annual Accounts for 2025/26 demonstrated a particularly strong financial performance for the Trust. KO reported that the organisation had delivered an adjusted financial surplus of £2.7m, exceeding the plan agreed at the start of the year. Despite this achievement, the Trust continued to operate with a historic underlying deficit and therefore remained reliant on deficit support funding. As part of the financial plan, the Trust had received £26m of deficit support funding and, due to its strong performance against plan, had also benefited from a further £1.6m of redistributed deficit support funding from the national allocation.

KO explained that the Trust had remained focused on efficiency and value for money throughout the year. The organisation had targeted £25m of efficiency savings and ultimately delivered approximately £22m. Although this fell slightly short of the original ambition, it was emphasised that it still represented over 5% of total expenditure and was a significant achievement. The Trust had been able to offset the shortfall through non-recurrent mitigating actions, enabling it to maintain its overall strong financial position. A major contributor to these efficiencies had been the successful reduction in agency staffing costs. Agency expenditure had fallen from 4.75% of the total pay bill in the previous year to 2.9% in 2025/26. It was clarified that this not only improved financial performance but also supported a more sustainable workforce model and enhanced continuity of care for patients.

The Trust had maintained strong financial discipline, including meeting external standards for prompt payment of suppliers. It was stressed that this was particularly important for supporting local businesses and suppliers across Herefordshire. Reference was made to the significant capital investments made during the year, including developments previously noted which had improved infrastructure and service delivery across the organisation. Despite the positive results, KO was clear that financial sustainability remained a challenge because of the Trust’s underlying deficit position and continued reliance on deficit support funding. Nationally this funding was expected to reduce over the coming years as organisations moved towards sustainable financial balance.

Consequently, the Trust had developed a break-even plan for 2026/27, which still assumed receipt of deficit support but on a reducing trajectory, with the longer-term objective of eliminating the historic deficit and supporting the ambitions of the NHS 10 Year Plan. KO outlined the sources of the Trust's income and expenditure explaining that the majority of funding came from Integrated Care Boards and Welsh commissioners, particularly Powys. The Trust spent more than £400m annually and, on average, over £1m every day delivering care across Herefordshire. Most expenditure related to staffing costs, including both substantive and temporary staff, with the remaining funds spent on medicines, supplies and the services required to support patient care. It was noted that the full annual report provided a more detailed breakdown of these financial flows.

With regards to cash management, it was reported that the Trust had continued to manage its cash balances tightly despite its challenging financial environment. At the end of the financial year, the organisation held a cash balance of £49m and this strong cash position had supported the Trust's ability to maintain prompt supplier payments and provided stability while major capital programmes were carried out.

KO concluded by summarising the outcome of the annual external audit. The Trust's auditor had completed the statutory audit process and had concluded that the accounts represented a true and fair view of the organisation's financial position, effectively giving the Trust a clean bill of health in relation to its accounts. The audit also considered value for money arrangements, including governance, internal controls and asset management. The previous year's governance-related weakness, which had been linked to oversight framework performance, had been removed by the auditor in recognition of the Trust's improved performance across a range of national metrics. However, the auditors continued to highlight concerns regarding financial sustainability, specifically the Trust's underlying deficit position and its need for deficit support funding. They also noted the shortfall against the full efficiency target. KO reported that the auditors had made suggestions around strengthening divisional accountability and improving delivery of efficiency programmes, learning that the Trust had already begun to incorporate into its approach for 2026/27. Overall, the audit provided strong assurance, while also identifying important areas for continued focus as the organisation worked towards long-term financial sustainability.

The Board accepted the Annual Accounts Review.

4	Questions from Members of the Public	FM	Information	
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There were no questions from the public for discussion.

Trust Board held in Public – Formal Board Business

5. Going the Extra Mile Quarterly Awards

Employee of the Quarter - Beverly Devey

FM reviewed Beverly Devey's Going the Extra Mile Award by highlighting her exceptional commitment, initiative and leadership in transforming the outdoor environment at Coningsby Children's Centre. Beverly had gone far beyond the expectations of her role, driven by a genuine passion to improve opportunities for local children and families. Through her determination and vision, Beverly had secured support from Leominster in Bloom, obtained donated plants, engaged local businesses and built strong community partnerships to bring the project to life.

The garden now provided a vibrant and inclusive space with sensory, imaginative play and literacy-focused areas designed to support children's learning, communication and development. FM emphasised that Beverly had devoted a significant amount of personal time outside her normal working hours and had worked collaboratively with speech and language therapy colleagues to ensure the space was accessible and inclusive for all children and families who used it.

Beverly's actions embodied the Trust's values of compassion and excellence and that her dedication would have a lasting positive impact on children, families, staff and the wider community. Although Beverly was unable to attend the meeting, FM expressed the Board's thanks and congratulations, describing her as a thoroughly deserving recipient whose contribution had made a real difference and merited recognition through the award.

Team of the Quarter - Delivery Suite

FM described the Delivery Suite team as worthy recipients of the quarterly Going the Extra Mile Team Award for the exceptional care they provided to a mother and baby during an extraordinarily difficult and high-risk birth. It was explained that, in circumstances requiring outstanding clinical expertise and calm leadership, the team demonstrated the highest standards of professional practice and compassionate care. Throughout the emergency, they communicated with clarity, honesty and reassurance, ensuring that the woman and her family remained informed, supported and involved, even during periods of significant uncertainty.

It was highlighted how the team worked seamlessly together while maintaining a calm and compassionate presence. As the situation escalated, staff responded swiftly and decisively, recognising changes in the clinical situation and adapting their approach appropriately. Most importantly, despite the pressure of a time-critical emergency, they never lost sight of the people at the centre of their care, treating the woman, her family and baby with dignity, kindness and compassion throughout their journey. FM stated that the team exemplified the Trust's values of compassion, accountability, respect and excellence. Their skill, professionalism and humanity made an enormous difference during one of the most critical moments in a family's life and that they were thoroughly deserving of the recognition. On behalf of the Board, FM thanked the Delivery Suite team for their exceptional care and congratulated them on receiving the award.				
6.	Apologies for Absence	FM	Information	Verbal
Noted as above.				
6a	Quorum and Declarations of interest	FM	Information	Verbal
The Board was quorate and there were no further declarations of interest.				
6.1	Minutes of meeting on 2nd July 2026	FM	Approval	Enclosure 04
Approved.				
6.1.1	Foundation Group Board Workshop Meeting held on 5th August 2026	FM	Information	Enclosure 05
The Board accepted the review of the FG Workshop.				
6.2	Matters Arising and Action Log	FM	Discussion	Enclosure 06
The action log was accepted with no further matters arising noted.				
7	Managing Directors Report	SS	Information	Enclosure 07-08
The report was taken as read and the following key points were noted. National attention remained focused on delivery of the NHS 10 Year Plan, particularly through the development of the neighbourhood health framework. Wye Valley NHS Trust and its partners had been working closely together to develop neighbourhood health plans that would support the creation of community-based facilities and neighbourhood health centres. These centres were intended to facilitate multidisciplinary and partnership working closer to patients' homes. Work was underway to determine how available capital resources could best support these ambitions. SS advised that the NHS operating model continued to evolve, with the national team placing significant emphasis on reducing layers of management, clarifying accountability and strengthening delivery against operational, financial and transformation objectives. While it was acknowledged that the Trust was generally performing well across many areas, it was noted that there remained opportunities for further improvement and that greater scrutiny from national bodies was expected over the coming months. Digital transformation remained a key priority. Progress continued with the NHS App programme, and work was taking place to ensure digital solutions supported the wider neighbourhood health agenda and enabled a more integrated place-based system. The aim was to create a joined-up approach across organisations that would improve connectivity and access to services for patients. SS also highlighted several positive developments within the Clinical Services Division. A new GP Local Enhanced Service had been introduced which enabled wound care, previously delivered within the acute trust, to be provided closer to patients' homes through community and GP settings. This was described as an important step towards delivering care in the most appropriate environment and improving accessibility for patients. Improvements in bereavement and mortuary services, including the successful implementation of a trust-wide deceased patient handover process was highlighted. This had strengthened safety, traceability and the consistency of information transfer. SS reflected on a recent visit she had made to the mortuary, where she had seen first-hand the significant improvements achieved by the team and praised the positive feedback received from bereaved relatives and staff across the Trust and commented on the professionalism and commitment demonstrated by the mortuary staff. SS reported that the Trust continued to deliver excellent cancer performance noting that permanent funding had recently been secured from the Integrated Care Board to support the rollout of the Gold Standards Framework. In addition, funding had been				

provided to establish a 24-hour specialist end-of-life advice line, which was expected to be operational from November. These developments would enhance support for patients approaching the end of life and improve the quality and consistency of care.

Progress within diagnostic services was highlighted with a number of digital initiatives being developed across the Trust, including the implementation of artificial intelligence-supported imaging referral tools. A substantial amount of work was taking place across the division and thanked staff for their continued commitment and achievements in delivering service improvements.

The Board accepted the Managing Director's report.

8	Integrated Performance Report	SS	Information	Enclosure 09-10
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The Integrated Performance Report was taken as read and the key points for highlight from each section was provided.

8.1	Quality (Including Mortality)	LF/CA
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LF reported that she was particularly proud of the Special Care Baby Unit achieving Stage 2 UNICEF Baby Friendly Initiative accreditation, describing it as an outstanding accomplishment that reflected excellent multidisciplinary working to support babies and families. It was explained that the team had already begun work towards Stage 3 accreditation and had received encouragement from the inspection team to achieve this within the following twelve months.

The publication of the latest national inpatient survey results reported that the Trust had continued to make improvements for a second consecutive year. It was noted that, after many years of limited movement in the survey results, a growing number of responses were now performing above the national average. A more detailed analysis would be presented to the Quality Committee and subsequently reported to the Board.

Preparations were underway for the seasonal flu vaccination programme for both staff and eligible patients. The importance of vaccination in protecting patients and maintaining safety across services was stressed, with the programme due to launch later in September.

LF reported positively on the Trust's falls performance, stating that the organisation benchmarked well in relation to the number of patients experiencing falls and, importantly, maintained very low levels of harm associated with those incidents. Further the Trust was preparing for Falls Awareness Week, which would focus on supporting patients and staff in preventing falls and promoting awareness across the organisation.

Mortality

CA reported that the Trust's mortality position had remained broadly stable. It was acknowledged that the current Summary Hospital-level Mortality Indicator (SHMI) remained elevated at 114 but explained that provisional data for the following month, which for the first time included Same Day Emergency Care (SDEC) activity, showed the SHMI reducing to 111. It was advised that as further months of SDEC data were incorporated into the calculation, the Trust expected to see a continued downward trend in this measure.

CA provided assurance that the crude inpatient mortality rate remained low at 1.24%, representing 58 inpatient deaths during the reporting period, with a further seven deaths occurring in the Emergency Department. Particularly positive progress made in relation to fractured neck of femur mortality was highlighted, where the SHMI had reduced by 20%. Provisional data suggested that this indicator would improve further in subsequent months. The Trust had not been identified as an outlier in the National Hip Fracture Database for two consecutive quarters and was performing above the national average against best practice tariff measures, demonstrating that sustained improvement work in this area was delivering positive outcomes.

Sepsis and stroke remained areas requiring continued oversight. Whilst the Trust was not considered an outlier in either area, the mortality indicators were higher than the organisation would normally expect. It was advised that a new sepsis lead had been appointed within the Emergency Department and that work was underway to strengthen the sepsis pathway. In addition, audits of stroke mortality and learning from deaths reviews were planned to identify any opportunities for further improvement.

Perinatal mortality remained an area of strong assurance. The latest 12-month rolling data showed an extended perinatal mortality rate of 2.57 per 1,000 births and a stillbirth rate of 0.7 per 1,000 births, both of which were below historical levels and well below the national average. These figures demonstrated sustained improvement in maternity outcomes and provided reassurance regarding the quality and safety of services.

CA described the learning from deaths process as robust. During July, Medical Examiners had reviewed 175 deaths, including 66 deaths at County Hospital and the remainder within community settings. 93% of patients had a RESPECT form in place and that 93% demonstrated appropriate recognition of clinical deterioration. It was concluded that mortality governance remained strong and that

there were encouraging signs that the Trust's mortality indicators would continue to improve as further SDEC activity was reflected within the national mortality measures		
8.2	Activity and Performance	AP
AP reported that the Trust had continued to deliver exceptionally strong cancer performance and was sustaining performance at or above NHS national standards during 2026/27. In June, the Trust had achieved particularly impressive results, placing it within the top ten trusts in England for both the 28-day Faster Diagnosis Standard and the 62-day treatment pathway target. He attributed this success to the dedication and hard work of clinical and operational teams and expressed his appreciation for their efforts in maintaining such high standards of care and performance. Ongoing challenges within urgent and emergency care continued and the Trust had experienced significant operational pressures during the summer months, demonstrating that seasonal demand was no longer confined to winter. Prolonged periods of extreme heat and heatwave conditions since June had placed considerable strain on estates, staff and services, while also driving increased attendances and demand. The Trust had observed surges in activity both during periods of high temperatures and immediately afterwards as conditions cooled. These pressures had required staff to manage a particularly challenging operational environment. The Trust was reviewing its response to both heatwave and extreme weather plans across the Foundation Group, with the intention of sharing learning across Herefordshire, Worcestershire and Warwickshire. Despite the difficulties experienced over the summer, several encouraging improvements in urgent and emergency care performance were noted including ambulance handover delays reduced, 24-hour waits within the Emergency Department had been eradicated, and the number of patients being cared for in corridor settings had decreased significantly during June and July. The organisation's focus was now on building on these improvements and ensuring that urgent and emergency care plans gained further momentum as preparations for winter intensified. These plans were closely linked to the Trust's wider strategic priorities, including neighbourhood health and the organisation's "four big moves" programme. It was explained that the Trust was collaborating closely with Powys colleagues to strengthen urgent and emergency care pathways and reduce avoidable admissions to hospital. This work included developing alternatives to secondary care, supporting the implementation of Powys' emerging single point of access model, expanding community services and increasing the ability of teams to care for patients at home. Initiatives including the recruitment of frailty consultants, the development of hospital-at-home services and the increasing use of community-based intravenous antibiotic treatment were being managed. While Powys' Better Together Programme was described as robust and positive, it was noted that many elements remained in the early stages of development and would require broader stakeholder engagement before their full benefits could be realised. There was some concern around the pace and ambition of the Powys plans although the Trust remained optimistic that continued collaboration would help strengthen integration and improve patient pathways across both health systems.		
8.3	Workforce	GE
GE reported that the Trust continued to perform exceptionally well in relation to workforce indicators. Wye Valley NHS Trust maintained the lowest sickness absence rate across the Foundation Group and remained one of the best-performing acute organisations in the NHS in this area. This was described as a significant achievement and a reflection of the efforts made to support staff health and wellbeing. The Trust's strong performance within the National Oversight Framework was highlighted, where it continued to receive a high-performing rating for its people metrics. It was explained that the organisation was determined to maintain this position and continue delivering high standards across its workforce agenda in the months ahead. Following the publication of the new NHS Staff Standards, work was underway with staff-side representatives and staff networks to ensure that the standards were fully embedded within the Trust's human resources policies, practices and procedures. These standards set expectations for high-quality employment practices and would help ensure that staff continued to receive appropriate support and opportunities within the organisation. The Trust was actively implementing the newly published NHS Leadership and Management Framework. Work was taking place to ensure that the framework became embedded throughout the organisation, with progress and implementation being monitored through the People and Organisational Development Committee and would support the development of leadership capability and strengthen management practice across the Trust.		

GE shared the positive news that the Trust had been shortlisted as a finalist in the HPMA National Awards in recognition of its work to improve staff health and wellbeing. This was a significant achievement and evidence of the progress being made in supporting the workforce. The Trust would continue to build on this work in the coming months as part of its wider people strategy

8.4	Finance Performance	KO
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KO reported that the Trust's financial position after the first four months of the 2026/27 financial year remained largely stable, which was a positive position at that stage of the year. At the end of July, the Trust was approximately £300k behind plan. This variance had arisen from a combination of financial pressures and mitigating factors but was primarily driven by delays in the delivery of planned efficiency schemes. The Trust's efficiency programme was around £1.2m behind target, although some of this shortfall had been offset through non-recurrent measures, resulting in only a small adverse variance against plan overall.

KO explained that the Cost Improvement Programme (CPIP) remained a key area of focus. At the end of July, approximately 59% of the £25m savings target had been fully developed or implemented and therefore sat within the lowest risk category. Progress had continued beyond the reporting period, with around 70% of the programme having reached that stage by the end of August. Whilst this demonstrated encouraging progress in reducing risk within the programme, it was cautioned that some early pressures remained evident and there continued to be a need to ensure the full delivery of planned efficiencies.

The organisation had now reached the point in the year where it was undertaking a formal review of its forecast outturn. This review would assess performance to date, consider known risks and determine the likely financial position for the remainder of the year. Particular attention would be paid to ensuring reductions in expenditure run rates were achieved, efficiency schemes were delivered in full and transformational programmes began generating benefits during the current financial year as well as providing recurring savings in future years.

A significant financial risk relating to the ongoing funding dispute with Powys regarding parity of funding arrangements with English commissioners was highlighted noting that the Trust's reported financial position currently assumed that the income it believed was due from Powys would be received. However, as this remained unresolved, it represented a risk that would need to be factored into the mid-year forecast review and future financial planning discussions.

In relation to capital expenditure and cash management, there were no significant concerns at that point in the year. Both areas continued to be actively monitored and managed to ensure that any emerging risks could be identified and mitigated promptly. Assurance was provided that while the Trust remained slightly behind plan and faced ongoing challenges around efficiency delivery and commissioner funding, its financial position remained stable, risks were being actively managed and work was continuing to strengthen performance over the remainder of the financial year.

The Board accepted the Integrated Performance Report.

FOR APPROVAL				
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9	Premises Assurance Model	CH	Approval	Enclosure 11
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CH presented the Premises Assurance Model (PAM) submission and explained that there had been significant changes to the process during the year, reflecting an increased national focus on estates and facilities assurance. It was advised that the PAM was receiving greater scrutiny nationally and that organisations were now required to demonstrate more clearly that boards were sighted on their submissions. Evidence of board oversight was also being linked to wider national assurance requirements and inquiry responses, increasing the visibility and importance of the process.

It was reported that the Trust had achieved positive ratings across all assessed domains and was rated either "Good" or "Requires Minimal Improvement" in every area, providing assurance that there were no significant or systemic areas of concern. It was emphasised that no new major risks had been identified through the assessment process and that the position remained stable.

CH acknowledged that there were some areas where governance arrangements could be strengthened further, particularly around data quality and digital maturity. It was explained that the Trust intended to use the forthcoming Private Finance Initiative (PFI) expiry programme as an opportunity to deliver longer-term improvements in these areas and enhance the quality of estates information and assurance processes.

The Board's approval was sought for submission of the PAM return by the national deadline. The submission would be made in good faith and noted that a small amount of additional information had become available since the paper had been drafted confirming that this information would further strengthen the evidence base supporting the submission and that all developments were moving in a positive direction.

The Board raised no concerns and approved the submission of the Premises Assurance Model return, endorsing the Trust's assessment and the planned submission ahead of the required deadline.

10	Experts at Hand Business Case	LF	Approval	Enclosure 12-14
LF presented the Experts at Hand business case and explained that it had already been reviewed and supported by the Trust Management Board because of the time-critical requirement to recruit into the new posts. The programme was being implemented nationally and that there would be significant competition across the country for therapists, social workers and education professionals needed to deliver the model. As a result, early approval had been necessary to enable recruitment to commence promptly. The proposal directly supported the Government's Special Educational Needs and Disabilities (SEND) reform programme, which aimed to improve the early identification and intervention of children and young people with special educational needs and disabilities. The Experts at Hand model would bring specialist support and expertise into mainstream schools, enabling earlier intervention and reducing the need for more intensive specialist services later unless those services were clinically required. LF outlined that the business case sought approval to recruit a range of specialist staff, including speech and language therapists and occupational therapists, with implementation planned to begin in October 2026. The cost of the programme during the first year would be approximately £300k increasing to around £500k per annum during years two and three. However, it was emphasised that all costs were fully funded through national funding allocations, meaning there would be no immediate financial pressure on the Trust from establishing the service. While funding had been secured for an initial three-year period, a further business case would be required if the service was to continue beyond that timeframe. LF expressed strong support for the proposal, highlighting the importance of improving support for children and young people with SEND and ensuring that specialist expertise was available earlier in their educational journey. The programme represented an important opportunity to improve outcomes for children and families through earlier intervention and better integrated support within schools. The Board approved the Experts at Hand Business Case.				

11	Green Plan Annual Update	AD	Information	Enclosure 15-16
The paper was taken as read. AD presented the annual update on the Trust's Green Plan, explaining that it was an annual progress report against the three-year Green Plan that had been refreshed and approved the previous year. It was reported that good progress had been made across a number of sustainability initiatives. Significant improvements had been achieved in the management and recording of food waste across both community sites and the County Hospital site, supported by the Trust's PFI partners. It was highlighted that the Trust's vehicle fleet had been converted to electric vehicles, meeting national standards, and that the infrastructure for nitrous oxide had been removed from the site, reducing emissions from a significant greenhouse gas. One of the most significant forthcoming achievements was the Integrated Energy Service, which was expected to become operational within the following month. Once implemented, it would decarbonise approximately 98% of the County Hospital site and virtually eliminate the use of fossil fuels across the estate. Considerable work had been undertaken over several years to reach this point, with major infrastructure developments completed during the previous year. While acknowledging the positive progress, it was also highlighted that although there was a clinical sustainability lead within one division, the Trust did not yet have a Trust-wide clinical sustainability lead, which was a national requirement. Work would therefore be undertaken during the year to address this through operational planning. Concern was expressed about the pace of progress on climate change adaptation. Although a substantial programme of work had been undertaken a few years earlier, progress since then had not been as rapid as hoped. It was observed that recent extreme weather events demonstrated that climate change was accelerating faster than anticipated and was already affecting patients, staff and facilities. As a result, the Trust needed to accelerate its adaptation plans. AD also drew attention to the Trust's sustainability metrics, which had now been aligned with national measures reporting that despite increases in activity levels and estate growth, energy consumption, water usage and waste production had remained broadly static. This was attributed to improvements in working practices and infrastructure changes that had enabled the organisation to				

grow while limiting its environmental impact. The Trust had made substantial progress and remained committed to further improvements.

In response, FM thanked AD for his leadership and recognised the scale of the work being undertaken by the team. Achieving a position where the site would soon be 98% free from fossil fuels was a significant accomplishment for both the organisation and Herefordshire.

It was clear the programme demonstrated the value of long-term planning, as major sustainability schemes required lengthy development and implementation periods. FM also highlighted the importance of developing meaningful performance indicators to measure environmental progress and suggested that some of the Trust's work could become a model for the wider NHS. The fact that energy and water consumption had been contained despite growing demand and activity levels was welcomed. FM encouraged everyone to remain environmentally conscious and recognised the collective contribution being made across the organisation.

The Board accepted the Green Plan Annual Update.

QUALITY

12	Board Briefing: Ockenden and Amos Review	LF	Assurance	Enclosure 17-18
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The paper was taken as read.

LF provided an update on the Trust's response to the Ockenden and Amos maternity reviews reminding the Board that at the previous meeting an overview of the findings from both reports and the associated ten-point national improvement plan that organisations were expected to address had been discussed. Since that meeting, NHSE had issued a further letter requiring all Trusts to submit a formal 100-day response, with mandated returns due on 25th September and 31st December 2026. This response required the Trust to undertake a comprehensive baseline assessment and gap analysis against the ten-point plan, together with a detailed review of maternity triage arrangements. A task and finish group established following publication of the reports continued to oversee this work and coordinate the Trust's response.

It was clarified that due NHSE requirements letter it had not been possible to complete a sufficiently robust self-assessment and gap analysis in time for Board approval at the September meeting. She also asked the Board to note the ongoing work to strengthen governance arrangements and oversight processes, including greater collaboration and support from colleagues across the Foundation Group, particularly Worcestershire Acute Hospitals NHS Trust and partner organisations within the wider group.

In response to recommendations arising from Ockenden and Amos, governance arrangements were being strengthened to reflect the new requirement for shared responsibility between Chief Nursing Officers and Chief Medical Officers. Meeting structures and reporting arrangements were being revised accordingly and noted that Chief Nursing Officers and Chief Medical Officers across the Foundation Group had already met to consider how governance could be further strengthened.

FM thanked LF and JJ for their leadership and emphasised the importance of learning from the findings of the reviews. FM welcomed the closer collaboration with Worcestershire and other Foundation Group partners and stressed the importance of ensuring that assurance statements were backed by clear evidence. The value of the NHSE ten-point plan was acknowledged and particularly welcomed the introduction of joint leadership responsibilities between Chief Nursing Officers and Chief Medical Officers, recognising this as an important step in promoting interprofessional working and shared decision-making.

FM also updated the Board on changes to the Trust's Maternity and Neonatal Safety Champion arrangements. LF had previously fulfilled the executive champion role but would now be joined by CA as a joint executive lead in line with the new shared accountability requirements. FM had continued in the non-executive champion role following her appointment as Chair and that SH had supported her in that capacity. With SH due to leave the Board at the end of the month, NT had agreed to take on the non-executive Maternity and Neonatal Safety Champion role. It was emphasised that maternity and neonatal safety remained a responsibility of the whole Board rather than a small number of designated individuals and reaffirmed the Board's commitment to maintaining transparency and robust oversight in this area.

Delegated authority from the Board for the Quality Committee, which was scheduled to meet on 24th September, to scrutinise and approve the submission on the Board's behalf to ensure the Trust met the national deadline of 25th September, was sought. The Board approved this delegated authority, allowing the Quality Committee to review and authorise the submission. FM requested sight of the assessment before submission and asked that feedback from the Quality Committee be shared to support final approval arrangements.

The Board accepted the Board Briefing: Ockenden and Amos Review. The Board approved the request for delegated authority to the Quality Committee to scrutinise and approve the first submission in advance of the 25th September 2026 deadline. Submission to be shared prior to submission with the Chair.				
13	Quality Committee Escalation and Assurance Reports – July and August 2026	LF	Assurance	Enclosure 19-20
The paper was taken as read. IJ highlighted two key areas of work that had received particular attention. It was noted that one of the Trust’s quality priorities was improving the transition process for children and young people moving from paediatric services into adult services. It was noted that this transition had not always provided the best experience for patients and families and that work was underway to strengthen the process. Quality Committee had been keen to ensure that the development of the new approach was informed directly by children, young people and their families, recognising that they were best placed to identify where improvements were needed and how services could be made more effective. Secondly the ward accreditation programme that had been reviewed by the Committee during August. All wards had been assessed against an accreditation framework designed to ensure that expected standards were being achieved. IJ particularly welcomed the development of the programme as a peer-review process, whereby staff from different wards and services visited and reviewed one another’s areas, providing constructive challenge and assessment. The Committee strongly supported this approach because it encouraged the sharing of learning and good practice across the organisation, allowing staff involved in the review process to benefit as much as the wards being assessed. FM reflected the extensive scrutiny already undertaken through the monthly Quality Committee, which involved significant executive and non-executive participation and provided comprehensive oversight and assurance on quality and safety issues on behalf of the Board. The Board accepted the Quality Committee Escalation and Assurance Reports for July and August 2026.				
14	Perinatal Staffing Report	JJ	Assurance	Enclosure 21
The paper was taken as read. JJ presented the perinatal staffing report and highlighted a number of workforce pressures alongside some encouraging developments. Sickness absence remained elevated within two staff groups and a further deep-dive review would be undertaken, similar to work completed the previous year, to provide assurance that attendance management processes were being applied consistently and that staff were receiving appropriate support to return to work as quickly as possible. This work would be undertaken in partnership with the Human Resources team. Staffing deployment remained high during the reporting period in order to maintain safe staffing levels and respond to patient acuity. This was largely linked to the ongoing sickness absence levels and the vacancies within the service. Despite these challenges, it was noted that recruitment activity had been positive and that a number of new staff were due to join the service from September onwards. As a result, improvements were expected during the third and fourth quarters of the year as those new recruits became established in post. The Board were further advised that staffing vacancies had contributed to some delays in induction of labour pathways during the month. However, it was anticipated that these delays would reduce once the newly recruited staff had completed their induction and were fully operational within the service. From a neonatal perspective, positive progress in workforce development was noted and two nurses had successfully completed their specialist neonatal training and were now qualified in specialty practice. This achievement had contributed to improved compliance against neonatal staffing and training requirements and provided additional resilience within the neonatal workforce. FM welcomed the planned review of sickness absence and emphasised the importance of understanding the underlying causes to ensure service safety and staff wellbeing. The Board congratulated the nurses who had achieved their specialist qualifications and were pleased that there were vacancies available, noting that a number of student midwives due to qualify through the University				

of Worcester were keen to remain working locally. It was positive for the Trust to be able to offer opportunities to newly qualified staff and strengthen the future maternity workforce.

The Board accepted the Perinatal Staffing Report.

15	Perinatal Safety Report	JJ	Assurance	Enclosure 22
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The paper was taken as read.

It was highlighted that consultant attendance, rota fill rates and consultant ward round compliance had all remained strong during the reporting period, providing assurance regarding senior clinical oversight within maternity services. It was reported that there had been one stillbirth and two neonatal deaths during the quarter, all of which had occurred in the second trimester.

Training compliance remained on track to meet Clinical Negligence Scheme for Trusts (CNST) requirements, although there had been a temporary reduction in performance due to the summer heatwave. Training sessions had been postponed because it had not been appropriate to place staff in confined training environments during the period of extreme temperatures. However, catch-up sessions had been scheduled and the service remained confident that it would achieve the required compliance standards ahead of the first submission milestone in October.

The number of unexpected admissions to the neonatal unit had shown an increase during the quarter and further analysis would be undertaken to determine whether there were any underlying themes or whether the increase simply represented normal variation, particularly as rates had been lower in previous quarters. The successful reinstatement of the home birth service was welcomed, which had resumed during the reporting period.

In relation to outcomes, it was highlighted that the Trust's rolling twelve-month crude perinatal mortality rate remained below the national average, providing reassurance regarding the overall quality and safety of maternity and neonatal care.

FM welcomed the continued focus on safety and workforce development and recognised the importance of monitoring neonatal admissions and mortality measures closely.

The Board accepted the Perinatal Safety Report.

16	Safeguarding Annual Report	LF	Assurance	Enclosure 23
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The paper was taken as read.

The report had been presented later than usual because the safeguarding teams were small services carrying significant workloads and had prioritised delivering frontline safeguarding support to vulnerable individuals. Safeguarding performance and activity continued to receive regular scrutiny through quarterly reports to the Quality Committee and it was noted that Board members had received safeguarding training at the Board Workshop earlier that day to support their statutory responsibilities.

LF's principal concern was the increasing demand and complexity being experienced across safeguarding services for adults, children and children looked after. Relatively small specialist teams were managing growing numbers of referrals involving some of the most vulnerable people in the community. Although this increase reflected a wider national trend and was not unique to the Trust, the importance of continuing to monitor workload pressures and ensuring that the teams remained able to provide effective safeguarding support was emphasised.

Ongoing attention was required regarding the capacity of the learning disability nursing team. Concerns about whether demand for learning disability nurse support might exceed current capacity was being monitored. To help address this, the Trust was recruiting learning disability champions who could support patients with learning disabilities within clinical areas. The Nightingale pathway within surgical services was a positive example of work designed to improve the experience and care of patients with learning disabilities accessing the Trust's services.

LF concluded by highlighting an area of which she was particularly proud noting relationships with local authority partners and other statutory organisations had strengthened considerably over the previous one to two years, especially in relation to children's services, children looked after and wider safeguarding arrangements. Partnership working had been a key organisational priority and that the positive progress made had been demonstrated during the Board's safeguarding workshop. These stronger collaborative relationships were an important factor in improving support for vulnerable individuals and ensuring a more joined-up approach to safeguarding across the system.

FM reflected on the importance of maintaining professional curiosity in all safeguarding interactions. While people often presented situations accurately, there were occasions when concerns only became apparent through further questioning or deeper exploration. Staff were encouraged to seek advice whenever they were uncertain and stressed that it was always preferable to refer concerns for further review rather than risk missing an opportunity to safeguard a vulnerable person. Safeguarding policies and guidance were available on the Trust intranet and staff should never feel isolated when dealing with potential safeguarding concerns as there was support from colleagues and specialist teams whenever needed.

The Board accepted the Safeguarding Annual Report.

17	Patient Experience Quarterly Report	LF	Assurance	Enclosure 24-25
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The paper was taken as read.

Patient experience continued to improve across a number of key measures. It was noted that the number of formal complaints received during the year had reduced compared with the previous year, which was a positive. At the same time, the number of concerns raised had increased, but this was encouraging because it enabled issues to be addressed and resolved earlier in a patient's care journey before escalating into a formal complaint. Significant improvements in the management of overdue complaints, with fewer aged complaints outstanding, better compliance with agreed response timescales and an increase in the number of complaints resolved satisfactorily at the first response, resulting in fewer cases being reopened or requiring further correspondence.

The growing impact of the Patient Engagement Group was highlighted. The group continued to go from strength to strength and provided valuable insight that directly informed service improvements. It was particularly reassuring that the patient representative had described the group as thoughtful, honest and lively, which reflected the quality of engagement and challenge being provided by patients and members of the public.

Further improvements in national patient experience measures were noted following publication of the latest inpatient survey results where the Trust had continued the positive progress seen in previous years, with more areas performing above the national average. A detailed analysis of these results would be presented to the Quality Committee later in the month. In addition, the Trust had received embargoed results from the national Maternity Survey, which were also encouraging, although these could not yet be publicly reported until formal publication later in the year.

LF recognised the contribution of the Trust's volunteers. Volunteer numbers had increased from around seventy to almost one hundred individuals, who were collectively providing well in excess of one thousand hours of volunteering support. The Board thanked those volunteers for the significant role they played in supporting patients, visitors and staff across the organisation.

FM emphasised that listening to patients and the public was fundamental to providing services that we would recommend to our families and friends. While the Trust aimed to minimise the need for formal complaints, feedback remained essential to improvement, particularly when issues were identified early. FM encouraged patients and families to continue sharing their experiences and recognised that relatively small changes to pathways and communication could make a substantial difference to the overall patient experience.

The Board accepted the Patient Experience Quarterly Report.

18	Infection Prevention and Control Annual Report 2025/26	LF	Assurance	Enclosure 26-27
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The paper was taken as read.

LF reported that, although the Trust had continued to perform well in many areas, there had been a national increase in MRSA bloodstream infections and the Trust had recorded three cases during the reporting period. It was stressed that even a single infection was one too many. All three cases had been subject to detailed review alongside system partners, including colleagues from Worcestershire Community, Worcestershire Acute and the Integrated Care Board. These reviews had not identified any lapses in care or specific learning points attributable to the Trust, although vigilance and collaborative working with partners continued to ensure every possible measure was being taken to prevent future infections.

Performance relating to C-Diff infections had improved significantly compared with previous years. The Board were reminded that this had previously been an area of concern but both the Trust and the wider Integrated Care System had achieved better results during the reporting period. Infection prevention metrics formed part of the National Oversight Framework and the Trust's performance was currently above average in this area, providing additional assurance regarding standards of infection prevention and control.

The effectiveness of the Trust's management of outbreaks, including norovirus and influenza incidents that had occurred throughout the year showed that these outbreaks had been managed well through the combined efforts of frontline staff and the Infection Prevention and Control Team, whose specialist advice had helped minimise the spread of infection and reduce disruption to operational services.

The Trust's transition from intensive NHSE support and oversight for infection prevention and cleanliness to a position of routine monitoring was a great positive. This was a significant milestone that reflected the progress made by teams across the organisation. Although a sustainability review was scheduled for May 2027, the move to routine surveillance was a strong indication of sustained improvement in infection prevention standards and cleanliness across the Trust.

FM noted that the annual report had already been subject to detailed scrutiny through the Quality Committee and welcomed the progress that had been achieved, particularly recognising the importance of moving from enhanced monitoring to routine surveillance and acknowledged the considerable effort that had been required to reach that position, thanking staff across the organisation for their contribution to maintaining high standards of infection prevention and control

The Board accepted the Infection Prevention and Control Annual Report.

GOVERNANCE AND RISK

19	Annual Review of Audit Committee Effectiveness / Terms of Reference	NT	Approval	Enclosure 28-30
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The paper was taken as read.

NT reported that the Audit Committee had continued to strengthen its arrangements during the year. GS and LR were thanked for their support in establishing a solid framework for the Committee's work, which had enabled members to focus effectively on key risks, identify areas requiring attention and ensure that governance gaps were recognised and addressed. The work of the Committee ultimately contributed to better outcomes for patients, staff and taxpayers.

NT highlighted the strong attendance record of Committee members and noted that the effectiveness of the Committee relied heavily on the quality of challenge, observations and feedback provided by both executive and non-executive members. The constructive engagement shown throughout the year was acknowledged and recognised the positive impact this had made on the Committee's performance.

The internal audit results for the year were among the strongest during her tenure as Committee Chair and the Committee deliberately selected challenging and high-risk areas for review rather than focusing on easier topics so the positive outcomes were a great positive. Executive colleagues and their teams were thanked for the significant work undertaken to achieve these results and noted that the findings demonstrated the strength of governance and control arrangements across the organisation.

NT referred to the Committee's ongoing engagement with both internal and external auditors noting that following each meeting, non-executive directors met privately with auditors and consistently received positive feedback about the culture within Wye Valley NHS Trust. Auditors had highlighted the openness of the organisation, the quality of working relationships with executive teams and the timely provision of information required to support their work. NT praised the culture that had been established and described it as exemplary.

The Board took assurance that the Audit Committee had discharged its responsibilities effectively during the year, noted the Committee's forward plans and formally approved the revised terms of reference.

20	Integrated Care Oversight and Assurance Committee Reports – June /August 2026	IJ	Assurance	Enclosure 31-32
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The papers were taken as read.

It was noted that IJ had recently assumed the role of Committee Chair, having taken over responsibility following the August meeting. The Committee provided assurance regarding the Trust's responsibilities within the wider Herefordshire health and care system, particularly through the One Herefordshire Partnership and oversight of key programmes and funding streams such as the Better Care Fund.

One of the principal areas of focus was the financial pressure being experienced within the Better Care Fund. While the budget remained under pressure, it was advised that the position was currently being managed appropriately and the Committee had received assurance that arrangements were in place to maintain oversight of the risks.

Concerns were highlighted regarding the leadership capacity available to support delivery of the Neighbourhood Health Programme. Neighbourhood health was a critical component of the NHS's future direction and an important strategic priority for the Trust. Delivering the scale of transformation required was challenging when many of the individuals leading the work also held significant full-time responsibilities elsewhere within the organisation. This issue was recognised and was being addressed.

Alongside these challenges, the Committee had been encouraged by progress being made in areas such as Urgent Community Response services, virtual wards and the Trust's developing approach to discharge-to-assess pathways. Although much of this work remained in its early stages, this was important progress in supporting integrated care and improving patient flow across the health and care system. Assurance was given that appropriate oversight arrangements were in place and that good progress continued to be made across the partnership agenda.

FM acknowledged the importance of the Committee's work in supporting place-based partnership arrangements and the delivery of the NHS's wider strategic ambitions. Integrated working across organisations would remain central to the future development of neighbourhood health services.

The Board accepted the Integrated Care Oversight and Assurance Committee Reports.

21	Executive Risk and Compliance Committee Escalation and Assurance Report - August 2026	LF	Assurance	Enclosure 33
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The paper was taken as read.

The Committee was now operating under a revised reporting cycle. Under the new approach, divisional clinical risks were reviewed in one month, while assurance reports from the Committee's various subgroups were considered in alternate months.

One specific issue had been discussed in detail referring to recent correspondence from NHSE concerning unlawful access to clinical records and noted that while any inappropriate access to patient information would be taken extremely seriously, the communication had created a degree of uncertainty and anxiety amongst clinical teams. Some clinicians had expressed concern about whether accessing patient records for legitimate purposes other than direct patient care, such as clinical audit activities, complaint investigations or providing specialist advice to colleagues, could potentially be viewed as inappropriate. CA had received a number of queries from clinicians seeking clarification and assurance. The issue had therefore been considered by the Executive Risk and Compliance Committee through its information governance responsibilities. CA was working with regional and national colleagues to obtain further guidance and support to clarify the position for staff and ensure a consistent interpretation of the requirements.

FM recognised the importance of achieving the correct balance between protecting patient confidentiality and ensuring clinicians and other staff could access records where there was a legitimate professional reason to do so. CA reported that the concerns had been escalated to regional colleagues and was awaiting national clarification. In the meantime, CA was working with the Information Governance Team, as Caldicott Guardian, to develop interim local guidance for staff. This guidance would help both clinical and appropriate non-clinical staff understand when access to records was permissible while awaiting definitive national advice. The issue had been discussed with colleagues across the Foundation Group and that regional medical leadership and the General Medical Council were involved in developing broader guidance. The guidance would address both clinical and non-clinical access requirements where there was a legitimate professional purpose.

FM stressed the importance of achieving a consistent approach across the Foundation Group. While strong safeguards were needed to prevent inappropriate access to records, clear guidance was equally important to protect staff and ensure patients' information could still be used appropriately for governance, audit, quality improvement and patient safety purposes.

The Board accepted the Executive Risk and Compliance Committee Escalation and Assurance Report.

22	Charity Trustee Escalation and Assurance Report – June 2026	GQ	Assurance	Enclosure 34
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The paper was taken as read with no escalations to raise.

GQ expressed her appreciation for the work undertaken by everyone who made the charity's activities possible and thanked the donors, fundraisers and members of the public whose generosity enabled the charity to continue supporting the Trust and its patients.

FM recognised the significant contribution made by those who donated to, fundraised for and supported the charity noting that the Trust continued to face significant pressures on its publicly funded resources and that charitable funds played an important role in

enabling enhancements and additional support for patients, families and staff that might not otherwise be possible. FM expressed gratitude to everyone who gave their time, effort or financial support to the charity and acknowledged the positive impact those contributions had across the organisation.

The Board accepted the Charity Trustee Escalation and Assurance Report.

23	Children and Young People Committee Escalation and Assurance Report – August 2026	JR	Assurance	Enclosure 35
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The paper was taken as read.

JR highlighted the ongoing Special Educational Needs and Disabilities (SEND) reforms and the associated Experts at Hand programme, which had been discussed earlier in the meeting noting the importance of the initiative and its potential to support children and young people by improving access to specialist expertise within mainstream settings. It was recognised that the programme could help address some of the challenges associated with waiting times for therapy services, which remained an area of concern for the Committee.

LF advised that recruitment to the Experts at Hand posts had already been undertaken successfully recognising it as an important step in supporting children and young people and in delivering the objectives of the SEND reforms.

The Board accepted the Children and Young People Committee Escalation and Assurance Report.

24	Any Other Business
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There was no further business for discussion.

10.	Questions from Members of the Public	FM	Information	Verbal Update
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Two questions had been received from members of the public.

- 1) The first question related to the Trust's online patient access platform and the plans for introducing a replacement system following the withdrawal of the previous portal.

KO responded that the former portal had reached the end of its life and was no longer supported, making replacement necessary. The Trust had successfully procured an alternative system that was already widely used elsewhere in the NHS and was currently being implemented. The new portal was expected to go live during the autumn and would support integration with the NHS App. In response to a specific question about test results, it was confirmed that functionality to allow patients to view their test results through the portal formed part of the implementation plan and was expected to be available by the end of the financial year, subject to the rollout progressing as planned.

FM welcomed the update and emphasised the benefits of digital access, noting that it would provide patients with more timely and accurate information, reduce delays associated with paper correspondence, support sustainability objectives through reduced printing and postage, and help create a single source of information for patients accessing Trust services.

- 2) The second question related to the impact of recent periods of extreme heat and how the Trust had managed the heatwave conditions.

AD explained that hospital wards and outpatient areas did not generally have air conditioning systems, although they did have various forms of ventilation that could provide cooling. However, it was acknowledged that these systems became less effective during periods of extreme heat. Temperatures were routinely monitored in some specialised environments, such as theatres, but not generally across wards and outpatient areas.

During the heatwaves, the Trust had implemented a range of practical measures, including encouraging the use of fans, ensuring staff and patients remained hydrated, allowing staff to wear cooler clothing rather than standard uniforms where appropriate, and deploying portable air conditioning units. Demand for portable cooling units had been so high that even rental companies struggled to meet requests. Although staff and some patients had reported discomfort during the hot weather, there had been no specific heat-related incidents. The Trust had proactively identified and supported higher-risk patients both within hospital and in community settings. Looking ahead, it was acknowledged that climate change was increasing the frequency and severity of heatwaves and explained that the Trust's Climate Change Adaptation Plan included measures such as improved cooling strategies, estate development, building design improvements, shade provision and tree planting. While air conditioning would form part of future solutions, it would not be practical or sustainable to rely solely on installing air conditioning in every building.

FM agreed that the question raised reflected important challenges that would need continued attention in future years.

There were no further questions from the public.

DATE AND TIME OF THE NEXT MEETING – Thursday ? October 2026 1.00 p.m.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board held in Public
Date of Meeting:	1st October 2026
Title of Report:	Foundation Group Strategy Committee (FGSC) report from the Meeting held on 17 September 2026
Lead Executive Director:	Chief Executive Officer
Author:	Chelsea Ireland, Foundation Group Executive Assistant
Reporting Route:	Direct to Board
Enclosures included with this report:	n/a
Purpose of report:	☐ Assurance ☐ Approval ☒ Information
Brief Description of Report Purpose	
The purpose of this report is to provide the Board with an overview of the FGSC meeting held on 17 th September 2026.	
Recommended Actions required by Board or Committee	
The Board is asked to receive and note this report.	
Executive Director Opinion¹	
n/a	

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

Trust Board Held in Public – 1st October 2026

FGSC Report from the Meeting held on 17 September 2026

Matters of Concern or Key Risks to Escalate to the Board	Major Actions Commissioned and Work Underway
• Research recruitment performance remained below the Foundation Group’s ambition in some areas and improvements were required in research readiness, attractiveness to commercial trials and supporting systems. • The Committee highlighted that some established Group forums, including the Data Quality Steering Group and Counting and Coding arrangements, had not continued consistently, creating a risk that collaborative infrastructure could weaken without clear oversight and leadership. • There remained a gap between the availability of analytical tools and their operational use. Members sought assurance that staff were able to access, understand and utilise information effectively to support decision-making. • Model Hospital benchmarking continued to identify material opportunities in productivity, length of stay, theatre utilisation and clinical efficiency. The Committee noted that learning was not always transferred consistently across organisations or departments. • PFI expiry was identified as a significant strategic risk and opportunity for WAHT and WVT, requiring consideration through future strategy development. • National uncertainty remained regarding local government reform, ICB footprints, tariff reform, NHS operating arrangements and wider NHS structural changes, all of which may have implications for organisational planning and delivery.	• Progression of the Foundation Group Strategy Refresh, including Trust-level strategy reviews and alignment of future strategic priorities across the four organisations by January 2027. • Development of a Foundation Group Information Strategy covering analytics, insight, data literacy, technology, infrastructure, AI and partnership working. • Mapping of key Foundation Group forums, executive leads and meeting schedules to ensure collaborative governance arrangements remain active and effective. • Development of a consistent Foundation Group approach to NHS Notify requirements and digital communications. • Development of enhanced research reporting, including time-to-trial metrics and measures that better explain the factors driving research performance. • Development of a stronger Foundation Group research proposition, including greater collaboration with universities, primary care, community and mental health partners and the creation of a more visible Group research identity. • Development of a standardised Foundation Group-wide point prevalence review methodology to support benchmarking, admission avoidance analysis, pathway redesign and contracting discussions. • Establishment of dedicated maternity and neonatal governance arrangements across the Foundation Group.

Matters of Concern or Key Risks to Escalate to the Board (continued)	Major Actions Commissioned and Work Underway (continued)
- Initial responses to the Maternity and Neonatal 10-Point Plan were being completed within compressed national timescales and prior to full completion of Trust governance cycles. The Committee also emphasised that national compliance requirements should not obscure known local maternity risks. - Existing aseptic manufacturing facilities continued to present a significant regional continuity risk, with programme delivery dependent upon national approvals and a challenging implementation timetable to December 2028. Further validation of financial and activity assumptions remained necessary prior to procurement. - Discussions regarding divisional earned autonomy identified potential risks where emergency care performance and costs remained dependent on actions taken by other divisions.	- Progression of Divisional Performance Framework pilots across the organisations, supported through an iterative learning approach and future reporting to FGSC. - Continued progression of the Aseptics Outline Business Case through national approvals and preparation for procurement, subject to approval by individual Trust Boards.
Positive Assurances to Provide the Board	Decisions Made by the Committee
- The Foundation Group operating model continued to demonstrate the benefits of collaboration whilst maintaining organisational sovereignty and accountability. - The Data Quality Steering Group had been re-established and corridor care data reviews demonstrated broadly consistent definitions and data capture across the four organisations. - All four Trusts were using or implementing elements of the Federated Data Platform and work was underway to strengthen information capability across the Group. - Positive progress had been made in aligning research activity across GEH and SWFT and developing wider teaching, academic and research partnerships across the Foundation Group. - Successful applications for doctoral, NIHR and innovation funding were reported, and all four organisations were operating within segment one nationally for time-to-trial performance.	- Approved the minutes of the meeting held on 18 June 2026 as an accurate record. - Supported the proposed approach to refreshing the Foundation Group Strategy. - Approved improvements to future research reporting, including routine reporting of time-to-trial performance. - Supported development of a standardised Foundation Group-wide point prevalence methodology. - Approved further work on maternity governance, impact evaluation and incorporation of findings from the national maternity inquiry. - Approved the Committee calendar of meetings for 2027/28. - Supported the Aseptics Outline Business Case in principle and recommended it to individual Trust Boards for consideration and approval, subject to completion of the national approval process.

Positive Assurances to Provide the Board (continued)	
• The collaborative maternity approach was recognised as a strong example of Foundation Group working, supporting peer review, challenge, shared learning and strengthened governance arrangements. • Managing Directors and care groups reported broad support for piloting the Divisional Performance Framework and developing a more proportionate model of earned autonomy. • The Foundation Group continued to be recognised nationally as a successful model that combined collaboration with clear organisational accountability. • Members welcomed the significant progress already made on the Aseptics Outline Business Case and the collaborative approach being taken across partner organisations.	
Comments on Effectiveness of the Meeting	Recommendation
• The Committee continued to provide strategic oversight and challenge across a broad range of Foundation Group initiatives, including strategy, analytics, research, finance, maternity services and operational performance. • Members demonstrated constructive challenge and professional curiosity, particularly in relation to the practical use of information, research collaboration, productivity opportunities and the impact of Foundation Group arrangements. • The meeting reinforced the value of collaborative working across the Foundation Group, with repeated emphasis on shared learning, peer review, benchmarking and the benefits of operating at scale. • Discussions remained focused on ensuring that collaborative programmes delivered tangible benefits and robust assurance for individual Trust Boards while preserving organisational sovereignty.	• The Board is asked to receive and note this report.

Chelsea Ireland

Foundation Group EA

WYE VALLEY NHS TRUST
ACTIONS UPDATE: Trust Board held in Public – 1st October 2026

Month	Meeting Type	Ref	Item	Action	Due Date	Owner	Status
Sept	Public	12	Ockenden and Amos Reports	The Board approved scrutiny and oversight of the national submission providing delegated authority to Quality Committee in advance of the deadline 25th September 2026. Caveat: to ensure the Chair has sight of proposed submission.	Sep-26	Lucy Flanagan/Ian James/Frances Martin	Closed

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	1st October 2026
Title of Report:	Chief Executive Officer's Report
Lead Executive Director:	Chief Executive Officer
Author:	Professor Sir Glen Burley, Chief Executive Officer
Reporting Route:	Direct to Board
Enclosures included with this report:	n/a
Purpose of report:	☐ Assurance ☐ Approval ☒ Information
Brief Description of Report Purpose	
The Chief Executive's report provides an update on a number of significant national and local developments that will influence the Trust's operational performance, strategic direction and future regulatory position during 2026/27.	
Recommended Actions required by Board or Committee	
The Board is invited to Note the key messages from the report.	
Executive Director Opinion¹	
The Trust continues to make progress locally against a backdrop of significant national reform. While workforce pressures, financial constraints and service demand remain key challenges, the Trust continues to advance its integration agenda, improve patient flow and prepare for emerging NHS policy developments.	

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

Rewiring the State

This Cabinet Office statement was published at the end of July soon after Andy Brunham took up post as PM. It sets out the aim to shift power, money, and control from central government in London to local mayors and regional leaders. The plan aims to boost local economies and improve public services by letting local people make their own choices. The stated core goals are;

- Devolve by default: Central government departments must prove why a decision should stay in London rather than local areas.
- Local tax powers: Mayors and councils will keep a share of local business rates and income tax, and can introduce an Overnight Visitor Levy (a small fee on hotel stays).
- Better public services: Local leaders will control technical education for 16-19 year-olds, local buses, and employment support.
- Wider coverage: Every part of England is expected to have a regional strategic authority by the end of 2028.

Local Government Reform

The core aim of the current Local Government Reform process is to abolish overlapping county and district councils to create unified, single-tier unitary authorities. This should simplify public access, remove administrative duplication, cut waste, and empower local areas to drive economic growth. Opponents argue the transition is disruptive, fails to guarantee net savings, strains resources, and risks distancing councils from rural communities.

Major structural changes were proposed across multiple English counties including Worcestershire and Warwickshire, where proposals for unitary options were submitted which would split both counties in two. Following widespread debate and logistical pushback over merging disparate systems, the government has now paused the implementation of these plans for numerous transition areas to carry out a comprehensive review.

The recent restructuring and clustering of ICBs sought to align their footprints wherever possible to the anticipated strategic authority boundaries. In doing so, it was acknowledged that there was some uncertainty about these and that other factors, such as NHS patient flows, should also be considered. This pause and re-think helps to vindicate the decision taken by the NHS to not implement an immediate fully aligned structure.

NHS Oversight Framework

The updated framework for 2026/27 describes a consistent and transparent approach to assessing integrated care boards (ICBs), NHS trusts and foundation trusts (providers). This framework sets out how NHS England will assess and oversee providers and ICBs, against a range of agreed metrics, promoting improvement while helping to identify quickly where organisations need support, as well as those that are performing well.

The framework is supported by a focused set of national priorities, including those set out in the Medium Term Planning Framework, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes.

Trust level data relating to Quarter 1 performance of 2026/27 has now been published which shows strong improvements across the Group. South Warwickshire University Foundation Trust now ranks 3rd overall out of 118 General Acute providers and is in segment 1 (of 4) for the first time, George Eliot Hospital NHS Trust is ranked 11th and placed in Segment 2 for the first time, Wye Valley NHS Trust are ranked 32nd (Segment

3) and Worcestershire Acute Hospitals NHS Trust are ranked 51st and placed in Segment 3, moving from segment 4 for the first time.

Such significant improvements do not come easy, so I would like to thank everyone for their contribution to this effort. As we enter the second half of the year and the challenges of the winter, it will be important for all Trusts in the Group

Thirlwall Inquiry - Countess of Chester Hospital

Led by Lady Justice Kathryn Thirlwall, the independent public inquiry published its final findings in September. The report concluded that there was a "complete failure" to protect babies at the Countess of Chester Hospital's neonatal unit from serial killer nurse Lucy Letby.

Key Findings

- **Missed Opportunities:** At least three deaths and seven non-fatal attacks could have been prevented if senior hospital managers and staff had acted sooner on warnings from consultant doctors.
- **Ignored Warnings:** Senior managers dismissed clinician concerns of deliberate harm, choosing instead to protect the hospital's reputation and forcing doctors who raised alarms to apologize to Letby.
- **Flawed NHS Systems:** Statistical spikes in infant mortality were ignored, incident reporting was poor, and safeguarding fundamentals were missing across the organisation.

Core Recommendations

- **Real-Time Safety Data:** Hospital boards must directly monitor neonatal safety data in real time, with mandatory board-level tracking of all infant deaths scheduled by 31 March 2027.
- **Police Referrals:** External reviews must never replace direct police referrals when deliberate harm to a patient is suspected.
- **Independent Oversight:** A new independent monitoring system is required to ensure NHS bodies actually implement safety recommendations.

The Government and NHS England are currently considering the full recommendations. In doing so they are mindful that the Inquiry looked back on events in one organisation around a decade ago. Much has changed, including the clearer accountabilities of the new operating model but how we tackle some of the other recommendations will require careful consideration or possibly alternative strategies.

6. Medical Division Update

Urgent and Emergency Care

The summer period saw extreme heat conditions with an associated unusually high ED attendance and acuity through May and June presenting ongoing significant challenge to maintain efficiency and safety within the department. The team have proudly demonstrated their resilience during this time, while continuing to transition to our new medical models following business case investments in Sept 2024. Our departmental efforts remain focussed to improve quality and performance at pace. Several positive developments have been implemented since the previous CEO report, March 2026:

- Embedded ED Safety Champion meeting and walkarounds with Execs
- Fully recruited Specialty Doctor expansion, with new rota implemented in August
- Uplift to AMU nurse staffing to meet acuity
- Approval for investment into Acute Floor Discharge Coordinators

- Increased utilisation and streaming to the new MSDEC footprint
- Implementation and standardisation of Model ED, including new Extended Emergency Medicine Ambulatory Care (EEMAC) pathway
- Improvements in Non-admitted pathways and Time to be Seen – including value-focused Pit-Stop; Review of Medical Leadership Roles; review of SOPs and escalation action cards
- Implementation of 'My Next Patient' principle, with ward sisters joining ED huddles twice a day.

4-hour performance remains challenged recently at 63.9% in August for all types and behind our planned trajectory for the year. September year-to-date is currently at 65.1%, which compares 65.6% a year ago in September 2025. The driver for the recent challenge to performance over the summer has been the gap in medical workforce due to delayed recruitment and sickness, with c35% loss rota capacity for Consultants, as well as delays with recruitment to the SpDr rota challenging available capacity. Despite workforce challenges, the team are proud to have seen a significant and sustained reduction in 24 hour length of stay breaches in ED, to now <1%.

Plans for further improvement:

- Relaunched process for streaming to Community Referral Hub
- Review and test of change for GP referred/ambulatory patients direct to specialty
- New ACOO for UEC improvement and flow matron joining the Trust, to redesign operational flow SOP's, escalation plans and action cards targeted to reduce corridor care
- Ongoing development of Single Point of Access; 24/7 CRH Hub, and exploration of trusted assessor to take GP referrals
- Developing the primary/secondary care interface forum for further opportunities for care in the community such as DVT and hypertension pathways.

Ambulatory & Frailty

The Geriatric team in tandem with the Integrated Care Division have continued to lead a frailty Virtual Ward model, which has seen sustained utilisation and benefit to patients with admission avoidance and reduced length of stay since. Following on from early positivity with the new service, the team and audit recognises further opportunity via the Virtual Ward pathway with further circa 15% of frailty bed that could be managed in the community. To facilitate this, the frailty teams are engaged in development of acute/ community MDTs.

The geriatric medicine team are also engaged and excited about reviewing a new model of care of fractured neck of femur, as part of Trust wide transformation for redesigned Community Hospital care, which targets earlier discharge to community.

Across Stroke services the team have continued to work toward SSNAP improvements and the development of the new medical model for front door as part of the system 'Model C' plan to the ICB, along with a briefing paper detailing what rehab beds would be needed to support model C. The stroke team are proud to be increasing there number of patients eligible and accepted for the thrombectomy pathway via tertiary centre, building on the early adoption last year of the CT AI imaging solution that underpins the pathway.

Following many years of locum usage, the directorate are proud that General Internal Medicine is building under solid Consultant Leadership, and with a nursing acuity uplift for Redbrook, our General Medicine Ward. The team are excited by 4 candidates due to be interviewed for the remaining Consultant vacancy.

Medical Specialties

Medical workforce recruitment continues to be a very positive and proud factor for the directorate. Since the last CEO report, gastroenterology, respiratory medicine and neurology have all recruited to their historic Consultant vacancies following many years of locum usage. The directorate are excited for the new recruits to join, who will provide the required sustainability for service development, redesign, as well as supporting the ongoing reduction in temporary staffing spend.

The directorate are hugely proud of their contribution to the Trust's national position for cancer care and outcomes. In particular, since the last CEO report, the Trust has launched its Lung Cancer Screening programme in partnership with primary care, with CT scans completed through our Wye Valley Community Diagnostic and Treatment centre. The screening programme recently identified its first patient at an asymptomatic very early stage of cancer.

We are pleased to have significantly reduced our waiting times for Echocardiography with the support of insourcing. Recruitment plans have progressed with 3x international trainees appointed and have started in post supporting a 'grow your own' approach for a hard to recruit to service.

In gastroenterology, the team are pleased to have launched a trial Capsule Sponge service in September, with the support of Cancer Alliance funding. The service offers great efficiency to services, reducing the need for endoscopy capacity, as well as far better patient experience via less invasive procedure.

In cardiology, there has been recent success in the award multi-year capital funding to replace and expand the existing aged Catheter Lab services. Design is underway with senior clinical oversight with view to business case in October. Meanwhile, working groups continue to work in collaboration with our radiology service to launch new cardiac MRI and Cardiac CT services at WVT, repatriating this work locally which is a significant contributor to our delayed outpatient performance.

Professor Sir Glen Burley
Chief Executive Officer



Compassion • Accountability • Respect • Excellence



Integrated Performance Report

August 2026





Sarah Shingler
Managing Director

August has seen continued progress across a number of key areas, despite sustained operational and financial pressures. Patient feedback remains encouraging, with recent survey results highlighting the compassion and professionalism of our staff, whilst also identifying opportunities to further improve communication and personalised care.

Demand across urgent and emergency care continues to exceed previous years and remains one of our most significant challenges. Alongside this, elective and cancer services continue to perform well, reflecting the commitment of teams across the Trust to maintaining access and delivering high-quality care.

Our workforce remains a key strength. Whilst recruitment challenges persist in some areas, turnover and sickness absence remain comparatively low, supported by continued investment in staff wellbeing, engagement and development.

Financially, the Trust remains broadly on plan, reporting a year-to-date deficit of £3.0m against a planned deficit of £2.7m. Delivery of the Cost Improvement Programme remains a significant priority and sustained focus through the Financial Recovery Board and divisional governance arrangements is helping drive increased accountability and delivery. Whilst challenges remain, particularly around efficiency delivery and the impact of ongoing demand pressures, there is continued confidence that the Trust can deliver its planned year-end position.

Looking ahead, our focus is increasingly turning towards winter preparedness. Demand across urgent and emergency care remains high, with pressures evident across acute, community and social care services. Experience from recent years demonstrates that winter pressures are no longer confined to the traditional winter months, requiring us to maintain resilience across the whole system whilst continuing to improve patient flow, discharge performance and bed capacity. Through our winter planning arrangements, we are working closely with system partners to ensure that services are as prepared as possible for periods of sustained demand, with a particular focus on maintaining patient safety, supporting staff wellbeing and delivering timely access to care. Whilst the operational and financial environment remains challenging, I remain confident in the capability, commitment and resilience of our staff. The progress highlighted throughout this report reflects the dedication of colleagues across the Trust and provides strong foundations as we enter what is expected to be another demanding winter period. Our priorities remain clear: delivering safe, high-quality care, improving access and experience for our patients, strengthening productivity and ensuring the organisation spends the Herefordshire pound wisely.



Chizo Agwu
Chief Medical Officer



Lucy Flanagan
Chief Nursing Officer

Adult inpatient survey results publication – August 2026

The National Inpatient Survey results were published on 26th August and summarised below. The full results analysis is also appended to this paper.

In summary, performance is above the national average in many areas, with particular strengths in the kindness and compassion shown by staff, information about medications, support for accessibility needs, cleanliness, patient experience on the virtual ward and at night.

Eight survey questions showed significant improvement compared with the previous years survey.

Patient feedback remains overwhelmingly positive regarding staff, reflecting continued recognition of the care provided despite operational pressures. Areas requiring further improvement include discharge planning and support after discharge, communication and information sharing, consideration of individual needs such as dietary and language requirements, privacy during care, and aspects of the hospital environment and facilities.

Negative feedback relating to overcrowding, boarding and staff shortages will be triangulated with complaints and concerns to inform targeted improvement actions.

Overall, the survey indicates sustained high performance and patient confidence in clinical care, while highlighting discharge processes, communication and patient-centred care planning as key priorities for improvement.

Ockenden- Amos 10-point plan assessment and submission

NHS England wrote to Trusts on 12th August 2026, providing an assessment tool to identify current baseline performance against the 10-point plan published in June 2026.

The Board delegated authority to Quality Committee to review and approve the assessment and associated evidence, to ensure the Trust could meet the national deadline of 25th September 2026.

Quality Committee reviewed and approved the submission on 24th September. Next steps are to establish the governance arrangements for ongoing development and monitoring of actions to respond to these reports.

A follow up submission will be required by 31st December to demonstrate progress against the baseline assessment.



Quality & Safety Performance – Mortality

We are driving this measure because:

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

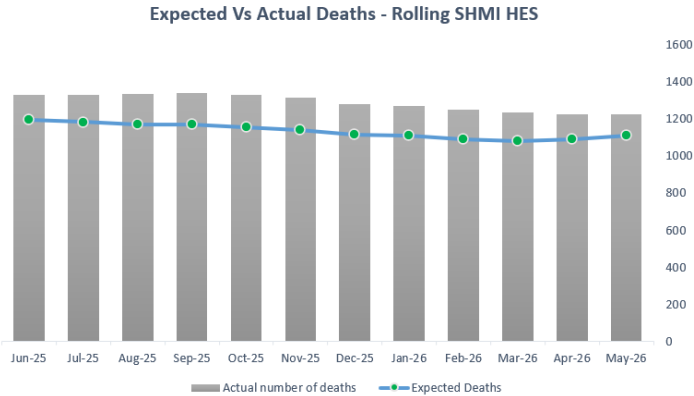
Data

Trust-level data (May 2025 – April 2026)

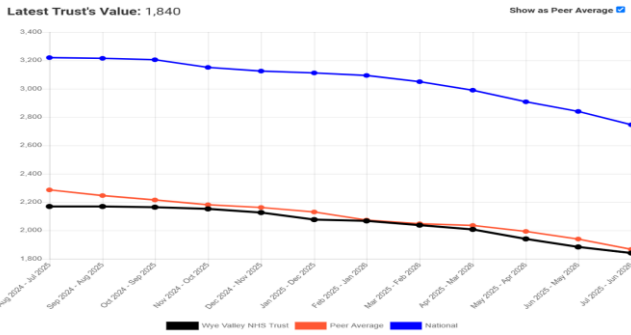
As expected SHMI

27,445 ↑(+1265) Provider spells 1,295 ↓(-10) Observed deaths 1,150 ↑(+15) Expected deaths 1.1260 ↓(+2.07) SHMI value

Indicator - Latest Static	Description/Notes	Data month	Month Actual	Deaths in Month	Change (Rate %)
Crude Mortality-All	% of Deaths by Discharges	Aug-26	0.86%	54	0.04%
Crude Mortality-Emergency	% of Deaths by Emergency Discharges		1.78%	52	-0.07%



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 May 2025 to April 2026 shows Wye Valley NHS Trust at 112.6, which equates to 1295 observed deaths against 1150 expected.
- Latest **crude mortality** rate for August 2026 was 0.86% for all admissions, which equates to 54 deaths. This is the sixth consecutive reduction in our crude mortality this year.
- Emergency Department** - The latest reported data shows the crude mortality rate to 0.11% for July 2026. The average crude mortality rate over the past 3 years is 0.20%.
- #NOF (Fractured Neck of Femur)** Latest 12-month rolling SHMI: 116 (-13) Observed: 35 Expected: 30
 - The latest 12-month rolling SHMI (May 2025 – April 2026) has reported a further significant reduction of nearly 13 points to 116. The HES-based SHMI, which provides a provisional look ahead, shows there is further reductions to come.
 - Latest NHFD (National Hip Fracture Database) clinical KPI's are all now reporting above the National mean for each measure. The vast majority continue to report improved outcomes with key measures, notably a further 4% increase in patients receiving appropriate bone medication, which has been consecutively increasing for the past 12 months. See latest performance in the table below.
 - The Quality Impact Assessment to be presented at CEAC in October for the use of slow-release opioids in the pain management of fractured neck of femur patients.
- Pneumonia:** Latest 12-month rolling SHMI: 107 (-1) Observed: 145 Expected: 135
 - Continued work on the Reducing Hospital Acquired Pneumonia programme. A full update was reported at the Trust Quality Committee in August.
- Sepsis:** Latest 12-month rolling SHMI: 112 (+1) Observed: 105 Expected: 95
 - A new ED Sepsis Lead has been identified, who will be able to provide senior clinical leadership to the planned quality improvements to the Sepsis pathway. A full update on the plan will be provided in the coming months.
- Stroke:** Latest 12-month rolling SHMI: 112 (+0↔) Observed: 115 Expected: 100
 - At this months Learning from Deaths Committee, there was a comprehensive report by the Stroke Mortality Lead on the learning from recent case reviews and the supporting actions and improvements put in place to improve the pathway and patient outcomes. The initial crude mortality data for the summer months looks improved compared to the previous years.
- Heart Failure:** Latest 12-month rolling SHMI: 94 (-6) Observed: 45 Expected: 50
- Perinatal Mortality** - Latest unadjusted 12-month rolling (September 2025 – August 2026) extended perinatal rate has remained at lower-than-average level at 3.19 deaths per 1000 live births. In addition, the latest stillbirth is now reporting well below the local average at 1.27 deaths per 1000 live births.
- Clinical Coding** - The SHMI dataset has now started to include SDEC spells. Based on the first month included, April 2026, there has been an increase in the number of spells and subsequently an increase in the number of expected deaths. This has had a positive effect on our overall SHMI with over a 2-point reduction.

Quality & Safety Performance – Quality Priority- Antimicrobial Stewardship

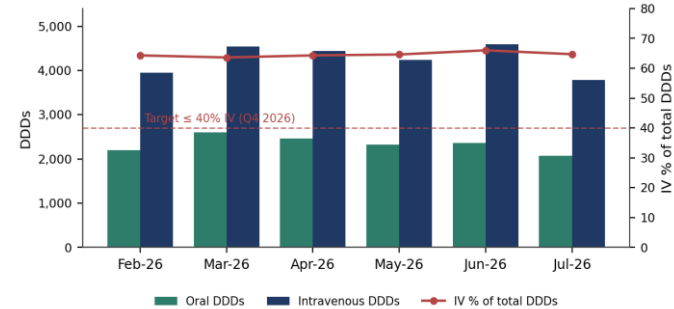
We are driving this measure because:

NHS England’s “Act Now: Protect Our Present, Secure Our Future” letter (November 2024) required Trust boards to review antimicrobial prescribing, publish three quality priorities and implement an accountability framework; the priorities in this report were established in response.

The priorities

Priority	Focus	Target
1	IV-to-oral switch	≤40% IV
2	Reduce broad-spectrum (Watch/Reserve) use	Sustained reduction in Watch + Reserve DDDs
3	Digital implementation	Real-time dashboards, improvement of order sets and templates

Priority 1 – IV to oral switch

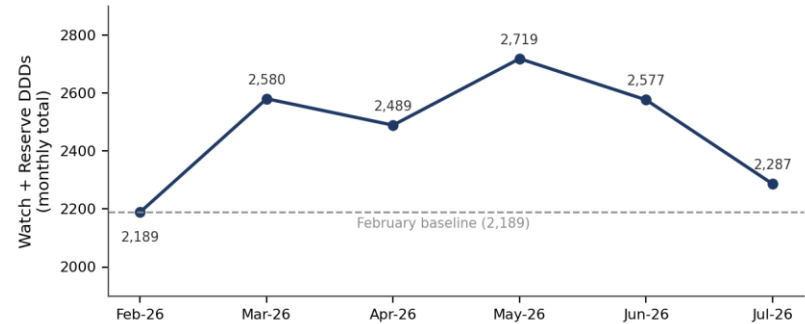


Target to reduce IV antibiotic use to ≤40% of combined oral and IV DDDs by Q4 2026, measured as IV DDDs as a proportion of combined oral and IV DDDs.

This graph presents performance against the target.

Current focus is on consultant and pharmacy engagement, education of the junior medical workforce and general awareness raising of the importance of switching to oral.

Priority 2 – Reduce broad spectrum use



Target to achieve a sustained reduction in Watch and Reserve DDDs against the February 2026 baseline (2,189 DDDs/month).

Particular focus on antibiotic use in gynaecology and gastrointestinal specialties.

Recent sepsis audit highlighted opportunity to change to narrow spectrum antibiotics where clinically appropriate.

Review of antibiotic guidelines for hospital and community acquired pneumonia.

Priority 3 – Digital implementation

Background

Monitoring of IV/oral switch and Watch/Reserve prescribing was previously conducted manually. Real-time dashboard reporting and improved order sets and templates were agreed as the third of the Trust’s three quality priorities for 2026–29.

Aim

Implement real-time dashboard reporting to replace manual monitoring and improve order sets and templates to support prescribing decisions.

Plan & Action

The Power BI AMS Dashboard was developed in August 2026, following the close of this reporting period; it is now the source of the administration data used for Priorities 1 and 2. The AMS team has begun reviewing how the dashboard’s wider reporting capability can be applied to future quarterly monitoring.

Quality & Safety Performance – Staffing - August data

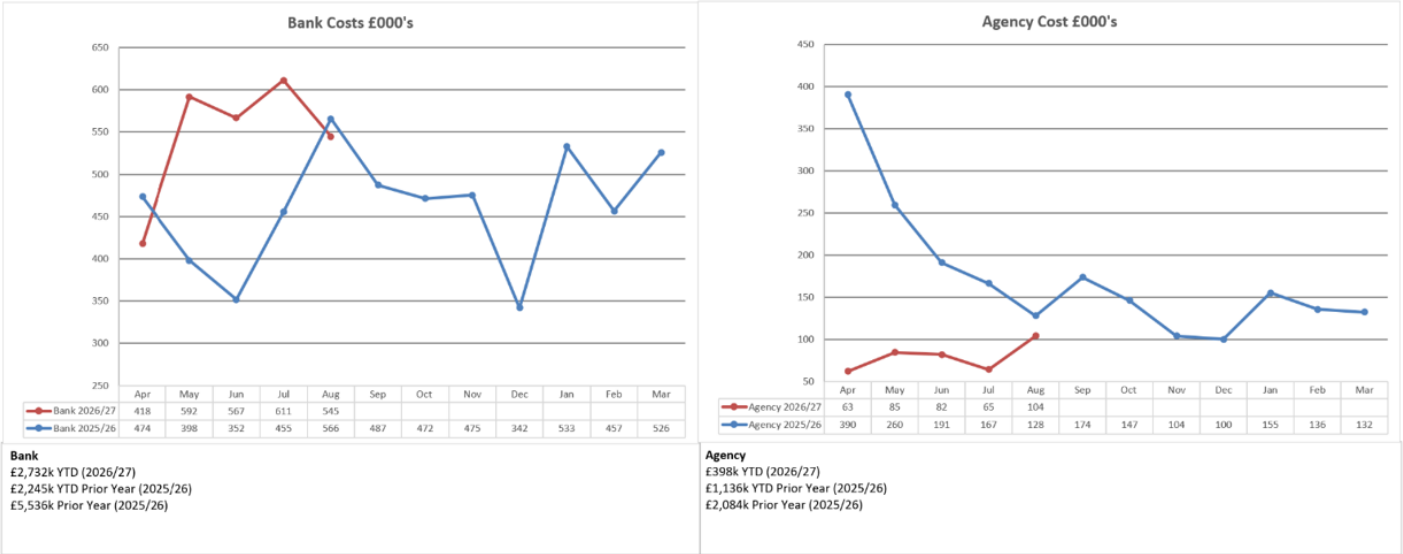
Fill Rate & CHPPD Data

	Day		Night		Overall (Actual) CHPPD
	RN Fill	HCA Fill	RN Fill	HCA Fill	
Primrose Unit	90%	75%	98%	94%	11.0
Maternity Ward	91%	94%	94%	87%	7.0
Children's Ward	117%	131%	137%	54%	29.8
Lugg Ward	116%	78%	101%	102%	6.4
Wye Ward	117%	74%	116%	77%	7.2
Cardiac Care Unit	100%	95%	100%	100%	11.8
Leominster Community Hospital	97%	102%	100%	118%	7.2
Bromyard Community Hospital	75%	92%	100%	120%	5.8
Ross Community Hospital	90%	95%	82%	107%	5.9
Teme Ward	126%	54%	92%	56%	12.4
Redbrook Ward	116%	94%	102%	122%	8.2
Special Baby Care Unit	97%	-	98%	-	23.9
Intensive Care Unit	112%	-	117%	-	27.2
Gilwern Ward	88%	128%	100%	122%	7.4
Acute Medical Unit	113%	83%	108%	119%	8.6
Ashgrove Ward	126%	85%	123%	113%	7.7
Dinmore Ward	121%	77%	100%	97%	7.5
Garway Ward	120%	89%	105%	121%	7.5
Frome Ward	126%	86%	99%	132%	7.2
Arrow Ward	136%	72%	140%	89%	8.1
Women's Health	80%	89%	100%	-	9.5

There are several areas above the fill rate for the following reasons:

- Paediatric Ward – Additional RN’s and HCA required to support ED, and patients needing enhanced care - RMN support
- Frome, Dinmore, Garway and Ashgrove Wards – Additional staffing requirements for additional boarding patients
- AMU and Redbrook Wards – Due to patient acuity and dependency, additional staff needed to support individual care needs – both wards have had recent business case approval
- Frome Ward, Teme Ward, Wye Ward and Lugg Ward - Due to Band 5 backfill for band 4 posts.
- Arrow Ward – Due to number of patients requiring non-invasive ventilation (NIV)
- Gilwern Ward – alignment of roster needed for additional staffing needs
- Bromyard – Due to additional D2A beds opening

Bank & Agency



- The agency expenditure limit set by NHS England has been applied to our Nurse Agency Reduction programme target for 26/27
- We have a cost productivity (CPIP) target of £1.2m
- CPIP delivery is on trajectory year to date, although behind plan in month 5
- There has been a significant rise in off framework shifts with 23 shifts overall; 21 of these were for the paediatric ward
- The off framework shifts alone account for the increased expenditure on agency in M5 compared to M4
- Bank costs have reduced yet are still above plan and this remains an area of particular focus
 - Additional weekly check and challenge meeting with finance and nursing colleagues
 - Increased senior oversight for shift authorisation
 - Optimising recruitment of newly qualified staff

Our Performance – Executive Summary



Andy Parker
Chief Operating
Officer

The Summer months were particularly challenging for our Urgent and Emergency Care (UEC) pathways emphasising that Winter plans should be all year-round UEC plans.

Compared with Summer 2025, June to August, we saw an increase of 4.8% of Emergency Department [ED] Type 1 attendances, 6.6% increase in non-elective admissions, but with a 2.6% reduction in >0 Length of Stay Non-Elective admissions.

As mentioned previously, the impact of the Summer extreme temperatures has seen surges in demand with significant variation in daily volumes of Type 1 attendances, from as low as 170 to as high as 252, one of our highest ever days, within a two weeks period within August. As part of our review of the summer period, we are reviewing the data to look at the common condition themes driving the Emergency Department (ED) attendances along with the staff and estates response across our Foundation Group linked to shared learning and a review of our Emergency Preparedness, Resilience and Response (EPRR) plans. This review will be shared with Boards at our next Foundation Group Workshop.

Our Winter Plan has been finalised and are included within this month's Trust Board Papers. These highlight the key areas we aim to deliver ahead of winter including working with System partners

- Delivering our 24/7 Single Point of Access [SPoA], with a 24/7 Trusted Assessor Model
- Delivering 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
- Implementing 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.
- Powys admission avoidance and step-down care schemes

Internally, we are focused on how we improve those areas that are within our influence of control, and using the Getting It Right First Time (GIRFT) ,Models of Care for ED, the first 72hrs of inpatient care and Discharge, all of which we have used as a basis for our improvements:

- Ward Based Processes. Including the use of Digital Whiteboards in January next year, focusing on early discharge through earlier identification of a "Golden Patient" on each ward, improved earlier Electronic Discharge Summary population along with quicker dispensing of medication. Supported by ensuring Medical Best Practice principles are adopted.
- Maximising our Hospital@Home capacity through regular ward check and challenges and ensuring a consistent approach for Community pathways
- Implementation and monitor of the GIRFT Clinical Operational Standards led by our Chief Medical Officer
- ED processes focused on Time to be Seen, Streaming and Navigation.

Our Elective activity plans remain on plan with our Theatre teams continuing to improve on their productivity schemes. The Integrated Care Board Cluster had a recent virtual visit by Professor Tim Biggs and the GIRFT team earlier in September and WVT were highlighted as driving excellent changes to cancer pathways along with:

- Improved average cases per 4-hour list continues to perform in the highest quartile nationally
- WVT cases per session has increased to 18% ahead of the national average
- The lowest percentage of clinical cancellation for treatment
- Development of our Community Diagnostic Pathway for direct to tests

The team are now focused on arthroplasty length of stay project that significantly reduced length of stay to below the national average continues to run and is focused on the next stage of achieving 23 hour / same day joints with trial lists in November.



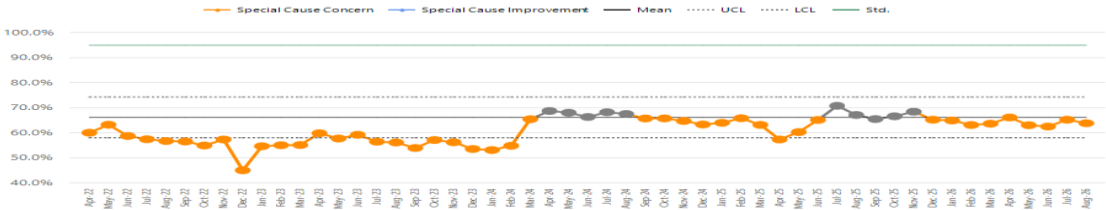
Operational Performance – Urgent and Emergency Care [UEC] / Emergency Department [ED] Performance

We are driving this measure because:

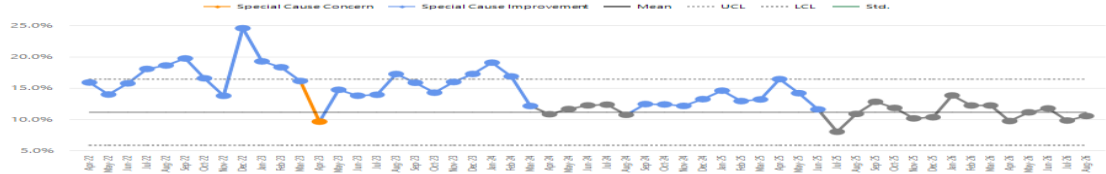
The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department [ED] where clinically appropriate. Performance has been adversely affected by year on year increases and higher acuity in emergency presentation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

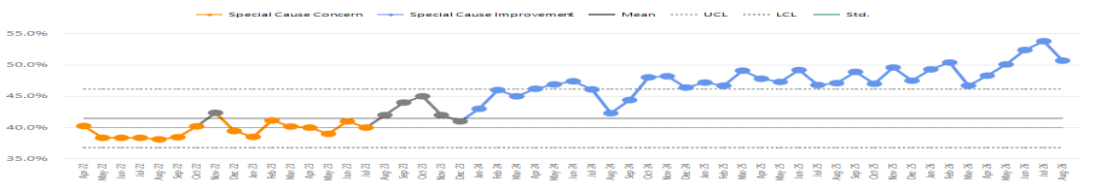
% Patients Spending less than 4hours In ED



% 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

- 6,338 Type 1 patients attended ED in August which 11 less than the previous month yet 455 more than August-25 [5,883]. The range of all attendances varied from 170 to 256 with 204 daily average.
- 1,635 ambulances conveyed to the Trust in month which was exactly the same as last month and 94 fewer than August-25. The range in month was 36 to 65 with a daily average of 52. This includes 11% from Powys [184].
- Ambulance handover delays over 1hr were 16% [233] of all conveyances with 76.3% [1,110] handed over within 45 minutes.
- Same Day Emergency Care [SDEC] treated 1,463 of all admissions [50.7% of all admissions] via a Same Day pathway with no overnight admissions.
- Our Type 1 ED attendances 4 hour Emergency Access Standard (EAS) ranks 78h Type 1 Trust in England for July.
- 10.6% [789] of patients spent 12 or more hours in ED which was 49 more than last month.

Current Actions at part of our UEC Improvement plans:

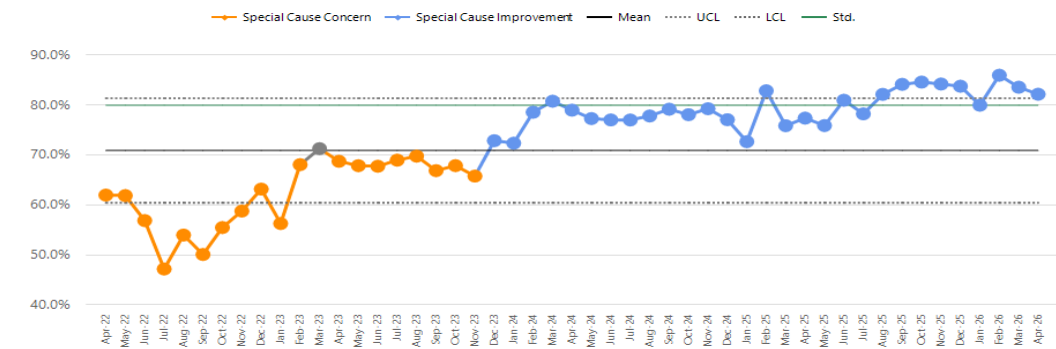
- Increased Navigation to internal and external pathways including Primary care and Community services via our Single Point of Access [SPoA]. Revised process to be trialled in September ahead of 24/7 Single Point of Access in November/December
- Internal pathways via our SDECs including the workforce model for Medical and Surgical along with a review of the operational hours.
- Focus on how we improve timeliness for Time to be Seen and treatment started within the hour and how we improve our performance for non-admitted and not referred patients in ED and minor illness and injury.
- Establish a 24/7 SPoA to support overnight Ambulance conveyances, provide coordination and senior clinical oversight overnight for virtual wards, Hospital@Home and scheduling of Urgent Community Response for management of overnight calls and ED re-direction patients that can be managed during daytime hours.
- Revised Speciality Doctors Rotas from end of August and Consultants Rotas from October to more appropriately match demand
- Implement Discharge Co-ordinators across the Acute Floor to support admissions avoidance pathways and earlier implementation of Discharge plans across 7 days

Operational Performance – Cancer Performance [July 26]

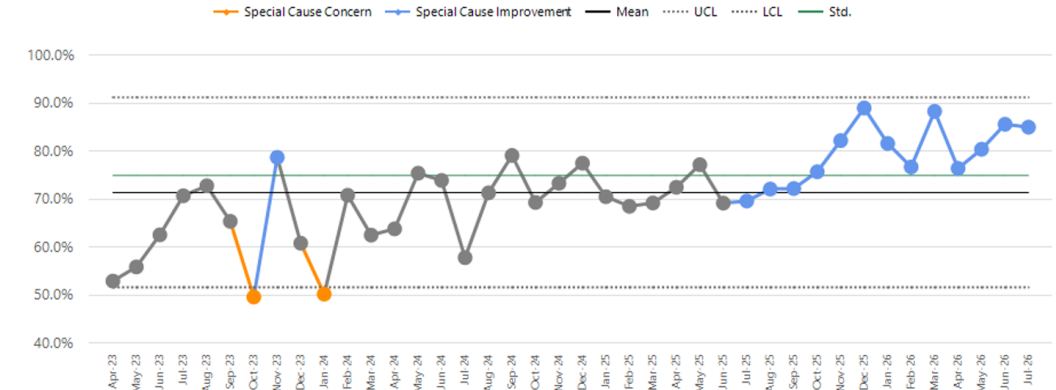
We are driving this measure because:

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

28 Days (Performance & Benchmark)



62 Days (Performance & Benchmark)



What the charts tell us

- 28 Day Faster Diagnosis performance for July 26 was 86.5%.
- 62 Days start of treatment target for July 26 was 85.1%.

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

Performance & actions

Referrals

As of July 2026, urgent suspected cancer referrals have increased by 17.3% compared with the same period three years earlier. Breast, Head & Neck and Lung pathways report increases of 37.4%, 31.5% and 46.7% over the same period. Wye Valley Trust is aligning with West Midlands Cancer Alliance guidance for urgent suspected cancer referrals from primary care, to ensure that all information received is of a consistently high quality. Cancer services will work with primary care colleagues to complete a piece of work to ensure patients are fit, ready and available for treatment.

Cancer Performance:

In July 2026, the Trust achieved the Faster Diagnosis Standard (FDS) of 86.5%, 6.5% ahead of the trust trajectory. Eight specialties achieved the target, with Breast achieving 95.8%, Skin 99.2% and Lung achieving 100%. Gynaecology (Gynae) did not meet the FDS target this month, achieving 60%. Bi-weekly improvement meetings are on-going with plans currently being worked up to implement a weekly Gynae FDS PTL with key stakeholders to ensure every patient pathway is scrutinised. All required actions will then feed into the weekly Cancer Patient Tracking List (PTL) Wye Valley Trust (WVT) reported 96.3% compliance with the 31-day target in July demonstrating sustained performance against this metric.

Wye Valley Trust (WVT) reported 85.1% compliance against the 62-day target, 0.1% above the national target. The Trust is ranked 8th nationally against this metric and is rated 3rd most improved since July 2025.

Developments update:

- Business justification for Genomics Consultant Nurse Specialist (CNS) is currently being prepared to be taken to the trust management board
- Gynae FDS PTL due to commence September 2026
- Equality, Diversity and Inclusion flags now live on Infoflex, cancer navigators alerted as soon as tracking to identify if patients require additional support
- Still awaiting approvals from West Midlands Cancer Alliance in relation to 26/27 bids to improve cancer performance
- Enhanced Power BI reports are now available, with further developments planned to improve visibility across the Trust, including clearer insight into current position and key bottlenecks for targeted focus.

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 weeks. Less than 1% of patients should wait 6 weeks or more for a diagnostic test. For 2026/27 the Trust aims to achieve 92% of patients waiting less than 6 weeks for a diagnostic test by March 2027.

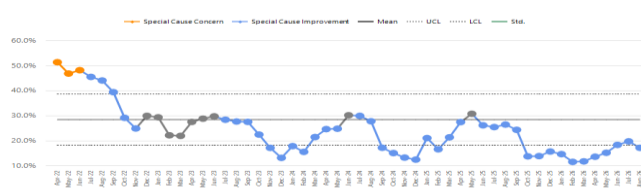
New/First Attendances

Total vs Plan	This Year	Plan	Diff / Var
	33,799	35,587	-1788 / -5%
Vs 2025/26	This Year	2025/26	Diff / Var
	33,799	33,050	749 / 2%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	10.9	3.2	71.0%

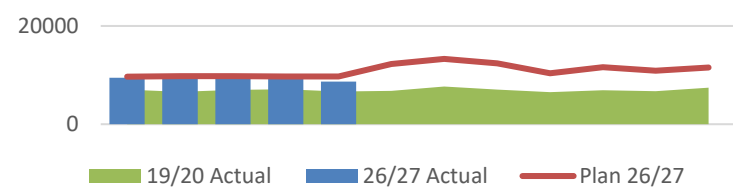
IP/DC Admissions (excl. Endoscopy)

Total Vs Plan	This Year	Plan	Diff / Var
	12,446	11,681	765 / 7%
vs 2025/26	This Year	2025/26	Diff / Var
	12,446	11,961	485 / 4%
Waitlist Clearance (wks)	Total	> 18 Wks	% <18 wks
	15.9	8.4	47.1%

Diagnostic Waits >6 weeks



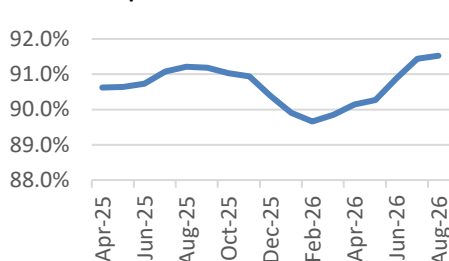
Diagnostic Activity



Follow Up Attendances

Total Vs Plan	This Year	Plan	Diff / Var
	72,170	75,649	-3479 / -5%
Total vs 2025/26	This Year	2025/26	Diff / Var
	72,170	75,323	-3153 / -4%
Waitlist Clearance (wks)	Total	> See By Date (SBD)	% Past SBD
	18.6	6.8	62.7%

Outpatient Clinic Utilisation



Performance & actions

Theatres

Although average Theatre utilisation dropped slightly in August, driven by the need to adjust Theatre schedules due to Theatre Maintenances across all our operating settings. The average theatre utilisation for the first 4 months remains at the national expected level of 85% Short notice cancellations 0-3 days before surgery has improved for the 4th consecutive month, Notably, the percentage of cases cancelled has fallen to below 1% for the first time (0.9%) While the % of cases cancelled has reduced further, national position has fallen to joint 2nd best

Elective Activity

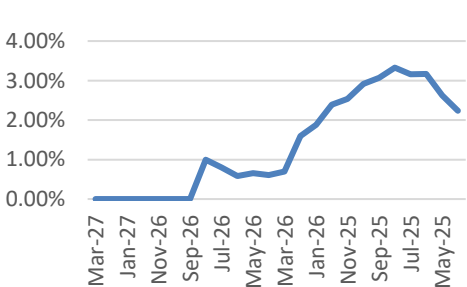
Remains broadly on plan. Inpatients and Day Cases procedures are 765 above plan and delivering well. Outpatients are behind plan driven by some challenges in some key medical specialties. For New Outpatients in particular the Division are reviewing how to recovery the position in the second half of the year.

Long waiting patients

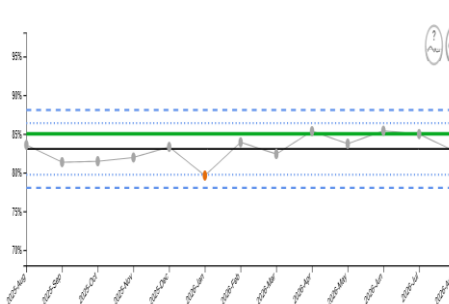
- At the end of August, we had 6 English patients were waiting 65 weeks. The delay in Theatre 14 has had an impact on this over the month
- c229 English patients were waiting over 52 weeks for treatment at the end of August

The end of August RTT position is not fully validated due to NHS England extension on the submission of the monthly position so Providers can fully review and validate their waiting lists to ensure their RTT position is correct.

English % Patients on Waiting List over 52 weeks



Theatres Utilisation (Uncapped)



What the charts tell us

- Performance against English RTT standard in August was c66% / 0.9 % 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 6% increase above predicted and 5% increase than 25/26



Geoffrey Etule
Chief People Officer

Sickness absence has dropped from 4.6% to 4.4% with Long Term Sickness at 2.32 % and Short Term sickness at 2.12 %. The main reasons for sickness absence are mental health conditions, gastro conditions, and flu. WVT continues to maintain 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 reduced to 7.8 % and HR teams will continue to take active steps to fill clinical vacancies and maintain low staff turnover below 10%. Turnover for qualified nurses & midwives remains low at 5.59% and turnover for band 2/3 hcs staff has reduced from 19.61% (Aug 2025) to 15.12%. The centralised recruitment process, ongoing drop-in recruitment activity and active work with the DWP in filling our vacancies continues to have a positive impact.

The Youth Jobs Grant is now active across Great Britain as part of the Youth Guarantee. It helps employers discover untapped talent by hiring a young person that needs a foothold in the labour market and helps to tackle high levels of youth unemployment and inactivity. The Trust has signed up with the DWP to be a partner and we will be using the apprenticeship levy in encouraging young people across Herefordshire to apply for suitable vacancies.

To increase our flexibility to address organisational change and service redesign the Trust will be running a mutually agreed resignation scheme following discussions at the financial recovery board. The scheme has been developed to assist in addressing some of the financial challenges facing the Trust in the years ahead. The WVT scheme is for non-clinical employees or non-practicing clinical employees.

In developing our caring and compassionate culture, 92 WVT consultants attended a civility saves lives session focusing on the importance of teamwork, compassion and kindness at work in order to deliver excellent patient care. In promoting good relations at work, we also supported East & South East Asian heritage month and we will be supporting Black History month and the Freedom To Speak Up month throughout October.

Our annual health & wellbeing week will run from 12th to 18th October with a key focus on actively promoting the flu vaccination campaign for all staff. The week is being supported by internal and external partners including Sodexo, Halo Leisure and Community First.

We are launching the 2026 NHS National Staff Survey on 1st October and all line managers have been informed about a response rate target of over 65%.

Performance appraisals are still a concern at 73% and WVT continues to perform well with mandatory training which now stands at 88.9%.

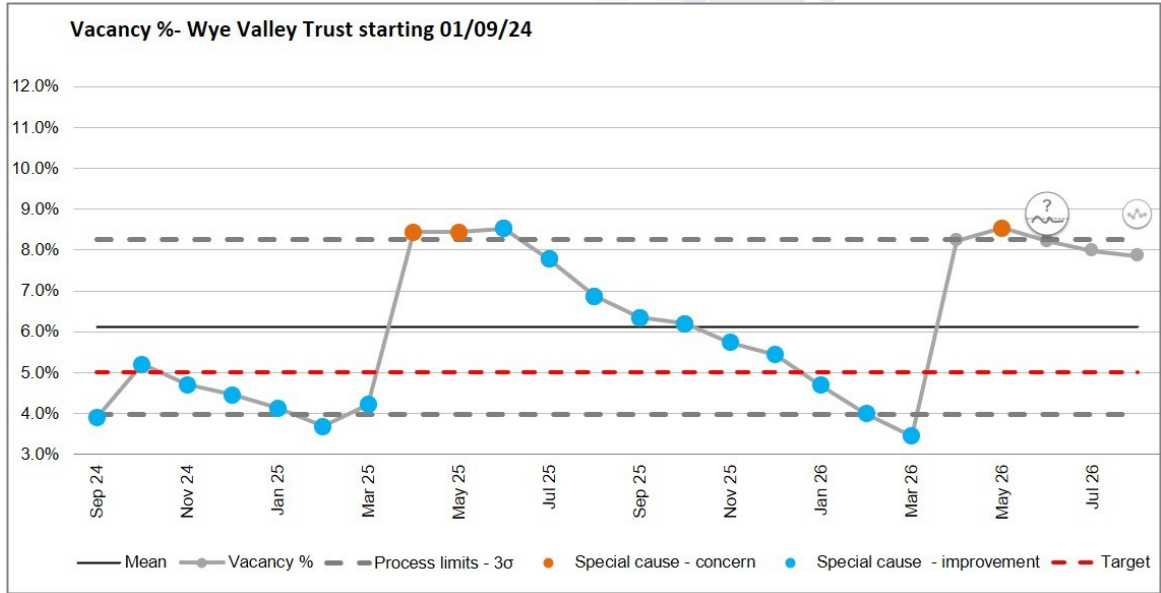
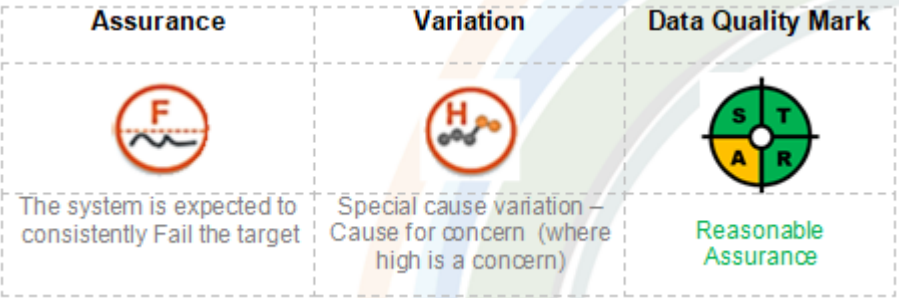


Workforce Performance – Vacancy

We are driving this measure because:

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

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
6.9%	6.3%	6.2%	5.7%	5.4%	4.7%	4.0%	3.4%	8.2%	8.5%	8.2%	8.0%	7.9%



Performance & actions

HCSW – vacancies currently stand at 16.70 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 and have signed up to the Yout Grant to employ young people.

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 40.08wte 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 69.14 wte 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

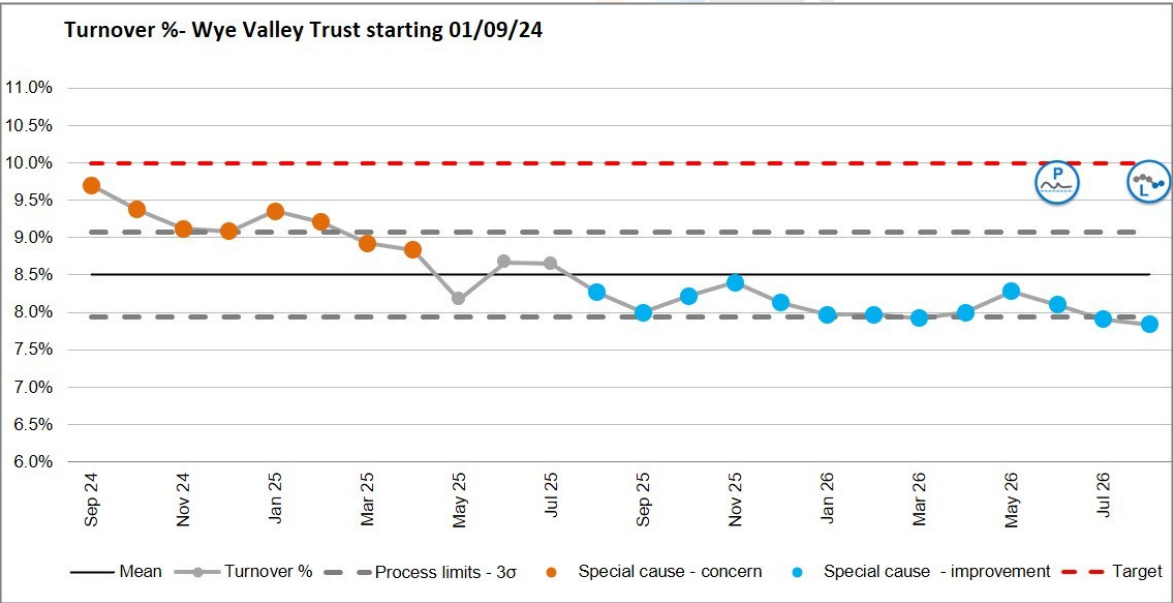
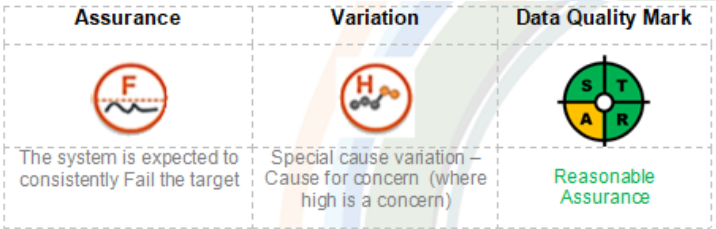
There is a large increase in the first month of 25/26, mainly related to an increase of substantive budget due to realignment of reserves, together with a bottom-up exercise and review of rostering areas, this rate was maintained in month 2 and 3. From month 4 onwards this has now decreased as budget has started to be moved to CIP codes and as a result of headcount reduction. Month 1 of 26/27 has shown a large increase, due to an increase in budget for the new financial year to cover usage, this has slightly increased in month 2 but come back down in month due to a decrease in budget, the trend continues in month 5 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.

Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
8.3%	8.0%	8.2%	8.4%	8.1%	8.0%	8.0%	7.9%	8.0%	8.3%	8.1%	7.9%	7.8%



Performance & actions

Turnover at Trust level is at 7.8% 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 15.12%. 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. WVT has signed up to the Youth Grant scheme to encourage young people to apply for suitable vacancies.

Turnover rates for qualified nurses remains low at 5.59% 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

Turnover of band 2 support staff

What the chart tells us

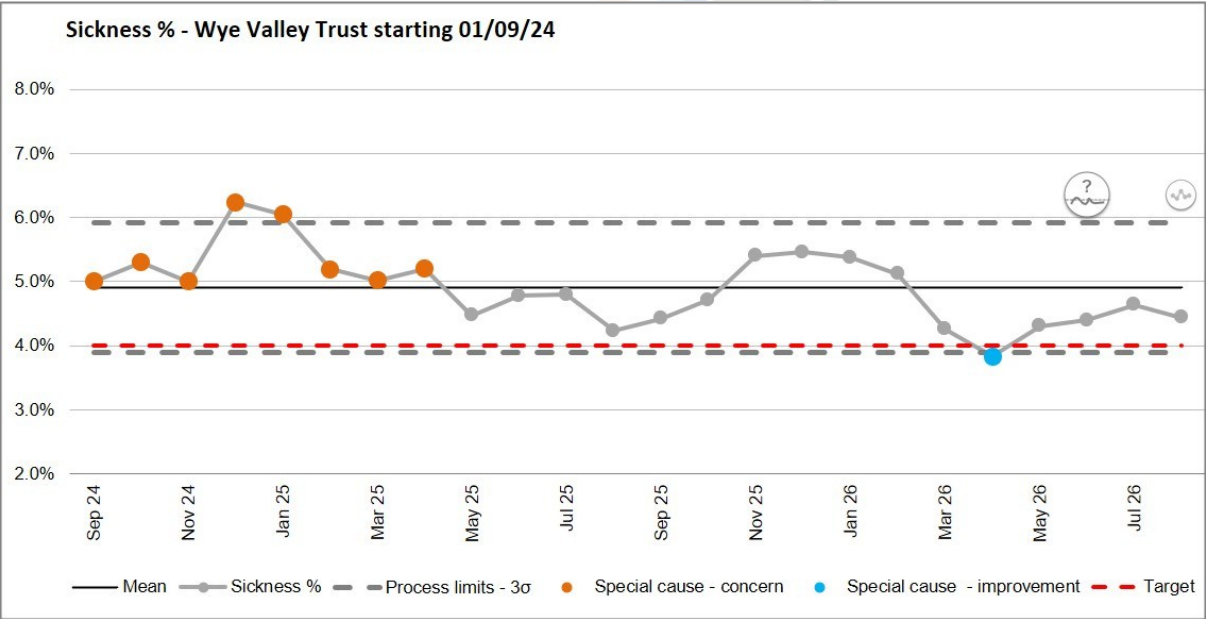
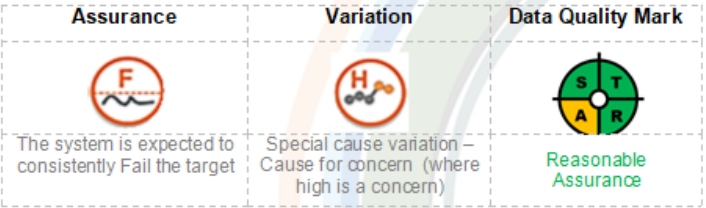
A fluctuating pattern in 25/26 but continuing with an overall decreasing trend, remaining consistent in the last 9 months.

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.

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



Performance & actions

During this month, overall sickness at Trust level is at 4.4% and the main reasons for absence are gastro conditions, mental health issues, and colds/flu.

At F&PE meetings, divisions will continue to present comprehensive data on sickness absence including 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. OH/HR are supporting the flu campaign for 2026.

Risks

What the chart tells us

This was a slight increase in the first month of 25/26 but reduced in month 2 to the position from 12 months ago, with a slight uptick in month 3, maintained in month 4 reverting back down to the lowest position in the last 2 years in month 5, before steadily increasing over the winter months, peaking in December 25, then reducing slightly in the first 2 months of the year before a large decrease in March 26, followed by a further decrease in April 26, to our lowest levels of sickness, this increased in month 2 back to levels seen at the end of 25/26 and remained constant in month 3, which has fluctuated since but remained fairly consistent.



Katie Osmond
Chief Finance Officer

Month 5 Income and Expenditure position

At the end of Month 5 we are slightly behind plan at (£3.0m) deficit against a (£2.7m) plan.

The plan includes a £24.7m efficiency challenge with focus continuing on the identification and delivery of CPIP to achieve our breakeven plan and improve our underlying position. This includes schemes relating to transformational change 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 August, 70% 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, Neighborhood 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 (£0.2m), largely driven by high-cost drugs and depreciation (both of which off-set by expenditure)
- Agency spend has seen runrate increases but continues to be positive 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 (£0.9m) primarily due to slippage on the timing of implementation and working up of a complex transformation plan. Mitigated through timing of expenditure and non recurrent benefits.

The plan for the second half of the financial year remains challenging; a mid year review is being undertaken in September to reassess outturn risk and identify mitigating actions. The key drivers of outturn risk remain efficiency under delivery, commissioner income risk and Welsh funding risk.

Cash and Capital

Cash balances at the end of August 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 August, mainly due to a delay in completion of the new modular theatre

Finance Headlines M5



YTD Deficit
(£3.0m) against
(£2.7m) deficit plan



CPIP YTD **£6.6m** delivered ☹️
Against £7.5m YTD target



Agency YTD Spend
£1.8m against
£3.0m YTD Budget



Forecast Outturn
To Match plan
£0m – Break Even



Bank Spend
£7.8m against
£6.4m YTD Budget



Total Workforce (S/B/A) ☹️
4,031 WTE worked against
3,937 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 5 - 31st August 2026 - 2026/27			
	2026-27 ANNUAL BUDGET	YEAR TO DATE			VARIANCE IN CURRENT MONTH
		BUDGET	ACTUAL	CUMULATIVE VARIANCE	
	£000	£000	£000	£000	£000
Operating income from patient care activities	374,395	154,926	154,366	(560)	↑ 141
Drugs Excluded	24,610	10,254	9,259	(995)	↓ (472)
Other operating income	15,401	6,340	7,583	1,242	↑ 215
Donations from non current assets	240	100	255	155	↑ 235
Total Operating Income	414,646	171,620	171,462	(158)	119
Substantive Pay	(238,310)	(98,306)	(98,115)	191	↑ 153
Bank & WLI Pay	(14,507)	(6,426)	(7,844)	(1,418)	↓ (456)
Agency pay	(5,638)	(3,021)	(1,809)	1,212	↑ 150
Subtotal Pay	(258,455)	(107,753)	(107,768)	(15)	(152)
Non Pay Expenditure	(100,744)	(43,507)	(45,238)	(1,730)	↓ (125)
Excluded Drugs	(24,610)	(10,254)	(9,649)	605	↑ 218
Total Operating Expenditure	(383,809)	(161,515)	(162,655)	(1,140)	(59)
EBITDA	30,837	10,106	8,807	(1,298)	59
Depreciation	(15,604)	(6,505)	(5,776)	729	↑ 146
Impairment (CDC & PFI)	0	0	0	0	→ 0
Interest Receivable	900	375	948	573	↑ 119
Interest Payable on Loans	(257)	(107)	(83)	25	↑ 9
Interest Payable on PFI	(3,030)	(525)	(525)	(0)	→ (0)
Dividends on PDC	(4,954)	(2,063)	(2,063)	0	→ 0
Operating Surplus/ (Deficit)	7,892	1,280	1,309	28	333
Technical Adjustments					
Donated Assets Adjustment	742	309	43	(266)	↓ (257)
Net impact of asset impairments	0	0	0	0	→ 0
Impact of IFRS16 Implementation of PFI Contract	(8,634)	(4,325)	(4,354)	(29)	↓ (68)
Adj. financial performance retained Surplus/ (Deficit)	0	(2,735)	(3,002)	(267)	8

Performance & actions

- The position at the end of Month 5 (August) was a deficit of (£3,002k) YTD. This is performing slightly behind plan with an overall negative variance of (£267k) YTD, £8k favourable in month.
- Income shows an adverse variance of (£158k) YTD. Income for patient care activities currently (£560k) behind plan, partially off-set by a favourable variance on other operating income of £1,242k. High-cost drugs income is (£995k) lower than planned YTD but aligns to expenditure. The position includes at risk income in relation to Powys activity. Lower depreciation funding of (£510k) is the main driver of the adverse position on patient care income.
 - Pay is adverse by (£15k) YTD. The net position in month includes agency - 1.99% of total pay costs in month which is an increase from 1.78% in month 4. Bank (including WLI) use further increases the total temporary staff proportion to 9.56% of overall pay, including costs for Industrial Action in M1 (c£150k). Nursing continue the year with no agency spend on Healthcare Support Workers.
 - Total Non-Pay (operating & non operating) is adverse by (£94k) 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 favorable due to higher cash balances than planned and timing of expenditure.
 - Within Adjustments, there is a PFI (£29k) adverse variance driven by technical adjustments to the control total for historical accounting changes on PFI.

Risks

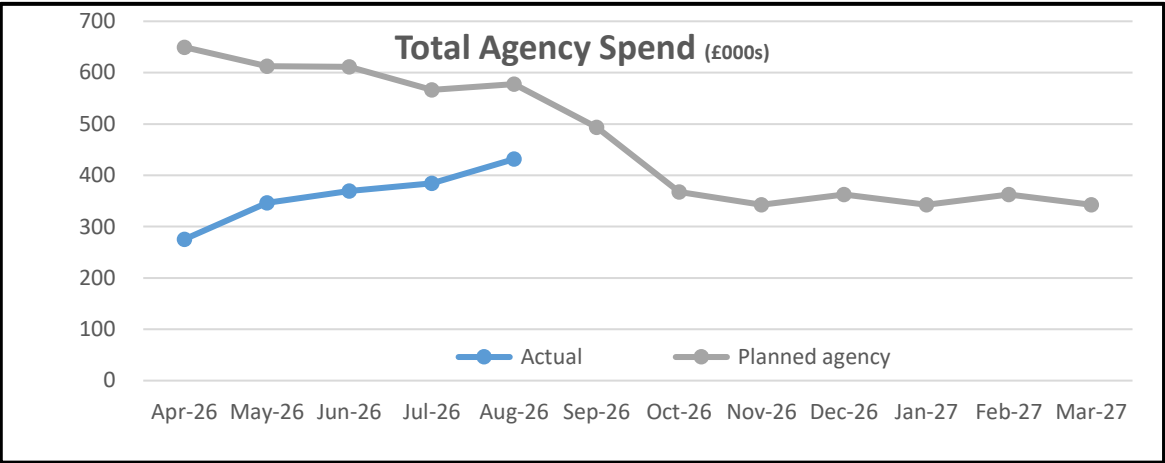
Key Financial risks mitigated throughout the year

- 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:

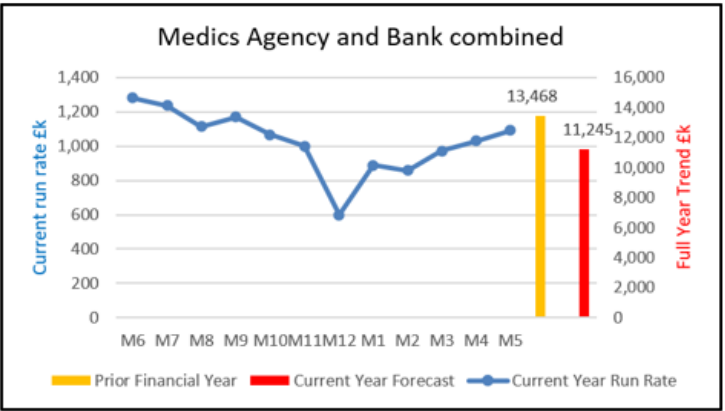
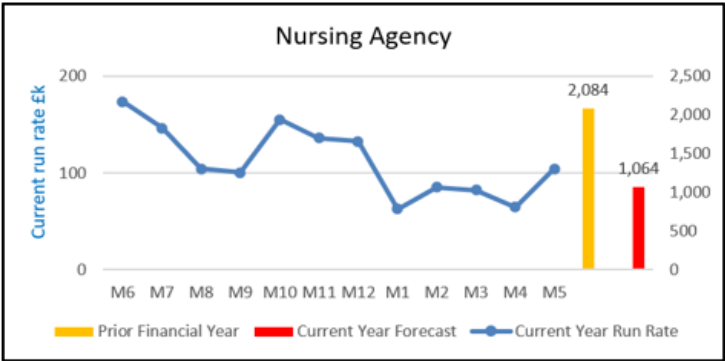
Tackling our high agency and medical bank spend levels (volume and price) is key to successfully mitigating financial risk and delivering the financial plan.



Performance & actions

Agency represents 1.68% of total pay costs year to date, with an aim to reduce spending down to zero by 2029/30, as per national guidance. Runrate has increased month on month but is performing better than plan YTD by £1.2m, including non recurrent savings in month. Total agency spend year to date is £1,809k.

- 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 £398k.
- Off framework Nurse Agency:** There have been 23 off framework shifts in August 2026, an increase from 17 in July 2026 and the highest monthly bookings this year (65 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 £4,843k, 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

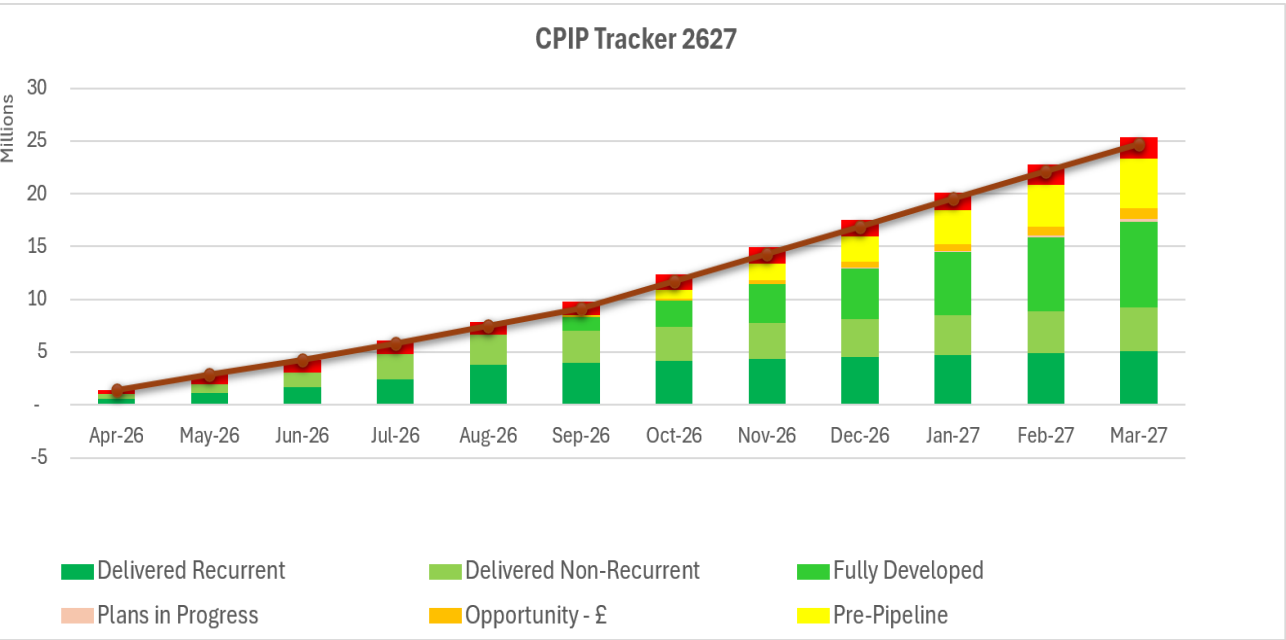
What the charts tell us

Agency performance is well within plan at Month 5 and will require a sustainable recurrent low level of spend to remain within target. Focus remains on high cost bank.

Finance Performance – Cost Improvement Programme

We are driving this measure because:

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



Performance & actions

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

The Trust efficiency delivery YTD at month 5 was £6.6m, £0.9m away from plan, mitigated through non recurrent benefits.

As at Month 5, 70% of schemes are in the fully developed or implemented category, 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. Plans to derisk future delivery are under way.

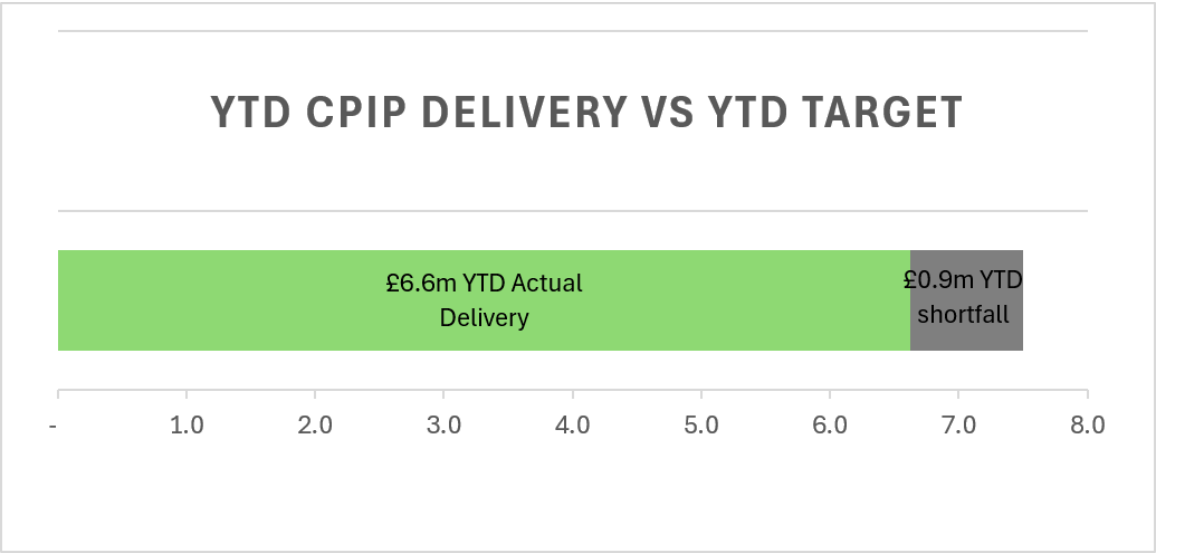
The FRB will continue into 2026/27 focusing on the identification and delivery of CPIP to achieve our breakeven plan, including shaping schemes relating to transformational change and the left shift into care closer to the community.

Risks

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

What the charts tell us

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



Finance Performance – Cash and Capital

We are driving this measure because:

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

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

Cash

Cash Balance				
Month	Performance	Target	Direction	Rating
June	46.1	36.8		
July	49.2	35.7		
August	49.4	49.5		

Better Payment Practice Code				
Month	Performance	Target	Direction	Rating
June	99.0%	95.0%		
July	98.9%	95.0%		
August	99.2%	95.0%		

Capital

To 31st August 2026, Month 5

Capital Scheme Type	Type of Capital Expenditure	Full Year Plan £k	Year to Date - Month			Full Year	
			Budget £k	Actual £k	Variance £k	Forecast £k	Variance £k
Local CDEL funded	Owned	8,439	5,375	1,947	3,428	8,439	0
IFRS16 Leases	Leased	1,000	751	22	729	1,000	0
National PDC schemes	Owned	6,838	730	446	284	6,838	0
Grant funded and Donated	Owned	2,938	1,803	2,503	(700)	2,938	0
Total Capital Programme		19,215	8,659	4,919	3,740	19,215	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.

Better Payment Practice Code

In Month 5, the Trust paid 99.2% of invoices within 30 days. This equates to 94.9% by invoice value. This is the fifteenth month, in a row, that we have achieved the 95% (by volume) target.

Capital

The capital expenditure for Month 5 was £4,919k, £3,740k lower than planned. The primary driver for this variance is the Modular Theatre project which is £3,175k under plan YTD. The lease relating to this project will be fully capitalised upon completion, which was planned for July but 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.

Statement of Financial Position							
August 2026	2025/26	2026/27			2026/27 Full Year		
	Accounts £000s	M5 Plan £000s	M5 YTD £000s	Variance £000s	Plan £000s	Forecast Actual £000s	Variance £000s
NON-CURRENT ASSETS:							
Property, Plant and Equipment	174,368	176,739	175,163	(1,576)	183,533	181,806	(1,727)
Intangible Assets	8,904	7,194	7,326	132	5,421	5,059	(362)
Trade and Other Receivables	1,410	1,197	1,464	267	1,197	1,410	213
TOTAL Non Current Assets	184,682	185,130	183,953	(1,177)	190,151	188,275	(1,876)
CURRENT ASSETS:							
Inventories	4,995	5,581	4,893	(688)	5,581	4,995	(586)
Trade and Other Receivables	29,505	33,943	22,733	(11,210)	38,493	33,764	(4,729)
Cash and Cash Equivalents	49,052	35,031	49,362	14,331	39,966	49,507	9,541
TOTAL Current Assets	83,552	74,555	76,988	2,433	84,040	88,266	4,226
TOTAL ASSETS	268,234	259,685	260,941	1,256	274,191	276,541	2,350
CURRENT LIABILITIES							
Trade and other payables	(46,261)	(43,006)	(43,942)	(936)	(40,943)	(44,117)	(3,174)
Borrowings - Loans, PFI and Finance Leases	(14,291)	(16,077)	(9,618)	6,459	(16,077)	(15,301)	776
Provisions	(185)	(49)	(46)	3	(49)	(185)	(136)
Total Current Liabilities	(60,737)	(59,132)	(53,606)	5,526	(57,069)	(59,603)	(2,534)
NET CURRENT ASSETS/(LIABILITIES)	22,815	15,423	23,382	7,959	26,971	28,663	1,692
TOTAL ASSETS LESS CURRENT LIABILITIES	207,497	200,553	207,335	6,782	217,122	216,938	(184)
NON-CURRENT LIABILITIES:							
Borrowings - Loans, PFI and Finance Leases	(30,565)	(25,738)	(29,111)	(3,373)	(18,719)	(19,699)	(980)
Provisions	(1,556)	(1,489)	(1,538)	(49)	(1,489)	(1,556)	(67)
Total Non-Current Liabilities	(32,121)	(27,227)	(30,649)	(3,422)	(20,208)	(21,255)	(1,047)
ASSETS LESS LIABILITIES	175,376	173,326	176,686	3,360	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)	(183,694)	(181,450)	2,244	(177,083)	(174,868)	2,215
TOTAL	175,376	173,326	176,686	3,360	196,914	195,683	(1,231)

Performance & actions

General

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

Non-Current Assets

Non-Current assets are £1.6m lower than plan at month 5.

Working balances

Net working balances - receivables less payables - have decreased by £12m compared to plan. This reduction in Net working balances , plus reduced capital spend, has increased cash by £14m when compared to plan. Net working balances have decreased by £0.5m in month 5 (compared to month 4).

Borrowings

Borrowings balances differ (plan versus actual) due to timing issues at plan formulation compared to year-end outturn.

Taxpayers Equity

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

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.



National Inpatient Survey 2025 Summary report

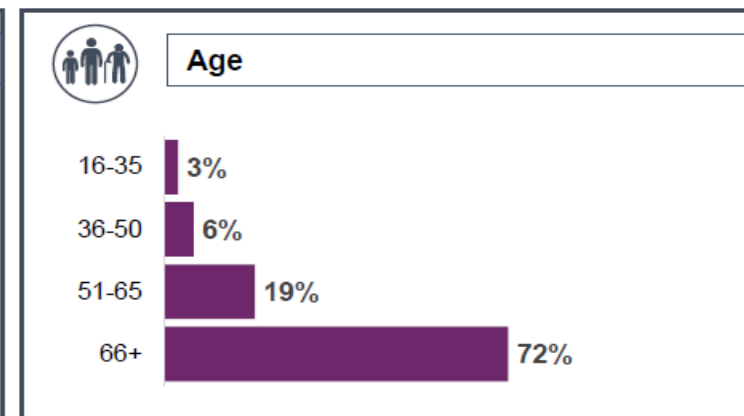
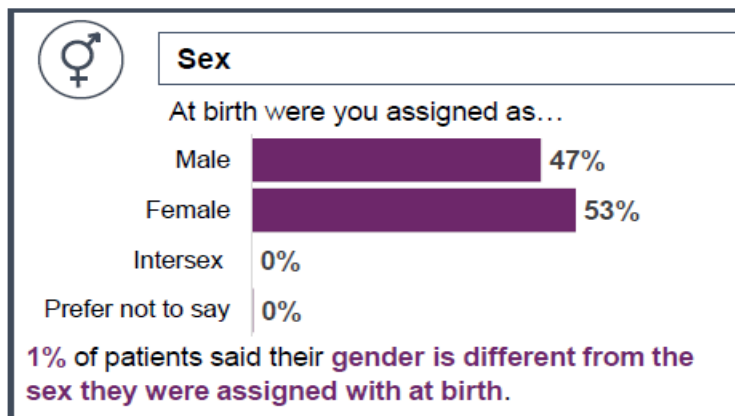
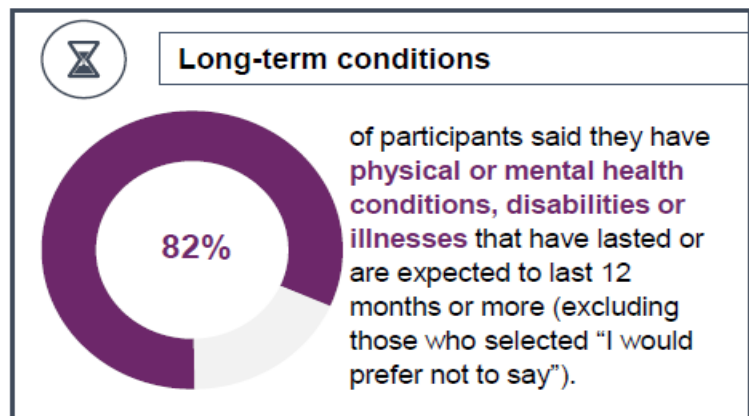
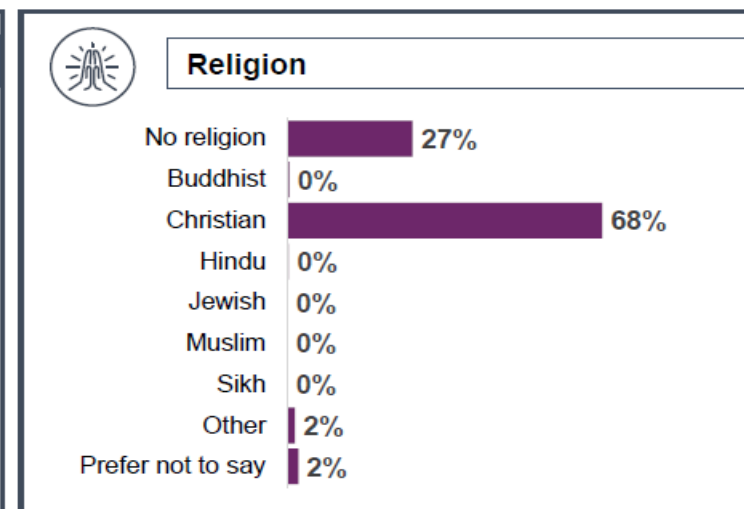
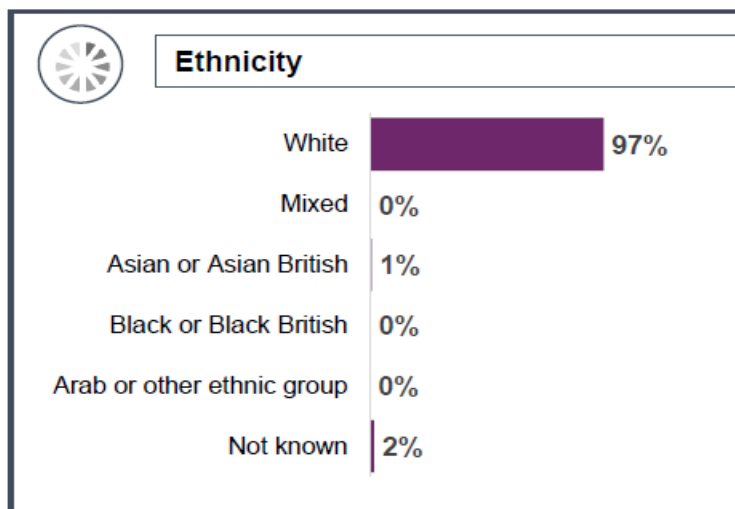
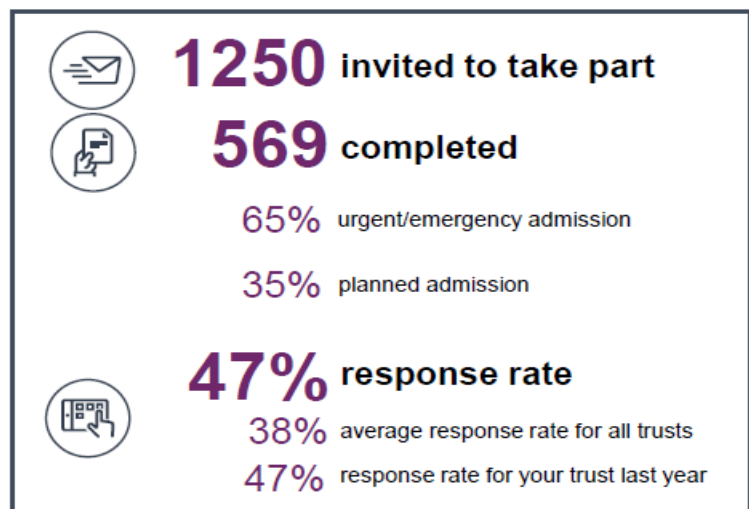
Published August 2026

Presented September 2026

Overview

Who took part in the survey?

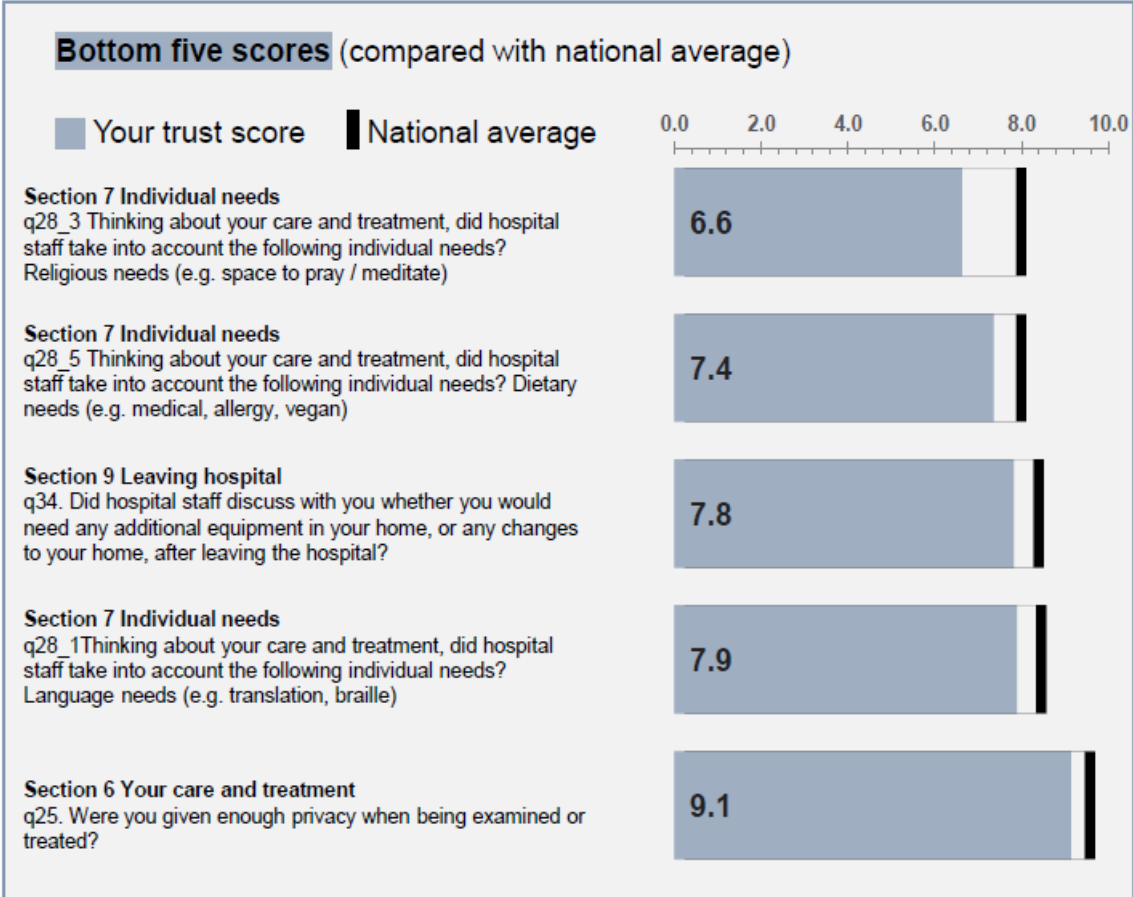
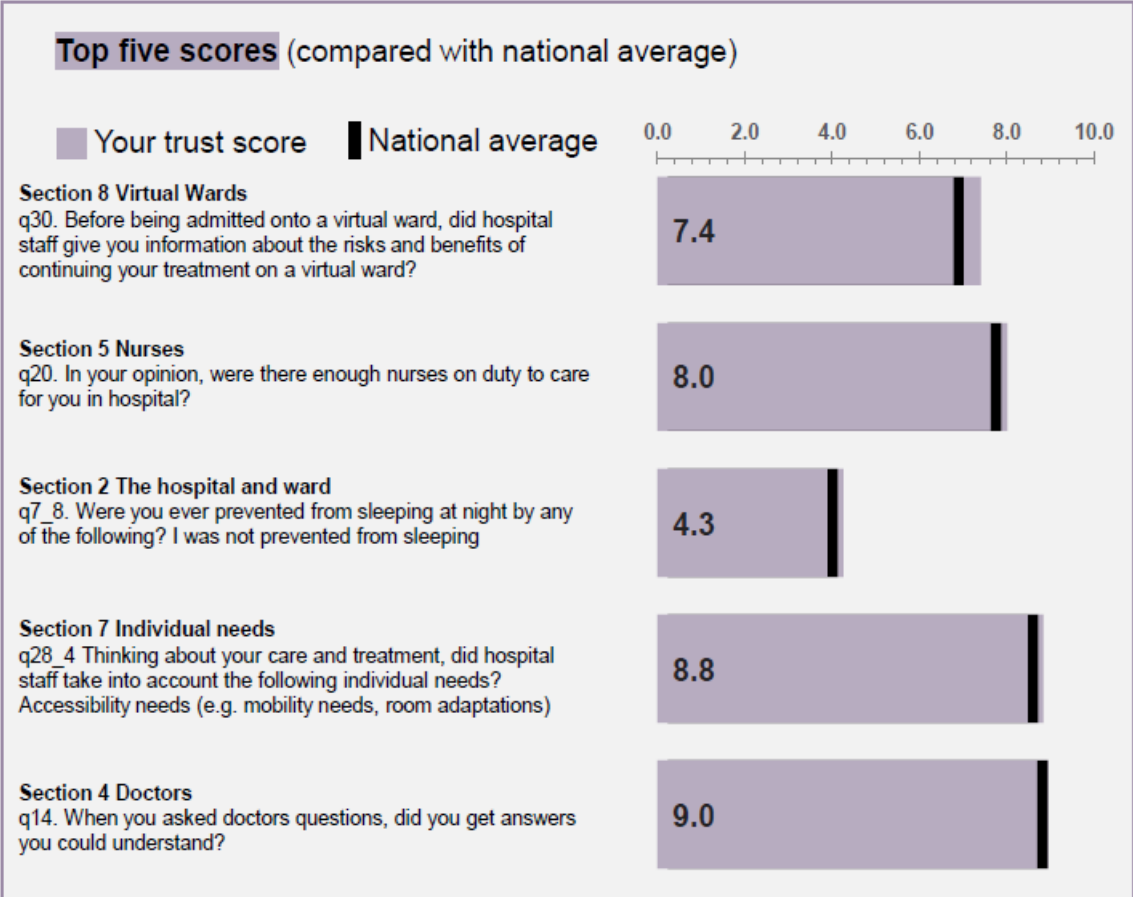
This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.



Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average (the average trust score across England).

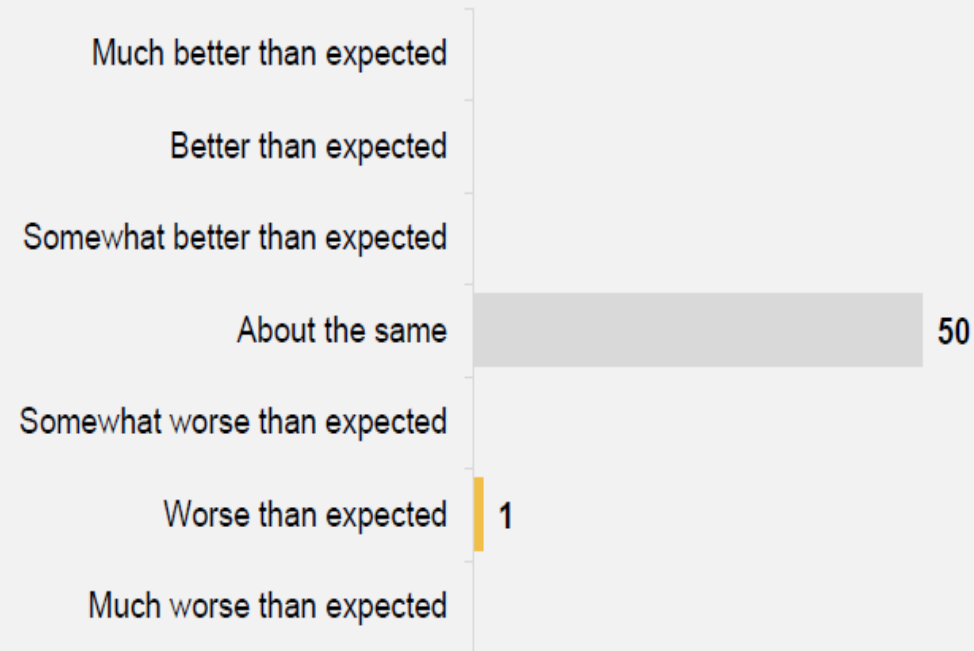
- **Top five scores:** These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.



Summary of findings for WVT

Comparison with other trusts

The number of questions at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The number of questions at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2025 vs 2024.



Summary of findings for WVT

Where patient experience **is best**

- ✓ **Information about virtual wards:** Patients getting information about risks & benefits of continuing treatment on virtual wards
- ✓ **Nurses:** Patients feeling there were enough nurses on duty to care for them
- ✓ **Sleeping:** Patients not being prevented from sleeping at night
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Accessibility needs
- ✓ **Answers from doctors:** Patients getting answers to their questions from doctors in a way they can understand

Where patient experience **could improve**

- **Individual needs:** Staff taking into account patients' individual needs: Religious needs
- **Individual needs:** Staff taking into account patients' individual needs: Dietary needs
- **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- **Individual needs:** Staff taking into account patients' individual needs: Language needs
- **Privacy:** Patients being given enough privacy when being examined or treated

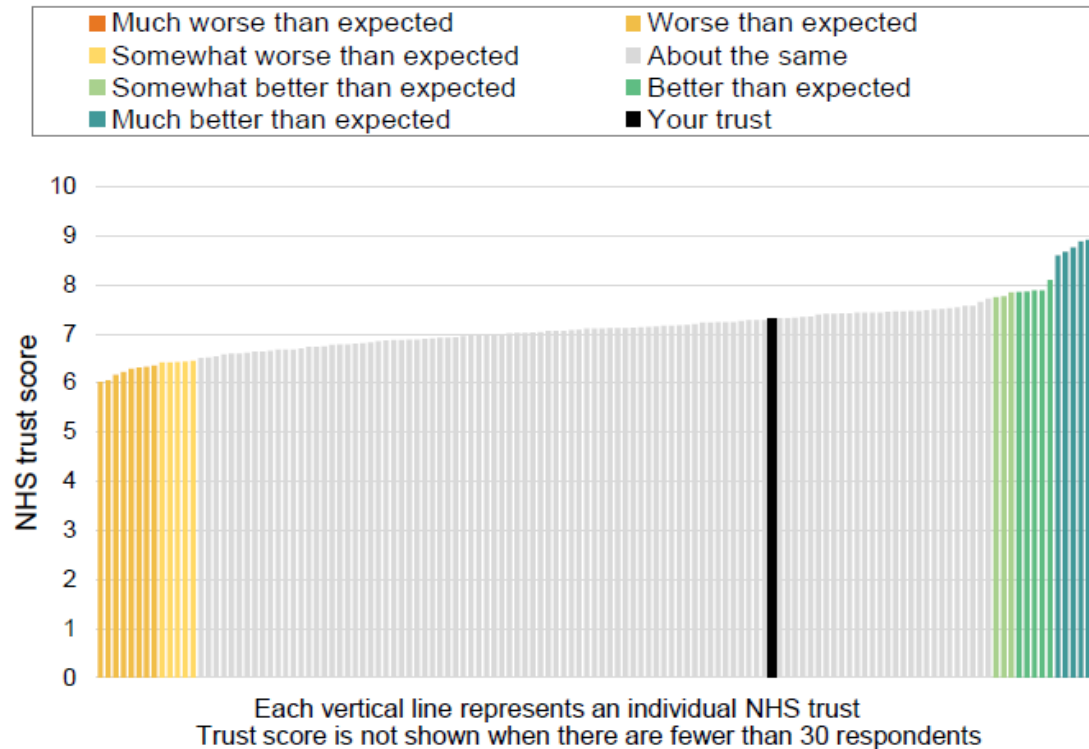
These questions are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.

Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.3 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Royal Orthopaedic Hospital NHS Foundation Trust	8.1
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	7.9
George Eliot Hospital NHS Trust	7.9
The Shrewsbury And Telford Hospital NHS Trust	7.5
University Hospitals of Leicester NHS Trust	7.5

Trusts with the lowest scores

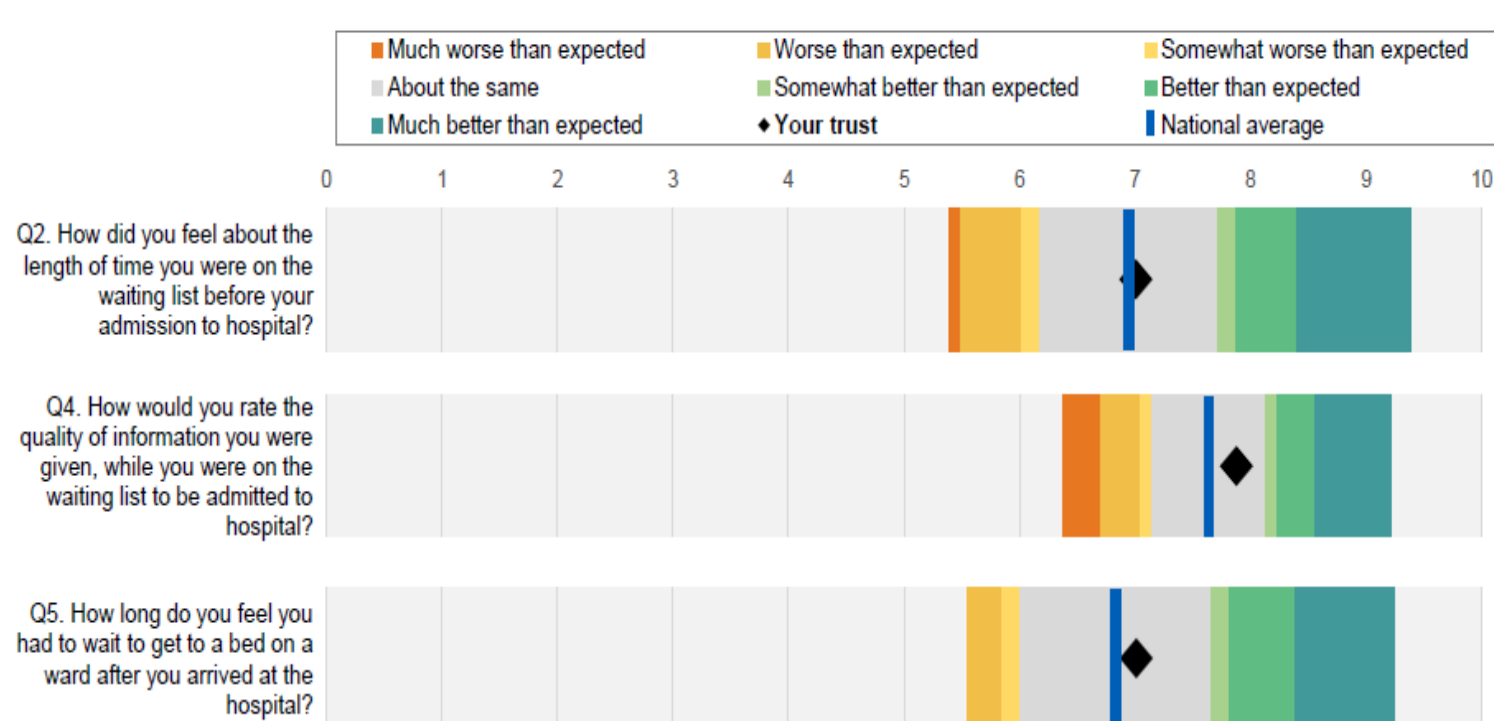
The Dudley Group NHS Foundation Trust	6.6
Sherwood Forest Hospitals NHS Foundation Trust	6.7
Nottingham University Hospitals NHS Trust	6.7
Walsall Healthcare NHS Trust	6.7
Northampton General Hospital NHS Trust	6.8

WVT scores remained about the same at 7.3 only 0.2 below the top five in the region

All scores in this section fall above the national average

Section 1. Admission to hospital (continued)

Question scores



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	204	7.0	6.9	5.4	9.4
About the same	210	7.9	7.6	6.4	9.2
About the same	546	7.0	6.8	5.5	9.2

Section 2. The hospital and ward

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.7 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Royal Orthopaedic Hospital NHS Foundation Trust	8.4
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	8.4
Sherwood Forest Hospitals NHS Foundation Trust	8.1
Sandwell and West Birmingham Hospitals NHS Trust	8.0
University Hospitals of North Midlands NHS Trust	7.9

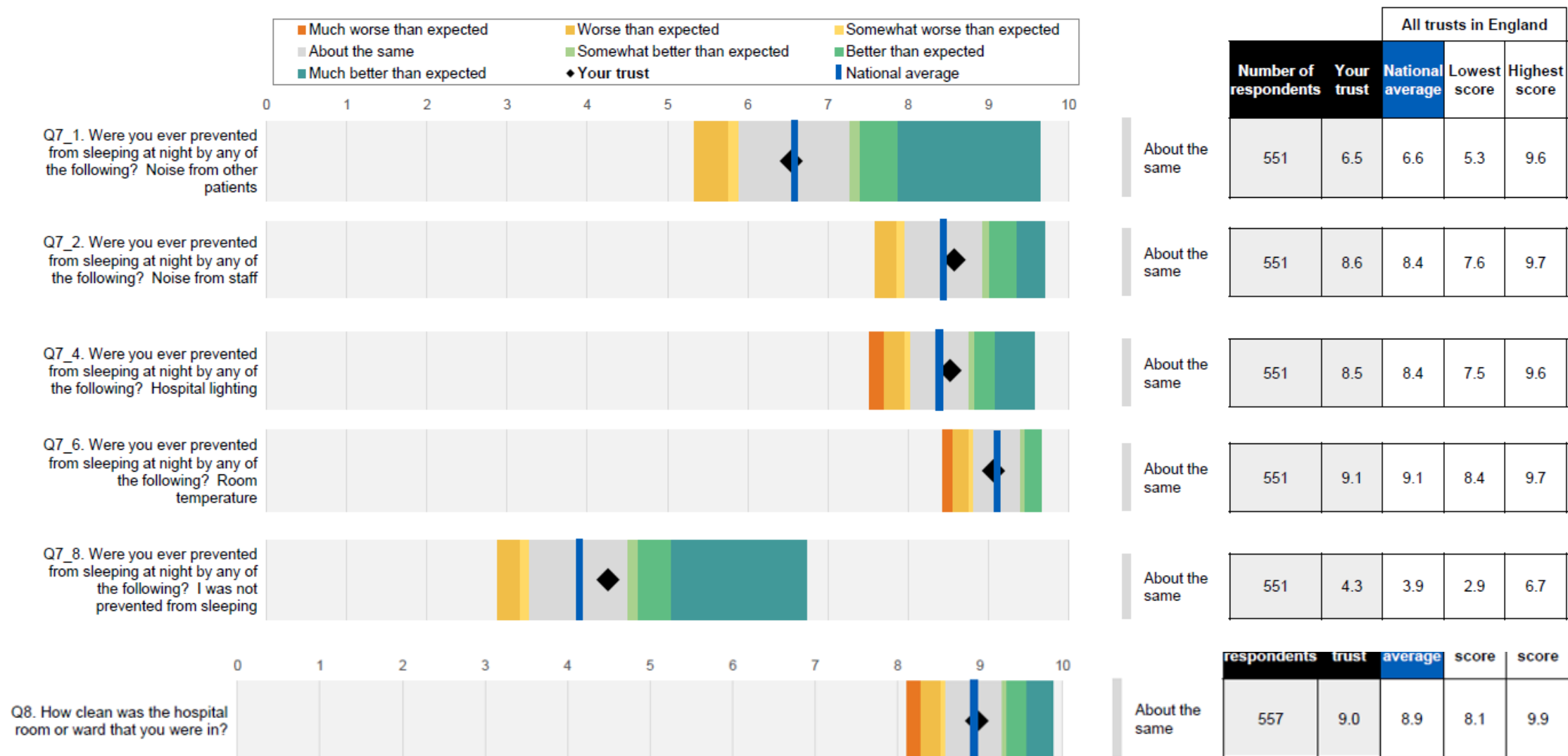
Trusts with the lowest scores

Northampton General Hospital NHS Trust	7.1
University Hospitals Coventry and Warwickshire NHS Trust	7.2
The Shrewsbury And Telford Hospital NHS Trust	7.2
United Lincolnshire Teaching Hospitals NHS Trust	7.3
The Royal Wolverhampton NHS Trust	7.3

WVT scored about the same at 7.7 with individual question scores being in line with or above national averages, achieved a score of 9 for cleanliness

Section 2. The hospital and ward (continued)

Question scores

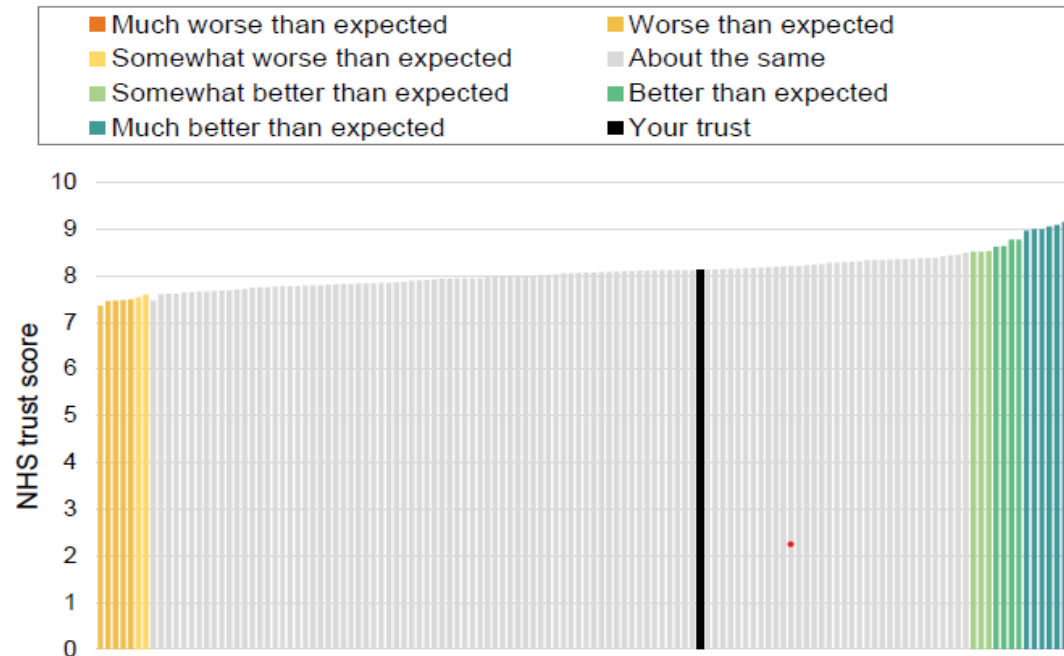


Section 3. Basic needs

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.1 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.3
The Royal Orthopaedic Hospital NHS Foundation Trust	9.1
George Eliot Hospital NHS Trust	8.6
University Hospitals of Derby and Burton NHS Foundation Trust	8.5
Sherwood Forest Hospitals NHS Foundation Trust	8.4

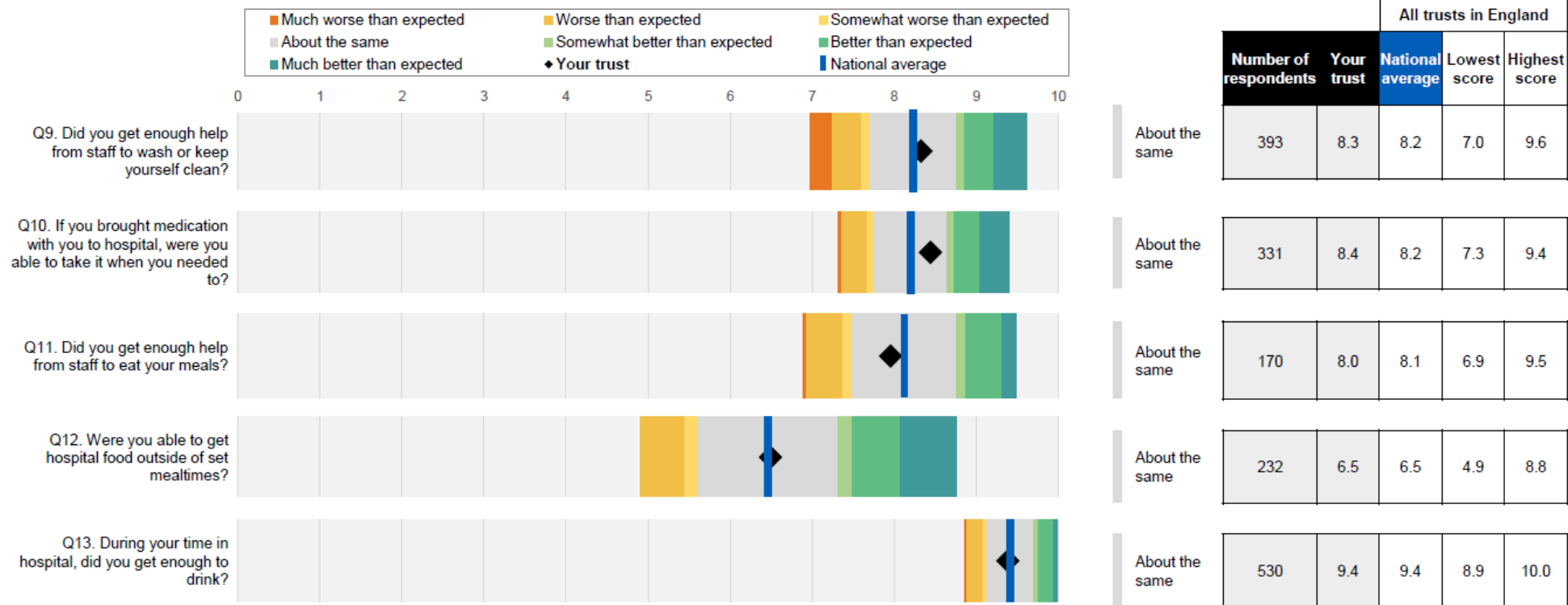
Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	7.5
University Hospitals Birmingham NHS Foundation Trust	7.5
Sandwell and West Birmingham Hospitals NHS Trust	7.6
University Hospitals Coventry and Warwickshire NHS Trust	7.7
Northampton General Hospital NHS Trust	7.8

Opportunities have been identified to learn from other parts of the foundation group to achieve improvements

Section 3. Basic needs (continued)

Question scores



Section 4. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.0 About the same



Comparison with other trusts within your region

Trusts with the highest scores

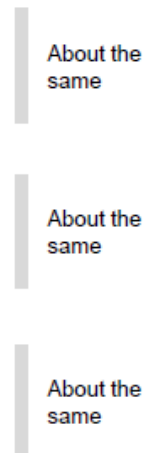
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.6
The Royal Orthopaedic Hospital NHS Foundation Trust	9.5
University Hospitals of North Midlands NHS Trust	9.1
Birmingham Women's and Children's NHS Foundation Trust	9.0
South Warwickshire University NHS Foundation Trust	9.0

Trusts with the lowest scores

United Lincolnshire Teaching Hospitals NHS Trust	8.5
Northampton General Hospital NHS Trust	8.5
Sandwell and West Birmingham Hospitals NHS Trust	8.5
The Dudley Group NHS Foundation Trust	8.6
The Shrewsbury And Telford Hospital NHS Trust	8.6

WVT score for this section was about the same at 9.0, favourable score to Birmingham Women's and SWFT.

Question scores



About the same

About the same

About the same

Section 5. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.7 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.5
The Royal Orthopaedic Hospital NHS Foundation Trust	9.2
Sherwood Forest Hospitals NHS Foundation Trust	8.8
George Eliot Hospital NHS Trust	8.7
South Warwickshire University NHS Foundation Trust	8.7

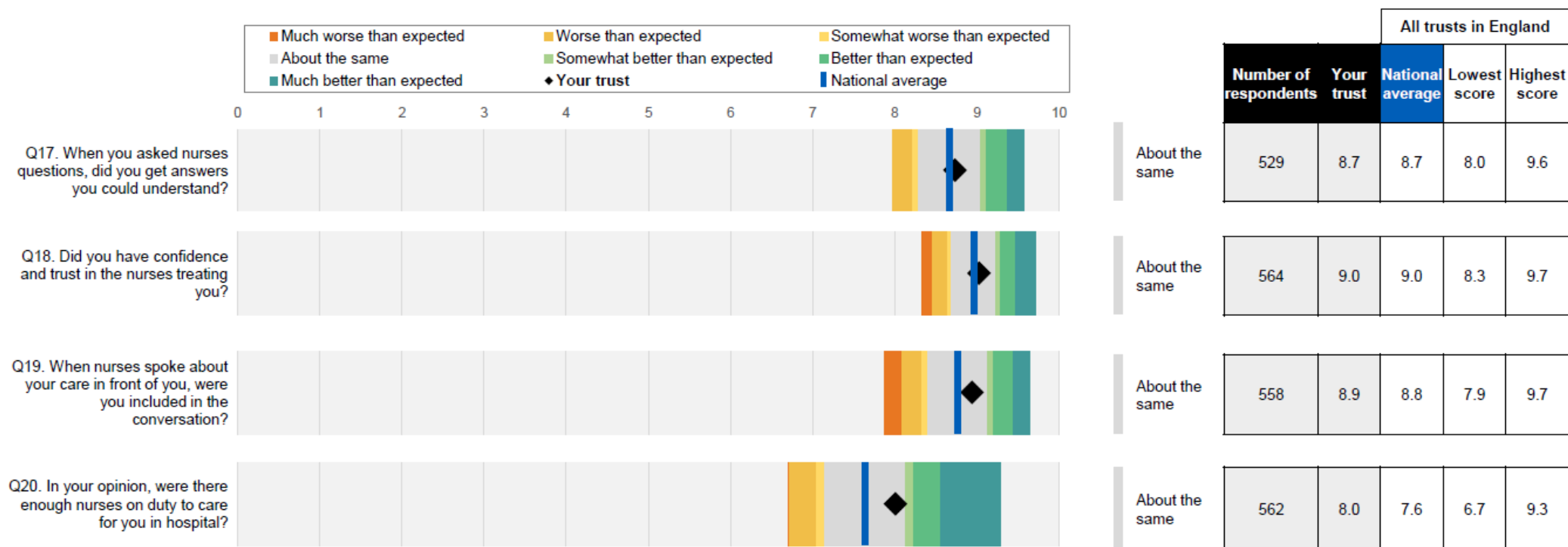
Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	8.1
Sandwell and West Birmingham Hospitals NHS Trust	8.1
University Hospitals Birmingham NHS Foundation Trust	8.1
University Hospitals Coventry and Warwickshire NHS Trust	8.2
Northampton General Hospital NHS Trust	8.2

Scores compare favourably to George Eliot and SWFT scores

Section 5. Nurses (continued)

Question scores

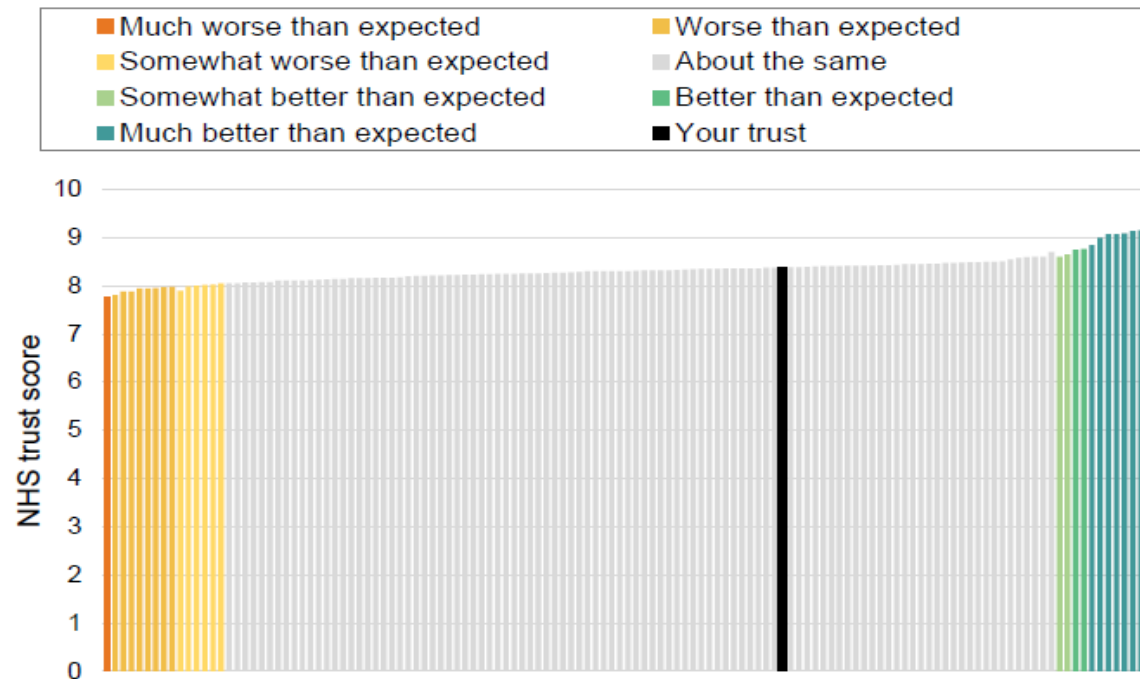


Section 6. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.3
The Royal Orthopaedic Hospital NHS Foundation Trust	9.1
Sherwood Forest Hospitals NHS Foundation Trust	8.6
South Warwickshire University NHS Foundation Trust	8.5
George Eliot Hospital NHS Trust	8.5

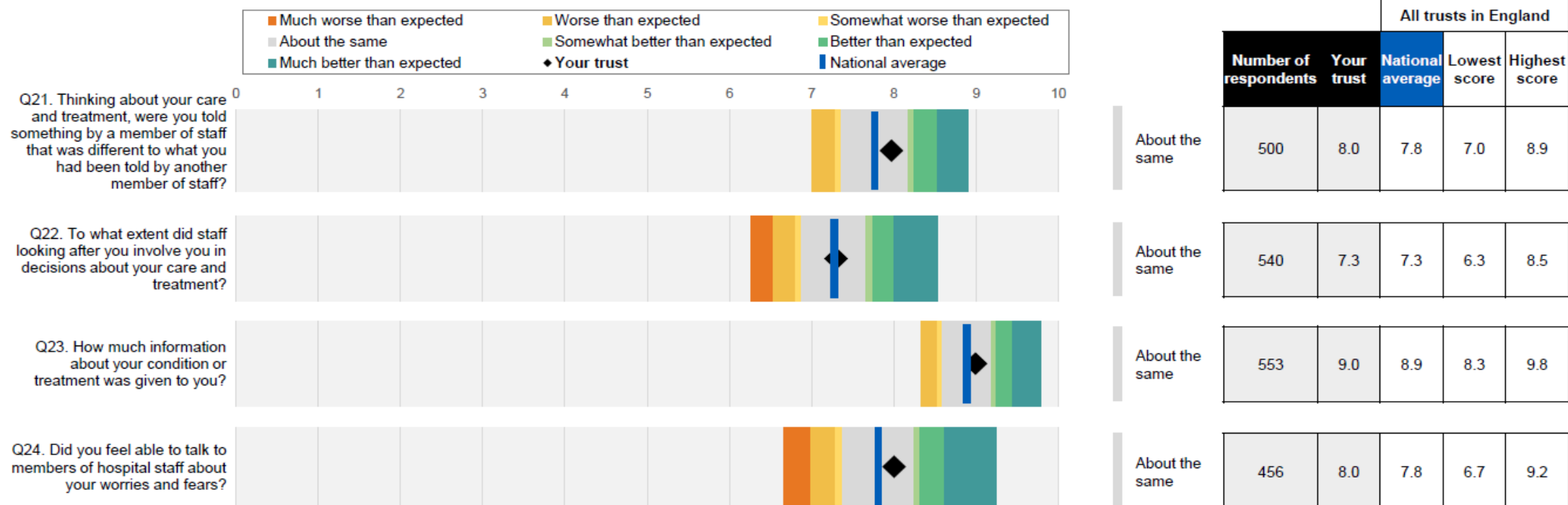
Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	7.9
Northampton General Hospital NHS Trust	7.9
University Hospitals Coventry and Warwickshire NHS Trust	8.0
University Hospitals Birmingham NHS Foundation Trust	8.1
United Lincolnshire Teaching Hospitals NHS Trust	8.1

Scores are on or above the national average

Section 6. Your care and treatment (continued)

Question scores

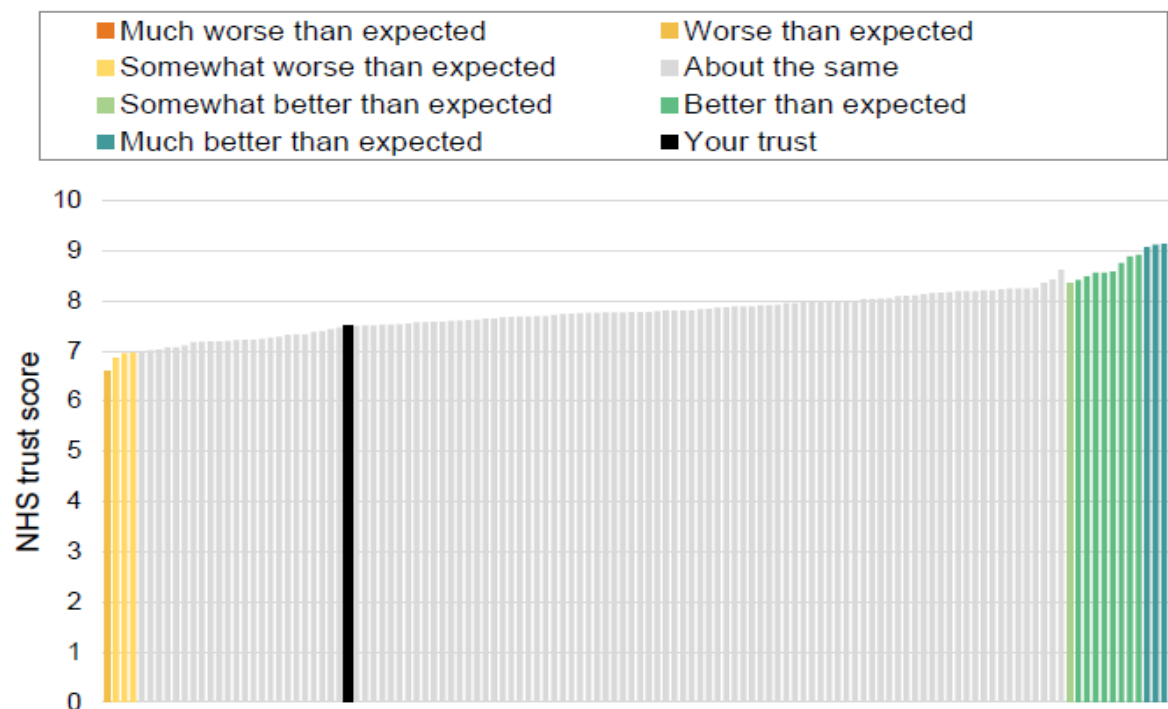


Section 7. Individual needs

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.5 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Royal Orthopaedic Hospital NHS Foundation Trust	9.3
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.1
George Eliot Hospital NHS Trust	8.5
The Shrewsbury And Telford Hospital NHS Trust	8.2
South Warwickshire University NHS Foundation Trust	8.2

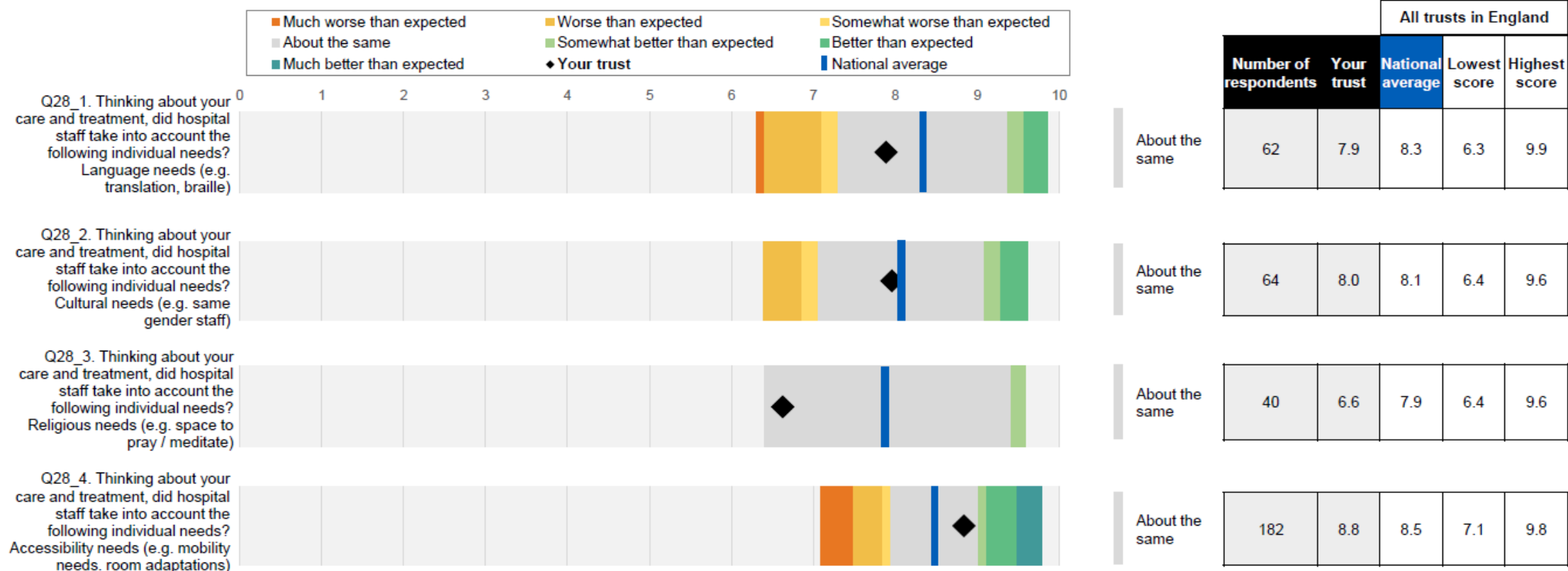
Trusts with the lowest scores

Kettering General Hospital NHS Foundation Trust	7.0
Northampton General Hospital NHS Trust	7.0
Sandwell and West Birmingham Hospitals NHS Trust	7.2
Birmingham Women's and Children's NHS Foundation Trust	7.2
University Hospitals Birmingham NHS Foundation Trust	7.4

Opportunities for shared learning across the group have been identified within this section

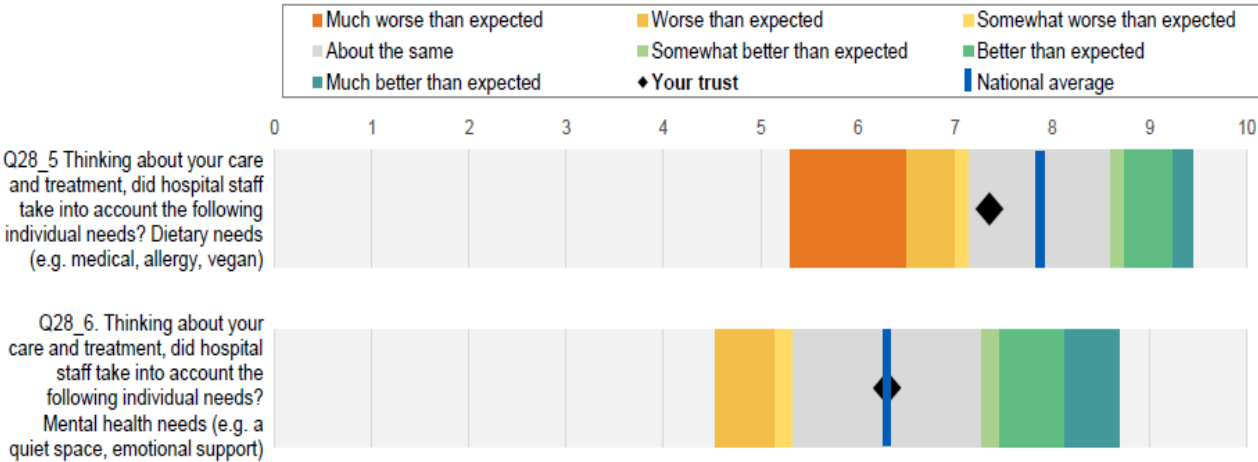
Section 7. Individual needs (continued)

Question scores



Section 7. Individual needs (continued)

Question scores



About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
122	7.4	7.9	5.3	9.5

About the same

Number of respondents	Your trust	National average	Lowest score	Highest score
91	6.3	6.3	4.5	8.7

Section 8. Virtual wards

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.4 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Royal Orthopaedic Hospital NHS Foundation Trust	9.1
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	8.0
University Hospitals of Leicester NHS Trust	7.9
University Hospitals of North Midlands NHS Trust	7.4
Wye Valley NHS Trust	7.4

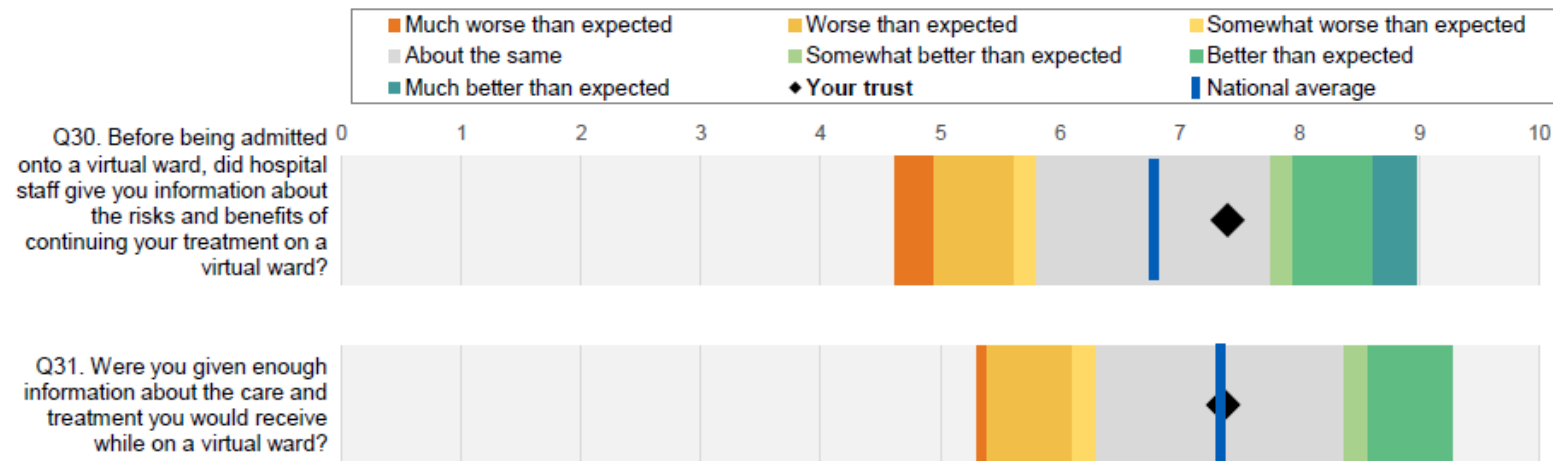
Trusts with the lowest scores

Worcestershire Acute Hospitals NHS Trust	5.9
The Shrewsbury And Telford Hospital NHS Trust	6.3
South Warwickshire University NHS Foundation Trust	6.4
Sandwell and West Birmingham Hospitals NHS Trust	6.5
The Dudley Group NHS Foundation Trust	6.6

WVT was placed in the top 5 Trusts in the region for this section

Section 8. Virtual wards (continued)

Question scores



About the same

About the same

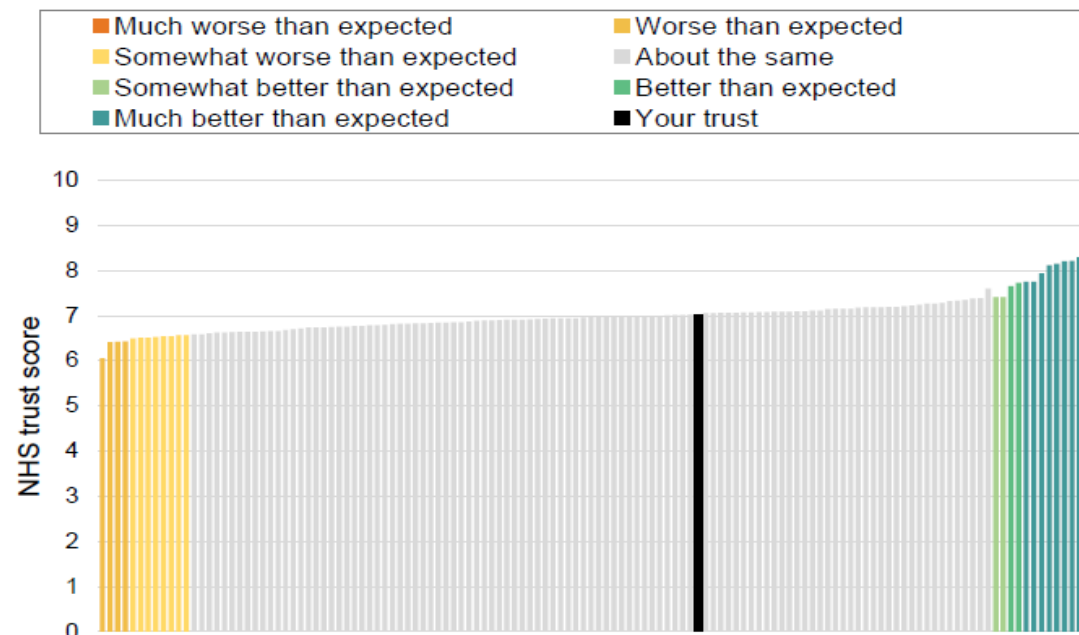
Number of respondents	Your trust	All trusts in England		
		National average	Lowest score	Highest score
36	7.4	6.8	4.6	9.0
42	7.4	7.3	5.3	9.3

Section 9. Leaving hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.0 About the same



Comparison with other trusts within your region

Trusts with the highest scores

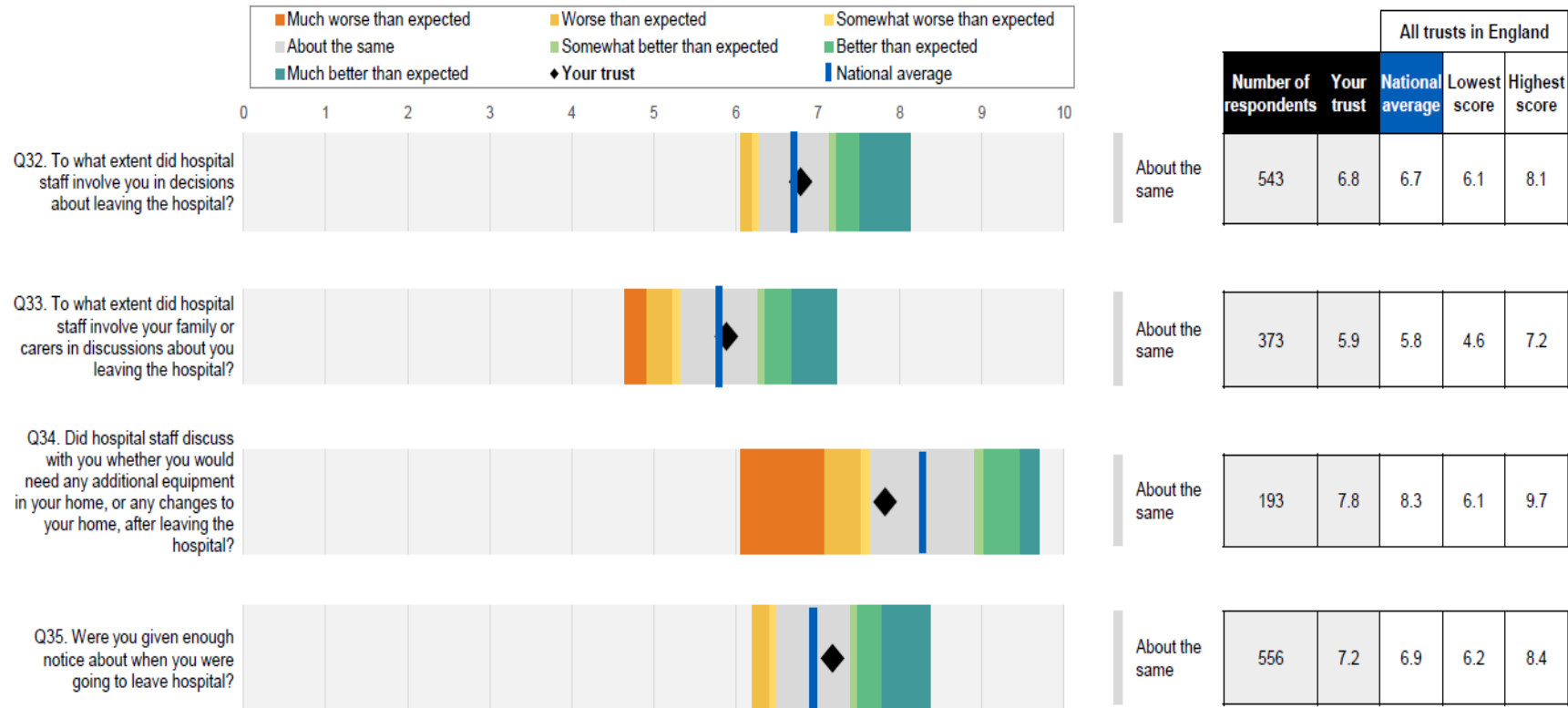
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	8.2
The Royal Orthopaedic Hospital NHS Foundation Trust	8.1
George Eliot Hospital NHS Trust	7.3
South Warwickshire University NHS Foundation Trust	7.2
University Hospitals of Leicester NHS Trust	7.2

Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	6.1
Northampton General Hospital NHS Trust	6.5
The Shrewsbury And Telford Hospital NHS Trust	6.6
Sandwell and West Birmingham Hospitals NHS Trust	6.6
United Lincolnshire Teaching Hospitals NHS Trust	6.6

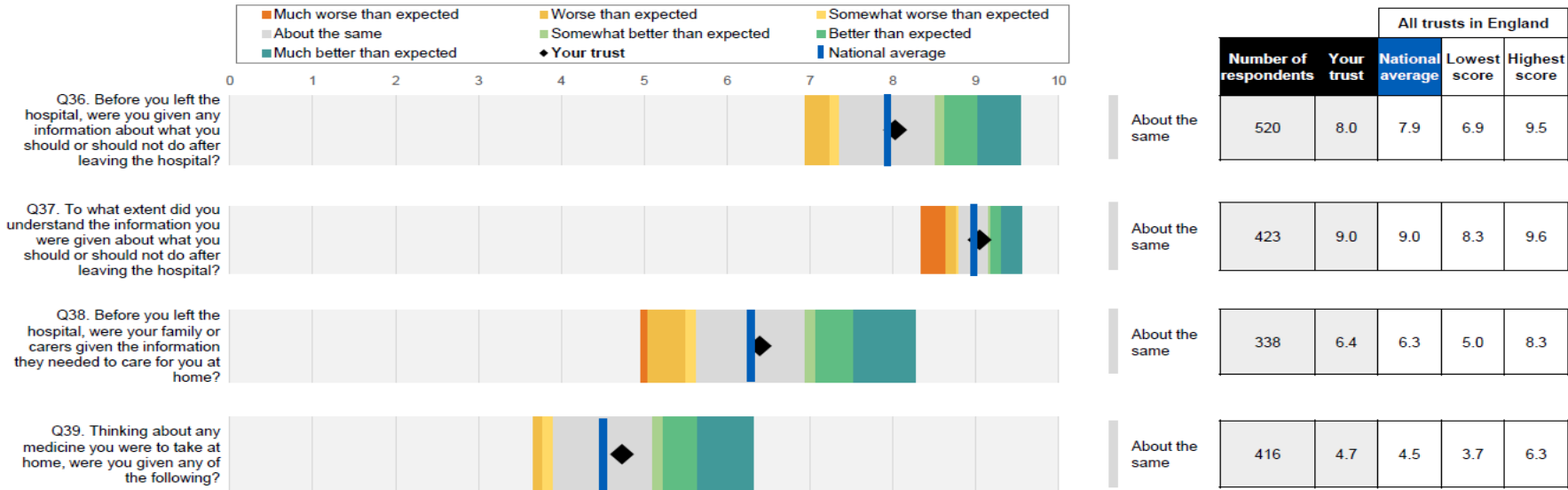
Section 9. Leaving hospital (continued)

Question scores



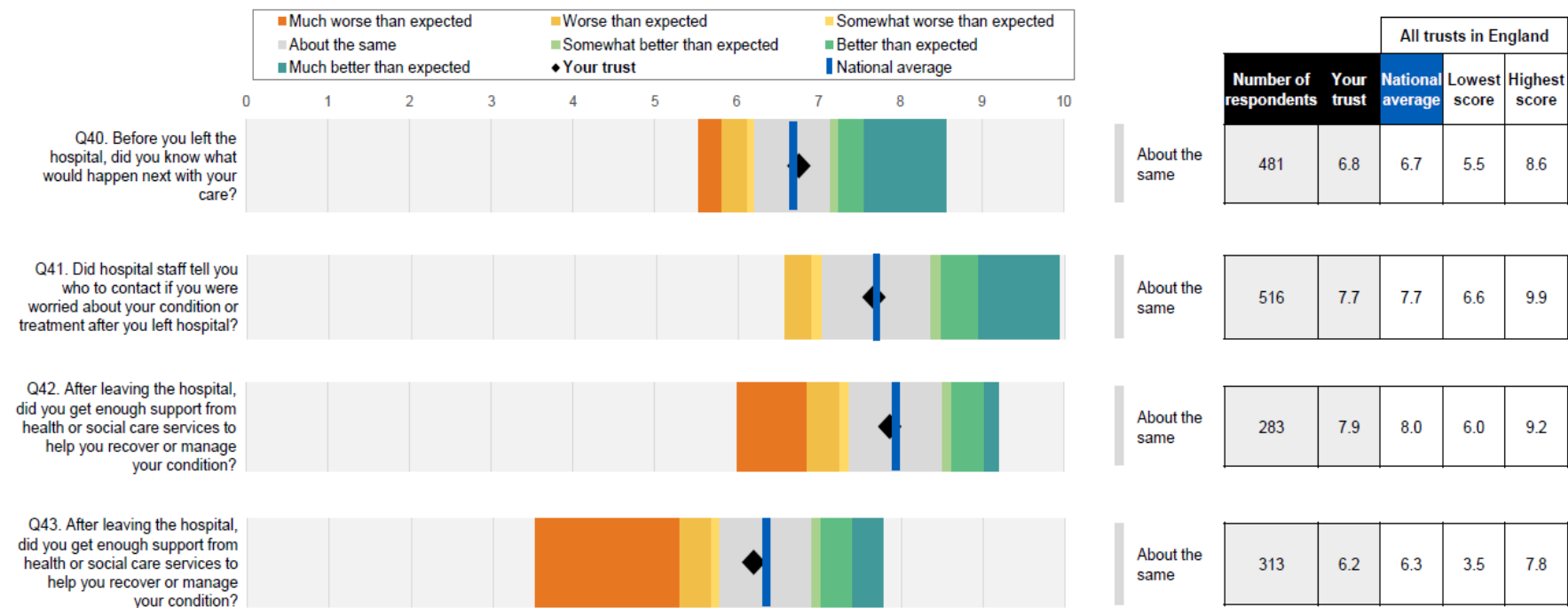
Section 9. Leaving hospital (continued)

Question scores



Section 9. Leaving hospital (continued)

Question scores

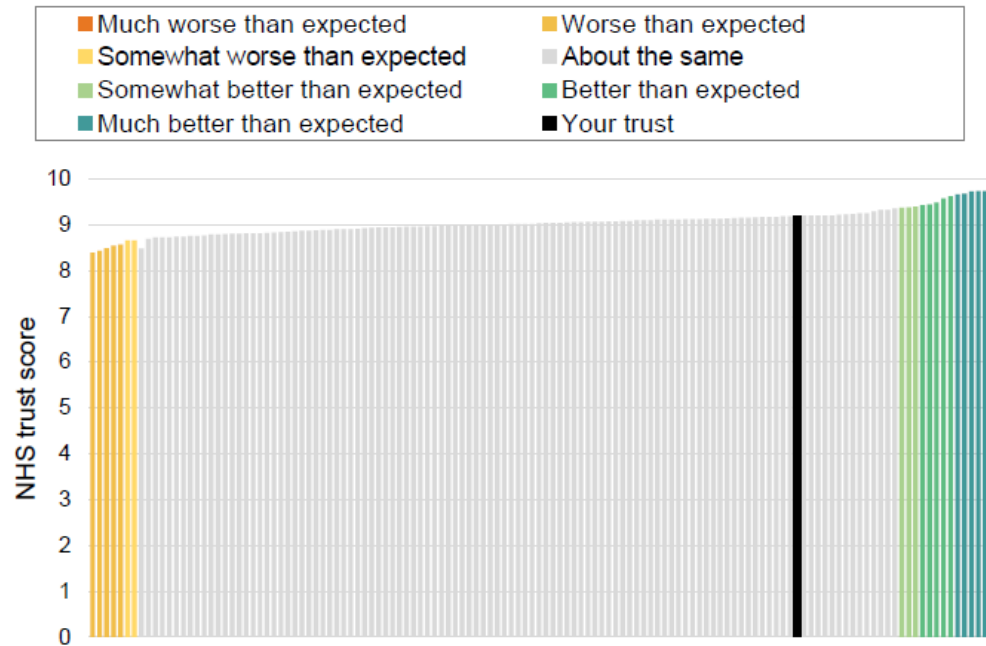


Section 10. Kindness and compassion

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.2 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.7
The Royal Orthopaedic Hospital NHS Foundation Trust	9.7
South Warwickshire University NHS Foundation Trust	9.3
George Eliot Hospital NHS Trust	9.3
Wye Valley NHS Trust	9.2

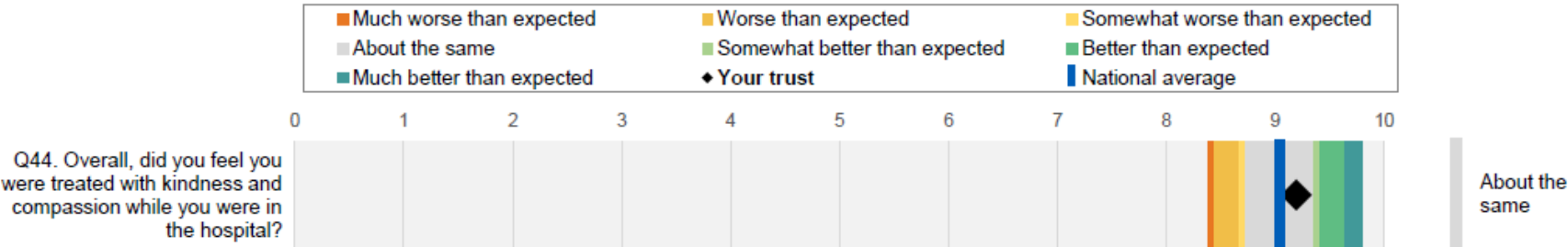
Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	8.5
Sandwell and West Birmingham Hospitals NHS Trust	8.7
The Royal Wolverhampton NHS Trust	8.7
The Shrewsbury And Telford Hospital NHS Trust	8.8
Northampton General Hospital NHS Trust	8.8

WVT is scoring above the national average and in the top 5 trusts for the region for kindness and compassion

Section 10. Kindness and compassion (continued)

Question score



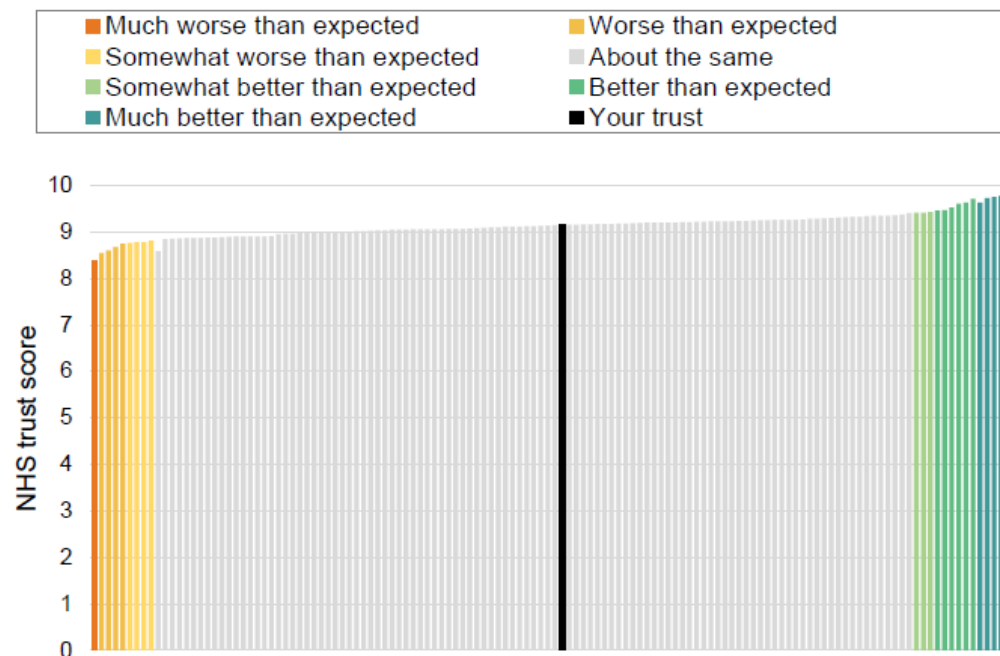
Number of respondents	Your trust	All trusts in England		
		National average	Lowest score	Highest score
562	9.2	9.0	8.4	9.8

Section 11. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.1 About the same



Comparison with other trusts within your region

Trusts with the highest scores

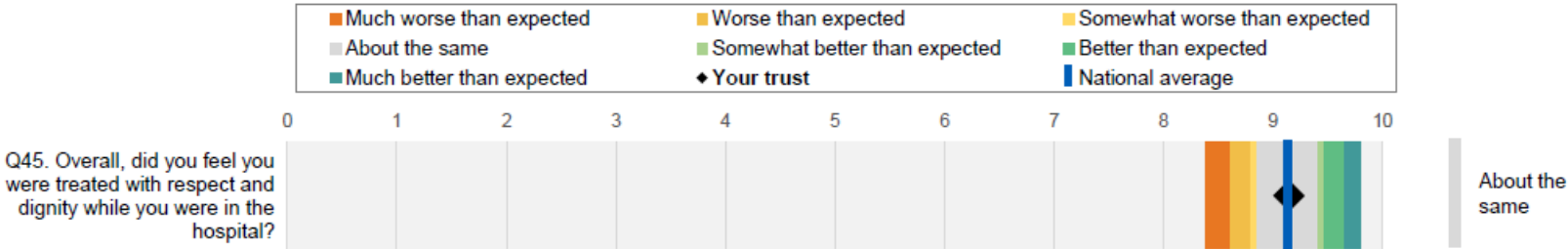
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.8
The Royal Orthopaedic Hospital NHS Foundation Trust	9.6
George Eliot Hospital NHS Trust	9.5
South Warwickshire University NHS Foundation Trust	9.4
University Hospitals of Derby and Burton NHS Foundation Trust	9.3

Trusts with the lowest scores

Birmingham Women's and Children's NHS Foundation Trust	8.6
Northampton General Hospital NHS Trust	8.9
University Hospitals Coventry and Warwickshire NHS Trust	8.9
The Shrewsbury And Telford Hospital NHS Trust	8.9
Sandwell and West Birmingham Hospitals NHS Trust	8.9

Section 11. Respect and dignity (continued)

Question score



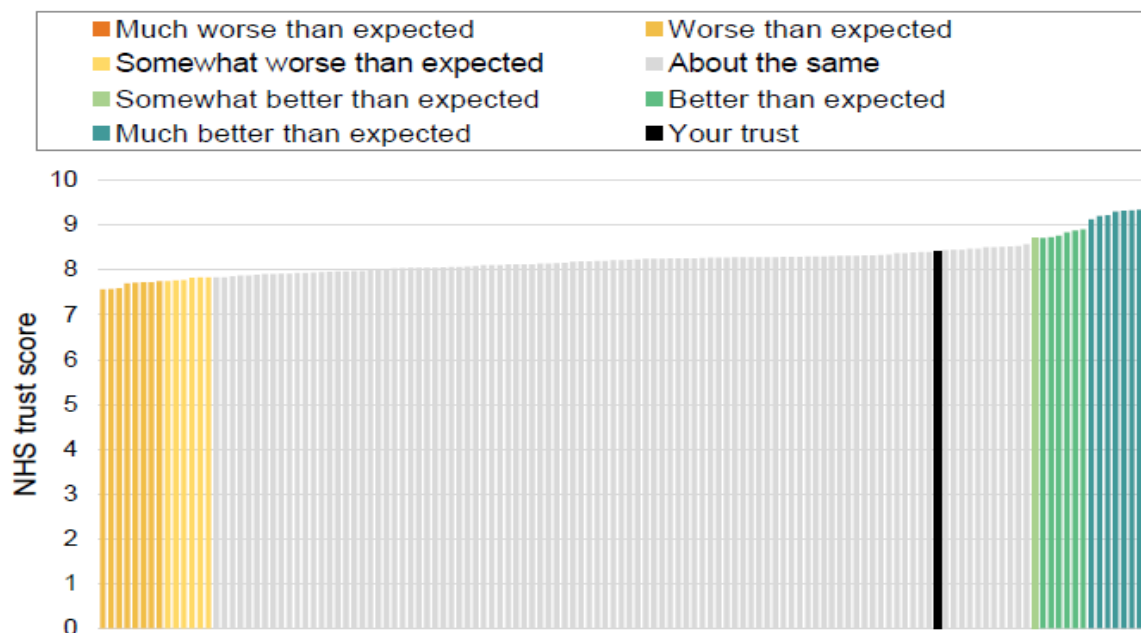
Number of respondents	Your trust	All trusts in England		
		National average	Lowest score	Highest score
558	9.1	9.1	8.4	9.8

Section 12. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4 About the same



Comparison with other trusts within your region

Trusts with the highest scores

The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.3
The Royal Orthopaedic Hospital NHS Foundation Trust	9.1
George Eliot Hospital NHS Trust	8.6
Sherwood Forest Hospitals NHS Foundation Trust	8.5
South Warwickshire University NHS Foundation Trust	8.5

Trusts with the lowest scores

Northampton General Hospital NHS Trust	7.7
University Hospitals Birmingham NHS Foundation Trust	7.9
United Lincolnshire Teaching Hospitals NHS Trust	7.9
The Royal Wolverhampton NHS Trust	8.0
University Hospitals Coventry and Warwickshire NHS Trust	8.0

Section 12. Overall experience (continued)

Question score



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
559	8.4	8.2	7.6	9.3

About the same

Performance Against Target (Status)

Meeting Target
Not Meeting Target

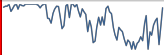
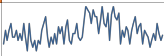
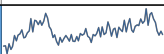
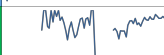
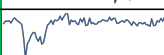
Activity Performance Only

Over 5% above Target
5% above to 2% below Target
More than 2% below Target to 5% below Target
Over 5% below Target

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

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

Quality of care, access and outcomes				Responsible Director	Standard	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Cancer	28 day referral to diagnosis confirmation to patients	Chief Operating Officer	80%	86.0%	83.6%	82.2%	84.3%	86.4%	86.5%			
	2 Week Wait all cancers	Chief Operating Officer	93%	80.1%	88.9%	86.2%	74.1%	86.4%	81.2%			
	Urgent referrals for breast symptoms	Chief Operating Officer	93%	53.3%	64.0%	69.2%	10.0%	53.3%	91.7%			
	Cancer 31 Days Combined	Chief Operating Officer	96%	98.0%	96.4%	94.9%	95.8%	96.7%	96.3%			
	Cancer 62 day pathway: Harm reviews - number of breaches over 104 days	Chief Operating Officer		6	4	9	6	4	6			
	Cancer 62 days Combined	Chief Operating Officer	75%	76.8%	88.4%	76.5%	80.5%	85.7%	85.1%			
	Cancer: number of cancer patients waiting over 62 days	Chief Operating Officer	Plan	36	32	42	27	30	35			
Primary care and community services	Community Service Contacts - Total	Chief Operating Officer	v 2025/26	126%	121%	110%	104%	109%	105%			
	Urgent Response > 1st Assessment completed within 2 hours (admission prevention)	Chief Operating Officer	70%	90%	95%	93%	91%	91%	93%	91%		
	% emergency admissions discharged to usual place of residence	Chief Operating Officer	90%	88%	87%	92%	92%	92%	93%	93%		
Urgent and emergency care	A&E Activity	Chief Operating Officer	Plan	96%	96%	104%	102%	107%	103%	109%		
	Ambulance handover within 30 minutes (WMAS Only)	Chief Operating Officer	98%	45.4%	45.8%	50.3%	55.7%	49.1%	65.5%	65.6%		
	Ambulance handover within 45 minutes (WMAS Only)	Chief Operating Officer	0%	59.1%	59.0%	62.9%	67.5%	62.2%	76.4%	76.3%		
	Ambulance handover over 60 minutes (WMAS Only)	Chief Operating Officer	0%	32.7%	30.9%	27.8%	25.0%	28.5%	15.6%	16.0%		
	Non Elective Activity - General & Acute (Adult & Paediatrics)	Chief Operating Officer	v 2025/26	124%	126%							
	Same Day Emergency Care (0 LOS Emergency adult admissions)	Chief Operating Officer	45%	50%	47%	48%	50%	52%	54%	51%		
	A&E - % of patients seen within 4 hours	Chief Operating Officer	78%	63.2%	63.7%	66.2%	63.1%	62.6%	65.3%	63.9%		
	A&E - Percentage of patients spending more than 12 hours in A&E	Chief Operating Officer		12.3%	12.3%	9.8%	11.2%	11.8%	9.9%	10.6%		
	A&E - Time to treatment	Chief Operating Officer		01:42	01:52	01:33	01:45	02:02	02:08	02:12		
	Time to be seen (average from arrival to time seen - clinician)	Chief Operating Officer	<15 minutes	00:26	00:26	00:25	00:25	00:28	00:26	00:25		
	A&E Quality Indicator - 12 Hour Trolley Waits	Chief Operating Officer	0	234	234	161	174	176	126	125		
	A&E - Unplanned Re-attendance with 7 days rate	Chief Operating Officer	3%	8.7%	7.9%	8.7%	8.3%	9.3%				

Latest Month				Latest Available Monthly Position					
Numerator	Denominator	Year to Date v Standard	Trend - Apr 2019 to date	WVT Latest month v benchmark	National or Regional	Pass/Fail	Trend Variation	DQ Mark	
1078	1246	85.0%			79.3%	July			
1074	1323	82.1%			75.6%				
22	24	64.5%			61.7%				
154	160	95.9%			92.5%				
		24.5							
118	138	82.0%			75.7%	Jul			
									
37017	35252	107%							
191	209	91.9%			85%	Jul			
2922	3143	92.3%			93%	Jul to Jun			
6536	5981	105%							
955	1455				73%	July			
328	1455								
233	1455	27.1%			12%				
1639	1304	122%							
1463	2886	51.1%			36%	Jul to Jun			
4768	7464	64.2%			75%	Aug			
789	7464	10.9%			8%	July to June			
					01:47				
					00:19				
		511							
107	5309	8.8%			10%		Jul to Jun		

Elective care	Referral to Treatment - Open Pathways (92% within 18 weeks) - English Standard	Chief Operating Officer	61%	66.0%	67.8%	67.3%	66.9%	66.0%	66.0%		15017	22761				65.4%	Jul			
	Referral to Treatment - Open Pathways (95% in 26 weeks) - Welsh Standard	Chief Operating Officer	TBC	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%	75.0%	75.1%	76.6%	76.9%	77.0%	75.8%	75.7%	9730	12855								
	Referral to Treatment Volume of Patients on Incomplete Pathways Waiting List	Chief Operating Officer		26034	26031	26420	27140	27486	27798											
	Referral to Treatment Number of Patients over 52 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	733	546	566	618	638	740							111379	July			
	Referral to Treatment Number of Patients over 65 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	210	219	241	263	283	328							9095				
	Referral to Treatment Number of Patients over 78 weeks on Incomplete Pathways Waiting List	Chief Operating Officer	0	79	108	125	138	144	170							1494				
	GP Referrals	Chief Operating Officer	2025/26	99%	107%	104%	99%	115%	100%	102%	3705	3639	104%							
	Outpatient Activity - New attendances (volume v plan)	Chief Operating Officer	Plan	99%	107%	95%	101%	97%	91%	100%	5409	5400	97%							
	Total Outpatient Activity (volume v plan)	Chief Operating Officer	Plan	106%	106%	96%	100%	95%	95%	98%	17339	17658	97%							
	Proportion of Total Outpatient Appointments which are New or Follow Up Procedure	Chief Operating Officer	46%	46%	47%	46%	48%	48%	48%		10812	22752	48%			46.6%	Jul to Jun			
	Total Elective Activity (volume v plan)	Chief Operating Officer	Plan	106%	108%	114%	105%	100%	98%	101%	2803	2778	103%							
	Elective Recovery Fund (ERF) Actual v Plan (£)	Chief Operating Officer	Plan	139%	147%								136%							
	BADS Daycase rates	Chief Operating Officer	Actual	78.7%	76.3%	82.9%	83.3%						83.1%			79%	Jul to Jun			
	Elective - Theatre utilisation (%) - Capped	Chief Operating Officer	85%	83.9%	82.4%	85.3%	83.7%	85.4%	85.0%	82.7%			84.5%			81%	May			
	Elective - Theatre utilisation (%) - Uncapped	Chief Operating Officer	85%	86.7%	85.9%	89.1%	86.7%	88.2%	88.2%	85.4%			87.6%			85%	Feb			
	Cancelled Operations on day of Surgery for non clinical reasons	Chief Operating Officer	10 per month	34	41	14	26	10	13	13			86			22029	Apr to Jun			
	Diagnostic Activity - Computerised Tomography	Chief Operating Officer	Plan	86%	91%	107%	107%	114%	101%	84%	3006	3581	102%							
	Diagnostic Activity - Endoscopy	Chief Operating Officer	Plan	107%	90%	92%	83%	79%	75%	97%	582	601	84%							
	Diagnostic Activity - Magnetic Resonance Imaging	Chief Operating Officer	Plan	98%	111%	99%	98%	98%	92%	87%	1525	1752	95%							
	Waiting Times - Diagnostic Waits >6 weeks	Chief Operating Officer	<5%	11.6%	11.8%	13.6%	15.2%	18.4%	19.8%	17.2%	1135	6591				23.1%	Jul			
	Maternity - % of women who have seen a midwife by 12 weeks and 6 days of pregnancy	Chief Nursing Officer	90%	94.4%	96.9%	95.0%	90.3%	94.9%	92.6%	95.1%	116	122	93.7%							
	Robson category - CS % of Cat 1 deliveries (rolling 6 month)	Chief Medical Officer	<15%	22.0%	22.0%	21.9%	24.0%	20.2%	16.0%	17.4%	16	92	17.4%							
	Robson category - CS % of Cat 2 deliveries (rolling 6 month)	Chief Medical Officer	<34%	56.7%	57.6%	59.0%	60.8%	62.5%	66.5%	70.5%	136	193	70.5%							
	Robson category - CS % of Cat 5 deliveries (rolling 6 month)	Chief Medical Officer	<60%	88.9%	89.8%	89.6%	90.3%	89.4%	90.8%	90.1%	137	152	90.1%							
	Maternity Activity (Deliveries)	Chief Nursing Officer	v 2024/25	89%	98%	109%	101%	96%	109%	108%	135	125	104%							
	Midwife to birth ratio	Chief Nursing Officer	1:26	1:32	1:27	1:25	1:24	1:25	1:28											
Outpatient transformation	DNA Rate (Acute Clinics)	Chief Operating Officer	<4%	5.8%	5.7%	5.9%	6.0%	6.1%	6.3%	6.2%	1696	25809	6.1%			6.8%	Jul to Jun			
	Outpatient - % OPD Slot Utilisation (All slot types)	Chief Operating Officer	90%	87.6%	90.1%	90.1%	88.9%	89.5%	88.9%	88.9%	14539	16347	89.4%							
	Outpatient Activity - Follow Up attendances (volume v plan)	Chief Operating Officer	Plan	110%	106%	97%	100%	94%	97%	97%	11930	12259	97%							
	Outpatients Activity - Virtual Total (% of total OP activity)	Chief Operating Officer	25%	19.7%	19.5%	20.2%	19.5%	18.9%	19.6%	18.6%	3228	14111	19.4%			18%	Jul to Jun			
Prevention long term conditions	Maternity - Smoking at Delivery	Chief Nursing Officer		5.6%	3.9%	2.9%	4.9%	5.1%	10.4%	6.6%	8	122								

Safe, high quality care	Bed Occupancy - Adult General & Acute Wards	Chief Operating Officer	<92%	100%	100%	100%	100%	100%	98%	98%	304	309	99%			95%	Jul			
	Bed occupancy - Community Wards	Chief Operating Officer	<92%	97%	96%	95%	97%	97%	96%	94%	79	84	96%							
	Mixed Sex Accommodation Breaches	Chief Nursing Officer	0	85	71	51	69	106	118	88			432			5431	Jul			
	Patient ward moves emergency admissions (acute)	Chief Operating Officer	4%	7%	8%	7%	8%	7%	8%		97	1223	7%							
	ALoS - General & Acute Adult Emergency Inpatients	Chief Operating Officer	4.5	5.8	6.9	3.5	3.3	3.4	3.2	3.1	8162	2619	3.3			4.4	Jul to Jun			
	ALoS – General & Acute Elective Inpatients	Chief Operating Officer	2.5	2.3	2.0	2.6	2.7	2.9	1.9	2.0	545	278	2.4			3.4				
	ALoS - General & Acute Adult (English)	Chief Operating Officer		4.9	5.6	3.2	3.1	3.0	3.0	2.9	7959	2645	3.1							
	ALoS - General & Acute Adult (Welsh)	Chief Operating Officer		6.6	7.3	4.6	4.3	5.2	3.5	3.5	1398	405	4.2							
	Medically fit for discharge - Acute	Chief Operating Officer	5%	19.0%	14.7%	14.5%	16.6%	17.0%	16.3%	14.7%	1372	9351				23.1%	Dec			
	Medically fit for discharge - Community	Chief Operating Officer	10%	21.0%	22.9%	22.5%	25.5%	23.1%	29.2%	23.0%	591	2572								
	Emergency readmissions within 30 days of discharge (G&A only)	Chief Medical Officer	5%	4.6%	2.2%						92	4143	4.6%			8.2%	Jun to May			
	Mortality SHMI - Rolling 12 months	Chief Medical Officer	<100	113.8	114.7	112.6					1295	1150				100				
	Never Events	Chief Nursing Officer	0	0	0	0	0	0	0	0			0							
	MRSA Bacteraemia	Chief Nursing Officer	0	0	0	0	0	1	0	1			2							
	MSSA Bacteraemia	Chief Nursing Officer		2	5	0	5	3	5	5			6							
	Number of external reportable >AD+1 clostridium difficile cases	Chief Nursing Officer	44	6	4	7	5	3	5	5			25							
	Number of falls with moderate harm and above	Chief Nursing Officer	2022/ 23 (30)	5	3	4	0	0	1	1			6							
	VTE Risk Assessments	Chief Medical Officer	95%	94.1%	94.5%	94.4%	93.6%	93.8%	94.7%	89.6%	3349	3737	94.1%							
	WHO Checklist	Chief Medical Officer	100%		99.8%			100%												
	% of people who have a TIA who are scanned and treated within 24 hours	Chief Medical Officer	60%	67.4%	62.9%	51.4%	54.3%	52.6%	64.4%	45.9%	17	37	54.2%							
	Stroke -% of patients meeting WVT thrombolysis pathway criteria receiving thrombolysis within 60 mins of entry (door to needle time)	Chief Medical Officer	90%	91.7%	60.0%	62.5%	60.0%	100.0%	80.0%	33.3%	4	12	59.0%							
	Stroke Indicator 80% patients = 90% stroke ward	Chief Medical Officer	80%	79.1%	70.7%	67.4%	81.6%	76.5%	85.7%	69.8%	30	43	76.3%							
	Cleaning Standards: Acute (Very High Risk)	Chief Nursing Officer	98%	97.0%	97.3%	97.1%	97.3%	97.5%	97.0%	97.2%			97.2%							
	Cleaning Standards: Community (Very High Risk)	Chief Nursing Officer	98%	99.0%	97.0%	97.4%	98.1%	98.9%	98.1%	96.3%			97.8%							
	Number of complaints	Chief Nursing Officer	2022/ 23 (253)	28	27	30	27	27	52	38			174							
	Complaints resolved within policy timeframe	Chief Nursing Officer	90%	40.0%	51.0%	47.0%	65.4%	52.8%	53.6%	58.8%	20	34	55.5%							

	Friends and Family Test - Response Rate (Community)	Chief Nursing Officer	30%							
	Friends and Family Test Score: A&E% Recommended/Experience by Patients	Chief Nursing Officer	95%	82%				77%	76%	80%
	Friends and Family Test Score: Acute % Recommended/Experience by Patients	Chief Nursing Officer	95%	93%				90%	89%	87%
	Friends and Family Test Score: Community % Recommended/Experience by Patients	Chief Nursing Officer	95%	98%				96%	94%	95%
	Friends and Family Test Score: Maternity % Recommended/Experience by Patients	Chief Nursing Officer	95%	100%				100%	88%	83%
	Friends and Family Test: Response rate (A&E)	Chief Nursing Officer	25%	15%						
	Friends and Family Test: Response rate (Acute inpatients)	Chief Nursing Officer	30%	13%						
	Friends and Family Test: Response rate (Maternity)	Chief Nursing Officer	30%	24%						

0	0	0.0%									
223	279							77%			
142	163	88.5%						94%			
320	337	95.2%						95%			
5	6	90.3%						91%			
151	1194	12.9%									
14	59	17.1%									

People		Responsible Director	Standard	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Looking after our people	Agency (agency spend as a % of total pay bill)	Chief People Officer	6.4%	2.4%	1.4%	1.3%	1.6%	1.7%	1.8%	2.0%
	Appraisals	Chief People Officer	85%	75.8%	75.6%	76.4%	76.0%	73.3%	72.6%	72.9%
	Mandatory Training	Chief People Officer	85%	88.8%	88.9%	89.4%	85.5%	87.4%	88.4%	88.9%
	Overall Sickness	Chief People Officer	4.0%	5.1%	4.3%	3.8%	4.3%	4.4%	4.6%	4.4%
	Staff Turnover Rate (Rolling 12 months)	Chief People Officer	10%	8.0%	7.9%	8.0%	8.3%	8.1%	7.9%	7.8%
	Clinical WTE Establishment	Chief People Officer		3162	3163	3222	3222	3209	3211	3213
	Clinical WTE Actual	Chief People Officer		2958	2965	2966	2953	2955	2970	2978
	Non-Clinical WTE Establishment	Chief People Officer		791	778	923	923	921	920	920
	Non-Clinical WTE Actual	Chief People Officer		838	840	838	839	836	832	830
	Frozen Posts (where no agency or bank is being used)	Chief People Officer								
	Vacancy Rate	Chief People Officer	5%	4.0%	3.4%	8.2%	8.5%	8.2%	8.0%	7.9%

Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/Fail	Trend Variation	DQ Mark
Numerator	Denominator			WVT Latest month v benchmark	National or Regional				
		2%							
		74%			76%	2021/22			
39234	44117	88%			88%				
5245	118226	4%			5%	May			
297	3784	8%							
325	4133	8%							

Finance and Use of Resources		Responsible Director	Standard	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Finance	I&E - Surplus/(Deficit) (£k)	Chief Finance Officer	≥0	£365	£1,276	-£703	-£504	-£823	-£385	-£587
	I&E - Margin (%)	Chief Finance Officer	≥0%	1.1%	2.5%	-2.1%	-1.5%	-2.4%	-1.1%	-1.7%
	I&E - Variance from plan (£k)	Chief Finance Officer	≥0	-£482	£417	-£184	-£6	-£268	£184	£6
	I&E - Variance from Plan (%)	Chief Finance Officer	≥0%	-56.9%	48.5%	-35.5%	-1.2%	-32.6%	32.3%	1.0%
	CPIP - Variance from plan (£k)	Chief Finance Officer	≥0	-£1,081	-£1,023	-£404	-£525	-£327	£241	£144
	Agency - expenditure (£k)	Chief Finance Officer	N/A	£512	£502	£276	£346	£371	£384	£432
	Agency - expenditure as % of total pay	Chief Finance Officer	N/A	2.4%	1.4%	1.3%	1.6%	1.7%	1.8%	2.0%
	Capital - Variance to plan (£k)	Chief Finance Officer	≥0	£293	-£2,367	-£44	£37	£147	£3,306	£213
	Cash - Balance at end of month (£m)	Chief Finance Officer	As Per Plan	£43	£49	£46	£51	£46	£49	£49
	BPPC - Invoices paid <30 days (% value £k)	Chief Finance Officer	≥95%	99.4%	98.7%	99.8%	92.1%	98.4%	98.5%	94.9%
	BPPC - Invoices paid <30 days (% volume)	Chief Finance Officer	≥95%	98.9%	98.9%	99.0%	99.1%	99.0%	98.9%	99.2%

Latest Month		Year to Date	Trend - Apr 2019 to date	Latest Available Monthly Position			Pass/Fail	Trend Variation	DQ Mark
Numerator	Denominator			WVT Latest month v benchmark	National or Regional				
		-£3,002							
-£587	£34,592								
		-£268							
£6	-£595								
		-£871							
		£1,809							
£432	£21,745	1.7%							
		£3,659							
		£49							
£11,444	£12,053	97.3%							
£5,090	£5,129	99.0%							

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board held in Public
Date of Meeting:	1st October 2026
Title of Report:	Winter Plan 26 and Winter Planning 26/27 Board Assurance Sign Off
Lead Executive Director:	Andy Parker, Chief Operating Officer
Author:	Andy Parker, Chief Operating Officer
Reporting Route:	Direct to Board
Enclosures included with this report:	High Level summary of Wye Valley NHS Trust Winter Plan 2026 Winter Planning 26/27 NHS England Provider Board Assurance Statement
Purpose of report:	☐ Assurance ☒ Approval ☐ Information
Brief Description of Report Purpose	
Winter places sustained pressure across the system, with increased demand, constrained capacity and heightened operational risk. Planning needs to be disciplined, realistic and focused on delivery to maintain resilience and continuity of care. Whilst operational resilience will remain critical, prevention through vaccination, infection prevention and control, and proactive management of patient flow must continue to underpin our winter response Maintaining patient flow across health and care systems is fundamental to managing winter pressures. Whilst increases in demand remain a significant challenge, the experience of recent winters has demonstrated that prolonged pressure is often driven by constraints within discharge pathways and delays in moving patients to the most appropriate setting for their ongoing care. While focused on winter, these plans form part of our Four Big Moves and our year-round approach to managing demand and performance. Aligning winter planning with broader priorities will improve consistency, strengthen readiness, and reduce reliance on reactive measures during peak periods. The attached summary provides the Trust Board with a high-level summary of our local plans and are reflective in the NHS England Board Assurance Statement that has already been submitted to the Trust Board ahead of today's Public Board to be submitted to NHS England by the 30th September 2026.	
Recommended Actions required by Board or Committee	
This Winter Plan has been tested within the Trusts with Senior Colleagues and also at NHS England Midlands Regional Stress Testing Event on the 10th September 2026. The recommendations and actions for WVT / Herefordshire are included in the High-level Summary around: - Governance and Control - Balancing Clinical and Operational Risk - Communication - Decision making under pressure	

Within the Winter Planning 26/27 Board Assurance Statement there are two areas of non-compliance within the Section B checklist

1. Section 2.2 Model Discharge Pathways
Less assurance from Powys around winter plans, ongoing executive and operational escalation meetings to obtain assurance around Powys health and social care resilience ahead of winter. Current impact assessment of Powys patients residing 2 days longer than Herefordshire patients in our acute inpatient beds.
2. Section 6.2 Local plans align to NHS Operational Pressures Escalation Levels with clear triggers and timely operational response.
These actions will be addressed over October and November, as detailed in the High-Level summary of Wye Valley NHS Trust Winter Plan 2026, with a review and rewrite of our local WVT Escalation Policy which will include exercising and awareness training for On Call Managers at all levels and key roles within our Command Structure as documented in our revised Escalation Policy over November and early December.

That the Board acknowledge areas highlighted of non-compliance, associated risks and mitigation and formally sign off the Trusts Winter Plan and Board Assurance Statement.

Please note that the Board Papers has a PDF version of the Excel Document of the Winter Planning 26/27 Board Assurance Document. The full Excel document for Trust Board Members to review the detail within each section was circulated previously for review

Executive Director Opinion¹

The Trusts Winter Plan has been developed with the Clinical Divisions, Executive Colleagues and shared with partners and is included within the Integrated Care Boards (ICB) Winter Plan for 26/27.

As the Trusts Designated Winter Director, I endorse this plan to the Board.

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



ICS Winter 2026/27 Plan

Herefordshire

Sepetmber 2026

This winter plan incorporates the Wye Valley NHS Trust's UEC Improvement Programme which is aligned to the organisation's 4 Big Moves and the National Neighbourhood Health Improvement Programme

UEC Schemes 2026/27 – Trust Red Lines

As a Trust, we are committing ourselves to “red lines” – non-negotiable standards:

- No patient waiting more than 24 hours in ED
- Eradicate ED and Ward corridor care
- No ambulance waits longer than 45 minutes
- No inappropriate use of SDECs for admitted patients
- No newly admitted patients placed in escalation areas

UEC Improvement Outcome Measures

- All of the Winter 2026/27 schemes will have a direct effect on at least one of the trust's three UEC improvement outcome measures
- Reducing corridor care
- A length of stay reduction of 0.7days
- An increase of 6 discharges per day

Herefordshire Winter Modelling – High Level Aims

Integrated Care Division •24/7 Single Point of Access •Neighbourhood Health – Integrated Teams Development / Palliative End of Life •Pathway 1 improvements – overnight bridging team •Review and relaunch virtual ward reconfiguration (including increase in step up and down opportunities) •Increased nursing capacity to support wards to improve EoL/Fast Track/CHC processes •Discharge Co-ordinators on the acute floor 7/7 •MADE events across Sept / Oct / Dec 26	Medical Division •Delivering improvements to non-admitted performance •Maximising streaming and SDEC capacity •Design and deliver Model ED (including EEMAC) •Implement ‘My Next Patient’ pull from ED to wards •Optimise MSDEC utilisation (including early ACP pull from ED) •Ward- based process improvements (including SHOP, CLD etc) •Timely EDS improvements (Quality Priority) •Implementation of electronic patient flow management system (e-Whiteboards)
Surgical Division •Ward-based processes improvements (CLD, SHOP) •Surgical SDEC optimisation (including launch of breast pathway) •Timely EDS improvements (Quality Priority) •Implementation of electronic patient flow management system (e-Whiteboards)	Clinical Support Division •Fully automate specimen processes •Re-allocate pharmacy resource to ward-based activities as part of new intake processes •Diagnostics Demand Management and Community CDC pathways
The UEC Improvement Plan 2026/27 has been designed by both clinical and operational leads, cross referenced against the UEC GIRFT checklist, Model 72hr, Model ED and Model Discharge guidance. 80% Bed Occupancy by 24th December 26	

UEC Schemes 2026/27 – Integrated Care/Neighbourhood Services

Scheme	Process Measure	Outcome Measure
Palliative and End of Life Care (PEoLC) – Gold Standards Framework implementation, new EOL medic in ED plus three month programme to increase specialist nursing capacity to support Fast Track/CHC processes and COMPASS (EoL access to A&G) & ReSPECT forms.	Reduction in ED attendances Reduction in admissions	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Review and implement improvements to pathway 1a discharges	Occupancy rate LOS- PW1 Reasons unable to discharge Reduce DRD	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Review and relaunch Virtual Ward utilisation to reconfigure and increase step up and step-down opportunities (maximising Frailty and EoL capacity)	Occupancy rate LOS- (ESD)- step down Admission Avoidance- (AA) – step up Readmissions CH & bedded D2A LOS improvements	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days
Implement 24/7 WVT Bridging Team for Pathway 1	Reduce Bed days lost	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days

UEC Schemes 2026/27 – Neighbourhood Health

Scheme	Process Measure	Outcome Measure
Neighbourhood Health – Integrated Neighbourhood Teams development (including risk stratified patients) – aligning NH footprints and multi-disciplinary working. Objective to strengthen operating model and escalation for complex decision making with patients with multiple co-morbidities and/or recent acute hospital admission focussed on 65yr+	Reduction in ED attendances Reduction in greater than 0 LOS admissions	Eradicate Corridor Care Reduce ambulance handover delays
Extend SPOA to 24/7 (scheduled UCR and SDEC Community urgent clinical care)	Reduction in ED attendances Reduction in admissions	Eradicate Corridor Care Reduce ambulance handover delays

UEC Schemes 2026/27 – Powys Schemes

Scheme	Process Measure	Outcome Measure
Proactive and responsive care planning with primary and community colleagues (virtual ward) Acute Floor Powys support – redirection back to Powys Community Services via Powys SPoA	Reduce bed days lost Powys Reduce LOS	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Single Point of Access with the ability to respond rapidly	Reduced admissions to G&A beds Increased discharges from FSDEC	Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Direct access to step down beds Community IVOPAT Community Geriatric oversight [subject to recruitment]	Reduce G&A admissions Reduce bed days lost Powys	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays

Plans currently developing with Executive leadership across WVT and Powys Health Board including details, measures, outcomes and timeframes tbc.

UEC Schemes 2026/27 - Surgical

Scheme	Process Measure	Outcome Measure
Introduce early morning huddles in SSDEC to pull patients from ED	TBC (following MDT workshop)	Eradicate corridor care Reduce ambulance handover delays
Launch breast pathway through SSDEC	TBC (following MDT workshop)	Eradicate corridor care Reduce ambulance handover delays
Design & deliver future expansion of SSDEC including demand & capacity, criteria, increased direct navigation, hot clinics, estate and workforce	TBC (following MDT workshop)	Eradicate corridor care Reduce ambulance handover delays
Increase Gynea SDEC capacity (+2) (subject to capital investment and deliverability)	TBC (following MDT workshop)	Eradicate corridor care Reduce ambulance handover delays

UEC Schemes 2026/27 - Medical

Scheme	Process Measure	Outcome Measure
Implement Ward Sisters/ED sisters/Nurse of the Day/Matron of the day 08:00 'My Next patient' huddle Implement 15:00 'My Next Patient' huddle for patient pull plans and appropriate step down/escalation space patients	• LOS in ED • No patients waiting in ED more than 24 hours • ED allocation numbers across time of day • 1 discharge/transfer to discharge lounge off each ward by 10 am. • Right patient, right place, right time, first time. -Reduction in inter-hospital moves per each patient stay. -No newly admitted patients in escalation areas	Increase Discharges by 6 a day Reduce LOS by 0.7 days Eradicate Corridor Care

UEC Schemes 2026/27 - Medical

Scheme	Process Measure	Outcome Measure
Implement 'My next patient/ principles at morning Board Round	• LOS in ED • No patients waiting in ED more than 24 hours • ED allocation numbers across time of day • 1 discharge/transfer to discharge lounge off each ward by 10 am. • Right patient, right place, right time, first time. -Reduction in inter-hospital moves per each patient stay. -No newly admitted patients in escalation areas	Increase Discharges by 6 a day Reduce LOS by 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Ward-based Improvements (CLD, SHOP, Timely EDS)	- SAFER Care Buddle measures - EDS completion rates - 7d / 21d Stranded numbers	Increase Discharges by 6 a day Reduce LOS by 0.7 days Eradicate Corridor Care Reduce ambulance handover delays

UEC Schemes 2026/27 - Medical

Scheme	Process Measure	Outcome Measure
Optimise the MSDEC utilisation including ACP pull 5 patients from ED at the start of the day	• 4-hour EAS • non-admitted performance • LoS	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Introduce and Emergency Medical Assessment and Care (EEMAC) alongside MSDEC including patient cohorting, registrar and ACP workforce alignment to nursing model,	• 4-hour EAS • non-admitted performance • LoS	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays

UEC Schemes 2026/27 - Medical

Scheme	Process Measure	Outcome Measure
Maximise navigation away from ED – including utilisation of 24/4 SPoA – including scheduling of community response.	- Increase in patients navigated - Utilisation of 24/7 SPoA	Eradicate Corridor Care Reduce ambulance handover delays
Maximise referral process from UCR to SDECs and SDECs to UCR	- Increase number of referrals from UCR to SDECs - Increase number of referrals from SDECs to UCR	Eradicate Corridor Care Reduce ambulance handover delays
Introduce Discharge Co-Ordinator role onto the Acute floor (subject to trust financial approval)	Increase patients directly discharged from ED/SDECs	Eradicate Corridor Care Reduce ambulance handover delays
Recovery of SpDr and Consultant staffing, completing ED workforce transformation	N/A	Reduce ambulance handover delays

UEC Schemes 2026/27 – Clinical Support

Scheme	Process Measure	Outcome Measure
Diagnostic Demand And Capacity Improvements – including DVT pathway, CT, Head Injuries	• Increase number of pathways delivered through CDC • Increase number of one stop and straight to test pathways • Improve diagnostic wait times	Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Pharmacy - Release ward-based staff to work on the wards, rather than in the dispensary, to facilitate timely discharges, communicate with patients about supply requirements to improve discharge processes	• Increase in discharges before 12:00 • Increase in discharges before 16:00 • Reduce patients waiting 12hrs • Increase number of discharges	Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays Increase Discharges by 6 a day

UEC Schemes 2026/27 – Cross Divisional

Scheme	Process Measure	Outcome Measure
Trust-wide ward based improvement programme including SAFER, CLD, SHOP, EDS completion	• Increase in discharges before 12:00 • Increase in discharges before 16:00 • Reduce patients waiting 12hrs • Increase number of discharges • % of EDS completed the day before and before 1000hrs / 1200hrs / 1600hrs	Increase Discharges by 6 a day Reduce LOS by 7 0.7 days Eradicate Corridor Care Reduce ambulance handover delays
Review and implement updated Patient Flow and Escalation Policy – reflecting OPEL levels and escalation and surge options	• N/A	Eradicate Corridor Care Reduce ambulance handover delays
MADE Events	To be undertaken: Last week in September Week before Herefordshire Half Term 14 th December till 24 th December (Monday to Friday) Multidisciplinary approach to reviewing all inpatients Hold MDT style review of each patient and discuss opportunities to utilise VW, bridging team, TEC to support discharge, voluntary sector. Learning opportunities for all staff involved	Bed Occupancy Eradicate Care Deliver 80% Bed Occupancy by 2359hrs 24th December 2026

Winter Planning Actions Post NHSE Regional Exercise Aegis Review [1]

Action	Requirement / Action
Governance and control	Strength command, control and governance arrangements. Clear processes are needed so that decisions can be made quickly during periods of pressure. Roles, responsibilities and accountability across the whole system need to be explicit. To be include in WVT Escalation Policy and via Exercising / Testing across Nov/Dec
Balancing clinical and operational risk	Establish who makes the decision and how the clinical balance of risk is assessed that supports Systemwide/ PLACE Operational decisions Clinical input was viewed as particularly valuable, with examples of clinical senates/discussions being used effectively to support difficult decisions. A structured, multidisciplinary discussion could help determine appropriate escalation, mitigations and further actions. Review establishment of Herefordshire Clinical Senate
Communication	Review communication across the entire PLACE was identified as essential. Everyone should understand: who is responsible for making decisions what actions are required who has accountability; when and how escalation decisions should be communicated Review Communication Section of WVT Escalation Policy and across System Partners

Winter Planning Actions Post NHSE Regional Exercise Aegis Review [2]

Action	Requirement
Decision-making under pressure	Processes should be agreed before winter pressures peak, rather than attempting to determine responsibilities or funding arrangements during a crisis. The aim is to ensure that decision-makers have the authority and information required to unlock actions and mitigations quickly. Consolidation of PLACE winter plans and Coordination across PLACE

Staff Vaccination Plans

Plans

- Trust plan in place. Staff vaccinations to commence 28/09/26- 31/03/27.
 - Walkin appointments available in Occupational health dept.
 - Targeted session throughout the Trust over the first 2 months with aim to have the majority of staff vaccinated by 30/11/26
 - Peer vaccinator programme developed to deliver frontline staff vaccinations in the workplace. *SOP Flu vaccination of healthcare staff via the peer vaccinator model*
 - All delivered vaccinations are uploaded onto RAVS.
 - All eligible frontline staff are identified via Workforce teams
-
- Targeted communication delivered to all trust employees on vaccination promotion plus information and resources on respiratory infections. Respiratory and gastrointestinal infection policies & pathways (Adult and paediatrics) reviewed to ensure risks are mitigated.
 - Specific infection cohort plans in place to support surge
 - Staff & patient Winter mask wearing guidance drafted and ready to launch as appropriate
 - POCT respiratory virus screening/ swabbing undertaken in ED & PAU to aid prompt identification & support appropriate patient placement.
-
- Trust plan in place to offer flu vaccination; to commence 01/10/26
 - Peer vaccinators trained to undertake inpatient vaccination for Influenza, lead by IPC nurse team
 - All inpatients vaccinated will be uploaded onto RAVS.
 - Discussion with ICB – not commissioned/requested to offer covid 19 vaccination

IPC Plans

Plans

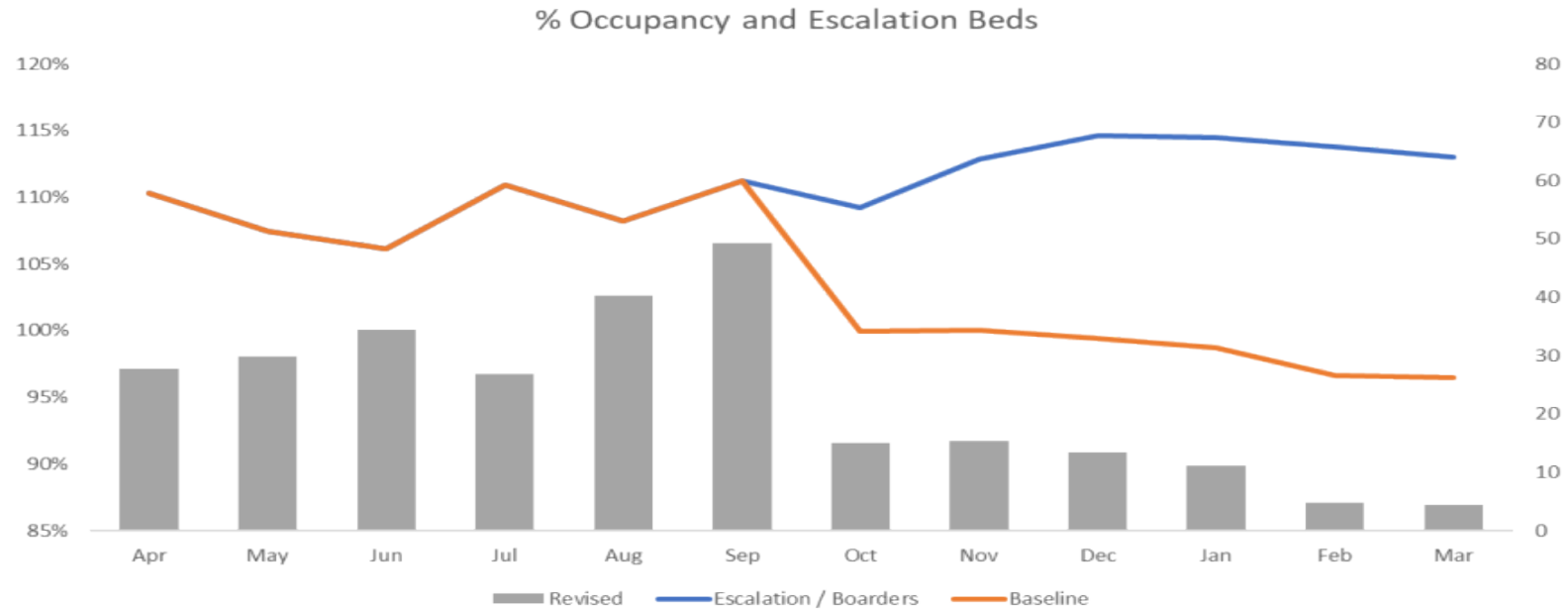
- POCT respiratory virus screening/ swabbing undertaken in ED & PAU.
 - IPC nurse team providing a 7-day service 01/10/26-31/03/27; review patient placement & cohort needs daily. Plus manage side room isolation usage
 - Cohort guidance/ resource folder provided to Clinical Site Management (CSM) team to aid patient placement out of hours
 - ICB & System patient management plans refreshed 2026 and circulated to CSM team
 - The site has limited additional capacity – major outbreaks can present operational challenges – yet well managed
- DIPC, IPC and Consultant microbiologist all engaged
- IPC nurse team lead on the trust Fit mask testing service
 - All staff fit tested to FFP3 or Hood recorded on ESR
 - Central database (locally created) with all Fit tested staff shared with Clinical leads and CSM weekly.
 - FFP3 mask stock monitored to ensure stock availability in times of heightened demand
 - All wards and acute emergency pathway have minimum PPE stock levels to ensure availability at all times.
 - Mutual aid arrangements available if required through Trust Procurement team
- Specific infection cohort plans in place to support surge
 - ICB & System patient management plans refreshed 2026 and circulated to CSM team for OOH management
 - IPC nurse team review patient placement & cohort needs daily. Plus manage side room isolation usage
 - Paeds respiratory isolation management agreed with Lead paediatrician Dec 2025
 - HCAI outbreak/ increase prevalence shared across System including ICB, Public health and Herefordshire Council

Staff Wellbeing Plans

Staff wellbeing programmes will continue throughout Winter 2026/27 including:

- Employee Assistance Programme (EAP) – available 24/7
- Access to personal health services – including direct physiotherapy referrals, onsite access to weekly advice and guidance from gym health and wellbeing coach
- Team Time/Schwartz rounds
- Access to external Oxford Mindfulness courses, for mental wellbeing

Bed Occupancy Bridging Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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Baseline

Baseline Occupancy	110%	107%	106%	111%	108%	111%	109%	113%	115%	114%	114%	113%
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Final

Beds Required	335	327	323	337	329	338	304	304	302	300	294	293
Beds Available	304	304	304	304	304	304	304	304	304	304	304	304

Baseline Occupancy	110%	107%	106%	111%	108%	111%	100.0%	100.0%	99.4%	98.7%	96.6%	96.5%
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Escalation / Boarding beds required	28	30	34	27	40	49	15	15	13	11	5	20
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Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):

Wye Valley Trust

If Other, write Provider/Trust Name:

Contact details (email, phone number):

andrew.parker@wvt.nhs.uk

Date:

17/09/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes		
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Planned	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	COO / Vaccination - Geoffrey Etule	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Trust plan in place. Staff vaccinations to commence 28/09/26- 31/03/27. Walkin appointments available in Occupational health dept. Targeted session throughout the Trust over the first 2 months with aim to have the majority of staff vaccinated by 30/11/26 Peer vaccinator programme developed to deliver frontline staff vaccinations in the workplace. SOP Flu vaccination of healthcare staff via the peer vaccinator model All delivered vaccinations are uploaded onto RAVS. All eligible frontline staff are identified via Workforce teams	Staff receiving vaccination from other healthcare providers such as Powys GP
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Targeted communication delivered to all trust employees on vaccination promotion plus information and resources on respiratory infections. Respiratory and gastrointestinal infection policies & pathways (Adult and most plan in place, to commence 1/1/26	N/A
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Peer vaccinators trained to undertake inpatient vaccination for Influenza, lead by IPC nurse team All inpatients vaccinated will be uploaded onto RAVS	Acuity of patients in secondary care may mean vaccination during admission is not clinically appropriate Powys patients vaccination status
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Health Inequalities is embedded within the Integrated Neighbourhood Teams	N/A
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Optimising UCR, VW and EDS to ensure timely discharges. The programme	Powys assurance remains a risk - emerging plans but Winter 26 remains a risk both P
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	No	Part of the UEC Improvement Programme reporting into UEC Improvement	Less assurance from Powys around winter plans, ongoing executive and operational e
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Home for Christmas initiative will include pre-christmas targeted discharge	N/A
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Increased capacity for MSDEC with ongoing work on demand and capacity fo	N/A
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Geriatrician-led H@ H - FSDEC on Acute floor and 7 day in reach into ED ar	N/A
Capacity					

3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Employee Assistance Programme (EAP) – available 24/7 Access to personal health services – including direct physiotherapy referrals, onsite access to weekly advice and guidance from gym health and wellbeing coach Team Time/Schwartz rounds	N/A
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Completed - ongoing demand and capacity reviews of SSDEC and specialty	N/A
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Sustainable cancer delivery proven at WVT. RTT plans delivering with m	N/A
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	12hr and RTT plan submitted as part of operational planning for 26/27 and d	Confidence around RTT / 12hr - 4hr EAS trjectories remain a risk if Winter / UEC are n
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Caseload and vulnerble patients and processes in place to step up/down cas	N/A
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Highest priority of UEC Improvement programme aligned to WVT's red lines. WVT patient flow and escalation policy to be reviewed and signed off in Oct to reflect the operational and clinical improvements and expectations. This will include Governance and Assurance as reflected in the NHSE Regional Exercise on the 10th September and feedback. To be completd by November 26 Clinical Operational Stanrds in place with operationbal dashbaord in place by end of October No UTC No receiveing areas for all speacilities - work in progress to address through estates strategy - but not for this winter	N/A
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Handover trajectories included in pack, WVT handover escalation SOP review	N/A
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Robust Herefordshire and Worcestershire escalation process in place includ	N/A
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The clinical and operational teams have carried out a gap analysis against b	N/A
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	POCT respiratory virus screening/ swabbing undertaken in ED & PAU. IPC nurse team providing a 7-day service 01/10/26-31/03/27; review patient placement & cohort needs daily. Plus manage side room isolation usage Cohort guidance/ resource folder provided to Clinical Site Management (CSM) team to aid patient placement out of hours ICB & System patient management plans refreshed 2026 and circulated to CSM team	N/A
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Plans shared with DIPIC, IPC and Consultant microbiologist	N/A
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	IPC nurse team lead on the trust Fit mask testing service All staff fit tested to FFP3 or Hood recorded on ESR Central database (locally created) with all Fit tested staff shared with Clinical leads and CSM weekly. FFP3 mask stock monitored to ensure stock availability in times of heightened demand All PPE monitored to ensure stock availability in times of heightened	N/A
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Specific infection cohort plans in place to support surge ICB & System patient management plans refreshed 2026 and circulated to CSM team for OOH management IPC nurse team providing a 7-day service 01/10/26-31/03/27; review patient placement & cohort needs daily. Plus manage side room isolation usage Paeds respiratory isolation management agreed with Lead paediatrician Dec 2025	N/A
Leadership and operational grip					

6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	No additional information required	N/A
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	No	Refresh of WVT policy - due in October 2026 to reflect this along with testing	N/A
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	No additional information required	N/A
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	No additional information required	N/A
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	No additional information required	N/A
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	No additional information required	N/A
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Employee Assistance Programme (EAP) – available 24/7Access to personal	N/A
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		N/A	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		N/A	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.		N/A	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Wye Valley NHS Trust

Provider CEO name: Glen Burley

Date reviewed:

Provider Chair name: Francis Martin

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Andy Parker email andrew.parker@wvt.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes

Please confirm date reviewed

17/09/2026

BAS Self-Assessment Dashboard

Trust										
Overall Assessment Rating: 5 - Full assurance										
Section B	Prevention	<table><tr><th>Rating</th></tr><tr><td>5 - Full assurance</td></tr><tr><td>4 - Substantial assurance</td></tr><tr><td>5 - Full assurance</td></tr><tr><td>5 - Full assurance</td></tr><tr><td>5 - Full assurance</td></tr><tr><td>4 - Substantial assurance</td></tr><tr><td>Awaiting assessment</td></tr></table>	Rating	5 - Full assurance	4 - Substantial assurance	5 - Full assurance	5 - Full assurance	5 - Full assurance	4 - Substantial assurance	Awaiting assessment
	Rating									
	5 - Full assurance									
	4 - Substantial assurance									
	5 - Full assurance									
	5 - Full assurance									
	5 - Full assurance									
	4 - Substantial assurance									
Awaiting assessment										
Flow, occupancy and discharge										
Capacity and community										
UEC Flow										
Infection Prevention and Control (IPC)										
Leadership and operational grip										
Specific actions for Mental Health Trusts										

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	1st October 2026
Title of Report:	Financial Recovery Board Terms of Reference
Lead Executive Director:	Chief Finance Officer
Author:	Gweny Scott, Company Secretary
Reporting Route:	Via Financial Recovery Board
Enclosures included with this report:	Terms of Reference
Purpose of report:	☐ Assurance ☒ Approval ☐ Information
Brief Description of Report Purpose	
Following a review in September 2025 where a number of changes were made to reflect the changing requirements and to strengthen the purpose, accountability, responsibilities and membership of the Board, a further review has been undertaken and no further amendments are deemed to be required.	
Recommended Actions required by Board or Committee	
For approval.	
Executive Director Opinion¹	
Agreed by the Chair that no further amendments required.	

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 Financial Recovery Board

TERMS OF REFERENCE

Remit	The purpose of the Financial Recovery Board (FRB) is to provide a formal forum for the collective ownership and oversight, by senior clinical and non-clinical leads, of the Financial Recovery Plan
Accountability Arrangements	The FRB is established in accordance with the Trust's Standing Orders and Scheme of Delegation. The FRB is accountable to the Trust Board and is authorised by the Board to oversee delivery of the Trust's annual Financial Plan, including the Cost and Productivity Improvement Programme (CPIP) and associated workforce and operational performance. . It is authorised to investigate any activity within its terms of reference and seek any information it requires including from any employee or professional advisors. All employees are directed to co-operate with any request made by the FRB. The FRB is authorised by the Trust Board to decide upon and require officers to implement appropriate action to ensure achievement of, or to correct deviation from, the Financial Plan. The FRB will make decisions based on the delegated authority of those in attendance as set out under the Scheme of Delegation and other views as may be delegated by the Trust Board from time to time.
Responsibilities	The overall duty of the FRB is to provide assurance to the Trust Board that the Trust is monitoring performance against the Financial Plan. The FRB will investigate and oversee any issue where the Trust Board may require additional assurance or where a Trust Board decision is required and will: • Determine the membership, priorities and term of the FRB stepping up and down as appropriate. • Receive status updates covering all CPIP and run-rate improvement schemes • Aim to prevent the realisation of adverse impacts through early identification of risks and issues. • Receive remedial proposals where significant variation exists from plans to deliver the elective activity /income. • Receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources. • Provide assurance to the Board that the programmes of work are being progressed as required and will escalate any significant concerns or variance to plan that have the potential to adversely impact delivery of the Trust's plans. • Test the assumptions and mechanics of the plan, seeking assurance that the plan is

	reasonably based including triangulation with activity / performance and workforce metrics. • Ensure that an action plan with specific ownership is created for each component of the plan and is tracked to completion. • Seek formal assurance from SROs that financial controls on key drivers of the deficit are operating effectively through regular reports. • Agree status reporting and items of escalation to the Trust Board. • Ensure that Quality Impact assessments are considered as appropriate. • Ascertain where increased focus is required through Finance and Performance Executive meetings to provide greater assurance on the delivery of detailed elements of the financial plan.
Membership / Attendance	Members of the FRB are: • Chairman • Non-Executive Directors • Associate Non-Executive Directors • Chief Executive Officer • Managing Director • Chief Finance Officer • Chief Operating Officer • Chief Strategy Officer • Chief People Officer • Chief Medical Officer • Chief Nursing Officer Members are expected to attend all meetings with deputies only being permitted by exception and must be capable of responding to actions. In attendance: • Other staff may be invited to attend as required to present reports or contribute to discussions. • Those from outside the Trust with relevant experience and expertise, where this is considered necessary. • Programme SROs and other key supporting officers may be invited to meetings as required to allow focus on particular areas of escalation or concern requiring FRB intervention.
Chair	The meeting will be chaired by the Trust Chairman
Quorum	The quorum for the transaction of business is four members (not including deputies) including two non-executive directors.
Reporting Arrangements	Relevant elements will feed into the Integrated Performance Report to the Trust Board. The Managing Director will chair an informal executive-led meeting, to review a highlight report on progress, risks and issues and capture key actions for progress prior to the next meeting of the FRB.
Frequency of Meeting	The FRB will usually be held monthly. The Chair may call an additional or special purposes meeting if they consider one is necessary.

Administration	The Deputy Company Secretary will organise the collation and distribution of the papers and keep a record of actions and matters arising to be carried forward. Papers will be issued a minimum of 48 hours before meetings and in exceptional circumstances tabled as necessary given the live status of the programme.
Date Approved	FRB: August 2024 FRB: September 2025 Trust Board: October 2025
Date Review	To be reviewed annually. Next review due by: September 2026

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board held in Public
Date of Meeting:	1st October 2026
Title of Report:	Thirlwall Inquiry Board Update
Lead Executive Director:	Chief Medical Officer
Author:	Chizo Agwu
Reporting Route:	Direct to Board
Enclosures included with this report:	Thirlwall Inquiry: Public Board Update
Purpose of report:	☐ Assurance ☐ Approval ☒ Information
Brief Description of Report Purpose	
The publication of the Thirlwall Inquiry Report highlights important lessons for the NHS in relation to patient safety, safeguarding, speaking up, leadership accountability and the escalation of concerns. The Inquiry has led to a number of immediate actions for NHS Trusts, including raising awareness of the Sudden and Unexpected Death in Infancy and Childhood (SUDIC) process, reviewing insulin security arrangements within neonatal services, considering neonatal CCTV requirements and ensuring the findings are discussed in public Board meetings. The Trust has a SUDIC policy in place and all relevant staff will be reminded of the requirements in line with national expectations. A Thirlwall Task and Finish Group is being established to undertake a detailed gap analysis, coordinate implementation of recommendations and monitor compliance with national actions. Progress will be overseen through the Quality Committee, with a further update to be provided to the Board as required. The Trust welcomes the opportunity to review and strengthen its arrangements for safeguarding, mortality oversight, patient safety governance and organisational learning in response to the Inquiry's findings.	
Recommended Actions required by Board or Committee	
To note the findings of the Thirlwall Inquiry and the actions being taken by the Trust in response.	
Executive Director Opinion¹	
A Thirlwall Task and Finish Group is being established to undertake a detailed gap analysis, coordinate implementation of recommendations and monitor compliance with national actions. Progress will be overseen through the Quality 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.

Thirlwall Inquiry: Public Board Update

Purpose

To provide the Board with a summary of the findings and recommendations arising from the Thirlwall Inquiry Report and outline the implications for the Trust.

Background

The Thirlwall Inquiry Report examined the events surrounding neonatal deaths and collapses at the Countess of Chester Hospital between 2015 and 2018. The Inquiry identified significant failures in patient safety, safeguarding, governance, leadership, escalation of concerns, organisational culture, and responses to whistleblowing. The report contains 17 recommendations directed at Government, NHS England, regulators and healthcare organisations.

Key Themes

The Inquiry concludes that patient safety must be the overriding priority in all healthcare organisations and highlights the need for:

- **Patient safety must be the overriding priority** in all organisational decision-making. The Inquiry highlights the need to act promptly on concerns, even where evidence is incomplete, and reinforces that safeguarding concerns should take precedence over employment or reputational considerations.
- **Speaking up and escalation of concerns** were central themes. The report emphasises the importance of staff feeling able to raise concerns without fear of detriment and recommends strengthened arrangements for whistleblowers and clearer processes for escalation.
- **Board oversight and governance** require strengthening, particularly through routine monitoring of mortality, trends, unexpected deaths, and emerging patient safety risks, with clear escalation routes to senior leadership and Boards.
- **Safeguarding responsibilities** extend to situations where there are concerns regarding potential harm caused by healthcare professionals. The Inquiry recommends mandatory safeguarding training for all staff and board members and the introduction of a national Suspicion of Deliberate Harm Protocol.
- **Data and digital systems** must support real-time monitoring and early detection of safety concerns. Improved interoperability of NHS systems and stronger use of mortality surveillance data are recommended.
- **Duty of Candour and leadership accountability** feature prominently. The Inquiry calls for stronger accountability of NHS managers, including an individual duty of candour and enhanced regulatory arrangements for senior leaders.

Immediate NHS Actions

Following publication of the Inquiry, NHS organisations have been asked to take a number of immediate actions, including:

- Installing CCTV cameras in neonatal units focused on storage fridges, cupboards or units by **30 November 2026**.

- Ensuring all relevant staff and Boards are informed of the **Sudden and Unexpected Death in Infancy and Childhood (SUDIC)** process by **28 September 2026**.
- Ensuring neonatal units meet requirements for insulin access control and storage by **31 March 2027**.
- Considering the findings of the Thirlwall Report at the next public Board meeting

Other Recommendations:

- Mandatory safeguarding training for all staff, Board members and Non-Executive Directors.
- Introduction of a national Suspicion of Deliberate Harm Protocol.
- Enhanced Board-level monitoring of child and neonatal deaths and formal escalation arrangements for concerning trends.
- Strengthened Freedom to Speak Up and whistleblowing arrangements.
- Greater accountability and regulatory oversight of NHS managers.
- Improved interoperability of digital systems and enhanced use of real-time mortality surveillance data.

Trust Position

The Trust welcomes the publication of the Inquiry and recognises the importance of ensuring that learning is embedded across the organisation. There are no immediate concerns regarding compliance with current statutory requirements; however, the Trust recognises that further work will be required to assess compliance with the full range of Inquiry recommendations

In relation to the immediate actions:

- The Trust already has a SUDIC policy in place. Relevant staff will be reminded of the policy requirements and the Board is being updated through this report to ensure compliance with the national timescale.
- The Trust will review compliance with the immediate requirement for CCTV monitoring of insulin storage areas within neonatal services. The wider Inquiry recommendation relating to CCTV monitoring within neonatal cots and incubators will be considered as further national guidance becomes available.
- Compliance with national requirements regarding insulin storage and access controls will be assessed as part of the Trust's gap analysis and implementation plan.

Governance and Oversight

A dedicated Thirlwall Task and Finish Group is being established to coordinate the Trust's response to the Inquiry recommendations and associated national requirements.

The Group will:

- Undertake a comprehensive gap analysis against the Inquiry recommendations.
- Develop an implementation plan.
- Monitor delivery of required actions.
- Provide assurance to the Trust through existing governance arrangements.

The Task and Finish Group will report through the Quality Committee and escalate any significant risks, resource implications or compliance concerns to the Board.

Conclusion

The Thirlwall Inquiry highlights important lessons for the NHS around patient safety, safeguarding, leadership accountability, mortality review, speaking up and organisational culture. The Trust has commenced work to review the recommendations and immediate actions and will ensure that any required changes are implemented through a structured programme of work overseen by the Quality Committee

Full report available on the internet via the following address: <https://thirlwall.public-inquiry.uk/>

WYE VALLEY NHS TRUST COVERING REPORT 2026/2027

Report to:	Public Board
Date of Meeting:	01/10/2026
Title of Report:	CNST MIS Yr 8 – Quarter 1 report
Lead Executive Director:	Chief Nursing Officer
Author:	Justine Jeffery – Director of Midwifery Cand Kuegler – Service Delivery and Programme Manager
Reporting Route:	Via Quality Committee
Appendices**	1. Q1 PQOM 26-27 2. Q1 Perinatal incident report 26-27 3. Medical Rota Compliance and Additional Consultant Roles Audit 4. Q1 Midwifery and Neonatal Nurse Safe Staffing Report 26-27 5. Q1 Obstetric Cover - Anaesthetic workforce rota extract 6. Q1 Claims Score Card 26-27 7. Health Inequalities (non-English speaking women) Project Summary report 8. MNVP Highlight report – July 2026 9. Patient Experience forum proposed TOR and Agenda – Sept 26 10. CQC Patient Survey Action plan 25/26 11. Q1 Saving Babies Lives 26-27 Board report and Action plan 12. MCB Local Action Plan Q1 26-27 13. Perinatal Safety Champions Meeting Notes 14. Perinatal Safety Champions proposed SOP and toolkit ** The appendices are included for review by Board Members in the Reading Room and includes some confidential information
Enclosures included in the report	MIS Year 8 Letter to Trusts
Purpose of report:	☒ Assurance ☐ Approval ☐ Information
Brief Description of Report Purpose	
MIS Year 8 Letter received from NHS Resolution on 19th Feb 2026 provided separately. The MIS Year 8 briefing outlines a significant redesign of the national incentive scheme, with a clear shift from process-driven compliance to outcome-focused assurance. The revised model introduces six streamlined 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 provides assurance on progress towards meeting the new safety actions.

A. Workforce and Capacity • Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action. • Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use. • Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags. • Operational capacity monitoring, including elective Caesarean activity via SitRep. • Funded midwifery establishment (Birth-Rate+) as a minimum and introduces funded neonatal establishment requirements. • Confirms need for trained anaesthetic assistants and progress towards peri-operative team models.	B. Training • Year 8 strengthens training and assurance with two compliance checkpoints (30 Nov plus one local). • Training continues to cover fetal monitoring, maternity emergencies and neonatal resuscitation. • In-situ simulation now required in both hospital and community settings. • Anaesthetic training requirement reduced to a half-day to support attendance. • IFH scenarios must be included by year end to align with ABC preparation.	C. Learning from Reviews and Investigations • Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement. • PMRT, MNSI and EN learning now aligned, with SPEN as the single national notification route. • PMRT external review threshold increased to 60%. • Quarterly Board-level thematic reports required. • Greater focus on learning → action → impact. • Statutory Duty of Candour reporting removed from MIS (already a legal requirement).
D. Service-User Voice, Experience and Equity • Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments. • Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care. • Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps. • MNVP structures no longer mandated, but MNVP Leads remain the gold standard where available; where capacity is limited, trusts must ensure diverse and representative service user voices inform priorities, improvement work and governance.	E. Care Bundles • Year 8 introduces a more targeted local approach to SBLCB alongside preparation for the new Maternity Care Bundle (MCB). • Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence. • ICB assurance step removed as ICBs no longer hold a formal oversight role. • Trusts must develop an MCB implementation plan with quarterly Board oversight. • Requires development of neonatal pulse oximetry guidance.	F. Governance, Oversight and Culture • Clearer expectations for Board-level assurance and use of safety intelligence. • Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs. • Bimonthly Board Safety Champion meetings with MNVP involvement. • Live Perinatal Culture Improvement Plan required, with quarterly Board review.

Recommended Actions required by Board

The following recommendations require formal consideration to support full compliance with the Maternity Incentive Scheme, Year 8. The discussion, scrutiny and decision relating to each recommendation must be clearly recorded in the minutes of the relevant meeting. These minutes will form part of the Trust's evidence of compliance and must be available for review or inspection by NHS Resolution.

Workforce and Capacity

1. **Acknowledge compliance with >80% consultant presence in defined acute care situations.**
2. **Acknowledge the current Medical Rota Compliance and Additional Consultant Roles Audit, noting:**
 1. Neonatal Nursing workforce compliant.
 2. Neonatal Medical workforce non-compliant.
3. **Acknowledge that a fully funded midwifery establishment is in place.**
4. **Acknowledge compliance with 24/7 anaesthetic cover for obstetric services.**
5. **Receive assurance regarding ongoing workforce compliance monitoring through to the CNST declaration deadline of 30 November 2026.**

Training

6. **Acknowledge the CNST Year 8 Declaration Point 1 will be 26th October 2026, and will confirm training compliance exceeds 90% across all required staff groups and training modules.**
7. **Receive assurance that training compliance continues to be monitored and maintained towards the final CNST declaration.**

Learning from Investigations

8. **Acknowledge receipt of the quarterly PQOM Report demonstrating compliance with NHSE investigation requirements.**
9. **Acknowledge receipt of the quarterly Perinatal Incident report demonstrating compliance with CNST Safety Action C.**
10. **Acknowledge receipt of the quarterly PQOM Report demonstrating compliance with CNST Safety Action C.**
11. **Receive assurance that learning, themes and actions arising from perinatal incidents are identified, tracked and monitored through governance arrangements (currently quarterly, Perinatal Incident Reporting, Claims and Incidents).**

Service User Voice and Equity

12. **Acknowledge findings from the Health Inequalities (non-English speaking women) Project Summary report and endorse the associated improvement actions.**
13. **Receive assurance that patient insight, feedback and experience data are captured, triangulated and used to inform service improvement within maternity and neonatal services (CQC annual survey action plan, proposed Patient Experience meetings, MNVP highlight report).**

Care Bundles

14. **Acknowledge progress against Saving Babies' Lives Care Bundle (Version 3.2) implementation and acknowledge the self-assessed compliance status of 91% for Q1.**
15. **Acknowledge progress against the Maternal Care Bundle action plan, noting continued implementation activity and the requirement for Integrated Care Board support to achieve full compliance.**
16. **Acknowledge progress against the Neonatal pulse oximetry testing by the development of a Trust-wide guideline.**

17. Receive assurance regarding continued monitoring of care bundle compliance through to the final CNST declaration.

Board Oversight and Governance

18. Acknowledge receipt of the quarterly PQOM Report, Perinatal Incident Report and CNST Report, confirming alignment with the Perinatal Quality Oversight Model (PQOM).
19. Acknowledge receipt of proposed date of Maternity Outcomes Signal System (MOSS) alert drill and receive assurance that all identified actions will be monitored through governance processes.
20. Acknowledge progress in the Maternity and Neonatal Board Safety Champions forum review and QI work, and the introduction of procedural document and toolkit.
21. Acknowledge that the Perinatal Culture Improvement Plan demonstrating compliance with CNST Safety Action F4 will be submitted in Quarter 2.

Safety Action	Safety Sub-Action	Evidence	Required actions and recorded minutes required from QC																																								
A – Workforce and Capacity	A1 – Consultant attendance (Obstetric workforce)	Commenced – ongoing Obstetric Consultants - >80% consultant presence in defined acute care situations Q1 Consultant presence audit <table><tr><th>Reason for attendance</th><th>No. of instances</th><th>Attendance %</th><th>Comments</th></tr><tr><td>Caesarean birth for major placenta previa / invasive placenta</td><td>0</td><td>100%</td><td></td></tr><tr><td>Caesarean birth for women with BMI>50</td><td>1</td><td>100%</td><td></td></tr><tr><td>Caesarean birth <28/40</td><td>0</td><td>100%</td><td></td></tr><tr><td>Premature twins (<30/40)</td><td>0</td><td>100%</td><td></td></tr><tr><td>4th degree perineal tear repair</td><td>1</td><td>100%</td><td></td></tr><tr><td>Unexpected intrapartum stillbirth</td><td>0</td><td>100%</td><td></td></tr><tr><td>Eclampsia</td><td>0</td><td>100%</td><td></td></tr><tr><td>Maternal collapse e.g. septic shock / MOH</td><td>0</td><td>100%</td><td></td></tr><tr><td>PPH >2L where haemorrhage is continuing and MOH protocol instigated</td><td>2</td><td>100%</td><td></td></tr></table>	Reason for attendance	No. of instances	Attendance %	Comments	Caesarean birth for major placenta previa / invasive placenta	0	100%		Caesarean birth for women with BMI>50	1	100%		Caesarean birth <28/40	0	100%		Premature twins (<30/40)	0	100%		4 th degree perineal tear repair	1	100%		Unexpected intrapartum stillbirth	0	100%		Eclampsia	0	100%		Maternal collapse e.g. septic shock / MOH	0	100%		PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%		QC/Trust board to acknowledge >80% consultant presence in defined acute care situations.
	Reason for attendance	No. of instances	Attendance %	Comments																																							
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PPH >2L where haemorrhage is continuing and MOH protocol instigated	2	100%																																									
	A2 – Short-term locum certification (Obstetric workforce)	Compliant Locum Certification - Ensure Locum certification and maintenance of a local database of all short-term Locums No Short-term Locums during Q1	No Action required – ongoing compliance towards 30 th November																																								
	A3 – Neonatal Workforce Establishment (nursing and medical)	Commenced – ongoing Neonatal workforce (Nursing and medical) – clear plan for fully funded neonatal nursing and medical establishment aligning with BAPM standards and nursing workforce calculator output (2020)	QC/Trust board to acknowledge Nursing (Compliant), Medical (Non-compliant) Plan in place																																								

		• Neonatal Nursing staffing • Medical Neonatal staffing non-compliant. Medical staffing Tier 2 appointments will ensure compliance – Business Case approved at TMB on 1st May 2026. See Appendix 4 for Medical Rota Compliance and Additional Consultant Roles Audit.	
	A4 – Midwifery Workforce Establishment	Compliant <i>Midwifery Workforce establishment - Fully funded midwifery establishment that aligns with Birthrate Plus (BR+) within the last three years</i> Birthrate+ review took place in November 2024 See Appendix 5 for Q1 Midwifery and Neonatal Nurse Safe Staffing Report 26-27	QC/Trust board to acknowledge a fully funded midwifery establishment.
	A5 – Anaesthetic workforce	Compliant <i>Anaesthetic Workforce – ensure obstetric services have duty anaesthetist and assistant available 24/7 in line with ACSA standards</i> Appendix 6 Q1 Obstetric Cover - Anaesthetic workforce rota extract	QC/Trust Board to acknowledge compliance with 24/7 anaesthetic cover for obstetric services.
	A6 – Planned caesarean birth capacity mapping	Commenced – ongoing <i>Planned caesarean birth capacity mapping – Annual demand capacity review showing how planned C/S activity compares with available theatre time, staffing recovery and post-natal ward capacity.</i> Q1 – ELLSCS scheduling QI project underway Complexity scoring under development and prospective audit of ELLSCSs underway Supplementary data review meeting planned for 18th September 2026, awaiting review of regional tool (September 2026 launch)	No Action required – ongoing compliance towards 30 th November
	A7 – Board and governance oversight	Commenced - ongoing <i>A six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams (Due in Q2 CNST MIS year 8 report)</i>	No Action required – ongoing compliance towards 30 th November. Six-monthly report will be presented in Q2.
B – Training	B1 – Obstetric emergency training	Compliant <i>Obstetric emergency training (annual, MDT, local learning, human factors, communication, teamwork, escalation pathways, situation awareness, Obs emergencies including impacted fetal head).</i>	No Action required – ongoing compliance towards 30 th November

	B2 – Neonatal resuscitation	Commenced – ongoing <i>Neonatal Resus annual training required against BAPM Neonatal Airway Safety Standard.</i> Service user insight limited due to absence of WVT MNVP Maternity lead	No Action required – ongoing compliance towards 30 th November
	B3 – Fetal Monitoring training	Compliant <i>Fetal Monitoring annual training (physiological EFM theory annual, MDT, local learning, human factors, communication, teamwork, escalation pathways, situation awareness, SBAR)</i> Service user insight limited due to absence of WVT MNVP Maternity lead	No Action required – ongoing compliance towards 30 th November
	B4 – in situ multi-professional perinatal emergencies simulations	Commenced – ongoing <i>In situ multi-professional perinatal emergencies x 2. One begins in hospital area, other begins in community area. (Where possible including ED, Paramedics)</i> Monthly drills held on acute site. Not yet undertaken in community setting.	No Action required – ongoing compliance towards 30 th November
	B5 – Training compliance oversight	Commenced – ongoing <i>Training Compliance oversight of training compliance quarterly maintaining > or equal to 90%, this must be achieved for every required staff group at TWO points during the MIS year.</i> Locally determined training compliance checkpoint agreed as 26th October 2026. Training compliance features in the PQOM report quarterly (Appendix 1).	QC/Trust board to acknowledge 1 st declaration point 26 th October 2026
C – Learning from reviews and investigations	C1 – Notify all qualifying events	Compliant <i>Notify all qualifying events through NHSE (SPEN) portal to MBRRACE-UK, NHSR EN AND MNSI as soon as possible after death/ diagnosis</i> See Appendix 2 for Perinatal Incident report Q1 26/27	QC/Trust board to acknowledge receipt of Perinatal Incident report that confirm NHSE compliance
	C2 – Seek parents' views of care	Commenced – ongoing <i>Seek parents' views of care (multiple opportunities) during PMRT review</i> Appendix 2 Q1 26-27 Perinatal Incident report PMRT SOP under development – due for October O&G PAGG	QC/Trust board to acknowledge receipt of the PMRT with Action C compliance
	C3 – External multi-disciplinary reviewers	Commenced – ongoing <i>External MDT reviewers for a minimum of 60% of the deaths reviewed and documented with the PMRT tool.</i> Appendix 2 Q1 26-27 Perinatal Incident report PMRT SOP under development – due for October O&G PAGG	QC/Trust board to acknowledge receipt of the PMRT with Action C compliance

	C4 – Provide relevant information	Commenced – ongoing <i>Provide relevant information and access regarding the role of MNSI, NHSR EN scheme and PMRT reviews. Information about duty of candour must be provided for all parents.</i> Screenshot below from Q1 PQOM Report provides an incident summary. Minimum Data Set incident summary: <table><tr><th rowspan="2"></th><th colspan="3">No. of cases</th><th colspan="4">Concern raised</th></tr><tr><th>PMRT</th><th>MNSI</th><th>Moderate</th><th>MNSI</th><th>NHSR</th><th>CQC</th><th>Reg 28</th></tr><tr><td>April</td><td>2</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>May</td><td>1</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>June</td><td>1</td><td>0</td><td>3</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></table> Patient leaflets are not routinely available in alternate languages nor screened for readability. Service user insight limited due to absence of WVT MNVP Maternity lead		No. of cases			Concern raised				PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28	April	2	0	0	0	0	0	0	May	1	1	1	0	0	0	0	June	1	0	3	0	0	0	0	QC/Trust board to acknowledge receipt of the PQOM Report with Action C compliance QC/Trust board to acknowledge Trust wide issue with translated/accessible documents and provide support to address
	No. of cases			Concern raised																																						
	PMRT	MNSI	Moderate	MNSI	NHSR	CQC	Reg 28																																			
April	2	0	0	0	0	0	0																																			
May	1	1	1	0	0	0	0																																			
June	1	0	3	0	0	0	0																																			
	C5 – Offer parents a meeting with relevant specialists	Commenced – ongoing <i>Offer parents a meeting with relevant specialists to share the findings from reviews and investigations and relevant incidents reports</i>	No Action required – ongoing compliance towards 30th November																																							
	C6 – Thematic reports of learning and actions	Commenced – ongoing <i>Thematic reports of learning and actions that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT, PSIRF reviews, MOSS, NHSR claims scorecards. Use of demographic data to identify and understand any disparities in outcomes.</i> See Appendix 2 Q1 Perinatal Incident report, Appendix 8 Claims scorecard Q1 26/27.	QC/Trust board to acknowledge QC/Trust board to acknowledge receipt of Perinatal Incident reports that inform the themes, learning and actions within Perinatal services																																							
D – Service-user voice and equity	D1 – Communication support, equity and accessible information	Commenced – ongoing <i>Communication equity, language support and accessible information - Ensure translation, interpreting support, reasonable adjustments are supported</i> WordSkii and Anakin translation tools are embedded with considerable progress seen in offering and utilising interpreter services. See Appendix 9 Health Inequalities (non-English speaking women) Project Summary report. Patient leaflets are not routinely available in alternate languages nor screened for readability.	QC/Trust board to acknowledge Trust wide issue with translated/accessible documents and provide support to address																																							

		Structured Patient Experience forum to be established September 2026. See Appendix 10 Patient Experience forum - proposed TOR and agenda. Service user insight limited due to absence of WVT MNVP Maternity lead.	
	D2 - Service-user voice driving safety and quality improvement	Commenced - ongoing <i>Service user voice driving safety and quality improvement. Insights from women, families and carers are captured and used to inform service improvement.</i> Absence of MNVP Maternity Lead for WVT. MNVP members are quorate within the Perinatal Safety Champions forum. See Appendix 9 for MNVP Highlights report – July 2026. Structured Patient Experience forum to be established September 2026. See Appendix 10 Patient Experience forum - proposed TOR and agenda. CQC Patient Survey Feb 2025 WVT coproduced Action Plan 2026 under development (Appendix 11).	QC/Trust board to acknowledge constraints with lack of MNVP lead for WVT and agree status/progress
E – Care Bundles	E1 – Saving Babies Lives' Care Bundle (v3.2) - Quarterly reporting to the Trust board	Commenced – ongoing <i>Saving Babies Lives Care Bundle (SBL) – Quarterly reporting to Trust Board on progress against full implementation.</i> Q1 Compliant - Awaiting Q1 review with LMNS (self-assessed compliance level – 91%) See Appendix 12 for Q1 Saving Babies Lives 26-27 Board report and Action plan.	QC/Trust board to acknowledge and agree status/progress with SBL
	E2 – Maternal Care Bundle implementation plan	Commenced – ongoing <i>Maternal Care Bundle (MCB) – Implementation tool. In collaboration with all relevant services, the trust board agrees a plan to implement the bundle by March 27. Progress to be reviewed quarterly.</i> Appendix 13 - MCB Local Action Plan Q1 26-27. National tool has formatting issues, local tool created and utilised until new tool uploaded to futures platform. ICB engagement required to progress.	QC/Trust board to acknowledge MBC action plan ongoing and engagement required from the ICB for full implementation

F – Board oversight, governance, culture and leadership	E3 – Neonatal pulse oximetry testing	Commenced – ongoing <i>A standardised, equitable, and governance approved guideline required to the BAPM framework.</i> Local SOP developed. Due for presentation at September 2026 Neonatal and Maternity PAGG.	QC/Trust board to acknowledge and agree status/progress
	F1 – Board Oversight of Maternity and Neonatal Quality and Safety	Commenced – ongoing <i>Board Oversight of Maternity and Neonatal Quality and Safety. Information received includes a comprehensive assessment of perinatal quality and safety (Training, workforce, staff, service user experience, care bundles). QC findings and scrutiny are formally escalated to the Executive board according to the Perinatal Quality Oversight Model (PQOM).</i>	QC/Trust board to acknowledge receipt of the PQOM report, Perinatal Incident report and CNST report quarterly that aligns with the PQOM.
	F2 – Maternity Outcomes Signal System	Commenced <i>Maternity Outcomes Signal System (MOSS) – trust must send a completed copy to region and national team (drill or real)</i> MOSS signal not yet triggered. Drill planned for Q3 26/27.	QC/Trust board to acknowledge receipt of the proposed MOSS drill date.
	F3 – Maternity and Neonatal Board Safety Champions	Commenced – ongoing <i>Evidence that they are actively supporting the perinatal leadership team (including the MNVP Lead) in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board where any concerns are identified.</i> Safety Champions forum undergoing refresh. Additional front-line champions recruited and supporting documentation under development. Q1 meetings attended by at least one member of the PLT (Perinatal Leadership Team). Awaiting presentation of culture improvement plan (due 22nd July 2026 meeting). See Appendix 14 for Perinatal Safety Champions meeting notes. See Appendix 15 for proposed Perinatal Safety Champions SOP and toolkit.	
	F4 – Perinatal Culture Improvement Plan	Commenced <i>Trusts must demonstrate that they have a perinatal culture improvement plan in place which triangulates data and engagement from multiple sources and is reviewed by the Trust Board at least six-monthly.</i>	To be submitted in Q2.

Executive Director Opinion¹			
The maternity incentive scheme year 8 has seen a significant redesign of the scheme into 6 key domains as described in the report. Progress in Quarter 1 indicates that we are on track to deliver the scheme in line with declaration (due in December 2026). There are no matters for escalation to 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.

19 February 2026

Dear Colleagues,

As we have done in previous years, we are writing to provide advance notice of the forthcoming publication of the Maternity (Perinatal) Incentive Scheme (MIS) Year 8, expected to be published on 31 March 2026, and to support Trusts in preparing for implementation ahead of this.

As the scheme has undergone a substantial refresh this year in line with system priorities and feedback, we are providing this briefing prior to publication so that Trust Boards and perinatal leadership teams have early awareness of the Year 8 direction, themes and structural changes.

As in previous years, the detailed Year 8 Core Standards and Supplementary Guidance will be published on the NHS Resolution website once launched. The [FutureNHS MIS workspace](#) will be refreshed to reflect the updated scheme, and a new audit tool will be available. An online national launch event for all Trusts will take place on 23 April 2026 to share information around the scheme and the support available, and registration details can be found [here](#). We encourage all organisations and those working with the MIS to attend.

This correspondence is intended to provide an overview only. Please do not contact the MIS team with queries ahead of the anticipated full publication on 31 March.

Overview of the MIS Year 8 Development

Year 8 represents a significant shift in how MIS functions. It responds directly to the findings of our MIS evaluation, national inquiries, system feedback, and Trust-level learning from previous years. The refreshed scheme focuses on:

- Greater focus on outcomes, and the assurance of these, rather than processes
- Flexibility for local implementation, recognising that Trusts deliver safe care to meet the needs of their local population in diverse ways
- A single, coherent set of six safety actions, replacing the previous ten, promoting greater join-up via themes and across professions
- Increased Trust flexibility while emphasising Board accountability

This represents a reduction in prescribed process, combined with a greater emphasis on demonstrating the outcomes and improvements that matter most for women, babies and staff.

[Advise / Resolve / Learn](#)

Year 8 provides a bridge between the established MIS model and an approach that is more flexible, proportionate and focused on outcomes. It affords organisations more flexibility and accountability for focusing on the priorities that are specific to their organisation, and which matter most to women and families. This refreshed MIS is underpinned by a set of agreed priorities, developed among the system partners and service user voice representatives on our Collaborative Advisory Group.

The revised standards for Year 8 have been developed and agreed collaboratively with our Collaborative Advisory Group (CAG) which includes NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCOA), College of Operating Department Practitioners (CODP), the Neonatal Clinical Reference Group (CRG), The British Association of Perinatal Medicine (BAPM), the Neonatal Nursing Association (NNA), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI), the Nursing and Midwifery Council (NMC) and a group of service user representatives.

The Year 8 documents have also been shaped through external review with input from a wide range of provider Trusts including midwifery and neonatal leaders, obstetricians, neonatologists, governance and assurance leads, and service user representatives, alongside extensive feedback from regional maternity teams. We are sincerely grateful for the time and insight colleagues have contributed. Their input has helped refine the structure, clarify areas of ambiguity, and ensure the scheme reflects the realities of maternity and neonatal services.

Summary of Key Changes in Year 8

A streamlined set of six Core Safety Actions

The Year 8 Safety Actions have been designed to be clearer, more meaningful and less duplicative. Each follows an **Outcome / Why / What** structure, instead of long lists of technical requirements.

Trusts will have greater freedom to determine **how** the minimum standards are delivered locally, but Boards must be able to demonstrate:

- Assurance of safety outcomes
- Clear linkage between learning, action and improvement
- Effective governance and escalation
- Embedded service user voice
- The capacity, capability and readiness of maternity and neonatal teams

Separate **supplementary guidance** will provide examples of “what good looks like” rather than mandating specific approaches. This reflects practices which might be expected to be already established in high-performing Trusts.

Strengthened expectations for Trust Boards

Year 8 provides much clearer expectations around:

- The Executive Board's role in oversight, scrutiny, and approval of the final MIS declaration
- The relationship between the Quality Governance Committee (or equivalent) and the Trust Board
- The expectation that maternity and neonatal safety is monitored through a consistent governance cycle, aligned with the Perinatal Quality Oversight Model (PQOM)

Boards must be assured not only of compliance, but of the quality, impact and sustainability of local maternity and neonatal safety systems, with all evidence retained.

Updated requirements for cross-professional workforce planning

Year 8 integrates workforce expectations across midwifery, obstetrics, anaesthetics, neonatology, and perioperative teams (including trained anaesthetic assistants). Trusts must demonstrate funded establishments aligned to BR+, neonatal nursing and BAPM standards, alongside annual Caesarean birth capacity mapping and governance oversight of maternity and neonatal interdependencies.

Enhanced training requirements

Training expectations have been strengthened and re-focused to align with the BAPM Neonatal Airway Safety Standard, Avoiding Brain-injury in Childbirth (ABC) implementation preparation, and national MDT learning themes.

Two training compliance checkpoints are required each MIS year:

- **30 November** (mandatory), and
- **one other Trust-selected checkpoint**, declared in advance.

The principles around which staff groups are required to be included in training calculations, and exception rules, have been clarified to ensure equity and consistency across Trusts, including new and rotational staff, and those on long-term leave.

Stronger learning and investigation expectations

Learning from the Perinatal Mortality Review Tool (PMRT), MNSI, Early Notification Scheme (EN), Patient Safety Incident Response Framework (PSIRF), NHS Resolution claims scorecard and Maternity Outcome Signal System (MOSS) is brought together under a single Safety Action, with clearer expectations around:

- Notification timeliness
- External reviewer involvement
- Meaningful engagement of families
- Quarterly thematic learning reports to the Executive Board
- Demonstration of learning-into-action, including equity considerations

This aims to ensure genuine learning impact rather than procedural compliance.

Updated expectations around Service User Voice and Equity

The role of the Maternity & Neonatal Voices Partnership (MNVP) has been a major focus of feedback from providers, regional leaders and ICBs.

Year 8 reflects the reality that:

- MNVP commissioning models vary significantly across the country, and
- MNVP infrastructure does not sit under Trust control or MIS governance.

For this reason, Year 8 does not mandate the presence of a fully commissioned MNVP in order to meet the Safety Action. However, key expectations remain unchanged:

- Trusts must continue to ensure that service user voice is embedded in safety, improvement and decision-making.
- Where an MNVP exists, the MNVP Lead remains the gold-standard partner for independent service user representation.
- Where MNVP capacity is limited or absent, Trusts must take responsibility for ensuring that service user voices - particularly from underserved groups - are captured systematically and influence local priorities and improvement plans.

Trusts will be required to progress local work ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. They must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.

Care Bundles – SBLCB v3.2 and Maternal Care Bundle (MCB)

Trusts must report to Boards quarterly updating on overall progress on SBLCB v3.2 with oversight of all elements, and a focus on progressing locally agreed priorities. They must agree a Board-approved plan to implement the national Maternal Care Bundle in collaboration with all relevant services by March 2027, alongside a governance-approved neonatal pulse oximetry guideline.

Governance changes

Alongside strengthened Board-level oversight, there is now greater clarity on governance arrangements and organisational responsibilities. Trusts will be required to demonstrate that they have implemented the MOSS in accordance with NHSE guidance and can provide evidence to support this.

Key Dates for Trusts

3 March 2026	Final submission date for MIS year 7
31 March 2026	Expected publication of full MIS Year 8 core standards and separate supplemental guidance
23 April 2026	National MIS Year 8 launch event (online) – registration link
2 March 2027	Final submission date for MIS year 8

Year 7 Feedback Survey

To support ongoing refinement of the scheme with a focus on the way that our team support you, we are inviting trusts to complete a short survey on your year 7 MIS experience, including any suggestions, and reflections on the resources available.

Please submit your response using this [MIS Year 7 feedback survey link](#)

We thank you for your continued commitment to improving maternity and neonatal safety. We recognise the significant operational pressures on services, and it is our intention that Year 8 supports Trusts in focusing on the core elements of safe, effective care, informed by learning and supported through clear, proportionate assurance.

PRIVATE: CONFIDENTIAL

We look forward to working with you over the coming months and to engaging with your teams during the national launch event on **23 April 2026**.

The MIS Team

NHS Resolution

Escalation and Assurance Report

Report from: Quality Committee
Date of meeting: 24 September 2026
Report to: Trust Board

Alert: Including assurance items rated red and matters requiring escalation

No matters were identified requiring immediate escalation to the Trust Board.

Advise: Including assurance items rated amber, under monitoring and in development

Item/Topic	Quality Priority - Antimicrobial Stewardship
Rating rationale	IV-to-oral switching and broad-spectrum antibiotic use had not yet shown sustained improvement in the reported data. A new Power BI dashboard, three weekly antimicrobial ward rounds and targeted work in high-use areas provide a stronger basis for action, although data quality and the behavioural change required from prescribers continued to develop.
Outcome	The Committee requested clearer reporting of specific actions, barriers, accountability and impact at the next quarterly update.
Item/Topic	Quality Priority - Seek to Eliminate Corridor Care
Rating rationale	Corridor care reduced by 28% between June and August, including reductions in ED and ward areas. September pressures temporarily reversed some progress during the ITU decant, but the position improved once beds reopened. Ward-led initiatives, discharge improvement, twice-daily huddles and executive walk-rounds are being used to reduce length of stay and secure six additional discharges each day.
Outcome	The Committee welcomed progress but noted that the ambition to eliminate corridor care had not yet been achieved and required sustained multidisciplinary engagement and standardised discharge processes.
Item/Topic	Quality Priority – Electronic Discharge Summaries (EDS): Next Day Discharge Readiness
Rating rationale	The primary object of the project was to increase the number of patients with an EDS earlier in the day. A small-scale pilot in frailty wards was testing earlier identification of patients, advance completion of summaries and pharmacy preparation. Wider medical engagement and benchmarking of length of stay are needed before scaling.
Outcome	The Committee supported the test-of-change approach and encouraged continued multidisciplinary engagement and evaluation before wider rollout.
Item/Topic	Clinical Support Division Report - Pharmacy
Rating rationale	Performance remained strong for dispensing accuracy, ward-level TTOs, medicines reconciliation and discharge medicines referrals. However, the ICS aseptic review generated a 54-action improvement plan; aseptic capacity, respiratory support and constrained pharmacy accommodation remain material risks. External staffing support was being explored and a dispensing robot business was planned for completion in October.
Outcome	The Committee took assurance from the controls and progress and would continue to monitor delivery of the aseptic action plan, workforce capacity and estates mitigations.
Item/Topic	Mortality Report
Rating rationale	Trust-wide SHMI reduced and further improvement was anticipated as SDEC activity entered the rolling dataset. Hip-fracture mortality and clinical indicators improved substantially. Stroke and sepsis SHMI remained elevated, although recent activity and pathway changes were more reassuring and focused improvement work was in place.
Outcome	The Committee welcomed the improving overall and hip-fracture position.
Item/Topic	Maternity and Neonatal 10 point plan
Rating rationale	The report presented the baseline and assurance position for the Trust's Maternity and Neonatal 10 Point Plan, fulfilling national NHS England reporting mandates. The assessment recorded 12 requirements as compliant, nine partially compliant, four non-compliant and one not currently applicable requirement. Principal gaps concerned the implementation of Martha's Rule (in line with the national timetable), inequalities data, the new triage specification and strengthened reporting. Evidence was sufficient for the initial submission, with an action plan and approximately 12 months to address gaps.
Outcome	Acting under delegated authority, the Committee approved the submission. Detailed oversight would transfer to the planned Maternity and Neonatal Oversight Group, with consistent standards across the Foundation Group.

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: 24 September 2026
 Report to: Trust Board

Item/Topic	Maternity CNST Report – Quarter 1
Rating rationale	The Trust was on track against the six Year 8 safety actions, with Saving Babies’ Lives compliance in the mid-90% range. Further work was required on inequalities outcomes, accessible information, interpreter use, service-user voice and the perinatal improvement plan. The Maternity and Neonatal Voices Partnership remained under-resourced.
Outcome	The Committee took assurance on progress and agreed to receive continued oversight through quarterly safety reporting, with the perinatal improvement plan expected in October and final declaration evidence returning in the new year.
Item/Topic	Nurse Staffing Report
Rating rationale	Fill rates and care hours per patient day reduced in August, principally because of increased sickness, although remained within expected ranges. No harm was identified from staffing incidents. Agency use rose, driven particularly by demand for registered mental health nurses supporting children with complex needs. ED and community vacancies remained under review.
Outcome	The Committee was assured that daily and weekly staffing controls were operating and noted the continued monitoring of sickness, temporary staffing and the developing model for mental health support.
Item/Topic	Patient Flow Report
Rating rationale	ED stays over 24 hours and ambulance handovers over 60 minutes continued to reduce, with movement toward the 45-minute standard. Moves involving patients with dementia showed an overall downward trend but remained variable under system pressure. Additional flow leadership and discharge coordination had been introduced. Incidents highlighted the complexity of caring for patients with mental health, capacity, violence and aggression needs.
Outcome	The Committee welcomed the improving flow indicators and encouraged renewed operational focus on minimising avoidable ward moves for patients with dementia.
Item/Topic	Trust Infection Prevention and Control Committee (TIPCC) Summary Report - Performance
Rating rationale	Reported arthroplasty surgical-site infection rates remained above the national rate and required more granular analysis to distinguish deep infection, superficial infection and precautionary antibiotic prescribing. C. difficile infections had increased and a focused review was scheduled. The flu vaccination programme and national fit-mask testing reporting were commencing.
Outcome	The Committee requested clearer infection categorisation.
Item/Topic	Quality Impact Assessment (QIA) Process Assurance Report
Rating rationale	Use of QIAs and requests for advice were increasing, but activity was not consistently visible centrally because changes were approved through multiple routes. The process would be redesigned to be proportionate, streamlined and more reliably auditable.
Outcome	The Committee supported a focused redesign and would receive an update in 6 months.
Item/Topic	Patient Safety Incident Response Panel (PSIRP) Report
Rating rationale	Most reported incidents were low harm. A patient safety incident investigation was declared following a missed triage referral and delay in treatment. Two older investigations were awaiting executive sign-off, and duty-of-candour data required cleansing.
Outcome	The Committee welcomed the clearer report format, noted assurance on the harm profile and requested completion of outstanding sign-off, data cleansing and validation of the benchmarking denominator.

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: 24 September 2026
Report to: Trust Board

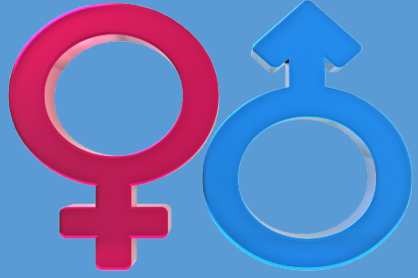
Assure: Including assurance items rated green	
Item/Topic	National Inpatient Survey Results
Rating rationale	The response rate was 47%, above the national average. Eight questions improved significantly and only one was worse than expected. Patients reported positively on cleanliness, care and compassion and communication with doctors. Improvement opportunities centred on meeting individual dietary, religious and language needs, privacy and aspects of discharge; Foundation Group comparisons identified areas for shared learning.
Outcome	The Committee welcomed the positive results. Detailed improvement planning and dissemination would continue through the Patient Experience Committee and divisions.
Item/Topic	Clinical Effectiveness and Audit Committee (CEAC) Summary Report
Summary	The clinical audit programme remained on track, with 99% of projects progressing as planned. Completion of a complex policy and standard operating procedure remained outstanding, including reassignment of the blood transfusion policy following the author’s retirement. The Committee Chair had stepped down on leaving the Trust and a successor was being sought.
Outcome	The Committee noted the report and a planned update on chairing arrangements next month.

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

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board held in Public
Date of Meeting:	1st October 2026
Title of Report:	Gender Pay Gap
Lead Executive Director:	Chief People Officer
Author:	Geoffrey Etule, Chief People Officer
Reporting Route:	People, Culture and Organisational Development Committee
Enclosures included with this report:	n/a
Purpose of report:	☒ Assurance ☐ Approval ☐ Information
Brief Description of Report Purpose	
This report provides information on the Gender Pay Gap for the Trust which is reflective of the national position with women still concentrated in nursing, midwifery, AHP, administrative and support roles, while men are disproportionately represented in medical consultant posts, management and senior technical roles. The Gender Pay Gap continues to close and the Trust is making further progress in reducing the gap by improving our recruitment, retention & career development practices. We are also taking steps to removing barriers to female career progression and their over representation in lower paying roles.	
Recommended Actions required by Board or Committee	
To support progress being made in addressing the Gender Pay Gap, the HR team and the Women's Network will be working on the following actions over the next year: - Work with our staff networks to promote opportunities available for all colleagues to access - Provide training to recruiting managers to ensure awareness of protected characteristics so that bias is reduced - Offer coaching and mentoring opportunities. - Improving recruitment practices through gender diverse recruitment panels and inclusive recruitment practices - Supporting women in senior roles by developing talent management strategies group wide to support women's careers and supporting aspiring women leaders to access opportunities for development and career progression - Improving workplace culture by promoting a zero-tolerance approach to any sexual harassment or discrimination - Providing flexible working options to help female workers who are disproportionately impacted by caregiving responsibilities - Working with staff networks group wide to identify collaborative actions to support more women into leadership positions	
Executive Director Opinion¹	
The Trust continues to make positive progress in addressing the Gender Pay Gap and the actions listed above would ensure that this progress continues over 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.



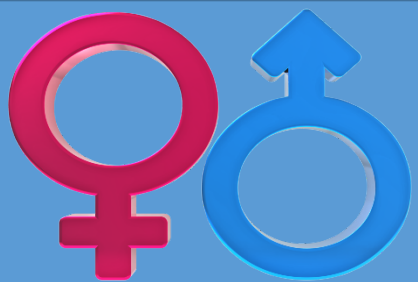
WVT Gender Pay Gap Reporting for 2025/26

(Snapshot date 31.03.26)

A quality of care in our hospital we would
want for ourselves, our families
and our friends.

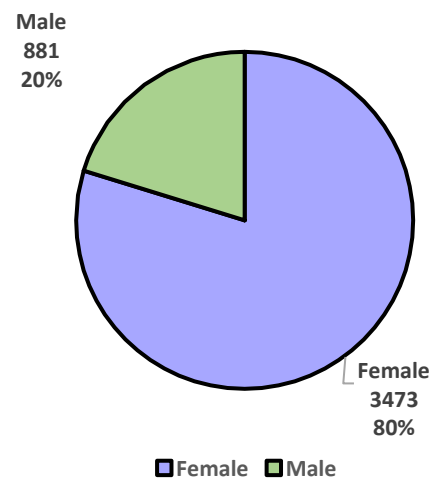


Compassion • Accountability • Respect • Excellence

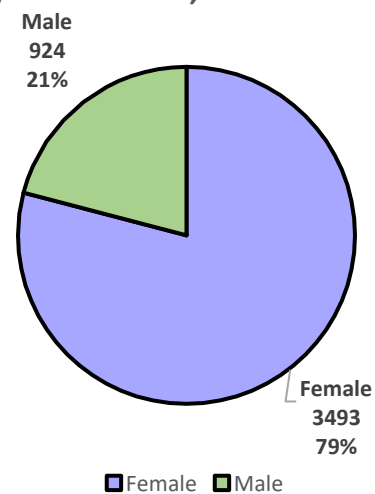


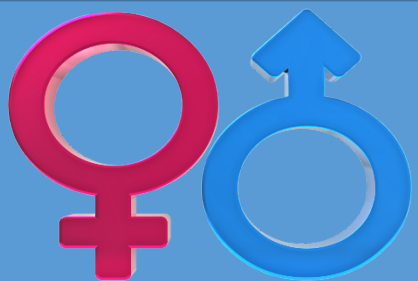
Exploring the Gender Pay Gap

2024/25 - Gender, Headcount and %

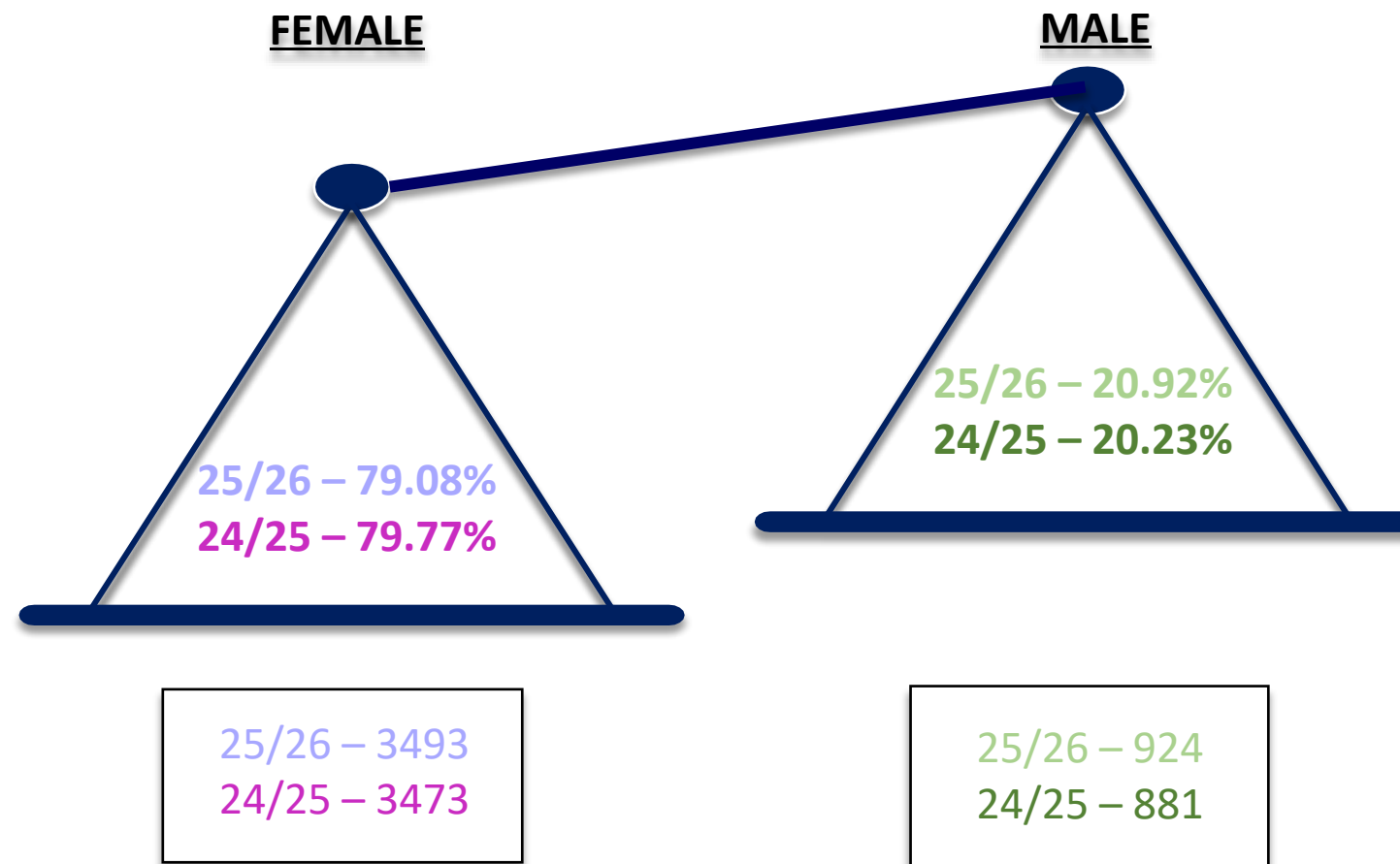


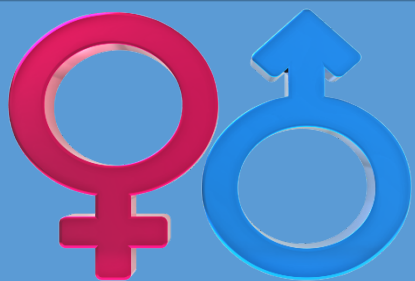
2025/26 - Gender, Headcount and %





Exploring the Gender Pay Gap



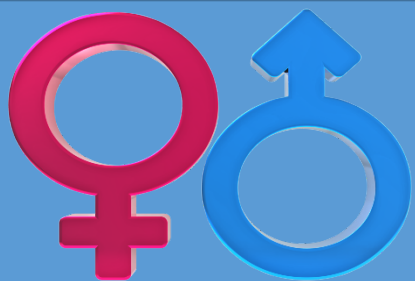


Employees by Pay Quartile

	UPPER QUARTILE		UPPER MIDDLE QUARTILE		LOWER MIDDLE QUARTILE		LOWER QUARTILE	
	F	M	F	M	F	M	F	M
25/26	64.99%	35.01%	84.71%	15.30%	84.16%	15.84%	82.59%	17.41%
24/25	66.48%	33.52%	85.57%	14.43%	82.92%	17.08%	84.10%	15.90%
Increase Decrease	Decrease 1.49%	Increase 1.49%	Decrease 0.86%	Increase 0.87%	Increase 1.24%	Decrease 1.24%	Decrease 1.51%	Increase 1.51%

This shows the proportion of male and female full pay relevant employees (headcount) in four quartile pay bands, which is done by dividing the rates of pay across the workforce into four equal parts. Their hourly rates of pay are sorted lowest to highest, then divided as equally as possible. Comparing results between the quartiles will indicate the distribution of full pay relevant to male and female employees across the Organisation.

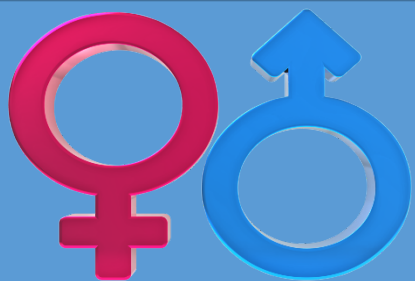




Ordinary Pay

MEAN		MEDIAN	
25/26 Female hourly rate £21.20 24/25 Female hourly rate £20.16	Increase of £1.04	25/26 Female hourly rate £19.44 24/25 Female hourly rate £18.66	Increase of £0.78
25/26 Male hourly rate £29.38 24/25 Male hourly rate £27.92	Increase of £1.47	25/26 Male hourly rate £23.17 24/25 Male hourly rate £21.56	Increase of £1.60
25/26 Pay Gap 27.83% 24/25 Pay Gap 27.78%	Increase of 0.05%	25/26 Pay Gap 16.10% 24/25 Pay Gap 13.47%	Increase of 2.63%

The Workforce within the Wye Valley Trust is reflecting that both females and males are attracting increased hourly rates of pay, however, the rate of increase is greater with males than females from a median perspective, therefore overall, there is an increase in pay gap from last year. From a mean perspective, there is only a slight increase in pay gap from last year. Year on year Wye Valley are looking to progress in reducing the pay gap.



Bonus Pay

QUALIFYING	Qualifying for a bonus payment		
	24/25 = 127	25/26 = 34	Decrease of 93
MALE	No of men qualifying for a bonus payment		
	24/25 = 85	25/26 = 22	Decrease of 63
FEMALE	No of women qualifying for a bonus payment		
	24/25 = 42	25/26 = 12	Decrease of 30
MEAN	Difference between the average hourly earnings		
	24/25 = 0.9%	25/26 = 4.13%	Increase of 3.20%

Bonus Pay includes anything that relates to profit sharing, productivity, performance, incentive and commission received in the form of cash or vouchers. Clinical Excellence Awards and Discretionary Points identified as bonuses for NHS staff are awarded to staff in the medical workforce, which are predominantly male.

WYE VALLEY NHS TRUST REPORT COVERSHEET

Report to:	Trust Board Held in Public
Date of Meeting:	1 October 2026
Title of Report:	Board Assurance Framework and Risk Report
Lead Executive Director:	Managing Director
Author:	Gweny Scott, Associate Director of Corporate Governance / Company Secretary
Reporting Route:	Audit Committee and Executive Risk Management Committee
Enclosures included with this report:	Board Assurance Framework (including Trust Very High risk report)
Purpose of report:	☒ Assurance ☒ Approval ☐ Information
Brief Description of Report Purpose	
The Board Assurance Framework provides a structure and process that enables the Board to focus on the risks that might compromise achievement of the Trust's strategic objectives. It includes the key controls in place to manages these risks and assurance as to the effectiveness of the controls. The attached Board Assurance Framework (BAF) document comprises: • BAF Header providing headline information about each BAF risk • Heat Map showing the current overall degree of strategic risk • Current Board Risk Appetite Statement • Trust strategic objectives • Trust Very High risks (linked to BAF risks) • Separate summaries of each BAF risk Updates to each BAF risk (shown in red) reflect information received by the Board and/or its Committees since the last report in July. Each risk shows progress but no significant changes are proposed. The High Risk report demonstrates active risk management, with four risks reported in July now with reduced scores, which will therefore be removed from the next report.	
Recommended Actions required by Board	
The Board is asked to note and accept the BAF updates.	
Executive Director Opinion¹	
The BAF risks have been reviewed by the individual executive risk owners.	

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

Board Assurance Framework

2026/27

October 2026 Update

Board Assurance Framework Headlines September 2026

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

Likelihood

	1	2	3	4	5
5	Yellow	Orange	Red	Red (6)	Red
4	Yellow	Orange	Orange (4)	Red (7, 8, 2, 3, 5)	Red
3	Green	Yellow	Orange	Orange	Red
2	Green	Yellow	Yellow	Orange	Orange
1	Green	Green	Green	Yellow	Yellow

Consequence

RISK APPETITE LEVEL	D. NONE - Avoid Avoidance of risk and uncertainty is a key system objective	L. LOW/MINIMAL "As low as reasonably practicable" (ALARP) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2. MODERATE - Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3. HIGH - Open Willing to consider all potential delivery options and accept a degree of inherent risk while also providing an acceptable level of reward (and VFM)	4. SIGNIFICANT - Seek Going to be innovative and to choose options that have potentially higher business rewards (despite greater inherent risks)	5. SIGNIFICANT - Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
RISK TYPES						
FINANCE <i>How will we use our resources?</i>	Avoidance of financial loss is a key objective. We have no appetite for financial loss. We are only willing to accept the low-cost option as VFM is the primary concern. Tight controls in place with limited deviation decision taking authority.	We are only prepared to accept the possibility of very limited financial risk - VFM is the primary concern. Strong central control with limited deviation decision taking authority.	We are prepared to accept possibility of some limited financial risk. VFM is the primary concern but willing to consider other benefits or constraints. Resources are generally restricted to existing commitments. Strong central control is the default but central control of decisions is accepted.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not being the overarching factor. Resources are allocated in order to capitalise on opportunities. We carefully balance central control with devolution of decisions.	We will invest for the best possible return and accept the possibility of increased financial risk. Resources allocated without firm guarantee of returns. We intend to devolve decisions to lower levels of inherent risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. Our default is to devolve decisions where possible, only keeping central control for decisions with the highest levels of inherent risk.
REGULATION <i>How will we be perceived by our regulators?</i>	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of some limited regulatory challenges. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some more regulatory challenges as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to accept decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulators where we see a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
PEOPLE <i>How will we develop our people?</i>	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to accept some risks with regards to our workforce, where attempting to understand how the problem presented, where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk as a direct result from innovation or as long as there is the potential for improved recruitment and retention and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have impact on our people but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but is worthwhile due to long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive but that it is a catalyst to drive a positive change.
QUALITY <i>How will we deliver safer services?</i>	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely necessary.	Our preference is for risk avoidance. However if necessary, we will take decisions on quality where there is a low degree of inherent risks and possibility of improved outcomes and appropriate controls are in place.	We are prepared to accept the possibility of some impact on quality outcomes with potential for longer-term rewards.	We are willing to take decisions on quality where there may be higher inherent risks but potential for significant longer-term gains.	We seek to take high risk decisions on quality in pursuit of significant gains and mitigation to our other risks.
REPUTATION <i>How will we be perceived by the public and our partners?</i>	We have no appetite for any decisions that could lead to any negative or significant reputational damage to the organisation. External interest in the organisation viewed with concern.	Our appetite for risk taking limited to those events where there is no potential for any significant reputational damage to the organisation. Senior management distance themselves from chance of exposure to attention.	We are prepared to accept the possibility of limited reputational risk as long as appropriate controls are in place to limit the risk.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation where there is the potential for improved outcomes for stakeholders. New ideas seen as potentially enhancing reputation of the organisation.	We are comfortable to take decisions that may expose the organisation to scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
INNOVATION <i>How progressive and innovative do we want to be?</i>	Defensive approach to objectives – aim to create or protect, rather than to create or innovate. General avoidance of systems / technology developments.	Innovations always avoided unless essential or established and proved to be effective in a variety of settings	Tendency to stick to the status quo, innovations in practice generally avoided unless necessary. Systems / technology developments limited to improvements to protection of current operations & practice.	Innovation supported, with demonstration of commensurate improvements in management. Systems / technology developments used routinely to enable operational delivery.	Innovation pursued – desire to 'break the mould' and challenge current ways of working. New technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently breaking the mould and challenging current ways of working practices. Investment in new technologies as catalyst for operational delivery.

Approved April 2026

Trust Strategy from April 2026



WHO WE ARE
Wye Valley is proud to offer compassionate hospital and community services, helping people live healthier lives. As an ambitious trust covering a wide geographical area, we are committed to delivering the best joined-up care in partnership with others.

WHY WE EXIST
OUR PURPOSE
To improve the wellbeing, independence and health of the people we serve.

WHAT WE DO EVERY DAY
OUR MISSION
We give everyone the quality of care we would want for ourselves, our families and friends.

WHERE WE WANT TO GET TO
OUR VISION
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.

Being a supportive employer

- Attracting and retaining great talent
- Developing and valuing people
- Promoting health and wellbeing
- Nurturing our caring, inclusive culture

Innovating to improve care

- Connecting patient records
- Maximising the benefits from our digital tools
- Putting data insight and research at the heart of change
- Adopting smarter, more efficient technologies

Strengthening our services

- Reforming urgent & emergency care
- Streamlining referral pathways with general practice
- Transforming outpatient services
- Improving surgery waiting times

Treating people in the right place

- Enhancing our community and prevention services with partners
- Optimising the role of community hospitals
- Collaborating on fragile pathways
- Co-ordinating out-of-county pathways

Delivering on our responsibilities

- Being an effective host for our One Herefordshire partnership
- Spending wisely within our means
- Transitioning our PFI services smoothly
- Contributing to a more sustainable Herefordshire

Trust Strategic Objectives 2026/27

Being a supportive employer

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

Innovating to improve care

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

Strengthening our services

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

Treating people in the right place

- Implement the Neighbourhood Health programme with our partners
- Develop a plan for the future of community hospital beds

Ensuring a sustainable future

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

All Trust 'Very High' Risks (score 15+)

Risk #	Division	Current score	Risk	ERCC Review – July & September 2026	Aged risk (over 2 years)	Link to BAF
2160	Clinical Support	10	PACS functionality	Mitigations have been implemented and the score reduced from 15 to 10.	n/a	n/a
2211	Clinical Support	20	Aseptic services demand and capacity	Additional staffing through the partner SLA is close to approval; recruitment is expected to improve capacity and enable the risk to reduce or close.	No	BAF04
2227	Clinical Support	15	Ageing BacT/ALERT machine	Replacement equipment has been agreed; closure is expected once final approval and an implementation date are confirmed.	No	n/a
33	Corporate	20	Temporary Escalation Spaces	Actions to reduce corridor care are progressing and recent improvement has been seen, although bed pressures continue; the score remains 20 and the risk narrative will be refreshed.	Yes	BAF02
1070	Corporate	15	Ligature hazards	The revised policy and routine area reviews support ongoing mitigation; the score remains unchanged pending completion of the programme.	Yes	n/a
1704	Corporate	20	Financial plan	Delivery of the financial improvement plan remains closely managed; the mid-year review and forecasting exercise will test the position and inform the next risk review.	Yes	BAF03
1803	Corporate	15	Equipment maintenance backlog	The backlog will be reviewed by the Medical Equipment Committee; workforce constraints remain, but a reduction in score is anticipated following the review.	Yes	n/a
2190	Corporate	20	Tracking and monitoring of RTT waiting list	A workaround remains in place pending the scheduled system patch on 28 September; the score will be reviewed after implementation.	No	BAF02
2261	Corporate	15	Replacement of defibrillators	A phased replacement plan is progressing and provision is being considered through next year's medical equipment programme; affordability is being worked through.	No	n/a
789	Medical	20	Long stays in ED	The risk remains 20. Multiple urgent and emergency care and flow improvement programmes continue under established oversight.	Yes	BAF02
1288	Medical	15	Letter typing backlog	Delays are broadly stable at around three weeks for most specialties. Priority areas are supported through cross-cover, temporary staffing and recruitment, with regular F&PE monitoring.	Yes	n/a
2077	Medical	16	Resuscitation space in ED	The risk is linked to ED crowding. A safety assessment tool to support timely step-down from resuscitation is being taken through divisional governance.	No	BAF02
2185	Surgical	16	Psychiatric medication use in community paediatrics	All affected children have been individually reviewed and alternative pathways used where appropriate; specialist ICB psychiatry input is awaited for the remaining five, with escalation maintained.	No	n/a
2204	Surgical	16	Glaucoma waiting times	Waiting-list improvement has been sustained, but a backlog remains and two recent resignations may affect capacity; mitigations and the score are being reviewed.	No	BAF02/04
2228	Surgical	15	Diabetic foot service	A clinically approved pathway is in place and a cross-specialty review is being convened to address implementation and current clinical cover.	No	BAF04
687	Surgical	16	Lack of Health Psychology for children	This remains an accepted risk, with mitigations in place and previous escalation to the ICB; there is no change.	No	n/a
2245	Surgical	16	Recruitment challenges and lack of clinical staff resilience in the corneal service	Earlier recruitment progress is being reassessed following two recent ophthalmology resignations; alternative mitigations and the score are under review.	No	BAF04
2283	Corporate	20	Failure to achieve PFI asset handback in contractual condition	The PFI handback position is subject to established committee and dispute-avoidance oversight; a revised lifecycle plan is due in mid-October, after which the risk will be reassessed.	No	BAF07
2267	Clinical Support	25	The laboratory information management system (APEX) support will be withdrawn in May 2028.	Procurement is progressing through a joint specification with a partner trust, supported by a project manager and weekly oversight. The May 2028 extension provides time, but delivery remains tight; the Committee agreed the score of 25 was too high and would be reassessed.	No	n/a
1873	Clinical Support	8	Inappropriate use of Endoscopy recovery for inpatients due to UEC pressures	The control has remained effective despite recent system pressure. The score has reduced from 16 to 8 and the risk will be removed from this report.	n/a	BAF02
2027	Clinical Support	15	Loss of JAG accreditation for Endoscopy	The accreditation midpoint review was positive; the final JAG review is expected in November, with closure anticipated if accreditation is confirmed.	No	n/a
2243	Clinical Support	15	Lack of substantive clinical lead for laboratory haematology and blood transfusion	Interim consultant cover is in place and a substantive local clinical lead has been identified; the risk will close once the job-plan arrangement is agreed.	No	n/a
2334	Integrated Care Division	16	Removal of Hub GP in line with new UAPC Contract	Service provision is being maintained as a cost pressure. Following divisional review, the risk will be reworded to reflect the residual financial exposure, with ICB discussions continuing.	No	BAF03
2229	Medical	15	Secondary care management of difficult and severe asthma including biologic provision	Temporary specialist resource provides mitigation. The score remains 15 pending review of how long that cover will continue.	No	BAF04
2257	Medical	20	Lack of modified respiratory support unit (RSU) providing high flow nasal oxygen (HFNO) in a ward setting delivering 100% oxygen to patients in multiorgan failure	The score remains 20. Required works and the revised business case are being progressed through divisional review and Trust Management Board oversight.	No	n/a
2277	Medical	12	Aged estate in Cath Lab	Estate works and existing mitigations have enabled the score to reduce from 15 to 12.	No	n/a
2329	Medical	12	Inpatient discharge delays	The score has reduced from 15 to 12.	No	BAF02
115	Surgical	15	Inadequate AHP support to critical care	The level of AHP input is unchanged; the longer-term solution remains part of the wider therapies and critical-care standards review.	No	n/a
320	Medical	16	Compliance with care quality indicators due to inefficient flow of patients into specialty beds	The risk remains 16. A multifactor recovery programme is addressing flow, time to assessment and non-admitted performance, with oversight through F&PE and Trust improvement governance.	Yes	BAF02
2287	Corporate	16	Commercial/legal disputes during PFI Expiry Project	The PFI commercial position is being managed through the formal dispute-avoidance process; the revised lifecycle plan is due in mid-October and the score will then be reviewed.	No	BAF07

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

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

Risk	Cause	Result
The Trust does not achieve and sustain the required improvement in urgent and emergency care access and patient flow.	- Sustained growth in urgent and emergency demand, including higher acuity. - Variation in patient navigation, specialty response, ward-based flow and discharge processes. - Capacity constraints across acute, community, diagnostic and virtual services. - Delays within Trust processes and dependencies on system partners, including discharge pathways and Powys arrangements. - Low assurance on UEC schemes within Powys to mitigate admission avoidance within their community services. - Significant issues with Powys length of stay with no current sustainable plan to resolve.	- Prolonged waits in the Emergency Department, ambulance handover delays and use of escalation areas. - Increased risk to patient safety, experience, dignity and clinical outcomes. - Reduced acute capacity, delayed elective care and continued pressure on staff and services. - Failure to meet agreed access standards and improvement trajectories. - Loss of confidence and increased regulatory or system intervention.

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

Current Controls and Mitigations	
1. Single Point of Access/Community Referral Hub	2. Virtual Ward service
3. Urgent Community Response service	4. Discharge2Assess Service
5. Primary care interface	6. Falls Service
7. UEC improvement initiatives	8. Partnership with West Midlands Ambulance
9. Dedicated resource for Big Moves Transformation Programme in place for 2026/27	10. Criteria to Admit to acute care approach and Criteria Led Discharge
11. Monitoring of live patient flow data	12. New Community Diagnostic Centre (accredited by GIRFT)
13. Improvement Board overseeing Urgent and Emergency Care Programme (UECP).	

Gaps in Control	Related Actions	Lead	Due Date	Progress
Continued high demand for UEC.	Implement UEC Programme	COO	April 27	Programme progressed well between July and September, with the following workstreams all on track: national guidance, SDEC and Acute Surgical Unit and surgical ward based flow but patient navigation and CDC pathways encountering challenges.
	Implement Transformation Big Moves Programme workstream: Admission Avoidance & Early Supported Discharge	CPSO	April 2027	September 2026: 24/7 Community Referral Hub approved; Virtual Ward capacity increased, with utilisation and data quality under review; fast-track discharge test commencing in October.

Industrial Action	Implement well-established response for each period of industrial action	COO	Mar 27	November and December 2025 actions were well managed with limited impact on delivery of services. No industrial action currently planned (Sept 26).
UEC management with Powys	Work with Powys partners to strengthen admission avoidance	COO	Mar 27	In progress
	Work with Powys partners to expedite discharges.	COO	Mar 27	In progress
Sufficient capacity to deliver all workstreams of Big Moves Programme	Appoint additional resource	COO	Sept 26	Transformation and improvement resources have been realigned to the four Big Moves. Additional support for medical ward-based flow is being deployed.

Key Performance/Assurance Indicators	Date Reported	Performance	Change
% of people seen, treated or admitted within 4-hours in ED	September 26	Aug 26: 65.5%. Improved since January (65.2%) but deteriorated since July (69.3%)	↓
% of patients waiting over 12-hours in ED	June 26	April 26: 9.8%. Improved since Jan 26 (10.4%)	↑
% Ambulance handover times under 45mins	September 26	August 26: 76.3%. Improvement since June (62.9%) but deterioration since July (78%)	↓

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation	Sept 26	Segment 3 (quarter 1)	Segment 3 (quarter 4)	↔
Internal Audit: Community Services	Dec 25	Reasonable assurance	n/a	n/a
Provider Capability Assessment Rating	Feb 26	Amber/green	n/a	n/a

Summary Update:
Governance and improvement capacity have strengthened through the Improvement Board and Big Moves programme. Progress includes ward-based improvements, better flow information and approval of the 24/7 Community Referral Hub.

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

Date	September 2026
Risk Headline	Financial plan delivery
Risk owner	Chief Finance Officer

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

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

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

Gaps in Control	Related Actions	Lead	Due Date	Progress
Operational pressures challenging delivery of CPIP	See BAF02			
Continued use of temporary nursing staff in some areas	Implement Nursing Agency Reduction Plan (NARP)	CNO	March 27	September 2026: Nursing expenditure remains favourable YTD; however, Month 5 CPIP was behind plan and bank and agency usage increased. Weekly scrutiny, tighter agency approval and targeted recruitment actions continue.
Continued use of temporary medical staff	Implement Medical Agency Reduction Plan (MARP)	CMO	March 27	September 2026: delivery is favourable and forecast to outperform plan, supported by substantive recruitment and reduced agency expenditure. However, Month 5 medical staffing costs were adverse, driven mainly by increased bank usage.
Fully developed CPIPs to meet target	Develop fully deliverable plans to meet CPIP target.	CFO	March 27	September 2026: 70% of schemes are fully developed or implemented. Delivery is behind plan and around 1/4 of the programme remains high risk.
No agreed mechanism to resolve the disputed Welsh parity income assumption	Escalate to NHSE to seek resolution and mitigation.	CFO	March 27	September 2026: The £8m income assumption remains disputed. Contract assumptions are under review and partial mitigation is being scoped.

Key Assurance Indicators	Date Reported	Performance	Change
Income and Expenditure YTD	September 26	At month 5, the £3.0m deficit is £0.267m behind plan.	↓
Nursing Agency Reduction Plan (NARP)	September 26	At month 5, nursing expenditure is £0.163m favourable YTD, but CPIP is £0.012m behind plan in month.	↓
Medical Agency Reduction Plan (MARP)	September 26	At month 5, CPIP remains favourable, but medical staffing costs are £0.148m adverse in month.	↔
CPIP delivery YTD	September 26	At month 5, £6.6m has been delivered against a £7.5m target; recurrent delivery is £1.9m behind plan.	↓

Forecast financial outturn	September 26	Forecast remains break-even but high risk	↔
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Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
NHS Oversight Framework Segmentation	Jun 26	Segment 3 (quarter 4)	Segment 3 (quarter 3)	↔
Internal Audit: Key Financial Controls	June 26	Partial assurance	Reasonable assurance (2024/2025)	↓
External Audit Value for Money Assessment	2025/26	2 financial sustainability significant weaknesses, no governance weakness	2 financial sustainability significant weaknesses + 1 governance weakness (24/25)	↑
Provider Capability Rating	Feb 26	Amber-green (2025/26)	n/a	n/a
Internal Audit: CPIP programme	Mar 27	TBC	n/a	n/a
Internal Audit: Key Financial Controls	Dec 26	TBC	Partial assurance (2025/26)	TBC

Summary Update:
The Financial Recovery Board continues to oversee a materially challenged financial position. Performance remains behind plan, with delivery dependent on accelerating sustainable efficiencies and managing workforce and income pressures. While agency expenditure and scheme development provide some assurance, recurrent savings remain below plan and the forecast outturn is high risk, including the unresolved Welsh parity income issue. Mitigations include strengthened forecasting, enhanced oversight and controls, and accelerated transformation. The current risk score remains appropriate.

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

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

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

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

Current Controls and Mitigations	
1. Strengthened sickness absence management policy	2. Occupational health service
3. Freedom to Speak Up Guardian	4. Staff wellbeing support and initiatives
5. Targeted recruitment and retention arrangements, including centralised clinical support worker recruitment, recruitment events, DWP and Youth Jobs Grant partnership, pastoral support, apprenticeships, flexible working and review of starter and exit intelligence	6. Inclusion programme
7. E-roster in all nursing areas	8. Electronic job planning and oversight by Job Planning Committee
9. Staff networks	10. Winter vaccine programme
11. Strengthened sickness absence management	12. Medical and nursing agency reduction programmes
13. Workforce optimisation and productivity arrangements, including vacancy controls and workforce movement tracking	14. Clinical support worker (CSW) turnover is consistently above target

Gaps in Control	Related Actions	Lead	Due Date	Progress
E-Roster not in use in all areas	Implement E-Roster across Trust	CPO	Oct 26	Resources and plans for wider roll-out are under review; due date to be revised
Electronic job planning not fully implemented	Implement electronic job plans for all medical staff	CPO	March 27	Compliance in June 2026 was 89% signed-off job plans. Job planning induction training is in development.
Continued reliance on agency staff to fill gaps	Implement medical and nursing agency reduction plans	CMO/CNO	Mar 27	At Month 5, agency spend was under YTD budget, but bank usage was above plan. See BAF03

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Staff sickness absence rate at 4% or lower	August 2026	4.4% - improved but above target.	↓
Staff turnover below 10%	August 2026	7.8% overall but CSW turnover 15.12%.	↓
Workforce vacancies	August 2026	125.92 WTE vacancies – reduced	↓
100% compliance with e-job plans	June 26	89% (82% in December 25)	↑
Temporary staffing usage	August 2026	Agency spend below but bank spend above budget	↔
Workforce capability: appraisal rates	August 2026	73% -below target	↔
Workforce capability: mandatory training	August 2026	88.9% - above target	↔

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
National Staff Survey: we are safe and healthy	Mar 26	25/26: 6.21 (above average)	24/25: 6.20 (above average)	↑
National Staff Survey: staff engagement	Mar 26	25/26: 7.07 (above average)	24/25: 7.03 (above average)	↑
National Staff Survey: morale	Mar 26	25/26: 6.13 (above average)	24/25: 6.08 (above average)	↑
Internal Audit: Medical and surgical junior doctor rotas management	2024/25	Partial assurance	n/a	n/a
Internal Audit: Medical job planning	Mar 26	Reasonable assurance	Partial assurance	↑
Internal Audit: Health Rostering	Jun 24	Reasonable assurance	n/a	n/a

Summary Update:
Workforce assurance is mixed but improving. Sickness, turnover and vacancies have reduced, supported by targeted recruitment, retention and wellbeing controls. Residual risks remain in clinical support worker turnover, medical vacancies, bank usage, appraisal compliance and incomplete e-rostering and job planning. Independent assurance is broadly positive, but sustained improvement in workforce affordability, deployment and productivity is required; the current risk score remains appropriate.

Board Assurance Framework Risk Summary	
Risk Reference	BAF05
Strategic Pillar	Innovating to improve care

Date	September 2026
Risk Headline	Digital Strategy
Risk owner	Chief Finance Officer

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

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

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

Gaps in Control	Related Actions	Lead	Due Date	Progress
AI implementation plan	Ambient AI procurement	CFO	2028	The procurement process has commenced based on the pilot outcome
Current EPR system contract coming to an end	Implement Future EPR project	CFO	2028	Tender anticipated to launch summer 26
New patient portal required	Procure new patient portal	CFO	2027	A 3-month gap in service is anticipated
Benefits realisation arrangements are not yet fully established	Establish a benefits function to identify opportunities, inform investment decisions and measure delivery	CFO	TBC	In progress

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Delivery against the WVT digital roadmap and agreed programme milestones	Aug 26	Microsoft 365 project completed successfully. Funding allocated for Windows upgrade	↑
Benefits realised from completed WVT digital projects	Not yet available		

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

Summary Update:
The Board has reviewed the developing WVT Digital Strategy and a broad programme of activity is supporting clinical pathways, patient engagement, productivity and operational flow. The risk remains high because of the scale and interdependency of concurrent programmes, the resources required to deliver and embed change, and the need to demonstrate measurable benefits and sustained adoption.

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

Date	September 2026
Risk Headline	Cyber security
Risk owner	Chief Finance Officer

Risk	Cause	Result
Risk of a successful cyber-attack or significant technology failure preventing the Trust’s corporate and clinical services from operating safely.	- Increasing frequency and sophistication of attacks on internal systems and external services holding critical Trust data. - Large and diverse user base, including privileged users, increasing the attack surface and risk of credential compromise. - Reliance on third-party suppliers, shared services and remote connectivity, reducing direct control over resilience. - Increasing dependence on digital systems, including legacy infrastructure, for clinical care and operational processes.	- Disruption to clinical services and patient pathways, including delayed or unavailable records and systems. - Patient safety incidents and disruption to corporate support services. - Data breach, loss or corruption of data. - Financial, regulatory and reputational consequences, including high recovery costs and loss of public trust.

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

Current Controls and Mitigations	
1. IT partner cyber security arrangements in place and overseen by partnership board (with Trust representation)	2. Mandatory information governance training for all Trust staff and cyber-security training for Board
3. Technical controls include network segmentation, endpoint protection and access controls, supported by specialist cyber-security expertise.	4. Business-continuity planning and testing, including annual cyber scenario/table-top exercises.
5. Annual penetration testing	6. Information Asset Register
7. Annual table-top exercise	8. Monitoring of and response to national alerts
9. Business Continuity Plan for IT Services	10. Dual data centre architecture provides resilience in the event of attack/failure of one centre.
11. Counter fraud training and awareness raising including cyber	12. Independent annual review, with agreed management actions monitored through the Audit Committee and Information Governance routes.

Gaps in Control	Related Actions	Lead	Due Date	Progress
Further improvement is required against CAF and DSPT priority areas.	Implement recommendations of Internal Auditor 2024/25.	CFO	Oct 25	Complete – recommendations delivered and action closed.
	Implement the 2025/26 Internal Audit recommendations.	CFO	2026/27	New recommendations agreed; delivery will be monitored through established governance routes.

Key Performance/Assurance Indicators	Date Reported	Performance	Change
Malware protection – servers	June 2026	100%	↔
Malware protection – endpoints	June 2026	99.99%	↔
Data security mandatory training	May 2026	89.65%	↓

Independent Assurance	Date	Rating/Outcome	Previous rating (date)	Change
Cyber Assessment Framework (including follow-up)	June 2026	Risk rating: Medium Confidence level: High	Risk rating: very high Confidence rating: low (June 25)	↑

Summary Update:
Oversight and controls are established. Improvement actions continue through established governance routes. The external threat remains significant.

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

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

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

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

Current Controls and Mitigations	
1. PFI expiry governance structure aligned with national guidance	2. Dedicated project management resource
3. Periodic Expiry Health Checks by National Infrastructure & Service Transformation Authority (NISTA)	4. Joint Expiry Working Group (with PFI partners)
5. Lifecycle Progress Committee oversees asset maintenance needs	6. Representative from IPA engaged with PFI Expiry Committee
7. Separate and distinct governance structure for operational estate/PFI contract management	8. Joint working with Worcestershire Acute Hospitals NHS Trust to share support and learning on PFI expiry process
9. Project team participation in NISTA training	10. Two defined programme workstreams supported by a Project Execution Plan
11. Revised asset governance	12. Legal and commercial escalation

Gaps in Control	Related Actions	Lead	Due Date	Progress
Plan for future FM Service	Complete the staged business-case, due-diligence and mobilisation requirements for the future FM model	CSPO	March 29	OBC approved by Board September 2026
Completion of NISTA Health Check action plan	Implement all actions	CSPO	June Dec 26	Health check action plan now in progress
Implementation of condition survey recommendations	Agree and deliver prioritised asset condition compliance works	CSPO	March 29	Priority findings are being progressed. Completion remains dependent on validated evidence and incorporation of remaining findings into delivery plans.
Implementation of asset management compliance assessment recommendations	Agree and deliver prioritised asset management compliance works	CSPO	Dec 27	Priority compliance actions are being progressed through the revised asset governance structure. Assurance will strengthen as evidence is validated and findings are formally closed.
A costed programme resource plan for the final phase, including specialist commercial, legal, finance, workforce, operational,	Develop a programme resource plan for final phase	CSPO	Dec 26	Existing programme resources are in place. Further requirements for business-case development and mobilisation are being assessed.

estates and programme capability.				
Enhance governance and assurance around Assets	Implement revised governance structure	CSPO	Aug 26	Complete and moved to controls

Key Performance/Assurance Indicators	Date Reported	Performance
Programme milestones and gateways delivered to plan	Aug 26	Programme governance is established and key milestones are being monitored. Some delivery dependencies remain under active management.

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

Summary Update:
The risk will not reduce until evidence demonstrates compliant hand back and future FM operational readiness are improving.

Board Assurance Framework Risk Summary		Date	September 2026
Risk Reference	BAF08	Risk Headline	Partnerships
Strategic objectives and priorities	- Improve urgent and emergency care pathway, increasing our capacity and navigating away from ED - Implement the Neighbourhood Health programme with our partners - Develop a plan for the future of community hospital beds	Risk owner	Managing Director

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

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

Current Controls and Mitigations	
1. Strengthened One Herefordshire Partnership governance arrangements	2. Board oversight via new Integrated Care Oversight and Assurance Committee
3. Regular engagement with Powys Health Board to support improved discharge and reduced urgent care need.	4. Agreements in place with West Midlands Ambulance Service.
5. One Herefordshire Health and Care Partnership Alliance Agreement	6. Strengthened governance arrangements for Discharge to Assess (D2A) and Enhanced Health in Care Homes
7. Neighbourhood Health Delivery Board in place	8. Transformation Big Moves Programme
9. Improvement Board in place, to report to Trust Board	10. Alliance Agreement in place

Gaps in Control	Related Actions	Lead	Due Date	Progress
Limited control of Powys UEC flow and discharge	See BAF03 Financial delivery	-	-	-
LICU capacity unavailable despite ongoing contractual commitment	Develop and agree an alternative winter capacity proposal, including funding and value-for-money implications.	MD	Oct 26	TBC
Virtual ward bed model misaligned with demand profile	Reconfigure virtual bed allocation	MD	March 2027	Frailty model pilot in progress.
System capacity constraints for delivery of Neighbourhood Health programme	Implement Big Moves Transformation Programme with designated resource. The programme includes a number of workstreams aligned to the Neighbourhood Health Programme	CSPO	March 2027	Improvement Board established. Transformation Programme in place.
Significant cost pressures impacting ability to deliver a balanced plan	Align each cost pressure with a quantified operational mitigation and delivery trajectory.	CFO	Oct 2026	Monthly monitoring and integrated finance and performance reporting are being developed
Sustained growth in D2A demand, blocking flow and driving potential overspend	Implement D2A transformation programme	MD	March 2027	Revised model implemented and new performance and governance frameworks in place. Good progress reported on all workstreams.

Key Assurance Indicators	Date Reported	Performance	Change
BCF year to date financial delivery	August 2026	£0.087m overspend	-
BCF Forecast Outturn	August 2026	Overspend forecast	↓
BCF annual financial delivery 2025/26	June 2026	Revenue: £2.459m overspend, capital: £0.251m underspend.	n/a

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

Summary Update:
Contractual cost pressures are increasing the financial and operational risks.

Escalation and Assurance Report

Report from: Audit Committee
 Date of meeting: 9 September 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	Cyber Security
Rating rationale	The Trust's cyber security arrangements were delivered jointly with Hoople, its public sector IT partner, and the internal Information Governance team. The move to a separate Microsoft 365 environment had strengthened system separation. The Trust had met the Data Security and Protection Toolkit standard, and the independent cyber assessment reported a medium overall risk rating with high confidence in the Trust's self-assessment. Digital risks were reviewed monthly within the Trust and quarterly with Hoople, supported by national threat intelligence and clinical digital safety oversight. Artificial intelligence governance included executive sponsorship, policy, clinical review, staff training, data protection assessment, human oversight and incident reporting. The cyber risk remained rated 20 because of the external threat and increasing reliance on third-party suppliers. Areas requiring further development included testing of business continuity and recovery plans, oversight of staff-developed or internet-based software, culture and staff readiness, and the scale of out-of-hours support for a major incident.
Outcome	The Committee was assured that robust governance and monitoring arrangements were in place but recognised the continuing high inherent risk and identified areas for improvement. Action: future reporting would align with the BAF and include evidence that recovery plans for critical systems had been tested, together with progress on business continuity, out-of-hours resilience and third-party risk.
Item/Topic	Single Tender Waivers
Rating rationale	All requisitions over £10k now automatically went through the Procurement Team, enabling intervention where necessary and reducing the number of waivers. Interventions could include seeking additional quotations or identifying an alternative route to market. Procurement also reviewed cumulative spending below the £10k threshold to identify repeated purchases that together exceeded it. This enabled earlier intervention to secure value for money, including potential efficiencies across the Foundation Group. There were only four waivers during the period, none of which were high value. The number was likely to increase during the PFI exit but this was closely monitored.
Outcome	The Committee was assured by the process, which had resulted in a significant reduction in the last year.
Item/Topic	Contract Management: Management Update
Rating rationale	Resource for contract management in the Procurement Team was limited and this was a driver of many of the improvement findings in the recent Internal Audit report (see below). Progress was being made on these but some investment was required. All contracts known to the team had been logged on the Atamis system and categorised using NHSE definitions – gold, silver and bronze – based on value, complexity and risk. The team's resource was focused on those defined as 'gold'. The team ensured that a contract owner was allocated to all others. Training was provided to contract owners, which included use of the system and the key points to consider as part of contract management. Where orders were received in Procurement without a contract in place, appropriate interventions were made. It was recognised that there were contracts within the organisation that were not included on the system. The Committee was assured that the position was improving but there was more to do, supported by the clear Internal Audit recommendations.
Outcome	The Committee was assured that the contract management framework was improving, while recognising that further work and investment were required to embed it fully. Action: six-monthly reports, aligned with the Single Tender Waiver update, would include progress against the Internal Audit 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: Audit Committee
 Date of meeting: 9 September 2026
 Report to: Trust Board

Item/Topic	Losses and Special Payments Q1
Rating rationale	The value was higher than the same time last year, driven exclusively by blood and drugs wastage, while patient property losses had reduced. Plans to improve the latter would be presented to the Committee in December. Drugs wastage costs were high and included expired medicines. A year to date assessment would be requested from Pharmacy. It was noted that reducing wastage by sharing excess drugs nearing expiry was limited by licencing. Automated dispensing cabinets would shortly be installed which were expected to reduce wastage; the planned Pharmacy report would include an update on this.
Outcome	The Committee noted the increase in losses and was assured that the principal drivers had been identified. Action: the December report would include Pharmacy's year-to-date review of drug wastage and the expected impact of automated dispensing cabinets.
Item/Topic	Internal Audit Progress Report and Recommendations Tracker
Rating rationale	Delivery was progressing according to plan. The key financial controls – contract management audit was complete, closing the 2025/26 audit plan. An audit of complaints was in progress. Four further audits would commence during Q3 and Q4. The audit reports would also be presented at relevant Board committees as appropriate. Less progress than usual had been made on implementing recommendations, reflecting the holiday season. Responses were awaited on 12 actions, largely related to operations and medical job planning. This had been escalated for follow-up.
Outcome	The Committee was assured by progress against the plan and the escalation process in place to follow-up on outstanding recommendations.
Item/Topic	Internal Audit: Key Financial Controls – Contract Management
Rating rationale	The review was rated Partial Assurance. Contracts recorded on Atamis had named owners and risk-based classifications but Internal Audit could not confirm that the register captured all Trust contracts or that expiring and renewed contracts were consistently linked to the Procurement workplan. Agreed improvements included identifying contracts not yet recorded, ensuring contract owners were current and appropriately trained, linking contract records to the Procurement workplan, and retaining supplier performance information centrally. Service Level Agreements were outside scope and required further assurance because of their potential financial significance.
Outcome	The Committee noted the Partial Assurance opinion. Six-monthly reports would track implementation of the recommendations and provide further assurance on Service Level Agreements.
Item/Topic	Counter Fraud
Rating rationale	LCFS progress report Eight of 11 actions agreed from previous reviews had been implemented; the remaining actions were current. A conflicts of interest review would commence in October and a workshop was planned to assess beneficiary fraud risks arising from the new failure to prevent fraud offence. Eight referrals had been investigated during the period, with no wider control concern requiring escalation. Car parking review The review identified opportunities to strengthen the permit application and monitoring controls, including independent line manager approval and clearer permit information. Permits had been updated to display key identifying details. Although the open-access car parks relied on manual monitoring, sample testing of approved and rejected applications found no evidence of fraud. Reactive benchmarking The Trust received 14 referrals compared with the acute trust average of 24 but was in the highest quartile when referrals were considered per 1,000 staff, indicating positive awareness and reporting. Recruitment fraud was the most frequently reported type and working elsewhere while off sick was second. Low reporting in some categories might indicate further awareness was needed, although regional relevance and other contextual factors also influenced referral patterns.
Outcome	The Committee took assurance from progress against the workplan, the absence of fraud identified through the car parking review and the Trust's positive reporting culture. The remaining control improvements and planned conflicts of interest and failure to prevent fraud work would continue to be monitored through routine LCFS reporting.

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

Escalation and Assurance Report

Report from: Audit Committee
 Date of meeting: 9 September 2026
 Report to: Trust Board

Assure: Including assurance items rated green	
Item/Topic	Managing Conflicts of Interest
Rating rationale	The Trust had established a stronger process using ESR as the single system for staff declarations, supported by a refreshed policy, bite-sized guidance, regular communications and cross-checks against other information sources. A strong baseline had been achieved for decision-making staff, although ESR limitations meant there was no automated email reminder and some terminology did not clearly prompt all declaration types. The sustainable approach would place responsibility on individuals and line managers, with annual direct reminders to decision-making staff, regular register review and proportionate follow-up by the Corporate Governance Team. Directors' interests continued to be maintained separately through a manual process. The planned Counter Fraud review would provide further independent testing and benchmarking.
Outcome	The Committee took assurance from the established process and continual improvement approach, recognising that compliance depended on individual and line management accountability supported by proportionate corporate oversight.
Item/Topic	Board Assurance Framework
Rating rationale	The BAF was operating as a live document, with updates drawn from Board and committee reporting so that strategic risks, controls, assurances and actions remained aligned. The cyber risk would be updated following the Committee's detailed assurance review. A broader quality risk was being developed to capture the impact on patient safety, experience and effectiveness of prolonged waits across urgent, corridor and elective care. The Committee emphasised that its role was to assess the effectiveness of the BAF process and the reliability of controls and assurance, rather than duplicate detailed risk review undertaken elsewhere. It also requested clearer exception reporting where risk scores remained static or mitigating actions were not delivering the expected reduction.
Outcome	The Committee was assured that the BAF continued to mature and better connect strategic risks with committee assurance, while agreeing that future reporting should highlight by exception risks that were not progressing towards target.

To Note: Items received for information or approval	
Item/Topic	External Audit
Summary	Audit update The 2025/26 audit opinion was issued ahead of the national deadline and was unmodified. The audit certificate remained outstanding because the National Audit Office had not yet completed its work on the Department of Health and Social Care group accounts; this was a national timing issue and did not affect the audit opinion. The post-audit debrief with the Finance Team was positive and identified only minor opportunities for improvement. Sector benchmarking Benchmarking showed a positive 2025/26 comparative position, with margins and efficiency delivery above acute trust averages and improved cash. However, the 2026/27 plan remained challenging because the efficiency requirement was above average, with a high proportion of schemes assessed as high risk or unidentified, alongside a substantial underlying deficit and back-loaded capital programme.
Outcome	The Committee noted the audit certificate position and positive comparative performance, while recognising that delivery of the 2026/27 efficiency programme and reduction of the underlying financial deficit remained significant areas of risk requiring sustained Board oversight.
Item/Topic	Internal Audit Annual Report
Rating rationale	The final report was presented unchanged from the draft report previously presented, following conclusion of the 2025/26 plan.
Outcome	Noted

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

Escalation and Assurance Report

Report from: Charity Trustee
 Date of meeting: 17 September 2026
 Report to: Trust Board

To Note: Items received for information or approval	
Item/Topic	Quarter 1 Charitable Funds Finance Report
Summary	The value of charitable funds increased slightly to £2.2m, including £1.3m held as restricted funds, with commitments of £0.2m at the end of June. Income continued to exceed expenditure. The Trustee supported proactive use of available general funds for new equipment, service developments and wider community benefit, while recognising that restricted balances constrain flexibility.
Outcome	The Quarter 1 report was accepted. The Trustee encouraged teams to bring forward suitable proposals and supported revisiting previously deferred requests as funding becomes available.
Item/Topic	Annual Accounts and Report Plan 2025/26
Summary	The annual accounts were under review by the independent examiners and remained on track for submission to the Charity Trustee in December. A £128k accrual for equipment delivered but not yet paid for had been included in the annual accounts but was not recognised in the Quarter 4 finance report, identifying a need to strengthen charity-side processes for capturing accruals.
Outcome	The plan was accepted and remained on schedule. The accrual omission highlighted a process gap requiring improvement.
Item/Topic	Fundraising Update
Summary	Demand for charitable funding continued to increase as awareness improved, with previously deferred requests being revisited. Restricted funding, particularly within the Oncology Trust Fund, remained a constraint, although planned expenditure was expected to reduce balances. Development of a lottery scheme continued but was more complex and costly than anticipated, with a business case in preparation. The Trustee also considered the management of donated artwork and supported a panel approach and constructive signposting where offers are declined.
Outcome	The fundraising update was accepted. Development of the lottery business case will continue, and interested members will support an informal panel to review future artwork donations and improve alternative signposting.

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