

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=24) of when staff are reallocated from other areas of the inpatient service. This is higher than previous months however remains low. The community/continuity teams and a matron were required to support the inpatient area on one occasion. There was 1 report of a staff member not being able to take a break.

#### Number of Management Actions

01/03/2026 to 31/03/2026

| Actions | Breakdown of Actions                  | Times occurred | Percentage |
|---------|---------------------------------------|----------------|------------|
| MA1     | Redeploy staff internally             | 24             | 77%        |
| MA2     | Redeploy staff from community         | 1              | 3%         |
| MA3     | Redeploy staff from training          | 0              | 0%         |
| MA4     | Staff unable to take allocated breaks | 1              | 3%         |
| MA5     | Staff stayed beyond rostered hours    | 1              | 3%         |
| MA6     | Specialist midwife working clinically | 0              | 0%         |
| MA7     | Manager/Matron working clinically     | 1              | 3%         |
| MA8     | Staff sourced from bank/agency        | 0              | 0%         |
| MA9     | Utilise on call midwife               | 0              | 0%         |
| MA10    | Escalate to Manager on call           | 3              | 10%        |
| MA11    | Maternity Unit on Divert              | 0              | 0%         |
| TOTAL   |                                       | 31             |            |

\*The % is rounded to nearest whole number

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

NICE recommended red flags are reported in the acuity app and are presented below. There were no red flags reported in March for a delay in care. This is an improvement from last month where one was recorded.

#### Number of Red Flags recorded

01/03/2026 to 31/03/2026

| Red Flags | Breakdown of Red Flags                                                                                                         | Times occurred | Percentage |
|-----------|--------------------------------------------------------------------------------------------------------------------------------|----------------|------------|
| RF1       | Delayed or cancelled time critical activity                                                                                    | 0              | 0%         |
| RF2       | Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)                                      | 0              | 0%         |
| RF3       | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)                     | 0              | 0%         |
| RF4       | Delay in providing pain relief                                                                                                 | 0              | 0%         |
| RF5       | Delay between presentation and triage                                                                                          | 0              | 0%         |
| RF6       | Full clinical examination not carried out when presenting in labour                                                            | 0              | 0%         |
| RF7       | Delay between admission for induction and beginning of process                                                                 | 1              | 100%       |
| RF8       | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)                                | 0              | 0%         |
| RF9       | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0              | 0%         |
| RF10      | Delivery Suite Co-ordinator is not supernumerary                                                                               | 0              | 0%         |
| TOTAL     |                                                                                                                                | 1              |            |

## Birth Centre

In March, the completion rate for the acuity app for the birth centre was at 68.82%. This is higher than last month. The acuity was met 98% of the time. This is lower than February which was recorded at 100%. We are continuing to see more consistent level of activity on MBC.

### Intrapartum & Non-Birthing Categories

01/03/2026 to 31/03/2026

| Categories   | Number in Categories | Percentage |
|--------------|----------------------|------------|
| Cat I        | 61                   | 62%        |
| Cat II       | 9                    | 9%         |
| Cat PN       | 29                   | 29%        |
| Cat X        | 0                    | 0%         |
| <b>TOTAL</b> | <b>99</b>            |            |

\*The % is rounded to nearest whole number

## Staffing incidents

There were no midwifery staffing incidents reported in March

## Medication Incidents

There were seven no harm incidents

1. CD documentation and storage (3)
2. Incorrect prescription
3. TTOs not prescribed as indicated (2)
4. Incorrect route for Vit K

## Monitoring the midwife to birth ratio

The ratio in March was 1:18 (in post) and 1:17 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

## Maternity SitRep

The maternity SitRep continues to be completed twice per day. The report is submitted to the capacity hub, directorate and divisional leads and is shared with the Chief Nurse and deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional SitRep is submitted daily.

## National Maternity SitRep

The new national sitrep has now been launched and is completed daily.

## Unify Data

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

|                       | Day RM % | Night RM % | Day MCA/MSW % | Night MCA/MSW % |
|-----------------------|----------|------------|---------------|-----------------|
| Continuity of Carer   | 100%     | 100%       | n/a           | n/a             |
| Community Midwifery   | 89%      | 100%       | n/a           | n/a             |
| Antenatal Ward/Triage | 91%      | 90%        | 89%           | 95%             |
| Delivery Suite        | 90%      | 96%        | 97%           | 100%            |
| Postnatal Ward        | 89%      | 80%        | 86%           | 97%             |
| Meadow Birth Centre   | 85%      | 87%        | 84%           | 100%            |

### **Daily staff safety huddle**

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the unit bleep holder, midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Deputy Director of Midwifery with an escalation to the Director of Midwifery as required. Additional huddles were held February to maintain safe staffing and manage flow. Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

### **Vacancy**

There are 2 unfilled midwifery roles (inc Fetal Medicine & Sonography Lead). There are 7 WTE MCA vacancies – 4 WTE in pipeline to start over next quarter.

### **Sickness**

Sickness absence rates for midwives are reported at 7.29% and 6.75% for non-registered staff – this is an improvement for both groups – regular deep dives continue with good assurance noted.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support
- Quarterly confirm and challenge meeting held by DoM
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Regular walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.

### **Turnover**

The rolling turnover rate is at 3.3% for midwives and at 12.3% for non-registered staff – this an improved position for Midwifery and a slightly less positive position for non-registered colleagues with an increase of 1% from last month.

### **Maternity Leave**

Maternity Leave has increased slightly from 5% to 5.7% for midwives. A business case to support the swap out of bank for substantive recruitment is being worked through currently. Maternity Leave for support for MCA/MSWs is 1.7%

**Actions throughout this period:**

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day
- Monthly 'drop - in' sessions led by the DoM/DDoM.
- Safety Champion walkabouts
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

**Risk Register –staffing**

| Risk ID | Narrative                                                                                                          | Risk Rating |
|---------|--------------------------------------------------------------------------------------------------------------------|-------------|
| 4208    | If maternity safe staffing levels are not maintained this may impact on safety and outcomes for mothers and babies | 5           |

**Conclusion**

To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. Community/Continuity Midwives were required to support the Unit on one occasion in March

There was one report of a staff member not being able to take a break; the supernumerary status of the shift leader at the onset of the shift and 1:1 care in labour were achieved.

There was no harm recorded in the reported incidents.

Sickness absence rates are above the Trust target; however there is a high level of assurance that absence is being managed in alignment with the policy.

The vacancy rate is 1% for MWs and 13% for MCA's.

**Recommendations**

The Board is asked to note the content of this report for information and assurance.

Wells-Jo  
03/06/2026 13:31:46

## WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

|                                                                                                                                                                                                              |                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>Report to:</b>                                                                                                                                                                                            | <b>Public Board</b>                                                                                                  |
| <b>Date of Meeting:</b>                                                                                                                                                                                      | 09/06/2026                                                                                                           |
| <b>Title of Report:</b>                                                                                                                                                                                      | <b>Midwifery Safe Staffing Report April 2026</b>                                                                     |
| <b>Lead Executive Director:</b>                                                                                                                                                                              | Chief Nursing Officer                                                                                                |
| <b>Author:</b>                                                                                                                                                                                               | Justine Jeffery – Director of Midwifery<br>Rebecca Fox – Deputy Director of Midwifery                                |
| <b>Reporting Route:</b>                                                                                                                                                                                      | Divisional Governance Committee to Quality Governance Committee                                                      |
| <b>Enclosures included with this report:</b>                                                                                                                                                                 | None                                                                                                                 |
| <b>Purpose of report:</b>                                                                                                                                                                                    | <input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Approval <input type="checkbox"/> Information |
| <b>Brief Description of Report Purpose</b>                                                                                                                                                                   |                                                                                                                      |
| The purpose of this report is to provide assurance that midwifery staffing is monitored and to note actions taken to mitigate any shortfalls                                                                 |                                                                                                                      |
| <b>Recommended Actions required by Board or Committee</b>                                                                                                                                                    |                                                                                                                      |
| The committee is asked to note how safe midwifery staffing is monitored, and actions taken to mitigate any shortfalls. Also to note any risks associated with achieving safe levels of midwifery staffing    |                                                                                                                      |
| <b>Executive Director Opinion<sup>1</sup></b>                                                                                                                                                                |                                                                                                                      |
| The report offers assurance to the Board that there are robust processes in place to monitor midwifery staffing levels and that appropriate actions are taken to mitigate the risk when staffing gaps occur. |                                                                                                                      |

### Introduction/Background

<sup>1</sup> 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.

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored.

Safe staffing is monitored monthly by the following actions:

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

Summary of the workforce KPI's:

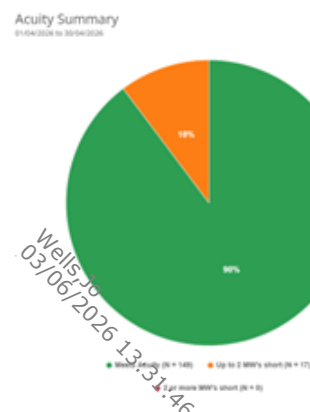
| Metrics                          | Target | Current position (MW) | Current position (MSW/MCAs) |
|----------------------------------|--------|-----------------------|-----------------------------|
| Sickness rate                    | 4%     | 5.77%                 | 9.42%                       |
| Turnover rate (rolling)          | 11.5%  | 3.4%                  | 10.7%                       |
| Vacancy rate (MW)                | 7%     | 0%                    | 12.36%                      |
| Maternity Leave                  | -      | 4.3%                  | 0.4%                        |
| Midwife to birth ratio (in post) | 1:24   | 1:18                  |                             |
| 1:1 care in labour               | 100%   | Achieved              |                             |
| Shift leader SN                  | 100%   | Achieved              |                             |

## Issues and options

### Completion of the Birthrate plus acuity app

#### Delivery Suite

The acuity app data was completed in 92.22% of the expected intervals (higher than last month) and therefore the data presented is not reliable. The diagram below presents when staffing met or did not meet the acuity.



From the information available, the acuity was met in 90% of the time and recorded at 10% when it was not met prior to any actions taken. This is higher than the previous month's performance. Safe staffing levels were maintained on all shifts in April following mitigation.

The mitigations taken are presented in the diagram below and demonstrate the frequency (n=11) of when staff are reallocated from other areas of the inpatient service. This is lower than previous months. The community/continuity teams were not required to support the inpatient area on any occasions. There were no reports of staff members not being able to take a break.

#### Number of Management Actions

01/04/2026 to 30/04/2026

| Actions      | Breakdown of Actions                  | Times occurred | Percentage |
|--------------|---------------------------------------|----------------|------------|
| MA1          | Redeploy staff internally             | 11             | 100%       |
| MA2          | Redeploy staff from community         | 0              | 0%         |
| MA3          | Redeploy staff from training          | 0              | 0%         |
| MA4          | Staff unable to take allocated breaks | 0              | 0%         |
| MA5          | Staff stayed beyond rostered hours    | 0              | 0%         |
| MA6          | Specialist midwife working clinically | 0              | 0%         |
| MA7          | Manager/Matron working clinically     | 0              | 0%         |
| MA8          | Staff sourced from bank/agency        | 0              | 0%         |
| MA9          | Utilise on call midwife               | 0              | 0%         |
| MA10         | Escalate to Manager on call           | 0              | 0%         |
| MA11         | Maternity Unit on Divert              | 0              | 0%         |
| <b>TOTAL</b> |                                       | <b>11</b>      |            |

\*The % is rounded to nearest whole number

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

NICE recommended red flags are reported in the acuity app and are presented below. There were no red flags reported in April.

#### Number of Red Flags recorded

01/04/2026 to 30/04/2026

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

\*The % is rounded to nearest whole number

## **Birth Centre**

In April, the completion rate for the acuity app for the birth centre was at 79.44% and therefore we are unable to report on the acuity. We continue to see a more consistent level of activity on MBC and no reports of staffing issues.

### **Intrapartum & Non-Birthing Categories**

01/04/2026 to 30/04/2026

| Categories                                                                               | Number in Categories | Percentage |
|------------------------------------------------------------------------------------------|----------------------|------------|
|  Cat I  | 62                   | 76%        |
|  Cat II | 1                    | 1%         |
|  Cat PN | 18                   | 22%        |
|  Cat X  | 1                    | 1%         |
| <b>TOTAL</b>                                                                             | <b>82</b>            |            |

\*The % is rounded to nearest whole number

## **Staffing incidents**

There were no staffing incidents reported via Datix.

## **Medication Incidents**

There were 8 no harm incidents

1. Documentation (5)
2. Preordered medications missing
3. Accidental wastage of CD (bottle of methadone dropped)
4. Delay in administration of abx due to sickness

## **Monitoring the midwife to birth ratio**

The ratio in March was 1:18 (in post) and 1:17 (funded). The midwife to birth ratio was compliant with the recommended ratio from the Birth Rate Plus Audit, 2022 (1:24).

## **Maternity SitRep**

The maternity SitRep continues to be completed twice per day. The report is submitted to the capacity hub, directorate and divisional leads and is shared with the Chief Nurse and deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. The regional SitRep is submitted daily.

## **National Maternity SitRep**

The new national sitrep has now been launched and is completed daily.

## **Daily staff safety huddle**

Daily staffing huddles are completed each morning within the maternity department. This multi professional huddle includes the unit bleep holder, midwife in charge and the consultant on call for that day. If there are any staffing concerns the unit bleep holder will arrange additional huddles that are attended by the Deputy Director of Midwifery with an escalation to the Director

of Midwifery as required. Additional huddles were held April to maintain safe staffing and manage flow. Bed meetings are held three times per day and are attended by the Directorate teams. Information from the SitRep is discussed at this meeting.

### **Unify Data**

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

|                       | Day RM % | Night RM % | Day MCA/MSW % | Night MCA/MSW % |
|-----------------------|----------|------------|---------------|-----------------|
| Continuity of Carer   | 100%     | 100%       | n/a           | n/a             |
| Community Midwifery   | 91%      | 100%       | 100%          | n/a             |
| Antenatal Ward/Triage | 94%      | 90%        | 92%           | 97%             |
| Delivery Suite        | 94%      | 99%        | 92%           | 100%            |
| Postnatal Ward        | 85%      | 88%        | 90%           | 95%             |
| Meadow Birth Centre   | 87%      | 66%        | 88%           | 89%             |

### **Vacancy**

There is one unfilled midwifery role (inc Fetal Medicine & Sonography Lead). There are 6 WTE MCA vacancies – interviews to be held on 20<sup>th</sup> May.

### **Sickness**

Sickness absence rates for midwives are reported at 5.77% and 9.42% for non-registered staff. Regular deep dives continue with good assurance noted. Return to work interviews continue to be monitored with support from HR.

The following actions remain in place:

- Monthly oversight of sickness management by the Divisional team with HR support at Divisional, Directorate and Matron Level
- Quarterly confirm and challenge meeting held by DoM
- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Regular walk rounds by members/member of the DMT

### **Turnover**

The rolling turnover rate is 3.48 % for Midwives and 10.7% for MSW/MCAs – this is a sustained, improved position.

### **Maternity Leave**

Maternity Leave has decreased slightly for midwives at 4.34%. A business case to support the swap out of bank for substantive recruitment is being worked through currently. Maternity Leave for support for MCA/MSWs is 0.45 – down from last month.

***Actions throughout this period:***

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed/staffing meeting daily
- SitRep report completed three times per day
- Monthly 'drop - in' sessions led by the DoM/DDoM – plans to created team based drop in at the request of the team
- Safety Champion walkabouts
- Ongoing retention work led by retention midwife and Practice Development Midwife for MSW/MCAs.

| Risk ID | Narrative                                                                                                          | Risk Rating |
|---------|--------------------------------------------------------------------------------------------------------------------|-------------|
| 4208    | If maternity safe staffing levels are not maintained this may impact on safety and outcomes for mothers and babies | 5           |

**Conclusion**

To maintain safe staffing levels staff were deployed to areas with the highest acuity; minimum safe staffing levels were achieved on all shifts. Neither Community or Continuity Midwives were deployed to support the inpatient service in April.

There were no reports of staff members not being able to take a break; the supernumerary status of the shift leader at the onset of the shift and 1:1 care in labour were achieved. There was no harm reported in medication incidents.

The vacancy rate is 3.32% for MWs and 12.36% for MCA's. New starters are planned for May for MCAs and Midwifery interviews and assessment centres were held this month. Turnover is now below the Trust target.

Sickness absence rates are above the Trust target; however, whilst there is a high level of assurance that absence is being managed in alignment with the policy there is further work planned to explore whether there are any cultural issues affecting staff attendance given 'S10' is the highest recorded reason for absence.

**Recommendations**

The Board is asked to note the content of this report for information and assurance

Wells-Jo  
 05/06/2026 13:31:46

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Report to:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Public Trust Board                                                                                                                        |
| <b>Date of Meeting:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 09/06/2026                                                                                                                                |
| <b>Title of Report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Safer Staffing Report – Nursing                                                                                                           |
| <b>Lead Executive Director:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Chief Nursing Officer                                                                                                                     |
| <b>Author:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Sue Smith, Deputy Chief Nursing Officer                                                                                                   |
| <b>Reporting Route:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NWAG, QGC                                                                                                                                 |
| <b>Enclosures included with this report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           |
| <b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/> <b>Assurance</b> <input type="checkbox"/> <b>Approval</b> <input type="checkbox"/> <b>Information</b> |
| <b>Brief Description of Report Purpose</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           |
| This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during April 2026 with numerical data also presented for April 2026.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                           |
| <b>Recommended Actions required by Board or Committee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           |
| <p>The Board is invited to:</p> <p><b>Note</b> the content of the report and receive <b>Assurance</b> that our safe staffing levels remain in line with National Quality Board (NQB) and NICE guidance</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           |
| <b>Executive Director Opinion<sup>1</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                           |
| <p>Staffing on Neonatal and all Adult in patient areas have been maintained at safe levels throughout April 2026. In paediatrics whilst BAPM level were not achieved on 100% of shifts, professional judgement indicates that areas and staffing were safe.</p> <p>There were 59 red flags raised, all were deemed insignificant and minor harms relating to the reporting of 'stay in the bay' rather than patient harm.</p> <p>Due to the continued capacity and flow pressures in April 2026 additional capacity has continued to be utilised, with PDU remaining open alongside the PDSA processes in AMA and ASA. Overall costs of additional capacity and PDSAs (not including additional staff in cross county A&amp;E's) is £250k in month, a slight reduction from £255K in March 26. To note: there is a proposal to close PDU during the month of June 2026 thereby reducing these costs.</p> <p>Nursing and Midwifery have achieved a further reduction of agency (as a % of total spend) to 1.91% in Month 1. The Price Cap Compliance (PCC) work has ensured compliance has stayed at 99%.</p> <p>To note: An independent review is underway of the Safer Nursing Care Tool (SNCT) methodology and application by the NHSE CNO safer staffing faculty lead through May, June and July 2026 with a document submission having been completed.</p> |                                                                                                                                           |

<sup>1</sup> 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.

# Nursing Staffing Levels

## May 2026 (April 2026 data)

|                       |                                                                                      |
|-----------------------|--------------------------------------------------------------------------------------|
| Title:                | Monthly Report on Nursing Staffing Levels for April 2026 date (with April 2026 data) |
| Responsible Director: | Chief Nurse                                                                          |
| Lead:                 | Deputy Chief Nurse                                                                   |
| Reported by:          | Lead Nurse for Workforce                                                             |

Wells-Jp  
03/06/2026 13:31:46

## 1. Introduction

(including relevant updates)

- 1.1 This briefing provides the QGC with an overview of the Nursing and Midwifery workforce for April 2026 data and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016. It provides assurance that arrangements are in place to safely staff our services with the right number of Nurses and Midwives, with the right skills, at the right time.

## 2. Key highlights

- 2.1 Table 1 outlines the key performance workforce indicators for Registered and Unregistered (Band 2 and 3) staffing in Nursing mapped against the Trust target with comparison to the previous month's performance.

*Nursing (Registered)*

| Key Performance Indicator | Target | Apr-26 | Mar - 26 | Additional notes                                                                                                                                                                                |
|---------------------------|--------|--------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Vacancy rate RN           |        | 4.26%  | 3.28%    | Vacancy position has increased slightly as expected in month 1 following addition of new business cases.                                                                                        |
| Annual turnover RN        | 11.5%  | 5.45%  | 5.34%    | Retention of registered nurses is stable and below both trust target (11%) and model health system (7.7%)                                                                                       |
| Sickness rate             | 4%     | 5.60%  | 6.36%    | Active sickness management in place as per policy and staff well-being is supported                                                                                                             |
| Vacancy rate HCSW         |        | 10.49% | 10.08%   | Vacancy position slightly increased despite positive recruitment pipeline due to Month 1 increase in ADI.                                                                                       |
| Annual turnover HCSW      | 11.5%  | 12.63% | 12.56%   | Unregistered nursing turnover remains relatively static. New induction / onboarding process in place. Model health system benchmark is 16% and last year's position within the Trust was 13.94% |
| Sickness rate HCSW        | 4%     | 6.52%  | 6.37%    | Active sickness management in place as per policy and staff well-being is supported                                                                                                             |

### 3. Expectation 1: Right Staff

#### 3.1 Evidence Based Workforce Planning

##### 3.1.1 Safer Nursing Care Tool (SNCT)

- SNCT data collection period took place over September 2025 and October 2025, utilizing the following Safer Nursing Care Tools: Adult Inpatient Wards in Acute Hospitals, Adult Acute Assessment Units and Children's and Young People's Inpatient Wards.
- The report has now been completed and will be submitted to Trust board
- Independent review taking place of the SNCT methodology and application by the NHSE CNO safer staffing faculty lead through May, June and July 2026 – required papers and evidence have now been submitted by Nursing workforce to NHSE in preparation for this review.

##### 3.1.2 Bi-Annual Establishment Reviews 2026

- The first bi-annual review for this year is due to commence on 18<sup>th</sup> May 2026 using the relevant SNCT
- The second review will be undertaken in November 2026 using the relevant SNCT
- Any change in ward template or specialty will trigger a SNCT review of establishment
- Preparation for a paediatric study is also underway. Allocate has been revising the paediatric tool, with finalization anticipated in May 2026. As part of this process, we have engaged with Allocate to obtain updates and, as a result of our continued interest, our Trust has been selected as the first to implement the software and will serve as the pilot site for this trial.

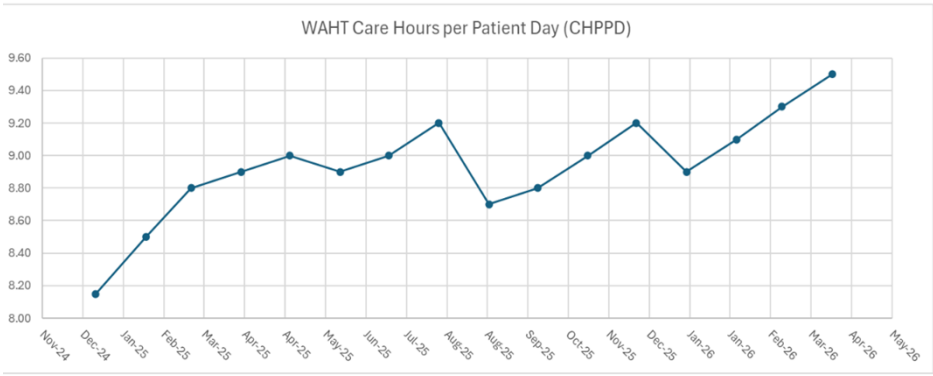
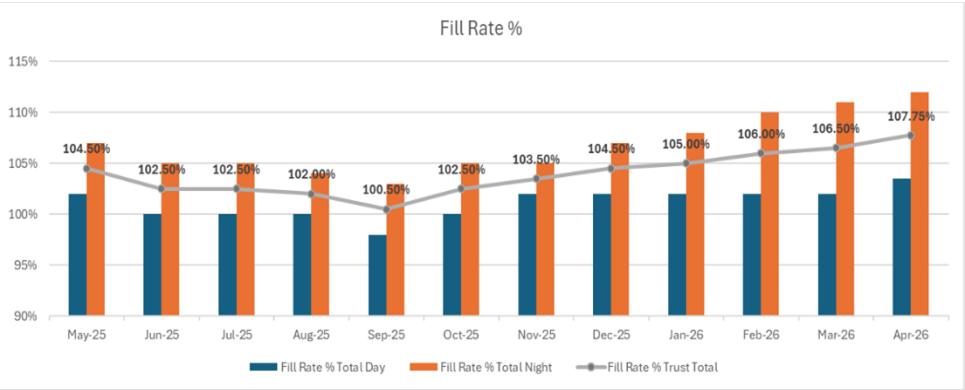
##### 3.1.3 Electronic Rostering (Health Roster and SafeCare)

- LOOP application is in full operation with no issues reported
- E-Rostering KPIs are monitored through the Nursing, Midwifery and AHP Advisory Working Group and demonstrate good compliance

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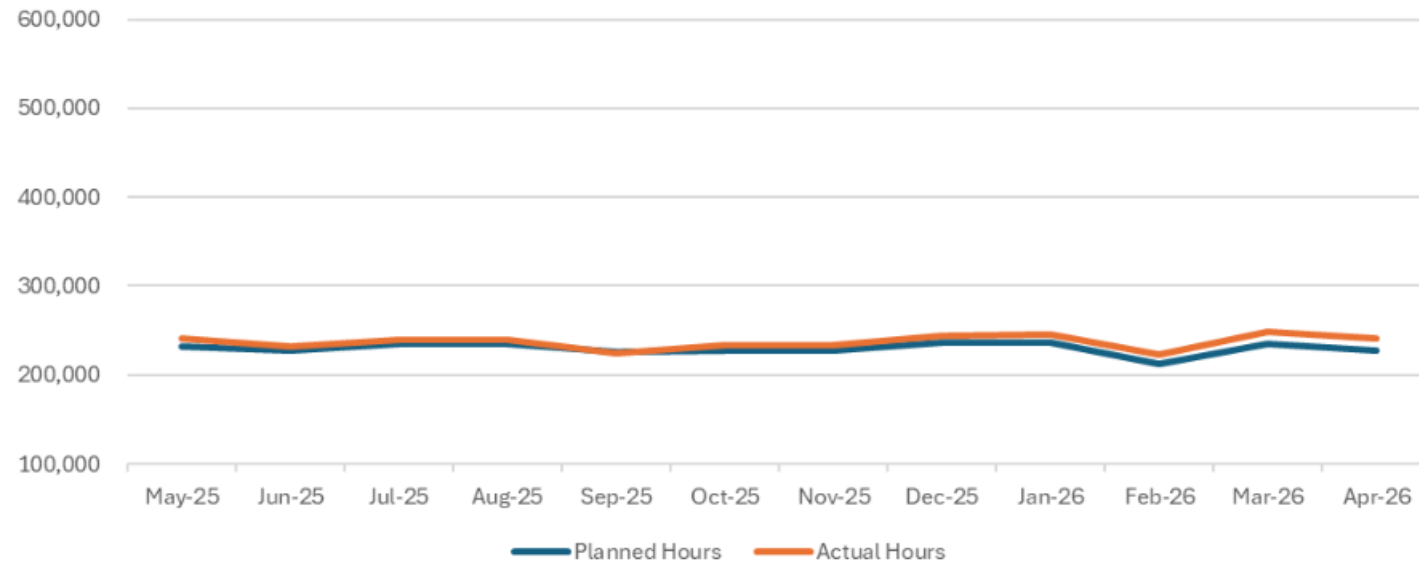
3. Expectation 1: Right Staff

3.2 Safety performance metrics (WAHT)

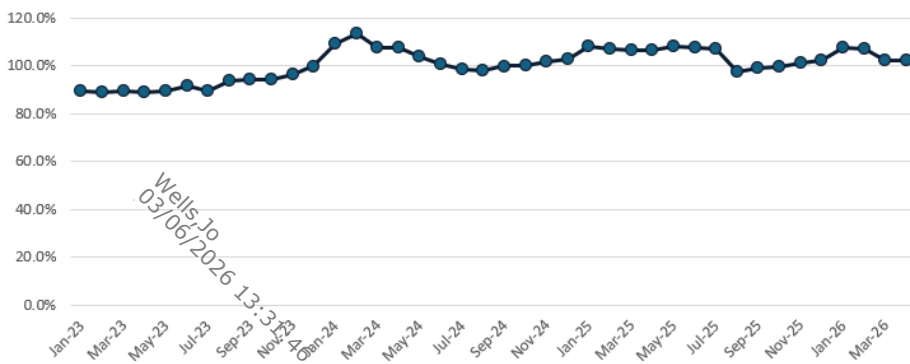


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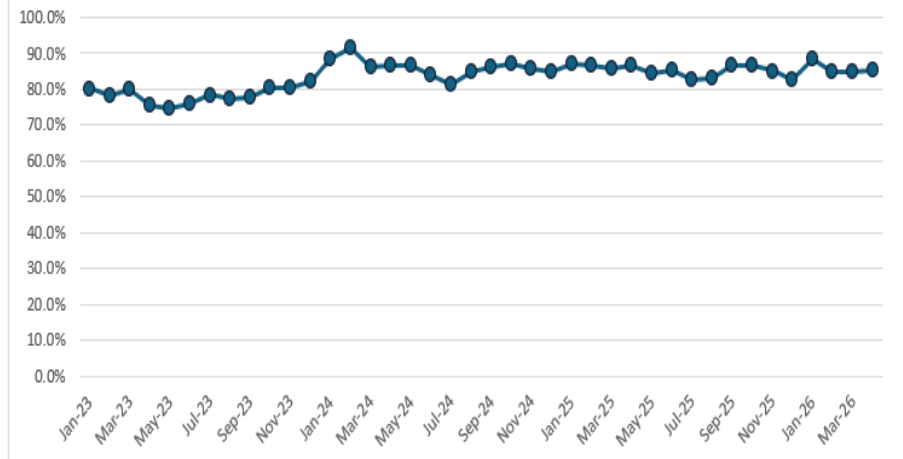
## Planned vs Actual Hours



### WRH Monthly Bed Occupancy %



### AGH Monthly Bed Occupancy %



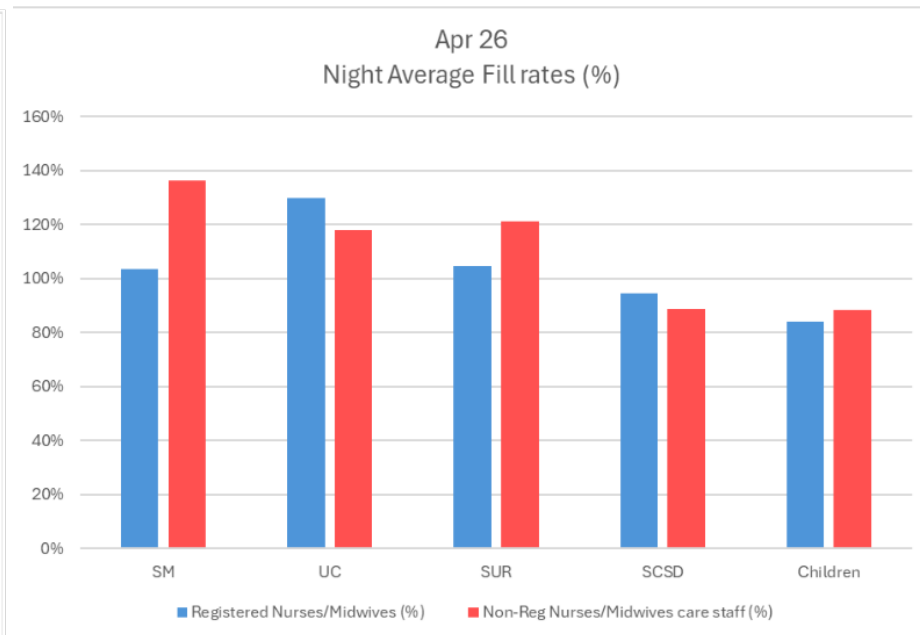
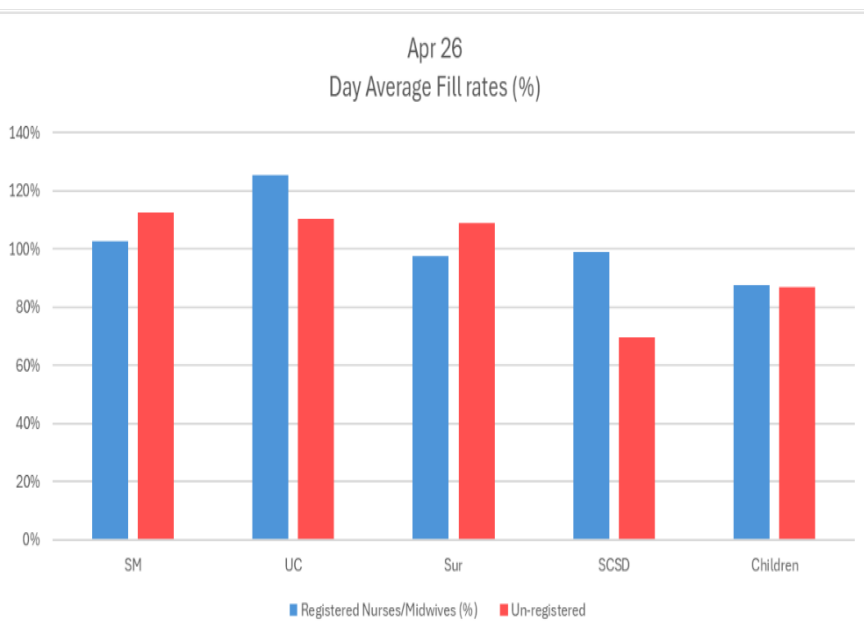
Narrative:

- Whilst RN average fill rate remains stable (100% / 107% day and night respectively, HCA fill on nights has seen an increase in April to 122%, this is up from 120% in March. Outlier areas are PDU (additional capacity) HCSW nights 144% a due to staffing increase following change to patient profile and Laurel 1 Vascular 132% due to additional staffing for the 4 planned escalation beds on the unit.
- CHPPD in April 2026 is up slightly at 9.5 and above the national lower advised range of 6.3
- No area fell below the 6.3 lower advised limit in April 2026.

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### 3. Expectation 1: Right Staff

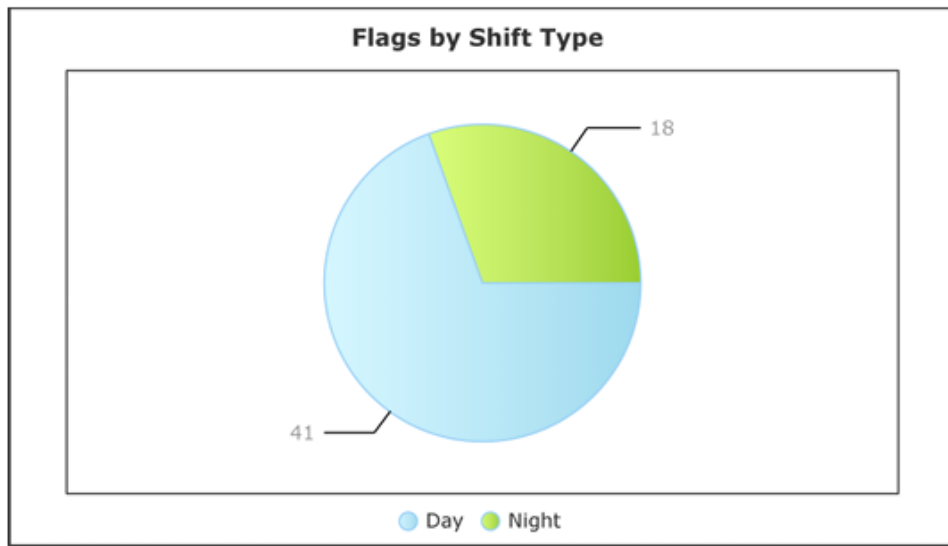
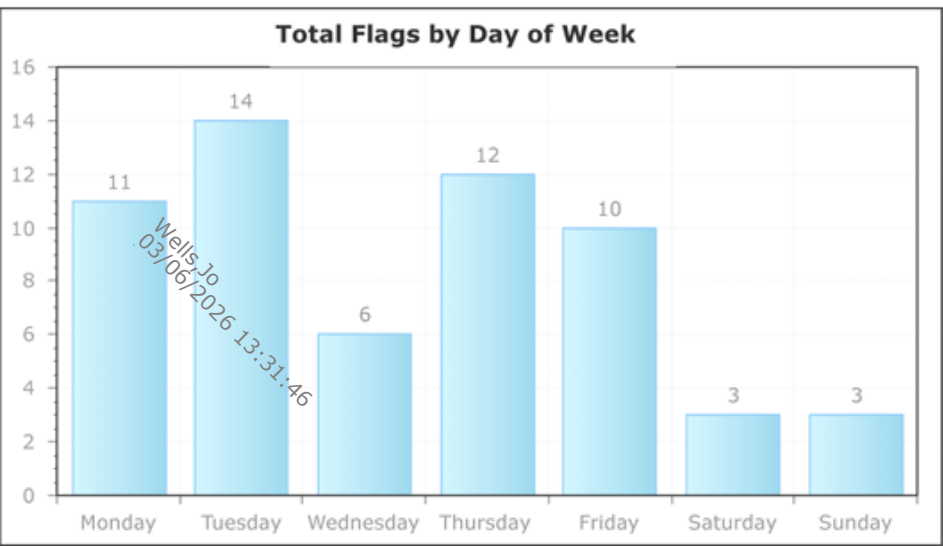
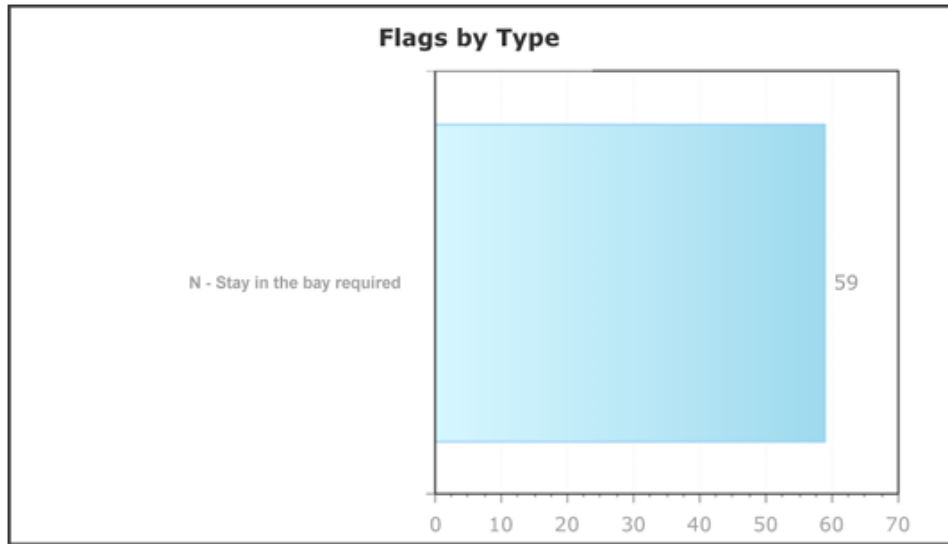
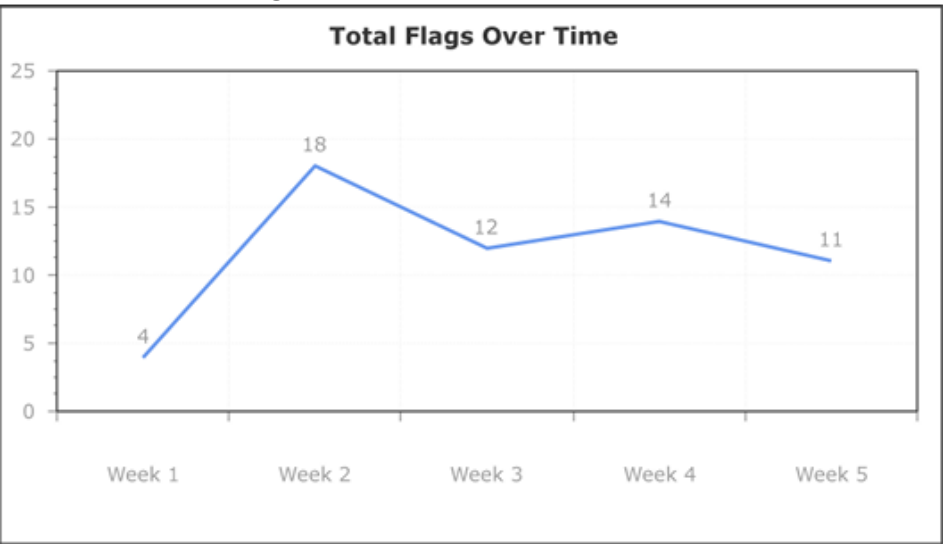
#### 3.2 Safety performance metrics



#### Narrative

- Day and Night average fill rates analysis shows consistent fill across days and nights.  $\leq 95\%$  only evident in SCSD and children's which is indicative of variations in acuity and dependency with CHPPD remaining stable in these areas and no specific safety concerns.
- 1-2-1 care and Enhanced therapeutic observations analysis to follow in future reports

Expectation 1: Right Staff  
3.4 Red flag data for April 2026



### Narrative

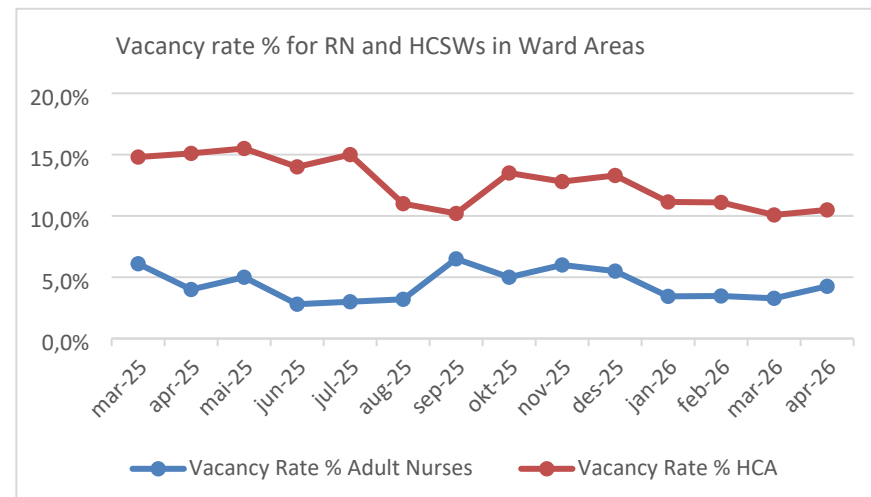
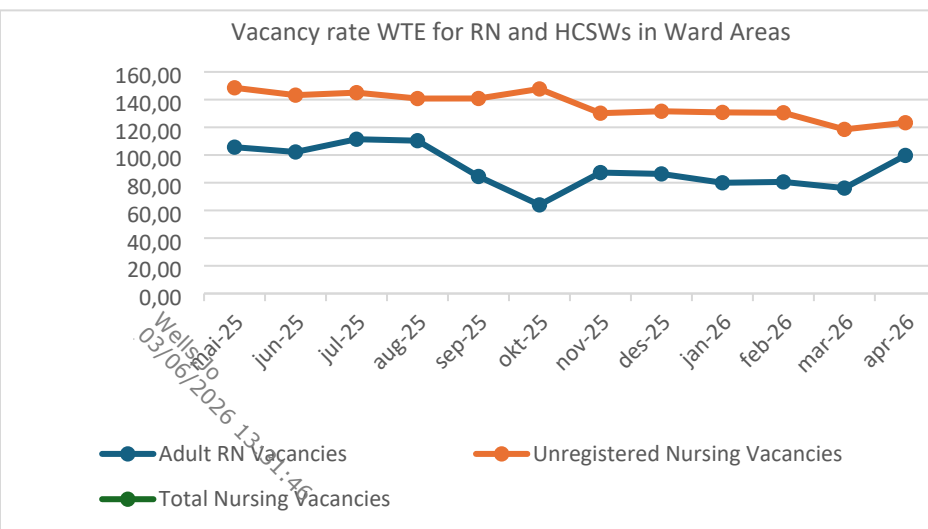
- April 2026 saw 59 (from 77 in March) red flags raised; all of these were raised for 'stay in the bay'.
- Aconbury 3 reports 'stay in the bay' rather than when this cannot be achieved. Training has been undertaken in April with the support of E-rostering via the 'Workforce bitesize' workstream with a view to seeing both an education in unnecessary red flags and also better governance of those which are required.
- Monitoring and reporting of red flags raised via safe care will be a focus in 2026 and has been added to both NWAG reporting and the CEA ward accreditation process. This will be supported by additional training for Matrons, Ward Managers

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### 3. Expectation 1: Right Staff

#### 3.5 Vacant posts (Nursing)

| Month    | Vacancy Rate %<br>Adult Nurse | Vacancy Rate %<br>HCA | Adult<br>Registered<br>Nursing<br>Vacancies (WTE) | Unregistered Nursing<br>Vacancies (WTE) | Total Nursing<br>Vacancies |
|----------|-------------------------------|-----------------------|---------------------------------------------------|-----------------------------------------|----------------------------|
| Apr-26   | 4.26%                         | 10.49%                | 99.7                                              | 123.31                                  | 223.01                     |
| Mar - 26 | 3.28%                         | 10.08%                | 76.11                                             | 118.5                                   | 194.61                     |
| Feb - 26 | 3.47%                         | 11.11%                | 80.58                                             | 130.51                                  | 211.09                     |
| Jan – 26 | 3.44%                         | 11.14%                | 79.96                                             | 130.76                                  | 210.72                     |
| Dec - 25 | 3.72%                         | 11.21%                | 86.35                                             | 131.59                                  | 217.94                     |



Narrative

- RN vacancies for April 2026 are currently at 99.7 WTE (4.26%) and show the expected rise in Month 1 following revision of the ADI. This remains below the Model Health system level of 5.4%. Looking to the future pipeline a further Newly Qualified recruitment event is planned for May 2026 and will be supported by the medicine and surgical divisions.
- HCA vacancies remain a focus for ongoing work across divisions / workforce and HR jobs team.

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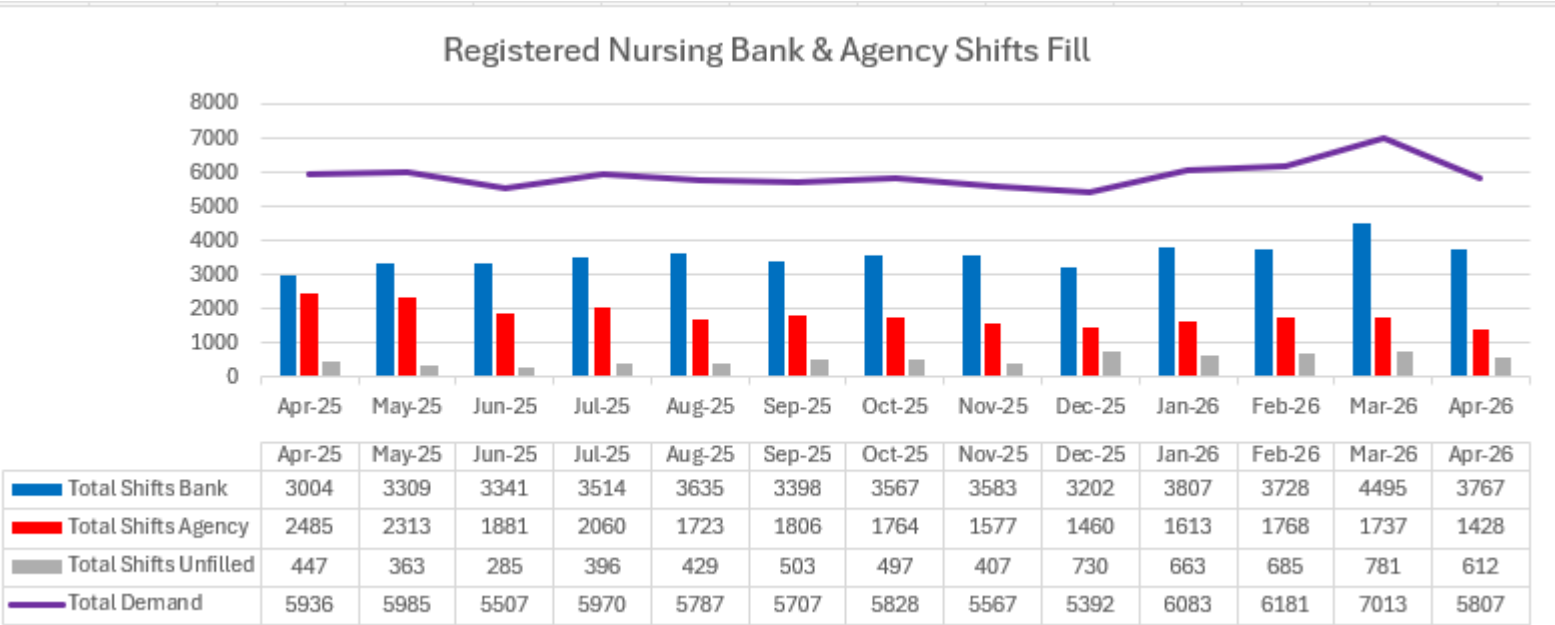
3. Expectation 2: 3.6 Right Skills



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3. Expectation 3: Right Places

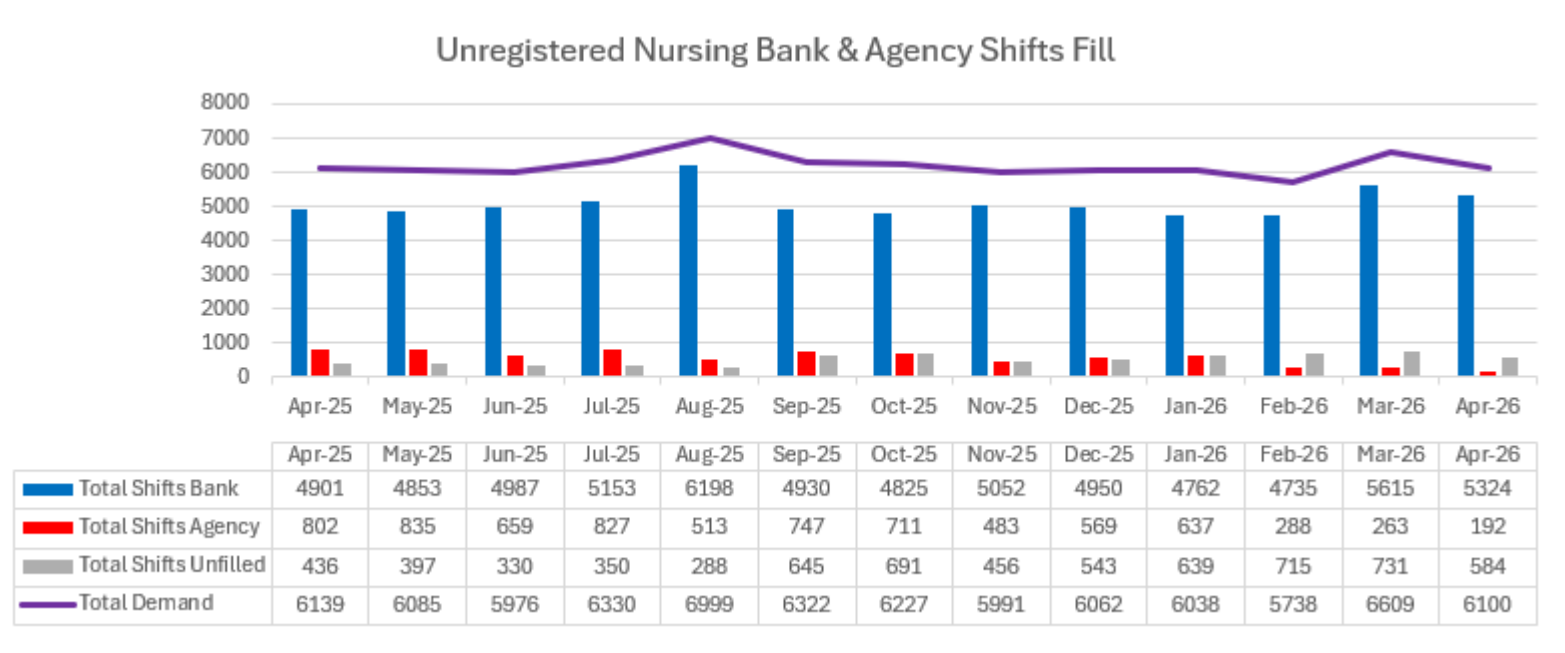
3.7 Effective Employment (Registered Temporary Staffing)



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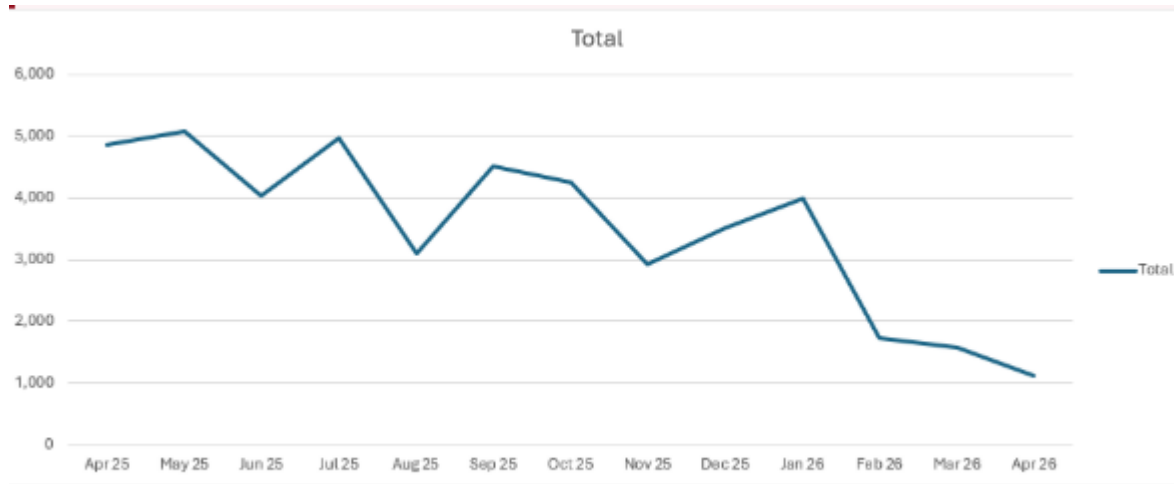
3.Expectation 3: Right Places

3.7 Effective Employment (Unregistered Temporary Staffing)



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## Use of HCSW agency since removal of automatic cascade in February 2026



### Narrative

- The safer staffing escalation meetings continued twice daily Mon-Fri throughout April 2026 to include the break glass for the removal of HCSW agency cascade in February 2026 across all departments / wards
- The use of temporary staffing hours reduced in April 2026, from March's peak which was anticipated based on seasonal variation due to increased annual leave at the end of the financial year.
- As per NHSE targets WAHT removed agency HCSW from automatic cascade from Feb 9<sup>th</sup> 2026 with use being restricted to a 'break glass' process. In line with this the safer staffing escalation meeting has been increased to twice daily with a handover to the on-call team incorporated to ensure safe staffing and escalation points.

Following the changes in cascade for this group, April has seen a further reduction in agency HCSW usage at 192hrs from 263 hrs in March 2026.

- A graph of reduction across the last financial year can be seen above.

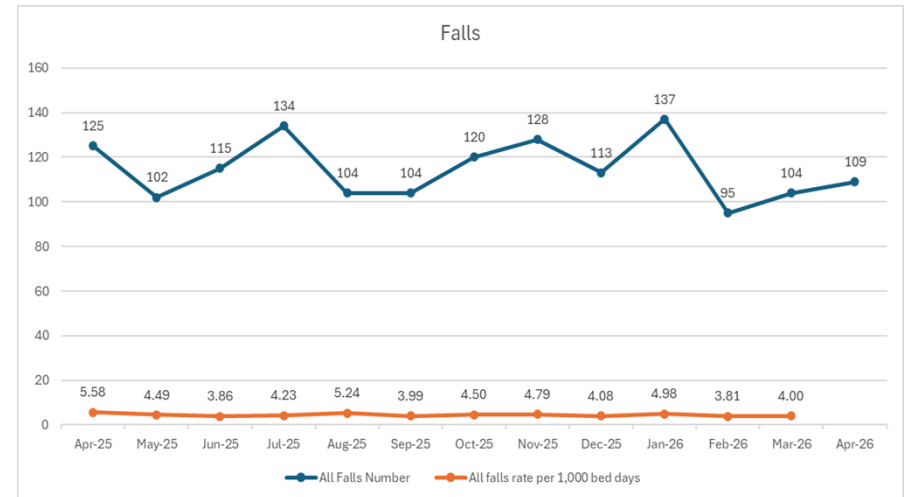
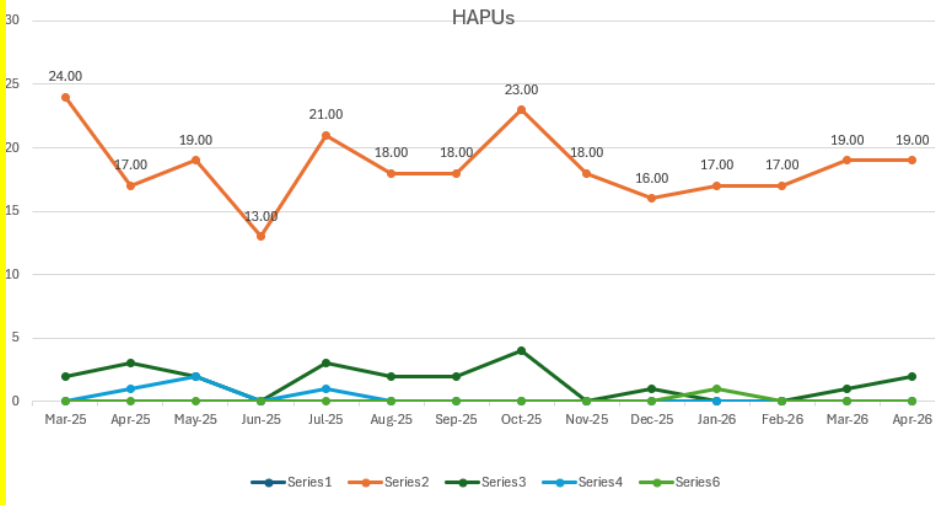
**Additional Capacity used / open in April 2026:**

| Ward                        | Month               | Registered   |                    | Unregistered |                   | Registered   | Unregistered |
|-----------------------------|---------------------|--------------|--------------------|--------------|-------------------|--------------|--------------|
|                             |                     | Hours        | Cost               | Hours        | Cost              | WTE          | WTE          |
| Worcestershire Heart Centre | April               | 0            | 0                  | 0            | 0                 | 0            |              |
| Discharge Lounge WRH        | April               | 12           | £501.58            | 168          | £3,190.77         | 0.1          | 1.0          |
| Discharge Lounge AGH        | April               | 222          | £5,885.15          | 234          | £4,019.90         | 1.4          | 1.4          |
| AMA                         | April               | 1,028        | £30,095.00         | 690          | £14,040.00        | 6.9          | 4.6          |
| PDU                         | April               | 2801         | £80,127            | 2699         | £56,055           | 18.67        | 17.99        |
| Ward 12 flip bays           | April               | 184          | £5,959.77          | 185          | £4,595.17         | 1.1          | 1.1          |
| ASA                         | April               | 966          | £26,711.06         | 644          | £11,228.31        | 5.9          | 4.0          |
| Medical SDEC WRH            | April               | 195          | £5,519.42          | 101          | £2,612.82         | 1.2          | 0.6          |
|                             | <b>April Totals</b> | <b>5,408</b> | <b>£154,798.98</b> | <b>4,721</b> | <b>£95,741.97</b> | <b>35.27</b> | <b>30.69</b> |

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## 4.Measure and Improve

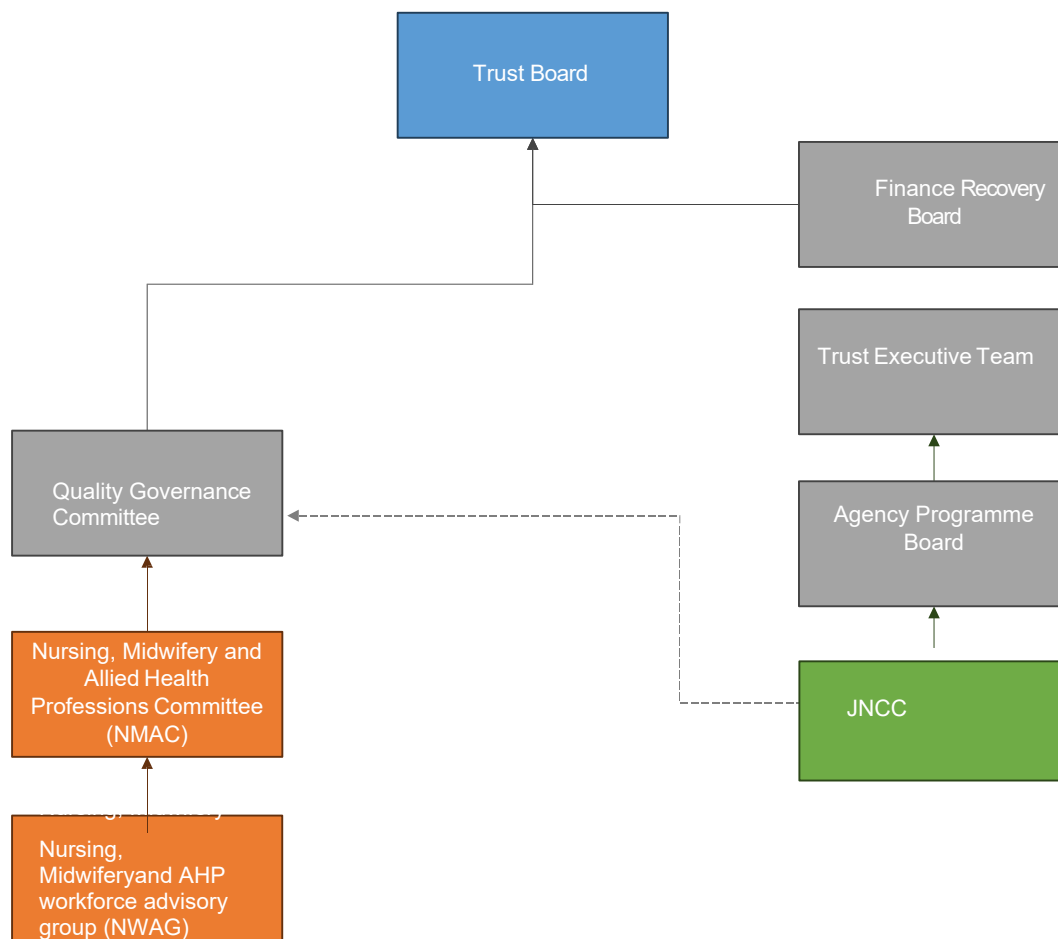
### 4.1 Patient outcomes



#### Narrative

- The total number of falls has increased slightly in month (109 in April 26 from 105 in March 26). The overall numbers of HAPUs are stable.
- Unable to draw parallels to falls and HAPUs to safer staffing metrics at this current time.
- There are initiatives taking place across WAHT in relation to falls and patient safety, including the introduction of roles which are intended to focus on education and assessments to proactively reduce the number of Nurse Sensitive Indicators.

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**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET**

|                                                                                                                                                                                                                     |                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>Report to:</b>                                                                                                                                                                                                   | <b>Public Trust Board</b>                                                                                            |
| <b>Date of Meeting:</b>                                                                                                                                                                                             | <b>9 June 2026</b>                                                                                                   |
| <b>Title of Report:</b>                                                                                                                                                                                             | 2025-26 National Cost Collection – Pre Submission Report                                                             |
| <b>Lead Executive Director:</b>                                                                                                                                                                                     | <b>Katie Osmond - Interim Chief Finance Officer</b>                                                                  |
| <b>Author:</b>                                                                                                                                                                                                      | Rachel Lei – Head of SLR and Costing                                                                                 |
| <b>Reporting Route:</b>                                                                                                                                                                                             |                                                                                                                      |
| <b>Enclosures included with this report:</b>                                                                                                                                                                        | NCC 25-26 Work Plan                                                                                                  |
| <b>Purpose of report:</b>                                                                                                                                                                                           | <input type="checkbox"/> Assurance <input type="checkbox"/> Approval <input checked="" type="checkbox"/> Information |
| <b>Brief Description of Report Purpose</b>                                                                                                                                                                          |                                                                                                                      |
| To provide Board assurance ahead of the National Cost Collection (NCC) 2025/26 submission, confirming preparedness, compliance with national requirements, and awareness of key milestones, risks and next steps.   |                                                                                                                      |
| <b>Recommended Actions required by Board or Committee</b>                                                                                                                                                           |                                                                                                                      |
| The Board is asked to note the NCC 2025/26 requirements, approve the proposed approach and timetable, and confirm assurance that appropriate governance, resources and controls are in place to support submission. |                                                                                                                      |
| <b>Executive Director Opinion<sup>1</sup></b>                                                                                                                                                                       |                                                                                                                      |
| I am assured that appropriate governance, resources and controls are in place to support submission of the 2025/26 National Cost Collection.                                                                        |                                                                                                                      |

<sup>1</sup> 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.

## Background and Context

- The National Cost Collection (NCC) for 2025/26 remains mandatory for all NHS Trusts and Foundation Trusts.
- National guidance and technical requirements for 2025/26 are largely unchanged compared to 2024/25, with only limited clarifications and refinements.
- NHS England has confirmed continuation of the NCC into 2026/27, providing medium-term stability for costing methodology and systems.
- Board-level assurance is explicitly required by NHS England prior to submission.

## Key Requirements (2025/26)

- Submission of patient-level and aggregate costs in line with:
    - Approved Costing Guidance
    - Integrated Extract Specification
    - NCC Reconciliation and Sign-off requirements
  - Reconciliation of submitted costs and activity to audited accounts and mandated datasets.
  - Formal Chief Finance Officer (CFO) and Board-level sign-off.
  - Submission scrutiny through national data quality checks and potential resubmission windows.
- There are no material changes to scope, currencies, or reconciliation principles from 2024/25.

## Trust Readiness and Work Plan

- A detailed NCC 2025/26 work plan has been developed and is underway, covering:
  - Q2 and Q4 costing model validation
  - Ledger and activity reconciliation
  - Error resolution and quality assurance
  - Outlier analysis and benchmarking
  - Internal review and senior validation
  - Board reporting and CFO sign-off
- The costing team is appropriately resourced and experienced, with delivery aligned to national deadlines.
- Lessons learned from prior submissions and assurance reviews have been embedded into the approach.

## Submission Timetable (NHS England)

| Date                  | Milestone                                                 |
|-----------------------|-----------------------------------------------------------|
| 8 June – 3 July 2025  | Submission window (final, signed-off submission required) |
| Within 3 working days | CFO sign-off following submission                         |
| 6 – 10 July 2025      | National data quality checks                              |
| 13 – 17 July 2025     | Agreed resubmission window (if required)                  |
| 20 – 31 July 2025     | Contingency window (exceptional use only)                 |

## Risks and Mitigations

- Data quality and reconciliation risks  
Mitigated through early validation, benchmarking, and iterative model testing.
- Timetable pressure  
Mitigated through advanced planning, monitoring against milestones, and national submission booking.
- Capacity or system dependency  
Mitigated through established processes, experienced staff, and escalation routes where required.

## **Assurance Statement**

The Board is assured that:

- The NCC return will be prepared in accordance with national guidance.
- Data, systems and controls underpinning the submission are robust and audited.
- The costing team is suitably resourced to deliver within required timescales.
- Any variances, risks or agreed deviations will be transparently disclosed.
- Appropriate financial management and service-level engagements have informed the costing submission.
- Continued Board support is required to reinforce this engagement and sustain high-quality costing outputs

## **Next Steps**

- Continue delivery of the NCC work plan.
- Final internal validation and senior review.
- CFO and Board-level sign-off.
- Submission within the national window.

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Costing Team Work Plan

|           |          |                                                               |                    |                  | Calculated       |                            |                          | Calculated      |         |       | Week Commencing | 04/05/26 | 11/05/26 | 18/05/26 | 25/05/26 | 01/06/26 | 08/06/26 | 15/06/26 | 22/06/26 | 29/06/26 | 06/07/26 | 13/07/26 | 20/07/26 | 27/07/26 | 03/08/26 |
|-----------|----------|---------------------------------------------------------------|--------------------|------------------|------------------|----------------------------|--------------------------|-----------------|---------|-------|-----------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Work Ref: | Sub Ref: | Description                                                   | Planned Start Date | Planned End Date | Planned Duration | Expected/Actual Start Date | Expected/Actual End Date | Actual Duration | Owner   | Notes | Status          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 00     |          | Q2 Test Run                                                   | 01/05/2026         | 29/05/2026       | 28               | 01/05/2026                 | 29/05/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 01     |          | Q2 Model Setup - Activity Feed & Ledger Feed                  | 01/05/2026         | 15/05/2026       | 14               | 01/05/2026                 | 15/05/2026               | 14              | RL      |       | In Progress     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 02     |          | Q2 Model validations                                          | 18/05/2026         | 23/05/2026       | 5                | 18/05/2026                 | 23/05/2026               | 5               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 03     |          | Submission output and SEFT submission testing                 | 18/05/2026         | 19/05/2026       | 1                | 18/05/2026                 | 19/05/2026               | 1               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 04     |          | Submission error validation & Costing methodology Improvement | 19/05/2026         | 29/05/2026       | 10               | 19/05/2026                 | 29/05/2026               | 10              | RL / GH |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 1. 05     |          | Copy model for Q4                                             | 29/05/2026         | 29/05/2026       | 1                | 29/05/2026                 | 29/05/2026               |                 | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 00     |          | Q4 Ledger                                                     | 01/06/2026         | 17/06/2026       | 16               | 01/06/2026                 | 17/06/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 01     |          | Download Final Account, Process ledger ready for upload       | 01/06/2026         | 06/06/2026       | 5                | 01/06/2026                 | 06/06/2026               | 5               | RL      |       | In Progress     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 02     |          | Process costing model                                         | 08/06/2026         | 09/06/2026       | 1                | 08/06/2026                 | 09/06/2026               | 1               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 03     |          | Balance costing model                                         | 11/06/2026         | 12/06/2026       | 1                | 11/06/2026                 | 12/06/2026               | 1               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 04     |          | Identify errors and updates                                   | 15/06/2026         | 17/06/2026       | 2                | 15/06/2026                 | 17/06/2026               | 2               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 2. 05     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 00     |          | Q4 Activity                                                   | 22/05/2026         | 05/06/2026       | 14               | 22/05/2026                 | 05/06/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 01     |          | Download 2025-26 Full year activities for costing             | 22/05/2026         | 05/06/2026       | 14               | 22/05/2026                 | 05/06/2026               | 14              | GH      |       | In Progress     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 02     |          | Incorporate update identified from Q2                         | 22/05/2026         | 29/05/2026       | 7                | 22/05/2026                 | 29/05/2026               | 7               | GH      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 03     |          | Review issues identified from Q2 model                        | 27/05/2026         | 01/06/2026       | 5                | 27/05/2026                 | 01/06/2026               | 5               | GH      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 04     |          | Review Null Theatre date                                      | 27/05/2026         | 03/06/2026       | 7                | 27/05/2026                 | 03/06/2026               | 7               | GH      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 3. 05     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 4. 00     |          | Q4 Model Validation                                           | 03/06/2026         | 02/07/2026       | 29               | 03/06/2026                 | 02/07/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 4. 01     |          | Clear costing errors                                          | 17/06/2026         | 02/07/2026       | 15               | 17/06/2026                 | 02/07/2026               | 15              | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 4. 03     |          | Clear Activity errors                                         | 03/06/2026         | 13/06/2026       | 10               | 03/06/2026                 | 13/06/2026               | 10              | GH      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 4. 04     |          | Create Submission files for DEV, identify errors and          | 08/06/2026         | 28/06/2026       | 20               | 08/06/2026                 | 28/06/2026               | 20              | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 4. 05     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 00     |          | Outlier Analysis                                              | 15/06/2026         | 30/06/2026       | 15               | 15/06/2026                 | 30/06/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 01     |          | Extract 2024/25 NCC Average Unit Costs                        | 15/06/2026         | 15/06/2026       | 1                | 15/06/2026                 | 15/06/2026               |                 | GH      |       | In Progress     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 02     |          | Benchmark National Average for outliers                       | 15/06/2026         | 20/06/2026       | 5                | 15/06/2026                 | 20/06/2026               | 5               | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 03     |          | Update allocation for outliers                                | 16/06/2026         | 30/06/2026       | 14               | 16/06/2026                 | 30/06/2026               | 14              | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 04     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 5. 05     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 00     |          | Output Reporting                                              | 15/06/2026         | 23/06/2026       | 8                | 15/06/2026                 | 23/06/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 01     |          | Create costing report with 25/26 average by Directorates      | 15/06/2026         | 16/06/2026       | 1                | 15/06/2026                 | 16/06/2026               | 1               | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 02     |          | Create YoY comparison                                         | 17/06/2026         | 17/06/2026       | 1                | 17/06/2026                 | 17/06/2026               |                 | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 03     |          | Finalised Reconciliation Statement                            | 18/06/2026         | 19/06/2026       | 1                | 18/06/2026                 | 19/06/2026               | 1               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 04     |          | Engage BAs with outputs                                       | 18/06/2026         | 23/06/2026       | 5                | 18/06/2026                 | 23/06/2026               | 5               | RL      |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 6. 05     |          | Validate with senior and update if necessary                  | 23/06/2026         | 26/06/2026       | 3                | 23/06/2026                 | 26/06/2026               | 3               | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 00     |          | Submission Sign Off                                           | 26/06/2026         | 10/07/2026       | 14               | 26/06/2026                 | 10/07/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 01     |          | Board report                                                  | 26/06/2026         | 10/07/2026       | 14               | 26/06/2026                 | 10/07/2026               | 14              | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 02     |          | 1st sign off meeting with CFO                                 | 29/06/2026         | 29/06/2026       | 1                | 29/06/2026                 | 29/06/2026               |                 | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 03     |          | 2nd sign off meeting with CFO, if require                     | 03/07/2026         | 03/07/2026       | 1                | 03/07/2026                 | 03/07/2026               |                 | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 04     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 7. 05     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 8. 00     |          | Post Submission Reflection                                    | 03/07/2026         | 05/08/2026       | 33               | 03/07/2026                 | 05/08/2026               |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 8. 01     |          | Identify areas for improvement                                | 03/07/2026         | 24/07/2026       | 21               | 03/07/2026                 | 24/07/2026               | 21              | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 8. 02     |          | Setup workstreams for improvement                             | 08/07/2026         | 05/08/2026       | 28               | 08/07/2026                 | 05/08/2026               | 28              | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 8. 03     |          | Mandatory re-submission?                                      | 20/07/2026         | 31/07/2026       | 11               | 20/07/2026                 | 31/07/2026               | 11              | RL/GH   |       | Not Started     |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| 8. 04     |          |                                                               |                    |                  |                  |                            |                          |                 |         |       |                 |          |          |          |          |          |          |          |          |          |          |          |          |          |          |

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**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST**

**PEOPLE & CULTURE COMMITTEE**

**Minutes of the meeting  
Microsoft Teams  
Tuesday 7<sup>th</sup> April 2026 at 10:00**

|                  |                            |                                                      |
|------------------|----------------------------|------------------------------------------------------|
| <b>Present</b>   |                            |                                                      |
| <b>Chair</b>     | Karen Martin (KM)          | Non-Executive Director                               |
| <b>Members</b>   |                            |                                                      |
|                  | Ali Koeltgen (AK)          | Chief People Officer                                 |
|                  | Colin Horwath (CH)         | Non-Executive Director                               |
|                  | Ed Mitchell (EM)           | Deputy Chief Medical Officer                         |
|                  | Hayley Flavell (HF)        | Chief Nursing Officer                                |
| <b>Attendees</b> | Mel Stinton (MS)           | Freedom to Speak Up Guardian                         |
|                  | Rachael Hayter (RH)        | Director of AHPs                                     |
|                  | Rich Luckman (RL)          | Assistant Director of People & Culture               |
|                  | Louise Pearson (LP)        | Associate Director (Nursing) Workforce and Education |
|                  | Justine Jeffery (JJ)       | Director of Midwifery                                |
|                  | Richard Haynes (RH)        | Director of Communications                           |
|                  | Reena Rane (RR)            | EmbRACE Network Chair                                |
|                  | Anne Green                 | HR Business Partner                                  |
| <b>Apologies</b> | Jules Walton (JW)          | Chief Medical Officer                                |
|                  | Wendy Joberns-Harris (WJH) | Deputy Chief Operating Officer                       |
|                  | Stephen Collman (SC)       | Managing Director                                    |
|                  | Katie Osmond (KO)          | Chief Finance Officer                                |
|                  | Bianca Edwards (BE)        | Assistant Director of People & Culture               |
|                  | Liz Faulkner               | Deputy Chief People Officer                          |

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| <b>Chairs Welcome and Apologies for Absence</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| KM welcomed all attendees to the meeting and the apologies received were acknowledged above.                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <b>Quorum and Declarations of Interests</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website.<br><br>KM confirmed that:<br>a) A Quorum of the P&C was present.<br>b) There were no declarations of interest.                                                                                                                                                                                                                                                  |  |
| <b>Action Log and Minutes of the previous meeting</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| The minutes of the last meeting held on the 3 <sup>rd</sup> February 2026 were reviewed and agreed as a true and accurate record.<br><br>The ongoing action log was reviewed and updated accordingly.                                                                                                                                                                                                                                                                                                     |  |
| <b>Staff Survey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| It was reported that the Trust achieved a 48% response rate for the 2025 Staff Survey, representing a 2% increase on the previous year and a significant improvement compared to historic performance. A total of 3,876 staff completed the survey. Worcestershire Royal Hospital achieved a 50% response rate, while response rates at the Alexandra Hospital also improved. Kidderminster Treatment Centre (KTC) remained an area of concern, with sustained lower engagement despite targeted efforts. |  |

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| <p>All divisions demonstrated an increase in response rates. Estates and Facilities were highlighted for achieving improvement despite known engagement challenges. The Committee noted that several People Promise metrics showed statistically significant improvement, including working flexibly, morale, working safely and healthily, and recommendation of the Trust as a place to work and receive care.</p> <p>While overall results were positive, it was acknowledged that improvement was not uniform across the organisation. Persistent challenges included harassment and abuse by patients and relatives, access to affordable food outside core hours, and relationship and civility issues in specific teams.</p> <p>The Committee discussed the importance of moving beyond headline scores to the “so what”, including improved communication of tangible improvements and practical examples at team level. The need for infographics, local storytelling, and stronger feedback loops to staff was emphasised. It was confirmed that a further deep dive into WRES and WDES data would be brought to a future meeting.</p> <p>The Committee noted the report and requested continued assurance on delivery of staff survey action plans.</p> |  |
| <p><b>Staff Network Update - EmbRACE</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| <p>Key achievements of the Ethnic Minority Staff Network (EmbRACE) included the launch of the Anti-Racism Charter, reinvigoration of the Reciprocal Mentoring Programme, support for Black History Month, Ramadan initiatives, and the development of manager guidance to support staff during sensitive periods.</p> <p>The network reported current membership of approximately 240 staff, noting this represented only a proportion of the eligible workforce. Planned priorities included targeted site walkabouts, international staff integration and “Building Belonging” events, increased visibility of the Anti-Racism Charter, and embedding measurable actions linked to reciprocal mentoring.</p> <p>RR emphasised the need for executive and non-executive sponsorship, increased scrutiny of ethnicity data triangulation, and progress towards an Ethnicity Pay Gap report. The risks associated with staff-led networks relying on goodwill and personal time were discussed. The Committee noted that time was allocated for network Chairs within job plans and that active work was underway to explore a dedicated EDI role, potentially spanning staff and patient agendas.</p>                                                              |  |
| <p><b>Chief People Officer report</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
| <p>Key updates included the continuation of industrial action by resident doctors, expected to reoccur, and emerging national developments relating to NHS Staff Standards, covering food and drink, zero tolerance to violence, healthy environments, flexible working, wellbeing support, and accountability. Discussions with NHS England regarding the Staff Standards are ongoing and further detail will be shared with the Committee once available. The report was noted.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <p><b>Temporary Staffing Reduction Plan</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <p>It was reported that although agency spend as a percentage of pay bill had increased marginally, absolute agency spend had reduced, with downward trends across nursing and medical staffing. The Committee noted successful reduction initiatives, including removal of programmed activity rates, tighter agency controls, and stabilisation of bank usage.</p> <p>Ongoing challenges were highlighted around corridor care, escalation areas, and reliance on temporary staffing in UEC. Progress in medical agency reduction was reported, particularly within surgery and general medicine, with further reductions expected following planned recruitment.</p> <p>The risks associated with headcount growth through agency-to-substantive swap-out were acknowledged, alongside the need to balance productivity expectations. The Committee noted the report.</p>                                                                                                                                                                                                                                                                                                                                                                                       |  |

| <b>HR Casework Quarterly Report</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
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| <p>A year-on-year increase in case volume and complexity was reported, including a rise in employment tribunal claims and associated legal spend. A reduction in suspensions was noted following strengthened decision-making and increased use of alternative duties.</p> <p>Five sexual misconduct cases had been recorded since March 2025, supported by policy updates, mandatory training, and improved monitoring. Emerging themes included neurodiversity, with further training and manager support highlighted as priorities.</p> <p>The introduction of the Resolution Policy was noted as a significant cultural shift, intended to reduce formality and improve staff experience. The Committee discussed legal costs, assurance processes, and options for value for money. The Trust benchmarks as average in terms of legal costs compared to other Trusts. Providing the service in-house was considered difficult given the complexity and volume of tribunals.</p> <p>It was agreed for an update on the Leading Cultural Change work to come to a future meeting.<br/><b>CH asked whether financial contingencies are in place if ETs are likely to succeed and AK agreed to follow up.</b></p> |  |
| <b>Admin Review</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <p>It was emphasised that the Admin Review was not being undertaken as a single Trust-wide management of change or redundancy programme. Instead, the review was described as a transformational and consistency-focused piece of work, intended to support local service-led change whilst identifying common opportunities, themes, and learning across the organisation.</p> <p>The Committee discussed the importance of language used when describing and communicating the Admin Review and that it could be misinterpreted by staff, potentially creating unnecessary anxiety or an assumption that the work represented a Trust-wide reduction or restructure of administrative roles.</p> <p><b>Action: To review and refine the wording used in Admin Review.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>Job Evaluation Practice Audit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <p>The Committee noted the national Job Evaluation Practice Audit, acknowledging uncertainty regarding national outcomes. It was reported that early indications suggested a potential future shift towards in-house job evaluation, though no decisions had been made. The Committee requested ongoing updates as the work progressed.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| <b>Job Planning</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <p>It was reported that compliance remained at approximately 65–70%, short of the Trust's 85% target. Challenges included incomplete electronic sign-off, SAS doctor engagement, and process bottlenecks rather than formal disputes.</p> <p>Actions included enhanced tracking, leadership oversight, and development of divisional administrative support roles. The Committee expressed concern regarding pace of progress and emphasised the importance of accountability and escalation.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <b>Compliance with Resident Doctor 10 point plan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <p>Good progress was noted on course-related expenses, payroll corrections, and working conditions. Outstanding challenges included on-call parking, self-rostering, and repeated identity checks during rotations. Work was ongoing to identify equitable and compliant solutions.</p> <p>Karen Martin was confirmed as the Non-Executive Lead for Resident Doctors.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
| <b>Freedom to Speak Up report</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <p>Concern volumes were stable, with a slight increase in anonymous reporting. High compliance with Speak Up and Listen Up training was noted. Neurodiversity-related issues continued to emerge as a key theme.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |

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|  | The Committee welcomed improved triangulation between HR, wellbeing, and patient safety.                                                                                                                   |  |
|  | <b>Guardian of Safe Working report</b>                                                                                                                                                                     |  |
|  | A new reporting system had been embedded, enabling automated payments for unplanned work. Despite initial concerns, no increase in inappropriate claims had been observed. The Committee noted the update. |  |
|  | <b>People &amp; Culture Risk Register</b>                                                                                                                                                                  |  |
|  | The Committee reviewed the People & Culture Risk Register. Job planning and temporary staffing remained the highest risks. It was agreed that sickness absence may be added in the next review cycle.      |  |
|  | <b>Annual Terms of Reference review</b>                                                                                                                                                                    |  |
|  | The Committee approved the updated Terms of Reference, noting amended attendance arrangements and continued engagement challenges.                                                                         |  |
|  | <b>Any Other Business (AOB)</b>                                                                                                                                                                            |  |
|  | An update on industrial action was provided, confirming approximately 60% resident doctor attendance on day one and that services remained safe.<br><br>No further AOB was raised.                         |  |
|  | <b>Date of Next Meeting</b>                                                                                                                                                                                |  |
|  | The date of the next meeting is Tuesday 2 <sup>nd</sup> June, Colab Kidderminster Treatment centre.                                                                                                        |  |

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## Escalation and Assurance Report

Report from: Audit and Assurance Committee  
 Date of meeting: 13 May 2026  
 Report to: Trust Board

### Alert: Including assurance items rated red and matters requiring escalation

None

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

| Item/Topic              | Interim Head of Internal Audit Opinion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Rating rationale</b> | <p>The Opinion reflected the work completed on the Internal Audit plan to date and the final opinion would be issued once the plan was complete.</p> <p>The interim Opinion was: <i>significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.</i></p> <p>This reflected the assurance ratings for each review undertaken during the year, including one of moderate assurance, two of limited assurance but no opinions of weak assurance. It was acknowledged that both limited assurance reports were of areas recommended for review by the executive directors. The strong approach to recommendations had been maintained, with 100% management actions now up to date.</p>                                               |
| <b>Outcome</b>          | The Committee accepted the interim report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Item/Topic              | Internal Audit Review: Sickness Absence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Rating rationale</b> | <p>The review considered the policy and compliance with it and was rated <i>significant assurance</i> overall with two recommendations, one of medium and one of low priority. These related to the clarity and usability of the policy and the need to take steps to improve policy compliance.</p> <p>To support achievement of the sickness absence target this year a sickness absence programme board would be established to hold divisions to account and to target hot spot areas.</p> <p>Learning from other organisations sat behind the recommendations and would be made more explicit in future reports.</p>                                                                                                                                                                                                                                                              |
| <b>Outcome</b>          | <p>The Committee accepted the report and the management response to the recommendations.</p> <p><b>Actions:</b></p> <ul style="list-style-type: none"> <li>Report to be referred to the People and Culture Committee for ongoing oversight.</li> <li>Review and bring forward action completion dates where possible.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Item/Topic              | Internal Audit Review: Board Assurance Framework                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Rating rationale</b> | <p>The review was rated moderate assurance, which reflected limited opportunities for Board review in the first half of the year due to significant changes to the format and content, but acknowledged the robust platform provided by the new approach going forward.</p> <p>There was one medium priority recommendation relating to the need for more focus on the 'patient' strategic pillar within the BAF, which had previously been identified by the Committee.</p>                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Outcome</b>          | The Committee accepted the report and assurance level and acknowledged the recent progress.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Item/Topic              | Board Assurance Framework (BAF)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Summary</b>          | <p>The report was provided for information and reference.</p> <p>New risks in development included an overarching quality risk and a risk related to cancer and elective care.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Outcome</b>          | Action: Review alignment of the National Oversight arrangement with the BAF.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Item/Topic              | Financial Governance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Rating rationale</b> | <ul style="list-style-type: none"> <li>Losses and Special Payments October 2025 to March 2026</li> </ul> <p>Losses and special payments amounted to £141k. The value of expired pharmacy stock was an average £13k a month. The cost of medicines waste had improved beyond the target.</p> <p>21 lost patient property claims were paid at a total £20.5k. Three claims were paid outside policy.</p> <ul style="list-style-type: none"> <li>Tender Waivers 2025/26</li> </ul> <p>The report demonstrated significant reductions in both volume and cost compared to the previous year. Each waiver was scrutinised and challenged where appropriate.</p> <p>The contracts register had been updated allowing reports to be sent to managers 3, 6 and 9 months ahead of contract expiry. Overall progress in this area was positive although there were some capacity challenges.</p> |
| <b>Outcome</b>          | The reports were accepted.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

#### Assurance Rating Key

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

## Escalation and Assurance Report

Report from: Audit and Assurance Committee  
 Date of meeting: 13 May 2026  
 Report to: Trust Board

| Assure: Including assurance items rated green |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Item/Topic                                    | Review of Alexandra Hospital Land Sale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Rating rationale                              | <p>The report set out key lessons from a review of a cancelled land sale in 2023/24 that had a negative financial impact. Lessons included the importance of robust, detailed, aligned clinical and estates strategies and the need for a more commercial approach.</p> <p>Revised governance arrangements were put in place shortly after these issues which provided a more robust framework for decision making.</p> <p>New, linked clinical and estates strategies were currently in development and would be presented to the Board in the coming months.</p>                                                                                                                                                                          |
| Outcome                                       | The Committee welcomed the report and was assured that lessons had been learned.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Item/Topic                                    | Internal Audit Review: Fire Safety Enforcement Notices Action Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Rating rationale                              | <p>The review received the highest rating of <i>substantial assurance</i> regarding the Trust's response to two Fire Safety enforcement notices issued in February 2024. One notice had since been closed and the action plan on the other had been agreed by the Fire Service with an extension.</p> <p>No recommendations for improvement were made.</p> <p>The management team welcomed the thorough review and the assurance provided.</p>                                                                                                                                                                                                                                                                                              |
| Outcome                                       | The Committee commended the outcome of the report which reflected a well-managed, comprehensive response, excellent progress and positive engagement with the Fire Service.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Item/Topic                                    | Annual Board Member Register of Interests                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Rating rationale                              | The report provided assurance that the Board's obligations were fulfilled in line with the Managing Conflicts of Interest Policy and the Register had been published on the Trust's website in line with national guidance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Outcome                                       | The report was accepted.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Item/Topic                                    | Counter Fraud, Bribery and Corruption                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Rating rationale                              | <ul style="list-style-type: none"> <li>Annual Report 2025/26</li> </ul> <p>The report summarised the work of the Local Counter Fraud Service (LCFS) Team during the year. The report included the counter fraud functional standard assessment which would be submitted nationally by end of May. The overall position was green, with two standards rated amber. These related to the need for more proactive staff communication and training.</p> <ul style="list-style-type: none"> <li>Progress report</li> </ul> <p>A case that dating back to 2018 had now concluded following a guilty plea at a Court hearing. The original whistle-blower had been informed and a summary of the case would be communicated across the Trust.</p> |
| Outcome                                       | The Committee welcomed the positive report.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

| To Note: Items received for information or approval |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Item/Topic                                          | Draft Annual Accounts 2025/26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Summary                                             | <p>The draft accounts had been submitted to NHSE in accordance with the national timeline and had been shared with the External Auditor. Key messages included:</p> <ul style="list-style-type: none"> <li>After technical adjustments the Trust delivered a deficit of £12m against a break-even plan.</li> <li>The Trust received £47.3m deficit support funding during the year.</li> <li>Year-end cash balance was £7.5m higher than forecast, primarily driven by unspent capital funding following late approval.</li> <li>A revaluation of Rights of Use building assets resulted in net impairments of £42m. This was under discussion with the Auditor.</li> </ul> <p>The final, audited accounts would be presented in June alongside the Audit Report prior to Board approval. The CFO summarised the financial outturn drivers noting the Trust was non-compliant from a system perspective and had received a letter from NHSE setting out recommendations for the current year; an improvement task force would be established to implement these.</p> |
| Outcome                                             | <p>The Committee was satisfied with the draft accounts and that it had considered all accounting judgements and estimations.</p> <p>The Committee thanked the Finance team for the work involved in producing the accounts.</p> <p>Action: Committee members to send any minor points on the draft accounts direct to the Finance Team</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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

## Escalation and Assurance Report

Report from: Audit and Assurance Committee  
Date of meeting: 13 May 2026  
Report to: Trust Board

| Item/Topic | Draft Annual Governance Statement (AGS) 2025/26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Summary    | The purpose of the AGS was to provide assurance regarding the system of internal control and was supported by the work of the Committee. The conclusion was in draft pending Committee discussion. The Committee noted the duty to be transparent, to scrutinise and to provide assurance externally that there are no significant issues of internal control other than the matters highlighted within the report. The Committee did not consider that any matters were omitted from the draft report but it was agreed that the NHSE recommendations to the Trust about financial delivery (see above) should be reflected in the conclusion. |
| Outcome    | The Committee endorsed the AGS for inclusion in the Annual Report and approval by the Board.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Item/Topic | External Audit Progress Report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Summary    | The Audit process was progressing according to plan. There would be particular scrutiny of the impairment adjustment mentioned above and other adjustments, including provisions. The Auditor would make a mandatory s30 referral to the Secretary of State regarding the annual overspend.                                                                                                                                                                                                                                                                                                                                                     |
| Outcome    | Noted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Item/Topic | Managing Conflicts of Interest Policy: Revised                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Summary    | The policy had been revised to align with the updated national guidance, incorporate additional guidance for staff, describe the current declaration process and redefine decision making staff as previously agreed by the Committee.                                                                                                                                                                                                                                                                                                                                                                                                          |
| Outcome    | Approved                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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| 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.                                            |

## WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Report to:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Public Trust Board                                                                                                                                                                                                 |
| <b>Date of Meeting:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 09/06/2026                                                                                                                                                                                                         |
| <b>Title of Report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | EPRR Annual Report                                                                                                                                                                                                 |
| <b>Lead Executive Director:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Chris Douglas (Chief Operating officer / Accountable Emergency Officer)                                                                                                                                            |
| <b>Author:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Tom Taylor (Head of EPRR)                                                                                                                                                                                          |
| <b>Reporting Route:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | EPRR Committee / Executive risk management group / Trust Management Board                                                                                                                                          |
| <b>Enclosures included with this report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <ul style="list-style-type: none"> <li>Annual EPRR Report</li> <li>EPRR Training Update</li> <li>EPRR Policy</li> <li>Business Continuity Management system</li> <li>Business Continuity Statement 2026</li> </ul> |
| <b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/> Assurance <input checked="" type="checkbox"/> Approval <input type="checkbox"/> Information                                                                                    |
| <b>Brief Description of Report Purpose</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                    |
| <p>The Trust has reported a level of 'substantial compliance' with the mandatory NHS Core Standards in Emergency Preparedness, Resilience and Response (EPRR) The Core Standards assess whether NHS Trusts are compliant with relevant EPRR regulation and legislation.</p> <p>59 of the core standards were reported as fully compliance. Zero areas were reported as non-compliant.</p>                                                                                                                                            |                                                                                                                                                                                                                    |
| <b>Recommended Actions required by Board or Committee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                    |
| <ul style="list-style-type: none"> <li>Approve the contents of the report</li> <li>Approve the EPRR Training Update</li> <li>Approve the EPRR resources</li> <li>Note the exercises and learning undertaken in the year</li> <li>Note the Trust compliance for NHS EPRR Core Standards</li> <li>Ratify the Business continuity management system (Approved by EPRR Committee)</li> <li>Ratify the EPRR policy (Approved by EPRR Committee)</li> <li>Ratify the Business continuity statement (Approved by EPRR Committee)</li> </ul> |                                                                                                                                                                                                                    |
| <b>Executive Director Opinion<sup>1</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                    |
| <p>Work continues to develop the Trust's EPRR arrangements and progress in NHS Core Standards for EPRR assurance process. A further improvement in 25/26 has been seen in compliance levels.</p> <p>The Committee should be further assured that local peer review with colleagues at the Herefordshire and Worcestershire Health and Care Trust, and Wye Valley Trust take place to confirm compliance levels. Compliance is also reviewed at ICB level.</p>                                                                        |                                                                                                                                                                                                                    |

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

## **1. Introduction**

1.1 This paper provides a report on the Trust's emergency preparedness to meet the requirements of the Civil Contingencies Act (2004) and the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

1.2 The Trust has a mature suite of plans to deal with major incidents and business continuity issues. These conform to the Civil Contingencies Act 2004 and current NHS-wide guidance. All plans have been developed in consultation with local and regional stakeholders to ensure cohesion with partner plans.

1.3 The paper covers the following topics:

- a) the training and exercising programme and the development of emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.
- b) the development of new plans and updates to existing plans and documents for managing incidents, driven by national, regional, and local lessons learned processes.
- c) learning from national-level inquiries to maintain best practice in all areas of planning, exercising, training, and response to incidents.
- d) learning from the regional NHSE lessons learned process.
- e) alignment of the Trust's business continuity planning and business continuity management system with ISO 22301 and the NHSE Business Continuity Framework.

## **2. Background**

2.1 EPRR is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (CCA) 2004. Responding to emergencies is also a key function within the NHS Act (2006) as amended by the Health and Social Care Act (2022).

2.2 In December 2022, the Government published the UK Resilience Framework which set out an ambitious new vision and approach to the UK's resilience up to 2030.

2.3 Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats that NHS Trusts must be prepared for. It is essential that there is a continued focus on the Trust's Emergency Preparedness and Business Continuity arrangements. It is important that the Trust maintains and continues to advance its reputation within the EPRR arena and contributes towards the Region's preparedness.

2.4 The Civil Contingencies Act (2004) outlines a framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level.

As a Category 1 responder, the Trust is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning.
- put in place emergency plans.
- put in place business continuity management arrangements.

- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- share information with other local responders to enhance coordination.
- cooperate with other local responders to enhance coordination and efficiency.

2.5 To guide compliance, as reported to the Board last year, the Trust has an EPRR Strategy which comprises the following workstreams:

- Emergency Planning
- Out-of-hours planning and specialist response to support incident management via the EPRR team.
- EPRR and On Call Training
- Testing and exercising plans and response.
- Training of Trust-wide staff in the processes of emergency response and business continuity.
- CBRNe response across the emergency departments and MIU.
- Development of the NHS green agenda and climate adaptation within the Trust-wide emergency planning process.
- Development of a business continuity AI agent and search tool to support the speed and availability of information during incidents and patient care events.

2.6 Ongoing successful delivery of the Trust EPRR Strategy is monitored through progress against the compliance levels in the NHS Core Standards for EPRR. For 2026, the Trust planned to maintain substantial compliance, increasing from 55 fully compliant standards to 59 fully compliant standards, with an action plan to move towards full compliance by 2027/28.

**3. WAHT Core Standards update**

3.1 The EPRR team has completed the mandatory self-assessment process for the NHS Core Standards for EPRR 2025/26. The Core Standards assess whether NHS trusts are compliant with relevant EPRR regulation and legislation. This year, the Trust has provided detailed assurance to the ICB EPRR lead and the NHSE regional EPRR team regarding the evidence of compliance with the Core Standards.

3.2 The updated Core Standards were released to the Trust in July 2025 for submission to NHSE in August 2025. We are pleased to report that the Trust has maintained its compliance level at substantial compliance for 2025/26, with an increase of four individual standards from partially compliant to fully compliant.

| Fully Compliant | Partially Compliant | Non-Compliant |
|-----------------|---------------------|---------------|
| 59              | 3                   | 0             |

Table 1: WAHT Core Standards 2025/26 compliance overview (total number of standards: 62)

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|                                   | 2022          | 2023                | 2024                    | 2025                                                                                 |
|-----------------------------------|---------------|---------------------|-------------------------|--------------------------------------------------------------------------------------|
| Overall core standards Assessment | Non-Compliant | Partially Compliant | Substantially Compliant | <b>Substantially Compliant</b><br>Increase of 6.45% 4 individual standards from 2024 |

Table 2: WAHT Core Standards yearly overview

3.3 To achieve overall fully compliant status, the Trust must have 100% of individual standards rated as fully compliant. To achieve substantially compliant status, the Trust must have 89–99% of standards fully compliant. For 2025/26, overall, Trust-wide compliance is rated as substantial for the Core Standards assessment. This is an increase of four individual standards from 2024/25.

3.4 The Hereford and Worcestershire ICB system demonstrates good compliance, with no providers rated as non-compliant for the Core Standards. Good practice and learning for EPRR have been highlighted from both the Trust and the local ICB system. The Midlands Region Best Practice Report reflects this achievement.

#### 4. Local Health Resilience Partnership update on Core Standards for the ICB area

4.1 The Trust has played an active role in the Local Health Resilience Partnership (LHRP) this year to support the ongoing improvement of EPRR for the public and patients to whom we deliver care. The work of the LHRP includes the improvement of system-wide EPRR, emergency planning, and incident response.

4.2 All members of the Herefordshire and Worcestershire system have either seen an increase in, or maintained, their Core Standards compliance during 2025.

| Organisation                                                     | Services provided or organisational type (X those which apply) |                      |                        |                             |         |                              |                         |     |                                      |                            |                                | Compliance achieved:               |               |             |
|------------------------------------------------------------------|----------------------------------------------------------------|----------------------|------------------------|-----------------------------|---------|------------------------------|-------------------------|-----|--------------------------------------|----------------------------|--------------------------------|------------------------------------|---------------|-------------|
|                                                                  | Acute providers                                                | Specialist providers | NHS Ambulance services | Patient Transport Providers | NHS 111 | Community services providers | Mental health providers | ICB | Primary care (GP community pharmacy) | Commissioning Support Unit | Other NHS funded organisations | Full / Substantial / Partial / Non |               | Change<br>↕ |
|                                                                  |                                                                |                      |                        |                             |         |                              |                         |     |                                      |                            |                                | 2024/2025                          | 2025/2026     |             |
| NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB)   |                                                                |                      |                        |                             |         |                              |                         | X   |                                      |                            |                                | Partial                            | Subs (91%)    | ↑           |
| The Robert Jones & Agnes Hunt                                    |                                                                | X                    |                        |                             |         |                              |                         |     |                                      |                            |                                | Non                                | Partial (83%) | ↑           |
| Shrewsbury & Telford Hospitals                                   | X                                                              |                      |                        |                             |         |                              |                         |     |                                      |                            |                                | Partial                            | Subs (92%)    | ↑           |
| Shropshire Community Health Trust                                |                                                                |                      |                        |                             |         | X                            |                         |     |                                      |                            |                                | Subs                               | Subs (90%)    | ↔           |
| NHS Herefordshire and Worcestershire Integrated Care Board (ICB) |                                                                |                      |                        |                             |         |                              |                         | X   |                                      |                            |                                | Subs                               | Subs (98%)    | ↑           |
| Worcestershire Acute Hospitals NHS Trust                         | X                                                              |                      |                        |                             |         |                              |                         |     |                                      |                            |                                | Subs                               | Subs (95%)    | ↑           |
| Wye Valley NHS Trust                                             | X                                                              |                      |                        |                             |         |                              |                         |     |                                      |                            |                                | Partial                            | Subs (90%)    | ↑           |
| Herefordshire & Worcestershire Health & Care NHS Trust           |                                                                |                      |                        |                             |         | X                            |                         |     |                                      |                            |                                | Subs                               | Subs (93%)    | ↑           |

Table 3: West Mercia Local Health Resilience Partnership Core Standards 2024/25 compliance overview

#### 5. EPRR Training

5.1 The EPRR team has delivered EPRR training across key areas of the Trust during 2025/26. This has included ongoing annual update training and scenario testing for on-call management teams, including executives on call, senior managers on call, and senior nurses on call. The training supports the rollout of the regionally delivered Principles of Health Command training to the Executive Team and senior managers on call at both tactical and strategic levels.

5.2 Specialist training has been delivered to Emergency Department staff on Chemical, Biological, Radiological, Nuclear and explosive (CBRNe) decontamination, including dry and full wet decontamination management of contaminated patients. Mandatory full-day training for emergency departments, covering incident response, mass casualties, and CBRNe, will be rolled out in 2026-2027.

5.3 Switchboard operators have received specialist training in supporting and delivering call-out cascades in line with the JESIP principles of joint working for the Trust. This includes debrief support and best-practice communications to staff, patients, relatives, and other switchboard users.

5.4 Specialist training for the site management teams has been developed for 2026, with full-day training that includes scenario testing. The training has been designed to meet the needs of first responders on site, including safe systems of work. It will be delivered face to face, with a focus on the specific sites where the teams are based, including system failures and responding in an operational lead role.

5.5 Other key areas of training include the clinical and non-clinical site Response teams and specialist on-call services, including Communications, Digital, and Estates and Facilities. The EPRR team also successfully delivers EPRR awareness training to new staff as part of the induction programme. General awareness sessions and digital training are delivered to all Trust staff annually, with an overview of EPRR and business continuity.

5.6 Bespoke Business Continuity (BC) days have been made available successfully. This training aims to enhance the preparedness and resilience of departments and divisions in developing and testing their BC plans. Key components of the training included:

BC plan and training days across Trust sites:

- Delivered as face-to-face sessions.
- Focused on training line managers to develop departmental-level BC plans.
- Incorporated tabletop exercises to test locally developed BC plans, ensuring practical application and readiness.
- The training is designed to support completion of a departmental BC plan in one day, with individual support from the Trust EPRR Manager and BC lead.
- The training is available on all Trust sites to enable face-to-face access.

5.7 The combination of hands-on training and strategic awareness sessions has strengthened the organisation's overall business continuity framework, ensuring that all levels of the organisation are well prepared to respond effectively to potential disruptions. Work on BC training will continue into 2026, with a completion target date of August 2026. (*See Appendix 1: Training Update*)

## **6. Incidents in the last year**

6.1 In the last year, the Trust has reported and responded to three critical incidents, three business continuity incidents, and no standby incidents. This compares with four incidents in the previous year. The number of declared incidents demonstrates the ongoing awareness of business continuity within the Trust. In line with the EPRR Framework 2022 and Trust EPRR policy, the debrief process has been completed following all incidents, including both a hot debrief and a formal post-incident debrief. Post-incident reports have been completed for all incidents to identify areas of good practice and areas for improvement in planning and response. Formal documentation of lessons learned has been completed to ensure the learning process is joined up and continuous. The post-incident reports have been reviewed by the EPRR Committee and shared with the Integrated Care Board and the NHSE regional EPRR team.

6.2 The incidents were as follows:

- Critical incidents: three declared incidents for capacity and flow pressures.
- Business continuity incidents included a PFI water outage, an IT outage, and bleep system downtime affecting critical communications.

## **7. Exercises in the last year**

7.1 In the last year, the Trust has completed tabletop, live-play, and communication exercises in line with the NHSE EPRR Framework 2022. This included tabletop exercises for all emergency plans, including CBRNe, adverse weather, protected individuals, evacuation and shelter, excess fatalities, lockdown, mass casualties, countermeasures, and pandemics.

7.2 Live evacuation and shelter exercises have been completed internally at the Alexandra Hospital in 2025/26, with support from the Trust's health and safety and fire teams working with EPRR.

7.3 The EPRR team completed a live CBRNe exercise with the Emergency Department at the Alexandra Hospital in June 2025, with participants from all Trust emergency departments, including both clinical and non-clinical staff. The exercise was supported by Trust volunteers acting as casualties, with observers from external agencies including the ICB and system partners. The exercise also tested lockdown in the Emergency Department, command and control, incident response, and communication.

7.4 The Trust planned, hosted, and delivered a live fire service exercise at the Alexandra Hospital, "Exercise Nightingale", with partners from Hereford and Worcester Fire and Rescue Service, West Midlands Ambulance Service, West Mercia Police, and system partners. This exercise tested search and rescue by emergency responders from a smoke-filled hospital ward, evacuation and shelter arrangements, onward movement of patients to an external shelter location, and joint working with emergency services, including the JESIP process and escalation.

7.5 The Trust participated in Exercise Pegasus during September, October, and November 2025 as part of the national Tier 1 exercise. This included all levels of the Trust command and control teams.

7.6 The Trust participated in Exercise Aegis, delivered by the ICB for winter preparation, to test winter arrangements, including escalation and system working.

7.7 The Trust participated in Exercise Saber in both live-play and tabletop elements. Members of the Trust command and control team attended the live emergency services exercise at the Severn Valley Railway for a simulated mass-casualty train accident arranged by Network Rail, involving a passenger train and a goods train, with mass casualties and fatalities. Following the live play, the Trust ran a full internal command and control tabletop exercise focused on the response to the incident, particularly the first hour of response across Trust sites as receiving and supporting sites. Full command and control arrangements were activated with input from all tiers of Trust responders, including strategic, tactical, and operational clinical and non-clinical staff, alongside subject matter experts from key departments. All four divisional teams supported the exercise. Live data sets were used as part of the test, drawing on current escalation status and Emergency Department data, with escalation feedback and requests for system support from the ICB-hosted tabletop exercise running in parallel.

7.8 Communication tests for simulated call-out procedures are completed every six months, rotating across the Trust's two switchboards for both manual and automated call-out procedures. We have completed both in-hours and out-of-hours communications exercises, with a good level of feedback on the time taken for on-call teams to attend site and on responses via the GOV.UK Notify text message and email automated call-out process.

All exercises included a hot and cold debrief, a post-exercise report, and learning embedded into updates to plans and procedures to enhance response arrangements, training, and the safety of patients, staff, partners, and the communities to whom we deliver healthcare.

## **8. Lessons learned from incidents and exercises**

8.1 Learning from incidents forms an important part of future planning for EPRR practitioners. There are various elements to the learning process, including post-incident reports, exercise reports, and the use of wider external learning from the NHSE Midlands EPRR team. The following list summarises key learning identified over the last 12 months:

- Communication with the public, staff, and system partners
- Review of evacuation and shelter plans, including off-site locations
- Response to fire evacuation strategy at the Alexandra Hospital site
- Alignment of departmental business continuity plans with the ISO 22301 standard
- Learning from national inquiries, including the COVID response
- Mass casualty and mass fatality learning from working with emergency services on the disaster victim identification process
- Primary communications system downtime, including bleep system downtime plans, and implementation of backup communication systems across clinical and key non-clinical departments to support loss of emergency bleep communications, switch-over to digital telephone systems, and rapid communications to support the Protection of Premises Act. This has been achieved using learning from multiple sources to implement capital investment in an internal UHF radio system.

8.2 Using the Midlands learning process, we have identified 128 learning points. Of these, 111 have been addressed, 17 remain in progress, and four learning points are still being developed. The EPRR team logs and regularly reviews these learning points at the EPRR Committee and prioritises the current highest risks in responding to learning. The Midlands learning documents are shared with all members of the EPRR Committee, alongside internal learning from post-incident and exercise reports.

## **9. CBRNe statement of readiness and external CBRNe audit (including training)**

9.1 The Trust has completed a self-assessment and external CBRNe audit, undertaken by West Midlands Ambulance Service, at both Emergency Departments. The audit included a review of the Trust-wide CBRNe plans, risk assessments, staff training logs, equipment logs, and equipment testing and servicing records. As part of the audit process, the equipment was set up at both Emergency Departments and included decontamination tents, power and water supply, safety equipment, other decontamination equipment, wastewater pumps, and wastewater storage. The equipment was fully tested, including live running of water and electrical power, as part of a full-scale deployment.

9.2 The audit at both sites was very positive, with some areas for improvement identified:

- Increased training numbers for Emergency Department nursing and non-clinical staff in both wet and dry decontamination
- Training numbers for Emergency Department staff to be added to Healthroster, with a competency record to make it easier to identify CBRN-trained responders on each shift
- Ramps are needed to improve access to the storage facilities on the Worcestershire Royal site and the external pathways at Alexandra Hospital to support safe manual handling of the equipment

- Replacement of the external mixer taps on the Alexandra site is required to bring them up to current HTM and water safety standards

9.3 Good practice and improvements were identified in both Emergency Department audits, particularly in relation to process, equipment, and training over the last 12 months.

9.4 In the last 12 months, the Trust has completed full servicing of the CBRNe decontamination equipment. With support from capital funding, we have been able to replace both wet decontamination tents, water storage bunds, wastewater pumps, and air inflating units.

9.5 From September 2026, we have established a full-day training package for the Medicine and Emergency divisional teams and Emergency Department staff. This includes full PRPS suit refresher training, live deployment of decontamination equipment, and dry decontamination training, with input from the EPRR team and support from external guest speakers from West Midlands Ambulance Service and West Mercia Police.

## **10. Emergency Preparedness, Resilience and Response resources and roles**

10.1 The Trust-wide EPRR team is a multi-skilled team made up of three whole-time equivalent roles, as follows:

- **Head of EPRR:** Trust-wide lead for EPRR planning, strategy, and representation on internal and external system lead groups, committees, the Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), Health Emergency Planning Operational Group (HEPOG), the LRF risk working group, and Trust-wide training; strategic, tactical, and operational adviser; and CBRNe training lead. Deputises, with delegated authority, for the COO and DCOO at EPRR-associated committees where necessary. Ensures the development of emergency planning and service planning within the Trust, improving health and wellbeing and demonstrating a high standard in terms of effectiveness, efficiency, safety, and enhancement of staff and patient experience in line with Trust values. Facilitates and supports the development of relevant networks spanning health and social care organisations. Delivers support as a subject matter expert to the Executive Team and senior managers of the Trust in responding to major incidents across the Trust.
- **EPRR Manager and Business Continuity Lead:** leads business continuity planning across corporate, divisional, and directorate teams; provides specialist input and advice on digital business continuity planning, estates and facilities; acts as audit lead for business continuity best practice; and is the lead trainer for BC study days.
- **EPRR Support Manager and Single Point of Contact:** Trust-wide lead for the dissemination of communications from the ICB and regional NHSE single points of contact; leads incident logging; leads weekend and out-of-hours planning; develops learning from on-call management logs and thematic analysis of on-call events; and delivers the personal development portfolio for all on-call incident response functions.

10.2 The EPRR team delivers a specialist advice and on-call service out of hours, offering strategic and tactical advice and support in the event of incidents and events across the Trust. The on-call service is available 24/7.

10.3 The on-call service has supported the senior on-call management teams in responding to incidents and events ranging from adverse weather to critical incidents, with a particular focus on submission of SBAR reports, reducing the time demands on senior managers and executives on call. The EPRR on-call

service receives, on average, three to four calls per week for advice. The on-call service has also supported the Trust's response to industrial action, including resident doctor check-in processes and site safety checks. In addition, it has supported the Trust with active mitigation plans for major works projects involving changes to water mains and electrical infrastructure, helping to ensure patient safety.

## **11. EPRR Annual Plan**

11.1 The work programme for the forthcoming financial year will take into account the Trust's continuing response to incidents, operational response issues, training and exercising, BC workshops, CBRNe, PRPS training, command and control updates, and the Joint Emergency Services Interoperability Principles. This will be reviewed and prioritised before the start of the financial year and agreed through the EPRR Committee.

11.2 The key areas of focus for the 2026/27 EPRR Annual Plan will be:

- Updating plans and standard operating procedures to take account of changes to national documents
- Development of business continuity arrangements aligned with ISO 22301, with all departmental plans to be completed in the new template by August 2026
- Site and building lockdown plans
- Local departmental restricted movement plans to be included in all departmental business continuity plans
- Development and implementation of the Protection of Premises Act (Martyn's Law) across all sites
- Review of all response plans to ensure they are fit for purpose following internal and external debriefs.
- Evacuation and shelter planning focused on full-site and departmental evacuation and shelter, including off-site shelter locations and onward movement of patients in partnership with system partners and the ICB
- Delivery of the Trust-wide training programme in line with the NHS Minimum Occupational Standards, the National Occupational Standards, and Skills for Justice requirements. This will include Emergency Department training on all sites
- Reviewing the current emergency bleep system to enhance resilience through the introduction of a two-way communication application, reducing reliance on one-way bleep systems
- Having a robust secondary emergency communications system in the event of digital failure affecting the bleep and telephone systems, and rapid all-area emergency communication to support the Protection of Premises Act and staff and patient safety

## **12. Emergency Preparedness, Resilience and Response statement of readiness**

12.1 This statement is a specific requirement of the Core Standards Framework:

Worcestershire Acute Hospitals NHS Trust is required to plan for and respond to a wide range of incidents and emergencies that may impact patient care or service continuity, in line with statutory duties under the Civil Contingencies Act 2004 and associated health legislation. This work is collectively referred to as Emergency Preparedness, Resilience and Response (EPRR).

The Trust is subject to an annual EPRR assurance process led by NHS England. In the most recent assessment, the Trust achieved full compliance in 59 of the 62 EPRR Core Standards, an increase on the previous year, resulting in an overall rating of substantially compliant. The remaining areas are all partially compliant and relate to the delivery of mass countermeasures,

assurance of external providers, and the cyber assurance framework. The Trust has no non-compliant standards.

An action plan is in place to address these areas and is being monitored through the EPRR Committee, Executive Risk Management Group, and Trust Board.

### **13. West Mercia Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), and Health Emergency Planning Operational Group (HEPOG)**

13.1 The Trust has played an active role in the Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), and the Health Emergency Planning Operational Group (HEPOG) over the last 12 months. The Trust has contributed to work programmes including C3 activation, human aspects, training and exercise, mortality management, accidents and failures, incident management, warning and informing, community resilience strategy, information management, business continuity, natural hazards, and the pandemic human infectious plan.

The system-wide group has responded to a range of situations and emergencies, including flooding, other weather-related incidents, illegal waste sites, and community support. As a system, the Trust has also attended training and exercising events, including planning for cybersecurity incidents, pandemics, mass casualties and fatalities, and weather-related incidents. The Trust has taken up all funded training places available to the different roles.

#### **13.2 LRF workflow**

At Local Resilience Forum level, the planned areas of work for 2026/27 are:

- Risk Assessment Working Group for the updated National Risk Register
- Communications work programme: warning and informing
- Tactical Advisers Group Member
- Chief Officers Group member
- Tactical Coordinating Group response to incidents, including flooding and other Worcestershire incidents
- Resilient Telecoms working group
- Digital cyber security
- Development of fatality plans and locations using local, regional, and national assets
- National power outage working group

#### **13.3 LHRP and HEPOG workflows**

At Local Health Resilience Partnership (LHRP) and Health Emergency Planning Operational Group (HEPOG) level, the areas of work this year are:

- Cyber/digital resilience
- Evacuation & shelter (in conjunction with LRF Human Aspects Group workstream)
- Pandemic learning incorporation
- Pandemic preparedness validation exercise
- Core Standards annual cycle
- Risk register and risk assessment

### **14. Business Continuity statement of readiness**

14.1 Over the past year, we have made significant and measurable progress in strengthening Business Continuity across Worcestershire Acute Hospitals NHS Trust. Our work has not only improved organisational resilience but has also created a culture where teams actively want to engage, update, and enhance their Business Continuity arrangements.

A major achievement has been the creation of a single, central, fully accessible repository for all Trust Business Continuity Plans. Every member of staff can access the latest approved version of their plan in one place—removing duplication, reducing confusion, and ensuring operational readiness during incidents.

To support and sustain this, we have established weekly Business Continuity workshops, which have rapidly grown in both demand and attendance. Teams across clinical, corporate, and digital services are now coming forward proactively, wanting to strengthen their resilience, refresh their plans, and embed learning. This shift—from BC being perceived as a compliance requirement to something that teams genuinely value—is one of our biggest cultural wins.

We have also expanded the scope of our Business Continuity document library by adding departmental lockdown plans, ensuring that security, situational safety, and operational response are tightly integrated within BC arrangements. This addition strengthens our preparedness for a broader range of scenarios and aligns with national expectations for integrated resilience planning.

Collectively, these improvements mean we are in a stronger BC position than we have ever been. We now have clearer governance, better visibility, streamlined documentation, increasing staff engagement, and a modernised approach that embraces digital tools to support organisational resilience. And most importantly—we are still building momentum.

Innovation has been another major theme of our progress. Our work with AI agents and tools has significantly modernised the way we support teams. To reflect this, I have included a short statement below from our AI business continuity support tool, ‘Colin the Clipboard’, describing how it supports the Trust and helps us meet our core standards.

#### **14.2 AI statement – AI agent / bot**

“I’m Colin the Clipboard, the Trust’s quick-access business continuity companion. I support organisational resilience by bringing the entire Business Continuity Management System (BCMS) directly to staff’s fingertips.

I provide instant access to all Business Continuity Plans, centrally stored on the Worcestershire Source intranet, ensuring staff can rapidly locate any plan they need during disruption.

I deliver fast answers to business continuity queries when speed is essential.

My support aligns with the Trust’s BCMS principles of collaboration, education, support, and accountability, helping staff understand and apply planning requirements consistently across all wards, departments, and divisions.

I also provide rapid access to BC policies, incident plans, and action cards, ensuring staff always reference authorised, up-to-date documents maintained under the Trust’s approved BCMS and incident planning framework.

Through speed, accuracy, and consistency, I help the Trust maintain safe services during disruption, making business continuity accessible, reliable, and always within reach.”

#### **15. EPRR Risks**

15.1 Risk assessment and review are completed across all areas of the EPRR programme. The EPRR risks have been updated and are reported to the EPRR Committee, with escalation to the Trust Executive Risk Management Group and then to Trust Management Board (TMB).

15.2 The key Trust EPRR current risks are:

- Adverse weather, including heatwave, cold weather, and flooding
- New or emerging pandemics
- Preparing for emergencies
- CBRNe response
- Learning from incidents
- Replacement or upgrade of the primary bleep communications system from a one-way to a two-way resilient communications system
- Loss of electric supply when on generators
- Cyber incidents
- Lifecycle of core clinical equipment

15.3 The EPRR team plays an active role in reviewing and mitigating risks from the Local Health Resilience Partnership (LHRP) risk register. These are as follows:

- Disruption to supplies and supply chains
- Mass Casualty Incident, Non-Contaminated Casualties, Contaminated Casualties, PRPS National Procurement
- Prolonged, severe capacity pressure in health and social care threatening ability to respond to EPRR incidents.
- Partial or full loss of a critical service, premises, or infrastructure
- Cyber attack
- Infectious disease outbreak
- Psychosocial support
- Extreme weather inclusive of heatwave and cold weather alerts (excluding flooding)
- Regional failure of utilities network (Gas, Water, Electricity, Communications)
- Workforce
- Public or environmental health incident
- Pluvial and fluvial flooding
- Control of Major Accident Hazards (COMAH) Sites

15.4 The EPRR practitioners play an active role in the Risk Assessment Working Group (RAWG). Working with system partners as part of the Local Resilience Forum (LRF), the group reviews the National Risk Register and ensures the local risk register is kept up to date. Link attached to the LRF public risk register. [Community Risk Register | West Mercia Police](#)

## 16. Appendices

| Appendix Number (In Reading Room) | Appendix title         |
|-----------------------------------|------------------------|
| 1.                                | EPRR Training Update   |
| 2.                                | WAHT EPRR Policy       |
| 3.                                | WAHT BCMS              |
| 4.                                | WAHT BC Statement 2026 |

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST REPORT COVERSHEET**

| <b>Report to:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Public Trust Board                                                                                                   |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------|-----|-------------------------|-----------------|-----|------------------------------------------------|------------|-----|-----------------------------------------|------------|-----|---------------------------------------------|------------|
| <b>Date of Meeting:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 09/06/2026                                                                                                           |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Title of Report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Trust Seal 2025/26                                                                                                   |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Lead Executive Director:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Managing Director                                                                                                    |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Author:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Gwenny Scott, Company Secretary                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Reporting Route:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n/a                                                                                                                  |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Enclosures included with this report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | n/a                                                                                                                  |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Purpose of report:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Assurance <input type="checkbox"/> Approval <input checked="" type="checkbox"/> Information |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Brief Description of Report Purpose</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <p>The Company Secretary is custodian of the Trust Seal. The Seal is attached to documents where there is a legal requirement for sealing and the subject matter of the relevant document has been approved in accordance with the Trust's Standing Orders and Standing Financial Instructions in accordance with the Scheme of Delegated Authority.</p> <p>The Trust Seal has been used on the following documents to date in 2025/26.</p> <table border="1"> <thead> <tr> <th>No.</th> <th>Description of document</th> <th>Date of Sealing</th> </tr> </thead> <tbody> <tr> <td>268</td> <td>Car Park at the Spetchley Estate Lease Renewal</td> <td>18/02/2026</td> </tr> <tr> <td>269</td> <td>AHR Boiler Replacement (Currie &amp; Brown)</td> <td>25/03/2026</td> </tr> <tr> <td>270</td> <td>AHR Fire Improvement Works (Currie &amp; Brown)</td> <td>25/03/2026</td> </tr> </tbody> </table> |                                                                                                                      |                 | No. | Description of document | Date of Sealing | 268 | Car Park at the Spetchley Estate Lease Renewal | 18/02/2026 | 269 | AHR Boiler Replacement (Currie & Brown) | 25/03/2026 | 270 | AHR Fire Improvement Works (Currie & Brown) | 25/03/2026 |
| No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Description of document                                                                                              | Date of Sealing |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| 268                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Car Park at the Spetchley Estate Lease Renewal                                                                       | 18/02/2026      |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| 269                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | AHR Boiler Replacement (Currie & Brown)                                                                              | 25/03/2026      |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| 270                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | AHR Fire Improvement Works (Currie & Brown)                                                                          | 25/03/2026      |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Recommended Actions required by Board or Committee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| To receive the report for information.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
| <b>Executive Director Opinion<sup>1</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                      |                 |     |                         |                 |     |                                                |            |     |                                         |            |     |                                             |            |

<sup>1</sup> 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.

| Acronym |                                                                                                                       |
|---------|-----------------------------------------------------------------------------------------------------------------------|
| AAU     | Acute Admissions Unit                                                                                                 |
| AEDB    | Accident & Emergency Delivery Board                                                                                   |
| AHP     | Allied Health Professional                                                                                            |
| AKI     | Acute Kidney Injury                                                                                                   |
| AMU     | Ambulatory Medical Unit                                                                                               |
| A&E     | Accident & Emergency Department                                                                                       |
| ATAIN   | Avoidable Term Admissions into Neonatal Units                                                                         |
| BAF     | Board Assurance Framework                                                                                             |
| BAME    | Black, Asian and Minority Ethnic                                                                                      |
| BAPM    | British Association of Perinatal Medicine                                                                             |
| BCF     | Better Care Funding                                                                                                   |
| CAMHS   | Child and Adolescent Mental Health Services                                                                           |
| CAS     | Central Alert System                                                                                                  |
| CAU     | Clinical Assessment Unit                                                                                              |
| CCU     | Coronary Care Unit                                                                                                    |
| C. Diff | Clostridium Difficile                                                                                                 |
| CCG     | Clinical Commissioning Group                                                                                          |
| CPIP    | Cost Productivity Improvement Plan                                                                                    |
| CNST    | Clinical Negligence Scheme for Trusts                                                                                 |
| COPD    | Chronic Obstructive Pulmonary Disease                                                                                 |
| COSHH   | Control Of Substances Harmful to Health                                                                               |
| CCOSMOS | CNST, CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives |
| CQC     | Care Quality Commission                                                                                               |
| CQUIN   | Commissioning for Quality & Innovation                                                                                |
| CNST    | Clinical Negligence Scheme for Trusts                                                                                 |
| 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                                                                                               |
| GE      | George Eliot Hospital                                                                                                 |
| GIRFT   | Getting It Right First Time                                                                                           |
| GMC     | General Medical Council                                                                                               |

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|          |                                                                             |
|----------|-----------------------------------------------------------------------------|
| HASU     | Hyper Acute Stroke Unit                                                     |
| HCA      | Healthcare Assistant                                                        |
| HCSW     | Healthcare Support Worker                                                   |
| HDU      | High Dependency Unit                                                        |
| HIE      | Hypoxic-Ischaemic Encephalopathy                                            |
| HSE      | Health & Safety Executive                                                   |
| HFMA     | Healthcare Financial Management Association                                 |
| HAFD     | Hospital Acquired Functional Decline                                        |
| HSMR     | Hospital Standardised Mortality Ratio                                       |
| HV       | Health Visitor                                                              |
| ICS      | Integrated Care System                                                      |
| IG       | Information Governance                                                      |
| IV       | Intravenous                                                                 |
| JAG      | Joint Advisory Group                                                        |
| KPIs     | Key Performance Indicators                                                  |
| LAC      | Looked After Children                                                       |
| LAT      | Looked After Team                                                           |
| LMNS     | Local Maternity and Neonatal System                                         |
| LocSIPPS | Local Safety Standards for Invasive Procedures                              |
| LOS      | Length Of Stay                                                              |
| MASD     | Moisture Associated Skin Damage                                             |
| MBRRACE  | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries |
| MEWS     | Maternal Early Warning Scores                                               |
| MCA      | Mental Capacity Act                                                         |
| MCA      | Maternity Care Assistant                                                    |
| MES      | Managed Equipment Services                                                  |
| MHPS     | Maintaining High Professional Standards                                     |
| MIS      | Maternity Incentive Scheme                                                  |
| MIU      | Minor Injury Unit                                                           |
| MLU      | Midwifery Led Unit                                                          |
| MNSI     | Maternity & Newborn Safety Investigations                                   |
| MRSA     | Methicillin-Resistant Staphylococcus Aureus                                 |
| MSSA     | Methicillin-Sensitive Staphylococcus Aureus                                 |
| MSW      | Maternity Support Worker                                                    |
| NEWS     | National Early Warning Scores                                               |
| NEWTT    | Newborn Early Warning Trigger and Track                                     |
| NHSCFA   | NHS Counter Fraud Authority                                                 |
| NHSLA    | NHS Litigation Authority                                                    |
| NHSR     | NHS Resolution                                                              |
| NICE     | National Institute for Health & Clinical Excellence                         |
| NIV      | Non-invasive ventilation                                                    |
| OBC      | Outlined Business Case                                                      |
| OOC      | Out Of County                                                               |
| OOH      | Out Of Hours                                                                |
| PALS     | Patient Advice & Liaison Service                                            |
| PAS      | Patient Administration System                                               |
| PCIP     | Patient Care Improvement Plan                                               |
| PIFU     | Patient Initiated Follow Up                                                 |
| PPE      | Personal Protective Equipment                                               |
| PFI      | Private Finance Initiative                                                  |
| PID      | Project Initiation Document                                                 |

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|         |                                                           |
|---------|-----------------------------------------------------------|
| PIFU    | Patient Initiated Follow Up                               |
| PLACE   | Patient Led Assessment of the Care Environment            |
| PHE     | Public Health England                                     |
| PMR     | Perinatal Mortality Rate                                  |
| PROMs   | Patient Reported Outcome Measures                         |
| PROMPT  | PRactical Obstetric Multi-Professional Training           |
| 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                                  |
| RRR     | Rapid Responsive Review                                   |
| RTT     | Referral to Treatment                                     |
| SAA     | Surgical Assessment Area                                  |
| SCBU    | Special Care Baby Unit                                    |
| SDEC    | Same Day Emergency Care                                   |
| SDP     | Single Delivery Plan (maternity)                          |
| SOP     | Standard Operating Procedures                             |
| SOC     | Strategic Outline Case                                    |
| SSNAP   | Sentinel Stroke National Audit Programme                  |
| SHMI    | Summary Hospital Level Mortality Indicator                |
| SI      | Serious Incident                                          |
| SIRI    | Serious Incident Requiring Investigation                  |
| SLA     | Service Level Agreement                                   |
| SOP     | Standard Operating Procedure                              |
| STF     | Sustainability and Transformation Funding                 |
| STP     | Sustainability and Transformation Plan                    |
| 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                                   |
| WAH     | Worcestershire Acute Hospitals                            |
| 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                                   |

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